By the Committees on Judiciary; and Health Regulation; and Senator Gardiner

590-05775-09 20092286c2

1 A bill to be entitled
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. 400.471, F.S.;
13 prohibiting the Agency for Health Care Administration
14 from renewing a license of a home health agency in
15 certain counties if the agency has been sanctioned for
16 certain misconduct; amending s. 400.474, F.S.;
17 authorizing the Agency for Health Care Administration
18 to deny, revoke, or suspend the license of or fine a
19 home health agency that provides remuneration to
20 certain facilities or bills the Medicaid program for
21 medically unnecessary services; providing that certain
22 administrative penalties do not apply to or preclude
23 certain discounts, compensations, waivers of payment,
24 or payment practices; amending s. 400.506, F.S.;
25 exempting certain items from a prohibition against
26 providing remuneration to certain persons by a nurse
27 registry; creating s. 408.8065, F.S.; providing
28 additional licensure requirements for home health
29 agencies, home medical equipment providers, and health

30 care clinics; imposing criminal penalties against a
31 person who knowingly submits misleading information to
32 the Agency for Health Care Administration in
33 connection with applications for certain licenses;
34 amending s. 408.810, F.S.; revising provisions
35 relating to information required for licensure;
36 requiring certain licensees to provide clients with a
37 description of Medicaid fraud and the statewide toll-
38 free telephone number for the central Medicaid fraud
39 hotline; amending s. 408.815, F.S.; providing
40 additional grounds to deny an application for a
41 license; amending s. 409.905, F.S.; authorizing the
42 Agency for Health Care Administration to require prior
43 authorization of care based on utilization rates;
44 requiring a home health agency to submit a plan of
45 care and documentation of a recipient's medical
46 condition to the Agency for Health Care Administration
47 when requesting prior authorization; prohibiting the
48 Agency for Health Care Administration from paying for
49 home health services unless specified requirements are
50 satisfied; amending s. 409.907, F.S.; providing for
51 certain out-of-state providers to enroll as Medicaid
52 providers; amending s. 409.912, F.S.; requiring the
53 Agency for Health Care Administration to establish
54 norms for the utilization of Medicaid services;
55 requiring the agency to submit a report relating to
56 the overutilization of Medicaid services; amending s.
57 409.913, F.S.; requiring that the annual report
58 submitted by the Agency for Health Care Administration

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59 and the Medicaid Fraud Control Unit of the Department
60 of Legal Affairs recommend changes necessary to
61 prevent and detect Medicaid fraud; requiring the
62 Agency for Health Care Administration to monitor
63 patterns of overutilization of Medicaid services;
64 requiring the agency to deny payment or require
65 repayment for Medicaid services under certain
66 circumstances; requiring the Agency for Health Care
67 Administration to immediately terminate a Medicaid
68 provider’s participation in the Medicaid program as a
69 result of certain adjudications against the provider
70 or certain affiliated persons; requiring the Agency
71 for Health Care Administration to suspend or terminate
72 a Medicaid provider’s participation in the Medicaid
73 program if the provider or certain affiliated persons
74 participating in the Medicaid program have been
75 suspended or terminated by the Federal Government or
76 another state; providing that a provider is subject to
77 sanctions for violations of law as the result of
78 actions or inactions of the provider or certain
79 affiliated persons; requiring the Agency for Health
80 Care Administration to use specified documents from a
81 provider’s records to calculate an overpayment by the
82 Medicaid program; prohibiting a provider from using
83 certain documents or data as evidence when challenging
84 a claim of overpayment by the Agency for Health Care
85 Administration; providing an exception; requiring that
86 the agency provide notice of certain administrative
87 sanctions to other regulatory agencies within a

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88 specified period; requiring the Agency for Health Care
89 Administration to withhold or deny Medicaid payments
90 under certain circumstances; requiring the agency to
91 terminate a provider’s participation in the Medicaid
92 program if the provider fails to repay certain
93 overpayments from the Medicaid program; requiring the
94 agency to provide at least annually information on
95 Medicaid fraud in an explanation of benefits letter;
96 requiring the Agency for Health Care Administration to
97 post a list on its website of Medicaid providers and
98 affiliated persons of providers who have been
99 terminated or sanctioned; requiring the agency to take
100 certain actions to improve the prevention and
101 detection of health care fraud through the use of
102 technology; amending s. 409.920, F.S.; defining the
103 term “managed care plan”; providing criminal penalties
104 and fines for Medicaid fraud; granting civil immunity
105 to certain persons who report suspected Medicaid
106 fraud; creating s. 409.9203, F.S.; authorizing the
107 payment of rewards to persons who report and provide
108 information relating to Medicaid fraud; amending s.
109 456.004, F.S.; requiring the Department of Health to
110 work cooperatively with the Agency for Health Care
111 Administration and the judicial system to recover
112 overpayments by the Medicaid program; amending s.
113 456.041, F.S.; requiring the Department of Health to
114 include a statement in the practitioner profile if a
115 practitioner has been terminated from participating in
116 the Medicaid program; creating s. 456.0635, F.S.;

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117 prohibiting Medicaid fraud in the practice of health
118 care professions; requiring the Department of Health
119 or boards within the department to refuse to admit to
120 exams and to deny licenses, permits, or certificates
121 to certain persons who have engaged in certain acts;
122 requiring health care practitioners to report
123 allegations of Medicaid fraud; specifying that
124 acceptance of the relinquishment of a license in
125 anticipation of charges relating to Medicaid fraud
126 constitutes permanent revocation of a license;
127 amending s. 456.072, F.S.; creating additional grounds
128 for the Department of Health to take disciplinary
129 action against certain applicants or licensees for
130 misconduct relating to a Medicaid program or to health
131 care fraud; amending s. 456.074, F.S.; requiring the
132 Department of Health to issue an emergency order
133 suspending the license of a person who engages in
134 certain criminal conduct relating to the Medicaid
135 program; amending s. 465.022, F.S.; authorizing
136 partnerships and corporations to obtain pharmacy
137 permits; requiring applicants or certain persons
138 affiliated with an applicant for a pharmacy permit to
139 submit a set of fingerprints for a criminal history
140 records check and pay the costs of the criminal
141 history records check; requiring the Department of
142 Health or Board of Pharmacy to deny an application for
143 a pharmacy permit for certain misconduct by the
144 applicant; or persons affiliated with the applicant;
145 amending s. 465.023, F.S.; authorizing the Department

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146 of Health or the Board of Pharmacy to take
147 disciplinary action against a permitee for certain
148 misconduct by the permitee, or persons affiliated with
149 the permitee; amending s. 825.103, F.S.; redefining
150 the term "exploitation of an elderly person or
151 disabled adult"; amending s. 921.0022, F.S.; revising
152 the severity level ranking of Medicaid fraud under the
153 Criminal Punishment Code; creating a pilot project to
154 monitor and verify the delivery of home health
155 services and provide for electronic claims for home
156 health services; requiring the Agency for Health Care
157 Administration to issue a report evaluating the pilot
158 project; creating a pilot project for home health care
159 management in Miami-Dade County; amending ss. 400.0077
160 and 430.608, F.S.; conforming cross-references to
161 changes made by the act; repealing s. 395.0199, F.S.,
162 relating to private utilization review of health care
163 services; amending ss. 395.405 and 400.0712, F.S.;
164 conforming cross-references; repealing s. 400.118(2),
165 F.S.; removing provisions requiring quality-of-care
166 monitors for nursing facilities in agency district
167 offices; amending s. 400.141, F.S.; deleting a
168 requirement that licensed nursing home facilities
169 provide the agency with a monthly report on the number
170 of vacant beds in the facility; conforming a cross-
171 reference; amending s. 400.147, F.S.; revising the
172 definition of the term "adverse incident" for
173 reporting purposes; requiring abuse, neglect, and
174 exploitation to be reported to the agency and the

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175 Department of Children and Family Services; deleting a
176 requirement that the agency submit an annual report on
177 nursing home adverse incidents to the Legislature;
178 amending s. 400.162, F.S.; revising requirements for
179 policies and procedures regarding the safekeeping of a
180 resident’s personal effects and property; amending s.
181 400.191; F.S.; revising the information on the
182 agency’s Internet site regarding nursing homes;
183 deleting the provision that requires the agency to
184 provide information about nursing homes in printed
185 form; amending s. 400.195, F.S.; conforming a cross-
186 reference; amending s. 400.23, F.S.; deleting the
187 requirement of the agency to adopt rules regarding the
188 eating assistance provided to residents; amending s.
189 400.9905, F.S.; revising the definition of the term
190 “clinic” as it relates to the Health Care Clinic Act;
191 excluding certain entities from the definition and
192 from licensure requirements of the act; amending s.
193 400.9935, F.S.; revising accreditation requirements
194 for clinics providing magnetic resonance imaging
195 services; amending s. 400.995, F.S.; revising agency
196 responsibilities with respect to agency administrative
197 penalties; amending s. 408.803, F.S.; revising
198 definitions applicable to part II of ch. 408, F.S.,
199 the “Health Care Licensing Procedures Act”; amending
200 s. 408.806, F.S.; revising contents of and procedures
201 relating to health care provider applications for
202 licensure; providing an exception from certain
203 licensure inspections for adult family-care homes;

204 authorizing the agency to provide electronic access to
205 certain information and documents; amending s.
206 408.808, F.S.; providing for a provisional license to
207 be issued to applicants applying for a change of
208 ownership; providing a time limit on provisional
209 licenses; amending s. 408.809, F.S.; revising
210 provisions relating to background screening of
211 specified employees; requiring health care providers
212 to submit to the agency an affidavit of compliance
213 with background screening requirements at the time of
214 license renewal; deleting a provision to conform to
215 changes made by the act; amending s. 408.811, F.S.;
216 providing for certain inspections to be accepted in
217 lieu of complete licensure inspections; granting
218 agency access to records requested during an offsite
219 review; providing timeframes for correction of certain
220 deficiencies and submission of plans to correct the
221 deficiencies; amending s. 408.813, F.S.; providing
222 classifications of violations of part II of ch. 408,
223 F.S.; providing for fines; amending s. 408.820, F.S.;
224 revising applicability of certain exemptions from
225 specified requirements of part II of ch. 408, F.S.;
226 creating s. 408.821, F.S.; requiring entities
227 regulated or licensed by the agency to designate a
228 liaison officer for emergency operations; authorizing
229 entities regulated or licensed by the agency to
230 temporarily exceed their licensed capacity to act as
231 receiving providers under specified circumstances;
232 providing requirements that apply while such entities

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233 are in an overcapacity status; providing for issuance
234 of an inactive license to such licensees under
235 specified conditions; providing requirements and
236 procedures with respect to the issuance and
237 reactivation of an inactive license; authorizing the
238 agency to adopt rules; amending s. 408.831, F.S.;
239 deleting provisions relating to the authorization for
240 entities regulated or licensed by the agency to exceed
241 their licensed capacity to act as receiving facilities
242 and issuance and reactivation of inactive licenses;
243 amending s. 408.918, F.S.; revising the requirements
244 of a provider to participate in the Florida 211
245 network; requiring the Public Service Commission to
246 request the Federal Communications Commission to
247 direct the revocation of a 211 number under certain
248 circumstances; deleting the requirement for the Agency
249 for Health Care Administration to seek assistance in
250 resolving jurisdictional disputes related to 211
251 numbers; providing that the Florida Alliance of
252 Information and Referral Services is the collaborative
253 organization for the state; amending s. 409.221, F.S.;
254 conforming a cross-reference; amending s. 409.901,
255 F.S.; redefining the term “change of ownership” as it
256 relates to Medicaid providers; repealing s. 429.071,
257 F.S., relating to the intergenerational respite care
258 assisted living facility pilot program; amending s.
259 429.08, F.S.; authorizing the agency to provide
260 information regarding licensed assisted living
261 facilities on its Internet website; abolishing local

262 coordinating workgroups established by agency field
263 offices; amending s. 429.14, F.S.; conforming a
264 reference; amending s. 429.19, F.S.; revising agency
265 procedures for imposition of fines for violations of
266 part I of ch. 429, F.S., the "Assisted Living
267 Facilities Act"; amending s. 429.23, F.S.; redefining
268 the term "adverse incident" for reporting purposes;
269 requiring abuse, neglect, and exploitation to be
270 reported to the agency and the Department of Children
271 and Family Services; deleting a requirement that the
272 agency submit an annual report on assisted living
273 facility adverse incidents to the Legislature;
274 repealing s. 429.26(9), F.S., relating to the removal
275 of the requirement for a resident of an assisted
276 living facility to undergo examinations and
277 evaluations under certain circumstances; amending s.
278 430.80, F.S.; revising the term "teaching nursing
279 home" as it relates to the implementation of a
280 teaching nursing home pilot project; revising the
281 requirements to be designated as a teaching nursing
282 home; conforming a cross-reference; amending ss.
283 435.04 and 435.05, F.S.; requiring employers of
284 certain employees to submit an affidavit of compliance
285 with level 2 screening requirements at the time of
286 license renewal; amending s. 483.031, F.S.; revising a
287 provision relating to the exemption of certain
288 clinical laboratories, to conform to changes made by
289 the act; amending s. 483.041, F.S.; redefining the
290 term "waived test" as it is used in part I of ch. 483,

291 F.S., the "Florida Clinical Laboratory Law"; repealing
292 s. 483.106, F.S., relating to applications for
293 certificates of exemption by clinical laboratories
294 that perform certain tests; amending ss. 483.172,
295 F.S.; conforming provisions; amending s. 627.4239,
296 F.S.; revising the term "standard reference
297 compendium"; amending s. 651.105, F.S.; revising the
298 time period in which the Office of Insurance
299 Regulation is required to examine the business of an
300 applicant for a certificate of authority and a
301 provider engaged in the execution of continuing care
302 contracts; amending s. 651.118, F.S.; conforming a
303 cross-reference; providing an effective date.
304
305 Be It Enacted by the Legislature of the State of Florida:
306
307 Section 1. The Legislature finds that:
308 (1) Immediate and proactive measures are necessary to
309 prevent, reduce, and mitigate health care fraud, waste, and
310 abuse and are essential to maintaining the integrity and
311 financial viability of health care delivery systems, including
312 those funded in whole or in part by the Medicare and Medicaid
313 trust funds. Without these measures, health care delivery
314 systems in this state will be depleted of necessary funds to
315 deliver patient care, and taxpayers' dollars will be devalued
316 and not used for their intended purposes.
317 (2) Sufficient justification exists for increased oversight
318 of health care clinics, home health agencies, providers of home
319 medical equipment, and other health care providers throughout

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320 the state, and in particular, in Miami-Dade County.
321 (3) The state's best interest is served by deterring health
322 care fraud, abuse, and waste and identifying patterns of
323 fraudulent or abusive Medicare and Medicaid activity early,
324 especially in high-risk localities, such as Miami-Dade County,
325 in order to prevent inappropriate expenditures of public funds
326 and harm to the state's residents.
327 (4) The Legislature designates Miami-Dade County as a
328 health care fraud crisis area for purposes of implementing
329 increased scrutiny of home health agencies, home medical
330 equipment providers, health care clinics, and other health care
331 providers in Miami-Dade County in order to assist the state's
332 efforts to prevent Medicaid fraud, waste, and abuse in the
333 county and throughout the state.
334 Section 2. Section 68.085, Florida Statutes, is amended to
335 read:
336 68.085 Awards to plaintiffs bringing action.—
337 (1) If the department proceeds with and prevails in an
338 action brought by a person under this act, except as provided in
339 subsection (2), the court shall order the distribution to the
340 person of at least 15 percent but not more than 25 percent of
341 the proceeds recovered under any judgment obtained by the
342 department in an action under s. 68.082 or of the proceeds of
343 any settlement of the claim, depending upon the extent to which
344 the person substantially contributed to the prosecution of the
345 action.
346 (2) If the department proceeds with an action which the
347 court finds to be based primarily on disclosures of specific
348 information, other than that provided by the person bringing the

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349 action, relating to allegations or transactions in a criminal,
350 civil, or administrative hearing; a legislative, administrative,
351 inspector general, or auditor general report, hearing, audit, or
352 investigation; or from the news media, the court may award such
353 sums as it considers appropriate, but in no case more than 10
354 percent of the proceeds recovered under a judgment or received
355 in settlement of a claim under this act, taking into account the
356 significance of the information and the role of the person
357 bringing the action in advancing the case to litigation.
358 (3) If the department does not proceed with an action under
359 this section, the person bringing the action or settling the
360 claim shall receive an amount which the court decides is
361 reasonable for collecting the civil penalty and damages. The
362 amount shall be not less than 25 percent and not more than 30
363 percent of the proceeds recovered under a judgment rendered in
364 an action under this act or in settlement of a claim under this
365 act.
366 (4) Following any distributions under subsection (1),
367 subsection (2), or subsection (3), the agency injured by the
368 submission of a false or fraudulent claim shall be awarded an
369 amount not to exceed its compensatory damages. If the action was
370 based on a claim of funds from the state Medicaid program, 10
371 percent of any remaining proceeds shall be deposited into the
372 Legal Affairs Revolving Trust Fund to fund rewards for persons
373 who report and provide information relating to Medicaid fraud
374 pursuant to s. 409.9203. Any remaining proceeds, including civil
375 penalties awarded under s. 68.082, shall be deposited in the
376 General Revenue Fund.
377 (5) Any payment under this section to the person bringing

378 the action shall be paid only out of the proceeds recovered from
379 the defendant.
380 (6) Whether or not the department proceeds with the action,
381 if the court finds that the action was brought by a person who
382 planned and initiated the violation of s. 68.082 upon which the
383 action was brought, the court may, to the extent the court
384 considers appropriate, reduce the share of the proceeds of the
385 action which the person would otherwise receive under this
386 section, taking into account the role of the person in advancing
387 the case to litigation and any relevant circumstances pertaining
388 to the violation. If the person bringing the action is convicted
389 of criminal conduct arising from his or her role in the
390 violation of s. 68.082, the person shall be dismissed from the
391 civil action and shall not receive any share of the proceeds of
392 the action. Such dismissal shall not prejudice the right of the
393 department to continue the action.
394 Section 3. Section 68.086, Florida Statutes, is amended to
395 read:
396 68.086 Expenses; attorney’s fees and costs.—
397 (1) If the department initiates an action under this act or
398 assumes control of an action brought by a person under this act,
399 the department shall be awarded its reasonable attorney’s fees,
400 expenses, and costs.
401 (2) If the court awards the person bringing the action
402 proceeds under this act, the person shall also be awarded an
403 amount for reasonable attorney’s fees and costs. Payment for
404 reasonable attorney’s fees and costs shall be made from the
405 recovered proceeds before the distribution of any award.
406 (3) If the department does not proceed with an action under

407 this act and the person bringing the action conducts the action
408 ~~defendant is the prevailing party~~, the court may ~~shall~~ award to
409 the defendant its reasonable attorney's fees and costs if the
410 defendant prevails in the action and the court finds that the
411 claim of ~~against~~ the person bringing the action was clearly
412 frivolous, clearly vexatious, or brought primarily for purposes
413 of harassment.
414 (4) No liability shall be incurred by the state government,
415 the affected agency, or the department for any expenses,
416 attorney's fees, or other costs incurred by any person in
417 bringing or defending an action under this act.
418 Section 4. Subsection (10) is added to section 400.471,
419 Florida Statutes, to read:
420 400.471 Application for license; fee.—
421 (10) The agency may not issue a renewal license for a home
422 health agency in any county having at least one licensed home
423 health agency and that has more than one home health agency per
424 5,000 persons, as indicated by the most recent population
425 estimates published by the Legislature's Office of Economic and
426 Demographic Research, if the applicant or any controlling
427 interest has been administratively sanctioned by the agency
428 since the last licensure renewal application for one or more of
429 the following acts:
430 (a) An intentional or negligent act that materially affects
431 the health or safety of a client of the provider;
432 (b) Knowingly providing home health services in an
433 unlicensed assisted living facility or unlicensed adult family-
434 care home, unless the home health agency or employee reports the
435 unlicensed facility or home to the agency within 72 hours after

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436 providing the services;
437 (c) Preparing or maintaining fraudulent patient records,
438 such as, but not limited to, charting ahead, recording vital
439 signs or symptoms which were not personally obtained or observed
440 by the home health agency's staff at the time indicated,
441 borrowing patients or patient records from other home health
442 agencies to pass a survey or inspection, or falsifying
443 signatures;
444 (d) Failing to provide at least one service directly to a
445 patient for a period of 60 days;
446 (e) Demonstrating a pattern of falsifying documents
447 relating to the training of home health aides or certified
448 nursing assistants or demonstrating a pattern of falsifying
449 health statements for staff who provide direct care to patients.
450 A pattern may be demonstrated by a showing of at least three
451 fraudulent entries or documents;
452 (f) Demonstrating a pattern of billing any payor for
453 services not provided. A pattern may be demonstrated by a
454 showing of at least three billings for services not provided
455 within a 12-month period;
456 (g) Demonstrating a pattern of failing to provide a service
457 specified in the home health agency's written agreement with a
458 patient or the patient's legal representative, or the plan of
459 care for that patient, unless a reduction in service is mandated
460 by Medicare, Medicaid, or a state program or as provided in s.
461 400.492(3). A pattern may be demonstrated by a showing of at
462 least three incidents, regardless of the patient or service, in
463 which the home health agency did not provide a service specified
464 in a written agreement or plan of care during a 3-month period;

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465 (h) Giving remuneration to a case manager, discharge
466 planner, facility-based staff member, or third-party vendor who
467 is involved in the discharge planning process of a facility
468 licensed under chapter 395, chapter 429, or this chapter from
469 whom the home health agency receives referrals or gives
470 remuneration as prohibited in s. 400.474(6)(a);
471 (i) Giving cash, or its equivalent, to a Medicare or
472 Medicaid beneficiary;
473 (j) Demonstrating a pattern of billing the Medicaid program
474 for services to Medicaid recipients which are medically
475 unnecessary. A pattern may be demonstrated by a showing of at
476 least two fraudulent entries or documents;
477 (k) Providing services to residents in an assisted living
478 facility for which the home health agency does not receive fair
479 market value remuneration; or
480 (l) Providing staffing to an assisted living facility for
481 which the home health agency does not receive fair market value
482 remuneration.
483 Section 5. Subsection (6) of section 400.474, Florida
484 Statutes, is amended to read:
485 400.474 Administrative penalties.—
486 (6) The agency may deny, revoke, or suspend the license of
487 a home health agency and shall impose a fine of $5,000 against a
488 home health agency that:
489 (a) Gives remuneration for staffing services to:
490 1. Another home health agency with which it has formal or
491 informal patient-referral transactions or arrangements; or
492 2. A health services pool with which it has formal or
493 informal patient-referral transactions or arrangements,

494

495 unless the home health agency has activated its comprehensive
496 emergency management plan in accordance with s. 400.492. This
497 paragraph does not apply to a Medicare-certified home health
498 agency that provides fair market value remuneration for staffing
499 services to a non-Medicare-certified home health agency that is
500 part of a continuing care facility licensed under chapter 651
501 for providing services to its own residents if each resident
502 receiving home health services pursuant to this arrangement
503 attests in writing that he or she made a decision without
504 influence from staff of the facility to select, from a list of
505 Medicare-certified home health agencies provided by the
506 facility, that Medicare-certified home health agency to provide
507 the services.
508 (b) Provides services to residents in an assisted living
509 facility for which the home health agency does not receive fair
510 market value remuneration.
511 (c) Provides staffing to an assisted living facility for
512 which the home health agency does not receive fair market value
513 remuneration.
514 (d) Fails to provide the agency, upon request, with copies
515 of all contracts with assisted living facilities which were
516 executed within 5 years before the request.
517 (e) Gives remuneration to a case manager, discharge
518 planner, facility-based staff member, or third-party vendor who
519 is involved in the discharge planning process of a facility
520 licensed under chapter 395, chapter 429, or this chapter from
521 whom the home health agency receives referrals.
522 (f) Fails to submit to the agency, within 15 days after the

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523 end of each calendar quarter, a written report that includes the
524 following data based on data as it existed on the last day of
525 the quarter:
526 1. The number of insulin-dependent diabetic patients
527 receiving insulin-injection services from the home health
528 agency;
529 2. The number of patients receiving both home health
530 services from the home health agency and hospice services;
531 3. The number of patients receiving home health services
532 from that home health agency; and
533 4. The names and license numbers of nurses whose primary
534 job responsibility is to provide home health services to
535 patients and who received remuneration from the home health
536 agency in excess of $25,000 during the calendar quarter.
537 (g) Gives cash, or its equivalent, to a Medicare or
538 Medicaid beneficiary.
539 (h) Has more than one medical director contract in effect
540 at one time or more than one medical director contract and one
541 contract with a physician-specialist whose services are mandated
542 for the home health agency in order to qualify to participate in
543 a federal or state health care program at one time.
544 (i) Gives remuneration to a physician without a medical
545 director contract being in effect. The contract must:
546 1. Be in writing and signed by both parties;
547 2. Provide for remuneration that is at fair market value
548 for an hourly rate, which must be supported by invoices
549 submitted by the medical director describing the work performed,
550 the dates on which that work was performed, and the duration of
551 that work; and

552 3. Be for a term of at least 1 year.
553
554 The hourly rate specified in the contract may not be increased
555 during the term of the contract. The home health agency may not
556 execute a subsequent contract with that physician which has an
557 increased hourly rate and covers any portion of the term that
558 was in the original contract.
559 (j) Gives remuneration to:
560 1. A physician, and the home health agency is in violation
561 of paragraph (h) or paragraph (i);
562 2. A member of the physician's office staff; or
563 3. An immediate family member of the physician,
564
565 if the home health agency has received a patient referral in the
566 preceding 12 months from that physician or physician's office
567 staff.
568 (k) Fails to provide to the agency, upon request, copies of
569 all contracts with a medical director which were executed within
570 5 years before the request.
571 (l) Demonstrates a pattern of billing the Medicaid program
572 for services to Medicaid recipients which are medically
573 unnecessary. A pattern may be demonstrated by a showing of at
574 least two medically unnecessary services.
575
576 Nothing in paragraph (e) or paragraph (j) shall be interpreted
577 as applying to or precluding any discount, compensation, waiver
578 of payment, or payment practice permitted by 52 U.S.C. s. 1320a-
579 7b(b) or regulations adopted thereunder, including 42 C.F.R. s.
580 1001.952, or by 42 U.S.C. s. 1395nn or regulations adopted

581 thereunder.

