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2009 Legislature CS for CS for CS for SB 1986, 2nd Engrossed

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1
2 An act relating to health care; providing legislative
3 findings; designating Miami-Dade County as a health
4 care fraud area of concern; amending s. 68.085, F.S.;
5 allocating certain funds recovered under the Florida
6 False Claims Act to fund rewards for persons who
7 report and provide information relating to Medicaid
8 fraud; amending s. 68.086, F.S.; providing that a
9 defendant who prevails in an action under the Florida
10 False Claims Act may be awarded attorney's fees and
11 costs against the person bringing the action under
12 certain circumstances; amending s. 395.003, F.S.;
13 authorizing a specialty-licensed children's hospital
14 to provide cardiology services to adults for
15 congenital heart disease under certain circumstances
16 without obtaining additional licensure as a provider
17 of adult cardiology services; providing an exception;
18 amending s. 400.471, F.S.; prohibiting the Agency for
19 Health Care Administration from renewing a license of
20 a home health agency in certain counties if the agency
21 has been sanctioned for certain misconduct; providing
22 limitations on licensing of home health agencies in
23 certain counties; amending s. 400.474, F.S.;
24 authorizing the Agency for Health Care Administration
25 to deny, revoke, or suspend the license of or fine a
26 home health agency that provides remuneration to
27 certain facilities or bills the Medicaid program for
28 medically unnecessary services; providing that certain
29 discounts, compensations, waivers of payments, or
30 payment practices; exempting nurse registries that
31 meet certain conditions from a prohibition; creating
32 s. 408.8065, F.S.; providing additional licensure
33 requirements for home health agencies, home medical
34 equipment providers, and health care clinics;
35 requiring the posting of a surety bond in a specified
36 minimum amount under certain circumstances; imposing
37 criminal penalties against a person who knowingly
38 submits misleading information to the Agency for
39 Health Care Administration in connection with
40 applications for certain licenses; amending s.
41 400.506, F.S.; exempting certain items from a
42 prohibition against providing remuneration to certain
43 persons by a nurse registry; amending ss. 395.602 and
44 408.07, F.S.; revising the definition of the term
45 "rural hospital" relating to hospital licensing and
46 regulation and health care administration; amending s.
47 408.040, F.S.; providing an exception to the
48 termination of certain certificates of need; creating
49 s. 408.8065, F.S.; providing additional licensure
50 requirements for home health agencies, home medical
51 equipment providers, and health care clinics;
52 requiring the posting of a surety bond in a specified
53 minimum amount under certain circumstances; providing
54 a penalty; amending s. 408.810, F.S.; revising
55 provisions relating to information required for
56 licensure; requiring certain licensees to provide
57 clients with a description of Medicaid fraud and the
58 statewide toll-free telephone number for the central
59 Medicaid fraud hotline; amending s. 408.815, F.S.;
60 providing additional grounds to deny an application
61 for a license; amending s. 409.905, F.S.; authorizing
62 the Agency for Health Care Administration to require
63 prior authorization of care based on utilization
64 rates; requiring a home health agency to submit a plan
65 of care and documentation of a recipient's medical
66 condition to the Agency for Health Care Administration
67 when requesting prior authorization; prohibiting the
68 Agency for Health Care Administration from paying for
69 home health services unless specified requirements are
70 satisfied; amending s. 409.907, F.S.; providing for
71 certain out-of-state providers to enroll as Medicaid
72 providers; amending s. 409.912, F.S.; requiring that
73 certain entities that provide comprehensive behavioral
74 health care services to certain Medicaid recipients be
75 licensed or authorized; requiring the Agency for
76 Health Care Administration to establish norms for the
77 utilization of Medicaid services; requiring the agency
78 to submit a report relating to the overutilization of
79 Medicaid services; revising the requirement for an

80 entity that contracts on a prepaid or fixed-sum basis
81 to meet certain surplus requirements; deleting the
82 requirement that an entity maintain certain
83 investments and restricted funds or deposits; revising
84 the circumstances in which the agency must prohibit
85 the entity from engaging in certain activities, cease
86 to process new enrollments, and not renew the entity's
87 contract; amending s. 409.913, F.S.; requiring that
88 the annual report submitted by the Agency for Health
89 Care Administration and the Medicaid Fraud Control
90 Unit of the Department of Legal Affairs recommend
91 changes necessary to prevent and detect Medicaid
92 fraud; requiring the Agency for Health Care
93 Administration to monitor patterns of overutilization
94 of Medicaid services; requiring the agency to deny
95 payment or require repayment for Medicaid services
96 under certain circumstances; requiring the Agency for
97 Health Care Administration to immediately terminate a
98 Medicaid provider's participation in the Medicaid
99 program as a result of certain adjudications against
100 the provider or certain affiliated persons; requiring
101 the Agency for Health Care Administration to suspend
102 or terminate a Medicaid provider's participation in
103 the Medicaid program if the provider or certain
104 affiliated persons participating in the Medicaid
105 program have been suspended or terminated by the
106 Federal Government or another state; providing that a
107 provider is subject to sanctions for violations of law
108 as the result of actions or inactions of the provider
109 or certain affiliated persons; requiring that the
110 agency provide notice of certain administrative
111 sanctions to other regulatory agencies within a
112 specified period; requiring the Agency for Health Care
113 Administration to withhold or deny Medicaid payments
114 under certain circumstances; requiring the agency to
115 terminate a provider's participation in the Medicaid
116 program if the provider fails to repay certain
117 overpayments from the Medicaid program; requiring the
118 agency to provide at least annually information on
119 Medicaid fraud in an explanation of benefits letter;
120 requiring the Agency for Health Care Administration to
121 post a list on its website of Medicaid providers and
122 affiliated persons of providers who have been
123 terminated or sanctioned; requiring the agency to take
124 certain actions to improve the prevention and
125 detection of health care fraud through the use of
126 technology; amending s. 409.920, F.S.; defining the
127 term "managed care organization"; providing criminal
128 penalties and fines for Medicaid fraud; granting civil
129 immunity to certain persons who report suspected
130 Medicaid fraud; creating s. 409.9203, F.S.;
131 authorizing the payment of rewards to persons who
132 report and provide information relating to Medicaid
133 fraud; amending s. 456.004, F.S.; requiring the
134 Department of Health to work cooperatively with the
135 Agency for Health Care Administration and the judicial
136 system to recover overpayments by the Medicaid
137 program; amending s. 456.053, F.S.; excluding
138 referrals to a sleep care provider for sleep related
139 testing to the definition of a referral; amending s.
140 456.041, F.S.; requiring the Department of Health to
141 include a statement in the practitioner profile if a
142 practitioner has been terminated from participating in
143 the Medicaid program; creating s. 456.0635, F.S.;
144 prohibiting Medicaid fraud in the practice of health
145 care professions; requiring the Department of Health
146 or boards within the department to refuse to admit to
147 exams and to deny licenses, permits, or certificates
148 to certain persons who have engaged in certain acts;
149 requiring health care practitioners to report
150 allegations of Medicaid fraud; specifying that
151 acceptance of the relinquishment of a license in
152 anticipation of charges relating to Medicaid fraud
153 constitutes permanent revocation of a license;
154 amending s. 456.072, F.S.; creating additional grounds
155 for the Department of Health to take disciplinary
156 action against certain applicants or licensees for
157 misconduct relating to a Medicaid program or to health
158 care fraud; amending s. 456.074, F.S.; requiring the
159 Department of Health to issue an emergency order
160 suspending the license of a person who engages in
161 certain criminal conduct relating to the Medicaid
162 program; amending s. 465.022, F.S.; authorizing
163 partnerships and corporations to obtain pharmacy
164 permits; requiring applicants or certain persons
165 affiliated with an applicant for a pharmacy permit to
166 submit a set of fingerprints for a criminal history
167 records check and pay the costs of the criminal
168 history records check; requiring the Department of

169 Health or Board of Pharmacy to deny an application for
170 a pharmacy permit for certain misconduct by the
171 applicant; or persons affiliated with the applicant;
172 amending s. 465.023, F.S.; authorizing the Department
173 of Health or the Board of Pharmacy to take
174 disciplinary action against a permittee for certain
175 misconduct by the permittee, or persons affiliated with
176 the permittee; amending s. 825.103, F.S.; redefining
177 the term "exploitation of an elderly person or
178 disabled adult"; amending s. 921.0022, F.S.; revising
179 the severity level ranking of Medicaid fraud under the
180 Criminal Punishment Code; creating a pilot project to
181 monitor and verify the delivery of home health
182 services and provide for electronic claims for home
183 health services; requiring the Agency for Health Care
184 Administration to issue a report evaluating the pilot
185 project; creating a pilot project for home health care
186 management in Miami-Dade County; amending ss. 400.0077
187 and 430.608, F.S.; conforming cross-references to
188 changes made by the act; repealing s. 395.0199, F.S.,
189 relating to private utilization review of health care
190 services; amending ss. 395.405 and 400.0712, F.S.;
191 conforming cross-references; repealing s. 400.118(2),
192 F.S.; removing provisions requiring quality-of-care
193 monitors for nursing facilities in agency district
194 offices; amending s. 400.141, F.S.; deleting a
195 requirement that licensed nursing home facilities
196 provide the agency with a monthly report on the number
197 of vacant beds in the facility; amending s. 400.147,
198 F.S.; revising the definition of the term "adverse
199 incident" for reporting purposes; requiring abuse,
200 neglect, and exploitation to be reported to the agency
201 and the Department of Children and Family Services;
202 deleting a requirement that the agency submit an
203 annual report on nursing home adverse incidents to the
204 Legislature; amending s. 400.162, F.S.; revising
205 requirements for policies and procedures regarding the
206 safekeeping of a resident's personal effects and
207 property; amending s. 400.191, F.S.; revising the
208 information on the agency's Internet site regarding
209 nursing homes; deleting the provision that requires
210 the agency to provide information about nursing homes
211 in printed form; amending s. 400.195, F.S.; conforming
212 a cross-reference; amending s. 400.23, F.S.; deleting
213 the requirement of the agency to adopt rules regarding
214 the eating assistance provided to residents; amending
215 s. 400.9935, F.S.; revising accreditation requirements
216 for clinics providing magnetic resonance imaging
217 services; amending s. 400.995, F.S.; revising agency
218 responsibilities with respect to agency administrative
219 penalties; amending s. 408.803, F.S.; revising
220 definitions applicable to part II of ch. 408, F.S.,
221 the "Health Care Licensing Procedures Act"; amending
222 s. 408.806, F.S.; revising contents of and procedures
223 relating to health care provider applications for
224 licensure; providing an exception from certain
225 licensure inspections for adult family-care homes;
226 authorizing the agency to provide electronic access to
227 certain information and documents; amending s.
228 408.808, F.S.; providing for a provisional license to
229 be issued to applicants applying for a change of
230 ownership; providing a time limit on provisional
231 licenses; amending s. 408.809, F.S.; revising
232 provisions relating to background screening of
233 specified employees; requiring health care providers
234 to submit to the agency an affidavit of compliance
235 with background screening requirements at the time of
236 license renewal; deleting a provision to conform to
237 changes made by the act; amending s. 408.811, F.S.;
238 providing for certain inspections to be accepted in
239 lieu of complete licensure inspections; granting
240 agency access to records requested during an offsite
241 review; providing timeframes for correction of certain
242 deficiencies and submission of plans to correct the
243 deficiencies; amending s. 408.813, F.S.; providing
244 classifications of violations of part II of ch. 408,
245 F.S.; providing for fines; amending s. 408.820, F.S.;
246 revising applicability of certain exemptions from
247 specified requirements of part II of ch. 408, F.S.;
248 creating s. 408.821, F.S.; requiring entities
249 regulated or licensed by the agency to designate a
250 liaison officer for emergency operations; authorizing
251 entities regulated or licensed by the agency to
252 temporarily exceed their licensed capacity to act as
253 receiving providers under specified circumstances;
254 providing requirements that apply while such entities
255 are in an overcapacity status; providing for issuance
256 of an inactive license to such licensees under
257 specified conditions; providing requirements and

258 procedures with respect to the issuance and
259 reactivation of an inactive license; authorizing the
260 agency to adopt rules; amending s. 408.831, F.S.;
261 deleting provisions relating to the authorization for
262 entities regulated or licensed by the agency to exceed
263 their licensed capacity to act as receiving facilities
264 and issuance and reactivation of inactive licenses;
265 amending s. 408.918, F.S.; revising the requirements
266 of a provider to participate in the Florida 211
267 network; requiring the Public Service Commission to
268 request the Federal Communications Commission to
269 direct the revocation of a 211 number under certain
270 circumstances; deleting the requirement for the Agency
271 for Health Care Administration to seek assistance in
272 resolving jurisdictional disputes related to 211
273 numbers; providing that the Florida Alliance of
274 Information and Referral Services is the collaborative
275 organization for the state; amending s. 409.221, F.S.;
276 conforming a cross-reference; amending s. 409.901,
277 F.S.; redefining the term "change of ownership" as it
278 relates to Medicaid providers; repealing s. 429.071,
279 F.S., relating to the intergenerational respite care
280 assisted living facility pilot program; amending s.
281 429.08, F.S.; authorizing the agency to provide
282 information regarding licensed assisted living
283 facilities on its Internet website; abolishing local
284 coordinating workgroups established by agency field
285 offices; amending s. 429.14, F.S.; conforming a
286 reference; amending s. 429.19, F.S.; revising agency
287 procedures for imposition of fines for violations of
288 part I of ch. 429, F.S., the "Assisted Living
289 Facilities Act"; amending s. 429.23, F.S.; redefining
290 the term "adverse incident" for reporting purposes;
291 requiring abuse, neglect, and exploitation to be
292 reported to the agency and the Department of Children
293 and Family Services; deleting a requirement that the
294 agency submit an annual report on assisted living
295 facility adverse incidents to the Legislature;
296 repealing s. 429.26(9), F.S., relating to the removal
297 of the requirement for a resident of an assisted
298 living facility to undergo examinations and
299 evaluations under certain circumstances; amending s.
300 430.80, F.S.; conforming a cross-reference; amending
301 ss. 435.04 and 435.05, F.S.; requiring employers of
302 certain employees to submit an affidavit of compliance
303 with level 2 screening requirements at the time of
304 license renewal; amending s. 483.031, F.S.; revising a
305 provision relating to the exemption of certain
306 clinical laboratories, to conform to changes made by
307 the act; amending s. 483.041, F.S.; redefining the
308 term "waived test" as it is used in part I of ch. 483,
309 F.S., the "Florida Clinical Laboratory Law"; repealing
310 s. 483.106, F.S., relating to applications for
311 certificates of exemption by clinical laboratories
312 that perform certain tests; amending s. 483.172, F.S.;
313 conforming provisions; amending s. 627.4239, F.S.;
314 revising the term "standard reference compendium" for
315 purposes of regulating the insurance coverage of drugs
316 used in the treatment of cancer; amending s. 651.118,
317 F.S.; conforming a cross-reference; creating s.
318 409.91207; requiring the agency to develop a plan to
319 create a medical home pilot project; providing waiver
320 authority for the agency; providing an exception;
321 requiring each medical home network to provide
322 specified services; providing responsibilities of the
323 agency; requiring the Secretary of the agency to
324 appoint a task force; requiring the agency to submit a
325 medical home implementation plan; specifying that
326 implementation of the medical home pilot project is
327 contingent upon legislative approval; authorizing the
328 agency to develop rules; providing an effective date.
329

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

331
332 Section 1. The Legislature finds that:
333 (1) Immediate and proactive measures are necessary to
334 prevent, reduce, and mitigate health care fraud, waste, and
335 abuse and are essential to maintaining the integrity and
336 financial viability of health care delivery systems, including
337 those funded in whole or in part by the Medicare and Medicaid
338 trust funds. Without these measures, health care delivery
339 systems in this state will be depleted of necessary funds to
340 deliver patient care, and taxpayers' dollars will be devalued
341 and not used for their intended purposes.
342 (2) Sufficient justification exists for increased oversight
343 of health care clinics, home health agencies, providers of home
344 medical equipment, and other health care providers throughout
345 the state, and in particular, in Miami-Dade County.
346 (3) The state's best interest is served by deterring health

347 care fraud, abuse, and waste and identifying patterns of
348 fraudulent or abusive Medicare and Medicaid activity early,
349 especially in high-risk localities, such as Miami-Dade County,
350 in order to prevent inappropriate expenditures of public funds
351 and harm to the state's residents.

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

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

361 68.085 Awards to plaintiffs bringing action.-

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

463 400.471 Application for license; fee.—

464 (10) The agency may not issue a renewal license for a home
465 health agency in any county having at least one licensed home
466 health agency and that has more than one home health agency per
467 5,000 persons, as indicated by the most recent population
468 estimates published by the Legislature's Office of Economic and
469 Demographic Research, if the applicant or any controlling
470 interest has been administratively sanctioned by the agency
471 during the two years prior to the submission of the licensure
472 renewal application for one or more of the following acts:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

544 400.474 Administrative penalties.—

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

548 (a) Gives remuneration for staffing services to:

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

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

553

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

612

613 The hourly rate specified in the contract may not be increased

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

618 (j) Gives remuneration to:

- 619 1. A physician, and the home health agency is in violation
- 620 of paragraph (h) or paragraph (i);
- 621 2. A member of the physician's office staff; or
- 622 3. An immediate family member of the physician,

623

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

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

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

636

637 Nothing in paragraph (e) or paragraph (j) shall be interpreted
638 as applying to or precluding any discount, compensation, waiver
639 of payment, or payment practice permitted by 52 U.S.C. s. 1320a
640 7(b) or regulations adopted thereunder, including 42 C.F.R. s.
641 1001.952, or 42 U.S.C. s. 1395nn or regulations adopted
642 thereunder.

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

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

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

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

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

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

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

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

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

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

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

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

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

699 (c) Submit a statement of the applicant's estimated startup
700 costs and sources of funds through the break-even point in
701 operations demonstrating that the applicant has the ability to
702 fund all startup costs, working capital, and contingency

703 financing. The statement must show that the applicant has at a
704 minimum 3 months of average projected expenses to cover startup
705 costs, working capital, and contingency financing. The minimum
706 amount for contingency funding may not be less than 1 month of
707 average projected expenses.

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

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

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

731 Section 9. Subsection (3) and paragraph (a) of subsection
732 (5) of section 408.810, Florida Statutes, are amended to read:
733 408.810 Minimum licensure requirements.—In addition to the
734 licensure requirements specified in this part, authorizing
735 statutes, and applicable rules, each applicant and licensee must
736 comply with the requirements of this section in order to obtain
737 and maintain a license.

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

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

746 (b) Required insurance or bonds.

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

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

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

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

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

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

772 408.815 License or application denial; revocation.—

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

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

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

787 (c) Terminated for cause, pursuant to the appeals
788 procedures established by the state or Federal Government, from
789 the federal Medicare program or from any other state Medicaid
790 program, unless the applicant has been in good standing with a
791 state Medicaid program or the federal Medicare program for the

792 most recent five years and the termination occurred at least 20
793 years prior to the date of the application.

