

The Florida Senate  
**BILL ANALYSIS AND FISCAL IMPACT STATEMENT**

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

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Prepared By: The Professional Staff of the Criminal Justice Committee

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BILL: CS/CS/SB 1986

INTRODUCER: Criminal Justice Committee; Health Regulation Committee; and Senators Gaetz and Peaden

SUBJECT: Medicaid Fraud

DATE: April 1, 2009 REVISED: \_\_\_\_\_

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Bell	Wilson	HR	Fav/CS
2.	Clodfelter	Cannon	CJ	Fav/CS
3.			JU	
4.			HA	
5.				
6.				

**Please see Section VIII. for Additional Information:**

- A. COMMITTEE SUBSTITUTE.....  Statement of Substantial Changes
- B. AMENDMENTS.....
  - Technical amendments were recommended
  - Amendments were recommended
  - Significant amendments were recommended

**I. Summary:**

The Committee Substitute for Senate Bill 1986 amends multiple sections of law to address systemic health care fraud. The bill increases the Medicaid program’s authority to address fraud, particularly as it relates to home health services. Health care facility and health care practitioner licensing standards are increased to keep fraudulent actors from obtaining a health care license in Florida. The bill creates disincentives to commit Medicaid fraud by: increasing the administrative penalties for committing Medicaid fraud; posting sanctioned and terminated Medicaid providers on the Agency for Health Care Administration (AHCA) website; and creating additional criminal felonies for committing health care fraud. The bill creates incentives for persons to report incidents of Medicaid fraud by: offering monetary rewards for persons who report Medicaid fraud to the authorities; removing a disincentive to pursue an action under the Florida False Claims Act; and providing civil immunity for persons who report suspected Medicaid fraud.

Miami-Dade County is designated as a health care fraud crisis area in the bill and the AHCA is directed to implement two pilot projects in Miami-Dade County to prevent the overutilization of

home health services and control, verify, and monitor the delivery of home health services in the Medicaid program.

This bill substantially amends ss. 68.085, 68.086, 400.0077, 400.471, 400.474, 400.506, 408.05, 408.810, 408.815, 409.905, 409.912, 409.913, 409.920, 430.608, 456.004, 456.041, 456.072, 456.074, 465.022, 465.023, 825.103, and 921.0022, F.S.

This bill creates ss. 408.8065, 409.9203, and 456.0635, F.S.

The bill creates three undesignated sections of law.

## II. Present Situation:

### National Recognition of Health Care Fraud in Florida

In a recent report by the United States Government Accountability Office (GAO), Florida was identified as one of the states experiencing the highest growth in Medicare home health spending and utilization, specifically in home health services.<sup>1</sup> Medicare home health spending in Florida increased by 90 percent from 2002 to 2006, while the number of Medicare beneficiaries only grew by 28 percent during the same time period. The GAO report found that the increase in Medicare home health spending and utilization was due in part to upcoding of Medicare claims by billing for outlier cases that qualified for additional payment. Miami-Dade County was cited in the report as an example of an unusually high number of outlier cases indicating fraudulent upcoding of Medicare home health claims.

In the 2007 Department of Health and Human Services and Department of Justice Health Care Fraud and Abuse Control Program Annual Report, there are descriptions of several projects to crack down on fraud in Florida.<sup>2</sup> The report describes the successful Medicare Fraud Strike Force that collaborated with local staff in Miami, Florida to target improper billing of durable Medical equipment and HIV infusion therapy services that resulted in 74 indictments involving charges filed against 120 defendants, who collectively billed the Medicare program more than \$400 million. The other Florida specific fraud cases included the federal conviction of the owner of Florida Pharmacy and F&M Medical for conspiring to defraud the government, submitting false claims and receiving kickbacks, and three subjects who were sentenced for their roles in a scheme to submit false claims in Medicare for medically unnecessary durable medical equipment (DME) in Florida.

In 2007, the Department of Health and Human Services, Office of the Inspector General, published “Aberrant Billing in South Florida for Beneficiaries with HIV/AIDS,” to identify claim patterns associated with HIV/AIDS infusion therapy that may indicate fraudulent or abusive activity in three South Florida counties, and to assess the effectiveness of past and current efforts to control inappropriate payments to infusion therapy providers in three South

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<sup>1</sup> Medicare, Improvements Needed to Address Improper Payments in Home Health, U.S. Government Accountability Office. Found at: <<http://www.gao.gov/new.items/d09185.pdf>> (Last visited March 24, 2009).

<sup>2</sup> The Department of Health and Human Services and The Department of Justice, Health Care Fraud and Abuse Control Program, Annual Report for FY 2007, November 2008. Found at: <<http://www.oig.hhs.gov/publications/docs/hcfac/hcfacreport2007.pdf>> (Last visited March 24, 2009).

Florida Counties.<sup>3</sup> The report found that in the last half of 2006, three South Florida counties accounted for half the amount, and 79 percent of the amount for drugs billed nationally for Medicare beneficiaries with HIV/AIDS; other metropolitan areas exhibit patterns of billing similar to South Florida but to a lesser extent; and that the Centers for Medicare and Medicaid Services (CMS) has had limited success in controlling aberrant billing practices of South Florida infusion therapy providers.

The federal government is responsible for the administration of the Medicare program. The states are primarily responsible for policing fraud in the Medicaid program; the CMS provides technical assistance, guidance and oversight in these efforts. Fraud schemes often cross state lines, and the CMS strives to improve information sharing among the Medicaid programs and other stakeholders.