582 Section 6. Paragraph (a) of subsection (15) of section
583 400.506, Florida Statutes, is amended to read:

584 400.506 Licensure of nurse registries; requirements;
585 penalties.—

586 (15)(a) The agency may deny, suspend, or revoke the license
587 of a nurse registry and shall impose a fine of $5,000 against a
588 nurse registry that:

589 1. Provides services to residents in an assisted living
590 facility for which the nurse registry does not receive fair
591 market value remuneration.

592 2. Provides staffing to an assisted living facility for
593 which the nurse registry does not receive fair market value
594 remuneration.

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

598 4. Gives remuneration to a case manager, discharge planner,
599 facility-based staff member, or third-party vendor who is
600 involved in the discharge planning process of a facility
601 licensed under chapter 395 or this chapter and from whom the
602 nurse registry receives referrals. However, this subparagraph
603 does not prohibit a nurse registry from providing promotional
604 items or promotional products, food, or beverages. The
605 cumulative value of these items may not exceed $50 for a single
606 event. The cumulative value of these items may not exceed $100
607 in a calendar year for all persons specified in this
608 subparagraph who are affiliated with a facility.

609 5. Gives remuneration to a physician, a member of the

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610 physician's office staff, or an immediate family member of the
611 physician, and the nurse registry received a patient referral in
612 the last 12 months from that physician or the physician's office
613 staff. However, this subparagraph does not prohibit a nurse
614 registry from providing promotional items or promotional
615 products, food, or beverages. The cumulative value of these
616 items may not exceed $50 for a single event. The cumulative
617 value of these items may not exceed $100 in a calendar year for
618 all persons specified in this subparagraph who are affiliated
619 with a physician's office.
620 Section 7. Section 408.8065, Florida Statutes, is created
621 to read:
622 408.8065 Additional licensure requirements for home health
623 agencies, home medical equipment providers, and health care
624 clinics.—
625 (1) An applicant for initial licensure, or initial
626 licensure due to a change of ownership, as a home health agency,
627 home medical equipment provider, or health care clinic shall:
628 (a) Demonstrate financial ability to operate, as required
629 under s. 408.810(8).
630 (b) Submit pro forma financial statements, including a
631 balance sheet, income and expense statement, and a statement of
632 cash flows for the first 2 years of operation which provide
633 evidence that the applicant has sufficient assets, credit, and
634 projected revenues to cover liabilities and expenses.
635 (c) Submit a statement of the applicant's estimated startup
636 costs and sources of funds through the break-even point in
637 operations demonstrating that the applicant has the ability to
638 fund all startup costs, working capital, and contingency

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639 financing. The statement must show that the applicant has at a
640 minimum 3 months of average projected expenses to cover startup
641 costs, working capital, and contingency financing. The minimum
642 amount for contingency funding may not be less than 1 month of
643 average projected expenses.
644 (d) Demonstrate the financial ability to operate if the
645 applicant's assets, credit, and projected revenues meet or
646 exceed projected liabilities and expenses, and provide
647 independent evidence that the funds necessary for startup costs,
648 working capital, and contingency financing exist and will be
649 available as needed.
650
651 All documents required under this subsection must be prepared in
652 accordance with generally accepted accounting principles and may
653 be in a compilation form. The financial statements must be
654 signed by a certified public accountant.
655 (2) In addition to the penalties provided in s. 408.812,
656 any person offering services requiring licensure under part III,
657 part VII, or part X of chapter 400, who knowingly files a false
658 or misleading license or license renewal application or who
659 submits false or misleading information related to such
660 application, and any person who violates or conspires to violate
661 this section, commits a felony of the third degree, punishable
662 as provided in s. 775.082, s. 775.083, or s. 775.084.
663 Section 8. Subsection (3) and paragraph (a) of subsection
664 (5) of section 408.810, Florida Statutes, are amended to read:
665 408.810 Minimum licensure requirements.—In addition to the
666 licensure requirements specified in this part, authorizing
667 statutes, and applicable rules, each applicant and licensee must

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668 comply with the requirements of this section in order to obtain
669 and maintain a license.
670 (3) Unless otherwise specified in this part, authorizing
671 statutes, or applicable rules, any information required to be
672 reported to the agency must be submitted within 21 calendar days
673 after the report period or effective date of the information,
674 whichever is earlier, including, but not limited to, any change
675 of:
676 (a) Information contained in the most recent application
677 for licensure.
678 (b) Required insurance or bonds.
679 (5)(a) On or before the first day services are provided to
680 a client, a licensee must inform the client and his or her
681 immediate family or representative, if appropriate, of the right
682 to report:
683 1. Complaints. The statewide toll-free telephone number for
684 reporting complaints to the agency must be provided to clients
685 in a manner that is clearly legible and must include the words:
686 "To report a complaint regarding the services you receive,
687 please call toll-free (phone number)."
688 2. Abusive, neglectful, or exploitative practices. The
689 statewide toll-free telephone number for the central abuse
690 hotline must be provided to clients in a manner that is clearly
691 legible and must include the words: "To report abuse, neglect,
692 or exploitation, please call toll-free (phone number)."
693 3. Medicaid fraud. An agency-written description of
694 Medicaid fraud and the statewide toll-free telephone number for
695 the central Medicaid fraud hotline must be provided to clients
696 in a manner that is clearly legible and must include the words:

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697 “To report suspected Medicaid fraud, please call toll-free
698 (phone number).”
699
700 The agency shall publish a minimum of a 90-day advance notice of
701 a change in the toll-free telephone numbers.
702 Section 9. Subsection (4) is added to section 408.815,
703 Florida Statutes, to read:
704 408.815 License or application denial; revocation.—
705 (4) In addition to the grounds provided in authorizing
706 statutes, the agency shall deny an application for a license or
707 license renewal if the applicant or a person having a
708 controlling interest in an applicant has been:
709 (a) Convicted of, or enters a plea of guilty or nolo
710 contendere to, regardless of adjudication, a felony under
711 chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or
712 42 U.S.C. ss. 1395-1396; or
713 (b) Terminated for cause, pursuant to the appeals
714 procedures established by the state or Federal Government, from
715 any state Medicaid program or the federal Medicare program.
716 Section 10. Subsection (4) of section 409.905, Florida
717 Statutes, is amended to read:
718 409.905 Mandatory Medicaid services.—The agency may make
719 payments for the following services, which are required of the
720 state by Title XIX of the Social Security Act, furnished by
721 Medicaid providers to recipients who are determined to be
722 eligible on the dates on which the services were provided. Any
723 service under this section shall be provided only when medically
724 necessary and in accordance with state and federal law.
725 Mandatory services rendered by providers in mobile units to

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726 Medicaid recipients may be restricted by the agency. Nothing in
727 this section shall be construed to prevent or limit the agency
728 from adjusting fees, reimbursement rates, lengths of stay,
729 number of visits, number of services, or any other adjustments
730 necessary to comply with the availability of moneys and any
731 limitations or directions provided for in the General
732 Appropriations Act or chapter 216.
733 (4) HOME HEALTH CARE SERVICES.—The agency shall pay for
734 nursing and home health aide services, supplies, appliances, and
735 durable medical equipment, necessary to assist a recipient
736 living at home. An entity that provides services pursuant to
737 this subsection shall be licensed under part III of chapter 400.
738 These services, equipment, and supplies, or reimbursement
739 therefor, may be limited as provided in the General
740 Appropriations Act and do not include services, equipment, or
741 supplies provided to a person residing in a hospital or nursing
742 facility.
743 (a) In providing home health care services, the agency may
744 require prior authorization of care based on diagnosis or
745 utilization rates. The agency shall require prior authorization
746 for visits for home health services that are not associated with
747 a skilled nursing visit when the home health agency utilization
748 rates exceed the state average by 50 percent or more. The home
749 health agency must submit the recipient's plan of care and
750 documentation that supports the recipient's diagnosis to the
751 agency when requesting prior authorization.
752 (b) The agency shall implement a comprehensive utilization
753 management program that requires prior authorization of all
754 private duty nursing services, an individualized treatment plan

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755 that includes information about medication and treatment orders,
756 treatment goals, methods of care to be used, and plans for care
757 coordination by nurses and other health professionals. The
758 utilization management program shall also include a process for
759 periodically reviewing the ongoing use of private duty nursing
760 services. The assessment of need shall be based on a child's
761 condition, family support and care supplements, a family's
762 ability to provide care, and a family's and child's schedule
763 regarding work, school, sleep, and care for other family
764 dependents. When implemented, the private duty nursing
765 utilization management program shall replace the current
766 authorization program used by the Agency for Health Care
767 Administration and the Children's Medical Services program of
768 the Department of Health. The agency may competitively bid on a
769 contract to select a qualified organization to provide
770 utilization management of private duty nursing services. The
771 agency is authorized to seek federal waivers to implement this
772 initiative.
773 (c) The agency may not pay for home health services, unless
774 the services are medically necessary, and:
775 1. The services are ordered by a physician.
776 2. The written prescription for the services is signed and
777 dated by the recipient's physician before the development of a
778 plan of care and before any request requiring prior
779 authorization.
780 3. The physician ordering the services is not employed,
781 under contract with, or otherwise affiliated with the home
782 health agency rendering the services. However, this subparagraph
783 does not apply to a home health agency affiliated with a

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784 retirement community, of which the parent corporation or a
785 related legal entity owns a rural health clinic certified under
786 42 C.F.R. part 491, subpart A, ss. 1-11, a nursing home licensed
787 under part II of chapter 400, or an apartment or single-family
788 home for independent living.
789 4. The physician ordering the services has examined the
790 recipient within the 30 days preceding the initial request for
791 the services and biannually thereafter.
792 5. The written prescription for the services includes the
793 recipient's acute or chronic medical condition or diagnosis, the
794 home health service required, and, for skilled nursing services,
795 the frequency and duration of the services.
796 6. The national provider identifier, Medicaid
797 identification number, or medical practitioner license number of
798 the physician ordering the services is listed on the written
799 prescription for the services, the claim for home health
800 reimbursement, and the prior authorization request.
801 Section 11. Subsection (1) of section 409.907, Florida
802 Statutes, is amended to read:
803 (1) Each provider agreement shall require the provider to
804 comply fully with all state and federal laws pertaining to the
805 Medicaid program, as well as all federal, state, and local laws
806 pertaining to licensure, if required, and the practice of any of
807 the healing arts, and shall require the provider to provide
808 services or goods of not less than the scope and quality it
809 provides to the general public. Providers physically located in
810 the State of Florida may be enrolled as Medicaid providers. A
811 provider located outside the State of Florida may be enrolled if
812 the provider's location is no more than 50 miles from the

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813 Florida state line, and the agency determines a need for that
814 provider type to ensure adequate access to care.
815 Section 12. Subsection (14) of section 409.912, Florida
816 Statutes, is amended to read:
817 409.912 Cost-effective purchasing of health care.—The
818 agency shall purchase goods and services for Medicaid recipients
819 in the most cost-effective manner consistent with the delivery
820 of quality medical care. To ensure that medical services are
821 effectively utilized, the agency may, in any case, require a
822 confirmation or second physician's opinion of the correct
823 diagnosis for purposes of authorizing future services under the
824 Medicaid program. This section does not restrict access to
825 emergency services or poststabilization care services as defined
826 in 42 C.F.R. part 438.114. Such confirmation or second opinion
827 shall be rendered in a manner approved by the agency. The agency
828 shall maximize the use of prepaid per capita and prepaid
829 aggregate fixed-sum basis services when appropriate and other
830 alternative service delivery and reimbursement methodologies,
831 including competitive bidding pursuant to s. 287.057, designed
832 to facilitate the cost-effective purchase of a case-managed
833 continuum of care. The agency shall also require providers to
834 minimize the exposure of recipients to the need for acute
835 inpatient, custodial, and other institutional care and the
836 inappropriate or unnecessary use of high-cost services. The
837 agency shall contract with a vendor to monitor and evaluate the
838 clinical practice patterns of providers in order to identify
839 trends that are outside the normal practice patterns of a
840 provider's professional peers or the national guidelines of a
841 provider's professional association. The vendor must be able to

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842 provide information and counseling to a provider whose practice
843 patterns are outside the norms, in consultation with the agency,
844 to improve patient care and reduce inappropriate utilization.
845 The agency may mandate prior authorization, drug therapy
846 management, or disease management participation for certain
847 populations of Medicaid beneficiaries, certain drug classes, or
848 particular drugs to prevent fraud, abuse, overuse, and possible
849 dangerous drug interactions. The Pharmaceutical and Therapeutics
850 Committee shall make recommendations to the agency on drugs for
851 which prior authorization is required. The agency shall inform
852 the Pharmaceutical and Therapeutics Committee of its decisions
853 regarding drugs subject to prior authorization. The agency is
854 authorized to limit the entities it contracts with or enrolls as
855 Medicaid providers by developing a provider network through
856 provider credentialing. The agency may competitively bid single-
857 source-provider contracts if procurement of goods or services
858 results in demonstrated cost savings to the state without
859 limiting access to care. The agency may limit its network based
860 on the assessment of beneficiary access to care, provider
861 availability, provider quality standards, time and distance
862 standards for access to care, the cultural competence of the
863 provider network, demographic characteristics of Medicaid
864 beneficiaries, practice and provider-to-beneficiary standards,
865 appointment wait times, beneficiary use of services, provider
866 turnover, provider profiling, provider licensure history,
867 previous program integrity investigations and findings, peer
868 review, provider Medicaid policy and billing compliance records,
869 clinical and medical record audits, and other factors. Providers
870 shall not be entitled to enrollment in the Medicaid provider

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871 network. The agency shall determine instances in which allowing
872 Medicaid beneficiaries to purchase durable medical equipment and
873 other goods is less expensive to the Medicaid program than long-
874 term rental of the equipment or goods. The agency may establish
875 rules to facilitate purchases in lieu of long-term rentals in
876 order to protect against fraud and abuse in the Medicaid program
877 as defined in s. 409.913. The agency may seek federal waivers
878 necessary to administer these policies.
879 (14)(a) The agency shall operate or contract for the
880 operation of utilization management and incentive systems
881 designed to encourage cost-effective use of services and to
882 eliminate services that are medically unnecessary. The agency
883 shall track Medicaid provider prescription and billing patterns
884 and evaluate them against Medicaid medical necessity criteria
885 and coverage and limitation guidelines adopted by rule. Medical
886 necessity determination requires that service be consistent with
887 symptoms or confirmed diagnosis of illness or injury under
888 treatment and not in excess of the patient's needs. The agency
889 shall conduct reviews of provider exceptions to peer group norms
890 and shall, using statistical methodologies, provider profiling,
891 and analysis of billing patterns, detect and investigate
892 abnormal or unusual increases in billing or payment of claims
893 for Medicaid services and medically unnecessary provision of
894 services. Providers that demonstrate a pattern of submitting
895 claims for medically unnecessary services shall be referred to
896 the Medicaid program integrity unit for investigation. In its
897 annual report, required in s. 409.913, the agency shall report
898 on its efforts to control overutilization as described in this
899 paragraph.

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900 (b) The agency shall develop a procedure for determining
901 whether health care providers and service vendors can provide
902 the Medicaid program using a business case that demonstrates
903 whether a particular good or service can offset the cost of
904 providing the good or service in an alternative setting or
905 through other means and therefore should receive a higher
906 reimbursement. The business case must include, but need not be
907 limited to:
908 1. A detailed description of the good or service to be
909 provided, a description and analysis of the agency's current
910 performance of the service, and a rationale documenting how
911 providing the service in an alternative setting would be in the
912 best interest of the state, the agency, and its clients.
913 2. A cost-benefit analysis documenting the estimated
914 specific direct and indirect costs, savings, performance
915 improvements, risks, and qualitative and quantitative benefits
916 involved in or resulting from providing the service. The cost-
917 benefit analysis must include a detailed plan and timeline
918 identifying all actions that must be implemented to realize
919 expected benefits. The Secretary of Health Care Administration
920 shall verify that all costs, savings, and benefits are valid and
921 achievable.
922 (c) If the agency determines that the increased
923 reimbursement is cost-effective, the agency shall recommend a
924 change in the reimbursement schedule for that particular good or
925 service. If, within 12 months after implementing any rate change
926 under this procedure, the agency determines that costs were not
927 offset by the increased reimbursement schedule, the agency may
928 revert to the former reimbursement schedule for the particular

929 good or service.
930 Section 13. Subsections (2), (7), (11), (13), (14), (15),
931 (21), (22), (24), (25), (27), (30), (31), and (36) of section
932 409.913, Florida Statutes, are amended, and subsections (37) and
933 (38) are added to that section, to read:
934 409.913 Oversight of the integrity of the Medicaid
935 program.—The agency shall operate a program to oversee the
936 activities of Florida Medicaid recipients, and providers and
937 their representatives, to ensure that fraudulent and abusive
938 behavior and neglect of recipients occur to the minimum extent
939 possible, and to recover overpayments and impose sanctions as
940 appropriate. Beginning January 1, 2003, and each year
941 thereafter, the agency and the Medicaid Fraud Control Unit of
942 the Department of Legal Affairs shall submit a joint report to
943 the Legislature documenting the effectiveness of the state's
944 efforts to control Medicaid fraud and abuse and to recover
945 Medicaid overpayments during the previous fiscal year. The
946 report must describe the number of cases opened and investigated
947 each year; the sources of the cases opened; the disposition of
948 the cases closed each year; the amount of overpayments alleged
949 in preliminary and final audit letters; the number and amount of
950 fines or penalties imposed; any reductions in overpayment
951 amounts negotiated in settlement agreements or by other means;
952 the amount of final agency determinations of overpayments; the
953 amount deducted from federal claiming as a result of
954 overpayments; the amount of overpayments recovered each year;
955 the amount of cost of investigation recovered each year; the
956 average length of time to collect from the time the case was
957 opened until the overpayment is paid in full; the amount

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958 determined as uncollectible and the portion of the uncollectible
959 amount subsequently reclaimed from the Federal Government; the
960 number of providers, by type, that are terminated from
961 participation in the Medicaid program as a result of fraud and
962 abuse; and all costs associated with discovering and prosecuting
963 cases of Medicaid overpayments and making recoveries in such
964 cases. The report must also document actions taken to prevent
965 overpayments and the number of providers prevented from
966 enrolling in or reenrolling in the Medicaid program as a result
967 of documented Medicaid fraud and abuse and must include policy
968 recommendations ~~recommend changes~~ necessary to prevent or
969 recover overpayments and changes necessary to prevent and detect
970 Medicaid fraud. All policy recommendations in the report must
971 include a detailed fiscal analysis, including, but not limited
972 to, implementation costs, estimated savings to the Medicaid
973 program, and the return on investment. The agency must submit
974 the policy recommendations and fiscal analyses in the report to
975 the appropriate estimating conference, pursuant to s. 216.137,
976 by February 15 of each year. The agency and the Medicaid Fraud
977 Control Unit of the Department of Legal Affairs each must
978 include detailed unit-specific performance standards,
979 benchmarks, and metrics in the report, including projected cost
980 savings to the state Medicaid program during the following
981 fiscal year.
982 (2) The agency shall conduct, or cause to be conducted by
983 contract or otherwise, reviews, investigations, analyses,
984 audits, or any combination thereof, to determine possible fraud,
985 abuse, overpayment, or recipient neglect in the Medicaid program
986 and shall report the findings of any overpayments in audit

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987 reports as appropriate. At least 5 percent of all audits shall
988 be conducted on a random basis. As part of its ongoing fraud
989 detection activities, the agency shall identify and monitor, by
990 contract or otherwise, patterns of overutilization of Medicaid
991 services based on state averages. The agency shall track
992 Medicaid provider prescription and billing patterns and evaluate
993 them against Medicaid medical necessity criteria and coverage
994 and limitation guidelines adopted by rule. Medical necessity
995 determination requires that service be consistent with symptoms
996 or confirmed diagnosis of illness or injury under treatment and
997 not in excess of the patient's needs. The agency shall conduct
998 reviews of provider exceptions to peer group norms and shall,
999 using statistical methodologies, provider profiling, and
1000 analysis of billing patterns, detect and investigate abnormal or
1001 unusual increases in billing or payment of claims for Medicaid
1002 services and medically unnecessary provision of services.
1003 (7) When presenting a claim for payment under the Medicaid
1004 program, a provider has an affirmative duty to supervise the
1005 provision of, and be responsible for, goods and services claimed
1006 to have been provided, to supervise and be responsible for
1007 preparation and submission of the claim, and to present a claim
1008 that is true and accurate and that is for goods and services
1009 that:
1010 (a) Have actually been furnished to the recipient by the
1011 provider prior to submitting the claim.
1012 (b) Are Medicaid-covered goods or services that are
1013 medically necessary.
1014 (c) Are of a quality comparable to those furnished to the
1015 general public by the provider's peers.