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

796 409.905 Mandatory Medicaid services.—The agency may make
797 payments for the following services, which are required of the
798 state by Title XIX of the Social Security Act, furnished by
799 Medicaid providers to recipients who are determined to be
800 eligible on the dates on which the services were provided. Any
801 service under this section shall be provided only when medically
802 necessary and in accordance with state and federal law.
803 Mandatory services rendered by providers in mobile units to
804 Medicaid recipients may be restricted by the agency. Nothing in
805 this section shall be construed to prevent or limit the agency
806 from adjusting fees, reimbursement rates, lengths of stay,
807 number of visits, number of services, or any other adjustments
808 necessary to comply with the availability of moneys and any
809 limitations or directions provided for in the General
810 Appropriations Act or chapter 216.

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

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

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

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

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

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

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

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

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

881 reimbursement, and the prior authorization request.

882 Section 12. Paragraph (a) of subsection (9) of section
883 409.907, Florida Statutes, is amended to read:
884 409.907 Medicaid provider agreements.—The agency may make
885 payments for medical assistance and related services rendered to
886 Medicaid recipients only to an individual or entity who has a
887 provider agreement in effect with the agency, who is performing
888 services or supplying goods in accordance with federal, state,
889 and local law, and who agrees that no person shall, on the
890 grounds of handicap, race, color, or national origin, or for any
891 other reason, be subjected to discrimination under any program
892 or activity for which the provider receives payment from the
893 agency.

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

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

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

922 395.602 Rural hospitals.—

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

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

- 927 1. The sole provider within a county with a population
928 density of no greater than 100 persons per square mile;
- 929 2. An acute care hospital, in a county with a population
930 density of no greater than 100 persons per square mile, which is
931 at least 30 minutes of travel time, on normally traveled roads
932 under normal traffic conditions, from any other acute care
933 hospital within the same county;
- 934 3. A hospital supported by a tax district or subdistrict
935 whose boundaries encompass a population of 100 persons or fewer
936 per square mile;
- 937 4. A hospital in a constitutional charter county with a
938 population of over 1 million persons that has imposed a local
939 option health service tax pursuant to law and in an area that
940 was directly impacted by a catastrophic event on August 24,
941 1992, for which the Governor of Florida declared a state of
942 emergency pursuant to chapter 125, and has 120 beds or less that
943 serves an agricultural community with an emergency room
944 utilization of no less than 20,000 visits and a Medicaid
945 inpatient utilization rate greater than 15 percent;
- 946 5. A hospital with a service area that has a population of
947 100 persons or fewer per square mile. As used in this
948 subparagraph, the term "service area" means the fewest number of
949 zip codes that account for 75 percent of the hospital's
950 discharges for the most recent 5-year period, based on
951 information available from the hospital inpatient discharge
952 database in the Florida Center for Health Information and Policy
953 Analysis at the Agency for Health Care Administration; or
- 954 6. A hospital designated as a critical access hospital, as
955 defined in s. 408.07(15).

956
957 Population densities used in this paragraph must be based upon
958 the most recently completed United States census. A hospital
959 that received funds under s. 409.9116 for a quarter beginning no
960 later than July 1, 2002, is deemed to have been and shall
961 continue to be a rural hospital from that date through June 30,
962 ~~2015~~ ~~2012~~, if the hospital continues to have 100 or fewer
963 licensed beds and an emergency room, or meets the criteria of
964 subparagraph 4. An acute care hospital that has not previously
965 been designated as a rural hospital and that meets the criteria
966 of this paragraph shall be granted such designation upon
967 application, including supporting documentation to the Agency
968 for Health Care Administration.

969 Section 14. Paragraph (a) of subsection (2) of section

970 408.040, Florida Statutes, is amended to read:
971 408.040 Conditions and monitoring.—
972 (2)(a) Unless the applicant has commenced construction, if
973 the project provides for construction, unless the applicant has
974 incurred an enforceable capital expenditure commitment for a
975 project, if the project does not provide for construction, or
976 unless subject to paragraph (b), a certificate of need shall
977 terminate 18 months after the date of issuance, except a
978 certificate of need of an entity which was issued on or before
979 April 1, 2009, shall terminate 36 months after the date of
980 issuance. The agency shall monitor the progress of the holder of
981 the certificate of need in meeting the timetable for project
982 development specified in the application, and may revoke the
983 certificate of need, if the holder of the certificate is not
984 meeting such timetable and is not making a good-faith effort, as
985 defined by rule, to meet it.

986 Section 15. Subsection (43) of section 408.07, Florida
987 Statutes, is amended to read:
988 408.07 Definitions.—As used in this chapter, with the
989 exception of ss. 408.031-408.045, the term:
990 (43) "Rural hospital" means an acute care hospital licensed
991 under chapter 395, having 100 or fewer licensed beds and an
992 emergency room, and which is:
993 (a) The sole provider within a county with a population
994 density of no greater than 100 persons per square mile;
995 (b) An acute care hospital, in a county with a population
996 density of no greater than 100 persons per square mile, which is
997 at least 30 minutes of travel time, on normally traveled roads
998 under normal traffic conditions, from another acute care
999 hospital within the same county;
1000 (c) A hospital supported by a tax district or subdistrict
1001 whose boundaries encompass a population of 100 persons or fewer
1002 per square mile;
1003 (d) A hospital with a service area that has a population of
1004 100 persons or fewer per square mile. As used in this paragraph,
1005 the term "service area" means the fewest number of zip codes
1006 that account for 75 percent of the hospital's discharges for the
1007 most recent 5-year period, based on information available from
1008 the hospital inpatient discharge database in the Florida Center
1009 for Health Information and Policy Analysis at the Agency for
1010 Health Care Administration; or
1011 (e) A critical access hospital.

1012
1013 Population densities used in this subsection must be based upon
1014 the most recently completed United States census. A hospital
1015 that received funds under s. 409.9116 for a quarter beginning no
1016 later than July 1, 2002, is deemed to have been and shall
1017 continue to be a rural hospital from that date through June 30,
1018 ~~2015~~ ~~2012~~, if the hospital continues to have 100 or fewer
1019 licensed beds and an emergency room, or meets the criteria of s.
1020 395.602(2)(e)4. An acute care hospital that has not previously
1021 been designated as a rural hospital and that meets the criteria
1022 of this subsection shall be granted such designation upon
1023 application, including supporting documentation, to the Agency
1024 for Health Care Administration.

1025 Section 16. Paragraph (b) of subsection (4), subsection
1026 (14), and subsection (17) of section 409.912, Florida Statutes,
1027 are amended to read:
1028 409.912 Cost-effective purchasing of health care.—The
1029 agency shall purchase goods and services for Medicaid recipients
1030 in the most cost-effective manner consistent with the delivery
1031 of quality medical care. To ensure that medical services are
1032 effectively utilized, the agency may, in any case, require a
1033 confirmation or second physician's opinion of the correct
1034 diagnosis for purposes of authorizing future services under the
1035 Medicaid program. This section does not restrict access to
1036 emergency services or poststabilization care services as defined
1037 in 42 C.F.R. part 438.114. Such confirmation or second opinion
1038 shall be rendered in a manner approved by the agency. The agency
1039 shall maximize the use of prepaid per capita and prepaid
1040 aggregate fixed-sum basis services when appropriate and other
1041 alternative service delivery and reimbursement methodologies,
1042 including competitive bidding pursuant to s. 287.057, designed
1043 to facilitate the cost-effective purchase of a case-managed
1044 continuum of care. The agency shall also require providers to
1045 minimize the exposure of recipients to the need for acute
1046 inpatient, custodial, and other institutional care and the
1047 inappropriate or unnecessary use of high-cost services. The
1048 agency shall contract with a vendor to monitor and evaluate the
1049 clinical practice patterns of providers in order to identify
1050 trends that are outside the normal practice patterns of a
1051 provider's professional peers or the national guidelines of a
1052 provider's professional association. The vendor must be able to
1053 provide information and counseling to a provider whose practice
1054 patterns are outside the norms, in consultation with the agency,
1055 to improve patient care and reduce inappropriate utilization.
1056 The agency may mandate prior authorization, drug therapy
1057 management, or disease management participation for certain
1058 populations of Medicaid beneficiaries, certain drug classes, or

1059 particular drugs to prevent fraud, abuse, overuse, and possible
1060 dangerous drug interactions. The Pharmaceutical and Therapeutics
1061 Committee shall make recommendations to the agency on drugs for
1062 which prior authorization is required. The agency shall inform
1063 the Pharmaceutical and Therapeutics Committee of its decisions
1064 regarding drugs subject to prior authorization. The agency is
1065 authorized to limit the entities it contracts with or enrolls as
1066 Medicaid providers by developing a provider network through
1067 provider credentialing. The agency may competitively bid single
1068 source-provider contracts if procurement of goods or services
1069 results in demonstrated cost savings to the state without
1070 limiting access to care. The agency may limit its network based
1071 on the assessment of beneficiary access to care, provider
1072 availability, provider quality standards, time and distance
1073 standards for access to care, the cultural competence of the
1074 provider network, demographic characteristics of Medicaid
1075 beneficiaries, practice and provider-to-beneficiary standards,
1076 appointment wait times, beneficiary use of services, provider
1077 turnover, provider profiling, provider licensure history,
1078 previous program integrity investigations and findings, peer
1079 review, provider Medicaid policy and billing compliance records,
1080 clinical and medical record audits, and other factors. Providers
1081 shall not be entitled to enrollment in the Medicaid provider
1082 network. The agency shall determine instances in which allowing
1083 Medicaid beneficiaries to purchase durable medical equipment and
1084 other goods is less expensive to the Medicaid program than long
1085 term rental of the equipment or goods. The agency may establish
1086 rules to facilitate purchases in lieu of long-term rentals in
1087 order to protect against fraud and abuse in the Medicaid program
1088 as defined in s. 409.913. The agency may seek federal waivers
1089 necessary to administer these policies.

1090 (4) The agency may contract with:
1091 (b) An entity that is providing comprehensive behavioral
1092 health care services to certain Medicaid recipients through a
1093 capitated, prepaid arrangement pursuant to the federal waiver
1094 provided for by s. 409.905(5). Such an entity must be licensed
1095 under chapter 624, chapter 636, or chapter 641, or authorized
1096 under paragraph (c), and must possess the clinical systems and
1097 operational competence to manage risk and provide comprehensive
1098 behavioral health care to Medicaid recipients. As used in this
1099 paragraph, the term "comprehensive behavioral health care
1100 services" means covered mental health and substance abuse
1101 treatment services that are available to Medicaid recipients.
1102 The secretary of the Department of Children and Family Services
1103 shall approve provisions of procurements related to children in
1104 the department's care or custody before prior to enrolling such
1105 children in a prepaid behavioral health plan. Any contract
1106 awarded under this paragraph must be competitively procured. In
1107 developing the behavioral health care prepaid plan procurement
1108 document, the agency shall ensure that the procurement document
1109 requires the contractor to develop and implement a plan to
1110 ensure compliance with s. 394.4574 related to services provided
1111 to residents of licensed assisted living facilities that hold a
1112 limited mental health license. Except as provided in
1113 subparagraph 8., and except in counties where the Medicaid
1114 managed care pilot program is authorized pursuant to s.
1115 409.91211, the agency shall seek federal approval to contract
1116 with a single entity meeting these requirements to provide
1117 comprehensive behavioral health care services to all Medicaid
1118 recipients not enrolled in a Medicaid managed care plan
1119 authorized under s. 409.91211 or a Medicaid health maintenance
1120 organization in an AHCA area. In an AHCA area where the Medicaid
1121 managed care pilot program is authorized pursuant to s.
1122 409.91211 in one or more counties, the agency may procure a
1123 contract with a single entity to serve the remaining counties as
1124 an AHCA area or the remaining counties may be included with an
1125 adjacent AHCA area and are shall be subject to this paragraph.
1126 Each entity must offer a sufficient choice of providers in its
1127 network to ensure recipient access to care and the opportunity
1128 to select a provider with whom they are satisfied. The network
1129 shall include all public mental health hospitals. To ensure
1130 unimpaired access to behavioral health care services by Medicaid
1131 recipients, all contracts issued pursuant to this paragraph must
1132 shall require 80 percent of the capitation paid to the managed
1133 care plan, including health maintenance organizations, to be
1134 expended for the provision of behavioral health care services.
1135 If in the event the managed care plan expends less than 80
1136 percent of the capitation paid pursuant to this paragraph for
1137 the provision of behavioral health care services, the difference
1138 shall be returned to the agency. The agency shall provide the
1139 managed-care plan with a certification letter indicating the
1140 amount of capitation paid during each calendar year for the
1141 provision of behavioral health care services pursuant to this
1142 section. The agency may reimburse for substance abuse treatment
1143 services on a fee-for-service basis until the agency finds that
1144 adequate funds are available for capitated, prepaid
1145 arrangements.
1146 1. By January 1, 2001, the agency shall modify the
1147 contracts with the entities providing comprehensive inpatient

1148 and outpatient mental health care services to Medicaid
1149 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
1150 Counties, to include substance abuse treatment services.

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

1157 3. Except as provided in subparagraph 8., by July 1, 2006,
1158 the agency and the Department of Children and Family Services
1159 shall contract with managed care entities in each AHCA area
1160 except area 6 or arrange to provide comprehensive inpatient and
1161 outpatient mental health and substance abuse services through
1162 capitated prepaid arrangements to all Medicaid recipients who
1163 are eligible to participate in such plans under federal law and
1164 regulation. In AHCA areas where eligible individuals number less
1165 than 150,000, the agency shall contract with a single managed
1166 care plan to provide comprehensive behavioral health services to
1167 all recipients who are not enrolled in a Medicaid health
1168 maintenance organization or a Medicaid capitated managed care
1169 plan authorized under s. 409.91211. The agency may contract with
1170 more than one comprehensive behavioral health provider to
1171 provide care to recipients who are not enrolled in a Medicaid
1172 capitated managed care plan authorized under s. 409.91211 or a
1173 Medicaid health maintenance organization in AHCA areas where the
1174 eligible population exceeds 150,000. In an AHCA area where the
1175 Medicaid managed care pilot program is authorized pursuant to s.
1176 409.91211 in one or more counties, the agency may procure a
1177 contract with a single entity to serve the remaining counties as
1178 an AHCA area or the remaining counties may be included with an
1179 adjacent AHCA area and shall be subject to this paragraph.

1180 Contracts for comprehensive behavioral health providers awarded
1181 pursuant to this section shall be competitively procured. Both
1182 for-profit and not-for-profit corporations ~~are shall be~~ eligible
1183 to compete. Managed care plans contracting with the agency under
1184 subsection (3) shall provide and receive payment for the same
1185 comprehensive behavioral health benefits as provided in AHCA
1186 rules, including handbooks incorporated by reference. In AHCA
1187 area 11, the agency shall contract with at least two
1188 comprehensive behavioral health care providers to provide
1189 behavioral health care to recipients in that area who are
1190 enrolled in, or assigned to, the MediPass program. One of the
1191 behavioral health care contracts ~~must shall~~ be with the existing
1192 provider service network pilot project, as described in
1193 paragraph (d), for the purpose of demonstrating the cost
1194 effectiveness of the provision of quality mental health services
1195 through a public hospital-operated managed care model. Payment
1196 shall be at an agreed-upon capitated rate to ensure cost
1197 savings. Of the recipients in area 11 who are assigned to
1198 MediPass under ~~the provisions of~~ s. 409.9122(2)(k), a minimum of
1199 50,000 of those MediPass-enrolled recipients shall be assigned
1200 to the existing provider service network in area 11 for their
1201 behavioral care.

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

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

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

1217 c. Subject to any limitations provided ~~for~~ in the General
1218 Appropriations Act, the agency, in compliance with appropriate
1219 federal authorization, shall develop policies and procedures
1220 that allow for certification of local and state funds.

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

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

1237 for the cost of behavioral health care provided to the displaced
1238 indigent care patient.

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

1247 8. All Medicaid-eligible children, except children in area
1248 1 and children in Highlands County, Hardee County, Polk County,
1249 or Manatee County of area 6, ~~that who~~ are open for child welfare
1250 services in the HomeSafeNet system, shall receive their
1251 behavioral health care services through a specialty prepaid plan
1252 operated by community-based lead agencies ~~either~~ through a
1253 single agency or formal agreements among several agencies. The
1254 specialty prepaid plan must result in savings to the state
1255 comparable to savings achieved in other Medicaid managed care
1256 and prepaid programs. Such plan must provide mechanisms to
1257 maximize state and local revenues. The specialty prepaid plan
1258 shall be developed by the agency and the Department of Children
1259 and Family Services. The agency ~~may is authorized to seek any~~
1260 federal waivers to implement this initiative. Medicaid-eligible
1261 children whose cases are open for child welfare services in the
1262 HomeSafeNet system and who reside in AHCA area 10 are exempt
1263 from the specialty prepaid plan upon the development of a
1264 service delivery mechanism for children who reside in area 10 as
1265 specified in s. 409.91211(3)(dd).

1266 (14)(a) The agency shall operate or contract for the
1267 operation of utilization management and incentive systems
1268 designed to encourage cost-effective use of services ~~and to~~
1269 ~~eliminate services that are medically unnecessary. The agency~~
1270 ~~shall track Medicaid provider prescription and billing patterns~~
1271 ~~and evaluate them against Medicaid medical necessity criteria~~
1272 ~~and coverage and limitation guidelines adopted by rule. Medical~~
1273 ~~necessity determination requires that service be consistent with~~
1274 ~~symptoms or confirmed diagnosis of illness or injury under~~
1275 ~~treatment and not in excess of the patient's needs. The agency~~
1276 ~~shall conduct reviews of provider exceptions to peer group norms~~
1277 ~~and shall, using statistical methodologies, provider profiling,~~
1278 ~~and analysis of billing patterns, detect and investigate~~
1279 ~~abnormal or unusual increases in billing or payment of claims~~
1280 ~~for Medicaid services and medically unnecessary provision of~~
1281 ~~services. Providers that demonstrate a pattern of submitting~~
1282 ~~claims for medically unnecessary services shall be referred to~~
1283 ~~the Medicaid program integrity unit for investigation. In its~~
1284 ~~annual report, required in s. 409.913, the agency shall report~~
1285 ~~on its efforts to control overutilization as described in this~~
1286 ~~paragraph.~~

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

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

1300 2. A cost-benefit analysis documenting the estimated
1301 specific direct and indirect costs, savings, performance
1302 improvements, risks, and qualitative and quantitative benefits
1303 involved in or resulting from providing the service. The cost
1304 benefit analysis must include a detailed plan and timeline
1305 identifying all actions that must be implemented to realize
1306 expected benefits. The Secretary of Health Care Administration
1307 shall verify that all costs, savings, and benefits are valid and
1308 achievable.