### **Legislative Actions to Combat Medicaid Fraud in Florida**

In response to findings and recommendations of the Thirteenth Statewide Grand Jury relating to durable medical equipment, clinics, adult living facilities, and home health care, the Legislature passed SB118 (Chapter 96-387, Laws of Florida) in 1996, relating to Medicaid fraud and abuse. In 2002, the Chair of the Senate Health, Aging, and Long-Term Care Committee appointed a Select Subcommittee on the Recovery of Medicaid Overpayments. The committee investigated whether overpayments had been made to Medicaid providers, how the AHCA determined overpayments, the effectiveness of Medicaid overpayment recoveries, and how to improve the state's recovery of Medicaid overpayments. During the 2002 Legislative session, significant statutory changes were passed that included:

- Improved tracking and accounting systems in the AHCA for recovery of Medicaid overpayments;
- Studies of the accuracy of Medicaid claims payments and eligibility determination;
- A contract with Heritage Information Systems to analyze and apply sophisticated drug algorithms to detect unusual drug utilization patterns and assist the AHCA in determining the cause; and
- A contract with Gold Standard Multimedia to provide handheld, wireless personal digital assistants (PDAs) to Medicaid-prescribing physicians.

Since the first Senate Select Subcommittee in 2002, the Legislature has passed legislation almost every year to address some component of Medicaid fraud. In 2003, the Florida Auditor General's audit report recommended more improvements to the Medicaid Fraud Control Unit in the Department of Legal Affairs.

In 2004, the Chair of the Senate Health, Aging, and Long-term Care Committee appointed another Select Subcommittee on prescription drug over-prescribing in the Medicaid program. The committee was assigned to investigate the over-prescribing of narcotics. The Seventeenth Statewide Grand Jury Report on Recipient Fraud in the Medicaid Program found that corrupt doctors and clinics work with willing Medicaid recipients to defraud Medicaid, and in many instances, doctors no longer affiliated with the Medicaid Program are still able to prescribe medication that is then billed by pharmacies to the program. During the 2004 Legislative

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<sup>3</sup> Found at: < <http://www.oig.hhs.gov/oei/reports/oei-09-07-00030.pdf> > (Last visited March 23, 2009).

Session, the Legislature passed CS/CS/SB 1064 which made substantial statutory changes to Medicaid recipient eligibility, dramatically increased the AHCA's authority to control pharmaceutical drug prescribing in the Medicaid program, authorized the AHCA to limit its Medicaid provider network, and increased the AHCA's authority to suspend or terminate providers in the Medicaid program for fraudulent or questionable behavior.

Most recently, during the 2008 Legislative Session, the Legislature passed CS/HB 7083 which substantially increased the regulatory provisions that govern the licensure of home health agencies and nurse registries to reduce Medicaid fraud and improve quality and accountability. The bill also specifically addressed home medical equipment fraud in the Medicaid system, allowing the AHCA to limit its network of home medical equipment providers and increased its home medical equipment Medicaid provider enrollment requirements.

### **Medicaid Fraud OPPAGA Reports**

Chapter 2004-344, Laws of Florida, required the Office of Program Policy Analysis and Government Accountability (OPPAGA) to report biennially on the AHCA's efforts to prevent, detect, and deter, as well as recover funds lost to, fraud and abuse in the Medicaid program. The OPPAGA has published three reports that address the AHCA's ability to address Medicaid fraud: AHCA Takes Steps to Improve Medicaid Program Integrity, but Further Actions are Needed, in 2004; Enhanced Detection and Stronger use of Sanctions Could Improve AHCA's Ability to Detect and Deter Overpayments to Providers, in 2006; and AHCA Making Progress But Stronger Detection, Sanctions, and Managed Care Oversight Needed, in 2008. The 2008 report recommends that the AHCA expand Florida's capabilities to detect Medicaid fraud, abuse and overbillings by developing advanced detection models; establish minimum fine amounts based on the amount of a provider's overpayments; and expand the oversight of Medicaid managed care organizations to detect and deter corporate fraud and abuse. Since the report, the AHCA has promulgated a new administrative rule to increase fines as recommended by the OPPAGA.<sup>4</sup> The next OPPAGA report will be published in January 2010.

### **Federal Medicaid Fraud and Abuse Requirements**

Federal law requires each state to have a Medicaid program integrity unit within the Medicaid state agency to detect and investigate Medicaid fraud and abuse. State Medicaid program integrity units must meet the requirements in federal law, which include: methods for the identification, investigation, and referral of Medicaid fraud; fraud and abuse reporting requirements; and collaboration with state and federal law enforcement.<sup>5</sup> The AHCA Bureau of Medicaid Program Integrity (MPI) is responsible for oversight of the Florida Medicaid program, as it pertains to these issues of fraud and abuse.

Federal law also requires states to establish and operate a state Medicaid fraud control unit (MFCU) to conduct a statewide program for the investigation and prosecution of health care providers that defraud the Medicaid program.<sup>6</sup> State MFCUs are certified by the Secretary of the U.S. Department of Health and Human Services annually. In addition, state MFCUs review

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<sup>4</sup> 59G-9.070, Florida Administration Code.

<sup>5</sup> 42 CFR Part 455.

<sup>6</sup> 42 USC Part 1396.

complaints of abuse or neglect of nursing home residents. MFCUs receive referrals from the Medicaid state agency and are responsible for collecting any overpayments it identifies. Under federal law, state MFCUs must be separate and distinct from the state agency responsible for administering the Medicaid program.<sup>7</sup> The Florida MFCU is located in the Office of the Attorney General.

