COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	____	(Y/N)
ADOPTED AS AMENDED	____	(Y/N)
ADOPTED W/O OBJECTION	____	(Y/N)
FAILED TO ADOPT	____	(Y/N)
WITHDRAWN	____	(Y/N)
OTHER		

Committee/Subcommittee hearing bill: Health Market Reform Subcommittee

Representative Perez offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Subsections (2) and (4) of section 383.327, Florida Statutes, are amended to read:

383.327 Birth and death records; reports.—

(2) Each maternal death, newborn death, and stillbirth shall be reported immediately to the medical examiner and the agency.

(4) A report shall be submitted ~~annually~~ to the agency. The contents of the report and the frequency at which it is submitted shall be prescribed by rule of the agency.

16 Section 2. Subsection (4) of section 395.003, Florida
17 Statutes, is amended to read:
18 395.003 Licensure; denial, suspension, and revocation.—
19 (4) The agency shall issue a license that ~~which~~ specifies
20 the service categories and the number of hospital beds in each
21 bed category for which a license is received. Such information
22 shall be listed on the face of the license. ~~All beds which are~~
23 ~~not covered by any specialty-bed-need methodology shall be~~
24 ~~specified as general beds.~~ A licensed facility shall not operate
25 a number of hospital beds greater than the number indicated by
26 the agency on the face of the license without approval from the
27 agency under conditions established by rule.
28 Section 3. Section 395.7015, Florida Statutes, is
29 repealed.
30 Section 4. Section 395.7016, Florida Statutes, is amended
31 to read:
32 395.7016 Annual appropriation.—The Legislature shall
33 appropriate each fiscal year from either the General Revenue
34 Fund or the Agency for Health Care Administration Tobacco
35 Settlement Trust Fund an amount sufficient to replace the funds
36 lost due to ~~reduction by chapter 2000-256, Laws of Florida, of~~
37 ~~the assessment on other health care entities under s. 395.7015,~~
38 ~~and~~ the reduction by chapter 2000-256, Laws of Florida, in the
39 assessment on hospitals under s. 395.701~~,~~ and to maintain
40 federal approval of the reduced amount of funds deposited into

41 the Public Medical Assistance Trust Fund under s. 395.701~~,~~ as
42 state match for the state's Medicaid program.
43 Section 5. Subsection (3) of section 400.19, Florida
44 Statutes, is amended to read:
45 400.19 Right of entry and inspection.—
46 (3) The agency shall conduct periodic, ~~every 15 months~~
47 ~~conduct at least one~~ unannounced licensure inspections
48 ~~inspection~~ to determine compliance by the licensee with
49 statutes, and with rules adopted ~~promulgated~~ under ~~the~~
50 ~~provisions of~~ those statutes, governing minimum standards of
51 construction, quality and adequacy of care, and rights of
52 residents. ~~The survey shall be conducted every 6 months for the~~
53 ~~next 2-year period~~ If the facility has been cited for a class I
54 deficiency or~~,~~ has been cited for two or more class II
55 deficiencies arising from separate surveys or investigations
56 within a 60-day period, the agency shall conduct an additional
57 licensure survey ~~or has had three or more substantiated~~
58 ~~complaints within a 6-month period, each resulting in at least~~
59 ~~one class I or class II deficiency~~. In addition to any other
60 fees or fines in this part, the agency shall assess a fine for
61 each facility that is subject to the additional licensure survey
62 ~~6-month survey cycle~~. The fine for the additional licensure
63 survey ~~2-year period~~ shall be $3,000 ~~$6,000, one-half to be paid~~
64 ~~at the completion of each survey~~. The agency may adjust such
65 ~~this~~ fine by the change in the Consumer Price Index, based on

66 the 12 months immediately preceding the increase, to cover the
67 cost of the additional surveys. The agency shall verify through
68 subsequent inspection that any deficiency identified during
69 inspection is corrected. However, the agency may verify the
70 correction of a class III or class IV deficiency unrelated to
71 resident rights or resident care without reinspecting the
72 facility if adequate written documentation has been received
73 from the facility, which provides assurance that the deficiency
74 has been corrected. The giving or causing to be given of advance
75 notice of such unannounced inspections by an employee of the
76 agency to any unauthorized person shall constitute cause for
77 suspension of not fewer than 5 working days according to ~~the~~
78 ~~provisions of~~ chapter 110.
79 Section 6. Subsections (23) through (30) of section
80 400.462, Florida Statutes, are renumbered as subsections (22)
81 through (29), respectively, and subsections (12), (14), (17),
82 and (21) and present subsection (22) of that section are amended
83 to read:
84 400.462 Definitions.—As used in this part, the term:
85 (12) "Home health agency" means a person or entity ~~an~~
86 ~~organization~~ that provides one or more home health services ~~and~~
87 ~~staffing services~~.
88 (14) "Home health services" means health and medical
89 services and medical supplies furnished ~~by an organization~~ to an
90 individual in the individual's home or place of residence. The

91 term includes ~~organizations that provide one or more of~~ the
92 following:
93 (a) Nursing care.
94 (b) Physical, occupational, respiratory, or speech
95 therapy.
96 (c) Home health aide services.
97 (d) Dietetics and nutrition practice and nutrition
98 counseling.
99 (e) Medical supplies, restricted to drugs and biologicals
100 prescribed by a physician.
101 (17) "Home infusion therapy provider" means a person or
102 entity ~~an organization~~ that employs, contracts with, or refers a
103 licensed professional who has received advanced training and
104 experience in intravenous infusion therapy and who administers
105 infusion therapy to a patient in the patient's home or place of
106 residence.
107 (21) "Nurse registry" means a ~~any~~ person or entity that
108 procures, offers, promises, or attempts to secure health-care-
109 related contracts for registered nurses, licensed practical
110 nurses, certified nursing assistants, home health aides,
111 companions, or homemakers, who are compensated by fees as
112 independent contractors, including, but not limited to,
113 contracts for the provision of services to patients and
114 contracts to provide private duty or staffing services to health

115 care facilities licensed under chapter 395, this chapter, or
116 chapter 429 or other business entities.
117 ~~(22) "Organization" means a corporation, government or~~
118 ~~governmental subdivision or agency, partnership or association,~~
119 ~~or any other legal or commercial entity, any of which involve~~
120 ~~more than one health care professional discipline; a health care~~
121 ~~professional and a home health aide or certified nursing~~
122 ~~assistant; more than one home health aide; more than one~~
123 ~~certified nursing assistant; or a home health aide and a~~
124 ~~certified nursing assistant. The term does not include an entity~~
125 ~~that provides services using only volunteers or only individuals~~
126 ~~related by blood or marriage to the patient or client.~~
127 Section 7. Subsections (1), (4), and (5) of section
128 400.464, Florida Statutes, are amended to read:
129 400.464 Home health agencies to be licensed; expiration of
130 license; exemptions; unlawful acts; penalties.—
131 (1) The requirements of part II of chapter 408 apply to
132 the provision of services that require licensure pursuant to
133 this part and part II of chapter 408 and persons or entities
134 licensed or registered by or applying for such licensure or
135 registration from the Agency for Health Care Administration
136 pursuant to this part. A license or registration issued by the
137 agency is required in order to operate a home health agency in
138 this state. A license or registration issued on or after July 1,
139 2018, must specify the home health services the licensee or

140 registrant ~~organization~~ is authorized to perform and indicate
141 whether such specified services are considered skilled care. The
142 provision or advertising of services that require licensure or
143 registration pursuant to this part without such services being
144 specified on the face of the license or registration issued on
145 or after July 1, 2018, constitutes unlicensed activity as
146 prohibited under s. 408.812.
147 (4)(a) A licensee or registrant ~~An organization~~ that
148 offers or advertises to the public any service for which
149 licensure or registration is required under this part must
150 include in the advertisement the license number or registration
151 number issued to the licensee or registrant ~~organization~~ by the
152 agency. The agency shall assess a fine of not less than $100 to
153 any licensee or registrant that ~~who~~ fails to include the license
154 or registration number when submitting the advertisement for
155 publication, broadcast, or printing. The fine for a second or
156 subsequent offense is $500. The holder of a license or
157 registration issued under this part may not advertise or
158 indicate to the public that it holds a home health agency or
159 nurse registry license or registration other than the one it has
160 been issued.
161 (b) The operation or maintenance of an unlicensed home
162 health agency or the performance of any home health services in
163 violation of this part is declared a nuisance, inimical to the
164 public health, welfare, and safety. The agency or any state

165 attorney may, in addition to other remedies provided in this
166 part, bring an action for an injunction to restrain such
167 violation, or to enjoin the future operation or maintenance of
168 the home health agency or the provision of home health services
169 in violation of this part or part II of chapter 408, until
170 compliance with this part or the rules adopted under this part
171 has been demonstrated to the satisfaction of the agency.
172 (c) A person or entity that ~~who~~ violates paragraph (a) is
173 subject to an injunctive proceeding under s. 408.816. A
174 violation of paragraph (a) or s. 408.812 is a deceptive and
175 unfair trade practice and constitutes a violation of the Florida
176 Deceptive and Unfair Trade Practices Act under part II of
177 chapter 501.
178 (d) A person or entity that ~~who~~ violates ~~the provisions of~~
179 paragraph (a) commits a misdemeanor of the second degree,
180 punishable as provided in s. 775.082 or s. 775.083. Any person
181 or entity that ~~who~~ commits a second or subsequent violation
182 commits a misdemeanor of the first degree, punishable as
183 provided in s. 775.082 or s. 775.083. Each day of continuing
184 violation constitutes a separate offense.
185 (e) A ~~Any~~ person or entity that ~~who~~ owns, operates, or
186 maintains an unlicensed home health agency and ~~who~~, after
187 receiving notification from the agency, fails to cease operation
188 and apply for a license under this part commits a misdemeanor of

the second degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continued operation is a separate offense.

(f) A ~~Any~~ home health agency that fails to cease operation after agency notification may be fined in accordance with s. 408.812.

(5) The following are exempt from ~~the~~ licensure as a home health agency under ~~requirements of~~ this part:

(a) A home health agency operated by the Federal Government.

(b) Home health services provided by a state agency, either directly or through a contractor with:

1. The Department of Elderly Affairs.

2. The Department of Health, a community health center, or a rural health network that furnishes home visits for the purpose of providing environmental assessments, case management, health education, personal care services, family planning, or followup treatment, or for the purpose of monitoring and tracking disease.

3. Services provided to persons with developmental disabilities, as defined in s. 393.063.

4. Companion and sitter organizations that were registered under s. 400.509(1) on January 1, 1999, and were authorized to provide personal services under a developmental services provider certificate on January 1, 1999, may continue to provide such services to past, present, and future clients of the

214 organization who need such services, notwithstanding ~~the~~
215 ~~provisions of~~ this act.
216 5. The Department of Children and Families.
217 (c) A health care professional, whether or not
218 incorporated, who is licensed under chapter 457; chapter 458;
219 chapter 459; part I of chapter 464; chapter 467; part I, part
220 III, part V, or part X of chapter 468; chapter 480; chapter 486;
221 chapter 490; or chapter 491; and who is acting alone within the
222 scope of his or her professional license to provide care to
223 patients in their homes.
224 (d) A home health aide or certified nursing assistant who
225 is acting in his or her individual capacity, within the
226 definitions and standards of his or her occupation, and who
227 provides hands-on care to patients in their homes.
228 (e) An individual who acts alone, in his or her individual
229 capacity, and who is not employed by or affiliated with a
230 licensed home health agency or registered with a licensed nurse
231 registry. This exemption does not entitle an individual to
232 perform home health services without the required professional
233 license.
234 (f) The delivery of instructional services in home
235 dialysis and home dialysis supplies and equipment.
236 (g) The delivery of nursing home services for which the
237 nursing home is licensed under part II of this chapter, to serve
238 its residents in its facility.