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

1317 (17) An entity contracting on a prepaid or fixed-sum basis
1318 shall ~~meet the, in addition to meeting any applicable statutory~~
1319 ~~surplus requirements of s. 641.225, also maintain at all times~~
1320 ~~in the form of cash, investments that mature in less than 180~~
1321 ~~days allowable as admitted assets by the Office of Insurance~~
1322 ~~Regulation, and restricted funds or deposits controlled by the~~
1323 ~~agency or the Office of Insurance Regulation, a surplus amount~~
1324 ~~equal to one and one-half times the entity's monthly Medicaid~~
1325 ~~prepaid revenues. As used in this subsection, the term "surplus"~~

1326 ~~means the entity's total assets minus total liabilities.~~ If an
1327 entity's surplus falls below an amount equal to the surplus
1328 requirements of s. 641.225 ~~one-and-one-half times the entity's~~
1329 ~~monthly Medicaid prepaid revenues~~, the agency shall prohibit the
1330 entity from engaging in marketing and preenrollment activities,
1331 shall cease to process new enrollments, and ~~may shall~~ not renew
1332 the entity's contract until the required balance is achieved.
1333 The requirements of this subsection do not apply:
1334 (a) Where a public entity agrees to fund any deficit
1335 incurred by the contracting entity; or
1336 (b) Where the entity's performance and obligations are
1337 guaranteed in writing by a guaranteeing organization which:
1338 1. Has been in operation for at least 5 years and has
1339 assets in excess of \$50 million; or
1340 2. Submits a written guarantee acceptable to the agency
1341 which is irrevocable during the term of the contracting entity's
1342 contract with the agency and, upon termination of the contract,
1343 until the agency receives proof of satisfaction of all
1344 outstanding obligations incurred under the contract.

1345 Section 17. Section 409.91207, Florida Statutes, is created
1346 to read:
1347 409.91207 Medical Home Pilot Project.—
1348 (1) The agency shall develop a plan to implement a medical
1349 home pilot project that utilizes primary care case management
1350 enhanced by medical home networks to provide coordinated and
1351 cost-effective care that is reimbursed on a fee-for-service
1352 basis and to compare the performance of the medical home
1353 networks with other existing Medicaid managed care models. The
1354 agency is authorized to seek a federal Medicaid waiver or an
1355 amendment to any existing Medicaid waiver, except for the
1356 current 1115 Medicaid waiver authorized in s. 409.91211, as
1357 needed, to develop the pilot project created in this section but
1358 must obtain approval of the Legislature prior to implementing
1359 the pilot project.
1360 (2) Each medical home network shall:
1361 (a) Provide Medicaid recipients primary care, coordinated
1362 services to control chronic illness, pharmacy services,
1363 specialty physician services, and hospital outpatient and
1364 inpatient services.
1365 (b) Coordinate with other health care providers, as
1366 necessary, to ensure that Medicaid recipients receive efficient
1367 and effective access to other needed medical services,
1368 consistent with the scope of services provided to Medipass
1369 recipients.
1370 (c) Consist of primary care physicians, federally qualified
1371 health centers, clinics affiliated with Florida medical schools
1372 or teaching hospitals, programs serving children with special
1373 health care needs, medical school faculty, statutory teaching
1374 hospitals, and other hospitals that agree to participate in the
1375 network. A managed care organization is eligible to be
1376 designated as a medical home network if it documents policies
1377 and procedures consistent with subsection (3).
1378 (3) The medical home pilot project developed by the agency
1379 must be designed to modify the processes and patterns of health
1380 care service delivery in the Medicaid program by requiring a
1381 medical home network to:
1382 (a) Assign a personal medical provider to lead an
1383 interdisciplinary team of professionals who share the
1384 responsibility for ongoing care to a specific panel of patients.
1385 (b) Require the personal medical provider to identify the
1386 patient's health care needs and respond to those needs either
1387 directly or through arrangements with other qualified providers.
1388 (c) Coordinate or integrate care across all parts of the
1389 health care delivery system.
1390 (d) Integrate information technology into the health care
1391 delivery system to enhance clinical performance and monitor
1392 patient outcomes.
1393 (4) The agency shall have the following duties, and
1394 responsibilities with respect to the development of the medical
1395 home pilot project:
1396 (a) To develop and recommend a medical home pilot project
1397 in at least two geographic regions in the state that will
1398 facilitate access to specialty services in the state's medical
1399 schools and teaching hospitals.
1400 (b) To develop and recommend funding strategies that
1401 maximize available state and federal funds, including:
1402 1. Enhanced primary care case management fees to
1403 participating federally qualified health centers and primary
1404 care clinics owned or operated by a medical school or teaching
1405 hospital.
1406 2. Enhanced payments to participating medical schools
1407 through the supplemental physician payment program using
1408 certified funds.
1409 3. Reimbursement for facility costs, in addition to medical
1410 services, for participating outpatient primary or specialty
1411 clinics.
1412 4. Supplemental Medicaid payments through the low-income
1413 pool and exempt fee-for-service rates for participating
1414 hospitals.

1415 5. Enhanced capitation rates for managed care organizations
1416 designated as medical home networks to reflect enhanced fee-for
1417 service payments to medical home network providers.
1418 (c) To develop and recommend criteria to designate medical
1419 home networks as eligible to participate in the pilot program
1420 and recommend incentives for medical home networks to
1421 participate in the medical home pilot project, including bonus
1422 payments and shared saving arrangements.
1423 (d) To develop a comprehensive fiscal estimate of the
1424 medical home pilot project that includes, but is not limited to,
1425 anticipated savings to the Medicaid program and any anticipated
1426 administrative costs.
1427 (e) To develop and recommend which medical services the
1428 medical home network would be responsible for providing to
1429 enrolled Medicaid recipients.
1430 (f) To develop and recommend methodologies to measure the
1431 performance of the medical home pilot project including patient
1432 outcomes, cost-effectiveness, provider participation, recipient
1433 satisfaction, and accountability to ensure the quality of the
1434 medical care provided to Medicaid recipients enrolled in the
1435 pilot.
1436 (g) To recommend policies and procedures for the medical
1437 home pilot project administration including, but not limited to:
1438 an implementation timeline, the Medicaid recipient enrollment
1439 process, recruitment and enrollment of Medicaid providers, and
1440 the reimbursement methodologies for participating Medicaid
1441 providers.
1442 (h) To determine and recommend methods to evaluate the
1443 medical home pilot project including but not limited to the
1444 comparison of the Medicaid fee-for service system, Medipass
1445 system, and other Medicaid managed care programs.
1446 (i) To develop and recommend standards and designation
1447 requirements for a medical home network that include, but are
1448 not limited to: medical care provided by the network, referral
1449 arrangements, medical record requirements, health information
1450 technology standards, follow-up care processes, and data
1451 collection requirements.
1452 (5) The Secretary of Health Care Administration shall
1453 appoint a task force by August 1, 2009, to assist the agency in
1454 the development and implementation of the medical home pilot
1455 project. The task force must include, but is not limited to,
1456 representatives of providers who could potentially participate
1457 in a medical home network, Medicaid recipients, and existing
1458 Medipass and managed care providers. Members of the task force
1459 shall serve without compensation but are entitled to
1460 reimbursement for per diem and travel expenses as provided in s.
1461 112.061.
1462 (6) The agency shall submit an implementation plan for the
1463 medical home pilot project authorized in this section to the
1464 Speaker of the House of Representatives, the President of the
1465 Senate, and the Governor by February 1, 2010. The implementation
1466 plan must include any approved waivers, waiver applications, or
1467 state plan amendments necessary to implement the medical home
1468 pilot project.
1469 (a) The agency shall post any waiver applications, or
1470 waiver amendments, authorized under this section on its Internet
1471 website 15 days before submitting the applications to the United
1472 States Centers for Medicare and Medicaid Services.
1473 (b) The implementation of the medical home pilot project,
1474 including any Medicaid waivers authorized in this section, is
1475 contingent upon review and approval by the Legislature.
1476 (c) Upon legislative approval to implement the medical home
1477 pilot project, the agency may initiate the adoption of
1478 administrative rules to implement and administer the medical
1479 home pilot project created in this section.
1480 Section 18. Subsections (2), (7), (11), (13), (14), (15),
1481 (24), (25), (27), (30), (31), and (36) of section 409.913,
1482 Florida Statutes, are amended, and subsections (37) and (38) are
1483 added to that section, to read:
1484 409.913 Oversight of the integrity of the Medicaid
1485 program.—The agency shall operate a program to oversee the
1486 activities of Florida Medicaid recipients, and providers and
1487 their representatives, to ensure that fraudulent and abusive
1488 behavior and neglect of recipients occur to the minimum extent
1489 possible, and to recover overpayments and impose sanctions as
1490 appropriate. Beginning January 1, 2003, and each year
1491 thereafter, the agency and the Medicaid Fraud Control Unit of
1492 the Department of Legal Affairs shall submit a joint report to
1493 the Legislature documenting the effectiveness of the state's
1494 efforts to control Medicaid fraud and abuse and to recover
1495 Medicaid overpayments during the previous fiscal year. The
1496 report must describe the number of cases opened and investigated
1497 each year; the sources of the cases opened; the disposition of
1498 the cases closed each year; the amount of overpayments alleged
1499 in preliminary and final audit letters; the number and amount of
1500 finest or penalties imposed; any reductions in overpayment
1501 amounts negotiated in settlement agreements or by other means;
1502 the amount of final agency determinations of overpayments; the
1503 amount deducted from federal claiming as a result of

1504 overpayments; the amount of overpayments recovered each year;
1505 the amount of cost of investigation recovered each year; the
1506 average length of time to collect from the time the case was
1507 opened until the overpayment is paid in full; the amount
1508 determined as uncollectible and the portion of the uncollectible
1509 amount subsequently reclaimed from the Federal Government; the
1510 number of providers, by type, that are terminated from
1511 participation in the Medicaid program as a result of fraud and
1512 abuse; and all costs associated with discovering and prosecuting
1513 cases of Medicaid overpayments and making recoveries in such
1514 cases. The report must also document actions taken to prevent
1515 overpayments and the number of providers prevented from
1516 enrolling in or reenrolling in the Medicaid program as a result
1517 of documented Medicaid fraud and abuse and must include policy
1518 recommendations ~~recommend changes~~ necessary to prevent or
1519 recover overpayments and changes necessary to prevent and detect
1520 Medicaid fraud. All policy recommendations in the report must
1521 include a detailed fiscal analysis, including, but not limited
1522 to, implementation costs, estimated savings to the Medicaid
1523 program, and the return on investment. The agency must submit
1524 the policy recommendations and fiscal analyses in the report to
1525 the appropriate estimating conference, pursuant to s. 216.137,
1526 by February 15 of each year. The agency and the Medicaid Fraud
1527 Control Unit of the Department of Legal Affairs each must
1528 include detailed unit-specific performance standards,
1529 benchmarks, and metrics in the report, including projected cost
1530 savings to the state Medicaid program during the following
1531 fiscal year.

1532 (2) The agency shall conduct, or cause to be conducted by
1533 contract or otherwise, reviews, investigations, analyses,
1534 audits, or any combination thereof, to determine possible fraud,
1535 abuse, overpayment, or recipient neglect in the Medicaid program
1536 and shall report the findings of any overpayments in audit
1537 reports as appropriate. At least 5 percent of all audits shall
1538 be conducted on a random basis. As part of its ongoing fraud
1539 detection activities, the agency shall identify and monitor, by
1540 contract or otherwise, patterns of overutilization of Medicaid
1541 services based on state averages. The agency shall track
1542 Medicaid provider prescription and billing patterns and evaluate
1543 them against Medicaid medical necessity criteria and coverage
1544 and limitation guidelines adopted by rule. Medical necessity
1545 determination requires that service be consistent with symptoms
1546 or confirmed diagnosis of illness or injury under treatment and
1547 not in excess of the patient's needs. The agency shall conduct
1548 reviews of provider exceptions to peer group norms and shall,
1549 using statistical methodologies, provider profiling, and
1550 analysis of billing patterns, detect and investigate abnormal or
1551 unusual increases in billing or payment of claims for Medicaid
1552 services and medically unnecessary provision of services.

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

- 1560 (a) Have actually been furnished to the recipient by the
1561 provider prior to submitting the claim.
- 1562 (b) Are Medicaid-covered goods or services that are
1563 medically necessary.
- 1564 (c) Are of a quality comparable to those furnished to the
1565 general public by the provider's peers.
- 1566 (d) Have not been billed in whole or in part to a recipient
1567 or a recipient's responsible party, except for such copayments,
1568 coinsurance, or deductibles as are authorized by the agency.
- 1569 (e) Are provided in accord with applicable provisions of
1570 all Medicaid rules, regulations, handbooks, and policies and in
1571 accordance with federal, state, and local law.
- 1572 (f) Are documented by records made at the time the goods or
1573 services were provided, demonstrating the medical necessity for
1574 the goods or services rendered. Medicaid goods or services are
1575 excessive or not medically necessary unless both the medical
1576 basis and the specific need for them are fully and properly
1577 documented in the recipient's medical record.

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

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

1587 (13) The agency shall immediately may terminate
1588 participation of a Medicaid provider in the Medicaid program and
1589 may seek civil remedies or impose other administrative sanctions
1590 against a Medicaid provider, if the provider or any principal,
1591 officer, director, agent, managing employee, or affiliated
1592 person of the provider, or any partner or shareholder having an

1593 ownership interest in the provider equal to 5 percent or
1594 greater, has been:

1595 (a) Convicted of a criminal offense related to the delivery
1596 of any health care goods or services, including the performance
1597 of management or administrative functions relating to the
1598 delivery of health care goods or services;

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

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

1605

1606 If the agency determines a provider did not participate or
1607 acquiesce in an offense specified in paragraph (a), paragraph
1608 (b), or paragraph (c), termination will not be imposed. If the
1609 agency effects a termination under this subsection, the agency
1610 shall issue an immediate final order pursuant to s.
1611 120.569(2)(n).

1612 (14) If the provider has been suspended or terminated from
1613 participation in the Medicaid program or the Medicare program by
1614 the Federal Government or any state, the agency must immediately
1615 suspend or terminate, as appropriate, the provider's
1616 participation in this state's the Florida Medicaid program for a
1617 period no less than that imposed by the Federal Government or
1618 any other state, and may not enroll such provider in this
1619 state's the Florida Medicaid program while such foreign
1620 suspension or termination remains in effect. The agency shall
1621 also immediately suspend or terminate, as appropriate, a
1622 provider's participation in this state's Medicaid program if the
1623 provider participated or acquiesced in any action for which any
1624 principal, officer, director, agent, managing employee, or
1625 affiliated person of the provider, or any partner or shareholder
1626 having an ownership interest in the provider equal to 5 percent
1627 or greater, was suspended or terminated from participating in
1628 the Medicaid program or the Medicare program by the Federal
1629 Government or any state. This sanction is in addition to all
1630 other remedies provided by law.

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

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

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

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

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

1650 (e) The provider is not in compliance with provisions of
1651 Medicaid provider publications that have been adopted by
1652 reference as rules in the Florida Administrative Code; with
1653 provisions of state or federal laws, rules, or regulations; with
1654 provisions of the provider agreement between the agency and the
1655 provider; or with certifications found on claim forms or on
1656 transmittal forms for electronically submitted claims that are
1657 submitted by the provider or authorized representative, as such
1658 provisions apply to the Medicaid program;

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

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

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

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

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

1682 (k) The provider or an authorized representative of the
1683 provider has included in a cost report costs that are not
1684 allowable under a Florida Title XIX reimbursement plan, after
1685 the provider or authorized representative had been advised in an
1686 audit exit conference or audit report that the costs were not
1687 allowable;

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

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

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

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

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

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

1707

1708 A provider is subject to sanctions for violations of this
1709 subsection as the result of actions or inactions of the
1710 provider, or actions or inactions of any principal, officer,
1711 director, agent, managing employee, or affiliated person of the
1712 provider, or any partner or shareholder having an ownership
1713 interest in the provider equal to 5 percent or greater, in which
1714 the provider participated or acquiesced.

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

1722 Such notification must include the provider's or person's name
1723 and license number and the specific reasons for sanction.

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

1738 (b) The agency shall may deny payment, or require
1739 repayment, if the goods or services were furnished, supervised,
1740 or caused to be furnished by a person who has been suspended or
1741 terminated from the Medicaid program or Medicare program by the
1742 Federal Government or any state.

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

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

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

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

1766 (a) Withhold, and continue to withhold during the pendency
1767 of an administrative hearing pursuant to chapter 120, any
1768 medical assistance reimbursement payments until such time as the
1769 overpayment is recovered, unless within 30 days after receiving
1770 notice thereof the provider:

1771 1. Makes repayment in full; or
1772 2. Establishes a repayment plan that is satisfactory to the
1773 Agency for Health Care Administration.

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

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

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

1796 (36) At least three times a year, the agency shall provide
1797 to each Medicaid recipient or his or her representative an
1798 explanation of benefits in the form of a letter that is mailed
1799 to the most recent address of the recipient on the record with
1800 the Department of Children and Family Services. The explanation
1801 of benefits must include the patient's name, the name of the
1802 health care provider and the address of the location where the
1803 service was provided, a description of all services billed to
1804 Medicaid in terminology that should be understood by a
1805 reasonable person, and information on how to report
1806 inappropriate or incorrect billing to the agency or other law
1807 enforcement entities for review or investigation. At least once
1808 a year, the letter also must include information on how to
1809 report criminal Medicaid fraud, the Medicaid Fraud Control
1810 Unit's toll-free hotline number, and information about the
1811 rewards available under s. 409.9203. The explanation of benefits
1812 may not be mailed for Medicaid independent laboratory services
1813 as described in s. 409.905(7) or for Medicaid certified match
1814 services as described in ss. 409.9071 and 1011.70.

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

1826 (38) In order to improve the detection of health care
1827 fraud, use technology to prevent and detect fraud, and maximize
1828 the electronic exchange of health care fraud information, the
1829 agency shall:

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

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

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

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

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

1855 409.920 Medicaid provider fraud.—

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

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

1859 (b) "Fiscal agent" means any individual, firm, corporation,

1860 partnership, organization, or other legal entity that has
1861 contracted with the agency to receive, process, and adjudicate
1862 claims under the Medicaid program.

1863 (c) "Item or service" includes:
1864 1. Any particular item, device, medical supply, or service
1865 claimed to have been provided to a recipient and listed in an
1866 itemized claim for payment; or
1867 2. In the case of a claim based on costs, any entry in the
1868 cost report, books of account, or other documents supporting
1869 such claim.

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

1878 (e) "Managed care plans" means a health insurer authorized
1879 under chapter 624, an exclusive provider organization authorized
1880 under chapter 627, a health maintenance organization authorized
1881 under chapter 641, the Children's Medical Services Network
1882 authorized under chapter 391, a prepaid health plan authorized
1883 under chapter 409, a provider service network authorized under
1884 chapter 409, a minority physician network authorized under
1885 chapter 409, and an emergency department diversion program
1886 authorized under chapter 409 or the General Appropriations Act,
1887 providing health care services pursuant to a contract with the
1888 Medicaid program.

1889 (2)(a) ~~A person may not~~ ~~it is unlawful to~~:
1890 1.~~4~~ Knowingly make, cause to be made, or aid and abet in
1891 the making of any false statement or false representation of a
1892 material fact, by commission or omission, in any claim submitted
1893 to the agency or its fiscal agent or a managed care plan for
1894 payment.

