Health Innovation Subcommittee

Action Packet

Tuesday, March 19, 2013
2:00 PM - 4:00 PM
306 HOB

Will Weatherford
Speaker

John Wood
Chair

COMMITTEE MEETING REPORT

Health Innovation Subcommittee

3/19/2013 2:00:00PM

Location: 306 HOB

Summary:

Health Innovation Subcommittee

Tuesday March 19, 2013 02:00 pm

CS/HB 675 Favorable — Yeas: 12 Nays: 0

HB 939 Favorable With Committee Substitute — Yeas: 12 Nays: 0
Amendment 725493 Adopted Without Objection

HB 1021 Favorable With Committee Substitute — Yeas: 13 Nays: 0
Amendment 951889 Adopted Without Objection

HB 1109 Favorable With Committee Substitute — Yeas: 13 Nays: 0
Amendment 775437 Adopted Without Objection

HB 1157 Favorable — Yeas: 13 Nays: 0

HB 1323 Favorable With Committee Substitute — Yeas: 11 Nays: 2
Amendment 170777 Adopted Without Objection

PCS for HB 1319 Favorable — Yeas: 11 Nays: 1

Rep. Patronis makes a Motion to Temporarily Postpone HB 939. Passed

Chairman Wood makes a Motion to Reconsider the prior motion to TP HB 939. Passed

Committee meeting was reported out: Tuesday, March 19, 2013 4:54:56PM

COMMITTEE MEETING REPORT

Health Innovation Subcommittee

3/19/2013 2:00:00PM

Location: 306 HOB

Attendance:

	Present	*Absent*	*Excused*
John Wood (Chair)	X		
Michael Bileca	X		
Joseph Gibbons	X		
Charles Hood, Jr.	X		
Mia Jones	X		
MaryLynn Magar	X		
Kionne McGhee	X		
Jimmy Patronis	X		
Sharon Pritchett	X		
Jake Raburn	X		
Ronald Renuart	X		
David Richardson	X		
W. Gregory Steube	X		
Totals:	**13**	**0**	**0**

Committee meeting was reported out: Tuesday, March 19, 2013 4:54:56PM

COMMITTEE MEETING REPORT

Health Innovation Subcommittee

3/19/2013 2:00:00PM

Location: 306 HOB

CS/HB 675 : Health Insurance Marketing Materials

[X] *Favorable*

	Yea	*Nay*	*No Vote*	*Absentee Yea*	*Absentee Nay*
Michael Bileca	X				
Joseph Gibbons	X				
Charles Hood, Jr.			X		
Mia Jones	X				
MaryLynn Magar	X				
Kionne McGhee	X				
Jimmy Patronis	X				
Sharon Pritchett	X				
Jake Raburn	X				
Ronald Renuart	X				
David Richardson	X				
W. Gregory Steube	X				
John Wood (Chair)	X				
	Total Yeas: 12	**Total Nays: 0**			

Appearances:

Pitts, Brian (General Public) - Information Only
Justice-2-Jesus
1119 Newton Ave. S.
St. Petersburg FL 33705
Phone: (727) 897-9291

Green, Jennifer (Lobbyist) - Proponent
Humana, Inc
P.O. Box 390
Tallahassee FL 32302
Phone: (850) 528-8809

Perdue, Tammy (Lobbyist) - Waive In Support
Associated Industries of Florida
516 N. Adams St.
Tallahassee FL 32301
Phone: (850) 224-7173

Pearce, Cecil (Lobbyist) - Waive In Support
Florida Insurance Council
150 S. Monroe St.
Tallahassee FL 32301
Phone: (850) 386-6668

Garner, Michael (Lobbyist) - Waive In Support
Florida Association of Health Plans, Inc.
200 W. College Ave., Ste. 104
Tallahassee FL 32301
Phone: (850) 386-2904

Committee meeting was reported out: Tuesday, March 19, 2013 4:54:56PM

COMMITTEE MEETING REPORT

Health Innovation Subcommittee

3/19/2013 2:00:00PM

Location: 306 HOB

HB 939 : Medicaid Fraud

[X] *Favorable With Committee Substitute*

	Yea	*Nay*	*No Vote*	*Absentee Yea*	*Absentee Nay*
Michael Bileca				X	
Joseph Gibbons	X				
Charles Hood, Jr.	X				
Mia Jones	X				
MaryLynn Magar	X				
Kionne McGhee	X				
Jimmy Patronis	X				
Sharon Pritchett	X				
Jake Raburn	X				
Ronald Renuart	X				
David Richardson	X				
W. Gregory Steube	X				
John Wood (Chair)	X				
	Total Yeas: 12	**Total Nays: 0**			

HB 939 Amendments

Amendment 725493

[X] *Adopted Without Objection*

Appearances:

Marshall, Anthony (Lobbyist) - Waive In Support
Florida Health Care Association
307 W. Park Ave.
Tallahassee FL 32301
Phone: (850) 224-3907

Christian, David (Lobbyist) - Proponent
Florida Chamber of Commerce
136 S. Bronough St.
Tallahassee Fl 32301
Phone: (850) 521-1211

Committee meeting was reported out: Tuesday, March 19, 2013 4:54:56PM

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health Innovation Subcommittee

Representative Pigman offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Paragraph (c) of subsection (3) of section 409.907, Florida Statutes, is amended, paragraph (k) is added to that subsection, and subsections (6), (7), and (8) of that section are amended, to read:

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

agency.

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

(c) Retain all medical and Medicaid-related records for 6 ~~a period of 5~~ years to satisfy all necessary inquiries by the agency.

(k) Report a change in any principal of the provider, including any officer, director, agent, managing employee, or affiliated person, or any partner or shareholder who has an ownership interest equal to 5 percent or more in the provider, to the agency in writing within 30 days after the change occurs. For a hospital licensed under chapter 395 or a nursing home licensed under part II of chapter 400, a principal of the provider is one who meets the definition of a controlling interest under s. 408.803.

(6) A Medicaid provider agreement may be revoked, at the option of the agency, due to ~~as the result of~~ a change of ownership of any facility, association, partnership, or other entity named as the provider in the provider agreement.

(a) If there is ~~In the event of~~ a change of ownership, the transferor remains liable for all outstanding overpayments, administrative fines, and any other moneys owed to the agency before the effective date of the change ~~of ownership~~. ~~In addition to the continuing liability of the transferor,~~ The transferee is also liable to the agency for all outstanding overpayments identified by the agency on or before the effective date of the change of ownership. ~~For purposes of this~~

~~subsection, the term "outstanding overpayment" includes any amount identified in a preliminary audit report issued to the transferor by the agency on or before the effective date of the change of ownership.~~ In the event of a change of ownership for a skilled nursing facility or intermediate care facility, the Medicaid provider agreement shall be assigned to the transferee if the transferee meets all other Medicaid provider qualifications. In the event of a change of ownership involving a skilled nursing facility licensed under part II of chapter 400, liability for all outstanding overpayments, administrative fines, and any moneys owed to the agency before the effective date of the change of ownership shall be determined in accordance with s. 400.179.

(b) At least 60 days before the anticipated date of the change of ownership, the transferor must ~~shall~~ notify the agency of the intended change ~~of ownership~~ and the transferee must ~~shall~~ submit to the agency a Medicaid provider enrollment application. If a change of ownership occurs without compliance with the notice requirements of this subsection, the transferor and transferee are ~~shall be~~ jointly and severally liable for all overpayments, administrative fines, and other moneys due to the agency, regardless of whether the agency identified the overpayments, administrative fines, or other moneys before or after the effective date of the change ~~of ownership~~. The agency may not approve a transferee's Medicaid provider enrollment application if the transferee or transferor has not paid or agreed in writing to a payment plan for all outstanding overpayments, administrative fines, and other moneys due to the

agency. This subsection does not preclude the agency from seeking any other legal or equitable remedies available to the agency for the recovery of moneys owed to the Medicaid program. In the event of a change of ownership involving a skilled nursing facility licensed under part II of chapter 400, liability for all outstanding overpayments, administrative fines, and any moneys owed to the agency before the effective date of the change of ownership shall be determined in accordance with s. 400.179 if the Medicaid provider enrollment application for change of ownership is submitted before the change ~~of ownership~~.