239 (h) The delivery of assisted living facility services for
240 which the assisted living facility is licensed under part I of
241 chapter 429, to serve its residents in its facility.
242 (i) The delivery of hospice services for which the hospice
243 is licensed under part IV of this chapter, to serve hospice
244 patients admitted to its service.
245 (j) A hospital that provides services for which it is
246 licensed under chapter 395.
247 (k) The delivery of community residential services for
248 which the community residential home is licensed under chapter
249 419, to serve the residents in its facility.
250 (l) A not-for-profit, community-based agency that provides
251 early intervention services to infants and toddlers.
252 (m) Certified rehabilitation agencies and comprehensive
253 outpatient rehabilitation facilities that are certified under
254 Title 18 of the Social Security Act.
255 (n) The delivery of adult family-care home services for
256 which the adult family-care home is licensed under part II of
257 chapter 429, to serve the residents in its facility.
258 <u>(o) A person or entity that provides skilled care by</u>
259 <u>health care professionals licensed solely under part I of</u>
260 <u>chapter 464; part I, part III, or part V of chapter 468; or</u>
261 <u>chapter 486.</u>

262 (p) A person or entity that provides services using only
263 volunteers or individuals related by blood or marriage to the
264 patient or client.
265 Section 8. Paragraph (g) of subsection (2) of section
266 400.471, Florida Statutes, is amended to read:
267 400.471 Application for license; fee.—
268 (2) In addition to the requirements of part II of chapter
269 408, the initial applicant, the applicant for a change of
270 ownership, and the applicant for the addition of skilled care
271 services must file with the application satisfactory proof that
272 the home health agency is in compliance with this part and
273 applicable rules, including:
274 (g) In the case of an application for initial licensure,
275 an application for a change of ownership, or an application for
276 the addition of skilled care services, documentation of
277 accreditation, or an application for accreditation, from an
278 accrediting organization that is recognized by the agency as
279 having standards comparable to those required by this part and
280 part II of chapter 408. A home health agency that does not
281 provide skilled care is exempt from this paragraph.
282 Notwithstanding s. 408.806, the ~~an initial~~ applicant must
283 provide proof of accreditation that is not conditional or
284 provisional and a survey demonstrating compliance with the
285 requirements of this part, part II of chapter 408, and
286 applicable rules from an accrediting organization that is

287 recognized by the agency as having standards comparable to those
288 required by this part and part II of chapter 408 within 120 days
289 after the date of the agency's receipt of the application for
290 licensure. Such accreditation must be continuously maintained by
291 the home health agency to maintain licensure. The agency shall
292 accept, in lieu of its own periodic licensure survey, the
293 submission of the survey of an accrediting organization that is
294 recognized by the agency if the accreditation of the licensed
295 home health agency is not provisional and if the licensed home
296 health agency authorizes release of, and the agency receives the
297 report of, the accrediting organization.
298 Section 9. Section 400.492, Florida Statutes, is amended
299 to read:
300 400.492 Provision of services during an emergency.—Each
301 home health agency shall prepare and maintain a comprehensive
302 emergency management plan that is consistent with the standards
303 adopted by national or state accreditation organizations and
304 consistent with the local special needs plan. The plan shall be
305 updated annually and shall provide for continuing home health
306 services during an emergency that interrupts patient care or
307 services in the patient's home. The plan shall include the means
308 by which the home health agency will continue to provide staff
309 to perform the same type and quantity of services to their
310 patients who evacuate to special needs shelters that were being
311 provided to those patients prior to evacuation. The plan shall

312 describe how the home health agency establishes and maintains an
313 effective response to emergencies and disasters, including:
314 notifying staff when emergency response measures are initiated;
315 providing for communication between staff members, county health
316 departments, and local emergency management agencies, including
317 a backup system; identifying resources necessary to continue
318 essential care or services or referrals to other <u>health care</u>
319 <u>providers</u> ~~organizations~~ subject to written agreement; and
320 prioritizing and contacting patients who need continued care or
321 services.
322 (1) Each patient record for patients who are listed in the
323 registry established pursuant to s. 252.355 shall include a
324 description of how care or services will be continued in the
325 event of an emergency or disaster. The home health agency shall
326 discuss the emergency provisions with the patient and the
327 patient's caregivers, including where and how the patient is to
328 evacuate, procedures for notifying the home health agency in the
329 event that the patient evacuates to a location other than the
330 shelter identified in the patient record, and a list of
331 medications and equipment which must either accompany the
332 patient or will be needed by the patient in the event of an
333 evacuation.
334 (2) Each home health agency shall maintain a current
335 prioritized list of patients who need continued services during
336 an emergency. The list shall indicate how services shall be

337 continued in the event of an emergency or disaster for each
338 patient and if the patient is to be transported to a special
339 needs shelter, and shall indicate if the patient is receiving
340 skilled nursing services and the patient's medication and
341 equipment needs. The list shall be furnished to county health
342 departments and to local emergency management agencies, upon
343 request.
344 (3) Home health agencies shall not be required to continue
345 to provide care to patients in emergency situations that are
346 beyond their control and that make it impossible to provide
347 services, such as when roads are impassable or when patients do
348 not go to the location specified in their patient records. Home
349 health agencies may establish links to local emergency
350 operations centers to determine a mechanism by which to approach
351 specific areas within a disaster area in order for the agency to
352 reach its clients. Home health agencies shall demonstrate a good
353 faith effort to comply with the requirements of this subsection
354 by documenting attempts of staff to follow procedures outlined
355 in the home health agency's comprehensive emergency management
356 plan, and by the patient's record, which support a finding that
357 the provision of continuing care has been attempted for those
358 patients who have been identified as needing care by the home
359 health agency and registered under s. 252.355, in the event of
360 an emergency or disaster under subsection (1).

361 (4) Notwithstanding the provisions of s. 400.464(2) or any
362 other provision of law to the contrary, a home health agency may
363 provide services in a special needs shelter located in any
364 county.
365 Section 10. Subsection (4) and paragraph (a) of subsection
366 (5) of section 400.506, Florida Statutes, are amended to read:
367 400.506 Licensure of nurse registries; requirements;
368 penalties.—
369 (4) A licensee ~~person~~ that provides, offers, or advertises
370 to the public any service for which licensure is required under
371 this section must include in such advertisement the license
372 number issued to it by the Agency for Health Care
373 Administration. The agency shall assess a fine of not less than
374 $100 against a ~~any~~ licensee that ~~who~~ fails to include the
375 license number when submitting the advertisement for
376 publication, broadcast, or printing. The fine for a second or
377 subsequent offense is $500.
378 (5)(a) In addition to the requirements of s. 408.812, a
379 ~~any~~ person or entity that ~~who~~ owns, operates, or maintains an
380 unlicensed nurse registry and ~~who~~, after receiving notification
381 from the agency, fails to cease operation and apply for a
382 license under this part commits a misdemeanor of the second
383 degree, punishable as provided in s. 775.082 or s. 775.083. Each
384 day of continued operation is a separate offense.

385 Section 11. Subsections (1), (2), (4), and (5) of section
386 400.509, Florida Statutes, are amended to read:
387 400.509 Registration of particular service providers
388 exempt from licensure; certificate of registration; regulation
389 of registrants.—
390 (1) A person or entity ~~Any organization~~ that provides
391 companion services or homemaker services and does not provide a
392 home health service to a person is exempt from licensure under
393 this part. However, a person or entity ~~any organization~~ that
394 provides companion services or homemaker services must register
395 with the agency. A person or entity ~~An organization~~ under
396 contract with the Agency for Persons with Disabilities that
397 ~~which~~ provides companion services only for persons with a
398 developmental disability, as defined in s. 393.063, is exempt
399 from registration.
400 (2) The requirements of part II of chapter 408 apply to
401 the provision of services that require registration or licensure
402 pursuant to this section and part II of chapter 408 and entities
403 registered by or applying for such registration from the Agency
404 for Health Care Administration pursuant to this section. Each
405 applicant for registration and each registrant must comply with
406 all provisions of part II of chapter 408. Registration or a
407 license issued by the agency is required for the operation of a
408 person or entity ~~an organization~~ that provides companion
409 services or homemaker services.

(4) Each registrant must obtain the employment or contract history of persons who are employed by or under contract with the person or entity ~~organization~~ and who will have contact at any time with patients or clients in their homes by:

(a) Requiring such persons to submit an employment or contractual history to the registrant; and

(b) Verifying the employment or contractual history, unless through diligent efforts such verification is not possible. The agency shall prescribe by rule the minimum requirements for establishing that diligent efforts have been made.

There is no monetary liability on the part of, and no cause of action for damages arises against, a former employer of a prospective employee of or prospective independent contractor with a registrant who reasonably and in good faith communicates his or her honest opinions about the former employee's or contractor's job performance. This subsection does not affect the official immunity of an officer or employee of a public corporation.

(5) A person or entity that offers or advertises to the public a service for which registration is required must include in its advertisement the registration number issued by the Agency for Health Care Administration.

434 Section 12. Subsection (3) of section 400.605, Florida
435 Statutes, is amended to read:
436 400.605 Administration; forms; fees; rules; inspections;
437 fines.—
438 (3) In accordance with s. 408.811, the agency shall
439 conduct ~~annual inspections of all licensees, except that~~
440 ~~licensure inspections may be conducted biennially for hospices~~
441 ~~having a 3-year record of substantial compliance. The agency~~
442 ~~shall conduct~~ such inspections and investigations as are
443 necessary in order to determine the state of compliance with ~~the~~
444 ~~provisions of~~ this part, part II of chapter 408, and applicable
445 rules.
446 Section 13. Section 400.60501, Florida Statutes, is
447 amended to read:
448 400.60501 Outcome measures; adoption of federal quality
449 measures; public reporting~~; annual report~~.—
450 (1) ~~No later than December 31, 2019,~~ The agency shall
451 adopt the national hospice outcome measures and survey data in
452 42 C.F.R. part 418 to determine the quality and effectiveness of
453 hospice care for hospices licensed in the state.
454 (2) The agency shall~~:~~
455 ~~(a)~~ make available to the public the national hospice
456 outcome measures and survey data in a format that is
457 comprehensible by a layperson and that allows a consumer to
458 compare such measures of one or more hospices.

459 ~~(b) Develop an annual report that analyzes and evaluates~~
460 ~~the information collected under this act and any other data~~
461 ~~collection or reporting provisions of law.~~
462 Section 14. Paragraphs (a), (b), (c), and (d) of
463 subsection (4) of section 400.9905, Florida Statutes, are
464 amended, and paragraphs (o), (p), and (q) are added to that
465 subsection, to read:
466 400.9905 Definitions.—
467 (4) "Clinic" means an entity where health care services
468 are provided to individuals and which tenders charges for
469 reimbursement for such services, including a mobile clinic and a
470 portable equipment provider. As used in this part, the term does
471 not include and the licensure requirements of this part do not
472 apply to:
473 (a) Entities licensed or registered by the state under
474 chapter 395; entities licensed or registered by the state and
475 providing only health care services within the scope of services
476 authorized under their respective licenses under ss. 383.30-
477 383.332, chapter 390, chapter 394, chapter 397, this chapter
478 except part X, chapter 429, chapter 463, chapter 465, chapter
479 466, chapter 478, chapter 484, or chapter 651; end-stage renal
480 disease providers authorized under 42 C.F.R. part 494 ~~405,~~
481 ~~subpart U~~; providers certified and providing only health care
482 services within the scope of services authorized under their
483 respective certifications under 42 C.F.R. part 485, subpart B,

484 ~~or~~ subpart H, or subpart J; providers certified and providing
485 only health care services within the scope of services
486 authorized under their respective certifications under 42 C.F.R.
487 part 486, subpart C; providers certified and providing only
488 health care services within the scope of services authorized
489 under their respective certifications under 42 C.F.R. part 491,
490 subpart A; providers certified by the Centers for Medicare and
491 Medicaid services under the federal Clinical Laboratory
492 Improvement Amendments and the federal rules adopted thereunder;
493 or any entity that provides neonatal or pediatric hospital-based
494 health care services or other health care services by licensed
495 practitioners solely within a hospital licensed under chapter
496 395.
497 (b) Entities that own, directly or indirectly, entities
498 licensed or registered by the state pursuant to chapter 395;
499 entities that own, directly or indirectly, entities licensed or
500 registered by the state and providing only health care services
501 within the scope of services authorized pursuant to their
502 respective licenses under ss. 383.30-383.332, chapter 390,
503 chapter 394, chapter 397, this chapter except part X, chapter
504 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter
505 484, or chapter 651; end-stage renal disease providers
506 authorized under 42 C.F.R. part 494 ~~405, subpart U~~; providers
507 certified and providing only health care services within the
508 scope of services authorized under their respective

509 certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart
510 H, or subpart J; providers certified and providing only health
511 care services within the scope of services authorized under
512 their respective certifications under 42 C.F.R. part 486,
513 subpart C; providers certified and providing only health care
514 services within the scope of services authorized under their
515 respective certifications under 42 C.F.R. part 491, subpart A;
516 providers certified by the Centers for Medicare and Medicaid
517 services under the federal Clinical Laboratory Improvement
518 Amendments and the federal rules adopted thereunder; or any
519 entity that provides neonatal or pediatric hospital-based health
520 care services by licensed practitioners solely within a hospital
521 licensed under chapter 395.
522 (c) Entities that are owned, directly or indirectly, by an
523 entity licensed or registered by the state pursuant to chapter
524 395; entities that are owned, directly or indirectly, by an
525 entity licensed or registered by the state and providing only
526 health care services within the scope of services authorized
527 pursuant to their respective licenses under ss. 383.30-383.332,
528 chapter 390, chapter 394, chapter 397, this chapter except part
529 X, chapter 429, chapter 463, chapter 465, chapter 466, chapter
530 478, chapter 484, or chapter 651; end-stage renal disease
531 providers authorized under 42 C.F.R. part 494 ~~405, subpart U~~;
532 providers certified and providing only health care services
533 within the scope of services authorized under their respective

534 certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart
535 H, or subpart J; providers certified and providing only health
536 care services within the scope of services authorized under
537 their respective certifications under 42 C.F.R. part 486,
538 subpart C; providers certified and providing only health care
539 services within the scope of services authorized under their
540 respective certifications under 42 C.F.R. part 491, subpart A;
541 providers certified by the Centers for Medicare and Medicaid
542 services under the federal Clinical Laboratory Improvement
543 Amendments and the federal rules adopted thereunder; or any
544 entity that provides neonatal or pediatric hospital-based health
545 care services by licensed practitioners solely within a hospital
546 under chapter 395.
547 (d) Entities that are under common ownership, directly or
548 indirectly, with an entity licensed or registered by the state
549 pursuant to chapter 395; entities that are under common
550 ownership, directly or indirectly, with an entity licensed or
551 registered by the state and providing only health care services
552 within the scope of services authorized pursuant to their
553 respective licenses under ss. 383.30-383.332, chapter 390,
554 chapter 394, chapter 397, this chapter except part X, chapter
555 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter
556 484, or chapter 651; end-stage renal disease providers
557 authorized under 42 C.F.R. part 494 ~~405, subpart U~~; providers
558 certified and providing only health care services within the

559 scope of services authorized under their respective
560 certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart
561 H, or subpart J; providers certified and providing only health
562 care services within the scope of services authorized under
563 their respective certifications under 42 C.F.R. part 486,
564 subpart C; providers certified and providing only health care
565 services within the scope of services authorized under their
566 respective certifications under 42 C.F.R. part 491, subpart A;
567 providers certified by the Centers for Medicare and Medicaid
568 services under the federal Clinical Laboratory Improvement
569 Amendments and the federal rules adopted thereunder; or any
570 entity that provides neonatal or pediatric hospital-based health
571 care services by licensed practitioners solely within a hospital
572 licensed under chapter 395.
573 (o) Entities that are, directly or indirectly, under the
574 common ownership of or that are subject to common control by a
575 mutual insurance holding company, as defined in s. 628.703, with
576 an entity licensed or certified under chapter 627 or chapter 641
577 which has $1 billion or more in total annual sales in this
578 state.
579 (p) Entities that are owned by an entity that is a
580 behavioral health care service provider in at least five other
581 states; that, together with its affiliates, have $90 million or
582 more in total annual revenues associated with the provision of
583 behavioral health care services; and wherein one or more of the

