A bill to be entitled

An act relating to health care; providing legislative findings; designating Miami-Dade County as a health care fraud crisis area of concern; amending s. 68.085, F.S.; allocating certain funds recovered under the Florida False Claims Act to fund rewards for persons who report and provide information relating to Medicaid fraud; amending s. 68.086, F.S.; providing that a defendant who prevails in an action under the Florida False Claims Act may be awarded attorney's fees and costs against the person bringing the action under certain circumstances; repealing s. 395.0199, F.S., relating to private utilization review of health care services; amending ss. 395.405, 400.0077, 400.0712, 430.608, and 430.80, F.S.; conforming cross-references to changes made by the act; amending s. 400.118, F.S.; removing provisions requiring quality-of-care monitors for nursing facilities in Agency for Health Care Administration district offices; amending s. 400.141, F.S.; revising reporting requirements for facility staff-to-resident ratios; amending s. 400.147, F.S.; revising reporting requirements under facility internal risk management and quality assurance programs; revising the definition of the term "adverse incident" for reporting purposes; requiring abuse, neglect, and exploitation to be reported to the agency and the Department of Children and Family Services; deleting a requirement that the agency submit an annual report on nursing home adverse incidents to the Legislature; amending s. 400.162, F.S.; revising

provisions relating to procedures and policies regarding the safekeeping of nursing home residents' property; amending s. 400.179, F.S.; revising payments by nursing homes to the agency; amending s. 400.191, F.S.; eliminating requirements for the agency to publish the Nursing Home Guide annually in printed form; revising information provided on the agency's Internet website; amending s. 400.195, F.S.; conforming a cross-reference; amending s. 400.23, F.S.; deleting provisions relating to minimum staffing requirements for nursing homes; amending s. 400.471, F.S.; prohibiting the Agency for Health Care Administration from renewing a license of a home health agency in certain counties if the agency has been sanctioned for certain misconduct; amending s. 400.474, F.S.; providing that specified provisions relating to remuneration do not apply to or preclude certain payment practices permitted under specified federal laws or regulations; requiring the agency to fine and authorizing the agency to deny, revoke, or suspend the license of or fine a home health agency that provides remuneration to certain facilities or bills the Medicaid program for medically unnecessary services; providing applicability; amending s. 400.506, F.S.; exempting nurse registries not participating in the Medicaid or Medicare program from certain disciplinary actions for paying remuneration to certain entities in exchange for patient referrals; amending s. 400.9905, F.S.; revising the definition of the term "clinic" to provide that pt. X of ch. 400, F.S., the

Health Care Clinic Act, does not apply to entities that do not seek reimbursement from insurance companies for medical services paid pursuant to certain personal injury protection coverage bodily liability coverage, personal umbrella liability coverage, or uninsured motorist coverage; amending s. 400.9935, F.S.; revising accreditation requirements for clinics providing magnetic resonance imaging services; amending s. 400.995, F.S.; revising agency responsibilities with respect to personnel and operations in certain injunctive proceedings; amending s. 408.803, F.S.; revising definitions applicable to pt. II of ch. 408, F.S., the "Health Care Licensing Procedures Act"; amending s. 408.806, F.S.; revising contents of and procedures relating to health care provider applications for licensure; providing an exception from certain licensure inspections for adult family-care homes; authorizing the agency to provide electronic access to certain information and documents; creating s. 408.8065, F.S.; providing additional licensure requirements for home health agencies, home medical equipment providers, and health care clinics; requiring the posting of a surety bond in a specified minimum amount under certain circumstances; imposing criminal penalties for certain unlicensed activities; imposing criminal penalties against a person who knowingly submits misleading information to the Agency for Health Care Administration in connection with applications for certain licenses; amending s. 408.808, F.S.; providing for a provisional license to be

issued to applicants applying for a change of ownership; providing a time limit on provisional licenses; amending s. 408.809, F.S.; revising provisions relating to background screening of specified employees; exempting certain persons from rescreening; permitting certain persons to apply for an exemption from disqualification under certain circumstances; requiring health care providers to submit to the agency an affidavit of compliance with background screening requirements at the time of license renewal; deleting a provision to conform to changes made by the act; amending s. 408.810, F.S.; revising provisions relating to information required for licensure; requiring certain licensees to provide clients with a description of Medicaid fraud and the statewide toll-free telephone number for the central Medicaid fraud hotline; amending s. 408.811, F.S.; providing for certain inspections to be accepted in lieu of complete licensure inspections; granting agency access to records requested during an offsite review; providing timeframes for correction of certain deficiencies and submission of plans to correct such deficiencies; amending s. 408.813, F.S.; providing classifications of violations of pt. II of ch. 408, F.S.; providing for fines; amending s. 408.815, F.S.; providing additional grounds to deny an application for a license; amending s. 408.820, F.S.; revising applicability of exemptions from specified requirements of pt. II of ch. 408, F.S.; conforming references; creating s. 408.821, F.S.; requiring entities regulated or licensed by the

agency to designate a safety liaison for emergency operations; providing that entities regulated or licensed by the agency may temporarily exceed their licensed capacity to act as receiving providers under specified circumstances; providing requirements while such entities are in an overcapacity status; providing for issuance of an inactive license to such licensees under specified conditions; providing requirements and procedures with respect to the issuance and reactivation of an inactive license; authorizing the agency to adopt rules; requiring licensees providing certain services to use an online database approved by the agency for reporting certain information relating to providers; amending s. 408.831, F.S.; deleting provisions relating to authorization for entities regulated or licensed by the agency to exceed their licensed capacity to act as receiving facilities and issuance and reactivation of inactive licenses; amending s. 408.918, F.S.; requiring accreditation by the National Alliance of Information and Referral Services for participation in the Florida 211 Network; eliminating the requirement that the agency seek certain assistance and guidance in resolving certain disputes; removing certain agency obligations relating to the Florida 211 Network; requiring the Florida Alliance of Information and Referral Services to perform certain functions related to the Florida 211 Network; amending s. 409.221, F.S.; conforming a cross-reference; amending s. 409.901, F.S.; revising a definition applicable to Medicaid providers; amending s.

409.905, F.S.; authorizing the Agency for Health Care Administration to require prior authorization of care based on billing rates; requiring a home health agency to submit a plan of care and documentation of a recipient's medical condition to the Agency for Health Care Administration when requesting prior authorization; prohibiting the Agency for Health Care Administration from paying for home health services unless specified requirements are satisfied; amending s. 409.907, F.S.; providing for certain out-of-state providers to enroll as Medicaid providers; requiring Medicaid provider agreements to require full compliance with the Agency for Health Care Administration's medical encounter data system and report actions that provide incentives for healthy behaviors; providing that a managed care plan shall not be sanctioned or precluded from operating in a new service area when it fails to execute a contract with at least one essential provider under certain circumstances; requiring a managed care plan to include any willing, qualified provider in its network under certain circumstances; requiring the managed care plan to offer at least the county billing rate to such provider; requiring the agency to submit an annual report to the Governor and Legislature that summarizes data regarding the agency's medical encounter data system; amending s. 409.908, F.S.; requiring the agency to adjust alternative health plan, health maintenance organization, and prepaid health plan capitation rates based on aggregate risk scores; providing

a limitation on risk score variance for a specified time period; requiring the agency to phase in risk-adjusted capitation rates; providing for a technical advisory panel to advise the agency during the transition to risk-adjusted capitation rates; amending s. 409.912, F.S.; authorizing the agency to contract with certain health centers that are federally qualified or supported to provide comprehensive behavioral health care services through a capitated, prepaid arrangement; requiring the agency to integrate acute care and behavioral health services in the public-hospital-operated managed care model; requiring an entity contracting on a prepaid or fixed-sum basis to meet the surplus requirements of health maintenance organizations; specifying the rate paid under certain circumstances to a physician or hospital by an entity that contracts with the agency on a prepaid or fixed-sum basis; requiring the Agency for Health Care Administration to eliminate utilization of medically unnecessary Medicaid services using certain methods; requiring the agency to include a report on the agency's activities to eliminate the use of medically unnecessary Medicaid services in the annual report required by s. 409.913; creating a pilot project to monitor and verify the delivery of home health services and provide for electronic claims for home health services; requiring the Agency for Health Care Administration to issue a report evaluating the pilot project; creating a pilot project for home health care management; authorizing the agency to

enter into certain contracts and to seek amendments to the state plan and waivers; requiring the Department of Health to employ a competitive sealed bid process to procure certain prescriptive assistive devices; requiring the Department of Management Services to administer the selection and procurement of the devices; creating s. 409.91207, F.S.; requiring the agency to establish a medical home pilot project in Alachua and Hillsborough Counties; requiring each county to be served by at least one medical home network consisting of specified entities; authorizing managed care organizations to seek designation as a medical home network; requiring each medical home network to provide specified services and comply with specified principles of operation; specifying procedures for enrollment of Medicaid recipients in a medical home network; requiring a medical home network to document capacity for coordinated systems of care; requiring medical home network services to be reimbursed based on Medicaid fee-for-service claims; authorizing specified enhanced benefits for entities participating in a medical home network; specifying that a medical home network is eligible for shared savings under certain circumstances; requiring a medical home network to maintain certain medical records and clinical data; requiring the agency to contract with the University of Florida for initial and final evaluations of the pilot project; requiring the agency to submit reports on medical home network performance to the Governor and Legislature; creating s.

409.91208, F.S.; providing legislative findings; requiring the agency to seek federal approval to implement an alternative payment methodology for medical school faculty; amending s. 409.91211, F.S.; requiring a Medicaid provider who receives low-income pool funds to serve Medicaid recipients regardless of the recipient's county of residence; extending the phasing in of risk-adjusted capitated rates for provider service networks; amending s. 409.9122, F.S.; specifying that individuals currently enrolled in a disease management or specialized HIV/AIDS plan stay in their plan unless they opt out; providing for mandatory assignment of certain Medicaid recipients to a medical home network in Alachua and Hillsborough Counties who are eligible for managed care plan enrollment; providing a definition; requiring the agency to convene a workgroup to evaluate the status and future viability of Medicaid managed care; requiring the workgroup to produce a report; requiring the agency to collect encounter data for services provided to patients enrolled in managed care plans; amending s. 409.9124, F.S.; requiring managed care rates to be based on a risk-adjusted methodology; requiring the agency to submit an annual report to the Governor and Legislature regarding the financial condition and trends affecting Medicaid managed care plans; amending s. 409.9128; requiring a managed care plan to reimburse a provider at a specified rate under specific circumstances; amending s. 409.913, F.S.; requiring that the annual report submitted by the Agency for Health Care

Administration and the Medicaid Fraud Control Unit of the Department of Legal Affairs recommend changes necessary to prevent and detect Medicaid fraud; requiring the Agency for Health Care Administration to monitor billing patterns for Medicaid services; requiring the agency to deny payment or require repayment for Medicaid services under certain circumstances; requiring the Agency for Health Care Administration to immediately terminate a Medicaid provider's participation in the Medicaid program as a result of certain adjudications against the provider or certain affiliated persons; requiring the Agency for Health Care Administration to suspend or terminate a Medicaid provider's participation in the Medicaid program if the provider or certain affiliated persons participating in the Medicaid program have been suspended or terminated by the Federal Government or another state; providing that a provider is subject to sanctions for violations of law as the result of actions or inactions of the provider or certain affiliated persons; requiring that the agency provide notice of certain administrative sanctions to other regulatory agencies within a specified period; requiring the Agency for Health Care Administration to withhold or deny Medicaid payments under certain circumstances; requiring the agency to terminate a provider's participation in the Medicaid program if the provider fails to repay certain overpayments from the Medicaid program; requiring the agency to provide the explanation of benefits letter three times a year;

requiring the agency to provide at least annually information on Medicaid fraud in an explanation of benefits letter; requiring the Agency for Health Care Administration to post a list on its website of Medicaid providers and affiliated persons of providers who have been terminated or sanctioned; requiring the agency to take certain actions to improve the prevention and detection of health care fraud through the use of technology; amending s. 409.920, F.S.; defining the term "managed care organization"; providing criminal penalties and fines for Medicaid fraud; granting civil immunity to certain persons who report suspected Medicaid fraud; creating s. 409.9203, F.S.; authorizing the payment of rewards to persons who report and provide information relating to Medicaid fraud; repealing s. 429.071, F.S., relating to the intergenerational respite care assisted living facility pilot program; amending s. 429.08, F.S.; authorizing the agency to provide information regarding licensed assisted living facilities electronically or on its Internet website; abolishing local coordinating workgroups established by agency field offices; deleting a fine; deleting provisions requiring the agency to provide certain information and notice to service providers; amending s. 429.14, F.S.; conforming a reference; amending s. 429.19, F.S.; revising agency procedures for imposition of fines for violations of pt. I of ch. 429, F.S., the "Assisted Living Facilities Act"; providing for the posting of certain information electronically or on the

agency's Internet website; amending s. 429.23, F.S.; revising the definition of the term "adverse incident" for reporting purposes; requiring abuse, neglect, and exploitation to be reported to the agency and the Department of Children and Family Services; deleting a requirement that the agency submit an annual report on assisted living facility adverse incidents to the Legislature; amending s. 429.26, F.S.; removing requirement for a resident of an assisted living facility to undergo examinations and evaluations under certain circumstances; amending ss. 435.04 and 435.05, F.S.; requiring employers of certain employees to submit an affidavit of compliance with level 2 screening requirements at the time of license renewal; amending s. 456.004, F.S.; requiring the Department of Health to work cooperatively with the Agency for Health Care Administration and the judicial system to recover overpayments by the Medicaid program; amending s. 456.053, F.S.; including referrals a health care provider for sleep-related testing in the definition of "referral"; amending s. 456.041, F.S.; requiring the Department of Health to include a statement in the practitioner profile if a practitioner has been terminated from participating in the Medicaid program; creating s. 456.0635, F.S.; prohibiting Medicaid fraud in the practice of health care professions; requiring the Department of Health or boards within the department to refuse to admit to exams and to deny licenses, permits, or certificates to certain persons

who have engaged in certain acts; requiring health care practitioners to report allegations of Medicaid fraud; specifying that acceptance of the relinquishment of a license in anticipation of charges relating to Medicaid fraud constitutes permanent revocation of a license; amending s. 456.072, F.S.; creating additional grounds for disciplinary action by the department against certain applicants or licensees for misconduct relating to a Medicaid program or to health care fraud; amending s. 456.074, F.S.; requiring the Department of Health to issue an emergency order suspending the license of a person who engages in certain criminal conduct relating to the Medicaid program; amending s. 456.42, F.S.; revising provisions specifying the information required to be included in written prescriptions for medicinal drugs; amending s. 465.022, F.S.; authorizing partnerships and corporations to obtain pharmacy permits; requiring applicants or certain persons affiliated with an applicant for a pharmacy permit to submit a set of fingerprints for a criminal history records check and pay the costs of the criminal history records check; requiring the Department of Health or Board of Pharmacy to deny an application for a pharmacy permit for certain misconduct by the applicant; or persons affiliated with the applicant; amending s. 465.023, F.S.; authorizing the Department of Health or the Board of Pharmacy to take disciplinary action against a permitee for certain misconduct by the permitee, or persons affiliated with the permitee; amending s. 483.031,

F.S.; conforming a reference; amending s. 483.041, F.S.; revising a definition applicable to pt. I of ch. 483, F.S., the "Florida Clinical Laboratory Law"; repealing s. 483.106, F.S., relating to applications for certificates of exemption by clinical laboratories that perform certain tests; amending s. 483.172, F.S.; conforming a reference; amending s. 627.4239, F.S.; revising the definition of the term "standard reference compendium" for purposes of regulating the insurance coverage of drugs used in the treatment of cancer; amending s. 651.118, F.S.; conforming a cross-reference; amending s. 825.103, F.S.; revising the term "exploitation of an elderly person or disabled adult"; amending s. 893.04, F.S.; authorizing a pharmacist to dispense a controlled substance and require photographic identification without documenting certain information; authorizing a pharmacist to dispense a controlled substance without verification of certain information by the prescriber under certain circumstances; amending s. 921.0022, F.S.; revising the severity level ranking of Medicaid fraud under the Criminal Punishment Code; providing an effective date.

