STORAGE NAME: h1445s1.hcs
DATE: April 10, 1997

HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
BILL RESEARCH & ECONOMIC IMPACT STATEMENT

BILL #: CS/HB 1445

RELATING TO: Medicaid

SPONSOR(S): Committee on Health Care Services, Rep. Arnall

STATUTE(S) AFFECTED: Section 409.907, 409.912, 409.9122, 409.920, F.S.

COMPANION BILL(S): CS/SB 508(s), CS/HB 1058(s)

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE SERVICES YEAS 10 NAYS 0
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(5)

I. SUMMARY:

This bill amends various statutes relating to Medicaid providers and services to:

- Require providers, seeking to enroll as a Medicaid provider, to submit a full set of fingerprints in order to permit a state and national criminal history records check, paid for by the provider. Exemptions are provided for hospitals, nursing homes, assisted living facilities, units of local government, qualifying directors of not-for-profit corporations, and persons who have been screened within the last year.
- Increase the penalty for persons who knowingly submit false information for the purpose of enrolling as a Medicaid provider from a 1st degree misdemeanor to 3rd degree felony.
- Permit county owned entities and federally qualified health centers contracting with AHCA to provide Medicaid services on a prepaid or fixed-sum basis to have until July 1, 1998, to obtain HMO licensure.
- Permit the entity providing mental health services on a capitated basis to Medicaid recipients to be licensed as a prepaid limited health service organization rather than as an insurer or HMO.
- Permit MediPass recipients to have direct access to chiropractors and podiatrists for up to a certain number of visits.

The Florida Department of Law Enforcement estimates that this bill will have a fiscal impact of $66,429, which should be covered by the $15 fee charged for the background screening.

II. SUBSTANTIVE RESEARCH:

A. PRESENT SITUATION:

Medicaid Provider Criminal Record Checks: The Federal Medicaid program was created in 1965 and implemented in Florida on January 1, 1970. In order to continue to receive federal Medicaid funding the state must meet certain federal standards including the requirement that the state have in place administrative procedures that enable it to exclude individuals or entities that have violated federal regulation. In 1993, the Medicaid program was transferred from the Department of Health & Rehabilitative Services (HRS) to the Agency for Health Care Administration (AHCA).

Section 409.907, F.S., provides the procedure for completing provider agreements and enrolling non-institutional providers in the Medicaid program. For years Medicaid provider agreements were quite provider friendly due to the lack of provider participation in the Medicaid program. Prior to last session's amendments, § 409.907 did not give AHCA specific authority to exclude providers that had violated federal and state law and regulation.

In 1996, §§ 409.907 and 409.913, F.S., were extensively amended to strengthen the ability of AHCA to identify and deal with Medicaid fraud and abuse. Prior to enrollment, AHCA may now conduct: a background investigation of the provider and any principal of the provider if the provider is a business entity; an onsite inspection of a provider's service location; a Florida Department of Law Enforcement (FDLE) background check; and deny enrollment if the provider, any principal of the provider, or any "affiliated" person, has been found to have committed certain acts (ch. 96-387, L.O.F.). Last year's "cut" bill," which provided for various funding reductions in the Medicaid program, also amended § 409.907, F.S., to permit AHCA to require a surety bond from a Medicaid provider not to exceed $50,000 (ch. 96-417, L.O.F.).

In cooperation with FDLE, the agency is now conducting statewide background checks on all providers, and all officers, directors, treating practitioners, and principal partners owning 5% or more in a provider entity. The background checks are being implemented as part of the current provider re-enrollment process. The background check is charged to the provider at a cost of $15.

As of February 1997, the agency has requested more than 13,500 FDLE background checks. Of those completed, approximately 3.6% have been tagged with "INDENTS," a term which indicates that an individual has a FDLE record of some type. Most turn out to be records of misdemeanors or minor offenses. Since the inception of the background check, of the 249 INDENTS routed to AHCA for review, 91 have been pended for further information from FDLE or discussion with AHCA's General Counsel. The remainder have been permitted to enroll or reenroll. Of the 91 pended individuals, 19 have either been, or are scheduled for, termination or exclusion from the Medicaid program.