### **Florida Medicaid Program**

Florida's Medicaid Program is jointly funded by the federal, state, and county governments to provide medical care to eligible individuals. Florida implemented its Medicaid program on January 1, 1970, to provide medical services to indigent people. The AHCA is the single state agency responsible for the Florida Medicaid Program. The statutory provisions for the Medicaid program appear in ss. 409.901 through 409.9205, F.S.

Some Medicaid services are mandatory services that must be covered by any state participating in the Medicaid program pursuant to federal law.<sup>8</sup> Other services are optional. A state may choose to include optional services in its state Medicaid plan, but if included, such services must be offered to all individuals statewide who meet Medicaid eligibility criteria as though they are mandatory benefits.<sup>9</sup> Similarly, some eligibility categories are mandatory<sup>10</sup> and some are optional.<sup>11</sup> Payments for services to individuals in the optional eligibility categories are subject to the availability of monies and any limitations established by the General Appropriations Act or chapter 216, F.S. For FY 2009-2010, the Florida Medicaid Program is projected to cover 2.6 million people<sup>12</sup> at an estimated cost of \$16.3 billion.<sup>13</sup>

### **Florida Medicaid Program Integrity**

The AHCA Bureau of Medicaid Program Integrity (MPI) is responsible for preventing and detecting fraud and abuse in the Medicaid program. The duties of the MPI are codified in ss. 409.913 and 409.9131, F.S., and include: ensuring that Medicaid recipients are not subject to fraud, abuse, or neglect; preventing fraud in the Medicaid system; recovering overpayments from Medicaid providers; and sanctioning or terminating providers from the Medicaid program, as appropriate. The AHCA has the authority to sanction providers for a variety of offenses; however, when the provider is not a natural person (a corporate entity), the AHCA's authority to sanction the provider for actions of owners, officers, or agents who have engaged in sanctionable offenses is unclear.

The MPI staff 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. When the MPI

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<sup>7</sup> 42 USC Part 1396.

<sup>8</sup> These mandatory services are codified in s. 409.905, F.S.

<sup>9</sup> Optional services covered under the Florida Medicaid Program are codified in s. 409.906, F.S.

<sup>10</sup> s. 409.903, F.S.

<sup>11</sup> s. 409.904, F.S.

<sup>12</sup> <<http://edr.state.fl.us/conferences/medicaid/medcases.pdf>>(Last visited on March 24, 2009).

<sup>13</sup> <<http://edr.state.fl.us/conferences/medicaid/medhistory.pdf>>(Last visited on March 24, 2009).

determines that Medicaid has overpaid a provider, the AHCA issues an audit report to the provider that includes a calculation of overpayment. The AHCA reports that providers send documentation on repeated occasions (duplications of prior documentation), newly discovered documents, or documents created after the issuance of a final audit report.

Subsections 409.913(13), (14), (15), and (16), F.S., give the MPI the authority to impose sanctions on a provider for various violations. These sanctions include suspending or terminating Medicaid providers for specified periods of time, and fining Medicaid providers. Under s. 409.913(16)(d), F.S., the AHCA may immediately suspend a provider and issue an immediate final order under s. 120.569(2)(n), F.S., if the AHCA receives information of patient abuse or neglect or of any act prohibited by s. 409.920, F.S. The AHCA has indicated that it is unclear whether the agency has the authority to impose the sanction of an immediate termination followed by an immediate final order under s. 409.913(13), F.S. During the 2007-2008 fiscal year, the MPI administratively sanctioned 472 Medicaid providers. The sanctions included 155 provider fines, six suspensions, ten Medicaid provider terminations, and several acknowledgement statements.<sup>14</sup>

Section 409.9131, F.S., provides definitions, provides the authority for the MPI to conduct Medicaid provider onsite medical records reviews, and specifies the process for Medicaid overpayment determination.

Under federal and state law, any suspected criminal violation identified by the MPI must be referred to the MFCU in the Office of the Attorney General.<sup>15</sup> The MPI and the MFCU are required to develop a memorandum of understanding, which includes protocols for referral of cases of suspected criminal fraud and return of those cases when investigation determines that administrative action by the AHCA is appropriate. During FY 2007-2008, the MPI referred 218 cases to the MFCU for investigation, identified \$28.9 million in overpayments, and saved the Medicaid program an estimated \$21.5 million in cost avoidance.<sup>16</sup>

### **Florida Medicaid Fraud Control Unit**

The MFCU is created in s. 16.59, F.S., within the Department of Legal Affairs, and is responsible for the criminal and civil enforcement of fraud perpetrated against the Medicaid program by Medicaid providers, and investigating abuse, neglect and exploitation of patients who reside in Medicaid funded facilities. Under s. 409.920, F.S., the MFCU is also directed to investigate the alleged misappropriation of patients' private funds in health care facilities receiving payments under the Medicaid program, refer all cases of abuse to the AHCA that are not criminal or fraudulent, publicize the Florida False Claims Act, and refer criminal cases to the Office of Statewide Prosecution.

The MFCU has 232 full-time employees and in fiscal year 2007-2008 the budget for the MFCU unit was \$18,360,869, of which 75 percent was federal funding and 25 percent came from

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<sup>14</sup> Annual Report on the State's Efforts to Control Medicaid Fraud and Abuse, FY 2007-2008 found at: < [http://www.fdhc.state.fl.us/docs/2008\\_Fraud\\_and\\_%20Abuse%20Binder\\_signed.pdf](http://www.fdhc.state.fl.us/docs/2008_Fraud_and_%20Abuse%20Binder_signed.pdf) > (Last visited March 24, 2009).

<sup>15</sup> See 42 CFR 455.21 and s. 409.913(4), F.S.