1895 2.~~4~~ Knowingly make, cause to be made, or aid and abet in
1896 the making of a claim for items or services that are not
1897 authorized to be reimbursed by the Medicaid program.

1898 3.~~4~~ Knowingly charge, solicit, accept, or receive
1899 anything of value, other than an authorized copayment from a
1900 Medicaid recipient, from any source in addition to the amount
1901 legally payable for an item or service provided to a Medicaid
1902 recipient under the Medicaid program or knowingly fail to credit
1903 the agency or its fiscal agent for any payment received from a
1904 third-party source.

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

1911 5.~~4~~ Knowingly solicit, offer, pay, or receive any
1912 remuneration, including any kickback, bribe, or rebate, directly
1913 or indirectly, overtly or covertly, in cash or in kind, in
1914 return for referring an individual to a person for the
1915 furnishing or arranging for the furnishing of any item or
1916 service for which payment may be made, in whole or in part,
1917 under the Medicaid program, or in return for obtaining,
1918 purchasing, leasing, ordering, or arranging for or recommending,
1919 obtaining, purchasing, leasing, or ordering any goods, facility,
1920 item, or service, for which payment may be made, in whole or in
1921 part, under the Medicaid program.

1922 6.~~4~~ Knowingly submit false or misleading information or
1923 statements to the Medicaid program for the purpose of being
1924 accepted as a Medicaid provider.

1925 7.~~4~~ Knowingly use or endeavor to use a Medicaid
1926 provider's identification number or a Medicaid recipient's
1927 identification number to make, cause to be made, or aid and abet
1928 in the making of a claim for items or services that are not
1929 authorized to be reimbursed by the Medicaid program.

1930 (b)1. A person who violates this subsection and receives or
1931 endeavors to receive anything of value of:
1932 a. Ten thousand dollars or less commits a felony of the
1933 third degree, punishable as provided in s. 775.082, s. 775.083,
1934 or s. 775.084.

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

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

1941 2. The value of separate funds, goods, or services that a
1942 person received or attempted to receive pursuant to a scheme or
1943 course of conduct may be aggregated in determining the degree of
1944 the offense.

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

1949 or managed care organization, whichever is greater.
1950 (8) A person who provides the state, any state agency, any
1951 of the state's political subdivisions, or any agency of the
1952 state's political subdivisions with information about fraud or
1953 suspected fraud by a Medicaid provider, including a managed care
1954 organization, is immune from civil liability for providing the
1955 information unless the person acted with knowledge that the
1956 information was false or with reckless disregard for the truth
1957 or falsity of the information.

1958 Section 20. Section 409.9203, Florida Statutes, is created
1959 to read:
1960 409.9203 Rewards for reporting Medicaid fraud.-
1961 (1) The Department of Law Enforcement or director of the
1962 Medicaid Fraud Control Unit shall, subject to availability of
1963 funds, pay a reward to a person who furnishes original
1964 information relating to and reports a violation of the state's
1965 Medicaid fraud laws, unless the person declines the reward, if
1966 the information and report:
1967 (a) Is made to the Office of the Attorney General, the
1968 Agency for Health Care Administration, the Department of Health,
1969 or the Department of Law Enforcement;
1970 (b) Relates to criminal fraud upon Medicaid funds or a
1971 criminal violation of Medicaid laws by another person; and
1972 (c) Leads to a recovery of a fine, penalty, or forfeiture
1973 of property.
1974 (2) The reward may not exceed the lesser of 25 percent of
1975 the amount recovered or \$500,000 in a single case.
1976 (3) The reward shall be paid from the Legal Affairs
1977 Revolving Trust Fund from moneys collected pursuant to s.
1978 68.085.
1979 (4) A person who receives a reward pursuant to this section
1980 is not eligible to receive any funds pursuant to the Florida
1981 False Claims Act for Medicaid fraud for which a reward is
1982 received pursuant to this section.

1983 Section 21. Subsection (11) is added to section 456.004,
1984 Florida Statutes, to read:
1985 456.004 Department; powers and duties.-The department, for
1986 the professions under its jurisdiction, shall:
1987 (11) Work cooperatively with the Agency for Health Care
1988 Administration and the judicial system to recover Medicaid
1989 overpayments by the Medicaid program. The department shall
1990 investigate and prosecute health care practitioners who have not
1991 remitted amounts owed to the state for an overpayment from the
1992 Medicaid program pursuant to a final order, judgment, or
1993 stipulation or settlement.

1994 Section 22. Present subsections (6) through (10) of section
1995 456.041, Florida Statutes, are renumbered as subsections (7)
1996 through (11), respectively, and a new subsection (6) is added to
1997 that section, to read:
1998 456.041 Practitioner profile; creation.-
1999 (6) The Department of Health shall provide in each
2000 practitioner profile for every physician or advanced registered
2001 nurse practitioner terminated for cause from participating in
2002 the Medicaid program, pursuant to s. 409.913, or sanctioned by
2003 the Medicaid program a statement that the practitioner has been
2004 terminated from participating in the Florida Medicaid program or
2005 sanctioned by the Medicaid program.

2006 Section 23. Paragraph (o) of subsection (3) of section
2007 456.053, Florida Statutes, is amended to read:
2008 456.053 Financial arrangements between referring health
2009 care providers and providers of health care services.-
2010 (3) DEFINITIONS.-For the purpose of this section, the word,
2011 phrase, or term:
2012 (o) "Referral" means any referral of a patient by a health
2013 care provider for health care services, including, without
2014 limitation:
2015 1. The forwarding of a patient by a health care provider to
2016 another health care provider or to an entity which provides or
2017 supplies designated health services or any other health care
2018 item or service; or
2019 2. The request or establishment of a plan of care by a
2020 health care provider, which includes the provision of designated
2021 health services or other health care item or service.
2022 3. The following orders, recommendations, or plans of care
2023 shall not constitute a referral by a health care provider:
2024 a. By a radiologist for diagnostic-imaging services.
2025 b. By a physician specializing in the provision of
2026 radiation therapy services for such services.
2027 c. By a medical oncologist for drugs and solutions to be
2028 prepared and administered intravenously to such oncologist's
2029 patient, as well as for the supplies and equipment used in
2030 connection therewith to treat such patient for cancer and the
2031 complications thereof.
2032 d. By a cardiologist for cardiac catheterization services.
2033 e. By a pathologist for diagnostic clinical laboratory
2034 tests and pathological examination services, if furnished by or
2035 under the supervision of such pathologist pursuant to a
2036 consultation requested by another physician.
2037 f. By a health care provider who is the sole provider or

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

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

2060 h. By a urologist for lithotripsy services.

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

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

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

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

2078 m. By a health care provider for sleep related testing.
2079 Section 24. Section 456.0635, Florida Statutes, is created
2080 to read:

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

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

2085 (2) Each board within the jurisdiction of the department,
2086 or the department if there is no board, shall refuse to admit a
2087 candidate to any examination and refuse to issue or renew a
2088 license, certificate, or registration to any applicant if the
2089 candidate or applicant or any principle, officer, agent,
2090 managing employee, or affiliated person of the applicant, has
2091 been:

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

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

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

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

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

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

2120 456.072 Grounds for discipline; penalties; enforcement.-
2121 (1) The following acts shall constitute grounds for which
2122 the disciplinary actions specified in subsection (2) may be
2123 taken:

2124 (ii) Being convicted of, or entering a plea of guilty or
2125 nolo contendere to, any misdemeanor or felony, regardless of
2126 adjudication, under 18 U.S.C. s. 669, ss. 285-287, s. 371, s.

2127 1001, s. 1035, s. 1341, s. 1343, s. 1347, s. 1349, or s. 1518,
2128 or 42 U.S.C. ss. 1320a-7b, relating to the Medicaid program.
2129 (jj) Failing to remit the sum owed to the state for an
2130 overpayment from the Medicaid program pursuant to a final order,
2131 judgment, or stipulation or settlement.
2132 (kk) Being terminated from the state Medicaid program
2133 pursuant to s. 409.913, any other state Medicaid program, or the
2134 federal Medicare program, unless eligibility to participate in
2135 the program from which the practitioner was terminated has been
2136 restored.
2137 (ll) Being convicted of, or entering a plea of guilty or
2138 nolo contendere to, any misdemeanor or felony, regardless of
2139 adjudication, a crime in any jurisdiction which relates to
2140 health care fraud.
2141 Section 26. Subsection (1) of section 456.074, Florida
2142 Statutes, is amended to read:
2143 456.074 Certain health care practitioners; immediate
2144 suspension of license.—
2145 (1) The department shall issue an emergency order
2146 suspending the license of any person licensed under chapter 458,
2147 chapter 459, chapter 460, chapter 461, chapter 462, chapter 463,
2148 chapter 464, chapter 465, chapter 466, or chapter 484 who pleads
2149 guilty to, is convicted or found guilty of, or who enters a plea
2150 of nolo contendere to, regardless of adjudication, to:
2151 (a) A felony under chapter 409, chapter 817, or chapter 893
2152 or under 21 U.S.C. ss. 801-970 or under 42 U.S.C. ss. 1395-1396;
2153 or—
2154 (b) A misdemeanor or felony under 18 U.S.C. s. 669, ss.
2155 285-287, s. 371, s. 1001, s. 1035, s. 1341, s. 1343, s. 1347, s.
2156 1349, or s. 1518 or 42 U.S.C. ss. 1320a-7b, relating to the
2157 Medicaid program.
2158 Section 27. Subsections (2) and (3) of section 465.022,
2159 Florida Statutes, are amended, present subsections (4), (5),
2160 (6), and (7) of that section are renumbered as subsections (5),
2161 (6), (7), and (8), respectively, and a new subsection (4) is
2162 added to that section, to read:
2163 465.022 Pharmacies; general requirements; fees.—
2164 (2) A pharmacy permit shall be issued only to a person who
2165 is at least 18 years of age, a partnership whose partners are
2166 all at least 18 years of age, or to a corporation that which is
2167 registered pursuant to chapter 607 or chapter 617 whose
2168 officers, directors, and shareholders are at least 18 years of
2169 age.
2170 (3) Any person, partnership, or corporation before engaging
2171 in the operation of a pharmacy shall file with the board a sworn
2172 application on forms provided by the department.
2173 (a) An application for a pharmacy permit must include a set
2174 of fingerprints from each person having an ownership interest of
2175 5 percent or greater and from any person who, directly or
2176 indirectly, manages, oversees, or controls the operation of the
2177 applicant, including officers and members of the board of
2178 directors of an applicant that is a corporation. The applicant
2179 must provide payment in the application for the cost of state
2180 and national criminal history records checks.
2181 1. For corporations having more than \$100 million of
2182 business taxable assets in this state, in lieu of these
2183 fingerprint requirements, the department shall require the
2184 prescription department manager who will be directly involved in
2185 the management and operation of the pharmacy to submit a set of
2186 fingerprints.
2187 2. A representative of a corporation described in
2188 subparagraph 1. satisfies the requirement to submit a set of his
2189 or her fingerprints if the fingerprints are on file with the
2190 department or the Agency for Health Care Administration, meet
2191 the fingerprint specifications for submission by the Department
2192 of Law Enforcement, and are available to the department.
2193 (b) The department shall submit the fingerprints provided
2194 by the applicant to the Department of Law Enforcement for a
2195 state criminal history records check. The Department of Law
2196 Enforcement shall forward the fingerprints to the Federal Bureau
2197 of Investigation for a national criminal history records check.
2198 (4) The department or board shall deny an application for a
2199 pharmacy permit if the applicant or an affiliated person,
2200 partner, officer, director, or prescription department manager
2201 of the applicant has:
2202 (a) Obtained a permit by misrepresentation or fraud;
2203 (b) Attempted to procure, or has procured, a permit for any
2204 other person by making, or causing to be made, any false
2205 representation;
2206 (c) Been convicted of, or entered a plea of guilty or nolo
2207 contendere to, regardless of adjudication, a crime in any
2208 jurisdiction which relates to the practice of, or the ability to
2209 practice, the profession of pharmacy;
2210 (d) Been convicted of, or entered a plea of guilty or nolo
2211 contendere to, regardless of adjudication, a crime in any
2212 jurisdiction which relates to health care fraud;
2213 (e) Been terminated for cause, pursuant to the appeals
2214 procedures established by the state or Federal Government, from
2215 any state Medicaid program or the federal Medicare program.

2216 unless the applicant has been in good standing with a state
2217 Medicaid program or the federal Medicare program for the most
2218 recent five years and the termination occurred at least 20 years
2219 ago; or
2220 (f) Dispensed any medicinal drug based upon a communication
2221 that purports to be a prescription as defined by s. 465.003(14)
2222 or s. 893.02 when the pharmacist knows or has reason to believe
2223 that the purported prescription is not based upon a valid
2224 practitioner-patient relationship that includes a documented
2225 patient evaluation, including history and a physical examination
2226 adequate to establish the diagnosis for which any drug is
2227 prescribed and any other requirement established by board rule
2228 under chapter 458, chapter 459, chapter 461, chapter 463,
2229 chapter 464, or chapter 466.

2230 Section 28. Subsection (1) of section 465.023, Florida
2231 Statutes, is amended to read:
2232 465.023 Pharmacy permittee; disciplinary action.—
2233 (1) The department or the board may revoke or suspend the
2234 permit of any pharmacy permittee, and may fine, place on
2235 probation, or otherwise discipline any pharmacy permittee if the
2236 permittee, or any affiliated person, partner, officer, director,
2237 or agent of the permittee, including a person fingerprinted
2238 under s. 465.022(3), who has:
2239 (a) Obtained a permit by misrepresentation or fraud or
2240 through an error of the department or the board;
2241 (b) Attempted to procure, or has procured, a permit for any
2242 other person by making, or causing to be made, any false
2243 representation;
2244 (c) Violated any of the requirements of this chapter or any
2245 of the rules of the Board of Pharmacy; of chapter 499, known as
2246 the "Florida Drug and Cosmetic Act"; of 21 U.S.C. ss. 301-392,
2247 known as the "Federal Food, Drug, and Cosmetic Act"; of 21
2248 U.S.C. ss. 821 et seq., known as the Comprehensive Drug Abuse
2249 Prevention and Control Act; or of chapter 893;
2250 (d) Been convicted or found guilty, regardless of
2251 adjudication, of a felony or any other crime involving moral
2252 turpitude in any of the courts of this state, of any other
2253 state, or of the United States; ~~or~~
2254 (e) Been convicted or disciplined by a regulatory agency of
2255 the Federal Government or a regulatory agency of another state
2256 for any offense that would constitute a violation of this
2257 chapter;
2258 (f) Been convicted of, or entered a plea of guilty or nolo
2259 contendere to, regardless of adjudication, a crime in any
2260 jurisdiction which relates to the practice of, or the ability to
2261 practice, the profession of pharmacy;
2262 (g) Been convicted of, or entered a plea of guilty or nolo
2263 contendere to, regardless of adjudication, a crime in any
2264 jurisdiction which relates to health care fraud; or
2265 (h)~~(e)~~ Dispensed any medicinal drug based upon a
2266 communication that purports to be a prescription as defined by
2267 s. 465.003(14) or s. 893.02 when the pharmacist knows or has
2268 reason to believe that the purported prescription is not based
2269 upon a valid practitioner-patient relationship that includes a
2270 documented patient evaluation, including history and a physical
2271 examination adequate to establish the diagnosis for which any
2272 drug is prescribed and any other requirement established by
2273 board rule under chapter 458, chapter 459, chapter 461, chapter
2274 463, chapter 464, or chapter 466.

2275 Section 29. Section 825.103, Florida Statutes, is amended
2276 to read:
2277 825.103 Exploitation of an elderly person or disabled
2278 adult; penalties.—
2279 (1) "Exploitation of an elderly person or disabled adult"
2280 means:
2281 (a) Knowingly, by deception or intimidation, obtaining or
2282 using, or endeavoring to obtain or use, an elderly person's or
2283 disabled adult's funds, assets, or property with the intent to
2284 temporarily or permanently deprive the elderly person or
2285 disabled adult of the use, benefit, or possession of the funds,
2286 assets, or property, or to benefit someone other than the
2287 elderly person or disabled adult, by a person who:
2288 1. Stands in a position of trust and confidence with the
2289 elderly person or disabled adult; or
2290 2. Has a business relationship with the elderly person or
2291 disabled adult; ~~or~~
2292 (b) Obtaining or using, endeavoring to obtain or use, or
2293 conspiring with another to obtain or use an elderly person's or
2294 disabled adult's funds, assets, or property with the intent to
2295 temporarily or permanently deprive the elderly person or
2296 disabled adult of the use, benefit, or possession of the funds,
2297 assets, or property, or to benefit someone other than the
2298 elderly person or disabled adult, by a person who knows or
2299 reasonably should know that the elderly person or disabled adult
2300 lacks the capacity to consent; ~~or~~
2301 (c) Breach of a fiduciary duty to an elderly person or
2302 disabled adult by the person's guardian or agent under a power
2303 of attorney which results in an unauthorized appropriation,
2304 sale, or transfer of property.