(c) As used in this subsection, the term:

1. "Administrative fines" includes any amount identified in a notice of a monetary penalty or fine which has been issued by the agency or other regulatory or licensing agency that governs the provider.

2. "Outstanding overpayment" includes any amount identified in a preliminary audit report issued to the transferor by the agency on or before the effective date of a change of ownership.

(7) ~~The agency may require,~~ As a condition of participating in the Medicaid program and before entering into the provider agreement, the agency may require ~~that~~ the provider to submit information, in an initial and any required renewal applications, concerning the professional, business, and personal background of the provider and permit an onsite inspection of the provider's service location by agency staff or other personnel designated by the agency to perform this

function. Before entering into a provider agreement, the agency may ~~shall~~ perform an ~~a random~~ onsite inspection~~, within 60 days after receipt of a fully complete new provider's application,~~ of the provider's service location ~~prior to making its first payment to the provider for Medicaid services~~ to determine the applicant's ability to provide the services in compliance with the Medicaid program and professional regulations ~~that the applicant is proposing to provide for Medicaid reimbursement~~. ~~The agency is not required to perform an onsite inspection of a provider or program that is licensed by the agency, that provides services under waiver programs for home and community-based services, or that is licensed as a medical foster home by the Department of Children and Family Services.~~ As a continuing condition of participation in the Medicaid program, a provider must ~~shall~~ immediately notify the agency of any current or pending bankruptcy filing. Before entering into the provider agreement, or as a condition of continuing participation in the Medicaid program, the agency may also require ~~that~~ Medicaid providers reimbursed on a fee-for-services basis or fee schedule basis that ~~which~~ is not cost-based to~~,~~ post a surety bond not to exceed $50,000 or the total amount billed by the provider to the program during the current or most recent calendar year, whichever is greater. For new providers, the amount of the surety bond shall be determined by the agency based on the provider's estimate of its first year's billing. If the provider's billing during the first year exceeds the bond amount, the agency may require the provider to acquire an additional bond equal to the actual billing level of the

provider. A provider's bond need ~~shall~~ not exceed $50,000 if a physician or group of physicians licensed under chapter 458, chapter 459, or chapter 460 has a 50 percent or greater ownership interest in the provider or if the provider is an assisted living facility licensed under chapter 429. The bonds permitted by this section are in addition to the bonds referenced in s. 400.179(2)(d). If the provider is a corporation, partnership, association, or other entity, the agency may require the provider to submit information concerning the background of that entity and of any principal of the entity, including any partner or shareholder having an ownership interest in the entity equal to 5 percent or greater, and any treating provider who participates in or intends to participate in Medicaid through the entity. The information must include:

(a) Proof of holding a valid license or operating certificate, as applicable, if required by the state or local jurisdiction in which the provider is located or if required by the Federal Government.

(b) Information concerning any prior violation, fine, suspension, termination, or other administrative action taken under the Medicaid laws or~~,~~ rules~~, or regulations~~ of this state or of any other state or the Federal Government; any prior violation of the laws or~~,~~ rules~~, or regulations~~ relating to the Medicare program; any prior violation of the rules ~~or regulations~~ of any other public or private insurer; and any prior violation of the laws or~~,~~ rules~~, or regulations~~ of any regulatory body of this or any other state.

(c) Full and accurate disclosure of any financial or

ownership interest that the provider, or any principal, partner, or major shareholder thereof, may hold in any other Medicaid provider or health care related entity or any other entity that is licensed by the state to provide health or residential care and treatment to persons.

(d) If a group provider, identification of all members of the group and attestation that all members of the group are enrolled in or have applied to enroll in the Medicaid program.

(8)~~(a)~~ Each provider, or each principal of the provider if the provider is a corporation, partnership, association, or other entity, seeking to participate in the Medicaid program must submit a complete set of his or her fingerprints to the agency for the purpose of conducting a criminal history record check. Principals of the provider include any officer, director, billing agent, managing employee, or affiliated person, or any partner or shareholder who has an ownership interest equal to 5 percent or more in the provider. However, for a hospital licensed under chapter 395 or a nursing home licensed under chapter 400, principals of the provider are those who meet the definition of a controlling interest under s. 408.803. A director of a not-for-profit corporation or organization is not a principal for purposes of a background investigation ~~as~~ required by this section if the director: serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration from the not-for-profit corporation or organization for his or her service on the board of directors, has no financial interest in

the not-for-profit corporation or organization, and has no family members with a financial interest in the not-for-profit corporation or organization; and if the director submits an affidavit, under penalty of perjury, to this effect to the agency and the not-for-profit corporation or organization submits an affidavit, under penalty of perjury, to this effect to the agency as part of the corporation's or organization's Medicaid provider agreement application. Notwithstanding the above, the agency may require a background check for any person reasonably suspected by the agency to have been convicted of a crime.

(a) This subsection does not apply to:

~~1. A hospital licensed under chapter 395;~~

~~2. A nursing home licensed under chapter 400;~~

~~3. A hospice licensed under chapter 400;~~

~~4. An assisted living facility licensed under chapter 429;~~

1.~~5.~~ A unit of local government, except that requirements of this subsection apply to nongovernmental providers and entities contracting with the local government to provide Medicaid services. The actual cost of the state and national criminal history record checks must be borne by the nongovernmental provider or entity; or

2.~~6.~~ Any business that derives more than 50 percent of its revenue from the sale of goods to the final consumer, and the business or its controlling parent is required to file a form 10-K or other similar statement with the Securities and Exchange Commission or has a net worth of $50 million or more.

(b) Background screening shall be conducted in accordance

with chapter 435 and s. 408.809. The cost of the state and national criminal record check shall be borne by the provider.

~~(c) Proof of compliance with the requirements of level 2 screening under chapter 435 conducted within 12 months before the date the Medicaid provider application is submitted to the agency fulfills the requirements of this subsection.~~

Section 2. Subsections (9), (13), (15), (16), (21), (22), (25), (28), (30), and (31) of section 409.913, Florida Statutes, are amended to read:

409.913 Oversight of the integrity of the Medicaid program.—The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. Beginning January 1, 2003, and each year thereafter, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit a joint report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report must describe the number of cases opened and investigated each year; the sources of the cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final agency determinations of overpayments; the

amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must include policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud. All policy recommendations in the report must include a detailed fiscal analysis, including, but not limited to, implementation costs, estimated savings to the Medicaid program, and the return on investment. The agency must submit the policy recommendations and fiscal analyses in the report to the appropriate estimating conference, pursuant to s. 216.137, by February 15 of each year. The agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs each must include detailed unit-specific performance standards, benchmarks, and metrics in the report, including projected cost savings to the state Medicaid program during the following fiscal year.

(9) A Medicaid provider shall retain medical, professional, financial, and business records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid for 6 ~~a period of 5~~ years after the date of furnishing such services or goods. The agency may investigate, review, or analyze such records, which must be made available during normal business hours. However, 24-hour notice must be provided if patient treatment would be disrupted. The provider must keep ~~is responsible for furnishing to the agency, and keeping~~ the agency informed of the location of~~,~~ the provider's Medicaid-related records. The authority of the agency to obtain Medicaid-related records from a provider is neither curtailed nor limited during a period of litigation between the agency and the provider.