<sup>16</sup> Annual Report on the State's Efforts to Control Medicaid Fraud and Abuse, FY 2007-2008 found at: < [http://www.fdhc.state.fl.us/docs/2008\\_Fraud\\_and\\_%20Abuse%20Binder\\_signed.pdf](http://www.fdhc.state.fl.us/docs/2008_Fraud_and_%20Abuse%20Binder_signed.pdf) > (Last visited March 20, 2009).

general revenue.<sup>17</sup> In fiscal year 2007-2008, the MFCU unit recovered \$56,722,698; these recoveries contributed \$5,684,855 to the state General Revenue Fund.

Of the \$56,722,628 recovered by the MFCU in the 2007-2008 fiscal year, \$51,120,765 was recovered from cases brought under the Florida False Claims Act.

### **Florida False Claims Act**

The Florida False Claims Act (FFCA)<sup>18</sup> authorizes civil actions by individuals and the state against persons who file false claims for payment or approval with a state agency. The FFCA is modeled after the Federal False Claims Act that was enacted during the Civil War in response to widespread fraud among defense contractors.<sup>19</sup> Actions brought by private entities on behalf of the state are called *qui tam* actions.<sup>20</sup>

The FFCA has often been used to combat health care, nursing home, Medicaid, and Medicare fraud. An action under the FFCA can be brought either by the state itself, or by a private individual on behalf of the state. The Department of Legal Affairs and then the Department of Financial Services are responsible for investigating and litigating actions brought under the FFCA. In addition to Florida, 22 states, the District of Columbia, New York City, and Chicago have a False Claims Act with *qui tam* provisions.<sup>21</sup>

Section 68.083(3), F.S., provides that when a *qui tam* action is filed in the circuit court of the Second Judicial Circuit, in and for Leon County, a copy of the complaint and disclosure of all material evidence must be served on the Attorney General, as head of the Department of Legal Affairs, and the Chief Financial Officer, as head of the Department of Financial Services.

Section 68.083(3), F.S., also provides that when a private individual brings a potential claim to the attention of the Department of Legal Affairs or the Department of Financial Services, these departments have 90 days to decide whether they are going to intervene, and take over litigating the FFCA action from the private individual.

Actions that violate the FFCA include:

- Submitting a false claim for payment or approval;

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<sup>17</sup> Annual Report on the State's Efforts to Control Medicaid Fraud and Abuse, FY 2007-2008 found at:

< [http://www.fdhc.state.fl.us/docs/2008\\_Fraud\\_and\\_%20Abuse%20Binder\\_signed.pdf](http://www.fdhc.state.fl.us/docs/2008_Fraud_and_%20Abuse%20Binder_signed.pdf) > (Last visited March 20, 2009).

<sup>18</sup> Sections 68.081-68.09, F.S.

<sup>19</sup> *False Claims Amendments Act of 1986*, S. Rep. No. 99-345, at 8 (1986), reprinted in 1986 U.S.C.C.A.N 5266, 5273 ("The Claims Act was adopted in 1863 and signed into law by President Abraham Lincoln in order to combat rampant fraud in Civil War defense contracts."); see also *Rainwater v. United States*, 356 U.S. 590, 592 (1958) ("The Act was originally passed in 1863 after disclosure of widespread fraud against the Government during the War Between the States.").

<sup>20</sup> *Qui tam* cases usually arise from an employee of an institution such as a health care provider who discovers that violations of the FFCA are occurring. This is a type of whistleblower action. In a *qui tam* action under the FFCA, the employee will sue on behalf of the state to collect money that was illegally defrauded from the state. A private entity that brings a successful FFCA action on behalf of the state will receive an amount that the court decides is reasonable for collecting the civil penalty and damages. The amount must not be less than 25 percent and not more than 30 percent of the proceeds recovered under a judgment.

<sup>21</sup> See THE FALSE CLAIMS ACT LEGAL CENTER, TAXPAYERS AGAINST FRAUD EDUCATION FUND, *State False Claims Acts*. Found at: <<http://www.taf.org/statefca.htm>> (last visited March 24, 2009).

- Making or using a false record to get a false or fraudulent claim paid or approved;
- Conspiring to make a false claim or to deceive an agency to get a false or fraudulent claim allowed or paid; or
- Making or using a false record to conceal, avoid, or decrease payments owed to the state government.<sup>22</sup>

The penalty for violating the FFCA is \$5,500 to \$11,000 per claim, plus three times the amount of damages to the state government for FFCA violations.

As enacted by section 6031 of the Deficit Reduction Act of 2005, section 1909 of the Social Security Act (Act) provides a financial incentive for States to enact false claims acts that establish liability to the State for the submission of false or fraudulent claims to the State's Medicaid program. If a State false claims act is determined to meet certain enumerated requirements, the State is entitled to an increase of 10 percentage points in the State medical assistance percentage, as determined by section 1905(b) of the Social Security Act, with respect to any amounts recovered under a State action brought under such a law.

Under section 1909(b) of the Act, the federal Office of the Inspector General (OIG) is required to determine, in consultation with the Attorney General of the United States, whether a state has in effect a law relating to false or fraudulent claims submitted to a State Medicaid program that is at least as effective as the Federal False Claims Act. The FFCA is very similar to the Federal False Claims Act, but Florida does not receive the 10 percent increase in recovered Medicaid monies. In 2007, the Legislature passed CS/SB 2312 to amend the FFCA, to conform to the Federal False Claims Act. However, in July 2008, the OIG ruled that the FFCA does not qualify.<sup>23</sup>

### **Agency for Health Care Administration**

The AHCA is created in s. 20.42, F.S., and is the chief health policy and planning entity for the state. The AHCA is the designated Medicaid state agency that is responsible for the administration of the Medicaid program. It is responsible for health facility licensure, inspection, and regulatory enforcement; investigation of consumer complaints related to health care facilities and managed care plans; the implementation of the certificate-of-need program; the operation of the Florida Center for Health Information and Policy Analysis; the administration of the Florida Healthy Kids Corporation contracts; the certification of health maintenance organizations and prepaid health clinics; and other duties prescribed by statute or agreement.

