HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1811 (PBC HC 04-01) Medicaid Fraud and Abuse
SPONSOR(S): Committee on Health Care
TIED BILLS: None. **IDEN./SIM. BILLS:** CS/SB 1064 (S)

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care	20 Y, 0 N	Garner	Collins
2) Health Appropriations (Sub)	11 Y, 0 N	Speir	Massengale
3) Appropriations	41 Y, 0 N w/CS	Speir	Baker
4)			
5)			

SUMMARY ANALYSIS

House Bill 1811 broadens the authority of the Agency for Health Care Administration (AHCA) related to combating fraud and abuse in the Medicaid program, particularly focused on prescribed drugs. The bill also gives the Medicaid Fraud Control Unit (MFCU) in the Department of Legal Affairs broader authority to pursue entities that try to defraud the Medicaid program. Most significantly, the bill does the following:

- Authorizes the Office of Statewide Prosecution to investigate and prosecute criminal violations of ss. 409.920 or 409.9201, F.S.
- Requires Medicaid applicants to agree to forfeit their entitlement to receive Medicaid services if they defraud the program.
- Gives AHCA the authority to require a confirmation or second physician's opinion for a diagnosis.
- Authorizes AHCA to terminate certain practitioners from the Medicaid program if they are prescribing inappropriately or inefficiently, as determined by AHCA.
- Gives AHCA the authority to mandate a recipient's participation in a provider lock-in program for a specified period of time.
- Requires AHCA to seek a federal waiver to terminate the eligibility of a Medicaid recipient from the program if he or she commits two offenses of fraud within 5 years.
- Allows AHCA to implement provider network controls.
- Authorizes AHCA to deny payment for inappropriate, medically unnecessary, or excessive goods or services.
- AHCA shall conduct a study of electronic systems to verify eligibility and identity of Medicaid recipients.
- Clarifies provider suspension or termination from the Medicaid program.
- Authorizes AHCA to deny payment to or require repayment from a provider terminated or suspended from Medicaid or Medicare by the federal government or any state.
- Authorizes AHCA to implement amnesty programs.
- Allows AHCA and MFCU to review a provider's non-Medicaid related records.
- Authorizes AHCA to limit, restrict, or suspend Medicaid recipient eligibility for a period of time.
- Makes it unlawful to knowingly use or endeavor to use a Medicaid provider's or recipient's identification number in the making of a claim for items or services that are not authorized to be reimbursed under the Medicaid program.
- Specifies that a Medicaid participating physician is required to make available to MFCU any accounts or records relevant to investigations of alleged abuse or neglect of patients, or to investigations of alleged misappropriation of patients' private funds.

- Establishes new criminal violations relating to Medicaid fraud.
- Provides an additional ground under which a health care practitioner who prescribes medicinal drugs or controlled substances may be subject to discipline.
- Amends the requirement that AHCA give pharmacists at least 1 week's notice prior to an audit.
- Expands the definition of "racketeering activity" to include crimes relating to Medicaid.
- Provides that the Statewide Grand Jury's jurisdiction includes criminal violations of Medicaid.
- Provides an effective date of July 1, 2004.

There could be extra revenue generated through the fines stipulated in the bill, although the extent of the fines to be levied is unknown. AHCA estimates that it will need an additional 17 positions to increase the Agency's efforts in deterring and detecting Medicaid fraud and abuse. In addition, AHCA requested funding to contract for prescribed drug cost-control planning and for the development of guidelines and tools to promote cost-effective drug use. The estimated cost of the positions and funding for additional fraud control activities in FY 2004-2005 is $1,691,304.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

1. Reduce government?	Yes[ ]	No[X]	N/A[ ]
2. Lower taxes?	Yes[ ]	No[ ]	N/A[X]
3. Expand individual freedom?	Yes[ ]	No[X]	N/A[ ]
4. Increase personal responsibility?	Yes[X]	No[ ]	N/A[ ]
5. Empower families?	Yes[ ]	No[ ]	N/A[X]

For any principle that received a "no" above, please explain:

1. This bill will expand the regulatory and oversight abilities of both the Agency for Health Care Administration and the Office of the Attorney General, which requires additional state resources.

3. This bill will expand the role of government in the Medicaid recipient's behavior.

B. EFFECT OF PROPOSED CHANGES:

Medicaid fraud and abuse have been high profile problems in recent years. Millions of dollars are drained off through fraud which should be used to benefit those people the Medicaid program was designed to help. Fraud is perpetrated by Medicaid providers, non-Medicaid providers, clinics, pharmacists, drug companies, Medicaid recipients, and industrious entrepreneurs.

The Agency for Health Care Administration (AHCA) and the Medicaid Fraud Control Unit (MFCU) have been working to combat fraud and abuse in all aspects of the Florida Medicaid program. AHCA is responsible for coordinating Medicaid overpayment and abuse prevention, detection, and recovery efforts. MFCU is responsible for investigating and prosecuting Medicaid fraud.