584 persons responsible for the operations of the entity is a health
585 care practitioner who is licensed in this state, who is
586 responsible for supervising the business activities of the
587 entity, and who is responsible for the entity's compliance with
588 state law for purposes of this part.
589 (q) Medicaid providers.
590
591 Notwithstanding this subsection, an entity shall be deemed a
592 clinic and must be licensed under this part in order to receive
593 reimbursement under the Florida Motor Vehicle No-Fault Law, ss.
594 627.730-627.7405, unless exempted under s. 627.736(5)(h).
595 Section 15. Paragraph (c) of subsection (3) of section
596 400.991, Florida Statutes, is amended to read:
597 400.991 License requirements; background screenings;
598 prohibitions.—
599 (3) In addition to the requirements of part II of chapter
600 408, the applicant must file with the application satisfactory
601 proof that the clinic is in compliance with this part and
602 applicable rules, including:
603 (c) Proof of financial ability to operate as required
604 under ss. 408.8065(1) and ~~s.~~ 408.810(8). ~~As an alternative to~~
605 ~~submitting proof of financial ability to operate as required~~
606 ~~under s. 408.810(8), the applicant may file a surety bond of at~~
607 ~~least $500,000 which guarantees that the clinic will act in full~~
608 ~~conformity with all legal requirements for operating a clinic,~~

609 ~~payable to the agency. The agency may adopt rules to specify~~
610 ~~related requirements for such surety bond.~~
611 Section 16. Paragraph (i) of subsection (1) of section
612 400.9935, Florida Statutes, is amended to read:
613 400.9935 Clinic responsibilities.—
614 (1) Each clinic shall appoint a medical director or clinic
615 director who shall agree in writing to accept legal
616 responsibility for the following activities on behalf of the
617 clinic. The medical director or the clinic director shall:
618 (i) Ensure that the clinic publishes a schedule of charges
619 for the medical services offered to patients. The schedule must
620 include the prices charged to an uninsured person paying for
621 such services by cash, check, credit card, or debit card. The
622 schedule may group services by price levels, listing services in
623 each price level. The schedule must be posted in a conspicuous
624 place in the reception area of any clinic that is considered an
625 ~~the~~ urgent care center as defined in s. 395.002(29)(b) and must
626 include, but is not limited to, the 50 services most frequently
627 provided by the clinic. ~~The schedule may group services by three~~
628 ~~price levels, listing services in each price level.~~ The posting
629 may be a sign that must be at least 15 square feet in size or
630 through an electronic messaging board that is at least 3 square
631 feet in size. The failure of a clinic, including a clinic that
632 is considered an urgent care center, to publish and post a
633 schedule of charges as required by this section shall result in

634 a fine of not more than $1,000, per day, until the schedule is
635 published and posted.
636 Section 17. Paragraph (a) of subsection (2) of section
637 408.033, Florida Statutes, is amended to read:
638 408.033 Local and state health planning.—
639 (2) FUNDING.—
640 (a) The Legislature intends that the cost of local health
641 councils be borne by assessments on selected health care
642 facilities subject to facility licensure by the Agency for
643 Health Care Administration, including abortion clinics, assisted
644 living facilities, ambulatory surgical centers, birth centers,
645 home health agencies, hospices, hospitals, intermediate care
646 facilities for the developmentally disabled, nursing homes, and
647 health care clinics~~, and multiphasic testing centers~~ and by
648 assessments on organizations subject to certification by the
649 agency pursuant to chapter 641, part III, including health
650 maintenance organizations and prepaid health clinics. Fees
651 assessed may be collected prospectively at the time of licensure
652 renewal and prorated for the licensure period.
653 Section 18. Paragraph (a) of subsection (1) of section
654 408.061, Florida Statutes, is amended to read:
655 408.061 Data collection; uniform systems of financial
656 reporting; information relating to physician charges;
657 confidential information; immunity.—

658 (1) The agency shall require the submission by health care
659 facilities, health care providers, and health insurers of data
660 necessary to carry out the agency's duties and to facilitate
661 transparency in health care pricing data and quality measures.
662 Specifications for data to be collected under this section shall
663 be developed by the agency and applicable contract vendors, with
664 the assistance of technical advisory panels including
665 representatives of affected entities, consumers, purchasers, and
666 such other interested parties as may be determined by the
667 agency.
668 (a) Data submitted by health care facilities, including
669 the facilities as defined in chapter 395, shall include, but are
670 not limited to,~~:~~ case-mix data, patient admission and discharge
671 data, hospital emergency department data which shall include the
672 number of patients treated in the emergency department of a
673 licensed hospital reported by patient acuity level, data on
674 hospital-acquired infections as specified by rule, data on
675 complications as specified by rule, data on readmissions as
676 specified by rule, including patient- ~~with patient~~ and provider-
677 specific identifiers ~~included~~, actual charge data by diagnostic
678 groups or other bundled groupings as specified by rule,
679 financial data, accounting data, operating expenses, expenses
680 incurred for rendering services to patients who cannot or do not
681 pay, interest charges, depreciation expenses based on the
682 expected useful life of the property and equipment involved, and

683 demographic data. The agency shall adopt nationally recognized
684 risk adjustment methodologies or software consistent with the
685 standards of the Agency for Healthcare Research and Quality and
686 as selected by the agency for all data submitted as required by
687 this section. Data may be obtained from documents including ~~such~~
688 ~~as~~, but not limited to,~~:~~ leases, contracts, debt instruments,
689 itemized patient statements or bills, medical record abstracts,
690 and related diagnostic information. ~~Reported~~ Data elements shall
691 be reported electronically in accordance with rules adopted by
692 the agency ~~rule 59E-7.012, Florida Administrative Code~~. Data
693 submitted shall be certified by the chief executive officer or
694 an appropriate and duly authorized representative or employee of
695 the licensed facility that the information submitted is true and
696 accurate.
697 Section 19. Subsection (4) of section 408.0611, Florida
698 Statutes, is amended to read:
699 408.0611 Electronic prescribing clearinghouse.—
700 (4) Pursuant to s. 408.061, the agency shall monitor the
701 implementation of electronic prescribing by health care
702 practitioners, health care facilities, and pharmacies. ~~By~~
703 ~~January 31 of each year,~~ The agency shall annually publish a
704 report on the progress of implementation of electronic
705 prescribing on its Internet website ~~to the Governor and the~~
706 ~~Legislature~~. Information reported pursuant to this subsection
707 shall include federal and private sector electronic prescribing

708 initiatives and, to the extent that data is readily available
709 from organizations that operate electronic prescribing networks,
710 the number of health care practitioners using electronic
711 prescribing and the number of prescriptions electronically
712 transmitted.
713 Section 20. Paragraphs (i) and (j) of subsection (1) of
714 section 408.062, Florida Statutes, are amended to read:
715 408.062 Research, analyses, studies, and reports.—
716 (1) The agency shall conduct research, analyses, and
717 studies relating to health care costs and access to and quality
718 of health care services as access and quality are affected by
719 changes in health care costs. Such research, analyses, and
720 studies shall include, but not be limited to:
721 (i) The use of emergency department services by patient
722 acuity level ~~and the implication of increasing hospital cost by~~
723 ~~providing nonurgent care in emergency departments~~. The agency
724 shall annually publish information ~~submit an annual report~~ based
725 on this monitoring and assessment on its Internet website ~~to the~~
726 ~~Governor, the Speaker of the House of Representatives, the~~
727 ~~President of the Senate, and the substantive legislative~~
728 ~~committees, due January 1~~.
729 (j) The making available on its Internet website, and in a
730 hard-copy format upon request, of patient charge, volumes,
731 length of stay, and performance indicators collected from health
732 care facilities pursuant to s. 408.061(1)(a) for specific

733 medical conditions, surgeries, and procedures provided in
734 inpatient and outpatient facilities as determined by the agency.
735 In making the determination of specific medical conditions,
736 surgeries, and procedures to include, the agency shall consider
737 such factors as volume, severity of the illness, urgency of
738 admission, individual and societal costs, and whether the
739 condition is acute or chronic. Performance outcome indicators
740 shall be risk adjusted or severity adjusted, as applicable,
741 using nationally recognized risk adjustment methodologies or
742 software consistent with the standards of the Agency for
743 Healthcare Research and Quality and as selected by the agency.
744 The website shall also provide an interactive search that allows
745 consumers to view and compare the information for specific
746 facilities, a map that allows consumers to select a county or
747 region, definitions of all of the data, descriptions of each
748 procedure, and an explanation about why the data may differ from
749 facility to facility. Such public data shall be updated
750 quarterly. The agency shall annually publish information
751 regarding ~~submit an annual status report on~~ the collection of
752 data and publication of health care quality measures on its
753 Internet website ~~to the Governor, the Speaker of the House of~~
754 ~~Representatives, the President of the Senate, and the~~
755 ~~substantive legislative committees, due January 1~~.
756 Section 21. Subsection (5) of section 408.063, Florida
757 Statutes, is amended to read:

758 408.063 Dissemination of health care information.—
759 ~~(5) The agency shall publish annually a comprehensive~~
760 ~~report of state health expenditures. The report shall identify:~~
761 ~~(a) The contribution of health care dollars made by all~~
762 ~~payors.~~
763 ~~(b) The dollars expended by type of health care service in~~
764 ~~Florida.~~
765 Section 22. Section 408.802, Florida Statutes, is amended
766 to read:
767 408.802 Applicability.~~—The provisions of~~ This part <u>applies</u>
768 ~~apply~~ to the provision of services that require licensure as
769 defined in this part and to the following entities licensed,
770 registered, or certified by the agency, as described in chapters
771 112, 383, 390, 394, 395, 400, 429, 440, ~~483,~~ and 765:
772 (1) Laboratories authorized to perform testing under the
773 Drug-Free Workplace Act, as provided under ss. 112.0455 and
774 440.102.
775 (2) Birth centers, as provided under chapter 383.
776 (3) Abortion clinics, as provided under chapter 390.
777 (4) Crisis stabilization units, as provided under parts I
778 and IV of chapter 394.
779 (5) Short-term residential treatment facilities, as
780 provided under parts I and IV of chapter 394.
781 (6) Residential treatment facilities, as provided under
782 part IV of chapter 394.

783 (7) Residential treatment centers for children and
784 adolescents, as provided under part IV of chapter 394.
785 (8) Hospitals, as provided under part I of chapter 395.
786 (9) Ambulatory surgical centers, as provided under part I
787 of chapter 395.
788 (10) Nursing homes, as provided under part II of chapter
789 400.
790 (11) Assisted living facilities, as provided under part I
791 of chapter 429.
792 (12) Home health agencies, as provided under part III of
793 chapter 400.
794 (13) Nurse registries, as provided under part III of
795 chapter 400.
796 (14) Companion services or homemaker services providers,
797 as provided under part III of chapter 400.
798 (15) Adult day care centers, as provided under part III of
799 chapter 429.
800 (16) Hospices, as provided under part IV of chapter 400.
801 (17) Adult family-care homes, as provided under part II of
802 chapter 429.
803 (18) Homes for special services, as provided under part V
804 of chapter 400.
805 (19) Transitional living facilities, as provided under
806 part XI of chapter 400.

807 (20) Prescribed pediatric extended care centers, as
808 provided under part VI of chapter 400.
809 (21) Home medical equipment providers, as provided under
810 part VII of chapter 400.
811 (22) Intermediate care facilities for persons with
812 developmental disabilities, as provided under part VIII of
813 chapter 400.
814 (23) Health care services pools, as provided under part IX
815 of chapter 400.
816 (24) Health care clinics, as provided under part X of
817 chapter 400.
818 ~~(25) Multiphasic health testing centers, as provided under~~
819 ~~part I of chapter 483.~~
820 (25)~~(26)~~ Organ, tissue, and eye procurement organizations,
821 as provided under part V of chapter 765.
822 Section 23. Subsections (10) through (14) of section
823 408.803, Florida Statutes, are renumbered as subsections (11)
824 through (15), respectively, subsection (3) is amended, and a new
825 subsection (10) is added to that section, to read:
826 408.803 Definitions.—As used in this part, the term:
827 (3) "Authorizing statute" means the statute authorizing
828 the licensed operation of a provider listed in s. 408.802 and
829 includes chapters 112, 383, 390, 394, 395, 400, 429, 440, ~~483,~~
830 and 765.

831 (10) "Low-risk provider" means a nonresidential provider,
832 including a nurse registry, a home medical equipment provider,
833 or a health care clinic.
834 Section 24. Paragraph (b) of subsection (7) of section
835 408.806, Florida Statutes, is amended to read:
836 408.806 License application process.—
837 (7)
838 (b) An initial inspection is not required for companion
839 services or homemaker services providers, as provided under part
840 III of chapter 400, or for health care services pools, as
841 provided under part IX of chapter 400, or for low-risk providers
842 as provided in s. 408.811(1)(c).
843 Section 25. Subsection (2) of section 408.808, Florida
844 Statutes, is amended to read:
845 408.808 License categories.—
846 (2) PROVISIONAL LICENSE.—An applicant against whom a
847 proceeding denying or revoking a license is pending at the time
848 of license renewal may be issued a provisional license effective
849 until final action not subject to further appeal. A provisional
850 license may also be issued to an applicant making initial
851 application for licensure or making application applying for a
852 change of ownership. A provisional license must be limited in
853 duration to a specific period of time, up to 12 months, as
854 determined by the agency.

