A bill to be entitled

An act relating to Medicaid compliance; amending s. 395.003, F.S.; requiring that certain hospitals comply with provisions relating to the establishment of a Medicaid compliance office and program as a condition of licensure; amending s. 409.913, F.S.; providing a definition; requiring that certain hospitals establish a Medicaid compliance office and program; requiring that each hospital appoint a compliance officer and committee; providing responsibilities for such compliance officer and committee; requiring each hospital to develop a code of conduct, policies and procedures, risk assessment and internal review process, training plan, and other specified procedures; providing requirements for such code of conduct, policies and procedures, risk assessment and internal review process, training plan, and other specified procedures; providing a penalty for failure to notify the Agency for Health Care Administration's inspector general of a reportable event; requiring that each hospital submit an annual report to the agency by a specified date; providing requirements for such report; providing an effective date.

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

Section 1. Subsection (11) is added to section 395.003, Florida Statutes, to read:

395.003 Licensure; denial, suspension, and revocation.—

(11) A hospital that is subject to s. 409.913(39) must comply with the requirements in that subsection as a condition of licensure.

Section 2. Subsection (39) is added to section 409.913, Florida Statutes, to read:

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

fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must include policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud. All policy recommendations in the report must include a detailed fiscal analysis, including, but not limited to, implementation costs, estimated savings to the Medicaid program, and the return on investment. The agency must submit the policy recommendations and fiscal analyses in the report to the appropriate estimating

conference, pursuant to s. 216.137, by February 15 of each year. The agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs each must include detailed unit-specific performance standards, benchmarks, and metrics in the report, including projected cost savings to the state Medicaid program during the following fiscal year.

(39)(a) For purposes of this subsection, the term "covered person" means:

1. An owner, officer, director, commissioner, or employee of the hospital;

2. A contractor, subcontractor, agent, or other person who provides patient care items or services or who performs billing or coding functions on behalf of the hospital, excluding a vendor whose only connection with the hospital is selling or otherwise providing medical supplies or equipment and who does not bill any federal health care program for such medical supplies or equipment; or

3. Physician or nonphysician personnel who are members of the hospital's active medical staff.

(b) Each hospital licensed under chapter 395 that annually accepts state or federal funds in the amount of $10 million or more to provide services to Medicaid recipients shall establish an office of Medicaid compliance within the hospital. The hospital shall appoint a compliance officer who is a member of senior management of the hospital and who shall report directly

to the chief executive officer or president of the hospital. The compliance officer shall:

1. Develop and implement policies, procedures, and practices designed to ensure compliance with all state and federal health care program requirements.

2. At least quarterly, submit a report regarding compliance matters directly to the chief executive officer or president of the hospital.

3. Monitor the day-to-day compliance activities of the hospital and analyze the hospital's risk areas for noncompliance.

4. Report any suspected or substantiated violations of the hospital's code of conduct or policies and procedures to the chief executive officer or president of the hospital and to the agency.

(c) Each hospital shall appoint a compliance committee that must include, at a minimum, a compliance officer and other members of senior management. The compliance officer shall serve as chair of the compliance committee. The compliance committee shall assist the compliance officer in fulfilling his or her responsibilities as provided in paragraph (b).

(d)1. Each hospital shall develop, implement, and annually distribute a written code of conduct to each covered person. The code of conduct must, at a minimum, address the hospital's:

a. Commitment to fully comply with all state and federal

health care program requirements.

b. Requirement that each covered person is expected to comply with all state and federal health care program requirements and with the hospital's policies and procedures.

c. Requirement that each covered person is expected to report to the compliance officer suspected violations of any state and federal health care program requirements or the hospital's policies and procedures.

d. Commitment to not retaliate against a covered person who reports a suspected violation as provided in sub-subparagraph c. and to maintain, as appropriate, the confidentiality and anonymity of such reports.

2. Each hospital shall evaluate the performance of its employees based on their compliance with the code of conduct. At least annually, the hospital shall review the code of conduct and make any necessary revisions.