(13) The agency shall ~~immediately~~ terminate participation of a Medicaid provider in the Medicaid program and may seek civil remedies or impose other administrative sanctions against a Medicaid provider, if the provider or any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, has been convicted of a criminal offense under federal law or the law of any state relating to the practice of the provider's profession, or a criminal offense listed under s. 408.809(4), s. 409.907(10), or s. 435.04(2) ~~has been:~~

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

~~to the delivery of health care goods or services;~~

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

~~(c) Found by a court of competent jurisdiction to have neglected or physically abused a patient in connection with the delivery of health care goods or services~~. If the agency determines that the ~~a~~ provider did not participate or acquiesce in the ~~an~~ offense ~~specified in paragraph (a), paragraph (b), or paragraph (c),~~ termination will not be imposed. If the agency effects a termination under this subsection,.the agency shall take final agency action ~~issue an immediate final order pursuant to s. 120.569(2)(n)~~.

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

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

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

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

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

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

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

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

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

(i) The provider or an authorized representative of the provider, or a person who has ordered, authorized, or prescribed the goods or services, has submitted or caused to be submitted a Medicaid provider enrollment application, a request for prior

authorization for Medicaid services, a drug exception request, or a Medicaid cost report that contains materially false or incorrect information;

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

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

(l) The provider is charged by information or indictment with fraudulent billing practices or an offense referenced in subsection (13). The sanction applied for this reason is limited to suspension of the provider's participation in the Medicaid program for the duration of the indictment unless the provider is found guilty pursuant to the information or indictment;

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

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

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

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

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

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

(16) The agency shall impose any of the following sanctions or disincentives on a provider or a person for any of the acts described in subsection (15):

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

(b) Termination for a specific period of time ranging ~~of~~ from more than 1 year to 20 years. Termination precludes ~~shall preclude~~ participation in the Medicaid program, which includes any action that results in a claim for payment to the Medicaid

program for ~~as a result of~~ furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services.

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

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

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

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

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

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

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

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

If a provider voluntarily relinquishes its Medicaid provider number or an associated license, or allows the associated licensure to expire after receiving written notice that the agency is conducting, or has conducted, an audit, survey, inspection, or investigation and that a sanction of suspension or termination will or would be imposed for noncompliance discovered as a result of the audit, survey, inspection, or investigation, the agency shall impose the sanction of termination for cause against the provider. The Secretary of Health Care Administration may make a determination that imposition of a sanction or disincentive is not in the best interest of the Medicaid program, in which case a sanction or disincentive may ~~shall~~ not be imposed.

(21) When making a determination that an overpayment has occurred, the agency shall prepare and issue an audit report to the provider showing the calculation of overpayments. The agency's determination must be based solely upon information available to it before issuance of the audit report and, in the case of documentation obtained to substantiate claims for Medicaid reimbursement, based solely upon contemporaneous records.

(22) The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment. A provider may not present or elicit testimony, ~~either~~ on direct examination or cross-examination in any court or administrative proceeding, regarding the purchase or acquisition by any means of drugs, goods, or supplies; sales or divestment by any means of drugs, goods, or supplies; or inventory of drugs, goods, or supplies, unless such acquisition, sales, divestment, or inventory is documented by written invoices, written inventory records, or other competent written documentary evidence maintained in the normal course of the provider's business. A provider may not present records to contest an overpayment or sanction unless such records are contemporaneous and, if requested during the audit process, were furnished to the agency or its agent upon request. This limitation does not apply to Medicaid cost report audits. Notwithstanding the applicable rules of discovery, all documentation to ~~that will~~ be offered as evidence at an administrative hearing on a Medicaid overpayment or an administrative sanction must be exchanged by all parties at

least 14 days before the administrative hearing or ~~must~~ be excluded from consideration.

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

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

(c) Overpayments owed to the agency bear interest at the rate of 10 percent per year from the date of final determination of the overpayment by the agency, and payment arrangements must be made within 30 days after the date of the final order, which is not subject to further appeal ~~at the conclusion of legal~~

~~proceedings~~. ~~A provider who does not enter into or adhere to an agreed-upon repayment schedule may be terminated by the agency for nonpayment or partial payment.~~

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

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

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

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

(31) If a provider requests an administrative hearing pursuant to chapter 120, such hearing must be conducted within 90 days following assignment of an administrative law judge, absent exceptionally good cause shown as determined by the

administrative law judge or hearing officer. Upon issuance of a final order, the outstanding balance of the amount determined to constitute the overpayment and fines is ~~shall become~~ due. If a provider fails to make payments in full, fails to enter into a satisfactory repayment plan, or fails to comply with the terms of a repayment plan or settlement agreement, the agency shall withhold ~~medical assistance~~ reimbursement payments for Medicaid services until the amount due is paid in full.

Section 3. Subsection (8) of section 409.920, Florida Statutes, is amended to read:

409.920 Medicaid provider fraud.—

(8) A person who provides the state, any state agency, any of the state's political subdivisions, or any agency of the state's political subdivisions with information about fraud or suspected fraudulent acts ~~fraud~~ by a Medicaid provider, including a managed care organization, is immune from civil liability for libel, slander, or any other relevant tort for providing ~~the~~ information about fraud or suspected fraudulent acts, unless the person acted with knowledge that the information was false or with reckless disregard for the truth or falsity of the information. Such immunity extends to reports of fraudulent acts or suspected fraudulent acts conveyed to or from the agency in any manner, including any forum and with any audience as directed by the agency, and includes all discussions subsequent to the report and subsequent inquiries from the agency, unless the person acted with knowledge that the information was false or with reckless disregard for the truth or falsity of the information. For purposes of this subsection,

the term "fraudulent acts" includes actual or suspected fraud and abuse, insurance fraud, licensure fraud, or public assistance fraud, including any fraud-related matters that a provider or health plan is required to report to the agency or a law enforcement agency.

Section 4. Subsection (3) of section 624.351, Florida Statutes, is amended, and subsection (8) is added to that section, to read:

624.351 Medicaid and Public Assistance Fraud Strike Force.—

(3) MEMBERSHIP.—The strike force shall consist of the following 11 members or their designees. A designee shall serve in the same capacity as the designating member ~~who may not designate anyone to serve in their place~~:

(a) The Chief Financial Officer, who shall serve as chair.

(b) The Attorney General, who shall serve as vice chair.

(c) The executive director of the Department of Law Enforcement.

(d) The Secretary of Health Care Administration.

(e) The Secretary of Children and Family Services.

(f) The State Surgeon General.

(g) Five members appointed by the Chief Financial Officer, consisting of two sheriffs, two chiefs of police, and one state attorney. When making these appointments, the Chief Financial Officer shall consider representation by geography, population, ethnicity, and other relevant factors in order to ensure that the membership of the strike force is representative of the state as a whole.

(8) This section is repealed June 30, 2014, unless reviewed and reenacted by the Legislature before that date.

Section 5. Subsection (3) is added to section 624.352, Florida Statutes, to to read:

624.352 Interagency agreements to detect and deter Medicaid and public assistance fraud.—

(3) This section is repealed June 30, 2014, unless reviewed and reenacted by the Legislature before that date.

Section 6. This act shall take effect July 1, 2013.

T I T L E A M E N D M E N T

Remove everything before the enacting clause and insert:

A bill to be entitled

An act relating to Medicaid fraud; amending s. 409.907, F.S.; increasing the number of years a provider must keep records; adding an additional provision relating to a change in principal that must be included in a Medicaid provider agreement with the Agency for Health Care Administration; adding definitions for "administrative fines" and "outstanding overpayment"; revising provisions relating to the agency's onsite inspection responsibilities; revising provisions relating to who is subject to background screening; amending s. 409.913, F.S.; increasing the number of years a provider must keep records; revising provisions specifying grounds for terminating a provider from the

program, for seeking certain remedies for violations, and for imposing certain sanctions; providing a limitation on the information the agency may consider when making a determination of overpayment; specifying the type of records a provider must present to contest an overpayment; deleting the requirement that the agency place payments withheld from a provider in a suspended account and revising when a provider must reimburse overpayments; revising venue requirements; adding provisions relating to the payment of fines; amending s. 409.920, F.S.; clarifying provisions relating to immunity from liability for persons who provide information about Medicaid fraud; amending s. 624.351, F.S.; revising membership requirements for the Medicaid and Public Assistance Fraud Strike Force within the Department of Financial Services; providing for future review and repeal; amending s. 624.352, F.S., relating to interagency agreements to detect and deter Medicaid and public assistance fraud; providing for future review and repeal; providing an effective date.

