By the Committee on Health Policy; and Senator Bean

588-02756-20 20201726c1

1 A bill to be entitled
2 An act relating to the Agency for Health Care
3 Administration; amending s. 383.327, F.S.; requiring
4 birth centers to report certain deaths and stillbirths
5 to the agency; removing a requirement that a certain
6 report be submitted annually to the agency;
7 authorizing the agency to prescribe by rule the
8 frequency at which such report is submitted; amending
9 s. 395.003, F.S.; removing a requirement that
10 specified information be listed on licenses for
11 certain facilities; repealing s. 395.7015, F.S.,
12 relating to an annual assessment on health care
13 entities; amending s. 395.7016, F.S.; conforming a
14 provision to changes made by the act; amending s.
15 400.19, F.S.; revising provisions requiring the agency
16 to conduct licensure inspections of nursing homes;
17 requiring the agency to conduct additional licensure
18 surveys under certain circumstances; requiring the
19 agency to assess a specified fine for such surveys;
20 amending s. 400.462, F.S.; revising definitions;
21 amending s. 400.464, F.S.; revising licensure
22 requirements for home health agencies; amending s.
23 400.471, F.S.; revising provisions related to certain
24 application requirements for home health agencies;
25 amending s. 400.492, F.S.; revising provisions related
26 to services provided by home health agencies during an
27 emergency; amending s. 400.506, F.S.; revising
28 provisions related to licensure requirements for nurse
29 registries; amending s. 400.509, F.S.; revising

30 provisions related to the registration of certain
31 service providers; amending s. 400.605, F.S.; removing
32 a requirement that the agency conduct specified
33 inspections of certain licensees; amending s.
34 400.60501, F.S.; deleting an obsolete date; removing a
35 requirement that the agency develop a specified annual
36 report; amending s. 400.9905, F.S.; revising the
37 definition of the term “clinic”; amending s. 400.991,
38 F.S.; removing the option for health care clinics to
39 file a surety bond under certain circumstances;
40 amending s. 400.9935, F.S.; removing a requirement
41 that certain directors conduct specified reviews;
42 requiring certain clinics to publish and post a
43 schedule of charges; amending s. 408.033, F.S.;
44 conforming a provision to changes made by the act;
45 amending s. 408.061, F.S.; revising provisions
46 requiring health care facilities to submit specified
47 data to the agency; amending s. 408.0611, F.S.;
48 removing the requirement that the agency annually
49 report to the Governor and the Legislature by a
50 specified date on the progress of implementation of
51 electronic prescribing; amending s. 408.062, F.S.;
52 removing requirements that the agency annually report
53 specified information to the Governor and Legislature
54 by a specified date and, instead, requiring the agency
55 to annually publish such information on its website;
56 amending s. 408.063, F.S.; removing a requirement that
57 the agency publish certain annual reports; amending s.
58 408.803, F.S.; conforming a definition to changes made

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59 by the act; defining the term “low-risk provider”;
60 amending ss. 408.802, 408.820, 408.831, and 408.832,
61 F.S.; conforming provisions to changes made by the
62 act; amending s. 408.806, F.S.; exempting certain
63 providers from a specified inspection; amending s.
64 408.808, F.S.; authorizing the issuance of a
65 provisional license to certain applicants; amending
66 ss. 408.809 and 409.907, F.S.; revising background
67 screening requirements for certain licensees and
68 providers; amending s. 408.811, F.S.; authorizing the
69 agency to grant certain providers an exemption from a
70 specified inspection under certain circumstances;
71 authorizing the agency to adopt rules to grant waivers
72 of certain inspections and extended inspection periods
73 under certain circumstances; amending s. 408.821,
74 F.S.; revising provisions requiring licensees to have
75 a specified plan; providing requirements for the
76 submission of such plan; amending s. 408.909, F.S.;
77 removing a requirement that the agency and Office of
78 Insurance Regulation evaluate a specified program;
79 amending s. 408.9091, F.S.; requiring the agency and
80 office to each, instead of jointly, submit a specified
81 annual report to the Governor and Legislature;
82 amending s. 409.905, F.S.; providing construction for
83 a provision that requires the agency to discontinue
84 its hospital retrospective review program under
85 certain circumstances; providing legislative intent;
86 amending s. 409.913, F.S.; revising the due date for a
87 certain annual report; deleting the requirement that

88 certain agencies submit their annual reports jointly;
89 amending s. 409.967, F.S.; revising the length of
90 managed care plan contracts procured by the agency
91 beginning during a specified timeframe; requiring the
92 agency to extend the term of certain existing managed
93 care plan contracts until a specified date; amending
94 s. 429.11, F.S.; removing an authorization for the
95 issuance of a provisional license to certain
96 facilities; amending s. 429.19, F.S.; removing
97 requirements that the agency develop and disseminate a
98 specified list and the Department of Children and
99 Families disseminate such list to certain providers;
100 amending ss. 429.35, 429.905, and 429.929, F.S.;
101 revising provisions requiring a biennial inspection
102 cycle for specified facilities and centers,
103 respectively; repealing part I of ch. 483, F.S.,
104 relating to the Florida Multiphasic Health Testing
105 Center Law; redesignating parts II and III of ch. 483,
106 F.S., as parts I and II, respectively; amending ss.
107 20.43, 381.0034, 456.001, 456.057, 456.076, and
108 456.47, F.S.; conforming cross-references; providing
109 effective dates.
110
111 Be It Enacted by the Legislature of the State of Florida:
112
113 Section 1. Subsections (2) and (4) of section 383.327,
114 Florida Statutes, are amended to read:
115 383.327 Birth and death records; reports.—
116 (2) Each maternal death, newborn death, and stillbirth

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117 shall be reported immediately to the medical examiner and the
118 agency.
119 (4) A report shall be submitted ~~annually~~ to the agency. The
120 contents of the report and the frequency with which it is
121 submitted shall be prescribed by rule of the agency.
122 Section 2. Subsection (4) of section 395.003, Florida
123 Statutes, is amended to read:
124 395.003 Licensure; denial, suspension, and revocation.—
125 (4) The agency shall issue a license that ~~which~~ specifies
126 the service categories and the number of hospital beds in each
127 bed category for which a license is received. Such information
128 shall be listed on the face of the license. ~~All beds which are~~
129 ~~not covered by any specialty-bed-need methodology shall be~~
130 ~~specified as general beds.~~ A licensed facility shall not operate
131 a number of hospital beds greater than the number indicated by
132 the agency on the face of the license without approval from the
133 agency under conditions established by rule.
134 Section 3. Section 395.7015, Florida Statutes, is repealed.
135 Section 4. Section 395.7016, Florida Statutes, is amended
136 to read:
137 395.7016 Annual appropriation.—The Legislature shall
138 appropriate each fiscal year from either the General Revenue
139 Fund or the Agency for Health Care Administration Tobacco
140 Settlement Trust Fund an amount sufficient to replace the funds
141 lost due to ~~reduction by chapter 2000-256, Laws of Florida, of~~
142 ~~the assessment on other health care entities under s. 395.7015,~~
143 ~~and~~ the reduction by chapter 2000-256, Laws of Florida, in the
144 assessment on hospitals under s. 395.701~~,~~ and to maintain
145 federal approval of the reduced amount of funds deposited into

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146 the Public Medical Assistance Trust Fund under s. 395.701~~,~~ as
147 state match for the state’s Medicaid program.
148 Section 5. Subsection (3) of section 400.19, Florida
149 Statutes, is amended to read:
150 400.19 Right of entry and inspection.—
151 (3) The agency shall conduct periodic, ~~every 15 months~~
152 ~~conduct at least one~~ unannounced licensure inspections
153 ~~inspection~~ to determine compliance by the licensee with
154 statutes, and with rules adopted ~~promulgated~~ under ~~the~~
155 ~~provisions of~~ those statutes, governing minimum standards of
156 construction, quality and adequacy of care, and rights of
157 residents. ~~The survey shall be conducted every 6 months for the~~
158 ~~next 2-year period~~ If the facility has been cited for a class I
159 deficiency or~~,~~ has been cited for two or more class II
160 deficiencies ~~arising from separate surveys or investigations~~
161 within a 60-day period, the agency shall conduct an additional
162 licensure survey ~~or has had three or more substantiated~~
163 ~~complaints within a 6-month period, each resulting in at least~~
164 ~~one class I or class II deficiency~~. In addition to any other
165 fees or fines in this part, the agency shall assess a fine for
166 each facility that is subject to the additional licensure survey
167 ~~6-month survey cycle~~. The fine for the additional licensure
168 survey is $3,000 ~~2-year period shall be $6,000, one-half to be~~
169 ~~paid at the completion of each survey~~. The agency may adjust
170 such ~~this~~ fine by the change in the Consumer Price Index, based
171 on the 12 months immediately preceding the increase, to cover
172 the cost of the additional surveys. The agency shall verify
173 through subsequent inspection that any deficiency identified
174 during inspection is corrected. However, the agency may verify

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175 the correction of a class III or class IV deficiency unrelated
176 to resident rights or resident care without reinspecting the
177 facility if adequate written documentation has been received
178 from the facility, which provides assurance that the deficiency
179 has been corrected. The giving or causing to be given of advance
180 notice of such unannounced inspections by an employee of the
181 agency to any unauthorized person shall constitute cause for
182 suspension of not fewer than 5 working days according to ~~the~~
183 ~~provisions of~~ chapter 110.
184 Section 6. Subsections (12), (14), (17), (21), and (22) of
185 section 400.462, Florida Statutes, are amended to read:
186 400.462 Definitions.—As used in this part, the term:
187 (12) "Home health agency" means a person or an entity ~~an~~
188 ~~organization~~ that provides one or more home health services ~~and~~
189 ~~staffing services~~.
190 (14) "Home health services" means health and medical
191 services and medical supplies furnished ~~by an organization~~ to an
192 individual in the individual's home or place of residence. The
193 term includes ~~organizations that provide one or more of~~ the
194 following:
195 (a) Nursing care.
196 (b) Physical, occupational, respiratory, or speech therapy.
197 (c) Home health aide services.
198 (d) Dietetics and nutrition practice and nutrition
199 counseling.
200 (e) Medical supplies, restricted to drugs and biologicals
201 prescribed by a physician.
202 (17) "Home infusion therapy provider" means a person or an
203 entity ~~an organization~~ that employs, contracts with, or refers a

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204 licensed professional who has received advanced training and
205 experience in intravenous infusion therapy and who administers
206 infusion therapy to a patient in the patient’s home or place of
207 residence.
208 (21) “Nurse registry” means any person or entity that
209 procures, offers, promises, or attempts to secure health-care-
210 related contracts for registered nurses, licensed practical
211 nurses, certified nursing assistants, home health aides,
212 companions, or homemakers, who are compensated by fees as
213 independent contractors, including, but not limited to,
214 contracts for the provision of services to patients and
215 contracts to provide private duty or staffing services to health
216 care facilities licensed under chapter 395, this chapter, or
217 chapter 429 or other business entities.
218 ~~(22) “Organization” means a corporation, government or~~
219 ~~governmental subdivision or agency, partnership or association,~~
220 ~~or any other legal or commercial entity, any of which involve~~
221 ~~more than one health care professional discipline; a health care~~
222 ~~professional and a home health aide or certified nursing~~
223 ~~assistant; more than one home health aide; more than one~~
224 ~~certified nursing assistant; or a home health aide and a~~
225 ~~certified nursing assistant. The term does not include an entity~~
226 ~~that provides services using only volunteers or only individuals~~
227 ~~related by blood or marriage to the patient or client.~~
228 Section 7. Subsections (1), (4), and (5) of section
229 400.464, Florida Statutes, are amended to read:
230 400.464 Home health agencies to be licensed; expiration of
231 license; exemptions; unlawful acts; penalties.—
232 (1) The requirements of part II of chapter 408 apply to the

233 provision of services that require licensure pursuant to this
234 part and part II of chapter 408 and entities licensed or
235 registered by or applying for such licensure or registration
236 from the Agency for Health Care Administration pursuant to this
237 part. A license issued by the agency is required in order to
238 operate a home health agency in this state. A license issued on
239 or after July 1, 2018, must specify the home health services the
240 licensee ~~organization~~ is authorized to perform and indicate
241 whether such specified services are considered skilled care. The
242 provision or advertising of services that require licensure
243 pursuant to this part without such services being specified on
244 the face of the license issued on or after July 1, 2018,
245 constitutes unlicensed activity as prohibited under s. 408.812.
246 (4)(a) A licensee ~~An organization~~ that offers or advertises
247 to the public any service for which licensure or registration is
248 required under this part must include in the advertisement the
249 license number or registration number issued to the licensee
250 ~~organization~~ by the agency. The agency shall assess a fine of
251 not less than $100 to any licensee or registrant who fails to
252 include the license or registration number when submitting the
253 advertisement for publication, broadcast, or printing. The fine
254 for a second or subsequent offense is $500. The holder of a
255 license issued under this part may not advertise or indicate to
256 the public that it holds a home health agency or nurse registry
257 license other than the one it has been issued.
258 (b) The operation or maintenance of an unlicensed home
259 health agency or the performance of any home health services in
260 violation of this part is declared a nuisance, inimical to the
261 public health, welfare, and safety. The agency or any state

262 attorney may, in addition to other remedies provided in this
263 part, bring an action for an injunction to restrain such
264 violation, or to enjoin the future operation or maintenance of
265 the home health agency or the provision of home health services
266 in violation of this part or part II of chapter 408, until
267 compliance with this part or the rules adopted under this part
268 has been demonstrated to the satisfaction of the agency.
269 (c) A person <u>or entity that</u> ~~who~~ violates paragraph (a) is
270 subject to an injunctive proceeding under s. 408.816. A
271 violation of paragraph (a) or s. 408.812 is a deceptive and
272 unfair trade practice and constitutes a violation of the Florida
273 Deceptive and Unfair Trade Practices Act under part II of
274 chapter 501.
275 (d) A person <u>or entity that</u> ~~who~~ violates ~~the provisions of~~
276 paragraph (a) commits a misdemeanor of the second degree,
277 punishable as provided in s. 775.082 or s. 775.083. Any person
278 <u>or entity that</u> ~~who~~ commits a second or subsequent violation
279 commits a misdemeanor of the first degree, punishable as
280 provided in s. 775.082 or s. 775.083. Each day of continuing
281 violation constitutes a separate offense.
282 (e) Any person <u>or entity that</u> ~~who~~ owns, operates, or
283 maintains an unlicensed home health agency and who, after
284 receiving notification from the agency, fails to cease operation
285 and apply for a license under this part commits a misdemeanor of
286 the second degree, punishable as provided in s. 775.082 or s.
287 775.083. Each day of continued operation is a separate offense.
288 (f) Any home health agency that fails to cease operation
289 after agency notification may be fined in accordance with s.
290 408.812.