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

Section 1. The Legislature finds that:

(1) Immediate and proactive measures are necessary to prevent, reduce, and mitigate health care fraud, waste, and abuse and are essential to maintaining the integrity and

financial viability of health care delivery systems, including those funded in whole or in part by the Medicare and Medicaid trust funds. Without these measures, health care delivery systems in this state will be depleted of necessary funds to deliver patient care, and taxpayers' dollars will be devalued and not used for their intended purposes.

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

(3) The state's best interest is served by deterring health care fraud, abuse, and waste and identifying patterns of fraudulent or abusive Medicare and Medicaid activity early, especially in high-risk localities, such as Miami-Dade County, in order to prevent inappropriate expenditures of public funds and harm to the state's residents.

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

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

68.085 Awards to plaintiffs bringing action.--

(1) If the department proceeds with and prevails in an

action brought by a person under this act, except as provided in subsection (2), the court shall order the distribution to the person of at least 15 percent but not more than 25 percent of the proceeds recovered under any judgment obtained by the department in an action under s. 68.082 or of the proceeds of any settlement of the claim, depending upon the extent to which the person substantially contributed to the prosecution of the action.

(2) If the department proceeds with an action which the court finds to be based primarily on disclosures of specific information, other than that provided by the person bringing the action, relating to allegations or transactions in a criminal, civil, or administrative hearing; a legislative, administrative, inspector general, or auditor general report, hearing, audit, or investigation; or from the news media, the court may award such sums as it considers appropriate, but in no case more than 10 percent of the proceeds recovered under a judgment or received in settlement of a claim under this act, taking into account the significance of the information and the role of the person bringing the action in advancing the case to litigation.

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

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

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

(6) Whether or not the department proceeds with the action, if the court finds that the action was brought by a person who planned and initiated the violation of s. 68.082 upon which the action was brought, the court may, to the extent the court considers appropriate, reduce the share of the proceeds of the action which the person would otherwise receive under this section, taking into account the role of the person in advancing the case to litigation and any relevant circumstances pertaining to the violation. If the person bringing the action is convicted of criminal conduct arising from his or her role in the violation of s. 68.082, the person shall be dismissed from the civil action and shall not receive any share of the proceeds of the action. Such dismissal shall not prejudice the right of the department to continue the action.

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

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

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

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

(3) If the department does not proceed with an action under this act and the person bringing the action conducts the action ~~defendant is the prevailing party~~, the court may ~~shall~~ award to the defendant its reasonable attorney's fees and costs if the defendant prevails in the action and the court finds that the claim of ~~against~~ the person bringing the action was clearly frivolous, clearly vexatious, or brought primarily for purposes of harassment.

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

Section 4. Section 395.0199, Florida Statutes, is repealed.

Section 5. Section 395.405, Florida Statutes, is amended to read:

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

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

400.0077 Confidentiality.--

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

Section 7. Subsection (1) of section 400.0712, Florida Statutes, is amended to read:

400.0712 Application for inactive license.--

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

Section 8. Subsection (3) of section 400.118, Florida Statutes, is renumbered as subsection (2), and present subsection (2) of that section is amended to read:

400.118 Quality assurance; early warning system; ~~monitoring;~~ rapid response teams.--

~~(2)(a) The agency shall establish within each district office one or more quality-of-care monitors, based on the number of nursing facilities in the district, to monitor all nursing~~

~~facilities in the district on a regular, unannounced, aperiodic basis, including nights, evenings, weekends, and holidays. Quality-of-care monitors shall visit each nursing facility at least quarterly. Priority for additional monitoring visits shall be given to nursing facilities with a history of resident care deficiencies. Quality-of-care monitors shall be registered nurses who are trained and experienced in nursing facility regulation, standards of practice in long-term care, and evaluation of patient care. Individuals in these positions shall not be deployed by the agency as a part of the district survey team in the conduct of routine, scheduled surveys, but shall function solely and independently as quality-of-care monitors. Quality-of-care monitors shall assess the overall quality of life in the nursing facility and shall assess specific conditions in the facility directly related to resident care, including the operations of internal quality improvement and risk management programs and adverse incident reports. The quality-of-care monitor shall include in an assessment visit observation of the care and services rendered to residents and formal and informal interviews with residents, family members, facility staff, resident guests, volunteers, other regulatory staff, and representatives of a long-term care ombudsman council or Florida advocacy council.~~

~~(b) Findings of a monitoring visit, both positive and negative, shall be provided orally and in writing to the facility administrator or, in the absence of the facility administrator, to the administrator on duty or the director of nursing. The quality-of-care monitor may recommend to the~~

~~facility administrator procedural and policy changes and staff training, as needed, to improve the care or quality of life of facility residents. Conditions observed by the quality-of-care monitor which threaten the health or safety of a resident shall be reported immediately to the agency area office supervisor for appropriate regulatory action and, as appropriate or as required by law, to law enforcement, adult protective services, or other responsible agencies.~~

~~(c) Any record, whether written or oral, or any written or oral communication generated pursuant to paragraph (a) or paragraph (b) shall not be subject to discovery or introduction into evidence in any civil or administrative action against a nursing facility arising out of matters which are the subject of quality-of-care monitoring, and a person who was in attendance at a monitoring visit or evaluation may not be permitted or required to testify in any such civil or administrative action as to any evidence or other matters produced or presented during the monitoring visits or evaluations. However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil or administrative action merely because they were presented during monitoring visits or evaluations, and any person who participates in such activities may not be prevented from testifying as to matters within his or her knowledge, but such witness may not be asked about his or her participation in such activities. The exclusion from the discovery or introduction of evidence in any civil or administrative action provided for herein shall not apply when the quality-of-care~~

~~monitor makes a report to the appropriate authorities regarding a threat to the health or safety of a resident.~~

Section 9. Section 400.141, Florida Statutes, is amended to read:

400.141 Administration and management of nursing home facilities.--

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

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

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

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

(d) ~~(4)~~ Provide for resident use of a community pharmacy as specified in s. 400.022(1)(q). Any other law to the contrary notwithstanding, a registered pharmacist licensed in Florida, that is under contract with a facility licensed under this chapter or chapter 429, shall repackage a nursing facility resident's bulk prescription medication which has been packaged by another pharmacist licensed in any state in the United States into a unit dose system compatible with the system used by the nursing facility, if the pharmacist is requested to offer such service. In order to be eligible for the repackaging, a resident or the resident's spouse must receive prescription medication benefits provided through a former employer as part of his or

her retirement benefits, a qualified pension plan as specified in s. 4972 of the Internal Revenue Code, a federal retirement program as specified under 5 C.F.R. s. 831, or a long-term care policy as defined in s. 627.9404(1). A pharmacist who correctly repackages and relabels the medication and the nursing facility which correctly administers such repackaged medication under ~~the provisions of~~ this paragraph may ~~subsection shall~~ not be held liable in any civil or administrative action arising from the repackaging. In order to be eligible for the repackaging, a nursing facility resident for whom the medication is to be repackaged shall sign an informed consent form provided by the facility which includes an explanation of the repackaging process and which notifies the resident of the immunities from liability provided in this paragraph ~~herein~~. A pharmacist who repackages and relabels prescription medications, as authorized under this paragraph ~~subsection~~, may charge a reasonable fee for costs resulting from the implementation of this provision.

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

(f) ~~(6)~~ Be allowed and encouraged by the agency to provide other needed services under certain conditions. If the facility has a standard licensure status, and has had no class I or class II deficiencies during the past 2 years or has been awarded a Gold Seal under the program established in s. 400.235, it may be encouraged by the agency to provide services, including, but not limited to, respite and adult day services, which enable individuals to move in and out of the facility. A facility is not subject to any additional licensure requirements for providing these services. Respite care may be offered to persons in need of short-term or temporary nursing home services. Respite care must be provided in accordance with this part and rules adopted by the agency. However, the agency shall, by rule, adopt modified requirements for resident assessment, resident care plans, resident contracts, physician orders, and other provisions, as appropriate, for short-term or temporary nursing home services. The agency shall allow for shared programming and staff in a facility which meets minimum standards and offers services pursuant to this paragraph ~~subsection~~, but, if the facility is cited for deficiencies in patient care, may require additional staff and programs appropriate to the needs of service recipients. A person who receives respite care may not be counted as a resident of the facility for purposes of the facility's licensed capacity unless that person receives 24-hour respite care. A person receiving either respite care for 24 hours or longer or adult day services must be included when calculating minimum staffing for the facility. Any costs and revenues generated by a nursing home facility from

nonresidential programs or services shall be excluded from the calculations of Medicaid per diems for nursing home institutional care reimbursement.

(g) ~~(7)~~ If the facility has a standard license or is a Gold Seal facility, exceeds the minimum required hours of licensed nursing and certified nursing assistant direct care per resident per day, and is part of a continuing care facility licensed under chapter 651 or a retirement community that offers other services pursuant to part III of this chapter or part I or part III of chapter 429 on a single campus, be allowed to share programming and staff. At the time of inspection and in the semiannual report required pursuant to paragraph (o) ~~subsection (15)~~, a continuing care facility or retirement community that uses this option must demonstrate through staffing records that minimum staffing requirements for the facility were met. Licensed nurses and certified nursing assistants who work in the nursing home facility may be used to provide services elsewhere on campus if the facility exceeds the minimum number of direct care hours required per resident per day and the total number of residents receiving direct care services from a licensed nurse or a certified nursing assistant does not cause the facility to violate the staffing ratios required under s. 400.23(3)(a). Compliance with the minimum staffing ratios shall be based on total number of residents receiving direct care services, regardless of where they reside on campus. If the facility receives a conditional license, it may not share staff until the conditional license status ends. This paragraph ~~subsection~~ does not restrict the agency's authority under federal or state law

to require additional staff if a facility is cited for deficiencies in care which are caused by an insufficient number of certified nursing assistants or licensed nurses. The agency may adopt rules for the documentation necessary to determine compliance with this provision.

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

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

(j) ~~(10)~~ Keep full records of resident admissions and discharges; medical and general health status, including medical records, personal and social history, and identity and address of next of kin or other persons who may have responsibility for the affairs of the residents; and individual resident care plans including, but not limited to, prescribed services, service frequency and duration, and service goals. The records shall be open to inspection by the agency.

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

(l) ~~(12)~~ Furnish copies of personnel records for employees affiliated with such facility, to any other facility licensed by

this state requesting this information pursuant to this part. Such information contained in the records may include, but is not limited to, disciplinary matters and any reason for termination. Any facility releasing such records pursuant to this part shall be considered to be acting in good faith and may not be held liable for information contained in such records, absent a showing that the facility maliciously falsified such records.

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

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

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

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

calendar quarter.

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

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

d.~~(d)~~ A nursing facility that has failed to comply with state minimum-staffing requirements for 2 consecutive days is 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 staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition.

(q)~~(18)~~ If the facility implements a dining and hospitality attendant program, ensure that the program is developed and implemented under the supervision of the facility director of nursing. A licensed nurse, licensed speech or

occupational therapist, or a registered dietitian must conduct training of dining and hospitality attendants. A person employed by a facility as a dining and hospitality attendant must perform tasks under the direct supervision of a licensed nurse.

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

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

(t) ~~(21)~~ Maintain in the medical record for each resident a daily chart of certified nursing assistant services provided to the resident. The certified nursing assistant who is caring for the resident must complete this record by the end of his or her shift. This record must indicate assistance with activities of daily living, assistance with eating, and assistance with drinking, and must record each offering of nutrition and hydration for those residents whose plan of care or assessment indicates a risk for malnutrition or dehydration.

(u) ~~(22)~~ Before November 30 of each year, subject to the availability of an adequate supply of the necessary vaccine, provide for immunizations against influenza viruses to all its consenting residents in accordance with the recommendations of

the United States Centers for Disease Control and Prevention, subject to exemptions for medical contraindications and religious or personal beliefs. Subject to these exemptions, any consenting person who becomes a resident of the facility after November 30 but before March 31 of the following year must be immunized within 5 working days after becoming a resident. Immunization shall not be provided to any resident who provides documentation that he or she has been immunized as required by this paragraph ~~subsection~~. This paragraph ~~subsection~~ does not prohibit a resident from receiving the immunization from his or her personal physician if he or she so chooses. A resident who chooses to receive the immunization from his or her personal physician shall provide proof of immunization to the facility. The agency may adopt and enforce any rules necessary to comply with or implement this paragraph ~~subsection~~.

(v) ~~(23)~~ Assess all residents for eligibility for pneumococcal polysaccharide vaccination (PPV) and vaccinate residents when indicated within 60 days after the effective date of this act in accordance with the recommendations of the United States Centers for Disease Control and Prevention, subject to exemptions for medical contraindications and religious or personal beliefs. Residents admitted after the effective date of this act shall be assessed within 5 working days of admission and, when indicated, vaccinated within 60 days in accordance with the recommendations of the United States Centers for Disease Control and Prevention, subject to exemptions for medical contraindications and religious or personal beliefs. Immunization shall not be provided to any resident who provides

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

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

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

Section 10. Present subsections (9) through (13) of section 400.147, Florida Statutes, are renumbered as subsections (10) through (14), respectively, subsection (5) and present subsection (14) are amended, and a new subsection (9) is added to that section, to read:

400.147 Internal risk management and quality assurance program.--

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

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

1. Death;

2. Brain or spinal damage;

3. Permanent disfigurement;

4. Fracture or dislocation of bones or joints;

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

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

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

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

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

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

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

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

(9) Abuse, neglect, or exploitation must be reported to the agency as required by 42 C.F.R. s. 483.13(c) and to the

department as required by chapters 39 and 415.

~~(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 type of staff involved.~~

Section 11. Subsection (3) of section 400.162, Florida Statutes, is amended to read:

400.162 Property and personal affairs of residents.--

(3) A licensee shall provide for the safekeeping of personal effects, funds, and other property of the resident in the facility. Whenever necessary for the protection of valuables, or in order to avoid unreasonable responsibility therefor, the licensee may require that such valuables be excluded or removed from the facility and kept at some place not subject to the control of the licensee. At the request of a resident, the facility shall mark the resident's personal property with the resident's name or another type of identification, without defacing the property. Any theft or loss of a resident's personal property shall be documented by the

facility. The facility shall develop policies and procedures to minimize the risk of theft or loss of the personal property of residents. A copy of the policy shall be provided to every employee and to each resident and resident's representative, if appropriate, at admission and when revised. Facility policies must include provisions related to reporting theft or loss of a resident's property to law enforcement and any facility waiver of liability for loss or theft. ~~The facility shall post notice of these policies and procedures, and any revision thereof, in places accessible to residents.~~

Section 12. Subsection (3) is added to section 400.179, Florida Statutes, to read:

400.179 Liability for Medicaid underpayments and overpayments.--

(3) The requirements of paragraph (2)(d) to acquire and maintain a bond or alternative shall be waived for license renewals on or after July 1, 2009, as long as the fund balance related to such payments held in the Grants and Donations Trust Fund exceeds 50 percent of the balance on June 30, 2009. The agency may impose the requirements of paragraph (2)(d) for license renewals occurring on or after the balance in the Grants and Donations Trust Fund related to such payments and withdrawals is less than 50 percent of the balance on June 30, 2009.