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

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

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

2320 Section 30. Paragraphs (g) and (i) of subsection (3) of
2321 section 921.0022, Florida Statutes, are amended to read:
2322 921.0022 Criminal Punishment Code; offense severity ranking
2323 chart.—

2324 (3) OFFENSE SEVERITY RANKING CHART
2325 (g) LEVEL 7

Florida Statute	Felony Degree	Description
2327 316.027(1)(b)	1st	Accident involving death, failure to stop; leaving scene.
2328 316.193(3)(c)2.	3rd	DUI resulting in serious bodily injury.
2329 316.1935(3)(b)	1st	Causing serious bodily injury or death to another person; driving at high speed or with wanton disregard for safety while fleeing
2330 327.35(3)(c)2.	3rd	Vessel BUI resulting in serious bodily injury.
2331 402.319(2)	2nd	Misrepresentation and negligence or intentional act resulting in great bodily harm, permanent disfigurement, permanent disability,
2332 409.920(2)(b)1.a.	3rd	Medicaid provider fraud; \$10,000 or less.
2333 409.920(2)(b)1.b.	2nd	Medicaid provider fraud; more than \$10,000, but less than \$50,000.
2334 456.065(2)	3rd	Practicing a health care profession without a license.
2335 456.065(2)	2nd	Practicing a health care profession without a license which results in serious bodily injury.
2336 458.327(1)	3rd	Practicing medicine without a license.
2337 459.013(1)	3rd	Practicing osteopathic medicine without a license.
2338 460.411(1)	3rd	Practicing chiropractic medicine without a license.
2339 461.012(1)	3rd	Practicing podiatric medicine without a license.
2340 462.17	3rd	Practicing naturopathy without a license.
2341 463.015(1)	3rd	Practicing optometry without a license.
2342 464.016(1)	3rd	Practicing nursing without a license.
2343 465.015(2)	3rd	Practicing pharmacy without a license.
2344 466.026(1)	3rd	Practicing dentistry or dental hygiene without a license.
2345 467.201	3rd	Practicing midwifery without a license.
2346 468.366	3rd	Delivering respiratory care services without a license.
2347 483.828(1)	3rd	Practicing as clinical laboratory personnel without a license.
2348 483.901(9)	3rd	Practicing medical physics without a license.
2349 484.013(1)(c)	3rd	Preparing or dispensing optical devices without a prescription.
2350 484.053	3rd	Dispensing hearing aids without a license.
2351 494.0018(2)	1st	Conviction of any violation of ss. 494.001-494.0077 in which the total money and property unlawfully obtained exceeded \$50,000 and
2352 560.123(8)(b)1.	3rd	Failure to report currency or payment instruments exceeding \$300 but less than \$20,000 by a money services business.
2353 560.125(5)(a)	3rd	Money services business by unauthorized person, currency or payment instruments exceeding \$300 but less than \$20,000.
2354 655.50(10)(b)1.	3rd	Failure to report financial transactions exceeding \$300 but less than \$20,000 by financial institution.
2355 775.21(10)(a)	3rd	Sexual predator; failure to register; failure to renew driver's license or identification card; other registration violations.
2356 775.21(10)(b)	3rd	Sexual predator working where children regularly congregate.
2357 775.21(10)(g)	3rd	Failure to report or providing false information about a sexual predator; harbor or conceal a sexual predator.
2358 782.051(3)	2nd	Attempted felony murder of a person by a person other than the perpetrator or the perpetrator of an attempted felony.
2359 782.07(1)	2nd	Killing of a human being by the act, procurement, or culpable negligence of another (manslaughter).
2360 782.071	2nd	Killing of a human being or viable fetus by the operation of a motor vehicle in a reckless manner (vehicular homicide).
2361 782.072	2nd	Killing of a human being by the operation of a vessel in a reckless manner (vessel homicide).
2362 784.045(1)(a)1.	2nd	Aggravated battery; intentionally causing great bodily harm or disfigurement.
2363 784.045(1)(a)2.	2nd	Aggravated battery; using deadly weapon.
2364 784.045(1)(b)	2nd	Aggravated battery; perpetrator aware victim pregnant.
2365 784.048(4)	3rd	Aggravated stalking; violation of injunction or court order.
2366 784.048(7)	3rd	Aggravated stalking; violation of court order.
2367 784.07(2)(d)	1st	Aggravated battery on law enforcement officer.
2368 784.074(1)(a)	1st	Aggravated battery on sexually violent predators facility staff.
2369 784.08(2)(a)	1st	Aggravated battery on a person 65 years of age or older.
2370 784.081(1)	1st	Aggravated battery on specified official or employee.
2371 784.082(1)	1st	Aggravated battery by detained person on visitor or other detainee.
2372 784.083(1)	1st	Aggravated battery on code inspector.
2373 790.07(4)	1st	Specified weapons violation subsequent to previous conviction of s. 790.07(1) or (2).
2374 790.16(1)	1st	Discharge of a machine gun under specified circumstances.
2375 790.165(2)	2nd	Manufacture, sell, possess, or deliver hoax bomb.
2376 790.165(3)	2nd	Possessing, displaying, or threatening to use any hoax bomb while committing or attempting to commit a felony.
2377 790.166(3)	2nd	Possessing, selling, using, or attempting to use a hoax weapon of mass destruction.
2378 790.166(4)	2nd	Possessing, displaying, or threatening to use a hoax weapon of mass destruction while committing or attempting to commit a felony.
2379 790.23	1st, PBL	Possession of a firearm by a person who qualifies for the penalty enhancements provided for in s. 874.04.
2380 794.08(4)	3rd	Female genital mutilation; consent by a parent, guardian, or a person in custodial authority to a victim younger than 18 years of
2381 796.03	2nd	Procuring any person under 16 years for prostitution.
2382 800.04(5)(c)1.	2nd	Lewd or lascivious molestation; victim less than 12 years of age; offender less than 18 years.
2383 800.04(5)(c)2.	2nd	Lewd or lascivious molestation; victim 12 years of age or older but less than 16 years; offender 18 years or older.
2384 806.01(2)	2nd	Maliciously damage structure by fire or explosive.
2385 810.02(3)(a)	2nd	Burglary of occupied dwelling; unarmed; no assault or battery.
2386 810.02(3)(b)	2nd	Burglary of unoccupied dwelling; unarmed; no assault or battery.
2387 810.02(3)(d)	2nd	Burglary of occupied conveyance; unarmed; no assault or battery.
2388 810.02(3)(e)	2nd	Burglary of authorized emergency vehicle.
2389 812.014(2)(a)1.	1st	Property stolen, valued at \$100,000 or more or a semitrailer deployed by a law enforcement officer; property stolen while causing
2390 812.014(2)(b)2.	2nd	Property stolen, cargo valued at less than \$50,000, grand theft in 2nd degree.
2391 812.014(2)(b)3.	2nd	Property stolen, emergency medical equipment; 2nd degree grand theft.
2392 812.014(2)(b)4.	2nd	Property stolen, law enforcement equipment from authorized emergency vehicle.
2393 812.0145(2)(a)	1st	Theft from person 65 years of age or older; \$50,000 or more.

2394	812.019(2)	1st	Stolen property; initiates, organizes, plans, etc., the theft of property and traffics in stolen property.
2395	812.131(2)(a)	2nd	Robbery by sudden snatching.
2396	812.133(2)(b)	1st	Carjacking; no firearm, deadly weapon, or other weapon.
2397	817.234(8)(a)	2nd	Solicitation of motor vehicle accident victims with intent to defraud.
2398	817.234(9)	2nd	Organizing, planning, or participating in an intentional motor vehicle collision.
2399	817.234(11)(c)	1st	Insurance fraud; property value \$100,000 or more.
2400	817.2341(2)(b) & (3)(b)1st		Making false entries of material fact or false statements regarding property values relating to the solvency of an insuring en
2401	825.102(3)(b)	2nd	Neglecting an elderly person or disabled adult causing great bodily harm, disability, or disfigurement.
2402	825.103(2)(b)	2nd	Exploiting an elderly person or disabled adult and property is valued at \$20,000 or more, but less than \$100,000.
2403	827.03(3)(b)	2nd	Neglect of a child causing great bodily harm, disability, or disfigurement.
2404	827.04(3)	3rd	Impregnation of a child under 16 years of age by person 21 years of age or older.
2405	837.05(2)	3rd	Giving false information about alleged capital felony to a law enforcement officer.
2406	838.015	2nd	Bribery.
2407	838.016	2nd	Unlawful compensation or reward for official behavior.
2408	838.021(3)(a)	2nd	Unlawful harm to a public servant.
2409	838.22	2nd	Bid tampering.
2410	847.0135(3)	3rd	Solicitation of a child, via a computer service, to commit an unlawful sex act.
2411	847.0135(4)	2nd	Traveling to meet a minor to commit an unlawful sex act.
2412	872.06	2nd	Abuse of a dead human body.
2413	874.10	1st,PBL	Knowingly initiates, organizes, plans, finances, directs, manages, or supervises criminal gang-related activity.
2414	893.13(1)(c)1.	1st	Sell, manufacture, or deliver cocaine (or other drug prohibited under s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4.
2415	893.13(1)(e)1.	1st	Sell, manufacture, or deliver cocaine or other drug prohibited under s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4..
2416	893.13(4)(a)	1st	Deliver to minor cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4. drugs).
2417	893.135(1)(a)1.	1st	Trafficking in cannabis, more than 25 lbs., less than 2,000 lbs.
2418	893.135(1)(b)1.a.	1st	Trafficking in cocaine, more than 28 grams, less than 200 grams.
2419	893.135(1)(c)1.a.	1st	Trafficking in illegal drugs, more than 4 grams, less than 14 grams.
2420	893.135(1)(d)1.	1st	Trafficking in phencyclidine, more than 28 grams, less than 200 grams.
2421	893.135(1)(e)1.	1st	Trafficking in methaqualone, more than 200 grams, less than 5 kilograms.
2422	893.135(1)(f)1.	1st	Trafficking in amphetamine, more than 14 grams, less than 28 grams.
2423	893.135(1)(g)1.a.	1st	Trafficking in flunitrazepam, 4 grams or more, less than 14 grams.
2424	893.135(1)(h)1.a.	1st	Trafficking in gamma-hydroxybutyric acid (GHB), 1 kilogram or more, less than 5 kilograms.
2425	893.135(1)(j)1.a.	1st	Trafficking in 1,4-Butanediol, 1 kilogram or more, less than 5 kilograms.
2426	893.135(1)(k)2.a.	1st	Trafficking in Phenethylamines, 10 grams or more, less than 200 grams.
2427	893.1351(2)	2nd	Possession of place for trafficking in or manufacturing of controlled substance.
2428	896.101(5)(a)	3rd	Money laundering, financial transactions exceeding \$300 but less than \$20,000.
2429	896.104(4)(a)1.	3rd	Structuring transactions to evade reporting or registration requirements, financial transactions exceeding \$300 but less than \$20,
2430	943.0435(4)(c)	2nd	Sexual offender vacating permanent residence; failure to comply with reporting requirements.
2431	943.0435(8)	2nd	Sexual offender; remains in state after indicating intent to leave; failure to comply with reporting requirements.
2432	943.0435(9)(a)	3rd	Sexual offender; failure to comply with reporting requirements.
2433	943.0435(13)	3rd	Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.
2434	943.0435(14)	3rd	Sexual offender; failure to report and reregister; failure to respond to address verification.
2435	944.607(9)	3rd	Sexual offender; failure to comply with reporting requirements.
2436	944.607(10)(a)	3rd	Sexual offender; failure to submit to the taking of a digitized photograph.
2437	944.607(12)	3rd	Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.
2438	944.607(13)	3rd	Sexual offender; failure to report and reregister; failure to respond to address verification.
2439	985.4815(10)	3rd	Sexual offender; failure to submit to the taking of a digitized photograph.
2440	985.4815(12)	3rd	Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.
2441	985.4815(13)	3rd	Sexual offender; failure to report and reregister; failure to respond to address verification.
2442	(i) LEVEL 9		
2443	FloridaStatute	FelonyDegree	Description
2444	316.193(3)(c)3.b.	1st	DUI manslaughter; failing to render aid or give information.
2445	327.35(3)(c)3.b.	1st	BUI manslaughter; failing to render aid or give information.
2446	<u>409.920(2)(b)1.c.</u>	<u>1st</u>	<u>Medicaid provider fraud; \$50,000 or more.</u>
2447	499.0051(9)	1st	Knowing sale or purchase of contraband prescription drugs resulting in great bodily harm.
2448	560.123(8)(b)3.	1st	Failure to report currency or payment instruments totaling or exceeding \$100,000 by money transmitter.
2449	560.125(5)(c)	1st	Money transmitter business by unauthorized person, currency, or payment instruments totaling or exceeding \$100,000.
2450	655.50(10)(b)3.	1st	Failure to report financial transactions totaling or exceeding \$100,000 by financial institution.
2451	775.0844	1st	Aggravated white collar crime.
2452	782.04(1)	1st	Attempt, conspire, or solicit to commit premeditated murder.
2453	782.04(3)	1st,PBL	Accomplice to murder in connection with arson, sexual battery, robbery, burglary, and other specified felonies.
2454	782.051(1)	1st	Attempted felony murder while perpetrating or attempting to perpetrate a felony enumerated in s. 782.04(3).
2455	782.07(2)	1st	Aggravated manslaughter of an elderly person or disabled adult.
2456	787.01(1)(a)1.	1st,PBL	Kidnapping; hold for ransom or reward or as a shield or hostage.
2457	787.01(1)(a)2.	1st,PBL	Kidnapping with intent to commit or facilitate commission of any felony.
2458	787.01(1)(a)4.	1st,PBL	Kidnapping with intent to interfere with performance of any governmental or political function.
2459	787.02(3)(a)	1st	False imprisonment; child under age 13; perpetrator also commits aggravated child abuse, sexual battery, or lewd or lascivious bat
2460	790.161	1st	Attempted capital destructive device offense.
2461	790.166(2)	1st,PBL	Possessing, selling, using, or attempting to use a weapon of mass destruction.
2462	794.011(2)	1st	Attempted sexual battery; victim less than 12 years of age.
2463	794.011(2)	Life	Sexual battery; offender younger than 18 years and commits sexual battery on a person less than 12 years.
2464	794.011(4)	1st	Sexual battery; victim 12 years or older, certain circumstances.
2465	794.011(8)(b)	1st	Sexual battery; engage in sexual conduct with minor 12 to 18 years by person in familial or custodial authority.
2466	794.08(2)	1st	Female genital mutilation; victim younger than 18 years of age.
2467	800.04(5)(b)	Life	Lewd or lascivious molestation; victim less than 12 years; offender 18 years or older.
2468	812.13(2)(a)	1st,PBL	Robbery with firearm or other deadly weapon.
2469	812.133(2)(a)	1st,PBL	Carjacking; firearm or other deadly weapon.
2470	812.135(2)(b)	1st	Home-invasion robbery with weapon.
2471	817.568(7)	2nd,PBL	Fraudulent use of personal identification information of an individual under the age of 18 by his or her parent, legal guardian, o
2472	827.03(2)	1st	Aggravated child abuse.
2473	847.0145(1)	1st	Selling, or otherwise transferring custody or control, of a minor.
2474	847.0145(2)	1st	Purchasing, or otherwise obtaining custody or control, of a minor.
2475	859.01	1st	Poisoning or introducing bacteria, radioactive materials, viruses, or chemical compounds into food, drink, medicine, or water with
2476	893.135	1st	Attempted capital trafficking offense.
2477	893.135(1)(a)3.	1st	Trafficking in cannabis, more than 10,000 lbs.
2478	893.135(1)(b)1.c.	1st	Trafficking in cocaine, more than 400 grams, less than 150 kilograms.
2479	893.135(1)(c)1.c.	1st	Trafficking in illegal drugs, more than 28 grams, less than 30 kilograms.
2480	893.135(1)(d)1.c.	1st	Trafficking in phencyclidine, more than 400 grams.
2481	893.135(1)(e)1.c.	1st	Trafficking in methaqualone, more than 25 kilograms.
2482	893.135(1)(f)1.c.	1st	Trafficking in amphetamine, more than 200 grams.

2483 893.135(1)(h)1.c. 1st Trafficking in gamma-hydroxybutyric acid (GHB), 10 kilograms or more.
2484 893.135(1)(j)1.c. 1st Trafficking in 1,4-Butanediol, 10 kilograms or more.
2485 893.135(1)(k)2.c. 1st Trafficking in Phenethylamines, 400 grams or more.
2486 896.101(5)(c) 1st Money laundering, financial instruments totaling or exceeding \$100,000.
2487 896.104(4)(a)3. 1st Structuring transactions to evade reporting or registration requirements, financial transactions totaling or exceeding \$100,000.
2488 Section 31. Pilot project to monitor home health services.
2489 The Agency for Health Care Administration shall develop and
2490 implement a home health agency monitoring pilot project in
2491 Miami-Dade County by January 1, 2010. The agency shall contract
2492 with a vendor to verify the utilization and delivery of home
2493 health services and provide an electronic billing interface for
2494 home health services. The contract must require the creation of
2495 a program to submit claims electronically for the delivery of
2496 home health services. The program must verify telephonically
2497 visits for the delivery of home health services using voice
2498 biometrics. The agency may seek amendments to the Medicaid state
2499 plan and waivers of federal laws, as necessary, to implement the
2500 pilot project. Notwithstanding s. 287.057(5)(f), Florida
2501 Statutes, the agency must award the contract through the
2502 competitive solicitation process. The agency shall submit a
2503 report to the Governor, the President of the Senate, and the
2504 Speaker of the House of Representatives evaluating the pilot
2505 project by February 1, 2011.
2506 Section 32. Pilot project for home health care management.
2507 The Agency for Health Care Administration shall implement a
2508 comprehensive care management pilot project for home health
2509 services by January 1, 2010, which includes face-to-face
2510 assessments by a nurse licensed pursuant to chapter 464, Florida
2511 Statutes, consultation with physicians ordering services to
2512 substantiate the medical necessity for services, and on-site or
2513 desk reviews of recipients' medical records in Miami-Dade
2514 County. The agency may enter into a contract with a qualified
2515 organization to implement the pilot project. The agency may seek
2516 amendments to the Medicaid state plan and waivers of federal
2517 laws, as necessary, to implement the pilot project.
2518 Section 33. Subsection (6) of section 400.0077, Florida
2519 Statutes, is amended to read:
2520 400.0077 Confidentiality.-
2521 (6) This section does not limit the subpoena power of the
2522 Attorney General pursuant to s. 409.920(10)(b) s.-409.920(9)(b).
2523 Section 34. Subsection (2) of section 430.608, Florida
2524 Statutes, is amended to read:
2525 430.608 Confidentiality of information.-
2526 (2) This section does not, however, limit the subpoena
2527 authority of the Medicaid Fraud Control Unit of the Department
2528 of Legal Affairs pursuant to s. 409.920(10)(b) s.-409.920(9)(b).
2529 Section 35. Section 395.0199, Florida Statutes, is
2530 repealed.
2531 Section 36. Section 395.405, Florida Statutes, is amended
2532 to read:
2533 395.405 Rulemaking.-The department shall adopt and enforce
2534 all rules necessary to administer ss. ~~395.0199~~, 395.401,
2535 395.4015, 395.402, 395.4025, 395.403, 395.404, and 395.4045.
2536 Section 37. Subsection (1) of section 400.0712, Florida
2537 Statutes, is amended to read:
2538 400.0712 Application for inactive license.-
2539 (1) As specified in ~~s. 408.831(4)~~ and this section, the
2540 agency may issue an inactive license to a nursing home facility
2541 for all or a portion of its beds. Any request by a licensee that
2542 a nursing home or portion of a nursing home become inactive must
2543 be submitted to the agency in the approved format. The facility
2544 may not initiate any suspension of services, notify residents,
2545 or initiate inactivity before receiving approval from the
2546 agency; and a licensee that violates this provision may not be
2547 issued an inactive license.
2548 Section 38. Subsection (2) of section 400.118, Florida
2549 Statutes, is repealed.
2550 Section 39. Section 400.141, Florida Statutes, is amended
2551 to read:
2552 400.141 Administration and management of nursing home
2553 facilities.-
2554 (1) Every licensed facility shall comply with all
2555 applicable standards and rules of the agency and shall:
2556 (a)(+) Be under the administrative direction and charge of
2557 a licensed administrator.
2558 (b)(+) Appoint a medical director licensed pursuant to
2559 chapter 458 or chapter 459. The agency may establish by rule
2560 more specific criteria for the appointment of a medical
2561 director.
2562 (c)(+) Have available the regular, consultative, and
2563 emergency services of physicians licensed by the state.
2564 (d)(+) Provide for resident use of a community pharmacy as
2565 specified in s. 400.022(1)(q). Any other law to the contrary
2566 notwithstanding, a registered pharmacist licensed in Florida,
2567 that is under contract with a facility licensed under this
2568 chapter or chapter 429, shall repackage a nursing facility
2569 resident's bulk prescription medication which has been packaged
2570 by another pharmacist licensed in any state in the United States
2571 into a unit dose system compatible with the system used by the

2572 nursing facility, if the pharmacist is requested to offer such
2573 service. In order to be eligible for the repackaging, a resident
2574 or the resident's spouse must receive prescription medication
2575 benefits provided through a former employer as part of his or
2576 her retirement benefits, a qualified pension plan as specified
2577 in s. 4972 of the Internal Revenue Code, a federal retirement
2578 program as specified under 5 C.F.R. s. 831, or a long-term care
2579 policy as defined in s. 627.9404(1). A pharmacist who correctly
2580 repackages and relabels the medication and the nursing facility
2581 which correctly administers such repackaged medication under ~~the~~
2582 ~~provisions of this paragraph may subsection shall~~ not be held
2583 liable in any civil or administrative action arising from the
2584 repackaging. In order to be eligible for the repackaging, a
2585 nursing facility resident for whom the medication is to be
2586 repackaged shall sign an informed consent form provided by the
2587 facility which includes an explanation of the repackaging
2588 process and which notifies the resident of the immunities from
2589 liability provided ~~in this paragraph herein~~. A pharmacist who
2590 repackages and relabels prescription medications, as authorized
2591 under this ~~paragraph subsection~~, may charge a reasonable fee for
2592 costs resulting from the implementation of this provision.