291 (5) The following are exempt from ~~the~~ licensure <u>as a home</u>
292 <u>health agency under</u> ~~requirements of~~ this part:
293 (a) A home health agency operated by the Federal
294 Government.
295 (b) Home health services provided by a state agency, either
296 directly or through a contractor with:
297 1. The Department of Elderly Affairs.
298 2. The Department of Health, a community health center, or
299 a rural health network that furnishes home visits for the
300 purpose of providing environmental assessments, case management,
301 health education, personal care services, family planning, or
302 followup treatment, or for the purpose of monitoring and
303 tracking disease.
304 3. Services provided to persons with developmental
305 disabilities, as defined in s. 393.063.
306 4. Companion and sitter organizations that were registered
307 under s. 400.509(1) on January 1, 1999, and were authorized to
308 provide personal services under a developmental services
309 provider certificate on January 1, 1999, may continue to provide
310 such services to past, present, and future clients of the
311 organization who need such services, notwithstanding the
312 provisions of this act.
313 5. The Department of Children and Families.
314 (c) A health care professional, whether or not
315 incorporated, who is licensed under chapter 457; chapter 458;
316 chapter 459; part I of chapter 464; chapter 467; part I, part
317 III, part V, or part X of chapter 468; chapter 480; chapter 486;
318 chapter 490; or chapter 491; and who is acting alone within the
319 scope of his or her professional license to provide care to

320 patients in their homes.
321 (d) A home health aide or certified nursing assistant who
322 is acting in his or her individual capacity, within the
323 definitions and standards of his or her occupation, and who
324 provides hands-on care to patients in their homes.
325 (e) An individual who acts alone, in his or her individual
326 capacity, and who is not employed by or affiliated with a
327 licensed home health agency or registered with a licensed nurse
328 registry. This exemption does not entitle an individual to
329 perform home health services without the required professional
330 license.
331 (f) The delivery of instructional services in home dialysis
332 and home dialysis supplies and equipment.
333 (g) The delivery of nursing home services for which the
334 nursing home is licensed under part II of this chapter, to serve
335 its residents in its facility.
336 (h) The delivery of assisted living facility services for
337 which the assisted living facility is licensed under part I of
338 chapter 429, to serve its residents in its facility.
339 (i) The delivery of hospice services for which the hospice
340 is licensed under part IV of this chapter, to serve hospice
341 patients admitted to its service.
342 (j) A hospital that provides services for which it is
343 licensed under chapter 395.
344 (k) The delivery of community residential services for
345 which the community residential home is licensed under chapter
346 419, to serve the residents in its facility.
347 (l) A not-for-profit, community-based agency that provides
348 early intervention services to infants and toddlers.

349 (m) Certified rehabilitation agencies and comprehensive
350 outpatient rehabilitation facilities that are certified under
351 Title 18 of the Social Security Act.
352 (n) The delivery of adult family-care home services for
353 which the adult family-care home is licensed under part II of
354 chapter 429, to serve the residents in its facility.
355 (o) A person or entity that provides skilled care by health
356 care professionals licensed solely under part I of chapter 464;
357 part I, part III, or part V of chapter 468; or chapter 486.
358 (p) A person or entity that provides services using only
359 volunteers or only individuals related by blood or marriage to
360 the patient or client.
361 Section 8. Paragraph (g) of subsection (2) of section
362 400.471, Florida Statutes, is amended to read:
363 400.471 Application for license; fee.—
364 (2) In addition to the requirements of part II of chapter
365 408, the initial applicant, the applicant for a change of
366 ownership, and the applicant for the addition of skilled care
367 services must file with the application satisfactory proof that
368 the home health agency is in compliance with this part and
369 applicable rules, including:
370 (g) In the case of an application for initial licensure, an
371 application for a change of ownership, or an application for the
372 addition of skilled care services, documentation of
373 accreditation, or an application for accreditation, from an
374 accrediting organization that is recognized by the agency as
375 having standards comparable to those required by this part and
376 part II of chapter 408. A home health agency that does not
377 provide skilled care is exempt from this paragraph.

378 Notwithstanding s. 408.806, the ~~an initial~~ applicant must
379 provide proof of accreditation that is not conditional or
380 provisional and a survey demonstrating compliance with the
381 requirements of this part, part II of chapter 408, and
382 applicable rules from an accrediting organization that is
383 recognized by the agency as having standards comparable to those
384 required by this part and part II of chapter 408 within 120 days
385 after the date of the agency's receipt of the application for
386 licensure. Such accreditation must be continuously maintained by
387 the home health agency to maintain licensure. The agency shall
388 accept, in lieu of its own periodic licensure survey, the
389 submission of the survey of an accrediting organization that is
390 recognized by the agency if the accreditation of the licensed
391 home health agency is not provisional and if the licensed home
392 health agency authorizes release of, and the agency receives the
393 report of, the accrediting organization.
394 Section 9. Section 400.492, Florida Statutes, is amended to
395 read:
396 400.492 Provision of services during an emergency.—Each
397 home health agency shall prepare and maintain a comprehensive
398 emergency management plan that is consistent with the standards
399 adopted by national or state accreditation organizations and
400 consistent with the local special needs plan. The plan shall be
401 updated annually and shall provide for continuing home health
402 services during an emergency that interrupts patient care or
403 services in the patient's home. The plan shall include the means
404 by which the home health agency will continue to provide staff
405 to perform the same type and quantity of services to their
406 patients who evacuate to special needs shelters that were being

407 provided to those patients prior to evacuation. The plan shall
408 describe how the home health agency establishes and maintains an
409 effective response to emergencies and disasters, including:
410 notifying staff when emergency response measures are initiated;
411 providing for communication between staff members, county health
412 departments, and local emergency management agencies, including
413 a backup system; identifying resources necessary to continue
414 essential care or services or referrals to other health care
415 providers ~~organizations~~ subject to written agreement; and
416 prioritizing and contacting patients who need continued care or
417 services.

418 (1) Each patient record for patients who are listed in the
419 registry established pursuant to s. 252.355 shall include a
420 description of how care or services will be continued in the
421 event of an emergency or disaster. The home health agency shall
422 discuss the emergency provisions with the patient and the
423 patient's caregivers, including where and how the patient is to
424 evacuate, procedures for notifying the home health agency in the
425 event that the patient evacuates to a location other than the
426 shelter identified in the patient record, and a list of
427 medications and equipment which must either accompany the
428 patient or will be needed by the patient in the event of an
429 evacuation.

430 (2) Each home health agency shall maintain a current
431 prioritized list of patients who need continued services during
432 an emergency. The list shall indicate how services shall be
433 continued in the event of an emergency or disaster for each
434 patient and if the patient is to be transported to a special
435 needs shelter, and shall indicate if the patient is receiving

436 skilled nursing services and the patient’s medication and
437 equipment needs. The list shall be furnished to county health
438 departments and to local emergency management agencies, upon
439 request.
440 (3) Home health agencies shall not be required to continue
441 to provide care to patients in emergency situations that are
442 beyond their control and that make it impossible to provide
443 services, such as when roads are impassable or when patients do
444 not go to the location specified in their patient records. Home
445 health agencies may establish links to local emergency
446 operations centers to determine a mechanism by which to approach
447 specific areas within a disaster area in order for the agency to
448 reach its clients. Home health agencies shall demonstrate a good
449 faith effort to comply with the requirements of this subsection
450 by documenting attempts of staff to follow procedures outlined
451 in the home health agency’s comprehensive emergency management
452 plan, and by the patient’s record, which support a finding that
453 the provision of continuing care has been attempted for those
454 patients who have been identified as needing care by the home
455 health agency and registered under s. 252.355, in the event of
456 an emergency or disaster under subsection (1).
457 (4) Notwithstanding the provisions of s. 400.464(2) or any
458 other provision of law to the contrary, a home health agency may
459 provide services in a special needs shelter located in any
460 county.
461 Section 10. Subsection (4) and paragraph (a) of subsection
462 (5) of section 400.506, Florida Statutes, are amended to read:
463 400.506 Licensure of nurse registries; requirements;
464 penalties.—

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465 (4) A licensee who ~~person that~~ provides, offers, or
466 advertises to the public any service for which licensure is
467 required under this section must include in such advertisement
468 the license number issued to the licensee ~~it~~ by the Agency for
469 Health Care Administration. The agency shall assess a fine of
470 not less than $100 against any licensee who fails to include the
471 license number when submitting the advertisement for
472 publication, broadcast, or printing. The fine for a second or
473 subsequent offense is $500.
474 (5)(a) In addition to the requirements of s. 408.812, any
475 person or entity that ~~who~~ owns, operates, or maintains an
476 unlicensed nurse registry and who, after receiving notification
477 from the agency, fails to cease operation and apply for a
478 license under this part commits a misdemeanor of the second
479 degree, punishable as provided in s. 775.082 or s. 775.083. Each
480 day of continued operation is a separate offense.
481 Section 11. Subsections (1), (2), (4), and (5) of section
482 400.509, Florida Statutes, are amended to read:
483 400.509 Registration of particular service providers exempt
484 from licensure; certificate of registration; regulation of
485 registrants.—
486 (1) Any person or entity ~~organization~~ that provides
487 companion services or homemaker services and does not provide a
488 home health service to a person is exempt from licensure under
489 this part. However, any person or entity ~~organization~~ that
490 provides companion services or homemaker services must register
491 with the agency. A person or an entity ~~An organization~~ under
492 contract with the Agency for Persons with Disabilities which
493 provides companion services only for persons with a

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494 developmental disability, as defined in s. 393.063, is exempt
495 from registration.
496 (2) The requirements of part II of chapter 408 apply to the
497 provision of services that require registration or licensure
498 pursuant to this section and part II of chapter 408 and entities
499 registered by or applying for such registration from the Agency
500 for Health Care Administration pursuant to this section. Each
501 applicant for registration and each registrant must comply with
502 all provisions of part II of chapter 408. Registration or a
503 license issued by the agency is required for <u>a person or an</u>
504 <u>entity to provide</u> ~~the operation of an organization that provides~~
505 companion services or homemaker services.
506 (4) Each registrant must obtain the employment or contract
507 history of persons who are employed by or under contract with
508 the <u>person or entity</u> ~~organization~~ and who will have contact at
509 any time with patients or clients in their homes by:
510 (a) Requiring such persons to submit an employment or
511 contractual history to the registrant; and
512 (b) Verifying the employment or contractual history, unless
513 through diligent efforts such verification is not possible. The
514 agency shall prescribe by rule the minimum requirements for
515 establishing that diligent efforts have been made.
516
517 There is no monetary liability on the part of, and no cause of
518 action for damages arises against, a former employer of a
519 prospective employee of or prospective independent contractor
520 with a registrant who reasonably and in good faith communicates
521 his or her honest opinions about the former employee’s or
522 contractor’s job performance. This subsection does not affect

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523 the official immunity of an officer or employee of a public
524 corporation.
525 (5) A person or an entity that offers or advertises to the
526 public a service for which registration is required must include
527 in its advertisement the registration number issued by the
528 Agency for Health Care Administration.
529 Section 12. Subsection (3) of section 400.605, Florida
530 Statutes, is amended to read:
531 400.605 Administration; forms; fees; rules; inspections;
532 fines.—
533 (3) In accordance with s. 408.811, the agency shall conduct
534 ~~annual inspections of all licensees, except that licensure~~
535 ~~inspections may be conducted biennially for hospices having a 3-~~
536 ~~year record of substantial compliance. The agency shall conduct~~
537 such inspections and investigations as are necessary in order to
538 determine the state of compliance with ~~the provisions of~~ this
539 part, part II of chapter 408, and applicable rules.
540 Section 13. Section 400.60501, Florida Statutes, is amended
541 to read:
542 400.60501 Outcome measures; adoption of federal quality
543 measures; public reporting~~; annual report~~.—
544 (1) ~~No later than December 31, 2019,~~ The agency shall adopt
545 the national hospice outcome measures and survey data in 42
546 C.F.R. part 418 to determine the quality and effectiveness of
547 hospice care for hospices licensed in the state.
548 (2) The agency shall~~:~~
549 ~~(a)~~ make available to the public the national hospice
550 outcome measures and survey data in a format that is
551 comprehensible by a layperson and that allows a consumer to

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552 compare such measures of one or more hospices.
553 ~~(b) Develop an annual report that analyzes and evaluates~~
554 ~~the information collected under this act and any other data~~
555 ~~collection or reporting provisions of law.~~
556 Section 14. Subsection (4) of section 400.9905, Florida
557 Statutes, is amended to read:
558 400.9905 Definitions.—
559 (4) "Clinic" means an entity where health care services are
560 provided to individuals and which tenders charges for
561 reimbursement for such services, including a mobile clinic and a
562 portable equipment provider. As used in this part, the term does
563 not include and the licensure requirements of this part do not
564 apply to:
565 (a) Entities licensed or registered by the state under
566 chapter 395; entities licensed or registered by the state and
567 providing only health care services within the scope of services
568 authorized under their respective licenses under ss. 383.30-
569 383.332, chapter 390, chapter 394, chapter 397, this chapter
570 except part X, chapter 429, chapter 463, chapter 465, chapter
571 466, chapter 478, chapter 484, or chapter 651; end-stage renal
572 disease providers authorized under 42 C.F.R. part 405, subpart
573 U; providers certified and providing only health care services
574 within the scope of services authorized under their respective
575 certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart
576 H, or subpart J; providers certified and providing only health
577 care services within the scope of services authorized under
578 their respective certifications under 42 C.F.R. part 486,
579 subpart C; providers certified and providing only health care
580 services within the scope of services authorized under their

581 respective certifications under 42 C.F.R. part 491, subpart A;
582 providers certified by the Centers for Medicare and Medicaid
583 services under the federal Clinical Laboratory Improvement
584 Amendments and the federal rules adopted thereunder; or any
585 entity that provides neonatal or pediatric hospital-based health
586 care services or other health care services by licensed
587 practitioners solely within a hospital licensed under chapter
588 395.
589 (b) Entities that own, directly or indirectly, entities
590 licensed or registered by the state pursuant to chapter 395;
591 entities that own, directly or indirectly, entities licensed or
592 registered by the state and providing only health care services
593 within the scope of services authorized pursuant to their
594 respective licenses under ss. 383.30-383.332, chapter 390,
595 chapter 394, chapter 397, this chapter except part X, chapter
596 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter
597 484, or chapter 651; end-stage renal disease providers
598 authorized under 42 C.F.R. part 405, subpart U; providers
599 certified and providing only health care services within the
600 scope of services authorized under their respective
601 certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart
602 H, or subpart J; providers certified and providing only health
603 care services within the scope of services authorized under
604 their respective certifications under 42 C.F.R. part 486,
605 subpart C; providers certified and providing only health care
606 services within the scope of services authorized under their
607 respective certifications under 42 C.F.R. part 491, subpart A;
608 providers certified by the Centers for Medicare and Medicaid
609 services under the federal Clinical Laboratory Improvement

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610 Amendments and the federal rules adopted thereunder; or any
611 entity that provides neonatal or pediatric hospital-based health
612 care services by licensed practitioners solely within a hospital
613 licensed under chapter 395.
614 (c) Entities that are owned, directly or indirectly, by an
615 entity licensed or registered by the state pursuant to chapter
616 395; entities that are owned, directly or indirectly, by an
617 entity licensed or registered by the state and providing only
618 health care services within the scope of services authorized
619 pursuant to their respective licenses under ss. 383.30-383.332,
620 chapter 390, chapter 394, chapter 397, this chapter except part
621 X, chapter 429, chapter 463, chapter 465, chapter 466, chapter
622 478, chapter 484, or chapter 651; end-stage renal disease
623 providers authorized under 42 C.F.R. part 405, subpart U;
624 providers certified and providing only health care services
625 within the scope of services authorized under their respective
626 certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart
627 H, or subpart J; providers certified and providing only health
628 care services within the scope of services authorized under
629 their respective certifications under 42 C.F.R. part 486,
630 subpart C; providers certified and providing only health care
631 services within the scope of services authorized under their
632 respective certifications under 42 C.F.R. part 491, subpart A;
633 providers certified by the Centers for Medicare and Medicaid
634 services under the federal Clinical Laboratory Improvement
635 Amendments and the federal rules adopted thereunder; or any
636 entity that provides neonatal or pediatric hospital-based health
637 care services by licensed practitioners solely within a hospital
638 under chapter 395.