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1016 (d) Have not been billed in whole or in part to a recipient
1017 or a recipient’s responsible party, except for such copayments,
1018 coinsurance, or deductibles as are authorized by the agency.
1019 (e) Are provided in accord with applicable provisions of
1020 all Medicaid rules, regulations, handbooks, and policies and in
1021 accordance with federal, state, and local law.
1022 (f) Are documented by records made at the time the goods or
1023 services were provided, demonstrating the medical necessity for
1024 the goods or services rendered. Medicaid goods or services are
1025 excessive or not medically necessary unless both the medical
1026 basis and the specific need for them are fully and properly
1027 documented in the recipient’s medical record.
1028
1029 The agency shall ~~may~~ deny payment or require repayment for goods
1030 or services that are not presented as required in this
1031 subsection.
1032 (11) The agency shall ~~may~~ deny payment or require repayment
1033 for inappropriate, medically unnecessary, or excessive goods or
1034 services from the person furnishing them, the person under whose
1035 supervision they were furnished, or the person causing them to
1036 be furnished.
1037 (13) The agency shall immediately ~~may~~ terminate
1038 participation of a Medicaid provider in the Medicaid program and
1039 may seek civil remedies or impose other administrative sanctions
1040 against a Medicaid provider, if the provider or any principal,
1041 officer, director, agent, managing employee, or affiliated
1042 person of the provider, or any partner or shareholder having an
1043 ownership interest in the provider equal to 5 percent or
1044 greater, has been:

1045 (a) Convicted of a criminal offense related to the delivery
1046 of any health care goods or services, including the performance
1047 of management or administrative functions relating to the
1048 delivery of health care goods or services;
1049 (b) Convicted of a criminal offense under federal law or
1050 the law of any state relating to the practice of the provider's
1051 profession; or
1052 (c) Found by a court of competent jurisdiction to have
1053 neglected or physically abused a patient in connection with the
1054 delivery of health care goods or services.
1055
1056 If the agency determines a provider did not participate or
1057 acquiesce in an offense specified in paragraph (a), paragraph
1058 (b), or paragraph (c), termination will not be imposed. If the
1059 agency effects a termination under this subsection, the agency
1060 shall issue an immediate final order pursuant to s.
1061 120.569(2)(n).
1062 (14) If the provider has been suspended or terminated from
1063 participation in the Medicaid program or the Medicare program by
1064 the Federal Government or any state, the agency must immediately
1065 suspend or terminate, as appropriate, the provider's
1066 participation in this state's ~~the Florida~~ Medicaid program for a
1067 period no less than that imposed by the Federal Government or
1068 any other state, and may not enroll such provider in this
1069 state's ~~the Florida~~ Medicaid program while such foreign
1070 suspension or termination remains in effect. The agency shall
1071 also immediately suspend or terminate, as appropriate, a
1072 provider's participation in this state's Medicaid program if the
1073 provider participated or acquiesced in any action for which any

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1074 principal, officer, director, agent, managing employee, or
1075 affiliated person of the provider, or any partner or shareholder
1076 having an ownership interest in the provider equal to 5 percent
1077 or greater, was suspended or terminated from participating in
1078 the Medicaid program or the Medicare program by the Federal
1079 Government or any state. This sanction is in addition to all
1080 other remedies provided by law.
1081 (15) The agency shall ~~may~~ seek a ~~any~~ remedy provided by
1082 law, including, but not limited to, any remedy ~~the remedies~~
1083 provided in subsections (13) and (16) and s. 812.035, if:
1084 (a) The provider's license has not been renewed, or has
1085 been revoked, suspended, or terminated, for cause, by the
1086 licensing agency of any state;
1087 (b) The provider has failed to make available or has
1088 refused access to Medicaid-related records to an auditor,
1089 investigator, or other authorized employee or agent of the
1090 agency, the Attorney General, a state attorney, or the Federal
1091 Government;
1092 (c) The provider has not furnished or has failed to make
1093 available such Medicaid-related records as the agency has found
1094 necessary to determine whether Medicaid payments are or were due
1095 and the amounts thereof;
1096 (d) The provider has failed to maintain medical records
1097 made at the time of service, or prior to service if prior
1098 authorization is required, demonstrating the necessity and
1099 appropriateness of the goods or services rendered;
1100 (e) The provider is not in compliance with provisions of
1101 Medicaid provider publications that have been adopted by
1102 reference as rules in the Florida Administrative Code; with

1103 provisions of state or federal laws, rules, or regulations; with
1104 provisions of the provider agreement between the agency and the
1105 provider; or with certifications found on claim forms or on
1106 transmittal forms for electronically submitted claims that are
1107 submitted by the provider or authorized representative, as such
1108 provisions apply to the Medicaid program;

1109 (f) The provider or person who ordered or prescribed the
1110 care, services, or supplies has furnished, or ordered the
1111 furnishing of, goods or services to a recipient which are
1112 inappropriate, unnecessary, excessive, or harmful to the
1113 recipient or are of inferior quality;

1114 (g) The provider has demonstrated a pattern of failure to
1115 provide goods or services that are medically necessary;

1116 (h) The provider or an authorized representative of the
1117 provider, or a person who ordered or prescribed the goods or
1118 services, has submitted or caused to be submitted false or a
1119 pattern of erroneous Medicaid claims;

1120 (i) The provider or an authorized representative of the
1121 provider, or a person who has ordered or prescribed the goods or
1122 services, has submitted or caused to be submitted a Medicaid
1123 provider enrollment application, a request for prior
1124 authorization for Medicaid services, a drug exception request,
1125 or a Medicaid cost report that contains materially false or
1126 incorrect information;

1127 (j) The provider or an authorized representative of the
1128 provider has collected from or billed a recipient or a
1129 recipient’s responsible party improperly for amounts that should
1130 not have been so collected or billed by reason of the provider’s
1131 billing the Medicaid program for the same service;

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1132 (k) The provider or an authorized representative of the
1133 provider has included in a cost report costs that are not
1134 allowable under a Florida Title XIX reimbursement plan, after
1135 the provider or authorized representative had been advised in an
1136 audit exit conference or audit report that the costs were not
1137 allowable;
1138 (l) The provider is charged by information or indictment
1139 with fraudulent billing practices. The sanction applied for this
1140 reason is limited to suspension of the provider's participation
1141 in the Medicaid program for the duration of the indictment
1142 unless the provider is found guilty pursuant to the information
1143 or indictment;
1144 (m) The provider or a person who has ordered, or prescribed
1145 the goods or services is found liable for negligent practice
1146 resulting in death or injury to the provider's patient;
1147 (n) The provider fails to demonstrate that it had available
1148 during a specific audit or review period sufficient quantities
1149 of goods, or sufficient time in the case of services, to support
1150 the provider's billings to the Medicaid program;
1151 (o) The provider has failed to comply with the notice and
1152 reporting requirements of s. 409.907;
1153 (p) The agency has received reliable information of patient
1154 abuse or neglect or of any act prohibited by s. 409.920; or
1155 (q) The provider has failed to comply with an agreed-upon
1156 repayment schedule.
1157
1158 A provider is subject to sanctions for violations of this
1159 subsection as the result of actions or inactions of the
1160 provider, or actions or inactions of any principal, officer,

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1161 director, agent, managing employee, or affiliated person of the
1162 provider, or any partner or shareholder having an ownership
1163 interest in the provider equal to 5 percent or greater, in which
1164 the provider participated or acquiesced.
1165 (21) When making a determination that an overpayment has
1166 occurred, the agency shall prepare and issue an audit report to
1167 the provider showing the calculation of overpayments. If the
1168 agency's determination that an overpayment has occurred is based
1169 upon a review of the provider's records, the calculation of the
1170 overpayment shall be based upon documentation created prior to
1171 the start of any investigation or created at the request of the
1172 agency.
1173 (22) The audit report, supported by agency work papers,
1174 showing an overpayment to a provider constitutes evidence of the
1175 overpayment. A provider may not present or elicit testimony,
1176 either on direct examination or cross-examination in any court
1177 or administrative proceeding, regarding the purchase or
1178 acquisition by any means of drugs, goods, or supplies; sales or
1179 divestment by any means of drugs, goods, or supplies; or
1180 inventory of drugs, goods, or supplies, unless such acquisition,
1181 sales, divestment, or inventory is documented by written
1182 invoices, written inventory records, or other competent written
1183 documentary evidence maintained in the normal course of the
1184 provider's business. Notwithstanding the applicable rules of
1185 discovery, all documentation that will be offered as evidence at
1186 an administrative hearing on a Medicaid overpayment must be
1187 exchanged by all parties at least 14 days before the
1188 administrative hearing or must be excluded from consideration.
1189 The documentation or data that a provider may rely upon or

1190 present as evidence that an overpayment has not occurred must
1191 have been created prior to the start of any agency investigation
1192 and must be made available to the agency before issuance of a
1193 final audit report, unless the documentation or data was created
1194 at the request of the agency. Documentation or data that was
1195 recreated due to extenuating circumstances beyond the provider's
1196 control, such as a disaster or the loss of records due to change
1197 of ownership, may be presented as evidence if evidence of the
1198 extenuating circumstance is also provided. This subsection does
1199 not prohibit the introduction of expert witness reports
1200 regarding an overpayment or the issues addressed in the audit.
1201 (24) If the agency imposes an administrative sanction
1202 pursuant to subsection (13), subsection (14), or subsection
1203 (15), except paragraphs (15)(e) and (o), upon any provider or
1204 any principal, officer, director, agent, managing employee, or
1205 affiliated person of the provider ~~other person~~ who is regulated
1206 by another state entity, the agency shall notify that other
1207 entity of the imposition of the sanction within 5 business days.
1208 Such notification must include the provider's or person's name
1209 and license number and the specific reasons for sanction.
1210 (25)(a) The agency shall ~~may~~ withhold Medicaid payments, in
1211 whole or in part, to a provider upon receipt of reliable
1212 evidence that the circumstances giving rise to the need for a
1213 withholding of payments involve fraud, willful
1214 misrepresentation, or abuse under the Medicaid program, or a
1215 crime committed while rendering goods or services to Medicaid
1216 recipients. If it is determined that fraud, willful
1217 misrepresentation, abuse, or a crime did not occur, the payments
1218 withheld must be paid to the provider within 14 days after such

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1219 determination with interest at the rate of 10 percent a year.
1220 Any money withheld in accordance with this paragraph shall be
1221 placed in a suspended account, readily accessible to the agency,
1222 so that any payment ultimately due the provider shall be made
1223 within 14 days.
1224 (b) The agency shall ~~may~~ deny payment, or require
1225 repayment, if the goods or services were furnished, supervised,
1226 or caused to be furnished by a person who has been suspended or
1227 terminated from the Medicaid program or Medicare program by the
1228 Federal Government or any state.
1229 (c) Overpayments owed to the agency bear interest at the
1230 rate of 10 percent per year from the date of determination of
1231 the overpayment by the agency, and payment arrangements must be
1232 made at the conclusion of legal proceedings. A provider who does
1233 not enter into or adhere to an agreed-upon repayment schedule
1234 may be terminated by the agency for nonpayment or partial
1235 payment.
1236 (d) The agency, upon entry of a final agency order, a
1237 judgment or order of a court of competent jurisdiction, or a
1238 stipulation or settlement, may collect the moneys owed by all
1239 means allowable by law, including, but not limited to, notifying
1240 any fiscal intermediary of Medicare benefits that the state has
1241 a superior right of payment. Upon receipt of such written
1242 notification, the Medicare fiscal intermediary shall remit to
1243 the state the sum claimed.
1244 (e) The agency may institute amnesty programs to allow
1245 Medicaid providers the opportunity to voluntarily repay
1246 overpayments. The agency may adopt rules to administer such
1247 programs.

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1248 (27) When the Agency for Health Care Administration has
1249 made a probable cause determination and alleged that an
1250 overpayment to a Medicaid provider has occurred, the agency,
1251 after notice to the provider, shall ~~may~~:
1252 (a) Withhold, and continue to withhold during the pendency
1253 of an administrative hearing pursuant to chapter 120, any
1254 medical assistance reimbursement payments until such time as the
1255 overpayment is recovered, unless within 30 days after receiving
1256 notice thereof the provider:
1257 1. Makes repayment in full; or
1258 2. Establishes a repayment plan that is satisfactory to the
1259 Agency for Health Care Administration.
1260 (b) Withhold, and continue to withhold during the pendency
1261 of an administrative hearing pursuant to chapter 120, medical
1262 assistance reimbursement payments if the terms of a repayment
1263 plan are not adhered to by the provider.
1264 (30) The agency shall ~~may~~ terminate a provider’s
1265 participation in the Medicaid program if the provider fails to
1266 reimburse an overpayment that has been determined by final
1267 order, not subject to further appeal, within 35 days after the
1268 date of the final order, unless the provider and the agency have
1269 entered into a repayment agreement.
1270 (31) If a provider requests an administrative hearing
1271 pursuant to chapter 120, such hearing must be conducted within
1272 90 days following assignment of an administrative law judge,
1273 absent exceptionally good cause shown as determined by the
1274 administrative law judge or hearing officer. Upon issuance of a
1275 final order, the outstanding balance of the amount determined to
1276 constitute the overpayment shall become due. If a provider fails

1277 to make payments in full, fails to enter into a satisfactory
1278 repayment plan, or fails to comply with the terms of a repayment
1279 plan or settlement agreement, the agency shall ~~may~~ withhold
1280 medical assistance reimbursement payments until the amount due
1281 is paid in full.
1282 (36) At least three times a year, the agency shall provide
1283 to each Medicaid recipient or his or her representative an
1284 explanation of benefits in the form of a letter that is mailed
1285 to the most recent address of the recipient on the record with
1286 the Department of Children and Family Services. The explanation
1287 of benefits must include the patient's name, the name of the
1288 health care provider and the address of the location where the
1289 service was provided, a description of all services billed to
1290 Medicaid in terminology that should be understood by a
1291 reasonable person, and information on how to report
1292 inappropriate or incorrect billing to the agency or other law
1293 enforcement entities for review or investigation. At least once
1294 a year, the letter also must include information on how to
1295 report criminal Medicaid fraud, the Medicaid Fraud Control
1296 Unit's toll-free hotline number, and information about the
1297 rewards available under s. 409.9203. The explanation of benefits
1298 may not be mailed for Medicaid independent laboratory services
1299 as described in s. 409.905(7) or for Medicaid certified match
1300 services as described in ss. 409.9071 and 1011.70.
1301 (37) The agency shall post on its website a current list of
1302 each Medicaid provider, including any principal, officer,
1303 director, agent, managing employee, or affiliated person of the
1304 provider, or any partner or shareholder having an ownership
1305 interest in the provider equal to 5 percent or greater, who has

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1306 been terminated from the Medicaid program or sanctioned under
1307 this section. The list must be searchable by a variety of search
1308 parameters and provide for the creation of formatted lists that
1309 may be printed or imported into other applications, including
1310 spreadsheets. The agency shall update the list at least monthly.
1311 (38) In order to improve the detection of health care
1312 fraud, use technology to prevent and detect fraud, and maximize
1313 the electronic exchange of health care fraud information, the
1314 agency shall:
1315 (a) Compile, maintain, and publish on its website a
1316 detailed list of all state and federal databases that contain
1317 health care fraud information and update the list at least
1318 biannually;
1319 (b) Develop a strategic plan to connect all databases that
1320 contain health care fraud information to facilitate the
1321 electronic exchange of health information between the agency,
1322 the Department of Health, the Department of Law Enforcement, and
1323 the Attorney General's Office. The plan must include recommended
1324 standard data formats, fraud-identification strategies, and
1325 specifications for the technical interface between state and
1326 federal health care fraud databases;
1327 (c) Monitor innovations in health information technology,
1328 specifically as it pertains to Medicaid fraud prevention and
1329 detection; and
1330 (d) Periodically publish policy briefs that highlight
1331 available new technology to prevent or detect health care fraud
1332 and projects implemented by other states, the private sector, or
1333 the Federal Government which use technology to prevent or detect
1334 health care fraud.

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1335 Section 14. Subsections (1) and (2) of section 409.920,
1336 Florida Statutes, are amended, present subsections (8) and (9)
1337 of that section are renumbered as subsections (9) and (10),
1338 respectively, and a new subsection (8) is added to that section,
1339 to read:
1340 409.920 Medicaid provider fraud.—
1341 (1) For the purposes of this section, the term:
1342 (a) “Agency” means the Agency for Health Care
1343 Administration.
1344 (b) “Fiscal agent” means any individual, firm, corporation,
1345 partnership, organization, or other legal entity that has
1346 contracted with the agency to receive, process, and adjudicate
1347 claims under the Medicaid program.
1348 (c) “Item or service” includes:
1349 1. Any particular item, device, medical supply, or service
1350 claimed to have been provided to a recipient and listed in an
1351 itemized claim for payment; or
1352 2. In the case of a claim based on costs, any entry in the
1353 cost report, books of account, or other documents supporting
1354 such claim.
1355 (d) “Knowingly” means that the act was done voluntarily and
1356 intentionally and not because of mistake or accident. As used in
1357 this section, the term “knowingly” also includes the word
1358 “willfully” or “willful” which, as used in this section, means
1359 that an act was committed voluntarily and purposely, with the
1360 specific intent to do something that the law forbids, and that
1361 the act was committed with bad purpose, either to disobey or
1362 disregard the law.
1363 (e) “Managed care plan” means a health maintenance

1364 organization authorized pursuant to chapter 641, a prepaid
1365 health plan authorized in s. 409.912, or an entity authorized
1366 pursuant to s. 409.91211(12) which contracts with the agency to
1367 provide medical services to Medicaid recipients.
1368 (2)(a) A person may not ~~It is unlawful to~~:
1369 1.~~(a)~~ Knowingly make, cause to be made, or aid and abet in
1370 the making of any false statement or false representation of a
1371 material fact, by commission or omission, in any claim submitted
1372 to the agency, ~~or~~ its fiscal agent, or a managed care plan for
1373 payment.
1374 2.~~(b)~~ Knowingly make, cause to be made, or aid and abet in
1375 the making of a claim for items or services that are not
1376 authorized to be reimbursed by the Medicaid program.
1377 3.~~(c)~~ Knowingly charge, solicit, accept, or receive
1378 anything of value, other than an authorized copayment from a
1379 Medicaid recipient, from any source in addition to the amount
1380 legally payable for an item or service provided to a Medicaid
1381 recipient under the Medicaid program or knowingly fail to credit
1382 the agency or its fiscal agent for any payment received from a
1383 third-party source.
1384 4.~~(d)~~ Knowingly make or in any way cause to be made any
1385 false statement or false representation of a material fact, by
1386 commission or omission, in any document containing items of
1387 income and expense that is or may be used by the agency to
1388 determine a general or specific rate of payment for an item or
1389 service provided by a provider.
1390 5.~~(e)~~ Knowingly solicit, offer, pay, or receive any
1391 remuneration, including any kickback, bribe, or rebate, directly
1392 or indirectly, overtly or covertly, in cash or in kind, in

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1393 return for referring an individual to a person for the
1394 furnishing or arranging for the furnishing of any item or
1395 service for which payment may be made, in whole or in part,
1396 under the Medicaid program, or in return for obtaining,
1397 purchasing, leasing, ordering, or arranging for or recommending,
1398 obtaining, purchasing, leasing, or ordering any goods, facility,
1399 item, or service, for which payment may be made, in whole or in
1400 part, under the Medicaid program.
1401 6.~~(f)~~ Knowingly submit false or misleading information or
1402 statements to the Medicaid program for the purpose of being
1403 accepted as a Medicaid provider.
1404 7.~~(g)~~ Knowingly use or endeavor to use a Medicaid
1405 provider's identification number or a Medicaid recipient's
1406 identification number to make, cause to be made, or aid and abet
1407 in the making of a claim for items or services that are not
1408 authorized to be reimbursed by the Medicaid program.
1409 (b)1. A person who violates this subsection and receives or
1410 endeavors to receive anything of value of:
1411 a. Ten thousand dollars or less commits a felony of the
1412 third degree, punishable as provided in s. 775.082, s. 775.083,
1413 or s. 775.084.
1414 b. More than $10,000, but less than $50,000, commits a
1415 felony of the second degree, punishable as provided in s.
1416 775.082, s. 775.083, or s. 775.084.
1417 c. Fifty thousand dollars or more commits a felony of the
1418 first degree, punishable as provided in s. 775.082, s. 775.083,
1419 or s. 775.084.
1420 2. The value of separate funds, goods, or services that a
1421 person received or attempted to receive pursuant to a scheme or

1422 course of conduct may be aggregated in determining the degree of
1423 the offense.
1424 3. In addition to the sentence authorized by law, a person
1425 who is convicted of a violation of this subsection shall pay a
1426 fine in an amount equal to five times the pecuniary gain
1427 unlawfully received or the loss incurred by the Medicaid program
1428 or managed care organization, whichever is greater.
1429 (8) A person who provides the state, any state agency, any
1430 of the state's political subdivisions, or any agency of the
1431 state's political subdivisions with information about fraud or
1432 suspected fraud by a Medicaid provider, including a managed care
1433 organization, is immune from civil liability for providing the
1434 information unless the person acted with knowledge that the
1435 information was false or with reckless disregard for the truth
1436 or falsity of the information.
1437 Section 15. Section 409.9203, Florida Statutes, is created
1438 to read:
1439 409.9203 Rewards for reporting Medicaid fraud.—
1440 (1) The Department of Law Enforcement or director of the
1441 Medicaid Fraud Control Unit shall, subject to availability of
1442 funds, pay a reward to a person who furnishes original
1443 information relating to and reports a violation of the state's
1444 Medicaid fraud laws, unless the person declines the reward, if
1445 the information and report:
1446 (a) Is made to the Office of the Attorney General, the
1447 Agency for Health Care Administration, the Department of Health,
1448 or the Department of Law Enforcement;
1449 (b) Relates to criminal fraud upon Medicaid funds or a
1450 criminal violation of Medicaid laws by another person; and

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1451 (c) Leads to a recovery of a fine, penalty, or forfeiture
1452 of property.
1453 (2) The reward may not exceed the lesser of 25 percent of
1454 the amount recovered or $500,000 in a single case.
1455 (3) The reward shall be paid from the Legal Affairs
1456 Revolving Trust Fund from moneys collected pursuant to s.
1457 68.085.
1458 (4) A person who receives a reward pursuant to this section
1459 is not eligible to receive any funds pursuant to the Florida
1460 False Claims Act for Medicaid fraud for which a reward is
1461 received pursuant to this section.
1462 Section 16. Subsection (11) is added to section 456.004,
1463 Florida Statutes, to read:
1464 456.004 Department; powers and duties.—The department, for
1465 the professions under its jurisdiction, shall:
1466 (11) Work cooperatively with the Agency for Health Care
1467 Administration and the judicial system to recover Medicaid
1468 overpayments by the Medicaid program. The department shall
1469 investigate and prosecute health care practitioners who have not
1470 remitted amounts owed to the state for an overpayment from the
1471 Medicaid program pursuant to a final order, judgment, or
1472 stipulation or settlement.
1473 Section 17. Present subsections (6) through (10) of section
1474 456.041, Florida Statutes, are renumbered as subsections (7)
1475 through (11), respectively, and a new subsection (6) is added to
1476 that section, to read:
1477 456.041 Practitioner profile; creation.—
1478 (6) The Department of Health shall provide in each
1479 practitioner profile for every physician or advanced registered

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1480 nurse practitioner terminated from participating in the Medicaid
1481 program, pursuant to s. 409.913, or sanctioned by the Medicaid
1482 program a statement that the practitioner has been terminated
1483 from participating in the Florida Medicaid program or sanctioned
1484 by the Medicaid program.
1485 Section 18. Section 456.0635, Florida Statutes, is created
1486 to read:
1487 456.0635 Medicaid fraud; disqualification for license,
1488 certificate, or registration.—
1489 (1) Medicaid fraud in the practice of a health care
1490 profession is prohibited.
1491 (2) Each board within the jurisdiction of the department,
1492 or the department if there is no board, shall refuse to admit a
1493 candidate to any examination and refuse to issue or renew a
1494 license, certificate, or registration to any applicant if the
1495 candidate or applicant or any principle, officer, agent,
1496 managing employee, or affiliated person of the applicant, has
1497 been:
1498 (a) Convicted of, or entered a plea of guilty or nolo
1499 contendere to, regardless of adjudication, a felony under
1500 chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or
1501 42 U.S.C. ss. 1395-1396; or
1502 (b) Terminated for cause, pursuant to the appeals
1503 procedures established by the state or Federal Government, from
1504 any state Medicaid program or the federal Medicare program.
1505 (3) Licensed health care practitioners shall report
1506 allegations of Medicaid fraud to the department, regardless of
1507 the practice setting in which the alleged Medicaid fraud
1508 occurred.