However, without specific statutory authority, AHCA is unable to access nationwide FBI criminal records. When the FBI conducts a criminal history check for a state or local agency for a noncriminal purpose, the search must comply with applicable federal criteria. Generally, federal criteria requires state law to identify the specific category of applicants, require fingerprinting of the applicants, and authorize the use of FBI records

for screening applicants. In addition, federal policy requires the state to designate the governmental agency responsible for receiving and screening the results to determine applicant suitability. The FBI criminal history records may not be released outside the receiving governmental agency. The current FBI processing fee is $24.

On January 16, 1996, the Thirteenth Statewide Grand Jury, was convened to take a comprehensive look at fraud against the government, particularly Medicaid fraud. The first recommendation of the grand jury in their first of three issued reports was that the "agency should require a complete criminal and financial background investigation of a prospective provider, at the expense of the applicant. The investigation should extend to all the persons listed as principals of a business entity on the application."

Medicaid Managed Care: Section 409.912, F.S., authorizes AHCA to purchase health care services for Medicaid recipients on a managed care basis. Last year the Legislature extensively amended this section to, among other things, specifically address public entities contracting with AHCA to provide health care services on a prepaid or fixed-sum basis. Three types of public entities were identified:

- A county-owned entity, which was required to be licensed under parts I and III of chapter 641 by July 1, 1997.
- An entity providing mental health care to Medicaid recipients in West Central Florida, which was required to be licensed under either chapter 624 or 641 by December 31, 1998.
- A federally qualified health center or an entity receiving financial support from the federal government, which was required to be licensed under parts I and II of chapter 641 by July 1, 1997.

As of the date of this research, none of the participating public providers have met the licensing requirements.

MediPass Services: MediPass is a primary care case management program administered by the Medicaid program. MediPass contracts directly with Medicaid enrolled primary care physicians and pays them a monthly per person fee of $3 to deliver and coordinate health care for their Medicaid patients. MediPass primary care providers are required to provide primary care services, including prevention, health maintenance and treatment of illness and injury; coordination of needed specialty and other health services; and 24-hour availability of primary care and other referral of other necessary medical services. To that effect, health services provided to MediPass enrollees must be prior authorized by the primary care physician and are reimbursed on a fee-for-service basis.

B. EFFECT OF PROPOSED CHANGES:

> Medicaid providers will be required to submit to, and pay for, a state and national criminal-history record check.

> Persons who knowingly submit false information in order to enroll as a Medicaid provider will be subject to increased penalties.

> County owned entities and federally qualified health centers contracting to provide managed health care to Medicaid recipients will have an extra year to obtain HMO licensure.

> The entity providing mental health services on a capitated basis will be licensed as a prepaid limited health service organization rather than as an insurer or HMO.

> MediPass recipients will not have to go through their primary care provider in order to have access to chiropractors and podiatrists for up to a certain number of visits.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

> Yes, the bill gives the Agency for Health Care Administration authority to impose additional requirements on prospective Medicaid providers.

> The bill reduces the amount of regulation imposed on a Medicaid managed mental health care provider since they will have to be licensed under chapter 636 as a prepaid limited health service organization rather than under chapters 624 or 641 as an insurer or HMO.

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

> The Florida Department of Law Enforcement will be required to conduct the criminal records background investigations required by AHCA.

> AHCA reports that permitting MediPass enrollees direct access to chiropractors and podiatrists will require creating an additional computer program. At present MediPass claims are paid to the MediPass provider by provider number. Now a system will have to be created that counts visits to chiropractors and podiatrists and allows payment up to a certain number of payments.

(3) any entitlement to a government service or benefit?

No.

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

N/A

(2) what is the cost of such responsibility at the new level/agency?

N/A

(3) how is the new agency accountable to the people governed?

N/A

2. Lower Taxes:

a. Does the bill increase anyone's taxes?

No.

b. Does the bill require or authorize an increase in any fees?

No, unless payment for the background screening is considered a provider application fee.

c. Does the bill reduce total taxes, both rates and revenues?

No.

d. Does the bill reduce total fees, both rates and revenues?

No.

e. Does the bill authorize any fee or tax increase by any local government?

No.

3. Personal Responsibility:

a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

No.

b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

No, unless the screening fee is passed on to the provider’s clients.

4. Individual Freedom:

   a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

      MediPass enrollees will be allowed to go to a chiropractor or podiatrist without have to be referred by their primary provider.

   b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

      No, since persons who have committed certain offenses are already prohibited from participating as a Medicaid provider. This bill would make them easier to detect.