AHCA has implemented a number of initiatives to combat Medicaid prescription drug fraud and abuse. These initiatives include:

- In early 2002, AHCA hired five area pharmacists to meet with physicians in their offices to discuss issues such as recipient doctor shopping, coordination of care, and appropriate utilization of pain medications. AHCA is in the process of adding four more area pharmacists.
- In FY 2002-2003, AHCA implemented a Diverted Pharmaceuticals Pilot Project in Broward, Miami-Dade, Monroe, and Palm Beach counties to prevent the fraudulent practice of reselling Medicaid prescribed drugs to wholesalers and pharmacies.
- In October 2002, AHCA implemented a recipient lock-in program. This program requires a recipient who has been identified as a high user and potential abuser of prescribed drugs, or who obtains prescriptions from multiple physicians, to obtain all of their medications from a single pharmacy. The program currently has 589 recipients enrolled, 200 of which were enrolled in the lock-in program in just the last quarter. The majority of lock-in recipients are using Oxycontin and other targeted medications. The intent is to ensure that at least one medical professional, the pharmacist, is aware of all the medications that the recipient is receiving.
- In February 2003, AHCA contracted with Heritage Information Systems to analyze and apply sophisticated drug algorithms used to detect unusual drug utilization patterns and assist AHCA in determining the cause. Prescription data are analyzed on a daily basis and summarized for AHCA on a weekly basis. Information is then disseminated to the appropriate drug utilization program for follow-up and action.

- In April 2003, AHCA began promoting the use of a website that allows a physician to view 90 days' history of all the Medicaid prescriptions filled for his or her patients. This allows the physician to check for abuse, compliance, and multiple prescribers.

To further provide physicians with the necessary information to monitor their patients' drug use, in the spring of 2003, AHCA contracted with Gold Standard MultiMedia to provide 1000 handheld, wireless Personal Digital Assistants (PDAs) to the top prescribing Medicaid physicians. The PDAs provide the physician with 60 days' history of all the Medicaid prescriptions for their patients along with clinical information to assist in the appropriate prescribing of medications.

Statewide Grand Jury Report

The Seventeenth Statewide Grand Jury released a report on December 4, 2003, on recipient fraud in Florida's Medicaid program. The Grand Jury studied the diversion of tens of millions of Medicaid dollars worth of prescription drugs by large numbers of Medicaid recipients. The Statewide Grand Jury found that there are few, if any, consequences to Medicaid recipients who sell their expensive medications to illegal drug wholesalers. According to the report, efforts to deal with the problem of recipient fraud have been hampered by the lack of effective state statutes, federal limitations that restrict Florida's attempt to control this fraud, and a lack of awareness by some state and federal officials of the extent of the problem of recipient fraud. The result is the waste of hundreds of millions of dollars, exploitation of Medicaid recipients, and the tainting of our supply of critical lifesaving medication. Accordingly, the Statewide Grand Jury further found that "the societal cost of this illicit trade in pharmaceuticals cannot be overstated."

The Statewide Grand Jury discussed the fact that the proliferation of infusion clinics has provided another way for Medicaid recipients to sell their drugs. Some infusion clinics recruit Medicaid recipients by offering them a small payment. The recipient is directed to a particular pharmacy, which then delivers the drugs in smaller doses (rather than one dose) directly to the clinic. The clinic turns around and sells the remaining doses on the black market. The pharmacy, however, bills Medicaid for all of the doses of drugs. The clinic then infuses perhaps one dose of the diluted drugs or in some instances, unbeknownst to the patient, simply infuses saline solutions into the Medicaid recipient. The clinic profits from the re-sale of the diverted drugs; and while the Medicaid recipient receives a small bribe for his or her participation, the patient is oftentimes not receiving any of the drugs that are medically appropriate. Thus, the losses are two-fold. First, some Medicaid recipients are receiving bad health care. Second, tax dollars that could be used elsewhere are being used to pay providers and recipients for drugs that are prescribed, bought, sold, and used fraudulently.

The Statewide Grand Jury reviewed how some criminals have recruited Medicaid recipients to pretend to have AIDS by using imposters to take blood tests for them. One such Medicaid recipient received more than $600,000 in AIDS medications by falsely claiming to have AIDS. In some instances, corrupt labs either exaggerate a Medicaid recipient's illness or completely falsify lab reports to come up with a phony AIDS diagnosis. Though these are often not Medicaid approved labs, Medicaid does accept lab reports from non-Medicaid labs to document the diagnosis. AHCA does not require a second opinion or follow-up lab work to verify the initial diagnosis. This bill gives AHCA the authority to require a confirmation or second physician's opinion of the correct diagnosis before authorizing payment for medical treatment, except in the case of a patient in an emergency department. The confirmation or second opinion shall be rendered in a manner approved by AHCA.

The Statewide Grand Jury concluded, "While drug diversion is only part of that fraud, the other societal costs of diversion—dollars lost to the system, the exploitation of recipients, the tainting of our pharmaceuticals—leaves too much at stake for Florida taxpayers to be content to chase after the fraud. AHCA must make greater efforts to get ahead of this fraud and stop it before it starts. We are confident that the Legislature will recognize the seriousness of the problems that we have identified and will be supportive of AHCA's efforts to address this fraud with renewed vigor."

