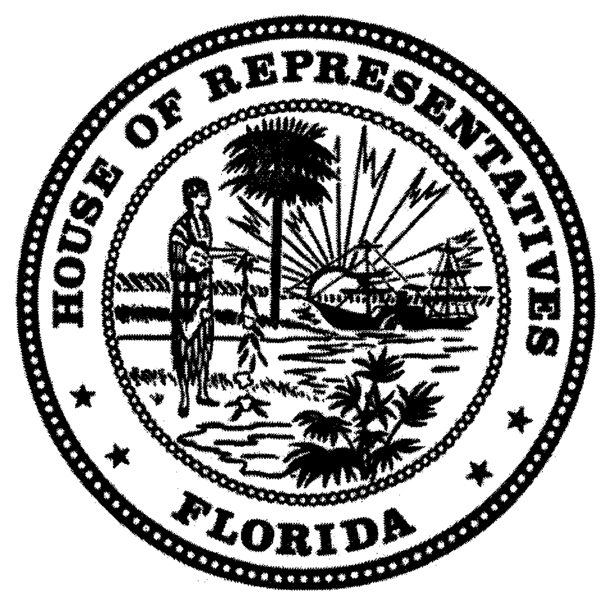

Health Innovation Subcommittee

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

Will Weatherford
Speaker

John Wood
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health Innovation Subcommittee

Start Date and Time: Tuesday, March 19, 2013 02:00 pm

End Date and Time: Tuesday, March 19, 2013 04:00 pm

Location: 306 HOB

Duration: 2.00 hrs

Consideration of the following bill(s):

CS/HB 675 Health Insurance Marketing Materials by Insurance & Banking Subcommittee, Ingram
HB 939 Medicaid Fraud by Pigman
HB 1021 Background Screening by Reed
HB 1109 Transitional Living Facilities by Magar
HB 1157 Health Flex Plans by Powell
HB 1323 Medicaid Eligibilty by Nuñez

Consideration of the following proposed committee substitute(s):

PCS for HB 1319 -- Assisted Living Facilities

Pursuant to rule 7.12, the deadline for amendments to bills on the agenda by non-appointed members is 6:00 p.m., Monday, March 18, 2013.

By request of the chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Monday, March 18, 2013.

NOTICE FINALIZED on 03/15/2013 16:00 by Iseminger.Bobbye

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 675 Health Insurance Marketing Materials
SPONSOR(S): Insurance & Banking; Ingram and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 648

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee	13 Y, 0 N, As CS	Cooper	Cooper
2) Health Innovation Subcommittee		McElroy	Shaw
3) Regulatory Affairs Committee			

SUMMARY ANALYSIS

The Employee Health Care Access Act is intended to promote the availability of health insurance coverage to small employers, and establishes certain requirements to accomplish that purpose. The Act defines small employer as any person, sole proprietor, self-employed person, independent contractor, firm, association, or other business entity that is based in Florida, actively engaged in business, with at least one, and no more than 50 employees.

Among its many features, the Act requires carriers to offer any small employer, upon request, a standard health benefit plan, a basic health benefit plan, and a high deductible plan that meets the requirements of health savings account plans. As a part of their offer, insurers must disclose certain information relating to health benefit mandates, managed care arrangements, and the plans' primary and preventive care features.

Current law also requires that each marketing communication that is to be used in the marketing of a health benefit plan be submitted for review by the Office of Insurance Regulation (OIR) prior to use. The law also requires such marketing communication to contain the disclosures referenced above.

The bill repeals an insurer's obligation to submit the marketing materials to OIR prior to use as well as the requirement that the marketing communication contain the specified disclosures. The bill does not repeal the mandate that the insurer present the disclosure statement to the small employer. Nor does the bill eliminate the ability of OIR to review the marketing communications and disclosure statements as part of complaint investigations or market conduct reviews. The bill also does not modify the current statutory authority of the Financial Services Commission to establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers.

The bill also addresses the regulation of advertising materials utilized by long-term care insurers. Long-term care insurance is insurance which covers the cost of certain health and personal services needed over a long period of time. Most of these benefits are not covered by traditional health insurance or Medicare. These include services in one's home such as assistance with Activities of Daily Living or Instrumental Activities of Daily Living as well as care in a variety of facility and community settings.

The bill deletes the current statutory requirement that insurers have to submit their advertising materials to OIR prior to their use. However, the bill still requires insurers to file the materials with OIR. The effect of this change is that insurers can immediately use their advertisements upon filing and the opportunity for OIR to disapprove before their use is removed. The bill retains the office's authority to disapprove an advertisement at any time and to enter an immediate order for the insurer to stop its use.

The bill should have a minimal positive fiscal impact on OIR. The bill may have a small positive fiscal impact for insurers. The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Employee Health Care Access Act

In 1992, the Florida Legislature created the Employee Health Care Access Act to promote the availability of health insurance coverage to small employers and to establish certain requirements to accomplish that purpose.[1] Small employer is defined as any person, sole proprietor, self-employed person, independent contractor, firm, association, or other business entity that is based in Florida, actively engaged in business, with at least one, and no more than 50 employees.[2]

Among its many features, the Act requires carriers to offer any small employer, upon request, a standard health benefit plan, a basic health benefit plan, and a high deductible plan that meets the requirements of health savings account plans.[3] The offer of coverage must include a statement disclosing the following:

a) An explanation of those mandated benefits and providers that are not covered by the policy or contract;
b) An explanation of the managed care and cost control features of the policy or contract, along with all appropriate mailing addresses and telephone numbers to be used by insureds in seeking information or authorization; and
c) An explanation of the primary and preventive care features of the policy or contract.[4]

Current law also requires that each marketing communication that is to be used in the marketing of a health benefit plan be submitted for review by the Office of Insurance Regulation (OIR) prior to use. The law also requires such marketing communication to contain the aforementioned disclosures.[5]

The bill repeals an insurer's obligation to submit the marketing materials to OIR prior to use as well the requirement that the marketing communication contain the specified disclosures. The bill does not repeal the mandate that the insurer present the disclosure statement to the small employer. Nor does the bill extinguish the ability of OIR to review the marketing communications and disclosure statements as part of complaint investigations or market conduct reviews. The bill also does not modify the current statutory authority of the Financial Services Commission (FSC) to establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers.

Long-Term Care Insurance

Long-term care insurance is insurance which covers the cost of certain health and personal services, most of which are not covered by traditional health insurance or Medicare, These include services in one's home such as assistance with Activities of Daily Living (ADL) as well as care in a variety of facility and community settings. Examples of ADLs include bathing, dressing, caring for incontinence, and eating. Other common long-term care services and supports are assistance to complete Instrumental Activities of Daily Living, which may include such activities as housework, taking medication, shopping for groceries or clothes, and the caring of pets.[6] Benefits may also be provided when the insured is experiencing cognitive impairment.

[1] Section 627.6699(2), F.S.
[2] Section 627.6699(3)(v), F.S.
[3] Section 627.6699(12)(b)1., F.S
[4] Section 627.6699(12)(d)1., F.S.
[5] Section 627.6699(12)(d)4., F.S.
[6] http://www.longtermcare.gov/LTC/Main_Site/Understanding/Definition/Index.aspx (last accessed: March 4, 2013).

The regulatory framework in statute for long-term care insurance policies is ss. 627.9401-627.9408, F.S. In part, the law requires the FSC to adopt rules setting forth standards for the advertising, marketing, and sale of long-term care policies in order "to protect applicants from unfair or deceptive sales or enrollment practices." The law also states that an insurer shall file with OIR any long-term care insurance advertising material at least 30 days before the date of use of the advertisement in Florida. Within 30 days after receiving the material OIR is required to review and disapprove any advertisement it finds violates the law. The statute further authorizes OIR to disapprove an advertisement at any time and to order its use be discontinued if the office determines the advertisement violates the law.[7]

The bill deletes the requirement that insurers have to submit their advertising materials to OIR prior to their use. However, the bill still requires insurers to file the materials with OIR. The effect of this change is that insurers can immediately use their advertisements upon filing and the opportunity for OIR to disapprove before their use is removed. The bill adds a new provision permitting OIR to issue notices of disapproval of materials. The bill also retains the office's authority to disapprove an advertisement at any time and to enter an immediate order for the insurer to stop its use.

B. SECTION DIRECTORY:

Section 1. Amends s. 627.6699, F.S., relating to standard, basic, high deductible, and limited health benefit plans for the Employee Health Care Access Act.

Section 2. Amends s. 627.9407, F.S., relating to disclosure, advertising, and performance standards for long-term care insurance.

Section 3. Provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

By potentially streamlining the process for distributing marketing materials, the bill may a small positive impact on insurers.

[7] Section 627.9407, F.S.

D. FISCAL COMMENTS:

According to OIR, "[t]here will be some reduction in staff time devoted to review of marketing material for health insurance, but the reduction would have no significant impact on resources otherwise allocated to health and life insurance form reviews."[8]

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 6th, 2013, the Insurance and Banking Subcommittee considered the bill, adopted one amendment, and reported the bill favorably as a committee substitute. The amendment provided that advertising materials for long-term care insurance may be used immediately by insurers upon filing without prior approval of OIR, but allowed OIR to disapprove subsequently.

The staff analysis has been updated to reflect the committee substitute.

[8] Bill Analysis for HB 675, Florida Office of Insurance Regulation, February 21, 2013. On file with the Insurance & Banking Subcommittee.

A bill to be entitled

An act relating to health insurance marketing materials; amending ss. 627.6699 and 627.9407, F.S.; deleting requirements that a health insurer submit proposed marketing communications or advertising material to the Office of Insurance Regulation for review and approval; establishing procedures for disapproval of long-term care insurance advertising materials; providing an effective date.

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

Section 1. Paragraph (d) of subsection (12) of section 627.6699, Florida Statutes, is amended to read:

627.6699 Employee Health Care Access Act.—

(12) STANDARD, BASIC, HIGH DEDUCTIBLE, AND LIMITED HEALTH BENEFIT PLANS.—

(d)1. Upon offering coverage under a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract for a ~~any~~ small employer group, the small employer carrier shall provide such employer group with a written statement that contains, at a minimum:

a. An explanation of those mandated benefits and providers that are not covered by the policy or contract;

b. An explanation of the managed care and cost control features of the policy or contract, along with all appropriate mailing addresses and telephone numbers to be used by insureds in seeking information or authorization; and

29 c. An explanation of the primary and preventive care
30 features of the policy or contract.
31
32 Such disclosure statement must be presented in a clear and
33 understandable form and format and must be separate from the
34 policy or certificate or evidence of coverage provided to the
35 employer group.
36 2. Before a small employer carrier issues a standard
37 health benefit plan, a basic health benefit plan, or a limited
38 benefit policy or contract, the carrier ~~it~~ must obtain from the
39 prospective policyholder a signed written statement in which the
40 prospective policyholder:
41 a. Certifies as to eligibility for coverage under the
42 standard health benefit plan, basic health benefit plan, or
43 limited benefit policy or contract;
44 b. Acknowledges the limited nature of the coverage and an
45 understanding of the managed care and cost control features of
46 the policy or contract;
47 c. Acknowledges that if misrepresentations are made
48 regarding eligibility for coverage under a standard health
49 benefit plan, a basic health benefit plan, or a limited benefit
50 policy or contract, the person making such misrepresentations
51 forfeits coverage provided by the policy or contract; and
52 d. If a limited plan is requested, acknowledges that the
53 prospective policyholder had been offered, at the time of
54 application for the insurance policy or contract, the
55 opportunity to purchase any health benefit plan offered by the
56 carrier and that the prospective policyholder ~~had~~ rejected that

57 coverage.
58
59 A copy of such written statement must ~~shall~~ be provided to the
60 prospective policyholder by ~~no later than at~~ the time of
61 delivery of the policy or contract, and the original of such
62 written statement must ~~shall~~ be retained in the files of the
63 small employer carrier for the period of time that the policy or
64 contract remains in effect or for 5 years, whichever ~~period~~ is
65 longer.
66 . 3. Any material statement made by an applicant for
67 coverage under a health benefit plan which falsely certifies ~~as~~
68 ~~to~~ the applicant's eligibility for coverage serves as the basis
69 for terminating coverage under the policy or contract.
70 ~~4. Each marketing communication that is intended to be~~
71 ~~used in the marketing of a health benefit plan in this state~~
72 ~~must be submitted for review by the office prior to use and must~~
73 ~~contain the disclosures stated in this subsection.~~
74 Section 2. Subsection (2) of section 627.9407, Florida
75 Statutes, is amended to read:
76 627.9407 Disclosure, advertising, and performance
77 standards for long-term care insurance.—
78 (2) ADVERTISING.—The commission shall adopt rules
79 establishing ~~setting forth~~ standards for the advertising,
80 marketing, and sale of long-term care insurance policies in
81 order to protect applicants from unfair or deceptive sales or
82 enrollment practices. An insurer shall file with the office any
83 long-term care insurance advertising material intended for use
84 in this state. The materials may be effective immediately,

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

85 subject to disapproval by the office. Following receipt of
86 notice of such disapproval, a long-term care insurer may not
87 issue or use any advertisement disapproved by the office or for
88 which the office has withdrawn approval ~~at least 30 days before~~
89 ~~the date of use of the advertisement in this state~~. ~~Within 30~~
90 ~~days after the date of receipt of the advertising material, the~~
91 ~~office shall review the material and shall disapprove any~~
92 ~~advertisement if, in the opinion of the office, such~~
93 ~~advertisement violates any of the provisions of this part or of~~
94 ~~part IX of chapter 626 or any rule of the commission.~~ The office
95 may disapprove an advertisement at any time and enter an
96 immediate order requiring that the use of the advertisement be
97 discontinued if it determines that the advertisement violates
98 ~~any of the provisions of~~ this part, ~~or of~~ part IX of chapter
99 626, or any rule of the commission.
100 Section 3. This act shall take effect July 1, 2013.

HB 939

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 939 Medicaid Fraud
SPONSOR(S): Pigman
TIED BILLS: **IDEN./SIM. BILLS:** SB 844

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		McElroy	Shaw
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

HB 939 modifies existing statutory provisions relating to fraud and abuse, provider controls and accountability in the Medicaid program. These modifications include the following:

- Increasing the length of time for retaining all medical and Medicaid related records from 5 to 6 years for Medicaid providers;
- Requiring Medicaid providers to report a change in any principal of the provider to the Agency for Health Care Administration (AHCA or the Agency) in writing no later than 30 days after the change occurs;
- Defining "administrative fines" and "outstanding overpayment" for purposes of liability for payment of such fines in the event of a change of ownership;
- Authorizing, rather than requiring, the AHCA to perform onsite inspections of the service location of a provider applying for a provider agreement before entering into a provider agreement with that provider, to determine that provider's ability to provide services in compliance with the Medicaid program and professional regulations;
- Extending the length of time before an administrative fine is assessed for failure to timely report an incidence of overpayment, abuse or fraud from 15 days to 60 days after detection.
- Requiring network providers under a Medicaid managed care program to submit a complete set of fingerprints for a criminal background check in order to participate in the Medicaid program;
- Requiring the Office of Medicaid Program Integrity to work with the Division of Insurance Fraud in reviewing and approving anti-fraud plans of insurers;
- Authorizing the AHCA to review and analyze information from sources other than enrolled Medicaid providers in conducting investigations;
- Requiring the AHCA to impose the sanction of termination for cause against a provider that voluntarily relinquishes their Medicaid provider number under certain circumstances;
- Limiting the timeframe for providers to submit records to the AHCA to 30 days after the provider has received the final audit report; Removing a requirement that the AHCA pay an interest rate of 10 percent a year on provider payments that have been withheld on a suspicion of fraud or abuse, if it is determined that there was no fraud or abuse;
- Clarifying the scope of immunity from civil liability for persons who report fraudulent acts or suspected fraudulent acts and providing a definition of fraudulent acts.

The bill does not appear to fiscal impact on state or local government.

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Health Care Fraud

In 2009, the Legislature passed CS/CS/CS/SB 1986 to address systematic health care fraud in Florida. Over three have now passed since these anti-fraud provisions were enacted and certain changes have been identified which would enhance Florida's efforts to prevent health care fraud and abuse in Florida's Medicaid program. This bill addresses some of the gaps in enforcement authority, strengthens the reporting requirements by Medicaid providers and Medicaid managed care organizations and defines the consequences for failure to comply with these requirements.

Medicaid

Medicaid is a medical assistance program that provides access to health care for low-income families and individuals. Medicaid also assists aged and disabled people with costs of nursing facility care and other medical expenses. The ACHA's Division of Medicaid administers the Florida Medicaid Program. The statutory authority for the Medicaid program is contained in ch. 409, F.S.

Medicaid reimburses health care providers that have a provider agreement with the AHCA only for goods and services that are covered by the Medicaid program and only for individuals who are eligible for Medicaid assistance from Medicaid. Section 409.907, F.S., establishes requirements for Medicaid provider agreements, which include among other things, background screening requirements, notification requirements for change of ownership of a Medicaid provider, authority for AHCA site visits of provider service locations and surety bond requirements. The statute does not provide for background screening for non-enrolled providers who participate in the Medicaid program as components of a Medicaid managed care network.

Currently, the Office of Medicaid Program Integrity reviews anti-fraud plans for all participating Medicaid plans. Additionally, under s. 626.9891, F.S., all insurance companies and managed care companies also submit their required anti-fraud plans to the Department of Financial Services, Division of Insurance Fraud for review.

Under s. 409.913, F.S., the AHCA is responsible for overseeing the integrity of the Medicaid program, to ensure the fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate.

Sections 409,920, 409.9201, 409.9203, and 409.9205, F.S., contain provisions relating specifically to Medicaid fraud. A person who provides the State with information about fraud or suspected fraud by a Medicaid provider, including a managed care organization, is immune from civil liability for providing that information unless the person knew the information was false or acted with reckless disregard for the truth or falsity of the information.[1]

Part IV of ch. 409, F.S., requires all Medicaid recipients to enroll in a managed care plan unless they are specifically exempted. The statewide Medicaid managed care program includes the long-term care managed care program and the managed care medical assistance program. The law directs the AHCA to begin implementation of the long term managed care program by July 1, 2012, with full implementation in all regions of the State by October 1, 2013. The State received federal approval of

[1] See s. 409.920(8), F.S.

this program on February 1, 2013.[2] Although the AHCA has received conditional approval,[3] the AHCA is still awaiting final approval of the managed medical assistance program whose full implementation is anticipated by October 1, 2014.

Background Screening

Chapter 435, F.S., establishes standards for background screening for employment. Section 435.03, F.S., sets standards for Level 1 background screening. Level 1 background screenings include, but are not limited to, employment history checks and statewide criminal correspondence checks through the Department of Law Enforcement and a check of the Dru Sjodin National Sex Offender Public Website, and may include local criminal records checks through local law enforcement agencies.

Level 2 background screenings include, but are not limited to, fingerprinting for statewide criminal history records checks through the Department of Law Enforcement and national criminal history records checks through the Federal Bureau of Investigation. They may also include local criminal records checks through local law enforcement agencies. Section 435.04(2), F.S., lists the offenses that will disqualify an applicant from employment.

Section 408.809, F.S., establishes background screening requirements and procedures for entities licensed by the AHCA. The AHCA must conduct Level 2 background screening for specified individuals. Each person subject to this section is subject to Level 2 background screening every 5 years. This section of law also specifies additional disqualifying offenses beyond those included in s. 435.04(2), F.S.

Effects of the bill

Section 409.907(3)(c), F.S. requires Medicaid providers to retain all medical and Medicaid-related records for 5 years. The bill extends the retention period to 6 years, which is consistent with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 administrative simplification rules.[4]

The bill requires a Medicaid provider to report, in writing, any change of any principal of the provider to AHCA within 30 days after the change occurs. "Principal" includes any officer, director, agent, managing employee, affiliated person or any partner or shareholder who has a 5% or greater interest in the provider.

The bill defines "administrative fines" and "outstanding overpayment". This functions to clarify the statutory provisions relating to the liability of Medicaid providers in a change of ownership for outstanding overpayments, administrative fines, and any other moneys owed to the AHCA.

Section 409.907(7) requires the AHCA to conduct random onsite inspections of Medicaid providers' service locations within 60 days after receipt of a fully complete new provider's application and prior to making the first payment to the provider for Medicaid services. The bill removes the 60 day time period, as well as the requirement for random inspections. This provides the ACHA with greater flexibility in performing its onsite inspections prior to entering into a provider agreement. The bill also removes the exception to random onsite-inspections granted to certain providers as the inspections are conducted at the discretion of the ACHA.

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[2] Agency for Health Care Administration, February 1, 2013 Waiver Approval Letter, http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Signed_approval_FL0962_new_1915c_02-01-2013.pdf (last visited on March 14, 2013).

[3] Agency for Health Care Administration, *February 20, 2013 Agreement in Principle Letter,* http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/Letter_from_CMS_re_Agreement_in_Principal_2013-02-20.pdf (Last visited on March1 4, 2013).

[4] See 45 CFR 164.316(b)(2).

Currently, only enrolled Medicaid providers are contractually required to submit a complete set of fingerprints to the ACHA for criminal history screening. The bill amends the statute to require Medicaid managed care network providers, and persons who meet the definition of controlling interest for certain hospitals and nursing homes to submit a full set of fingerprints to the ACHA.

Section 409.91212, F.S., requires AHCA to review anti-fraud plans of all Medicaid managed care organizations and Medicaid provider service networks. Anti-fraud plans for all insurance companies and managed care companies are also required to be submitted to the Department of Financial Services, Division of Insurance Fraud under s. 626. 9891, F.S. The bill amends this section to eliminate the duplicative submissions required under the statutes. Specifically, the bill amends this section and requires the AHCA to enter into an interagency agreement with the Division of Insurance Fraud in the Department of Financial Services to delineate the responsibilities of the two agencies in reviewing and approving anti-fraud plans of insurers under s. 626.9891, F.S.

The bill extends the length of time before an administrative fine is assessed against a managed care plan for failure to timely report an incidence of overpayment, abuse or fraud from 15 days to 60 days after detection. This change gives the managed care plan more time to conduct an internal investigation of the allegations.

Pursuant to s. 409.913, F.S., the ACHA may only review and analyze information from enrolled providers in its investigation of fraud, abuse, overpayment and/or recipient neglect in the Medicaid program. The bill authorizes the ACHA to review and analyze information from sources other than enrolled Medicaid providers when investigating or auditing a Medicaid provider.

Section 409.913(13), F.S., requires the AHCA to immediately terminate participation of a Medicaid provider that has been convicted of certain identified offenses. However, in order to immediately terminate a provider, the AHCA must show an immediate harm to the public health, which is not always possible. The bill removes "immediately" from the requirement the provision. The AHCA still must terminate a Medicaid provider from participation in the Medicaid program but the termination is no longer in conflict with the Administrative Procedures Act.[5] The bill additionally amends this section to clarify the instances of provider disqualification from participation on the Medicaid program.

Section. 409.913, F.S., delineates the noncriminal actions of Medicaid providers for which the AHCA may impose sanctions. The section provides penalties for the individual or provider who participated or acquiesced in the proscribed activity. The bill adds individuals or providers who "authorized" to those who may be sanctioned under this section. The bill also adds that the AHCA may sanction a provider if the provider is charged by information or indictment with any offense referenced in subsection (13).

Currently, if a Medicaid provider receives notification that it is going to be suspended or terminated, the provider is able to voluntarily terminate their contract. By doing this, a provider has the ability to avoid sanctions of suspension or termination, which would affect the ability of the provider to reenter the program in the future. The bill amends s. 409.913(16), F.S., to state that, if a Medicaid provider voluntarily relinquishes its Medicaid provider number after receiving notice of an audit or investigation for which the sanction of suspension or termination will be imposed, the AHCA must impose the sanction of termination for cause against the provider. The bill also amends this section to give the Secretary of the AHCA discretionary authority to make a determination to refrain from imposing a sanction if it is not in the best interest of the Medicaid program.

The bill amends s. 409.913(21), F.S., to specify that when the AHCA is making a determination that an overpayment has occurred, the determination must be based solely upon information available to it

[5] See s. 120.569(2)(n), F.S. which requires that "if any agency head finds that an immediate danger to the public health , safety, or welfare requires an immediate final order, it shall recite with particularity the facts underlying such finding in the final order, which shall be appealable or enjoinable from the date ordered."

before it issues the audit report and, in the case of documentation obtained to substantiate claims for Medicaid reimbursement, based solely upon contemporaneous records.

The bill amends s. 409.913(22), F.S., to state that 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 AHCA within 30 days after the provider received the final audit report. Also, all documentation to be offered as evidence in an administrative hearing on an administrative sanction (in addition to Medicaid overpayments) must be exchanged by all parties at least 14 days before the administrative hearing or otherwise it will be excluded from consideration.

The bill amends s. 409.913(25), F.S., to remove the requirement that the AHCA pay interest at the rate of 10 percent a year on Medicaid payments that have been withheld from a provider based on suspected fraud or criminal activity, if it is determined that there was no fraud or that a crime did not occur. Also, payment arrangements for overpayments and fines owed to the AHCA must be made within 30 days after the date of the final order and are not subject to further appeal.

Section 409.913(28), F.S., provides that venue for all Medicaid program integrity overpayments cases shall lie in Leon County. This creates questions as to whether venue for all administrative fines cases also lie in Leon County. The bill amends s. 409.913(28), F.S., to make Leon County the proper venue for all Medicaid program integrity cases.

The bill amends s. 409.913(29), F.S., to authorize the AHCA and the Medicaid Fraud Control Unit of the Department of Legal Affairs to review a *person's*, in addition to a provider's, Medicaid-related and non-Medicaid-related records in order to determine the total output of a provider's practice to reconcile quantities of goods or services billed to Medicaid with quantities of goods or services used in the provider's total practice.

Section 409.913(30), F.S., requires the AHCA to terminate a provider's participation in the Medicaid program if the provider fails to pay a fine within 35 days after the date of the final order imposing the fine. The bill amends this section to reduce the time within which a provider must reimburse an overpayment to 30 days after the date of the final order.

The bill amends s. 409.913(31), F.S., to include fines, as well as overpayments, to the outstanding balance due upon the issuance of a final order at the conclusion of a requested administrative hearing.

The bill amends s. 409.920, F.S., to clarify that the existing immunity from civil liability extended to persons who provide information about fraud or suspected fraudulent acts is for civil liability for libel, slander, or any other relevant tort. The bill defines "fraudulent acts" for purposes of immunity from civil liability to include actual or suspected fraud and abuse, insurance fraud, licensure fraud or public insurance fraud; including any fraud-related matters that a provider or health plan is required to report to the AHCA or a law enforcement agency. The immunity from civil liability extends to reports conveyed to the AHCA in any manner, including forums, and incorporates all discussions subsequent to the report and subsequent inquiries from the AHCA.

The bill provides an effective date of July 1, 2013.

B. SECTION DIRECTORY:

Section 1 amends s. 409.07, F.S., relating to Medicaid provider agreements.

Section 2 amends s. 409.91212, F.S., relating to Medicaid managed care fraud.

Section 3 amends s. 409.913, F.S., relating to oversight of the integrity of the Medicaid program.

Section 4 amends s. 409.920, F.S., relating to Medicaid provider fraud.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Entities and individual health care providers under Medicaid currently exempt from background checks will be required to complete the same requirements as other Medicaid providers. Health care providers who do not participate in the Medicaid program under fee-for-service but become a member of a Medicaid managed care provider network will be required to undergo background screening.

The total fee for a Level 2 background screening is $64.50 ($24.00 for the state portion, $16.50 for the national portion, and $24.00 for retention). There is an additional fee of $11-$16 for electronic screening, depending on the provider. The cost of the screening is borne by the individual provider.[6]

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

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[6] Agency for Health Care Administration, *House Bill 944 Analysis & Economic Impact Statement* (March 14, 2013).

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to Medicaid fraud; amending s.
3 409.907, F.S.; increasing the number of years a
4 provider must keep records; adding an additional
5 provision relating to a change in principal that must
6 be included in a Medicaid provider agreement with the
7 Agency for Health Care Administration; adding
8 definitions for "administrative fines" and
9 "outstanding overpayment"; revising provisions
10 relating to the agency's onsite inspection
11 responsibilities; revising provisions relating to who
12 is subject to background screening; amending s.
13 409.91212, F.S.; requiring the agency to enter into an
14 interagency agreement with the Division of Insurance
15 Fraud regarding anti-fraud plans by managed care
16 plans; revising the time period in which a managed
17 care plan must report fraud or abuse; delaying the
18 imposition of certain fines for failing to report;
19 amending s. 409.913, F.S.; authorizing the agency to
20 review and analyze sources other than providers in
21 order to carry out its duties with respect to its
22 Medicaid oversight responsibilities; increasing the
23 number of years a provider must keep records; revising
24 provisions specifying grounds for terminating a
25 provider from the program, for seeking certain
26 remedies for violations, and for imposing certain
27 sanctions; providing a limitation on the information
28 the agency may consider when making a determination of

29 overpayment; specifying the type of records a provider
30 must present to contest an overpayment; deleting the
31 requirement that the agency pay interest on certain
32 payments withheld from a provider and revising when a
33 provider must reimburse overpayments; revising venue
34 requirements; adding provisions relating to the
35 payment of fines; amending s. 409.920, F.S.;
36 clarifying provisions relating to immunity from
37 liability for persons who provide information about
38 Medicaid fraud; providing an effective date.
39
40 Be It Enacted by the Legislature of the State of Florida:
41
42 Section 1. Paragraph (c) of subsection (3) of section
43 409.907, Florida Statutes, is amended and paragraph (k) is added
44 to that subsection, and subsections (6), (7), and (8) of that
45 section are amended to read:
46 409.907 Medicaid provider agreements.—The agency may make
47 payments for medical assistance and related services rendered to
48 Medicaid recipients only to an individual or entity who has a
49 provider agreement in effect with the agency, who is performing
50 services or supplying goods in accordance with federal, state,
51 and local law, and who agrees that no person shall, on the
52 grounds of handicap, race, color, or national origin, or for any
53 other reason, be subjected to discrimination under any program
54 or activity for which the provider receives payment from the
55 agency.
56 (3) The provider agreement developed by the agency, in

57 addition to the requirements specified in subsections (1) and
58 (2), shall require the provider to:
59 (c) Retain all medical and Medicaid-related records for 6
60 ~~a period of 5~~ years to satisfy all necessary inquiries by the
61 agency.
62 (k) Report a change in any principal of the provider,
63 including any officer, director, agent, managing employee, or
64 affiliated person, or any partner or shareholder who has an
65 ownership interest equal to 5 percent or more in the provider,
66 to the agency in writing within 30 days after the change occurs.
67 For a hospital licensed under chapter 395 or a nursing home
68 licensed under part II of chapter 400, a principal of the
69 provider is one who meets the definition of a controlling
70 interest under s. 408.803.
71 (6) A Medicaid provider agreement may be revoked, at the
72 option of the agency, due to ~~as the result of~~ a change of
73 ownership of any facility, association, partnership, or other
74 entity named as the provider in the provider agreement.
75 (a) If there is ~~In the event of~~ a change of ownership, the
76 transferor remains liable for all outstanding overpayments,
77 administrative fines, and any other moneys owed to the agency
78 before the effective date of the change ~~of ownership~~. ~~In~~
79 ~~addition to the continuing liability of the transferor,~~ The
80 transferee is also liable to the agency for all outstanding
81 overpayments identified by the agency on or before the effective
82 date of the change of ownership. ~~For purposes of this~~
83 ~~subsection, the term "outstanding overpayment" includes any~~
84 ~~amount identified in a preliminary audit report issued to the~~

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85 ~~transferor by the agency on or before the effective date of the~~
86 ~~change of ownership.~~ In the event of a change of ownership for a
87 skilled nursing facility or intermediate care facility, the
88 Medicaid provider agreement shall be assigned to the transferee
89 if the transferee meets all other Medicaid provider
90 qualifications. In the event of a change of ownership involving
91 a skilled nursing facility licensed under part II of chapter
92 400, liability for all outstanding overpayments, administrative
93 fines, and any moneys owed to the agency before the effective
94 date of the change of ownership shall be determined in
95 accordance with s. 400.179.
96 (b) At least 60 days before the anticipated date of the
97 change of ownership, the transferor must ~~shall~~ notify the agency
98 of the intended change ~~of ownership~~ and the transferee must
99 ~~shall~~ submit to the agency a Medicaid provider enrollment
100 application. If a change of ownership occurs without compliance
101 with the notice requirements of this subsection, the transferor
102 and transferee are ~~shall be~~ jointly and severally liable for all
103 overpayments, administrative fines, and other moneys due to the
104 agency, regardless of whether the agency identified the
105 overpayments, administrative fines, or other moneys before or
106 after the effective date of the change ~~of ownership~~. The agency
107 may not approve a transferee's Medicaid provider enrollment
108 application if the transferee or transferor has not paid or
109 agreed in writing to a payment plan for all outstanding
110 overpayments, administrative fines, and other moneys due to the
111 agency. This subsection does not preclude the agency from
112 seeking any other legal or equitable remedies available to the

113 agency for the recovery of moneys owed to the Medicaid program.
114 In the event of a change of ownership involving a skilled
115 nursing facility licensed under part II of chapter 400,
116 liability for all outstanding overpayments, administrative
117 fines, and any moneys owed to the agency before the effective
118 date of the change of ownership shall be determined in
119 accordance with s. 400.179 if the Medicaid provider enrollment
120 application for change of ownership is submitted before the
121 change ~~of ownership~~.
122 (c) As used in this subsection, the term:
123 1. "Administrative fines" includes any amount identified
124 in a notice of a monetary penalty or fine which has been issued
125 by the agency or other regulatory or licensing agency that
126 governs the provider.
127 2. "Outstanding overpayment" includes any amount
128 identified in a preliminary audit report issued to the
129 transferor by the agency on or before the effective date of a
130 change of ownership.
131 (7) ~~The agency may require,~~ As a condition of
132 participating in the Medicaid program and before entering into
133 the provider agreement, the agency may require ~~that~~ the provider
134 to submit information, in an initial and any required renewal
135 applications, concerning the professional, business, and
136 personal background of the provider and permit an onsite
137 inspection of the provider's service location by agency staff or
138 other personnel designated by the agency to perform this
139 function. Before entering into a provider agreement, the agency
140 may ~~shall~~ perform an ~~a random~~ onsite inspection~~, within 60 days~~

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141 ~~after receipt of a fully complete new provider's application,~~ of
142 the provider's service location ~~prior to making its first~~
143 ~~payment to the provider for Medicaid services~~ to determine the
144 applicant's ability to provide the services in compliance with
145 the Medicaid program and professional regulations ~~that the~~
146 ~~applicant is proposing to provide for Medicaid reimbursement~~.
147 ~~The agency is not required to perform an onsite inspection of a~~
148 ~~provider or program that is licensed by the agency, that~~
149 ~~provides services under waiver programs for home and community-~~
150 ~~based services, or that is licensed as a medical foster home by~~
151 ~~the Department of Children and Family Services.~~ As a continuing
152 condition of participation in the Medicaid program, a provider
153 must ~~shall~~ immediately notify the agency of any current or
154 pending bankruptcy filing. Before entering into the provider
155 agreement, or as a condition of continuing participation in the
156 Medicaid program, the agency may also require that Medicaid
157 providers reimbursed on a fee-for-services basis or fee schedule
158 basis that ~~which~~ is not cost-based, post a surety bond not to
159 exceed $50,000 or the total amount billed by the provider to the
160 program during the current or most recent calendar year,
161 whichever is greater. For new providers, the amount of the
162 surety bond shall be determined by the agency based on the
163 provider's estimate of its first year's billing. If the
164 provider's billing during the first year exceeds the bond
165 amount, the agency may require the provider to acquire an
166 additional bond equal to the actual billing level of the
167 provider. A provider's bond need ~~shall~~ not exceed $50,000 if a
168 physician or group of physicians licensed under chapter 458,

169 chapter 459, or chapter 460 has a 50 percent or greater
170 ownership interest in the provider or if the provider is an
171 assisted living facility licensed under chapter 429. The bonds
172 permitted by this section are in addition to the bonds
173 referenced in s. 400.179(2)(d). If the provider is a
174 corporation, partnership, association, or other entity, the
175 agency may require the provider to submit information concerning
176 the background of that entity and of any principal of the
177 entity, including any partner or shareholder having an ownership
178 interest in the entity equal to 5 percent or greater, and any
179 treating provider who participates in or intends to participate
180 in Medicaid through the entity. The information must include:
181 (a) Proof of holding a valid license or operating
182 certificate, as applicable, if required by the state or local
183 jurisdiction in which the provider is located or if required by
184 the Federal Government.
185 (b) Information concerning any prior violation, fine,
186 suspension, termination, or other administrative action taken
187 under the Medicaid laws or~~,~~ rules~~, or regulations~~ of this state
188 or of any other state or the Federal Government; any prior
189 violation of the laws or~~,~~ rules~~, or regulations~~ relating to the
190 Medicare program; any prior violation of the rules ~~or~~
191 ~~regulations~~ of any other public or private insurer; and any
192 prior violation of the laws or~~,~~ rules~~, or regulations~~ of any
193 regulatory body of this or any other state.
194 (c) Full and accurate disclosure of any financial or
195 ownership interest that the provider, or any principal, partner,
196 or major shareholder thereof, may hold in any other Medicaid

197 provider or health care related entity or any other entity that
198 is licensed by the state to provide health or residential care
199 and treatment to persons.
200 (d) If a group provider, identification of all members of
201 the group and attestation that all members of the group are
202 enrolled in or have applied to enroll in the Medicaid program.
203 (8) ~~(a)~~ Each provider, or each principal of the provider if
204 the provider is a corporation, partnership, association, or
205 other entity, seeking to participate in the Medicaid program,
206 including Medicaid managed care network providers, must submit a
207 complete set of his or her fingerprints to the agency for the
208 purpose of conducting a criminal history record check.
209 Principals of the provider include any officer, director,
210 billing agent, managing employee, or affiliated person, or any
211 partner or shareholder who has an ownership interest equal to 5
212 percent or more in the provider. However, for a hospital
213 licensed under chapter 395 or a nursing home licensed under
214 chapter 400, principals of the provider are those who meet the
215 definition of a controlling interest under s. 408.803. A
216 director of a not-for-profit corporation or organization is not
217 a principal for purposes of a background investigation ~~as~~
218 required by this section if the director: serves solely in a
219 voluntary capacity for the corporation or organization, does not
220 regularly take part in the day-to-day operational decisions of
221 the corporation or organization, receives no remuneration from
222 the not-for-profit corporation or organization for his or her
223 service on the board of directors, has no financial interest in
224 the not-for-profit corporation or organization, and has no