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1509 (4) The acceptance by a licensing authority of a
1510 candidate’s relinquishment of a license which is offered in
1511 response to or anticipation of the filing of administrative
1512 charges alleging Medicaid fraud or similar charges constitutes
1513 the permanent revocation of the license.
1514 Section 19. Paragraphs (ii), (jj), (kk), and (ll) are added
1515 to subsection (1) of section 456.072, Florida Statutes, to read:
1516 456.072 Grounds for discipline; penalties; enforcement.—
1517 (1) The following acts shall constitute grounds for which
1518 the disciplinary actions specified in subsection (2) may be
1519 taken:
1520 (ii) Being convicted of, or entering a plea of guilty or
1521 nolo contendere to, any misdemeanor or felony, regardless of
1522 adjudication, under 18 U.S.C. s. 669, ss. 285-287, s. 371, s.
1523 1001, s. 1035, s. 1341, s. 1343, s. 1347, s. 1349, or s. 1518,
1524 or 42 U.S.C. ss. 1320a-7b, relating to the Medicaid program.
1525 (jj) Failing to remit the sum owed to the state for an
1526 overpayment from the Medicaid program pursuant to a final order,
1527 judgment, or stipulation or settlement.
1528 (kk) Being terminated from the state Medicaid program
1529 pursuant to s. 409.913, any other state Medicaid program, or the
1530 federal Medicare program.
1531 (ll) Being convicted of, or entering a plea of guilty or
1532 nolo contendere to, any misdemeanor or felony, regardless of
1533 adjudication, a crime in any jurisdiction which relates to
1534 health care fraud.
1535 Section 20. Subsection (1) of section 456.074, Florida
1536 Statutes, is amended to read:
1537 456.074 Certain health care practitioners; immediate

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1538 suspension of license.—
1539 (1) The department shall issue an emergency order
1540 suspending the license of any person licensed under chapter 458,
1541 chapter 459, chapter 460, chapter 461, chapter 462, chapter 463,
1542 chapter 464, chapter 465, chapter 466, or chapter 484 who pleads
1543 guilty to, is convicted or found guilty of, or who enters a plea
1544 of nolo contendere to, regardless of adjudication, to:
1545 (a) A felony under chapter 409, chapter 817, or chapter 893
1546 or under 21 U.S.C. ss. 801-970 or under 42 U.S.C. ss. 1395-1396;
1547 or.
1548 (b) A misdemeanor or felony under 18 U.S.C. s. 669, ss.
1549 285-287, s. 371, s. 1001, s. 1035, s. 1341, s. 1343, s. 1347, s.
1550 1349, or s. 1518 or 42 U.S.C. ss. 1320a-7b, relating to the
1551 Medicaid program.
1552 Section 21. Subsections (2) and (3) of section 465.022,
1553 Florida Statutes, are amended, present subsections (4), (5),
1554 (6), and (7) of that section are renumbered as subsections (5),
1555 (6), (7), and (8), respectively, and a new subsection (4) is
1556 added to that section, to read:
1557 465.022 Pharmacies; general requirements; fees.—
1558 (2) A pharmacy permit shall be issued only to a person who
1559 is at least 18 years of age, a partnership whose partners are
1560 all at least 18 years of age, or to a corporation that which is
1561 registered pursuant to chapter 607 or chapter 617 whose
1562 officers, directors, and shareholders are at least 18 years of
1563 age.
1564 (3) Any person, partnership, or corporation before engaging
1565 in the operation of a pharmacy shall file with the board a sworn
1566 application on forms provided by the department.

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1567 (a) An application for a pharmacy permit must include a set
1568 of fingerprints from each person having an ownership interest of
1569 5 percent or greater and from any person who, directly or
1570 indirectly, manages, oversees, or controls the operation of the
1571 applicant, including officers and members of the board of
1572 directors of an applicant that is a corporation. The applicant
1573 must provide payment in the application for the cost of state
1574 and national criminal history records checks.
1575 1. For corporations having more than $100 million of
1576 business taxable assets in this state, in lieu of these
1577 fingerprint requirements, the department shall require the
1578 prescription department manager who will be directly involved in
1579 the management and operation of the pharmacy to submit a set of
1580 fingerprints.
1581 2. A representative of a corporation described in
1582 subparagraph 1. satisfies the requirement to submit a set of his
1583 or her fingerprints if the fingerprints are on file with the
1584 department or the Agency for Health Care Administration, meet
1585 the fingerprint specifications for submission by the Department
1586 of Law Enforcement, and are available to the department.
1587 (b) The department shall submit the fingerprints provided
1588 by the applicant to the Department of Law Enforcement for a
1589 state criminal history records check. The Department of Law
1590 Enforcement shall forward the fingerprints to the Federal Bureau
1591 of Investigation for a national criminal history records check.
1592 (4) The department or board shall deny an application for a
1593 pharmacy permit if the applicant or an affiliated person,
1594 partner, officer, director, or prescription department manager
1595 of the applicant has:

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1596 (a) Obtained a permit by misrepresentation or fraud;
1597 (b) Attempted to procure, or has procured, a permit for any
1598 other person by making, or causing to be made, any false
1599 representation;
1600 (c) Been convicted of, or entered a plea of guilty or nolo
1601 contendere to, regardless of adjudication, a crime in any
1602 jurisdiction which relates to the practice of, or the ability to
1603 practice, the profession of pharmacy;
1604 (d) Been convicted of, or entered a plea of guilty or nolo
1605 contendere to, regardless of adjudication, a crime in any
1606 jurisdiction which relates to health care fraud;
1607 (e) Been terminated for cause, pursuant to the appeals
1608 procedures established by the state or Federal Government, from
1609 any state Medicaid program or the federal Medicare program; or
1610 (f) Dispensed any medicinal drug based upon a communication
1611 that purports to be a prescription as defined by s. 465.003(14)
1612 or s. 893.02 when the pharmacist knows or has reason to believe
1613 that the purported prescription is not based upon a valid
1614 practitioner-patient relationship that includes a documented
1615 patient evaluation, including history and a physical examination
1616 adequate to establish the diagnosis for which any drug is
1617 prescribed and any other requirement established by board rule
1618 under chapter 458, chapter 459, chapter 461, chapter 463,
1619 chapter 464, or chapter 466.
1620 Section 22. Subsection (1) of section 465.023, Florida
1621 Statutes, is amended to read:
1622 465.023 Pharmacy permittee; disciplinary action.—
1623 (1) The department or the board may revoke or suspend the
1624 permit of any pharmacy permittee, and may fine, place on

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1625 probation, or otherwise discipline any pharmacy permittee if the
1626 permittee, or any affiliated person, partner, officer, director,
1627 or agent of the permittee, including a person fingerprinted
1628 under s. 465.022(3), ~~who~~ has:
1629 (a) Obtained a permit by misrepresentation or fraud or
1630 through an error of the department or the board;
1631 (b) Attempted to procure, or has procured, a permit for any
1632 other person by making, or causing to be made, any false
1633 representation;
1634 (c) Violated any of the requirements of this chapter or any
1635 of the rules of the Board of Pharmacy; of chapter 499, known as
1636 the “Florida Drug and Cosmetic Act”; of 21 U.S.C. ss. 301-392,
1637 known as the “Federal Food, Drug, and Cosmetic Act”; of 21
1638 U.S.C. ss. 821 et seq., known as the Comprehensive Drug Abuse
1639 Prevention and Control Act; or of chapter 893;
1640 (d) Been convicted or found guilty, regardless of
1641 adjudication, of a felony or any other crime involving moral
1642 turpitude in any of the courts of this state, of any other
1643 state, or of the United States; ~~or~~
1644 (e) Been convicted or disciplined by a regulatory agency of
1645 the Federal Government or a regulatory agency of another state
1646 for any offense that would constitute a violation of this
1647 chapter;
1648 (f) Been convicted of, or entered a plea of guilty or nolo
1649 contendere to, regardless of adjudication, a crime in any
1650 jurisdiction which relates to the practice of, or the ability to
1651 practice, the profession of pharmacy;
1652 (g) Been convicted of, or entered a plea of guilty or nolo
1653 contendere to, regardless of adjudication, a crime in any

1654 jurisdiction which relates to health care fraud; or

1655 (h) ~~(e)~~ Dispensed any medicinal drug based upon a
1656 communication that purports to be a prescription as defined by
1657 s. 465.003(14) or s. 893.02 when the pharmacist knows or has
1658 reason to believe that the purported prescription is not based
1659 upon a valid practitioner-patient relationship that includes a
1660 documented patient evaluation, including history and a physical
1661 examination adequate to establish the diagnosis for which any
1662 drug is prescribed and any other requirement established by
1663 board rule under chapter 458, chapter 459, chapter 461, chapter
1664 463, chapter 464, or chapter 466.

1665 Section 23. Section 825.103, Florida Statutes, is amended
1666 to read:

1667 825.103 Exploitation of an elderly person or disabled
1668 adult; penalties.—

1669 (1) "Exploitation of an elderly person or disabled adult"
1670 means:

1671 (a) Knowingly, by deception or intimidation, obtaining or
1672 using, or endeavoring to obtain or use, an elderly person's or
1673 disabled adult's funds, assets, or property with the intent to
1674 temporarily or permanently deprive the elderly person or
1675 disabled adult of the use, benefit, or possession of the funds,
1676 assets, or property, or to benefit someone other than the
1677 elderly person or disabled adult, by a person who:

1678 1. Stands in a position of trust and confidence with the
1679 elderly person or disabled adult; or

1680 2. Has a business relationship with the elderly person or
1681 disabled adult; ~~or~~

1682 (b) Obtaining or using, endeavoring to obtain or use, or

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1683 conspiring with another to obtain or use an elderly person's or
1684 disabled adult's funds, assets, or property with the intent to
1685 temporarily or permanently deprive the elderly person or
1686 disabled adult of the use, benefit, or possession of the funds,
1687 assets, or property, or to benefit someone other than the
1688 elderly person or disabled adult, by a person who knows or
1689 reasonably should know that the elderly person or disabled adult
1690 lacks the capacity to consent; or~~.~~
1691 (c) Breach of a fiduciary duty to an elderly person or
1692 disabled adult by the person's guardian or agent under a power
1693 of attorney which results in an unauthorized appropriation,
1694 sale, or transfer of property.
1695 (2)(a) If the funds, assets, or property involved in the
1696 exploitation of the elderly person or disabled adult is valued
1697 at $100,000 or more, the offender commits a felony of the first
1698 degree, punishable as provided in s. 775.082, s. 775.083, or s.
1699 775.084.
1700 (b) If the funds, assets, or property involved in the
1701 exploitation of the elderly person or disabled adult is valued
1702 at $20,000 or more, but less than $100,000, the offender commits
1703 a felony of the second degree, punishable as provided in s.
1704 775.082, s. 775.083, or s. 775.084.
1705 (c) If the funds, assets, or property involved in the
1706 exploitation of an elderly person or disabled adult is valued at
1707 less than $20,000, the offender commits a felony of the third
1708 degree, punishable as provided in s. 775.082, s. 775.083, or s.
1709 775.084.
1710 Section 24. Paragraphs (g) and (i) of subsection (3) of
1711 section 921.0022, Florida Statutes, are amended to read:

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1712 921.0022 Criminal Punishment Code; offense severity ranking
1713 chart.—
1714 (3) OFFENSE SEVERITY RANKING CHART
1715 (g) LEVEL 7

Florida Statute	Felony Degree	Description
1716		
316.027(1)(b)	1st	Accident involving death, failure to stop; leaving scene.
1717		
316.193(3)(c)2.	3rd	DUI resulting in serious bodily injury.
1718		
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.
1719		
327.35(3)(c)2.	3rd	Vessel BUI resulting in serious bodily injury.
1720		
402.319(2)	2nd	Misrepresentation and negligence or intentional act resulting in great bodily harm, permanent disfiguration, permanent disability, or death.
1721		
409.920(2)(b)1.a.	3rd	Medicaid provider fraud; $10,000 or less.

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1722

409.920(2)(b)1.b.	2nd	Medicaid provider fraud; more than $10,000, but less than $50,000.

1723

456.065(2)	3rd	Practicing a health care profession without a license.

1724

456.065(2)	2nd	Practicing a health care profession without a license which results in serious bodily injury.

1725

458.327(1)	3rd	Practicing medicine without a license.

1726

459.013(1)	3rd	Practicing osteopathic medicine without a license.

1727

460.411(1)	3rd	Practicing chiropractic medicine without a license.

1728

461.012(1)	3rd	Practicing podiatric medicine without a license.

1729

462.17	3rd	Practicing naturopathy without a license.

1730

463.015(1)	3rd	Practicing optometry without a license.

1731

464.016(1)	3rd	Practicing nursing without a license.

1732

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	465.015(2)	3rd	Practicing pharmacy without a license.
1733	466.026(1)	3rd	Practicing dentistry or dental hygiene without a license.
1734	467.201	3rd	Practicing midwifery without a license.
1735	468.366	3rd	Delivering respiratory care services without a license.
1736	483.828(1)	3rd	Practicing as clinical laboratory personnel without a license.
1737	483.901(9)	3rd	Practicing medical physics without a license.
1738	484.013(1)(c)	3rd	Preparing or dispensing optical devices without a prescription.
1739	484.053	3rd	Dispensing hearing aids without a license.
1740	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.
1741	560.123(8)(b)1.	3rd	Failure to report currency or payment

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			instruments exceeding $300 but less than $20,000 by a money services business.
1742	560.125(5)(a)	3rd	Money services business by unauthorized person, currency or payment instruments exceeding $300 but less than $20,000.
1743	655.50(10)(b)1.	3rd	Failure to report financial transactions exceeding $300 but less than $20,000 by financial institution.
1744	775.21(10)(a)	3rd	Sexual predator; failure to register; failure to renew driver's license or identification card; other registration violations.
1745	775.21(10)(b)	3rd	Sexual predator working where children regularly congregate.
1746	775.21(10)(g)	3rd	Failure to report or providing false information about a sexual predator; harbor or conceal a sexual predator.
1747	782.051(3)	2nd	Attempted felony murder of a person by a person other than the perpetrator or the perpetrator of an attempted felony.
1748	782.07(1)	2nd	Killing of a human being by the act, procurement, or culpable negligence of

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			another (manslaughter).
1749	782.071	2nd	Killing of a human being or viable fetus by the operation of a motor vehicle in a reckless manner (vehicular homicide).
1750	782.072	2nd	Killing of a human being by the operation of a vessel in a reckless manner (vessel homicide).
1751	784.045(1)(a)1.	2nd	Aggravated battery; intentionally causing great bodily harm or disfigurement.
1752	784.045(1)(a)2.	2nd	Aggravated battery; using deadly weapon.
1753	784.045(1)(b)	2nd	Aggravated battery; perpetrator aware victim pregnant.
1754	784.048(4)	3rd	Aggravated stalking; violation of injunction or court order.
1755	784.048(7)	3rd	Aggravated stalking; violation of court order.
1756	784.07(2)(d)	1st	Aggravated battery on law enforcement officer.
1757	784.074(1)(a)	1st	Aggravated battery on sexually violent

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		predators facility staff.
1758		
784.08(2)(a)	1st	Aggravated battery on a person 65 years of age or older.
1759		
784.081(1)	1st	Aggravated battery on specified official or employee.
1760		
784.082(1)	1st	Aggravated battery by detained person on visitor or other detainee.
1761		
784.083(1)	1st	Aggravated battery on code inspector.
1762		
790.07(4)	1st	Specified weapons violation subsequent to previous conviction of s. 790.07(1) or (2).
1763		
790.16(1)	1st	Discharge of a machine gun under specified circumstances.
1764		
790.165(2)	2nd	Manufacture, sell, possess, or deliver hoax bomb.
1765		
790.165(3)	2nd	Possessing, displaying, or threatening to use any hoax bomb while committing or attempting to commit a felony.
1766		
790.166(3)	2nd	Possessing, selling, using, or attempting to use a hoax weapon of mass

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			destruction.
1767			
	790.166(4)	2nd	Possessing, displaying, or threatening to use a hoax weapon of mass destruction while committing or attempting to commit a felony.
1768			
	790.23	1st,PBL	Possession of a firearm by a person who qualifies for the penalty enhancements provided for in s. 874.04.
1769			
	794.08(4)	3rd	Female genital mutilation; consent by a parent, guardian, or a person in custodial authority to a victim younger than 18 years of age.
1770			
	796.03	2nd	Procuring any person under 16 years for prostitution.
1771			
	800.04(5)(c)1.	2nd	Lewd or lascivious molestation; victim less than 12 years of age; offender less than 18 years.
1772			
	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.
1773			
	806.01(2)	2nd	Maliciously damage structure by fire or explosive.

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1774

810.02(3)(a)	2nd	Burglary of occupied dwelling; unarmed; no assault or battery.
810.02(3)(b)	2nd	Burglary of unoccupied dwelling; unarmed; no assault or battery.
810.02(3)(d)	2nd	Burglary of occupied conveyance; unarmed; no assault or battery.
810.02(3)(e)	2nd	Burglary of authorized emergency vehicle.
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.
812.014(2)(b)2.	2nd	Property stolen, cargo valued at less than $50,000, grand theft in 2nd degree.
812.014(2)(b)3.	2nd	Property stolen, emergency medical equipment; 2nd degree grand theft.
812.014(2)(b)4.	2nd	Property stolen, law enforcement equipment from authorized emergency vehicle.

1775 1776 1777 1778 1779 1780 1781 1782

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	812.0145(2)(a)	1st	Theft from person 65 years of age or older; $50,000 or more.
1783			
	812.019(2)	1st	Stolen property; initiates, organizes, plans, etc., the theft of property and traffics in stolen property.
1784			
	812.131(2)(a)	2nd	Robbery by sudden snatching.
1785			
	812.133(2)(b)	1st	Carjacking; no firearm, deadly weapon, or other weapon.
1786			
	817.234(8)(a)	2nd	Solicitation of motor vehicle accident victims with intent to defraud.
1787			
	817.234(9)	2nd	Organizing, planning, or participating in an intentional motor vehicle collision.
1788			
	817.234(11)(c)	1st	Insurance fraud; property value $100,000 or more.
1789			
	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.
1790			
	825.102(3)(b)	2nd	Neglecting an elderly person or disabled

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			adult causing great bodily harm, disability, or disfigurement.
1791	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.
1792	827.03(3)(b)	2nd	Neglect of a child causing great bodily harm, disability, or disfigurement.
1793	827.04(3)	3rd	Impregnation of a child under 16 years of age by person 21 years of age or older.
1794	837.05(2)	3rd	Giving false information about alleged capital felony to a law enforcement officer.
1795	838.015	2nd	Bribery.
1796	838.016	2nd	Unlawful compensation or reward for official behavior.
1797	838.021(3)(a)	2nd	Unlawful harm to a public servant.
1798	838.22	2nd	Bid tampering.
1799	847.0135(3)	3rd	Solicitation of a child, via a computer service, to commit an unlawful sex act.

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1800

847.0135(4)	2nd	Traveling to meet a minor to commit an unlawful sex act.

1801

872.06	2nd	Abuse of a dead human body.

1802

874.10	1st,PBL	Knowingly initiates, organizes, plans, finances, directs, manages, or supervises criminal gang-related activity.

1803

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.

1804

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.

1805

893.13(4)(a)	1st	Deliver to minor cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a),

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(2)(b), or (2)(c)4. drugs).

1806

893.135(1)(a)1.	1st	Trafficking in cannabis, more than 25 lbs., less than 2,000 lbs.

1807

893.135(1)(b)1.a.	1st	Trafficking in cocaine, more than 28 grams, less than 200 grams.

1808

893.135(1)(c)1.a.	1st	Trafficking in illegal drugs, more than 4 grams, less than 14 grams.

1809

893.135(1)(d)1.	1st	Trafficking in phencyclidine, more than 28 grams, less than 200 grams.

1810

893.135(1)(e)1.	1st	Trafficking in methaqualone, more than 200 grams, less than 5 kilograms.

1811

893.135(1)(f)1.	1st	Trafficking in amphetamine, more than 14 grams, less than 28 grams.

1812

893.135(1)(g)1.a.	1st	Trafficking in flunitrazepam, 4 grams or more, less than 14 grams.

1813

893.135(1)(h)1.a.	1st	Trafficking in gamma-hydroxybutyric acid (GHB), 1 kilogram or more, less than 5 kilograms.

1814

893.135(1)(j)1.a.	1st	Trafficking in 1,4-Butanediol, 1 kilogram or more, less than 5

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kilograms.

1815

893.135(1)(k)2.a.	1st	Trafficking in Phenethylamines, 10 grams or more, less than 200 grams.

1816

893.1351(2)	2nd	Possession of place for trafficking in or manufacturing of controlled substance.

1817

896.101(5)(a)	3rd	Money laundering, financial transactions exceeding $300 but less than $20,000.

1818

896.104(4)(a)1.	3rd	Structuring transactions to evade reporting or registration requirements, financial transactions exceeding $300 but less than $20,000.

1819

943.0435(4)(c)	2nd	Sexual offender vacating permanent residence; failure to comply with reporting requirements.