2593 ~~(e)(45)~~ Provide for the access of the facility residents to
2594 dental and other health-related services, recreational services,
2595 rehabilitative services, and social work services appropriate to
2596 their needs and conditions and not directly furnished by the
2597 licensee. When a geriatric outpatient nurse clinic is conducted
2598 in accordance with rules adopted by the agency, outpatients
2599 attending such clinic shall not be counted as part of the
2600 general resident population of the nursing home facility, nor
2601 shall the nursing staff of the geriatric outpatient clinic be
2602 counted as part of the nursing staff of the facility, until the
2603 outpatient clinic load exceeds 15 a day.

2604 ~~(f)(6)~~ Be allowed and encouraged by the agency to provide
2605 other needed services under certain conditions. If the facility
2606 has a standard licensure status, and has had no class I or class
2607 II deficiencies during the past 2 years or has been awarded a
2608 Gold Seal under the program established in s. 400.235, it may be
2609 encouraged by the agency to provide services, including, but not
2610 limited to, respite and adult day services, which enable
2611 individuals to move in and out of the facility. A facility is
2612 not subject to any additional licensure requirements for
2613 providing these services. Respite care may be offered to persons
2614 in need of short-term or temporary nursing home services.
2615 Respite care must be provided in accordance with this part and
2616 rules adopted by the agency. However, the agency shall, by rule,
2617 adopt modified requirements for resident assessment, resident
2618 care plans, resident contracts, physician orders, and other
2619 provisions, as appropriate, for short-term or temporary nursing
2620 home services. The agency shall allow for shared programming and
2621 staff in a facility which meets minimum standards and offers
2622 services pursuant to this ~~paragraph subsection~~, but, if the
2623 facility is cited for deficiencies in patient care, may require
2624 additional staff and programs appropriate to the needs of
2625 service recipients. A person who receives respite care may not
2626 be counted as a resident of the facility for purposes of the
2627 facility's licensed capacity unless that person receives 24-hour
2628 respite care. A person receiving either respite care for 24
2629 hours or longer or adult day services must be included when
2630 calculating minimum staffing for the facility. Any costs and
2631 revenues generated by a nursing home facility from
2632 nonresidential programs or services shall be excluded from the
2633 calculations of Medicaid per diems for nursing home
2634 institutional care reimbursement.

2635 ~~(g)(7)~~ If the facility has a standard license or is a Gold
2636 Seal facility, exceeds the minimum required hours of licensed
2637 nursing and certified nursing assistant direct care per resident
2638 per day, and is part of a continuing care facility licensed
2639 under chapter 651 or a retirement community that offers other
2640 services pursuant to part III of this chapter or part I or part
2641 III of chapter 429 on a single campus, be allowed to share
2642 programming and staff. At the time of inspection and in the
2643 semiannual report required pursuant to ~~paragraph (o) subsection~~
2644 ~~(15)~~, a continuing care facility or retirement community that
2645 uses this option must demonstrate through staffing records that
2646 minimum staffing requirements for the facility were met.
2647 Licensed nurses and certified nursing assistants who work in the
2648 nursing home facility may be used to provide services elsewhere
2649 on campus if the facility exceeds the minimum number of direct
2650 care hours required per resident per day and the total number of
2651 residents receiving direct care services from a licensed nurse
2652 or a certified nursing assistant does not cause the facility to
2653 violate the staffing ratios required under s. 400.23(3)(a).
2654 Compliance with the minimum staffing ratios shall be based on
2655 total number of residents receiving direct care services,
2656 regardless of where they reside on campus. If the facility
2657 receives a conditional license, it may not share staff until the
2658 conditional license status ends. This ~~paragraph subsection~~ does
2659 not restrict the agency's authority under federal or state law
2660 to require additional staff if a facility is cited for

2661 deficiencies in care which are caused by an insufficient number
2662 of certified nursing assistants or licensed nurses. The agency
2663 may adopt rules for the documentation necessary to determine
2664 compliance with this provision.

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

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

2675 (j)(10) Keep full records of resident admissions and
2676 discharges; medical and general health status, including medical
2677 records, personal and social history, and identity and address
2678 of next of kin or other persons who may have responsibility for
2679 the affairs of the residents; and individual resident care plans
2680 including, but not limited to, prescribed services, service
2681 frequency and duration, and service goals. The records shall be
2682 open to inspection by the agency.

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

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

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

2704 (n)(14) Submit to the agency the information specified in
2705 s. 400.071(1)(b) for a management company within 30 days after
2706 the effective date of the management agreement.

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

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

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

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

2733 d.(d) A nursing facility that has failed to comply with
2734 state minimum-staffing requirements for 2 consecutive days is
2735 prohibited from accepting new admissions until the facility has
2736 achieved the minimum-staffing requirements for a period of 6
2737 consecutive days. For the purposes of this sub-subparagraph
2738 ~~paragraph~~, any person who was a resident of the facility and was
2739 absent from the facility for the purpose of receiving medical
2740 care at a separate location or was on a leave of absence is not
2741 considered a new admission. Failure to impose such an admissions
2742 moratorium constitutes a class II deficiency.

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

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

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

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

~~(p)(17)~~ Notify a licensed physician when a resident
2757 exhibits signs of dementia or cognitive impairment or has a
2758 change of condition in order to rule out the presence of an
2759 underlying physiological condition that may be contributing to
2760 such dementia or impairment. The notification must occur within
2761 30 days after the acknowledgment of such signs by facility
2762 staff. If an underlying condition is determined to exist, the
2763 facility shall arrange, with the appropriate health care
2764 provider, the necessary care and services to treat the
2765 condition.

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

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

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

~~(t)(21)~~ Maintain in the medical record for each resident a
2786 daily chart of certified nursing assistant services provided to
2787 the resident. The certified nursing assistant who is caring for
2788 the resident must complete this record by the end of his or her
2789 shift. This record must indicate assistance with activities of
2790 daily living, assistance with eating, and assistance with
2791 drinking, and must record each offering of nutrition and
2792 hydration for those residents whose plan of care or assessment
2793 indicates a risk for malnutrition or dehydration.

~~(u)(22)~~ Before November 30 of each year, subject to the
2795 availability of an adequate supply of the necessary vaccine,
2796 provide for immunizations against influenza viruses to all its
2797 consenting residents in accordance with the recommendations of
2798 the United States Centers for Disease Control and Prevention,
2799 subject to exemptions for medical contraindications and
2800 religious or personal beliefs. Subject to these exemptions, any
2801 consenting person who becomes a resident of the facility after
2802 November 30 but before March 31 of the following year must be
2803 immunized within 5 working days after becoming a resident.
2804 Immunization shall not be provided to any resident who provides
2805 documentation that he or she has been immunized as required by
2806 this ~~paragraph subsection~~. This ~~paragraph subsection~~ does not
2807 prohibit a resident from receiving the immunization from his or
2808 her personal physician if he or she so chooses. A resident who
2809 chooses to receive the immunization from his or her personal
2810 physician shall provide proof of immunization to the facility.
2811 The agency may adopt and enforce any rules necessary to comply
2812 with or implement this subsection.

~~(v)(23)~~ Assess all residents for eligibility for
2814 pneumococcal polysaccharide vaccination (PPV) and vaccinate
2815 residents when indicated within 60 days after the effective date
2816 of this act in accordance with the recommendations of the United
2817 States Centers for Disease Control and Prevention, subject to
2818 exemptions for medical contraindications and religious or
2819 personal beliefs. Residents admitted after the effective date of
2820 this act shall be assessed within 5 working days of admission
2821 and, when indicated, vaccinated within 60 days in accordance
2822 with the recommendations of the United States Centers for
2823 Disease Control and Prevention, subject to exemptions for
2824 medical contraindications and religious or personal beliefs.
2825 Immunization shall not be provided to any resident who provides
2826 documentation that he or she has been immunized as required by
2827 this ~~paragraph subsection~~. This ~~paragraph subsection~~ does not
2828 prohibit a resident from receiving the immunization from his or
2829 her personal physician if he or she so chooses. A resident who
2830 chooses to receive the immunization from his or her personal
2831 physician shall provide proof of immunization to the facility.
2832 The agency may adopt and enforce any rules necessary to comply
2833 with or implement this ~~paragraph subsection~~.

~~(w)(24)~~ Annually encourage and promote to its employees the
2835 benefits associated with immunizations against influenza viruses
2836 in accordance with the recommendations of the United States
2837 Centers for Disease Control and Prevention. The agency may adopt
2838

2839 and enforce any rules necessary to comply with or implement this
2840 ~~paragraph subsection.~~
2841 (2) Facilities that have been awarded a Gold Seal under the
2842 program established in s. 400.235 may develop a plan to provide
2843 certified nursing assistant training as prescribed by federal
2844 regulations and state rules and may apply to the agency for
2845 approval of their program.
2846 Section 40. Subsections (5), (9), (10), (11), (12), (13),
2847 (14), and (15) of section 400.147, Florida Statutes, are amended
2848 to read:
2849 400.147 Internal risk management and quality assurance
2850 program.—
2851 (5) For purposes of reporting to the agency under this
2852 section, the term "adverse incident" means:
2853 (a) An event over which facility personnel could exercise
2854 control and which is associated in whole or in part with the
2855 facility's intervention, rather than the condition for which
2856 such intervention occurred, and which results in one of the
2857 following:
2858 1. Death;
2859 2. Brain or spinal damage;
2860 3. Permanent disfigurement;
2861 4. Fracture or dislocation of bones or joints;
2862 5. A limitation of neurological, physical, or sensory
2863 function;
2864 6. Any condition that required medical attention to which
2865 the resident has not given his or her informed consent,
2866 including failure to honor advanced directives; ~~or~~
2867 7. Any condition that required the transfer of the
2868 resident, within or outside the facility, to a unit providing a
2869 more acute level of care due to the adverse incident, rather
2870 than the resident's condition prior to the adverse incident; ~~or~~
2871 8. An event that is reported to law enforcement or its
2872 personnel for investigation; or
2873 ~~(b) Abuse, neglect, or exploitation as defined in s.~~
2874 ~~415.102.~~
2875 ~~(c) Abuse, neglect and harm as defined in s. 39.01;~~
2876 ~~(b)(4) Resident elopement, if the elopement places the~~
2877 ~~resident at risk of harm or injury.~~ ~~or~~
2878 ~~(c) An event that is reported to law enforcement.~~
2879 (9) Abuse, neglect, or exploitation must be reported to the
2880 agency as required by 42 C.F.R. s. 483.13(c) and to the
2881 department as required by chapters 39 and 415.
2882 ~~(10)(9)~~ By the 10th of each month, each facility subject to
2883 this section shall report any notice received pursuant to s.
2884 400.0233(2) and each initial complaint that was filed with the
2885 clerk of the court and served on the facility during the
2886 previous month by a resident or a resident's family member,
2887 guardian, conservator, or personal legal representative. The
2888 report must include the name of the resident, the resident's
2889 date of birth and social security number, the Medicaid
2890 identification number for Medicaid-eligible persons, the date or
2891 dates of the incident leading to the claim or dates of
2892 residency, if applicable, and the type of injury or violation of
2893 rights alleged to have occurred. Each facility shall also submit
2894 a copy of the notices received pursuant to s. 400.0233(2) and
2895 complaints filed with the clerk of the court. This report is
2896 confidential as provided by law and is not discoverable or
2897 admissible in any civil or administrative action, except in such
2898 actions brought by the agency to enforce the provisions of this
2899 part.
2900 ~~(11)(10)~~ The agency shall review, as part of its licensure
2901 inspection process, the internal risk management and quality
2902 assurance program at each facility regulated by this section to
2903 determine whether the program meets standards established in
2904 statutory laws and rules, is being conducted in a manner
2905 designed to reduce adverse incidents, and is appropriately
2906 reporting incidents as required by this section.
2907 ~~(12)(11)~~ There is no monetary liability on the part of, and
2908 a cause of action for damages may not arise against, any risk
2909 manager for the implementation and oversight of the internal
2910 risk management and quality assurance program in a facility
2911 licensed under this part as required by this section, or for any
2912 act or proceeding undertaken or performed within the scope of
2913 the functions of such internal risk management and quality
2914 assurance program if the risk manager acts without intentional
2915 fraud.
2916 ~~(13)(12)~~ If the agency, through its receipt of the adverse
2917 incident reports prescribed in subsection (7), or through any
2918 investigation, has a reasonable belief that conduct by a staff
2919 member or employee of a facility is grounds for disciplinary
2920 action by the appropriate regulatory board, the agency shall
2921 report this fact to the regulatory board.
2922 ~~(14)(13)~~ The agency may adopt rules to administer this
2923 section.
2924 ~~(14) The agency shall annually submit to the Legislature a~~
2925 ~~report on nursing home adverse incidents. The report must~~
2926 ~~include the following information arranged by county:~~
2927 ~~(a) The total number of adverse incidents.~~

2928 ~~(b) A listing, by category, of the types of adverse~~
2929 ~~incidents, the number of incidents occurring within each~~
2930 ~~category, and the type of staff involved.~~
2931 ~~(c) A listing, by category, of the types of injury caused~~
2932 ~~and the number of injuries occurring within each category.~~
2933 ~~(d) Types of liability claims filed based on an adverse~~
2934 ~~incident or reportable injury.~~
2935 ~~(e) Disciplinary action taken against staff, categorized by~~
2936 ~~type of staff involved.~~
2937 (15) Information gathered by a credentialing organization
2938 under a quality assurance program is not discoverable from the
2939 credentialing organization. This subsection does not limit
2940 discovery of, access to, or use of facility records, including
2941 those records from which the credentialing organization gathered
2942 its information.
2943 Section 41. Subsection (3) of section 400.162, Florida
2944 Statutes, is amended to read:
2945 400.162 Property and personal affairs of residents.—
2946 (3) A licensee shall provide for the safekeeping of
2947 personal effects, funds, and other property of the resident in
2948 the facility. Whenever necessary for the protection of
2949 valuables, or in order to avoid unreasonable responsibility
2950 therefor, the licensee may require that such valuables be
2951 excluded or removed from the facility and kept at some place not
2952 subject to the control of the licensee. At the request of a
2953 resident, the facility shall mark the resident's personal
2954 property with the resident's name or another type of
2955 identification, without defacing the property. Any theft or loss
2956 of a resident's personal property shall be documented by the
2957 facility. The facility shall develop policies and procedures to
2958 minimize the risk of theft or loss of the personal property of
2959 residents. A copy of the policy shall be provided to every
2960 employee and to each resident and the resident's representative
2961 if appropriate at admission and when revised. Facility policies
2962 must include provisions related to reporting theft or loss of a
2963 resident's property to law enforcement and any facility waiver
2964 of liability for loss or theft. ~~The facility shall post notice~~
2965 ~~of these policies and procedures, and any revision thereof, in~~
2966 ~~places accessible to residents.~~
2967 Section 42. Paragraphs (a) and (b) of subsection (2) of
2968 section 400.191, Florida Statutes, are amended to read:
2969 400.191 Availability, distribution, and posting of reports
2970 and records.—
2971 (2) The agency shall publish the Nursing Home Guide
2972 ~~annually in consumer friendly printed form and~~ quarterly in
2973 electronic form to assist consumers and their families in
2974 comparing and evaluating nursing home facilities.
2975 (a) The agency shall provide an Internet site which shall
2976 include at least the following information either directly or
2977 indirectly through a link to another established site or sites
2978 of the agency's choosing:
2979 1. A section entitled "Have you considered programs that
2980 provide alternatives to nursing home care?" which shall be the
2981 first section of the Nursing Home Guide and which shall
2982 prominently display information about available alternatives to
2983 nursing homes and how to obtain additional information regarding
2984 these alternatives. The Nursing Home Guide shall explain that
2985 this state offers alternative programs that permit qualified
2986 elderly persons to stay in their homes instead of being placed
2987 in nursing homes and shall encourage interested persons to call
2988 the Comprehensive Assessment Review and Evaluation for Long-Term
2989 Care Services (CARES) Program to inquire if they qualify. The
2990 Nursing Home Guide shall list available home and community-based
2991 programs which shall clearly state the services that are
2992 provided and indicate whether nursing home services are included
2993 if needed.
2994 2. A list by name and address of all nursing home
2995 facilities in this state, including any prior name by which a
2996 facility was known during the previous 24-month period.
2997 3. Whether such nursing home facilities are proprietary or
2998 nonproprietary.
2999 4. The current owner of the facility's license and the year
3000 that that entity became the owner of the license.
3001 5. The name of the owner or owners of each facility and
3002 whether the facility is affiliated with a company or other
3003 organization owning or managing more than one nursing facility
3004 in this state.
3005 6. The total number of beds in each facility and the most
3006 recently available occupancy levels.
3007 7. The number of private and semiprivate rooms in each
3008 facility.
3009 8. The religious affiliation, if any, of each facility.
3010 9. The languages spoken by the administrator and staff of
3011 each facility.
3012 10. Whether or not each facility accepts Medicare or
3013 Medicaid recipients or insurance, health maintenance
3014 organization, Veterans Administration, CHAMPUS program, or
3015 workers' compensation coverage.
3016 11. Recreational and other programs available at each