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225 family members with a financial interest in the not-for-profit
226 corporation or organization; and if the director submits an
227 affidavit, under penalty of perjury, to this effect to the
228 agency and the not-for-profit corporation or organization
229 submits an affidavit, under penalty of perjury, to this effect
230 to the agency as part of the corporation's or organization's
231 Medicaid provider agreement application. Notwithstanding the
232 above, the agency may require a background check for any person
233 reasonably suspected by the agency to have been convicted of a
234 crime.
235 <u>(a)</u> This subsection does not apply to:
236 ~~1. A hospital licensed under chapter 395;~~
237 ~~2. A nursing home licensed under chapter 400;~~
238 ~~3. A hospice licensed under chapter 400;~~
239 ~~4. An assisted living facility licensed under chapter 429;~~
240 <u>1.</u>~~5.~~ A unit of local government, except that requirements
241 of this subsection apply to nongovernmental providers and
242 entities contracting with the local government to provide
243 Medicaid services. The actual cost of the state and national
244 criminal history record checks must be borne by the
245 nongovernmental provider or entity; or
246 <u>2.</u>~~6.~~ Any business that derives more than 50 percent of its
247 revenue from the sale of goods to the final consumer, and the
248 business or its controlling parent is required to file a form
249 10-K or other similar statement with the Securities and Exchange
250 Commission or has a net worth of $50 million or more.
251 (b) Background screening shall be conducted in accordance
252 with chapter 435 and s. 408.809. The cost of the state and

253 national criminal record check shall be borne by the provider.
254 ~~(c) Proof of compliance with the requirements of level 2~~
255 ~~screening under chapter 435 conducted within 12 months before~~
256 ~~the date the Medicaid provider application is submitted to the~~
257 ~~agency fulfills the requirements of this subsection.~~
258 Section 2. Subsections (1) and (6) of section 409.91212,
259 Florida Statutes, are amended to read:
260 409.91212 Medicaid managed care fraud.—
261 (1) Each managed care plan, as defined in s.
262 409.920(1)(e), shall adopt an anti-fraud plan addressing the
263 detection and prevention of overpayments, abuse, and fraud
264 relating to the provision of and payment for Medicaid services
265 and submit the plan to the Office of Medicaid Program Integrity
266 within the agency for approval. The office shall enter into an
267 interagency agreement with the Division of Insurance Fraud in
268 the Department of Financial Services which delineates the
269 responsibilities of the agency in reviewing and approving anti-
270 fraud plans for entities that are also required to submit anti-
271 fraud plans under s. 626.9891. At a minimum, the anti-fraud plan
272 must include:
273 (a) A written description or chart outlining the
274 organizational arrangement of the plan's personnel who are
275 responsible for the investigation and reporting of possible
276 overpayment, abuse, or fraud;
277 (b) A description of the plan's procedures for detecting
278 and investigating possible acts of fraud, abuse, and
279 overpayment;
280 (c) A description of the plan's procedures for the

281 mandatory reporting of possible overpayment, abuse, or fraud to
282 the Office of Medicaid Program Integrity within the agency;
283 (d) A description of the plan's program and procedures for
284 educating and training personnel on how to detect and prevent
285 fraud, abuse, and overpayment;
286 (e) The name, address, telephone number, e-mail address,
287 and fax number of the individual responsible for carrying out
288 the anti-fraud plan; and
289 (f) A summary of the results of the investigations of
290 fraud, abuse, or overpayment which were conducted during the
291 previous year by the managed care organization's fraud
292 investigative unit.
293 (6) Each managed care plan shall report all suspected or
294 confirmed instances of provider or recipient fraud or abuse
295 within 60 ~~15~~ calendar days after detection to the Office of
296 Medicaid Program Integrity within the agency. At a minimum the
297 report must contain the name of the provider or recipient, the
298 Medicaid billing number or tax identification number, and a
299 description of the fraudulent or abusive act. The office ~~of~~
300 ~~Medicaid Program Integrity in the agency~~ shall forward the
301 report of suspected overpayment, abuse, or fraud to the
302 appropriate investigative unit, including, but not limited to,
303 the Bureau of Medicaid program integrity, the Medicaid fraud
304 control unit, the Division of Public Assistance Fraud, the
305 Division of Insurance Fraud, or the Department of Law
306 Enforcement.
307 (a) Failure to timely report shall result in an
308 administrative fine of $1,000 per calendar day after the 60th

309 ~~15th~~ day of detection.
310 (b) Failure to timely report may result in additional
311 administrative, civil, or criminal penalties.
312 Section 3. Subsections (2), (9), (13), (15), (16), (21),
313 (22), (25), (28), (29), (30) and (31) of section 409.913,
314 Florida Statutes, are amended to read:
315 409.913 Oversight of the integrity of the Medicaid
316 program.—The agency shall operate a program to oversee the
317 activities of Florida Medicaid recipients, and providers and
318 their representatives, to ensure that fraudulent and abusive
319 behavior and neglect of recipients occur to the minimum extent
320 possible, and to recover overpayments and impose sanctions as
321 appropriate. Beginning January 1, 2003, and each year
322 thereafter, the agency and the Medicaid Fraud Control Unit of
323 the Department of Legal Affairs shall submit a joint report to
324 the Legislature documenting the effectiveness of the state's
325 efforts to control Medicaid fraud and abuse and to recover
326 Medicaid overpayments during the previous fiscal year. The
327 report must describe the number of cases opened and investigated
328 each year; the sources of the cases opened; the disposition of
329 the cases closed each year; the amount of overpayments alleged
330 in preliminary and final audit letters; the number and amount of
331 fines or penalties imposed; any reductions in overpayment
332 amounts negotiated in settlement agreements or by other means;
333 the amount of final agency determinations of overpayments; the
334 amount deducted from federal claiming as a result of
335 overpayments; the amount of overpayments recovered each year;
336 the amount of cost of investigation recovered each year; the

337 average length of time to collect from the time the case was
338 opened until the overpayment is paid in full; the amount
339 determined as uncollectible and the portion of the uncollectible
340 amount subsequently reclaimed from the Federal Government; the
341 number of providers, by type, that are terminated from
342 participation in the Medicaid program as a result of fraud and
343 abuse; and all costs associated with discovering and prosecuting
344 cases of Medicaid overpayments and making recoveries in such
345 cases. The report must also document actions taken to prevent
346 overpayments and the number of providers prevented from
347 enrolling in or reenrolling in the Medicaid program as a result
348 of documented Medicaid fraud and abuse and must include policy
349 recommendations necessary to prevent or recover overpayments and
350 changes necessary to prevent and detect Medicaid fraud. All
351 policy recommendations in the report must include a detailed
352 fiscal analysis, including, but not limited to, implementation
353 costs, estimated savings to the Medicaid program, and the return
354 on investment. The agency must submit the policy recommendations
355 and fiscal analyses in the report to the appropriate estimating
356 conference, pursuant to s. 216.137, by February 15 of each year.
357 The agency and the Medicaid Fraud Control Unit of the Department
358 of Legal Affairs each must include detailed unit-specific
359 performance standards, benchmarks, and metrics in the report,
360 including projected cost savings to the state Medicaid program
361 during the following fiscal year.
362 (2) The agency shall conduct, or cause to be conducted by
363 contract or otherwise, reviews, investigations, analyses,
364 audits, or any combination thereof, to determine possible fraud,

365 abuse, overpayment, or recipient neglect in the Medicaid program
366 and ~~shall~~ report the findings of any overpayments in audit
367 reports as appropriate. At least 5 percent of all audits must
368 ~~shall~~ be conducted on a random basis. As part of its ongoing
369 fraud detection activities, the agency shall identify and
370 monitor, by contract or otherwise, patterns of overutilization
371 of Medicaid services based on state averages. The agency shall
372 track Medicaid provider prescription and billing patterns and
373 evaluate them against Medicaid medical necessity criteria and
374 coverage and limitation guidelines adopted by rule. Medical
375 necessity determination requires that service be consistent with
376 symptoms or confirmed diagnosis of illness or injury under
377 treatment and not in excess of the patient's needs. The agency
378 shall conduct reviews of provider exceptions to peer group norms
379 and ~~shall~~, using statistical methodologies, provider profiling,
380 and analysis of billing patterns, shall detect and investigate
381 abnormal or unusual increases in billing or payment of claims
382 for Medicaid services and medically unnecessary provision of
383 services. The agency may review and analyze information from
384 sources other than enrolled Medicaid providers in conducting its
385 activities under this subsection.
386 (9) A Medicaid provider shall retain medical,
387 professional, financial, and business records pertaining to
388 services and goods furnished to a Medicaid recipient and billed
389 to Medicaid for 6 ~~a period of 5~~ years after the date of
390 furnishing such services or goods. The agency may investigate,
391 review, or analyze such records, which must be made available
392 during normal business hours. However, 24-hour notice must be

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393 provided if patient treatment would be disrupted. The provider
394 must keep ~~is responsible for furnishing to the agency, and~~
395 ~~keeping~~ the agency informed of the location of, the provider's
396 Medicaid-related records. The authority of the agency to obtain
397 Medicaid-related records from a provider is neither curtailed
398 nor limited during a period of litigation between the agency and
399 the provider.
400 (13) The agency shall ~~immediately~~ terminate participation
401 of a Medicaid provider in the Medicaid program and may seek
402 civil remedies or impose other administrative sanctions against
403 a Medicaid provider, if the provider or any principal, officer,
404 director, agent, managing employee, or affiliated person of the
405 provider, or any partner or shareholder having an ownership
406 interest in the provider equal to 5 percent or greater, has been
407 convicted of a criminal offense under federal law or the law of
408 any state relating to the practice of the provider's profession,
409 or a criminal offense listed under s. 409.907(10), s.
410 408.809(4), or s. 435.04(2) ~~has been:~~
411 ~~(a) Convicted of a criminal offense related to the~~
412 ~~delivery of any health care goods or services, including the~~
413 ~~performance of management or administrative functions relating~~
414 ~~to the delivery of health care goods or services;~~
415 ~~(b) Convicted of a criminal offense under federal law or~~
416 ~~the law of any state relating to the practice of the provider's~~
417 ~~profession; or~~
418 ~~(c) Found by a court of competent jurisdiction to have~~
419 ~~neglected or physically abused a patient in connection with the~~
420 ~~delivery of health care goods or services~~. If the agency

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421 determines that the ~~a~~ provider did not participate or acquiesce
422 in the ~~an~~ offense ~~specified in paragraph (a), paragraph (b), or~~
423 ~~paragraph (c),~~ termination will not be imposed. If the agency
424 effects a termination under this subsection, the agency shall
425 take final action ~~issue an immediate final order pursuant to s.~~
426 ~~120.569(2)(n)~~.
427 (15) The agency shall seek a remedy provided by law,
428 including, but not limited to, any remedy provided in
429 subsections (13) and (16) and s. 812.035, if:
430 (a) The provider's license has not been renewed, or has
431 been revoked, suspended, or terminated, for cause, by the
432 licensing agency of any state;
433 (b) The provider has failed to make available or has
434 refused access to Medicaid-related records to an auditor,
435 investigator, or other authorized employee or agent of the
436 agency, the Attorney General, a state attorney, or the Federal
437 Government;
438 (c) The provider has not furnished or has failed to make
439 available such Medicaid-related records as the agency has found
440 necessary to determine whether Medicaid payments are or were due
441 and the amounts thereof;
442 (d) The provider has failed to maintain medical records
443 made at the time of service, or prior to service if prior
444 authorization is required, demonstrating the necessity and
445 appropriateness of the goods or services rendered;
446 (e) The provider is not in compliance with provisions of
447 Medicaid provider publications that have been adopted by
448 reference as rules in the Florida Administrative Code; with

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449 provisions of state or federal laws, rules, or regulations; with
450 provisions of the provider agreement between the agency and the
451 provider; or with certifications found on claim forms or on
452 transmittal forms for electronically submitted claims that are
453 submitted by the provider or authorized representative, as such
454 provisions apply to the Medicaid program;
455 (f) The provider or person who ordered, authorized, or
456 prescribed the care, services, or supplies has furnished, or
457 ordered or authorized the furnishing of, goods or services to a
458 recipient which are inappropriate, unnecessary, excessive, or
459 harmful to the recipient or are of inferior quality;
460 (g) The provider has demonstrated a pattern of failure to
461 provide goods or services that are medically necessary;
462 (h) The provider or an authorized representative of the
463 provider, or a person who ordered, authorized, or prescribed the
464 goods or services, has submitted or caused to be submitted false
465 or a pattern of erroneous Medicaid claims;
466 (i) The provider or an authorized representative of the
467 provider, or a person who has ordered, authorized, or prescribed
468 the goods or services, has submitted or caused to be submitted a
469 Medicaid provider enrollment application, a request for prior
470 authorization for Medicaid services, a drug exception request,
471 or a Medicaid cost report that contains materially false or
472 incorrect information;
473 (j) The provider or an authorized representative of the
474 provider has collected from or billed a recipient or a
475 recipient's responsible party improperly for amounts that should
476 not have been so collected or billed by reason of the provider's

477 billing the Medicaid program for the same service;
478 (k) The provider or an authorized representative of the
479 provider has included in a cost report costs that are not
480 allowable under a Florida Title XIX reimbursement plan~~,~~ after
481 the provider or authorized representative had been advised in an
482 audit exit conference or audit report that the costs were not
483 allowable;
484 (l) The provider is charged by information or indictment
485 with fraudulent billing practices <u>or an offense referenced in</u>
486 <u>subsection (13)</u>. The sanction applied for this reason is limited
487 to suspension of the provider's participation in the Medicaid
488 program for the duration of the indictment unless the provider
489 is found guilty pursuant to the information or indictment;
490 (m) The provider or a person who ~~has~~ ordered<u>, authorized,</u>
491 or prescribed the goods or services is found liable for
492 negligent practice resulting in death or injury to the
493 provider's patient;
494 (n) The provider fails to demonstrate that it had
495 available during a specific audit or review period sufficient
496 quantities of goods, or sufficient time in the case of services,
497 to support the provider's billings to the Medicaid program;
498 (o) The provider has failed to comply with the notice and
499 reporting requirements of s. 409.907;
500 (p) The agency has received reliable information of
501 patient abuse or neglect or of any act prohibited by s. 409.920;
502 or
503 (q) The provider has failed to comply with an agreed-upon
504 repayment schedule.

505

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

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

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

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

528 (c) Imposition of a fine of up to $5,000 for each
529 violation. Each day that an ongoing violation continues, such as
530 refusing to furnish Medicaid-related records or refusing access
531 to records, is considered~~, for the purposes of this section, to~~
532 ~~be~~ a separate violation. Each instance of improper billing of a

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533 Medicaid recipient; each instance of including an unallowable
534 cost on a hospital or nursing home Medicaid cost report after
535 the provider or authorized representative has been advised in an
536 audit exit conference or previous audit report of the cost
537 unallowability; each instance of furnishing a Medicaid recipient
538 goods or professional services that are inappropriate or of
539 inferior quality as determined by competent peer judgment; each
540 instance of knowingly submitting a materially false or erroneous
541 Medicaid provider enrollment application, request for prior
542 authorization for Medicaid services, drug exception request, or
543 cost report; each instance of inappropriate prescribing of drugs
544 for a Medicaid recipient as determined by competent peer
545 judgment; and each false or erroneous Medicaid claim leading to
546 an overpayment to a provider is considered~~, for the purposes of~~
547 ~~this section, to be~~ a separate violation.

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

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

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

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

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561 (h) Comprehensive followup reviews of providers every 6
562 months to ensure that they are billing Medicaid correctly.
563 (i) Corrective-action plans that ~~would~~ remain in effect
564 ~~for providers~~ for up to 3 years and that are ~~would be~~ monitored
565 by the agency every 6 months while in effect.
566 (j) Other remedies as permitted by law to effect the
567 recovery of a fine or overpayment.
568
569 If a provider voluntarily relinquishes its Medicaid provider
570 number or an associated license, or allows the associated
571 licensure to expire after receiving written notice that the
572 agency is conducting, or has conducted, an audit, survey,
573 inspection, or investigation and that a sanction of suspension
574 or termination will or would be imposed for noncompliance
575 discovered as a result of the audit, survey, inspection, or
576 investigation, the agency shall impose the sanction of
577 termination for cause against the provider. The Secretary of
578 Health Care Administration may make a determination that
579 imposition of a sanction or disincentive is not in the best
580 interest of the Medicaid program, in which case a sanction or
581 disincentive may ~~shall~~ not be imposed.
582 (21) When making a determination that an overpayment has
583 occurred, the agency shall prepare and issue an audit report to
584 the provider showing the calculation of overpayments. The
585 agency's determination must be based solely upon information
586 available to it before issuance of the audit report and, in the
587 case of documentation obtained to substantiate claims for
588 Medicaid reimbursement, based solely upon contemporaneous

589 records.
590 (22) The audit report, supported by agency work papers,
591 showing an overpayment to a provider constitutes evidence of the
592 overpayment. A provider may not present or elicit testimony~~,~~
593 ~~either~~ on direct examination or cross-examination in any court
594 or administrative proceeding, regarding the purchase or
595 acquisition by any means of drugs, goods, or supplies; sales or
596 divestment by any means of drugs, goods, or supplies; or
597 inventory of drugs, goods, or supplies, unless such acquisition,
598 sales, divestment, or inventory is documented by written
599 invoices, written inventory records, or other competent written
600 documentary evidence maintained in the normal course of the
601 provider's business. A provider may not present records to
602 contest an overpayment or sanction unless such records are
603 contemporaneous and, if requested during the audit process, were
604 furnished to the agency or its agent upon request or were
605 furnished within 30 days after the provider received the final
606 audit report. This limitation does not apply to Medicaid cost
607 report audits. Notwithstanding the applicable rules of
608 discovery, all documentation to ~~that will~~ be offered as evidence
609 at an administrative hearing on a Medicaid overpayment or an
610 administrative sanction must be exchanged by all parties at
611 least 14 days before the administrative hearing or ~~must~~ be
612 excluded from consideration.
613 (25)(a) The agency shall withhold Medicaid payments, in
614 whole or in part, to a provider upon receipt of reliable
615 evidence that the circumstances giving rise to the need for a
616 withholding of payments involve fraud, willful

617 misrepresentation, or abuse under the Medicaid program, or a
618 crime committed while rendering goods or services to Medicaid
619 recipients. If it is determined that fraud, willful
620 misrepresentation, abuse, or a crime did not occur, the payments
621 withheld must be paid to the provider within 14 days after such
622 determination ~~with interest at the rate of 10 percent a year.~~
623 ~~Any money withheld in accordance with this paragraph shall be~~
624 ~~placed in a suspended account, readily accessible to the agency,~~
625 ~~so that any payment ultimately due the provider shall be made~~
626 ~~within 14 days~~.

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

632 (c) Overpayments owed to the agency bear interest at the
633 rate of 10 percent per year from the date of determination of
634 the overpayment by the agency, and payment arrangements must be
635 made <u>within 30 days after the date of the final order and are</u>
636 <u>not subject to further appeal</u> ~~at the conclusion of legal~~
637 ~~proceedings~~. ~~A provider who does not enter into or adhere to an~~
638 ~~agreed-upon repayment schedule may be terminated by the agency~~
639 ~~for nonpayment or partial payment.~~

640 (d) The agency, upon entry of a final agency order, a
641 judgment or order of a court of competent jurisdiction, or a
642 stipulation or settlement, may collect the moneys owed by all
643 means allowable by law, including, but not limited to, notifying
644 any fiscal intermediary of Medicare benefits that the state has

645 a superior right of payment. Upon receipt of such written
646 notification, the Medicare fiscal intermediary shall remit to
647 the state the sum claimed.
648 (e) The agency may institute amnesty programs to allow
649 Medicaid providers the opportunity to voluntarily repay
650 overpayments. The agency may adopt rules to administer such
651 programs.
652 (28) Venue for all Medicaid program integrity ~~overpayment~~
653 cases lies ~~shall lie~~ in Leon County, at the discretion of the
654 agency.
655 (29) Notwithstanding other provisions of law, the agency
656 and the Medicaid Fraud Control Unit of the Department of Legal
657 Affairs may review a person's or provider's Medicaid-related and
658 non-Medicaid-related records in order to determine the total
659 output of a provider's practice to reconcile quantities of goods
660 or services billed to Medicaid with quantities of goods or
661 services used in the provider's total practice.
662 (30) The agency shall terminate a provider's participation
663 in the Medicaid program if the provider fails to reimburse an
664 overpayment or pay an agency-imposed fine that has been
665 determined by final order, not subject to further appeal, within
666 30 ~~35~~ days after the date of the final order, unless the
667 provider and the agency have entered into a repayment agreement.
668 (31) If a provider requests an administrative hearing
669 pursuant to chapter 120, such hearing must be conducted within
670 90 days following assignment of an administrative law judge,
671 absent exceptionally good cause shown as determined by the
672 administrative law judge or hearing officer. Upon issuance of a

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673 final order, the outstanding balance of the amount determined to
674 constitute the overpayment and fines is ~~shall become~~ due. If a
675 provider fails to make payments in full, fails to enter into a
676 satisfactory repayment plan, or fails to comply with the terms
677 of a repayment plan or settlement agreement, the agency shall
678 withhold ~~medical assistance~~ reimbursement payments for Medicaid
679 services until the amount due is paid in full.
680 Section 4. Subsection (8) of section 409.920, Florida
681 Statutes, is amended to read:
682 409.920 Medicaid provider fraud.—
683 (8) A person who provides the state, any state agency, any
684 of the state's political subdivisions, or any agency of the
685 state's political subdivisions with information about fraud or
686 suspected fraudulent acts ~~fraud~~ by a Medicaid provider,
687 including a managed care organization, is immune from civil
688 liability for libel, slander, or any other relevant tort for
689 providing ~~the~~ information about fraud or suspected fraudulent
690 acts, unless the person acted with knowledge that the
691 information was false or with reckless disregard for the truth
692 or falsity of the information. Such immunity extends to reports
693 of fraudulent acts or suspected fraudulent acts conveyed to or
694 from the agency in any manner, including any forum and with any
695 audience as directed by the agency, and includes all discussions
696 subsequent to the report and subsequent inquiries from the
697 agency, unless the person acted with knowledge that the
698 information was false or with reckless disregard for the truth
699 or falsity of the information. For purposes of this subsection,
700 the term "fraudulent acts" includes actual or suspected fraud

701 and abuse, insurance fraud, licensure fraud, or public
702 assistance fraud, including any fraud-related matters that a
703 provider or health plan is required to report to the agency or a
704 law enforcement agency.
705 Section 5. This act shall take effect July 1, 2013.

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		

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1 Committee/Subcommittee hearing bill: Health Innovation
2 Subcommittee
3 Representative Pigman offered the following:
4
5 **Amendment (with title amendment)**
6 Remove everything after the enacting clause and insert:
7 Section 1. Paragraph (c) of subsection (3) of section
8 409.907, Florida Statutes, is amended, paragraph (k) is added to
9 that subsection, and subsections (6), (7), and (8) of that
10 section are amended, to read:
11 409.907 Medicaid provider agreements.—The agency may make
12 payments for medical assistance and related services rendered to
13 Medicaid recipients only to an individual or entity who has a
14 provider agreement in effect with the agency, who is performing
15 services or supplying goods in accordance with federal, state,
16 and local law, and who agrees that no person shall, on the
17 grounds of handicap, race, color, or national origin, or for any
18 other reason, be subjected to discrimination under any program
19 or activity for which the provider receives payment from the

20 agency.

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

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

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

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

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

48 ~~subsection, the term "outstanding overpayment" includes any~~
49 ~~amount identified in a preliminary audit report issued to the~~
50 ~~transferor by the agency on or before the effective date of the~~
51 ~~change of ownership.~~ In the event of a change of ownership for a
52 skilled nursing facility or intermediate care facility, the
53 Medicaid provider agreement shall be assigned to the transferee
54 if the transferee meets all other Medicaid provider
55 qualifications. In the event of a change of ownership involving
56 a skilled nursing facility licensed under part II of chapter
57 400, liability for all outstanding overpayments, administrative
58 fines, and any moneys owed to the agency before the effective
59 date of the change of ownership shall be determined in
60 accordance with s. 400.179.
61 (b) At least 60 days before the anticipated date of the
62 change of ownership, the transferor must ~~shall~~ notify the agency
63 of the intended change ~~of ownership~~ and the transferee must
64 ~~shall~~ submit to the agency a Medicaid provider enrollment
65 application. If a change of ownership occurs without compliance
66 with the notice requirements of this subsection, the transferor
67 and transferee are ~~shall be~~ jointly and severally liable for all
68 overpayments, administrative fines, and other moneys due to the
69 agency, regardless of whether the agency identified the
70 overpayments, administrative fines, or other moneys before or
71 after the effective date of the change ~~of ownership~~. The agency
72 may not approve a transferee's Medicaid provider enrollment
73 application if the transferee or transferor has not paid or
74 agreed in writing to a payment plan for all outstanding
75 overpayments, administrative fines, and other moneys due to the

76 agency. This subsection does not preclude the agency from
77 seeking any other legal or equitable remedies available to the
78 agency for the recovery of moneys owed to the Medicaid program.
79 In the event of a change of ownership involving a skilled
80 nursing facility licensed under part II of chapter 400,
81 liability for all outstanding overpayments, administrative
82 fines, and any moneys owed to the agency before the effective
83 date of the change of ownership shall be determined in
84 accordance with s. 400.179 if the Medicaid provider enrollment
85 application for change of ownership is submitted before the
86 change ~~of ownership~~.
87 (c) As used in this subsection, the term:
88 1. "Administrative fines" includes any amount identified
89 in a notice of a monetary penalty or fine which has been issued
90 by the agency or other regulatory or licensing agency that
91 governs the provider.
92 2. "Outstanding overpayment" includes any amount
93 identified in a preliminary audit report issued to the
94 transferor by the agency on or before the effective date of a
95 change of ownership.
96 (7) ~~The agency may require,~~ As a condition of
97 participating in the Medicaid program and before entering into
98 the provider agreement, the agency may require ~~that~~ the provider
99 to submit information, in an initial and any required renewal
100 applications, concerning the professional, business, and
101 personal background of the provider and permit an onsite
102 inspection of the provider's service location by agency staff or
103 other personnel designated by the agency to perform this

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

132 provider. A provider's bond need ~~shall~~ not exceed $50,000 if a
133 physician or group of physicians licensed under chapter 458,
134 chapter 459, or chapter 460 has a 50 percent or greater
135 ownership interest in the provider or if the provider is an
136 assisted living facility licensed under chapter 429. The bonds
137 permitted by this section are in addition to the bonds
138 referenced in s. 400.179(2)(d). If the provider is a
139 corporation, partnership, association, or other entity, the
140 agency may require the provider to submit information concerning
141 the background of that entity and of any principal of the
142 entity, including any partner or shareholder having an ownership
143 interest in the entity equal to 5 percent or greater, and any
144 treating provider who participates in or intends to participate
145 in Medicaid through the entity. The information must include:
146 (a) Proof of holding a valid license or operating
147 certificate, as applicable, if required by the state or local
148 jurisdiction in which the provider is located or if required by
149 the Federal Government.
150 (b) Information concerning any prior violation, fine,
151 suspension, termination, or other administrative action taken
152 under the Medicaid laws or~~,~~ rules~~, or regulations~~ of this state
153 or of any other state or the Federal Government; any prior
154 violation of the laws or~~,~~ rules~~, or regulations~~ relating to the
155 Medicare program; any prior violation of the rules ~~or~~
156 ~~regulations~~ of any other public or private insurer; and any
157 prior violation of the laws or~~,~~ rules~~, or regulations~~ of any
158 regulatory body of this or any other state.
159 (c) Full and accurate disclosure of any financial or

160 ownership interest that the provider, or any principal, partner,
161 or major shareholder thereof, may hold in any other Medicaid
162 provider or health care related entity or any other entity that
163 is licensed by the state to provide health or residential care
164 and treatment to persons.
165 (d) If a group provider, identification of all members of
166 the group and attestation that all members of the group are
167 enrolled in or have applied to enroll in the Medicaid program.
168 (8) ~~(a)~~ Each provider, or each principal of the provider if
169 the provider is a corporation, partnership, association, or
170 other entity, seeking to participate in the Medicaid program
171 must submit a complete set of his or her fingerprints to the
172 agency for the purpose of conducting a criminal history record
173 check. Principals of the provider include any officer, director,
174 billing agent, managing employee, or affiliated person, or any
175 partner or shareholder who has an ownership interest equal to 5
176 percent or more in the provider. However, for a hospital
177 licensed under chapter 395 or a nursing home licensed under
178 chapter 400, principals of the provider are those who meet the
179 definition of a controlling interest under s. 408.803. A
180 director of a not-for-profit corporation or organization is not
181 a principal for purposes of a background investigation ~~as~~
182 required by this section if the director: serves solely in a
183 voluntary capacity for the corporation or organization, does not
184 regularly take part in the day-to-day operational decisions of
185 the corporation or organization, receives no remuneration from
186 the not-for-profit corporation or organization for his or her
187 service on the board of directors, has no financial interest in

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

199 (a) This subsection does not apply to:

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

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

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

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

204 1.~~5.~~ A unit of local government, except that requirements
205 of this subsection apply to nongovernmental providers and
206 entities contracting with the local government to provide
207 Medicaid services. The actual cost of the state and national
208 criminal history record checks must be borne by the
209 nongovernmental provider or entity; or

210 2.~~6.~~ Any business that derives more than 50 percent of its
211 revenue from the sale of goods to the final consumer, and the
212 business or its controlling parent is required to file a form
213 10-K or other similar statement with the Securities and Exchange
214 Commission or has a net worth of $50 million or more.

215 (b) Background screening shall be conducted in accordance

216 with chapter 435 and s. 408.809. The cost of the state and
217 national criminal record check shall be borne by the provider.
218 ~~(c) Proof of compliance with the requirements of level 2~~
219 ~~screening under chapter 435 conducted within 12 months before~~
220 ~~the date the Medicaid provider application is submitted to the~~
221 ~~agency fulfills the requirements of this subsection.~~
222 Section 2. Subsections (9), (13), (15), (16), (21), (22),
223 (25), (28), (30), and (31) of section 409.913, Florida Statutes,
224 are amended to read:
225 409.913 Oversight of the integrity of the Medicaid
226 program.—The agency shall operate a program to oversee the
227 activities of Florida Medicaid recipients, and providers and
228 their representatives, to ensure that fraudulent and abusive
229 behavior and neglect of recipients occur to the minimum extent
230 possible, and to recover overpayments and impose sanctions as
231 appropriate. Beginning January 1, 2003, and each year
232 thereafter, the agency and the Medicaid Fraud Control Unit of
233 the Department of Legal Affairs shall submit a joint report to
234 the Legislature documenting the effectiveness of the state's
235 efforts to control Medicaid fraud and abuse and to recover
236 Medicaid overpayments during the previous fiscal year. The
237 report must describe the number of cases opened and investigated
238 each year; the sources of the cases opened; the disposition of
239 the cases closed each year; the amount of overpayments alleged
240 in preliminary and final audit letters; the number and amount of
241 fines or penalties imposed; any reductions in overpayment
242 amounts negotiated in settlement agreements or by other means;
243 the amount of final agency determinations of overpayments; the

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

272 (9) A Medicaid provider shall retain medical,
273 professional, financial, and business records pertaining to
274 services and goods furnished to a Medicaid recipient and billed
275 to Medicaid for 6 ~~a period of 5~~ years after the date of
276 furnishing such services or goods. The agency may investigate,
277 review, or analyze such records, which must be made available
278 during normal business hours. However, 24-hour notice must be
279 provided if patient treatment would be disrupted. The provider
280 must keep ~~is responsible for furnishing to the agency, and~~
281 ~~keeping~~ the agency informed of the location of~~,~~ the provider's
282 Medicaid-related records. The authority of the agency to obtain
283 Medicaid-related records from a provider is neither curtailed
284 nor limited during a period of litigation between the agency and
285 the provider.
286 (13) The agency shall ~~immediately~~ terminate participation
287 of a Medicaid provider in the Medicaid program and may seek
288 civil remedies or impose other administrative sanctions against
289 a Medicaid provider, if the provider or any principal, officer,
290 director, agent, managing employee, or affiliated person of the
291 provider, or any partner or shareholder having an ownership
292 interest in the provider equal to 5 percent or greater, has been
293 convicted of a criminal offense under federal law or the law of
294 any state relating to the practice of the provider's profession,
295 or a criminal offense listed under s. 408.809(4), s.
296 409.907(10), or s. 435.04(2) ~~has been:~~
297 ~~(a) Convicted of a criminal offense related to the~~
298 ~~delivery of any health care goods or services, including the~~
299 ~~performance of management or administrative functions relating~~

300 ~~to the delivery of health care goods or services;~~
301 ~~(b) Convicted of a criminal offense under federal law or~~
302 ~~the law of any state relating to the practice of the provider's~~
303 ~~profession; or~~
304 ~~(c) Found by a court of competent jurisdiction to have~~
305 ~~neglected or physically abused a patient in connection with the~~
306 ~~delivery of health care goods or services~~. If the agency
307 determines that the ~~a~~ provider did not participate or acquiesce
308 in the ~~an~~ offense ~~specified in paragraph (a), paragraph (b), or~~
309 ~~paragraph (c),~~ termination will not be imposed. If the agency
310 effects a termination under this subsection, the agency shall
311 take final agency action ~~issue an immediate final order pursuant~~
312 ~~to s. 120.569(2)(n)~~.
313 (15) The agency shall seek a remedy provided by law,
314 including, but not limited to, any remedy provided in
315 subsections (13) and (16) and s. 812.035, if:
316 (a) The provider's license has not been renewed, or has
317 been revoked, suspended, or terminated, for cause, by the
318 licensing agency of any state;
319 (b) The provider has failed to make available or has
320 refused access to Medicaid-related records to an auditor,
321 investigator, or other authorized employee or agent of the
322 agency, the Attorney General, a state attorney, or the Federal
323 Government;
324 (c) The provider has not furnished or has failed to make
325 available such Medicaid-related records as the agency has found
326 necessary to determine whether Medicaid payments are or were due
327 and the amounts thereof;

328 (d) The provider has failed to maintain medical records
329 made at the time of service, or prior to service if prior
330 authorization is required, demonstrating the necessity and
331 appropriateness of the goods or services rendered;
332 (e) The provider is not in compliance with provisions of
333 Medicaid provider publications that have been adopted by
334 reference as rules in the Florida Administrative Code; with
335 provisions of state or federal laws, rules, or regulations; with
336 provisions of the provider agreement between the agency and the
337 provider; or with certifications found on claim forms or on
338 transmittal forms for electronically submitted claims that are
339 submitted by the provider or authorized representative, as such
340 provisions apply to the Medicaid program;
341 (f) The provider or person who ordered, authorized, or
342 prescribed the care, services, or supplies has furnished, or
343 ordered or authorized the furnishing of, goods or services to a
344 recipient which are inappropriate, unnecessary, excessive, or
345 harmful to the recipient or are of inferior quality;
346 (g) The provider has demonstrated a pattern of failure to
347 provide goods or services that are medically necessary;
348 (h) The provider or an authorized representative of the
349 provider, or a person who ordered, authorized, or prescribed the
350 goods or services, has submitted or caused to be submitted false
351 or a pattern of erroneous Medicaid claims;
352 (i) The provider or an authorized representative of the
353 provider, or a person who has ordered, authorized, or prescribed
354 the goods or services, has submitted or caused to be submitted a
355 Medicaid provider enrollment application, a request for prior

356 authorization for Medicaid services, a drug exception request,
357 or a Medicaid cost report that contains materially false or
358 incorrect information;
359 (j) The provider or an authorized representative of the
360 provider has collected from or billed a recipient or a
361 recipient's responsible party improperly for amounts that should
362 not have been so collected or billed by reason of the provider's
363 billing the Medicaid program for the same service;
364 (k) The provider or an authorized representative of the
365 provider has included in a cost report costs that are not
366 allowable under a Florida Title XIX reimbursement plan~~,~~ after
367 the provider or authorized representative had been advised in an
368 audit exit conference or audit report that the costs were not
369 allowable;
370 (l) The provider is charged by information or indictment
371 with fraudulent billing practices <u>or an offense referenced in</u>
372 <u>subsection (13)</u>. The sanction applied for this reason is limited
373 to suspension of the provider's participation in the Medicaid
374 program for the duration of the indictment unless the provider
375 is found guilty pursuant to the information or indictment;
376 (m) The provider or a person who ~~has~~ ordered<u>, authorized,</u>
377 or prescribed the goods or services is found liable for
378 negligent practice resulting in death or injury to the
379 provider's patient;
380 (n) The provider fails to demonstrate that it had
381 available during a specific audit or review period sufficient
382 quantities of goods, or sufficient time in the case of services,
383 to support the provider's billings to the Medicaid program;

384 (o) The provider has failed to comply with the notice and
385 reporting requirements of s. 409.907;
386 (p) The agency has received reliable information of
387 patient abuse or neglect or of any act prohibited by s. 409.920;
388 or
389 (q) The provider has failed to comply with an agreed-upon
390 repayment schedule.
391
392 A provider is subject to sanctions for violations of this
393 subsection as the result of actions or inactions of the
394 provider, or actions or inactions of any principal, officer,
395 director, agent, managing employee, or affiliated person of the
396 provider, or any partner or shareholder having an ownership
397 interest in the provider equal to 5 percent or greater, in which
398 the provider participated or acquiesced.
399 (16) The agency shall impose any of the following
400 sanctions or disincentives on a provider or a person for any of
401 the acts described in subsection (15):
402 (a) Suspension for a specific period of time of not more
403 than 1 year. Suspension precludes ~~shall preclude~~ participation
404 in the Medicaid program, which includes any action that results
405 in a claim for payment to the Medicaid program for ~~as a result~~
406 ~~of~~ furnishing, supervising a person who is furnishing, or
407 causing a person to furnish goods or services.
408 (b) Termination for a specific period of time ranging ~~of~~
409 from more than 1 year to 20 years. Termination precludes ~~shall~~
410 ~~preclude~~ participation in the Medicaid program, which includes
411 any action that results in a claim for payment to the Medicaid

412 program <u>for</u> ~~as a result of~~ furnishing, supervising a person who
413 is furnishing, or causing a person to furnish goods or services.
414 (c) Imposition of a fine of up to $5,000 for each
415 violation. Each day that an ongoing violation continues, such as
416 refusing to furnish Medicaid-related records or refusing access
417 to records, is considered~~, for the purposes of this section, to~~
418 ~~be~~ a separate violation. Each instance of improper billing of a
419 Medicaid recipient; each instance of including an unallowable
420 cost on a hospital or nursing home Medicaid cost report after
421 the provider or authorized representative has been advised in an
422 audit exit conference or previous audit report of the cost
423 unallowability; each instance of furnishing a Medicaid recipient
424 goods or professional services that are inappropriate or of
425 inferior quality as determined by competent peer judgment; each
426 instance of knowingly submitting a materially false or erroneous
427 Medicaid provider enrollment application, request for prior
428 authorization for Medicaid services, drug exception request, or
429 cost report; each instance of inappropriate prescribing of drugs
430 for a Medicaid recipient as determined by competent peer
431 judgment; and each false or erroneous Medicaid claim leading to
432 an overpayment to a provider is considered~~, for the purposes of~~
433 ~~this section, to be~~ a separate violation.
434 (d) Immediate suspension, if the agency has received
435 information of patient abuse or neglect or of any act prohibited
436 by s. 409.920. Upon suspension, the agency must issue an
437 immediate final order under s. 120.569(2)(n).
438 (e) A fine, not to exceed $10,000, for a violation of
439 paragraph (15)(i).