855 Section 26. Subsections (6) through (9) of section
856 408.809, Florida Statutes, are renumbered as subsections (5)
857 through (8), respectively, and subsections (2) and (4) and
858 present subsection (5) of that section are amended to read:
859 408.809 Background screening; prohibited offenses.—
860 (2) Every 5 years following his or her licensure,
861 employment, or entry into a contract in a capacity that under
862 subsection (1) would require level 2 background screening under
863 chapter 435, each such person must submit to level 2 background
864 rescreening as a condition of retaining such license or
865 continuing in such employment or contractual status. For any
866 such rescreening, the agency shall request the Department of Law
867 Enforcement to forward the person's fingerprints to the Federal
868 Bureau of Investigation for a national criminal history record
869 check unless the person's fingerprints are enrolled in the
870 Federal Bureau of Investigation's national retained print arrest
871 notification program. If the fingerprints of such a person are
872 not retained by the Department of Law Enforcement under s.
873 943.05(2)(g) and (h), the person must submit fingerprints
874 electronically to the Department of Law Enforcement for state
875 processing, and the Department of Law Enforcement shall forward
876 the fingerprints to the Federal Bureau of Investigation for a
877 national criminal history record check. The fingerprints shall
878 be retained by the Department of Law Enforcement under s.
879 943.05(2)(g) and (h) and enrolled in the national retained print

880 arrest notification program when the Department of Law
881 Enforcement begins participation in the program. The cost of the
882 state and national criminal history records checks required by
883 level 2 screening may be borne by the licensee or the person
884 fingerprinted. ~~Until a specified agency is fully implemented in~~
885 ~~the clearinghouse created under s. 435.12,~~ The agency may accept
886 as satisfying the requirements of this section proof of
887 compliance with level 2 screening standards submitted within the
888 previous 5 years to meet any provider or professional licensure
889 requirements of ~~the agency, the Department of Health, the~~
890 ~~Department of Elderly Affairs, the Agency for Persons with~~
891 ~~Disabilities, the Department of Children and Families, or~~ the
892 Department of Financial Services for an applicant for a
893 certificate of authority or provisional certificate of authority
894 to operate a continuing care retirement community under chapter
895 651, provided that:
896 (a) The screening standards and disqualifying offenses for
897 the prior screening are equivalent to those specified in s.
898 435.04 and this section;
899 (b) The person subject to screening has not had a break in
900 service from a position that requires level 2 screening for more
901 than 90 days; and
902 (c) Such proof is accompanied, under penalty of perjury,
903 by an attestation of compliance with chapter 435 and this
904 section using forms provided by the agency.

905 (4) In addition to the offenses listed in s. 435.04, all
906 persons required to undergo background screening pursuant to
907 this part or authorizing statutes must not have an arrest
908 awaiting final disposition for, must not have been found guilty
909 of, regardless of adjudication, or entered a plea of nolo
910 contendere or guilty to, and must not have been adjudicated
911 delinquent and the record not have been sealed or expunged for
912 any of the following offenses or any similar offense of another
913 jurisdiction:
914 (a) Any authorizing statutes, if the offense was a felony.
915 (b) This chapter, if the offense was a felony.
916 (c) Section 409.920, relating to Medicaid provider fraud.
917 (d) Section 409.9201, relating to Medicaid fraud.
918 (e) Section 741.28, relating to domestic violence.
919 (f) Section 777.04, relating to attempts, solicitation,
920 and conspiracy to commit an offense listed in this subsection.
921 (g) Section 817.034, relating to fraudulent acts through
922 mail, wire, radio, electromagnetic, photoelectronic, or
923 photooptical systems.
924 (h) Section 817.234, relating to false and fraudulent
925 insurance claims.
926 (i) Section 817.481, relating to obtaining goods by using
927 a false or expired credit card or other credit device, if the
928 offense was a felony.

929 (j) Section 817.50, relating to fraudulently obtaining
930 goods or services from a health care provider.
931 (k) Section 817.505, relating to patient brokering.
932 (l) Section 817.568, relating to criminal use of personal
933 identification information.
934 (m) Section 817.60, relating to obtaining a credit card
935 through fraudulent means.
936 (n) Section 817.61, relating to fraudulent use of credit
937 cards, if the offense was a felony.
938 (o) Section 831.01, relating to forgery.
939 (p) Section 831.02, relating to uttering forged
940 instruments.
941 (q) Section 831.07, relating to forging bank bills,
942 checks, drafts, or promissory notes.
943 (r) Section 831.09, relating to uttering forged bank
944 bills, checks, drafts, or promissory notes.
945 (s) Section 831.30, relating to fraud in obtaining
946 medicinal drugs.
947 (t) Section 831.31, relating to the sale, manufacture,
948 delivery, or possession with the intent to sell, manufacture, or
949 deliver any counterfeit controlled substance, if the offense was
950 a felony.
951 (u) Section 895.03, relating to racketeering and
952 collection of unlawful debts.

953 (v) Section 896.101, relating to the Florida Money
954 Laundering Act.
955
956 If, upon rescreening, a person who is currently employed or
957 contracted with a licensee ~~as of June 30, 2014,~~ and was screened
958 and qualified under <u>s.</u> ~~ss. 435.03 and~~ 435.04~~,~~ has a
959 disqualifying offense that was not a disqualifying offense at
960 the time of the last screening, but is a current disqualifying
961 offense and was committed before the last screening, he or she
962 may apply for an exemption from the appropriate licensing agency
963 and, if agreed to by the employer, may continue to perform his
964 or her duties until the licensing agency renders a decision on
965 the application for exemption if the person is eligible to apply
966 for an exemption and the exemption request is received by the
967 agency no later than 30 days after receipt of the rescreening
968 results by the person.
969 ~~(5) A person who serves as a controlling interest of, is~~
970 ~~employed by, or contracts with a licensee on July 31, 2010, who~~
971 ~~has been screened and qualified according to standards specified~~
972 ~~in s. 435.03 or s. 435.04 must be rescreened by July 31, 2015,~~
973 ~~in compliance with the following schedule. If, upon rescreening,~~
974 ~~such person has a disqualifying offense that was not a~~
975 ~~disqualifying offense at the time of the last screening, but is~~
976 ~~a current disqualifying offense and was committed before the~~
977 ~~last screening, he or she may apply for an exemption from the~~

978 ~~appropriate licensing agency and, if agreed to by the employer,~~
979 ~~may continue to perform his or her duties until the licensing~~
980 ~~agency renders a decision on the application for exemption if~~
981 ~~the person is eligible to apply for an exemption and the~~
982 ~~exemption request is received by the agency within 30 days after~~
983 ~~receipt of the rescreening results by the person. The~~
984 ~~rescreening schedule shall be:~~
985 ~~(a) Individuals for whom the last screening was conducted~~
986 ~~on or before December 31, 2004, must be rescreened by July 31,~~
987 ~~2013.~~
988 ~~(b) Individuals for whom the last screening conducted was~~
989 ~~between January 1, 2005, and December 31, 2008, must be~~
990 ~~rescreened by July 31, 2014.~~
991 ~~(c) Individuals for whom the last screening conducted was~~
992 ~~between January 1, 2009, through July 31, 2011, must be~~
993 ~~rescreened by July 31, 2015.~~
994 Section 27. Subsection (1) of section 408.811, Florida
995 Statutes, is amended to read:
996 408.811 Right of inspection; copies; inspection reports;
997 plan for correction of deficiencies.—
998 (1) An authorized officer or employee of the agency may
999 make or cause to be made any inspection or investigation deemed
1000 necessary by the agency to determine the state of compliance
1001 with this part, authorizing statutes, and applicable rules. The
1002 right of inspection extends to any business that the agency has

1003 reason to believe is being operated as a provider without a
1004 license, but inspection of any business suspected of being
1005 operated without the appropriate license may not be made without
1006 the permission of the owner or person in charge unless a warrant
1007 is first obtained from a circuit court. Any application for a
1008 license issued under this part, authorizing statutes, or
1009 applicable rules constitutes permission for an appropriate
1010 inspection to verify the information submitted on or in
1011 connection with the application.
1012 (a) All inspections shall be unannounced, except as
1013 specified in s. 408.806.
1014 (b) Inspections for relicensure shall be conducted
1015 biennially unless otherwise specified by this section,
1016 authorizing statutes, or applicable rules.
1017 (c) The agency may exempt a low-risk provider from a
1018 licensure inspection if the provider or a controlling interest
1019 has an excellent regulatory history with regard to deficiencies,
1020 sanctions, complaints, or other regulatory actions as defined in
1021 agency rule. The agency must conduct unannounced licensure
1022 inspections on at least 10 percent of the exempt low-risk
1023 providers to verify regulatory compliance.
1024 (d) The agency may adopt rules to waive any inspection,
1025 including a relicensure inspection, or grant an extended time
1026 period between relicensure inspections based upon:

1027 1. An excellent regulatory history with regard to
1028 deficiencies, sanctions, complaints, or other regulatory
1029 measures.
1030 2. Outcome measures that demonstrate quality performance.
1031 3. Successful participation in a recognized, quality
1032 program.
1033 4. Accreditation status.
1034 5. Other measures reflective of quality and safety.
1035 6. The length of time between inspections.
1036
1037 The agency shall continue to conduct unannounced licensure
1038 inspections on at least 10 percent of providers that qualify for
1039 an exemption or extended period between relicensure inspections.
1040 The agency may conduct an inspection of any provider at any time
1041 to verify regulatory compliance.
1042 Section 28. Subsection (24) of section 408.820, Florida
1043 Statutes, is amended to read:
1044 408.820 Exemptions.—Except as prescribed in authorizing
1045 statutes, the following exemptions shall apply to specified
1046 requirements of this part:
1047 ~~(24) Multiphasic health testing centers, as provided under~~
1048 ~~part I of chapter 483, are exempt from s. 408.810(5)-(10).~~
1049 Section 29. Subsections (1) and (2) of section 408.821,
1050 Florida Statutes, are amended to read:

1051 408.821 Emergency management planning; emergency
1052 operations; inactive license.—
1053 (1) A licensee required by authorizing statutes and agency
1054 rule to have a comprehensive ~~an~~ emergency management ~~operations~~
1055 plan must designate a safety liaison to serve as the primary
1056 contact for emergency operations. Such licensee shall submit its
1057 comprehensive emergency management plan to the local emergency
1058 management agency, county health department, or Department of
1059 Health as follows:
1060 (a) Submit the plan within 30 days after initial licensure
1061 and change of ownership, and notify the agency within 30 days
1062 after submission of the plan.
1063 (b) Submit the plan annually and within 30 days after any
1064 significant modification, as defined by agency rule, to a
1065 previously approved plan.
1066 (c) Submit necessary plan revisions within 30 days after
1067 notification that plan revisions are required.
1068 (d) Notify the agency within 30 days after approval of its
1069 plan by the local emergency management agency, county health
1070 department, or Department of Health.
1071 (2) An entity subject to this part may temporarily exceed
1072 its licensed capacity to act as a receiving provider in
1073 accordance with an approved comprehensive emergency management
1074 ~~operations~~ plan for up to 15 days. While in an overcapacity
1075 status, each provider must furnish or arrange for appropriate

1076 care and services to all clients. In addition, the agency may
1077 approve requests for overcapacity in excess of 15 days, which
1078 approvals may be based upon satisfactory justification and need
1079 as provided by the receiving and sending providers.
1080 Section 30. Subsection (3) of section 408.831, Florida
1081 Statutes, is amended to read:
1082 408.831 Denial, suspension, or revocation of a license,
1083 registration, certificate, or application.—
1084 (3) This section provides standards of enforcement
1085 applicable to all entities licensed or regulated by the Agency
1086 for Health Care Administration. This section controls over any
1087 conflicting provisions of chapters 39, 383, 390, 391, 394, 395,
1088 400, 408, 429, 468, ~~483,~~ and 765 or rules adopted pursuant to
1089 those chapters.
1090 Section 31. Section 408.832, Florida Statutes, is amended
1091 to read:
1092 408.832 Conflicts.—In case of conflict between ~~the~~
1093 ~~provisions of~~ this part and the authorizing statutes governing
1094 the licensure of health care providers by the Agency for Health
1095 Care Administration found in s. 112.0455 and chapters 383, 390,
1096 394, 395, 400, 429, 440, ~~483,~~ and 765, ~~the provisions of~~ this
1097 part shall prevail.
1098 Section 32. Subsection (9) of section 408.909, Florida
1099 Statutes, is amended to read:
1100 408.909 Health flex plans.—

1101 ~~(9) PROGRAM EVALUATION.—The agency and the office shall~~
1102 ~~evaluate the pilot program and its effect on the entities that~~
1103 ~~seek approval as health flex plans, on the number of enrollees,~~
1104 ~~and on the scope of the health care coverage offered under a~~
1105 ~~health flex plan; shall provide an assessment of the health flex~~
1106 ~~plans and their potential applicability in other settings; shall~~
1107 ~~use health flex plans to gather more information to evaluate~~
1108 ~~low-income consumer driven benefit packages; and shall, by~~
1109 ~~January 15, 2016, and annually thereafter, jointly submit a~~
1110 ~~report to the Governor, the President of the Senate, and the~~
1111 ~~Speaker of the House of Representatives.~~
1112 Section 33. Paragraph (d) of subsection (10) of section
1113 408.9091, Florida Statutes, is amended to read:
1114 408.9091 Cover Florida Health Care Access Program.—
1115 (10) PROGRAM EVALUATION.—The agency and the office shall:
1116 ~~(d) Jointly submit by March 1, annually, a report to the~~
1117 ~~Governor, the President of the Senate, and the Speaker of the~~
1118 ~~House of Representatives which provides the information~~
1119 ~~specified in paragraphs (a)-(c) and recommendations relating to~~
1120 ~~the successful implementation and administration of the program.~~
1121 Section 34. Effective upon becoming a law, paragraph (a)
1122 of subsection (5) of section 409.905, Florida Statutes, is
1123 amended to read:
1124 409.905 Mandatory Medicaid services.—The agency may make
1125 payments for the following services, which are required of the