Grand Jury Recommendations
At the conclusion of the report, the Statewide Grand Jury issued a series of recommendations to the Florida Legislature and to AHCA. Many of these proposals can be accomplished under current state and federal law. Some, however, require changes to state law, while others could be realized after changes to federal law. This bill enacts the following recommendations from the Statewide Grand Jury:

- Criminalize the sale of Medicaid drugs by recipients making an offense of Medicaid fraud under Chapter 409.
- Criminalize the purchase of Medicaid drugs from a recipient and tie the degree of felony to the value of drugs.
- Recipients who abuse or defraud the Medicaid program should have all of their Medicaid services locked in to one provider for each category of service. Recipients should be locked in for a period of one year the first time they are found to be defrauding the Medicaid system and three years the second time they are caught.
- AHCA should seek authority from the federal Centers for Medicare and Medicaid Services and the Florida Legislature to terminate the eligibility of recipients who are found to be abusing or defrauding the Medicaid system for the third time.
- The recipient enrollment form should be amended to include an agreement that recipients may lose their eligibility for abusing or defrauding the Medicaid program.
- Prohibit Medicaid from reimbursing for drugs, goods, or services prescribed by non-Medicaid providers and prohibit Medicaid from reimbursing for medications infused by non-Medicaid providers.
- Medicaid should require a second opinion by a Medicaid enrolled physician to confirm all diagnoses of serious medical conditions such as HIV/AIDS, cancer, and so on.
- Broaden Medicaid's restrictions and pre-authorizations to simultaneously include all drugs within a class likely to be diverted.
- Require AHCA to conduct a study and recommend a plan to implement an electronic verification system in the Medicaid program.
- Mail explanation of benefits forms to all recipients so that they can be alerted to all billings made under their Medicaid number.
- Encourage Medicaid to improve communications and information sharing with all agencies involved in anti-fraud efforts.

The bill makes several statutory changes broadening AHCA's authority related to combating fraud and abuse in the Medicaid program, particularly focused on prescribed drugs. Among the statutory changes is AHCA's ability to implement provider network controls, including but not limited to, competitive bidding and provider credentialing. The bill also makes several statutory changes giving MFCU broader authority to pursue entities who try to defraud the Medicaid program.

Medicaid Fraud and Abuse
Federal law requires states to establish programs designed to educate physicians and pharmacists regarding fraud, abuse, and inappropriate prescribing. In the past few years, federal and state agencies have expanded investigation and prosecution of Medicaid fraud and abuse. In almost all cases, the investigations are focused on providers who may be double billing, over-billing, or charging for services not actually delivered to recipients. A 1999 General Accounting Office report on Medicaid fraud and abuse suggests that this area deserves the ongoing attention of state government.

HB 1811 w/CS ensures that Medicaid fraud and abuse will maintain the ongoing attention of state government. It requires the Office of Program Policy Analysis and Government Accountability to provide biennial reports to the Legislature regarding the agency's efforts to prevent, detect, deter, and recover Medicaid fund lost to fraud and abuse.

This bill also creates a section of law addressing Medicaid fraud, especially as it relates to prescription drugs. Newly created s. 409.9201, F.S., makes it a felony to knowingly sell, attempt, conspire, or cause

another to sell a legend drug that was paid for by the Medicaid program. It also makes it a felony to knowingly purchase, attempt, or conspire to purchase a legend drug that was paid for by the Medicaid program and intended for use by another person. And lastly, it provides that a person who knowingly makes, causes, conspires, or attempts to make any false statement or representation for the purpose of obtaining goods or services from the Medicaid program commits a felony.

Medicaid Program Integrity

Sections 409.913 and 409.9131, F.S., prescribe the activities of AHCA related to oversight of the integrity of the Medicaid program. Staff of the Medicaid Program Integrity (MPI) section develop and use statistical methodologies to identify providers who exhibit aberrant billing patterns, conduct investigations and audits of these providers, calculate provider overpayments, initiate recovery of overpayments in instances of provider abuse, and recommend administrative sanctions for providers who have abused or defrauded Medicaid. Any suspected criminal violation identified by AHCA must be referred to MFCU in the Office of the Attorney General. AHCA and MFCU are required to develop a memorandum of understanding that includes protocols for referral of cases of suspected criminal fraud and return of those cases when investigation determines that administrative action by AHCA is appropriate.

To assist AHCA in preventing and deterring Medicaid provider fraud and abuse, Florida's Legislature has made a number of substantive changes to state law affecting AHCA's program integrity functions since 1996. These changes include clarifying agency processes related to entering into provider agreements; and requiring follow-up reviews of providers with a history of overpayments, that certain providers post surety bonds, and that AHCA conduct criminal background checks of potential providers.

The Office of Medicaid Program Integrity is funded through federal and state revenues. With the exception of the OMNI Subsystem of the Florida Medicaid Management Information System (FMMIS), the federal match for program integrity activities is 50 percent. The federal match for the OMNI subsystem is 75 percent.

HB 1811 w/CS makes several statutory changes expanding Medicaid Program Integrity's ability to combat Medicaid provider and recipient fraud and abuse. Specifically:

- The bill expands AHCA's ability to address recipient fraud and abuse by requiring second opinions before future payments are authorized for certain diagnosis; requiring certain recipients to participate in provider lock-in programs; and will allow, with federal approval, allow the program to terminate a recipient's eligibility if they are found to have committed fraud two times in a period of five years.

- The bill also expands the Agency's ability to address provider fraud and abuse by allowing the Agency to limit its provider networks through competitive bidding and provider credentialing; suspending or terminating providers for inappropriate prescribing patterns; and allowing more extensive use of prepayment review of provider claims to ensure compliance with Medicaid rules.

