879426

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 04/15/2009 | . | |
| | . | |
| | . | |
| | . | |

---

---

The Committee on Health and Human Services Appropriations (Gaetz) recommended the following:

1 **Senate Amendment (with title amendment)**

2

3 Delete lines 552 - 798

4 and insert:

5 health agency rendering the services. However, this
6 provision does not apply to a home health agency affiliated with
7 a retirement community, of which the parent corporation or a
8 related legal entity owns a rural health clinic certified under
9 42 CFR, Part 491, Subpart A, Sections 1-11, a nursing home
10 licensed under part II of chapter 400, and apartments and single
11 family homes for independent living.

879426

4. The physician ordering the services has examined the recipient within the 30 days preceding the initial request for the services and biannually thereafter.

5. The written prescription for the services includes the recipient's acute or chronic medical condition or diagnosis, the home health service required, and for skilled nursing services the frequency and duration of the services.

6. The national provider identifier, Medicaid identification number, or medical practitioner license number of the physician ordering the services is listed on the written prescription for the services, the claim for home health reimbursement, and the prior authorization request.

Section 12. Subsection (1) of section 409.907, Florida Statutes, is amended to read:

(1) Each provider agreement shall require the provider to comply fully with all state and federal laws pertaining to the Medicaid program, as well as all federal, state, and local laws pertaining to licensure, if required, and the practice of any of the healing arts, and shall require the provider to provide services or goods of not less than the scope and quality it provides to the general public. Providers physically located in the State of Florida may be enrolled as Medicaid providers. A provider located outside the State of Florida may be enrolled if the provider's location is no more than 50 miles from the Florida state line, and the agency determines a need for that provider type to ensure adequate access to care.

Section 13. Subsection (14) of section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.—The

879426

41 agency shall purchase goods and services for Medicaid recipients
42 in the most cost-effective manner consistent with the delivery
43 of quality medical care. To ensure that medical services are
44 effectively utilized, the agency may, in any case, require a
45 confirmation or second physician's opinion of the correct
46 diagnosis for purposes of authorizing future services under the
47 Medicaid program. This section does not restrict access to
48 emergency services or poststabilization care services as defined
49 in 42 C.F.R. part 438.114. Such confirmation or second opinion
50 shall be rendered in a manner approved by the agency. The agency
51 shall maximize the use of prepaid per capita and prepaid
52 aggregate fixed-sum basis services when appropriate and other
53 alternative service delivery and reimbursement methodologies,
54 including competitive bidding pursuant to s. 287.057, designed
55 to facilitate the cost-effective purchase of a case-managed
56 continuum of care. The agency shall also require providers to
57 minimize the exposure of recipients to the need for acute
58 inpatient, custodial, and other institutional care and the
59 inappropriate or unnecessary use of high-cost services. The
60 agency shall contract with a vendor to monitor and evaluate the
61 clinical practice patterns of providers in order to identify
62 trends that are outside the normal practice patterns of a
63 provider's professional peers or the national guidelines of a
64 provider's professional association. The vendor must be able to
65 provide information and counseling to a provider whose practice
66 patterns are outside the norms, in consultation with the agency,
67 to improve patient care and reduce inappropriate utilization.
68 The agency may mandate prior authorization, drug therapy
69 management, or disease management participation for certain

879426

70 populations of Medicaid beneficiaries, certain drug classes, or
71 particular drugs to prevent fraud, abuse, overuse, and possible
72 dangerous drug interactions. The Pharmaceutical and Therapeutics
73 Committee shall make recommendations to the agency on drugs for
74 which prior authorization is required. The agency shall inform
75 the Pharmaceutical and Therapeutics Committee of its decisions
76 regarding drugs subject to prior authorization. The agency is
77 authorized to limit the entities it contracts with or enrolls as
78 Medicaid providers by developing a provider network through
79 provider credentialing. The agency may competitively bid single-
80 source-provider contracts if procurement of goods or services
81 results in demonstrated cost savings to the state without
82 limiting access to care. The agency may limit its network based
83 on the assessment of beneficiary access to care, provider
84 availability, provider quality standards, time and distance
85 standards for access to care, the cultural competence of the
86 provider network, demographic characteristics of Medicaid
87 beneficiaries, practice and provider-to-beneficiary standards,
88 appointment wait times, beneficiary use of services, provider
89 turnover, provider profiling, provider licensure history,
90 previous program integrity investigations and findings, peer
91 review, provider Medicaid policy and billing compliance records,
92 clinical and medical record audits, and other factors. Providers
93 shall not be entitled to enrollment in the Medicaid provider
94 network. The agency shall determine instances in which allowing
95 Medicaid beneficiaries to purchase durable medical equipment and
96 other goods is less expensive to the Medicaid program than long-
97 term rental of the equipment or goods. The agency may establish
98 rules to facilitate purchases in lieu of long-term rentals in