The agency is responsible for licensing, certifying, or registering the following health care facilities, providers, or programs:

- Abortion Clinics;
- Adult Day Care Centers;
- Adult Family Care Homes;
- Ambulatory Surgical Centers;
- Assisted Living Facilities;
- Birth Centers;

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<sup>22</sup> Section 68.082(2), F.S.

<sup>23</sup> See < <http://www.oig.hhs.gov/fraud/docs/falseclaimsact/Florida.pdf> > (Last visited March 24, 2009).



- Clinical Laboratories;
- Commercial HMOs/PHCs/EPOs;
- Comprehensive Outpatient Rehabilitation Facilities;
- Certificate of Need/Financial Analysis (CON/FA);
- Crisis Stabilization Units and Short Term Residential Treatment Facilities;
- Diagnostic Imaging Services;
- Drug-free Workplace Laboratories;
- Extended Congregate Care;
- Health Care Clinics;
- Health Care Services Pools;
- Health Flex Plan Programs;
- Homes for Special Services;
- Home Health Aides;
- Home Health Agencies;
- Homemaker/Companion Organizations;
- Home Medical Equipment Providers;
- Hospices;
- Hospitals;
- Intermediate Care Facilities for the Developmentally Disabled;
- Limited Mental Health;
- Limited Nursing Services;
- Medicaid HMOs;
- Multiphasic Health Testing Centers;
- Nurse Registries;
- Nursing Homes;
- Organ, Tissue and Eye Procurement Organizations;
- Partial Hospitalization Programs;
- Portable X-rays;
- Prescribed Pediatric Extended Care Centers;
- Rehabilitation Agencies;
- Residential Treatment Centers for Children and Adolescents;
- Residential Treatment Facilities;
- Risk Management and Patient Safety;
- Risk Managers;
- Rural Health Clinics;
- Transitional Living Facilities; and
- Utilization Review.

### **Core Licensure Provisions**

In addition to specific authorizing statutes that provide the regulatory structure for these activities, part II of ch. 408, F.S., provides general licensing provisions. The purpose of this part is to provide a streamlined and consistent set of basic licensing requirements for all providers licensed by the agency in order to minimize confusion, standardize terminology, and include

issues that are otherwise not adequately addressed in the Florida Statutes pertaining to specific providers.<sup>24</sup>

Part II of chapter 408, F.S.:

- Provides definitions; the license application process; procedures for a change of ownership; general information about background screening; minimum licensure requirements and agency action with respect to approving, denying or suspending licenses; inspection authority; and rulemaking authority;
- Prohibits unlicensed activity; and
- Authorizes the agency to impose administrative fines and pursue other regulatory and enforcement actions.

### **Licensure of Home Health Agencies**

Home health agencies are organizations that provide home health services and staffing services. Home health services are health and medical services and medical supplies furnished to an individual in the individual's home or place of residence. The services include: nursing care; physical, occupational, respiratory, or speech therapy; home health aide services (assistance with daily living such as bathing, dressing, eating, personal hygiene, and ambulation); dietetics and nutrition practice and nutrition counseling; and medical supplies, restricted to drugs and biologicals prescribed by a physician.<sup>25</sup>

Home health agency personnel are employed by or under contract with a home health agency. Staffing services are provided to health care facilities or other business entities on a temporary basis by licensed health care personnel and by certified nursing assistants and home health aides who are employed by, or work under the auspices of, a licensed home health agency.<sup>26</sup>

Home health agencies are organizations licensed and regulated by AHCA. The licensure requirements for home health agencies are found in the general provisions of part II of ch. 408, F.S., the specific home health agency provisions of part III of ch. 400, F.S., and chapter 59A-8, Florida Administrative Code.

To obtain a home health agency license, an applicant must:<sup>27</sup>

- Submit an application under oath which includes the name, address, social security number and federal employer identification number or taxpayer identification number of the applicant and each controlling interest, and the name of the person who will manage the provider;
- Submit information identifying the service areas and counties to be served;
- Submit proof of professional and commercial liability insurance of not less than \$250,000 per claim; and
- Submit proof of financial ability to operate, or a \$50,000 surety bond;
- Submit a licensure fee of \$1,660; and

<sup>24</sup> s. 408.801, F.S.

<sup>25</sup> s. 400.462(14), F.S.

<sup>26</sup> s. 400.462(29), F.S.

<sup>27</sup> s.408.806, 408.810, and 400.471, F.S., respectively.

- Pass a survey by the AHCA inspectors.

In 2008, the Legislature significantly strengthened the home health agency licensure requirements to address fraud and abuse in the Medicaid and Medicare programs. Effective July 1, 2008, applicants must also:

- Submit a business plan detailing the agency's methods to obtain patients and recruit and maintain staff;
- Provide evidence of contingency funding equivalent to 1 month's average operating expenses;
- Submit a balance sheet, income and expense statement, and statement of cash flows for the first 2 years of operation which shows sufficient assets, credit, and projected revenues to cover liabilities and expenses;
- Disclose all ownership interests in other health care entities held by controlling interests; and
- Be accredited by an organization recognized by the AHCA.