1820

943.0435(8)	2nd	Sexual offender; remains in state after indicating intent to leave; failure to comply with reporting requirements.

1821

943.0435(9)(a)	3rd	Sexual offender; failure to comply with reporting requirements.

1822

943.0435(13)	3rd	Failure to report or providing false

			information about a sexual offender; harbor or conceal a sexual offender.
1823	943.0435(14)	3rd	Sexual offender; failure to report and reregister; failure to respond to address verification.
1824	944.607(9)	3rd	Sexual offender; failure to comply with reporting requirements.
1825	944.607(10)(a)	3rd	Sexual offender; failure to submit to the taking of a digitized photograph.
1826	944.607(12)	3rd	Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.
1827	944.607(13)	3rd	Sexual offender; failure to report and reregister; failure to respond to address verification.
1828	985.4815(10)	3rd	Sexual offender; failure to submit to the taking of a digitized photograph.
1829	985.4815(12)	3rd	Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.
1830	985.4815(13)	3rd	Sexual offender; failure to report and

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reregister; failure to respond to address verification.

1831

1832

1833 (i) LEVEL 9

Florida Statute	Felony Degree	Description
316.193(3)(c)3.b.	1st	DUI manslaughter; failing to render aid or give information.
327.35(3)(c)3.b.	1st	BUI manslaughter; failing to render aid or give information.
409.920(2)(b)1.c.	1st	Medicaid provider fraud; $50,000 or more.
499.0051(9)	1st	Knowing sale or purchase of contraband prescription drugs resulting in great bodily harm.
560.123(8)(b)3.	1st	Failure to report currency or payment instruments totaling or exceeding $100,000 by money transmitter.
560.125(5)(c)	1st	Money transmitter business by unauthorized person, currency, or payment instruments totaling or exceeding $100,000.

1834 1835 1836 1837 1838 1839

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1840

655.50(10)(b)3.	1st	Failure to report financial transactions totaling or exceeding $100,000 by financial institution.

1841

775.0844	1st	Aggravated white collar crime.

1842

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

1843

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

1844

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

1845

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

1846

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

1847

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

1848

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

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			political function.
1849	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.
1850	790.161	1st	Attempted capital destructive device offense.
1851	790.166(2)	1st,PBL	Possessing, selling, using, or attempting to use a weapon of mass destruction.
1852	794.011(2)	1st	Attempted sexual battery; victim less than 12 years of age.
1853	794.011(2)	Life	Sexual battery; offender younger than 18 years and commits sexual battery on a person less than 12 years.
1854	794.011(4)	1st	Sexual battery; victim 12 years or older, certain circumstances.
1855	794.011(8)(b)	1st	Sexual battery; engage in sexual conduct with minor 12 to 18 years by person in familial or custodial authority.
1856			

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	794.08(2)	1st	Female genital mutilation; victim younger than 18 years of age.
1857	800.04(5)(b)	Life	Lewd or lascivious molestation; victim less than 12 years; offender 18 years or older.
1858	812.13(2)(a)	1st,PBL	Robbery with firearm or other deadly weapon.
1859	812.133(2)(a)	1st,PBL	Carjacking; firearm or other deadly weapon.
1860	812.135(2)(b)	1st	Home-invasion robbery with weapon.
1861	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.
1862	827.03(2)	1st	Aggravated child abuse.
1863	847.0145(1)	1st	Selling, or otherwise transferring custody or control, of a minor.
1864	847.0145(2)	1st	Purchasing, or otherwise obtaining custody or control, of a minor.
1865			

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	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.
1866	893.135	1st	Attempted capital trafficking offense.
1867	893.135(1)(a)3.	1st	Trafficking in cannabis, more than 10,000 lbs.
1868	893.135(1)(b)1.c.	1st	Trafficking in cocaine, more than 400 grams, less than 150 kilograms.
1869	893.135(1)(c)1.c.	1st	Trafficking in illegal drugs, more than 28 grams, less than 30 kilograms.
1870	893.135(1)(d)1.c.	1st	Trafficking in phencyclidine, more than 400 grams.
1871	893.135(1)(e)1.c.	1st	Trafficking in methaqualone, more than 25 kilograms.
1872	893.135(1)(f)1.c.	1st	Trafficking in amphetamine, more than 200 grams.
1873	893.135(1)(h)1.c.	1st	Trafficking in gamma-hydroxybutyric acid (GHB), 10 kilograms or more.
1874			

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	893.135(1)(j)1.c.	1st	Trafficking in 1,4-Butanediol, 10 kilograms or more.
1875	893.135(1)(k)2.c.	1st	Trafficking in Phenethylamines, 400 grams or more.
1876	896.101(5)(c)	1st	Money laundering, financial instruments totaling or exceeding $100,000.
1877	896.104(4)(a)3.	1st	Structuring transactions to evade reporting or registration requirements, financial transactions totaling or exceeding $100,000.

1878
1879 Section 25. Pilot project to monitor home health services.—
1880 The Agency for Health Care Administration shall develop and
1881 implement a home health agency monitoring pilot project in
1882 Miami-Dade County by January 1, 2010. The agency shall contract
1883 with a vendor to verify the utilization and delivery of home
1884 health services and provide an electronic billing interface for
1885 home health services. The contract must require the creation of
1886 a program to submit claims electronically for the delivery of
1887 home health services. The program must verify telephonically
1888 visits for the delivery of home health services using voice
1889 biometrics. The agency may seek amendments to the Medicaid state
1890 plan and waivers of federal laws, as necessary, to implement the
1891 pilot project. Notwithstanding s. 287.057(5)(f), Florida
1892 Statutes, the agency must award the contract through the
1893 competitive solicitation process. The agency shall submit a

1894 report to the Governor, the President of the Senate, and the
1895 Speaker of the House of Representatives evaluating the pilot
1896 project by February 1, 2011.
1897 Section 26. Pilot project for home health care management.—
1898 The Agency for Health Care Administration shall implement a
1899 comprehensive care management pilot project for home health
1900 services by January 1, 2010, which includes face-to-face
1901 assessments by a nurse licensed pursuant to chapter 464, Florida
1902 Statutes, consultation with physicians ordering services to
1903 substantiate the medical necessity for services, and on-site or
1904 desk reviews of recipients' medical records in Miami-Dade
1905 County. The agency may enter into a contract with a qualified
1906 organization to implement the pilot project. The agency may seek
1907 amendments to the Medicaid state plan and waivers of federal
1908 laws, as necessary, to implement the pilot project.
1909 Section 27. Subsection (6) of section 400.0077, Florida
1910 Statutes, is amended to read:
1911 400.0077 Confidentiality.—
1912 (6) This section does not limit the subpoena power of the
1913 Attorney General pursuant to s. 409.920(10)(b) s. 409.920(9)(b).
1914 Section 28. Subsection (2) of section 430.608, Florida
1915 Statutes, is amended to read:
1916 430.608 Confidentiality of information.—
1917 (2) This section does not, however, limit the subpoena
1918 authority of the Medicaid Fraud Control Unit of the Department
1919 of Legal Affairs pursuant to s. 409.920(10)(b) s. 409.920(9)(b).
1920 Section 29. Section 395.0199, Florida Statutes, is
1921 repealed.
1922 Section 30. Section 395.405, Florida Statutes, is amended

1923 to read:

1924 395.405 Rulemaking.—The department shall adopt and enforce
1925 all rules necessary to administer ss. ~~395.0199,~~ 395.401,
1926 395.4015, 395.402, 395.4025, 395.403, 395.404, and 395.4045.

1927 Section 31. Subsection (1) of section 400.0712, Florida
1928 Statutes, is amended to read:

1929 400.0712 Application for inactive license.—

1930 (1) As specified in ~~s. 408.831(4) and~~ this section, the
1931 agency may issue an inactive license to a nursing home facility
1932 for all or a portion of its beds. Any request by a licensee that
1933 a nursing home or portion of a nursing home become inactive must
1934 be submitted to the agency in the approved format. The facility
1935 may not initiate any suspension of services, notify residents,
1936 or initiate inactivity before receiving approval from the
1937 agency; and a licensee that violates this provision may not be
1938 issued an inactive license.

1939 Section 32. Subsection (2) of section 400.118, Florida
1940 Statutes, is repealed.

1941 Section 33. Section 400.141, Florida Statutes, is amended
1942 to read:

1943 400.141 Administration and management of nursing home
1944 facilities.—

1945 (1) Every licensed facility shall comply with all
1946 applicable standards and rules of the agency and shall:

1947 (a) ~~(1)~~ Be under the administrative direction and charge of
1948 a licensed administrator.

1949 (b) ~~(2)~~ Appoint a medical director licensed pursuant to
1950 chapter 458 or chapter 459. The agency may establish by rule
1951 more specific criteria for the appointment of a medical

1952 director.
1953 (c)~~(3)~~ Have available the regular, consultative, and
1954 emergency services of physicians licensed by the state.
1955 (d)~~(4)~~ Provide for resident use of a community pharmacy as
1956 specified in s. 400.022(1)(q). Any other law to the contrary
1957 notwithstanding, a registered pharmacist licensed in Florida,
1958 that is under contract with a facility licensed under this
1959 chapter or chapter 429, shall repackage a nursing facility
1960 resident's bulk prescription medication which has been packaged
1961 by another pharmacist licensed in any state in the United States
1962 into a unit dose system compatible with the system used by the
1963 nursing facility, if the pharmacist is requested to offer such
1964 service. In order to be eligible for the repackaging, a resident
1965 or the resident's spouse must receive prescription medication
1966 benefits provided through a former employer as part of his or
1967 her retirement benefits, a qualified pension plan as specified
1968 in s. 4972 of the Internal Revenue Code, a federal retirement
1969 program as specified under 5 C.F.R. s. 831, or a long-term care
1970 policy as defined in s. 627.9404(1). A pharmacist who correctly
1971 repackages and relabels the medication and the nursing facility
1972 which correctly administers such repackaged medication under ~~the~~
1973 ~~provisions of~~ this paragraph may ~~subsection shall~~ not be held
1974 liable in any civil or administrative action arising from the
1975 repackaging. In order to be eligible for the repackaging, a
1976 nursing facility resident for whom the medication is to be
1977 repackaged shall sign an informed consent form provided by the
1978 facility which includes an explanation of the repackaging
1979 process and which notifies the resident of the immunities from
1980 liability provided in this paragraph ~~herein~~. A pharmacist who

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1981 repackages and relabels prescription medications, as authorized
1982 under this paragraph ~~subsection~~, may charge a reasonable fee for
1983 costs resulting from the implementation of this provision.
1984 (e)~~(5)~~ Provide for the access of the facility residents to
1985 dental and other health-related services, recreational services,
1986 rehabilitative services, and social work services appropriate to
1987 their needs and conditions and not directly furnished by the
1988 licensee. When a geriatric outpatient nurse clinic is conducted
1989 in accordance with rules adopted by the agency, outpatients
1990 attending such clinic shall not be counted as part of the
1991 general resident population of the nursing home facility, nor
1992 shall the nursing staff of the geriatric outpatient clinic be
1993 counted as part of the nursing staff of the facility, until the
1994 outpatient clinic load exceeds 15 a day.
1995 (f)~~(6)~~ Be allowed and encouraged by the agency to provide
1996 other needed services under certain conditions. If the facility
1997 has a standard licensure status, and has had no class I or class
1998 II deficiencies during the past 2 years or has been awarded a
1999 Gold Seal under the program established in s. 400.235, it may be
2000 encouraged by the agency to provide services, including, but not
2001 limited to, respite and adult day services, which enable
2002 individuals to move in and out of the facility. A facility is
2003 not subject to any additional licensure requirements for
2004 providing these services. Respite care may be offered to persons
2005 in need of short-term or temporary nursing home services.
2006 Respite care must be provided in accordance with this part and
2007 rules adopted by the agency. However, the agency shall, by rule,
2008 adopt modified requirements for resident assessment, resident
2009 care plans, resident contracts, physician orders, and other

2010 provisions, as appropriate, for short-term or temporary nursing
2011 home services. The agency shall allow for shared programming and
2012 staff in a facility which meets minimum standards and offers
2013 services pursuant to this paragraph ~~subsection~~, but, if the
2014 facility is cited for deficiencies in patient care, may require
2015 additional staff and programs appropriate to the needs of
2016 service recipients. A person who receives respite care may not
2017 be counted as a resident of the facility for purposes of the
2018 facility's licensed capacity unless that person receives 24-hour
2019 respite care. A person receiving either respite care for 24
2020 hours or longer or adult day services must be included when
2021 calculating minimum staffing for the facility. Any costs and
2022 revenues generated by a nursing home facility from
2023 nonresidential programs or services shall be excluded from the
2024 calculations of Medicaid per diems for nursing home
2025 institutional care reimbursement.
2026 (g)~~(7)~~ If the facility has a standard license or is a Gold
2027 Seal facility, exceeds the minimum required hours of licensed
2028 nursing and certified nursing assistant direct care per resident
2029 per day, and is part of a continuing care facility licensed
2030 under chapter 651 or a retirement community that offers other
2031 services pursuant to part III of this chapter or part I or part
2032 III of chapter 429 on a single campus, be allowed to share
2033 programming and staff. At the time of inspection and in the
2034 semiannual report required pursuant to paragraph (o) ~~subsection~~
2035 ~~(15)~~, a continuing care facility or retirement community that
2036 uses this option must demonstrate through staffing records that
2037 minimum staffing requirements for the facility were met.
2038 Licensed nurses and certified nursing assistants who work in the

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2039 nursing home facility may be used to provide services elsewhere
2040 on campus if the facility exceeds the minimum number of direct
2041 care hours required per resident per day and the total number of
2042 residents receiving direct care services from a licensed nurse
2043 or a certified nursing assistant does not cause the facility to
2044 violate the staffing ratios required under s. 400.23(3)(a).
2045 Compliance with the minimum staffing ratios shall be based on
2046 total number of residents receiving direct care services,
2047 regardless of where they reside on campus. If the facility
2048 receives a conditional license, it may not share staff until the
2049 conditional license status ends. This paragraph ~~subsection~~ does
2050 not restrict the agency’s authority under federal or state law
2051 to require additional staff if a facility is cited for
2052 deficiencies in care which are caused by an insufficient number
2053 of certified nursing assistants or licensed nurses. The agency
2054 may adopt rules for the documentation necessary to determine
2055 compliance with this provision.
2056 (h)~~(8)~~ Maintain the facility premises and equipment and
2057 conduct its operations in a safe and sanitary manner.
2058 (i)~~(9)~~ If the licensee furnishes food service, provide a
2059 wholesome and nourishing diet sufficient to meet generally
2060 accepted standards of proper nutrition for its residents and
2061 provide such therapeutic diets as may be prescribed by attending
2062 physicians. In making rules to implement this paragraph
2063 ~~subsection~~, the agency shall be guided by standards recommended
2064 by nationally recognized professional groups and associations
2065 with knowledge of dietetics.
2066 (j)~~(10)~~ Keep full records of resident admissions and
2067 discharges; medical and general health status, including medical

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2068 records, personal and social history, and identity and address
2069 of next of kin or other persons who may have responsibility for
2070 the affairs of the residents; and individual resident care plans
2071 including, but not limited to, prescribed services, service
2072 frequency and duration, and service goals. The records shall be
2073 open to inspection by the agency.
2074 (k)~~(11)~~ Keep such fiscal records of its operations and
2075 conditions as may be necessary to provide information pursuant
2076 to this part.
2077 (l)~~(12)~~ Furnish copies of personnel records for employees
2078 affiliated with such facility, to any other facility licensed by
2079 this state requesting this information pursuant to this part.
2080 Such information contained in the records may include, but is
2081 not limited to, disciplinary matters and any reason for
2082 termination. Any facility releasing such records pursuant to
2083 this part shall be considered to be acting in good faith and may
2084 not be held liable for information contained in such records,
2085 absent a showing that the facility maliciously falsified such
2086 records.
2087 (m)~~(13)~~ Publicly display a poster provided by the agency
2088 containing the names, addresses, and telephone numbers for the
2089 state's abuse hotline, the State Long-Term Care Ombudsman, the
2090 Agency for Health Care Administration consumer hotline, the
2091 Advocacy Center for Persons with Disabilities, the Florida
2092 Statewide Advocacy Council, and the Medicaid Fraud Control Unit,
2093 with a clear description of the assistance to be expected from
2094 each.
2095 (n)~~(14)~~ Submit to the agency the information specified in
2096 s. 400.071(1)(b) for a management company within 30 days after

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2097 the effective date of the management agreement.

2098 (o)1.~~(15)~~ Submit semiannually to the agency, or more
2099 frequently if requested by the agency, information regarding
2100 facility staff-to-resident ratios, staff turnover, and staff
2101 stability, including information regarding certified nursing
2102 assistants, licensed nurses, the director of nursing, and the
2103 facility administrator. For purposes of this reporting:

2104 a.~~(a)~~ Staff-to-resident ratios must be reported in the
2105 categories specified in s. 400.23(3)(a) and applicable rules.
2106 The ratio must be reported as an average for the most recent
2107 calendar quarter.

2108 b.~~(b)~~ Staff turnover must be reported for the most recent
2109 12-month period ending on the last workday of the most recent
2110 calendar quarter prior to the date the information is submitted.
2111 The turnover rate must be computed quarterly, with the annual
2112 rate being the cumulative sum of the quarterly rates. The
2113 turnover rate is the total number of terminations or separations
2114 experienced during the quarter, excluding any employee
2115 terminated during a probationary period of 3 months or less,
2116 divided by the total number of staff employed at the end of the
2117 period for which the rate is computed, and expressed as a
2118 percentage.

2119 c.~~(c)~~ The formula for determining staff stability is the
2120 total number of employees that have been employed for more than
2121 12 months, divided by the total number of employees employed at
2122 the end of the most recent calendar quarter, and expressed as a
2123 percentage.

2124 d.~~(d)~~ A nursing facility that has failed to comply with
2125 state minimum-staffing requirements for 2 consecutive days is

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

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

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

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

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

(p)~~(17)~~ Notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. The notification must occur within 30 days after the acknowledgment of such signs by facility

2155 staff. If an underlying condition is determined to exist, the
2156 facility shall arrange, with the appropriate health care
2157 provider, the necessary care and services to treat the
2158 condition.
2159 (q) ~~(18)~~ If the facility implements a dining and hospitality
2160 attendant program, ensure that the program is developed and
2161 implemented under the supervision of the facility director of
2162 nursing. A licensed nurse, licensed speech or occupational
2163 therapist, or a registered dietitian must conduct training of
2164 dining and hospitality attendants. A person employed by a
2165 facility as a dining and hospitality attendant must perform
2166 tasks under the direct supervision of a licensed nurse.
2167 (r) ~~(19)~~ Report to the agency any filing for bankruptcy
2168 protection by the facility or its parent corporation,
2169 divestiture or spin-off of its assets, or corporate
2170 reorganization within 30 days after the completion of such
2171 activity.
2172 (s) ~~(20)~~ Maintain general and professional liability
2173 insurance coverage that is in force at all times. In lieu of
2174 general and professional liability insurance coverage, a state-
2175 designated teaching nursing home and its affiliated assisted
2176 living facilities created under s. 430.80 may demonstrate proof
2177 of financial responsibility as provided in s. 430.80(3)(g) ~~s.~~
2178 ~~430.80(3)(h)~~.
2179 (t) ~~(21)~~ Maintain in the medical record for each resident a
2180 daily chart of certified nursing assistant services provided to
2181 the resident. The certified nursing assistant who is caring for
2182 the resident must complete this record by the end of his or her
2183 shift. This record must indicate assistance with activities of

2184 daily living, assistance with eating, and assistance with
2185 drinking, and must record each offering of nutrition and
2186 hydration for those residents whose plan of care or assessment
2187 indicates a risk for malnutrition or dehydration.
2188 (u) ~~(22)~~ Before November 30 of each year, subject to the
2189 availability of an adequate supply of the necessary vaccine,
2190 provide for immunizations against influenza viruses to all its
2191 consenting residents in accordance with the recommendations of
2192 the United States Centers for Disease Control and Prevention,
2193 subject to exemptions for medical contraindications and
2194 religious or personal beliefs. Subject to these exemptions, any
2195 consenting person who becomes a resident of the facility after
2196 November 30 but before March 31 of the following year must be
2197 immunized within 5 working days after becoming a resident.
2198 Immunization shall not be provided to any resident who provides
2199 documentation that he or she has been immunized as required by
2200 this paragraph ~~subsection~~. This paragraph ~~subsection~~ does not
2201 prohibit a resident from receiving the immunization from his or
2202 her personal physician if he or she so chooses. A resident who
2203 chooses to receive the immunization from his or her personal
2204 physician shall provide proof of immunization to the facility.
2205 The agency may adopt and enforce any rules necessary to comply
2206 with or implement this subsection.
2207 (v) ~~(23)~~ Assess all residents for eligibility for
2208 pneumococcal polysaccharide vaccination (PPV) and vaccinate
2209 residents when indicated within 60 days after the effective date
2210 of this act in accordance with the recommendations of the United
2211 States Centers for Disease Control and Prevention, subject to
2212 exemptions for medical contraindications and religious or

2213 personal beliefs. Residents admitted after the effective date of
2214 this act shall be assessed within 5 working days of admission
2215 and, when indicated, vaccinated within 60 days in accordance
2216 with the recommendations of the United States Centers for
2217 Disease Control and Prevention, subject to exemptions for
2218 medical contraindications and religious or personal beliefs.
2219 Immunization shall not be provided to any resident who provides
2220 documentation that he or she has been immunized as required by
2221 this paragraph ~~subsection~~. This paragraph ~~subsection~~ does not
2222 prohibit a resident from receiving the immunization from his or
2223 her personal physician if he or she so chooses. A resident who
2224 chooses to receive the immunization from his or her personal
2225 physician shall provide proof of immunization to the facility.
2226 The agency may adopt and enforce any rules necessary to comply
2227 with or implement this paragraph ~~subsection~~.
2228 (w) ~~(24)~~ Annually encourage and promote to its employees the
2229 benefits associated with immunizations against influenza viruses
2230 in accordance with the recommendations of the United States
2231 Centers for Disease Control and Prevention. The agency may adopt
2232 and enforce any rules necessary to comply with or implement this
2233 paragraph ~~subsection~~.
2234 (2) Facilities that have been awarded a Gold Seal under the
2235 program established in s. 400.235 may develop a plan to provide
2236 certified nursing assistant training as prescribed by federal
2237 regulations and state rules and may apply to the agency for
2238 approval of their program.
2239 Section 34. Subsections (5), (9), (10), (11), (12), (13),
2240 (14), and (15) of section 400.147, Florida Statutes, are amended
2241 to read:

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2242 400.147 Internal risk management and quality assurance
2243 program.—
2244 (5) For purposes of reporting to the agency under this
2245 section, the term “adverse incident” means:
2246 (a) An event over which facility personnel could exercise
2247 control and which is associated in whole or in part with the
2248 facility’s intervention, rather than the condition for which
2249 such intervention occurred, and which results in one of the
2250 following:
2251 1. Death;
2252 2. Brain or spinal damage;
2253 3. Permanent disfigurement;
2254 4. Fracture or dislocation of bones or joints;
2255 5. A limitation of neurological, physical, or sensory
2256 function;
2257 6. Any condition that required medical attention to which
2258 the resident has not given his or her informed consent,
2259 including failure to honor advanced directives; ~~or~~
2260 7. Any condition that required the transfer of the
2261 resident, within or outside the facility, to a unit providing a
2262 more acute level of care due to the adverse incident, rather
2263 than the resident’s condition prior to the adverse incident; or
2264 8. An event that is reported to law enforcement or its
2265 personnel for investigation; or
2266 ~~(b) Abuse, neglect, or exploitation as defined in s.~~
2267 ~~415.102;~~
2268 ~~(c) Abuse, neglect and harm as defined in s. 39.01;~~
2269 (b)~~(d)~~ Resident elopement, if the elopement places the
2270 resident at risk of harm or injury.~~; or~~

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2271 ~~(c) An event that is reported to law enforcement.~~

2272 (9) Abuse, neglect, or exploitation must be reported to the
2273 agency as required by 42 C.F.R. s. 483.13(c) and to the
2274 department as required by chapters 39 and 415.