440 (f) Imposition of liens against provider assets,
441 including, but not limited to, financial assets and real
442 property, not to exceed the amount of fines or recoveries
443 sought, upon entry of an order determining that such moneys are
444 due or recoverable.
445 (g) Prepayment reviews of claims for a specified period of
446 time.
447 (h) Comprehensive followup reviews of providers every 6
448 months to ensure that they are billing Medicaid correctly.
449 (i) Corrective-action plans that ~~would~~ remain in effect
450 ~~for providers~~ for up to 3 years and that are ~~would be~~ monitored
451 by the agency every 6 months while in effect.
452 (j) Other remedies as permitted by law to effect the
453 recovery of a fine or overpayment.
454
455 If a provider voluntarily relinquishes its Medicaid provider
456 number or an associated license, or allows the associated
457 licensure to expire after receiving written notice that the
458 agency is conducting, or has conducted, an audit, survey,
459 inspection, or investigation and that a sanction of suspension
460 or termination will or would be imposed for noncompliance
461 discovered as a result of the audit, survey, inspection, or
462 investigation, the agency shall impose the sanction of
463 termination for cause against the provider. The Secretary of
464 Health Care Administration may make a determination that
465 imposition of a sanction or disincentive is not in the best
466 interest of the Medicaid program, in which case a sanction or
467 disincentive may ~~shall~~ not be imposed.

468 (21) When making a determination that an overpayment has
469 occurred, the agency shall prepare and issue an audit report to
470 the provider showing the calculation of overpayments. The
471 agency's determination must be based solely upon information
472 available to it before issuance of the audit report and, in the
473 case of documentation obtained to substantiate claims for
474 Medicaid reimbursement, based solely upon contemporaneous
475 records.
476 (22) The audit report, supported by agency work papers,
477 showing an overpayment to a provider constitutes evidence of the
478 overpayment. A provider may not present or elicit testimony~~,~~
479 ~~either~~ on direct examination or cross-examination in any court
480 or administrative proceeding, regarding the purchase or
481 acquisition by any means of drugs, goods, or supplies; sales or
482 divestment by any means of drugs, goods, or supplies; or
483 inventory of drugs, goods, or supplies, unless such acquisition,
484 sales, divestment, or inventory is documented by written
485 invoices, written inventory records, or other competent written
486 documentary evidence maintained in the normal course of the
487 provider's business. A provider may not present records to
488 contest an overpayment or sanction unless such records are
489 contemporaneous and, if requested during the audit process, were
490 furnished to the agency or its agent upon request. This
491 limitation does not apply to Medicaid cost report audits.
492 Notwithstanding the applicable rules of discovery, all
493 documentation to ~~that will~~ be offered as evidence at an
494 administrative hearing on a Medicaid overpayment or an
495 administrative sanction must be exchanged by all parties at

496 least 14 days before the administrative hearing or ~~must~~ be
497 excluded from consideration.
498 (25)(a) The agency shall withhold Medicaid payments, in
499 whole or in part, to a provider upon receipt of reliable
500 evidence that the circumstances giving rise to the need for a
501 withholding of payments involve fraud, willful
502 misrepresentation, or abuse under the Medicaid program~~,~~ or a
503 crime committed while rendering goods or services to Medicaid
504 recipients. If it is determined that fraud, willful
505 misrepresentation, abuse, or a crime did not occur, the payments
506 withheld must be paid to the provider within 14 days after such
507 determination ~~with interest at the rate of 10 percent a year.~~
508 ~~Any money withheld in accordance with this paragraph shall be~~
509 ~~placed in a suspended account, readily accessible to the agency,~~
510 ~~so that any payment ultimately due the provider shall be made~~
511 ~~within 14 days~~. Amounts not paid within 14 days accrue interest
512 at the rate of 10 percent per year, beginning after the 14th
513 day.
514 (b) The agency shall deny payment, or require repayment,
515 if the goods or services were furnished, supervised, or caused
516 to be furnished by a person who has been suspended or terminated
517 from the Medicaid program or Medicare program by the Federal
518 Government or any state.
519 (c) Overpayments owed to the agency bear interest at the
520 rate of 10 percent per year from the date of final determination
521 of the overpayment by the agency, and payment arrangements must
522 be made within 30 days after the date of the final order, which
523 is not subject to further appeal ~~at the conclusion of legal~~

524 ~~proceedings~~. ~~A provider who does not enter into or adhere to an~~
525 ~~agreed-upon repayment schedule may be terminated by the agency~~
526 ~~for nonpayment or partial payment.~~
527 (d) The agency, upon entry of a final agency order, a
528 judgment or order of a court of competent jurisdiction, or a
529 stipulation or settlement, may collect the moneys owed by all
530 means allowable by law, including, but not limited to, notifying
531 any fiscal intermediary of Medicare benefits that the state has
532 a superior right of payment. Upon receipt of such written
533 notification, the Medicare fiscal intermediary shall remit to
534 the state the sum claimed.
535 (e) The agency may institute amnesty programs to allow
536 Medicaid providers the opportunity to voluntarily repay
537 overpayments. The agency may adopt rules to administer such
538 programs.
539 (28) Venue for all Medicaid program integrity ~~overpayment~~
540 cases <u>lies</u> ~~shall lie~~ in Leon County, at the discretion of the
541 agency.
542 (30) The agency shall terminate a provider's participation
543 in the Medicaid program if the provider fails to reimburse an
544 overpayment <u>or pay an agency-imposed fine</u> that has been
545 determined by final order, not subject to further appeal, within
546 <u>30</u> ~~35~~ days after the date of the final order, unless the
547 provider and the agency have entered into a repayment agreement.
548 (31) If a provider requests an administrative hearing
549 pursuant to chapter 120, such hearing must be conducted within
550 90 days following assignment of an administrative law judge,
551 absent exceptionally good cause shown as determined by the

552 administrative law judge or hearing officer. Upon issuance of a
553 final order, the outstanding balance of the amount determined to
554 constitute the overpayment and fines is ~~shall become~~ due. If a
555 provider fails to make payments in full, fails to enter into a
556 satisfactory repayment plan, or fails to comply with the terms
557 of a repayment plan or settlement agreement, the agency shall
558 withhold ~~medical assistance~~ reimbursement payments for Medicaid
559 services until the amount due is paid in full.
560 Section 3. Subsection (8) of section 409.920, Florida
561 Statutes, is amended to read:
562 409.920 Medicaid provider fraud.—
563 (8) A person who provides the state, any state agency, any
564 of the state's political subdivisions, or any agency of the
565 state's political subdivisions with information about fraud or
566 suspected fraudulent acts ~~fraud~~ by a Medicaid provider,
567 including a managed care organization, is immune from civil
568 liability for libel, slander, or any other relevant tort for
569 providing ~~the~~ information about fraud or suspected fraudulent
570 acts, unless the person acted with knowledge that the
571 information was false or with reckless disregard for the truth
572 or falsity of the information. Such immunity extends to reports
573 of fraudulent acts or suspected fraudulent acts conveyed to or
574 from the agency in any manner, including any forum and with any
575 audience as directed by the agency, and includes all discussions
576 subsequent to the report and subsequent inquiries from the
577 agency, unless the person acted with knowledge that the
578 information was false or with reckless disregard for the truth
579 or falsity of the information. For purposes of this subsection,

580 the term "fraudulent acts" includes actual or suspected fraud
581 and abuse, insurance fraud, licensure fraud, or public
582 assistance fraud, including any fraud-related matters that a
583 provider or health plan is required to report to the agency or a
584 law enforcement agency.
585 Section 4. Subsection (3) of section 624.351, Florida
586 Statutes, is amended, and subsection (8) is added to that
587 section, to read:
588 624.351 Medicaid and Public Assistance Fraud Strike
589 Force.—
590 (3) MEMBERSHIP.—The strike force shall consist of the
591 following 11 members or their designees. A designee shall serve
592 in the same capacity as the designating member ~~who may not~~
593 ~~designate anyone to serve in their place~~:
594 (a) The Chief Financial Officer, who shall serve as chair.
595 (b) The Attorney General, who shall serve as vice chair.
596 (c) The executive director of the Department of Law
597 Enforcement.
598 (d) The Secretary of Health Care Administration.
599 (e) The Secretary of Children and Family Services.
600 (f) The State Surgeon General.
601 (g) Five members appointed by the Chief Financial Officer,
602 consisting of two sheriffs, two chiefs of police, and one state
603 attorney. When making these appointments, the Chief Financial
604 Officer shall consider representation by geography, population,
605 ethnicity, and other relevant factors in order to ensure that
606 the membership of the strike force is representative of the
607 state as a whole.

608 (8) This section is repealed June 30, 2014, unless
609 reviewed and reenacted by the Legislature before that date.
610 Section 5. Subsection (3) is added to section 624.352,
611 Florida Statutes, to to read:
612 624.352 Interagency agreements to detect and deter
613 Medicaid and public assistance fraud.—
614 (3) This section is repealed June 30, 2014, unless
615 reviewed and reenacted by the Legislature before that date.
616 Section 6. This act shall take effect July 1, 2013.
617
618 ---
619 **T I T L E A M E N D M E N T**
620 Remove everything before the enacting clause and insert:
621 A bill to be entitled
622 An act relating to Medicaid fraud; amending s.
623 409.907, F.S.; increasing the number of years a
624 provider must keep records; adding an additional
625 provision relating to a change in principal that must
626 be included in a Medicaid provider agreement with the
627 Agency for Health Care Administration; adding
628 definitions for "administrative fines" and
629 "outstanding overpayment"; revising provisions
630 relating to the agency's onsite inspection
631 responsibilities; revising provisions relating to who
632 is subject to background screening; amending s.
633 409.913, F.S.; increasing the number of years a
634 provider must keep records; revising provisions
635 specifying grounds for terminating a provider from the

636 program, for seeking certain remedies for violations,
637 and for imposing certain sanctions; providing a
638 limitation on the information the agency may consider
639 when making a determination of overpayment; specifying
640 the type of records a provider must present to contest
641 an overpayment; deleting the requirement that the
642 agency place payments withheld from a provider in a
643 suspended account and revising when a provider must
644 reimburse overpayments; revising venue requirements;
645 adding provisions relating to the payment of fines;
646 amending s. 409.920, F.S.; clarifying provisions
647 relating to immunity from liability for persons who
648 provide information about Medicaid fraud; amending s.
649 624.351, F.S.; revising membership requirements for
650 the Medicaid and Public Assistance Fraud Strike Force
651 within the Department of Financial Services; providing
652 for future review and repeal; amending s. 624.352,
653 F.S., relating to interagency agreements to detect and
654 deter Medicaid and public assistance fraud; providing
655 for future review and repeal; providing an effective
656 date.

HB 1021

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1021 Background Screening
SPONSOR(S): Reed
TIED BILLS: **IDEN./SIM. BILLS:** SB 1112

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Guzzo	Shaw
2) Judiciary Committee			
3) Appropriations Committee			
4) Health & Human Services Committee			

SUMMARY ANALYSIS

In 2012, the Legislature created the Care Provider Background Screening Clearinghouse (Clearinghouse) to create a single program of screening individuals for criminal background checks prior to employment in certain health related service positions. The Clearinghouse is being implemented by six state agencies and final implementation is required to be completed by October 1, 2013. Designated agencies include the Agency for Health Care Administration (AHCA), the Department of Health, the Department of Children and Families, the Department of Elder Affairs, the Agency for Persons with Disabilities, and Vocational Rehabilitation within the Department of Education.

In anticipation of implementation of the Clearinghouse, the bill:

- Clarifies that employers must perform the registration and initiation of all criminal history background checks made through the Clearinghouse;
- Makes the requirement to submit a photo at the time of screening only to the Clearinghouse;
- Allows the Department of Highway Safety and Motor Vehicles to share driver's license photographs with AHCA's Background Screening Unit through an interagency agreement; and
- Specifies demographic information that must be submitted with a request for a criminal background check to verify proper identity as required for a federal check.

Additionally, the bill:

- Eliminates the three-year waiting period to apply for an exemption from disqualification for a criminal offense for individuals who have completed all monetary sanctions for a felony disqualifying offense, as long as all sanctions are paid or completed before eligibility for an exemption; and
- Updates the disqualifying offenses in chapter 435, F.S., to include criminal offenses involving theft that are similar to existing disqualifying offenses.

The bill does not appear to have a significant fiscal impact on state or local government.

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Previous Legislation

Florida has one of the largest vulnerable populations in the country with over 25% of the state's population over the age of 65, and many more children and disabled adults. These vulnerable populations require special care because they are at an increased risk of abuse.

In 1995, the Legislature created standard procedures for criminal history background screening of prospective employees, owners, operators, contractors, and volunteers. Chapter 435, F.S., outlines the screening requirements. In 2010, the Legislature substantially rewrote the requirements and procedures for background screening.[1] Major changes made by the 2010 legislation include:

- No person who is required to be screened may begin work until the screening has been completed.
- All Level 1[2] screenings were increased to Level 2[3] screenings.
- By July 1, 2012, all fingerprints submitted to the Florida Department of Law Enforcement (FDLE) must be submitted electronically.
- Certain personnel that were not being screened were required to begin Level 2 screening.
- The addition of serious crimes that disqualify an individual from employment working with vulnerable populations.
- Authorization for agencies to request the retention of fingerprints by FDLE.
- That an exemption for a disqualifying felony may not be granted until at least three years after the completion of all sentencing sanctions for that felony.
- That all exemptions from disqualification may be granted only by the agency head.

In 2012, the Legislature passed CS/CS/CS/HB 943, which created the Care Provider Background Screening Clearinghouse (Clearinghouse) to create a single "program" of screening individuals and allow for the results of criminal history checks of persons acting as covered care providers to be shared among the specified agencies. Designated agencies include the Agency for Health Care Administration (AHCA), the Department of Health, the Department of Children and Families, the Department of Elder Affairs, the Agency for Persons with Disabilities, and Vocational Rehabilitation within the Department of Education. Once a person's screening record is in the Clearinghouse, that person will avoid the need for any future state screens and related fees.

The Clearinghouse is in the process of being implemented by six designated state agencies and final implementation is required to be completed by October 1, 2013.

Current Background Screening Law

Florida licensure laws require providers licensed by AHCA to conduct Level II criminal background screening for:[4]

[1] Chapter 2010-114, L.O.F.
[2] Section 435.03, F.S. Level 1 screenings are name-based demographic screenings that must include, but are not limited to, employment history checks and statewide criminal correspondence checks through FDLE. Level 1 screenings may also include local criminal records checks through local law enforcement agencies. A person undergoing a Level 1 screening must not have been found guilty of any of the listed offenses.
[3] Section 435.04, F.S. A Level 2 screening consists of a fingerprint-based search of FDLE and the Federal Bureau of Investigation databases for state and national criminal arrest records. Any person undergoing a Level 2 screening must not have been found guilty of any of the listed offenses.

- The licensee;
- Administrators and financial officers;
- Staff of health care providers who offer residential and home care services that provide personal care services or have access to client property, funds or living areas; and
- Any person who is a controlling interest if there is reason to suspect they have committed a disqualifying criminal offense.

Current background screening standards in chapter 435, F.S., and s. 408.809, F.S., include various disqualifying offenses pertaining, but not limited to, domestic violence, patient brokering, criminal use of personal identification information, fraudulent use of credit cards, forgery, and possession/sale of illegal drugs.

There are some criminal offenses similar to current disqualifying offenses already in chapter 435, F.S., and s. 408.809, F.S., but they are not considered disqualifying offenses. For example, s. 408.809(4)(k), F.S., states that fraudulent use of credit cards, if the offense was a felony, as described in s.817.61, F.S., is a disqualifying offense. Under current background screening standards, obtaining goods by use of a false or expired credit, if the offense was a felony, as described in s. 817.841, F.S., is not considered a disqualifying offense.

The Department of Highway Safety and Motor Vehicles (DHSMV) has the authority to maintain a record of driver license photographs together with other data required for identification and retrieval.[5] The DHSMV also has the authority to share those photographs, through interagency agreements, with specific[6] state agencies.

Collecting photographs at the time of screening was an important part of implementing the Clearinghouse. The requirement to submit a photograph was added to law during the 2012 Legislative Session. However, instead of being in the Clearinghouse statute of s. 435.12, F.S., the requirement currently exists in the general Level 2 screening standards of s. 435.04(1)(e), F.S.

Designated agencies have the authority to grant exemptions from disqualification.[7] The exemptions enable people who have been convicted of a disqualifying criminal offense to present information as to why they should not be excluded from working with vulnerable individuals. The information includes, specifics of the offense, how long ago the offense occurred, work history, and rehabilitation. Current law states that an applicant who applies for an exemption for a felony offense must have had three years elapse since completion of any sentence or have been lawfully released from confinement, supervision, or sanction for the disqualifying felony.[8] The three-year waiting period would include even the smallest sanction, such as an unpaid balance of a fine. The requirement is similar for disqualifying misdemeanors, except that there is no specific time frame mandated post completion of being lawfully released from confinement, supervision, or sanction.

The term "sanction" does not currently have a formal definition in chapter 435, F.S. Numerous state agencies are bound by chapter 435, F.S., and the interpretation of the term "sanction" varies widely among the agencies.[9]

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[4] Section 408.809, F.S.

[5] Section 322.142(4), F.S.

[6] Section 322.142(4), F.S., provides that the Department of Highway Safety and Motor Vehicles may provide reproductions of the file or digital record to the Department of Business and Professional Regulation, the Department of State, the Department of Revenue, the Department of Children and Families, the Department of Financial Services, or to district medical examiners.

[7] Section 435.07, F.S.

[8] *Id.*

[9] HB 1021 Bill Analysis and Economic Impact Statement, Agency for Health Care Administration, at page 4, March 13, 2013 (on file with the Health Innovation Subcommittee).

Employers of individuals subject to screening by a specified agency are required to register with the Clearinghouse and maintain the employment status of all employees with the Clearinghouse for screenings conducted after the date the state agency begins participation in the Clearinghouse. Initial employment status and any change in status must be reported within 10 business days.[10] Currently, it is not a requirement that screenings be initiated through the Clearinghouse.

Effect of Proposed Changes

The bill amends ss. 408.809 and 435.04, F.S., to provide additional disqualifying offenses. The criminal offenses added include obtaining goods by use of false or expired credit cards, if the offense was a felony (s. 817.481, F.S.), fraudulently obtaining goods or services from a health care provider (s. 817.50, F.S.), racketeering (s. 895.03, F.S.), violating the Florida Money Laundering Act (s. 896.101, F.S.), and criminal offenses that involve attempts, solicitation, and conspiracy to commit an offense.[11]

The bill relocates language from s. 435.04(1)(e)2, F.S., to s. 435.12(2)(d), F.S. As a result, the submission of a photograph will be a requirement of the Clearinghouse, and not a requirement for all screenings conducted pursuant to chapter 435, F.S. This change will allow the agency to enter into an agreement with the DHSMV, to verify photographs of individuals that have been background screened through the Clearinghouse by comparing the submitted photograph to the driver's license photograph.

The amends s. 435.04(1)(e), F.S., to require vendors who submit fingerprints on behalf of employers to submit the necessary information required by law, or the state agency, in order to process the submission.

The bill modifies requirements relating to exemptions from disqualification. Some applicants who are otherwise qualified for an exemption are unaware of outstanding monetary sanctions related to their disqualifying offense until being notified by the agency. In some cases, the applicant's criminal case may have been closed for over a decade but the applicant may still have an outstanding monetary sanction related to the disqualifying offense. Once the outstanding monetary sanction has been paid, the applicant would not be eligible to be granted an exemption from disqualification for period of three years post completion of the sanction.

The bill amends s. 435.07, F.S., to delete the term "sanction", and replace it with "nonmonetary condition imposed by the court" to eliminate differing interpretations of the term sanction. Court ordered nonmonetary sanctions could include various types of community service and rehabilitation courses, such as anger management, theft prevention courses, and drug rehabilitation. Monetary sanctions that are court ordered could include any fee, fine, fund, lien, civil judgment, application, and costs of prosecution, trust or restitution. The bill would eliminate the three-year waiting period for individuals that have completed all monetary sanctions for a felony disqualifying offense. The three-year waiting period would still apply for any felony disqualifying offense where, confinement, supervision, or nonmonetary condition is involved. As a result, well qualified and rehabilitated employees will have an opportunity to gain lawful employment in the healthcare facilities licensed by AHCA.[12]

Finally, the bill requires screenings to be initiated and registered through the Clearinghouse prior to referring an employee or potential employee for electronic fingerprint submission. AHCA will be able to obtain information on the initiating facility and allow screening tracking updates to be sent to the initiating facility as the information becomes available.[13] Providers will be able to obtain screening results much faster than screenings not initiated through the Clearinghouse.[14]

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[10] Section 435.12(2), F.S.
[11] *See Supra* at FN 9.
[12] *Id.*
[13] *Id.*
[14] *Id.*

B. SECTION DIRECTORY:

Section 1: Amends s. 322.142, F.S., relating to color photographic or digital imaged licenses.
Section 2: Amends s. 408.809, F.S., relating to background screening prohibited offenses.
Section 3: Amends s. 435.04, F.S., relating to Level 2 screening standards.
Section 4: Amends s. 435.07, F.S., relating to exemptions from disqualification.
Section 5: Amends s. 435.12, F.S., relating to the Care Provider Background Screening Clearinghouse.
Section 6: Provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

No additional rule-making authority is necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to background screening; amending s.
3 322.142, F.S.; allowing the Department of Highway
4 Safety and Motor Vehicles to share driver license
5 photographs with the Agency for Health Care
6 Administration pursuant to an interagency agreement;
7 amending ss. 408.809 and 435.04, F.S.; adding
8 additional disqualifying offenses to background
9 screening provisions; amending s. 435.07, F.S.;
10 revising terminology; requiring that individuals
11 seeking an exemption from disqualification must have
12 completed all nonmonetary conditions imposed by the
13 court for the disqualifying felony; requiring that all
14 persons seeking an exemption from disqualification
15 have paid any court-ordered monetary penalty in full
16 before being eligible to apply; amending s. 435.12,
17 F.S.; requiring that a photograph of the person taken
18 at the time the fingerprints are processed be
19 submitted to the Care Provider Background Screening
20 Clearinghouse before submission of the electronic
21 fingerprints; requiring specified information to be
22 included with the initiation of the screening
23 registration within the clearinghouse; providing an
24 effective date.
25
26 Be It Enacted by the Legislature of the State of Florida:
27
28 Section 1. Subsection (4) of section 322.142, Florida

29 Statutes, is amended to read:
30 322.142 Color photographic or digital imaged licenses.—
31 (4) The department may maintain a film negative or print
32 file. The department shall maintain a record of the digital
33 image and signature of the licensees, together with other data
34 required by the department for identification and retrieval.
35 Reproductions from the file or digital record are exempt from
36 the provisions of s. 119.07(1) and shall be made and issued only
37 for departmental administrative purposes; for the issuance of
38 duplicate licenses; in response to law enforcement agency
39 requests; to the Department of Business and Professional
40 Regulation pursuant to an interagency agreement for the purpose
41 of accessing digital images for reproduction of licenses issued
42 by the Department of Business and Professional Regulation; to
43 the Department of State pursuant to an interagency agreement to
44 facilitate determinations of eligibility of voter registration
45 applicants and registered voters in accordance with ss. 98.045
46 and 98.075; to the Department of Revenue pursuant to an
47 interagency agreement for use in establishing paternity and
48 establishing, modifying, or enforcing support obligations in
49 Title IV-D cases; to the Department of Children and Family
50 Services pursuant to an interagency agreement to conduct
51 protective investigations under part III of chapter 39 and
52 chapter 415; to the Department of Children and Family Services
53 pursuant to an interagency agreement specifying the number of
54 employees in each of that department's regions to be granted
55 access to the records for use as verification of identity to
56 expedite the determination of eligibility for public assistance

57 and for use in public assistance fraud investigations; to the
58 Agency for Health Care Administration pursuant to an interagency
59 agreement for the purpose of verifying photographs in the Care
60 Provider Background Screening Clearinghouse authorized in s.
61 435.12; to the Department of Financial Services pursuant to an
62 interagency agreement to facilitate the location of owners of
63 unclaimed property, the validation of unclaimed property claims,
64 and the identification of fraudulent or false claims; or to
65 district medical examiners pursuant to an interagency agreement
66 for the purpose of identifying a deceased individual,
67 determining cause of death, and notifying next of kin of any
68 investigations, including autopsies and other laboratory
69 examinations, authorized in s. 406.011.
70 Section 2. Paragraphs (h) through (q) of subsection (4) of
71 section 408.809, Florida Statutes, are redesignated as
72 paragraphs (j) through (s), respectively, and new paragraphs (h)
73 and (i) are added to that subsection to read:
74 408.809 Background screening; prohibited offenses.—
75 (4) In addition to the offenses listed in s. 435.04, all
76 persons required to undergo background screening pursuant to
77 this part or authorizing statutes must not have an arrest
78 awaiting final disposition for, must not have been found guilty
79 of, regardless of adjudication, or entered a plea of nolo
80 contendere or guilty to, and must not have been adjudicated
81 delinquent and the record not have been sealed or expunged for
82 any of the following offenses or any similar offense of another
83 jurisdiction:
84 (h) Section 817.481, relating to obtaining goods by using

85 false, expired, etc., credit cards, if the offense was a felony.
86 (i) Section 817.50, relating to fraudulently obtaining
87 goods, services, etc., from a health care provider.
88 Section 3. Paragraphs (d) through (yy) of subsection (2)
89 of section 435.04, Florida Statutes, are redesignated as
90 paragraphs (e) through (zz), respectively, paragraph (e) of
91 subsection (1) of that section is amended, and a new paragraph
92 (d) is added to subsection (2) of that section, to read:
93 435.04 Level 2 screening standards.—
94 (1)
95 (e) Vendors who submit fingerprints on behalf of employers
96 must:
97 1. Meet the requirements of s. 943.053; and
98 2. Have the ability to communicate electronically with the
99 state agency accepting screening results from the Department of
100 Law Enforcement and provide the necessary information required
101 by law, or the agency, in order to process the submission ~~a~~
102 ~~photograph of the applicant taken at the time the fingerprints~~
103 ~~are submitted~~.
104 (2) The security background investigations under this
105 section must ensure that no persons subject to the provisions of
106 this section have been arrested for and are awaiting final
107 disposition of, have been found guilty of, regardless of
108 adjudication, or entered a plea of nolo contendere or guilty to,
109 or have been adjudicated delinquent and the record has not been
110 sealed or expunged for, any offense prohibited under any of the
111 following provisions of state law or similar law of another
112 jurisdiction:

113 (d) Section 777.04, relating to attempts, solicitation,
114 and conspiracy to commit an offense.
115 Section 4. Subsections (1) and (2) of section 435.07,
116 Florida Statutes, are amended to read:
117 435.07 Exemptions from disqualification.—Unless otherwise
118 provided by law, the provisions of this section apply to
119 exemptions from disqualification for disqualifying offenses
120 revealed pursuant to background screenings required under this
121 chapter, regardless of whether those disqualifying offenses are
122 listed in this chapter or other laws.
123 (1)(a) The head of the appropriate agency may grant to any
124 employee otherwise disqualified from employment an exemption
125 from disqualification for:
126 1.(a) Felonies for which at least 3 years have elapsed
127 since the applicant for the exemption has completed or been
128 lawfully released from confinement, supervision, or nonmonetary
129 condition imposed by the court sanction for the disqualifying
130 felony;
131 2.(b) Misdemeanors prohibited under any of the statutes
132 cited in this chapter or under similar statutes of other
133 jurisdictions for which the applicant for the exemption has
134 completed or been lawfully released from confinement,
135 supervision, or nonmonetary condition imposed by the court
136 sanction;
137 3.(c) Offenses that were felonies when committed but that
138 are now misdemeanors and for which the applicant for the
139 exemption has completed or been lawfully released from
140 confinement, supervision, or nonmonetary condition imposed by

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

141 <u>the court</u> ~~sanction~~; or

142 <u>4.</u>~~(d)~~ Findings of delinquency. For offenses that would be
143 felonies if committed by an adult and the record has not been
144 sealed or expunged, the exemption may not be granted until at
145 least 3 years have elapsed since the applicant for the exemption
146 has completed or been lawfully released from confinement,
147 supervision, or <u>nonmonetary condition imposed by the court</u>
148 ~~sanction~~ for the disqualifying offense.

149 <u>(b) A person who wishes to apply for an exemption who was</u>
150 <u>ordered to pay any amount for any fee, fine, fund, lien, civil</u>
151 <u>judgment, application, costs of prosecution, trust, or</u>
152 <u>restitution as part of the judgment and sentence for any</u>
153 <u>disqualifying felony or misdemeanor must have paid the court-</u>
154 <u>ordered amount in full before being eligible for an exemption;</u>
155

156 For the purposes of this subsection, the term "felonies" means
157 both felonies prohibited under any of the statutes cited in this
158 chapter or under similar statutes of other jurisdictions.

159 (2) Persons employed, or applicants for employment, by
160 treatment providers who treat adolescents 13 years of age and
161 older who are disqualified from employment solely because of
162 crimes under s. 817.563, s. 893.13, or s. 893.147 may be
163 exempted from disqualification from employment pursuant to this
164 chapter without application of the waiting period in
165 <u>subparagraph (1)(a)1.</u> paragraph ~~(1)(a)~~.

166 Section 5. Subsection (2) of section 435.12, Florida
167 Statutes, is amended to read:

168 435.12 Care Provider Background Screening Clearinghouse.—

CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

169 (2)(a) To ensure that the information in the clearinghouse
170 is current, the fingerprints of an employee required to be
171 screened by a specified agency and included in the clearinghouse
172 must be:
173 1. Retained by the Department of Law Enforcement pursuant
174 to s. 943.05(2)(g) and (h) and (3), and the Department of Law
175 Enforcement must report the results of searching those
176 fingerprints against state incoming arrest fingerprint
177 submissions to the Agency for Health Care Administration for
178 inclusion in the clearinghouse.
179 2. Resubmitted for a Federal Bureau of Investigation
180 national criminal history check every 5 years until such time as
181 the fingerprints are retained by the Federal Bureau of
182 Investigation.
183 3. Subject to retention on a 5-year renewal basis with
184 fees collected at the time of initial submission or resubmission
185 of fingerprints.
186 <u>4. Submitted with a photograph of the person taken at the</u>
187 <u>time the fingerprints are submitted.</u>
188 (b) Until such time as the fingerprints are retained at
189 the Federal Bureau of Investigation, an employee with a break in
190 service of more than 90 days from a position that requires
191 screening by a specified agency must submit to a national
192 screening if the person returns to a position that requires
193 screening by a specified agency.
194 (c) An employer of persons subject to screening by a
195 specified agency must register with the clearinghouse and
196 maintain the employment status of all employees within the

197 clearinghouse. Initial employment status and any changes in
198 status must be reported within 10 business days.
199 (d) An employer must register and initiate all criminal
200 history checks through the clearinghouse before referring an
201 employee or potential employee for electronic fingerprint
202 submission to the Department of Law Enforcement. The
203 registration must include the employee's full name (first,
204 middle, last), social security number, date of birth, mailing
205 address, sex, and race.
206 Section 6. This act shall take effect July 1, 2013.

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 ___

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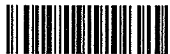
1 Committee/Subcommittee hearing bill: Health Innovation
2 Subcommittee
3 Representative Reed offered the following:
4
5 **Amendment (with directory and title amendments)**
6 Between lines 87 and 88, insert:
7 (t) Section 895.03, relating to racketeering and illegal
8 debts.
9 (u) Section 896.101, relating to the Florida Money
10 Laundering Act.
11
12 Remove lines 100-101 and insert:
13 Law Enforcement and provide the first, middle and last name,
14 social security number, date of birth, mailing address, sex, and
15 race of the applicant ~~a~~
16
17
18
19 ---
20 **D I R E C T O R Y A M E N D M E N T**



21 Remove line 73 and insert:

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

23

24

25

26 ---

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

28 Remove lines 7-9 and insert:

29 amending s. 408.809, F.S.; adding additional disqualifying

30 offenses to background screening provisions; amending s. 435.04,

31 F.S.; requiring certain identifying information to be included

32 for background checks submitted to the FBI; amending s. 435.07,

33 F.S.;

34

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1109 Transitional Living Facilities
SPONSOR(S): Magar
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Guzzo	Shaw
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Transitional Living Facilities (TLFs) provide specialized health care services including, but not limited to, rehabilitative services, community re-entry training, aids for independent living, and counseling to individuals who sustain brain or spinal cord injuries. The bill consolidates the oversight, care and services of clients of TLFs under specific licensure requirements of the Agency for Health Care Administration (AHCA).

The bill promotes coordination between various state agencies involved in the regulation of TLFs by requiring AHCA, the Department of Health, the Agency for Persons with Disabilities, and the Department of Children and Families to develop an electronic database to ensure relevant client data is communicated timely and effectively.

Specifically, the bill makes the following changes:

- Adds specific admission and discharge requirements and clarifies what constitutes an “appropriate” and an “inappropriate” client for a TLF;
- Adds care and service plan requirements detailing orders for medical care, client functional capability and goals, and transition plans;
- Requires TLFs to provide specific professional services directed toward improving the client’s functional status;
- Enables TLF clients to manage their funds and personal possessions, have visitors, and present grievances as appropriate;
- Provides standards for medication management, use of restraints, infection control, safeguards for clients’ funds, and emergency preparedness;
- Adds provisions to protect clients from abuse including, proper staff screening, training, prevention, identification, and investigation;
- Provides AHCA the authority to develop rules for physical plant standards, personnel, and services to clients;
- Creates sanctions for violations and provides authority to place a court-ordered receiver if the licensee fails to take responsibility for the facility and places clients at risk;
- Provides standard licensure criteria, including compliance with local zoning, liability insurance, fire-safety inspection, and sanitation requirements; and
- Revises the Brain and Spinal Cord Injury Advisory Council’s rights to entry and inspection of TLFs.

The bill has an insignificant negative fiscal impact related to implementation and maintenance of the electronic database. (see fiscal comments)

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Transitional living facilities provide specialized health care services, including, but not limited to, rehabilitative services, community reentry training, aids for independent living, and counseling to spinal-cord-injured persons and head-injured persons.[1] There are currently thirteen transitional living facilities licensed in Florida.[2] The Agency is the licensing authority and one of the regulatory authorities that oversee transitional living facilities pursuant to chapter 408, part II, chapter 400, part V, F.S., and Rule 59A-17, F.A.C. The current licensure fee is $4,588.00 with a $90 per bed fee per biennium.[3]

AHCA governs the physical plant and fiscal management of these facilities and adopts rules, along with DOH, which monitors services for persons with traumatic brain and spinal cord injuries. Investigations concerning allegations of abuse and neglect of children and vulnerable adults are performed by DCF.

Section 400.805, F.S., mandates requirements for transitional living facilities. Section 400.805(2), F.S., provides the licensure requirements and fees for operation of a transitional living facility as well as level 2 background screening requirements for all TLF personnel. Section 400.805(3)(a) requires AHCA, in consultation with DOH, to adopt rules governing the physical plant and the fiscal management of transitional living facilities.

Compared to other types of facilities regulated by AHCA, the detail and scope of regulations for TLFs is significantly narrower and less restrictive, as it focuses more on solvency than resident care.

Recent investigations conducted by AHCA, in conjunction with DCF and DOH, have resulted in findings of instances where TLFs are providing care to a large number of clients who do not have an appropriate diagnosis of spinal cord injured or head injured.[4]

State agencies involved in the regulation of TLFs strive to maintain a level of coordination sufficient to provide quality care to clients of TLFs. AHCA is responsible for the licensure of TLFs, while DOH monitors services for persons with traumatic brain and spinal cord injuries, and DCF investigates allegations of abuse and neglect of children and vulnerable adults. In working together during the recent investigations, gaps and deficiencies were discovered in the TLF regulatory structure.

The Brain and Spinal Cord Injury Program (BSCIP) is administered through DOH. Services provided by the BSCIP include:

- Case management;
- Acute care, and inpatient and outpatient rehabilitation;
- Transitional living;
- Assistive technology;

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[1] Section 400.805(1)(c), F.S.

[2] HB 1109 Bill Analysis, Economic Impact Statement, Agency for Health Care Administration, at page 1, March 15, 2013 (on file with the Health Innovation subcommittee).

[3] *Id.; See* also sections 400.805(2)(b), and 408.805(2), F.S. (the fees contained in ch. 400, F.S., do not reflect the current fees, pursuant to s. 408.805(2), F.S., fees may be adjusted annually not more than the change in consumer price index based on the 12 months immediately preceding the increase).

[4] Agency for Health Care Administration, Statement of Deficiencies and Plan of Correction (*August 3, 2012)*, available at http://www.upps.ahca.myflorida.com/dm_web/(s(ner1fpywccezpxoyuqpyogfn))/doc_results.aspx?file_number=35930769&provider_type=TRANSITIONAL+LIVING+FACILITY++&client_code=34&provider_name=FLORIDA+INSTITUTE+FOR+NEUROLOGIC+REHAB%2c+INC&lic_id=28343 (last viewed March 17, 2013).

- Home and vehicle modifications;
- Nursing home transition facilitation; and
- Long-term support for survivors and families through contractual agreements with community based agencies.

Section 381.76, F.S., provides that an individual must be a legal Florida resident who has sustained a moderate to severe traumatic brain or spinal cord injury meeting the state's definition of such injuries to be eligible for services. The State definition of a "brain injury" is an insult to the skull, brain or its covering, resulting from external trauma, which produces an altered state of consciousness or anatomic, motor, sensory, cognitive or behavioral deficit. The current definition of a TLF does not incorporate the term "brain injured". Instead, it refers to the provision of specialized services to spinal-cord-injured persons and *head-injured persons.* The term "head-injured" may allow for a broad interpretation of the word in determining if an individual is appropriate for placement in a TLF.

The Brain and Spinal Cord Injury Advisory Council has rights to entry and inspection of transitional living facilities granted under section 400.805(4), F.S.

Effect of Proposed Changes

The bill consolidates the oversight of care and services of clients of TLFs under specific licensure requirements of AHCA and promotes coordination between AHCA, DOH, APD, DCF, and the Brain and Spinal Cord Injury Program.

This bill repeals the current TLF regulations in s. 400.805, F.S. and creates Part XI of chapter 400, to include ss. 400.9970-400.9984, F.S.

This bill creates s. 400.9970, F.S., and states the intent of the legislation is to provide for the development, establishment and enforcement of basic standards for TLFs to ensure quality of care and services to residents.

Section 400.9971 is created to define terms relating to TLFs, and adds new terminology to include chemical and physical restraints and their use.

Section 400.9972, F.S., is created to provide licensure requirements for TLFs, including compliance with local zoning, liability insurance, fire-safety inspection, and sanitation requirements. This section also provides the application fees for TLFs and adds language to clarify that the fees must be adjusted to conform with the annual cost of living adjustment, pursuant to s. 408.805(2), F.S.

<u>Admission, Transfer and Discharge Requirements</u>

The bill creates s. 400.9973, F.S. to establish requirements that TLFs must have in place for client admission, transfer and discharge from the facility. The facility is required to have admission, transfer and discharge policies and procedures in writing. The client's admission to the facility must be under the supervision of the administrator or designee and must be in line with facility policies and procedures.