Regulation of Medicaid Providers

Section 409.913(28), F.S., enacted in the 2002 legislative session, gives AHCA and MFCU the authority to review Medicaid-related records to determine and reconcile a provider's total output of goods or services against Medicaid billings, notwithstanding any other law. To determine a provider's total output of goods and services, Medicaid and non-Medicaid records need to be examined. If a provider's total output of goods and services cannot be determined, reconciliation of whether or not the provider had adequate inventory to support their billings to the Medicaid program cannot be completed. This prevents MFCU from developing evidence to determine whether or not Medicaid fraud has been committed. This bill authorizes AHCA and MFCU to review a provider's non-Medicaid-related records

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 409.920, F.S., contains provisions related to Medicaid provider fraud, and requires the Attorney General to conduct a statewide program of Medicaid fraud control. The duties of the program include investigation of possible criminal violations pertaining to the administration of the Medicaid program, in the provision of medical assistance, or in the activities of Medicaid providers. The Attorney General is required to investigate alleged abuse or neglect of patients in health care facilities receiving Medicaid payments, and misappropriation of patient's private funds in facilities receiving Medicaid payments. The Attorney General is required to refer all suspected abusive activities not of a criminal nature to AHCA, as well as each instance of overpayment that is discovered during the course of an investigation. This bill requires a Medicaid participating physician to allow access to records to the Office of the Attorney General to determine the existence of fraud or alleged misappropriation of a patient's private funds.

This bill amends s. 409.920 F.S., to make it a crime to knowingly use or endeavor to use a Medicaid provider's identification number or a Medicaid recipient's identification number to make, cause to be made, or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed by the Medicaid program.

Presently, non-Medicaid providers may write prescriptions for Medicaid recipients. Thus, a provider who is terminated from the Medicaid program, regardless of the egregiousness of the basis for termination, may continue to take actions that result in enrolled providers submitting claims to Medicaid. For example, a physician who has been terminated from the Medicaid program may continue to prescribe medications if they remain licensed to practice in Florida. Those prescriptions may then be filled at a pharmacy that is an enrolled Medicaid provider and billed to the Medicaid program. This bill prohibits ACHA from reimbursing any person or entity for any prescription for medications, medical supplies, or medical services if the prescription was written by a physician or other prescribing practitioner who is not enrolled in the Medicaid program. However, non-Medicaid providers may continue to have prescriptions honored by Medicaid if:

- It involves a bona fide emergency medical condition as determined by AHCA.
- The medical services are provided in a hospital emergency department, hospital inpatient or hospital outpatient setting, and nursing homes.
- Pro bono services are pre-approved by AHCA.
- The prescribing physicians are board certified specialists treating Medicaid recipients referred for treatment by a treating physician who is enrolled in the Medicaid program.
- The prescriptions were written for dually eligible Medicare beneficiaries by an authorized Medicare provider who is not enrolled in the Medicaid program.
- Physicians who are not enrolled in the Medicaid program who provides a medically-necessary service or prescription not otherwise reasonably available from a Medicaid-enrolled physician.
- There are instances where the agency cannot practically notify a pharmacy at the point of sale that a prescription will be approved for processing under other provisions of this bill.

In order to ensure the Agency finds a way to notify pharmacies that a prescription is approved, the bill sunsets this last exemption on July 1, 2005, and requires the Agency to conduct a study of the feasibility of an electronic verification system.

Medicaid Peer Review Process

Certain Medicaid services are subject to utilization review by a Peer Review Organization (PRO) under contract with AHCA. The purpose of the utilization review program is to safeguard against unnecessary and inappropriate medical care rendered to Medicaid recipients. Medical services and/or records are reviewed for medical necessity, quality of care, appropriateness of place of service and length of stay (inpatient hospital). This bill amends s. 409.9131, F.S., to change the definition of "peer review" to

require a determination of the adequacy of the documentation in the physician's records in cases involving a determination of medical necessity.

The following Medicaid services are subject to review by a PRO:

- Inpatient Hospital Services.
- Home Health Services.
- Community Mental Health Services.
- Targeted Case Management.
- Home and Community Based Waiver Services for the Developmentally Disabled.

The Bureau of Medicaid Program Integrity (MPI) monitors this information on an ongoing basis in an effort to control fraud and abuse. If the MPI staff suspect that there is a problem with a provider's records based on their initial review of the records, they are required to send the records to another physician to review.

There are certain procedures or types of services for which Medicaid can only reimburse on a limited basis or a certain number of times per month. If a procedure can only be performed three times in a one-month period, and Medicaid is billed a fourth time or more, the MPI staff know that this is a problem and can take the necessary measures to seek repayment for claims that exceed the three allowable reimbursements. Currently, the way the statute is written, MPI staff would have to send the records of the physician who over-billed to a peer for review, even though MPI staff knows that all they need to do is seek repayment for the unallowable claims. The current statute implies that AHCA must use its limited resources to have a practicing physician review the medical records, even where the basis of the overpayment is not within the purview of the physician's review. This bill allows AHCA to deny payment, rather than just requiring repayment, for inappropriate, medically unnecessary, or excessive goods or services.