1126 state by Title XIX of the Social Security Act, furnished by
1127 Medicaid providers to recipients who are determined to be
1128 eligible on the dates on which the services were provided. Any
1129 service under this section shall be provided only when medically
1130 necessary and in accordance with state and federal law.
1131 Mandatory services rendered by providers in mobile units to
1132 Medicaid recipients may be restricted by the agency. Nothing in
1133 this section shall be construed to prevent or limit the agency
1134 from adjusting fees, reimbursement rates, lengths of stay,
1135 number of visits, number of services, or any other adjustments
1136 necessary to comply with the availability of moneys and any
1137 limitations or directions provided for in the General
1138 Appropriations Act or chapter 216.
1139 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
1140 all covered services provided for the medical care and treatment
1141 of a recipient who is admitted as an inpatient by a licensed
1142 physician or dentist to a hospital licensed under part I of
1143 chapter 395. However, the agency shall limit the payment for
1144 inpatient hospital services for a Medicaid recipient 21 years of
1145 age or older to 45 days or the number of days necessary to
1146 comply with the General Appropriations Act.
1147 (a)1. The agency may implement reimbursement and
1148 utilization management reforms in order to comply with any
1149 limitations or directions in the General Appropriations Act,
1150 which may include, but are not limited to: prior authorization

1151 for inpatient psychiatric days; prior authorization for
1152 nonemergency hospital inpatient admissions for individuals 21
1153 years of age and older; authorization of emergency and urgent-
1154 care admissions within 24 hours after admission; enhanced
1155 utilization and concurrent review programs for highly utilized
1156 services; reduction or elimination of covered days of service;
1157 adjusting reimbursement ceilings for variable costs; adjusting
1158 reimbursement ceilings for fixed and property costs; and
1159 implementing target rates of increase.
1160 2. The agency may limit prior authorization for hospital
1161 inpatient services to selected diagnosis-related groups, based
1162 on an analysis of the cost and potential for unnecessary
1163 hospitalizations represented by certain diagnoses. Admissions
1164 for normal delivery and newborns are exempt from requirements
1165 for prior authorization.
1166 3. In implementing the provisions of this section related
1167 to prior authorization, the agency shall ensure that the process
1168 for authorization is accessible 24 hours per day, 7 days per
1169 week and authorization is automatically granted when not denied
1170 within 4 hours after the request. Authorization procedures must
1171 include steps for review of denials.
1172 4. Upon implementing the prior authorization program for
1173 hospital inpatient services, the agency shall discontinue its
1174 hospital retrospective review program. However, this
1175 subparagraph may not be construed to prevent the agency from

1176 conducting retrospective reviews under s. 409.913, including
1177 reviews in which overpayment is suspected due to improper
1178 claiming, mistake, or any other reason that does not rise to the
1179 level of fraud or abuse.
1180 Section 35. It is the intent of the Legislature that s.
1181 409.905(5)(a), Florida Statutes, as amended by this act, confirm
1182 and clarify existing law.
1183 Section 36. Subsection (8) of section 409.907, Florida
1184 Statutes, is amended to read:
1185 409.907 Medicaid provider agreements.—The agency may make
1186 payments for medical assistance and related services rendered to
1187 Medicaid recipients only to an individual or entity who has a
1188 provider agreement in effect with the agency, who is performing
1189 services or supplying goods in accordance with federal, state,
1190 and local law, and who agrees that no person shall, on the
1191 grounds of handicap, race, color, or national origin, or for any
1192 other reason, be subjected to discrimination under any program
1193 or activity for which the provider receives payment from the
1194 agency.
1195 (8)(a) A level 2 background screening pursuant to chapter
1196 435 must be conducted through the agency on each of the
1197 following:
1198 1. The ~~Each~~ provider, or each principal of the provider if
1199 the provider is a corporation, partnership, association, or
1200 other entity~~, seeking to participate in the Medicaid program~~

1201 ~~must submit a complete set of his or her fingerprints to the~~
1202 ~~agency for the purpose of conducting a criminal history record~~
1203 ~~check~~.
1204 2. Principals of the provider, who include any officer,
1205 director, billing agent, managing employee, or affiliated
1206 person, or any partner or shareholder who has an ownership
1207 interest equal to 5 percent or more in the provider. However,
1208 for a hospital licensed under chapter 395 or a nursing home
1209 licensed under chapter 400, principals of the provider are those
1210 who meet the definition of a controlling interest under s.
1211 408.803. A director of a not-for-profit corporation or
1212 organization is not a principal for purposes of a background
1213 investigation required by this section if the director: serves
1214 solely in a voluntary capacity for the corporation or
1215 organization, does not regularly take part in the day-to-day
1216 operational decisions of the corporation or organization,
1217 receives no remuneration from the not-for-profit corporation or
1218 organization for his or her service on the board of directors,
1219 has no financial interest in the not-for-profit corporation or
1220 organization, and has no family members with a financial
1221 interest in the not-for-profit corporation or organization; and
1222 if the director submits an affidavit, under penalty of perjury,
1223 to this effect to the agency and the not-for-profit corporation
1224 or organization submits an affidavit, under penalty of perjury,

1225 to this effect to the agency as part of the corporation's or
1226 organization's Medicaid provider agreement application.
1227 3. Any person who participates or seeks to participate in
1228 the Medicaid program by way of rendering services to Medicaid
1229 recipients or having direct access to Medicaid recipients,
1230 recipient living areas, or the financial, medical, or service
1231 records of a Medicaid recipient or who supervises the delivery
1232 of goods or services to a Medicaid recipient. This subparagraph
1233 does not impose additional screening requirements on any
1234 providers licensed under part II of chapter 408.
1235 (b) Notwithstanding paragraph (a) ~~the above~~, the agency
1236 may require a background check for any person reasonably
1237 suspected by the agency to have been convicted of a crime.
1238 (c) ~~(a)~~ Paragraph (a) ~~This subsection~~ does not apply to:
1239 1. A unit of local government, except that requirements of
1240 this subsection apply to nongovernmental providers and entities
1241 contracting with the local government to provide Medicaid
1242 services. The actual cost of the state and national criminal
1243 history record checks must be borne by the nongovernmental
1244 provider or entity; or
1245 2. Any business that derives more than 50 percent of its
1246 revenue from the sale of goods to the final consumer, and the
1247 business or its controlling parent is required to file a form
1248 10-K or other similar statement with the Securities and Exchange
1249 Commission or has a net worth of $50 million or more.

1250 (d) ~~(b)~~ Background screening shall be conducted in
1251 accordance with chapter 435 and s. 408.809. The cost of the
1252 state and national criminal record check shall be borne by the
1253 provider.
1254 Section 37. Section 409.913, Florida Statutes, is amended
1255 to read:
1256 409.913 Oversight of the integrity of the Medicaid
1257 program.—The agency shall operate a program to oversee the
1258 activities of Florida Medicaid recipients, and providers and
1259 their representatives, to ensure that fraudulent and abusive
1260 behavior and neglect of recipients occur to the minimum extent
1261 possible, and to recover overpayments and impose sanctions as
1262 appropriate. Each January 15 ~~1~~, the agency and the Medicaid
1263 Fraud Control Unit of the Department of Legal Affairs shall
1264 submit a ~~joint~~ report to the Legislature documenting the
1265 effectiveness of the state's efforts to control Medicaid fraud
1266 and abuse and to recover Medicaid overpayments during the
1267 previous fiscal year. The report must describe the number of
1268 cases opened and investigated each year; the sources of the
1269 cases opened; the disposition of the cases closed each year; the
1270 amount of overpayments alleged in preliminary and final audit
1271 letters; the number and amount of fines or penalties imposed;
1272 any reductions in overpayment amounts negotiated in settlement
1273 agreements or by other means; the amount of final agency
1274 determinations of overpayments; the amount deducted from federal

1275 claiming as a result of overpayments; the amount of overpayments
1276 recovered each year; the amount of cost of investigation
1277 recovered each year; the average length of time to collect from
1278 the time the case was opened until the overpayment is paid in
1279 full; the amount determined as uncollectible and the portion of
1280 the uncollectible amount subsequently reclaimed from the Federal
1281 Government; the number of providers, by type, that are
1282 terminated from participation in the Medicaid program as a
1283 result of fraud and abuse; and all costs associated with
1284 discovering and prosecuting cases of Medicaid overpayments and
1285 making recoveries in such cases. The report must also document
1286 actions taken to prevent overpayments and the number of
1287 providers prevented from enrolling in or reenrolling in the
1288 Medicaid program as a result of documented Medicaid fraud and
1289 abuse and must include policy recommendations necessary to
1290 prevent or recover overpayments and changes necessary to prevent
1291 and detect Medicaid fraud. All policy recommendations in the
1292 report must include a detailed fiscal analysis, including, but
1293 not limited to, implementation costs, estimated savings to the
1294 Medicaid program, and the return on investment. The agency must
1295 submit the policy recommendations and fiscal analyses in the
1296 report to the appropriate estimating conference, pursuant to s.
1297 216.137, by February 15 of each year. The agency and the
1298 Medicaid Fraud Control Unit of the Department of Legal Affairs
1299 each must include detailed unit-specific performance standards,

1300 benchmarks, and metrics in the report, including projected cost
1301 savings to the state Medicaid program during the following
1302 fiscal year.
1303 (1) For the purposes of this section, the term:
1304 (a) "Abuse" means:
1305 1. Provider practices that are inconsistent with generally
1306 accepted business or medical practices and that result in an
1307 unnecessary cost to the Medicaid program or in reimbursement for
1308 goods or services that are not medically necessary or that fail
1309 to meet professionally recognized standards for health care.
1310 2. Recipient practices that result in unnecessary cost to
1311 the Medicaid program.
1312 (b) "Complaint" means an allegation that fraud, abuse, or
1313 an overpayment has occurred.
1314 (c) "Fraud" means an intentional deception or
1315 misrepresentation made by a person with the knowledge that the
1316 deception results in unauthorized benefit to herself or himself
1317 or another person. The term includes any act that constitutes
1318 fraud under applicable federal or state law.
1319 (d) "Medical necessity" or "medically necessary" means any
1320 goods or services necessary to palliate the effects of a
1321 terminal condition, or to prevent, diagnose, correct, cure,
1322 alleviate, or preclude deterioration of a condition that
1323 threatens life, causes pain or suffering, or results in illness
1324 or infirmity, which goods or services are provided in accordance

1325 with generally accepted standards of medical practice. For
1326 purposes of determining Medicaid reimbursement, the agency is
1327 the final arbiter of medical necessity. Determinations of
1328 medical necessity must be made by a licensed physician employed
1329 by or under contract with the agency and must be based upon
1330 information available at the time the goods or services are
1331 provided.
1332 (e) "Overpayment" includes any amount that is not
1333 authorized to be paid by the Medicaid program whether paid as a
1334 result of inaccurate or improper cost reporting, improper
1335 claiming, unacceptable practices, fraud, abuse, or mistake.
1336 (f) "Person" means any natural person, corporation,
1337 partnership, association, clinic, group, or other entity,
1338 whether or not such person is enrolled in the Medicaid program
1339 or is a provider of health care.
1340 (2) The agency shall conduct, or cause to be conducted by
1341 contract or otherwise, reviews, investigations, analyses,
1342 audits, or any combination thereof, to determine possible fraud,
1343 abuse, overpayment, or recipient neglect in the Medicaid program
1344 and shall report the findings of any overpayments in audit
1345 reports as appropriate. At least 5 percent of all audits shall
1346 be conducted on a random basis. As part of its ongoing fraud
1347 detection activities, the agency shall identify and monitor, by
1348 contract or otherwise, patterns of overutilization of Medicaid
1349 services based on state averages. The agency shall track

1350 Medicaid provider prescription and billing patterns and evaluate
1351 them against Medicaid medical necessity criteria and coverage
1352 and limitation guidelines adopted by rule. Medical necessity
1353 determination requires that service be consistent with symptoms
1354 or confirmed diagnosis of illness or injury under treatment and
1355 not in excess of the patient's needs. The agency shall conduct
1356 reviews of provider exceptions to peer group norms and shall,
1357 using statistical methodologies, provider profiling, and
1358 analysis of billing patterns, detect and investigate abnormal or
1359 unusual increases in billing or payment of claims for Medicaid
1360 services and medically unnecessary provision of services.
1361 (3) The agency may conduct, or may contract for,
1362 prepayment review of provider claims to ensure cost-effective
1363 purchasing; to ensure that billing by a provider to the agency
1364 is in accordance with applicable provisions of all Medicaid
1365 rules, regulations, handbooks, and policies and in accordance
1366 with federal, state, and local law; and to ensure that
1367 appropriate care is rendered to Medicaid recipients. Such
1368 prepayment reviews may be conducted as determined appropriate by
1369 the agency, without any suspicion or allegation of fraud, abuse,
1370 or neglect, and may last for up to 1 year. Unless the agency has
1371 reliable evidence of fraud, misrepresentation, abuse, or
1372 neglect, claims shall be adjudicated for denial or payment
1373 within 90 days after receipt of complete documentation by the
1374 agency for review. If there is reliable evidence of fraud,

1375 misrepresentation, abuse, or neglect, claims shall be
1376 adjudicated for denial of payment within 180 days after receipt
1377 of complete documentation by the agency for review.
1378 (4) Any suspected criminal violation identified by the
1379 agency must be referred to the Medicaid Fraud Control Unit of
1380 the Office of the Attorney General for investigation. The agency
1381 and the Attorney General shall enter into a memorandum of
1382 understanding, which must include, but need not be limited to, a
1383 protocol for regularly sharing information and coordinating
1384 casework. The protocol must establish a procedure for the
1385 referral by the agency of cases involving suspected Medicaid
1386 fraud to the Medicaid Fraud Control Unit for investigation, and
1387 the return to the agency of those cases where investigation
1388 determines that administrative action by the agency is
1389 appropriate. Offices of the Medicaid program integrity program
1390 and the Medicaid Fraud Control Unit of the Department of Legal
1391 Affairs, shall, to the extent possible, be collocated. The
1392 agency and the Department of Legal Affairs shall periodically
1393 conduct joint training and other joint activities designed to
1394 increase communication and coordination in recovering
1395 overpayments.
1396 (5) A Medicaid provider is subject to having goods and
1397 services that are paid for by the Medicaid program reviewed by
1398 an appropriate peer-review organization designated by the
1399 agency. The written findings of the applicable peer-review

1400 organization are admissible in any court or administrative
1401 proceeding as evidence of medical necessity or the lack thereof.
1402 (6) Any notice required to be given to a provider under
1403 this section is presumed to be sufficient notice if sent to the
1404 address last shown on the provider enrollment file. It is the
1405 responsibility of the provider to furnish and keep the agency
1406 informed of the provider's current address. United States Postal
1407 Service proof of mailing or certified or registered mailing of
1408 such notice to the provider at the address shown on the provider
1409 enrollment file constitutes sufficient proof of notice. Any
1410 notice required to be given to the agency by this section must
1411 be sent to the agency at an address designated by rule.
1412 (7) When presenting a claim for payment under the Medicaid
1413 program, a provider has an affirmative duty to supervise the
1414 provision of, and be responsible for, goods and services claimed
1415 to have been provided, to supervise and be responsible for
1416 preparation and submission of the claim, and to present a claim
1417 that is true and accurate and that is for goods and services
1418 that:
1419 (a) Have actually been furnished to the recipient by the
1420 provider prior to submitting the claim.
1421 (b) Are Medicaid-covered goods or services that are
1422 medically necessary.
1423 (c) Are of a quality comparable to those furnished to the
1424 general public by the provider's peers.