Section 13. Subsection (2) of section 400.191, Florida Statutes, is amended to read:

400.191 Availability, distribution, and posting of reports and records.--

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

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

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

2. A list by name and address of all nursing home facilities in this state, including any prior name by which a facility was known during the previous 24-month period.

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

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

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

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

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

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

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

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

11. Recreational and other programs available at each facility.

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

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

14. Survey and deficiency information, including all federal and state recertification, licensure, revisit, and complaint survey information, for each facility for the past 30 months. For noncertified nursing homes, state survey and

deficiency information, including licensure, revisit, and complaint survey information for the past 30 months shall be provided.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~13. A summary of the deficiency data for each facility~~

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

(b) ~~(c)~~ The agency may provide the following additional information on an Internet site or in printed form as the information becomes available:

1. The licensure status history of each facility.

2. The rating history of each facility.

3. The regulatory history of each facility, which may include federal sanctions, state sanctions, federal fines, state fines, and other actions.

4. Whether the facility currently possesses the Gold Seal designation awarded pursuant to s. 400.235.

5. Internet links to the Internet sites of the facilities or their affiliates.

Section 14. Paragraph (d) of subsection (1) of section 400.195, Florida Statutes, is amended to read:

400.195 Agency reporting requirements.--

(1) For the period beginning June 30, 2001, and ending June 30, 2005, the Agency for Health Care Administration shall provide a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives with respect to

nursing homes. The first report shall be submitted no later than December 30, 2002, and subsequent reports shall be submitted every 6 months thereafter. The report shall identify facilities based on their ownership characteristics, size, business structure, for-profit or not-for-profit status, and any other characteristics the agency determines useful in analyzing the varied segments of the nursing home industry and shall report:

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

Section 15. Paragraph (b) of subsection (3) of section 400.23, Florida Statutes, is amended to read:

400.23 Rules; evaluation and deficiencies; licensure status.--

(3)

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

staffing standards.

Section 16. Subsection (10) is added to section 400.471, Florida Statutes, to read:

400.471 Application for license; fee.--

(10) The agency may not issue a renewal license for a home health agency in any county having at least one licensed home health agency and that has more than one home health agency per 5,000 persons, as indicated by the most recent population estimates published by the Office of Economic and Demographic Research, if the applicant or any controlling interest has been administratively sanctioned by the agency since the last licensure renewal application for one or more of the following acts:

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

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

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

(d) Failing to provide at least one service directly to a

patient for a period of 60 days;

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

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

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

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

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

Medicaid beneficiary;

(j) Demonstrating a pattern of billing the Medicaid program for services to Medicaid recipients which are medically unnecessary. A pattern may be demonstrated by a showing of at least two fraudulent entries or documents;

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

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

Section 17. Subsection (6) of section 400.474, Florida Statutes, is amended to read:

400.474 Administrative penalties.--

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

(a) Gives remuneration for staffing services to:

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

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

unless the home health agency has activated its comprehensive emergency management plan in accordance with s. 400.492. This paragraph does not apply to a Medicare-certified home health agency that provides fair market value remuneration for staffing services to a non-Medicare-certified home health agency that is

part of a continuing care facility licensed under chapter 651 for providing services to its own residents if each resident receiving home health services pursuant to this arrangement attests in writing that he or she made a decision without influence from staff of the facility to select, from a list of Medicare-certified home health agencies provided by the facility, that Medicare-certified home health agency to provide the services.

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

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

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

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

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

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

agency;

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

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

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

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

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

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

1. Be in writing and signed by both parties;

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

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

The hourly rate specified in the contract may not be increased during the term of the contract. The home health agency may not

execute a subsequent contract with that physician which has an increased hourly rate and covers any portion of the term that was in the original contract.

(j) Gives remuneration to:

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

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

3. An immediate family member of the physician,

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

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

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

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

Section 18. Paragraph (a) of subsection (15) of section 400.506, Florida Statutes, is amended to read:

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

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

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

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

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

4. Gives remuneration to a case manager, discharge planner, facility-based staff member, or third-party vendor who is involved in the discharge planning process of a facility licensed under chapter 395 or this chapter and from whom the nurse registry receives referrals. This subparagraph does not apply to a nurse registry that does not participate in the Medicaid or Medicare programs.

5. Gives remuneration to a physician, a member of the physician's office staff, or an immediate family member of the physician, and the nurse registry received a patient referral in the last 12 months from that physician or the physician's office staff. This subparagraph does not apply to a nurse registry that

does not participate in the Medicaid or Medicare programs.

Section 19. Paragraph (m) is added to subsection (4) of section 400.9905, Florida Statutes, to read:

400.9905 Definitions.--

(4) "Clinic" means an entity at which health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider. For purposes of this part, the term does not include and the licensure requirements of this part do not apply to:

(m) Entities that do not seek reimbursement from insurance companies for medical services paid pursuant to personal injury protection coverage required by s. 627.736, bodily liability coverage, uninsured motorist coverage, or personal umbrella liability coverage.

Section 20. Paragraph (a) of subsection (7) of section 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 upon 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 accrediting organization 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.

Section 21. Subsection (6) of section 400.995, Florida Statutes, is amended to read:

400.995 Agency administrative penalties.--

(6) During an inspection, the agency~~, as an alternative to or in conjunction with an administrative action against a clinic for violations of this part and adopted rules,~~ shall make a reasonable attempt to discuss each violation ~~and recommended corrective action~~ with the owner, medical director, or clinic director of the clinic, prior to written notification. ~~The agency, instead of fixing a period within which the clinic shall enter into compliance with standards, may request a plan of~~

~~corrective action from the clinic which demonstrates a good faith effort to remedy each violation by a specific date, subject to the approval of the agency.~~

Section 22. Subsections (5), (9), and (13) of section 408.803, Florida Statutes, are amended to read:

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

(5) "Change of ownership" means:

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

(b) An event in which 51 ~~45~~ percent or more of the ownership, ~~voting~~ shares, membership, or controlling interest of a licensee is in any manner transferred or otherwise assigned. This paragraph does not apply to a licensee that is publicly traded on a recognized stock exchange. ~~In a corporation whose shares are not publicly traded on a recognized stock exchange is transferred or assigned, including the final transfer or assignment of multiple transfers or assignments over a 2-year period that cumulatively total 45 percent or greater.~~

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

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

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

Section 23. Paragraph (a) of subsection (1), subsection (2), paragraph (c) of subsection (7), and subsection (8) of section 408.806, Florida Statutes, are amended to read:

408.806 License application process.--

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

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

1. The applicant;

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

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

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

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

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

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

(d) The agency shall notify the licensee by mail or electronically at least 90 days prior to the expiration of a license that a renewal license is necessary to continue operation. The failure to timely submit a renewal application and license fee shall result in a $50 per day late fee charged to the licensee by the agency; however, the aggregate amount of

the late fee may not exceed 50 percent of the licensure fee or $500, whichever is less. If an application is received after the required filing date and exhibits a hand-canceled postmark obtained from a United States post office dated on or before the required filing date, no fine will be levied.

(7)

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

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

(a) Licensure applications.

(b) Required signatures.

(c) Payment of fees.

(d) Notarization of applications.

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

Section 24. Section 408.8065, Florida Statutes, is created to read:

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

clinics.--

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

(a) Demonstrate financial ability to operate, as required under s. 408.810(8).

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

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

(d) Demonstrate the financial ability to operate if the applicant's assets, credit, and projected revenues meet or exceed projected liabilities and expenses, and provide independent evidence that the funds necessary for startup costs, working capital, and contingency financing exist and will be available as needed.

All documents required under this subsection must be prepared in

accordance with generally accepted accounting principles and may be in a compilation form. The financial statements must be signed by a certified public accountant.

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

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

Section 25. Subsection (2) of section 408.808, Florida Statutes, is amended to read:

408.808 License categories.--

(2) PROVISIONAL LICENSE.--A provisional license may be issued to an applicant pursuant to s. 408.809(3). An applicant against whom a proceeding denying or revoking a license is pending at the time of license renewal may be issued a

provisional license effective until final action not subject to further appeal. A provisional license may also be issued to an applicant applying for a change of ownership. A provisional license shall be limited in duration to a specific period of time, not to exceed 12 months, as determined by the agency.

Section 26. Subsection (5) of section 408.809, Florida Statutes, is amended, and new subsections (5) and (6) are added to that section, to read:

408.809 Background screening; prohibited offenses.--

(5) Effective October 1, 2009, in addition to the offenses listed in ss. 435.03 and 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any of the following offenses or any similar offense of another jurisdiction:

(a) A violation of any authorizing statutes, if the offense was a felony.

(b) A violation of this chapter, if the offense was a felony.

(c) A violation of s. 409.920, relating to Medicaid provider fraud, if the offense was a felony.

(d) A violation of s. 409.9201, relating to Medicaid fraud, if the offense was a felony.

(e) A violation of s. 741.28, relating to domestic violence.

(f) A violation of chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(g) A violation of s. 810.02, relating to burglary.

(h) A violation of s. 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(i) A violation of s. 817.234, relating to false and fraudulent insurance claims.

(j) A violation of s. 817.505, relating to patient brokering.

(k) A violation of s. 817.568, relating to criminal use of personal identification information.

(l) A violation of s. 817.60, relating to obtaining a credit card through fraudulent means.

(m) A violation of s. 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(n) A violation of s. 831.01, relating to forgery.

(o) A violation of s. 831.02, relating to uttering forged instruments.

(p) A violation of s. 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(q) A violation of s. 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

(r) A violation of s. 831.30, relating to fraud in obtaining medicinal drugs.

(s) A violation of s. 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.

A person who serves as a controlling interest of or is employed by a licensee on September 30, 2009, shall not be required by law to submit to rescreening if that licensee has in its possession written evidence that the person has been screened and qualified according to the standards specified in s. 435.03 or s. 435.04. However, if such person has been convicted of a disqualifying offense listed in this subsection, he or she may apply for an exemption from the appropriate licensing agency before September 30, 2009, and if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption for an offense listed in this subsection. Exemptions from disqualification may be granted pursuant to s. 435.07.

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

~~(5) Background screening is not required to obtain a certificate of exemption issued under s. 483.106.~~

Section 27. Subsection (3) and paragraph (a) of subsection (5) of section 408.810, Florida Statutes, are amended to read:

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

(3) Unless otherwise specified in this part, authorizing

statutes, or applicable rules, any information required to be reported to the agency must be submitted within 21 calendar days after the report period or effective date of the information, whichever is earlier, including, but not limited to, any change of:

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

(b) Required insurance or bonds.

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

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

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

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

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

Section 28. Present subsection (4) of section 408.811, Florida Statutes, is renumbered as subsection (6), subsections (2) and (3) are amended, and new subsections (4) and (5) are added to that section, to read:

408.811 Right of inspection; copies; inspection reports; plan for correction of deficiencies.--

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

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

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

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

Section 29. Section 408.813, Florida Statutes, is amended to read:

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

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

(2) Violations of this part, authorizing statutes, or applicable rules shall be classified according to the nature of the violation and the gravity of its probable effect on clients. The scope of a violation may be cited as an isolated, patterned, or widespread deficiency. An isolated deficiency is a deficiency affecting one or a very limited number of clients, or involving one or a very limited number of staff, or a situation that occurred only occasionally or occurred in a very limited number of locations. A patterned deficiency is a deficiency in which more than a very limited number of clients are affected, or more than a very limited number of staff are involved, or the situation has occurred in several locations, or the same client

or clients have been affected by repeated occurrences of the same deficient practice but the effect of the deficient practice is not found to be pervasive throughout the provider. A widespread deficiency is a deficiency in which the problems causing the deficiency are pervasive in the provider or represent systemic failure that has affected or has the potential to affect a large portion of the provider's clients. This subsection does not affect the legislative determination of the amount of a fine imposed under authorizing statutes. Violations shall be classified on the written notice as follows:

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

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

notwithstanding the correction of the violation.

(c) Class III violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines indirectly or potentially threaten the physical or emotional health, safety, or security of clients, other than class I or class II violations. The agency shall impose an administrative fine as provided by law for a cited class III violation. A citation for a class III violation must specify the time within which the violation is required to be corrected. If a class III violation is corrected within the time specified, a fine may not be imposed.

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

Section 30. Subsection (4) is added to section 408.815, Florida Statutes, to read:

408.815 License or application denial; revocation.--

(4) In addition to the grounds provided in authorizing statutes, the agency shall deny an application for a license or

license renewal if the applicant or a person having a controlling interest in an applicant has been:

(a) Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, unless the sentence and any subsequent period of probation for such conviction or plea ended more than 15 years prior to the date of the application;

(b) Terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5 years; or

(c) Terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from the federal Medicare program or from any other state Medicaid program, unless the applicant has been in good standing with a state Medicaid program or the federal Medicare program for the most recent 5 years and the termination occurred more than 19 years prior to the date of the application.

Section 31. Subsections (12) through (29) of section 408.820, Florida Statutes, are renumbered as subsections (11) through (28), respectively, and present subsections (11), (12), (13), (21), and (26) of that section are amended to read:

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

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

~~408.811.~~

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

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

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

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

Section 32. Section 408.821, Florida Statutes, is created to read:

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

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

(2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved emergency operations plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers.

(3)(a) An inactive license may be issued to a licensee

subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider:

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

2. Is currently licensed.

3. Does not have a provisional license.

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

(b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements

of this part and applicable rules and statutes.

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

Section 33. Subsections (3), (4), and (5) of section 408.831, Florida Statutes, are amended to read:

408.831 Denial, suspension, or revocation of a license, registration, certificate, or application.--

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

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

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

~~2. Is currently licensed.~~

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

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

~~(b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the licensee expiration date, and all licensure fees must be current, paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes.~~

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

those chapters.

Section 34. Subsection (2) of section 408.918, Florida Statutes, is amended, and subsection (3) is added to that section, to read:

408.918 Florida 211 Network; uniform certification requirements.--

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

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

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

(3) The Florida Alliance of Information and Referral Services is the 211 collaborative organization for the state

that is responsible for studying, designing, implementing, supporting, and coordinating the Florida 211 Network and receiving federal grants.

Section 35. Paragraph (e) of subsection (4) of section 409.221, Florida Statutes, is amended to read:

409.221 Consumer-directed care program.--

(4) CONSUMER-DIRECTED CARE.--

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

1. Personal care.

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

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

4. Assistance in taking self-administered medication.

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

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

Section 36. Subsection (5) of section 409.901, Florida Statutes, is amended to read:

409.901 Definitions; ss. 409.901-409.920.--As used in ss.

409.901-409.920, except as otherwise specifically provided, the term:

(5) "Change of ownership" means:

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

(b) An event in which 51 ~~45~~ percent or more of the ownership, ~~voting~~ shares, membership, or controlling interest of a provider is in any manner transferred or otherwise assigned. This paragraph does not apply to a licensee that is publicly traded on a recognized stock exchange; or

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

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

Section 37. Subsection (4) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be

eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

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

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

care and documentation that supports the recipient's diagnosis to the agency when requesting prior authorization.

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

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

1. The services are ordered by a physician.

2. The written prescription for the services is signed and dated by the recipient's physician before the development of a

plan of care and before any request requiring prior authorization.