Each resident admitted to the facility is required to be admitted upon prescription by a licensed physician and must remain under the care of the physician for the duration of the client's stay in the facility. Clients admitted to the facility must have a brain and spinal cord injury, as defined in section 381.745(2), F.S.[5]

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[5] Brain or spinal cord injury means a lesion to the spinal cord or cauda equina, resulting from external trauma, with evidence of significant involvement of two of the following deficits or dysfunctions: Motor deficit; Sensory deficit; or Bowel and bladder dysfunction. And an insult to the skull, brain, or its covering, resulting from external trauma that produces an altered state of consciousness or anatomic motor, sensory, cognitive, or behavioral deficits.

Clients admitted to the TLF must not present significant risk of infection to other clients or personnel. Documentation must be provided indicating the person is free of apparent signs and symptoms of communicable disease. The client must not be a danger to self or others as determined by a physician. Clients requiring mental health treatment or nursing supervision on a 24-hour basis or bedridden must not be admitted to the facility.

Upon a client meeting the admission criteria, the medical or nursing director must implement a preadmission plan stating the services the facility will be providing to the client. The facility must provide adequate notice to clients of a discharge or transfer plan which includes the appropriate transfer location if the client is not independent. If the client terminates the residency, a transfer or discharge plan is not required.

Individual Program Plans and Client Services

The bill creates s. 400.9974, F.S., to require each client in the facility to have an individual program plan which is developed by an interdisciplinary team, consisting of persons who possess the knowledge, skills, and expertise necessary to accurately identify the client's needs, design appropriate services and specialized programs responsive to those needs, and must include the client and the client's representative in plan development. The program plan must be completed prior to admission and every 30 days thereafter. If a significant change in the client's condition occurs, reevaluation must occur. The facility must have qualified staff to carry out and monitor interventions in accordance with the stated goals of the individual's program plan.

Each Individual program plan must include the following:

- Physician's orders, diagnosis, medical history, physical exams and rehab needs;
- A preliminary nursing evaluation with physician orders for immediate care to be completed upon admission;
- A standardized assessment of the client's functional capability; and
- A plan to achieve transition to the community within 90 days of admission.

Provider Responsibilities

The bill creates s. 400.9975, F.S., to require TLF licensees to ensure that every client:

- Lives in a safe environment;
- Is treated with respect, recognition of personal dignity and privacy;
- Retains use of their own clothes and personal property;
- Has unrestricted private communications which includes mail, telephone and visitors,
- Participates in community services and activities;
- Manages their financial affairs unless the client or the client's representative authorizes the administrator of the facility to provide safekeeping for funds;
- Has reasonable opportunity for regular exercise and be outdoors several times a week.
- Exercises civil and religious liberties;
- Has adequate access and appropriate health care services;
- Has the ability to present grievances and recommend changes in policies, procedures and services;
- Is enabled to have a representative participate in the process of treatment for the client;
- Receives prompt responses from the facility to communications from family and friends;
- Have visits by individuals with a relationship to the client and any reasonable hour; and
- Has the opportunity to leave the facility to visit, take trips or vacations.

Additionally, the client's representative must be promptly notified of any significant incidents or changes in the client's condition.

The administrator is required to ensure a written notice of provider responsibilities is posted in a prominent place in the facility which includes the statewide toll-free telephone number for reporting complaints to the AHCA and the statewide toll-free number of Disability Rights of Florida. The facility must ensure the client has access to a telephone to call the AHCA, central abuse hotline, Disabilities Rights of Florida and the local advocacy council. The facility cannot take retaliatory action against a client for filing a complaint or grievance.

Medication Practices

The bill creates s. 400.9976, F.S., to require TLFs to maintain a medication administration record for each client, and for each dose, including medications that are self-administered. All medications, including those that are self-administered, must be administered as ordered by the physician. Drug administration errors and adverse drug reactions must be recorded and reported immediately to the physician. The interdisciplinary team determines if a client is capable of self-administration of medications.

Client Protection

The bill creates s. 400.9977, F.S., to establish provisions relating to the protection of clients from abuse, neglect, mistreatment, and exploitation. The bill provides that the facility is responsible for developing and implementing policies and procedures for screening and training employees, protection of clients and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and exploitation. The facility is also required to identify clients whose history renders them at risk for abusing other clients. Further, the bill requires facilities to implement procedures to:

- Screen potential employees for a history of abuse, neglect or mistreatment of client;
- Train employees through orientation and on-going sessions on abuse prohibition practices;
- Implement procedures to provide clients, families and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retribution;
- Implement procedures to identify events such as suspicious bruising of clients that may constitute abuse to determine the direction of the investigation;
- Investigate different types of incidents and identify staff members responsible for the initial reporting and reporting of results to the proper authorities;
- Protect clients from harm during an investigation; and
- Report all alleged violations and all substantiated incidents as required under chapters 39 and 415, F.S., and to the appropriate licensing authorities.

The facility must identify, correct, and intervene in situations in which abuse, neglect, mistreatment or exploitation is likely to occur, including, the physical environment that makes abuse and/or neglect more likely to occur, such as secluded areas.

The facility is required to have a sufficient number of staff to meet the needs of the clients, and must assure that staff has knowledge of the individual client's care needs. The facility must analyze the occurrences of abuse, exploitation, mistreatment or neglect and determine what changes are needed to policies and procedures to prevent further occurrences.

Restraints and Seclusion

The bill creates s. 400.9978, F.S., to require physical and chemical restraints to be, ordered and documented, by the client's physician, with the consent of the client or client's representative. The bill provides that the use of chemical restraints is limited to the prescribed dosage of medications by the

client's physician. Clients receiving medications that can serve as a restraint must be evaluated by their physician at least monthly to assess the:

- Continued need for the medication;
- Level of the medication in client's blood; and
- Need for adjustments in the prescription.

The facility is required to ensure that clients are free from unnecessary drugs and physical restraints. All interventions to manage inappropriate client behaviors must be administered with sufficient safeguards and supervision.

Background Screening and Administration/Management

The bill creates s. 400.9979, F.S., to require all facility personnel to complete a level 2 background screening as required in s. 408.809(1)(e), F.S. pursuant to Chapter 435. The facility must maintain personnel records which contain the staff's background screening, job description, documentation of compliance with training requirements, and a copy of all licenses or certifications held by staff who perform services for which licensure or certification is required. The record must also include a copy of all job performance evaluations.

The bill requires the facility to:

- Implement infection control policies and procedures.
- Maintain liability insurance as defined by section 624.605, F.S., at all times.
- Designate one person as administrator who is responsible for the overall management of the facility.
- Designate in writing a person responsible for the facility when the administrator is absent for 24 hours.
- Obtain approval of the comprehensive emergency management plan from their local emergency management agency.
- Maintain written records in a form and system in accordance with medical and business practices and be available for submission to AHCA upon request. The records must include:
  - A daily census record;
  - A report of all accident or unusual incidents involving clients or staff members that caused or had the potential to cause injury or harm to any person or property within the facility;
  - Agreements with third party providers; and
  - Agreements with consultants employed by the facility and documentation of each consultant's visits and required written, dated reports.

Property and Personal Affairs of Clients

The bill creates s. 400.9980, F.S., to require facilities to give clients options of using their own personal belongings, and to choose their own roommate whenever possible. The bill provides that the admission of a client to a facility, and their presence therein, shall not confer on a licensee, administrator, employee, or representative any authority to manage, use, or dispose of any property of the client. The licensee, administrator employee or representative may not act as the client's guardian, trustee, payee for social security or other benefits. The licensee, administrator, employee or representative may act as the power of attorney for a client if the licensee has filed a surety bond with AHCA in an amount equal to twice the average monthly income of the client. When the power of attorney is granted to the licensee, administrator, staff, or representative, they must notify the client on a monthly basis of any transactions made on their behalf and a copy of such statement given to the client must be retained in the client's file and be available for inspection.

The bill requires the facility to, upon consent from the client, provide for the safekeeping of personal effects. The personal effects may not be in excess of $1,000 and funds of the client may not be in excess of $500 in cash, and the facility must keep complete and accurate records of all funds and personal effects received.

The bill provides that for any funds or other property belonging to or due to a client, such funds shall be trust funds which shall be kept separate from the funds and property of the licensee or shall be specifically credited to the client. At least once every month, unless upon order of a court of competent jurisdiction, the facility must furnish the client and the client's representative a complete and verified statement of all funds and other property, detailing the amount and items received, together with their sources and disposition.

The bill provides that any licensee, administrator, or staff, 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.

In the event of the death of a client, the facility must return all refunds, funds, and property held in trust to the client's personal representative. If the client has no spouse or adult next of kin or such person cannot be located, funds due the client must 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.

The bill authorizes AHCA to adopt rules to clarify terms and specify procedures and documentation necessary to administer the provisions relating to the proper management of clients' funds and personal property and the execution of surety bonds.

Rules Establishing Standards

The bill creates s. 400.9981, F.S., to authorize AHCA to publish and enforce rules, which include criteria to ensure reasonable and consistent quality of care and client safety. Further, the bill authorizes AHCA in consultation with DOH, to adopt and enforce rules which must include reasonable and fair criteria in relation to the:

- Location of TLFs;
- Qualifications of all personnel having responsibility for any part of the client's care and services;
- Requirements for personnel procedures, insurance coverage, and reporting procedures;
- Services provided to clients; and the
- Preparation and annual update of a comprehensive emergency management plan.

Penalties and Violations

The bill creates s. 400.9982, F.S., to authorize AHCA to adopt rules to enforce penalties, and require AHCA to classify each violation according to the nature of the violation and the gravity of its probable effect on the client. The classification of violations, as defined in s. 408.813, F.S., must be included on the written notice of the violation in the following categories:

- Class "I" violations will result in issuance of a citation regardless of correction and impose an administrative fine up to $10,000 for a widespread violation.
- Class "II" violations will result in an administrative fine up to $5,000 for a widespread violation.
- Class "III" violations will result in an administrative fine up to $1,000 for an uncorrected deficiency of a widespread violation.
- Class "IV" violations will result in an administrative fine not less than $100 and not exceeding $200 for an uncorrected deficiency.

Receivership Proceedings

The bill creates s. 400.9983, F.S., to authorize AHCA to petition a court for the appointment of a receiver when any of the following conditions exist:

- The facility is closing or has informed the Agency that it intends to close;
- The Agency determines the conditions exit in the facility that presents danger to the health, safety or welfare of the clients of the facility; or
- The facility cannot meet its financial obligation for providing food, shelter, care and utilities.

The bill provides that petitions for receivership take priority over other court business. A hearing must be conducted within five days of the petition filing. AHCA must notify the owner or administrator of the facility named in the petition and the date of the hearing. The court may grant the petition only upon a finding that the health, safety or welfare of the client is threatened if a condition existing at the time the petition was filed is allowed to continue.

A receiver may be appointed from a list of qualified persons developed by AHCA. The receiver must make provisions for the continued health, safety and welfare of all clients and perform all duties set out by the court. The receiver must operate the facility to assure the safety and adequate health care for the clients. The receiver may use all resources and consumable goods in the provision of care services to the client and correct or eliminate any deficiency in the structure or furnishings of the facility which endangers the safety of clients and staff. The receiver may hire or contract staff to carry out the duties of the receiver. The receiver must also honor all leases and mortgages, and has the power to direct and manage, and to discharge employees of the facility.

Interagency Communication

The bill creates s. 400.9984, F.S., to require AHCA, DOH, APD, and DCF to develop an electronic database to ensure relevant data pertaining to the regulation of TLFs is communicated timely among the agencies for the protection of clients. The bill requires the system to include a brain and spinal cord injury registry and a client abuse registry.

B. SECTION DIRECTORY:

Section 1: Designates ss. 400.9970 through 400.9984, F.S., as part XI of chapter 400, to be entitled "Transitional Living Facilities.
Section 2: Creates s. 400.9970, F.S., providing legislative intent.
Section 3: Creates s. 400.9971, F.S., providing definitions relating to transitional living facilities.
Section 4: Creates s. 400.9972, F.S., relating to required licensure; fees; and applications.
Section 5: Creates s. 400.9973, F.S., relating to client admission, transfer, and discharge.
Section 6: Creates s. 400.9974, F.S., relating to individual program plans; and client services.
Section 7: Creates s. 400.9975, F.S., relating to licensee responsibilities.
Section 8: Creates s. 400.9976, F.S., relating to medication practices.
Section 9: Creates s. 400.9977, F.S., relating to protection from abuse, neglect, mistreatment, and exploitation.
Section 10: Creates s. 400.9978, F.S., relating to restraints and seclusion; and client safety.
Section 11: Creates s. 400.9979, F.S., relating to background screening; administration and management.
Section 12: Creates s. 400.9980, F.S., relating to property and personal affairs of clients.
Section 13: Creates s. 400.9981, F.S., relating to rules establishing standards.
Section 14: Creates s. 400.9982, F.S., relating to violations and penalties.
Section 15: Creates s. 400.9983, F.S., relating to receivership proceedings.
Section 16: Creates s. 400.9984, F.S., relating to interagency communication.
Section 17: Repeals s. 400.805, F.S., relating to transitional living facilities.

Section 18: Amends s. 381.78, F.S., relating to the advisory council on brain and spinal cord injuries.
Section 19: Provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   According to AHCA, the development of an electronic database will have a negative fiscal impact of $164,060 or year one and $64,020 for each recurring year.[6] (See fiscal comments)

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

The bill requires the development of an electronic database to allow specific information from other state agencies to be stored in one database supported and maintained by AHCA. According to AHCA, developers will have to use WEB services to pull other agencies' data into the shared SQL server database and the database will need to be developed to store like data to maximize the reporting potential to obtain the desired oversight. A web user interface will have to be designed and developed to display the pertinent user information and reports will have be written to display statistical and detailed information. User manuals, training documents, and technical specifications will be required to define the system.[7]

A project of this size will require a Project Manager and a Business Analyst to make sure efficient use of the resources provided work to implement the business requirements and achieve the intended result.[8]

The total estimated fiscal impact for implementation is $164,060 for year one and $64,020 for each recurring year.

[6] *See Supra* at FN 2.
[7] *Id.*
[8] *Id.*

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to transitional living facilities;
3 creating part XI of ch. 400, F.S., entitled
4 "Transitional Living Facilities"; creating s.
5 400.9970, F.S.; providing legislative intent; creating
6 s. 400.9971, F.S.; providing definitions; creating s.
7 400.9972, F.S.; requiring the licensure of
8 transitional living facilities; providing fees;
9 providing license application requirements; creating
10 s. 400.9973, F.S.; providing requirements for
11 transitional living facilities relating to client
12 admission, transfer, and discharge; creating s.
13 400.9974, F.S.; requiring an individual program plan
14 to be developed for each client; providing plan
15 requirements; creating s. 400.9975, F.S.; providing
16 licensee responsibilities; providing notice
17 requirements; prohibiting a licensee or employee of a
18 facility from serving notice upon a client to leave
19 the premises or take other retaliatory action;
20 requiring the client and client's representative to be
21 provided with certain information; requiring the
22 licensee to develop and implement certain policies and
23 procedures; creating s. 400.9976, F.S.; providing
24 licensee requirements relating to medication
25 practices; creating s. 400.9977, F.S.; providing
26 requirements for the screening of potential employees
27 and monitoring of employees for the protection of
28 clients; requiring licensees to implement certain

29 procedures; creating s. 400.9978, F.S.; providing
30 requirements for the use of physical restraints and
31 chemical restraint medication on clients; creating s.
32 400.9979, F.S.; providing background screening
33 requirements; requiring the licensee to maintain
34 certain personnel records; providing administrative
35 responsibilities for licensees; providing
36 recordkeeping requirements; creating s. 400.9980,
37 F.S.; providing requirements relating to property and
38 personal affairs of clients; providing requirements
39 for a licensee with respect to obtaining surety bonds;
40 providing recordkeeping requirements relating to the
41 safekeeping of personal effects; providing
42 requirements for trust funds received by licensee and
43 credited to the client; providing a penalty for
44 certain misuse of a resident's personal needs
45 allowance; providing criminal penalties for
46 violations; providing for the disposition of property
47 in the event of the death of a client; authorizing the
48 Agency for Health Care Administration to adopt rules;
49 creating s. 400.9981, F.S.; requiring the agency, in
50 consultation with the Department of Health, to adopt
51 and enforce certain rules; creating s. 400.9982, F.S.;
52 providing procedures relating to violations and
53 penalties; providing administrative fines for
54 specified classes of violations; creating s. 400.9983,
55 F.S.; authorizing the agency to institute receivership
56 proceedings under certain conditions; providing

57 requirements for proceedings; creating s. 400.9984,
58 F.S.; requiring the Agency for Health Care
59 Administration, the Department of Health, the Agency
60 for Persons with Disabilities, and the Department of
61 Children and Families to develop an electronic
62 database for certain purposes; repealing s. 400.805,
63 F.S., relating to transitional living facilities;
64 amending s. 381.78, F.S.; conforming provisions to
65 changes made by the act; providing an effective date.
66
67 Be It Enacted by the Legislature of the State of Florida:
68
69 Section 1. Sections 400.9970 through 400.9984, Florida
70 Statutes, are designated as part XI of chapter 400, Florida
71 Statutes, entitled "Transitional Living Facilities."
72 Section 2. Section 400.9970, Florida Statutes, is created
73 to read:
74 400.9970 Legislative intent.—It is the intent of the
75 Legislature to provide for the licensure of transitional living
76 facilities and require the development, establishment, and
77 enforcement of basic standards by the department to ensure
78 quality of care and services to clients in transitional living
79 facilities.
80 Section 3. Section 400.9971, Florida Statutes, is created
81 to read:
82 400.9971 Definitions.—As used in this part, the term:
83 (1) "Agency" means the Agency for Health Care
84 Administration.

85 (2) "Chemical restraint" means a pharmacologic drug that
86 physically limits, restricts, or deprives an individual of
87 movement or mobility and is used for discipline or convenience
88 and not required for the treatment of medical symptoms.
89 (3) "Client representative" means the parent of a child
90 client, or the client's guardian, designated representative or
91 designee, surrogate, or attorney in fact.
92 (4) "Department" means the Department of Health.
93 (5) "Licensee" means an individual issued a license by the
94 agency.
95 (6) "Physical restraint" means a device that physically
96 limits, restricts, or deprives an individual of movement or
97 mobility, including, but not limited to, a half-bed rail, a
98 full-bed rail, a geriatric chair, and a posey restraint. The
99 term includes any device that was not specifically manufactured
100 as a restraint but that has been altered, arranged, or otherwise
101 used for this purpose. The term does not include bandage
102 material used for the purpose of binding a wound or injury.
103 (7) "Transitional living facility" means a site where
104 specialized health care services are provided, including, but
105 not limited to, rehabilitative services, community reentry
106 training, aids for independent living, and counseling to brain-
107 injured persons and spinal-cord-injured persons. The term does
108 not include a hospital licensed under chapter 395 or any
109 federally operated hospital or facility.
110 Section 4. Section 400.9972, Florida Statutes, is created
111 to read:
112 400.9972 License required; fee; application.—

113 (1) The requirements of part II of chapter 408 apply to
114 the provision of services that require licensure pursuant to
115 this part and part II of chapter 408 and to entities licensed by
116 or applying for such licensure from the agency pursuant to this
117 part. A license issued by the agency is required for the
118 operation of a transitional living facility in this state.
119 (2) In accordance with this part, an applicant or a
120 licensee shall pay a fee for each license application submitted
121 under this part. The license fee shall consist of a $4,000
122 license fee and a $78.50 per-bed fee per biennium and shall
123 conform with the annual adjustment authorized in s. 408.805.
124 (3) Each applicant for licensure must provide:
125 (a) The location of the facility for which a license is
126 sought and documentation, signed by the appropriate local
127 government official, that states that the applicant has met
128 local zoning requirements.
129 (b) Proof of liability insurance as defined in s. 624.605.
130 (c) Proof of compliance with local zoning requirements,
131 including compliance with the requirements of chapter 419 if the
132 proposed facility is a community residential home.
133 (d) Proof that the facility has received a satisfactory
134 firesafety inspection.
135 (e) Documentation of a satisfactory sanitation inspection
136 of the facility by the county health department.
137 Section 5. Section 400.9973, Florida Statutes, is created
138 to read:
139 400.9973 Client admission, transfer, and discharge.—
140 (1) Each transitional living facility must have written

141 policies and procedures governing the admission, transfer, and
142 discharge of clients.
143 (2) The admission of each client to a transitional living
144 facility must be under the supervision of the facility
145 administrator or designee and must be in accordance with the
146 licensee's policies and procedures.
147 (3) A client admitted to a transitional living facility
148 must:
149 (a) Have a brain or spinal cord injury as defined in s.
150 381.745(2).
151 (b) Be admitted upon prescription by a licensed physician
152 and must remain under the care of the licensed physician for the
153 duration of the client's stay in the facility.
154 (c) Not present a significant risk of infection to other
155 client or personnel. A health care practitioner must provide
156 documentation that the person is free of apparent signs and
157 symptoms of communicable disease.
158 (d) Not present a danger to self or others as determined
159 by a physician or mental health practitioner licensed under
160 chapter 490 or chapter 491.
161 (e) Not require 24-hour licensed professional mental
162 health treatment.
163 (f) Not be bedridden.
164 (g) Not require 24-hour nursing supervision.
165 (4) If a client meets the admission criteria in subsection
166 (3), the medical or nursing director of the facility must
167 implement a preadmission plan that delineates services to be
168 provided and appropriate sources for such services.

169 (5) The licensee must provide adequate notice to clients
170 of transfer or discharge plans, including the location of an
171 acceptable transfer location if the client is unable to live
172 independently. This subsection does not apply if a client
173 voluntarily terminates residency.
174 Section 6. Section 400.9974, Florida Statutes, is created
175 to read:
176 400.9974 Individual program plans; client services.—
177 (1) An interdisciplinary team consisting of persons who
178 possess the knowledge, skills, and expertise necessary to
179 accurately identify the comprehensive array of the individual's
180 needs and design appropriate services and specialized programs
181 responsive to those needs, in collaboration with the client and
182 the client's representative, must develop an individual program
183 plan for each client.
184 (2) The individual program plan must include:
185 (a) The client's physician's orders, diagnosis, medical
186 history, physical examination, and rehabilitative or restorative
187 needs.
188 (b) A preliminary nursing evaluation with physician's
189 orders for immediate care, completed on admission.
190 (c) A comprehensive, accurate, reproducible, and
191 standardized assessment of the client's functional capability.
192 (d) Steps necessary for the client to achieve transition
193 to the community within 90 days after admission.
194 (3) The individual program plan must be completed before
195 admission to the facility and be reevaluated at least every 30
196 days after admission. A reevaluation of the plan must occur if

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197 the client fails to meet projected improvements in the plan or a
198 significant change in the client's condition occurs.
199 (4) Each client must receive the professional program
200 services needed to implement the client's individual program
201 plan.
202 (5) The licensee must employ available qualified
203 professional staff to carry out and monitor the various
204 professional interventions in accordance with the stated goals
205 and objectives of every individual program plan.
206 (6) Each client must receive a continuous treatment
207 program that includes aggressive, consistent implementation of a
208 program of specialized and general training, treatment, health
209 services, and related services that is directed toward:
210 (a) The acquisition of the behaviors necessary for the
211 client to function with as much self-determination and
212 independence as possible; and
213 (b) The prevention or deceleration of regression or loss
214 of current optimal functional status.
215 Section 7. Section 400.9975, Florida Statutes, is created
216 to read:
217 400.9975 Licensee responsibilities.—
218 (1) The licensee shall:
219 (a) Ensure that each client:
220 1. Lives in a safe environment free from abuse, neglect,
221 and exploitation.
222 2. Is treated with consideration and respect and with due
223 recognition of personal dignity, individuality, and the need for
224 privacy.

225 3. Retains and uses his or her own clothes and other
226 personal property in his or her immediate living quarters, so as
227 to maintain individuality and personal dignity, except when the
228 licensee can demonstrate that such retention and use would be
229 unsafe, impractical, or an infringement upon the rights of other
230 clients.
231 4. Has unrestricted private communication, including
232 receiving and sending unopened correspondence, access to a
233 telephone, and visiting with any person of his or her choice, at
234 any time between the hours of 9 a.m. and 9 p.m. at a minimum.
235 Upon request, the licensee shall make provisions to extend
236 visiting hours for caregivers and guests.
237 5. Participates in and benefits from community services
238 and activities to achieve the highest possible level of
239 independence, autonomy, and interaction within the community.
240 6. Manages his or her financial affairs unless the client
241 or, if applicable, the client's representative authorizes the
242 administrator of the facility to provide safekeeping for funds
243 as provided in this part.
244 7. Has reasonable opportunity for regular exercise several
245 times a week and to be outdoors at regular and frequent
246 intervals except when prevented by inclement weather.
247 8. Exercises civil and religious liberties, including the
248 right to independent personal decisions. No religious belief or
249 practice, including attendance at religious services, shall be
250 imposed upon any client.
251 9. Has access to adequate health care as appropriate for
252 the client and consistent with established and recognized

253 standards within the community.
254 10. Has the ability to present grievances and recommend
255 changes in policies, procedures, and services to the staff of
256 the licensee, governing officials, or any other person without
257 restraint, interference, coercion, discrimination, or reprisal.
258 Each licensee shall establish a grievance procedure to
259 facilitate a client's exercise of this right. This right
260 includes access to ombudsman volunteers and advocates and the
261 right to be a member of, be active in, and associate with
262 advocacy or special interest groups.
263 (b) Promote participation of each client's representative
264 in the process of providing treatment to the client unless the
265 representative's participation is unobtainable or inappropriate.
266 (c) Answer communications from each client's family and
267 friends promptly and appropriately.
268 (d) Promote visits by individuals with a relationship to
269 the client at any reasonable hour, without requiring prior
270 notice, or in any area of the facility that provides direct
271 client care services to the client, consistent with the client's
272 and other clients' privacy, unless the interdisciplinary team
273 determines that such a visit would not be appropriate.
274 (e) Promote leave from the facility for visits, trips, or
275 vacations.
276 (f) Promptly notify the client's representative of any
277 significant incidents or changes in the client's condition,
278 including, but not limited to, serious illness, accident, abuse,
279 unauthorized absence, or death.
280 (2) The administrator of a facility shall ensure that a

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281 written notice of licensee responsibilities is posted in a
282 prominent place in each building where clients reside and read
283 or explained to clients who cannot read. This notice shall
284 include the statewide toll-free telephone number for reporting
285 complaints to the agency, must be provided to clients in a
286 manner that is clearly legible, and must include the words: "To
287 report a complaint regarding the services you receive, please
288 call toll-free ...[telephone number]...; the statewide toll-free
289 telephone number for the central abuse hotline must be provided
290 to clients in a manner that is clearly legible and must include
291 the words: "To report abuse, neglect or exploitation, please
292 call toll-free ...[telephone number]..." and the Disability
293 Rights of Florida and the Florida local advocacy council, where
294 complaints may be lodged. The licensee must ensure a client's
295 access to a telephone to call the agency, central abuse hotline,
296 Disabilities Rights of Florida, and the Florida local advocacy
297 council.
298 (3) No licensee or employee of a facility may serve notice
299 upon a client to leave the premises or take any other
300 retaliatory action against any person who:
301 (a) Files an internal or external complaint or grievance
302 regarding the facility.
303 (b) Appears as a witness in any hearing inside or outside
304 the facility.
305 (4) Before or at the time of admission, the client and the
306 client's representative shall be provided with a copy of the
307 client's contract and a copy of the licensee's responsibilities
308 as provided in subsection (1).

309 (5) The licensee must develop and implement policies and
310 procedures governing the release of any client information,
311 including consent necessary from the client or the client's
312 representative.
313 Section 8. Section 400.9976, Florida Statutes, is created
314 to read:
315 400.9976 Medication practices.—
316 (1) An individual medication administration record must be
317 maintained for each client. Each dose of medication, including a
318 self-administered dose, shall be properly recorded in the
319 client's record. All medications must be administered in
320 compliance with the physician's orders. All medications,
321 including those that are self-administered, must be administered
322 without discrepancy between what the physician has ordered and
323 what is administered.
324 (2) If the interdisciplinary team determines that self-
325 administration of medications is an appropriate objective, and
326 if the physician does not specify otherwise, a client must be
327 taught to self-administer his or her medication without a staff
328 person's obtaining, selecting, or preparing the medication for
329 the client. This includes all forms of administration, including
330 orally, via injection, and via suppository. The client's
331 physician must be informed of the interdisciplinary team's
332 decision that self-administration of medications is an objective
333 for the client. A client may not self-administer medication
334 until he or she demonstrates the competency to take the correct
335 medication in the correct dosage at the correct time.
336 (3) Medication administration discrepancies and adverse

337 drug reactions must be recorded and reported immediately to a
338 physician.
339 Section 9. Section 400.9977, Florida Statutes, is created
340 to read:
341 400.9977 Protection from abuse, neglect, mistreatment, and
342 exploitation.—The licensee must develop and implement policies
343 and procedures for the screening and training of employees, the
344 protection of clients, and the prevention, identification,
345 investigation, and reporting of abuse, neglect, mistreatment,
346 and exploitation. This includes the licensee's identification of
347 clients whose personal histories render them at risk for abusing
348 other clients, development of intervention strategies to prevent
349 occurrences, monitoring for changes that would trigger abusive
350 behavior, and reassessment of the interventions on a regular
351 basis. Licensees must implement procedures to:
352 (1) Screen potential employees for a history of abuse,
353 neglect, or mistreatment of clients. The screening shall include
354 an attempt to obtain information from previous employers and
355 current employers and verification with the appropriate
356 licensing boards and registries.
357 (2) Train employees, through orientation and ongoing
358 sessions, on issues related to abuse prohibition practices,
359 including identification of abuse, neglect, mistreatment, and
360 exploitation, appropriate interventions to deal with aggressive
361 or catastrophic reactions of clients, the process to report
362 allegations without fear of reprisal, and recognition of signs
363 of frustration and stress that may lead to abuse.
364 (3) Provide clients, families, and staff with information

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365 on how and to whom they may report concerns, incidents, and
366 grievances without the fear of retribution and provide feedback
367 regarding the concerns that have been expressed. A licensee must
368 identify, correct, and intervene in situations in which abuse,
369 neglect, mistreatment, or exploitation is likely to occur,
370 including:
371 (a) Evaluating the physical environment of the facility to
372 identify characteristics that may make abuse or neglect more
373 likely to occur, such as secluded areas.
374 (b) Providing sufficient staff on each shift to meet the
375 needs of the clients, and ensuring that the staff assigned have
376 knowledge of the individual clients' care needs. The licensee
377 shall identify inappropriate behaviors of its staff, such as
378 using derogatory language, rough handling, ignoring clients
379 while giving care, and directing clients who need toileting
380 assistance to urinate or defecate in their beds.
381 (c) Assessing, planning care for, and monitoring clients
382 with needs and behaviors that might lead to conflict or neglect,
383 such as clients with a history of aggressive behaviors, clients
384 who have behaviors such as entering other clients' rooms,
385 clients with self-injurious behaviors, clients with
386 communication disorders, and clients who require heavy nursing
387 care or are totally dependent on staff.
388 (4) Identify events, such as suspicious bruising of
389 clients, occurrences, patterns, and trends that may constitute
390 abuse and determine the direction of the investigation.
391 (5) Investigate different types of incidents, identify the
392 staff member responsible for the initial reporting, investigate

393 alleged violations, and report results to the proper
394 authorities.
395 (6) Protect clients from harm during an investigation.
396 (7) Report all alleged violations and all substantiated
397 incidents, as required under chapters 39 and 415, to the
398 licensing authorities and report any knowledge it has of any
399 actions by a court of law that would indicate an employee is
400 unfit for service to the licensing authorities and other
401 agencies as required. The licensee must take all necessary
402 corrective actions depending on the results of the
403 investigation.
404
405 The licensee must analyze the occurrences to determine what
406 changes are needed, if any, to policies and procedures to
407 prevent further occurrences.
408 Section 10. Section 400.9978, Florida Statutes, is created
409 to read:
410 400.9978 Restraints and seclusion; client safety.—
411 (1) The use of physical restraints must be ordered and
412 documented by the client's physician with the consent of the
413 client or, if applicable, the client's representative.
414 (2) The use of chemical restraints is limited to
415 prescribed dosages of medications prescribed by the client's
416 physician with the consent of the client or, if applicable, the
417 client's representative and must be consistent with the client's
418 diagnosis.
419 (3) A client who is receiving a medication that can serve
420 as a chemical restraint must be evaluated by his or her

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421 physician at least monthly to assess:
422 (a) The continued need for the medication.
423 (b) The level of the medication in the client's blood.
424 (c) The need for adjustments in the prescription.
425 (4) The licensee shall ensure that clients are free from
426 unnecessary drugs and physical restraints and are provided
427 treatment to reduce dependency on drugs and physical restraints.
428 (5) The licensee may use physical restraints only as an
429 integral part of an individual program plan that is intended to
430 lead to less restrictive means of managing and eliminating the
431 behavior for which the restraint is applied.
432 (6) Interventions to manage inappropriate client behavior
433 must be employed with sufficient safeguards and supervision to
434 ensure that the safety, welfare, and civil and human rights of
435 each client are adequately protected.
436 Section 11. Section 400.9979, Florida Statutes, is created
437 to read:
438 400.9979 Background screening; administration and
439 management.—
440 (1) The agency shall require level 2 background screening
441 for personnel as required in s. 408.809(1)(e) pursuant to
442 chapter 435 and s. 408.809.
443 (2) The licensee shall maintain personnel records for each
444 staff member that contain, at a minimum, documentation of
445 background screening, if applicable, a job description,
446 documentation of compliance with all training requirements of
447 this part or applicable rule, the employment application,
448 references, a copy of all job performance evaluations, and, for

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449 each staff member who performs services for which licensure or
450 certification is required, a copy of all licenses or
451 certification held by the staff member.
452 (3) The licensee must:
453 (a) Develop and implement infection control policies and
454 procedures and include such policies and procedures in the
455 licensee's policy manual.
456 (b) Maintain liability insurance as defined in s. 624.605.
457 (c) Designate one person as an administrator who is
458 responsible and accountable for the overall management of the
459 facility.
460 (d) Designate a person in writing to be responsible for
461 the facility when the administrator is absent from the facility
462 for more than 24 hours.
463 (e) Obtain approval of the comprehensive emergency
464 management plan, pursuant to s. 400.9981(2)(e), from the local
465 emergency management agency. Pending the approval of the plan,
466 the local emergency management agency shall ensure that the
467 following agencies, at a minimum, are given the opportunity to
468 review the plan: the Department of Health, the Agency for Health
469 Care Administration, and the Division of Emergency Management.
470 Appropriate volunteer organizations must also be given the
471 opportunity to review the plan. The local emergency management
472 agency shall complete its review within 60 days and either
473 approve the plan or advise the licensee of necessary revisions.
474 (f) Maintain written records in a form and system that
475 comply with medical and business practices and make such records
476 available in the facility for review or submission to the agency

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477 upon request. The records shall include:
478 1. A daily census record that indicates the number of
479 clients currently receiving services in the facility, including
480 information regarding any public funding of such clients.
481 2. A record of all accidents or unusual incidents
482 involving any client or staff member that caused, or had the
483 potential to cause, injury or harm to any person or property
484 within the facility. Such records must contain a clear
485 description of each accident or incident, the names of the
486 persons involved, a description of all medical or other services
487 provided to these persons specifying who provided such services,
488 and the steps taken to prevent recurrence of such accidents or
489 incidents.
490 3. A copy of current agreements with third-party
491 providers.
492 4. A copy of current agreements with each consultant
493 employed by the licensee and documentation of each consultant's
494 visits and required written, dated reports.
495 Section 12. Section 400.9980, Florida Statutes, is created
496 to read:
497 400.9980 Property and personal affairs of clients.—
498 (1) A client shall be given the option of using his or her
499 own belongings, as space permits; choosing his or her roommate;
500 and, whenever possible, unless the client is adjudicated
501 incompetent or incapacitated under state law, managing his or
502 her own affairs.
503 (2) The admission of a client to a facility and his or her
504 presence therein shall not confer on a licensee, administrator,

505 employee, or representative thereof any authority to manage,
506 use, or dispose of any property of the client, nor shall such
507 admission or presence confer on any of such persons any
508 authority or responsibility for the personal affairs of the
509 client except that which may be necessary for the safe
510 management of the facility or for the safety of the client.
511 (3) A licensee, administrator, employee, or representative
512 thereof may:
513 (a) Not act as the guardian, trustee, or conservator for
514 any client or any of such client's property.
515 (b) Act as a competent client's payee for social security,
516 veteran's, or railroad benefits if the client provides consent
517 and the licensee files a surety bond with the agency in an
518 amount equal to twice the average monthly aggregate income or
519 personal funds due to the client, or expendable for the client's
520 account, that are received by a licensee.
521 (c) Act as the power of attorney for a client if the
522 licensee has filed a surety bond with the agency in an amount
523 equal to twice the average monthly income of the client, plus
524 the value of any client's property under the control of the
525 attorney in fact.
526
527 The bond under paragraph (b) or paragraph (c) shall be executed
528 by the licensee as principal and a licensed surety company. The
529 bond shall be conditioned upon the faithful compliance of the
530 licensee with the requirements of licensure and shall be payable
531 to the agency for the benefit of any client who suffers a
532 financial loss as a result of the misuse or misappropriation of

533 funds held pursuant to this subsection. Any surety company that
534 cancels or does not renew the bond of any licensee shall notify
535 the agency in writing not less than 30 days in advance of such
536 action, giving the reason for the cancellation or nonrenewal.
537 Any licensee, administrator, employee, or representative thereof
538 who is granted power of attorney for any client of the facility
539 shall, on a monthly basis, notify the client in writing of any
540 transaction made on behalf of the client pursuant to this
541 subsection, and a copy of such notification given to the client
542 shall be retained in each client's file and available for agency
543 inspection.
544 (4) A licensee, upon mutual consent with the client, shall
545 provide for the safekeeping in the facility of the client's
546 personal effects of a value not in excess of $1,000 and the
547 client's funds not in excess of $500 cash and shall keep
548 complete and accurate records of all such funds and personal
549 effects received. If a client is absent from a facility for 24
550 hours or more, the licensee may provide for the safekeeping of
551 the client's personal effects of a value in excess of $1,000.
552 (5) Any funds or other property belonging to or due to a
553 client or expendable for his or her account that is received by
554 licensee shall be trust funds and shall be kept separate from
555 the funds and property of the licensee and other clients or
556 shall be specifically credited to such client. Such trust funds
557 shall be used or otherwise expended only for the account of the
558 client. At least once every month, unless upon order of a court
559 of competent jurisdiction, the licensee shall furnish the client
560 and the client's representative a complete and verified

561 statement of all funds and other property to which this
562 subsection applies, detailing the amount and items received,
563 together with their sources and disposition. In any event, the
564 licensee shall furnish such statement annually and upon the
565 discharge or transfer of a client. Any governmental agency or
566 private charitable agency contributing funds or other property
567 to the account of a client shall also be entitled to receive
568 such statement monthly and upon the discharge or transfer of the
569 client.
570 (6)(a) In addition to any damages or civil penalties to
571 which a person is subject, any person who:
572 1. Intentionally withholds a client's personal funds,
573 personal property, or personal needs allowance, or who demands,
574 beneficially receives, or contracts for payment of all or any
575 part of a client's personal property or personal needs allowance
576 in satisfaction of the facility rate for supplies and services;
577 or
578 2. Borrows from or pledges any personal funds of a client,
579 other than the amount agreed to by written contract under s.
580 429.24,
581
582 commits a misdemeanor of the first degree, punishable as
583 provided in s. 775.082 or s. 775.083.
584 (b) Any licensee, administrator, employee, or
585 representative thereof who is granted power of attorney for any
586 client of the facility and who misuses or misappropriates funds
587 obtained through this power commits a felony of the third
588 degree, punishable as provided in s. 775.082, s. 775.083, or s.