Medicaid Prepayment Review
AHCA currently has the authority under s. 409.913(3), F.S., to conduct, or contract for, prepayment review of provider claims to ensure cost-effective purchasing, billing, and provision of care to Medicaid recipients. The prepayment reviews may be conducted as determined appropriate by AHCA, without any suspicion or allegation of fraud, abuse, or neglect. The current statute does not specify the length of time the prepayment review can last or how quickly claims must be adjudicated for denial or payment, whether or not there is evidence of fraud, misrepresentation, abuse, or neglect. The bill allows prepayment review to last up to one year. It requires the agency to make payment on claims within 90 days after the receipt of all necessary documentation unless AHCA has reliable evidence of fraud. If there is reliable evidence of fraud, misrepresentation, abuse, or neglect, claims shall be adjudicated for denial of payment within 180 days the receipt of all necessary documentation.

Withholding of Payments
Section 409.913(24), F.S., gives AHCA the authority to withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud, willful misrepresentation, or abuse under the Medicaid program, or a crime committed while rendering goods or services to Medicaid recipients, pending the completion of legal proceedings. This section does not currently give AHCA the authority to deny payment, or require repayment, where the goods or services were furnished, supervised, or caused to be furnished by a person who has been suspended or terminated from the Medicaid or Medicare program by the federal government or any state. This bill amends the section to give AHCA the necessary authority.

Medicaid Amnesty Program
Currently, there is no amnesty program in place under the Medicaid program, and AHCA is without authority to institute one. Such programs would serve as an incentive for repayment by providers who would otherwise be reluctant to come forward out of fear of penalties and sanctions from AHCA. This

bill authorizes AHCA to implement amnesty programs that encourage voluntary repayment of overpayments.

Medicaid Pharmacy Audits
Section 409.913(2), F.S., requires AHCA to conduct, or cause to be conducted audits to determine possible fraud or abuse in the Medicaid program. AHCA currently contracts for audits of pharmacies to determine compliance with Medicaid policy, rules and regulations. Under this contract, all audits are conducted or supervised by a pharmacist licensed in the State of Florida. During the 2003 legislative Session, CS/CS/SB 1428 passed requiring AHCA to give pharmacists at least one weeks' prior notice of a pharmacy audit. This bill amends this provision to only require a 1 week notice at the beginning of the audit cycle. The bill also includes a prohibition against the use of extrapolation for determining penalties related to these audits.

Practice Pattern Identification Program
AHCA is responsible for identifying health care utilization and practice patterns within the Medicaid program that are not cost effective or medically appropriate. AHCA and the Drug Utilization Review Board are involved in a practice pattern utilization program under s.409.912(16)(b)(1), F.S., which evaluates practitioner prescribing patterns. Currently, AHCA and the board do not consult with DOH under the practice pattern identification program. This bill requires AHCA and the Drug Utilization Review Board to consult with DOH under the practice pattern identification program.

Also, the current statute specifies that practitioners who are prescribing inappropriately or inefficiently, as determined by AHCA, may have their prescribing of certain drugs subject to prior authorization. AHCA does not currently have the authority to terminate someone from prescribing in the Medicaid program if they find the practitioner is prescribing inappropriately or inefficiently. This bill gives AHCA the authority to remove practitioners from the program for inappropriate prescribing patterns.

Sanctioning of Medicaid Provider
Section 409.913(15), F.S., gives AHCA the authority to impose sanctions or disincentives on a provider or a person for various reasons. These sanctions include suspension or termination for specified periods of time. The statute does not specify that an individual who is terminated or suspended cannot be involved in actions that result in a claim for payment to the Medicaid program as a result of furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services. The bill makes that statutory change by specifying that suspension or termination from the Medicaid program precludes participation in Medicaid during that period which includes any action that results in a claim for payment to the Medicaid program as a result of furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services.

Disciplinary Actions for Practice Patterns
Section 456.072, F.S., specifies the acts that shall constitute grounds for which disciplinary actions can be taken against health care practitioners. This section does not currently allow the Department of Health (DOH) to investigate and discipline for bad practice patterns when prescribing medicinal drugs or controlled substances, which patterns aren't identified in a single, patient-specific case. This bill amends s. 456.072, F.S., to provide that a health care practitioner who prescribes medicinal drugs or controlled substances may be subject to discipline by DOH or the appropriate board having jurisdiction over the health care practitioner if the practitioner is found to have engaged in a pattern of practice when prescribing medicinal drugs or controlled substances which demonstrates a lack of reasonable skill or safety to patients, a violation of any provision of this chapter, a violation of the applicable practice act, or for a violation of any rules adopted pursuant to this chapter or the applicable practice act of the prescribing practitioner. Notwithstanding s. 456.073(13), F.S., the department may initiate an investigation and establish such a pattern from billing records, data, or any other information obtained by the department

Medicaid Sanctions against Recipients

Section 1128B of the Social Security Act provides for criminal penalties for acts involving federal health care programs, and allows for suspension of Medicaid benefits for up to one year, for individuals convicted of certain federal crimes. Florida currently does not have a law that authorizes suspension of eligibility if an individual is convicted of federal health care crimes provided in Section 1128B of the Social Security Act. This bill creates s. 409.9021, F.S., which requires Medicaid applicants to agree to forfeit their entitlement to goods and services in the Medicaid program if they are found to have abused or defrauded the program. AHCA is instructed in this bill to seek a federal waiver to terminate the eligibility of Medicaid recipients if they commit a third offense of fraud or abuse.