879426

99 order to protect against fraud and abuse in the Medicaid program
100 as defined in s. 409.913. The agency may seek federal waivers
101 necessary to administer these policies.
102 (14)(a) The agency shall operate or contract for the
103 operation of utilization management and incentive systems
104 designed to encourage cost-effective use of services and to
105 eliminate services that are medically unnecessary. The agency
106 shall track Medicaid provider prescription and billing patterns
107 and evaluate them against Medicaid medical necessity criteria
108 and coverage and limitation guidelines promulgated in rule.
109 Medical necessity determination requires that service be
110 consistent with symptoms or confirmed diagnosis of illness or
111 injury under treatment and not in excess of the patient's needs.
112 The agency shall conduct reviews of provider exceptions to peer
113 group norms and shall, using statistical methodologies, provider
114 profiling and analysis of billing patterns, detect and
115 investigate abnormal or unusual increases in billing or payment
116 of claims for Medicaid services and medically unnecessary
117 provision of services. Providers that demonstrate a pattern of
118 submitting claims for medically unnecessary services shall be
119 referred to the Medicaid program integrity unit for
120 investigation. In its annual report, required in s. 409.913, the
121 agency shall report on its efforts to control overutilization as
122 described above.
123 (b) The agency shall develop a procedure for determining
124 whether health care providers and service vendors can provide
125 the Medicaid program using a business case that demonstrates
126 whether a particular good or service can offset the cost of
127 providing the good or service in an alternative setting or

879426

128 through other means and therefore should receive a higher
129 reimbursement. The business case must include, but need not be
130 limited to:
131 1. A detailed description of the good or service to be
132 provided, a description and analysis of the agency's current
133 performance of the service, and a rationale documenting how
134 providing the service in an alternative setting would be in the
135 best interest of the state, the agency, and its clients.
136 2. A cost-benefit analysis documenting the estimated
137 specific direct and indirect costs, savings, performance
138 improvements, risks, and qualitative and quantitative benefits
139 involved in or resulting from providing the service. The cost-
140 benefit analysis must include a detailed plan and timeline
141 identifying all actions that must be implemented to realize
142 expected benefits. The Secretary of Health Care Administration
143 shall verify that all costs, savings, and benefits are valid and
144 achievable.
145 (c) If the agency determines that the increased
146 reimbursement is cost-effective, the agency shall recommend a
147 change in the reimbursement schedule for that particular good or
148 service. If, within 12 months after implementing any rate change
149 under this procedure, the agency determines that costs were not
150 offset by the increased reimbursement schedule, the agency may
151 revert to the former reimbursement schedule for the particular
152 good or service.
153 Section 13. Subsections (2), (7), (11), (13), (14), (15),
154 (21), (22), (24), (25), (27), (30), (31), and (36) of section
155 409.913, Florida Statutes, are amended, and subsection (37) is
156 added to that section, to read:

879426

157 409.913 Oversight of the integrity of the Medicaid
158 program.—The agency shall operate a program to oversee the
159 activities of Florida Medicaid recipients, and providers and
160 their representatives, to ensure that fraudulent and abusive
161 behavior and neglect of recipients occur to the minimum extent
162 possible, and to recover overpayments and impose sanctions as
163 appropriate. Beginning January 1, 2003, and each year
164 thereafter, the agency and the Medicaid Fraud Control Unit of
165 the Department of Legal Affairs shall submit a joint report to
166 the Legislature documenting the effectiveness of the state's
167 efforts to control Medicaid fraud and abuse and to recover
168 Medicaid overpayments during the previous fiscal year. The
169 report must describe the number of cases opened and investigated
170 each year; the sources of the cases opened; the disposition of
171 the cases closed each year; the amount of overpayments alleged
172 in preliminary and final audit letters; the number and amount of
173 fines or penalties imposed; any reductions in overpayment
174 amounts negotiated in settlement agreements or by other means;
175 the amount of final agency determinations of overpayments; the
176 amount deducted from federal claiming as a result of
177 overpayments; the amount of overpayments recovered each year;
178 the amount of cost of investigation recovered each year; the
179 average length of time to collect from the time the case was
180 opened until the overpayment is paid in full; the amount
181 determined as uncollectible and the portion of the uncollectible
182 amount subsequently reclaimed from the Federal Government; the
183 number of providers, by type, that are terminated from
184 participation in the Medicaid program as a result of fraud and
185 abuse; and all costs associated with discovering and prosecuting

879426

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 ~~recommend changes~~ 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.