Specifically, applicants must provide a balance sheet, income and expense statement, and statement of cash flows for the first 2 years of operation which provide evidence of having sufficient assets, credit, and projected revenues to cover liabilities and expenses. The applicant has demonstrated financial ability to operate if the applicant's assets, credit, and projected revenues meet or exceed projected liabilities and expenses. An applicant may not project an operating margin of 15 percent or greater for any month in the first year of operation. All documents required under this paragraph must be prepared in accordance with generally accepted accounting principles and compiled and signed by a certified public accountant.<sup>28</sup>

In addition, the 2008 changes prohibit licensure of an applicant that shares common controlling interest with a home health agency in the same county and within 10 miles of the applicant.<sup>29</sup>

Florida law prohibits unlicensed activity, authorizes the AHCA to fine unlicensed providers \$500 for each day of noncompliance, and authorizes state attorneys and the AHCA to enjoin unlicensed providers.<sup>30</sup> Unlicensed activity is a second degree misdemeanor for the first offense, and a first degree misdemeanor for each subsequent offense.<sup>31</sup> In addition, a controlling interest that withholds any evidence of financial instability commits a second-degree misdemeanor.<sup>32</sup>

Prior to 2008, the AHCA saw significant growth in the number of applications and new licenses of home health care agencies.<sup>33</sup> The AHCA received 431 new licensure applications for home health agencies during 2007. Two hundred fifty-two (58.5 percent) of those were for new home health agency licenses in Miami-Dade County. According to the AHCA, the new accreditation requirement has slowed the growth in new licensees, but the agency continues to receive a high volume of applications. Since July 1, 2008, the AHCA received 331 applications, most of which

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<sup>28</sup> s. 400.471(2)(f), F.S.

<sup>29</sup> s. 400.471, F.S.

<sup>30</sup> s. 400.464(4), F.S.

<sup>31</sup> s. 400.464(4), F.S.

<sup>32</sup> s. 408.810(9), F.S.

<sup>33</sup> Florida Senate Interim Project Report 2008-135, November 2007. Found at: [http://www.flsenate.gov/data/Publications/2008/Senate/reports/interim\\_reports/pdf/2008-135hr.pdf](http://www.flsenate.gov/data/Publications/2008/Senate/reports/interim_reports/pdf/2008-135hr.pdf) (Last visited March 24, 2009).

were from Miami-Dade County. As of December 31, 2008, there were 2,225 licensed home health agencies in the state.<sup>34</sup> In Miami-Dade County, the number of licensed home health agencies increased from 216 in August 1999 to 895 as of March 6, 2009, which is a 75 percent increase in licensees in that county.

According to a project conducted by the MPI, home health agency Medicaid reimbursement for home health aide services unassociated with a skilled nursing service increased substantially in Miami-Dade County between 2005 and 2007. In coordination with the MFCU and the federal government, the MPI participated in a project to target home health agencies in Miami-Dade County. Some of the questionable home health practices that were discovered include:

- Home health aides working 20-25 hour days;
- Patient brokering by aides;
- Alteration of records;
- Billing for skilled nursing services that were not provided;
- Payment of physicians by referrals;
- Payment to patients;
- Patients receiving services that are not medically necessary; and
- Physicians with financial interests in the agencies referring to those entities.

### **Licensure of Health Care Clinics**

Certain health care clinics are licensed by the AHCA under part X of ch. 400, F.S. A clinic is defined as an entity at which health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider.<sup>35</sup> However, there are numerous exceptions to the clinics that must be licensed and subject to regulation under this part. Each clinic subject to licensure must appoint a medical director or clinic director. Each licensed clinic engaged in magnetic resonance imaging services must be accredited and maintain accreditation by the Joint Commission on Accreditation of Healthcare Organizations, the American College of Radiology, or the Accreditation Association for Ambulatory Health Care within one year after licensure. However, a clinic may request a single, 6-month extension.

A health care clinic licensure applicant must:<sup>36</sup>

- Submit an application including information on the identity of the owners, the number and profession of medical providers employed, and the medical director;
- Submit proof of financial ability to operate a clinic or a \$500,000 surety bond;
- Pass a level 2 background screening; and
- Have a medical director or clinic director who agrees in writing to accept legal responsibility pursuant to s. 400.9935, F.S., for various activities on behalf of the clinic, including ensuring billing is not fraudulent, taking corrective action if unlawful charges are discovered, and ensuring that the AHCA has full access to the clinic and its billing records.

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<sup>34</sup> Source: AHCA Home Care Unit, Bureau of Health Facility Regulation.

<sup>35</sup> s. 400.9905(4), F.S.

<sup>36</sup> Section 409.991, F.S.

Under s. 400.991(5), F.S., a clinic license may not be granted to an applicant who has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening in ch. 435, F.S., or a violation of insurance fraud under s. 817.234, F.S., within the past 5 years. The AHCA may deny, revoke, or suspend a health care clinic license and impose administrative fines of up to \$5,000 per violation pursuant to section 400.995, F.S.

### **Licensure of Home Medical Equipment Providers**

Durable medical equipment and medical supply providers are licensed and regulated by the AHCA, as home medical equipment providers, under part VII of chapter 400, F.S., and part II of chapter 408, F.S. Home medical equipment includes any products defined as home medical equipment by the Federal Food and Drug Administration, reimbursed under Medicare part B durable medical equipment benefits, or reimbursed under the Florida Medicaid durable medical equipment program.