COMMITTEE MEETING REPORT

Health Innovation Subcommittee

3/19/2013 2:00:00PM

Location: 306 HOB

HB 1021 : Background Screening

[X] *Favorable With Committee Substitute*

	Yea	*Nay*	*No Vote*	*Absentee Yea*	*Absentee Nay*
Michael Bileca	X				
Joseph Gibbons	X				
Charles Hood, Jr.	X				
Mia Jones	X				
MaryLynn Magar	X				
Kionne McGhee	X				
Jimmy Patronis	X				
Sharon Pritchett	X				
Jake Raburn	X				
Ronald Renuart	X				
David Richardson	X				
W. Gregory Steube	X				
John Wood (Chair)	X				
	Total Yeas: 13	**Total Nays: 0**			

HB 1021 Amendments

Amendment 951889

[X] *Adopted Without Objection*

Appearances:

Fontaine, Mark (Lobbyist) - Proponent
Florida Alcohol & Drug Abuse Association, Inc
2868 Mahan Dr. Ste. 1
Tallahassee FL 32308
Phone: (850) 878-2196

Pitts, Brian (General Public) - Proponent
Justice-2-Jesus
1119 Newton Ave. S.
St. Petersburg FL 33705
Phone: (727) 897-9291

Committee meeting was reported out: Tuesday, March 19, 2013 4:54:56PM

Amendment No.

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

Committee/Subcommittee hearing bill: Health Innovation Subcommittee

Representative Reed offered the following:

Amendment (with directory and title amendments)

Between lines 87 and 88, insert:

(t) Section 895.03, relating to racketeering and illegal debts.

(u) Section 896.101, relating to the Florida Money Laundering Act.

Remove lines 100-101 and insert:

Law Enforcement and provide the first, middle and last name, social security number, date of birth, mailing address, sex, and race of the applicant ~~a~~

D I R E C T O R Y A M E N D M E N T

Amendment No.

Remove line 73 and insert:

(i), (t), and (u) are added to that subsection to read:

T I T L E A M E N D M E N T

Remove lines 7-9 and insert:

amending s. 408.809, F.S.; adding additional disqualifying offenses to background screening provisions; amending s. 435.04, F.S.; requiring certain identifying information to be included for background checks submitted to the FBI; amending s. 435.07, F.S.;

COMMITTEE MEETING REPORT

Health Innovation Subcommittee

3/19/2013 2:00:00PM

Location: 306 HOB

HB 1109 : Transitional Living Facilities

[X] *Favorable With Committee Substitute*

	Yea	*Nay*	*No Vote*	*Absentee Yea*	*Absentee Nay*
Michael Bileca	X				
Joseph Gibbons	X				
Charles Hood, Jr.	X				
Mia Jones	X				
MaryLynn Magar	X				
Kionne McGhee	X				
Jimmy Patronis	X				
Sharon Pritchett	X				
Jake Raburn	X				
Ronald Renuart	X				
David Richardson	X				
W. Gregory Steube	X				
John Wood (Chair)	X				
	Total Yeas: 13	**Total Nays: 0**			

HB 1109 Amendments

Amendment 775437

[X] *Adopted Without Objection*

Appearances:

Smith, Sylvia (Lobbyist) - Proponent
Disability Rights Florida
2728 Centerview Blvd.
Tallahassee FL 32301
Phone: (850) 322-2258

Pitts, Brian (General Public) - Information Only
Justice-2-Jesus
1119 Newton Ave. S.
St. Petersburg FL 33705
Phone: (727) 897-9291

Committee meeting was reported out: Tuesday, March 19, 2013 4:54:56PM

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health Innovation Subcommittee

Representative Magar offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Sections 400.9970 through 400.9984, Florida Statutes, are designated as part XI of chapter 400, Florida Statutes, entitled "Transitional Living Facilities."

Section 2. Section 400.9970, Florida Statutes, is created to read:

400.9970 Legislative intent.—It is the intent of the Legislature to provide for the licensure of transitional living facilities and require the development, establishment, and enforcement of basic standards by the Agency to ensure quality of care and services to clients in transitional living facilities. It is the policy of the state that the least restrictive appropriate available treatment be used based on the individual needs and best interests of the client and consistent

with optimum improvement of the client's condition. The goal of a transitional living program for individuals who have brain or spinal cord injuries is to assist each individual who has such a disability to achieve a higher level of independent functioning and to enable that person to reenter the community.

Section 3. Section 400.9971, Florida Statutes, is created to read:

400.9971 Definitions.—As used in this part, the term:

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

(2) "Chemical restraint" means a pharmacologic drug that physically limits, restricts, or deprives an individual of movement or mobility and is used for client protection or safety and is not required for the treatment of medical conditions or symptoms.

(3) "Client's representative" means the parent of a child client, or the client's guardian, designated representative or designee, surrogate, or attorney in fact.

(4) "Department" means the Department of Health.

(5) "Licensee" means an individual issued a license by the agency.

(6) "Physical restraint" means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the individual's body so that he or she cannot easily remove the restraint and which restricts freedom of movement or normal access to one's body, including, but not limited to, a half-bed rail, a full-bed rail, a geriatric chair, and a posey restraint. The term includes any device that was not

specifically manufactured as a restraint but that has been altered, arranged, or otherwise used for this purpose. The term does not include bandage material used for the purpose of binding a wound or injury.

(7) "Transitional living facility" means a site where specialized health care services are provided, including, but not limited to, rehabilitative services, behavior modification, community reentry training, aids for independent living, and counseling to brain injured persons and spinal-cord-injured persons. The term does not include a hospital licensed under chapter 395 or any federally operated hospital or facility.

Section 4. Section 400.9972, Florida Statutes, is created to read:

400.9972 License required; fee; application.—

(1) The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to this part and part II of chapter 408 and to entities licensed by or applying for such licensure from the agency pursuant to this part. A license issued by the agency is required for the operation of a transitional living facility in this state.

(2) In accordance with this part, an applicant or a licensee shall pay a fee for each license application submitted under this part. The license fee shall consist of a $4,588 license fee and a $90 per-bed fee per biennium and shall conform to the annual adjustment authorized in s. 408.805.

(3) Each applicant for licensure must provide:

(a) The location of the facility for which a license is sought and documentation, signed by the appropriate local

government official, that states that the applicant has met local zoning requirements.

(b) Proof of liability insurance as defined in s. 624.605.

(c) Proof of compliance with local zoning requirements, including compliance with the requirements of chapter 419 if the proposed facility is a community residential home.

(d) Proof that the facility has received a satisfactory fire safety inspection.

(e) Documentation of a satisfactory sanitation inspection of the facility by the county health department.

Section 5. Section 400.9973, Florida Statutes, is created to read:

400.9973 Client admission, transfer, and discharge.—

(1) Each transitional living facility must have written policies and procedures governing the admission, transfer, and discharge of clients.

(2) The admission of each client to a transitional living facility must be in accordance with the licensee's policies and procedures.

(3) A client admitted to a transitional living facility must have a brain or spinal cord injury,, such as a lesion to the spinal cord or cauda equina syndrome, with evidence of significant involvement of two of the following deficits or dysfunctions:

(a) Motor deficit.

(b) Sensory deficit.

(c) Bowel and bladder dysfunction.

(d) An injury to the skull, brain, or its covering that produces an altered state of consciousness or anatomic motor, sensory, cognitive, or behavioral deficits.

(4) Clients whose medical and diagnosis does not positively identify a cause of the client's condition, or whose symptoms are inconsistent with the known cause of injury, or whose recovery is inconsistent with the known medical condition may be admitted for an evaluation for a period not to exceed ninety (90) days.