3017 facility.
3018 12. Special care units or programs offered at each
3019 facility.
3020 13. Whether the facility is a part of a retirement
3021 community that offers other services pursuant to part III of
3022 this chapter or part I or part III of chapter 429.
3023 14. Survey and deficiency information, including all
3024 federal and state recertification, licensure, revisit, and
3025 complaint survey information, for each facility for the past 30
3026 months. For noncertified nursing homes, state survey and
3027 deficiency information, including licensure, revisit, and
3028 complaint survey information for the past 30 months shall be
3029 provided.
3030 ~~15.—A summary of the deficiency data for each facility over~~
3031 ~~the past 30 months. The summary may include a score, rating, or~~
3032 ~~comparison ranking with respect to other facilities based on the~~
3033 ~~number of citations received by the facility on recertification,~~
3034 ~~licensure, revisit, and complaint surveys; the severity and~~
3035 ~~scope of the citations; and the number of recertification~~
3036 ~~surveys the facility has had during the past 30 months. The~~
3037 ~~score, rating, or comparison ranking may be presented in either~~
3038 ~~numeric or symbolic form for the intended consumer audience.~~
3039 ~~(b) The agency shall provide the following information in~~
3040 ~~printed form:~~
3041 ~~1. A section entitled "Have you considered programs that~~
3042 ~~provide alternatives to nursing home care?" which shall be the~~
3043 ~~first section of the Nursing Home Guide and which shall~~
3044 ~~prominently display information about available alternatives to~~
3045 ~~nursing homes and how to obtain additional information regarding~~
3046 ~~these alternatives. The Nursing Home Guide shall explain that~~
3047 ~~this state offers alternative programs that permit qualified~~
3048 ~~elderly persons to stay in their homes instead of being placed~~
3049 ~~in nursing homes and shall encourage interested persons to call~~
3050 ~~the Comprehensive Assessment Review and Evaluation for Long-Term~~
3051 ~~Care Services (CARES) Program to inquire if they qualify. The~~
3052 ~~Nursing Home Guide shall list available home and community-based~~
3053 ~~programs which shall clearly state the services that are~~
3054 ~~provided and indicate whether nursing home services are included~~
3055 ~~if needed.~~
3056 ~~2. A list by name and address of all nursing home~~
3057 ~~facilities in this state.~~
3058 ~~3. Whether the nursing home facilities are proprietary or~~
3059 ~~nonproprietary.~~
3060 ~~4. The current owner or owners of the facility's license~~
3061 ~~and the year that entity became the owner of the license.~~
3062 ~~5. The total number of beds, and of private and semiprivate~~
3063 ~~rooms, in each facility.~~
3064 ~~6. The religious affiliation, if any, of each facility.~~
3065 ~~7. The name of the owner of each facility and whether the~~
3066 ~~facility is affiliated with a company or other organization~~
3067 ~~owning or managing more than one nursing facility in this state.~~
3068 ~~8. The languages spoken by the administrator and staff of~~
3069 ~~each facility.~~
3070 ~~9. Whether or not each facility accepts Medicare or~~
3071 ~~Medicaid recipients or insurance, health maintenance~~
3072 ~~organization, Veterans Administration, CHAMPUS program, or~~
3073 ~~workers' compensation coverage.~~
3074 ~~10.—Recreational programs, special care units, and other~~
3075 ~~programs available at each facility.~~
3076 ~~11. The Internet address for the site where more detailed~~
3077 ~~information can be seen.~~
3078 ~~12.—A statement advising consumers that each facility will~~
3079 ~~have its own policies and procedures related to protecting~~
3080 ~~resident property.~~
3081 ~~13.—A summary of the deficiency data for each facility over~~
3082 ~~the past 30 months. The summary may include a score, rating, or~~
3083 ~~comparison ranking with respect to other facilities based on the~~
3084 ~~number of citations received by the facility on recertification,~~
3085 ~~licensure, revisit, and complaint surveys; the severity and~~
3086 ~~scope of the citations; the number of citations; and the number~~
3087 ~~of recertification surveys the facility has had during the past~~
3088 ~~30 months. The score, rating, or comparison ranking may be~~
3089 ~~presented in either numeric or symbolic form for the intended~~
3090 ~~consumer audience.~~
3091 Section 43. Paragraph (d) of subsection (1) of section
3092 400.195, Florida Statutes, is amended to read:
3093 400.195 Agency reporting requirements.—
3094 (1) For the period beginning June 30, 2001, and ending June
3095 30, 2005, the Agency for Health Care Administration shall
3096 provide a report to the Governor, the President of the Senate,
3097 and the Speaker of the House of Representatives with respect to
3098 nursing homes. The first report shall be submitted no later than
3099 December 30, 2002, and subsequent reports shall be submitted
3100 every 6 months thereafter. The report shall identify facilities
3101 based on their ownership characteristics, size, business
3102 structure, for-profit or not-for-profit status, and any other
3103 characteristics the agency determines useful in analyzing the
3104 varied segments of the nursing home industry and shall report:
3105 (d) Information regarding deficiencies cited, including

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

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

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

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

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

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

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

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

3139 4. The agency shall recognize the use of licensed nurses
3140 for compliance with minimum staffing requirements for certified
3141 nursing assistants, provided that the facility otherwise meets
3142 the minimum staffing requirements for licensed nurses and that
3143 the licensed nurses are performing the duties of a certified
3144 nursing assistant. Unless otherwise approved by the agency,
3145 licensed nurses counted toward the minimum staffing requirements
3146 for certified nursing assistants must exclusively perform the
3147 duties of a certified nursing assistant for the entire shift and
3148 not also be counted toward the minimum staffing requirements for
3149 licensed nurses. If the agency approved a facility's request to
3150 use a licensed nurse to perform both licensed nursing and
3151 certified nursing assistant duties, the facility must allocate
3152 the amount of staff time specifically spent on certified nursing
3153 assistant duties for the purpose of documenting compliance with
3154 minimum staffing requirements for certified and licensed nursing
3155 staff. In no event may the hours of a licensed nurse with dual
3156 job responsibilities be counted twice.

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

3167 (c) Licensed practical nurses licensed under chapter 464
3168 who are providing nursing services in nursing home facilities
3169 under this part may supervise the activities of other licensed
3170 practical nurses, certified nursing assistants, and other
3171 unlicensed personnel providing services in such facilities in
3172 accordance with rules adopted by the Board of Nursing.

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

3175 400.9935 Clinic responsibilities.—

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

3195 agency shall deny a change of ownership application if the
3196 clinic is not in compliance with the accreditation requirements.
3197 When a clinic adds, replaces, or modifies magnetic resonance
3198 imaging equipment and the accreditation agency requires new
3199 accreditation, the clinic must be accredited within 1 year after
3200 the date of the addition, replacement, or modification but may
3201 request a single, 6-month extension if the clinic provides
3202 evidence of good cause to the agency.

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

3205 400.995 Agency administrative penalties.—

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

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

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

3220 (5) "Change of ownership" means:

3221 (a) An event in which the licensee sells or otherwise
3222 transfers its ownership changes to a different individual or
3223 legal entity as evidenced by a change in federal employer
3224 identification number or taxpayer identification number; or
3225 (b) An event in which 51 45 percent or more of the
3226 ownership, ~~voting~~ shares, ~~membership,~~ or controlling interest of
3227 a licensee is in any manner transferred or otherwise assigned.
3228 ~~This paragraph does not apply to a licensee that is publicly~~
3229 ~~traded on a recognized stock exchange in a corporation whose~~
3230 ~~shares are not publicly traded on a recognized stock exchange is~~
3231 ~~transferred or assigned, including the final transfer or~~
3232 ~~assignment of multiple transfers or assignments over a 2-year~~
3233 ~~period that cumulatively total 45 percent or greater.~~

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

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

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

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

3257 408.806 License application process.—

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

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

3265 1. The applicant;
3266 2. The administrator or a similarly titled person who is
3267 responsible for the day-to-day operation of the provider;
3268 3. The financial officer or similarly titled person who is
3269 responsible for the financial operation of the licensee or
3270 provider; and

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

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

3282 (b) The applicant for initial licensure due to a change of
3283 ownership must submit an application that must be received by

3284 the agency at least 60 days prior to the date of change of
3285 ownership.

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

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

3304 (7)

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

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

3313 (a) Licensure applications.
3314 (b) Required signatures.
3315 (c) Payment of fees.
3316 (d) Notarization of applications.

3317

3318 Requirements for electronic submission of any documents required
3319 by this part or authorizing statutes may be established by rule.

3320 As an alternative to sending documents as required by
3321 authorizing statutes, the agency may provide electronic access
3322 to information or documents.

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

3325 408.808 License categories.—

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

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

3338 408.809 Background screening; prohibited offenses.—

3339 (5) Effective October 1, 2009, in addition to the offenses
3340 listed in ss. 435.03 and 435.04, all persons required to undergo
3341 background screening pursuant to this part or authorizing
3342 statutes must not have been found guilty of, regardless of
3343 adjudication, or entered a plea of nolo contendere or guilty to,
3344 any of the following offenses or any similar offense of another
3345 jurisdiction:

3346 (a) Any authorizing statutes, if the offense was a felony.
3347 (b) This chapter, if the offense was a felony.
3348 (c) Section 409.920, relating to Medicaid provider fraud,
3349 if the offense was a felony.
3350 (d) Section 409.9201, relating to Medicaid fraud, if the
3351 offense was a felony.
3352 (e) Section 741.28, relating to domestic violence.
3353 (f) Chapter 784, relating to assault, battery, and culpable
3354 negligence, if the offense was a felony.
3355 (g) Section 810.02, relating to burglary.
3356 (h) Section 817.034, relating to fraudulent acts through
3357 mail, wire, radio, electromagnetic, photoelectronic, or
3358 photooptical systems.
3359 (i) Section 817.234, relating to false and fraudulent
3360 insurance claims.
3361 (j) Section 817.505, relating to patient brokering.
3362 (k) Section 817.568, relating to criminal use of personal
3363 identification information.
3364 (l) Section 817.60, relating to obtaining a credit card
3365 through fraudulent means.
3366 (m) Section 817.61, relating to fraudulent use of credit
3367 cards, if the offense was a felony.
3368 (n) Section 831.01, relating to forgery.
3369 (o) Section 831.02, relating to uttering forged
3370 instruments.
3371 (p) Section 831.07, relating to forging bank bills, checks,
3372 drafts, or promissory notes.

3373 (q) Section 831.09, relating to uttering forged bank bills,
3374 checks, drafts, or promissory notes.
3375 (r) Section 831.30, relating to fraud in obtaining
3376 medicinal drugs.
3377 (s) Section 831.31, relating to the sale, manufacture,
3378 delivery, or possession with the intent to sell, manufacture, or
3379 deliver any counterfeit controlled substance, if the offense was
3380 a felony.

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

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

3401 Section 51. Section 408.811, Florida Statutes, is amended
3402 to read:

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

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

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

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

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

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

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

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

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

3453 (b) A licensee shall, upon the request of any person who
3454 has completed a written application with intent to be admitted
3455 by such provider, any person who is a client of such provider,
3456 or any relative, spouse, or guardian of any such person, furnish
3457 to the requester a copy of the last inspection report pertaining
3458 to the licensed provider that was issued by the agency or by an
3459 accrediting organization if such report is used in lieu of a
3460 licensure inspection.

3461 Section 52. Section 408.813, Florida Statutes, is amended

3462 to read:

3463 408.813 Administrative fines; violations.—As a penalty for

3464 any violation of this part, authorizing statutes, or applicable

3465 rules, the agency may impose an administrative fine.

3466 (1) Unless the amount or aggregate limitation of the fine

3467 is prescribed by authorizing statutes or applicable rules, the

3468 agency may establish criteria by rule for the amount or

3469 aggregate limitation of administrative fines applicable to this

3470 part, authorizing statutes, and applicable rules. Each day of

3471 violation constitutes a separate violation and is subject to a

3472 separate fine. For fines imposed by final order of the agency

3473 and not subject to further appeal, the violator shall pay the

3474 fine plus interest at the rate specified in s. 55.03 for each

3475 day beyond the date set by the agency for payment of the fine.

3476 (2) Violations of this part, authorizing statutes, or

3477 applicable rules shall be classified according to the nature of

3478 the violation and the gravity of its probable effect on clients.

3479 The scope of a violation may be cited as an isolated, patterned,

3480 or widespread deficiency. An isolated deficiency is a deficiency

3481 affecting one or a very limited number of clients, or involving

3482 one or a very limited number of staff, or a situation that

3483 occurred only occasionally or in a very limited number of

3484 locations. A patterned deficiency is a deficiency in which more

3485 than a very limited number of clients are affected, or more than

3486 a very limited number of staff are involved, or the situation

3487 has occurred in several locations, or the same client or clients

3488 have been affected by repeated occurrences of the same deficient

3489 practice but the effect of the deficient practice is not found

3490 to be pervasive throughout the provider. A widespread deficiency

3491 is a deficiency in which the problems causing the deficiency are

3492 pervasive in the provider or represent systemic failure that has

3493 affected or has the potential to affect a large portion of the

3494 provider's clients. This subsection does not affect the

3495 legislative determination of the amount of a fine imposed under

3496 authorizing statutes. Violations shall be classified on the

3497 written notice as follows:

3498 (a) Class "I" violations are those conditions or

3499 occurrences related to the operation and maintenance of a

3500 provider or to the care of clients which the agency determines

3501 present an imminent danger to the clients of the provider or a

3502 substantial probability that death or serious physical or

3503 emotional harm would result therefrom. The condition or practice

3504 constituting a class I violation shall be abated or eliminated

3505 within 24 hours, unless a fixed period, as determined by the

3506 agency, is required for correction. The agency shall impose an

3507 administrative fine as provided by law for a cited class I

3508 violation. A fine shall be levied notwithstanding the correction

3509 of the violation.

3510 (b) Class "II" violations are those conditions or

3511 occurrences related to the operation and maintenance of a

3512 provider or to the care of clients which the agency determines

3513 directly threaten the physical or emotional health, safety, or

3514 security of the clients, other than class I violations. The

3515 agency shall impose an administrative fine as provided by law

3516 for a cited class II violation. A fine shall be levied

3517 notwithstanding the correction of the violation.

3518 (c) Class "III" violations are those conditions or

3519 occurrences related to the operation and maintenance of a

3520 provider or to the care of clients which the agency determines

3521 indirectly or potentially threaten the physical or emotional

3522 health, safety, or security of clients, other than class I or

3523 class II violations. The agency shall impose an administrative

3524 fine as provided in this section for a cited class III

3525 violation. A citation for a class III violation must specify the

3526 time within which the violation is required to be corrected. If

3527 a class III violation is corrected within the time specified, a

3528 fine may not be imposed.

3529 (d) Class "IV" violations are those conditions or

3530 occurrences related to the operation and maintenance of a

3531 provider or to required reports, forms, or documents that do not

3532 have the potential of negatively affecting clients. These

3533 violations are of a type that the agency determines do not

3534 threaten the health, safety, or security of clients. The agency

3535 shall impose an administrative fine as provided in this section

3536 for a cited class IV violation. A citation for a class IV

3537 violation must specify the time within which the violation is

3538 required to be corrected. If a class IV violation is corrected

3539 within the time specified, a fine may not be imposed.

3540 Section 53. Subsections (11), (12), (13), (14), (15), (16),

3541 (17), (18), (19), (20), (21), (22), (23), (24), (25), (26),

3542 (27), (28), and (29) of section 408.820, Florida Statutes, are

3543 amended to read:

3544 408.820 Exemptions.—Except as prescribed in authorizing

3545 statutes, the following exemptions shall apply to specified

3546 requirements of this part:

3547 ~~(11) Private review agents, as provided under part I of~~

3548 ~~chapter 395, are exempt from ss. 408.806(7), 408.810, and~~

3549 ~~408.811.~~

3550 (11)~~(12)~~ Health care risk managers, as provided under part

3551 I of chapter 395, are exempt from ss. 408.806(7), 408.810(4)
3552 (10) 408.810, and 408.811.
3553 (12)(13) Nursing homes, as provided under part II of
3554 chapter 400, are exempt from ss. 408.810(7) and 408.813(2) e-
3555 408.810(7).
3556 (13)(14) Assisted living facilities, as provided under part
3557 I of chapter 429, are exempt from s. 408.810(10).
3558 (14)(15) Home health agencies, as provided under part III
3559 of chapter 400, are exempt from s. 408.810(10).
3560 (15)(16) Nurse registries, as provided under part III of
3561 chapter 400, are exempt from s. 408.810(6) and (10).
3562 (16)(17) Companion services or homemaker services
3563 providers, as provided under part III of chapter 400, are exempt
3564 from s. 408.810(6)-(10).
3565 (17)(18) Adult day care centers, as provided under part III
3566 of chapter 429, are exempt from s. 408.810(10).
3567 (18)(19) Adult family-care homes, as provided under part II
3568 of chapter 429, are exempt from s. 408.810(7)-(10).
3569 (19)(20) Homes for special services, as provided under part
3570 V of chapter 400, are exempt from s. 408.810(7)-(10).
3571 (20)(21) Transitional living facilities, as provided under
3572 part V of chapter 400, are exempt from s. 408.810(10) e-
3573 408.810(7)-(10).
3574 (21)(22) Prescribed pediatric extended care centers, as
3575 provided under part VI of chapter 400, are exempt from s.
3576 408.810(10).
3577 (22)(23) Home medical equipment providers, as provided
3578 under part VII of chapter 400, are exempt from s. 408.810(10).
3579 (23)(24) Intermediate care facilities for persons with
3580 developmental disabilities, as provided under part VIII of
3581 chapter 400, are exempt from s. 408.810(7).
3582 (24)(25) Health care services pools, as provided under part
3583 IX of chapter 400, are exempt from s. 408.810(6)-(10).
3584 (25)(26) Health care clinics, as provided under part X of
3585 chapter 400, are exempt from s. 408.810(6), (7), (10) e-
3586 408.809 and 408.810(1), (6), (7), and (10).
3587 (26)(27) Clinical laboratories, as provided under part I of
3588 chapter 483, are exempt from s. 408.810(5)-(10).
3589 (27)(28) Multiphasic health testing centers, as provided
3590 under part II of chapter 483, are exempt from s. 408.810(5)
3591 (10).
3592 (28)(29) Organ and tissue procurement agencies, as provided
3593 under chapter 765, are exempt from s. 408.810(5)-(10).
3594 Section 54. Section 408.821, Florida Statutes, is created
3595 to read:
3596 408.821 Emergency management planning; emergency
3597 operations; inactive license.-
3598 (1) A licensee required by authorizing statutes to have an
3599 emergency operations plan must designate a safety liaison to
3600 serve as the primary contact for emergency operations.
3601 (2) An entity subject to this part may temporarily exceed
3602 its licensed capacity to act as a receiving provider in
3603 accordance with an approved emergency operations plan for up to
3604 15 days. While in an overcapacity status, each provider must
3605 furnish or arrange for appropriate care and services to all
3606 clients. In addition, the agency may approve requests for
3607 overcapacity in excess of 15 days, which approvals may be based
3608 upon satisfactory justification and need as provided by the
3609 receiving and sending providers.
3610 (3)(a) An inactive license may be issued to a licensee
3611 subject to this section when the provider is located in a
3612 geographic area in which a state of emergency was declared by
3613 the Governor if the provider:
3614 1. Suffered damage to its operation during the state of
3615 emergency.
3616 2. Is currently licensed.
3617 3. Does not have a provisional license.
3618 4. Will be temporarily unable to provide services but is
3619 reasonably expected to resume services within 12 months.
3620 (b) An inactive license may be issued for a period not to
3621 exceed 12 months but may be renewed by the agency for up to 12
3622 additional months upon demonstration to the agency of progress
3623 toward reopening. A request by a licensee for an inactive
3624 license or to extend the previously approved inactive period
3625 must be submitted in writing to the agency, accompanied by
3626 written justification for the inactive license, which states the
3627 beginning and ending dates of inactivity and includes a plan for
3628 the transfer of any clients to other providers and appropriate
3629 licensure fees. Upon agency approval, the licensee shall notify
3630 clients of any necessary discharge or transfer as required by
3631 authorizing statutes or applicable rules. The beginning of the
3632 inactive licensure period shall be the date the provider ceases
3633 operations. The end of the inactive period shall become the
3634 license expiration date, and all licensure fees must be current,
3635 must be paid in full, and may be prorated. Reactivation of an
3636 inactive license requires the prior approval by the agency of a
3637 renewal application, including payment of licensure fees and
3638 agency inspections indicating compliance with all requirements
3639 of this part and applicable rules and statutes.