This bill addresses recipient fraud in other federal health care programs. It authorizes AHCA to limit, restrict, or suspend Medicaid eligibility for a period of up to one year for those recipients convicted of a fraudulent act under or against a federal health care program, and with federal approval, allows the program to terminate a recipient if they are found to have committed fraud two times in a period of five years.

Medicaid Disease Management

Results of disease management studies conducted around the country indicate that closely managing patients with chronic diseases can reduce the higher cost services these patients often require and at the same time improve quality of life for the patient. Disease-management also can prevent or delay the onset of the more severe stages of a disease. Since 1995, a number of states have developed and implemented disease management programs.

Disease management programs emphasize treatment of patients with chronic disease such as diabetes, asthma, heart disease, and HIV/AIDS. Goals of state disease management programs include controlling Medicaid costs and improving the quality of health care provided to the chronically ill. For example, Medicaid cost savings are realized through the reduction in emergency room services for chronic disease. Disease management programs throughout the states are not uniform; differences among disease management programs include disease coverage, program administration, and the type of service and professionals offered to patients.

In 1997, the Florida Legislature authorized disease management and directed AHCA to “select methods for implementing the program that included best practices, prevention strategies, clinical-practice improvement, clinical interventions and protocols, outcomes research, information technology, and other tools.” The Florida disease management initiative has been designed to promote and measure: health outcomes, improved care, reduced inpatient hospitalization, reduced emergency room visits, reduced costs, and better educated providers and patients. AHCA contracts with disease management organizations to provide disease management services to Medicaid recipients enrolled in the Primary Care Case Management program (MediPass) who have been diagnosed with diabetes, HIV/AIDS, asthma, hemophilia, congestive heart failure, end stage renal disease, mental illness, or hypertension. This bill gives AHCA the authority to mandate prior authorization, drug-therapy-management, or disease-management participation for certain Medicaid recipients or for certain drugs.

Medicaid Pharmacy Lock-in

A state may require (lock in) a beneficiary who has used Medicaid services or items at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the state, to receive goods and services from a single provider or limited group of providers for a reasonable period of time. The Medicaid Bureau of Pharmacy Services recently implemented a program that may restrict a patient to filling all of his or her prescriptions at one pharmacy. The purpose of this program is to control duplicate and inappropriate drug therapies. Any patient is eligible for the lock-in. Patients most likely to benefit from this service are those who see multiple physicians with complicated drug regimens. Also, patients suspected of “doctor shopping” could be restricted to one pharmacy for their Medicaid prescriptions.

This bill amends s. 409.912, F.S., to allow AHCA to mandate a recipient's participation in a provider lock-in program. AHCA may limit the receipt of goods or services by a recipient to a single provider for a period of no less than one year.

The lock-in programs shall include, but are not limited to, pharmacies, medical doctors, and infusion clinics. This bill provides that the lock-in program shall not be applicable to emergency services and care provided to the recipient in a hospital emergency department. AHCA is given authority to seek federal waivers necessary to implement this subsection.

Medicaid Fraud Control Unit

Section 16.59, F.S., creates the Medicaid Fraud Control Unit (MFCU) within the Department of Legal Affairs. The unit is authorized to investigate all violations of s. 409.920, F.S., relating to Medicaid provider fraud, and any criminal violations discovered during the course of those investigations. The unit is authorized to refer any criminal violation to the appropriate prosecuting authority. As part of ongoing investigations, MFCU may request physician's accounts or records if MFCU suspects fraud. Currently, the statute does not allow MFCU to request a physician's accounts or records if MFCU suspects patient neglect or abuse, or theft of patient funds.

At present, MFCU is not included in the list of agencies that form unlicensed assisted living facility workgroups at local AHCA field offices. Since MFCU now has federal investigative authority over such facilities, MFCU should be included in the group of agencies. This bill amends s. 400.408, F.S., to include MFCU in the workgroups.

Further, MFCU's state statutory right of entry found in s. 409.920(8)(a), F.S., is limited to the premises of providers participating in the Medicaid program. Recent amendments to MFCU's federal investigative authority [see 42 U.S.C.A.1396b(q)(4) and 42 CFR, 1001.1301(a)(1)(iv)], however, extended MFCU's authority to investigate complaints of patient abuse and neglect to all health care facilities that provide basic nursing care services or personal care services, regardless of whether the facility receives Medicaid funds.

For the past several years, MFCU has lead and participated in Operation Spotcheck, an operation where multi-agency teams perform unannounced inspections at nursing homes, assisted living facilities, and other similar health care premises around Florida. As part of the Spotcheck protocol, MFCU investigators ask permission for the team to enter the premises prior to the inspection. Permission has not yet been refused by any provider. There is the possibility, however, that an administrator will refuse to allow MFCU or the Spotcheck team on the premises. This bill amends s. 400.434, F.S., to allow MFCU to enter and inspect assisted living facilities without permission.

Office of Statewide Prosecution

The Statewide Prosecutor serves as the legal adviser to the Statewide Grand Jury, which is supervised by the Florida Supreme Court. The Office of Statewide Prosecution is authorized to investigate and prosecute multi-circuit organized crime. The office uses a police/prosecutor team approach in multi-offender, multi-offense, multi-jurisdictional criminal cases. The goal of the teams is to dismantle the organizations through effective prosecution and civil, administrative, and regulatory sanctions where appropriate.