5. Family Empowerment:

   a. If the bill purports to provide services to families or children:

      (1) Who evaluates the family's needs?

      N/A

      (2) Who makes the decisions?

      N/A

      (3) Are private alternatives permitted?

      N/A

      (4) Are families required to participate in a program?

      N/A

      (5) Are families penalized for not participating in a program?

      No.

   b. Does the bill directly affect the legal rights and obligations between family members?

      No.

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. SECTION-BY-SECTION RESEARCH:

Section 1. Amends s. 409.907, F.S., relating to Medicaid provider agreements, to:
(a) Require providers and any officer, director, agent, managing employee, or affiliated person, or any partner, or shareholder who has an ownership interest equal to 5% or more in the provider if the provider is a business entity, to submit a full set of fingerprints in order to permit a state and national criminal-history records check, to be paid for by the provider; and
(b) Provide exemptions for hospitals, nursing homes, assisted living facilities, certain directors of not-for-profit corporations, and persons who have previously been screened pursuant to ch. 435 if conducted within the last 12 months.

Section 2. Amends s. 409.912, F.S., relating to agency purchase of managed health care for Medicaid recipients, to:
(a) Permit county owned entities and federally qualified health centers until July 1, 1998, to be licensed under parts I and III of chapter 641, F.S.; and
(b) Permit an entity providing mental health services in certain counties on a capitated basis to be licensed under chapter 636, rather than 624 or 641.

Section 3. Amends s. 409.9122, F.S., relating to mandatory Medicaid managed care enrollment, to permit MediPass recipients up to 10 visits to a chiropractor and 4 visits to a podiatrist before needing prior authorization from the MediPass primary care provider.

Section 4. Amends s. 409.920, F.S., relating to Medicaid provider fraud, to increase the penalty for knowingly submitting false information in order to be enroll as a Medicaid provider from a 1st degree misdemeanor to a 3rd degree felony.

Section 5. Creates s. 636.0145, F.S., relating to Medicaid providers certified under chapter 636, F.S., to exempt them from certain provisions of chapter.

Section 6. Provides an effective date of July 1, 1997.

III. FISCAL RESEARCH & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

None.

2. Recurring Effects:

Florida Department of Law Enforcement

General Revenue (2 FTEs)	
Salary & Benefits	$54,007
Expenses	5,842
OCO	6,580

3. Long Run Effects Other Than Normal Growth:

None.

4. Total Revenues and Expenditures:

General Revenue	$66,429

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

None.

2. Recurring Effects:

None.

3. Long Run Effects Other Than Normal Growth:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

Each provider, and each principal of the provider will incur a cost of $39 each ($15 for the FDLE background check and $24 for the FBI background check).

2. Direct Private Sector Benefits:

   Any effort which prevents criminal participation in the Medicaid program should result in reduced Medicaid costs which should, in turn, benefit Florida taxpayers.

3. Effects on Competition, Private Enterprise and Employment Markets:

   Elimination of fraudulent providers should benefit legitimate provider participants in the Medicaid program.

D. FISCAL COMMENTS:

Medicaid receives approximately 10,000 requests per year from provider agreement applicants, each of which involves an average of 3 principals who require background screening as part of the provider agreement process. The $15 fee charged for background checks would raise about $450,000 which will more than cover the cost of providing the checks.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

Units of local government are expressly exempted from the criminal record background screening requirements applicable to Medicaid providers.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority of counties or municipalities to raise revenues.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

The MediPass program receives federal Medicaid matching funds via a federal waiver. Permitting MediPass enrollees direct access to chiropractors and podiatrists will require obtaining federal approval and amending the waiver. Completing this process, as well as establishing the computer payment system which counts chiropractor and podiatrist visits, may not be accomplished by July 1, 1997, the effective date of this bill.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

The bill as originally filed only addressed conducting state and national background screening on Medicaid providers. In addition to providing several exemptions from that requirement, the bill also includes provisions which:

- Increase the penalty for persons who knowingly submit false information in order to enroll as a Medicaid provider.

- Permit county-owned entities and federally qualified health centers contracting to provide managed health care to Medicaid recipients an extra year to obtain HMO licensure.
- Permit an entity providing mental health services on a capitated basis to be licensed as a prepaid limited health service organization rather than as an insurer or HMO.
- Permit MediPass direct access to chiropractors and podiatrists for up to a certain number of visits.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by: Legislative Research Director:

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