2275 (10) ~~(9)~~ By the 10th of each month, each facility subject to
2276 this section shall report any notice received pursuant to s.
2277 400.0233(2) and each initial complaint that was filed with the
2278 clerk of the court and served on the facility during the
2279 previous month by a resident or a resident's family member,
2280 guardian, conservator, or personal legal representative. The
2281 report must include the name of the resident, the resident's
2282 date of birth and social security number, the Medicaid
2283 identification number for Medicaid-eligible persons, the date or
2284 dates of the incident leading to the claim or dates of
2285 residency, if applicable, and the type of injury or violation of
2286 rights alleged to have occurred. Each facility shall also submit
2287 a copy of the notices received pursuant to s. 400.0233(2) and
2288 complaints filed with the clerk of the court. This report is
2289 confidential as provided by law and is not discoverable or
2290 admissible in any civil or administrative action, except in such
2291 actions brought by the agency to enforce the provisions of this
2292 part.

2293 (11) ~~(10)~~ The agency shall review, as part of its licensure
2294 inspection process, the internal risk management and quality
2295 assurance program at each facility regulated by this section to
2296 determine whether the program meets standards established in
2297 statutory laws and rules, is being conducted in a manner
2298 designed to reduce adverse incidents, and is appropriately
2299 reporting incidents as required by this section.

(12)~~(11)~~ There is no monetary liability on the part of, and a cause of action for damages may not arise against, any risk manager for the implementation and oversight of the internal risk management and quality assurance program in a facility licensed under this part as required by this section, or for any act or proceeding undertaken or performed within the scope of the functions of such internal risk management and quality assurance program if the risk manager acts without intentional fraud.

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

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

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

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

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

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

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

~~(e) Disciplinary action taken against staff, categorized by~~

2329 ~~type of staff involved.~~

2330 (15) Information gathered by a credentialing organization
2331 under a quality assurance program is not discoverable from the
2332 credentialing organization. This subsection does not limit
2333 discovery of, access to, or use of facility records, including
2334 those records from which the credentialing organization gathered
2335 its information.

2336 Section 35. Subsection (3) of section 400.162, Florida
2337 Statutes, is amended to read:

2338 400.162 Property and personal affairs of residents.—

2339 (3) A licensee shall provide for the safekeeping of
2340 personal effects, funds, and other property of the resident in
2341 the facility. Whenever necessary for the protection of
2342 valuables, or in order to avoid unreasonable responsibility
2343 therefor, the licensee may require that such valuables be
2344 excluded or removed from the facility and kept at some place not
2345 subject to the control of the licensee. At the request of a
2346 resident, the facility shall mark the resident's personal
2347 property with the resident's name or another type of
2348 identification, without defacing the property. Any theft or loss
2349 of a resident's personal property shall be documented by the
2350 facility. The facility shall develop policies and procedures to
2351 minimize the risk of theft or loss of the personal property of
2352 residents. A copy of the policy shall be provided to every
2353 employee and to each resident <u>and the resident's representative</u>
2354 <u>if appropriate</u> at admission <u>and when revised</u>. Facility policies
2355 must include provisions related to reporting theft or loss of a
2356 resident's property to law enforcement and any facility waiver
2357 of liability for loss or theft. ~~The facility shall post notice~~

2358 ~~of these policies and procedures, and any revision thereof, in~~
2359 ~~places accessible to residents.~~
2360 Section 36. Paragraphs (a) and (b) of subsection (2) of
2361 section 400.191, Florida Statutes, are amended to read:
2362 400.191 Availability, distribution, and posting of reports
2363 and records.—
2364 (2) The agency shall publish the Nursing Home Guide
2365 ~~annually in consumer-friendly printed form and~~ quarterly in
2366 electronic form to assist consumers and their families in
2367 comparing and evaluating nursing home facilities.
2368 (a) The agency shall provide an Internet site which shall
2369 include at least the following information either directly or
2370 indirectly through a link to another established site or sites
2371 of the agency's choosing:
2372 1. A section entitled "Have you considered programs that
2373 provide alternatives to nursing home care?" which shall be the
2374 first section of the Nursing Home Guide and which shall
2375 prominently display information about available alternatives to
2376 nursing homes and how to obtain additional information regarding
2377 these alternatives. The Nursing Home Guide shall explain that
2378 this state offers alternative programs that permit qualified
2379 elderly persons to stay in their homes instead of being placed
2380 in nursing homes and shall encourage interested persons to call
2381 the Comprehensive Assessment Review and Evaluation for Long-Term
2382 Care Services (CARES) Program to inquire if they qualify. The
2383 Nursing Home Guide shall list available home and community-based
2384 programs which shall clearly state the services that are
2385 provided and indicate whether nursing home services are included
2386 if needed.

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2387 2. A list by name and address of all nursing home
2388 facilities in this state, including any prior name by which a
2389 facility was known during the previous 24-month period.
2390 3. Whether such nursing home facilities are proprietary or
2391 nonproprietary.
2392 4. The current owner of the facility’s license and the year
2393 that that entity became the owner of the license.
2394 5. The name of the owner or owners of each facility and
2395 whether the facility is affiliated with a company or other
2396 organization owning or managing more than one nursing facility
2397 in this state.
2398 6. The total number of beds in each facility and the most
2399 recently available occupancy levels.
2400 7. The number of private and semiprivate rooms in each
2401 facility.
2402 8. The religious affiliation, if any, of each facility.
2403 9. The languages spoken by the administrator and staff of
2404 each facility.
2405 10. Whether or not each facility accepts Medicare or
2406 Medicaid recipients or insurance, health maintenance
2407 organization, Veterans Administration, CHAMPUS program, or
2408 workers’ compensation coverage.
2409 11. Recreational and other programs available at each
2410 facility.
2411 12. Special care units or programs offered at each
2412 facility.
2413 13. Whether the facility is a part of a retirement
2414 community that offers other services pursuant to part III of
2415 this chapter or part I or part III of chapter 429.

2416 14. Survey and deficiency information, including all
2417 federal and state recertification, licensure, revisit, and
2418 complaint survey information, for each facility for the past 30
2419 months. For noncertified nursing homes, state survey and
2420 deficiency information, including licensure, revisit, and
2421 complaint survey information for the past 30 months shall be
2422 provided.
2423 ~~15. A summary of the deficiency data for each facility over~~
2424 ~~the past 30 months. The summary may include a score, rating, or~~
2425 ~~comparison ranking with respect to other facilities based on the~~
2426 ~~number of citations received by the facility on recertification,~~
2427 ~~licensure, revisit, and complaint surveys; the severity and~~
2428 ~~scope of the citations; and the number of recertification~~
2429 ~~surveys the facility has had during the past 30 months. The~~
2430 ~~score, rating, or comparison ranking may be presented in either~~
2431 ~~numeric or symbolic form for the intended consumer audience.~~
2432 ~~(b) The agency shall provide the following information in~~
2433 ~~printed form:~~
2434 ~~1. A section entitled "Have you considered programs that~~
2435 ~~provide alternatives to nursing home care?" which shall be the~~
2436 ~~first section of the Nursing Home Guide and which shall~~
2437 ~~prominently display information about available alternatives to~~
2438 ~~nursing homes and how to obtain additional information regarding~~
2439 ~~these alternatives. The Nursing Home Guide shall explain that~~
2440 ~~this state offers alternative programs that permit qualified~~
2441 ~~elderly persons to stay in their homes instead of being placed~~
2442 ~~in nursing homes and shall encourage interested persons to call~~
2443 ~~the Comprehensive Assessment Review and Evaluation for Long-Term~~
2444 ~~Care Services (CARES) Program to inquire if they qualify. The~~

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2445 ~~Nursing Home Guide shall list available home and community-based~~
2446 ~~programs which shall clearly state the services that are~~
2447 ~~provided and indicate whether nursing home services are included~~
2448 ~~if needed.~~
2449 ~~2. A list by name and address of all nursing home~~
2450 ~~facilities in this state.~~
2451 ~~3. Whether the nursing home facilities are proprietary or~~
2452 ~~nonproprietary.~~
2453 ~~4. The current owner or owners of the facility's license~~
2454 ~~and the year that entity became the owner of the license.~~
2455 ~~5. The total number of beds, and of private and semiprivate~~
2456 ~~rooms, in each facility.~~
2457 ~~6. The religious affiliation, if any, of each facility.~~
2458 ~~7. The name of the owner of each facility and whether the~~
2459 ~~facility is affiliated with a company or other organization~~
2460 ~~owning or managing more than one nursing facility in this state.~~
2461 ~~8. The languages spoken by the administrator and staff of~~
2462 ~~each facility.~~
2463 ~~9. Whether or not each facility accepts Medicare or~~
2464 ~~Medicaid recipients or insurance, health maintenance~~
2465 ~~organization, Veterans Administration, CHAMPUS program, or~~
2466 ~~workers' compensation coverage.~~
2467 ~~10. Recreational programs, special care units, and other~~
2468 ~~programs available at each facility.~~
2469 ~~11. The Internet address for the site where more detailed~~
2470 ~~information can be seen.~~
2471 ~~12. A statement advising consumers that each facility will~~
2472 ~~have its own policies and procedures related to protecting~~
2473 ~~resident property.~~

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2474 ~~13. A summary of the deficiency data for each facility over~~
2475 ~~the past 30 months. The summary may include a score, rating, or~~
2476 ~~comparison ranking with respect to other facilities based on the~~
2477 ~~number of citations received by the facility on recertification,~~
2478 ~~licensure, revisit, and complaint surveys; the severity and~~
2479 ~~scope of the citations; the number of citations; and the number~~
2480 ~~of recertification surveys the facility has had during the past~~
2481 ~~30 months. The score, rating, or comparison ranking may be~~
2482 ~~presented in either numeric or symbolic form for the intended~~
2483 ~~consumer audience.~~
2484 Section 37. Paragraph (d) of subsection (1) of section
2485 400.195, Florida Statutes, is amended to read:
2486 400.195 Agency reporting requirements.—
2487 (1) For the period beginning June 30, 2001, and ending June
2488 30, 2005, the Agency for Health Care Administration shall
2489 provide a report to the Governor, the President of the Senate,
2490 and the Speaker of the House of Representatives with respect to
2491 nursing homes. The first report shall be submitted no later than
2492 December 30, 2002, and subsequent reports shall be submitted
2493 every 6 months thereafter. The report shall identify facilities
2494 based on their ownership characteristics, size, business
2495 structure, for-profit or not-for-profit status, and any other
2496 characteristics the agency determines useful in analyzing the
2497 varied segments of the nursing home industry and shall report:
2498 (d) Information regarding deficiencies cited, including
2499 information used to develop the Nursing Home Guide WATCH LIST
2500 pursuant to s. 400.191, and applicable rules, a summary of data
2501 generated on nursing homes by Centers for Medicare and Medicaid
2502 Services Nursing Home Quality Information Project, and

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2503 information collected pursuant to s. 400.147(10) ~~s. 400.147(9)~~,
2504 relating to litigation.
2505 Section 38. Subsection (3) of section 400.23, Florida
2506 Statutes, is amended to read:
2507 400.23 Rules; evaluation and deficiencies; licensure
2508 status.—
2509 (3)(a)1. The agency shall adopt rules providing minimum
2510 staffing requirements for nursing homes. These requirements
2511 shall include, for each nursing home facility:
2512 a. A minimum certified nursing assistant staffing of 2.6
2513 hours of direct care per resident per day beginning January 1,
2514 2003, and increasing to 2.7 hours of direct care per resident
2515 per day beginning January 1, 2007. Beginning January 1, 2002, no
2516 facility shall staff below one certified nursing assistant per
2517 20 residents, and a minimum licensed nursing staffing of 1.0
2518 hour of direct care per resident per day but never below one
2519 licensed nurse per 40 residents.
2520 b. Beginning January 1, 2007, a minimum weekly average
2521 certified nursing assistant staffing of 2.9 hours of direct care
2522 per resident per day. For the purpose of this sub-subparagraph,
2523 a week is defined as Sunday through Saturday.
2524 2. Nursing assistants employed under s. 400.211(2) may be
2525 included in computing the staffing ratio for certified nursing
2526 assistants only if their job responsibilities include only
2527 nursing-assistant-related duties.
2528 3. Each nursing home must document compliance with staffing
2529 standards as required under this paragraph and post daily the
2530 names of staff on duty for the benefit of facility residents and
2531 the public.

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2532 4. The agency shall recognize the use of licensed nurses
2533 for compliance with minimum staffing requirements for certified
2534 nursing assistants, provided that the facility otherwise meets
2535 the minimum staffing requirements for licensed nurses and that
2536 the licensed nurses are performing the duties of a certified
2537 nursing assistant. Unless otherwise approved by the agency,
2538 licensed nurses counted toward the minimum staffing requirements
2539 for certified nursing assistants must exclusively perform the
2540 duties of a certified nursing assistant for the entire shift and
2541 not also be counted toward the minimum staffing requirements for
2542 licensed nurses. If the agency approved a facility's request to
2543 use a licensed nurse to perform both licensed nursing and
2544 certified nursing assistant duties, the facility must allocate
2545 the amount of staff time specifically spent on certified nursing
2546 assistant duties for the purpose of documenting compliance with
2547 minimum staffing requirements for certified and licensed nursing
2548 staff. In no event may the hours of a licensed nurse with dual
2549 job responsibilities be counted twice.
2550 (b) ~~The agency shall adopt rules to allow properly trained~~
2551 ~~staff of a nursing facility, in addition to certified nursing~~
2552 ~~assistants and licensed nurses, to assist residents with eating.~~
2553 ~~The rules shall specify the minimum training requirements and~~
2554 ~~shall specify the physiological conditions or disorders of~~
2555 ~~residents which would necessitate that the eating assistance be~~
2556 ~~provided by nursing personnel of the facility.~~ Nonnursing staff
2557 providing eating assistance to residents ~~under the provisions of~~
2558 ~~this subsection~~ shall not count toward compliance with minimum
2559 staffing standards.
2560 (c) Licensed practical nurses licensed under chapter 464

2561 who are providing nursing services in nursing home facilities
2562 under this part may supervise the activities of other licensed
2563 practical nurses, certified nursing assistants, and other
2564 unlicensed personnel providing services in such facilities in
2565 accordance with rules adopted by the Board of Nursing.
2566 Section 39. Paragraph (l) of subsection (4) of section
2567 400.9905, Florida Statutes, is amended, and paragraph (m) is
2568 added to that subsection, to read:
2569 400.9905 Definitions.—
2570 (4) “Clinic” means an entity at which health care services
2571 are provided to individuals and which tenders charges for
2572 reimbursement for such services, including a mobile clinic and a
2573 portable equipment provider. For purposes of this part, the term
2574 does not include and the licensure requirements of this part do
2575 not apply to:
2576 (l) Orthotic, ~~or~~ prosthetic, pediatric cardiological, or
2577 perinatological clinical facilities that are a publicly traded
2578 corporation or that are wholly owned, directly or indirectly, by
2579 a publicly traded corporation. As used in this paragraph, a
2580 publicly traded corporation is a corporation that issues
2581 securities traded on an exchange registered with the United
2582 States Securities and Exchange Commission as a national
2583 securities exchange.
2584 (m) Entities that do not seek reimbursement from insurance
2585 companies for medical services paid pursuant to personal injury
2586 protection coverage required by s. 627.736, bodily injury
2587 liability coverage, personal liability umbrella coverage, or
2588 uninsured motorist coverage.
2589 Section 40. Paragraph (a) of subsection (7) of section

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400.9935, Florida Statutes, is amended to read:

400.9935 Clinic responsibilities.—

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

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2619 Section 41. Subsection (6) of section 400.995, Florida
2620 Statutes, is amended to read:
2621 400.995 Agency administrative penalties.—
2622 (6) During an inspection, the agency~~, as an alternative to~~
2623 ~~or in conjunction with an administrative action against a clinic~~
2624 ~~for violations of this part and adopted rules,~~ shall make a
2625 reasonable attempt to discuss each violation ~~and recommended~~
2626 ~~corrective action~~ with the owner, medical director, or clinic
2627 director of the clinic, prior to written notification. ~~The~~
2628 ~~agency, instead of fixing a period within which the clinic shall~~
2629 ~~enter into compliance with standards, may request a plan of~~
2630 ~~corrective action from the clinic which demonstrates a good~~
2631 ~~faith effort to remedy each violation by a specific date,~~
2632 ~~subject to the approval of the agency.~~
2633 Section 42. Subsections (5), (9), and (13) of section
2634 408.803, Florida Statutes, are amended to read:
2635 408.803 Definitions.—As used in this part, the term:
2636 (5) "Change of ownership" means:
2637 (a) An event in which the licensee sells or otherwise
2638 transfers its ownership ~~changes~~ to a different individual or
2639 ~~legal~~ entity as evidenced by a change in federal employer
2640 identification number or taxpayer identification number; or
2641 (b) An event in which 51 ~~45~~ percent or more of the
2642 ownership, ~~voting~~ shares, membership, or controlling interest of
2643 a licensee is in any manner transferred or otherwise assigned.
2644 This paragraph does not apply to a licensee that is publicly
2645 traded on a recognized stock exchange ~~in a corporation whose~~
2646 ~~shares are not publicly traded on a recognized stock exchange is~~
2647 ~~transferred or assigned, including the final transfer or~~

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2648 ~~assignment of multiple transfers or assignments over a 2-year~~
2649 ~~period that cumulatively total 45 percent or greater~~.
2650
2651 A change solely in the management company or board of directors
2652 is not a change of ownership.
2653 (9) "Licensee" means an individual, corporation,
2654 partnership, firm, association, ~~or~~ governmental entity<u>, or other</u>
2655 <u>entity</u> that is issued a permit, registration, certificate, or
2656 license by the agency. The licensee is legally responsible for
2657 all aspects of the provider operation.
2658 (13) "Voluntary board member" means a board member <u>or</u>
2659 <u>officer</u> of a not-for-profit corporation or organization who
2660 serves solely in a voluntary capacity, does not receive any
2661 remuneration for his or her services on the board of directors,
2662 and has no financial interest in the corporation or
2663 organization. ~~The agency shall recognize a person as a voluntary~~
2664 ~~board member following submission of a statement to the agency~~
2665 ~~by the board member and the not-for-profit corporation or~~
2666 ~~organization that affirms that the board member conforms to this~~
2667 ~~definition. The statement affirming the status of the board~~
2668 ~~member must be submitted to the agency on a form provided by the~~
2669 ~~agency.~~
2670 Section 43. Paragraph (a) of subsection (1), subsection
2671 (2), paragraph (c) of subsection (7), and subsection (8) of
2672 section 408.806, Florida Statutes, are amended to read:
2673 408.806 License application process.—
2674 (1) An application for licensure must be made to the agency
2675 on forms furnished by the agency, submitted under oath, and
2676 accompanied by the appropriate fee in order to be accepted and

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2677 considered timely. The application must contain information
2678 required by authorizing statutes and applicable rules and must
2679 include:
2680 (a) The name, address, and social security number of:
2681 1. The applicant;
2682 2. The administrator or a similarly titled person who is
2683 responsible for the day-to-day operation of the provider;
2684 3. The financial officer or similarly titled person who is
2685 responsible for the financial operation of the licensee or
2686 provider; and
2687 4. Each controlling interest if the applicant or
2688 controlling interest is an individual.
2689 (2)(a) The applicant for a renewal license must submit an
2690 application that must be received by the agency at least 60 days
2691 but no more than 120 days before ~~prior to~~ the expiration of the
2692 current license. An application received more than 120 days
2693 before the expiration of the current license shall be returned
2694 to the applicant. If the renewal application and fee are
2695 received prior to the license expiration date, the license shall
2696 not be deemed to have expired if the license expiration date
2697 occurs during the agency's review of the renewal application.
2698 (b) The applicant for initial licensure due to a change of
2699 ownership must submit an application that must be received by
2700 the agency at least 60 days prior to the date of change of
2701 ownership.
2702 (c) For any other application or request, the applicant
2703 must submit an application or request that must be received by
2704 the agency at least 60 days but no more than 120 days before
2705 ~~prior to~~ the requested effective date, unless otherwise

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2706 specified in authorizing statutes or applicable rules. An
2707 application received more than 120 days before the requested
2708 effective date shall be returned to the applicant.
2709 (d) The agency shall notify the licensee by mail or
2710 electronically at least 90 days before ~~prior to~~ the expiration
2711 of a license that a renewal license is necessary to continue
2712 operation. The failure to timely submit a renewal application
2713 and license fee shall result in a $50 per day late fee charged
2714 to the licensee by the agency; however, the aggregate amount of
2715 the late fee may not exceed 50 percent of the licensure fee or
2716 $500, whichever is less. If an application is received after the
2717 required filing date and exhibits a hand-canceled postmark
2718 obtained from a United States post office dated on or before the
2719 required filing date, no fine will be levied.
2720 (7)
2721 (c) If an inspection is required by the authorizing statute
2722 for a license application other than an initial application, the
2723 inspection must be unannounced. This paragraph does not apply to
2724 inspections required pursuant to ss. 383.324, 395.0161(4),
2725 429.67(6), and 483.061(2).
2726 (8) The agency may establish procedures for the electronic
2727 notification and submission of required information, including,
2728 but not limited to:
2729 (a) Licensure applications.
2730 (b) Required signatures.
2731 (c) Payment of fees.
2732 (d) Notarization of applications.
2733
2734 Requirements for electronic submission of any documents required

2735 by this part or authorizing statutes may be established by rule.
2736 As an alternative to sending documents as required by
2737 authorizing statutes, the agency may provide electronic access
2738 to information or documents.
2739 Section 44. Subsection (2) of section 408.808, Florida
2740 Statutes, is amended to read:
2741 408.808 License categories.—
2742 (2) PROVISIONAL LICENSE.—A provisional license may be
2743 issued to an applicant pursuant to s. 408.809(3). An applicant
2744 against whom a proceeding denying or revoking a license is
2745 pending at the time of license renewal may be issued a
2746 provisional license effective until final action not subject to
2747 further appeal. A provisional license may also be issued to an
2748 applicant applying for a change of ownership. A provisional
2749 license shall be limited in duration to a specific period of
2750 time, not to exceed 12 months, as determined by the agency.
2751 Section 45. Subsection (5) of section 408.809, Florida
2752 Statutes, is amended, and subsection (6) is added to that
2753 section, to read:
2754 408.809 Background screening; prohibited offenses.—
2755 (5) Effective October 1, 2009, in addition to the offenses
2756 listed in ss. 435.03 and 435.04, all persons required to undergo
2757 background screening pursuant to this part or authorizing
2758 statutes must not have been found guilty of, regardless of
2759 adjudication, or entered a plea of nolo contendere or guilty to,
2760 any of the following offenses or any similar offense of another
2761 jurisdiction:
2762 (a) Any authorizing statutes, if the offense was a felony.
2763 (b) This chapter, if the offense was a felony.