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

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

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

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

Section 38. Paragraphs (k) and (l) are added to subsection (3) of section 409.907, Florida Statutes, subsection (9) is amended, subsection (12) is renumbered as subsection (13) and amended, and new subsections (12) and (14) are added to that section, to read:

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

(3) The provider agreement developed by the agency, in addition to the requirements specified in subsections (1) and (2), shall require the provider to:

(k) Fully comply with the agency's medical encounter data system.

(l) Report specific actions by the managed care plan to provide incentives for healthy behaviors.

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

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

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

(b) Deny the application if the agency finds that it is in the best interest of the Medicaid program to do so. The agency may consider the factors listed in subsection (10), as well as any other factor that could affect the effective and efficient administration of the program, including, but not limited to, the applicant's demonstrated ability to provide services, conduct business, and operate a financially viable concern; the current availability of medical care, services, or supplies to recipients, taking into account geographic location and reasonable travel time; the number of providers of the same type already enrolled in the same geographic area; and the credentials, experience, success, and patient outcomes of the provider for the services that it is making application to

provide in the Medicaid program. The agency shall deny the application if the agency finds that a provider; any officer, director, agent, managing employee, or affiliated person; or any partner or shareholder having an ownership interest equal to 5 percent or greater in the provider if the provider is a corporation, partnership, or other business entity, has failed to pay all outstanding fines or overpayments assessed by final order of the agency or final order of the Centers for Medicare and Medicaid Services, not subject to further appeal, unless the provider agrees to a repayment plan that includes withholding Medicaid reimbursement until the amount due is paid in full.

(12) A managed care plan that has the capacity to provide covered services to all enrollees in compliance with agency requirements, with the exception of at least one essential provider despite a good faith effort to execute a contract with that provider, shall not be sanctioned or precluded from operating in a new service area by the agency as long as the managed care plan demonstrates its ability to provide services within a reasonable travel time and distance or arranges for single case coverage and negotiates in good faith to execute a contract with the provider. For purposes of this subsection, "good faith effort" means the managed care plan:

(a) Offers a rate equivalent to, or greater than, the rate specified in s. 409.9128(5)(d).

(b) Does not engage in a pattern of unfair business practices, including unreasonable claims denials, payment delays, or referral patterns.

(13) ~~(12)~~ Licensed, certified, or otherwise qualified

providers are not entitled to enrollment in a Medicaid provider network. However, a managed care plan that is relying on subsection (12) to meet agency requirements for a specific service area shall include any willing, qualified provider located in that area in the managed care plan's network and offer a rate equivalent to, or greater than, the Medicaid fee schedule or county billing rate specified in s. 409.915.

(14) By January 1, 2010, and annually thereafter until full compliance is reached, the agency shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report that summarizes data regarding the agency's medical encounter data system, including the number of participating plans, the level of compliance of each plan, and specific problem areas. The report shall include issues and recommendations developed by the technical assistance panel created in s. 409.908(4)(b).

Section 39. Subsection (4) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.--Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based

on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(4) Subject to any limitations or directions provided for in the General Appropriations Act, alternative health plans, health maintenance organizations, and prepaid health plans shall be reimbursed a fixed, prepaid amount negotiated, or competitively bid pursuant to s. 287.057, by the agency and prospectively paid to the provider monthly for each Medicaid recipient enrolled. The amount may not exceed the average amount the agency determines it would have paid, based on claims experience, for recipients in the same or similar category of eligibility. The agency shall calculate capitation rates on a

regional basis and~~, beginning September 1, 1995,~~ shall include age-band differentials in such calculations.

(a) As of September 1, 2011, or the date the agency determines that its encounter data is complete, valid, and tested through a simulated rate-setting process, whichever is later, the agency shall begin a budget-neutral adjustment of capitation rates based on aggregate risk scores for each plan's enrollees. During the first 2 years of the adjustment, the agency shall ensure that no plan has an aggregate risk score that varies by more than 10 percent from the aggregate weighted average for all plans. The risk-adjusted capitation rates shall be phased in as follows:

1. In the first fiscal year, 75 percent of the capitation rate shall be based on the current methodology and 25 percent shall be based on the risk-adjusted capitation rate methodology.

2. In the second fiscal year, 50 percent of the capitation rate shall be based on the current methodology and 50 percent shall be based on the risk-adjusted rate methodology.

3. In the third fiscal year, the risk-adjusted capitation methodology shall be fully implemented.

(b) The secretary of the agency shall convene a technical advisory panel to advise the agency in the area of risk-adjusted rate-setting during the transition to risk-adjusted capitation rates described in paragraph (a). The panel shall include representatives of prepaid plans in counties not included in the demonstration sites established under s. 409.91211(1). The panel shall advise the agency regarding:

1. The selection of a base year of encounter data to be

used to set risk-adjusted rates.

2. The completeness and accuracy of the encounter data.

3. The effect of risk-adjusted rates on prepaid plans based on a review of a simulated rate-setting process.

Section 40. Paragraph (b) of subsection (4) and subsections (14), (17), and (19) of section 409.912, Florida Statutes, are amended, and subsections (54) and (55) are added to that section, to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The

agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards,

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

(4) The agency may contract with:

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

the department's care or custody prior to enrolling such children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. Except as provided in subparagraph 8., and except in counties where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211, the agency shall seek federal approval to contract with a single entity meeting these requirements to provide comprehensive behavioral health care services to all Medicaid recipients not enrolled in a Medicaid managed care plan authorized under s. 409.91211 or a Medicaid health maintenance organization in an AHCA area. In an AHCA area where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and shall be subject to this paragraph. Each entity must offer sufficient choice of providers in its network to ensure recipient access to care and the opportunity to select a provider with whom they are satisfied. The network shall include all public mental health hospitals. To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph

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

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

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

3. Except as provided in subparagraph 8., by July 1, 2006, the agency and the Department of Children and Family Services shall contract with managed care entities in each AHCA area

except area 6 or arrange to provide comprehensive inpatient and outpatient mental health and substance abuse services through capitated prepaid arrangements to all Medicaid recipients who are eligible to participate in such plans under federal law and regulation. In AHCA areas where eligible individuals number less than 150,000, the agency shall contract with a single managed care plan to provide comprehensive behavioral health services to all recipients who are not enrolled in a Medicaid health maintenance organization or a Medicaid capitated managed care plan authorized under s. 409.91211. The agency may contract with more than one comprehensive behavioral health provider to provide care to recipients who are not enrolled in a Medicaid capitated managed care plan authorized under s. 409.91211 or a Medicaid health maintenance organization in AHCA areas where the eligible population exceeds 150,000. In an AHCA area where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and shall be subject to this paragraph. Contracts for comprehensive behavioral health providers awarded pursuant to this section shall be competitively procured. Both for-profit and not-for-profit corporations shall be eligible to compete. Managed care plans contracting with the agency under subsection (3) shall provide and receive payment for the same comprehensive behavioral health benefits as provided in AHCA rules, including handbooks incorporated by reference. In AHCA area 11, the agency shall contract with at least two

comprehensive behavioral health care providers to provide behavioral health care to recipients in that area who are enrolled in, or assigned to, the MediPass program. One of the behavioral health care contracts shall be with the existing provider service network pilot project, as described in paragraph (d), for the purpose of demonstrating the cost-effectiveness of the provision of quality mental health services through a public hospital-operated managed care model. The agency is directed to integrate the provision of acute care and behavioral health services in the public hospital-operated managed care model to the extent feasible and consistent with continuity of care and patient choice. Payment shall be at an agreed-upon capitated rate to ensure cost savings. Of the recipients in area 11 who are assigned to MediPass under the provisions of s. 409.9122(2)(k), a minimum of 50,000 of those MediPass-enrolled recipients shall be assigned to the existing provider service network in area 11 for their behavioral care.

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

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

b. If the agency determines that the proposed capitation rate in any area is insufficient to provide appropriate services, the agency may adjust the capitation rate to ensure

that care will be available. The agency and the department may use existing general revenue to address any additional required match but may not over-obligate existing funds on an annualized basis.

c. Subject to any limitations provided for in the General Appropriations Act, the agency, in compliance with appropriate federal authorization, shall develop policies and procedures that allow for certification of local and state funds.

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

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

7. Traditional community mental health providers under contract with the Department of Children and Family Services pursuant to part IV of chapter 394, child welfare providers

under contract with the Department of Children and Family Services in areas 1 and 6, and inpatient mental health providers licensed pursuant to chapter 395 must be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid behavioral health services.

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

(c) A federally qualified health center or an entity owned by one or more federally qualified health centers or an entity owned by other migrant and community health centers receiving non-Medicaid financial support from the Federal Government to

provide health care services on a prepaid or fixed-sum basis to recipients. A federally qualified health center or an entity that is owned by one or more federally qualified health centers and is reimbursed by the agency on a prepaid basis is exempt from parts I and III of chapter 641, but must comply with the solvency requirements in s. 641.2261(2) and meet the appropriate requirements governing financial reserve, quality assurance, and patients' rights established by the agency.

(14)(a) The agency shall operate or contract for the operation of utilization management and incentive systems designed to encourage cost-effective use of services and to eliminate services that are medically unnecessary. The agency shall track Medicaid provider prescription and billing patterns and evaluate them against Medicaid medical necessity criteria as provided in agency rules. Medical necessity determination requires that service be consistent with symptoms or confirmed diagnosis of illness or injury under treatment and not in excess of the patient's needs. The agency shall conduct reviews of provider exceptions to peer group norms and shall, using statistical methodologies, provider profiling, and analysis of billing patterns, detect and investigate abnormal or unusual increases in billing or payment of claims for Medicaid services and medically unnecessary provision of services. Providers that demonstrate a pattern of submitting claims for medically unnecessary services shall be referred to the Medicaid program integrity unit for investigation. The agency shall report on its efforts to eliminate medically necessary services in the annual report required by s. 409.913.

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

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

2. A cost-benefit analysis documenting the estimated specific direct and indirect costs, savings, performance improvements, risks, and qualitative and quantitative benefits involved in or resulting from providing the service. The cost-benefit analysis must include a detailed plan and timeline identifying all actions that must be implemented to realize expected benefits. The Secretary of Health Care Administration shall verify that all costs, savings, and benefits are valid and achievable.

(c) If the agency determines that the increased reimbursement is cost-effective, the agency shall recommend a change in the reimbursement schedule for that particular good or service. If, within 12 months after implementing any rate change under this procedure, the agency determines that costs were not offset by the increased reimbursement schedule, the agency may

revert to the former reimbursement schedule for the particular good or service.

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

~~(a) Where a public entity agrees to fund any deficit incurred by the contracting entity; or~~

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

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

~~2. Submits a written guarantee acceptable to the agency which is irrevocable during the term of the contracting entity's contract with the agency and, upon termination of the contract,~~

~~until the agency receives proof of satisfaction of all outstanding obligations incurred under the contract.~~

(19) For services provided on or after July 1, 2009, an entity that contracts with the agency on a prepaid or fixed-sum basis for the provision of Medicaid services shall reimburse any hospital or physician that is outside the entity's authorized geographic service area as specified in its contract with the agency, and that provides services authorized by the entity to its members, at a rate negotiated with the hospital or physician for the provision of services or according to the lesser of the following:

(a) The usual and customary charges made to the general public by the hospital or physician; or

(b) The Florida Medicaid fee-for-service reimbursement rate that would have been paid to the hospital or physician by the agency if the enrollee had been a MediPass recipient established for the hospital or physician.

(54) The agency shall develop and implement a home health agency monitoring pilot project in Miami-Dade County by January 1, 2010. The agency shall contract with a vendor to verify the use and delivery of home health services and provide an electronic billing interface for home health services. The contract must require the creation of a program to submit claims electronically for the delivery of home health services. The program must verify telephonically visits for the delivery of home health services using voice biometrics. The agency may seek amendments to the Medicaid state plan and waivers of federal laws, as necessary, to implement the pilot project.

Notwithstanding s. 287.057(5)(f), the agency must award the contract through the competitive solicitation process. The agency shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives evaluating the pilot project by February 1, 2011.

(55) The agency shall implement a comprehensive care management pilot project for home health services by January 1, 2010, which includes face-to-face assessments by a nurse licensed pursuant to chapter 464, consultation with physicians ordering services to substantiate the medical necessity for services, and on-site or desk reviews of recipients' medical records in Miami-Dade County. The agency may enter into a contract with a qualified organization to implement the pilot project. The agency may seek amendments to the Medicaid state plan and waivers of federal laws, as necessary, to implement the pilot project.

Section 41. Section 409.91207, Florida Statutes, is created to read:

409.91207 Medical Home Pilot Projects.--

(1) PURPOSE.--The agency shall establish pilot projects in Alachua and Hillsborough Counties to test the potential for coordinated and cost-effective care in a fee-for-service environment and to compare performance of these pilot projects with other managed care models, including, but not limited to, primary care case management.

(2) ORGANIZATION.--

(a) Each county in the pilot project shall be served by at least one medical home network. A medical home network shall

consist of:

1. Primary care providers who also provide disease management. Eligible primary care providers include physicians, federally qualified health centers, medical schools, teaching hospitals, or programs serving children with special health care needs currently authorized as a network under an existing Medicaid waiver.

2. Specialty care providers who are employed by or under contract with a medical school or programs that serve children with special health care needs currently authorized as a network under an existing Medicaid waiver.

3. One or more hospitals.

(b) A medical home network shall coordinate with other providers, as necessary, to ensure that Medicaid participants receive efficient and effective access to services, consistent with the scope of services provided to MediPass recipients.

(c) A managed care organization may seek designation by the agency as a medical home network by documenting policies and procedures consistent with the principles provided in subsection (4).

(3) SERVICE CAPABILITIES.--A medical home network shall provide primary care, coordinated services to control chronic illnesses, pharmacy services, outpatient specialty physician services, and inpatient services.

(4) PRINCIPLES.--A medical home network shall modify the processes and patterns of health care service delivery by applying the following principles:

(a) A personal medical provider shall lead an

interdisciplinary team of professionals who share the responsibility for ongoing care to a specific panel of patients.

(b) The personal medical provider shall identify the patient's health care needs and respond to those needs either through direct care or arrangements with other qualified providers.

(c) Care shall be coordinated or integrated across all areas of health service delivery.

(d) Information technology shall be integrated into delivery systems to enhance clinical performance and monitor patient outcomes.

(5) ENROLLMENT.--Each MediPass recipient receiving primary care at a participating federally qualified health center or primary care clinic owned and operated by a medical school or teaching hospital shall be enrolled in the program if the recipient does not opt out of enrollment pursuant to s. 409.9122. Other Medicaid recipients shall be enrolled consistent with s. 409.9122(2)(e)1.

(6) ACCESS STANDARDS AND NETWORK ADEQUACY.--A medical home network shall document the capacity for coordinated systems of care through written agreements between providers that establish arrangements for referral, access to medical records, and followup care.

(7) FINANCING.--Services provided by a medical home network shall be reimbursed based on claims filed for Medicaid fee-for-service payments. A managed care organization designated as a medical home network shall receive capitated rates that reflect enhanced payments to fee-for-service medical home

networks, as authorized in the General Appropriations Act. In addition, the following entities that participate in a medical home network shall be eligible to receive an enhanced payment, as authorized in the General Appropriations Act:

(a) A primary care physician, federally qualified health center, or primary care clinic owned and operated by a medical school or teaching hospital shall be eligible to receive enhanced primary care case management fees.

(b) A medical school shall be eligible to receive enhanced payments through the supplemental physician payment program using such certified funds.

(c) An outpatient specialty clinic operated by a medical school shall be eligible to bill Medicaid for facility costs, in addition to professional services.

(d) A hospital shall be eligible to receive supplemental Medicaid payments and exempt rates.