1425 (d) Have not been billed in whole or in part to a
1426 recipient or a recipient's responsible party, except for such
1427 copayments, coinsurance, or deductibles as are authorized by the
1428 agency.
1429 (e) Are provided in accord with applicable provisions of
1430 all Medicaid rules, regulations, handbooks, and policies and in
1431 accordance with federal, state, and local law.
1432 (f) Are documented by records made at the time the goods
1433 or services were provided, demonstrating the medical necessity
1434 for the goods or services rendered. Medicaid goods or services
1435 are excessive or not medically necessary unless both the medical
1436 basis and the specific need for them are fully and properly
1437 documented in the recipient's medical record.
1438
1439 The agency shall deny payment or require repayment for goods or
1440 services that are not presented as required in this subsection.
1441 (8) The agency shall not reimburse any person or entity
1442 for any prescription for medications, medical supplies, or
1443 medical services if the prescription was written by a physician
1444 or other prescribing practitioner who is not enrolled in the
1445 Medicaid program. This section does not apply:
1446 (a) In instances involving bona fide emergency medical
1447 conditions as determined by the agency;

1448 (b) To a provider of medical services to a patient in a
1449 hospital emergency department, hospital inpatient or outpatient
1450 setting, or nursing home;
1451 (c) To bona fide pro bono services by preapproved non-
1452 Medicaid providers as determined by the agency;
1453 (d) To prescribing physicians who are board-certified
1454 specialists treating Medicaid recipients referred for treatment
1455 by a treating physician who is enrolled in the Medicaid program;
1456 (e) To prescriptions written for dually eligible Medicare
1457 beneficiaries by an authorized Medicare provider who is not
1458 enrolled in the Medicaid program;
1459 (f) To other physicians who are not enrolled in the
1460 Medicaid program but who provide a medically necessary service
1461 or prescription not otherwise reasonably available from a
1462 Medicaid-enrolled physician; or
1463 (9) A Medicaid provider shall retain medical,
1464 professional, financial, and business records pertaining to
1465 services and goods furnished to a Medicaid recipient and billed
1466 to Medicaid for a period of 5 years after the date of furnishing
1467 such services or goods. The agency may investigate, review, or
1468 analyze such records, which must be made available during normal
1469 business hours. However, 24-hour notice must be provided if
1470 patient treatment would be disrupted. The provider must keep the
1471 agency informed of the location of the provider's Medicaid-
1472 related records. The authority of the agency to obtain Medicaid-

1473 related records from a provider is neither curtailed nor limited
1474 during a period of litigation between the agency and the
1475 provider.
1476 (10) Payments for the services of billing agents or
1477 persons participating in the preparation of a Medicaid claim
1478 shall not be based on amounts for which they bill nor based on
1479 the amount a provider receives from the Medicaid program.
1480 (11) The agency shall deny payment or require repayment
1481 for inappropriate, medically unnecessary, or excessive goods or
1482 services from the person furnishing them, the person under whose
1483 supervision they were furnished, or the person causing them to
1484 be furnished.
1485 (12) The complaint and all information obtained pursuant
1486 to an investigation of a Medicaid provider, or the authorized
1487 representative or agent of a provider, relating to an allegation
1488 of fraud, abuse, or neglect are confidential and exempt from the
1489 provisions of s. 119.07(1):
1490 (a) Until the agency takes final agency action with
1491 respect to the provider and requires repayment of any
1492 overpayment, or imposes an administrative sanction;
1493 (b) Until the Attorney General refers the case for
1494 criminal prosecution;
1495 (c) Until 10 days after the complaint is determined
1496 without merit; or

1497 (d) At all times if the complaint or information is
1498 otherwise protected by law.
1499 (13) The agency shall terminate participation of a
1500 Medicaid provider in the Medicaid program and may seek civil
1501 remedies or impose other administrative sanctions against a
1502 Medicaid provider, if the provider or any principal, officer,
1503 director, agent, managing employee, or affiliated person of the
1504 provider, or any partner or shareholder having an ownership
1505 interest in the provider equal to 5 percent or greater, has been
1506 convicted of a criminal offense under federal law or the law of
1507 any state relating to the practice of the provider's profession,
1508 or a criminal offense listed under s. 408.809(4), s.
1509 409.907(10), or s. 435.04(2). If the agency determines that the
1510 provider did not participate or acquiesce in the offense,
1511 termination will not be imposed. If the agency effects a
1512 termination under this subsection, the agency shall take final
1513 agency action.
1514 (14) If the provider has been suspended or terminated from
1515 participation in the Medicaid program or the Medicare program by
1516 the Federal Government or any state, the agency must immediately
1517 suspend or terminate, as appropriate, the provider's
1518 participation in this state's Medicaid program for a period no
1519 less than that imposed by the Federal Government or any other
1520 state, and may not enroll such provider in this state's Medicaid
1521 program while such foreign suspension or termination remains in

1522 effect. The agency shall also immediately suspend or terminate,
1523 as appropriate, a provider's participation in this state's
1524 Medicaid program if the provider participated or acquiesced in
1525 any action for which any principal, officer, director, agent,
1526 managing employee, or affiliated person of the provider, or any
1527 partner or shareholder having an ownership interest in the
1528 provider equal to 5 percent or greater, was suspended or
1529 terminated from participating in the Medicaid program or the
1530 Medicare program by the Federal Government or any state. This
1531 sanction is in addition to all other remedies provided by law.
1532 (15) The agency shall seek a remedy provided by law,
1533 including, but not limited to, any remedy provided in
1534 subsections (13) and (16) and s. 812.035, if:
1535 (a) The provider's license has not been renewed, or has
1536 been revoked, suspended, or terminated, for cause, by the
1537 licensing agency of any state;
1538 (b) The provider has failed to make available or has
1539 refused access to Medicaid-related records to an auditor,
1540 investigator, or other authorized employee or agent of the
1541 agency, the Attorney General, a state attorney, or the Federal
1542 Government;
1543 (c) The provider has not furnished or has failed to make
1544 available such Medicaid-related records as the agency has found
1545 necessary to determine whether Medicaid payments are or were due
1546 and the amounts thereof;

1547 (d) The provider has failed to maintain medical records
1548 made at the time of service, or prior to service if prior
1549 authorization is required, demonstrating the necessity and
1550 appropriateness of the goods or services rendered;
1551 (e) The provider is not in compliance with provisions of
1552 Medicaid provider publications that have been adopted by
1553 reference as rules in the Florida Administrative Code; with
1554 provisions of state or federal laws, rules, or regulations; with
1555 provisions of the provider agreement between the agency and the
1556 provider; or with certifications found on claim forms or on
1557 transmittal forms for electronically submitted claims that are
1558 submitted by the provider or authorized representative, as such
1559 provisions apply to the Medicaid program;
1560 (f) The provider or person who ordered, authorized, or
1561 prescribed the care, services, or supplies has furnished, or
1562 ordered or authorized the furnishing of, goods or services to a
1563 recipient which are inappropriate, unnecessary, excessive, or
1564 harmful to the recipient or are of inferior quality;
1565 (g) The provider has demonstrated a pattern of failure to
1566 provide goods or services that are medically necessary;
1567 (h) The provider or an authorized representative of the
1568 provider, or a person who ordered, authorized, or prescribed the
1569 goods or services, has submitted or caused to be submitted false
1570 or a pattern of erroneous Medicaid claims;

1571 (i) The provider or an authorized representative of the
1572 provider, or a person who has ordered, authorized, or prescribed
1573 the goods or services, has submitted or caused to be submitted a
1574 Medicaid provider enrollment application, a request for prior
1575 authorization for Medicaid services, a drug exception request,
1576 or a Medicaid cost report that contains materially false or
1577 incorrect information;
1578 (j) The provider or an authorized representative of the
1579 provider has collected from or billed a recipient or a
1580 recipient's responsible party improperly for amounts that should
1581 not have been so collected or billed by reason of the provider's
1582 billing the Medicaid program for the same service;
1583 (k) The provider or an authorized representative of the
1584 provider has included in a cost report costs that are not
1585 allowable under a Florida Title XIX reimbursement plan after the
1586 provider or authorized representative had been advised in an
1587 audit exit conference or audit report that the costs were not
1588 allowable;
1589 (l) The provider is charged by information or indictment
1590 with fraudulent billing practices or an offense referenced in
1591 subsection (13). The sanction applied for this reason is limited
1592 to suspension of the provider's participation in the Medicaid
1593 program for the duration of the indictment unless the provider
1594 is found guilty pursuant to the information or indictment;

1595 (m) The provider or a person who ordered, authorized, or
1596 prescribed the goods or services is found liable for negligent
1597 practice resulting in death or injury to the provider's patient;
1598 (n) The provider fails to demonstrate that it had
1599 available during a specific audit or review period sufficient
1600 quantities of goods, or sufficient time in the case of services,
1601 to support the provider's billings to the Medicaid program;
1602 (o) The provider has failed to comply with the notice and
1603 reporting requirements of s. 409.907;
1604 (p) The agency has received reliable information of
1605 patient abuse or neglect or of any act prohibited by s. 409.920;
1606 or
1607 (q) The provider has failed to comply with an agreed-upon
1608 repayment schedule.
1609
1610 A provider is subject to sanctions for violations of this
1611 subsection as the result of actions or inactions of the
1612 provider, or actions or inactions of any principal, officer,
1613 director, agent, managing employee, or affiliated person of the
1614 provider, or any partner or shareholder having an ownership
1615 interest in the provider equal to 5 percent or greater, in which
1616 the provider participated or acquiesced.
1617 (16) The agency shall impose any of the following
1618 sanctions or disincentives on a provider or a person for any of
1619 the acts described in subsection (15):

1620 (a) Suspension for a specific period of time of not more
1621 than 1 year. Suspension precludes participation in the Medicaid
1622 program, which includes any action that results in a claim for
1623 payment to the Medicaid program for furnishing, supervising a
1624 person who is furnishing, or causing a person to furnish goods
1625 or services.
1626 (b) Termination for a specific period of time ranging from
1627 more than 1 year to 20 years. Termination precludes
1628 participation in the Medicaid program, which includes any action
1629 that results in a claim for payment to the Medicaid program for
1630 furnishing, supervising a person who is furnishing, or causing a
1631 person to furnish goods or services.
1632 (c) Imposition of a fine of up to $5,000 for each
1633 violation. Each day that an ongoing violation continues, such as
1634 refusing to furnish Medicaid-related records or refusing access
1635 to records, is considered a separate violation. Each instance of
1636 improper billing of a Medicaid recipient; each instance of
1637 including an unallowable cost on a hospital or nursing home
1638 Medicaid cost report after the provider or authorized
1639 representative has been advised in an audit exit conference or
1640 previous audit report of the cost unallowability; each instance
1641 of furnishing a Medicaid recipient goods or professional
1642 services that are inappropriate or of inferior quality as
1643 determined by competent peer judgment; each instance of
1644 knowingly submitting a materially false or erroneous Medicaid

1645 provider enrollment application, request for prior authorization
1646 for Medicaid services, drug exception request, or cost report;
1647 each instance of inappropriate prescribing of drugs for a
1648 Medicaid recipient as determined by competent peer judgment; and
1649 each false or erroneous Medicaid claim leading to an overpayment
1650 to a provider is considered a separate violation.
1651 (d) Immediate suspension, if the agency has received
1652 information of patient abuse or neglect or of any act prohibited
1653 by s. 409.920. Upon suspension, the agency must issue an
1654 immediate final order under s. 120.569(2)(n).
1655 (e) A fine, not to exceed $10,000, for a violation of
1656 paragraph (15)(i).
1657 (f) Imposition of liens against provider assets,
1658 including, but not limited to, financial assets and real
1659 property, not to exceed the amount of fines or recoveries
1660 sought, upon entry of an order determining that such moneys are
1661 due or recoverable.
1662 (g) Prepayment reviews of claims for a specified period of
1663 time.
1664 (h) Comprehensive followup reviews of providers every 6
1665 months to ensure that they are billing Medicaid correctly.
1666 (i) Corrective-action plans that remain in effect for up
1667 to 3 years and that are monitored by the agency every 6 months
1668 while in effect.