Home medical equipment includes:

- Oxygen and related breathing equipment;
- Manual, motorized, or customized wheelchairs and related seating and positioning, but does not include prosthetics or orthotics or any splints, braces, or aids custom fabricated by a licensed health care practitioner;
- Motorized scooters;
- Personal transfer systems; and
- Specialty beds, such as a hospital bed.

In 2008, the Legislature added requirements for a home medical equipment provider to enroll as a Medicaid provider and obtain a Medicaid provider contract. The Medicaid home medical equipment providers must:

- Be licensed by the local government agency as a business or merchant or provide documentation from the city or county authority that no licensure is required;
- Be licensed by the Department of Health, Board of Orthotics and Prosthetics, if providing orthotics and prosthetic devices;
- Hold a Home Medical Equipment Provider license under part III of ch. 400, F.S.;
- Comply with all applicable laws relating to qualifications or licensure;
- Have an in-state business location or be located not more than fifty miles from the Florida state line;
- Meet all the general Medicaid provider requirements and qualifications;
- Be fully operational;
- Submit a surety bond as part of the enrollment application unless the provider is owned and operated by a governmental entity. One \$50,000 bond is required for each provider location up to a maximum of five bonds statewide or an aggregate bond of \$250,000;
- Pass a site visit unless the applicant is associated with a pharmacy or rural health clinic, or provides only orthotic or prosthetic devices and is licensed by the Board of Orthotics and Prosthetics;

- Be accredited and maintain accreditation by a Center for Medicare and Medicaid Services (CMS) Deemed Accreditation Organization for suppliers of durable medical equipment, prosthetics, orthotics and supplies;
- Provide services or supplies directly to the Medicaid recipient or caregiver, or provide the services or supplies by mail, and may not subcontract or consign the function to a third party (with certain exceptions);
  - Have a physical business location that meets criteria regarding signage, public accessibility, telephone access, location within Florida, and co-location, with certain exceptions;
  - Maintain a stock of equipment and supplies readily available to meet the needs of customers; and
  - Obtain a level 2 background screening for staff in direct contact with or providing direct services to recipients.

### **Department of Health**

The Department of Health is responsible for the licensure of most health care practitioners in the state. Chapter 456, F.S., provides general provisions for the regulation of health care professions in addition to the regulatory authority in specific practice acts for each profession or occupation. Section 456.001, F.S., defines “health care practitioner” as any person licensed under:

- Chapter 457 (acupuncture);
- Chapter 458 (medical practice);
- Chapter 459 (osteopathic medicine);
- Chapter 460 (chiropractic medicine);
- Chapter 461 (podiatric medicine);
- Chapter 462 (naturopathy);
- Chapter 463 (optometry);
- Chapter 464 (nursing);
- Chapter 465 (pharmacy);
- Chapter 466 (dentistry);
- Chapter 467 (midwifery);
- Part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468 (speech-language pathology and audiology; nursing home administration; occupational therapy; respiratory therapy; dietetics and nutrition practice; athletic trainers; and orthotics, prosthetics, and pedorthics);
- Chapter 478 (electrolysis);
- Chapter 480 (massage practice);
- Part III or part IV of chapter 483 (clinical laboratory personnel and medical physicists);
- Chapter 484 (dispensing of optical devices and hearing aids);
- Chapter 486 (physical therapy practice);
- Chapter 490 (psychological services); or
- Chapter 491 (clinical, counseling, and psychotherapy services).

Section 456.072, F.S., and various practice acts regulating health care professions under the regulatory jurisdiction of the DOH contain provisions establishing grounds for which disciplinary action may be taken against licensed health care practitioners.<sup>37</sup>

### **Health Care Practitioner Disciplinary Proceedings**

Section 456.073, F.S., sets forth procedures the DOH must follow in order to conduct disciplinary proceedings against practitioners under its jurisdiction. The DOH, for the boards under its jurisdiction, must investigate all written complaints filed with it that are legally sufficient. Complaints are legally sufficient if they contain facts, which, if true, show that a licensee has violated any applicable regulations governing the licensee's profession or occupation. Even if the original complainant withdraws or otherwise indicates a desire that the complaint not be investigated or prosecuted to its completion, the DOH at its discretion may continue its investigation of the complaint. The DOH may investigate anonymous, written complaints or complaints filed by confidential informants if the complaints are legally sufficient and the DOH has reason to believe after a preliminary inquiry that the alleged violations are true. If the DOH has reasonable cause to believe that a licensee has violated any applicable regulations governing the licensee's profession, it may initiate an investigation on its own.

When investigations of licensees within the DOH's jurisdiction are determined to be complete and legally sufficient, the DOH is required to prepare, and submit to a probable cause panel of the appropriate board, if there is a board, an investigative report along with a recommendation of the DOH regarding the existence of probable cause. A board has discretion over whether to delegate the responsibility of determining probable cause to the department or to retain the responsibility to do so by appointing a probable cause panel for the board. The determination as to whether probable cause exists must be made by majority vote of a probable cause panel of the appropriate board, or by the DOH if there is no board or if the board has delegated the probable cause determination to the DOH.

The subject of the complaint must be notified regarding the DOH's investigation of alleged violations that may subject the licensee to disciplinary action. When the DOH investigates a complaint, it must provide the subject of the complaint or her or his attorney a copy of the complaint or document that resulted in the initiation of the investigation. Except for cases involving physicians, within 20 days after the service of the complaint, the subject of the complaint may submit a written response to the information contained in the complaint. The DOH may conduct an investigation without notification to the subject if the act under investigation is a criminal offense. If the department's secretary or her or his designee and the chair of its probable cause panel agree, in writing, that notification to the subject of the investigation would be detrimental to the investigation, then the DOH may withhold notification of the subject.