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2764 (c) Section 409.920, relating to Medicaid provider fraud,
2765 if the offense was a felony.
2766 (d) Section 409.9201, relating to Medicaid fraud, if the
2767 offense was a felony.
2768 (e) Section 741.28, relating to domestic violence.
2769 (f) Chapter 784, relating to assault, battery, and culpable
2770 negligence, if the offense was a felony.
2771 (g) Section 810.02, relating to burglary.
2772 (h) Section 817.034, relating to fraudulent acts through
2773 mail, wire, radio, electromagnetic, photoelectronic, or
2774 photooptical systems.
2775 (i) Section 817.234, relating to false and fraudulent
2776 insurance claims.
2777 (j) Section 817.505, relating to patient brokering.
2778 (k) Section 817.568, relating to criminal use of personal
2779 identification information.
2780 (l) Section 817.60, relating to obtaining a credit card
2781 through fraudulent means.
2782 (m) Section 817.61, relating to fraudulent use of credit
2783 cards, if the offense was a felony.
2784 (n) Section 831.01, relating to forgery.
2785 (o) Section 831.02, relating to uttering forged
2786 instruments.
2787 (p) Section 831.07, relating to forging bank bills, checks,
2788 drafts, or promissory notes.
2789 (q) Section 831.09, relating to uttering forged bank bills,
2790 checks, drafts, or promissory notes.
2791 (r) Section 831.30, relating to fraud in obtaining
2792 medicinal drugs.

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2793 (s) Section 831.31, relating to the sale, manufacture,
2794 delivery, or possession with the intent to sell, manufacture, or
2795 deliver any counterfeit controlled substance, if the offense was
2796 a felony.
2797
2798 A person who serves as a controlling interest of or is employed
2799 by a licensee on September 30, 2009, is not required by law to
2800 submit to rescreening if that licensee has in its possession
2801 written evidence that the person has been screened and qualified
2802 according to the standards specified in s. 435.03 or s. 435.04.
2803 However, if such person has a disqualifying offense listed in
2804 this section, he or she may apply for an exemption from the
2805 appropriate licensing agency before September 30, 2009, and if
2806 agreed to by the employer, may continue to perform his or her
2807 duties until the licensing agency renders a decision on the
2808 application for exemption for offenses listed in this section.
2809 Exemptions from disqualification may be granted pursuant to s.
2810 435.07. ~~Background screening is not required to obtain a~~
2811 ~~certificate of exemption issued under s. 483.106.~~
2812 (6) The attestations required under ss. 435.04(5) and
2813 435.05(3) must be submitted at the time of license renewal,
2814 notwithstanding the provisions of ss. 435.04(5) and 435.05(3)
2815 which require annual submission of an affidavit of compliance
2816 with background screening requirements.
2817 Section 46. Section 408.811, Florida Statutes, is amended
2818 to read:
2819 408.811 Right of inspection; copies; inspection reports;
2820 plan for correction of deficiencies.—
2821 (1) An authorized officer or employee of the agency may

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2822 make or cause to be made any inspection or investigation deemed
2823 necessary by the agency to determine the state of compliance
2824 with this part, authorizing statutes, and applicable rules. The
2825 right of inspection extends to any business that the agency has
2826 reason to believe is being operated as a provider without a
2827 license, but inspection of any business suspected of being
2828 operated without the appropriate license may not be made without
2829 the permission of the owner or person in charge unless a warrant
2830 is first obtained from a circuit court. Any application for a
2831 license issued under this part, authorizing statutes, or
2832 applicable rules constitutes permission for an appropriate
2833 inspection to verify the information submitted on or in
2834 connection with the application.
2835 (a) All inspections shall be unannounced, except as
2836 specified in s. 408.806.
2837 (b) Inspections for relicensure shall be conducted
2838 biennially unless otherwise specified by authorizing statutes or
2839 applicable rules.
2840 (2) Inspections conducted in conjunction with
2841 certification, comparable licensure requirements, or a
2842 recognized or approved accreditation organization may be
2843 accepted in lieu of a complete licensure inspection. However, a
2844 licensure inspection may also be conducted to review any
2845 licensure requirements that are not also requirements for
2846 certification.
2847 (3) The agency shall have access to and the licensee shall
2848 provide, or if requested send, copies of all provider records
2849 required during an inspection or other review at no cost to the
2850 agency, including records requested during an offsite review.

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2851 (4) A deficiency must be corrected within 30 calendar days
2852 after the provider is notified of inspection results unless an
2853 alternative timeframe is required or approved by the agency.
2854 (5) The agency may require an applicant or licensee to
2855 submit a plan of correction for deficiencies. If required, the
2856 plan of correction must be filed with the agency within 10
2857 calendar days after notification unless an alternative timeframe
2858 is required.
2859 (6)(a) ~~(4)(a)~~ Each licensee shall maintain as public
2860 information, available upon request, records of all inspection
2861 reports pertaining to that provider that have been filed by the
2862 agency unless those reports are exempt from or contain
2863 information that is exempt from s. 119.07(1) and s. 24(a), Art.
2864 I of the State Constitution or is otherwise made confidential by
2865 law. Effective October 1, 2006, copies of such reports shall be
2866 retained in the records of the provider for at least 3 years
2867 following the date the reports are filed and issued, regardless
2868 of a change of ownership.
2869 (b) A licensee shall, upon the request of any person who
2870 has completed a written application with intent to be admitted
2871 by such provider, any person who is a client of such provider,
2872 or any relative, spouse, or guardian of any such person, furnish
2873 to the requester a copy of the last inspection report pertaining
2874 to the licensed provider that was issued by the agency or by an
2875 accrediting organization if such report is used in lieu of a
2876 licensure inspection.
2877 Section 47. Section 408.813, Florida Statutes, is amended
2878 to read:
2879 408.813 Administrative fines; violations.—As a penalty for

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2880 any violation of this part, authorizing statutes, or applicable
2881 rules, the agency may impose an administrative fine.
2882 (1) Unless the amount or aggregate limitation of the fine
2883 is prescribed by authorizing statutes or applicable rules, the
2884 agency may establish criteria by rule for the amount or
2885 aggregate limitation of administrative fines applicable to this
2886 part, authorizing statutes, and applicable rules. Each day of
2887 violation constitutes a separate violation and is subject to a
2888 separate fine. For fines imposed by final order of the agency
2889 and not subject to further appeal, the violator shall pay the
2890 fine plus interest at the rate specified in s. 55.03 for each
2891 day beyond the date set by the agency for payment of the fine.
2892 (2) Violations of this part, authorizing statutes, or
2893 applicable rules shall be classified according to the nature of
2894 the violation and the gravity of its probable effect on clients.
2895 The scope of a violation may be cited as an isolated, patterned,
2896 or widespread deficiency. An isolated deficiency is a deficiency
2897 affecting one or a very limited number of clients, or involving
2898 one or a very limited number of staff, or a situation that
2899 occurred only occasionally or in a very limited number of
2900 locations. A patterned deficiency is a deficiency in which more
2901 than a very limited number of clients are affected, or more than
2902 a very limited number of staff are involved, or the situation
2903 has occurred in several locations, or the same client or clients
2904 have been affected by repeated occurrences of the same deficient
2905 practice but the effect of the deficient practice is not found
2906 to be pervasive throughout the provider. A widespread deficiency
2907 is a deficiency in which the problems causing the deficiency are
2908 pervasive in the provider or represent systemic failure that has

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2909 affected or has the potential to affect a large portion of the
2910 provider's clients. This subsection does not affect the
2911 legislative determination of the amount of a fine imposed under
2912 authorizing statutes. Violations shall be classified on the
2913 written notice as follows:
2914 (a) Class "I" violations are those conditions or
2915 occurrences related to the operation and maintenance of a
2916 provider or to the care of clients which the agency determines
2917 present an imminent danger to the clients of the provider or a
2918 substantial probability that death or serious physical or
2919 emotional harm would result therefrom. The condition or practice
2920 constituting a class I violation shall be abated or eliminated
2921 within 24 hours, unless a fixed period, as determined by the
2922 agency, is required for correction. The agency shall impose an
2923 administrative fine as provided by law for a cited class I
2924 violation. A fine shall be levied notwithstanding the correction
2925 of the violation.
2926 (b) Class "II" violations are those conditions or
2927 occurrences related to the operation and maintenance of a
2928 provider or to the care of clients which the agency determines
2929 directly threaten the physical or emotional health, safety, or
2930 security of the clients, other than class I violations. The
2931 agency shall impose an administrative fine as provided by law
2932 for a cited class II violation. A fine shall be levied
2933 notwithstanding the correction of the violation.
2934 (c) Class "III" violations are those conditions or
2935 occurrences related to the operation and maintenance of a
2936 provider or to the care of clients which the agency determines
2937 indirectly or potentially threaten the physical or emotional

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2938 health, safety, or security of clients, other than class I or
2939 class II violations. The agency shall impose an administrative
2940 fine as provided in this section for a cited class III
2941 violation. A citation for a class III violation must specify the
2942 time within which the violation is required to be corrected. If
2943 a class III violation is corrected within the time specified, a
2944 fine may not be imposed.
2945 (d) Class "IV" violations are those conditions or
2946 occurrences related to the operation and maintenance of a
2947 provider or to required reports, forms, or documents that do not
2948 have the potential of negatively affecting clients. These
2949 violations are of a type that the agency determines do not
2950 threaten the health, safety, or security of clients. The agency
2951 shall impose an administrative fine as provided in this section
2952 for a cited class IV violation. A citation for a class IV
2953 violation must specify the time within which the violation is
2954 required to be corrected. If a class IV violation is corrected
2955 within the time specified, a fine may not be imposed.
2956 Section 48. Subsections (11), (12), (13), (14), (15), (16),
2957 (17), (18), (19), (20), (21), (22), (23), (24), (25), (26),
2958 (27), (28), and (29) of section 408.820, Florida Statutes, are
2959 amended to read:
2960 408.820 Exemptions.—Except as prescribed in authorizing
2961 statutes, the following exemptions shall apply to specified
2962 requirements of this part:
2963 ~~(11) Private review agents, as provided under part I of~~
2964 ~~chapter 395, are exempt from ss. 408.806(7), 408.810, and~~
2965 ~~408.811.~~
2966 (11) ~~(12)~~ Health care risk managers, as provided under part

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2967 I of chapter 395, are exempt from ss. 408.806(7), 408.810(4)-
2968 (10) ~~408.810~~, and 408.811.
2969 (12)~~(13)~~ Nursing homes, as provided under part II of
2970 chapter 400, are exempt from ss. 408.810(7) and 408.813(2) ~~s.~~
2971 ~~408.810(7)~~.
2972 (13)~~(14)~~ Assisted living facilities, as provided under part
2973 I of chapter 429, are exempt from s. 408.810(10).
2974 (14)~~(15)~~ Home health agencies, as provided under part III
2975 of chapter 400, are exempt from s. 408.810(10).
2976 (15)~~(16)~~ Nurse registries, as provided under part III of
2977 chapter 400, are exempt from s. 408.810(6) and (10).
2978 (16)~~(17)~~ Companion services or homemaker services
2979 providers, as provided under part III of chapter 400, are exempt
2980 from s. 408.810(6)-(10).
2981 (17)~~(18)~~ Adult day care centers, as provided under part III
2982 of chapter 429, are exempt from s. 408.810(10).
2983 (18)~~(19)~~ Adult family-care homes, as provided under part II
2984 of chapter 429, are exempt from s. 408.810(7)-(10).
2985 (18)~~(20)~~ Homes for special services, as provided under part
2986 V of chapter 400, are exempt from s. 408.810(7)-(10).
2987 (20)~~(21)~~ Transitional living facilities, as provided under
2988 part V of chapter 400, are exempt from s. 408.810(10) ~~s.~~
2989 ~~408.810(7)-(10)~~.
2990 (21)~~(22)~~ Prescribed pediatric extended care centers, as
2991 provided under part VI of chapter 400, are exempt from s.
2992 408.810(10).
2993 (22)~~(23)~~ Home medical equipment providers, as provided
2994 under part VII of chapter 400, are exempt from s. 408.810(10).
2995 (23)~~(24)~~ Intermediate care facilities for persons with

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2996 developmental disabilities, as provided under part VIII of
2997 chapter 400, are exempt from s. 408.810(7).
2998 (24)~~(25)~~ Health care services pools, as provided under part
2999 IX of chapter 400, are exempt from s. 408.810(6)-(10).
3000 (25)~~(26)~~ Health care clinics, as provided under part X of
3001 chapter 400, are exempt from s. 408.810(6), (7), (10) ~~ss.~~
3002 ~~408.809 and 408.810(1), (6), (7), and (10)~~.
3003 (26)~~(27)~~ Clinical laboratories, as provided under part I of
3004 chapter 483, are exempt from s. 408.810(5)-(10).
3005 (27)~~(28)~~ Multiphasic health testing centers, as provided
3006 under part II of chapter 483, are exempt from s. 408.810(5)-
3007 (10).
3008 (28)~~(29)~~ Organ and tissue procurement agencies, as provided
3009 under chapter 765, are exempt from s. 408.810(5)-(10).
3010 Section 49. Section 408.821, Florida Statutes, is created
3011 to read:
3012 408.821 Emergency management planning; emergency
3013 operations; inactive license.—
3014 (1) A licensee required by authorizing statutes to have an
3015 emergency operations plan must designate a safety liaison to
3016 serve as the primary contact for emergency operations.
3017 (2) An entity subject to this part may temporarily exceed
3018 its licensed capacity to act as a receiving provider in
3019 accordance with an approved emergency operations plan for up to
3020 15 days. While in an overcapacity status, each provider must
3021 furnish or arrange for appropriate care and services to all
3022 clients. In addition, the agency may approve requests for
3023 overcapacity in excess of 15 days, which approvals may be based
3024 upon satisfactory justification and need as provided by the

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3025 receiving and sending providers.
3026 (3)(a) An inactive license may be issued to a licensee
3027 subject to this section when the provider is located in a
3028 geographic area in which a state of emergency was declared by
3029 the Governor if the provider:
3030 1. Suffered damage to its operation during the state of
3031 emergency.
3032 2. Is currently licensed.
3033 3. Does not have a provisional license.
3034 4. Will be temporarily unable to provide services but is
3035 reasonably expected to resume services within 12 months.
3036 (b) An inactive license may be issued for a period not to
3037 exceed 12 months but may be renewed by the agency for up to 12
3038 additional months upon demonstration to the agency of progress
3039 toward reopening. A request by a licensee for an inactive
3040 license or to extend the previously approved inactive period
3041 must be submitted in writing to the agency, accompanied by
3042 written justification for the inactive license, which states the
3043 beginning and ending dates of inactivity and includes a plan for
3044 the transfer of any clients to other providers and appropriate
3045 licensure fees. Upon agency approval, the licensee shall notify
3046 clients of any necessary discharge or transfer as required by
3047 authorizing statutes or applicable rules. The beginning of the
3048 inactive licensure period shall be the date the provider ceases
3049 operations. The end of the inactive period shall become the
3050 license expiration date, and all licensure fees must be current,
3051 must be paid in full, and may be prorated. Reactivation of an
3052 inactive license requires the prior approval by the agency of a
3053 renewal application, including payment of licensure fees and

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3054 agency inspections indicating compliance with all requirements
3055 of this part and applicable rules and statutes.
3056 (4) The agency may adopt rules relating to emergency
3057 management planning, communications, and operations. Licensees
3058 providing residential or inpatient services must utilize an
3059 online database approved by the agency to report information to
3060 the agency regarding the provider's emergency status, planning,
3061 or operations.
3062 Section 50. Section 408.831, Florida Statutes, is amended
3063 to read:
3064 408.831 Denial, suspension, or revocation of a license,
3065 registration, certificate, or application.—
3066 (1) In addition to any other remedies provided by law, the
3067 agency may deny each application or suspend or revoke each
3068 license, registration, or certificate of entities regulated or
3069 licensed by it:
3070 (a) If the applicant, licensee, or a licensee subject to
3071 this part which shares a common controlling interest with the
3072 applicant has failed to pay all outstanding fines, liens, or
3073 overpayments assessed by final order of the agency or final
3074 order of the Centers for Medicare and Medicaid Services, not
3075 subject to further appeal, unless a repayment plan is approved
3076 by the agency; or
3077 (b) For failure to comply with any repayment plan.
3078 (2) In reviewing any application requesting a change of
3079 ownership or change of the licensee, registrant, or
3080 certificateholder, the transferor shall, prior to agency
3081 approval of the change, repay or make arrangements to repay any
3082 amounts owed to the agency. Should the transferor fail to repay

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3083 or make arrangements to repay the amounts owed to the agency,
3084 the issuance of a license, registration, or certificate to the
3085 transferee shall be delayed until repayment or until
3086 arrangements for repayment are made.
3087 ~~(3) An entity subject to this section may exceed its~~
3088 ~~licensed capacity to act as a receiving facility in accordance~~
3089 ~~with an emergency operations plan for clients of evacuating~~
3090 ~~providers from a geographic area where an evacuation order has~~
3091 ~~been issued by a local authority having jurisdiction. While in~~
3092 ~~an overcapacity status, each provider must furnish or arrange~~
3093 ~~for appropriate care and services to all clients. In addition,~~
3094 ~~the agency may approve requests for overcapacity beyond 15 days,~~
3095 ~~which approvals may be based upon satisfactory justification and~~
3096 ~~need as provided by the receiving and sending facilities.~~
3097 ~~(4)(a) An inactive license may be issued to a licensee~~
3098 ~~subject to this section when the provider is located in a~~
3099 ~~geographic area where a state of emergency was declared by the~~
3100 ~~Governor if the provider:~~
3101 ~~1. Suffered damage to its operation during that state of~~
3102 ~~emergency.~~
3103 ~~2. Is currently licensed.~~
3104 ~~3. Does not have a provisional license.~~
3105 ~~4. Will be temporarily unable to provide services but is~~
3106 ~~reasonably expected to resume services within 12 months.~~
3107 ~~(b) An inactive license may be issued for a period not to~~
3108 ~~exceed 12 months but may be renewed by the agency for up to 12~~
3109 ~~additional months upon demonstration to the agency of progress~~
3110 ~~toward reopening. A request by a licensee for an inactive~~
3111 ~~license or to extend the previously approved inactive period~~

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3112 ~~must be submitted in writing to the agency, accompanied by~~
3113 ~~written justification for the inactive license, which states the~~
3114 ~~beginning and ending dates of inactivity and includes a plan for~~
3115 ~~the transfer of any clients to other providers and appropriate~~
3116 ~~licensure fees. Upon agency approval, the licensee shall notify~~
3117 ~~clients of any necessary discharge or transfer as required by~~
3118 ~~authorizing statutes or applicable rules. The beginning of the~~
3119 ~~inactive licensure period shall be the date the provider ceases~~
3120 ~~operations. The end of the inactive period shall become the~~
3121 ~~licensee expiration date, and all licensure fees must be~~
3122 ~~current, paid in full, and may be prorated. Reactivation of an~~
3123 ~~inactive license requires the prior approval by the agency of a~~
3124 ~~renewal application, including payment of licensure fees and~~
3125 ~~agency inspections indicating compliance with all requirements~~
3126 ~~of this part and applicable rules and statutes.~~
3127 (3) ~~(5)~~ This section provides standards of enforcement
3128 applicable to all entities licensed or regulated by the Agency
3129 for Health Care Administration. This section controls over any
3130 conflicting provisions of chapters 39, 383, 390, 391, 394, 395,
3131 400, 408, 429, 468, 483, and 765 or rules adopted pursuant to
3132 those chapters.
3133 Section 51. Subsection (2) of section 408.918, Florida
3134 Statutes, is amended, and subsection (3) is added to that
3135 section, to read:
3136 408.918 Florida 211 Network; uniform certification
3137 requirements.—
3138 (2) In order to participate in the Florida 211 Network, a
3139 211 provider must be fully accredited by the National ~~certified~~
3140 ~~by the Agency for Health Care Administration. The agency shall~~

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3141 ~~develop criteria for certification, as recommended by the~~
3142 ~~Florida~~ Alliance of Information and Referral Services or have
3143 received approval to operate, pending accreditation, from its
3144 affiliate, the Florida Alliance of Information and Referral
3145 Services~~, and shall adopt the criteria as administrative rules~~.
3146 ~~(a)~~ If any provider of information and referral services or
3147 other entity leases a 211 number from a local exchange company
3148 and is not authorized as described in this section, ~~certified by~~
3149 ~~the agency, the agency shall, after consultation with the local~~
3150 ~~exchange company and~~ the Public Service Commission shall~~,~~
3151 request that the Federal Communications Commission direct the
3152 local exchange company to revoke the use of the 211 number.
3153 ~~(b) The agency shall seek the assistance and guidance of~~
3154 ~~the Public Service Commission and the Federal Communications~~
3155 ~~Commission in resolving any disputes arising over jurisdiction~~
3156 ~~related to 211 numbers.~~
3157 (3) The Florida Alliance of Information and Referral
3158 Services is the 211 collaborative organization for the state
3159 which is responsible for studying, designing, implementing,
3160 supporting, and coordinating the Florida 211 Network and for
3161 receiving federal grants.
3162 Section 52. Paragraph (e) of subsection (4) of section
3163 409.221, Florida Statutes, is amended to read:
3164 409.221 Consumer-directed care program.—
3165 (4) CONSUMER-DIRECTED CARE.—
3166 (e) *Services.*—Consumers shall use the budget allowance only
3167 to pay for home and community-based services that meet the
3168 consumer’s long-term care needs and are a cost-efficient use of
3169 funds. Such services may include, but are not limited to, the

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3170 following:
3171 1. Personal care.
3172 2. Homemaking and chores, including housework, meals,
3173 shopping, and transportation.
3174 3. Home modifications and assistive devices which may
3175 increase the consumer's independence or make it possible to
3176 avoid institutional placement.
3177 4. Assistance in taking self-administered medication.
3178 5. Day care and respite care services, including those
3179 provided by nursing home facilities pursuant to <u>s. 400.141(1)(f)</u>
3180 ~~s. 400.141(6)~~ or by adult day care facilities licensed pursuant
3181 to s. 429.907.
3182 6. Personal care and support services provided in an
3183 assisted living facility.
3184 Section 53. Subsection (5) of section 409.901, Florida
3185 Statutes, is amended to read:
3186 409.901 Definitions; ss. 409.901-409.920.—As used in ss.
3187 409.901-409.920, except as otherwise specifically provided, the
3188 term:
3189 (5) "Change of ownership" means<u>:</u>
3190 <u>(a)</u> An event in which the provider <u>ownership</u> changes to a
3191 different <u>individual</u> ~~legal~~ entity <u>as evidenced by a change in</u>
3192 <u>federal employer identification number or taxpayer</u>
3193 <u>identification number;</u> ~~or~~
3194 <u>(b) An event</u> in which <u>51</u> ~~45~~ percent or more of the
3195 ownership, ~~voting~~ shares, <u>membership,</u> or controlling interest <u>of</u>
3196 <u>a provider is in any manner transferred or otherwise assigned.</u>
3197 <u>This paragraph does not apply to a licensee that is publicly</u>
3198 <u>traded on a recognized stock exchange; or</u>