For the Statewide Prosecutor to handle a case, the crime must have occurred in more than one judicial circuit or be part of a conspiracy affecting more than one judicial circuit, and it must be one of the offenses enumerated in the law. Currently, the Statewide Prosecutor does not have specific authority to investigate and prosecute any criminal violations of chapter 409, F.S. This bill amends s. 16.56, F.S., to allow the Office of Statewide Prosecution to investigate and prosecute any criminal violation of the Medicaid program by recipients, providers, and other persons.

State vs. Gabriel Harden, et al., (Fla. 3rd DCA 2004)

In a January 2004 ruling, the Third District Court of Appeal held that s. 409.920(2), F.S., the Medicaid provider fraud statute, is unconstitutional under the supremacy clause of the U.S. Constitution (Art. VI, c1.2). Section 409.920, F.S., makes certain specified activities relating to Medicaid claims unlawful and declares violations to be a third degree felony. The State of Florida charged Gabriel Harden and nine other defendants with violating the "anti-kickback" provision of s. 409.920(e), F.S., by paying drivers for the "solicitation of transportation" of Medicaid-eligible children to dental facilities for treatment. Those drivers were allegedly employed by three corporate entities providing dental services to children. In dismissing the state's complaint, the trial court in Miami-Dade County held that s. 409.920(2), F.S., was preempted by the federal Medicaid Act and a federal rule. On appeal to the Third District Court of Appeals, the state argued Florida's anti-kickback statute did not conflict with the federal version and that there was no preemption under the Supremacy Clause of the U.S. Constitution.

The federal Medicaid anti-kickback statute, 42 U.S.C. 1320-7b, does not apply to compensation paid through a bona fide employment relationship and expressly protects such arrangements from prosecution. In contrast, Florida's anti-kickback statute does not have a "safe harbor" provision for such conduct. The federal anti-kickback statute also contains a "knowing and willful" mens rea requirement. Florida's anti-kickback statute (s. 409.920(1)(d) and (2), F.S.) only requires that the defendant act "knowingly." Therefore, because Florida criminalizes conduct that is protected under federal law, the Third District Court of Appeal affirmed the trial court's decision by holding s. 409.920, F.S., violates the Supremacy Clause. This bill amends s. 409.920, F.S., to redefine the term "knowingly" as an act done voluntarily and intentionally and not because of mistake or accident. "Knowingly" also includes the word "willfully" or "willful" which, as used in this section, means that an act was committed voluntarily and purposely, with the specific intent to do something the law forbids that is, with bad purpose either to disobey or disregard the law.

Racketeering and Illegal Debts
Section 895.02, F.S., provides definitions for ss. 895.01- 895.08, F.S., regarding offenses concerning racketeering and illegal debts. Medicaid provider fraud is covered under this section, but Medicaid recipient fraud is not. This bill adds Medicaid recipient fraud activity to list of activities that may be considered racketeering activity.

Florida Contraband Forfeiture Act
Sections 932.701- 932.707, F.S., are known as the Florida Contraband Forfeiture Act. Section 932.701(2), F.S., provides a definition for a "contraband article" under the act. The definition does not currently include any contraband obtained as a result of Medicaid provider fraud under s. 409.920, F.S. The bill expands the definition of "contraband article" to include anything acquired through Medicaid fraud, including real and personal property.

Disposition of Liens and Forfeited Property
Section 932.7055, F.S., relates to the disposition of liens and forfeited property. Currently, this section does not specify where proceeds accrued pursuant to the Contraband Forfeiture Act, by MFCU, shall be deposited. This bill requires the proceeds to be deposited in AHCA's Grants and Donations Trust Fund.

C. SECTION DIRECTORY:

Section 1. Amends s. 16.56, F.S., providing that the Office of Statewide Prosecution may investigate and prosecute any criminal violation of s. 409.920 or s. 409.9201, F.S., which cover the operation of the Medicaid program.

Section 2. Amends s. 400.408, F.S., including the Medicaid Fraud Control Unit of the Department of Legal Affairs in the AHCA local coordinating workgroups for identifying unlicensed assisted living facilities.

Section 3. Amends s. 400.434, F.S., giving the Medicaid Fraud Control Unit of the Department of Legal Affairs the authority to enter and inspect facilities licensed under part III of ch. 400, F.S., relating to assisted living facilities.

Section 4. Creates s. 409.9021, F.S., requiring a Medicaid applicant to agree in writing, subject to federal approval, to forfeit his or her entitlement to goods and services in the Medicaid program if he or she is found to have defrauded the program two times in a period of five years.

Section 5. Amends s. 409.912, F.S., relating to the cost-effective purchasing of health care for Medicaid recipients requiring second opinions in certain cases allowing for the termination of providers, and requiring lock-in programs.

Section 6. Amends s. 409.913, F.S., relating to oversight of the integrity of the Medicaid program and denial of payment for goods or services that are not presented as required in s. 409.913(7), F.S.

Section 7. Amends s. 409.9131, F.S., to change the definition of "peer review" and to require a certification that submitted cost reports are in compliance with federal and state laws.

Section 8. Amends s. 409.920, F.S., relating to definitions in Medicaid provider fraud.

Section 9. Creates s. 409.9201, F.S., making it a felony to sell Medicaid drugs, goods and services in a manner other than to benefit an eligible recipient.