589 775.084.

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

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

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

614 400.9981 Rules establishing standards.—

615 (1) It is the intent of the Legislature that rules
616 published and enforced pursuant to this part and part II of

617 chapter 408 include criteria to ensure reasonable and consistent
618 quality of care and client safety. Rules should make reasonable
619 efforts to accommodate the needs and preferences of clients to
620 enhance the quality of life in transitional living facilities.
621 (2) The agency, in consultation with the Department of
622 Health, may adopt and enforce rules to implement this part and
623 part II of chapter 408, which shall include reasonable and fair
624 criteria in relation to:
625 (a) The location of transitional living facilities.
626 (b) The number of qualifications of all personnel,
627 including management, medical, nursing, and other professional
628 personnel and nursing assistants and support personnel having
629 responsibility for any part of the care given to clients. The
630 licensee must have enough qualified professional staff available
631 to carry out and monitor the various professional interventions
632 in accordance with the stated goals and objectives of each
633 individual program plan.
634 (c) Requirements for personnel procedures, insurance
635 coverage, reporting procedures, and documentation necessary to
636 implement this part.
637 (d) Services provided to clients of transitional living
638 facilities.
639 (e) The preparation and annual update of a comprehensive
640 emergency management plan in consultation with the Division of
641 Emergency Management. At a minimum, the rules must provide for
642 plan components that address emergency evacuation
643 transportation; adequate sheltering arrangements; postdisaster
644 activities, including provision of emergency power, food, and

645 water; postdisaster transportation; supplies; staffing;
646 emergency equipment; individual identification of clients and
647 transfer of records; communication with families; and responses
648 to family inquiries.
649 Section 14. Section 400.9982, Florida Statutes, is created
650 to read:
651 400.9982 Violations; penalties.—
652 (1) Each violation of this part and rules adopted pursuant
653 thereto shall be classified according to the nature of the
654 violation and the gravity of its probable effect on facility
655 clients. The agency shall indicate the classification on the
656 written notice of the violation as follows:
657 (a) Class "I" violations are defined in s. 408.813. The
658 agency shall issue a citation regardless of correction and
659 impose an administrative fine of $5,000 for an isolated
660 violation, $7,500 for a patterned violation, and $10,000 for a
661 widespread violation. Violations may be identified and a fine
662 must be levied notwithstanding the correction of the deficiency
663 giving rise to the violation.
664 (b) Class "II" violations are defined in s. 408.813. The
665 agency shall impose an administrative fine of $1,000 for an
666 isolated violation, $2,500 for a patterned violation, and $5,000
667 for a widespread violation. A fine must be levied
668 notwithstanding the correction of the deficiency giving rise to
669 the violation.
670 (c) Class "III" violations are defined in s. 408.813. The
671 agency shall impose an administrative fine of $500 for an
672 isolated violation, $750 for a patterned violation, and $1,000

673 for a widespread violation. If a deficiency giving rise to a
674 class "III" violation is corrected within the time specified by
675 the agency, a fine may not be imposed.
676 (d) Class "IV" violations are defined in s. 408.813. The
677 agency shall impose an administrative fine for a cited class IV
678 violation in an amount not less than $100 and not exceeding $200
679 for each violation.
680 Section 15. Section 400.9983, Florida Statutes, is created
681 to read:
682 400.9983 Receivership proceedings.—
683 (1) As an alternative to or in conjunction with an
684 injunctive proceeding, the agency may petition a court of
685 competent jurisdiction for the appointment of a receiver when
686 any of the following conditions exists:
687 (a) The licensee is closing the facility or has informed
688 the agency that it intends to close the facility and adequate
689 arrangements have not been made for relocation of the clients
690 within 7 days, exclusive of weekends and holidays, after the
691 closing of the facility.
692 (b) A condition in the facility presents an imminent
693 danger to the health, safety, or welfare of the clients of the
694 facility or a substantial probability of death or serious
695 physical harm to clients of the facility.
696 (c) The licensee cannot meet its financial obligation for
697 providing food, shelter, care, and utilities. Evidence such as
698 the issuance of bad checks or an accumulation of delinquent
699 bills for such items as personnel salaries, food, drugs, or
700 utilities shall constitute prima facie evidence that the

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701 ownership of the facility lacks the financial ability to
702 operate.
703 (2) Petitions for receivership shall take precedence over
704 other court business unless the court determines that some other
705 pending proceeding having similar statutory precedence has
706 priority. A hearing shall be conducted within 5 days after the
707 filing of the petition, at which time all interested parties
708 shall have the opportunity to present evidence pertaining to the
709 petition. The agency shall notify the owner or administrator of
710 the facility named in the petition of the filing of the petition
711 and the date set for the hearing. The court may grant the
712 petition only upon finding that the health, safety, or welfare
713 of clients of the facility would be threatened if a condition
714 existing at the time the petition was filed is allowed to
715 continue. A receiver may not be appointed when the owner or
716 administrator, or a representative of the owner or
717 administrator, is not present at the hearing on the petition
718 unless the court determines that one or more of the conditions
719 in subsection (1) exist; that the licensee or administrator
720 cannot be found; that all reasonable means of locating the owner
721 or the administrator and notifying him or her of the petition
722 and hearing have been exhausted; or that the owner or
723 administrator, after notification of the hearing, chooses not to
724 attend. After such findings, the court may appoint any person
725 qualified by education, training, or experience to carry out the
726 responsibilities of a receiver pursuant to this section, except
727 that the court may not appoint any owner or affiliate of the
728 licensee of the facility. The receiver may be selected from a

729 list of persons qualified to act as receivers developed by the
730 agency and presented to the court with each petition for
731 receivership. Under no circumstances shall the agency or
732 designated agency employee be appointed as a receiver for more
733 than 60 days; however, the receiver may petition the court, one
734 time only, for a 30-day extension. The court shall grant the
735 extension upon a showing of good cause.
736 (3) The receiver shall make provisions for the continued
737 health, safety, and welfare of all clients of the facility and:
738 (a) Shall exercise those powers and perform those duties
739 set out by the court.
740 (b) Shall operate the facility in such a manner as to
741 ensure safety and adequate health care for the clients.
742 (c) Shall take such action as is reasonably necessary to
743 protect or conserve the assets or property of the facility for
744 which the receiver is appointed, or the proceeds from any
745 transfer thereof, and may use them only in the performance of
746 the powers and duties set forth in this section and by order of
747 the court.
748 (d) May use the building, fixtures, furnishings, and any
749 accompanying consumable goods in the provision of care and
750 services to clients and to any other persons receiving services
751 from the facility at the time the petition for receivership was
752 filed. The receiver shall collect payments for all goods and
753 services provided to clients or others during the period of the
754 receivership at the same rate of payment charged by the owners
755 at the time the petition for receivership was filed or at a fair
756 and reasonable rate otherwise approved by the court for private-

757 pay clients.
758 (e) May correct or eliminate any deficiency in the
759 structure or furnishings of the facility that endangers the
760 safety or health of clients while they remain in the facility,
761 provided the total cost of correction does not exceed $10,000.
762 The court may order expenditures for this purpose in excess of
763 $10,000 on application from the receiver after notice to the
764 owner and a hearing.
765 (f) May let contracts and hire agents and employees to
766 carry out the powers and duties of the receiver under this
767 section.
768 (g) Shall honor all leases, mortgages, and secured
769 transactions governing the building in which the facility is
770 located and all goods and fixtures in the building of which the
771 receiver has taken possession, but only to the extent of
772 payments that, in the case of a rental agreement, are for the
773 use of the property during the period of receivership or that,
774 in the case of a purchase agreement, become due during the
775 period of receivership.
776 (h) Shall have full power to direct and manage and to
777 discharge employees of the facility, subject to any contract
778 rights such employees may have. The receiver shall pay employees
779 at the rate of compensation, including benefits, approved by the
780 court. A receivership does not relieve the owner of any
781 obligation to employees made before the appointment of a
782 receiver and not carried out by the receiver.
783 (i) Shall be entitled to take possession of all property
784 or assets of clients that are in the possession of a facility or

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785 <u>its licensee. The receiver shall preserve all property or assets</u>
786 <u>and all client records of which the receiver takes possession</u>
787 <u>and shall provide for the prompt transfer of the property,</u>
788 <u>assets, and records to the new placement of any transferred</u>
789 <u>client. An inventory list certified by the owner and receiver</u>
790 <u>shall be made at the time the receiver takes possession of the</u>
791 <u>facility.</u>
792 <u>(4)(a) A person who is served with notice of an order of</u>
793 <u>the court appointing a receiver and of the receiver's name and</u>
794 <u>address shall be liable to pay the receiver for any goods or</u>
795 <u>services provided by the receiver after the date of the order if</u>
796 <u>the person would have been liable for the goods or services as</u>
797 <u>supplied by the owner. The receiver shall give a receipt for</u>
798 <u>each payment and shall keep a copy of each receipt on file. The</u>
799 <u>receiver shall deposit accounts received in a separate account</u>
800 <u>and shall use this account for all disbursements.</u>
801 <u>(b) The receiver may bring an action to enforce the</u>
802 <u>liability created by paragraph (a).</u>
803 <u>(c) A payment to the receiver of any sum owing to the</u>
804 <u>licensee shall discharge the obligation to the licensee.</u>
805 <u>(5)(a) A receiver may petition the court that he or she</u>
806 <u>not be required to honor any lease, mortgage, secured</u>
807 <u>transaction, or other wholly or partially executory contract</u>
808 <u>entered into by the licensee if the rent, price, or rate of</u>
809 <u>interest required to be paid under the agreement was</u>
810 <u>substantially in excess of a reasonable rent, price, or rate of</u>
811 <u>interest at the time the contract was entered into, or if any</u>
812 <u>material provision of the agreement was unreasonable, when</u>

813 compared to contracts negotiated under similar conditions. Any
814 relief in this form provided by the court shall be limited to
815 the life of the receivership unless otherwise determined by the
816 court.
817 (b) If the receiver is in possession of real estate or
818 goods subject to a lease, mortgage, or security interest that
819 the receiver has obtained a court order to avoid under paragraph
820 (a), and if the real estate or goods are necessary for the
821 continued operation of the facility under this part, the
822 receiver may apply to the court to set a reasonable rental,
823 price, or rate of interest to be paid by the receiver during the
824 duration of the receivership. The court shall hold a hearing on
825 the application within 15 days. The receiver shall send notice
826 of the application to any known persons who own the property
827 involved or mortgage holders at least 10 days before the
828 hearing. Payment by the receiver of the amount determined by the
829 court to be reasonable is a defense to any action against the
830 receiver for payment or for possession of the goods or real
831 estate subject to the lease, security interest, or mortgage
832 involved by any person who received such notice, but the payment
833 does not relieve the licensee of any liability for the
834 difference between the amount paid by the receiver and the
835 amount due under the original lease, security interest, or
836 mortgage involved.
837 (6) The court shall set the compensation of the receiver,
838 which will be considered a necessary expense of a receivership.
839 (7) A receiver may be held liable in a personal capacity
840 only for the receiver's own gross negligence, intentional acts,

841 or breach of fiduciary duty.
842 (8) The court may require a receiver to post a bond.
843 (9) The court may terminate a receivership when:
844 (a) The court determines that the receivership is no
845 longer necessary because the conditions that gave rise to the
846 receivership no longer exist; or
847 (b) All of the clients in the facility have been
848 transferred or discharged.
849 (10) Within 30 days after the termination, unless this
850 time period is extended by the court, the receiver shall give
851 the court a complete accounting of all property of which the
852 receiver has taken possession, of all funds collected and
853 disbursed, and of the expenses of the receivership.
854 (11) Nothing in this section relieves any licensee,
855 administrator, or employee of a licensee placed in receivership
856 of any civil or criminal liability incurred, or of any duty
857 imposed by law, by reason of acts or omissions of the licensee,
858 administrator, or employee before the appointment of a receiver,
859 nor shall anything contained in this section be construed to
860 suspend during the receivership any obligation of the licensee,
861 administrator, or employee for payment of taxes or other
862 operating and maintenance expenses of the facility or of the
863 licensee, administrator, employee, or any other person for the
864 payment of mortgages or liens. The licensee shall retain the
865 right to sell or mortgage any facility under receivership,
866 subject to approval of the court that ordered the receivership.
867 A licensee that is placed in receivership by the court is liable
868 for all expenses and costs incurred by the Health Care Trust

869 Fund that are related to capital improvement and operating
870 costs.
871 Section 16. Section 400.9984, Florida Statutes, is created
872 to read:
873 400.9984 Interagency communication.—The agency, the
874 department, the Agency for Persons with Disabilities, and the
875 Department of Children and Families shall develop an electronic
876 database to ensure that relevant information pertaining to the
877 regulation of transitional living facilities and clients is
878 timely and effectively communicated among agencies in order to
879 facilitate the protection of clients. Electronic sharing of
880 information shall include, at a minimum, a brain and spinal cord
881 injury registry and a client abuse registry.
882 Section 17. Section 400.805, Florida Statutes, is
883 repealed.
884 Section 18. Paragraph (b) of subsection (4) of section
885 381.78, Florida Statutes, is amended to read:
886 381.78 Advisory council on brain and spinal cord
887 injuries.—
888 (4) The council shall:
889 (b) Annually appoint a five-member committee composed of
890 one individual who has a brain injury or has a family member
891 with a brain injury, one individual who has a spinal cord injury
892 or has a family member with a spinal cord injury, and three
893 members who shall be chosen from among these representative
894 groups: physicians, other allied health professionals,
895 administrators of brain and spinal cord injury programs, and
896 representatives from support groups with expertise in areas

897 related to the rehabilitation of individuals who have brain or
898 spinal cord injuries, except that one and only one member of the
899 committee shall be an administrator of a transitional living
900 facility. Membership on the council is not a prerequisite for
901 membership on this committee.
902 1. The committee shall perform onsite visits to those
903 transitional living facilities identified by the Agency for
904 Health Care Administration as being in possible violation of the
905 statutes and rules regulating such facilities. ~~The committee~~
906 ~~members have the same rights of entry and inspection granted~~
907 ~~under s. 400.805(4) to designated representatives of the agency.~~
908 2. Factual findings of the committee resulting from an
909 onsite investigation of a facility pursuant to subparagraph 1.
910 shall be adopted by the agency in developing its administrative
911 response regarding enforcement of statutes and rules regulating
912 the operation of the facility.
913 3. Onsite investigations by the committee shall be funded
914 by the Health Care Trust Fund.
915 4. Travel expenses for committee members shall be
916 reimbursed in accordance with s. 112.061.
917 5. Members of the committee shall recuse themselves from
918 participating in any investigation that would create a conflict
919 of interest under state law, and the council shall replace the
920 member, either temporarily or permanently.
921 Section 19. This act shall take effect July 1, 2013.

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

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1 Committee/Subcommittee hearing bill: Health Innovation
2 Subcommittee
3 Representative Magar offered the following:
4
5 **Amendment (with title amendment)**
6 Remove everything after the enacting clause and insert:
7 Section 1. Sections 400.9970 through 400.9984, Florida
8 Statutes, are designated as part XI of chapter 400, Florida
9 Statutes, entitled "Transitional Living Facilities."
10 Section 2. Section 400.9970, Florida Statutes, is created
11 to read:
12 400.9970 Legislative intent.—It is the intent of the
13 Legislature to provide for the licensure of transitional living
14 facilities and require the development, establishment, and
15 enforcement of basic standards by the Agency to ensure quality
16 of care and services to clients in transitional living
17 facilities. It is the policy of the state that the least
18 restrictive appropriate available treatment be used based on the
19 individual needs and best interests of the client and consistent

20 with optimum improvement of the client's condition. The goal of
21 a transitional living program for individuals who have brain or
22 spinal cord injuries is to assist each individual who has such a
23 disability to achieve a higher level of independent functioning
24 and to enable that person to reenter the community.
25 Section 3. Section 400.9971, Florida Statutes, is created
26 to read:
27 400.9971 Definitions.—As used in this part, the term:
28 (1) "Agency" means the Agency for Health Care
29 Administration.
30 (2) "Chemical restraint" means a pharmacologic drug that
31 physically limits, restricts, or deprives an individual of
32 movement or mobility and is used for client protection or safety
33 and is not required for the treatment of medical conditions or
34 symptoms.
35 (3) "Client's representative" means the parent of a child
36 client, or the client's guardian, designated representative or
37 designee, surrogate, or attorney in fact.
38 (4) "Department" means the Department of Health.
39 (5) "Licensee" means an individual issued a license by
40 the agency.
41 (6) "Physical restraint" means any manual method or
42 physical or mechanical device, material, or equipment attached
43 or adjacent to the individual's body so that he or she cannot
44 easily remove the restraint and which restricts freedom of
45 movement or normal access to one's body, including, but not
46 limited to, a half-bed rail, a full-bed rail, a geriatric chair,
47 and a posey restraint. The term includes any device that was not

48 specifically manufactured as a restraint but that has been
49 altered, arranged, or otherwise used for this purpose. The term
50 does not include bandage material used for the purpose of
51 binding a wound or injury.
52 (7) "Transitional living facility" means a site where
53 specialized health care services are provided, including, but
54 not limited to, rehabilitative services, behavior modification,
55 community reentry training, aids for independent living, and
56 counseling to brain injured persons and spinal-cord-injured
57 persons. The term does not include a hospital licensed under
58 chapter 395 or any federally operated hospital or facility.
59 Section 4. Section 400.9972, Florida Statutes, is created
60 to read:
61 400.9972 License required; fee; application.—
62 (1) The requirements of part II of chapter 408 apply to
63 the provision of services that require licensure pursuant to
64 this part and part II of chapter 408 and to entities licensed by
65 or applying for such licensure from the agency pursuant to this
66 part. A license issued by the agency is required for the
67 operation of a transitional living facility in this state.
68 (2) In accordance with this part, an applicant or a
69 licensee shall pay a fee for each license application submitted
70 under this part. The license fee shall consist of a $4,588
71 license fee and a $90 per-bed fee per biennium and shall conform
72 to the annual adjustment authorized in s. 408.805.
73 (3) Each applicant for licensure must provide:
74 (a) The location of the facility for which a license is
75 sought and documentation, signed by the appropriate local

76 government official, that states that the applicant has met
77 local zoning requirements.
78 (b) Proof of liability insurance as defined in s.
79 624.605.
80 (c) Proof of compliance with local zoning requirements,
81 including compliance with the requirements of chapter 419 if the
82 proposed facility is a community residential home.
83 (d) Proof that the facility has received a satisfactory
84 fire safety inspection.
85 (e) Documentation of a satisfactory sanitation inspection
86 of the facility by the county health department.
87 Section 5. Section 400.9973, Florida Statutes, is created
88 to read:
89 400.9973 Client admission, transfer, and discharge.—
90 (1) Each transitional living facility must have written
91 policies and procedures governing the admission, transfer, and
92 discharge of clients.
93 (2) The admission of each client to a transitional living
94 facility must be in accordance with the licensee's policies and
95 procedures.
96 (3) A client admitted to a transitional living facility
97 must have a brain or spinal cord injury,, such as a lesion to
98 the spinal cord or cauda equina syndrome, with evidence of
99 significant involvement of two of the following deficits or
100 dysfunctions:
101 (a) Motor deficit.
102 (b) Sensory deficit.
103 (c) Bowel and bladder dysfunction.

104 (d) An injury to the skull, brain, or its covering that
105 produces an altered state of consciousness or anatomic motor,
106 sensory, cognitive, or behavioral deficits.
107 (4) Clients whose medical and diagnosis does not
108 positively identify a cause of the client's condition, or whose
109 symptoms are inconsistent with the known cause of injury, or
110 whose recovery is inconsistent with the known medical condition
111 may be admitted for an evaluation for a period not to exceed
112 ninety (90) days.
113 (5) A client admitted to a transitional living facility
114 must be admitted upon prescription by a licensed physician and
115 must remain under the care of a licensed physician for the
116 duration of the client's stay in the facility.
117 (6) A transitional living facility may not admit a client
118 whose primary admitting diagnosis is mental illness.
119 (7) A person may not be admitted to a transitional living
120 facility if the person:
121 (a) Presents significant risk of infection to other
122 client or personnel. A health care practitioner must provide
123 documentation that the person is free of apparent signs and
124 symptoms of communicable disease;
125 (b) Is a danger to self or others as determined by a
126 physician, or mental health practitioner licensed under chapter
127 490 or chapter 491, unless the facility provides adequate
128 staffing and support to ensure patient safety;
129 (c) Is bedridden; or
130 (d) Requires 24-hour nursing supervision.

131 (7) If the client meets the admission criteria, the
132 medical or nursing director of the facility must complete an
133 initial evaluation of the client's functional skills, behavioral
134 status, cognitive status, educational/vocational potential,
135 medical status, psychosocial status, sensorimotor capacity, and
136 other related skills and abilities within the first seventy-two
137 hours following the client's admission to the facility. An
138 initial comprehensive treatment plan that delineates services to
139 be provided and appropriate sources for such services must be
140 implemented within the first four days of admission.
141 (8) Each transitional living facility shall develop a
142 discharge plan for each client prior to or on admission to the
143 facility. The discharge plan must identify the intended
144 discharge site and possible alternative discharge sites. For
145 each discharge site identified, the discharge plan must identify
146 the skills, behaviors, and other conditions that the client must
147 achieve to be appropriate for discharge. Discharge plans must
148 be reviewed and updated as necessary, but not less than once
149 monthly.
150 (9) As soon as practicable, a transitional living facility
151 shall discharge clients who no longer require any of the
152 specialized services described in s. 400.9971(7); are not making
153 measurable progress in accordance with their comprehensive
154 treatment plan, or if the transitional living facility is no
155 longer the most appropriate, least restrictive treatment option.
156 (10) Each transitional living facility shall provide at
157 least 30 days' notice to clients of transfer or discharge plans,
158 including the location of an acceptable transfer location if the

159 client is unable to live independently. This requirement does
160 not apply if a client voluntarily terminates residency.
161 (11) A client may not reside in a transitional living
162 facility for a period of more than 2 years. An exception may be
163 made if a referral is made to Disability Rights of Florida at
164 least 21 months after admission and the client or, if
165 appropriate, the client's guardian requests that the client
166 continue to receive treatment at the transitional living
167 facility.
168 Section 6. Section 400.9974, Florida Statutes, is created
169 to read:
170 400.9974 Client treatment plans; client services.—
171 (1) Each transitional living facility shall develop a
172 comprehensive treatment plan for each client as soon as
173 possible, but no later than 30 days following development of the
174 initial comprehensive treatment plan. Comprehensive treatment
175 plans must be reviewed and updated if the client fails to meet
176 projected improvements in the plan or if a significant change in
177 the client's condition occurs. Treatment plans must be reviewed
178 and updated no less than once monthly. Comprehensive treatment
179 plans must be developed by an interdisciplinary team, consisting
180 of the case manager, program director, nurse, and appropriate
181 therapists. The client, and/or if appropriate, the client's
182 representative must be included in developing the comprehensive
183 treatment plan.
184 (2) The comprehensive treatment plan must include:

185 (a) The physician's orders and the client's diagnosis,
186 medical history, physical examination, and rehabilitative or
187 restorative needs.
188 (b) A preliminary nursing evaluation with physician's
189 orders for immediate care, completed on admission.
190 (c) A comprehensive, accurate, reproducible, and
191 standardized assessment of the client's functional capability
192 and the treatments designed to achieve skills, behaviors, and
193 other conditions to return to the community, and shall specify
194 measurable goals.
195 (d) Steps necessary for the client to achieve transition
196 to the community and estimated length of time to achieve the
197 goals.
198 (3) The client, and/or if appropriate, the client's
199 representative, shall consent to the continued treatment at the
200 transitional living facility. If such consent is not given, the
201 transitional living facility shall discharge the client as soon
202 as practicable.
203 (4) Each client must receive the professional program
204 services needed to implement the client's individual program
205 plan.
206 (5) The licensee must employ available qualified
207 professional staff to carry out and monitor the various
208 professional interventions in accordance with the stated goals
209 and objectives of every individual program plan.
210 (6) Each client must receive a continuous treatment
211 program that includes appropriate, consistent implementation of

212 a program of specialized and general training, treatment, health
213 services, and related services that is directed toward:
214 (a) The acquisition of the behaviors necessary for the
215 client to function with as much self-determination and
216 independence as possible;
217 (b) The prevention or deceleration of regression or loss
218 of current optimal functional status; and
219 (c) An appropriate plan to address behavioral issues that
220 preclude independent functioning in the community.
221 Section 7. Section 400.9975, Florida Statutes, is created
222 to read:
223 400.9975 Licensee responsibilities.—
224 (1) The licensee shall ensure that each client:
225 (a) Lives in a safe environment free from abuse, neglect,
226 and exploitation.
227 (b) Is treated with consideration and respect and with
228 due recognition of personal dignity, individuality, and the need
229 for privacy.
230 (c) Retains and uses his or her own clothes and other
231 personal property in his or her immediate living quarters, so as
232 to maintain individuality and personal dignity, except when the
233 licensee can demonstrate that such retention and use would be
234 unsafe, impractical, or an infringement upon the rights of other
235 clients.
236 (d) Has unrestricted private communication, including
237 receiving and sending unopened correspondence, access to a
238 telephone, and visiting with any person of his or her choice.
239 Upon request, the licensee shall make provisions to modify

240 visiting hours for caregivers and guests. The facility shall
241 restrict communication in accordance with any court order or
242 written instruction of a guardian. Any restriction on a client's
243 communication for therapeutic reasons shall be reviewed no less
244 often than weekly and the restrictions shall be removed as soon
245 as it is no longer clinically indicated. The basis for the
246 restrictions shall be explained to the client and, if
247 applicable, the client's representative. The client shall
248 nonetheless retain the right to call the abuse hotline, the
249 agency, and Disability Rights of Florida at any and all times.
250 (e) Participates in and benefits from community services
251 and activities to achieve the highest possible level of
252 independence, autonomy, and interaction within the community.
253 (f) Manages his or her financial affairs unless the
254 client or, if applicable, the client's representative authorizes
255 the administrator of the facility to provide safekeeping for
256 funds as provided in this part.
257 (g) Has reasonable opportunity for regular exercise
258 several times a week and to be outdoors at regular and frequent
259 intervals except when prevented by inclement weather.
260 (h) Exercises civil and religious liberties, including
261 the right to independent personal decisions. No religious belief
262 or practice, including attendance at religious services, shall
263 be imposed upon any client.
264 (i) Has access to adequate and appropriate health care as
265 appropriate for the client and consistent with established and
266 recognized standards within the community.

267 (j) Has the ability to present grievances and recommend
268 changes in policies, procedures, and services to the staff of
269 the licensee, governing officials, or any other person without
270 restraint, interference, coercion, discrimination, or reprisal.
271 Each licensee shall establish a grievance procedure to
272 facilitate a client's exercise of this right. This right
273 includes access to Disability Rights of Florida and other
274 advocates and the right to be a member of, be active in, and
275 associate with advocacy or special interest groups.
276 (2) The licensee shall:
277 (a) Promote participation of each client's representative
278 in the process of providing treatment to the client unless the
279 representative's participation is unobtainable or inappropriate.
280 (b) Answer communications from each client's family,
281 guardians, and friends promptly and appropriately.
282 (c) Promote visits by individuals with a relationship to
283 the client at any reasonable hour, without requiring prior
284 notice, or in any area of the facility that provides direct
285 client care services to the client, consistent with the client's
286 and other clients' privacy, unless the interdisciplinary team
287 determines that such a visit would not be appropriate.
288 (d) Promote leave from the facility for visits, trips, or
289 vacations.
290 (e) Promptly notify the client's representative of any
291 significant incidents or changes in the client's condition,
292 including, but not limited to, serious illness, accident, abuse,
293 unauthorized absence, or death.

294 (3) The administrator of a facility shall ensure that a
295 written notice of licensee responsibilities is posted in a
296 prominent place in each building where clients reside and read
297 or explained to clients who cannot read. This notice shall
298 include the statewide toll-free telephone number for reporting
299 complaints to the agency, must be provided to clients in a
300 manner that is clearly legible, and must include the words: "To
301 report a complaint regarding the services you receive, please
302 call toll-free ...[telephone number]...; the Disability Rights
303 of Florida (telephone number); and the statewide toll-free
304 telephone number for the central abuse hotline must be provided
305 to clients in a manner that is clearly legible and must include
306 the words: "To report abuse, neglect or exploitation, please
307 call toll-free ...[telephone number]..." where complaints may be
308 lodged. The licensee must ensure a client's access to a
309 telephone to call the agency, central abuse hotline, Disability
310 Rights of Florida.
311 (4) No licensee or employee of a facility may serve
312 notice upon a client to leave the premises or take any other
313 retaliatory action against any person solely due to the
314 following:
315 (a) Files an internal or external complaint or grievance
316 regarding the facility.
317 (b) Appears as a witness in any hearing inside or outside
318 the facility.
319 (5) Before or at the time of admission, the client and
320 the client's representative shall be provided with a copy of the
321 licensee's responsibilities as provided in subsection (1).

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

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

328 400.9976 Medication practices.—

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

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

349 to respond to missed doses, and knows who to contact with
350 questions.
351 (3) Medication administration discrepancies and adverse
352 drug reactions must be recorded and reported immediately to a
353 physician.
354 Section 9. Section 400.9977, Florida Statutes, is
355 created to read:
356 400.9977 Protection from abuse, neglect, mistreatment,
357 and exploitation.—The licensee must develop and implement
358 policies and procedures for the screening and training of
359 employees, the protection of clients, and the prevention,
360 identification, investigation, and reporting of abuse, neglect,
361 and exploitation. This includes the licensee's identification of
362 clients whose personal histories render them at risk for abusing
363 other clients, development of intervention strategies to prevent
364 occurrences, monitoring for changes that would trigger abusive
365 behavior, and reassessment of the interventions on a regular
366 basis. A licensee shall implement procedures to:
367 (1) Screen potential employees for a history of abuse,
368 neglect, or mistreatment of clients. The screening shall include
369 an attempt to obtain information from previous employers and
370 current employers and verification with the appropriate
371 licensing boards and registries.
372 (2) Train employees, through orientation and ongoing
373 sessions, on issues related to abuse prohibition practices,
374 including identification of abuse, neglect, mistreatment, and
375 exploitation, appropriate interventions to deal with aggressive
376 or catastrophic reactions of clients, the process to report

377 allegations without fear of reprisal, and recognition of signs
378 of frustration and stress that may lead to abuse.
379 (3) Provide clients, families, and staff with information
380 on how and to whom they may report concerns, incidents, and
381 grievances without the fear of retribution and provide feedback
382 regarding the concerns that have been expressed. A licensee must
383 identify, correct, and intervene in situations in which abuse,
384 neglect, mistreatment, or exploitation is likely to occur,
385 including:
386 (a) Evaluating the physical environment of the facility
387 to identify characteristics that may make abuse or neglect more
388 likely to occur, such as secluded areas.
389 (b) Providing sufficient staff on each shift to meet the
390 needs of the clients, and ensuring that the staff assigned have
391 knowledge of the individual clients' care needs. The licensee
392 shall identify inappropriate behaviors of its staff, such as
393 using derogatory language, rough handling, ignoring clients
394 while giving care, and directing clients who need toileting
395 assistance to urinate or defecate in their beds.
396 (c) Assessing, planning care for, and monitoring clients
397 with needs and behaviors that might lead to conflict or neglect,
398 such as clients with a history of aggressive behaviors, clients
399 who have behaviors such as entering other clients' rooms,
400 clients with self-injurious behaviors, clients with
401 communication disorders, and clients who require heavy nursing
402 care or are totally dependent on staff.

403 (4) Identify events, such as suspicious bruising of
404 clients, occurrences, patterns, and trends that may constitute
405 abuse and determine the direction of the investigation.
406 (5) Investigate different types of incidents, identify
407 the staff member responsible for the initial reporting,
408 investigate alleged violations, and report results to the proper
409 authorities. The licensee must analyze the occurrences to
410 determine what changes are needed, if any, to policies and
411 procedures to prevent further occurrences and to take all
412 necessary corrective actions depending on the results of the
413 investigation.
414 (6) Protect clients from harm during an investigation.
415 (7) Report all alleged violations and all substantiated
416 incidents, as required under chapters 39 and 415, to the
417 licensing authorities and to all other agencies as required, and
418 to report any knowledge it has of any actions by a court of law
419 that would indicate an employee is unfit for service.
420 Section 10. Section 400.9978, Florida Statutes, is
421 created to read:
422 400.9978 Restraints and seclusion; client safety.—
423 (1) The use of physical restraints must be ordered and
424 documented by a physician and must be consistent with policies
425 and procedures adopted by the facility. The client or, if
426 applicable, the client's representative must be informed of the
427 facility's physical restraint policies and procedures at the
428 time of admission.
429 (2) The use of chemical restraints is limited to
430 prescribed dosages of medications as ordered by a physician,

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

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

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

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

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

453 (a) The continued need for the medication.

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

456 (c) The need for adjustments in the prescription.

457 (5) The licensee shall ensure that clients are free from
458 unnecessary drugs and physical restraints and are provided
459 treatment to reduce dependency on drugs and physical restraints.
460 (6) The licensee may use physical restraints only as an
461 integral part of an individual program plan that is intended to
462 lead to less restrictive means of managing and eliminating the
463 behavior for which the restraint is applied.
464 (7) Interventions to manage inappropriate client behavior
465 must be employed with sufficient safeguards and supervision to
466 ensure that the safety, welfare, and civil and human rights of
467 each client are adequately protected.
468 Section 11. Section 400.9979, Florida Statutes, is
469 created to read:
470 400.9979 Background screening; administration and
471 management.—
472 (1) The agency shall require level 2 background screening
473 for personnel as required in s. 408.809(1)(e) pursuant to
474 chapter 435 and s. 408.809.
475 (2) The licensee shall maintain personnel records for
476 each staff member that contain, at a minimum, documentation of
477 background screening, if applicable, a job description,
478 documentation of compliance with all training requirements of
479 this part or applicable rule, the employment application,
480 references, a copy of all job performance evaluations, and, for
481 each staff member who performs services for which licensure or
482 certification is required, a copy of all licenses or
483 certification held by the staff member.
484 (3) The licensee must:

485 (a) Develop and implement infection control policies and
486 procedures and include such policies and procedures in the
487 licensee's policy manual.
488 (b) Maintain liability insurance as defined in s.
489 624.605.
490 (c) Designate one person as an administrator who is
491 responsible and accountable for the overall management of the
492 facility.
493 (d) Designate a person in writing to be responsible for
494 the facility when the administrator is absent from the facility
495 for more than 24 hours.
496 (e) Designate in writing a program director who is
497 responsible for supervising the therapeutic and behavioral
498 staff, determining the levels of supervision, and room placement
499 for each client.
500 (f) Designate in writing a person to be responsible when
501 the program director is absent from the facility for more than
502 24 hours.
503 (g) Obtain approval of the comprehensive emergency
504 management plan, pursuant to s. 400.9981(2)(e), from the local
505 emergency management agency. Pending the approval of the plan,
506 the local emergency management agency shall ensure that the
507 following agencies, at a minimum, are given the opportunity to
508 review the plan: the Department of Health, the Agency for Health
509 Care Administration, and the Division of Emergency Management.
510 Appropriate volunteer organizations must also be given the
511 opportunity to review the plan. The local emergency management

512 agency shall complete its review within 60 days and either
513 approve the plan or advise the licensee of necessary revisions.
514 (h) Maintain written records in a form and system that
515 comply with medical and business practices and make such records
516 available in the facility for review or submission to the agency
517 upon request. The records shall include:
518 1. A daily census record that indicates the number of
519 clients currently receiving services in the facility, including
520 information regarding any public funding of such clients.
521 2. A record of all accidents or unusual incidents
522 involving any client or staff member that caused, or had the
523 potential to cause, injury or harm to any person or property
524 within the facility. Such records must contain a clear
525 description of each accident or incident, the names of the
526 persons involved, a description of all medical or other services
527 provided to these persons specifying who provided such services,
528 and the steps taken to prevent recurrence of such accidents or
529 incidents.
530 3. A copy of current agreements with third-party
531 providers.
532 4. A copy of current agreements with each consultant
533 employed by the licensee and documentation of each consultant's
534 visits and required written, dated reports.
535 Section 12. Section 400.9980, Florida Statutes, is
536 created to read:
537 400.9980 Property and personal affairs of clients.—
538 (1) A client shall be given the option of using his or
539 her own belongings, as space permits; choosing his or her

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

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

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

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

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

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

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

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

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

596 shall be used or otherwise expended only for the account of the
597 client. At least once every month, unless upon order of a court
598 of competent jurisdiction, the licensee shall furnish the client
599 and the client's representative a complete and verified
600 statement of all funds and other property to which this
601 subsection applies, detailing the amount and items received,
602 together with their sources and disposition. In any event, the
603 licensee shall furnish such statement annually and upon the
604 discharge or transfer of a client. Any governmental agency or
605 private charitable agency contributing funds or other property
606 to the account of a client shall also be entitled to receive
607 such statement monthly and upon the discharge or transfer of the
608 client.
609 (6)(a) In addition to any damages or civil penalties to
610 which a person is subject, any person who:
611 1. Intentionally withholds a client's personal funds,
612 personal property, or personal needs allowance, or who demands,
613 beneficially receives, or contracts for payment of all or any
614 part of a client's personal property or personal needs allowance
615 in satisfaction of the facility rate for supplies and services;
616 or
617 2. Borrows from or pledges any personal funds of a
618 client, other than the amount agreed to by written contract
619 under s. 429.24, commits a misdemeanor of the first degree,
620 punishable as provided in s. 775.082 or s. 775.083.
621 (b) Any licensee, administrator, employee, or
622 representative thereof who is granted power of attorney for any
623 client of the facility and who misuses or misappropriates funds

624 obtained through this power commits a felony of the third
625 degree, punishable as provided in s. 775.082, s. 775.083, or s.
626 775.084.
627 (7) In the event of the death of a client, a licensee
628 shall return all refunds, funds, and property held in trust to
629 the client's personal representative, if one has been appointed
630 at the time the licensee disburses such funds, or, if not, to
631 the client's spouse or adult next of kin named in a beneficiary
632 designation form provided by the licensee to the client. If the
633 client has no spouse or adult next of kin or such person cannot
634 be located, funds due the client shall be placed in an interest
635 bearing account and all property held in trust by the licensee
636 shall be safeguarded until such time as the funds and property
637 are disbursed pursuant to the Florida Probate Code. Such funds
638 shall be kept separate from the funds and property of the
639 licensee and other clients of the facility. If the funds of the
640 deceased client are not disbursed pursuant to the Florida
641 Probate Code within 2 years after the client's death, the funds
642 shall be deposited in the Health Care Trust Fund administered by
643 the agency.
644 (8) The agency may by rule clarify terms and specify
645 procedures and documentation necessary to administer the
646 provisions of this section relating to the proper management of
647 clients' funds and personal property and the execution of surety
648 bonds.
649 Section 13. Section 400.9981, Florida Statutes, is
650 created to read:
651 400.9981 Rules establishing standards.—

652 (1) It is the intent of the Legislature that rules
653 published and enforced pursuant to this part and part II of
654 chapter 408 include criteria to ensure reasonable and consistent
655 quality of care and client safety. Rules should make reasonable
656 efforts to accommodate the needs and preferences of clients to
657 enhance the quality of life in transitional living facilities.
658 (2) The agency, in consultation with the Department of
659 Health, may adopt and enforce rules to implement this part and
660 part II of chapter 408, which shall include reasonable and fair
661 criteria in relation to:
662 (a) The location of transitional living facilities.
663 (b) The number of qualifications of all personnel,
664 including management, medical, nursing, and other professional
665 personnel and nursing assistants and support personnel having
666 responsibility for any part of the care given to clients. The
667 licensee must have enough qualified professional staff available
668 to carry out and monitor the various professional interventions
669 in accordance with the stated goals and objectives of each
670 individual program plan.
671 (c) Requirements for personnel procedures, insurance
672 coverage, reporting procedures, and documentation necessary to
673 implement this part.
674 (d) Services provided to clients of transitional living
675 facilities.
676 (e) The preparation and annual update of a comprehensive
677 emergency management plan in consultation with the Division of
678 Emergency Management. At a minimum, the rules must provide for
679 plan components that address emergency evacuation

680 transportation; adequate sheltering arrangements; post disaster
681 activities, including provision of emergency power, food, and
682 water; post disaster transportation; supplies; staffing;
683 emergency equipment; individual identification of clients and
684 transfer of records; communication with families; and responses
685 to family inquiries.
686 Section 14. Section 400.9982, Florida Statutes, is
687 created to read:
688 400.9982 Violations; penalties.—
689 (1) Each violation of this part and rules adopted
690 pursuant thereto shall be classified according to the nature of
691 the violation and the gravity of its probable effect on facility
692 clients. The agency shall indicate the classification on the
693 written notice of the violation as follows:
694 (a) Class "I" violations are defined in s. 408.813. The
695 agency shall issue a citation regardless of correction and
696 impose an administrative fine of $5,000 for an isolated
697 violation, $7,500 for a patterned violation, and $10,000 for a
698 widespread violation. Violations may be identified and a fine
699 must be levied notwithstanding the correction of the deficiency
700 giving rise to the violation.
701 (b) Class "II" violations are defined in s. 408.813. The
702 agency shall impose an administrative fine of $1,000 for an
703 isolated violation, $2,500 for a patterned violation, and $5,000
704 for a widespread violation. A fine must be levied
705 notwithstanding the correction of the deficiency giving rise to
706 the violation.