(8) SHARED SAVINGS.--The agency shall analyze spending for enrolled medical home network patients compared to capitation rates that would have been paid for the same population in the same region during the same year. The agency shall report the results of this comparison as part of the Social Services Estimating Conference. Each medical home network that achieves savings equal to the prepaid health plan area discount factor is eligible for an appropriation of the shared savings. When the savings exceed the area discount factor, the medical home network shall be eligible for an appropriation of the full amount of the excess savings. To the extent possible, savings shared with the medical home network shall be distributed as

bonus payments for quality performance.

(9) QUALITY ASSURANCE AND ACCOUNTABILITY.--A medical home network shall maintain medical records and clinical data as necessary to assess the utilization, cost, and outcome of services provided to enrollees.

(10) EVALUATION.--The agency shall report medical home network performance on a quarterly basis. The agency shall contract with the University of Florida to comprehensively evaluate the pilot projects created under this section, including a comparison of the medical home network to other models of managed care. An initial evaluation shall cover a 24-month period beginning with the implementation of the pilot projects in all pilot project counties. A final evaluation shall cover a 60-month period beginning with the implementation of the pilot projects in all pilot project counties. The initial evaluation shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by June 30, 2012. The final evaluation shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by June 30, 2015. The final evaluation shall include the following:

(a) Quality of care indicators, including, but not limited to, hospital admission rates for preventable and chronic diseases; emergency department utilization rates; hospital readmission rates; and specific performance indicators related to diabetes, hypertension, obesity, and tobacco use prevention and cessation.

(b) Financial performance compared to expenditures for

similar patients enrolled in MediPass and compared to the capitation rates that would have been paid if the medical home enrollees were in prepaid plans.

(11) AUTHORITY.--The agency shall seek any federal waivers or amend the Medicaid state plan as necessary to implement the provisions of this subsection.

Section 42. Section 409.91208, Florida Statutes, is created to read:

409.91208 Reimbursement for services provided by medical schools.--

(1) FINDINGS AND INTENT.--

(a) The Legislature finds that there is a critical shortage of physicians that threatens access to health care.

(b) The Legislature further finds that the physician workforce shortage is likely to become worse in the future due to an aging physician population.

(c) The Legislature further finds that one of the primary reasons for the physician workforce shortage is the failure to adequately provide for graduate medical education in this state.

(d) The Legislature further finds a nexus between the infrastructure for graduate medical education and the goal of providing access to services for Medicaid patients.

(e) The Legislature further finds that managed care is a responsible and valuable tool for ensuring a sustainable Medicaid program.

(f) Finally, the Legislature finds that federal regulations create a barrier to simultaneously supporting graduate medical education and maintaining cost-effective

purchasing of services in the Medicaid program through managed care.

(2) ALTERNATIVE PAYMENT METHOD.--The agency shall seek federal approval to implement an alternative payment methodology for medical school faculty who provide services in the Medicaid program so that direct payments may be made to physicians employed by or under contract with the state's medical schools for costs associated with graduate medical education. The agency shall amend its Medicaid policies as necessary to implement the provisions of this subsection.

Section 43. Paragraph (b) of subsection (1) and paragraph (e) of subsection (3) of section 409.91211, Florida Statutes, are amended to read:

409.91211 Medicaid managed care pilot program.--

(1)

(b) This waiver authority is contingent upon federal approval to preserve the upper-payment-limit funding mechanism for hospitals, including a guarantee of a reasonable growth factor, a methodology to allow the use of a portion of these funds to serve as a risk pool for demonstration sites, provisions to preserve the state's ability to use intergovernmental transfers, and provisions to protect the disproportionate share program authorized pursuant to this chapter. Upon completion of the evaluation conducted under s. 3, ch. 2005-133, Laws of Florida, the agency may request statewide expansion of the demonstration projects. Statewide phase-in to additional counties shall be contingent upon review and approval by the Legislature. Under the upper-payment-limit program, or

the low-income pool as implemented by the Agency for Health Care Administration pursuant to federal waiver, the state matching funds required for the program shall be provided by local governmental entities through intergovernmental transfers in accordance with published federal statutes and regulations. The Agency for Health Care Administration shall distribute upper-payment-limit, disproportionate share hospital, and low-income pool funds according to published federal statutes, regulations, and waivers and the low-income pool methodology approved by the federal Centers for Medicare and Medicaid Services. A provider who receives supplemental payments shall serve Medicaid recipients regardless of their county of residence in this state and may not restrict access to care based on residency in a county in this state other than the one in which the provider is located.

(3) The agency shall have the following powers, duties, and responsibilities with respect to the pilot program:

(e) To implement policies and guidelines for phasing in financial risk for approved provider service networks over a 5-year ~~3-year~~ period. These policies and guidelines must include an option for a provider service network to be paid fee-for-service rates. For any provider service network established in a managed care pilot area, the option to be paid fee-for-service rates shall include a savings-settlement mechanism that is consistent with s. 409.912(44). This model shall be converted to a risk-adjusted capitated rate no later than the beginning of the sixth ~~fourth~~ year of operation, and may be converted earlier at the option of the provider service network. Federally

qualified health centers may be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid primary care services.

Section 44. Paragraph (e) of subsection (2) and subsection (7) of section 409.9122, Florida Statutes, are amended, and subsection (15) is added to that section, to read:

409.9122 Mandatory Medicaid managed care enrollment; programs and procedures.--

(2)

(e) Medicaid recipients who are already enrolled in a managed care plan or MediPass shall be offered the opportunity to change managed care plans or MediPass providers on a staggered basis, as defined by the agency. All Medicaid recipients shall have 30 days in which to make a choice of managed care plans or MediPass providers. Enrolled Medicaid recipients who have a known diagnosis consistent with HIV/AIDS shall be offered the opportunity to change plans on a staggered basis; however, these individuals shall remain in their current disease management or specialized HIV/AIDS plan unless they actively choose to opt out of that plan. In counties that have two or more managed care plans, a recipient already enrolled in MediPass who fails to make a choice during the annual period shall be assigned to a managed care plan if he or she is eligible for enrollment in the managed care plan. The agency shall apply for a state plan amendment or federal waiver authority, if necessary, to implement the provisions of this paragraph. All newly eligible Medicaid recipients shall have 30 days in which to make a choice of managed care plans or MediPass

providers. Those Medicaid recipients who do not make a choice shall be assigned in accordance with paragraph (f). To facilitate continuity of care, for a Medicaid recipient who is also a recipient of Supplemental Security Income (SSI), prior to assigning the SSI recipient to a managed care plan or MediPass, the agency shall determine whether the SSI recipient has an ongoing relationship with a MediPass provider or managed care plan. If the SSI recipient has an ongoing relationship with a managed care plan, the agency shall assign the recipient to that managed care plan. Those SSI recipients who do not have such a provider relationship shall be assigned to a managed care plan or MediPass provider in accordance with paragraph (f).

1. Notwithstanding this paragraph and paragraphs (f) and (k), a Medicaid recipient who resides in Alachua County or Hillsborough County who would otherwise be subject to mandatory assignment because the recipient failed to make a choice shall be assigned by the agency to a medical home network operated pursuant to s. 409.91207 using a method that enrolls 35 percent of those recipients in medical home networks and 65 percent in managed care plans. In making these assignments, the agency shall consider the capability of the networks to meet patient needs.

2. For purposes of subparagraph 1., the term "managed care plans" includes health maintenance organizations, exclusive provider organizations, provider service networks, minority physician networks, the Children's Medical Services Network, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act.

(7) The agency shall convene a workgroup to evaluate the current status and future viability of Medicaid managed care. The workgroup shall complete a report by January 1, 2010, that considers the following issues ~~investigate the feasibility of developing managed care plan and MediPass options for the following groups of Medicaid recipients~~:

(a) The performance of managed care plans in achieving access to care, quality services, and cost containment. ~~Pregnant women and infants.~~

(b) The effect of recent changes to payment rates for managed care plans. ~~Elderly and disabled recipients, especially those who are at risk of nursing home placement.~~

(c) The status of contractual relationships between managed care plans and providers, especially providers critically necessary for compliance with network adequacy standards. ~~Persons with developmental disabilities.~~

(d) The availability of other models for managed care that may improve performance, ensure stability, and contain costs in the future. ~~Qualified Medicare beneficiaries.~~

~~(e) Adults who have chronic, high-cost medical conditions.~~

~~(f) Adults and children who have mental health problems.~~

~~(g) Other recipients for whom managed care plans and MediPass offer the opportunity of more cost-effective care and greater access to qualified providers.~~

(15) The agency shall collect encounter data in conformity with s. 409.91211(3)(p)4. on services provided to patients enrolled in managed care plans. The agency shall collect financial and utilization encounter data in a uniform manner

based on common definitions delineated by category of service and eligibility group.

Section 45. Subsection (4) of section 409.9124, Florida Statutes, is amended, and paragraph (d) is added to subsection (1) of that section, to read:

409.9124 Managed care reimbursement.--The agency shall develop and adopt by rule a methodology for reimbursing managed care plans.

(1) Final managed care rates shall be published annually prior to September 1 of each year, based on methodology that:

(d) Is risk adjusted in accordance with s. 409.908(4).

(4) The agency shall quarterly examine the financial condition of each managed care plan, and its performance in serving Medicaid patients, and shall utilize examinations performed by the Office of Insurance Regulation wherever possible. No later than January 1, 2010, and at least annually thereafter, the agency shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives regarding the financial condition and trends affecting Medicaid managed care plans in order to assess the viability of these plans, identify any specific risks to future performance, assess overall rate adequacy, and recommend any changes necessary to ensure a resilient and effective managed care program that meets the needs of Medicaid participants.

Section 46. Subsection (5) of section 409.9128, Florida Statutes, is amended to read:

409.9128 Requirements for providing emergency services and care.--

(5) Reimbursement for services provided to an enrollee of a managed care plan under this section on or after July 1, 2009, by a provider who does not have a contract with the managed care plan shall be the lesser of:

(a) The provider's charges;

(b) The usual and customary provider charges for similar services in the community where the services were provided;

(c) The charge mutually agreed to by the entity and the provider within 60 days after submittal of the claim; or

(d) The Medicaid fee-for-service rate that would have been paid to the provider by the agency if the enrollee had been a MediPass recipient.

Section 47. Section 409.913, Florida Statutes, is amended to read:

409.913 Oversight of the integrity of the Medicaid program.--The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. Beginning January 1, 2003, and each year thereafter, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit a joint report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report must describe the number of cases opened and investigated each year; the sources of the cases opened; the disposition of

the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must include policy recommendations ~~recommend changes~~ necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud. All policy recommendations in the report must include a detailed fiscal analysis, including, but not limited to, implementation costs, estimated savings to the Medicaid program, and the return on investment. The agency must submit the policy recommendations and fiscal analyses in the report to the appropriate estimating conference, pursuant to s. 216.137,

by February 15 of each year. The agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs each must include detailed unit-specific performance standards, benchmarks, and metrics in the report, including projected cost savings to the state Medicaid program during the following fiscal year.

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

(a) "Abuse" means:

1. Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care.

2. Recipient practices that result in unnecessary cost to the Medicaid program.

(b) "Complaint" means an allegation that fraud, abuse, or an overpayment has occurred.

(c) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.

(d) "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance

with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

(e) "Overpayment" includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

(f) "Person" means any natural person, corporation, partnership, association, clinic, group, or other entity, whether or not such person is enrolled in the Medicaid program or is a provider of health care.

(2) The agency shall conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and shall report the findings of any overpayments in audit reports as appropriate. At least 5 percent of all audits shall be conducted on a random basis. As part of its ongoing fraud detection activities, the agency shall identify and monitor, by contract or otherwise, patterns of overutilization of Medicaid services based on state averages. The agency shall track Medicaid provider prescription and billing patterns and evaluate them against Medicaid medical necessity criteria and coverage and limitation guidelines adopted by rule. Medical necessity

determination requires that service be consistent with symptoms or confirmed diagnosis of illness or injury under treatment and not in excess of the patient's needs. The agency shall conduct reviews of provider exceptions to peer group norms and shall, using statistical methodologies, provider profiling, and analysis of billing patterns, detect and investigate abnormal or unusual increases in billing or payment of claims for Medicaid services and medically unnecessary provision of services.

(3) The agency may conduct, or may contract for, prepayment review of provider claims to ensure cost-effective purchasing; to ensure that billing by a provider to the agency is in accordance with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law; and to ensure that appropriate care is rendered to Medicaid recipients. Such prepayment reviews may be conducted as determined appropriate by the agency, without any suspicion or allegation of fraud, abuse, or neglect, and may last for up to 1 year. Unless the agency has reliable evidence of fraud, misrepresentation, abuse, or neglect, claims shall be adjudicated for denial or payment within 90 days after receipt of complete documentation by the agency for review. If there is reliable evidence of fraud, misrepresentation, abuse, or neglect, claims shall be adjudicated for denial of payment within 180 days after receipt of complete documentation by the agency for review.

(4) Any suspected criminal violation identified by the agency must be referred to the Medicaid Fraud Control Unit of the Office of the Attorney General for investigation. The agency

and the Attorney General shall enter into a memorandum of understanding, which must include, but need not be limited to, a protocol for regularly sharing information and coordinating casework. The protocol must establish a procedure for the referral by the agency of cases involving suspected Medicaid fraud to the Medicaid Fraud Control Unit for investigation, and the return to the agency of those cases where investigation determines that administrative action by the agency is appropriate. Offices of the Medicaid program integrity program and the Medicaid Fraud Control Unit of the Department of Legal Affairs, shall, to the extent possible, be collocated. The agency and the Department of Legal Affairs shall periodically conduct joint training and other joint activities designed to increase communication and coordination in recovering overpayments.

(5) A Medicaid provider is subject to having goods and services that are paid for by the Medicaid program reviewed by an appropriate peer-review organization designated by the agency. The written findings of the applicable peer-review organization are admissible in any court or administrative proceeding as evidence of medical necessity or the lack thereof.

(6) Any notice required to be given to a provider under this section is presumed to be sufficient notice if sent to the address last shown on the provider enrollment file. It is the responsibility of the provider to furnish and keep the agency informed of the provider's current address. United States Postal Service proof of mailing or certified or registered mailing of such notice to the provider at the address shown on the provider

enrollment file constitutes sufficient proof of notice. Any notice required to be given to the agency by this section must be sent to the agency at an address designated by rule.

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

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

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

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

(d) Have not been billed in whole or in part to a recipient or a recipient's responsible party, except for such copayments, coinsurance, or deductibles as are authorized by the agency.

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

(f) Are documented by records made at the time the goods or services were provided, demonstrating the medical necessity for the goods or services rendered. Medicaid goods or services are excessive or not medically necessary unless both the medical basis and the specific need for them are fully and properly

documented in the recipient's medical record.

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

(8) The agency shall not reimburse any person or entity for any prescription for medications, medical supplies, or medical services if the prescription was written by a physician or other prescribing practitioner who is not enrolled in the Medicaid program. This section does not apply:

(a) In instances involving bona fide emergency medical conditions as determined by the agency;

(b) To a provider of medical services to a patient in a hospital emergency department, hospital inpatient or outpatient setting, or nursing home;

(c) To bona fide pro bono services by preapproved non-Medicaid providers as determined by the agency;

(d) To prescribing physicians who are board-certified specialists treating Medicaid recipients referred for treatment by a treating physician who is enrolled in the Medicaid program;

(e) To prescriptions written for dually eligible Medicare beneficiaries by an authorized Medicare provider who is not enrolled in the Medicaid program;

(f) To other physicians who are not enrolled in the Medicaid program but who provide a medically necessary service or prescription not otherwise reasonably available from a Medicaid-enrolled physician; or

(9) A Medicaid provider shall retain medical,

professional, financial, and business records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid for a period of 5 years after the date of furnishing such services or goods. The agency may investigate, review, or analyze such records, which must be made available during normal business hours. However, 24-hour notice must be provided if patient treatment would be disrupted. The provider is responsible for furnishing to the agency, and keeping the agency informed of the location of, the provider's Medicaid-related records. The authority of the agency to obtain Medicaid-related records from a provider is neither curtailed nor limited during a period of litigation between the agency and the provider.