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

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

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

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

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

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

3662 (2) In reviewing any application requesting a change of
3663 ownership or change of the licensee, registrant, or
3664 certificateholder, the transferor shall, prior to agency
3665 approval of the change, repay or make arrangements to repay any
3666 amounts owed to the agency. Should the transferor fail to repay
3667 or make arrangements to repay the amounts owed to the agency,
3668 the issuance of a license, registration, or certificate to the
3669 transferee shall be delayed until repayment or until
3670 arrangements for repayment are made.

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

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

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

3687 ~~2. Is currently licensed.~~

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

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

3691 ~~(b) An inactive license may be issued for a period not to~~
3692 ~~exceed 12 months but may be renewed by the agency for up to 12~~
3693 ~~additional months upon demonstration to the agency of progress~~
3694 ~~toward reopening. A request by a licensee for an inactive~~
3695 ~~license or to extend the previously approved inactive period~~
3696 ~~must be submitted in writing to the agency, accompanied by~~
3697 ~~written justification for the inactive license, which states the~~
3698 ~~beginning and ending dates of inactivity and includes a plan for~~
3699 ~~the transfer of any clients to other providers and appropriate~~
3700 ~~licensure fees. Upon agency approval, the licensee shall notify~~
3701 ~~clients of any necessary discharge or transfer as required by~~
3702 ~~authorizing statutes or applicable rules. The beginning of the~~
3703 ~~inactive licensure period shall be the date the provider ceases~~
3704 ~~operations. The end of the inactive period shall become the~~
3705 ~~licensee expiration date, and all licensure fees must be~~
3706 ~~current, paid in full, and may be prorated. Reactivation of an~~
3707 ~~inactive license requires the prior approval by the agency of a~~
3708 ~~renewal application, including payment of licensure fees and~~
3709 ~~agency inspections indicating compliance with all requirements~~
3710 ~~of this part and applicable rules and statutes.~~

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

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

3720 408.918 Florida 211 Network; uniform certification
3721 requirements.—

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

3729 ~~Services, and shall adopt the criteria as administrative rules.~~

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

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

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

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

3748 409.221 Consumer-directed care program.—

3749 (4) CONSUMER-DIRECTED CARE.—

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

- 3755 1. Personal care.
- 3756 2. Homemaking and chores, including housework, meals,
3757 shopping, and transportation.
- 3758 3. Home modifications and assistive devices which may
3759 increase the consumer's independence or make it possible to
3760 avoid institutional placement.
- 3761 4. Assistance in taking self-administered medication.
- 3762 5. Day care and respite care services, including those
3763 provided by nursing home facilities pursuant to s. 400.141(1)(f)
3764 ~~s. 400.141(6)~~ or by adult day care facilities licensed pursuant
3765 to s. 429.907.

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

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

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

3773 (5) "Change of ownership" means:

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

3778 (b) An event in which 51 45 percent or more of the
3779 ownership, voting shares, membership, or controlling interest of
3780 a provider is in any manner transferred or otherwise assigned.
3781 This paragraph does not apply to a licensee that is publicly
3782 traded on a recognized stock exchange; or

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

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

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

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

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

3800 (1)

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

3807 ~~(2) Each field office of the Agency for Health Care~~
3808 ~~Administration shall establish a local coordinating workgroup~~
3809 ~~which includes representatives of local law enforcement~~
3810 ~~agencies, state attorneys, the Medicaid Fraud Control Unit of~~
3811 ~~the Department of Legal Affairs, local fire authorities, the~~
3812 ~~Department of Children and Family Services, the district long~~
3813 ~~term care ombudsman council, and the district human rights~~
3814 ~~advocacy committee to assist in identifying the operation of~~
3815 ~~unlicensed facilities and to develop and implement a plan to~~
3816 ~~ensure effective enforcement of state laws relating to such~~
3817 ~~facilities. The workgroup shall report its findings, actions,~~

3818 ~~and recommendations semiannually to the Director of Health~~
3819 ~~Quality Assurance of the agency.~~
3820 (2)(3) It is unlawful to knowingly refer a person for
3821 residency to an unlicensed assisted living facility; to an
3822 assisted living facility the license of which is under denial or
3823 has been suspended or revoked; or to an assisted living facility
3824 that has a moratorium pursuant to part II of chapter 408. ~~Any~~
3825 ~~person who violates this subsection commits a noncriminal~~
3826 ~~violation, punishable by a fine not exceeding \$500 as provided~~
3827 ~~in s. 775.082.~~
3828 (a) Any health care practitioner, as defined in s. 456.001,
3829 who is aware of the operation of an unlicensed facility shall
3830 report that facility to the agency. Failure to report a facility
3831 that the practitioner knows or has reasonable cause to suspect
3832 is unlicensed shall be reported to the practitioner's licensing
3833 board.
3834 (b) Any ~~provider as defined in s. 408.803 hospital or~~
3835 ~~community mental health center licensed under chapter 395 or~~
3836 ~~chapter 394~~ which knowingly discharges a patient or client to an
3837 unlicensed facility is subject to sanction by the agency.
3838 (c) Any employee of the agency or department, or the
3839 Department of Children and Family Services, who knowingly refers
3840 a person for residency to an unlicensed facility; to a facility
3841 the license of which is under denial or has been suspended or
3842 revoked; or to a facility that has a moratorium pursuant to part
3843 II of chapter 408 is subject to disciplinary action by the
3844 agency or department, or the Department of Children and Family
3845 Services.
3846 (d) The employer of any person who is under contract with
3847 the agency or department, or the Department of Children and
3848 Family Services, and who knowingly refers a person for residency
3849 to an unlicensed facility; to a facility the license of which is
3850 under denial or has been suspended or revoked; or to a facility
3851 that has a moratorium pursuant to part II of chapter 408 shall
3852 be fined and required to prepare a corrective action plan
3853 designed to prevent such referrals.
3854 ~~(e) The agency shall provide the department and the~~
3855 ~~Department of Children and Family Services with a list of~~
3856 ~~licensed facilities within each county and shall update the list~~
3857 ~~at least quarterly.~~
3858 ~~(f) At least annually, the agency shall notify, in~~
3859 ~~appropriate trade publications, physicians licensed under~~
3860 ~~chapter 458 or chapter 459, hospitals licensed under chapter~~
3861 ~~395, nursing home facilities licensed under part II of chapter~~
3862 ~~400, and employees of the agency or the department, or the~~
3863 ~~Department of Children and Family Services, who are responsible~~
3864 ~~for referring persons for residency, that it is unlawful to~~
3865 ~~knowingly refer a person for residency to an unlicensed assisted~~
3866 ~~living facility and shall notify them of the penalty for~~
3867 ~~violating such prohibition. The department and the Department of~~
3868 ~~Children and Family Services shall, in turn, notify service~~
3869 ~~providers under contract to the respective departments who have~~
3870 ~~responsibility for resident referrals to facilities. Further,~~
3871 ~~the notice must direct each noticed facility and individual to~~
3872 ~~contact the appropriate agency office in order to verify the~~
3873 ~~licensure status of any facility prior to referring any person~~
3874 ~~for residency. Each notice must include the name, telephone~~
3875 ~~number, and mailing address of the appropriate office to~~
3876 ~~contact.~~
3877 Section 61. Paragraph (e) of subsection (1) of section
3878 429.14, Florida Statutes, is amended to read:
3879 429.14 Administrative penalties.—
3880 (1) In addition to the requirements of part II of chapter
3881 408, the agency may deny, revoke, and suspend any license issued
3882 under this part and impose an administrative fine in the manner
3883 provided in chapter 120 against a licensee of an assisted living
3884 facility for a violation of any provision of this part, part II
3885 of chapter 408, or applicable rules, or for any of the following
3886 actions by a licensee of an assisted living facility, for the
3887 actions of any person subject to level 2 background screening
3888 under s. 408.809, or for the actions of any facility employee:
3889 (e) A citation of any of the following deficiencies as
3890 ~~specified~~ defined in s. 429.19:
3891 1. One or more cited class I deficiencies.
3892 2. Three or more cited class II deficiencies.
3893 3. Five or more cited class III deficiencies that have been
3894 cited on a single survey and have not been corrected within the
3895 times specified.
3896 Section 62. Section 429.19, Florida Statutes, is amended to
3897 read:
3898 429.19 Violations; imposition of administrative fines;
3899 grounds.—
3900 (1) In addition to the requirements of part II of chapter
3901 408, the agency shall impose an administrative fine in the
3902 manner provided in chapter 120 for the violation of any
3903 provision of this part, part II of chapter 408, and applicable
3904 rules by an assisted living facility, for the actions of any
3905 person subject to level 2 background screening under s. 408.809,
3906 for the actions of any facility employee, or for an intentional

3907 or negligent act seriously affecting the health, safety, or
3908 welfare of a resident of the facility.

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

3914 (a) Class "I" violations are defined in s. 408.813 ~~these~~
3915 ~~conditions or occurrences related to the operation and~~
3916 ~~maintenance of a facility or to the personal care of residents~~
3917 ~~which the agency determines present an imminent danger to the~~
3918 ~~residents or guests of the facility or a substantial probability~~
3919 ~~that death or serious physical or emotional harm would result~~
3920 ~~therefrom. The condition or practice constituting a class I~~
3921 ~~violation shall be abated or eliminated within 24 hours, unless~~
3922 ~~a fixed period, as determined by the agency, is required for~~
3923 ~~correction.~~ The agency shall impose an administrative fine for a
3924 cited class I violation in an amount not less than \$5,000 and
3925 not exceeding \$10,000 for each violation. ~~A fine may be levied~~
3926 ~~notwithstanding the correction of the violation.~~

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

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

3950 (d) Class "IV" violations are defined in s. 408.813 ~~these~~
3951 ~~conditions or occurrences related to the operation and~~
3952 ~~maintenance of a building or to required reports, forms, or~~
3953 ~~documents that do not have the potential of negatively affecting~~
3954 ~~residents. These violations are of a type that the agency~~
3955 ~~determines do not threaten the health, safety, or security of~~
3956 ~~residents of the facility.~~ The agency shall impose an
3957 administrative fine for a cited class IV violation in an amount
3958 not less than \$100 and not exceeding \$200 for each violation. ~~A~~
3959 ~~citation for a class IV violation must specify the time within~~
3960 ~~which the violation is required to be corrected. If a class IV~~
3961 ~~violation is corrected within the time specified, no fine shall~~
3962 ~~be imposed. Any class IV violation that is corrected during the~~
3963 ~~time an agency survey is being conducted will be identified as~~
3964 ~~an agency finding and not as a violation.~~

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

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

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

3975 (c) Any previous violations.

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

3978 (e) The licensed capacity of the facility.

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

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

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

3993 (7) In addition to any administrative fines imposed, the
3994 agency may assess a survey fee, equal to the lesser of one half
3995 of the facility's biennial license and bed fee or \$500, to cover

3996 the cost of conducting initial complaint investigations that
3997 result in the finding of a violation that was the subject of the
3998 complaint or monitoring visits conducted under s. 429.28(3)(c)
3999 to verify the correction of the violations.

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

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

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

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

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

4035 (a) An event over which facility personnel could exercise
4036 control rather than as a result of the resident's condition and
4037 results in:
4038 1. Death;
4039 2. Brain or spinal damage;
4040 3. Permanent disfigurement;
4041 4. Fracture or dislocation of bones or joints;
4042 5. Any condition that required medical attention to which
4043 the resident has not given his or her consent, including failure
4044 to honor advanced directives;
4045 6. Any condition that requires the transfer of the resident
4046 from the facility to a unit providing more acute care due to the
4047 incident rather than the resident's condition before the
4048 incident; ~~or-~~

4049 7. An event that is reported to law enforcement or its
4050 personnel for investigation; or

4051 ~~(b) Abuse, neglect, or exploitation as defined in s.~~
4052 ~~415.102;~~

4053 ~~(c) Events reported to law enforcement; or~~

4054 (b)(d) Resident elopement, if the elopement places the
4055 resident at risk of harm or injury.

4056 ~~(6) Abuse, neglect, or exploitation must be reported to the~~
4057 ~~Department of Children and Family Services as required under~~
4058 ~~chapter 415. The agency shall annually submit to the Legislature~~
4059 ~~a report on assisted-living-facility adverse incident reports.~~
4060 ~~The report must include the following information arranged by~~
4061 ~~county:~~

4062 ~~(a) A total number of adverse incidents;~~

4063 ~~(b) A listing, by category, of the type of adverse~~
4064 ~~incidents occurring within each category and the type of staff~~
4065 ~~involved;~~

4066 ~~(c) A listing, by category, of the types of injuries, if~~
4067 ~~any, and the number of injuries occurring within each category;~~

4068 ~~(d) Types of liability claims filed based on an adverse~~
4069 ~~incident report or reportable injury; and~~

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

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

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

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

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

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

4083 (b) Participate in a nationally recognized accreditation
4084 program and hold a valid accreditation, such as the

4085 accreditation awarded by the Joint Commission on Accreditation
4086 of Healthcare Organizations;
4087 (c) Have been in business in this state for a minimum of 10
4088 consecutive years;
4089 (d) Demonstrate an active program in multidisciplinary
4090 education and research that relates to gerontology;
4091 (e) Have a formalized contractual relationship with at
4092 least one accredited health profession education program located
4093 in this state;
4094 (f) Have a formalized contractual relationship with an
4095 accredited hospital that is designated by law as a teaching
4096 hospital; and
4097 (g) Have senior staff members who hold formal faculty
4098 appointments at universities, which must include at least one
4099 accredited health profession education program.
4100 (h) Maintain insurance coverage pursuant to s.
4101 400.141(1)(s) ~~s. 400.141(20)~~ or proof of financial
4102 responsibility in a minimum amount of \$750,000. Such proof of
4103 financial responsibility may include:
4104 1. Maintaining an escrow account consisting of cash or
4105 assets eligible for deposit in accordance with s. 625.52; or
4106 2. Obtaining and maintaining pursuant to chapter 675 an
4107 unexpired, irrevocable, nontransferable and nonassignable letter
4108 of credit issued by any bank or savings association organized
4109 and existing under the laws of this state or any bank or savings
4110 association organized under the laws of the United States that
4111 has its principal place of business in this state or has a
4112 branch office which is authorized to receive deposits in this
4113 state. The letter of credit shall be used to satisfy the
4114 obligation of the facility to the claimant upon presentment of a
4115 final judgment indicating liability and awarding damages to be
4116 paid by the facility or upon presentment of a settlement
4117 agreement signed by all parties to the agreement when such final
4118 judgment or settlement is a result of a liability claim against
4119 the facility.
4120 Section 66. Subsection (5) of section 435.04, Florida
4121 Statutes, is amended to read:
4122 435.04 Level 2 screening standards.-
4123 (5) Under penalty of perjury, all employees in such
4124 positions of trust or responsibility shall attest to meeting the
4125 requirements for qualifying for employment and agreeing to
4126 inform the employer immediately if convicted of any of the
4127 disqualifying offenses while employed by the employer. Each
4128 employer of employees in such positions of trust or
4129 responsibilities which is licensed or registered by a state
4130 agency shall submit to the licensing agency annually or at the
4131 time of license renewal, under penalty of perjury, an affidavit
4132 of compliance with the provisions of this section.
4133 Section 67. Subsection (3) of section 435.05, Florida
4134 Statutes, is amended to read:
4135 435.05 Requirements for covered employees.-Except as
4136 otherwise provided by law, the following requirements shall
4137 apply to covered employees:
4138 (3) Each employer required to conduct level 2 background
4139 screening must sign an affidavit annually or at the time of
4140 license renewal, under penalty of perjury, stating that all
4141 covered employees have been screened or are newly hired and are
4142 awaiting the results of the required screening checks.
4143 Section 68. Subsection (2) of section 483.031, Florida
4144 Statutes, is amended to read:
4145 483.031 Application of part; exemptions.-This part applies
4146 to all clinical laboratories within this state, except:
4147 (2) A clinical laboratory that performs only waived tests
4148 ~~and has received a certificate of exemption from the agency~~
4149 ~~under s. 483.106.~~
4150 Section 69. Subsection (10) of section 483.041, Florida
4151 Statutes, is amended to read:
4152 483.041 Definitions.-As used in this part, the term:
4153 (10) "Waived test" means a test that the federal Centers
4154 for Medicare and Medicaid Services Health Care Financing
4155 Administration has determined qualifies for a certificate of
4156 waiver under the federal Clinical Laboratory Improvement
4157 Amendments of 1988, and the federal rules adopted thereunder.
4158 Section 70. Section 483.106, Florida Statutes, is repealed.
4159 Section 71. Subsection (3) of section 483.172, Florida
4160 Statutes, is amended to read:
4161 483.172 License fees.-
4162 (3) The agency shall assess ~~a biennial fee of \$100 for a~~
4163 ~~certificate of exemption and~~ a \$100 biennial license fee under
4164 this section for facilities surveyed by an approved accrediting
4165 organization.
4166 Section 72. Paragraph (b) of subsection (1) of section
4167 627.4239, Florida Statutes, is amended to read:
4168 627.4239 Coverage for use of drugs in treatment of cancer.-
4169 (1) DEFINITIONS.-As used in this section, the term:
4170 (b) "Standard reference compendium" means authoritative
4171 compendia identified by the Secretary of the United States
4172 Department of Health and Human Services and recognized by the
4173 federal Centers for Medicare and Medicaid Services+

4174 ~~1. The United States Pharmacopeia Drug Information;~~
4175 ~~2. The American Medical Association Drug Evaluations; or~~
4176 ~~3. The American Hospital Formulary Service Drug~~
4177 ~~Information.~~
4178 Section 73. Subsection (13) of section 651.118, Florida
4179 Statutes, is amended to read:
4180 651.118 Agency for Health Care Administration; certificates
4181 of need; sheltered beds; community beds.-
4182 (13) Residents, as defined in this chapter, are not
4183 considered new admissions for the purpose of s. 400.141
4184 ~~(1)(c)1.d. s. 400.141(15)(d).~~
4185 Section 74. This act shall take effect July 1, 2009.

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