Section 10. Amends s. 456.072, F.S., to provide that a health care practitioner who prescribes medicinal drugs or controlled substances may be subject to discipline by DOH or the appropriate board.

Section 11. Amends s. 465.188, F.S., amending the requirement that AHCA give pharmacists at least 1 week's notice prior to a pharmacy audit.

Section 12. Creates s. 812.0191, F.S., relating to dealing in property paid for in whole or in part by the Medicaid program

Section 13. Amends s. 895.02, F.S., expanding the definition of "racketeering activity" to include crimes committed under s. 409.9201, F.S., relating to Medicaid recipient fraud.

Section 14. Amends s. 905.34, F.S., providing that the Statewide Grand Jury's jurisdiction includes any criminal violation of s. 409.920 or s. 409.9201, F.S.

Section 15. Amends s. 932.701, F.S., expanding the definition of "contraband article" to include anything acquired by proceeds obtained as a result of Medicaid provider fraud.

Section 16. Amends s. 932.7055, F.S., requiring that proceeds collected under the Contraband Forfeiture Act be deposited in AHCA's Grants and Donations Trust Fund.

Sections 17 through 31. Amend ss. 394.9082, 400.0077, 409.9065, 409.9071, 409.908, 409.91196, 409.9122, 409.9131, 430.608, 636.0145, 641.225, and 641.386 F.S., correcting cross references; and reenact ss. 921.0022(3)(g), 409.920, 705.101(6), 932.701, 932.703(4), and 932.701, F.S.

Section 32. Requires the Agency to report on the feasibility of creating a database for the verification of providers qualified and not qualified to write prescriptions for Medicaid recipients.

Section 33. Appropriates $262,087 from the MQATF and DOH and 4 FTEs to implement provisions of this act in FY 2004-05.

Section 34. Provides an effective date of July 1, 2004.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

AHCA estimates that it will need an additional 17 positions to increase the agency's efforts in deterring and detecting Medicaid fraud and abuse. In addition, AHCA requested funding to contract for prescribed drug cost control planning and for the development of guidelines and tools to promote cost effective drug use.

1. Revenues: This is the federal Medicaid match. It is equal to the federal Medicaid expenditure shown in the Administrative Trust Fund below.

	Fiscal Year 2004-05	Fiscal Year 2005-06
Nonrecurring Title XIX Grants	$25,288	$0
Recurring Title XIX Grants	$922,956	$922,956
Total Revenues	$948,244	$922,956

2. Expenditures:

Nonrecurring	Fiscal Year 2004-05	Fiscal Year 2005-06
Agency Standard Expense & OCO Package		
Professional Staff (17FTEs)	$38,200	$0
Laptop Computers (7)	$10,276	$0
Docking Station and Components (7)	$2,100	$0
Total Nonrecurring Expenditures	$50,576	$0

Recurring	Fiscal Year 2004-05	Fiscal Year 2005-06
Salaries		
Senior Pharmacist (1 FTE)	$80,944	$80,944
Government Analyst II (5 FTE)	$314,682	$314,682
Government Analyst I (1 FTE)	$49,484	$49,484
Systems Project Consultant (1 FTE)	$59,037	$59,037
Registered Nursing Consultant (1 FTE)	$60,353	$60,353
Administrative Assistant I (1 FTE)	$31,430	$31,430
Senior Attorney (2 FTE)	$140,109	$140,109
Senior Pharmacist (3 FTE)	$244,061	$244,061
Senior Investigator (2 FTE)	$111,128	$111,128
Total Salary	$1,091,228	$1,091,228
Expenses		
Professional Staff (17)	$187,000	$187,000
Additional Travel Expenses	$ 12,500	$ 12,500
Contractual Pharmacy Services	$350,000	$350,000
Expenses Total	$569,500	$569,500
Total Recurring Costs	$1,640,728	$1,640,728
Total Costs (Nonrecurring + Recurring)	$1,691,304	$1,640,728

Funding of Expenditures:		
General Revenue Fund	$743,060	$717,772
Administrative Trust Fund	$948,244	$922,956
Total Expenditures (Nonrecurring + Recurring)	$1,691,304	$1,640,728

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None

2. Expenditures:

None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill gives AHCA and MFCU additional powers to combat Medicaid fraud and abuse, potentially resulting in additional penalties to Medicaid providers and beneficiaries. The bill provides authority for AHCA to implement amnesty programs designed to allow Medicaid providers the opportunity to voluntarily repay overpayments, with reduced, or no penalty to the provider. It could provide an incentive for repayment by providers who would otherwise be reluctant to come forward out of fear of penalties and sanctions from AHCA.

D. FISCAL COMMENTS:

Although the House Budget does not include funding for the requested positions, the Senate Budget for Fiscal Year 2004-2005 includes 17 positions and $1.6 million for Medicaid Fraud efforts. Therefore, the necessary funding will be a conference issue.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Agency for Health Care Administration and the Office of the Attorney General have sufficient rulemaking authority to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On April 2, 2004, the Subcommittee on Health Appropriations favorably recommended one technical amendment correcting a drafting error.

On April 3, 2004, the Appropriations Committee favorably adopted a strike everything amendment conforming the bill to the Senate Companion. The Committee favorably reported the bill with a Committee Substitute.