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639 (d) Entities that are under common ownership, directly or
640 indirectly, with an entity licensed or registered by the state
641 pursuant to chapter 395; entities that are under common
642 ownership, directly or indirectly, with an entity licensed or
643 registered by the state and providing only health care services
644 within the scope of services authorized pursuant to their
645 respective licenses under ss. 383.30-383.332, chapter 390,
646 chapter 394, chapter 397, this chapter except part X, chapter
647 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter
648 484, or chapter 651; end-stage renal disease providers
649 authorized under 42 C.F.R. part 405, subpart U; providers
650 certified and providing only health care services within the
651 scope of services authorized under their respective
652 certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart
653 H, or subpart J; providers certified and providing only health
654 care services within the scope of services authorized under
655 their respective certifications under 42 C.F.R. part 486,
656 subpart C; providers certified and providing only health care
657 services within the scope of services authorized under their
658 respective certifications under 42 C.F.R. part 491, subpart A;
659 providers certified by the Centers for Medicare and Medicaid
660 services under the federal Clinical Laboratory Improvement
661 Amendments and the federal rules adopted thereunder; or any
662 entity that provides neonatal or pediatric hospital-based health
663 care services by licensed practitioners solely within a hospital
664 licensed under chapter 395.
665 (e) An entity that is exempt from federal taxation under 26
666 U.S.C. s. 501(c)(3) or (4), an employee stock ownership plan
667 under 26 U.S.C. s. 409 that has a board of trustees at least

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668 two-thirds of which are Florida-licensed health care
669 practitioners and provides only physical therapy services under
670 physician orders, any community college or university clinic,
671 and any entity owned or operated by the federal or state
672 government, including agencies, subdivisions, or municipalities
673 thereof.
674 (f) A sole proprietorship, group practice, partnership, or
675 corporation that provides health care services by physicians
676 covered by s. 627.419, that is directly supervised by one or
677 more of such physicians, and that is wholly owned by one or more
678 of those physicians or by a physician and the spouse, parent,
679 child, or sibling of that physician.
680 (g) A sole proprietorship, group practice, partnership, or
681 corporation that provides health care services by licensed
682 health care practitioners under chapter 457, chapter 458,
683 chapter 459, chapter 460, chapter 461, chapter 462, chapter 463,
684 chapter 466, chapter 467, chapter 480, chapter 484, chapter 486,
685 chapter 490, chapter 491, or part I, part III, part X, part
686 XIII, or part XIV of chapter 468, or s. 464.012, and that is
687 wholly owned by one or more licensed health care practitioners,
688 or the licensed health care practitioners set forth in this
689 paragraph and the spouse, parent, child, or sibling of a
690 licensed health care practitioner if one of the owners who is a
691 licensed health care practitioner is supervising the business
692 activities and is legally responsible for the entity’s
693 compliance with all federal and state laws. However, a health
694 care practitioner may not supervise services beyond the scope of
695 the practitioner’s license, except that, for the purposes of
696 this part, a clinic owned by a licensee in s. 456.053(3)(b)

697 which provides only services authorized pursuant to s.
698 456.053(3)(b) may be supervised by a licensee specified in s.
699 456.053(3)(b).
700 (h) Clinical facilities affiliated with an accredited
701 medical school at which training is provided for medical
702 students, residents, or fellows.
703 (i) Entities that provide only oncology or radiation
704 therapy services by physicians licensed under chapter 458 or
705 chapter 459 or entities that provide oncology or radiation
706 therapy services by physicians licensed under chapter 458 or
707 chapter 459 which are owned by a corporation whose shares are
708 publicly traded on a recognized stock exchange.
709 (j) Clinical facilities affiliated with a college of
710 chiropractic accredited by the Council on Chiropractic Education
711 at which training is provided for chiropractic students.
712 (k) Entities that provide licensed practitioners to staff
713 emergency departments or to deliver anesthesia services in
714 facilities licensed under chapter 395 and that derive at least
715 90 percent of their gross annual revenues from the provision of
716 such services. Entities claiming an exemption from licensure
717 under this paragraph must provide documentation demonstrating
718 compliance.
719 (l) Orthotic, prosthetic, pediatric cardiology, or
720 perinatology clinical facilities or anesthesia clinical
721 facilities that are not otherwise exempt under paragraph (a) or
722 paragraph (k) and that are a publicly traded corporation or are
723 wholly owned, directly or indirectly, by a publicly traded
724 corporation. As used in this paragraph, a publicly traded
725 corporation is a corporation that issues securities traded on an

726 exchange registered with the United States Securities and
727 Exchange Commission as a national securities exchange.
728 (m) Entities that are owned by a corporation that has $250
729 million or more in total annual sales of health care services
730 provided by licensed health care practitioners where one or more
731 of the persons responsible for the operations of the entity is a
732 health care practitioner who is licensed in this state and who
733 is responsible for supervising the business activities of the
734 entity and is responsible for the entity's compliance with state
735 law for purposes of this part.
736 (n) Entities that employ 50 or more licensed health care
737 practitioners licensed under chapter 458 or chapter 459 where
738 the billing for medical services is under a single tax
739 identification number. The application for exemption under this
740 subsection shall contain information that includes: the name,
741 residence, and business address and phone number of the entity
742 that owns the practice; a complete list of the names and contact
743 information of all the officers and directors of the
744 corporation; the name, residence address, business address, and
745 medical license number of each licensed Florida health care
746 practitioner employed by the entity; the corporate tax
747 identification number of the entity seeking an exemption; a
748 listing of health care services to be provided by the entity at
749 the health care clinics owned or operated by the entity and a
750 certified statement prepared by an independent certified public
751 accountant which states that the entity and the health care
752 clinics owned or operated by the entity have not received
753 payment for health care services under personal injury
754 protection insurance coverage for the preceding year. If the

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755 agency determines that an entity which is exempt under this
756 subsection has received payments for medical services under
757 personal injury protection insurance coverage, the agency may
758 deny or revoke the exemption from licensure under this
759 subsection.
760 (o) Entities that are, directly or indirectly, under the
761 common ownership of or that are subject to common control by a
762 mutual insurance holding company, as defined in s. 628.703, with
763 an entity licensed or certified under chapter 627 or chapter 641
764 which has $1 billion or more in total annual sales in this
765 state.
766 (p) Entities that are owned by an entity that is a
767 behavioral health service provider in at least 5 states other
768 than Florida and that, together with its affiliates, has $90
769 million or more in total annual revenues associated with the
770 provision of behavioral health services and where one or more of
771 the persons responsible for the operations of the entity is a
772 health care practitioner who is licensed in this state and who
773 is responsible for supervising the business activities of the
774 entity and who is responsible for the entity's compliance with
775 state law for purposes of this part.
776 (q) Medicaid providers.
777
778 Notwithstanding this subsection, an entity shall be deemed a
779 clinic and must be licensed under this part in order to receive
780 reimbursement under the Florida Motor Vehicle No-Fault Law, ss.
781 627.730-627.7405, unless exempted under s. 627.736(5)(h).
782 Section 15. Paragraph (c) of subsection (3) of section
783 400.991, Florida Statutes, is amended to read:

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784 400.991 License requirements; background screenings;
785 prohibitions.—
786 (3) In addition to the requirements of part II of chapter
787 408, the applicant must file with the application satisfactory
788 proof that the clinic is in compliance with this part and
789 applicable rules, including:
790 (c) Proof of financial ability to operate as required under
791 ss. 408.8065(1) and 408.810(8) ~~s. 408.810(8). As an alternative~~
792 ~~to submitting proof of financial ability to operate as required~~
793 ~~under s. 408.810(8), the applicant may file a surety bond of at~~
794 ~~least $500,000 which guarantees that the clinic will act in full~~
795 ~~conformity with all legal requirements for operating a clinic,~~
796 ~~payable to the agency. The agency may adopt rules to specify~~
797 ~~related requirements for such surety bond~~.
798 Section 16. Paragraph (i) of subsection (1) of section
799 400.9935, Florida Statutes, is amended to read:
800 400.9935 Clinic responsibilities.—
801 (1) Each clinic shall appoint a medical director or clinic
802 director who shall agree in writing to accept legal
803 responsibility for the following activities on behalf of the
804 clinic. The medical director or the clinic director shall:
805 (i) Ensure that the clinic publishes a schedule of charges
806 for the medical services offered to patients. The schedule must
807 include the prices charged to an uninsured person paying for
808 such services by cash, check, credit card, or debit card. The
809 schedule may group services by price levels, listing services in
810 each price level. The schedule must be posted in a conspicuous
811 place in the reception area of any clinic that is an ~~the~~ urgent
812 care center as defined in s. 395.002(29)(b) and must include,

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813 but is not limited to, the 50 services most frequently provided
814 by the clinic. ~~The schedule may group services by three price~~
815 ~~levels, listing services in each price level.~~ The posting may be
816 a sign that must be at least 15 square feet in size or through
817 an electronic messaging board that is at least 3 square feet in
818 size. The failure of a clinic, including a clinic that is an
819 urgent care center, to publish and post a schedule of charges as
820 required by this section shall result in a fine of not more than
821 $1,000, per day, until the schedule is published and posted.
822 Section 17. Paragraph (a) of subsection (2) of section
823 408.033, Florida Statutes, is amended to read:
824 408.033 Local and state health planning.—
825 (2) FUNDING.—
826 (a) The Legislature intends that the cost of local health
827 councils be borne by assessments on selected health care
828 facilities subject to facility licensure by the Agency for
829 Health Care Administration, including abortion clinics, assisted
830 living facilities, ambulatory surgical centers, birth centers,
831 home health agencies, hospices, hospitals, intermediate care
832 facilities for the developmentally disabled, nursing homes, and
833 health care clinics, ~~and multiphasic testing centers~~ and by
834 assessments on organizations subject to certification by the
835 agency pursuant to chapter 641, part III, including health
836 maintenance organizations and prepaid health clinics. Fees
837 assessed may be collected prospectively at the time of licensure
838 renewal and prorated for the licensure period.
839 Section 18. Paragraph (a) of subsection (1) of section
840 408.061, Florida Statutes, is amended to read:
841 408.061 Data collection; uniform systems of financial

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842 reporting; information relating to physician charges;
843 confidential information; immunity.—
844 (1) The agency shall require the submission by health care
845 facilities, health care providers, and health insurers of data
846 necessary to carry out the agency’s duties and to facilitate
847 transparency in health care pricing data and quality measures.
848 Specifications for data to be collected under this section shall
849 be developed by the agency and applicable contract vendors, with
850 the assistance of technical advisory panels including
851 representatives of affected entities, consumers, purchasers, and
852 such other interested parties as may be determined by the
853 agency.
854 (a) Data submitted by health care facilities, including the
855 facilities as defined in chapter 395, shall include, but are not
856 limited to, ~~:~~ case-mix data, patient admission and discharge
857 data, hospital emergency department data which shall include the
858 number of patients treated in the emergency department of a
859 licensed hospital reported by patient acuity level, data on
860 hospital-acquired infections as specified by rule, data on
861 complications as specified by rule, data on readmissions as
862 specified by rule, including patient- ~~with patient~~ and provider-
863 specific identifiers ~~included~~, actual charge data by diagnostic
864 groups or other bundled groupings as specified by rule,
865 financial data, accounting data, operating expenses, expenses
866 incurred for rendering services to patients who cannot or do not
867 pay, interest charges, depreciation expenses based on the
868 expected useful life of the property and equipment involved, and
869 demographic data. The agency shall adopt nationally recognized
870 risk adjustment methodologies or software consistent with the

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871 standards of the Agency for Healthcare Research and Quality and
872 as selected by the agency for all data submitted as required by
873 this section. Data may be obtained from documents including ~~such~~
874 ~~as~~, but not limited to, ~~:~~ leases, contracts, debt instruments,
875 itemized patient statements or bills, medical record abstracts,
876 and related diagnostic information. ~~Reported~~ Data elements shall
877 be reported electronically in accordance with the inpatient data
878 reporting instructions as prescribed by agency rule ~~59E-7.012,~~
879 ~~Florida Administrative Code~~. Data submitted shall be certified
880 by the chief executive officer or an appropriate and duly
881 authorized representative or employee of the licensed facility
882 that the information submitted is true and accurate.
883 Section 19. Subsection (4) of section 408.0611, Florida
884 Statutes, is amended to read:
885 408.0611 Electronic prescribing clearinghouse.—
886 (4) Pursuant to s. 408.061, the agency shall monitor the
887 implementation of electronic prescribing by health care
888 practitioners, health care facilities, and pharmacies. ~~By~~
889 ~~January 31 of each year,~~ The agency shall report annually on its
890 website on the progress of implementation of electronic
891 prescribing ~~to the Governor and the Legislature~~. Information
892 reported pursuant to this subsection must ~~shall~~ include federal
893 and private sector electronic prescribing initiatives and, to
894 the extent that data is readily available from organizations
895 that operate electronic prescribing networks, the number of
896 health care practitioners using electronic prescribing and the
897 number of prescriptions electronically transmitted.
898 Section 20. Paragraphs (i) and (j) of subsection (1) of
899 section 408.062, Florida Statutes, are amended to read:

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900 408.062 Research, analyses, studies, and reports.—
901 (1) The agency shall conduct research, analyses, and
902 studies relating to health care costs and access to and quality
903 of health care services as access and quality are affected by
904 changes in health care costs. Such research, analyses, and
905 studies shall include, but not be limited to:
906 (i) The use of emergency department services by patient
907 acuity level ~~and the implication of increasing hospital cost by~~
908 ~~providing nonurgent care in emergency departments~~. The agency
909 shall publish annually on its website information ~~submit an~~
910 ~~annual report~~ based on this monitoring and assessment ~~to the~~
911 ~~Governor, the Speaker of the House of Representatives, the~~
912 ~~President of the Senate, and the substantive legislative~~
913 ~~committees, due January 1~~.
914 (j) The making available on its Internet website, and in a
915 hard-copy format upon request, of patient charge, volumes,
916 length of stay, and performance indicators collected from health
917 care facilities pursuant to s. 408.061(1)(a) for specific
918 medical conditions, surgeries, and procedures provided in
919 inpatient and outpatient facilities as determined by the agency.
920 In making the determination of specific medical conditions,
921 surgeries, and procedures to include, the agency shall consider
922 such factors as volume, severity of the illness, urgency of
923 admission, individual and societal costs, and whether the
924 condition is acute or chronic. Performance outcome indicators
925 shall be risk adjusted or severity adjusted, as applicable,
926 using nationally recognized risk adjustment methodologies or
927 software consistent with the standards of the Agency for
928 Healthcare Research and Quality and as selected by the agency.