(5) A client admitted to a transitional living facility must be admitted upon prescription by a licensed physician and must remain under the care of a licensed physician for the duration of the client's stay in the facility.

(6) A transitional living facility may not admit a client whose primary admitting diagnosis is mental illness.

(7) A person may not be admitted to a transitional living facility if the person:

(a) Presents significant risk of infection to other client or personnel. A health care practitioner must provide documentation that the person is free of apparent signs and symptoms of communicable disease;

(b) Is a danger to self or others as determined by a physician, or mental health practitioner licensed under chapter 490 or chapter 491, unless the facility provides adequate staffing and support to ensure patient safety;

(c) Is bedridden; or

(d) Requires 24-hour nursing supervision.

(7) If the client meets the admission criteria, the medical or nursing director of the facility must complete an initial evaluation of the client's functional skills, behavioral status, cognitive status, educational/vocational potential, medical status, psychosocial status, sensorimotor capacity, and other related skills and abilities within the first seventy-two hours following the client's admission to the facility. An initial comprehensive treatment plan that delineates services to be provided and appropriate sources for such services must be implemented within the first four days of admission.

(8) Each transitional living facility shall develop a discharge plan for each client prior to or on admission to the facility. The discharge plan must identify the intended discharge site and possible alternative discharge sites. For each discharge site identified, the discharge plan must identify the skills, behaviors, and other conditions that the client must achieve to be appropriate for discharge. Discharge plans must be reviewed and updated as necessary, but not less than once monthly.

(9) As soon as practicable, a transitional living facility shall discharge clients who no longer require any of the specialized services described in s. 400.9971(7); are not making measurable progress in accordance with their comprehensive treatment plan, or if the transitional living facility is no longer the most appropriate, least restrictive treatment option.

(10) Each transitional living facility shall provide at least 30 days' notice to clients of transfer or discharge plans, including the location of an acceptable transfer location if the

client is unable to live independently. This requirement does not apply if a client voluntarily terminates residency.

(11) A client may not reside in a transitional living facility for a period of more than 2 years. An exception may be made if a referral is made to Disability Rights of Florida at least 21 months after admission and the client or, if appropriate, the client's guardian requests that the client continue to receive treatment at the transitional living facility.

Section 6. Section 400.9974, Florida Statutes, is created to read:

400.9974 Client treatment plans; client services.—

(1) Each transitional living facility shall develop a comprehensive treatment plan for each client as soon as possible, but no later than 30 days following development of the initial comprehensive treatment plan. Comprehensive treatment plans must be reviewed and updated if the client fails to meet projected improvements in the plan or if a significant change in the client's condition occurs. Treatment plans must be reviewed and updated no less than once monthly. Comprehensive treatment plans must be developed by an interdisciplinary team, consisting of the case manager, program director, nurse, and appropriate therapists. The client, and/or if appropriate, the client's representative must be included in developing the comprehensive treatment plan.

(2) The comprehensive treatment plan must include:

(a) The physician's orders and the client's diagnosis, medical history, physical examination, and rehabilitative or restorative needs.

(b) A preliminary nursing evaluation with physician's orders for immediate care, completed on admission.

(c) A comprehensive, accurate, reproducible, and standardized assessment of the client's functional capability and the treatments designed to achieve skills, behaviors, and other conditions to return to the community, and shall specify measurable goals.

(d) Steps necessary for the client to achieve transition to the community and estimated length of time to achieve the goals.

(3) The client, and/or if appropriate, the client's representative, shall consent to the continued treatment at the transitional living facility. If such consent is not given, the transitional living facility shall discharge the client as soon as practicable.

(4) Each client must receive the professional program services needed to implement the client's individual program plan.

(5) The licensee must employ available qualified professional staff to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of every individual program plan.

(6) Each client must receive a continuous treatment program that includes appropriate, consistent implementation of

a program of specialized and general training, treatment, health services, and related services that is directed toward:

(a) The acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible;

(b) The prevention or deceleration of regression or loss of current optimal functional status; and

(c) An appropriate plan to address behavioral issues that preclude independent functioning in the community.

Section 7. Section 400.9975, Florida Statutes, is created to read:

400.9975 Licensee responsibilities.—

(1) The licensee shall ensure that each client:

(a) Lives in a safe environment free from abuse, neglect, and exploitation.

(b) Is treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.

(c) Retains and uses his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the licensee can demonstrate that such retention and use would be unsafe, impractical, or an infringement upon the rights of other clients.

(d) Has unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice. Upon request, the licensee shall make provisions to modify

visiting hours for caregivers and guests. The facility shall restrict communication in accordance with any court order or written instruction of a guardian. Any restriction on a client's communication for therapeutic reasons shall be reviewed no less often than weekly and the restrictions shall be removed as soon as it is no longer clinically indicated. The basis for the restrictions shall be explained to the client and, if applicable, the client's representative. The client shall nonetheless retain the right to call the abuse hotline, the agency, and Disability Rights of Florida at any and all times.

(e) Participates in and benefits from community services and activities to achieve the highest possible level of independence, autonomy, and interaction within the community.

(f) Manages his or her financial affairs unless the client or, if applicable, the client's representative authorizes the administrator of the facility to provide safekeeping for funds as provided in this part.

(g) Has reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.

(h) Exercises civil and religious liberties, including the right to independent personal decisions. No religious belief or practice, including attendance at religious services, shall be imposed upon any client.

(i) Has access to adequate and appropriate health care as appropriate for the client and consistent with established and recognized standards within the community.

(j) Has the ability to present grievances and recommend changes in policies, procedures, and services to the staff of the licensee, governing officials, or any other person without restraint, interference, coercion, discrimination, or reprisal. Each licensee shall establish a grievance procedure to facilitate a client's exercise of this right. This right includes access to Disability Rights of Florida and other advocates and the right to be a member of, be active in, and associate with advocacy or special interest groups.

(2) The licensee shall:

(a) Promote participation of each client's representative in the process of providing treatment to the client unless the representative's participation is unobtainable or inappropriate.

(b) Answer communications from each client's family, guardians, and friends promptly and appropriately.

(c) Promote visits by individuals with a relationship to the client at any reasonable hour, without requiring prior notice, or in any area of the facility that provides direct client care services to the client, consistent with the client's and other clients' privacy, unless the interdisciplinary team determines that such a visit would not be appropriate.

(d) Promote leave from the facility for visits, trips, or vacations.

(e) Promptly notify the client's representative of any significant incidents or changes in the client's condition, including, but not limited to, serious illness, accident, abuse, unauthorized absence, or death.

(3) The administrator of a facility shall ensure that a written notice of licensee responsibilities is posted in a prominent place in each building where clients reside and read or explained to clients who cannot read. This notice shall include the statewide toll-free telephone number for reporting complaints to the agency, must be provided to clients in a manner that is clearly legible, and must include the words: "To report a complaint regarding the services you receive, please call toll-free ...[telephone number]...; the Disability Rights of Florida (telephone number); and the statewide toll-free telephone number for the central abuse hotline must be provided to clients in a manner that is clearly legible and must include the words: "To report abuse, neglect or exploitation, please call toll-free ...[telephone number]..." where complaints may be lodged. The licensee must ensure a client's access to a telephone to call the agency, central abuse hotline, Disability Rights of Florida.

(4) No licensee or employee of a facility may serve notice upon a client to leave the premises or take any other retaliatory action against any person solely due to the following:

(a) Files an internal or external complaint or grievance regarding the facility.

(b) Appears as a witness in any hearing inside or outside the facility.

(5) Before or at the time of admission, the client and the client's representative shall be provided with a copy of the licensee's responsibilities as provided in subsection (1).

(6) The licensee must develop and implement policies and procedures governing the release of any client information, including consent necessary from the client or the client's representative.

Section 8. Section 400.9976, Florida Statutes, is created to read:

400.9976 Medication practices.—

(1) An individual medication administration record must be maintained for each client. Each dose of medication, including a self-administered dose, shall be properly recorded in the client's record. Each patient who is self-administering medication shall be given a pill organizer. Medication must be placed in the pill organizer by a nurse. A nurse shall document the date and time medication is placed into each patient's pill organizer. All medications must be administered in compliance with the physician's orders.