(10) Payments for the services of billing agents or persons participating in the preparation of a Medicaid claim shall not be based on amounts for which they bill nor based on the amount a provider receives from the Medicaid program.

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

(12) The complaint and all information obtained pursuant to an investigation of a Medicaid provider, or the authorized representative or agent of a provider, relating to an allegation of fraud, abuse, or neglect are confidential and exempt from the provisions of s. 119.07(1):

(a) Until the agency takes final agency action with respect to the provider and requires repayment of any

overpayment, or imposes an administrative sanction;

(b) Until the Attorney General refers the case for criminal prosecution;

(c) Until 10 days after the complaint is determined without merit; or

(d) At all times if the complaint or information is otherwise protected by law.

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

(a) Convicted of a criminal offense related to the delivery of any health care goods or services, including the performance of management or administrative functions relating to the delivery of health care goods or services;

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

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

If the agency determines a provider did not participate or acquiesce in an offense specified in paragraph (a), paragraph

(b), or paragraph (c), termination will not be imposed. If the agency effects a termination under this subsection, the agency shall issue an immediate final order pursuant to s. 120.569(2)(n).

(14) If the provider has been suspended or terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from participation in any other state ~~the~~ Medicaid program or the federal Medicare program by the Federal Government or any state, the agency must immediately suspend or terminate, as appropriate, the provider's participation in this state's ~~the Florida~~ Medicaid program for a period no less than that imposed by the Federal Government or any other state, and may not enroll such provider in this state's ~~the Florida~~ Medicaid program while such foreign suspension or termination remains in effect. The agency shall also immediately suspend or terminate, as appropriate, a provider's participation in this state's Medicaid program if the provider participated or acquiesced in any action for which any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, was suspended or terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from any other state Medicaid program or the federal Medicare program. This sanction is in addition to all other remedies provided by law.

(15) The agency shall ~~may~~ seek a ~~any~~ remedy provided by law, including, but not limited to, any remedy ~~the remedies~~

provided in subsections (13) and (16) and s. 812.035, if:

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

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

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

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

(e) The provider is not in compliance with provisions of Medicaid provider publications that have been adopted by reference as rules in the Florida Administrative Code; with provisions of state or federal laws, rules, or regulations; with provisions of the provider agreement between the agency and the provider; or with certifications found on claim forms or on transmittal forms for electronically submitted claims that are submitted by the provider or authorized representative, as such provisions apply to the Medicaid program;

(f) The provider or person who ordered or prescribed the care, services, or supplies has furnished, or ordered the

furnishing of, goods or services to a recipient which are inappropriate, unnecessary, excessive, or harmful to the recipient or are of inferior quality;

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

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

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

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

(k) The provider or an authorized representative of the provider has included in a cost report costs that are not allowable under a Florida Title XIX reimbursement plan, after the provider or authorized representative had been advised in an audit exit conference or audit report that the costs were not allowable;

(l) The provider is charged by information or indictment

with fraudulent billing practices. The sanction applied for this reason is limited to suspension of the provider's participation in the Medicaid program for the duration of the indictment unless the provider is found guilty pursuant to the information or indictment;

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

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

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

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

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

A provider is subject to sanctions for violations of this subsection as the result of actions or inactions of the provider, or actions or inactions of any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, in which the provider participated or acquiesced.

(16) The agency shall impose any of the following

sanctions or disincentives on a provider or a person for any of the acts described in subsection (15):

(a) Suspension for a specific period of time of not more than 1 year. Suspension shall preclude participation in the Medicaid program, which includes any action that results in a claim for payment to the Medicaid program as a result of furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services.

(b) Termination for a specific period of time of from more than 1 year to 20 years. Termination shall preclude participation in the Medicaid program, which includes any action that results in a claim for payment to the Medicaid program as a result of furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services.

(c) Imposition of a fine of up to $5,000 for each violation. Each day that an ongoing violation continues, such as refusing to furnish Medicaid-related records or refusing access to records, is considered, for the purposes of this section, to be a separate violation. Each instance of improper billing of a Medicaid recipient; each instance of including an unallowable cost on a hospital or nursing home Medicaid cost report after the provider or authorized representative has been advised in an audit exit conference or previous audit report of the cost unallowability; each instance of furnishing a Medicaid recipient goods or professional services that are inappropriate or of inferior quality as determined by competent peer judgment; each instance of knowingly submitting a materially false or erroneous Medicaid provider enrollment application, request for prior

authorization for Medicaid services, drug exception request, or cost report; each instance of inappropriate prescribing of drugs for a Medicaid recipient as determined by competent peer judgment; and each false or erroneous Medicaid claim leading to an overpayment to a provider is considered, for the purposes of this section, to be a separate violation.

(d) Immediate suspension, if the agency has received information of patient abuse or neglect or of any act prohibited by s. 409.920. Upon suspension, the agency must issue an immediate final order under s. 120.569(2)(n).

(e) A fine, not to exceed $10,000, for a violation of paragraph (15)(i).

(f) Imposition of liens against provider assets, including, but not limited to, financial assets and real property, not to exceed the amount of fines or recoveries sought, upon entry of an order determining that such moneys are due or recoverable.

(g) Prepayment reviews of claims for a specified period of time.

(h) Comprehensive followup reviews of providers every 6 months to ensure that they are billing Medicaid correctly.

(i) Corrective-action plans that would remain in effect for providers for up to 3 years and that would be monitored by the agency every 6 months while in effect.

(j) Other remedies as permitted by law to effect the recovery of a fine or overpayment.

The Secretary of Health Care Administration may make a

determination that imposition of a sanction or disincentive is not in the best interest of the Medicaid program, in which case a sanction or disincentive shall not be imposed.

(17) In determining the appropriate administrative sanction to be applied, or the duration of any suspension or termination, the agency shall consider:

(a) The seriousness and extent of the violation or violations.

(b) Any prior history of violations by the provider relating to the delivery of health care programs which resulted in either a criminal conviction or in administrative sanction or penalty.

(c) Evidence of continued violation within the provider's management control of Medicaid statutes, rules, regulations, or policies after written notification to the provider of improper practice or instance of violation.

(d) The effect, if any, on the quality of medical care provided to Medicaid recipients as a result of the acts of the provider.

(e) Any action by a licensing agency respecting the provider in any state in which the provider operates or has operated.

(f) The apparent impact on access by recipients to Medicaid services if the provider is suspended or terminated, in the best judgment of the agency.

The agency shall document the basis for all sanctioning actions and recommendations.

(18) The agency may take action to sanction, suspend, or terminate a particular provider working for a group provider, and may suspend or terminate Medicaid participation at a specific location, rather than or in addition to taking action against an entire group.

(19) The agency shall establish a process for conducting followup reviews of a sampling of providers who have a history of overpayment under the Medicaid program. This process must consider the magnitude of previous fraud or abuse and the potential effect of continued fraud or abuse on Medicaid costs.

(20) In making a determination of overpayment to a provider, the agency must use accepted and valid auditing, accounting, analytical, statistical, or peer-review methods, or combinations thereof. Appropriate statistical methods may include, but are not limited to, sampling and extension to the population, parametric and nonparametric statistics, tests of hypotheses, and other generally accepted statistical methods. Appropriate analytical methods may include, but are not limited to, reviews to determine variances between the quantities of products that a provider had on hand and available to be purveyed to Medicaid recipients during the review period and the quantities of the same products paid for by the Medicaid program for the same period, taking into appropriate consideration sales of the same products to non-Medicaid customers during the same period. In meeting its burden of proof in any administrative or court proceeding, the agency may introduce the results of such statistical methods as evidence of overpayment.

(21) When making a determination that an overpayment has

occurred, the agency shall prepare and issue an audit report to the provider showing the calculation of overpayments.

(22) The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment. A provider may not present or elicit testimony, either on direct examination or cross-examination in any court or administrative proceeding, regarding the purchase or acquisition by any means of drugs, goods, or supplies; sales or divestment by any means of drugs, goods, or supplies; or inventory of drugs, goods, or supplies, unless such acquisition, sales, divestment, or inventory is documented by written invoices, written inventory records, or other competent written documentary evidence maintained in the normal course of the provider's business. Notwithstanding the applicable rules of discovery, all documentation that will be offered as evidence at an administrative hearing on a Medicaid overpayment must be exchanged by all parties at least 14 days before the administrative hearing or must be excluded from consideration.

(23)(a) In an audit or investigation of a violation committed by a provider which is conducted pursuant to this section, the agency is entitled to recover all investigative, legal, and expert witness costs if the agency's findings were not contested by the provider or, if contested, the agency ultimately prevailed.

(b) The agency has the burden of documenting the costs, which include salaries and employee benefits and out-of-pocket expenses. The amount of costs that may be recovered must be reasonable in relation to the seriousness of the violation and

must be set taking into consideration the financial resources, earning ability, and needs of the provider, who has the burden of demonstrating such factors.

(c) The provider may pay the costs over a period to be determined by the agency if the agency determines that an extreme hardship would result to the provider from immediate full payment. Any default in payment of costs may be collected by any means authorized by law.

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

(25)(a) The agency shall ~~may~~ withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud, willful misrepresentation, or abuse under the Medicaid program, or a crime committed while rendering goods or services to Medicaid recipients. If it is determined that fraud, willful misrepresentation, abuse, or a crime did not occur, the payments withheld must be paid to the provider within 14 days after such determination with interest at the rate of 10 percent a year. Any money withheld in accordance with this paragraph shall be

placed in a suspended account, readily accessible to the agency, so that any payment ultimately due the provider shall be made within 14 days.

(b) The agency shall ~~may~~ deny payment, or require repayment, if the goods or services were furnished, supervised, or caused to be furnished by a person who has been suspended or terminated from the Medicaid program or Medicare program by the Federal Government or any state.

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

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

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

(26) The agency may impose administrative sanctions

against a Medicaid recipient, or the agency may seek any other remedy provided by law, including, but not limited to, the remedies provided in s. 812.035, if the agency finds that a recipient has engaged in solicitation in violation of s. 409.920 or that the recipient has otherwise abused the Medicaid program.

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

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

1. Makes repayment in full; or

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

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

(28) Venue for all Medicaid program integrity overpayment cases shall lie in Leon County, at the discretion of the agency.

(29) Notwithstanding other provisions of law, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs may review a provider's Medicaid-related and non-Medicaid-related records in order to determine the total output of a provider's practice to reconcile quantities of goods or

services billed to Medicaid with quantities of goods or services used in the provider's total practice.

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

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

(32) Duly authorized agents and employees of the agency shall have the power to inspect, during normal business hours, the records of any pharmacy, wholesale establishment, or manufacturer, or any other place in which drugs and medical supplies are manufactured, packed, packaged, made, stored, sold, or kept for sale, for the purpose of verifying the amount of drugs and medical supplies ordered, delivered, or purchased by a provider. The agency shall provide at least 2 business days'

prior notice of any such inspection. The notice must identify the provider whose records will be inspected, and the inspection shall include only records specifically related to that provider.

(33) In accordance with federal law, Medicaid recipients convicted of a crime pursuant to 42 U.S.C. s. 1320a-7b may be limited, restricted, or suspended from Medicaid eligibility for a period not to exceed 1 year, as determined by the agency head or designee.

(34) To deter fraud and abuse in the Medicaid program, the agency may limit the number of Schedule II and Schedule III refill prescription claims submitted from a pharmacy provider. The agency shall limit the allowable amount of reimbursement of prescription refill claims for Schedule II and Schedule III pharmaceuticals if the agency or the Medicaid Fraud Control Unit determines that the specific prescription refill was not requested by the Medicaid recipient or authorized representative for whom the refill claim is submitted or was not prescribed by the recipient's medical provider or physician. Any such refill request must be consistent with the original prescription.

(35) The Office of Program Policy Analysis and Government Accountability shall provide a report to the President of the Senate and the Speaker of the House of Representatives on a biennial basis, beginning January 31, 2006, on the agency's efforts to prevent, detect, and deter, as well as recover funds lost to, fraud and abuse in the Medicaid program.

(36) At least three times a year, the agency shall provide to each Medicaid recipient or his or her representative an

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

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

(38) In order to improve the detection of health care fraud, use technology to prevent and detect fraud, and maximize the electronic exchange of health care fraud information, the agency shall:

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

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

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

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

Section 48. Subsections (1) and (2) of section 409.920, Florida Statutes, are amended, present subsections (8) and (9) of that section are renumbered as subsections (9) and (10), respectively, and a new subsection (8) is added to that section,

to read:

409.920 Medicaid provider fraud.--

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

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

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

(c) "Item or service" includes:

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

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

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

(e) "Managed care plan" means a health insurer authorized under chapter 624, an exclusive provider organization authorized under chapter 627, a health maintenance organization authorized under chapter 641, the Children's Medical Services Network

authorized under chapter 391, a prepaid health plan authorized under chapter 409, a provider service network authorized under chapter 409, a minority physician network authorized under chapter 409, and emergency department diversion programs authorized under chapter 409 or the General Appropriations Act, providing health care services pursuant to a contract with the Medicaid program

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

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

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

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

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

service provided by a provider.

5.~~(e)~~ Knowingly solicit, offer, pay, or receive any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made, in whole or in part, under the Medicaid program, or in return for obtaining, purchasing, leasing, ordering, or arranging for or recommending, obtaining, purchasing, leasing, or ordering any goods, facility, item, or service, for which payment may be made, in whole or in part, under the Medicaid program.

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

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

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

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

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

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

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

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

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

Section 49. Section 409.9203, Florida Statutes, is created to read:

409.9203 Rewards for reporting Medicaid fraud.--

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

the information and report:

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

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

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

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

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

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

Section 50. Section 429.071, Florida Statutes, is repealed.

Section 51. Paragraph (e) of subsection (1) and subsections (2) and (3) of section 429.08, Florida Statutes, are amended to read:

429.08 Unlicensed facilities; referral of person for residency to unlicensed facility; penalties; verification of licensure status.--

(1)

(e) The agency shall publish ~~provide to the department's elder information and referral providers~~ a list, by county, of

licensed assisted living facilities~~, to assist persons who are considering an assisted living facility placement in locating a licensed facility~~. This information may be provided electronically or on the agency's Internet website.

~~(2) Each field office of the Agency for Health Care Administration shall establish a local coordinating workgroup which includes representatives of local law enforcement agencies, state attorneys, the Medicaid Fraud Control Unit of the Department of Legal Affairs, local fire authorities, the Department of Children and Family Services, the district long-term care ombudsman council, and the district human rights advocacy committee to assist in identifying the operation of unlicensed facilities and to develop and implement a plan to ensure effective enforcement of state laws relating to such facilities. The workgroup shall report its findings, actions, and recommendations semiannually to the Director of Health Quality Assurance of the agency.~~

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

(a) Any health care practitioner, as defined in s. 456.001, who is aware of the operation of an unlicensed facility shall report that facility to the agency. Failure to report a

facility that the practitioner knows or has reasonable cause to suspect is unlicensed shall be reported to the practitioner's licensing board.