929 The website shall also provide an interactive search that allows
930 consumers to view and compare the information for specific
931 facilities, a map that allows consumers to select a county or
932 region, definitions of all of the data, descriptions of each
933 procedure, and an explanation about why the data may differ from
934 facility to facility. Such public data shall be updated
935 quarterly. The agency shall publish annually on its website
936 information ~~submit an annual status report~~ on the collection of
937 data and publication of health care quality measures ~~to the~~
938 ~~Governor, the Speaker of the House of Representatives, the~~
939 ~~President of the Senate, and the substantive legislative~~
940 ~~committees, due January 1~~.
941 Section 21. Subsection (5) of section 408.063, Florida
942 Statutes, is amended to read:
943 408.063 Dissemination of health care information.—
944 ~~(5) The agency shall publish annually a comprehensive~~
945 ~~report of state health expenditures. The report shall identify:~~
946 ~~(a) The contribution of health care dollars made by all~~
947 ~~payors.~~
948 ~~(b) The dollars expended by type of health care service in~~
949 ~~Florida.~~
950 Section 22. Section 408.802, Florida Statutes, is amended
951 to read:
952 408.802 Applicability.~~—The provisions of~~ This part applies
953 ~~apply~~ to the provision of services that require licensure as
954 defined in this part and to the following entities licensed,
955 registered, or certified by the agency, as described in chapters
956 112, 383, 390, 394, 395, 400, 429, 440, ~~483,~~ and 765:
957 (1) Laboratories authorized to perform testing under the

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958 Drug-Free Workplace Act, as provided under ss. 112.0455 and
959 440.102.
960 (2) Birth centers, as provided under chapter 383.
961 (3) Abortion clinics, as provided under chapter 390.
962 (4) Crisis stabilization units, as provided under parts I
963 and IV of chapter 394.
964 (5) Short-term residential treatment facilities, as
965 provided under parts I and IV of chapter 394.
966 (6) Residential treatment facilities, as provided under
967 part IV of chapter 394.
968 (7) Residential treatment centers for children and
969 adolescents, as provided under part IV of chapter 394.
970 (8) Hospitals, as provided under part I of chapter 395.
971 (9) Ambulatory surgical centers, as provided under part I
972 of chapter 395.
973 (10) Nursing homes, as provided under part II of chapter
974 400.
975 (11) Assisted living facilities, as provided under part I
976 of chapter 429.
977 (12) Home health agencies, as provided under part III of
978 chapter 400.
979 (13) Nurse registries, as provided under part III of
980 chapter 400.
981 (14) Companion services or homemaker services providers, as
982 provided under part III of chapter 400.
983 (15) Adult day care centers, as provided under part III of
984 chapter 429.
985 (16) Hospices, as provided under part IV of chapter 400.
986 (17) Adult family-care homes, as provided under part II of

chapter 429.

(18) Homes for special services, as provided under part V of chapter 400.

(19) Transitional living facilities, as provided under part XI of chapter 400.

(20) Prescribed pediatric extended care centers, as provided under part VI of chapter 400.

(21) Home medical equipment providers, as provided under part VII of chapter 400.

(22) Intermediate care facilities for persons with developmental disabilities, as provided under part VIII of chapter 400.

(23) Health care services pools, as provided under part IX of chapter 400.

(24) Health care clinics, as provided under part X of chapter 400.

~~(25) Multiphasic health testing centers, as provided under part I of chapter 483.~~

(25)~~(26)~~ Organ, tissue, and eye procurement organizations, as provided under part V of chapter 765.

Section 23. Present subsections (10) through (14) of section 408.803, Florida Statutes, are redesignated as subsections (11) through (15), respectively, a new subsection (10) is added to that section, and subsection (3) of that section is amended, to read:

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

(3) "Authorizing statute" means the statute authorizing the licensed operation of a provider listed in s. 408.802 and includes chapters 112, 383, 390, 394, 395, 400, 429, 440, ~~483,~~

1016 and 765.
1017 (10) “Low-risk provider” means nurse registries, home
1018 medical equipment providers, and health care clinics.
1019 Section 24. Paragraph (b) of subsection (7) of section
1020 408.806, Florida Statutes, is amended to read:
1021 408.806 License application process.—
1022 (7)
1023 (b) An initial inspection is not required for companion
1024 services or homemaker services providers~~,~~ as provided under part
1025 III of chapter 400, ~~or~~ for health care services pools~~,~~ as
1026 provided under part IX of chapter 400, or for low-risk providers
1027 as provided under s. 408.811.
1028 Section 25. Subsection (2) of section 408.808, Florida
1029 Statutes, is amended to read:
1030 408.808 License categories.—
1031 (2) PROVISIONAL LICENSE.—An applicant against whom a
1032 proceeding denying or revoking a license is pending at the time
1033 of license renewal may be issued a provisional license effective
1034 until final action not subject to further appeal. A provisional
1035 license may also be issued to an applicant for initial licensure
1036 or applying for a change of ownership. A provisional license
1037 must be limited in duration to a specific period of time, up to
1038 12 months, as determined by the agency.
1039 Section 26. Subsections (2) and (5) of section 408.809,
1040 Florida Statutes, are amended to read:
1041 408.809 Background screening; prohibited offenses.—
1042 (2) Every 5 years following his or her licensure,
1043 employment, or entry into a contract in a capacity that under
1044 subsection (1) would require level 2 background screening under

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1045 chapter 435, each such person must submit to level 2 background
1046 rescreening as a condition of retaining such license or
1047 continuing in such employment or contractual status. For any
1048 such rescreening, the agency shall request the Department of Law
1049 Enforcement to forward the person’s fingerprints to the Federal
1050 Bureau of Investigation for a national criminal history record
1051 check unless the person’s fingerprints are enrolled in the
1052 Federal Bureau of Investigation’s national retained print arrest
1053 notification program. If the fingerprints of such a person are
1054 not retained by the Department of Law Enforcement under s.
1055 943.05(2)(g) and (h), the person must submit fingerprints
1056 electronically to the Department of Law Enforcement for state
1057 processing, and the Department of Law Enforcement shall forward
1058 the fingerprints to the Federal Bureau of Investigation for a
1059 national criminal history record check. The fingerprints shall
1060 be retained by the Department of Law Enforcement under s.
1061 943.05(2)(g) and (h) and enrolled in the national retained print
1062 arrest notification program when the Department of Law
1063 Enforcement begins participation in the program. The cost of the
1064 state and national criminal history records checks required by
1065 level 2 screening may be borne by the licensee or the person
1066 fingerprinted. ~~Until a specified agency is fully implemented in~~
1067 ~~the clearinghouse created under s. 435.12,~~ The agency may accept
1068 as satisfying the requirements of this section proof of
1069 compliance with level 2 screening standards submitted within the
1070 previous 5 years to meet any provider or professional licensure
1071 requirements of ~~the agency, the Department of Health, the~~
1072 ~~Department of Elderly Affairs, the Agency for Persons with~~
1073 ~~Disabilities, the Department of Children and Families, or~~ the

1074 Department of Financial Services for an applicant for a
1075 certificate of authority or provisional certificate of authority
1076 to operate a continuing care retirement community under chapter
1077 651, provided that:
1078 (a) The screening standards and disqualifying offenses for
1079 the prior screening are equivalent to those specified in s.
1080 435.04 and this section;
1081 (b) The person subject to screening has not had a break in
1082 service from a position that requires level 2 screening for more
1083 than 90 days; and
1084 (c) Such proof is accompanied, under penalty of perjury, by
1085 an attestation of compliance with chapter 435 and this section
1086 using forms provided by the agency.
1087 ~~(5) A person who serves as a controlling interest of, is~~
1088 ~~employed by, or contracts with a licensee on July 31, 2010, who~~
1089 ~~has been screened and qualified according to standards specified~~
1090 ~~in s. 435.03 or s. 435.04 must be rescreened by July 31, 2015,~~
1091 ~~in compliance with the following schedule. If, upon rescreening,~~
1092 ~~such person has a disqualifying offense that was not a~~
1093 ~~disqualifying offense at the time of the last screening, but is~~
1094 ~~a current disqualifying offense and was committed before the~~
1095 ~~last screening, he or she may apply for an exemption from the~~
1096 ~~appropriate licensing agency and, if agreed to by the employer,~~
1097 ~~may continue to perform his or her duties until the licensing~~
1098 ~~agency renders a decision on the application for exemption if~~
1099 ~~the person is eligible to apply for an exemption and the~~
1100 ~~exemption request is received by the agency within 30 days after~~
1101 ~~receipt of the rescreening results by the person. The~~
1102 ~~rescreening schedule shall be:~~

1103 ~~(a) Individuals for whom the last screening was conducted~~
1104 ~~on or before December 31, 2004, must be rescreened by July 31,~~
1105 ~~2013.~~
1106 ~~(b) Individuals for whom the last screening conducted was~~
1107 ~~between January 1, 2005, and December 31, 2008, must be~~
1108 ~~rescreened by July 31, 2014.~~
1109 ~~(c) Individuals for whom the last screening conducted was~~
1110 ~~between January 1, 2009, through July 31, 2011, must be~~
1111 ~~rescreened by July 31, 2015.~~
1112 Section 27. Subsection (1) of section 408.811, Florida
1113 Statutes, is amended to read:
1114 408.811 Right of inspection; copies; inspection reports;
1115 plan for correction of deficiencies.—
1116 (1) An authorized officer or employee of the agency may
1117 make or cause to be made any inspection or investigation deemed
1118 necessary by the agency to determine the state of compliance
1119 with this part, authorizing statutes, and applicable rules. The
1120 right of inspection extends to any business that the agency has
1121 reason to believe is being operated as a provider without a
1122 license, but inspection of any business suspected of being
1123 operated without the appropriate license may not be made without
1124 the permission of the owner or person in charge unless a warrant
1125 is first obtained from a circuit court. Any application for a
1126 license issued under this part, authorizing statutes, or
1127 applicable rules constitutes permission for an appropriate
1128 inspection to verify the information submitted on or in
1129 connection with the application.
1130 (a) All inspections shall be unannounced, except as
1131 specified in s. 408.806.

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1132 (b) Inspections for relicensure shall be conducted
1133 biennially unless otherwise specified by this section,
1134 authorizing statutes, or applicable rules.
1135 (c) The agency may exempt a low-risk provider from
1136 licensure inspection if the provider or controlling interest has
1137 an excellent regulatory history with regard to deficiencies,
1138 sanctions, complaints, and other regulatory actions, as defined
1139 by rule. The agency shall continue to conduct unannounced
1140 licensure inspections for at least 10 percent of exempt low-risk
1141 providers to verify compliance.
1142 (d) The agency may adopt rules to waive a routine
1143 inspection, including inspection for relicensure, or allow for
1144 an extended period between relicensure inspections for specific
1145 providers based upon:
1146 1. A favorable regulatory history with regard to
1147 deficiencies, sanctions, complaints, and other regulatory
1148 measures.
1149 2. Outcome measures that demonstrate quality performance.
1150 3. Successful participation in a recognized quality
1151 assurance program.
1152 4. Accreditation status.
1153 5. Other measures reflective of quality and safety.
1154 6. The length of time between inspections.
1155
1156 The agency shall continue to conduct unannounced licensure
1157 inspections for at least 10 percent of providers that qualify
1158 for a waiver or extended period between relicensure inspections.
1159 (e) The agency maintains the authority to conduct an
1160 inspection of any provider at any time to determine regulatory

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1161 compliance.
1162 Section 28. Subsection (24) of section 408.820, Florida
1163 Statutes, is amended to read:
1164 408.820 Exemptions.—Except as prescribed in authorizing
1165 statutes, the following exemptions shall apply to specified
1166 requirements of this part:
1167 ~~(24) Multiphasic health testing centers, as provided under~~
1168 ~~part I of chapter 483, are exempt from s. 408.810(5)-(10).~~
1169 Section 29. Subsections (1) and (2) of section 408.821,
1170 Florida Statutes, are amended to read:
1171 408.821 Emergency management planning; emergency
1172 operations; inactive license.—
1173 (1) A licensee required by authorizing statutes and agency
1174 rule to have a comprehensive ~~an~~ emergency management ~~operations~~
1175 plan must designate a safety liaison to serve as the primary
1176 contact for emergency operations. Such licensee shall submit its
1177 comprehensive emergency management plan to the local emergency
1178 management agency, county health department, or Department of
1179 Health as follows:
1180 (a) Submit the plan within 30 days after initial licensure
1181 and change of ownership, and notify the agency within 30 days
1182 after submission of the plan.
1183 (b) Submit the plan annually and within 30 days after any
1184 significant modification, as defined by agency rule, to a
1185 previously approved plan.
1186 (c) Respond with necessary plan revisions within 30 days
1187 after notification that plan revisions are required.
1188 (d) Notify the agency within 30 days after approval of its
1189 plan by the local emergency management agency, county health