707 (c) Class "III" violations are defined in s. 408.813. The
708 agency shall impose an administrative fine of $500 for an
709 isolated violation, $750 for a patterned violation, and $1,000
710 for a widespread violation. If a deficiency giving rise to a
711 class "III" violation is corrected within the time specified by
712 the agency, a fine may not be imposed.
713 (d) Class "IV" violations are defined in s. 408.813. The
714 agency shall impose an administrative fine for a cited class IV
715 violation in an amount not less than $100 and not exceeding $200
716 for each violation.
717 Section 15. Section 400.9983, Florida Statutes, is
718 created to read:
719 400.9983 Receivership proceedings.—The agency may access
720 the provisions of s. 429.22 regarding receivership proceedings
721 for transitional living facilities.
722 Section 16. Section 400.9984, Florida Statutes, is
723 created to read:
724 400.9984 Interagency communication.—The agency, the
725 department, the Agency for Persons with Disabilities, and the
726 Department of Children and Families shall develop electronic
727 systems to ensure that relevant information pertaining to the
728 regulation of transitional living facilities and clients is
729 timely and effectively communicated among agencies in order to
730 facilitate the protection of clients. Electronic sharing of
731 information shall include, at a minimum, a brain and spinal cord
732 injury registry and a client abuse registry.
733 Section 17. Section 400.805, Florida Statutes, is
734 repealed.

735 Section 18. Paragraph (b) of subsection (4) of section
736 381.78, Florida Statutes, is amended to read:
737 381.78 Advisory council on brain and spinal cord injuries.—
738 (4) The council shall:
739 (b) Annually appoint a five-member committee composed of
740 one individual who has a brain injury or has a family member
741 with a brain injury, one individual who has a spinal cord injury
742 or has a family member with a spinal cord injury, and three
743 members who shall be chosen from among these representative
744 groups: physicians, other allied health professionals,
745 administrators of brain and spinal cord injury programs, and
746 representatives from support groups with expertise in areas
747 related to the rehabilitation of individuals who have brain or
748 spinal cord injuries, except that one and only one member of the
749 committee shall be an administrator of a transitional living
750 facility. Membership on the council is not a prerequisite for
751 membership on this committee.
752 1. The committee shall perform onsite visits to those
753 transitional living facilities identified by the Agency for
754 Health Care Administration as being in possible violation of the
755 statutes and rules regulating such facilities. ~~The committee~~
756 ~~members have the same rights of entry and inspection granted~~
757 ~~under s. 400.805(4) to designated representatives of the agency.~~
758 2. Factual findings of the committee resulting from an
759 onsite investigation of a facility pursuant to subparagraph 1.
760 shall be adopted by the agency in developing its administrative
761 response regarding enforcement of statutes and rules regulating
762 the operation of the facility.

763 3. Onsite investigations by the committee shall be funded
764 by the Health Care Trust Fund.
765 4. Travel expenses for committee members shall be
766 reimbursed in accordance with s. 112.061.
767 5. Members of the committee shall recuse themselves from
768 participating in any investigation that would create a conflict
769 of interest under state law, and the council shall replace the
770 member, either temporarily or permanently.
771 Section 19. This act shall take effect July 1, 2013.
772
773
774 ---
775 **T I T L E A M E N D M E N T**
776 Remove everything before the enacting clause and insert:
777 An act relating to transitional living facilities; creating part
778 XI of ch. 400, F.S., entitled "Transitional Living Facilities";
779 creating s. 400.9970, F.S.; providing legislative intent;
780 creating s. 400.9971, F.S.; providing definitions; creating s.
781 400.9972, F.S.; requiring the licensure of transitional living
782 facilities; providing fees; providing license application
783 requirements; creating s. 400.9973, F.S.; providing requirements
784 for transitional living facilities relating to client admission,
785 transfer, and discharge; creating s.400.9974, F.S.; requiring an
786 individual treatment plan to be developed for each client;
787 providing plan requirements; creating s. 400.9975, F.S.;
788 providing licensee responsibilities; providing notice
789 requirements; prohibiting a licensee or employee of a facility
790 from serving notice upon a client to leave the premises or take

791 other retaliatory action; requiring the client and client's
792 representative to be provided with certain information;
793 requiring the licensee to develop and implement certain policies
794 and procedures; creating s. 400.9976, F.S.; providing licensee
795 requirements relating to medication practices; creating s.
796 400.9977, F.S.; providing requirements for the screening of
797 potential employees and monitoring of employees for the
798 protection of clients; requiring licensees to implement certain
799 procedures; creating s. 400.9978, F.S.; providing requirements
800 for the use of physical restraints and chemical restraint
801 medication on clients; creating s.400.9979, F.S.; providing
802 background screening requirements; requiring the licensee to
803 maintain certain personnel records; providing administrative
804 responsibilities for licensees; providing recordkeeping
805 requirements; creating s. 400.9980, F.S.; providing requirements
806 relating to property and personal affairs of clients; providing
807 requirements for a licensee with respect to obtaining surety
808 bonds; providing recordkeeping requirements relating to the
809 safekeeping of personal effects; providing requirements for
810 trust funds received by a licensee and credited to the client;
811 providing a penalty for certain misuse of a resident's personal
812 needs allowance; providing criminal penalties for violations;
813 providing for the disposition of property in the event of the
814 death of a client; authorizing the Agency for Health Care
815 Administration to adopt rules; creating s. 400.9981, F.S.;
816 requiring the agency, in consultation with the Department of
817 Health, to adopt and enforce certain rules; creating s.
818 400.9982, 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

HB 1157

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1157 Health Flex Plans
SPONSOR(S): Powell
TIED BILLS: **IDEN./SIM. BILLS:** SB 1278

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Poche	Shaw
2) Insurance & Banking Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Health flex plans were established in 2002 as a pilot program in Indian River County to offer basic affordable health care services to low-income uninsured state residents. Health insurers, health maintenance organizations, and other entities were encouraged to develop low cost, basic benefit health coverage plans that would provide uninsured individuals with access to primary care treatment, prescription drugs, screenings, and diagnostic and radiology procedures. Subsequent legislation has expanded availability of the program to other counties.

There are currently more than 12,000 individuals enrolled in three health flex plans in six counties. Under current law, the pilot program will end on July 1, 2013, unless it is extended by legislative action.

House Bill 1157 extends the health flex plan program to July 1, 2018.

The bill does not appear to have a fiscal impact on state or local government.

The bill provides an effective date of June 30, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

The health flex plan program was established in 2002 as a pilot program to offer basic affordable health care services to low-income uninsured state residents "by encouraging health insurers, health maintenance organizations, health-care-provider-sponsored organizations, local governments, health care districts, or other public or private community-based organizations to develop alternative approaches to traditional health insurance which emphasize coverage for basic and preventive health care services."[1] Health flex plans are not insurance products. Plan providers are not subject to the Florida Insurance Code. The plans are also not required to offer the mandated health benefits found in chapter 627, F.S., or chapter 641, F.S., as applicable. Health flex plans provide coverage for basic health care services, such as preventive health screenings, office visits for primary care treatment, basic prescription drug coverage, blood chemistry screenings, and certain diagnostic and radiology procedures.

Eligibility to enroll in a health flex plan is limited to persons who:

- Are residents of the state;
- Are 64 years old or younger;
- Have a family income equal to or less than 300 percent of the federal poverty level;[2]
- Are not covered by private insurance and are not eligible for coverage through a public health insurance program or have not been covered for the past six months, with exceptions.[3]

The program was initially available in Indian River County from July 2002 until July 2004. Subsequent legislation in 2003 extended the program to July 2008, and later legislation expanded the counties of availability. In 2008, the Legislature passed and the Governor signed HB 461, which extended the program from July 2008 to July 2013.[4] Current law provides for expiration of the program on July 1, 2013.[5]

There are three health flex plans in the state, American Care, Inc., Preferred Medical Plan, Inc., and Vita Health Plan, operating in Broward, Hillsborough, Miami-Dade, Palm Beach, Polk, and St. Lucie counties. The following chart shows the total enrollment in each of the plans[6]:

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[1] S. 408.909(1), F.S.; *see also* Florida Agency for Health Care Administration and Office of Insurance Regulation, *Health Flex Plan Program Annual Report-January 2012*, page 2, available at http://ahca.myflorida.com/mchq/managed_health_care/Health_Flex/ANNUAL_REPORT-FINAL_2013[1].pdf (on file with Health Innovation Subcommittee staff).

[2] The federal poverty level for a family of four, based on 2013 federal guidelines, is $23,550. 300 percent of the federal poverty level for a family of four is $70,650. *See* U.S. Department of Health and Human Services, Office of the Assistance Secretary for Planning and Evaluation, *2013 Poverty Guidelines*, available at http://aspe.hhs.gov/poverty/13poverty.cfm (last viewed March 14, 2013); *see also* 78 Fed. Reg. 5,182, 5,183 (January 24, 2013).

[3] S. 408.909(5)(a)2.a. and b., and (b), F.S., contain specific criteria to be eligible for health flex plan coverage under the exceptions.

[4] S. 1, Ch. 2008-118, L.O.F.

[5] S. 408.909(10), F.S.

[6] Florida Agency for Health Care Administration and the Office of Insurance Regulation, *Health Flex Plan Program Annual Report-January 2013*, page 6, available at http://ahca.myflorida.com/mchq/managed_health_care/Health_Flex/ANNUAL_REPORT-FINAL_2013[1].pdf (on file with Health Innovation Subcommittee staff).

COMPANY	ENROLLEES
American Care, Inc.	347
Preferred Medical Plan, Inc.	1,630
Vita Health Plan	10,150
TOTAL	**12,127**

Patient Protection and Affordable Care Act

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act ("PPACA")[7], as amended by the Health Care and Education Reconciliation Act of 2010[8]. The law contains comprehensive changes to the entire health care system in the United States. Most of the PPACA provisions take effect in 2014; however, many changes are phased in, starting from the day the bill was signed on March 23, 2010 and continuing through 2019.

Specifically, PPACA:

- Requires most U.S. citizens and legal residents to obtain health insurance coverage or pay a penalty;
- Substantially expands Medicaid;
- Establishes new requirements on employers and health plans;
- Restructures the private health insurance market;
- Creates health insurance exchanges for individuals and employers to obtain coverage;
- Sets minimum standards for health coverage offered in the health insurance exchange; and
- Provides premium tax credits and cost-sharing subsidies for eligible individuals that obtain coverage through the health insurance exchange.

Health Insurance Exchanges under PPACA

PPACA requires that a health insurance exchange be established in each state. Individuals and small businesses will be able to purchase health insurance coverage that meets the minimum essential coverage provisions of PPACA. The exchanges must begin open enrollment on October 1, 2013, for coverage effective January 1, 2014. The exchange is not an insurer; instead, it will provide eligible individuals and businesses with access to qualified health plans. Each plan must be one of following "metal levels":

- Bronze: 60% actuarial value[9]
- Silver: 70% actuarial value
- Gold: 80% actuarial value
- Platinum: 90% actuarial value

In addition to enrolling individuals in qualified health plans, the exchange will also determine eligibility for Medicaid and the Child Health Insurance Plan (CHIP). The exchange will also determine if an individual is eligible for advance premium tax credits and cost-sharing reductions.

Individuals with household income between 100% and 400% of poverty are eligible to receive an advance premium tax credit if "affordable coverage"[10] is not available through an employer. The

[7] P.L. 111-148, 124 Stat. 119 (2010)
[8] P.L. 111-152, 124 Stat. 1029 (2010)
[9] Actuarial value is calculated by computing the ratio of total expected payments by the plan for essential health benefits and cost-sharing rules with the total costs of the essential health benefits the standard population is expected to incur. For example, a health plan with an actuarial value of 80 percent would be expected to pay an average of 80 percent of a standard population's expected medical expenses for the EHB. Individuals covered by the plan would then be expected to pay the remaining 20 percent, on average, through cost sharing such as deductibles, co-pays, and co-insurance.
[10] See discussion of "affordable coverage" under Employer Responsibility supra.

amount of the tax credit that an individual can receive is based on the premium for the second lowest cost silver plan in the exchange and area where the person is eligible to purchase coverage. The amount of the tax credit varies with income so the premium that a person would have to pay for the second lowest cost silver plan would not exceed a specified percentage of their income as follows:

Income Level	Premium as a Percent of Income
Up to 133% FPL	2% of income
133-150% FPL	3 – 4% of income
150-200% FPL	4 – 6.3% of income
200-250% FPL	6.3 – 8.05% of income
250-300% FPL	8.05 – 9.5% of income
300-400% FPL	9.5% of income

Effect of Proposed Changes

The bill extends the health flex plan program for 5 years, from July 1, 2013 to July 1, 2018.

Because eligibility for health flex plans is limited to individuals at or below 300 percent of the federal poverty level, it is likely that many people currently enrolled in a health flex plan would qualify for subsidized health insurance coverage in the federal health insurance exchange. However, since advance premium tax credits are not available to individuals having incomes below 100 percent of the federal poverty level, these individuals are likely to choose to remain in the health flex plan program.

B. SECTION DIRECTORY:

Section 1: Amends s. 408.909, F.S., relating to health flex plans.
Section 2: Provides an effective date of June 30, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Failure to extend the pilot program could leave 12,127 residents of Florida with no coverage for health care services until January 1, 2014.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to health flex plans; amending s.
3 408.909, F.S.; revising the expiration date to extend
4 the availability of health flex plans to low-income
5 uninsured state residents; providing an effective
6 date.
7
8 Be It Enacted by the Legislature of the State of Florida:
9
10 Section 1. Section 408.909, Florida Statutes, is amended
11 to read:
12 408.909 Health flex plans.—
13 (1) INTENT.—The Legislature finds that a significant
14 proportion of the residents of this state are unable to obtain
15 affordable health insurance coverage. Therefore, it is the
16 intent of the Legislature to expand the availability of health
17 care options for low-income uninsured state residents by
18 encouraging health insurers, health maintenance organizations,
19 health-care-provider-sponsored organizations, local governments,
20 health care districts, or other public or private community-
21 based organizations to develop alternative approaches to
22 traditional health insurance which emphasize coverage for basic
23 and preventive health care services. To the maximum extent
24 possible, these options should be coordinated with existing
25 governmental or community-based health services programs in a
26 manner that is consistent with the objectives and requirements
27 of such programs.
28 (2) DEFINITIONS.—As used in this section, the term:

29 (a) "Agency" means the Agency for Health Care
30 Administration.
31 (b) "Office" means the Office of Insurance Regulation of
32 the Financial Services Commission.
33 (c) "Enrollee" means an individual who has been determined
34 to be eligible for and is receiving health care coverage under a
35 health flex plan approved under this section.
36 (d) "Health care coverage" or "health flex plan coverage"
37 means health care services that are covered as benefits under an
38 approved health flex plan or that are otherwise provided, either
39 directly or through arrangements with other persons, via a
40 health flex plan on a prepaid per capita basis or on a prepaid
41 aggregate fixed-sum basis.
42 (e) "Health flex plan" means a health plan approved under
43 subsection (3) which guarantees payment for specified health
44 care coverage provided to the enrollee who purchases coverage
45 directly from the plan or through a small business purchasing
46 arrangement sponsored by a local government.
47 (f) "Health flex plan entity" means a health insurer,
48 health maintenance organization, health-care-provider-sponsored
49 organization, local government, health care district, other
50 public or private community-based organization, or public-
51 private partnership that develops and implements an approved
52 health flex plan and is responsible for administering the health
53 flex plan and paying all claims for health flex plan coverage by
54 enrollees of the health flex plan.
55 (3) PROGRAM.—The agency and the office shall each approve
56 or disapprove health flex plans that provide health care

57 coverage for eligible participants. A health flex plan may limit
58 or exclude benefits otherwise required by law for insurers
59 offering coverage in this state, may cap the total amount of
60 claims paid per year per enrollee, may limit the number of
61 enrollees, or may take any combination of those actions. A
62 health flex plan offering may include the option of a
63 catastrophic plan supplementing the health flex plan.
64 (a) The agency shall develop guidelines for the review of
65 applications for health flex plans and shall disapprove or
66 withdraw approval of plans that do not meet or no longer meet
67 minimum standards for quality of care and access to care. The
68 agency shall ensure that the health flex plans follow
69 standardized grievance procedures similar to those required of
70 health maintenance organizations.
71 (b) The office shall develop guidelines for the review of
72 health flex plan applications and provide regulatory oversight
73 of health flex plan advertisement and marketing procedures. The
74 office shall disapprove or shall withdraw approval of plans
75 that:
76 1. Contain any ambiguous, inconsistent, or misleading
77 provisions or any exceptions or conditions that deceptively
78 affect or limit the benefits purported to be assumed in the
79 general coverage provided by the health flex plan;
80 2. Provide benefits that are unreasonable in relation to
81 the premium charged or contain provisions that are unfair or
82 inequitable or contrary to the public policy of this state, that
83 encourage misrepresentation, or that result in unfair
84 discrimination in sales practices;

85 3. Cannot demonstrate that the health flex plan is
86 financially sound and that the applicant is able to underwrite
87 or finance the health care coverage provided; or
88 4. Cannot demonstrate that the applicant and its
89 management are in compliance with the standards required under
90 s. 624.404(3).
91 (c) The agency and the Financial Services Commission may
92 adopt rules as needed to administer this section.
93 (4) LICENSE NOT REQUIRED.—Neither the licensing
94 requirements of the Florida Insurance Code nor chapter 641,
95 relating to health maintenance organizations, is applicable to a
96 health flex plan approved under this section, unless expressly
97 made applicable. However, for the purpose of prohibiting unfair
98 trade practices, health flex plans are considered to be
99 insurance subject to the applicable provisions of part IX of
100 chapter 626, except as otherwise provided in this section.
101 (5) ELIGIBILITY.—Eligibility to enroll in an approved
102 health flex plan is limited to residents of this state who:
103 (a)1. Have a family income equal to or less than 300
104 percent of the federal poverty level;
105 2. Are not covered by a private insurance policy and are
106 not eligible for coverage through a public health insurance
107 program, such as Medicare or Medicaid, or another public health
108 care program, such as Kidcare, and have not been covered at any
109 time during the past 6 months, except that:
110 a. A person who was covered under an individual health
111 maintenance contract issued by a health maintenance organization
112 licensed under part I of chapter 641 which was also an approved

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

113 health flex plan on October 1, 2008, may apply for coverage in
114 the same health maintenance organization's health flex plan
115 without a lapse in coverage if all other eligibility
116 requirements are met; or
117 b. A person who was covered under Medicaid or Kidcare and
118 lost eligibility for the Medicaid or Kidcare subsidy due to
119 income restrictions within 90 days prior to applying for health
120 care coverage through an approved health flex plan may apply for
121 coverage in a health flex plan without a lapse in coverage if
122 all other eligibility requirements are met; and
123 3. Have applied for health care coverage as an individual
124 through an approved health flex plan and have agreed to make any
125 payments required for participation, including periodic payments
126 or payments due at the time health care services are provided;
127 or
128 (b) Are part of an employer group of which at least 75
129 percent of the employees have a family income equal to or less
130 than 300 percent of the federal poverty level and the employer
131 group is not covered by a private health insurance policy and
132 has not been covered at any time during the past 6 months. If
133 the health flex plan entity is a health insurer, health plan, or
134 health maintenance organization licensed under Florida law, only
135 50 percent of the employees must meet the income requirements
136 for the purpose of this paragraph.
137 (6) RECORDS.—Each health flex plan shall maintain
138 enrollment data and reasonable records of its losses, expenses,
139 and claims experience and shall make those records reasonably
140 available to enable the office to monitor and determine the

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

141 financial viability of the health flex plan, as necessary.
142 Provider networks and total enrollment by area shall be reported
143 to the agency biannually to enable the agency to monitor access
144 to care.
145 (7) NOTICE.—The denial of coverage by a health flex plan,
146 or the nonrenewal or cancellation of coverage, must be
147 accompanied by the specific reasons for denial, nonrenewal, or
148 cancellation. Notice of nonrenewal or cancellation must be
149 provided at least 45 days in advance of the nonrenewal or
150 cancellation, except that 10 days' written notice must be given
151 for cancellation due to nonpayment of premiums. If the health
152 flex plan fails to give the required notice, the health flex
153 plan coverage must remain in effect until notice is
154 appropriately given.
155 (8) NONENTITLEMENT.—Coverage under an approved health flex
156 plan is not an entitlement, and a cause of action does not arise
157 against the state, a local government entity, or any other
158 political subdivision of this state, or against the agency, for
159 failure to make coverage available to eligible persons under
160 this section.
161 (9) PROGRAM EVALUATION.—The agency and the office shall
162 evaluate the pilot program and its effect on the entities that
163 seek approval as health flex plans, on the number of enrollees,
164 and on the scope of the health care coverage offered under a
165 health flex plan; shall provide an assessment of the health flex
166 plans and their potential applicability in other settings; shall
167 use health flex plans to gather more information to evaluate
168 low-income consumer driven benefit packages; and shall, by

169 January 1, 2005, and annually thereafter, jointly submit a
170 report to the Governor, the President of the Senate, and the
171 Speaker of the House of Representatives.
172 (10) EXPIRATION.—This section expires July 1, 2018 ~~July 1,~~
173 ~~2013~~.
174 Section 2. This act shall take effect June 30, 2013.

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

HB 1323

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1323 Medicaid Eligibilty
SPONSOR(S): Nuñez
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Poche MW	Shaw
2) Health Care Appropriations Subcommittee			

SUMMARY ANALYSIS

The bill amends s. 409.902, F.S., relating to Medicaid eligibility.

Currently, some individuals applying for long-term care Medicaid services are using various methods to shelter their assets in order to become eligible for Medicaid.

The bill requires the Department of Children and Families to apply additional asset transfer limitations for individuals applying for Medicaid nursing facility services, institutional hospice services, and home and community-based waiver programs.

- The bill provides certain restrictions on personal services contracts, which are used to transfer assets to a family member or caregiver in return for specific services.
- The bill also provides certain conditions that must be met for a spouse that refuses make their financial resources available to the spouse receiving Medicaid long-term care services.

The bill requires the Agency for Health Care Administration (AHCA) to seek recovery of all Medicaid-covered expenses and pursue court-ordered medical support in instances of a spouse refusing to make their resources available to a spouse seeking Medicaid long-term care services.

The bill has a potential significant positive fiscal impact to the state through imposing stricter regulations on eligibility requirements for Medicaid long-term care. The bill directs AHCA to seek recovery of improper Medicaid payments which could require significant Agency resources. See Fiscal Comments.

The bill is effective upon becoming law.

This document does not reflect the intent or official position of the bill sponsor or House of Representatives.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Medicaid Overview

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by AHCA and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families (DCF), the Agency for Persons with Disabilities (APD), and the Department of Elderly Affairs (DOEA).

The structure of each state's Medicaid program varies, but what states must pay for are largely determined by the federal government, as a condition of receiving federal funds. Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections.

Florida Medicaid is the second largest single program in the state behind public education, representing 28 percent of the total FY 2010-11 budget. Medicaid general revenue expenditures represent 17 percent of the total General Revenue funds appropriated in FY 2010-11. Florida's program is the 4th largest in the nation, and the 5th largest in terms of expenditures. Current estimates indicate the program will cost $20.8 billion in FY 2012-2013. By FY 2013-2014, the estimated program cost is $22.2 billion.

Medicaid Long-Term Care

Long-term care is currently provided to elderly and disabled Medicaid recipients though nursing home placement and through home and community based services. Home and community based services provide care in a community setting instead of a nursing home or other institution. Home and community based services are provided through six Medicaid waiver programs and one state plan program administered by DOEA in partnership with AHCA. These waiver programs are administered through contracts with the 11 Aging Resource Centers[1] and local service providers, and provide alternative, less restrictive long-term care options for elders who qualify for skilled nursing home care.

The Medicaid eligibility income threshold for institutional care placement, home and community based care services, and hospice services, is 300 percent of the Supplemental Security Income (SSI) federal benefit rate.[2] The current SSI federal benefit rate is $710 for an individual,[3] therefore, individuals with incomes under $2,130 per month are eligible for Medicaid long-term care services.[4]

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[1] The 2004 Legislature created the Aging Resource Center initiative to reduce fragmentation in the elder services system. To provide easier access to elder services, the Legislature directed DOEA to establish a process to help the 11 area agencies on aging transition to Aging Resource Centers.

[2] Rule 65A-1.713(1)(d), F.A.C.

[3] Social Security Administration, *see* http://www.ssa.gov/oact/cola/SSI.html (last viewed on March 17, 2013).

[4] Florida Department of Children and Families, *SSI-Related Programs Fact Sheets*, January 2013, page 10, available at www.dcf.fl.us/programs/access/docs/ssifactsheet.pdf

Medicaid Long-Term Care Planning

A 2009 study by the National Alliance for Caregiving and AARP found that about 43.5 million Americans look after someone age 50 or older, which is a 28 percent increase from 2004.[5] Some individuals, with assistance from financial planners and attorneys, have developed methods of arranging assets in such a way that they are not countable when Medicaid eligibility is determined. Elder law attorneys across the country actively advertise services to assist elderly individuals with personal service contracts and other asset protection methods. For example, the website of a South Florida law firm prominently displays the following sentences on their website:

- "Asset Protection For People With Too Much Income or Assets to Qualify for Government Programs;" and
- "For ten years we have successfully helped families preserve their assets and qualify for Florida Nursing Home Medicaid benefits and Assisted Living public benefits."[6]

Transfer of Assets

According to DCF, some individuals, prior to entering a nursing facility or enrolling in a Medicaid home and community based service waiver program, transfer accumulated assets to a relative through a contract which provides that the relative will provide personal services to the individual for a specified period of time.[7] Current DCF policy does not preclude the transfer of funds to relatives when contracts are drawn up to prepay for future personal services.[8] According to DCF, many of the contracted services incorporated into the contracts are services that close relatives would normally provide without charge such as visitation, transportation, entertainment, and oversight of medical care.[9]

If a transfer of assets was made in the form of a personal services contract, within a 36 month (3 year) look back period, DCF must make a determination if the contracted services were for fair market value.[10] The look back period is calculated from the date of application for Medicaid.[11] If a transfer of assets for less than fair market value is found, the state must withhold payment for nursing facility care and other long-term care services for a period of time referred to as the penalty period. The length of the penalty period is determined by dividing the value of the transferred asset by the average monthly private-pay rate for nursing facility care in the state.[12]

Spousal Impoverishment

Section 1924 of the Social Security Act provides requirements to prevent "spousal impoverishment," which can leave the spouse who is still living at home in the community with little or no income or resources.[13] When the couple applies for Medicaid, an assessment of their resources is made and a protected resource amount of $115,920[14] is set aside for the community spouse and the remainder is considered available for the individual applying for Medicaid.[15]

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[5] National Alliance for Caregiving (in collaboration with AARP), *Caregiving in the U.S., Executive Summary*, 2009, available at http://www.caregiving.org/pdf/research/FINALRegularExSum50plus.pdf (last viewed on March 17, 2013).
[6] See http://www.buxtonlaw.com/flmedicaidplanning.shtml (last viewed on March 17, 2013).
[7] Florida Department of Children and Families, *Staff Analysis and Economic Impact- HB 1323*, pages 1-2 (on file with the Health Innovation Subcommittee staff).
[8] Id.
[9] Id.
[10] Rule 65A-1.712(3), F.A.C.
[11] Id.
[12] Rule 65A-1.712(3)(g)1., F.A.C.; the average monthly private pay nursing facility rate is $7,362 per rule 65A-1.716(5)(d), F.A.C.
[13] 42 U.S.C. 1396r-5(d).
[14] This is an amount is known as the "community spouse resource allocation". See supra, FN 4 at page 12.
[15] Rule 65A-1.712(4), F.A.C.

Additionally, section 1924 of the Social Security Act provides that an individual applying for Medicaid cannot be determined ineligible for assistance based on assets of their spouse when:

- The applicant assigns his or her rights to support from the community spouse to the state;
- The applicant is physically or mentally unable to assign his right by the state has the right to bring a support proceeding against the community spouse; or
- The state determines the denial of eligibility would work an undue hardship.[16]

According to DCF, when an applicant signs a document assigning his or her rights to the state, the state has the authority to seek financial support from the community spouse for Medicaid funds spent on the spouse of the nursing facility.[17] While DCF indicates that it has authority to seek financial support from the community spouse under these circumstances, there is no mechanism to actually recover funds from the community spouse.[18]

Deficit Reduction Act

The Federal Deficit Reduction Act of 2005 (DRA)[19] contained provisions aimed at discouraging the use of "Medicaid planning" techniques and to impose penalties on transactions which are intended to protect wealth while enabling access to public benefits.[20] The Congressional Budget Office (CBO) estimated that the DRA would reduce federal Medicaid spending by $11.5 billion over the first five years and $43.2 billion within ten years. The DRA made changes to:

- Medicaid transfer of asset rules;
- Medicaid annuity rules;
- spousal impoverishment rules;
- home equity rules; and
- rules pertaining to treatment of continuing care retirement community entrance fees.

Transfer of Assets

The Act extended the "look-back period" for any transfers of assets from 36 months to 60 months, on or after February 8, 2006. In addition, the Act changed the start date of the penalty period, which is the period during which and individual is ineligible for Medicaid payment for long-term care services because of a transfer of assets for less than fair market value.[21] The Act changed the start date of the penalty period from the month of the transfer of assets to the date of application for Medicaid.[22]

Spousal Impoverishment

When a couple applies for Medicaid, an assessment of their resources is made and a protected resource amount of $115,920 is set aside for the community spouse and the remainder is considered available for the individual applying for Medicaid. This protected amount is known as the Community Spouse Resource Allowance (CSRA). The DRA provided that an increase in the CSRA cannot be granted until the maximum available income of the institutionalized spouse is allocated to the community spouse.[23]

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[16] 42 U.S.C. 1396r-(5)(c)(3)(C).
[17] See supra, FN 7 at pages 2-3.
[18] Id. at page 3.
[19] P.L. 109-171 (2005).
[20] Department of Health and Human Services, Centers for Medicare and Medicaid, *The Deficit Reduction Act: Important Facts for State Government Officials*, available at https://www.cms.gov/**DeficitReductionAct**/Downloads/Checklist1.pdf (last viewed on March 18, 2013).
[21] Id.
[22] Id.
[23] Id.

Recovery of Medicaid-Covered Expenses

Federal regulations[24] and the Florida Medicaid Third-Party Liability (TPL) Act[25] allow for recovery of amounts paid for medical expenses by Medicaid for which there is another liable third party (i.e., the recipient has other insurance coverage, such as private insurance or Medicare). AHCA has a current contract with a Medicaid third party liability vendor, Affiliated Computer Services (ACS). It is the role of the ACS to identify potential third party payors and to recoup from them costs that have been paid by Medicaid.

Effect of Proposed Changes

The bill requires DCF to apply additional asset transfer limitations for individuals applying for Medicaid nursing facility services, institutional hospice services, and home and community-based waiver programs. The new limitations apply to asset transfers made after July 1, 2013.

The bill applies the following new conditions to individuals who enter into personal services contracts:

- The contracted services must not duplicate services that would be available through other sources or providers, such as Medicaid, Medicare, private insurance, or another legally obligated third party;
- The contracted services must directly benefit the individual and are not services that are normally provided out of consideration for the individual;
- The cost to deliver the services must be computed in a manner that reflects the actual number of hours to be expended and the contract must clearly identify each specific service and the average number of hours required to deliver each service each month;
- The hourly rate for each contracted service must be equal to or less than the amount normally charged by a professional who traditionally provides the same or similar services;
- The cost of contracted services must be provided on a prospective basis only and does not apply to services provided before July 1, 2013; and
- The contract must provide fair compensation to the individual during her or his lifetime as set forth in the life expectancy tables published by the Office of the Actuary of the Social Security Administration.

The bill applies the following new conditions to a community spouse who refuses to make her or his resources available to the institutional spouse:

- Requiring proof that an estrangement existed between the spouses during the months before the individual submitted an application for institutional care services. If the individuals have not lived separate and apart without cohabitation and without interruption for at least 36 months, all resources of both individuals must be considered to determine eligibility.
- Transfer of assets between spouses that are in excess of the Community Spouse Resource Allowance must be considered. If such a transfer was made within the look back period, it is considered a transfer of assets for less than fair market value and therefore subject to a penalty period.
- An undue hardship does not exist when the individual, or person acting on his or her behalf, transfers resources to the community spouse and the community spouse refuses to make her or his resources available to the institutional spouse.
- The institutional spouse must be determined ineligible for Medicaid if she or he, or the person acting on her or his behalf, refuses to provide information about the community spouse or

[24] 42 U.S.C. §1396k(a).

[25] S. 409.910, F.S.

cooperate in the pursuit of court-ordered medical support or the recovery of Medicaid expenses paid by the state on her or his behalf.

The bill requires AHCA to seek recovery of all Medicaid-covered expenses and pursue court-ordered medical support from the community spouse when she or he refuses to make her or his assets available to the institutional spouse.

The bill provides DCF sufficient rule-making authority to implement the provisions of this bill.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.902, F.S., relating to designated single state agency; payment requirements; program title; release of medical records.
Section 2: Provides an effective date of upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:
The bill could result in savings to the state by applying stricter asset transfer limitations for certain individuals applying for nursing facility services under the Medicaid program.

2. Expenditures:

See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Nursing home and Medicaid long-term care managed care providers may experience a positive fiscal impact if a greater number of individuals are required to pay for their care with private pay, rather than Medicaid.

D. FISCAL COMMENTS:

The bill directs AHCA to seek recovery from the community spouse for monies paid by Medicaid on behalf of the eligible recipient which is to be accomplished by pursuing court-ordered medical support

from the community spouse. This pursuit could be accomplished through its contract with a third party liability vendor. The fiscal impact of these changes cannot be determined at this time.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill grants appropriate rule-making authority to DCF to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

On lines 34 and 35, the terms "directly benefit" and "consideration" lack specificity. It will be difficult to determine how a provided service directly benefits the recipient of the service. Also, services and acts "normally provided out of consideration" are not clear in the meaning of "consideration".

On lines 38 and 39, the bill requires a contract for personal care services to specify the number of hours to be expended. It does not specify over what time period those hours will span. It is recommended that language be added indicating that the contract must specify the number of hours to be expended "over the life of the contract."

On lines 42 through 44, the bill requires the hourly rate at which personal care services are to be billed under the contract is no more than the amount normally charged by a professional who traditionally provides the same or similar services. Professionals who provide personal care services charge different rates according to the market in which they operate. The hourly rate to provide certain services may likely be higher in a major city compared to the hourly rate compared in a rural county. It is recommended that language be added to the bill to read:

"4. The hourly rate for each contracted service is no more than the usual and customary amount charged by a professional who traditionally provides the same or similar services in the community where the contracted services are to be performed."

At lines 58 through 63, the bill requires proof that estrangement existed during the months before the individual submitted an application for institutional care services for a period of 36 months, otherwise all resources of both individuals shall be considered to determine eligibility. Including this provision counteracts the provision of 42 U.S.C. 1396r-5(c)(3), which states:

> "The institutionalized spouse shall not be ineligible by reason of resources determined...to be available for the cost of care where-
> (A) the institutionalized spouse has assigned to the State any rights to support from the community spouse;

(B) the institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but the state has the right to bring a support proceeding against a community spouse without such assignment; or
(C) the State determines that denial of eligibility would work an undue hardship."

Essentially, if an individual desires to assign his or her rights to support to the state, he or she does not have to meet a requirement to show estrangement in order to receive Medicaid. Requiring the individuals to be estranged for a period of time is not part of the criteria referenced in the federal law. Therefore, this language may be construed as being more restrictive than the federal language.

At lines 64 through 72, the bill does not comply with sections 1917 and 1924 of the Social Security Act, which permit transfer of assets between spouses without application of a transfer of asset penalty period as the resources of both individuals are counted in the eligibility phase. Also, this language appears to negate the cited language from 42 U.S.C. 1396r-5(c)(3).