(e)1. Each hospital shall develop and implement written policies and procedures regarding the operation of its compliance office and program. The policies and procedures must address the criminal penalties for violations under Title XI of the Social Security Act, 42 U.S.C. ss. 1320a-7b(b) and 1395nn, including implementing regulations and other federal guidance; the types of business or financial arrangements that violate such federal laws and regulations; and the penalties associated with violations of state anti-rebating and anti-kickback laws

applicable to hospitals and health care providers.

2. The hospital shall distribute the policies and procedures to each covered person. The hospital shall enforce and comply with its policies and procedures and shall evaluate the performance of its employees based on their compliance with the policies and procedures. At least annually, the hospital shall assess and update the policies and procedures, as necessary.

3. Within 90 days after implementing the policies and procedures required under this paragraph, each hospital subject to this subsection shall develop and implement a centralized annual risk assessment and internal review process to identify and address risks associated with arrangements as defined in paragraph (f). The risk assessment and internal review process shall be evaluated and updated annually, if necessary, and must include procedures for:

a. Identifying and prioritizing risks;

b. Developing and implementing remediation plans in response to such risks, including internal auditing and monitoring of the identified risk areas; and

c. Tracking results to assess the effectiveness of the remediation plans.

(f)1. Each hospital shall develop a written training plan that ensures:

a. A covered person, except an individual employed only in

food service, maintenance, or housekeeping, receives adequate training regarding the hospital's code of conduct and policies and procedures.

b. A covered person receives adequate training regarding business or financial arrangements that may violate Title XI of the Social Security Act, 42 U.S.C. ss. 1320a-7b(b) and 1395nn, including implementing regulations and other federal guidance; the hospital's policies and procedures governing such arrangements; the hospital's internal review and approval processes for such arrangements; the hospital's tracking of remuneration to and from sources of health care business or referrals; and the penalties associated with violations of state anti-rebating and anti-kickback laws applicable to hospitals and health care providers.

c. Each individual involved in the development, approval, management, or review of the hospital's arrangements understands his or her personal obligation to know the applicable legal requirements and the hospital's code of conduct and policies and procedures.

d. A covered person understands the criminal penalties and sanctions imposed under Title XI of the Social Security Act, 42 U.S.C. ss. 1320a-7b(b) and 1395nn, and has been provided examples of violations under such federal laws and related regulations.

2. The training plan must include information regarding

the topics to be addressed, the identification of covered persons required to attend each training session, the length of the training, the schedule for training, and the format of the training.

3. For purposes of this paragraph, the term "arrangements" means any contract, transaction, or agreement that:

a. Involves, directly or indirectly, the offer, payment, solicitation, or receipt of anything of value;

b. Is between the hospital and any actual or potential source of health care business or referrals, or any actual or potential recipient of health care business or referrals from the hospital; or

c. Is between the hospital and a physician or a physician's immediate family member who makes a referral to the hospital for health services.

(g)1. For purposes of this paragraph, the term "focus arrangement" means each arrangement, as defined in paragraph (f), that is between a hospital subject to this subsection and:

a. Any actual source of health care business or referrals to the hospital and involves, directly or indirectly, the offer, payment, or provision of anything of value; or

b. Any physician or a physician's immediate family member, as defined in 42 C.F.R. s. 411.351, who makes a referral, as defined at 42 U.S.C. s. 1395nn(h)(5), to the hospital for designated health services, as defined in 42 U.S.C. s.

1395nn(h)(6).

2. Each hospital subject to this subsection shall create procedures reasonably designed to ensure that each existing and new or renewed focus arrangement does not violate Title XI of the Social Security Act, 42 U.S.C. ss. 1320a-7b(b) and 1395nn, or the federal regulations, directives, and guidance related to those statutes. The procedures must include the following:

a. Creating and maintaining a centralized tracking system for all existing and new or renewed focus arrangements;

b. Tracking remuneration to and from all parties to focus arrangements;

c. Tracking service and activity logs to ensure that parties to the focus arrangement are performing the services required under the applicable focus arrangement, if applicable;

d. Monitoring the use of leased space, medical supplies, medical devices, equipment, or other patient care items to ensure that such use is consistent with the terms of the applicable focus arrangement, if applicable;

e. Establishing and implementing a written review and approval process for all focus arrangements to ensure that all existing and new or renewed focus arrangements do not violate Title XI of the Social Security Act, 42 U.S.C. ss. 1320a-7b(b) and 1395nn, which must, at a minimum, include:

(I) A legal review of all focus arrangements;

(II) A process for specifying the business need or

business rationale for all focus arrangements; and

(III) A process for determining and documenting the fair market value of the remuneration specified in the focus arrangement;

f. Requiring the compliance officer to, at least annually, review the focus arrangements tracking system, internal review and approval process, and other focus arrangement procedures and to provide a report on the results of such review to the compliance committee; and

g. Implementing effective responses when suspected violations of Title XI of the Social Security Act, 42 U.S.C. ss. 1320a-7b(b) and 1395nn are discovered, including disclosing reportable events pursuant to paragraph (h).

(h)1. For purposes of this paragraph, the term "reportable event" means:

a. A substantial overpayment for inpatient or outpatient Medicare services, Medicaid managed care services, or any other state or federal health care program services;

b. A matter that a reasonable person would consider a probable violation of criminal, civil, or administrative laws applicable to any state or federal health care program for which penalties or exclusions may be authorized;

c. The employment of or contracting with a covered person who is an "ineligible person," which means an individual or entity who:

(I) Is currently excluded, debarred, suspended, or otherwise ineligible to participate in federal health care programs or in federal procurement or non-procurement programs; or

(II) Has been convicted of a criminal offense pursuant to 42 U.S.C. s. 1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible; and

d. The filing of a bankruptcy petition by the hospital.

2. If a hospital subject to this subsection determines, after a reasonable opportunity to conduct an appropriate review or investigation of the allegations, that a reportable event has occurred or is occurring, the hospital shall notify the agency's inspector general within 30 days after making such determination.

3. When notifying the agency's inspector general of a reportable event, the hospital shall include a complete description of all details relevant to the reportable event, including the types of claims, transactions, or other conduct giving rise to the reportable event; the period during which the conduct occurred; the names of entities and individuals believed to be implicated, including an explanation of their roles in the reportable event; and any additional information necessary for the agency's inspector general to investigate the reportable event.

4. The agency's inspector general shall, after

investigating the reportable event and concluding that it is a violation of federal law governing a state or federal health care program, report all relevant details regarding the reportable event to the appropriate federal agency for further investigation.

5. In addition to any actions that may be taken against a license under s. 395.003, a hospital that fails to notify the agency's inspector general of a reportable event within the timeframe required in subparagraph 2. shall be fined $1,000 each day per reportable event until the agency's inspector general is notified.

(i) By January 1, 2019, and each year thereafter, a hospital that is subject to this subsection shall submit to the agency a report detailing the hospital's compliance activities during the preceding year. Each report must include, at a minimum:

1. Any change in the identity, position description, or other noncompliance job responsibilities of the compliance officer.

2. Any change in the membership of the compliance committee.

3. The dates of each report made by the compliance officer to the chief executive officer or president of the hospital.

4. A summary of any change or amendment to the hospital's code of conduct or policies and procedures as required in

paragraphs (d) and (e).

5. A copy of the hospital's training plan developed pursuant to paragraph (f) and for each type of training required by the training plan, a description of the training, including a summary of the topics to be addressed; the length of sessions; a schedule of training sessions; a general description of the categories of individuals required to complete the training; and the process by which the hospital ensures that each covered person receives the required training.

6. All reports of suspected or substantiated violations of the hospital's code of conduct or policies and procedures reported to the chief executive officer or president of the hospital and the agency.

7. Details regarding the hospital's risk assessment and internal review process required in paragraph (e).

8. Details of all reportable events as defined in paragraph (h), when the agency's inspector general was notified of each reportable event, and the status of the state investigation of each reportable event, and, if applicable, the status of the federal investigation of each reportable event.

Section 3. This act shall take effect July 1, 2017.