1190 <u>department, or Department of Health.</u>
1191 (2) An entity subject to this part may temporarily exceed
1192 its licensed capacity to act as a receiving provider in
1193 accordance with an approved <u>comprehensive</u> emergency <u>management</u>
1194 ~~operations~~ plan for up to 15 days. While in an overcapacity
1195 status, each provider must furnish or arrange for appropriate
1196 care and services to all clients. In addition, the agency may
1197 approve requests for overcapacity in excess of 15 days, which
1198 approvals may be based upon satisfactory justification and need
1199 as provided by the receiving and sending providers.
1200 Section 30. Subsection (3) of section 408.831, Florida
1201 Statutes, is amended to read:
1202 408.831 Denial, suspension, or revocation of a license,
1203 registration, certificate, or application.—
1204 (3) This section provides standards of enforcement
1205 applicable to all entities licensed or regulated by the Agency
1206 for Health Care Administration. This section controls over any
1207 conflicting provisions of chapters 39, 383, 390, 391, 394, 395,
1208 400, 408, 429, 468, ~~483,~~ and 765 or rules adopted pursuant to
1209 those chapters.
1210 Section 31. Section 408.832, Florida Statutes, is amended
1211 to read:
1212 408.832 Conflicts.—In case of conflict between the
1213 provisions of this part and the authorizing statutes governing
1214 the licensure of health care providers by the Agency for Health
1215 Care Administration found in s. 112.0455 and chapters 383, 390,
1216 394, 395, 400, 429, 440, ~~483,~~ and 765, the provisions of this
1217 part shall prevail.
1218 Section 32. Subsection (9) of section 408.909, Florida

1219 Statutes, is amended to read:
1220 408.909 Health flex plans.—
1221 ~~(9) PROGRAM EVALUATION.—The agency and the office shall~~
1222 ~~evaluate the pilot program and its effect on the entities that~~
1223 ~~seek approval as health flex plans, on the number of enrollees,~~
1224 ~~and on the scope of the health care coverage offered under a~~
1225 ~~health flex plan; shall provide an assessment of the health flex~~
1226 ~~plans and their potential applicability in other settings; shall~~
1227 ~~use health flex plans to gather more information to evaluate~~
1228 ~~low-income consumer driven benefit packages; and shall, by~~
1229 ~~January 15, 2016, and annually thereafter, jointly submit a~~
1230 ~~report to the Governor, the President of the Senate, and the~~
1231 ~~Speaker of the House of Representatives.~~
1232 Section 33. Paragraph (d) of subsection (10) of section
1233 408.9091, Florida Statutes, is amended to read:
1234 408.9091 Cover Florida Health Care Access Program.—
1235 (10) PROGRAM EVALUATION.—The agency and the office shall:
1236 ~~(d) Jointly submit by March 1, annually, a report to the~~
1237 ~~Governor, the President of the Senate, and the Speaker of the~~
1238 ~~House of Representatives which provides the information~~
1239 ~~specified in paragraphs (a)-(c) and recommendations relating to~~
1240 ~~the successful implementation and administration of the program.~~
1241 Section 34. Effective upon becoming a law, paragraph (a) of
1242 subsection (5) of section 409.905, Florida Statutes, is amended
1243 to read:
1244 409.905 Mandatory Medicaid services.—The agency may make
1245 payments for the following services, which are required of the
1246 state by Title XIX of the Social Security Act, furnished by
1247 Medicaid providers to recipients who are determined to be

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1248 eligible on the dates on which the services were provided. Any
1249 service under this section shall be provided only when medically
1250 necessary and in accordance with state and federal law.
1251 Mandatory services rendered by providers in mobile units to
1252 Medicaid recipients may be restricted by the agency. Nothing in
1253 this section shall be construed to prevent or limit the agency
1254 from adjusting fees, reimbursement rates, lengths of stay,
1255 number of visits, number of services, or any other adjustments
1256 necessary to comply with the availability of moneys and any
1257 limitations or directions provided for in the General
1258 Appropriations Act or chapter 216.
1259 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
1260 all covered services provided for the medical care and treatment
1261 of a recipient who is admitted as an inpatient by a licensed
1262 physician or dentist to a hospital licensed under part I of
1263 chapter 395. However, the agency shall limit the payment for
1264 inpatient hospital services for a Medicaid recipient 21 years of
1265 age or older to 45 days or the number of days necessary to
1266 comply with the General Appropriations Act.
1267 (a)1. The agency may implement reimbursement and
1268 utilization management reforms in order to comply with any
1269 limitations or directions in the General Appropriations Act,
1270 which may include, but are not limited to: prior authorization
1271 for inpatient psychiatric days; prior authorization for
1272 nonemergency hospital inpatient admissions for individuals 21
1273 years of age and older; authorization of emergency and urgent-
1274 care admissions within 24 hours after admission; enhanced
1275 utilization and concurrent review programs for highly utilized
1276 services; reduction or elimination of covered days of service;

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1277 adjusting reimbursement ceilings for variable costs; adjusting
1278 reimbursement ceilings for fixed and property costs; and
1279 implementing target rates of increase.
1280 2. The agency may limit prior authorization for hospital
1281 inpatient services to selected diagnosis-related groups, based
1282 on an analysis of the cost and potential for unnecessary
1283 hospitalizations represented by certain diagnoses. Admissions
1284 for normal delivery and newborns are exempt from requirements
1285 for prior authorization.
1286 3. In implementing the provisions of this section related
1287 to prior authorization, the agency shall ensure that the process
1288 for authorization is accessible 24 hours per day, 7 days per
1289 week and authorization is automatically granted when not denied
1290 within 4 hours after the request. Authorization procedures must
1291 include steps for review of denials.
1292 4. Upon implementing the prior authorization program for
1293 hospital inpatient services, the agency shall discontinue its
1294 hospital retrospective review program. However, this
1295 subparagraph may not be construed to prevent the agency from
1296 conducting retrospective reviews under s. 409.913.
1297 Section 35. It is the intent of the Legislature that
1298 section 409.905(5)(a), Florida Statutes, as amended by this act,
1299 confirms and clarifies existing law.
1300 Section 36. Subsection (8) of section 409.907, Florida
1301 Statutes, is amended to read:
1302 409.907 Medicaid provider agreements.—The agency may make
1303 payments for medical assistance and related services rendered to
1304 Medicaid recipients only to an individual or entity who has a
1305 provider agreement in effect with the agency, who is performing

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1306 services or supplying goods in accordance with federal, state,
1307 and local law, and who agrees that no person shall, on the
1308 grounds of handicap, race, color, or national origin, or for any
1309 other reason, be subjected to discrimination under any program
1310 or activity for which the provider receives payment from the
1311 agency.
1312 (8)(a) A level 2 background screening pursuant to chapter
1313 435 must be conducted through the agency on each of the
1314 following:
1315 1. The ~~Each~~ provider, or each principal of the provider if
1316 the provider is a corporation, partnership, association, or
1317 other entity~~, seeking to participate in the Medicaid program~~
1318 ~~must submit a complete set of his or her fingerprints to the~~
1319 ~~agency for the purpose of conducting a criminal history record~~
1320 ~~check~~.
1321 2. Principals of the provider, who include any officer,
1322 director, billing agent, managing employee, or affiliated
1323 person, or any partner or shareholder who has an ownership
1324 interest equal to 5 percent or more in the provider. However,
1325 for a hospital licensed under chapter 395 or a nursing home
1326 licensed under chapter 400, principals of the provider are those
1327 who meet the definition of a controlling interest under s.
1328 408.803. A director of a not-for-profit corporation or
1329 organization is not a principal for purposes of a background
1330 investigation required by this section if the director: serves
1331 solely in a voluntary capacity for the corporation or
1332 organization, does not regularly take part in the day-to-day
1333 operational decisions of the corporation or organization,
1334 receives no remuneration from the not-for-profit corporation or

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1335 organization for his or her service on the board of directors,
1336 has no financial interest in the not-for-profit corporation or
1337 organization, and has no family members with a financial
1338 interest in the not-for-profit corporation or organization; and
1339 if the director submits an affidavit, under penalty of perjury,
1340 to this effect to the agency and the not-for-profit corporation
1341 or organization submits an affidavit, under penalty of perjury,
1342 to this effect to the agency as part of the corporation's or
1343 organization's Medicaid provider agreement application.
1344 3. Any person who participates or seeks to participate in
1345 the Florida Medicaid program by way of rendering services to
1346 Medicaid recipients or having direct access to Medicaid
1347 recipients, recipient living areas, or the financial, medical,
1348 or service records of a Medicaid recipient or who supervises the
1349 delivery of goods or services to a Medicaid recipient. This
1350 subparagraph does not impose additional screening requirements
1351 on any providers licensed under part II of chapter 408.
1352 (b) Notwithstanding paragraph (a) ~~the above~~, the agency may
1353 require a background check for any person reasonably suspected
1354 by the agency to have been convicted of a crime.
1355 (c)~~(a)~~ Paragraph (a) ~~This subsection~~ does not apply to:
1356 1. A unit of local government, except that requirements of
1357 this subsection apply to nongovernmental providers and entities
1358 contracting with the local government to provide Medicaid
1359 services. The actual cost of the state and national criminal
1360 history record checks must be borne by the nongovernmental
1361 provider or entity; or
1362 2. Any business that derives more than 50 percent of its
1363 revenue from the sale of goods to the final consumer, and the

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1364 business or its controlling parent is required to file a form
1365 10-K or other similar statement with the Securities and Exchange
1366 Commission or has a net worth of $50 million or more.
1367 (d) ~~(b)~~ Background screening shall be conducted in
1368 accordance with chapter 435 and s. 408.809. The cost of the
1369 state and national criminal record check shall be borne by the
1370 provider.
1371 Section 37. Section 409.913, Florida Statutes, is amended
1372 to read:
1373 409.913 Oversight of the integrity of the Medicaid
1374 program.—The agency shall operate a program to oversee the
1375 activities of Florida Medicaid recipients, and providers and
1376 their representatives, to ensure that fraudulent and abusive
1377 behavior and neglect of recipients occur to the minimum extent
1378 possible, and to recover overpayments and impose sanctions as
1379 appropriate. Each January 15 ~~January 1~~, the agency and the
1380 Medicaid Fraud Control Unit of the Department of Legal Affairs
1381 shall submit reports ~~a joint report~~ to the Legislature
1382 documenting the effectiveness of the state's efforts to control
1383 Medicaid fraud and abuse and to recover Medicaid overpayments
1384 during the previous fiscal year. The report must describe the
1385 number of cases opened and investigated each year; the sources
1386 of the cases opened; the disposition of the cases closed each
1387 year; the amount of overpayments alleged in preliminary and
1388 final audit letters; the number and amount of fines or penalties
1389 imposed; any reductions in overpayment amounts negotiated in
1390 settlement agreements or by other means; the amount of final
1391 agency determinations of overpayments; the amount deducted from
1392 federal claiming as a result of overpayments; the amount of

1393 overpayments recovered each year; the amount of cost of
1394 investigation recovered each year; the average length of time to
1395 collect from the time the case was opened until the overpayment
1396 is paid in full; the amount determined as uncollectible and the
1397 portion of the uncollectible amount subsequently reclaimed from
1398 the Federal Government; the number of providers, by type, that
1399 are terminated from participation in the Medicaid program as a
1400 result of fraud and abuse; and all costs associated with
1401 discovering and prosecuting cases of Medicaid overpayments and
1402 making recoveries in such cases. The report must also document
1403 actions taken to prevent overpayments and the number of
1404 providers prevented from enrolling in or reenrolling in the
1405 Medicaid program as a result of documented Medicaid fraud and
1406 abuse and must include policy recommendations necessary to
1407 prevent or recover overpayments and changes necessary to prevent
1408 and detect Medicaid fraud. All policy recommendations in the
1409 report must include a detailed fiscal analysis, including, but
1410 not limited to, implementation costs, estimated savings to the
1411 Medicaid program, and the return on investment. The agency must
1412 submit the policy recommendations and fiscal analyses in the
1413 report to the appropriate estimating conference, pursuant to s.
1414 216.137, by February 15 of each year. The agency and the
1415 Medicaid Fraud Control Unit of the Department of Legal Affairs
1416 each must include detailed unit-specific performance standards,
1417 benchmarks, and metrics in the report, including projected cost
1418 savings to the state Medicaid program during the following
1419 fiscal year.
1420 (1) For the purposes of this section, the term:
1421 (a) “Abuse” means:

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1422 1. Provider practices that are inconsistent with generally
1423 accepted business or medical practices and that result in an
1424 unnecessary cost to the Medicaid program or in reimbursement for
1425 goods or services that are not medically necessary or that fail
1426 to meet professionally recognized standards for health care.
1427 2. Recipient practices that result in unnecessary cost to
1428 the Medicaid program.
1429 (b) “Complaint” means an allegation that fraud, abuse, or
1430 an overpayment has occurred.
1431 (c) “Fraud” means an intentional deception or
1432 misrepresentation made by a person with the knowledge that the
1433 deception results in unauthorized benefit to herself or himself
1434 or another person. The term includes any act that constitutes
1435 fraud under applicable federal or state law.
1436 (d) “Medical necessity” or “medically necessary” means any
1437 goods or services necessary to palliate the effects of a
1438 terminal condition, or to prevent, diagnose, correct, cure,
1439 alleviate, or preclude deterioration of a condition that
1440 threatens life, causes pain or suffering, or results in illness
1441 or infirmity, which goods or services are provided in accordance
1442 with generally accepted standards of medical practice. For
1443 purposes of determining Medicaid reimbursement, the agency is
1444 the final arbiter of medical necessity. Determinations of
1445 medical necessity must be made by a licensed physician employed
1446 by or under contract with the agency and must be based upon
1447 information available at the time the goods or services are
1448 provided.
1449 (e) “Overpayment” includes any amount that is not
1450 authorized to be paid by the Medicaid program whether paid as a

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1451 result of inaccurate or improper cost reporting, improper
1452 claiming, unacceptable practices, fraud, abuse, or mistake.
1453 (f) “Person” means any natural person, corporation,
1454 partnership, association, clinic, group, or other entity,
1455 whether or not such person is enrolled in the Medicaid program
1456 or is a provider of health care.
1457 (2) The agency shall conduct, or cause to be conducted by
1458 contract or otherwise, reviews, investigations, analyses,
1459 audits, or any combination thereof, to determine possible fraud,
1460 abuse, overpayment, or recipient neglect in the Medicaid program
1461 and shall report the findings of any overpayments in audit
1462 reports as appropriate. At least 5 percent of all audits shall
1463 be conducted on a random basis. As part of its ongoing fraud
1464 detection activities, the agency shall identify and monitor, by
1465 contract or otherwise, patterns of overutilization of Medicaid
1466 services based on state averages. The agency shall track
1467 Medicaid provider prescription and billing patterns and evaluate
1468 them against Medicaid medical necessity criteria and coverage
1469 and limitation guidelines adopted by rule. Medical necessity
1470 determination requires that service be consistent with symptoms
1471 or confirmed diagnosis of illness or injury under treatment and
1472 not in excess of the patient’s needs. The agency shall conduct
1473 reviews of provider exceptions to peer group norms and shall,
1474 using statistical methodologies, provider profiling, and
1475 analysis of billing patterns, detect and investigate abnormal or
1476 unusual increases in billing or payment of claims for Medicaid
1477 services and medically unnecessary provision of services.
1478 (3) The agency may conduct, or may contract for, prepayment
1479 review of provider claims to ensure cost-effective purchasing;