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to Medicaid eligibility; amending s.
3 409.902, F.S.; providing asset transfer limitations
4 for the determination of eligibility for certain
5 nursing facility services under the Medicaid program
6 after a specified date; requiring the Department of
7 Children and Families to take certain actions if a
8 community spouse refuses to make certain resources
9 available to the institutional spouse; authorizing the
10 Agency for Health Care Administration to recover
11 certain Medicaid expenses; authorizing the department
12 to adopt rules; providing an effective date.
13
14 Be It Enacted by the Legislature of the State of Florida:
15
16 Section 1. Subsection (9) is added to section 409.902,
17 Florida Statutes, to read:
18 409.902 Designated single state agency; payment
19 requirements; program title; release of medical records;
20 eligibility requirements.—
21 (9) In determining eligibility for nursing facility
22 services, including institutional hospice services and home and
23 community-based waiver programs under the Medicaid program, the
24 Department of Children and Families shall apply the asset
25 transfer limitations specified in paragraph (a) for transfers
26 made after July 1, 2013.
27 (a) An individual who enters into a personal services
28 contract with a relative is considered to have transferred

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

29 assets without fair compensation to qualify for Medicaid unless:
30 1. The contracted services do not duplicate services
31 available through other sources or providers, such as Medicaid,
32 Medicare, private insurance, or another legally obligated third
33 party;
34 2. The contracted services directly benefit the individual
35 and are not services normally provided out of consideration for
36 the individual;
37 3. The actual cost to deliver services is computed in a
38 manner that clearly reflects the actual number of hours to be
39 expended and the contract clearly identifies each specific
40 service and the average number of hours required to deliver each
41 service each month;
42 4. The hourly rate for each contracted service is no more
43 than the amount normally charged by a professional who
44 traditionally provides the same or similar services;
45 5. The cost of contracted services is provided on a
46 prospective basis only and does not apply to services provided
47 before July 1, 2013; and
48 6. The contract for services provides fair compensation to
49 the individual during his or her lifetime as set forth in the
50 life expectancy tables published by the Office of the Chief
51 Actuary of the United States Social Security Administration.
52 (b) When determining eligibility for nursing facility
53 services, including institutional hospice services and home and
54 community-based waiver programs under the Medicaid program, if a
55 community spouse refuses to make his or her resources available
56 to his or her institutional spouse, the Department of Children

57 and Families shall:
58 1. Require proof that estrangement existed during the
59 months before the individual submitted an application for
60 institutional care services. If the individuals have not lived
61 separate and apart without cohabitation and without interruption
62 for at least 36 months, all resources of both individuals shall
63 be considered to determine eligibility.
64 2. Consider transfer of assets between spouses in excess
65 of the Community Spouse Resource Allowance within the look-back
66 period to be a transfer of assets for less than fair market
67 value and therefore subject to a penalty period.
68 3. Determine that undue hardship does not exist when the
69 individual, or the person acting on his or her behalf, transfers
70 resources to the community spouse and the community spouse
71 refuses to make her or his resources available to the
72 institutional spouse.
73 4. Determine the institutional spouse to be ineligible for
74 Medicaid if he or she, or the person acting on his or her
75 behalf, refuses to provide information about the community
76 spouse or cooperate in the pursuit of court-ordered medical
77 support or the recovery of Medicaid expenses paid by the state
78 on his or her behalf.
79 (c) The Agency for Health Care Administration shall seek
80 recovery of all Medicaid-covered expenses and pursue court-
81 ordered medical support from the community spouse when he or she
82 refuses to make his or her assets available to the institutional
83 spouse.
84 (d) The Department of Children and Families may adopt

85 rules to implement this subsection.

86 Section 2. This act shall take effect upon becoming a law.

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	___	

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1 Committee/Subcommittee hearing bill: Health Innovation
2 Subcommittee
3 Representative Nuñez offered the following:
4
5 **Amendment**
6 Remove lines 52-78 and insert:
7 (b) When determining eligibility for nursing facility
8 services, including institutional hospice services and home and
9 community based waiver programs under the Medicaid program, the
10 Department of Children and Families shall determine the
11 institutional spouse to be ineligible for Medicaid if he or she,
12 or the person acting on his or her behalf, refuses to provide
13 information about the community spouse or cooperate in the
14 pursuit of court ordered medical support or the recovery of
15 Medicaid expenses paid by the state on his or her behalf.
16
17

PCS for HB 1319

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 1319 Assisted Living Facilities
SPONSOR(S): Health Innovation Subcommittee; Gonzalez
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Innovation Subcommittee		Guzzo	Shaw

SUMMARY ANALYSIS

The proposed committee substitute strengthens the regulation of Assisted Living Facilities (ALFs) and makes other regulatory changes to improve the quality of ALFs.

Specifically, the bill:

- Clarifies who is responsible for assuring that mental health residents in an ALF receive necessary services.
- Requires ALFs to provide information to new residents upon admission that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right.
- Creates a provisional Extended Congregate Care (ECC) license for new ALFs and specifies when the Agency for Health Care Administration (AHCA) may deny or revoke a facility's ECC license.
- Reduces by half the number of monitoring visits AHCA must conduct for ALFs with Limited Nursing Services (LNS) licenses and ECC licenses.
- Requires facilities with one or more, rather than three or more, state supported mental health residents obtain a limited mental health (LMH) license.
- Allows AHCA to revoke the license of a facility with a controlling interest that has or had a 25 percent or greater financial or ownership interest in a second facility which closed due to financial inability to operate or was the subject of other specified administrative sanctions.
- Clarifies the criteria under which AHCA must revoke or deny a facility's license.
- Specifies circumstances under which AHCA must impose an immediate moratorium on a facility.
- Sets fines for all classes of violations to a fixed amount at the midpoint of the current range and multiplies these new fine amounts for facilities licensed for 100 or more beds by 1.5 times.
- Allows AHCA to impose a fine for a class I violation even if it is corrected before AHCA inspects a facility.
- Doubles fines for repeated serious violations.
- Requires that fines be imposed for repeat minor violations regardless of correction.
- Doubles the fines for minor violations if a facility is cited for the same minor violation three or more times over the course of three licensure inspections.
- Specifies a fine amount of $500 for ALFs that are not in compliance with background screening requirements.
- Adds certain responsible parties and agency personnel to the list of people who must report abuse or neglect to the Department of Children and Families' (the DCF) central abuse hotline.
- Requires new facility staff, who have not previously completed core training, to attend a 2 hour pre-service orientation before interacting with residents.
- Requires AHCA to conduct a study of inter-surveyor reliability in order to determine the consistency with which regulations are applied to facilities.
- Requires AHCA to propose a plan for an ALF rating system by November 1, 2013.
- Requires AHCA to create a website to assist consumers in selecting an ALF by January 1, 2014.

See fiscal impact on state government.

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Assisted Living Facility Reform

In April of 2011, the Miami Herald completed a three part investigative series relating to assisted living facilities (ALFs). This series highlighted concerns with the management and administration of ALFs and garnered the attention of not only the public, but many state lawmakers, stakeholders, and facility residents and their families.

Assisted Living Facility Workgroups

In July 2011, Governor Rick Scott directed AHCA to examine the regulation and oversight of ALFs. In response, AHCA created the ALF workgroup. The workgroup's objective was to make recommendations to the Governor and Legislature that would improve the monitoring of safety in ALFs to help ensure the well-being of residents. After a series of meetings, the workgroup produced a final report and recommendations that they felt could strengthen oversight and reassure the public that ALFs are safe. Such recommendations included increasing administrator qualifications, expanding training for administrators and other staff, increasing survey inspection activity, and improving the integration of information among all agencies involved in the regulation of ALFs. The workgroup also noted several other issues that would require more time to evaluate and recommended they be examined by a Phase II workgroup.

Phase II of the workgroup began meeting in June 2012 to resume examining those issues not addressed by Phase I of the workgroup. Phase II of the workgroup will concluded in October, 2012 and produced a final report and recommendations to the Governor and the Legislature on November 26, 2012.

The issue of improving inter-agency communication was included in the workgroup's recommendations. Specifically, the workgroup recommended improving coordination between various federal, state and local agencies with any role in long-term care facilities oversight, especially ALFs. This includes AHCA, the Long Term Care Ombudsman Program, local fire authorities, local health departments, the Department of Children and Families, the Department of Elder Affairs, local law enforcement and the Attorney General's Office.[1]

Assisted Living Facility Negotiated Rulemaking Committee

In June, 2012, DOEA, in consultation with AHCA, DCF, and DOH, began conducting negotiated rulemaking meetings to address ALF regulation. The purpose of the meetings was to draft and amend mutually acceptable proposed rules addressing the safety and quality of services and care provided to residents within ALFs. Most of the issues addressed by the Committee were identified by Phase I of the workgroup as areas of concern that could be reformed via the rulemaking process. The Committee produced a Final Summary Report containing all the proposed rule changes agreed upon by the Committee. These proposed rule changes are currently in the final stages of the standard proposed rule changing process required by law.

[1] Florida Assisted Living Workgroup, Phase II Recommendations, November 26, 2012, available at http://www.ahca.myflorida.com/SCHSCommitteesCouncils/ALWG/index.shtm.

Assisted Living Facilities - General

An ALF is a residential establishment, or part of a residential establishment, that provides housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.[2,3] A personal service is direct physical assistance with, or supervision of, the activities of daily living and the self-administration of medication.[4] Activities of daily living include: ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks.[5]

An ALF is required to provide care and services appropriate to the needs of the residents accepted for admission to the facility.[6] The owner or facility administrator determines whether an individual is appropriate for admission to the facility based on certain criteria.[7] If a resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, as determined by the facility administrator or health care provider, the resident must be discharged in accordance with the Resident Bill of Rights.[8]

There are currently 3,036 licensed ALFs in Florida with 85,413 beds.[9] An ALF must have a standard license issued by AHCA, pursuant to part I of ch. 429, F.S., and part II of ch. 408, F.S.

Specialty Licensed Facilities

In addition to a standard license, an ALF may have one or more specialty licenses that allow the ALF to provide additional care. These specialty licenses include: limited nursing services,[10] limited mental health services,[11] and extended congregate care services.[12]

Limited Mental Health License

A mental health resident is "an individual who receives social security disability income due to a mental disorder as determined by the Social Security Administration or receives supplemental security income due to a mental disorder as determined by the Social Security Administration and receives optional state supplementation."[13] A LMH license is required for any facility serving 3 or more mental health residents. [14] To obtain this license, the facility may not have any current uncorrected deficiencies or violations and facility administrator, as well as staff providing direct care to residents must complete 6 hours of training related to LMH duties, which is either provided by or approved by DCF.[15] A LMH license can be obtained during initial licensure, during relicensure, or upon request of the licensee.[16] There are 1,073 facilities with LNS licenses.[17]

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[2] Section 429.02(5), F.S.
[3] An ALF does not include an adult family-care home or a non-transient public lodging establishment.
[4] Section 429.02(16), F.S.
[5] Section 429.02(1), F.S.
[6] For specific minimum standards see Rule 58A-5.0182, F.A.C.
[7] S. 429.26, F.S., and Rule 58A-5.0181, F.A.C.
[8] S. 429.28, F.S.
[9] Agency for Health Care Administration, information provided to the Health Innovation Subcommittee February 4, 2013.
[10] S. 429.07(3)(c), F.S.
[11] S. 429.075, F.S.
[12] Section 429.07(3)(b), F.S.
[13] S. 429.02, F.S.
[14] S. 429.075, F.S.
[15] S. 429.075, F.S.
[16] S. 429.075, F.S.
[17] Agency for Health Care Administration, information provided to the Health Innovation Subcommittee February 4, 2013.

Extended Congregate Care License

The ECC specialty license allows an ALF to provide, directly or through contract, services performed by licensed nurses and supportive services to individuals who would otherwise be disqualified from continued residency in an ALF.[18] There are 279 facilities with ECC licenses.[19]

In order for ECC services to be provided, AHCA must first determine that all requirements in law and rule are met. ECC licensure is regulated pursuant to s. 429.07, F.S., and Rule 58A-5, F.A.C.

The primary purpose of ECC services is to allow residents, as their acuity level rises, to remain in a familiar setting. An ALF licensed to provide ECC services may also admit an individual who exceeds the admission criteria for a facility with a standard license, if the individual is determined appropriate for admission to the ECC facility. A licensed facility must adopt its own requirements within guidelines for continued residency set forth by rule. However, the facility may not serve residents who require 24-hour supervision.

Licensed ECC facilities may provide the following additional services:[20]

- Total help with bathing, dressing, grooming, and toileting;
- Nursing assessments conducted more frequently than monthly;
- Measuring and recording basic vital functions and weight;
- Dietary management, including providing special diets, monitoring nutrition, and observing the resident's food and fluid intake and output;
- Assisting with self-administered medications;
- Supervising residents with dementia and cognitive impairments;
- Health education, counseling, and implementing health-promoting programs;
- Rehabilitative services; and
- Escort services to health-related appointments.

Before being admitted to an ECC licensed facility to receive ECC services, the prospective resident must undergo a medical examination.[21] The ALF must develop a service plan that sets forth how the facility will meet the resident's needs and must maintain a written progress report on each resident who receives ECC services.

ALFs with an ECC license must meet the following staffing requirements:[22]

- Specify a staff member to serve as the ECC supervisor if the administrator does not perform this function;
- The administrator of an ECC licensed facility must have a minimum of 2 years of managerial, nursing, social work, therapeutic recreation, or counseling experience in a residential, long-term care, or acute care setting; and
- A baccalaureate degree may be substituted for one year of the required experience and a nursing home administrator licensed under chapter 468, F.S., shall be considered qualified.

An ECC administrator or supervisor, if different from the administrator, must complete the core training required of a standard licensed ALF administrator (26 hours plus a competency test), and 4 hours of initial training in ECC care within 3 months of beginning employment. The administrator must complete a minimum of 4 hours of continued education every 2 years. [23]

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[18] S. 429.07(3)(b), F.S.
[19] *See supra* at FN 17.
[20] Rule 58A-5.030(8)(b), F.A.C.
[21] Rule 58A-5.030(6), F.A.C.
[22] Rule 58A-5.030(4), F.A.C.
[23] Rule 58A-5.0191(7), F.A.C.

All staff providing direct ECC care to residents must complete at least 2 hours of initial service training, provided by the administrator, within 6 months of beginning employment.[24]

ALFs with a standard license must pay a biennial license fee of $300 per license, with an additional fee of $50 per resident. The total fee may not exceed $10,000. In addition to the total fee assessed for standard licensed ALFs, facilities providing ECC services must pay an additional fee of $400 per license, with an additional fee of $10 per resident.[25]

Limited Nursing Services License

Limited nursing services are services beyond those provided by standard licensed ALFs. A facility with a LNS specialty license may provide the following services:[26]

- Passive range of motion exercises;
- Ice caps or heat relief;
- Cutting toenails of diabetic residents;
- Ear and Eye irrigations;
- Urine dipstick tests;
- Replacement of urinary catheters;
- Digital stool removal therapies;
- Applying and changing routine dressings that do not require packing or irrigation;
- Care for stage 2 pressure sores;
- Caring for casts, braces and splints;
- Conducting nursing assessments;
- Caring for and monitoring the application of anti-embolism stockings or hosiery;
- Administration and regulation of portable oxygen;
- Applying, caring for and monitoring a transcutaneous electric nerve stimulator; and
- Catheter, colostomy, ileostomy care and maintenance.

A facility holding only a standard or LNS license must meet the admission and continued residency criteria contained in Rule 59A-5.0181, F.A.C.[27] The following admission and continued residency criteria for potential residents must be met:[28]

- Be at least 18 years of age;
- Be free from signs and symptoms of any communicable disease;
- Be able to perform the activities of daily living;
- Be able to transfer, with assistance if necessary;
- Be capable of taking their own medications with assistance from staff if necessary;
- Not be a danger to themselves or others;
- Not require licensed professional mental health treatment on a 24-hour a day basis;
- Not be bedridden;
- Not have any stage 3 or 4 pressure sores;
- Not require nursing services for oral or other suctioning, assistance with tube feeding, monitoring of blood gases, intermittent positive pressure breathing therapy, or treatment of surgical incisions or wounds;
- Not require 24-hour nursing supervision;
- Not require skilled rehabilitative services; and

[24] *Id.*
[25] S.429.07(4), F.S.
[26] Rule 58A-5.031(1), F.A.C.
[27] Rule 58A-5.031(2), F.A.C.
[28] Rule 58A-5.0181(1), F.A.C.

- Have been determined by the administrator to be appropriate for admission to the facility.

Facilities licensed to provide limited nursing services must employ or contract with a nurse to provide necessary services to facility residents.[29] Licensed LNS facilities must maintain written progress reports on each resident receiving LNS. A registered nurse representing AHCA must visit these facilities at least twice a year to monitor residents and determine compliance.[30] A nursing assessment must be conducted at least monthly on each resident receiving limited nursing services.[31]

Facilities licensed to provide LNS must pay the standard licensure fee of $300 per license, with an additional fee of $50 per resident and the total fee may not exceed $10,000. In addition the standard fee, in order to obtain the LNS specialty license facilities must pay an additional biennial fee of $250 per license, with an additional fee of $10 per bed.[32] There are 1,084 facilities with LMH licenses.[33]

Staff Training

Administrators and Managers

Administrators and other ALF staff must meet minimum training and education requirements established by the DOEA by rule.[34,35] This training and education is intended to assist facilities to appropriately respond to the needs of residents, maintain resident care and facility standards, and meet licensure requirements.[36]

The current ALF core training requirements established by the DOEA consist of a minimum of 26 hours of training and passing a competency test. Administrators and managers must successfully complete the core training requirements within 3 months after becoming a facility administrator or manager. The minimum passing score for the competency test is 75 percent.[37]

Administrators and managers must participate in 12 hours of continuing education in topics related to assisted living every 2 years. A newly hired administrator or manager, who has successfully completed the ALF core training and continuing education requirements, is not required to retake the core training. An administrator or manager, who has successfully completed the core training but has not maintained the continuing education requirements, must retake the ALF core training and retake the competency test.[38]

Staff with Direct Care Responsibilities

Facility administrators or managers are required to provide or arrange for 6 hours of in-service training for facility staff who provide direct care to residents. The training covers a variety of topics as provided by rule.[39] Staff training requirements must generally be met within 30 days after staff begin employment at the facility, however, staff must have at least 1 hour of infection control training before providing direct care to residents. Also, nurses, certified nursing assistants, and home health aides who are on staff with an ALF are exempt from many of the training requirements. In addition to the standard 6

[29] Rule 58A-5.031(2), F.A.C.
[30] S. 429.07(2)(c), F.S.
[31] *Id.*
[32] S. 429.07(4)(c), F.S.
[33] *See supra* at FN 17.
[34] Rule 58A-5.0191, F.A.C.
[35] Many of the training requirements in rule may be subject to change due to the recent DOEA negotiated rulemaking process.
[36] Section 429.52(1), F.S.
[37] Administrators who have attended core training prior to July 1, 1997, and managers who attended the core training program prior to April 20, 1998, are not required to take the competency test. Administrators licensed as nursing home administrators in accordance with Part II of Chapter 468, F.S., are exempt from this requirement.
[38] Rule 58A-5.0191, F.A.C.
[39] See note 26.

hours of in-service training, staff must also complete 1 hour of elopement training and 1 hour of training on do not resuscitate orders, and may have to complete training on special topics such as self-administration of medication and persons with Alzheimer's disease, if applicable.

ECC Specific Training

The administrator and ECC supervisor, if different from the administrator, must complete 4 hours of initial training in extended congregate care prior to the facility receiving its ECC license or within 3 months after beginning employment in the facility as an administrator or ECC supervisor. They must also complete a minimum of 4 hours of continuing education every 2 years in topics relating to the physical, psychological, or social needs of frail elderly and disabled persons, or persons with Alzheimer's disease or related disorders.[40]

All direct care staff providing care to residents in an ECC program must complete at least 2 hours of in-service training, provided by the facility administrator or ECC supervisor, within 6 months after beginning employment in the facility. The training must address ECC concepts and requirements, including the delivery of personal care and supportive services in an ECC facility.[41]

LMH Specific Training

Administrators, managers, and staff, who have direct contact with mental health residents in a licensed LMH facility must receive a minimum of 6 hours of specialized training in working with individuals with mental health diagnoses and a minimum of 3 hours of continuing education dealing with mental health diagnoses or mental health treatment every 2 years.[42]

<u>Inspections and Surveys</u>

AHCA is required to conduct a survey, investigation, or monitoring visit of an ALF:

- Prior to the issuance of a license.
- Prior to biennial renewal of a license.
- When there is a change of ownership.
- To monitor facilities licensed to provide LNS or ECC services, or facilities cited in the previous year for a class I or class II, or four or more uncorrected class III, violations.[43]
- Upon receipt of an oral or written complaint of practices that threaten the health, safety, or welfare of residents.
- If AHCA has reason to believe a facility is violating a provision of part III of ch. 429, F.S., relating to adult day care centers, or an administrative rule.
- To determine if cited deficiencies have been corrected.
- To determine if a facility is operating without a license.[44]

Abbreviated Surveys

An applicant for licensure renewal is eligible for an abbreviated biennial survey by AHCA if the applicant does not have any:

- Class I or class II violations or uncorrected class III violations.
- Confirmed long-term care ombudsman council complaints reported to AHCA by the council.
- Confirmed licensing complaints within the two licensing periods immediately preceding the current renewal date.[45]

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[40] Rule 58A-5.0191(7)(b), F.A.C.
[41] Rule 58A-5.0191(7)(c), F.A.C.
[42] S. 429.075, F.S. and Rule 58A-5.0191(8), F.A.C.
[43] *See below* information under subheading "Violations and Penalties" for a description of each class of violation.
[44] *See* s. 429.34, F.S., and Rule 58A-5.033, F.A.C.

An abbreviated survey allows for a quicker and less intrusive survey by narrowing the range of items that AHCA must inspect.[46] AHCA is required to expand an abbreviated survey or conduct a full survey if violations which threaten or potentially threaten the health, safety, or security of residents are identified during an abbreviated survey.[47]

Monitoring Visits

Facilities with LNS or ECC licenses are subject to monitoring visits by AHCA in which the agency inspects the facility for compliance with the requirements of the specialty license type. An LNS licensee is subject to monitoring inspections at least twice a year. At least one registered nurse must be included in the inspection team to monitor residents receiving LNS and to determine if the facility is complying with applicable regulatory requirements.[48] An ECC licensee is subject to quarterly monitoring inspections. At least one registered nurse must be included in the inspection team. AHCA may waive one of the required yearly monitoring visits for an ECC facility that has been licensed for at least 24 months, if the registered nurse who participated in the monitoring inspections determines that the ECC services are being provided appropriately, and there are no serious violations or substantiated complaints about the quality of service or care.[49]

Violations and Penalties

Part II of ch. 408, F.S., provides general licensure standards for all facilities regulated by AHCA. Under s. 408.813, F.S., ALFs may be subject to administrative fines imposed by AHCA for certain types of violations. Violations are categorized into four classes according to the nature of the violation and the gravity of its probable effect on residents.

Class I violations are those conditions that AHCA determines present an imminent danger to residents or a substantial probability of death or serious physical or emotional harm. Examples include resident death due to medical neglect, risk of resident death due to inability to exit in an emergency, and the suicide of a mental health resident in an ALF licensed for Limited Mental Health. AHCA must issue a fine between $5,000 and $10,000 for each violation.

Class II violations are those conditions that AHCA determines directly threaten the physical or emotional health, safety, or security of the clients. Examples include having no qualified staff in the facility, the failure to call 911 in a timely manner for resident in a semi-comatose state, and rodents in food storage area. AHCA must issue a fine a between $1,000 and $5,000 for each violation.

Class III violations are those conditions that AHCA determines indirectly or potentially threaten the physical or emotional health, safety, or security of clients. Examples include missing or incomplete resident assessments, erroneous documentation of medication administration, and failure to correct unsatisfactory DOH food service inspection findings in a timely manner. AHCA must issue a fine between $500 and $1,000 for each violation, but no fine may be imposed if the facility corrects the violation.

Class IV violations are those conditions that do not have the potential of negatively affecting clients. Examples include failure to file an adverse incident report, incorrect phone numbers posted for advocacy resources, and failure to post current menus. AHCA can only fine a facility (between $100 and $200 for each violation) if the problem is not corrected. [50,51]

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[45] Rule 58A-5.033(2), F.A.C.

[46] Rule 58A-5.033(2)(b)

[47] *Id.*

[48] S. 429.07(3)(c), F.S.

[49] S. 429.07(3)(b), F.S.

[50] When fixing the amount of the fine, the AHCA must consider the following factors: the gravity of the violation and the extent to which any laws or rules were violated, actions taken to correct the violations, any previous violations, the financial benefit of committing or continuing the violation, and the licensed capacity of the facility. Section 429.19(3), F.S.

[51] Section 429.19(2), F.S.

In addition to financial penalties, AHCA can take other actions against a facility. AHCA may deny, revoke, and suspend any license for any of the actions listed in s. 429.14(1)(a)-(k), F.S. AHCA is required to deny or revoke the license of an ALF that has two or more class I violations that are similar to violations identified during a survey, inspection, monitoring visit, or complaint investigation occurring within the previous 2 years.[52] AHCA may also impose an immediate moratorium or emergency suspension on any provider if it determines that any condition presents a threat to the health, safety, or welfare of a client.[53] AHCA is required to publicly post notification of a license suspension or revocation, or denial of a license renewal, at the facility.[54] Finally, Florida's Criminal Code, under ch. 825, F.S., provides criminal penalties for the abuse, neglect, and exploitation of elderly persons[55] and disabled adults.[56]

Central Abuse Hotline

The Department of Children and Families (DCF) is required under s. 415.103, F.S., to establish and maintain a central abuse hotline to receive reports, in writing or through a single statewide toll-free telephone number, of known or suspected abuse, neglect, or exploitation of a vulnerable adult[57] at any hour of the day or night, any day of the week.[58] Persons listed in s. 415.1034, F.S., who know, or have reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited are required to immediately report such knowledge or suspicion to the central abuse hotline.[59]

Long-Term Care Ombudsman Program

The Long-Term Care Ombudsman program within the Department of Elder Affairs (DOEA), must "identify, investigate, and resolve complaints made by or on behalf of residents of long-term care facilities relating to actions or omissions by providers or representatives of providers of long-term care services, other public or private agencies, guardians, or representative payees that may adversely affect."[60] The program consists of a state and local council, both of which serve under the ombudsman,[61] an individual appointed by Secretary of DOEA to head the ombudsman program.[62] The complaints, as well as the identities of the complainants made to the Ombudsman councils are confidential, with few exceptions.[63] Upon admission to an ALF, residents must be provided a brochure

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[52] Section 429.14(4), F.S.
[53] Section 408.814, F.S.
[54] Section 429.14(7), F.S.
[55] "Elderly person" means a person 60 years of age or older who is suffering from the infirmities of aging as manifested by advanced age or organic brain damage, or other physical, mental, or emotional dysfunction, to the extent that the ability of the person to provide adequately for the person's own care or protection is impaired. Section 825.101(5), F.S. It does not constitute a defense to a prosecution for any violation of this chapter that the accused did not know the age of the victim. Section 825.104, F.S.
[56] "Disabled adult" means a person 18 years of age or older who suffers from a condition of physical or mental incapacitation due to a developmental disability, organic brain damage, or mental illness, or who has one or more physical or mental limitations that restrict the person's ability to perform the normal activities of daily living. Section 825.101(4), F.S.
[57] "Vulnerable adult" means a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging. Section 415.102(27), F.S.
[58] The central abuse hotline is operated by the DCF to: accept reports for investigation when there is a reasonable cause to suspect that a vulnerable adult has been or is being abused, neglected, or exploited; determine whether the allegations require an immediate, 24-hour, or next-working-day response priority; when appropriate, refer calls that do not allege the abuse, neglect, or exploitation of a vulnerable adult to other organizations that might better resolve the reporter's concerns; immediately identify and locate prior reports of abuse, neglect, or exploitation through the central abuse hotline; Section 415.103(1), F.S.
[59] Section 415.1034, F.S.
[60] S. 400.0065, F.S.
[61] S. 400.0065, F.S.
[62] S. 400.0060, F.S.
[63] S. 400.0077, F.S.

with contact information of the local ombudsman council,[64] to enable the residents to report mistreatments within the ALF.

AHCA Development/Updates

AHCA has taken steps to help provide more efficient and effective care to residents of ALFs. From July 1, 2011 through June 1, 2012, AHCA has:[65]

- Issued 595 final orders for ALFs;
- Issued 11 suspensions and moratoria;
- Issued 9 denials;
- Issued 11 revocations;
- Closed 38 facilities; and
- Imposed $1,513,046 in sanctions by final order.

AHCA has also initiated several proactive approaches, including:[66]

- Issuing monthly press releases regarding sanctions, closures, and other actions;
- Holding monthly interagency meetings with Agency partners;
- Establishing an ALF enforcement unit;
- Revising the ALF survey process to include resident interviews; and
- Providing statewide joint training for administrators, providers, and associations.

Effect of Proposed Changes

The bill amends s. 394.4574, F.S., to clarify that Medicaid prepaid behavioral health plans are responsible for enrolled state supported mental health residents and that managing entities under contract with the DCF are responsible for such residents who are not enrolled with a Medicaid prepaid behavioral health plan. This section requires a mental health resident's community living support plan be completed and provided to the administrator of the facility when the facility admits a mental health resident and be updated when there is a significant change to the resident's behavioral health status. The resident's case manager must keep a 2-year record of any face-to-face interaction with the resident. Finally, this section charges the entity responsible for a mental health resident to ensure that there is adequate and consistent monitoring of the community living support plan and to report any concerns about a regulated provider failing to provide services or otherwise acting in a manner with the potential to cause harm to the resident.

The bill amends s. 400.0078, F.S., to require that ALFs provide information to new residents upon admission to the facility that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right.

The bill amends s. 429.07, F.S., to make changes to improve the regulation of facilities with ECC and LNS specialty licenses. These changes include:

- Requiring that an ALF be licensed for 2 or more years before being issued an ECC license that is not provisional.
- Creating a provisional ECC license for ALFs that have been licensed for less than 2 years.
- The provisional license lasts for a period of 6 months.

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[64] Rule 58A-5.0181, F.A.C.

[65] Assisted Living Facility Workgroup Phase II, AHCA presentation, June 25, 2012, available at http://www.ahca.myflorida.com/SCHS/CommitteesCouncils/ALWG/index.shtm.

[66] *Id.*

- The facility must inform AHCA when it has admitted one or more residents requiring ECC services.
- After the facility admits one or more ECC residents, AHCA must inspect the facility for compliance with the requirements of the ECC license.
- If the licensee demonstrates compliance with the requirements of an ECC license, AHCA must grant the facility an ECC license that is not provisional.
- If the licensee fails to demonstrate compliance with the requirements of an ECC license, the licensee must immediately suspend ECC services and the provisional ECC license expires.
- Reducing monitoring visits for facilities with ECC licenses from quarterly to twice a year, and for facilities with LNS licenses from twice a year to once a year.
- Clarifying under what circumstances the AHCA may waive one of the required monitoring visits for facilities with ECC licenses and also allowing AHCA to waive the required monitoring visit for facilities with an LNS license under the same conditions.
- Clarifying under what circumstances AHCA may deny or revoke a facility's ECC license.

The bill amends s. 429.075, F.S., to require:

- Facilities with one or more mental health residents to obtain a LMH license.
- ALFs to provide written documentation that the facility requested an assessment of a mental health resident for appropriateness of placement, within 72 hours of the resident being admitted.

The bill amends s. 429.14, F.S., to:

- Allow AHCA to revoke, rather than just deny, a license for a facility with a controlling interest that has, or had, a 25 percent or greater financial or ownership interest in a second facility that closed due to financial inability to operate or was the subject of other specified administrative sanctions.
- Add additional criteria under which AHCA must deny or revoke a facility's license unless there are mitigating circumstances. The criteria include:
    - Applicant or licensee had a license that was revoked or denied by AHCA, DCF, DJJ, or APD.
    - There are 2 moratoria issued within a 2-year period.
    - The facility is cited for 2 or more class I violations arising from unrelated circumstances during the same investigation.
    - The facility is cited for 2 or more class I violations within 2 years.
- Require AHCA to impose an immediate moratorium on a facility that fails to provide AHCA with access to the facility, prohibits a regulatory inspection, denies access to records, or prohibits the confidential interview of facility staff or residents.
- Exempt a facility from the 45-day notice requirement in s. 429.28(k), F.S., if that facility is required to relocate all or some of its residents due to action by AHCA.

The bill amends s. 429.19, F.S., relating to the impositions of fines in order to reduce the discretion of AHCA and to make such penalties more predictable. Specifically, the bill would:

- Fix the dollar amount for fines at $7,500 for class I violations, $3,000 for class II violations, $750 for class III violations, and $150 for class IV violations for facilities licensed for few than 100 beds at the time of the violation. This is the midpoint of the current ranges for fines in current law.
- Multiply fines amounts by 1.5 times for facilities licensed for 100 or more beds, so that the fine is $11,250 for class I violations, $4,500 for class II violations, $1,125 for class IV violations, and $225 for class IV violations.
- Allow the AHCA to impose a fine on a facility for a class I violation, even if the facility corrects the violation before the AHCA conducts an investigation. Facilities can still challenge such fines through an administrative hearing pursuant to ch. 120, F.S.

- Double the fines for facilities with repeat class I and class II violations.
- Impose a fine on facilities with repeat class III and class IV violations, regardless of correction. Current law prohibiting the AHCA from assessing fines for corrected class III and IV violations continues for the first survey finding such violations.
- Double the fines for class III or class IV violations if a facility is cited for two or more such violations, stemming from the same regulation, during the AHCA's last two licensure inspections.
- Fine a facility $500 for failure to comply with background screening requirements. This fine will take the place of fines based on the class of the violation.

The bill amends s. 429.41 to clarify that an abbreviated biennial inspection may not be used for a facility that has confirmed ombudsman or licensure complaints, if those complaints resulted in a citation for licensure violation.

The bill amends s. 429.52, F.S., to:

- Require ALFs to provide a 2 hour pre-service orientation for new facility employees who have not previously completed core training. The pre-service orientation must cover topics that help the employee provide responsible care and respond to the needs of the residents. The employee and the facility's administrator must sign an affidavit that the employee completed the orientation and the facility must keep the affidavit in the employee's work file.
- Require AHCA in conjunction with DOEA to establish a database for the collection of documentation relating to the training and competency testing of employees and administrators.

The bill amends s. 429.54, F.S., to require AHCA, DOEA, DCF, and APD to develop or modify electronic systems of communication among state-supported automated systems to ensure that important information is being shared and coordinated timely and effectively to facilitate the protection of residents.

The bill creates s. 429.55, F.S., to require AHCA to conduct a study of inter-surveyor reliability to determine if different surveyors consistently apply licensure standards. AHCA must report its findings and make recommendations to the Governor, the President of the Senate, and the Speaker of the House by November 1, 2013.

Finally, the bill creates s. 429.56, F.S., to:

- Require AHCA to propose a rating system for ALFs to assist consumers in selecting the best facility for themselves. AHCA must submit the proposal to the Governor, the President of the Senate, and the Speaker of the House by November 1, 2013.
- Require AHCA to create a webpage, that is easily accessible through the front page of the AHCA website, which contains information on each licensed ALF, including, but not limited to: types of licenses held and its history of violations.
    - The name and address of the facility.
    - The types of licenses held by the facility.
    - The facility's license expiration date and status.
    - Any other relevant information that AHCA currently collects.
    - A list of the facility's violations, including, a summary of the violation, any sanctions imposed by final order, and the date of the correction.
    - Links to inspection reports on file with AHCA.

B. SECTION DIRECTORY:

Section 1: Amends s. 394.4574, F.S., relating to responsibilities for coordination of services for a mental health resident who resides in an assisted living facility that holds a limited mental health license.
Section 2: Amends s. 400.0078, F.S., relating to citizen access to State Long-Term Care Ombudsman Program services.
Section 3: Amends s. 429.07, F.S., relating to license required; fee.
Section 4: Amends s. 429.075, F.S., relating to limited mental health licenses.
Section 5: Amends s. 429.14, F.S., relating to administrative penalties.
Section 6: Amends s. 429.19, F.S., relating to violations; imposition of administrative fines; grounds.
Section 7: Amends s. 429.41, F.S., relating to rules establishing standards.
Section 8: Amends s. 429.52, F.S., relating to staff training and educational programs; and core educational requirements.
Section 9: Amends s. 429.54, F.S., relating to collection of information; local subsidy.
Section 10: Creates s. 429.55, F.S., relating to inter-surveyor reliability.
Section 11: Creates s. 429.56, F.S., relating to consumer information.
Section 12: Provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   AHCA has not reviewed the PCS; however, the agency may have some costs associated with creating the ALF administrator and employee training database and with creating the website containing information about ALFs for the public.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill revises fines used to sanction facilities with violations, but such fines can still be challenged and settled through ch. 120, F.S. Facilities with fewer than 100 beds with class I violations will now be assessed a fine of $7,500 (current law allows the fine to be between $5,000 and $10,000). Some facilities will see a reduction in their fine, while other will see an increase. The range for fines for class II, III, and IV violations are replaced with an amount equal to the midpoint of the range. Fines for facilities with 100 beds or more will see higher fines.

Facilities would also be assessed a fine for class I violations even if they are corrected when the AHCA visits the facility. Facilities violating the background screening requirements would be levied a fine of $500. Currently, facilities are cited for a class II or III violation for not screening the background of facility staff so the fine amount can vary. All fines are subject to challenge through an administrative hearing under ch. 120, F.S.

Facilities would be required to provide new employees that have not already gone through the ALF core training program with a 2 hour pre-service training session before they work with residents. The cost of this training is not expected to be significant and in many cases is already provided.

Facilities with specialty licenses that meet licensure standards would see fewer monitoring visits from the AHCA. This will positively impact the facilities as they will have less interruption of staff time due to such visits.