(2) If the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise, a client must be taught to self-administer his or her medication without a staff person. This includes all forms of administration, including orally, via injection, and via suppository. The client's physician must be informed of the interdisciplinary team's decision that self-administration of medications is an objective for the client. A client may not self-administer medication until he or she demonstrates the competency to take the correct medication in the correct dosage at the correct time, knows how

to respond to missed doses, and knows who to contact with questions.

(3) Medication administration discrepancies and adverse drug reactions must be recorded and reported immediately to a physician.

Section 9. Section 400.9977, Florida Statutes, is created to read:

400.9977 Protection from abuse, neglect, mistreatment, and exploitation.—The licensee must develop and implement policies and procedures for the screening and training of employees, the protection of clients, and the prevention, identification, investigation, and reporting of abuse, neglect, and exploitation. This includes the licensee's identification of clients whose personal histories render them at risk for abusing other clients, development of intervention strategies to prevent occurrences, monitoring for changes that would trigger abusive behavior, and reassessment of the interventions on a regular basis. A licensee shall implement procedures to:

(1) Screen potential employees for a history of abuse, neglect, or mistreatment of clients. The screening shall include an attempt to obtain information from previous employers and current employers and verification with the appropriate licensing boards and registries.

(2) Train employees, through orientation and ongoing sessions, on issues related to abuse prohibition practices, including identification of abuse, neglect, mistreatment, and exploitation, appropriate interventions to deal with aggressive or catastrophic reactions of clients, the process to report

allegations without fear of reprisal, and recognition of signs of frustration and stress that may lead to abuse.

(3) Provide clients, families, and staff with information on how and to whom they may report concerns, incidents, and grievances without the fear of retribution and provide feedback regarding the concerns that have been expressed. A licensee must identify, correct, and intervene in situations in which abuse, neglect, mistreatment, or exploitation is likely to occur, including:

(a) Evaluating the physical environment of the facility to identify characteristics that may make abuse or neglect more likely to occur, such as secluded areas.

(b) Providing sufficient staff on each shift to meet the needs of the clients, and ensuring that the staff assigned have knowledge of the individual clients' care needs. The licensee shall identify inappropriate behaviors of its staff, such as using derogatory language, rough handling, ignoring clients while giving care, and directing clients who need toileting assistance to urinate or defecate in their beds.

(c) Assessing, planning care for, and monitoring clients with needs and behaviors that might lead to conflict or neglect, such as clients with a history of aggressive behaviors, clients who have behaviors such as entering other clients' rooms, clients with self-injurious behaviors, clients with communication disorders, and clients who require heavy nursing care or are totally dependent on staff.

(4) Identify events, such as suspicious bruising of clients, occurrences, patterns, and trends that may constitute abuse and determine the direction of the investigation.

(5) Investigate different types of incidents, identify the staff member responsible for the initial reporting, investigate alleged violations, and report results to the proper authorities. The licensee must analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences and to take all necessary corrective actions depending on the results of the investigation.

(6) Protect clients from harm during an investigation.

(7) Report all alleged violations and all substantiated incidents, as required under chapters 39 and 415, to the licensing authorities and to all other agencies as required, and to report any knowledge it has of any actions by a court of law that would indicate an employee is unfit for service.

Section 10. Section 400.9978, Florida Statutes, is created to read:

400.9978 Restraints and seclusion; client safety.—

(1) The use of physical restraints must be ordered and documented by a physician and must be consistent with policies and procedures adopted by the facility. The client or, if applicable, the client's representative must be informed of the facility's physical restraint policies and procedures at the time of admission.

(2) The use of chemical restraints is limited to prescribed dosages of medications as ordered by a physician,

must be consistent with the client's diagnosis and the policies and procedures adopted by the facility. The client or, if applicable, the client's representative, must be informed of the facility's chemical restraint policies and procedures at the time of admission.

(3) Based on a physician's assessment, when a patient exhibits symptoms that present an immediate risk of injury or death to self or others, a physician may issue an emergency treatment order to immediately administer rapid response psychotropic medications or other chemical restraints. Each emergency treatment order must be documented and maintained in the patient's record.

(a) An emergency treatment order is effective for no more than 24 hours.

(b) Whenever a client is medicated in accordance with this section, the client's representative or responsible party and the client's physician must be notified as soon as practicable.

(4) A client who is prescribed and receiving a medication that can serve as a chemical restraint, but not on an emergency basis, must be evaluated by his or her physician at least monthly to assess:

(a) The continued need for the medication.

(b) The level of the medication in the client's blood as appropriate.

(c) The need for adjustments in the prescription.

(5) The licensee shall ensure that clients are free from unnecessary drugs and physical restraints and are provided treatment to reduce dependency on drugs and physical restraints.

(6) The licensee may use physical restraints only as an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied.

(7) Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare, and civil and human rights of each client are adequately protected.

Section 11. Section 400.9979, Florida Statutes, is created to read:

400.9979 Background screening; administration and management.—

(1) The agency shall require level 2 background screening for personnel as required in s. 408.809(1)(e) pursuant to chapter 435 and s. 408.809.

(2) The licensee shall maintain personnel records for each staff member that contain, at a minimum, documentation of background screening, if applicable, a job description, documentation of compliance with all training requirements of this part or applicable rule, the employment application, references, a copy of all job performance evaluations, and, for each staff member who performs services for which licensure or certification is required, a copy of all licenses or certification held by the staff member.

(3) The licensee must:

(a) Develop and implement infection control policies and procedures and include such policies and procedures in the licensee's policy manual.

(b) Maintain liability insurance as defined in s. 624.605.

(c) Designate one person as an administrator who is responsible and accountable for the overall management of the facility.

(d) Designate a person in writing to be responsible for the facility when the administrator is absent from the facility for more than 24 hours.

(e) Designate in writing a program director who is responsible for supervising the therapeutic and behavioral staff, determining the levels of supervision, and room placement for each client.

(f) Designate in writing a person to be responsible when the program director is absent from the facility for more than 24 hours.

(g) Obtain approval of the comprehensive emergency management plan, pursuant to s. 400.9981(2)(e), from the local emergency management agency. Pending the approval of the plan, the local emergency management agency shall ensure that the following agencies, at a minimum, are given the opportunity to review the plan: the Department of Health, the Agency for Health Care Administration, and the Division of Emergency Management. Appropriate volunteer organizations must also be given the opportunity to review the plan. The local emergency management

agency shall complete its review within 60 days and either approve the plan or advise the licensee of necessary revisions.

(h) Maintain written records in a form and system that comply with medical and business practices and make such records available in the facility for review or submission to the agency upon request. The records shall include:

1. A daily census record that indicates the number of clients currently receiving services in the facility, including information regarding any public funding of such clients.

2. A record of all accidents or unusual incidents involving any client or staff member that caused, or had the potential to cause, injury or harm to any person or property within the facility. Such records must contain a clear description of each accident or incident, the names of the persons involved, a description of all medical or other services provided to these persons specifying who provided such services, and the steps taken to prevent recurrence of such accidents or incidents.

3. A copy of current agreements with third-party providers.

4. A copy of current agreements with each consultant employed by the licensee and documentation of each consultant's visits and required written, dated reports.

Section 12. Section 400.9980, Florida Statutes, is created to read:

400.9980 Property and personal affairs of clients.—

(1) A client shall be given the option of using his or her own belongings, as space permits; choosing his or her

roommate if practical and not clinically contraindicated; and, whenever possible, unless the client is adjudicated incompetent or incapacitated under state law, managing his or her own affairs.

(2) The admission of a client to a facility and his or her presence therein shall not confer on a licensee, administrator, employee, or representative thereof any authority to manage, use, or dispose of any property of the client, nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the client except that which may be necessary for the safe management of the facility or for the safety of the client.