1480 to ensure that billing by a provider to the agency is in
1481 accordance with applicable provisions of all Medicaid rules,
1482 regulations, handbooks, and policies and in accordance with
1483 federal, state, and local law; and to ensure that appropriate
1484 care is rendered to Medicaid recipients. Such prepayment reviews
1485 may be conducted as determined appropriate by the agency,
1486 without any suspicion or allegation of fraud, abuse, or neglect,
1487 and may last for up to 1 year. Unless the agency has reliable
1488 evidence of fraud, misrepresentation, abuse, or neglect, claims
1489 shall be adjudicated for denial or payment within 90 days after
1490 receipt of complete documentation by the agency for review. If
1491 there is reliable evidence of fraud, misrepresentation, abuse,
1492 or neglect, claims shall be adjudicated for denial of payment
1493 within 180 days after receipt of complete documentation by the
1494 agency for review.
1495 (4) Any suspected criminal violation identified by the
1496 agency must be referred to the Medicaid Fraud Control Unit of
1497 the Office of the Attorney General for investigation. The agency
1498 and the Attorney General shall enter into a memorandum of
1499 understanding, which must include, but need not be limited to, a
1500 protocol for regularly sharing information and coordinating
1501 casework. The protocol must establish a procedure for the
1502 referral by the agency of cases involving suspected Medicaid
1503 fraud to the Medicaid Fraud Control Unit for investigation, and
1504 the return to the agency of those cases where investigation
1505 determines that administrative action by the agency is
1506 appropriate. Offices of the Medicaid program integrity program
1507 and the Medicaid Fraud Control Unit of the Department of Legal
1508 Affairs, shall, to the extent possible, be collocated. The

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1509 agency and the Department of Legal Affairs shall periodically
1510 conduct joint training and other joint activities designed to
1511 increase communication and coordination in recovering
1512 overpayments.
1513 (5) A Medicaid provider is subject to having goods and
1514 services that are paid for by the Medicaid program reviewed by
1515 an appropriate peer-review organization designated by the
1516 agency. The written findings of the applicable peer-review
1517 organization are admissible in any court or administrative
1518 proceeding as evidence of medical necessity or the lack thereof.
1519 (6) Any notice required to be given to a provider under
1520 this section is presumed to be sufficient notice if sent to the
1521 address last shown on the provider enrollment file. It is the
1522 responsibility of the provider to furnish and keep the agency
1523 informed of the provider's current address. United States Postal
1524 Service proof of mailing or certified or registered mailing of
1525 such notice to the provider at the address shown on the provider
1526 enrollment file constitutes sufficient proof of notice. Any
1527 notice required to be given to the agency by this section must
1528 be sent to the agency at an address designated by rule.
1529 (7) When presenting a claim for payment under the Medicaid
1530 program, a provider has an affirmative duty to supervise the
1531 provision of, and be responsible for, goods and services claimed
1532 to have been provided, to supervise and be responsible for
1533 preparation and submission of the claim, and to present a claim
1534 that is true and accurate and that is for goods and services
1535 that:
1536 (a) Have actually been furnished to the recipient by the
1537 provider prior to submitting the claim.

1538 (b) Are Medicaid-covered goods or services that are
1539 medically necessary.
1540 (c) Are of a quality comparable to those furnished to the
1541 general public by the provider's peers.
1542 (d) Have not been billed in whole or in part to a recipient
1543 or a recipient's responsible party, except for such copayments,
1544 coinsurance, or deductibles as are authorized by the agency.
1545 (e) Are provided in accord with applicable provisions of
1546 all Medicaid rules, regulations, handbooks, and policies and in
1547 accordance with federal, state, and local law.
1548 (f) Are documented by records made at the time the goods or
1549 services were provided, demonstrating the medical necessity for
1550 the goods or services rendered. Medicaid goods or services are
1551 excessive or not medically necessary unless both the medical
1552 basis and the specific need for them are fully and properly
1553 documented in the recipient's medical record.
1554
1555 The agency shall deny payment or require repayment for goods or
1556 services that are not presented as required in this subsection.
1557 (8) The agency shall not reimburse any person or entity for
1558 any prescription for medications, medical supplies, or medical
1559 services if the prescription was written by a physician or other
1560 prescribing practitioner who is not enrolled in the Medicaid
1561 program. This section does not apply:
1562 (a) In instances involving bona fide emergency medical
1563 conditions as determined by the agency;
1564 (b) To a provider of medical services to a patient in a
1565 hospital emergency department, hospital inpatient or outpatient
1566 setting, or nursing home;

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1567 (c) To bona fide pro bono services by preapproved non-
1568 Medicaid providers as determined by the agency;
1569 (d) To prescribing physicians who are board-certified
1570 specialists treating Medicaid recipients referred for treatment
1571 by a treating physician who is enrolled in the Medicaid program;
1572 (e) To prescriptions written for dually eligible Medicare
1573 beneficiaries by an authorized Medicare provider who is not
1574 enrolled in the Medicaid program;
1575 (f) To other physicians who are not enrolled in the
1576 Medicaid program but who provide a medically necessary service
1577 or prescription not otherwise reasonably available from a
1578 Medicaid-enrolled physician; or
1579 (9) A Medicaid provider shall retain medical, professional,
1580 financial, and business records pertaining to services and goods
1581 furnished to a Medicaid recipient and billed to Medicaid for a
1582 period of 5 years after the date of furnishing such services or
1583 goods. The agency may investigate, review, or analyze such
1584 records, which must be made available during normal business
1585 hours. However, 24-hour notice must be provided if patient
1586 treatment would be disrupted. The provider must keep the agency
1587 informed of the location of the provider's Medicaid-related
1588 records. The authority of the agency to obtain Medicaid-related
1589 records from a provider is neither curtailed nor limited during
1590 a period of litigation between the agency and the provider.
1591 (10) Payments for the services of billing agents or persons
1592 participating in the preparation of a Medicaid claim shall not
1593 be based on amounts for which they bill nor based on the amount
1594 a provider receives from the Medicaid program.
1595 (11) The agency shall deny payment or require repayment for

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1596 inappropriate, medically unnecessary, or excessive goods or
1597 services from the person furnishing them, the person under whose
1598 supervision they were furnished, or the person causing them to
1599 be furnished.
1600 (12) The complaint and all information obtained pursuant to
1601 an investigation of a Medicaid provider, or the authorized
1602 representative or agent of a provider, relating to an allegation
1603 of fraud, abuse, or neglect are confidential and exempt from the
1604 provisions of s. 119.07(1):
1605 (a) Until the agency takes final agency action with respect
1606 to the provider and requires repayment of any overpayment, or
1607 imposes an administrative sanction;
1608 (b) Until the Attorney General refers the case for criminal
1609 prosecution;
1610 (c) Until 10 days after the complaint is determined without
1611 merit; or
1612 (d) At all times if the complaint or information is
1613 otherwise protected by law.
1614 (13) The agency shall terminate participation of a Medicaid
1615 provider in the Medicaid program and may seek civil remedies or
1616 impose other administrative sanctions against a Medicaid
1617 provider, if the provider or any principal, officer, director,
1618 agent, managing employee, or affiliated person of the provider,
1619 or any partner or shareholder having an ownership interest in
1620 the provider equal to 5 percent or greater, has been convicted
1621 of a criminal offense under federal law or the law of any state
1622 relating to the practice of the provider’s profession, or a
1623 criminal offense listed under s. 408.809(4), s. 409.907(10), or
1624 s. 435.04(2). If the agency determines that the provider did not

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1625 participate or acquiesce in the offense, termination will not be
1626 imposed. If the agency effects a termination under this
1627 subsection, the agency shall take final agency action.
1628 (14) If the provider has been suspended or terminated from
1629 participation in the Medicaid program or the Medicare program by
1630 the Federal Government or any state, the agency must immediately
1631 suspend or terminate, as appropriate, the provider's
1632 participation in this state's Medicaid program for a period no
1633 less than that imposed by the Federal Government or any other
1634 state, and may not enroll such provider in this state's Medicaid
1635 program while such foreign suspension or termination remains in
1636 effect. The agency shall also immediately suspend or terminate,
1637 as appropriate, a provider's participation in this state's
1638 Medicaid program if the provider participated or acquiesced in
1639 any action for which any principal, officer, director, agent,
1640 managing employee, or affiliated person of the provider, or any
1641 partner or shareholder having an ownership interest in the
1642 provider equal to 5 percent or greater, was suspended or
1643 terminated from participating in the Medicaid program or the
1644 Medicare program by the Federal Government or any state. This
1645 sanction is in addition to all other remedies provided by law.
1646 (15) The agency shall seek a remedy provided by law,
1647 including, but not limited to, any remedy provided in
1648 subsections (13) and (16) and s. 812.035, if:
1649 (a) The provider's license has not been renewed, or has
1650 been revoked, suspended, or terminated, for cause, by the
1651 licensing agency of any state;
1652 (b) The provider has failed to make available or has
1653 refused access to Medicaid-related records to an auditor,

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1654 investigator, or other authorized employee or agent of the
1655 agency, the Attorney General, a state attorney, or the Federal
1656 Government;
1657 (c) The provider has not furnished or has failed to make
1658 available such Medicaid-related records as the agency has found
1659 necessary to determine whether Medicaid payments are or were due
1660 and the amounts thereof;
1661 (d) The provider has failed to maintain medical records
1662 made at the time of service, or prior to service if prior
1663 authorization is required, demonstrating the necessity and
1664 appropriateness of the goods or services rendered;
1665 (e) The provider is not in compliance with provisions of
1666 Medicaid provider publications that have been adopted by
1667 reference as rules in the Florida Administrative Code; with
1668 provisions of state or federal laws, rules, or regulations; with
1669 provisions of the provider agreement between the agency and the
1670 provider; or with certifications found on claim forms or on
1671 transmittal forms for electronically submitted claims that are
1672 submitted by the provider or authorized representative, as such
1673 provisions apply to the Medicaid program;
1674 (f) The provider or person who ordered, authorized, or
1675 prescribed the care, services, or supplies has furnished, or
1676 ordered or authorized the furnishing of, goods or services to a
1677 recipient which are inappropriate, unnecessary, excessive, or
1678 harmful to the recipient or are of inferior quality;
1679 (g) The provider has demonstrated a pattern of failure to
1680 provide goods or services that are medically necessary;
1681 (h) The provider or an authorized representative of the
1682 provider, or a person who ordered, authorized, or prescribed the

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1683 goods or services, has submitted or caused to be submitted false
1684 or a pattern of erroneous Medicaid claims;
1685 (i) The provider or an authorized representative of the
1686 provider, or a person who has ordered, authorized, or prescribed
1687 the goods or services, has submitted or caused to be submitted a
1688 Medicaid provider enrollment application, a request for prior
1689 authorization for Medicaid services, a drug exception request,
1690 or a Medicaid cost report that contains materially false or
1691 incorrect information;
1692 (j) The provider or an authorized representative of the
1693 provider has collected from or billed a recipient or a
1694 recipient's responsible party improperly for amounts that should
1695 not have been so collected or billed by reason of the provider's
1696 billing the Medicaid program for the same service;
1697 (k) The provider or an authorized representative of the
1698 provider has included in a cost report costs that are not
1699 allowable under a Florida Title XIX reimbursement plan after the
1700 provider or authorized representative had been advised in an
1701 audit exit conference or audit report that the costs were not
1702 allowable;
1703 (l) The provider is charged by information or indictment
1704 with fraudulent billing practices or an offense referenced in
1705 subsection (13). The sanction applied for this reason is limited
1706 to suspension of the provider's participation in the Medicaid
1707 program for the duration of the indictment unless the provider
1708 is found guilty pursuant to the information or indictment;
1709 (m) The provider or a person who ordered, authorized, or
1710 prescribed the goods or services is found liable for negligent
1711 practice resulting in death or injury to the provider's patient;

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1712 (n) The provider fails to demonstrate that it had available
1713 during a specific audit or review period sufficient quantities
1714 of goods, or sufficient time in the case of services, to support
1715 the provider’s billings to the Medicaid program;
1716 (o) The provider has failed to comply with the notice and
1717 reporting requirements of s. 409.907;
1718 (p) The agency has received reliable information of patient
1719 abuse or neglect or of any act prohibited by s. 409.920; or
1720 (q) The provider has failed to comply with an agreed-upon
1721 repayment schedule.
1722
1723 A provider is subject to sanctions for violations of this
1724 subsection as the result of actions or inactions of the
1725 provider, or actions or inactions of any principal, officer,
1726 director, agent, managing employee, or affiliated person of the
1727 provider, or any partner or shareholder having an ownership
1728 interest in the provider equal to 5 percent or greater, in which
1729 the provider participated or acquiesced.
1730 (16) The agency shall impose any of the following sanctions
1731 or disincentives on a provider or a person for any of the acts
1732 described in subsection (15):
1733 (a) Suspension for a specific period of time of not more
1734 than 1 year. Suspension precludes participation in the Medicaid
1735 program, which includes any action that results in a claim for
1736 payment to the Medicaid program for furnishing, supervising a
1737 person who is furnishing, or causing a person to furnish goods
1738 or services.
1739 (b) Termination for a specific period of time ranging from
1740 more than 1 year to 20 years. Termination precludes

1741 participation in the Medicaid program, which includes any action
1742 that results in a claim for payment to the Medicaid program for
1743 furnishing, supervising a person who is furnishing, or causing a
1744 person to furnish goods or services.
1745 (c) Imposition of a fine of up to $5,000 for each
1746 violation. Each day that an ongoing violation continues, such as
1747 refusing to furnish Medicaid-related records or refusing access
1748 to records, is considered a separate violation. Each instance of
1749 improper billing of a Medicaid recipient; each instance of
1750 including an unallowable cost on a hospital or nursing home
1751 Medicaid cost report after the provider or authorized
1752 representative has been advised in an audit exit conference or
1753 previous audit report of the cost unallowability; each instance
1754 of furnishing a Medicaid recipient goods or professional
1755 services that are inappropriate or of inferior quality as
1756 determined by competent peer judgment; each instance of
1757 knowingly submitting a materially false or erroneous Medicaid
1758 provider enrollment application, request for prior authorization
1759 for Medicaid services, drug exception request, or cost report;
1760 each instance of inappropriate prescribing of drugs for a
1761 Medicaid recipient as determined by competent peer judgment; and
1762 each false or erroneous Medicaid claim leading to an overpayment
1763 to a provider is considered a separate violation.
1764 (d) Immediate suspension, if the agency has received
1765 information of patient abuse or neglect or of any act prohibited
1766 by s. 409.920. Upon suspension, the agency must issue an
1767 immediate final order under s. 120.569(2)(n).
1768 (e) A fine, not to exceed $10,000, for a violation of
1769 paragraph (15)(i).