Facilities with any state supported mentally ill residents would have to meet limited mental health licensure requirements with one or more mental health residents. Facilities with one or two state supported mentally ill residents that do not meet these requirements may see increased costs to comply. Some facilities with one or two such residents however, may already meet the requirements for a limited mental health license.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

No additional rule-making authority is necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to assisted living facilities;
3 amending s. 394.4574, F.S.; providing that Medicaid
4 prepaid behavioral health plans are responsible for
5 enrolled mental health residents; providing that
6 managing entities under contract with the Department
7 of Children and Families are responsible for mental
8 health residents who are not enrolled with a Medicaid
9 prepaid behavioral health plan; deleting a provision
10 to conform to changes made by the act; requiring that
11 the community living support plan be completed and
12 provided to the administrator of a facility upon the
13 mental health resident's admission; requiring the
14 community living support plan to be updated when there
15 is a significant change to the mental health
16 resident's behavioral health; requiring the case
17 manager assigned to a mental health resident of an
18 assisted living facility that holds a limited mental
19 health license to keep a record of the date and time
20 of face-to-face interactions with the resident and to
21 make the record available to the responsible entity
22 for inspection; requiring that the record be
23 maintained for a specified time; requiring the
24 responsible entity to ensure that there is adequate
25 and consistent monitoring and enforcement of community
26 living support plans and cooperative agreements and
27 that concerns are reported to the appropriate
28 regulatory oversight organization under certain

29 circumstances; amending s. 400.0078, F.S.; requiring
30 that residents of long-term care facilities be
31 informed that retaliatory action cannot be taken
32 against a resident for presenting grievances or for
33 exercising any other resident right; amending s.
34 429.07, F.S.; providing that an extended congregate
35 care license is issued to certain facilities that have
36 been licensed as assisted living facilities under
37 certain circumstances; providing the purpose of an
38 extended congregate care license; providing that the
39 initial extended congregate care license of an
40 assisted living facility is provisional under certain
41 circumstances; requiring the licensee to notify the
42 Agency for Health Care Administration whenever it
43 accepts a resident who qualifies for extended
44 congregate care services; requiring the agency to
45 inspect the facility for compliance with the
46 requirements of an extended congregate care license;
47 authorizing the agency to waive one of the required
48 yearly monitoring visits under certain circumstances;
49 authorizing the agency to deny or revoke a facility's
50 extended congregate care license for certain reasons
51 or on certain grounds; requiring a registered nurse
52 representing the agency to visit the facility at least
53 annually, rather than twice a year, to monitor
54 residents who are receiving limited nursing services;
55 providing that the agency's monitoring visits may be
56 in conjunction with other agency inspections;

57 authorizing the agency to waive one of the required
58 yearly monitoring visits for certain facilities;
59 amending s. 429.075, F.S.; requiring an assisted
60 living facility that serves one or more mental health
61 residents to obtain a limited mental health license;
62 revising the methods in which a limited mental health
63 facility may satisfy the appropriateness of placement
64 requirements to include providing written evidence to
65 the Department of Children and Family Services that a
66 request for documentation was sent within 72 hours of
67 admission; amending s. 429.14, F.S.; revising the
68 actions in which the agency may deny, revoke, or
69 suspend the license of an assisted living facility and
70 impose an administrative fine; revising the criteria
71 upon which the agency must deny or revoke the license
72 of an assisted living facility; providing that the
73 licensee may present certain factors in mitigation of
74 the revocation of a license; requiring the agency to
75 impose an immediate moratorium on the license of an
76 assisted living facility under certain circumstances;
77 deleting a provision requiring the agency to provide a
78 list of facilities with denied, suspended, or revoked
79 licenses to the Department of Business and
80 Professional Regulation; exempting a facility from the
81 45-day notice requirement if it is required to
82 relocate some or all of its residents; amending s.
83 429.19, F.S.; revising the amounts and uses of
84 administrative fines; requiring the agency to levy a

85 fine for violations that are corrected before an
86 inspection if noncompliance occurred within a
87 specified period of time; deleting factors that the
88 agency is required to consider to determine penalties
89 and fines; amending s. 429.41, F.S.; clarifying that
90 an abbreviated biennial inspection may not be used for
91 a facility that has confirmed ombudsman or licensure
92 complaints, which resulted in a citation for licensure
93 violation; amending s. 429.52, F.S.; requiring each
94 newly hired employee of an assisted living facility to
95 attend a preservice orientation provided by the
96 assisted living facility; requiring the employee and
97 administrator to sign an affidavit upon completion of
98 the preservice orientation; requiring the assisted
99 living facility to maintain the signed affidavit in
100 each employee's work file; conforming a cross-
101 reference; requiring the Agency for Health Care
102 Administration in conjunction with the Department of
103 Elder Affairs to establish a database for the
104 collection of employee and administrator training
105 documentation; amending s. 429.54, F.S.; requiring the
106 development of electronic systems of communication
107 among all agencies involved in the regulation of
108 assisted living facilities; creating s. 429.55, F.S.;
109 requiring the Agency for Health Care Administration to
110 study the reliability of facility surveys and submit
111 to the Governor and the Legislature its findings and
112 recommendations; creating s. 429.56, F.S.; requiring

113 the agency to propose a rating system of assisted
114 living facilities for consumers; providing criteria
115 for the content; providing an effective date.
116
117 Be It Enacted by the Legislature of the State of Florida:
118
119
120 Section 1. Section 394.4574, Florida Statutes, is amended
121 to read:
122 394.4574 ~~Department~~ Responsibilities for coordination of
123 services for a mental health resident who resides in an assisted
124 living facility that holds a limited mental health license.—
125 (1) As used in this section, the term "mental health
126 resident" ~~"mental health resident," for purposes of this~~
127 ~~section,~~ means an individual who receives social security
128 disability income due to a mental disorder as determined by the
129 Social Security Administration or receives supplemental security
130 income due to a mental disorder as determined by the Social
131 Security Administration and receives optional state
132 supplementation.
133 (2) Medicaid prepaid behavioral health plans are
134 responsible for enrolled mental health residents, and managing
135 entities under contract with the department are responsible for
136 mental health residents who are not enrolled with a Medicaid
137 prepaid behavioral health plan. Each responsible entity shall
138 ~~The department must~~ ensure that:
139 (a) A mental health resident has been assessed by a
140 psychiatrist, clinical psychologist, clinical social worker, or

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

141 psychiatric nurse, or an individual who is supervised by one of
142 these professionals, and determined to be appropriate to reside
143 in an assisted living facility. The documentation must be
144 provided to the administrator of the facility within 30 days
145 after the mental health resident has been admitted to the
146 facility. An evaluation completed upon discharge from a state
147 mental hospital meets the requirements of this subsection
148 related to appropriateness for placement as a mental health
149 resident if it was completed within 90 days before ~~prior to~~
150 admission to the facility.
151 (b) A cooperative agreement, as required in s. 429.075, is
152 developed between the mental health care services provider that
153 serves a mental health resident and the administrator of the
154 assisted living facility with a limited mental health license in
155 which the mental health resident is living. ~~Any entity that~~
156 ~~provides Medicaid prepaid health plan services shall ensure the~~
157 ~~appropriate coordination of health care services with an~~
158 ~~assisted living facility in cases where a Medicaid recipient is~~
159 ~~both a member of the entity's prepaid health plan and a resident~~
160 ~~of the assisted living facility. If the entity is at risk for~~
161 ~~Medicaid targeted case management and behavioral health~~
162 ~~services, the entity shall inform the assisted living facility~~
163 ~~of the procedures to follow should an emergent condition arise.~~
164 (c) The community living support plan, as defined in s.
165 429.02, has been prepared by a mental health resident and a
166 mental health case manager of that resident in consultation with
167 the administrator of the facility or the administrator's
168 designee. The plan must be completed and provided to the

169 administrator of the assisted living facility with a limited
170 mental health license in which the mental health resident lives
171 upon the resident's admission. The support plan and the
172 agreement may be in one document.
173 (d) The assisted living facility with a limited mental
174 health license is provided with documentation that the
175 individual meets the definition of a mental health resident.
176 (e) The mental health services provider assigns a case
177 manager to each mental health resident for whom the entity is
178 responsible ~~who lives in an assisted living facility with a~~
179 ~~limited mental health license~~. The case manager is responsible
180 for coordinating the development of and implementation of the
181 community living support plan defined in s. 429.02. The plan
182 must be updated at least annually, or when there is a
183 significant change to the resident's behavioral health status,
184 such as an inpatient admission or a change in behavioral status,
185 medications, level of service, or residence. Each case manager
186 shall keep a record of the date and time of any face-to-face
187 interaction with the resident and make the record available to
188 the responsible entity for inspection. The record must be
189 retained for at least 2 years after the date of the most recent
190 interaction.
191 (f) Adequate and consistent monitoring and enforcement of
192 community living support plans and cooperative agreements are
193 conducted by the resident's case manager.
194 (g) Concerns are reported to the appropriate regulatory
195 oversight organization if a regulated provider fails to deliver
196 appropriate services or otherwise acts in a manner that has the

197 potential to result in harm to the resident.
198 (3) The Secretary of Children and Family Services, in
199 consultation with the Agency for Health Care Administration,
200 shall ~~annually~~ require each district administrator to develop,
201 with community input, a detailed annual plan that demonstrates
202 ~~detailed plans that demonstrate~~ how the district will ensure the
203 provision of state-funded mental health and substance abuse
204 treatment services to residents of assisted living facilities
205 that hold a limited mental health license. These plans must be
206 consistent with the substance abuse and mental health district
207 plan developed pursuant to s. 394.75 and must address case
208 management services; access to consumer-operated drop-in
209 centers; access to services during evenings, weekends, and
210 holidays; supervision of the clinical needs of the residents;
211 and access to emergency psychiatric care.
212 Section 2. Subsection (2) of section 400.0078, Florida
213 Statutes, is amended to read:
214 400.0078 Citizen access to State Long-Term Care Ombudsman
215 Program services.—
216 (2) ~~Every resident or representative of a resident shall~~
217 ~~receive,~~ Upon admission to a long-term care facility, each
218 resident or representative of a resident must receive
219 information regarding the purpose of the State Long-Term Care
220 Ombudsman Program, the statewide toll-free telephone number for
221 receiving complaints, information that retaliatory action cannot
222 be taken against a resident for presenting grievances or for
223 exercising any other resident right, and other relevant
224 information regarding how to contact the program. Residents or

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225 their representatives must be furnished additional copies of
226 this information upon request.
227 Section 3. Paragraphs (b) and (c) of subsection (3) of
228 section 429.07, Florida Statutes, are amended to read:
229 429.07 License required; fee.—
230 (3) In addition to the requirements of s. 408.806, each
231 license granted by the agency must state the type of care for
232 which the license is granted. Licenses shall be issued for one
233 or more of the following categories of care: standard, extended
234 congregate care, limited nursing services, or limited mental
235 health.
236 (a) A standard license shall be issued to facilities
237 providing one or more of the personal services identified in s.
238 429.02. Such facilities may also employ or contract with a
239 person licensed under part I of chapter 464 to administer
240 medications and perform other tasks as specified in s. 429.255.
241 (b) An extended congregate care license shall be issued to
242 facilities that have been licensed as assisted living facilities
243 for 2 or more years and that provide ~~providing~~, directly or
244 through contract, services beyond those authorized in paragraph
245 (a), including services performed by persons licensed under part
246 I of chapter 464 and supportive services, as defined by rule, to
247 persons who would otherwise be disqualified from continued
248 residence in a facility licensed under this part. An extended
249 congregate care license may also be issued to those facilities
250 that have provisional extended congregate care licenses and meet
251 the requirements for licensure under subparagraph 2. The primary
252 purpose of extended congregate care services is to allow

253 residents, as they become more impaired, the option of remaining
254 in a familiar setting from which they would otherwise be
255 disqualified for continued residency. A facility licensed to
256 provide extended congregate care services may also admit an
257 individual who exceeds the admission criteria for a facility
258 with a standard license, if the individual is determined
259 appropriate for admission to the extended congregate care
260 facility.
261 1. In order for extended congregate care services to be
262 provided, the agency must first determine that all requirements
263 established in law and rule are met and must specifically
264 designate, on the facility's license, that such services may be
265 provided and whether the designation applies to all or part of
266 the facility. Such designation may be made at the time of
267 initial licensure or relicensure, or upon request in writing by
268 a licensee under this part and part II of chapter 408. The
269 notification of approval or the denial of the request shall be
270 made in accordance with part II of chapter 408. Existing
271 facilities qualifying to provide extended congregate care
272 services must have maintained a standard license and may not
273 have been subject to administrative sanctions during the
274 previous 2 years, or since initial licensure if the facility has
275 been licensed for less than 2 years, for any of the following
276 reasons:
277 a. A class I or class II violation;
278 b. Three or more repeat or recurring class III violations
279 of identical or similar resident care standards from which a
280 pattern of noncompliance is found by the agency;

281 c. Three or more class III violations that were not
282 corrected in accordance with the corrective action plan approved
283 by the agency;
284 d. Violation of resident care standards which results in
285 requiring the facility to employ the services of a consultant
286 pharmacist or consultant dietitian;
287 e. Denial, suspension, or revocation of a license for
288 another facility licensed under this part in which the applicant
289 for an extended congregate care license has at least 25 percent
290 ownership interest; or
291 f. Imposition of a moratorium pursuant to this part or
292 part II of chapter 408 or initiation of injunctive proceedings.
293 2. If an assisted living facility has been licensed for
294 less than 2 years but meets all other licensure requirements for
295 an extended congregate care license, it shall be issued a
296 provisional extended congregate care license for a period of 6
297 months. Within the first 3 months after the provisional license
298 is issued, the licensee shall notify the agency when it has
299 admitted an extended congregate care resident, after which an
300 unannounced inspection shall be made to determine compliance
301 with requirements of an extended congregate care license. If the
302 licensee demonstrates compliance with all of the requirements of
303 an extended congregate care license during the inspection, the
304 licensee shall be issued an extended congregate care license. In
305 addition to sanctions authorized under this part, if violations
306 are found during the inspection and the licensee fails to
307 demonstrate compliance with all assisted living requirements
308 during a followup inspection, the licensee shall immediately

309 suspend extended congregate care services, and the provisional
310 extended congregate care license expires.
311 3.~~2.~~ A facility that is licensed to provide extended
312 congregate care services shall maintain a written progress
313 report on each person who receives services which describes the
314 type, amount, duration, scope, and outcome of services that are
315 rendered and the general status of the resident's health. A
316 registered nurse, or appropriate designee, representing the
317 agency shall visit the facility at least twice a year ~~quarterly~~
318 to monitor residents who are receiving extended congregate care
319 services and to determine if the facility is in compliance with
320 this part, part II of chapter 408, and relevant rules. One of
321 the visits may be in conjunction with the regular survey. The
322 monitoring visits may be provided through contractual
323 arrangements with appropriate community agencies. A registered
324 nurse shall serve as part of the team that inspects the
325 facility. The agency may waive one of the required yearly
326 monitoring visits for a facility ~~that has been licensed for at~~
327 ~~least 24 months to provide extended congregate care services,~~
328 ~~if, during the inspection, the registered nurse determines that~~
329 ~~extended congregate care services are being provided~~
330 ~~appropriately, and~~ if the facility has held an extended
331 congregate care license during the last 24 months, has had no
332 class I or class II violations, has had ~~and~~ no uncorrected class
333 III violations, and has had no confirmed ombudsman council
334 complaints that resulted in a citation for licensure. ~~The agency~~
335 ~~must first consult with the long-term care ombudsman council for~~
336 ~~the area in which the facility is located to determine if any~~

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337 ~~complaints have been made and substantiated about the quality of~~
338 ~~services or care. The agency may not waive one of the required~~
339 ~~yearly monitoring visits if complaints have been made and~~
340 ~~substantiated.~~
341 4.~~3.~~ A facility that is licensed to provide extended
342 congregate care services must:
343 a. Demonstrate the capability to meet unanticipated
344 resident service needs.
345 b. Offer a physical environment that promotes a homelike
346 setting, provides for resident privacy, promotes resident
347 independence, and allows sufficient congregate space as defined
348 by rule.
349 c. Have sufficient staff available, taking into account
350 the physical plant and firesafety features of the building, to
351 assist with the evacuation of residents in an emergency.
352 d. Adopt and follow policies and procedures that maximize
353 resident independence, dignity, choice, and decisionmaking to
354 permit residents to age in place, so that moves due to changes
355 in functional status are minimized or avoided.
356 e. Allow residents or, if applicable, a resident's
357 representative, designee, surrogate, guardian, or attorney in
358 fact to make a variety of personal choices, participate in
359 developing service plans, and share responsibility in
360 decisionmaking.
361 f. Implement the concept of managed risk.
362 g. Provide, directly or through contract, the services of
363 a person licensed under part I of chapter 464.
364 h. In addition to the training mandated in s. 429.52,

365 provide specialized training as defined by rule for facility
366 staff.
367 <u>5.</u>~~4.~~ A facility that is licensed to provide extended
368 congregate care services is exempt from the criteria for
369 continued residency set forth in rules adopted under s. 429.41.
370 A licensed facility must adopt its own requirements within
371 guidelines for continued residency set forth by rule. However,
372 the facility may not serve residents who require 24-hour nursing
373 supervision. A licensed facility that provides extended
374 congregate care services must also provide each resident with a
375 written copy of facility policies governing admission and
376 retention.
377 ~~5. The primary purpose of extended congregate care~~
378 ~~services is to allow residents, as they become more impaired,~~
379 ~~the option of remaining in a familiar setting from which they~~
380 ~~would otherwise be disqualified for continued residency. A~~
381 ~~facility licensed to provide extended congregate care services~~
382 ~~may also admit an individual who exceeds the admission criteria~~
383 ~~for a facility with a standard license, if the individual is~~
384 ~~determined appropriate for admission to the extended congregate~~
385 ~~care facility.~~
386 6. Before the admission of an individual to a facility
387 licensed to provide extended congregate care services, the
388 individual must undergo a medical examination as provided in s.
389 429.26(4) and the facility must develop a preliminary service
390 plan for the individual.
391 7. <u>If</u> ~~When~~ a facility can no longer provide or arrange for
392 services in accordance with the resident's service plan and

393 needs and the facility's policy, the facility <u>must</u> ~~shall~~ make
394 arrangements for relocating the person in accordance with s.
395 429.28(1)(k).
396 ~~8. Failure to provide extended congregate care services~~
397 ~~may result in denial of extended congregate care license~~
398 ~~renewal.~~
399
400 <u>The agency may deny or revoke a facility's extended congregate</u>
401 <u>care license for not meeting the standards of an extended</u>
402 <u>congregate care license or for any of the grounds listed in this</u>
403 <u>subsection.</u>
404 (c) A limited nursing services license shall be issued to
405 a facility that provides services beyond those authorized in
406 paragraph (a) and as specified in this paragraph.
407 1. In order for limited nursing services to be provided in
408 a facility licensed under this part, the agency must first
409 determine that all requirements established in law and rule are
410 met and must specifically designate, on the facility's license,
411 that such services may be provided. Such designation may be made
412 at the time of initial licensure or <u>licensure renewal</u>
413 ~~relicensure~~, or upon request in writing by a licensee under this
414 part and part II of chapter 408. Notification of approval or
415 denial of such request shall be made in accordance with part II
416 of chapter 408. <u>An</u> existing <u>facility that qualifies</u> ~~facilities~~
417 ~~qualifying~~ to provide limited nursing services <u>must</u> ~~shall~~ have
418 maintained a standard license and may not have been subject to
419 administrative sanctions that affect the health, safety, and
420 welfare of residents for the previous 2 years or since initial

421 licensure if the facility has been licensed for less than 2
422 years.
423 2. A facility ~~Facilities~~ that is ~~are~~ licensed to provide
424 limited nursing services shall maintain a written progress
425 report on each person who receives such nursing services. The~~,~~
426 ~~which~~ report must describe ~~describes~~ the type, amount, duration,
427 scope, and outcome of services that are rendered and the general
428 status of the resident's health. A registered nurse representing
429 the agency shall visit the facility ~~such facilities~~ at least
430 annually ~~twice a year~~ to monitor residents who are receiving
431 limited nursing services and to determine if the facility is in
432 compliance with applicable provisions of this part, part II of
433 chapter 408, and related rules. The monitoring visits may be
434 provided through contractual arrangements with appropriate
435 community agencies. A registered nurse shall also serve as part
436 of the team that inspects such facility. Visits may be in
437 conjunction with other agency inspections. The agency may waive
438 one of the required yearly monitoring visits for a facility that
439 has:
440 a. A limited nursing services license for at least 24
441 months;
442 b. No class I or class II violations and no uncorrected
443 class III violations; and
444 c. No confirmed ombudsman council complaints that resulted
445 in a citation for licensure.
446 3. A person who receives limited nursing services under
447 this part must meet the admission criteria established by the
448 agency for assisted living facilities. When a resident no longer

449 meets the admission criteria for a facility licensed under this
450 part, arrangements for relocating the person shall be made in
451 accordance with s. 429.28(1)(k), unless the facility is licensed
452 to provide extended congregate care services.
453 Section 4. Section 429.075, Florida Statutes, is amended
454 to read:
455 429.075 Limited mental health license.—An assisted living
456 facility that serves one ~~three~~ or more mental health residents
457 must obtain a limited mental health license.
458 (1) To obtain a limited mental health license, a facility
459 must hold a standard license as an assisted living facility,
460 must not have any current uncorrected ~~deficiencies or~~
461 violations, and must ensure that, within 6 months after
462 receiving a limited mental health license, the facility
463 administrator and the staff of the facility who are in direct
464 contact with mental health residents must complete training of
465 no less than 6 hours related to their duties. Such designation
466 may be made at the time of initial licensure or relicensure or
467 upon request in writing by a licensee under this part and part
468 II of chapter 408. Notification of approval or denial of such
469 request shall be made in accordance with this part, part II of
470 chapter 408, and applicable rules. This training must ~~will~~ be
471 provided by or approved by the Department of Children and Family
472 Services.
473 (2) A facility that is ~~Facilities~~ licensed to provide
474 services to mental health residents must ~~shall~~ provide
475 appropriate supervision and staffing to provide for the health,
476 safety, and welfare of such residents.

477 (3) A facility that has a limited mental health license
478 must:
479 (a) Have a copy of each mental health resident's community
480 living support plan and the cooperative agreement with the
481 mental health care services provider. The support plan and the
482 agreement may be combined.
483 (b) Have documentation that is provided by the Department
484 of Children and Family Services that each mental health resident
485 has been assessed and determined to be able to live in the
486 community in an assisted living facility that has ~~with~~ a limited
487 mental health license, or provide written evidence that a
488 request for documentation was sent to the Department of Children
489 and Family Services within 72 hours of admission.
490 (c) Make the community living support plan available for
491 inspection by the resident, the resident's legal guardian, the
492 resident's health care surrogate, and other individuals who have
493 a lawful basis for reviewing this document.
494 (d) Assist the mental health resident in carrying out the
495 activities identified in the individual's community living
496 support plan.
497 (4) A facility that has ~~with~~ a limited mental health
498 license may enter into a cooperative agreement with a private
499 mental health provider. For purposes of the limited mental
500 health license, the private mental health provider may act as
501 the case manager.
502 Section 5. Section 429.14, Florida Statutes, is amended to
503 read:
504 429.14 Administrative penalties.—

505 (1) In addition to the requirements of part II of chapter
506 408, the agency may deny, revoke, and suspend any license issued
507 under this part and impose an administrative fine in the manner
508 provided in chapter 120 against a licensee for a violation of
509 any provision of this part, part II of chapter 408, or
510 applicable rules, or for any of the following actions by a
511 licensee, for the actions of any person subject to level 2
512 background screening under s. 408.809, or for the actions of any
513 facility staff ~~employee~~:
514 (a) An intentional or negligent act seriously affecting
515 the health, safety, or welfare of a resident of the facility.
516 (b) A ~~The~~ determination by the agency that the owner lacks
517 the financial ability to provide continuing adequate care to
518 residents.
519 (c) Misappropriation or conversion of the property of a
520 resident of the facility.
521 (d) Failure to follow the criteria and procedures provided
522 under part I of chapter 394 relating to the transportation,
523 voluntary admission, and involuntary examination of a facility
524 resident.
525 (e) A citation of any of the following violations
526 ~~deficiencies~~ as specified in s. 429.19:
527 1. One or more cited class I violations ~~deficiencies~~.
528 2. Three or more cited class II violations ~~deficiencies~~.
529 3. Five or more cited class III violations ~~deficiencies~~
530 that have been cited on a single survey and have not been
531 corrected within the times specified.
532 (f) Failure to comply with the background screening

533 standards of this part, s. 408.809(1), or chapter 435.
534 (g) Violation of a moratorium.
535 (h) Failure of the license applicant, the licensee during
536 relicensure, or a licensee that holds a provisional license to
537 meet the minimum license requirements of this part, or related
538 rules, at the time of license application or renewal.
539 (i) An intentional or negligent life-threatening act in
540 violation of the uniform firesafety standards for assisted
541 living facilities or other firesafety standards which ~~that~~
542 threatens the health, safety, or welfare of a resident of a
543 facility, as communicated to the agency by the local authority
544 having jurisdiction or the State Fire Marshal.
545 (j) Knowingly operating any unlicensed facility or
546 providing without a license any service that must be licensed
547 under this chapter or chapter 400.
548 (k) Any act constituting a ground upon which application
549 for a license may be denied.
550 (2) Upon notification by the local authority having
551 jurisdiction or by the State Fire Marshal, the agency may deny
552 or revoke the license of an assisted living facility that fails
553 to correct cited fire code violations that affect or threaten
554 the health, safety, or welfare of a resident of a facility.
555 (3) The agency may deny or revoke a license of an ~~to any~~
556 applicant or controlling interest as defined in part II of
557 chapter 408 which has or had a 25-percent or greater financial
558 or ownership interest in any other facility that is licensed
559 under this part, or in any entity licensed by this state or
560 another state to provide health or residential care, if that

561 ~~which~~ facility or entity during the 5 years prior to the
562 application for a license closed due to financial inability to
563 operate; had a receiver appointed or a license denied,
564 suspended, or revoked; was subject to a moratorium; or had an
565 injunctive proceeding initiated against it.
566 (4) The agency shall deny or revoke the license of an
567 assisted living facility if:
568 (a) The applicant or licensee had a license that was
569 revoked by the agency, the Department of Children and Family
570 Services, the Department of Juvenile Justice, or the Agency for
571 Persons with Disabilities.
572 (b) There are two moratoria, issued pursuant to this part
573 or part II of chapter 408, within a 2-year period which are
574 imposed by final order;
575 (c) The facility is cited for two or more class I
576 violations arising from unrelated circumstances during the same
577 survey or investigation; or
578 (d) The facility is cited for two or more class I
579 violations arising from separate surveys or investigations
580 within a 2-year period ~~that has two or more class I violations~~
581 ~~that are similar or identical to violations identified by the~~
582 ~~agency during a survey, inspection, monitoring visit, or~~
583 ~~complaint investigation occurring within the previous 2 years~~.
584 The licensee may present factors in mitigation of revocation,
585 and the agency may make a determination not to revoke a license
586 based upon a showing that revocation is inappropriate under the
587 circumstances.
588 (5) An action taken by the agency to suspend, deny, or

589 revoke a facility's license under this part or part II of
590 chapter 408, in which the agency claims that the facility owner
591 or an employee of the facility has threatened the health,
592 safety, or welfare of a resident of the facility must be heard
593 by the Division of Administrative Hearings of the Department of
594 Management Services within 120 days after receipt of the
595 facility's request for a hearing, unless that time limitation is
596 waived by both parties. The administrative law judge shall ~~must~~
597 render a decision within 30 days after receipt of a proposed
598 recommended order.
599 (6) The agency shall impose an immediate moratorium, as
600 provided under s. 408.814, on an assisted living facility that
601 fails to provide the agency access to the facility or prohibits
602 the agency from conducting a regulatory inspection. The licensee
603 may not restrict agency staff in accessing and copying records
604 or in conducting interviews with facility staff or any
605 individual who receives services from the facility ~~provide to~~
606 ~~the Division of Hotels and Restaurants of the Department of~~
607 ~~Business and Professional Regulation, on a monthly basis, a list~~
608 ~~of those assisted living facilities that have had their licenses~~
609 ~~denied, suspended, or revoked or that are involved in an~~
610 ~~appellate proceeding pursuant to s. 120.60 related to the~~
611 ~~denial, suspension, or revocation of a license~~.
612 (7) Agency notification of a license suspension or
613 revocation, or denial of a license renewal, shall be posted and
614 visible to the public at the facility.
615 (8) If a facility is required to relocate some or all of
616 its residents due to agency action, that facility is exempt from

617 the 45 days' notice requirement in s. 429.28(1)(k). This
618 provision does not exempt the facility from any deadlines for
619 corrective action set by the agency.
620 Section 6. Section 429.19, Florida Statutes, is amended to
621 read:
622 429.19 Violations; imposition of administrative fines;
623 grounds.—
624 (1) In addition to the requirements of part II of chapter
625 408, the agency shall impose an administrative fine in the
626 manner provided in chapter 120 for the violation of any
627 provision of this part, part II of chapter 408, and applicable
628 rules by an assisted living facility, for the actions of any
629 person subject to level 2 background screening under s. 408.809,
630 for the actions of any facility employee, or for an intentional
631 or negligent act seriously affecting the health, safety, or
632 welfare of a resident of the facility.
633 (2) Each violation of this part and adopted rules must
634 ~~shall~~ be classified according to the nature of the violation and
635 the gravity of its probable effect on facility residents. The
636 agency shall indicate the classification on the written notice
637 of the violation as follows:
638 (a) Class "I" violations are defined in s. 408.813. The
639 agency shall impose an administrative fine of $7,500 for each ~~a~~
640 cited class I violation in a facility that is licensed for fewer
641 than 100 beds at the time of the violation ~~in an amount not less~~
642 ~~than $5,000 and not exceeding $10,000 for each violation~~. The
643 agency shall impose an administrative fine of $11,250 for each
644 cited class I violation in a facility that is licensed for 100

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645 or more beds at the time of the violation. If the noncompliance
646 occurs within the prior 12 months, the fine must be levied for
647 violations that are corrected before an inspection.
648 (b) Class "II" violations are defined in s. 408.813. The
649 agency shall impose an administrative fine of $3,000 for each ~~a~~
650 cited class II violation in a facility that is licensed for
651 fewer than 100 beds at the time of the violation ~~in an amount~~
652 ~~not less than $1,000 and not exceeding $5,000 for each~~
653 ~~violation~~. The agency shall impose an administrative fine of
654 $4,500 for each cited class II violation in a facility that is
655 licensed for 100 or more beds at the time of the violation.
656 (c) Class "III" violations are defined in s. 408.813. The
657 agency shall impose an administrative fine of $750 for each ~~a~~
658 cited class III violation in a facility that is licensed for
659 fewer than 100 beds at the time of the violation ~~in an amount~~
660 ~~not less than $500 and not exceeding $1,000 for each violation~~.
661 The agency shall impose an administrative fine of $1,125 for
662 each cited class III violation in a facility that is licensed
663 for 100 or more beds at the time of the violation.
664 (d) Class "IV" violations are defined in s. 408.813. The
665 agency shall impose an administrative fine of $150 for each ~~a~~
666 cited class IV violation in a facility that is licensed for
667 fewer than 100 beds at the time of the violation ~~in an amount~~
668 ~~not less than $100 and not exceeding $200 for each violation~~.
669 The agency shall impose an administrative fine of $225 for each
670 cited class IV violation in a facility that is licensed for 100
671 or more beds at the time of the violation.
672 (e) Any fine imposed for class I and class II violations

673 must be doubled if a facility was previously cited for one or
674 more class I or class II violations during the agency's last
675 licensure inspection or any inspection or complaint
676 investigation since the last licensure inspection.
677 (f) Notwithstanding s. 408.813(2)(c) and (d) and s.
678 408.832, a fine must be imposed for each class III and class IV
679 violation, regardless of correction, if a facility was
680 previously cited for one or more class III or class IV
681 violations during the agency's last licensure inspection or any
682 inspection or complaint investigation since the last licensure
683 inspection, for the same regulatory violation. A fine imposed
684 for class III or class IV violations must be doubled if a
685 facility was previously cited for one or more class III or class
686 IV violations during the agency's last two licensure inspections
687 for the same regulatory violation.
688 (g) Regardless of the class of violation cited, instead of
689 the fine amounts listed in paragraphs (a)-(d), the agency shall
690 impose an administrative fine of $500 if a facility is found not
691 to be in compliance with the background screening requirements
692 as provided in s. 408.809.
693 ~~(3) For purposes of this section, in determining if a~~
694 ~~penalty is to be imposed and in fixing the amount of the fine,~~
695 ~~the agency shall consider the following factors:~~
696 ~~(a) The gravity of the violation, including the~~
697 ~~probability that death or serious physical or emotional harm to~~
698 ~~a resident will result or has resulted, the severity of the~~
699 ~~action or potential harm, and the extent to which the provisions~~
700 ~~of the applicable laws or rules were violated.~~

701 ~~(b) Actions taken by the owner or administrator to correct~~
702 ~~violations.~~
703 ~~(c) Any previous violations.~~
704 ~~(d) The financial benefit to the facility of committing or~~
705 ~~continuing the violation.~~
706 ~~(e) The licensed capacity of the facility.~~
707 (3) ~~(4)~~ Each day of continuing violation after the date
708 established by the agency ~~fixed~~ for correction ~~termination~~ of
709 the violation~~, as ordered by the agency,~~ constitutes an
710 additional, separate, and distinct violation.
711 (4) ~~(5)~~ An ~~Any~~ action taken to correct a violation shall be
712 documented in writing by the owner or administrator of the
713 facility and verified through followup visits by agency
714 personnel. The agency may impose a fine and, in the case of an
715 owner-operated facility, revoke or deny a facility's license
716 when a facility administrator fraudulently misrepresents action
717 taken to correct a violation.
718 (5) ~~(6)~~ A ~~Any~~ facility whose owner fails to apply for a
719 change-of-ownership license in accordance with part II of
720 chapter 408 and operates the facility under the new ownership is
721 subject to a fine of $5,000.
722 (6) ~~(7)~~ In addition to any administrative fines imposed,
723 the agency may assess a survey fee, equal to the lesser of one
724 half of the facility's biennial license and bed fee or $500, to
725 cover the cost of conducting initial complaint investigations
726 that result in the finding of a violation that was the subject
727 of the complaint or monitoring visits conducted under s.
728 429.28(3)(c) to verify the correction of the violations.

729 (7) ~~(8)~~ During an inspection, the agency shall make a
730 reasonable attempt to discuss each violation with the owner or
731 administrator of the facility, prior to written notification.
732 (8) ~~(9)~~ The agency shall develop and disseminate an annual
733 list of all facilities sanctioned or fined for violations of
734 state standards, the number and class of violations involved,
735 the penalties imposed, and the current status of cases. The list
736 shall be disseminated, at no charge, to the Department of
737 Elderly Affairs, the Department of Health, the Department of
738 Children and Family Services, the Agency for Persons with
739 Disabilities, the area agencies on aging, the Florida Statewide
740 Advocacy Council, and the state and local ombudsman councils.
741 The Department of Children and Family Services shall disseminate
742 the list to service providers under contract to the department
743 who are responsible for referring persons to a facility for
744 residency. The agency may charge a fee commensurate with the
745 cost of printing and postage to other interested parties
746 requesting a copy of this list. This information may be provided
747 electronically or through the agency's Internet site.
748 Section 7. Subsection (5) of section 429.41, Florida
749 Statutes, is amended to read:
750 429.41 Rules establishing standards.—
751 (5) In order to allocate resources effectively, the agency
752 may use an abbreviated biennial standard licensure inspection
753 that consists of a review of key quality-of-care standards in
754 lieu of a full inspection in a facility that has a good record
755 of past performance. However, a full inspection must be
756 conducted in a facility that has a history of class I or class

757 II violations, uncorrected class III violations, confirmed
758 ombudsman council complaints that resulted in a citation for
759 licensure, or confirmed licensure complaints which resulted in a
760 citation for a licensure violation, within the previous
761 licensure period immediately preceding the inspection or if a
762 potentially serious problem is identified during the abbreviated
763 inspection. The agency, in consultation with the department,
764 shall develop the key quality-of-care standards with input from
765 the State Long-Term Care Ombudsman Council and representatives
766 of provider groups for incorporation into its rules.
767 Section 8. Present subsections (1) through (11) of section
768 429.52, Florida Statutes, are redesignated as subsections (2)
769 through (12), respectively, new subsections (1) and (11) are
770 added to that section, and present subsection (9) of that
771 section is amended, to read:
772 429.52 Staff training and educational programs; core
773 educational requirement.—
774 (1) Effective October 1, 2013, each new assisted living
775 facility employee who has not previously completed core training
776 must attend a preservice orientation provided by the facility
777 before interacting with residents. The preservice orientation
778 must be at least 2 hours in duration and cover topics that help
779 the employee provide responsible care and respond to the needs
780 of residents of the facility. Upon completion, the employee and
781 the administrator of the facility must sign an affidavit stating
782 that the employee completed the required preservice orientation.
783 The facility must keep the affidavit in the employee's work
784 file.

785 (10) ~~(9)~~ The training required by this section must ~~shall~~
786 be conducted by persons registered with the department as having
787 the requisite experience and credentials to conduct the
788 training. A person seeking to register as a trainer must provide
789 the department with proof of completion of the minimum core
790 training education requirements, successful passage of the
791 competency test established under this section, and proof of
792 compliance with the continuing education requirement in
793 subsection (5) ~~(4)~~.
794 (11) The agency in conjunction with the department shall
795 establish a database for collection of training requirements,
796 competency testing, and documentation required pursuant to this
797 part. The database shall be used by administrators and licensees
798 to determine eligibility of staff. The department may adopt
799 additional reporting requirements by rules. Effective July 1,
800 2014, organizations and individuals providing training, testing,
801 or documentation under this part must submit the following
802 electronically to the agency:
803 (a) The trainee's names and identifying information; dates
804 of training, tests or certificates of successful passage,
805 completion, and attendance; and scores for competency testing
806 for persons trained, tested or issued certificates.
807 (b) Identifying information for the organization or
808 individual providing the training, testing or certificates.
809
810 Failure to comply with reporting requirements may result in
811 suspension of the authority to offer training, testing, or issue
812 certificates.

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

813 Section 9. Subsection (3) is added to section 429.54,
814 Florida Statutes, to read:
815 429.54 Collection of information; local subsidy.—
816 (3) Subject to the availability of funds, the agency, the
817 department, the Department of Children and Family Services, and
818 the Agency for Persons with Disabilities shall develop or modify
819 electronic systems of communication among state-supported
820 automated systems to ensure that relevant information pertaining
821 to the regulation of assisted living facilities and facility
822 staff is timely and effectively communicated among agencies in
823 order to facilitate the protection of residents.
824 Section 10. Section 429.55, Florida Statutes, is created
825 to read:
826 429.55 Intersurveyor reliability.-- The Legislature finds
827 that consistent regulation of assisted living facilities
828 benefits residents and operators of such facilities. To
829 determine whether surveys are consistent between surveys and
830 surveyors, the Agency for Health Care Administration shall
831 conduct a study of intersurveyor reliability for assisted living
832 facilities. By November 1, 2013, the agency shall report to the
833 Governor, the President of the Senate, and the Speaker of the
834 House of Representatives its findings and make any
835 recommendations to improve intersurveyor reliability.
836 Section 11. Section 429.56, Florida Statutes, is created
837 to read:
838 429.56 Consumer Information.-- The Legislature finds that
839 consumers need additional information on the quality of care and
840 service in assisted living facilities in order to select the

841 best facility for themselves or their loved ones. Therefore, the
842 Agency for Health Care Administration shall:
843 (1) Propose a rating system for assisted living
844 facilities. The proposal must include, but is not limited to,
845 the data elements to be used, the method of collecting the data,
846 the method of determining the rating, an estimate of the initial
847 and ongoing costs of a rating system to both the agency and
848 assisted living facilities, and a timetable for the
849 implementation of the rating system for assisted living
850 facilities. The agency shall submit its proposal to the
851 Governor, the President of the Senate, and the Speaker of the
852 House of Representatives by November 1, 2013.
853 (2) By January 1, 2014, create a content that is easily
854 accessible through the front page of the agency's website. At a
855 minimum, the content must include:
856 (a) Information on each licensed assisted living facility,
857 including, but not limited to:
858 1. The name and address of the facility.
859 2. The number and type of licensed beds in the facility.
860 3. The types of licenses held by the facility.
861 4. The facility's license expiration date and status.
862 5. Other relevant information that the agency currently
863 collects.
864 (b) A list of the facility's violations, including, for
865 each violation:
866 1. A summary of the violation which is presented in a
867 manner understandable by the general public;
868 2. Any sanctions imposed by final order; and

869 3. The date of the correction.

870 (c) Links to inspection reports that the agency has on

871 file.

872 Section 12. This act shall take effect July 1, 2013.