1669 (j) Other remedies as permitted by law to effect the
1670 recovery of a fine or overpayment.
1671
1672 If a provider voluntarily relinquishes its Medicaid provider
1673 number or an associated license, or allows the associated
1674 licensure to expire after receiving written notice that the
1675 agency is conducting, or has conducted, an audit, survey,
1676 inspection, or investigation and that a sanction of suspension
1677 or termination will or would be imposed for noncompliance
1678 discovered as a result of the audit, survey, inspection, or
1679 investigation, the agency shall impose the sanction of
1680 termination for cause against the provider. The agency's
1681 termination with cause is subject to hearing rights as may be
1682 provided under chapter 120. The Secretary of Health Care
1683 Administration may make a determination that imposition of a
1684 sanction or disincentive is not in the best interest of the
1685 Medicaid program, in which case a sanction or disincentive may
1686 not be imposed.
1687 (17) In determining the appropriate administrative
1688 sanction to be applied, or the duration of any suspension or
1689 termination, the agency shall consider:
1690 (a) The seriousness and extent of the violation or
1691 violations.
1692 (b) Any prior history of violations by the provider
1693 relating to the delivery of health care programs which resulted

1694 in either a criminal conviction or in administrative sanction or
1695 penalty.
1696 (c) Evidence of continued violation within the provider's
1697 management control of Medicaid statutes, rules, regulations, or
1698 policies after written notification to the provider of improper
1699 practice or instance of violation.
1700 (d) The effect, if any, on the quality of medical care
1701 provided to Medicaid recipients as a result of the acts of the
1702 provider.
1703 (e) Any action by a licensing agency respecting the
1704 provider in any state in which the provider operates or has
1705 operated.
1706 (f) The apparent impact on access by recipients to
1707 Medicaid services if the provider is suspended or terminated, in
1708 the best judgment of the agency.
1709
1710 The agency shall document the basis for all sanctioning actions
1711 and recommendations.
1712 (18) The agency may take action to sanction, suspend, or
1713 terminate a particular provider working for a group provider,
1714 and may suspend or terminate Medicaid participation at a
1715 specific location, rather than or in addition to taking action
1716 against an entire group.
1717 (19) The agency shall establish a process for conducting
1718 followup reviews of a sampling of providers who have a history

1719 of overpayment under the Medicaid program. This process must
1720 consider the magnitude of previous fraud or abuse and the
1721 potential effect of continued fraud or abuse on Medicaid costs.
1722 (20) In making a determination of overpayment to a
1723 provider, the agency must use accepted and valid auditing,
1724 accounting, analytical, statistical, or peer-review methods, or
1725 combinations thereof. Appropriate statistical methods may
1726 include, but are not limited to, sampling and extension to the
1727 population, parametric and nonparametric statistics, tests of
1728 hypotheses, and other generally accepted statistical methods.
1729 Appropriate analytical methods may include, but are not limited
1730 to, reviews to determine variances between the quantities of
1731 products that a provider had on hand and available to be
1732 purveyed to Medicaid recipients during the review period and the
1733 quantities of the same products paid for by the Medicaid program
1734 for the same period, taking into appropriate consideration sales
1735 of the same products to non-Medicaid customers during the same
1736 period. In meeting its burden of proof in any administrative or
1737 court proceeding, the agency may introduce the results of such
1738 statistical methods as evidence of overpayment.
1739 (21) When making a determination that an overpayment has
1740 occurred, the agency shall prepare and issue an audit report to
1741 the provider showing the calculation of overpayments. The
1742 agency's determination must be based solely upon information
1743 available to it before issuance of the audit report and, in the

1744 case of documentation obtained to substantiate claims for
1745 Medicaid reimbursement, based solely upon contemporaneous
1746 records. The agency may consider addenda or modifications to a
1747 note that was made contemporaneously with the patient care
1748 episode if the addenda or modifications are germane to the note.
1749 (22) The audit report, supported by agency work papers,
1750 showing an overpayment to a provider constitutes evidence of the
1751 overpayment. A provider may not present or elicit testimony on
1752 direct examination or cross-examination in any court or
1753 administrative proceeding, regarding the purchase or acquisition
1754 by any means of drugs, goods, or supplies; sales or divestment
1755 by any means of drugs, goods, or supplies; or inventory of
1756 drugs, goods, or supplies, unless such acquisition, sales,
1757 divestment, or inventory is documented by written invoices,
1758 written inventory records, or other competent written
1759 documentary evidence maintained in the normal course of the
1760 provider's business. A provider may not present records to
1761 contest an overpayment or sanction unless such records are
1762 contemporaneous and, if requested during the audit process, were
1763 furnished to the agency or its agent upon request. This
1764 limitation does not apply to Medicaid cost report audits. This
1765 limitation does not preclude consideration by the agency of
1766 addenda or modifications to a note if the addenda or
1767 modifications are made before notification of the audit, the
1768 addenda or modifications are germane to the note, and the note

1769 was made contemporaneously with a patient care episode.
1770 Notwithstanding the applicable rules of discovery, all
1771 documentation to be offered as evidence at an administrative
1772 hearing on a Medicaid overpayment or an administrative sanction
1773 must be exchanged by all parties at least 14 days before the
1774 administrative hearing or be excluded from consideration.
1775 (23)(a) In an audit, ~~or~~ investigation, or enforcement
1776 action for ~~of~~ a violation committed by a provider which is
1777 conducted or taken pursuant to this section, the agency or
1778 contractor is entitled to recover any and all investigative and~~,~~
1779 legal costs incurred as a result of such audit, investigation,
1780 or enforcement action. Such costs may include, but are not
1781 limited to, salaries and benefits of personnel, costs related to
1782 the time spent by an attorney and other personnel working on the
1783 case, and any other expenses incurred by the agency or
1784 contractor that are associated with the case, including any~~, and~~
1785 expert witness costs and attorney fees incurred on behalf of the
1786 agency or contractor if the agency's findings were not contested
1787 by the provider or, if contested, the agency ultimately
1788 prevailed.
1789 (24) If the agency imposes an administrative sanction
1790 pursuant to subsection (13), subsection (14), or subsection
1791 (15), except paragraphs (15)(e) and (o), upon any provider or
1792 any principal, officer, director, agent, managing employee, or
1793 affiliated person of the provider who is regulated by another

1794 state entity, the agency shall notify that other entity of the
1795 imposition of the sanction within 5 business days. Such
1796 notification must include the provider's or person's name and
1797 license number and the specific reasons for sanction.
1798 (25)(a) The agency shall withhold Medicaid payments, in
1799 whole or in part, to a provider upon receipt of reliable
1800 evidence that the circumstances giving rise to the need for a
1801 withholding of payments involve fraud, willful
1802 misrepresentation, or abuse under the Medicaid program, or a
1803 crime committed while rendering goods or services to Medicaid
1804 recipients. If it is determined that fraud, willful
1805 misrepresentation, abuse, or a crime did not occur, the payments
1806 withheld must be paid to the provider within 14 days after such
1807 determination. Amounts not paid within 14 days accrue interest
1808 at the rate of 10 percent per year, beginning after the 14th
1809 day.
1810 (b) The agency shall deny payment, or require repayment,
1811 if the goods or services were furnished, supervised, or caused
1812 to be furnished by a person who has been suspended or terminated
1813 from the Medicaid program or Medicare program by the Federal
1814 Government or any state.
1815 (c) Overpayments owed to the agency bear interest at the
1816 rate of 10 percent per year from the date of final determination
1817 of the overpayment by the agency, and payment arrangements must

1818 be made within 30 days after the date of the final order, which
1819 is not subject to further appeal.
1820 (d) The agency, upon entry of a final agency order, a
1821 judgment or order of a court of competent jurisdiction, or a
1822 stipulation or settlement, may collect the moneys owed by all
1823 means allowable by law, including, but not limited to, notifying
1824 any fiscal intermediary of Medicare benefits that the state has
1825 a superior right of payment. Upon receipt of such written
1826 notification, the Medicare fiscal intermediary shall remit to
1827 the state the sum claimed.
1828 (e) The agency may institute amnesty programs to allow
1829 Medicaid providers the opportunity to voluntarily repay
1830 overpayments. The agency may adopt rules to administer such
1831 programs.
1832 (26) The agency may impose administrative sanctions
1833 against a Medicaid recipient, or the agency may seek any other
1834 remedy provided by law, including, but not limited to, the
1835 remedies provided in s. 812.035, if the agency finds that a
1836 recipient has engaged in solicitation in violation of s. 409.920
1837 or that the recipient has otherwise abused the Medicaid program.
1838 (27) When the Agency for Health Care Administration has
1839 made a probable cause determination and alleged that an
1840 overpayment to a Medicaid provider has occurred, the agency,
1841 after notice to the provider, shall:

1842 (a) Withhold, and continue to withhold during the pendency
1843 of an administrative hearing pursuant to chapter 120, any
1844 medical assistance reimbursement payments until such time as the
1845 overpayment is recovered, unless within 30 days after receiving
1846 notice thereof the provider:
1847 1. Makes repayment in full; or
1848 2. Establishes a repayment plan that is satisfactory to
1849 the Agency for Health Care Administration.
1850 (b) Withhold, and continue to withhold during the pendency
1851 of an administrative hearing pursuant to chapter 120, medical
1852 assistance reimbursement payments if the terms of a repayment
1853 plan are not adhered to by the provider.
1854 (28) Venue for all Medicaid program integrity cases lies
1855 in Leon County, at the discretion of the agency.
1856 (29) Notwithstanding other provisions of law, the agency
1857 and the Medicaid Fraud Control Unit of the Department of Legal
1858 Affairs may review a provider's Medicaid-related and non-
1859 Medicaid-related records in order to determine the total output
1860 of a provider's practice to reconcile quantities of goods or
1861 services billed to Medicaid with quantities of goods or services
1862 used in the provider's total practice.
1863 (30) The agency shall terminate a provider's participation
1864 in the Medicaid program if the provider fails to reimburse an
1865 overpayment or pay an agency-imposed fine that has been
1866 determined by final order, not subject to further appeal, within

1867 30 days after the date of the final order, unless the provider
1868 and the agency have entered into a repayment agreement.
1869 (31) If a provider requests an administrative hearing
1870 pursuant to chapter 120, such hearing must be conducted within
1871 90 days following assignment of an administrative law judge,
1872 absent exceptionally good cause shown as determined by the
1873 administrative law judge or hearing officer. Upon issuance of a
1874 final order, the outstanding balance of the amount determined to
1875 constitute the overpayment and fines is due. If a provider fails
1876 to make payments in full, fails to enter into a satisfactory
1877 repayment plan, or fails to comply with the terms of a repayment
1878 plan or settlement agreement, the agency shall withhold
1879 reimbursement payments for Medicaid services until the amount
1880 due is paid in full.
1881 (32) Duly authorized agents and employees of the agency
1882 shall have the power to inspect, during normal business hours,
1883 the records of any pharmacy, wholesale establishment, or
1884 manufacturer, or any other place in which drugs and medical
1885 supplies are manufactured, packed, packaged, made, stored, sold,
1886 or kept for sale, for the purpose of verifying the amount of
1887 drugs and medical supplies ordered, delivered, or purchased by a
1888 provider. The agency shall provide at least 2 business days'
1889 prior notice of any such inspection. The notice must identify
1890 the provider whose records will be inspected, and the inspection

1891 shall include only records specifically related to that
1892 provider.
1893 (33) In accordance with federal law, Medicaid recipients
1894 convicted of a crime pursuant to 42 U.S.C. s. 1320a-7b may be
1895 limited, restricted, or suspended from Medicaid eligibility for
1896 a period not to exceed 1 year, as determined by the agency head
1897 or designee.
1898 (34) To deter fraud and abuse in the Medicaid program, the
1899 agency may limit the number of Schedule II and Schedule III
1900 refill prescription claims submitted from a pharmacy provider.
1901 The agency shall limit the allowable amount of reimbursement of
1902 prescription refill claims for Schedule II and Schedule III
1903 pharmaceuticals if the agency or the Medicaid Fraud Control Unit
1904 determines that the specific prescription refill was not
1905 requested by the Medicaid recipient or authorized representative
1906 for whom the refill claim is submitted or was not prescribed by
1907 the recipient's medical provider or physician. Any such refill
1908 request must be consistent with the original prescription.
1909 (35) The Office of Program Policy Analysis and Government
1910 Accountability shall provide a report to the President of the
1911 Senate and the Speaker of the House of Representatives on a
1912 biennial basis, beginning January 31, 2006, on the agency's
1913 efforts to prevent, detect, and deter, as well as recover funds
1914 lost to, fraud and abuse in the Medicaid program.

1915 (36) The agency may provide to a sample of Medicaid
1916 recipients or their representatives through the distribution of
1917 explanations of benefits information about services reimbursed
1918 by the Medicaid program for goods and services to such
1919 recipients, including information on how to report inappropriate
1920 or incorrect billing to the agency or other law enforcement
1921 entities for review or investigation, information on how to
1922 report criminal Medicaid fraud to the Medicaid Fraud Control
1923 Unit's toll-free hotline number, and information about the
1924 rewards available under s. 409.9203. The explanation of benefits
1925 may not be mailed for Medicaid independent laboratory services
1926 as described in s. 409.905(7) or for Medicaid certified match
1927 services as described in ss. 409.9071 and 1011.70.
1928 (37) The agency shall post on its website a current list
1929 of each Medicaid provider, including any principal, officer,
1930 director, agent, managing employee, or affiliated person of the
1931 provider, or any partner or shareholder having an ownership
1932 interest in the provider equal to 5 percent or greater, who has
1933 been terminated for cause from the Medicaid program or
1934 sanctioned under this section. The list must be searchable by a
1935 variety of search parameters and provide for the creation of
1936 formatted lists that may be printed or imported into other
1937 applications, including spreadsheets. The agency shall update
1938 the list at least monthly.