(3) A licensee, administrator, employee, or representative thereof may:

(a) Not act as the guardian, trustee, or conservator for any client or any of such client's property.

(b) Act as a competent client's payee for social security, veteran's, or railroad benefits if the client provides consent and the licensee files a surety bond with the agency in an amount equal to twice the average monthly aggregate income or personal funds due to the client, or expendable for the client's account, that are received by a licensee.

(c) Act as the power of attorney for a client if the licensee has filed a surety bond with the agency in an amount equal to twice the average monthly income of the client, plus the value of any client's property under the control of the attorney in fact. The bond under paragraph (b) or paragraph (c) shall be executed by the licensee as principal and a licensed

surety company. The bond shall be conditioned upon the faithful compliance of the licensee with the requirements of licensure and shall be payable to the agency for the benefit of any client who suffers a financial loss as a result of the misuse or misappropriation of funds held pursuant to this subsection. Any surety company that cancels or does not renew the bond of any licensee shall notify the agency in writing not less than 30 days in advance of such action, giving the reason for the cancellation or nonrenewal. Any licensee, administrator, employee, or representative thereof who is granted power of attorney for any client of the facility shall, on a monthly basis, notify the client in writing of any transaction made on behalf of the client pursuant to this subsection, and a copy of such notification given to the client shall be retained in each client's file and available for agency inspection.

(4) A licensee, upon mutual consent with the client, shall provide for the safekeeping in the facility of the client's personal effects of a value not in excess of $1,000 and the client's funds not in excess of $500 cash and shall keep complete and accurate records of all such funds and personal effects received. If a client is absent from a facility for 24 hours or more, the licensee may provide for the safekeeping of the client's personal effects of a value in excess of $1,000.

(5) Any funds or other property belonging to or due to a client or expendable for his or her account that is received by licensee shall be trust funds and shall be kept separate from the funds and property of the licensee and other clients or shall be specifically credited to such client. Such trust funds

shall be used or otherwise expended only for the account of the client. At least once every month, unless upon order of a court of competent jurisdiction, the licensee shall furnish the client and the client's representative a complete and verified statement of all funds and other property to which this subsection applies, detailing the amount and items received, together with their sources and disposition. In any event, the licensee shall furnish such statement annually and upon the discharge or transfer of a client. Any governmental agency or private charitable agency contributing funds or other property to the account of a client shall also be entitled to receive such statement monthly and upon the discharge or transfer of the client.

(6)(a) In addition to any damages or civil penalties to which a person is subject, any person who:

1. Intentionally withholds a client's personal funds, personal property, or personal needs allowance, or who demands, beneficially receives, or contracts for payment of all or any part of a client's personal property or personal needs allowance in satisfaction of the facility rate for supplies and services; or

2. Borrows from or pledges any personal funds of a client, other than the amount agreed to by written contract under s. 429.24, commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(b) Any licensee, administrator, employee, or representative thereof who is granted power of attorney for any client of the facility and who misuses or misappropriates funds

obtained through this power commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(7) In the event of the death of a client, a licensee shall return all refunds, funds, and property held in trust to the client's personal representative, if one has been appointed at the time the licensee disburses such funds, or, if not, to the client's spouse or adult next of kin named in a beneficiary designation form provided by the licensee to the client. If the client has no spouse or adult next of kin or such person cannot be located, funds due the client shall be placed in an interest bearing account and all property held in trust by the licensee shall be safeguarded until such time as the funds and property are disbursed pursuant to the Florida Probate Code. Such funds shall be kept separate from the funds and property of the licensee and other clients of the facility. If the funds of the deceased client are not disbursed pursuant to the Florida Probate Code within 2 years after the client's death, the funds shall be deposited in the Health Care Trust Fund administered by the agency.

(8) The agency may by rule clarify terms and specify procedures and documentation necessary to administer the provisions of this section relating to the proper management of clients' funds and personal property and the execution of surety bonds.

Section 13. Section 400.9981, Florida Statutes, is created to read:

400.9981 Rules establishing standards.—

(1) It is the intent of the Legislature that rules published and enforced pursuant to this part and part II of chapter 408 include criteria to ensure reasonable and consistent quality of care and client safety. Rules should make reasonable efforts to accommodate the needs and preferences of clients to enhance the quality of life in transitional living facilities.

(2) The agency, in consultation with the Department of Health, may adopt and enforce rules to implement this part and part II of chapter 408, which shall include reasonable and fair criteria in relation to:

(a) The location of transitional living facilities.

(b) The number of qualifications of all personnel, including management, medical, nursing, and other professional personnel and nursing assistants and support personnel having responsibility for any part of the care given to clients. The licensee must have enough qualified professional staff available to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of each individual program plan.

(c) Requirements for personnel procedures, insurance coverage, reporting procedures, and documentation necessary to implement this part.

(d) Services provided to clients of transitional living facilities.

(e) The preparation and annual update of a comprehensive emergency management plan in consultation with the Division of Emergency Management. At a minimum, the rules must provide for plan components that address emergency evacuation

transportation; adequate sheltering arrangements; post disaster activities, including provision of emergency power, food, and water; post disaster transportation; supplies; staffing; emergency equipment; individual identification of clients and transfer of records; communication with families; and responses to family inquiries.

Section 14. Section 400.9982, Florida Statutes, is created to read:

400.9982 Violations; penalties.—

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

(a) Class "I" violations are defined in s. 408.813. The agency shall issue a citation regardless of correction and impose an administrative fine of $5,000 for an isolated violation, $7,500 for a patterned violation, and $10,000 for a widespread violation. Violations may be identified and a fine must be levied notwithstanding the correction of the deficiency giving rise to the violation.

(b) Class "II" violations are defined in s. 408.813. The agency shall impose an administrative fine of $1,000 for an isolated violation, $2,500 for a patterned violation, and $5,000 for a widespread violation. A fine must be levied notwithstanding the correction of the deficiency giving rise to the violation.

(c) Class "III" violations are defined in s. 408.813. The agency shall impose an administrative fine of $500 for an isolated violation, $750 for a patterned violation, and $1,000 for a widespread violation. If a deficiency giving rise to a class "III" violation is corrected within the time specified by the agency, a fine may not be imposed.

(d) Class "IV" violations are defined in s. 408.813. The agency shall impose an administrative fine for a cited class IV violation in an amount not less than $100 and not exceeding $200 for each violation.

Section 15. Section 400.9983, Florida Statutes, is created to read:

400.9983 Receivership proceedings.—The agency may access the provisions of s. 429.22 regarding receivership proceedings for transitional living facilities.

Section 16. Section 400.9984, Florida Statutes, is created to read:

400.9984 Interagency communication.—The agency, the department, the Agency for Persons with Disabilities, and the Department of Children and Families shall develop electronic systems to ensure that relevant information pertaining to the regulation of transitional living facilities and clients is timely and effectively communicated among agencies in order to facilitate the protection of clients. Electronic sharing of information shall include, at a minimum, a brain and spinal cord injury registry and a client abuse registry.

Section 17. Section 400.805, Florida Statutes, is repealed.

Section 18. Paragraph (b) of subsection (4) of section 381.78, Florida Statutes, is amended to read:

381.78 Advisory council on brain and spinal cord injuries.—

(4) The council shall:

(b) Annually appoint a five-member committee composed of one individual who has a brain injury or has a family member with a brain injury, one individual who has a spinal cord injury or has a family member with a spinal cord injury, and three members who shall be chosen from among these representative groups: physicians, other allied health professionals, administrators of brain and spinal cord injury programs, and representatives from support groups with expertise in areas related to the rehabilitation of individuals who have brain or spinal cord injuries, except that one and only one member of the committee shall be an administrator of a transitional living facility. Membership on the council is not a prerequisite for membership on this committee.