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1770 (f) Imposition of liens against provider assets, including,
1771 but not limited to, financial assets and real property, not to
1772 exceed the amount of fines or recoveries sought, upon entry of
1773 an order determining that such moneys are due or recoverable.
1774 (g) Prepayment reviews of claims for a specified period of
1775 time.
1776 (h) Comprehensive followup reviews of providers every 6
1777 months to ensure that they are billing Medicaid correctly.
1778 (i) Corrective-action plans that remain in effect for up to
1779 3 years and that are monitored by the agency every 6 months
1780 while in effect.
1781 (j) Other remedies as permitted by law to effect the
1782 recovery of a fine or overpayment.
1783
1784 If a provider voluntarily relinquishes its Medicaid provider
1785 number or an associated license, or allows the associated
1786 licensure to expire after receiving written notice that the
1787 agency is conducting, or has conducted, an audit, survey,
1788 inspection, or investigation and that a sanction of suspension
1789 or termination will or would be imposed for noncompliance
1790 discovered as a result of the audit, survey, inspection, or
1791 investigation, the agency shall impose the sanction of
1792 termination for cause against the provider. The agency's
1793 termination with cause is subject to hearing rights as may be
1794 provided under chapter 120. The Secretary of Health Care
1795 Administration may make a determination that imposition of a
1796 sanction or disincentive is not in the best interest of the
1797 Medicaid program, in which case a sanction or disincentive may
1798 not be imposed.

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1799 (17) In determining the appropriate administrative sanction
1800 to be applied, or the duration of any suspension or termination,
1801 the agency shall consider:
1802 (a) The seriousness and extent of the violation or
1803 violations.
1804 (b) Any prior history of violations by the provider
1805 relating to the delivery of health care programs which resulted
1806 in either a criminal conviction or in administrative sanction or
1807 penalty.
1808 (c) Evidence of continued violation within the provider's
1809 management control of Medicaid statutes, rules, regulations, or
1810 policies after written notification to the provider of improper
1811 practice or instance of violation.
1812 (d) The effect, if any, on the quality of medical care
1813 provided to Medicaid recipients as a result of the acts of the
1814 provider.
1815 (e) Any action by a licensing agency respecting the
1816 provider in any state in which the provider operates or has
1817 operated.
1818 (f) The apparent impact on access by recipients to Medicaid
1819 services if the provider is suspended or terminated, in the best
1820 judgment of the agency.
1821
1822 The agency shall document the basis for all sanctioning actions
1823 and recommendations.
1824 (18) The agency may take action to sanction, suspend, or
1825 terminate a particular provider working for a group provider,
1826 and may suspend or terminate Medicaid participation at a
1827 specific location, rather than or in addition to taking action

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1828 against an entire group.
1829 (19) The agency shall establish a process for conducting
1830 followup reviews of a sampling of providers who have a history
1831 of overpayment under the Medicaid program. This process must
1832 consider the magnitude of previous fraud or abuse and the
1833 potential effect of continued fraud or abuse on Medicaid costs.
1834 (20) In making a determination of overpayment to a
1835 provider, the agency must use accepted and valid auditing,
1836 accounting, analytical, statistical, or peer-review methods, or
1837 combinations thereof. Appropriate statistical methods may
1838 include, but are not limited to, sampling and extension to the
1839 population, parametric and nonparametric statistics, tests of
1840 hypotheses, and other generally accepted statistical methods.
1841 Appropriate analytical methods may include, but are not limited
1842 to, reviews to determine variances between the quantities of
1843 products that a provider had on hand and available to be
1844 purveyed to Medicaid recipients during the review period and the
1845 quantities of the same products paid for by the Medicaid program
1846 for the same period, taking into appropriate consideration sales
1847 of the same products to non-Medicaid customers during the same
1848 period. In meeting its burden of proof in any administrative or
1849 court proceeding, the agency may introduce the results of such
1850 statistical methods as evidence of overpayment.
1851 (21) When making a determination that an overpayment has
1852 occurred, the agency shall prepare and issue an audit report to
1853 the provider showing the calculation of overpayments. The
1854 agency’s determination must be based solely upon information
1855 available to it before issuance of the audit report and, in the
1856 case of documentation obtained to substantiate claims for

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1857 Medicaid reimbursement, based solely upon contemporaneous
1858 records. The agency may consider addenda or modifications to a
1859 note that was made contemporaneously with the patient care
1860 episode if the addenda or modifications are germane to the note.
1861 (22) The audit report, supported by agency work papers,
1862 showing an overpayment to a provider constitutes evidence of the
1863 overpayment. A provider may not present or elicit testimony on
1864 direct examination or cross-examination in any court or
1865 administrative proceeding, regarding the purchase or acquisition
1866 by any means of drugs, goods, or supplies; sales or divestment
1867 by any means of drugs, goods, or supplies; or inventory of
1868 drugs, goods, or supplies, unless such acquisition, sales,
1869 divestment, or inventory is documented by written invoices,
1870 written inventory records, or other competent written
1871 documentary evidence maintained in the normal course of the
1872 provider's business. A provider may not present records to
1873 contest an overpayment or sanction unless such records are
1874 contemporaneous and, if requested during the audit process, were
1875 furnished to the agency or its agent upon request. This
1876 limitation does not apply to Medicaid cost report audits. This
1877 limitation does not preclude consideration by the agency of
1878 addenda or modifications to a note if the addenda or
1879 modifications are made before notification of the audit, the
1880 addenda or modifications are germane to the note, and the note
1881 was made contemporaneously with a patient care episode.
1882 Notwithstanding the applicable rules of discovery, all
1883 documentation to be offered as evidence at an administrative
1884 hearing on a Medicaid overpayment or an administrative sanction
1885 must be exchanged by all parties at least 14 days before the

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1886 administrative hearing or be excluded from consideration.
1887 (23)(a) In an audit, ~~or~~ investigation, or enforcement
1888 action taken for ~~of~~ a violation committed by a provider which is
1889 conducted pursuant to this section, the agency is entitled to
1890 recover all investigative and~~,~~ legal costs incurred as a result
1891 of such audit, investigation, or enforcement action. The costs
1892 associated with an investigation, audit, or enforcement action
1893 may include, but are not limited to, salaries and benefits of
1894 personnel, costs related to the time spent by an attorney and
1895 other personnel working on the case, and any other expenses
1896 incurred by the agency or contractor which are associated with
1897 the case, including any~~, and~~ expert witness costs and attorney
1898 fees incurred on behalf of the agency or contractor if the
1899 agency's findings were not contested by the provider or, if
1900 contested, the agency ultimately prevailed.
1901 (b) The agency has the burden of documenting the costs,
1902 which include salaries and employee benefits and out-of-pocket
1903 expenses. The amount of costs that may be recovered must be
1904 reasonable in relation to the seriousness of the violation and
1905 must be set taking into consideration the financial resources,
1906 earning ability, and needs of the provider, who has the burden
1907 of demonstrating such factors.
1908 (c) The provider may pay the costs over a period to be
1909 determined by the agency if the agency determines that an
1910 extreme hardship would result to the provider from immediate
1911 full payment. Any default in payment of costs may be collected
1912 by any means authorized by law.
1913 (24) If the agency imposes an administrative sanction
1914 pursuant to subsection (13), subsection (14), or subsection

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1915 (15), except paragraphs (15)(e) and (o), upon any provider or
1916 any principal, officer, director, agent, managing employee, or
1917 affiliated person of the provider who is regulated by another
1918 state entity, the agency shall notify that other entity of the
1919 imposition of the sanction within 5 business days. Such
1920 notification must include the provider's or person's name and
1921 license number and the specific reasons for sanction.
1922 (25)(a) The agency shall withhold Medicaid payments, in
1923 whole or in part, to a provider upon receipt of reliable
1924 evidence that the circumstances giving rise to the need for a
1925 withholding of payments involve fraud, willful
1926 misrepresentation, or abuse under the Medicaid program, or a
1927 crime committed while rendering goods or services to Medicaid
1928 recipients. If it is determined that fraud, willful
1929 misrepresentation, abuse, or a crime did not occur, the payments
1930 withheld must be paid to the provider within 14 days after such
1931 determination. Amounts not paid within 14 days accrue interest
1932 at the rate of 10 percent per year, beginning after the 14th
1933 day.
1934 (b) The agency shall deny payment, or require repayment, if
1935 the goods or services were furnished, supervised, or caused to
1936 be furnished by a person who has been suspended or terminated
1937 from the Medicaid program or Medicare program by the Federal
1938 Government or any state.
1939 (c) Overpayments owed to the agency bear interest at the
1940 rate of 10 percent per year from the date of final determination
1941 of the overpayment by the agency, and payment arrangements must
1942 be made within 30 days after the date of the final order, which
1943 is not subject to further appeal.

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1944 (d) The agency, upon entry of a final agency order, a
1945 judgment or order of a court of competent jurisdiction, or a
1946 stipulation or settlement, may collect the moneys owed by all
1947 means allowable by law, including, but not limited to, notifying
1948 any fiscal intermediary of Medicare benefits that the state has
1949 a superior right of payment. Upon receipt of such written
1950 notification, the Medicare fiscal intermediary shall remit to
1951 the state the sum claimed.
1952 (e) The agency may institute amnesty programs to allow
1953 Medicaid providers the opportunity to voluntarily repay
1954 overpayments. The agency may adopt rules to administer such
1955 programs.
1956 (26) The agency may impose administrative sanctions against
1957 a Medicaid recipient, or the agency may seek any other remedy
1958 provided by law, including, but not limited to, the remedies
1959 provided in s. 812.035, if the agency finds that a recipient has
1960 engaged in solicitation in violation of s. 409.920 or that the
1961 recipient has otherwise abused the Medicaid program.
1962 (27) When the Agency for Health Care Administration has
1963 made a probable cause determination and alleged that an
1964 overpayment to a Medicaid provider has occurred, the agency,
1965 after notice to the provider, shall:
1966 (a) Withhold, and continue to withhold during the pendency
1967 of an administrative hearing pursuant to chapter 120, any
1968 medical assistance reimbursement payments until such time as the
1969 overpayment is recovered, unless within 30 days after receiving
1970 notice thereof the provider:
1971 1. Makes repayment in full; or
1972 2. Establishes a repayment plan that is satisfactory to the

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1973 Agency for Health Care Administration.
1974 (b) Withhold, and continue to withhold during the pendency
1975 of an administrative hearing pursuant to chapter 120, medical
1976 assistance reimbursement payments if the terms of a repayment
1977 plan are not adhered to by the provider.
1978 (28) Venue for all Medicaid program integrity cases lies in
1979 Leon County, at the discretion of the agency.
1980 (29) Notwithstanding other provisions of law, the agency
1981 and the Medicaid Fraud Control Unit of the Department of Legal
1982 Affairs may review a provider’s Medicaid-related and non-
1983 Medicaid-related records in order to determine the total output
1984 of a provider’s practice to reconcile quantities of goods or
1985 services billed to Medicaid with quantities of goods or services
1986 used in the provider’s total practice.
1987 (30) The agency shall terminate a provider’s participation
1988 in the Medicaid program if the provider fails to reimburse an
1989 overpayment or pay an agency-imposed fine that has been
1990 determined by final order, not subject to further appeal, within
1991 30 days after the date of the final order, unless the provider
1992 and the agency have entered into a repayment agreement.
1993 (31) If a provider requests an administrative hearing
1994 pursuant to chapter 120, such hearing must be conducted within
1995 90 days following assignment of an administrative law judge,
1996 absent exceptionally good cause shown as determined by the
1997 administrative law judge or hearing officer. Upon issuance of a
1998 final order, the outstanding balance of the amount determined to
1999 constitute the overpayment and fines is due. If a provider fails
2000 to make payments in full, fails to enter into a satisfactory
2001 repayment plan, or fails to comply with the terms of a repayment

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2002 plan or settlement agreement, the agency shall withhold
2003 reimbursement payments for Medicaid services until the amount
2004 due is paid in full.
2005 (32) Duly authorized agents and employees of the agency
2006 shall have the power to inspect, during normal business hours,
2007 the records of any pharmacy, wholesale establishment, or
2008 manufacturer, or any other place in which drugs and medical
2009 supplies are manufactured, packed, packaged, made, stored, sold,
2010 or kept for sale, for the purpose of verifying the amount of
2011 drugs and medical supplies ordered, delivered, or purchased by a
2012 provider. The agency shall provide at least 2 business days'
2013 prior notice of any such inspection. The notice must identify
2014 the provider whose records will be inspected, and the inspection
2015 shall include only records specifically related to that
2016 provider.
2017 (33) In accordance with federal law, Medicaid recipients
2018 convicted of a crime pursuant to 42 U.S.C. s. 1320a-7b may be
2019 limited, restricted, or suspended from Medicaid eligibility for
2020 a period not to exceed 1 year, as determined by the agency head
2021 or designee.
2022 (34) To deter fraud and abuse in the Medicaid program, the
2023 agency may limit the number of Schedule II and Schedule III
2024 refill prescription claims submitted from a pharmacy provider.
2025 The agency shall limit the allowable amount of reimbursement of
2026 prescription refill claims for Schedule II and Schedule III
2027 pharmaceuticals if the agency or the Medicaid Fraud Control Unit
2028 determines that the specific prescription refill was not
2029 requested by the Medicaid recipient or authorized representative
2030 for whom the refill claim is submitted or was not prescribed by

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2031 the recipient’s medical provider or physician. Any such refill
2032 request must be consistent with the original prescription.
2033 (35) The Office of Program Policy Analysis and Government
2034 Accountability shall provide a report to the President of the
2035 Senate and the Speaker of the House of Representatives on a
2036 biennial basis, beginning January 31, 2006, on the agency’s
2037 efforts to prevent, detect, and deter, as well as recover funds
2038 lost to, fraud and abuse in the Medicaid program.
2039 (36) The agency may provide to a sample of Medicaid
2040 recipients or their representatives through the distribution of
2041 explanations of benefits information about services reimbursed
2042 by the Medicaid program for goods and services to such
2043 recipients, including information on how to report inappropriate
2044 or incorrect billing to the agency or other law enforcement
2045 entities for review or investigation, information on how to
2046 report criminal Medicaid fraud to the Medicaid Fraud Control
2047 Unit’s toll-free hotline number, and information about the
2048 rewards available under s. 409.9203. The explanation of benefits
2049 may not be mailed for Medicaid independent laboratory services
2050 as described in s. 409.905(7) or for Medicaid certified match
2051 services as described in ss. 409.9071 and 1011.70.
2052 (37) The agency shall post on its website a current list of
2053 each Medicaid provider, including any principal, officer,
2054 director, agent, managing employee, or affiliated person of the
2055 provider, or any partner or shareholder having an ownership
2056 interest in the provider equal to 5 percent or greater, who has
2057 been terminated for cause from the Medicaid program or
2058 sanctioned under this section. The list must be searchable by a
2059 variety of search parameters and provide for the creation of