(2) The agency shall conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and shall report the findings of any overpayments in audit reports as appropriate. At least 5 percent of all audits shall be conducted on a random basis. As part of its ongoing fraud detection activities, the agency shall identify and monitor, by contract or otherwise, patterns of overutilization of Medicaid services based on state averages. The agency shall track

879426

215 Medicaid provider prescription and billing patterns and evaluate
216 them against Medicaid medical necessity criteria and coverage
217 and limitation guidelines promulgated in rule. Medical necessity
218 determination requires that service be consistent with symptoms
219 or confirmed diagnosis of illness or injury under treatment and
220 not in excess of the patient's needs. The agency shall conduct
221 reviews of provider exceptions to peer group norms and shall,
222 using statistical methodologies, provider profiling and analysis
223 of billing patterns, detect and investigate abnormal or unusual
224 increases in billing or payment of claims for Medicaid services
225 and medically unnecessary provision of services.
226 (7) When presenting a claim for payment under the Medicaid
227 program, a provider has an affirmative duty to supervise the
228 provision of, and be responsible for, goods and services claimed
229 to have been provided, to supervise and be responsible for
230 preparation and submission of the claim, and to present a claim
231 that is true and accurate and that is for goods and services
232 that:
233 (a) Have actually been furnished to the recipient by the
234 provider prior to submitting the claim.
235 (b) Are Medicaid-covered goods or services that are
236 medically necessary.
237 (c) Are of a quality comparable to those furnished to the
238 general public by the provider's peers.
239 (d) Have not been billed in whole or in part to a recipient
240 or a recipient's responsible party, except for such copayments,
241 coinsurance, or deductibles as are authorized by the agency.
242 (e) Are provided in accord with applicable provisions of
243 all Medicaid rules, regulations, handbooks, and policies and in

879426

244 accordance with federal, state, and local law.
245 (f) Are documented by records made at the time the goods or
246 services were provided, demonstrating the medical necessity for
247 the goods or services rendered. Medicaid goods or services are
248 excessive or not medically necessary unless both the medical
249 basis and the specific need for them are fully and properly
250 documented in the recipient's medical record.
251
252 The agency shall ~~may~~ deny payment or require repayment for goods
253 or services that are not presented as required in this
254 subsection.
255 (11) The agency shall ~~may~~ deny payment or require repayment
256 for inappropriate, medically unnecessary, or excessive goods or
257 services from the person furnishing them, the person under whose
258 supervision they were furnished, or the person causing them to
259 be furnished.
260 (13) The agency shall immediately ~~may~~ terminate
261 participation of a Medicaid provider in the Medicaid program and
262 may seek civil remedies or impose other administrative sanctions
263 against a Medicaid provider, if the provider or any principal,
264 officer, director, agent, managing employee, or affiliated
265 person of the provider, or any partner or shareholder having an
266 ownership interest in the provider equal to 5 percent or
267 greater, has been:
268 (a) Convicted of a criminal offense related to the delivery
269 of any health care goods or services, including the performance
270 of management or administrative functions relating to the
271 delivery of health care goods or services;
272 (b) Convicted of a criminal offense under federal law or

879426

273 the law of any state relating to the practice of the provider's
274 profession; or
275 (c) Found by a court of competent jurisdiction to have
276 neglected or physically abused a patient in connection with the
277 delivery of health care goods or services.
278
279 If the agency determines a provider did not participate or
280 acquiesce in an offense in paragraphs (a), (b), or (c) of this
281 subsection, a termination will not be imposed. If the agency
282 effects a termination under this subsection, the agency shall
283 issue an immediate final order pursuant to s. 120.569(2)(n).
284
285 ================= T I T L E A M E N D M E N T ================
286 And the title is amended as follows:
287 Delete lines 48 - 66
288 and insert:
289 unless specified requirements are satisfied; providing an
290 exemption for home health agencies that meet certain
291 requirements; amending s. 409.907; authorizing the Agency for
292 Health Care Administration to enroll Medicaid providers located
293 outside of the state of Florida if specified requirements are
294 satisfied; amending s. 409.912, F.S.; requiring the Agency for
295 Health Care Administration to establish norms for the
296 utilization of Medicaid services; requiring the agency include
297 information relating to the overutilization of Medicaid services
298 in the annual report submitted by the Agency for Health Care
299 Administration and the Medicaid Fraud Control Unit; amending s.
300 409.913, F.S.; requiring that the annual report submitted by the
301 Agency for Health Care Administration and the Medicaid Fraud

879426

302 Control Unit of the Department of Legal Affairs recommend
303 changes necessary to prevent and detect Medicaid fraud;
304 requiring the Agency for Health Care Administration to monitor
305 patterns of overutilization of Medicaid services; requiring the
306 agency to deny payment or require repayment for Medicaid
307 services under certain circumstances; requiring the Agency for
308 Health Care Administration to immediately terminate a Medicaid
309 provider's participation in the Medicaid program as a result of
310 certain adjudications against the provider or certain affiliated
311 persons; providing the Agency for Health Care Administration the
312 discretion not to terminate certain providers; requiring