1. The committee shall perform onsite visits to those transitional living facilities identified by the Agency for Health Care Administration as being in possible violation of the statutes and rules regulating such facilities. ~~The committee members have the same rights of entry and inspection granted under s. 400.805(4) to designated representatives of the agency.~~

2. Factual findings of the committee resulting from an onsite investigation of a facility pursuant to subparagraph 1. shall be adopted by the agency in developing its administrative response regarding enforcement of statutes and rules regulating the operation of the facility.

3. Onsite investigations by the committee shall be funded by the Health Care Trust Fund.

4. Travel expenses for committee members shall be reimbursed in accordance with s. 112.061.

5. Members of the committee shall recuse themselves from participating in any investigation that would create a conflict of interest under state law, and the council shall replace the member, either temporarily or permanently.

Section 19. This act shall take effect July 1, 2013.

T I T L E A M E N D M E N T

Remove everything before the enacting clause and insert: An act relating to transitional living facilities; creating part XI of ch. 400, F.S., entitled "Transitional Living Facilities"; creating s. 400.9970, F.S.; providing legislative intent; creating s. 400.9971, F.S.; providing definitions; creating s. 400.9972, F.S.; requiring the licensure of transitional living facilities; providing fees; providing license application requirements; creating s. 400.9973, F.S.; providing requirements for transitional living facilities relating to client admission, transfer, and discharge; creating s.400.9974, F.S.; requiring an individual treatment plan to be developed for each client; providing plan requirements; creating s. 400.9975, F.S.; providing licensee responsibilities; providing notice requirements; prohibiting a licensee or employee of a facility from serving notice upon a client to leave the premises or take

other retaliatory action; requiring the client and client's representative to be provided with certain information; requiring the licensee to develop and implement certain policies and procedures; creating s. 400.9976, F.S.; providing licensee requirements relating to medication practices; creating s. 400.9977, F.S.; providing requirements for the screening of potential employees and monitoring of employees for the protection of clients; requiring licensees to implement certain procedures; creating s. 400.9978, F.S.; providing requirements for the use of physical restraints and chemical restraint medication on clients; creating s.400.9979, F.S.; providing background screening requirements; requiring the licensee to maintain certain personnel records; providing administrative responsibilities for licensees; providing recordkeeping requirements; creating s. 400.9980, F.S.; providing requirements relating to property and personal affairs of clients; providing requirements for a licensee with respect to obtaining surety bonds; providing recordkeeping requirements relating to the safekeeping of personal effects; providing requirements for trust funds received by a licensee and credited to the client; providing a penalty for certain misuse of a resident's personal needs allowance; providing criminal penalties for violations; providing for the disposition of property in the event of the death of a client; authorizing the Agency for Health Care Administration to adopt rules; creating s. 400.9981, F.S.; requiring the agency, in consultation with the Department of Health, to adopt and enforce certain rules; creating s. 400.9982, F.S.; providing procedures relating to violations and

819 penalties; providing administrative fines for specified classes
820 of violations; creating s. 400.9983, F.S.; authorizing the
821 agency to access the provisions of s. 429.22, F.S., regarding
822 receivership proceedings; creating s. 400.9984, F.S.; requiring
823 the Agency for Health Care Administration, the Department of
824 Health, the Agency for Persons with Disabilities, and the
825 Department of Children and Families to develop an electronic
826 database for certain purposes; repealing s. 400.805, F.S.,
827 relating to transitional living facilities; amending s. 381.78,
828 F.S.; conforming provisions to changes made by the act;
829 providing an effective date.
830

COMMITTEE MEETING REPORT

Health Innovation Subcommittee

3/19/2013 2:00:00PM

Location: 306 HOB

HB 1157 : Health Flex Plans

[X] *Favorable*

	Yea	*Nay*	*No Vote*	*Absentee Yea*	*Absentee Nay*
Michael Bileca	X				
Joseph Gibbons	X				
Charles Hood, Jr.	X				
Mia Jones	X				
MaryLynn Magar	X				
Kionne McGhee	X				
Jimmy Patronis	X				
Sharon Pritchett	X				
Jake Raburn	X				
Ronald Renuart	X				
David Richardson	X				
W. Gregory Steube	X				
John Wood (Chair)	X				
	Total Yeas: 13	**Total Nays: 0**			

Appearances:

Pitts, Brian (General Public) - Information Only
Justice-2-Jesus
1119 Newton Ave. S.
St. Petersburg FL 33705
Phone: (727) 897-9291

Committee meeting was reported out: Tuesday, March 19, 2013 4:54:56PM

COMMITTEE MEETING REPORT

Health Innovation Subcommittee

3/19/2013 2:00:00PM

Location: 306 HOB

HB 1323 : Medicaid Eligibilty

[X] *Favorable With Committee Substitute*

	Yea	*Nay*	*No Vote*	*Absentee Yea*	*Absentee Nay*
Michael Bileca	X				
Joseph Gibbons	X				
Charles Hood, Jr.	X				
Mia Jones		X			
MaryLynn Magar	X				
Kionne McGhee	X				
Jimmy Patronis	X				
Sharon Pritchett	X				
Jake Raburn	X				
Ronald Renuart	X				
David Richardson		X			
W. Gregory Steube	X				
John Wood (Chair)	X				
	Total Yeas: 11	**Total Nays: 2**			

HB 1323 Amendments

Amendment 170777

[X] *Adopted Without Objection*

Appearances:

Pitts, Brian (General Public) - Information Only
Justice-2-Jesus
1119 Newton Ave. S.
St. Petersburg FL 33705
Phone: (727) 897-9291

Huston, Amanda (Lobbyist) (State Employee) - Information Only
DCF
1317 Winewood Blvd.
Tallahassee FL 32399-070
Phone: (850)717-4641

Baker, Dorthene (State Employee) - Information Only
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Committee meeting was reported out: Tuesday, March 19, 2013 4:54:56PM

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 1323 (2013)

Amendment No.

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

Committee/Subcommittee hearing bill: Health Innovation Subcommittee

Representative Nuñez offered the following:

Amendment

Remove lines 52-78 and insert:

(b) When determining eligibility for nursing facility services, including institutional hospice services and home and community based waiver programs under the Medicaid program, the Department of Children and Families shall determine the institutional spouse to be ineligible for Medicaid if he or she, or the person acting on his or her behalf, refuses to provide information about the community spouse or cooperate in the pursuit of court ordered medical support or the recovery of Medicaid expenses paid by the state on his or her behalf.

COMMITTEE MEETING REPORT

Health Innovation Subcommittee

3/19/2013 2:00:00PM

Location: 306 HOB

PCS for HB 1319 : Assisted Living Facilities

[X] *Favorable*

	Yea	*Nay*	*No Vote*	*Absentee Yea*	*Absentee Nay*
Michael Bileca	X				
Joseph Gibbons	X				
Charles Hood, Jr.			X		
Mia Jones		X			
MaryLynn Magar	X				
Kionne McGhee	X				
Jimmy Patronis	X				
Sharon Pritchett	X				
Jake Raburn	X				
Ronald Renuart	X				
David Richardson	X				
W. Gregory Steube	X				
John Wood (Chair)	X				
	Total Yeas: 11	**Total Nays: 1**			

Appearances:

Lange, Pat (State Employee) - Information Only
Florida Assisted Living Assn.
2447 Millcreek Court, Ste. 3
Tallahassee Florida 32308
Phone: (850) 383-1159

Lee, Brian (General Public) - Opponent
Executive Director, Families for Better Care
P O Box 982
Tallahassee FL 32302
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Pitts, Brian (General Public) - Information Only
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Committee meeting was reported out: Tuesday, March 19, 2013 4:54:56PM

COMMITTEE MEETING REPORT

Health Innovation Subcommittee

3/19/2013 2:00:00PM

Location: 306 HOB

Actionable Items

Rep. Patronis makes a Motion to Temporarily Postpone HB 939.

[X] *Passed*

Chairman Wood makes a Motion to Reconsider the prior motion to TP HB 939.

[X] *Passed*

Committee meeting was reported out: Tuesday, March 19, 2013 4:54:56PM