2060 formatted lists that may be printed or imported into other
2061 applications, including spreadsheets. The agency shall update
2062 the list at least monthly.
2063 (38) In order to improve the detection of health care
2064 fraud, use technology to prevent and detect fraud, and maximize
2065 the electronic exchange of health care fraud information, the
2066 agency shall:
2067 (a) Compile, maintain, and publish on its website a
2068 detailed list of all state and federal databases that contain
2069 health care fraud information and update the list at least
2070 biannually;
2071 (b) Develop a strategic plan to connect all databases that
2072 contain health care fraud information to facilitate the
2073 electronic exchange of health information between the agency,
2074 the Department of Health, the Department of Law Enforcement, and
2075 the Attorney General's Office. The plan must include recommended
2076 standard data formats, fraud identification strategies, and
2077 specifications for the technical interface between state and
2078 federal health care fraud databases;
2079 (c) Monitor innovations in health information technology,
2080 specifically as it pertains to Medicaid fraud prevention and
2081 detection; and
2082 (d) Periodically publish policy briefs that highlight
2083 available new technology to prevent or detect health care fraud
2084 and projects implemented by other states, the private sector, or
2085 the Federal Government which use technology to prevent or detect
2086 health care fraud.
2087 Section 38. Subsection (1) of section 409.967, Florida
2088 Statutes, is amended to read:

2089 409.967 Managed care plan accountability.—
2090 (1) Beginning with the contract procurement process
2091 initiated during the 2023 calendar year, the agency shall
2092 establish a 6-year ~~5-year~~ contract with each managed care plan
2093 selected through the procurement process described in s.
2094 409.966. A plan contract may not be renewed; however, the agency
2095 may extend the term of a plan contract to cover any delays
2096 during the transition to a new plan. The agency shall extend
2097 until December 31, 2024, the term of existing plan contracts
2098 awarded pursuant to the invitation to negotiate published in
2099 July 2017.
2100 Section 39. Subsection (6) of section 429.11, Florida
2101 Statutes, is amended to read:
2102 429.11 Initial application for license; provisional
2103 license.—
2104 ~~(6) In addition to the license categories available in s.~~
2105 ~~408.808, a provisional license may be issued to an applicant~~
2106 ~~making initial application for licensure or making application~~
2107 ~~for a change of ownership. A provisional license shall be~~
2108 ~~limited in duration to a specific period of time not to exceed 6~~
2109 ~~months, as determined by the agency.~~
2110 Section 40. Subsection (9) of section 429.19, Florida
2111 Statutes, is amended to read:
2112 429.19 Violations; imposition of administrative fines;
2113 grounds.—
2114 ~~(9) The agency shall develop and disseminate an annual list~~
2115 ~~of all facilities sanctioned or fined for violations of state~~
2116 ~~standards, the number and class of violations involved, the~~
2117 ~~penalties imposed, and the current status of cases. The list~~

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2118 ~~shall be disseminated, at no charge, to the Department of~~
2119 ~~Elderly Affairs, the Department of Health, the Department of~~
2120 ~~Children and Families, the Agency for Persons with Disabilities,~~
2121 ~~the area agencies on aging, the Florida Statewide Advocacy~~
2122 ~~Council, the State Long-Term Care Ombudsman Program, and state~~
2123 ~~and local ombudsman councils. The Department of Children and~~
2124 ~~Families shall disseminate the list to service providers under~~
2125 ~~contract to the department who are responsible for referring~~
2126 ~~persons to a facility for residency. The agency may charge a fee~~
2127 ~~commensurate with the cost of printing and postage to other~~
2128 ~~interested parties requesting a copy of this list. This~~
2129 ~~information may be provided electronically or through the~~
2130 ~~agency's Internet site.~~
2131 Section 41. Subsection (2) of section 429.35, Florida
2132 Statutes, is amended to read:
2133 429.35 Maintenance of records; reports.—
2134 (2) Within 60 days after the date of <u>an</u> ~~the biennial~~
2135 inspection <u>conducted</u> ~~visit required~~ under s. 408.811 or within
2136 30 days after the date of <u>an</u> ~~any~~ interim visit, the agency shall
2137 forward the results of the inspection to the local ombudsman
2138 council in the district where the facility is located; to at
2139 least one public library or, in the absence of a public library,
2140 the county seat in the county in which the inspected assisted
2141 living facility is located; and, when appropriate, to the
2142 district Adult Services and Mental Health Program Offices.
2143 Section 42. Subsection (2) of section 429.905, Florida
2144 Statutes, is amended to read:
2145 429.905 Exemptions; monitoring of adult day care center
2146 programs colocated with assisted living facilities or licensed

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2147 nursing home facilities.—
2148 (2) A licensed assisted living facility, a licensed
2149 hospital, or a licensed nursing home facility may provide
2150 services during the day which include, but are not limited to,
2151 social, health, therapeutic, recreational, nutritional, and
2152 respite services, to adults who are not residents. Such a
2153 facility need not be licensed as an adult day care center;
2154 however, the agency must monitor the facility during the regular
2155 inspection ~~and at least biennially~~ to ensure adequate space and
2156 sufficient staff. If an assisted living facility, a hospital, or
2157 a nursing home holds itself out to the public as an adult day
2158 care center, it must be licensed as such and meet all standards
2159 prescribed by statute and rule. For the purpose of this
2160 subsection, the term "day" means any portion of a 24-hour day.
2161 Section 43. Section 429.929, Florida Statutes, is amended
2162 to read:
2163 429.929 Rules establishing standards.—
2164 ~~(1)~~ The agency shall adopt rules to implement this part.
2165 The rules must include reasonable and fair standards. Any
2166 conflict between these standards and those that may be set forth
2167 in local, county, or municipal ordinances shall be resolved in
2168 favor of those having statewide effect. Such standards must
2169 relate to:
2170 <u>(1)</u>~~(a)~~ The maintenance of adult day care centers with
2171 respect to plumbing, heating, lighting, ventilation, and other
2172 building conditions, including adequate meeting space, to ensure
2173 the health, safety, and comfort of participants and protection
2174 from fire hazard. Such standards may not conflict with chapter
2175 553 and must be based upon the size of the structure and the

2176 number of participants.
2177 (2) ~~(b)~~ The number and qualifications of all personnel
2178 employed by adult day care centers who have responsibilities for
2179 the care of participants.
2180 (3) ~~(c)~~ All sanitary conditions within adult day care
2181 centers and their surroundings, including water supply, sewage
2182 disposal, food handling, and general hygiene, and maintenance of
2183 sanitary conditions, to ensure the health and comfort of
2184 participants.
2185 (4) ~~(d)~~ Basic services provided by adult day care centers.
2186 (5) ~~(e)~~ Supportive and optional services provided by adult
2187 day care centers.
2188 (6) ~~(f)~~ Data and information relative to participants and
2189 programs of adult day care centers, including, but not limited
2190 to, the physical and mental capabilities and needs of the
2191 participants, the availability, frequency, and intensity of
2192 basic services and of supportive and optional services provided,
2193 the frequency of participation, the distances traveled by
2194 participants, the hours of operation, the number of referrals to
2195 other centers or elsewhere, and the incidence of illness.
2196 (7) ~~(g)~~ Components of a comprehensive emergency management
2197 plan, developed in consultation with the Department of Health
2198 and the Division of Emergency Management.
2199 ~~(2) Pursuant to this part, s. 408.811, and applicable~~
2200 ~~rules, the agency may conduct an abbreviated biennial inspection~~
2201 ~~of key quality-of-care standards, in lieu of a full inspection,~~
2202 ~~of a center that has a record of good performance. However, the~~
2203 ~~agency must conduct a full inspection of a center that has had~~
2204 ~~one or more confirmed complaints within the licensure period~~

2205 ~~immediately preceding the inspection or which has a serious~~
2206 ~~problem identified during the abbreviated inspection. The agency~~
2207 ~~shall develop the key quality-of-care standards, taking into~~
2208 ~~consideration the comments and recommendations of provider~~
2209 ~~groups. These standards shall be included in rules adopted by~~
2210 ~~the agency.~~
2211 Section 44. Part I of chapter 483, Florida Statutes, is
2212 repealed, and part II and part III of that chapter are
2213 redesignated as part I and part II, respectively.
2214 Section 45. Paragraph (g) of subsection (3) of section
2215 20.43, Florida Statutes, is amended to read:
2216 20.43 Department of Health.—There is created a Department
2217 of Health.
2218 (3) The following divisions of the Department of Health are
2219 established:
2220 (g) Division of Medical Quality Assurance, which is
2221 responsible for the following boards and professions established
2222 within the division:
2223 1. The Board of Acupuncture, created under chapter 457.
2224 2. The Board of Medicine, created under chapter 458.
2225 3. The Board of Osteopathic Medicine, created under chapter
2226 459.
2227 4. The Board of Chiropractic Medicine, created under
2228 chapter 460.
2229 5. The Board of Podiatric Medicine, created under chapter
2230 461.
2231 6. Naturopathy, as provided under chapter 462.
2232 7. The Board of Optometry, created under chapter 463.
2233 8. The Board of Nursing, created under part I of chapter

2234 464.

2235 9. Nursing assistants, as provided under part II of chapter
2236 464.

2237 10. The Board of Pharmacy, created under chapter 465.

2238 11. The Board of Dentistry, created under chapter 466.

2239 12. Midwifery, as provided under chapter 467.

2240 13. The Board of Speech-Language Pathology and Audiology,
2241 created under part I of chapter 468.

2242 14. The Board of Nursing Home Administrators, created under
2243 part II of chapter 468.

2244 15. The Board of Occupational Therapy, created under part
2245 III of chapter 468.

2246 16. Respiratory therapy, as provided under part V of
2247 chapter 468.

2248 17. Dietetics and nutrition practice, as provided under
2249 part X of chapter 468.

2250 18. The Board of Athletic Training, created under part XIII
2251 of chapter 468.

2252 19. The Board of Orthotists and Prosthetists, created under
2253 part XIV of chapter 468.

2254 20. Electrolysis, as provided under chapter 478.

2255 21. The Board of Massage Therapy, created under chapter
2256 480.

2257 22. The Board of Clinical Laboratory Personnel, created
2258 under part I ~~part II~~ of chapter 483.

2259 23. Medical physicists, as provided under part II ~~part III~~
2260 of chapter 483.

2261 24. The Board of Opticianry, created under part I of
2262 chapter 484.

2263 25. The Board of Hearing Aid Specialists, created under
2264 part II of chapter 484.
2265 26. The Board of Physical Therapy Practice, created under
2266 chapter 486.
2267 27. The Board of Psychology, created under chapter 490.
2268 28. School psychologists, as provided under chapter 490.
2269 29. The Board of Clinical Social Work, Marriage and Family
2270 Therapy, and Mental Health Counseling, created under chapter
2271 491.
2272 30. Emergency medical technicians and paramedics, as
2273 provided under part III of chapter 401.
2274 Section 46. Subsection (3) of section 381.0034, Florida
2275 Statutes, is amended to read:
2276 381.0034 Requirement for instruction on HIV and AIDS.—
2277 (3) The department shall require, as a condition of
2278 granting a license under chapter 467 or part I ~~part II~~ of
2279 chapter 483, that an applicant making initial application for
2280 licensure complete an educational course acceptable to the
2281 department on human immunodeficiency virus and acquired immune
2282 deficiency syndrome. Upon submission of an affidavit showing
2283 good cause, an applicant who has not taken a course at the time
2284 of licensure shall be allowed 6 months to complete this
2285 requirement.
2286 Section 47. Subsection (4) of section 456.001, Florida
2287 Statutes, is amended to read:
2288 456.001 Definitions.—As used in this chapter, the term:
2289 (4) “Health care practitioner” means any person licensed
2290 under chapter 457; chapter 458; chapter 459; chapter 460;
2291 chapter 461; chapter 462; chapter 463; chapter 464; chapter 465;

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

2292 chapter 466; chapter 467; part I, part II, part III, part V,
2293 part X, part XIII, or part XIV of chapter 468; chapter 478;
2294 chapter 480; part I or part II ~~part II or part III~~ of chapter
2295 483; chapter 484; chapter 486; chapter 490; or chapter 491.
2296 Section 48. Paragraphs (h) and (i) of subsection (2) of
2297 section 456.057, Florida Statutes, are amended to read:
2298 456.057 Ownership and control of patient records; report or
2299 copies of records to be furnished; disclosure of information.—
2300 (2) As used in this section, the terms “records owner,”
2301 “health care practitioner,” and “health care practitioner’s
2302 employer” do not include any of the following persons or
2303 entities; furthermore, the following persons or entities are not
2304 authorized to acquire or own medical records, but are authorized
2305 under the confidentiality and disclosure requirements of this
2306 section to maintain those documents required by the part or
2307 chapter under which they are licensed or regulated:
2308 (h) Clinical laboratory personnel licensed under part I
2309 ~~part II~~ of chapter 483.
2310 (i) Medical physicists licensed under part II ~~part III~~ of
2311 chapter 483.
2312 Section 49. Paragraph (j) of subsection (1) of section
2313 456.076, Florida Statutes, is amended to read:
2314 456.076 Impaired practitioner programs.—
2315 (1) As used in this section, the term:
2316 (j) “Practitioner” means a person licensed, registered,
2317 certified, or regulated by the department under part III of
2318 chapter 401; chapter 457; chapter 458; chapter 459; chapter 460;
2319 chapter 461; chapter 462; chapter 463; chapter 464; chapter 465;
2320 chapter 466; chapter 467; part I, part II, part III, part V,

2321 part X, part XIII, or part XIV of chapter 468; chapter 478;
2322 chapter 480; part I or part II ~~part II or part III~~ of chapter
2323 483; chapter 484; chapter 486; chapter 490; or chapter 491; or
2324 an applicant for a license, registration, or certification under
2325 the same laws.
2326 Section 50. Paragraph (b) of subsection (1) of section
2327 456.47, Florida Statutes, is amended to read:
2328 456.47 Use of telehealth to provide services.—
2329 (1) DEFINITIONS.—As used in this section, the term:
2330 (b) "Telehealth provider" means any individual who provides
2331 health care and related services using telehealth and who is
2332 licensed or certified under s. 393.17; part III of chapter 401;
2333 chapter 457; chapter 458; chapter 459; chapter 460; chapter 461;
2334 chapter 463; chapter 464; chapter 465; chapter 466; chapter 467;
2335 part I, part III, part IV, part V, part X, part XIII, or part
2336 XIV of chapter 468; chapter 478; chapter 480; part I or part II
2337 ~~part II or part III~~ of chapter 483; chapter 484; chapter 486;
2338 chapter 490; or chapter 491; who is licensed under a multistate
2339 health care licensure compact of which Florida is a member
2340 state; or who is registered under and complies with subsection
2341 (4).
2342 Section 51. Except as otherwise expressly provided in this
2343 act and except for this section, which shall become effective
2344 upon this act becoming a law, this act shall take effect July 1,
2345 2020.