(b) Any provider as defined in s. 408.803 that ~~hospital or community mental health center licensed under chapter 395 or chapter 394 which~~ knowingly discharges a patient or client to an unlicensed facility is subject to sanction by the agency.

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

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

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

~~(f) At least annually, the agency shall notify, in~~

~~appropriate trade publications, physicians licensed under chapter 458 or chapter 459, hospitals licensed under chapter 395, nursing home facilities licensed under part II of chapter 400, and employees of the agency or the department, or the Department of Children and Family Services, who are responsible for referring persons for residency, that it is unlawful to knowingly refer a person for residency to an unlicensed assisted living facility and shall notify them of the penalty for violating such prohibition. The department and the Department of Children and Family Services shall, in turn, notify service providers under contract to the respective departments who have responsibility for resident referrals to facilities. Further, the notice must direct each noticed facility and individual to contact the appropriate agency office in order to verify the licensure status of any facility prior to referring any person for residency. Each notice must include the name, telephone number, and mailing address of the appropriate office to contact.~~

Section 52. Paragraph (e) of subsection (1) of section 429.14, Florida Statutes, is amended to read:

429.14 Administrative penalties.--

(1) In addition to the requirements of part II of chapter 408, the agency may deny, revoke, and suspend any license issued under this part and impose an administrative fine in the manner provided in chapter 120 against a licensee of an assisted living facility for a violation of any provision of this part, part II of chapter 408, or applicable rules, or for any of the following actions by a licensee of an assisted living facility, for the

actions of any person subject to level 2 background screening under s. 408.809, or for the actions of any facility employee:

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

1. One or more cited class I deficiencies.

2. Three or more cited class II deficiencies.

3. Five or more cited class III deficiencies that have been cited on a single survey and have not been corrected within the times specified.

Section 53. Subsections (2), (8), and (9) of section 429.19, Florida Statutes, are amended to read:

429.19 Violations; imposition of administrative fines; grounds.--

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

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

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

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

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

(d) Class "IV" violations are defined in s. 408.813 ~~those conditions or occurrences related to the operation and~~

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

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

(9) The agency shall develop and disseminate an annual list of all facilities sanctioned or fined ~~$5,000 or more~~ for violations of state standards, the number and class of violations involved, the penalties imposed, and the current

status of cases. The list shall be disseminated, at no charge, to the Department of Elderly Affairs, the Department of Health, the Department of Children and Family Services, the Agency for Persons with Disabilities, the area agencies on aging, the Florida Statewide Advocacy Council, and the state and local ombudsman councils. The Department of Children and Family Services shall disseminate the list to service providers under contract to the department who are responsible for referring persons to a facility for residency. The agency may charge a fee commensurate with the cost of printing and postage to other interested parties requesting a copy of this list. This information may be provided electronically or on the agency's Internet website.

Section 54. Subsections (2) and (6) of section 429.23, Florida Statutes, are amended to read:

429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.--

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

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

1. Death;

2. Brain or spinal damage;

3. Permanent disfigurement;

4. Fracture or dislocation of bones or joints;

5. Any condition that required medical attention to which

the resident has not given his or her consent, including failure to honor advanced directives;

6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or~~.~~

7. An event that is reported to law enforcement or its personnel for investigation; or

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

~~(c) Events reported to law enforcement; or~~

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

(6) Abuse, neglect, or exploitation must be reported to the Department of Children and Family Services as required under chapter 415. ~~The agency shall annually submit to the Legislature a report on assisted living facility adverse incident reports. The report must include the following information arranged by county:~~

~~(a) A total number of adverse incidents;~~

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

~~(c) A listing, by category, of the types of injuries, if any, and the number of injuries occurring within each category;~~

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

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

~~by the type of staff involved.~~

Section 55. Subsections (10) through (12) of section 429.26, Florida Statutes, are renumbered as subsections (9) through (11), respectively, and present subsection (9) of that section is amended to read:

429.26 Appropriateness of placements; examinations of residents.--

~~(9) If, at any time after admission to a facility, a resident appears to need care beyond that which the facility is licensed to provide, the agency shall require the resident to be physically examined by a licensed physician, physician assistant, or licensed nurse practitioner. This examination shall, to the extent possible, be performed by the resident's preferred physician or nurse practitioner and shall be paid for by the resident with personal funds, except as provided in s. 429.18(2). Following this examination, the examining physician, physician assistant, or licensed nurse practitioner shall complete and sign a medical form provided by the agency. The completed medical form shall be submitted to the agency within 30 days after the date the facility owner or administrator is notified by the agency that the physical examination is required. After consultation with the physician, physician assistant, or licensed nurse practitioner who performed the examination, a medical review team designated by the agency shall then determine whether the resident is appropriately residing in the facility. The medical review team shall base its decision on a comprehensive review of the resident's physical and functional status, including the resident's preferences, and~~

~~not on an isolated health-related problem. In the case of a mental health resident, if the resident appears to have needs in addition to those identified in the community living support plan, the agency may require an evaluation by a mental health professional, as determined by the Department of Children and Family Services. A facility may not be required to retain a resident who requires more services or care than the facility is able to provide in accordance with its policies and criteria for admission and continued residency. Members of the medical review team making the final determination may not include the agency personnel who initially questioned the appropriateness of a resident's placement. Such determination is final and binding upon the facility and the resident. Any resident who is determined by the medical review team to be inappropriately residing in a facility shall be given 30 days' written notice to relocate by the owner or administrator, unless the resident's continued residence in the facility presents an imminent danger to the health, safety, or welfare of the resident or a substantial probability exists that death or serious physical harm would result to the resident if allowed to remain in the facility.~~

Section 56. Subsection (2) of section 430.608, Florida Statutes, is amended to read:

430.608 Confidentiality of information.--

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

Section 57. Paragraph (h) of subsection (3) of section

430.80, Florida Statutes, is amended to read:

430.80 Implementation of a teaching nursing home pilot project.--

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

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

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

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

Section 58. Subsection (5) of section 435.04, Florida Statutes, is amended to read:

435.04 Level 2 screening standards.--

(5) Under penalty of perjury, all employees in such positions of trust or responsibility shall attest to meeting the requirements for qualifying for employment and agreeing to inform the employer immediately if convicted of any of the disqualifying offenses while employed by the employer. Each employer of employees in such positions of trust or responsibilities which is licensed or registered by a state agency shall submit to the licensing agency annually or at the time of license renewal, under penalty of perjury, an affidavit of compliance with the provisions of this section.

Section 59. Subsection (3) of section 435.05, Florida Statutes, is amended to read:

435.05 Requirements for covered employees.--Except as otherwise provided by law, the following requirements shall apply to covered employees:

(3) Each employer required to conduct level 2 background screening must sign an affidavit annually or at the time of license renewal, under penalty of perjury, stating that all covered employees have been screened or are newly hired and are awaiting the results of the required screening checks.

Section 60. Subsection (11) is added to section 456.004, Florida Statutes, to read:

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

(11) Work cooperatively with the Agency for Health Care Administration and the judicial system to recover Medicaid overpayments by the Medicaid program. The department shall investigate and prosecute health care practitioners who have not

remitted amounts owed to the state for an overpayment from the Medicaid program pursuant to a final order, judgment, or stipulation or settlement.

Section 61. Present subsections (6) through (10) of section 456.041, Florida Statutes, are renumbered as subsections (7) through (11), respectively, and a new subsection (6) is added to that section, to read:

456.041 Practitioner profile; creation.--

(6) The Department of Health shall provide in each practitioner profile for every physician or advanced registered nurse practitioner terminated for cause from participating in the Medicaid program, pursuant to s. 409.913, or sanctioned by the Medicaid program, a statement that the practitioner has been terminated from participating in the Florida Medicaid program or sanctioned by the Medicaid program.

Section 62. Paragraph (o) of subsection (3) of section 456.053, Florida Statutes, is amended to read:

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

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

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

2. The request or establishment of a plan of care by a health care provider, which includes the provision of designated

health services or other health care item or service.

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

a. By a radiologist for diagnostic-imaging services.

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

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

d. By a cardiologist for cardiac catheterization services.

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

f. By a health care provider who is the sole provider or member of a group practice for designated health services or other health care items or services that are prescribed or provided solely for such referring health care provider's or group practice's own patients, and that are provided or performed by or under the direct supervision of such referring health care provider or group practice; provided, however, that effective July 1, 1999, a physician licensed pursuant to chapter 458, chapter 459, chapter 460, or chapter 461 may refer a patient to a sole provider or group practice for diagnostic imaging services, excluding radiation therapy services, for which the sole provider or group practice billed both the

technical and the professional fee for or on behalf of the patient, if the referring physician has no investment interest in the practice. The diagnostic imaging service referred to a group practice or sole provider must be a diagnostic imaging service normally provided within the scope of practice to the patients of the group practice or sole provider. The group practice or sole provider may accept no more than 15 percent of their patients receiving diagnostic imaging services from outside referrals, excluding radiation therapy services.

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

h. By a urologist for lithotripsy services.

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

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

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

l. By a health care provider whose principal professional practice consists of treating patients in their private residences for services to be rendered in such private residences, except for services rendered by a home health agency licensed under chapter 400. For purposes of this sub-subparagraph, the term "private residences" includes patient's private homes, independent living centers, and assisted living

facilities, but does not include skilled nursing facilities.

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

Section 63. Section 456.0635, Florida Statutes, is created to read:

456.0635 Medicaid fraud; disqualification for license, certificate, or registration.--

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

(2) Each board within the jurisdiction of the department, or the department if there is no board, shall refuse to admit a candidate to any examination and refuse to issue or renew a license, certificate, or registration to any applicant if the candidate or applicant or any principle, officer, agent, managing employee, or affiliated person of the applicant, has been:

(a) Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, unless the sentence and any subsequent period of probation for such conviction or plea ended more than 15 years prior to the date of the application;

(b) Terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5 years; or

(c) Terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from the federal Medicare program or from any other state Medicaid

program, unless the applicant has been in good standing with a state Medicaid program or the federal Medicare program for the most recent 5 years and the termination occurred more than 19 years prior to the date of the application.

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

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

Section 64. Paragraphs (ii), (jj), (kk), and (ll) are added to subsection (1) of section 456.072, Florida Statutes, to read:

456.072 Grounds for discipline; penalties; enforcement.--

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

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

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

(kk) Being terminated for cause from the state Medicaid program pursuant to s. 409.913, or being terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, the federal Medicare program, unless eligibility to participate in that program has been restored, or from any other state Medicaid program.

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

Section 65. Subsection (1) of section 456.074, Florida Statutes, is amended to read:

456.074 Certain health care practitioners; immediate suspension of license.--

(1) The department shall issue an emergency order suspending the license of any person licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 464, chapter 465, chapter 466, or chapter 484 who pleads guilty to, is convicted or found guilty of, or who enters a plea of nolo contendere to, regardless of adjudication, to:

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

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

Section 66. Section 456.42, Florida Statutes, is amended

to read:

456.42 Written prescriptions for medicinal drugs.--A written prescription for a medicinal drug issued by a health care practitioner licensed by law to prescribe such drug must be legibly printed or typed so as to be capable of being understood by the pharmacist filling the prescription; must contain the name of the prescribing practitioner, the name and strength of the drug prescribed, the quantity of the drug prescribed ~~in both textual and numerical formats~~, and the directions for use of the drug; must be dated ~~with the month written out in textual letters~~; and must be signed by the prescribing practitioner on the day when issued. A written prescription for a controlled substance listed in chapter 893 must have the quantity of the drug prescribed in both textual and numerical formats and must be dated with the abbreviated month written out on the face of the prescription. However, a prescription that is electronically generated and transmitted must contain the name of the prescribing practitioner, the name and strength of the drug prescribed, the quantity of the drug prescribed in numerical format, and the directions for use of the drug and must be dated and signed by the prescribing practitioner only on the day issued, which signature may be in an electronic format as defined in s. 668.003(4).

Section 67. Subsections (2) and (3) of section 465.022, Florida Statutes, are amended, present subsections (4), (5), (6), and (7) of that section are renumbered as subsections (5), (6), (7), and (8), respectively, and a new subsection (4) is added to that section, to read:

465.022 Pharmacies; general requirements; fees.--

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

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

(a) An application for a pharmacy permit must include a set of fingerprints from each person having an ownership interest of 5 percent or greater and from any person who, directly or indirectly, manages, oversees, or controls the operation of the applicant, including officers and members of the board of directors of an applicant that is a corporation. The applicant must provide payment in the application for the cost of state and national criminal history records checks.

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

2. A representative of a corporation described in subparagraph 1. satisfies the requirement to submit a set of his or her fingerprints if the fingerprints are on file with the department or the Agency for Health Care Administration, meet

the fingerprint specifications for submission by the Department of Law Enforcement, and are available to the department.

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

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

(a) Obtained a permit by misrepresentation or fraud;

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

(c) Been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to the practice of, or the ability to practice, the profession of pharmacy, unless the sentence and any subsequent period of probation for such conviction or plea ended more than 15 years prior to the date of the application;

(d) Been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to health care fraud, unless the sentence and any subsequent period of probation for such conviction or plea ended more than 15 years prior to the date of the application;

(e) Been terminated for cause, pursuant to the appeals

procedures established by the state or Federal Government, from the federal Medicare program or from any other state Medicaid program, unless the applicant has been in good standing with a state Medicaid program or the federal Medicare program for the most recent 5 years and the termination occurred more than 19 years prior to the date of the application; or

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

Section 68. Subsection (1) of section 465.023, Florida Statutes, is amended to read:

465.023 Pharmacy permittee; disciplinary action.--

(1) The department or the board may revoke or suspend the permit of any pharmacy permittee, and may fine, place on probation, or otherwise discipline any pharmacy permittee if the permittee, or any affiliated person, partner, officer, director, or agent of the permittee, including a person fingerprinted under s. 465.022(3), ~~who~~ has:

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

(b) Attempted to procure, or has procured, a permit for

any other person by making, or causing to be made, any false representation;

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

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

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

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

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

(h) ~~(e)~~ Dispensed any medicinal drug based upon a communication that purports to be a prescription as defined by s. 465.003(14) or s. 893.02 when the pharmacist knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship that includes a

documented patient evaluation, including history and a physical examination adequate to establish the diagnosis for which any drug is prescribed and any other requirement established by board rule under chapter 458, chapter 459, chapter 461, chapter 463, chapter 464, or chapter 466.

Section 69. Subsection (2) of section 483.031, Florida Statutes, is amended to read:

483.031 Application of part; exemptions.--This part applies to all clinical laboratories within this state, except:

(2) A clinical laboratory that performs only waived tests ~~and has received a certificate of exemption from the agency under s. 483.106~~.

Section 70. Subsection (10) of section 483.041, Florida Statutes, is amended to read:

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

(10) "Waived test" means a test that the federal Centers for Medicare and Medicaid Services ~~Health Care Financing Administration~~ has determined qualifies for a certificate of waiver under the federal Clinical Laboratory Improvement Amendments of 1988, and the federal rules adopted thereunder.

Section 71. Section 483.106, Florida Statutes, is repealed.

Section 72. Subsection (3) of section 483.172, Florida Statutes, is amended to read:

483.172 License fees.--

(3) The agency shall assess ~~a biennial fee of $100 for a certificate of exemption and~~ a $100 biennial license fee under this section for facilities surveyed by an approved accrediting

organization.