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3199 (c) When the provider is licensed or registered by the
3200 agency, an event considered a change of ownership for licensure
3201 as defined in s. 408.803 ~~in a corporation whose shares are not~~
3202 ~~publicly traded on a recognized stock exchange is transferred or~~
3203 ~~assigned, including the final transfer or assignment of multiple~~
3204 ~~transfers or assignments over a 2-year period that cumulatively~~
3205 ~~total 45 percent or more~~.
3206
3207 A change solely in the management company or board of directors
3208 is not a change of ownership.
3209 Section 54. Section 429.071, Florida Statutes, is repealed.
3210 Section 55. Paragraph (e) of subsection (1) and subsections
3211 (2) and (3) of section 429.08, Florida Statutes, are amended to
3212 read:
3213 429.08 Unlicensed facilities; referral of person for
3214 residency to unlicensed facility; penalties; verification of
3215 licensure status.—
3216 (1)
3217 (e) The agency shall publish ~~provide to the department's~~
3218 ~~elder information and referral providers~~ a list, by county, of
3219 licensed assisted living facilities~~, to assist persons who are~~
3220 ~~considering an assisted living facility placement in locating a~~
3221 ~~licensed facility~~. This information may be provided
3222 electronically or through the agency's Internet site.
3223 ~~(2) Each field office of the Agency for Health Care~~
3224 ~~Administration shall establish a local coordinating workgroup~~
3225 ~~which includes representatives of local law enforcement~~
3226 ~~agencies, state attorneys, the Medicaid Fraud Control Unit of~~
3227 ~~the Department of Legal Affairs, local fire authorities, the~~

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3228 ~~Department of Children and Family Services, the district long-~~
3229 ~~term care ombudsman council, and the district human rights~~
3230 ~~advocacy committee to assist in identifying the operation of~~
3231 ~~unlicensed facilities and to develop and implement a plan to~~
3232 ~~ensure effective enforcement of state laws relating to such~~
3233 ~~facilities. The workgroup shall report its findings, actions,~~
3234 ~~and recommendations semiannually to the Director of Health~~
3235 ~~Quality Assurance of the agency.~~
3236 <u>(2)</u>~~(3)~~ It is unlawful to knowingly refer a person for
3237 residency to an unlicensed assisted living facility; to an
3238 assisted living facility the license of which is under denial or
3239 has been suspended or revoked; or to an assisted living facility
3240 that has a moratorium pursuant to part II of chapter 408. ~~Any~~
3241 ~~person who violates this subsection commits a noncriminal~~
3242 ~~violation, punishable by a fine not exceeding $500 as provided~~
3243 ~~in s. 775.083.~~
3244 (a) Any health care practitioner, as defined in s. 456.001,
3245 who is aware of the operation of an unlicensed facility shall
3246 report that facility to the agency. Failure to report a facility
3247 that the practitioner knows or has reasonable cause to suspect
3248 is unlicensed shall be reported to the practitioner’s licensing
3249 board.
3250 (b) Any <u>provider as defined in s. 408.803</u> ~~hospital or~~
3251 ~~community mental health center licensed under chapter 395 or~~
3252 ~~chapter 394~~ which knowingly discharges a patient or client to an
3253 unlicensed facility is subject to sanction by the agency.
3254 (c) Any employee of the agency or department, or the
3255 Department of Children and Family Services, who knowingly refers
3256 a person for residency to an unlicensed facility; to a facility

3257 the license of which is under denial or has been suspended or
3258 revoked; or to a facility that has a moratorium pursuant to part
3259 II of chapter 408 is subject to disciplinary action by the
3260 agency or department, or the Department of Children and Family
3261 Services.
3262 (d) The employer of any person who is under contract with
3263 the agency or department, or the Department of Children and
3264 Family Services, and who knowingly refers a person for residency
3265 to an unlicensed facility; to a facility the license of which is
3266 under denial or has been suspended or revoked; or to a facility
3267 that has a moratorium pursuant to part II of chapter 408 shall
3268 be fined and required to prepare a corrective action plan
3269 designed to prevent such referrals.
3270 ~~(e) The agency shall provide the department and the~~
3271 ~~Department of Children and Family Services with a list of~~
3272 ~~licensed facilities within each county and shall update the list~~
3273 ~~at least quarterly.~~
3274 ~~(f) At least annually, the agency shall notify, in~~
3275 ~~appropriate trade publications, physicians licensed under~~
3276 ~~chapter 458 or chapter 459, hospitals licensed under chapter~~
3277 ~~395, nursing home facilities licensed under part II of chapter~~
3278 ~~400, and employees of the agency or the department, or the~~
3279 ~~Department of Children and Family Services, who are responsible~~
3280 ~~for referring persons for residency, that it is unlawful to~~
3281 ~~knowingly refer a person for residency to an unlicensed assisted~~
3282 ~~living facility and shall notify them of the penalty for~~
3283 ~~violating such prohibition. The department and the Department of~~
3284 ~~Children and Family Services shall, in turn, notify service~~
3285 ~~providers under contract to the respective departments who have~~

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3286 ~~responsibility for resident referrals to facilities. Further,~~
3287 ~~the notice must direct each noticed facility and individual to~~
3288 ~~contact the appropriate agency office in order to verify the~~
3289 ~~licensure status of any facility prior to referring any person~~
3290 ~~for residency. Each notice must include the name, telephone~~
3291 ~~number, and mailing address of the appropriate office to~~
3292 ~~contact.~~
3293 Section 56. Paragraph (e) of subsection (1) of section
3294 429.14, Florida Statutes, is amended to read:
3295 429.14 Administrative penalties.—
3296 (1) In addition to the requirements of part II of chapter
3297 408, the agency may deny, revoke, and suspend any license issued
3298 under this part and impose an administrative fine in the manner
3299 provided in chapter 120 against a licensee of an assisted living
3300 facility for a violation of any provision of this part, part II
3301 of chapter 408, or applicable rules, or for any of the following
3302 actions by a licensee of an assisted living facility, for the
3303 actions of any person subject to level 2 background screening
3304 under s. 408.809, or for the actions of any facility employee:
3305 (e) A citation of any of the following deficiencies as
3306 specified ~~defined~~ in s. 429.19:
3307 1. One or more cited class I deficiencies.
3308 2. Three or more cited class II deficiencies.
3309 3. Five or more cited class III deficiencies that have been
3310 cited on a single survey and have not been corrected within the
3311 times specified.
3312 Section 57. Section 429.19, Florida Statutes, is amended to
3313 read:
3314 429.19 Violations; imposition of administrative fines;

3315 grounds.—

3316 (1) In addition to the requirements of part II of chapter
3317 408, the agency shall impose an administrative fine in the
3318 manner provided in chapter 120 for the violation of any
3319 provision of this part, part II of chapter 408, and applicable
3320 rules by an assisted living facility, for the actions of any
3321 person subject to level 2 background screening under s. 408.809,
3322 for the actions of any facility employee, or for an intentional
3323 or negligent act seriously affecting the health, safety, or
3324 welfare of a resident of the facility.

3325 (2) Each violation of this part and adopted rules shall be
3326 classified according to the nature of the violation and the
3327 gravity of its probable effect on facility residents. The agency
3328 shall indicate the classification on the written notice of the
3329 violation as follows:

3330 (a) Class "I" violations are defined in s. 408.813 ~~those~~
3331 ~~conditions or occurrences related to the operation and~~
3332 ~~maintenance of a facility or to the personal care of residents~~
3333 ~~which the agency determines present an imminent danger to the~~
3334 ~~residents or guests of the facility or a substantial probability~~
3335 ~~that death or serious physical or emotional harm would result~~
3336 ~~therefrom. The condition or practice constituting a class I~~
3337 ~~violation shall be abated or eliminated within 24 hours, unless~~
3338 ~~a fixed period, as determined by the agency, is required for~~
3339 ~~correction~~. The agency shall impose an administrative fine for a
3340 cited class I violation in an amount not less than $5,000 and
3341 not exceeding $10,000 for each violation. ~~A fine may be levied~~
3342 ~~notwithstanding the correction of the violation.~~

3343 (b) Class "II" violations are defined in s. 408.813 ~~those~~

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3344 ~~conditions or occurrences related to the operation and~~
3345 ~~maintenance of a facility or to the personal care of residents~~
3346 ~~which the agency determines directly threaten the physical or~~
3347 ~~emotional health, safety, or security of the facility residents,~~
3348 ~~other than class I violations~~. The agency shall impose an
3349 administrative fine for a cited class II violation in an amount
3350 not less than $1,000 and not exceeding $5,000 for each
3351 violation. ~~A fine shall be levied notwithstanding the correction~~
3352 ~~of the violation.~~
3353 (c) Class “III” violations are defined in s. 408.813 ~~those~~
3354 ~~conditions or occurrences related to the operation and~~
3355 ~~maintenance of a facility or to the personal care of residents~~
3356 ~~which the agency determines indirectly or potentially threaten~~
3357 ~~the physical or emotional health, safety, or security of~~
3358 ~~facility residents, other than class I or class II violations~~.
3359 The agency shall impose an administrative fine for a cited class
3360 III violation in an amount not less than $500 and not exceeding
3361 $1,000 for each violation. ~~A citation for a class III violation~~
3362 ~~must specify the time within which the violation is required to~~
3363 ~~be corrected. If a class III violation is corrected within the~~
3364 ~~time specified, no fine may be imposed, unless it is a repeated~~
3365 ~~offense.~~
3366 (d) Class “IV” violations are defined in s. 408.813 ~~those~~
3367 ~~conditions or occurrences related to the operation and~~
3368 ~~maintenance of a building or to required reports, forms, or~~
3369 ~~documents that do not have the potential of negatively affecting~~
3370 ~~residents. These violations are of a type that the agency~~
3371 ~~determines do not threaten the health, safety, or security of~~
3372 ~~residents of the facility~~. The agency shall impose an

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3373 administrative fine for a cited class IV violation in an amount
3374 not less than $100 and not exceeding $200 for each violation. ~~A~~
3375 ~~citation for a class IV violation must specify the time within~~
3376 ~~which the violation is required to be corrected. If a class IV~~
3377 ~~violation is corrected within the time specified, no fine shall~~
3378 ~~be imposed. Any class IV violation that is corrected during the~~
3379 ~~time an agency survey is being conducted will be identified as~~
3380 ~~an agency finding and not as a violation.~~
3381 (3) For purposes of this section, in determining if a
3382 penalty is to be imposed and in fixing the amount of the fine,
3383 the agency shall consider the following factors:
3384 (a) The gravity of the violation, including the probability
3385 that death or serious physical or emotional harm to a resident
3386 will result or has resulted, the severity of the action or
3387 potential harm, and the extent to which the provisions of the
3388 applicable laws or rules were violated.
3389 (b) Actions taken by the owner or administrator to correct
3390 violations.
3391 (c) Any previous violations.
3392 (d) The financial benefit to the facility of committing or
3393 continuing the violation.
3394 (e) The licensed capacity of the facility.
3395 (4) Each day of continuing violation after the date fixed
3396 for termination of the violation, as ordered by the agency,
3397 constitutes an additional, separate, and distinct violation.
3398 (5) Any action taken to correct a violation shall be
3399 documented in writing by the owner or administrator of the
3400 facility and verified through followup visits by agency
3401 personnel. The agency may impose a fine and, in the case of an

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3402 owner-operated facility, revoke or deny a facility's license
3403 when a facility administrator fraudulently misrepresents action
3404 taken to correct a violation.
3405 (6) Any facility whose owner fails to apply for a change-
3406 of-ownership license in accordance with part II of chapter 408
3407 and operates the facility under the new ownership is subject to
3408 a fine of $5,000.
3409 (7) In addition to any administrative fines imposed, the
3410 agency may assess a survey fee, equal to the lesser of one half
3411 of the facility's biennial license and bed fee or $500, to cover
3412 the cost of conducting initial complaint investigations that
3413 result in the finding of a violation that was the subject of the
3414 complaint or monitoring visits conducted under s. 429.28(3)(c)
3415 to verify the correction of the violations.
3416 (8) <u>During an inspection,</u> the agency~~, as an alternative to~~
3417 ~~or in conjunction with an administrative action against a~~
3418 ~~facility for violations of this part and adopted rules,~~ shall
3419 make a reasonable attempt to discuss each violation ~~and~~
3420 ~~recommended corrective action~~ with the owner or administrator of
3421 the facility, prior to written notification. ~~The agency, instead~~
3422 ~~of fixing a period within which the facility shall enter into~~
3423 ~~compliance with standards, may request a plan of corrective~~
3424 ~~action from the facility which demonstrates a good faith effort~~
3425 ~~to remedy each violation by a specific date, subject to the~~
3426 ~~approval of the agency.~~
3427 (9) The agency shall develop and disseminate an annual list
3428 of all facilities sanctioned or fined ~~$5,000 or more~~ for
3429 violations of state standards, the number and class of
3430 violations involved, the penalties imposed, and the current

3431 status of cases. The list shall be disseminated, at no charge,
3432 to the Department of Elderly Affairs, the Department of Health,
3433 the Department of Children and Family Services, the Agency for
3434 Persons with Disabilities, the area agencies on aging, the
3435 Florida Statewide Advocacy Council, and the state and local
3436 ombudsman councils. The Department of Children and Family
3437 Services shall disseminate the list to service providers under
3438 contract to the department who are responsible for referring
3439 persons to a facility for residency. The agency may charge a fee
3440 commensurate with the cost of printing and postage to other
3441 interested parties requesting a copy of this list. This
3442 information may be provided electronically or through the
3443 agency's Internet site.
3444 Section 58. Subsections (2) and (6) of section 429.23,
3445 Florida Statutes, are amended to read:
3446 429.23 Internal risk management and quality assurance
3447 program; adverse incidents and reporting requirements.—
3448 (2) Every facility licensed under this part is required to
3449 maintain adverse incident reports. For purposes of this section,
3450 the term, "adverse incident" means:
3451 (a) An event over which facility personnel could exercise
3452 control rather than as a result of the resident's condition and
3453 results in:
3454 1. Death;
3455 2. Brain or spinal damage;
3456 3. Permanent disfigurement;
3457 4. Fracture or dislocation of bones or joints;
3458 5. Any condition that required medical attention to which
3459 the resident has not given his or her consent, including failure

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3460 to honor advanced directives;
3461 6. Any condition that requires the transfer of the resident
3462 from the facility to a unit providing more acute care due to the
3463 incident rather than the resident’s condition before the
3464 incident; or.
3465 7. An event that is reported to law enforcement or its
3466 personnel for investigation; or
3467 (b) Abuse, neglect, or exploitation as defined in s.
3468 415.102;
3469 (c) Events reported to law enforcement; or
3470 (b)(d) Resident elopement, if the elopement places the
3471 resident at risk of harm or injury.
3472 (6) Abuse, neglect, or exploitation must be reported to the
3473 Department of Children and Family Services as required under
3474 chapter 415 The agency shall annually submit to the Legislature
3475 a report on assisted living facility adverse incident reports.
3476 The report must include the following information arranged by
3477 county:
3478 (a) A total number of adverse incidents;
3479 (b) A listing, by category, of the type of adverse
3480 incidents occurring within each category and the type of staff
3481 involved;
3482 (c) A listing, by category, of the types of injuries, if
3483 any, and the number of injuries occurring within each category;
3484 (d) Types of liability claims filed based on an adverse
3485 incident report or reportable injury; and
3486 (e) Disciplinary action taken against staff, categorized by
3487 the type of staff involved.
3488 Section 59. Subsection (9) of section 429.26, Florida

3489 Statutes, is repealed.
3490 Section 60. Subsections (1) and (3) of section 430.80,
3491 Florida Statutes, are amended to read:
3492 430.80 Implementation of a teaching nursing home pilot
3493 project.—
3494 (1) As used in this section, the term “teaching nursing
3495 home” means a nursing home facility licensed under chapter 400
3496 which contains a minimum of 275 ~~400~~ licensed nursing home beds;
3497 has access to a resident senior population of sufficient size to
3498 support education, training, and research relating to geriatric
3499 care; and has a contractual relationship with a federally funded
3500 accredited geriatric research center in this state or operates
3501 in its own right a geriatric research center.
3502 (3) To be designated as a teaching nursing home, a nursing
3503 home licensee must, at a minimum:
3504 (a) Provide a comprehensive program of integrated senior
3505 services that include institutional services and community-based
3506 services;
3507 (b) Participate in a nationally recognized accreditation
3508 program and hold a valid accreditation, such as the
3509 accreditation awarded by the Joint Commission on Accreditation
3510 of Healthcare Organizations, or possess a Gold Seal Award as
3511 conferred by the state of Florida on its licensed nursing home;
3512 (c) Have been in business in this state for a minimum of 10
3513 consecutive years;
3514 (d) Demonstrate an active program in multidisciplinary
3515 education and research that relates to gerontology;
3516 (e) Have a formalized contractual relationship with at
3517 least one accredited health profession education program located

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3518 in this state;

3519 ~~(f) Have a formalized contractual relationship with an~~
3520 ~~accredited hospital that is designated by law as a teaching~~
3521 ~~hospital; and~~

3522 (f)~~(g)~~ Have senior staff members who hold formal faculty
3523 appointments at universities, which must include at least one
3524 accredited health profession education program; and~~.~~

3525 (g)~~(h)~~ Maintain insurance coverage pursuant to s.
3526 400.141(1)(s) ~~s. 400.141(20)~~ or proof of financial
3527 responsibility in a minimum amount of $750,000. Such proof of
3528 financial responsibility may include:

3529 1. Maintaining an escrow account consisting of cash or
3530 assets eligible for deposit in accordance with s. 625.52; or

3531 2. Obtaining and maintaining pursuant to chapter 675 an
3532 unexpired, irrevocable, nontransferable and nonassignable letter
3533 of credit issued by any bank or savings association organized
3534 and existing under the laws of this state or any bank or savings
3535 association organized under the laws of the United States that
3536 has its principal place of business in this state or has a
3537 branch office which is authorized to receive deposits in this
3538 state. The letter of credit shall be used to satisfy the
3539 obligation of the facility to the claimant upon presentment of a
3540 final judgment indicating liability and awarding damages to be
3541 paid by the facility or upon presentment of a settlement
3542 agreement signed by all parties to the agreement when such final
3543 judgment or settlement is a result of a liability claim against
3544 the facility.

3545 Section 61. Subsection (5) of section 435.04, Florida
3546 Statutes, is amended to read:

3547 435.04 Level 2 screening standards.—
3548 (5) Under penalty of perjury, all employees in such
3549 positions of trust or responsibility shall attest to meeting the
3550 requirements for qualifying for employment and agreeing to
3551 inform the employer immediately if convicted of any of the
3552 disqualifying offenses while employed by the employer. Each
3553 employer of employees in such positions of trust or
3554 responsibilities which is licensed or registered by a state
3555 agency shall submit to the licensing agency annually or at the
3556 time of license renewal, under penalty of perjury, an affidavit
3557 of compliance with the provisions of this section.
3558 Section 62. Subsection (3) of section 435.05, Florida
3559 Statutes, is amended to read:
3560 435.05 Requirements for covered employees.—Except as
3561 otherwise provided by law, the following requirements shall
3562 apply to covered employees:
3563 (3) Each employer required to conduct level 2 background
3564 screening must sign an affidavit annually or at the time of
3565 license renewal, under penalty of perjury, stating that all
3566 covered employees have been screened or are newly hired and are
3567 awaiting the results of the required screening checks.
3568 Section 63. Subsection (2) of section 483.031, Florida
3569 Statutes, is amended to read:
3570 483.031 Application of part; exemptions.—This part applies
3571 to all clinical laboratories within this state, except:
3572 (2) A clinical laboratory that performs only waived tests
3573 ~~and has received a certificate of exemption from the agency~~
3574 ~~under s. 483.106~~.
3575 Section 64. Subsection (10) of section 483.041, Florida

3576 Statutes, is amended to read:
3577 483.041 Definitions.—As used in this part, the term:
3578 (10) “Waived test” means a test that the federal Centers
3579 for Medicare and Medicaid Services ~~Health Care Financing~~
3580 ~~Administration~~ has determined qualifies for a certificate of
3581 waiver under the federal Clinical Laboratory Improvement
3582 Amendments of 1988, and the federal rules adopted thereunder.
3583 Section 65. Section 483.106, Florida Statutes, is repealed.
3584 Section 66. Subsection (3) of section 483.172, Florida
3585 Statutes, is amended to read:
3586 483.172 License fees.—
3587 (3) The agency shall assess ~~a biennial fee of $100 for a~~
3588 ~~certificate of exemption and~~ a $100 biennial license fee under
3589 this section for facilities surveyed by an approved accrediting
3590 organization.
3591 Section 67. Paragraph (b) of subsection (1) of section
3592 627.4239, Florida Statutes, is amended to read:
3593 627.4239 Coverage for use of drugs in treatment of cancer.—
3594 (1) DEFINITIONS.—As used in this section, the term:
3595 (b) “Standard reference compendium” means authoritative
3596 compendia identified by the Secretary of the United States
3597 Department of Health and Human Services and recognized by the
3598 federal Centers for Medicare and Medicaid Services~~:~~
3599 ~~1. The United States Pharmacopeia Drug Information;~~
3600 ~~2. The American Medical Association Drug Evaluations; or~~
3601 ~~3. The American Hospital Formulary Service Drug~~
3602 ~~Information~~.
3603 Section 68. Subsection (1) of section 651.105, Florida
3604 Statutes, is amended to read:

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3605 651.105 Examination and inspections.—
3606 (1) The office may at any time, and shall at least once
3607 every 5 ~~3~~ years, examine the business of any applicant for a
3608 certificate of authority and any provider engaged in the
3609 execution of care contracts or engaged in the performance of
3610 obligations under such contracts, in the same manner as is
3611 provided for examination of insurance companies pursuant to s.
3612 624.316. Such examinations shall be made by a representative or
3613 examiner designated by the office, whose compensation will be
3614 fixed by the office pursuant to s. 624.320. Routine examinations
3615 may be made by having the necessary documents submitted to the
3616 office; and, for this purpose, financial documents and records
3617 conforming to commonly accepted accounting principles and
3618 practices, as required under s. 651.026, will be deemed
3619 adequate. The final written report of each such examination
3620 shall be filed with the office and, when so filed, will
3621 constitute a public record. Any provider being examined shall,
3622 upon request, give reasonable and timely access to all of its
3623 records. The representative or examiner designated by the office
3624 may at any time examine the records and affairs and inspect the
3625 physical property of any provider, whether in connection with a
3626 formal examination or not.
3627 Section 69. Subsection (13) of section 651.118, Florida
3628 Statutes, is amended to read:
3629 651.118 Agency for Health Care Administration; certificates
3630 of need; sheltered beds; community beds.—
3631 (13) Residents, as defined in this chapter, are not
3632 considered new admissions for the purpose of s. 400.141
3633 (1)(o)1.d. ~~s. 400.141(15)(d).~~

3634 Section 70. This act shall take effect July 1, 2009.

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