1939 (38) In order to improve the detection of health care
1940 fraud, use technology to prevent and detect fraud, and maximize
1941 the electronic exchange of health care fraud information, the
1942 agency shall:
1943 (a) Compile, maintain, and publish on its website a
1944 detailed list of all state and federal databases that contain
1945 health care fraud information and update the list at least
1946 biannually;
1947 (b) Develop a strategic plan to connect all databases that
1948 contain health care fraud information to facilitate the
1949 electronic exchange of health information between the agency,
1950 the Department of Health, the Department of Law Enforcement, and
1951 the Attorney General's Office. The plan must include recommended
1952 standard data formats, fraud identification strategies, and
1953 specifications for the technical interface between state and
1954 federal health care fraud databases;
1955 (c) Monitor innovations in health information technology,
1956 specifically as it pertains to Medicaid fraud prevention and
1957 detection; and
1958 (d) Periodically publish policy briefs that highlight
1959 available new technology to prevent or detect health care fraud
1960 and projects implemented by other states, the private sector, or
1961 the Federal Government which use technology to prevent or detect
1962 health care fraud.

1963 Section 38. Subsection (1) of section 409.967, Florida
1964 Statutes, is amended to read:
1965 409.967 Managed care plan accountability.—
1966 (1) <u>Beginning with the contract procurement process</u>
1967 <u>initiated during the 2023 calendar year,</u> the agency shall
1968 establish a <u>6-year</u> ~~5-year~~ contract with each managed care plan
1969 selected through the procurement process described in s.
1970 409.966. A plan contract may not be renewed; however, the agency
1971 may extend the term of a plan contract to cover any delays
1972 during the transition to a new plan. <u>The agency shall extend</u>
1973 <u>until December 31, 2024, the term of existing plan contracts</u>
1974 <u>awarded pursuant to the invitation to negotiate published in</u>
1975 <u>July 2017.</u>
1976 Section 39. Paragraph (b) of subsection (5) of section
1977 409.973, Florida Statutes, is amended to read:
1978 409.973 Benefits.—
1979 (5) PROVISION OF DENTAL SERVICES.—
1980 (b) In the event the Legislature takes no action before
1981 July 1, 2017, with respect to the report findings required under
1982 subparagraph (a)2., the agency shall implement a statewide
1983 Medicaid prepaid dental health program for children and adults
1984 with a choice of at least two licensed dental managed care
1985 providers who must have substantial experience in providing
1986 dental care to Medicaid enrollees and children eligible for
1987 medical assistance under Title XXI of the Social Security Act

1988 and who meet all agency standards and requirements. To qualify
1989 as a provider under the prepaid dental health program, the
1990 entity must be licensed as a prepaid limited health service
1991 organization under part I of chapter 636 or as a health
1992 maintenance organization under part I of chapter 641. The
1993 contracts for program providers shall be awarded through a
1994 competitive procurement process. Beginning with the contract
1995 procurement process initiated during the 2023 calendar year, the
1996 contracts must be for 6 ~~5~~ years and may not be renewed; however,
1997 the agency may extend the term of a plan contract to cover
1998 delays during a transition to a new plan provider. The agency
1999 shall include in the contracts a medical loss ratio provision
2000 consistent with s. 409.967(4). The agency is authorized to seek
2001 any necessary state plan amendment or federal waiver to commence
2002 enrollment in the Medicaid prepaid dental health program no
2003 later than March 1, 2019. The agency shall extend until December
2004 31, 2024, the term of existing plan contracts awarded pursuant
2005 to the invitation to negotiate published in October 2017.
2006 Section 40. Subsection (6) of section 429.11, Florida
2007 Statutes, is amended to read:
2008 429.11 Initial application for license; provisional
2009 license.—
2010 ~~(6) In addition to the license categories available in s.~~
2011 ~~408.808, a provisional license may be issued to an applicant~~
2012 ~~making initial application for licensure or making application~~

2013 ~~for a change of ownership. A provisional license shall be~~
2014 ~~limited in duration to a specific period of time not to exceed 6~~
2015 ~~months, as determined by the agency.~~
2016 Section 41. Subsection (9) of section 429.19, Florida
2017 Statutes, is amended to read:
2018 429.19 Violations; imposition of administrative fines;
2019 grounds.—
2020 ~~(9) The agency shall develop and disseminate an annual~~
2021 ~~list of all facilities sanctioned or fined for violations of~~
2022 ~~state standards, the number and class of violations involved,~~
2023 ~~the penalties imposed, and the current status of cases. The list~~
2024 ~~shall be disseminated, at no charge, to the Department of~~
2025 ~~Elderly Affairs, the Department of Health, the Department of~~
2026 ~~Children and Families, the Agency for Persons with Disabilities,~~
2027 ~~the area agencies on aging, the Florida Statewide Advocacy~~
2028 ~~Council, the State Long-Term Care Ombudsman Program, and state~~
2029 ~~and local ombudsman councils. The Department of Children and~~
2030 ~~Families shall disseminate the list to service providers under~~
2031 ~~contract to the department who are responsible for referring~~
2032 ~~persons to a facility for residency. The agency may charge a fee~~
2033 ~~commensurate with the cost of printing and postage to other~~
2034 ~~interested parties requesting a copy of this list. This~~
2035 ~~information may be provided electronically or through the~~
2036 ~~agency's Internet site.~~

2037 Section 42. Subsection (2) of section 429.35, Florida
2038 Statutes, is amended to read:
2039 429.35 Maintenance of records; reports.—
2040 (2) Within 60 days after the date of an ~~the biennial~~
2041 inspection conducted ~~visit required~~ under s. 408.811 or within
2042 30 days after the date of an ~~any~~ interim visit, the agency shall
2043 forward the results of the inspection to the local ombudsman
2044 council in the district where the facility is located; to at
2045 least one public library or, in the absence of a public library,
2046 the county seat in the county in which the inspected assisted
2047 living facility is located; and, when appropriate, to the
2048 district Adult Services and Mental Health Program Offices.
2049 Section 43. Subsection (2) of section 429.905, Florida
2050 Statutes, is amended to read:
2051 429.905 Exemptions; monitoring of adult day care center
2052 programs colocated with assisted living facilities or licensed
2053 nursing home facilities.—
2054 (2) A licensed assisted living facility, a licensed
2055 hospital, or a licensed nursing home facility may provide
2056 services during the day which include, but are not limited to,
2057 social, health, therapeutic, recreational, nutritional, and
2058 respite services, to adults who are not residents. Such a
2059 facility need not be licensed as an adult day care center;
2060 however, the agency must monitor the facility during the regular
2061 inspection ~~and at least biennially~~ to ensure adequate space and

2062 sufficient staff. If an assisted living facility, a hospital, or
2063 a nursing home holds itself out to the public as an adult day
2064 care center, it must be licensed as such and meet all standards
2065 prescribed by statute and rule. For the purpose of this
2066 subsection, the term "day" means any portion of a 24-hour day.
2067 Section 44. Subsection (2) of section 429.929, Florida
2068 Statutes, is amended to read:
2069 429.929 Rules establishing standards.—
2070 ~~(2) Pursuant to this part, s. 408.811, and applicable~~
2071 ~~rules, the agency may conduct an abbreviated biennial inspection~~
2072 ~~of key quality-of-care standards, in lieu of a full inspection,~~
2073 ~~of a center that has a record of good performance. However, the~~
2074 ~~agency must conduct a full inspection of a center that has had~~
2075 ~~one or more confirmed complaints within the licensure period~~
2076 ~~immediately preceding the inspection or which has a serious~~
2077 ~~problem identified during the abbreviated inspection. The agency~~
2078 ~~shall develop the key quality-of-care standards, taking into~~
2079 ~~consideration the comments and recommendations of provider~~
2080 ~~groups. These standards shall be included in rules adopted by~~
2081 ~~the agency.~~
2082 Section 45. <u>Part I of chapter 483, Florida Statutes, is</u>
2083 <u>repealed.</u>
2084 Section 46. Except as otherwise expressly provided in this
2085 act and except for this section, which shall take effect upon

2086 this act becoming a law, this act shall take effect July 1,
2087 2020.
2088
2089 ---
2090 **T I T L E A M E N D M E N T**
2091 Remove everything before the enacting clause and insert:
2092 A bill to be entitled
2093 An act relating to the Agency for Health Care
2094 Administration; amending s. 383.327, F.S.; requiring
2095 birth centers to report certain deaths and stillbirths
2096 to the Agency for Health Care Administration; removing
2097 a requirement that a certain report be submitted
2098 annually to the agency; authorizing the agency to
2099 prescribe by rule the frequency at which such report
2100 is submitted; amending s. 395.003, F.S.; removing a
2101 requirement that specified information be listed on
2102 licenses for certain facilities; repealing s.
2103 395.7015, F.S., relating to an annual assessment on
2104 health care entities; amending s. 395.7016, F.S.;
2105 conforming a provision to changes made by the act;
2106 amending s. 400.19, F.S.; revising provisions
2107 requiring the agency to conduct licensure inspections
2108 of nursing homes; requiring the agency to conduct
2109 additional licensure surveys under certain
2110 circumstances; revising a provision requiring the

2111 agency to assess a specified fine for such surveys;
2112 amending s. 400.462, F.S.; revising definitions;
2113 amending ss. 400.464, 400.471, 400.492, 400.506, and
2114 400.509, F.S.; revising provisions relating to
2115 licensure requirements for home health agencies to
2116 conform to changes made by the act; exempting certain
2117 persons and entities from such licensure requirements;
2118 amending s. 400.605, F.S.; removing a requirement that
2119 the agency conduct specified inspections of certain
2120 licensees; amending s. 400.60501, F.S.; removing an
2121 obsolete date and a requirement that the agency
2122 develop a specified annual report; amending s.
2123 400.9905, F.S.; revising the definition of the term
2124 "clinic"; amending s. 400.991, F.S.; conforming
2125 provisions to changes made by the act; removing the
2126 option for health care clinics to file a surety bond
2127 under certain circumstances; amending s. 400.9935,
2128 F.S.; requiring certain clinics to publish and post a
2129 schedule of charges; amending s. 408.033, F.S.;
2130 conforming a provision to changes made by the act;
2131 amending s. 408.061, F.S.; revising provisions
2132 requiring health care facilities to submit specified
2133 data to the agency; amending s. 408.0611, F.S.;
2134 requiring the agency to annually publish a report on
2135 the progress of implementation of electronic

2136 prescribing on its Internet website; amending s.
2137 408.062, F.S.; requiring the agency to annually
2138 publish certain information on its Internet website;
2139 removing a requirement that the agency submit certain
2140 annual reports to the Governor and Legislature;
2141 amending s. 408.063, F.S.; removing a requirement that
2142 the agency annually publish certain reports; amending
2143 ss. 408.802, 408.820, 408.831, and 408.832, F.S.;
2144 conforming provisions to changes made by the act;
2145 amending s. 408.803, F.S.; conforming a provision to
2146 changes made by the act; providing a definition of the
2147 term "low-risk provider"; amending s. 408.806, F.S.;
2148 exempting certain low-risk providers from a specified
2149 inspection; amending s. 408.808, F.S.; authorizing the
2150 issuance of a provisional license to certain
2151 applicants; amending s. 408.809, F.S.; revising
2152 provisions relating to background screening
2153 requirements for certain licensure applicants;
2154 removing an obsolete date and provisions relating to
2155 certain rescreening requirements; amending s. 408.811,
2156 F.S.; authorizing the agency to exempt certain low-
2157 risk providers from inspections and conduct
2158 unannounced licensure inspections of such providers
2159 under certain circumstances; authorizing the agency to
2160 adopt rules to waive routine inspections and grant

2161 extended time periods between relicensure inspections
2162 under certain conditions; amending s. 408.821, F.S.;
2163 revising provisions requiring licensees to have a
2164 specified plan; providing requirements for the
2165 submission of such plan; amending s. 408.909, F.S.;
2166 removing a requirement that the agency and Office of
2167 Insurance Regulation evaluate a specified program;
2168 amending s. 408.9091, F.S.; removing a requirement
2169 that the agency and office jointly submit a specified
2170 annual report to the Governor and Legislature;
2171 amending s. 409.905, F.S.; providing construction for
2172 a provision that requires the agency to discontinue
2173 its hospital retrospective review program under
2174 certain circumstances; providing legislative intent;
2175 amending s. 409.907, F.S.; requiring that a specified
2176 background screening be conducted through the agency
2177 on certain persons and entities; amending s. 409.913,
2178 F.S.; revising a requirement that the agency and the
2179 Medicaid Fraud Control Unit of the Department of Legal
2180 Affairs submit a specified report to the Legislature;
2181 authorizing the agency to recover specified costs
2182 associated with an audit, investigation, or
2183 enforcement action relating to provider fraud under
2184 the Medicaid program; amending ss. 409.967 and
2185 409.973, F.S.; revising the length of managed care

2186 plan and Medicaid prepaid dental health program
2187 contracts, respectively, procured by the agency
2188 beginning during a specified timeframe; requiring the
2189 agency to extend the term of certain existing
2190 contracts until a specified date; amending s. 429.11,
2191 F.S.; removing an authorization for the issuance of a
2192 provisional license to certain facilities; amending s.
2193 429.19, F.S.; removing requirements that the agency
2194 develop and disseminate a specified list and the
2195 Department of Children and Families disseminate such
2196 list to certain providers; amending ss. 429.35,
2197 429.905, and 429.929, F.S.; revising provisions
2198 requiring a biennial inspection cycle for specified
2199 facilities and centers, respectively; repealing part I
2200 of chapter 483, F.S., relating to The Florida
2201 Multiphasic Health Testing Center Law; providing
2202 effective dates.