Section 73. Paragraph (b) of subsection (1) of section 627.4239, Florida Statutes, is amended to read:

627.4239 Coverage for use of drugs in treatment of cancer.--

(1) DEFINITIONS.--As used in this section, the term:

(b) "Standard reference compendium" means authoritative compendia identified by the Secretary of the United States Department of Health and Human Services and recognized by the federal Centers for Medicare and Medicaid Services~~:~~

~~1. The United States Pharmacopeia Drug Information;~~

~~2. The American Medical Association Drug Evaluations; or~~

~~3. The American Hospital Formulary Service Drug Information~~.

Section 74. Subsection (13) of section 651.118, Florida Statutes, is amended to read:

651.118 Agency for Health Care Administration; certificates of need; sheltered beds; community beds.--

(13) Residents, as defined in this chapter, are not considered new admissions for the purpose of s. 400.141(1)(o)1.d.~~(15)(d).~~

Section 75. Section 825.103, Florida Statutes, is amended to read:

825.103 Exploitation of an elderly person or disabled adult; penalties.--

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

(a) Knowingly, by deception or intimidation, obtaining or

using, or endeavoring to obtain or use, an elderly person's or disabled adult's funds, assets, or property with the intent to temporarily or permanently deprive the elderly person or disabled adult of the use, benefit, or possession of the funds, assets, or property, or to benefit someone other than the elderly person or disabled adult, by a person who:

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

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

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

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

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

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

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

Section 76. Paragraph (d) of subsection (2) of section 893.04, Florida Statutes, is amended to read:

893.04 Pharmacist and practitioner.--

(2)

(d) Each written prescription prescribed by a practitioner in this state for a controlled substance listed in Schedule II, Schedule III, or Schedule IV must include both a written and a numerical notation of the quantity of the controlled substance prescribed on the face of the prescription and a notation of the date~~,~~ with the abbreviated month written out on the face of the prescription. A pharmacist may, upon verification by the prescriber, document any information required by this paragraph. If the prescriber is not available to verify a prescription, the pharmacist may dispense the controlled substance but may insist that the person to whom the controlled substance is dispensed provide valid photographic identification. If a prescription includes a numerical notation of the quantity of the controlled substance or date but does not include the quantity or date

written out in textual format, the pharmacist may dispense the controlled substance without verification by the prescriber of the quantity or date if the pharmacy previously dispensed another prescription for the person to whom the prescription was written.

Section 77. Paragraphs (g) and (i) of subsection (3) of section 921.0022, Florida Statutes, are amended to read:

921.0022 Criminal Punishment Code; offense severity ranking chart.--

(3) OFFENSE SEVERITY RANKING CHART

(g) LEVEL 7

Florida Statute	Felony Degree	Description
316.027(1)(b)	1st	Accident involving death, failure to stop; leaving scene.
316.193(3)(c)2.	3rd	DUI resulting in serious bodily injury.
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.
327.35(3)(c)2.	3rd	Vessel BUI resulting in serious bodily injury.
402.319(2)	2nd	Misrepresentation and negligence or intentional act resulting in great bodily harm, permanent disfiguration, permanent disability, or death.
409.920(2)(b)1.a.	3rd	Medicaid provider fraud; $10,000 or less.
409.920(2)(b)1.b.	2nd	Medicaid provider fraud; more than $10,000, but less than $50,000.
456.065(2)	3rd	Practicing a health care profession without a license.

456.065(2)	2nd	Practicing a health care profession without a license which results in serious bodily injury.
458.327(1)	3rd	Practicing medicine without a license.
459.013(1)	3rd	Practicing osteopathic medicine without a license.
460.411(1)	3rd	Practicing chiropractic medicine without a license.
461.012(1)	3rd	Practicing podiatric medicine without a license.
462.17	3rd	Practicing naturopathy without a license.
463.015(1)	3rd	Practicing optometry without a license.

464.016(1)	3rd	Practicing nursing without a license.
465.015(2)	3rd	Practicing pharmacy without a license.
466.026(1)	3rd	Practicing dentistry or dental hygiene without a license.
467.201	3rd	Practicing midwifery without a license.
468.366	3rd	Delivering respiratory care services without a license.
483.828(1)	3rd	Practicing as clinical laboratory personnel without a license.
483.901(9)	3rd	Practicing medical physics without a license.

484.013(1)(c)	3rd	Preparing or dispensing optical devices without a prescription.
484.053	3rd	Dispensing hearing aids without a license.
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.
560.123(8)(b)1.	3rd	Failure to report currency or payment instruments exceeding $300 but less than $20,000 by a money services business.
560.125(5)(a)	3rd	Money services business by unauthorized person, currency or payment instruments exceeding $300 but less than $20,000.

655.50(10)(b)1.	3rd	Failure to report financial transactions exceeding $300 but less than $20,000 by financial institution.
775.21(10)(a)	3rd	Sexual predator; failure to register; failure to renew driver's license or identification card; other registration violations.
775.21(10)(b)	3rd	Sexual predator working where children regularly congregate.
775.21(10)(g)	3rd	Failure to report or providing false information about a sexual predator; harbor or conceal a sexual predator.
782.051(3)	2nd	Attempted felony murder of a person by a person other than the perpetrator or the perpetrator of an attempted felony.

782.07(1)	2nd	Killing of a human being by the act, procurement, or culpable negligence of another (manslaughter).
782.071	2nd	Killing of a human being or viable fetus by the operation of a motor vehicle in a reckless manner (vehicular homicide).
782.072	2nd	Killing of a human being by the operation of a vessel in a reckless manner (vessel homicide).
784.045(1)(a)1.	2nd	Aggravated battery; intentionally causing great bodily harm or disfigurement.
784.045(1)(a)2.	2nd	Aggravated battery; using deadly weapon.
784.045(1)(b)	2nd	Aggravated battery; perpetrator aware victim pregnant.

784.048(4)	3rd	Aggravated stalking; violation of injunction or court order.
784.048(7)	3rd	Aggravated stalking; violation of court order.
784.07(2)(d)	1st	Aggravated battery on law enforcement officer.
784.074(1)(a)	1st	Aggravated battery on sexually violent predators facility staff.
784.08(2)(a)	1st	Aggravated battery on a person 65 years of age or older.
784.081(1)	1st	Aggravated battery on specified official or employee.
784.082(1)	1st	Aggravated battery by detained person on visitor or other detainee.

784.083(1)	1st	Aggravated battery on code inspector.
790.07(4)	1st	Specified weapons violation subsequent to previous conviction of s. 790.07(1) or (2).
790.16(1)	1st	Discharge of a machine gun under specified circumstances.
790.165(2)	2nd	Manufacture, sell, possess, or deliver hoax bomb.
790.165(3)	2nd	Possessing, displaying, or threatening to use any hoax bomb while committing or attempting to commit a felony.
790.166(3)	2nd	Possessing, selling, using, or attempting to use a hoax weapon of mass destruction.

790.166(4)	2nd	Possessing, displaying, or threatening to use a hoax weapon of mass destruction while committing or attempting to commit a felony.
790.23	1st,PBL	Possession of a firearm by a person who qualifies for the penalty enhancements provided for in s. 874.04.
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.
796.03	2nd	Procuring any person under 16 years for prostitution.
800.04(5)(c)1.	2nd	Lewd or lascivious molestation; victim less than 12 years of age; offender less than 18 years.

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.
806.01(2)	2nd	Maliciously damage structure by fire or explosive.
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.
4731			
4732			
	812.014(2)(b)2.	2nd	Property stolen, cargo valued at less than $50,000, grand theft in 2nd degree.
4733			
4734			
	812.014(2)(b)3.	2nd	Property stolen, emergency medical equipment; 2nd degree grand theft.
4735			
4736			
	812.014(2)(b)4.	2nd	Property stolen, law enforcement equipment from authorized emergency vehicle.
4737			
4738			
	812.0145(2)(a)	1st	Theft from person 65 years of age or older; $50,000 or more.
4739			
4740			
	812.019(2)	1st	Stolen property; initiates, organizes, plans, etc., the theft of property and traffics in stolen

		property.
812.131(2)(a)	2nd	Robbery by sudden snatching.
812.133(2)(b)	1st	Carjacking; no firearm, deadly weapon, or other weapon.
817.234(8)(a)	2nd	Solicitation of motor vehicle accident victims with intent to defraud.
817.234(9)	2nd	Organizing, planning, or participating in an intentional motor vehicle collision.
817.234(11)(c)	1st	Insurance fraud; property value $100,000 or more.
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.
825.102(3)(b)	2nd	Neglecting an elderly person or disabled adult causing great bodily harm, disability, or disfigurement.
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.
827.03(3)(b)	2nd	Neglect of a child causing great bodily harm, disability, or disfigurement.
827.04(3)	3rd	Impregnation of a child under 16 years of age by person 21 years of age or older.
837.05(2)	3rd	Giving false information about

		alleged capital felony to a law enforcement officer.
838.015	2nd	Bribery.
838.016	2nd	Unlawful compensation or reward for official behavior.
838.021(3)(a)	2nd	Unlawful harm to a public servant.
838.22	2nd	Bid tampering.
847.0135(3)	3rd	Solicitation of a child, via a computer service, to commit an unlawful sex act.
847.0135(4)	2nd	Traveling to meet a minor to commit an unlawful sex act.
872.06	2nd	Abuse of a dead human body.

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

893.13(4)(a)	1st	Deliver to minor cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4. drugs).
893.135(1)(a)1.	1st	Trafficking in cannabis, more than 25 lbs., less than 2,000 lbs.
893.135(1)(b)1.a.	1st	Trafficking in cocaine, more than 28 grams, less than 200 grams.
893.135(1)(c)1.a.	1st	Trafficking in illegal drugs, more than 4 grams, less than 14 grams.
893.135(1)(d)1.	1st	Trafficking in phencyclidine, more than 28 grams, less than 200 grams.
893.135(1)(e)1.	1st	Trafficking in methaqualone, more than 200 grams, less than 5 kilograms.
893.135(1)(f)1.	1st	Trafficking in amphetamine, more than

			14 grams, less than 28 grams.
893.135(1)(g)1.a.	1st	Trafficking in flunitrazepam, 4 grams or more, less than 14 grams.	
893.135(1)(h)1.a.	1st	Trafficking in gamma-hydroxybutyric acid (GHB), 1 kilogram or more, less than 5 kilograms.	
893.135(1)(j)1.a.	1st	Trafficking in 1,4-Butanediol, 1 kilogram or more, less than 5 kilograms.	
893.135(1)(k)2.a.	1st	Trafficking in Phenethylamines, 10 grams or more, less than 200 grams.	
893.1351(2)	2nd	Possession of place for trafficking in or manufacturing of controlled substance.	
896.101(5)(a)	3rd	Money laundering, financial	

			transactions exceeding $300 but less than $20,000.
4809			
4810			
	896.104(4)(a)1.	3rd	Structuring transactions to evade reporting or registration requirements, financial transactions exceeding $300 but less than $20,000.
4811			
4812			
	943.0435(4)(c)	2nd	Sexual offender vacating permanent residence; failure to comply with reporting requirements.
4813			
4814			
	943.0435(8)	2nd	Sexual offender; remains in state after indicating intent to leave; failure to comply with reporting requirements.
4815			
4816			
	943.0435(9)(a)	3rd	Sexual offender; failure to comply with reporting requirements.
4817			
4818			
	943.0435(13)	3rd	Failure to report or providing false information about a sexual offender;

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

			the taking of a digitized photograph.
4831			
4832			
	985.4815(12)	3rd	Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.
4833			
4834			
	985.4815(13)	3rd	Sexual offender; failure to report and reregister; failure to respond to address verification.
4835			
4836	(i) LEVEL 9		
4837			
	Florida Statute	Felony Degree	Description
4838			
4839			
	316.193(3)(c)3.b.	1st	DUI manslaughter; failing to render aid or give information.
4840			
4841			
	327.35(3)(c)3.b.	1st	BUI manslaughter; failing to render aid or give information.
4842			
4843			
	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.
655.50(10)(b)3.	1st	Failure to report financial transactions totaling or exceeding $100,000 by financial institution.
775.0844	1st	Aggravated white collar crime.

782.04(1)	1st	Attempt, conspire, or solicit to commit premeditated murder.
782.04(3)	1st,PBL	Accomplice to murder in connection with arson, sexual battery, robbery, burglary, and other specified felonies.
782.051(1)	1st	Attempted felony murder while perpetrating or attempting to perpetrate a felony enumerated in s. 782.04(3).
782.07(2)	1st	Aggravated manslaughter of an elderly person or disabled adult.
787.01(1)(a)1.	1st,PBL	Kidnapping; hold for ransom or reward or as a shield or hostage.
787.01(1)(a)2.	1st,PBL	Kidnapping with intent to commit or facilitate commission of any felony.

787.01(1)(a)4.	1st,PBL	Kidnapping with intent to interfere with performance of any governmental or political function.
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.
790.161	1st	Attempted capital destructive device offense.
790.166(2)	1st,PBL	Possessing, selling, using, or attempting to use a weapon of mass destruction.
794.011(2)	1st	Attempted sexual battery; victim less than 12 years of age.
794.011(2)	Life	Sexual battery; offender younger than 18 years and commits sexual battery on

		a person less than 12 years.
794.011(4)	1st	Sexual battery; victim 12 years or older, certain circumstances.
794.011(8)(b)	1st	Sexual battery; engage in sexual conduct with minor 12 to 18 years by person in familial or custodial authority.
794.08(2)	1st	Female genital mutilation; victim younger than 18 years of age.
800.04(5)(b)	Life	Lewd or lascivious molestation; victim less than 12 years; offender 18 years or older.
812.13(2)(a)	1st,PBL	Robbery with firearm or other deadly weapon.
812.133(2)(a)	1st,PBL	Carjacking; firearm or other deadly

		weapon.
812.135(2)(b)	1st	Home-invasion robbery with weapon.
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.
827.03(2)	1st	Aggravated child abuse.
847.0145(1)	1st	Selling, or otherwise transferring custody or control, of a minor.
847.0145(2)	1st	Purchasing, or otherwise obtaining custody or control, of a minor.
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.
893.135		1st	Attempted capital trafficking offense.
893.135(1)(a)3.		1st	Trafficking in cannabis, more than 10,000 lbs.
893.135(1)(b)1.c.		1st	Trafficking in cocaine, more than 400 grams, less than 150 kilograms.
893.135(1)(c)1.c.		1st	Trafficking in illegal drugs, more than 28 grams, less than 30 kilograms.
893.135(1)(d)1.c.		1st	Trafficking in phencyclidine, more than 400 grams.
893.135(1)(e)1.c.		1st	Trafficking in methaqualone, more than 25 kilograms.

893.135(1)(f)1.c.	1st	Trafficking in amphetamine, more than 200 grams.
893.135(1)(h)1.c.	1st	Trafficking in gamma-hydroxybutyric acid (GHB), 10 kilograms or more.
893.135(1)(j)1.c.	1st	Trafficking in 1,4-Butanediol, 10 kilograms or more.
893.135(1)(k)2.c.	1st	Trafficking in Phenethylamines, 400 grams or more.
896.101(5)(c)	1st	Money laundering, financial instruments totaling or exceeding $100,000.
896.104(4)(a)3.	1st	Structuring transactions to evade reporting or registration requirements, financial transactions totaling or exceeding $100,000.

Section 78. In order to identify and realize potential cost savings for prescriptive assistive devices purchased by the Department of Health, all prescriptive assistive devices

procured by the department that cost more than $2,500 shall be acquired on a competitive sealed bid basis through MyFloridaMarketPlace in accordance with s. 287.057, Florida Statutes. Any deviation from these guidelines shall be in accordance with s. 287.057(5)(a), Florida Statutes. The Department of Management Services shall administer the selection and the procurement of such devices.

Section 79. This act shall take effect July 1, 2009.