If the subject of the complaint makes a written request and agrees to maintain the confidentiality of the information, the subject may review the DOH's complete investigative file. The licensee

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<sup>37</sup> The following sections of law provide grounds for which discipline may be imposed by boards for licensed health care practitioners under the Division of Medical Quality Assurance within the Department of Health: ss. 457.109, 458.331, 459.015, 460.413, 461.013, 462.14, 463.016, 464.018, 465.016, 466.028, 467.203, 468.1295, 468.1755, 468.217, 468.365, 468.518, 468.719, 468.811, 478.52, 480.046, 483.825, 483.901, 484.014, 484.056, 486.125, 490.009, and 491.009, F.S.

may respond within 20 days of the licensee's review of the investigative file to information in the file before it is considered by the probable cause panel. Complaints and information obtained by the DOH during its investigations are exempt from the Public Records Law until 10 days after probable cause has been found to exist by the probable cause panel or the DOH, or until the subject of the investigation waives confidentiality. If no probable cause is found to exist, the complaints and information remain confidential in perpetuity.

When the DOH presents its recommendations regarding the existence of probable cause to the probable cause panel of the appropriate board, the panel may find that probable cause exists or does not exist, or it may find that additional investigative information is necessary in order to make its findings regarding probable cause. Probable cause proceedings are exempt from the noticing requirements of ch. 120, F.S. After the panel convenes and receives the DOH's final investigative report, the panel may make additional requests for investigative information. Section 456.073(4), F.S., specifies time limits within which the probable cause panel may request additional investigative information from the DOH and within which the probable cause panel must make a determination regarding the existence of probable cause. Within 30 days of receiving the final investigative report, the DOH or the appropriate probable cause panel must make a determination regarding the existence of probable cause. The secretary of the DOH may grant an extension of the 15-day and 30-day time limits outlined in s. 456.073(4), F.S. If the panel does not issue a letter of guidance or find probable cause within the 30-day time limit as extended, the DOH must make a determination regarding the existence of probable cause within 10 days after the time limit has elapsed.

Instead of making a finding of probable cause, the probable cause panel may issue a letter of guidance to the subject of a disciplinary complaint. Letters of guidance do not constitute discipline. If the panel finds that probable cause exists, it must direct the DOH to file a formal administrative complaint against the licensee under the provisions of ch. 120, F.S. The DOH has the option of not prosecuting the complaint if it finds that probable cause has been improvidently found by the probable cause panel. In the event the DOH does not prosecute the complaint on the grounds that probable cause was improvidently found, it must refer the complaint back to the board that then may independently prosecute the complaint. The DOH must report to the appropriate board any investigation or disciplinary proceeding not before the Division of Administrative Hearings under ch. 120, F.S., or otherwise not completed within 1 year of the filing of the complaint. The appropriate probable cause panel then has the option to retain independent legal counsel, employ investigators, and continue the investigation, as it deems necessary.

When an administrative complaint is filed against a subject based on an alleged disciplinary violation, the subject of the complaint is informed of her or his right to request an informal hearing if there are no disputed issues of material fact, or a formal hearing if there are disputed issues of material fact or the subject disputes the allegations of the complaint. The subject may waive her or his rights to object to the allegations of the complaint, which allows the DOH to proceed with the prosecution of the case without the licensee's involvement. Once the administrative complaint has been filed, the licensee has 21 days to respond to the DOH. If the subject of the complaint and the DOH do not agree in writing that there are no disputed issues of material fact, s. 456.073(5), F.S., requires a formal hearing before a hearing officer of the Division of Administrative Hearings under ch. 120, F.S. The hearing provides a forum for the



licensee to dispute the allegations of the administrative complaint. At any point before an administrative hearing is held, the licensee and the DOH may reach a settlement. The settlement is prepared by the prosecuting attorney and sent to the appropriate board. The board may accept, reject, or modify the settlement offer. If accepted, the board may issue a final order to dispose of the complaint. If rejected or modified by the board, the licensee and DOH may renegotiate a settlement or the licensee may request a formal hearing. If a hearing is held, the hearing officer makes findings of fact and conclusions of law that are placed in a recommended order. The licensee and the DOH's prosecuting attorney may file exceptions to the hearing officer's findings of facts. The boards resolve the exceptions to the hearing officer's findings of facts when they issue a final order for the disciplinary action.

The boards within the DOH have the status of an agency for certain administrative actions, including licensee discipline. A board may issue an order imposing discipline on any licensee under its jurisdiction as authorized by the profession's practice act and the provisions of ch. 456, F.S. Typically, boards are authorized to impose the following disciplinary penalties against licensees: refusal to certify, or to certify with restrictions, an application for a license; suspension or permanent revocation of a license; restriction of practice or license; imposition of an administrative fine for each count or separate offense; issuance of a reprimand or letter of concern; placement of the licensee on probation for a specified period of time and subject to specified conditions; or corrective action.

### **Emergency Suspension of a License**

Section 120.60(6), F.S., authorizes an agency to take emergency action against a license if the agency finds that immediate serious danger to the public health, safety, or welfare requires emergency suspension, restriction, or limitation of a license.<sup>38</sup> The agency may take such action by any procedure that is fair under the circumstances if: the procedure provides at least the same procedural protection as is given by other statutes, the Florida Constitution, or the United States Constitution; the agency takes only that action necessary to protect the public interest under the emergency procedure; and the agency states in writing at the time of, or prior to, its action the specific facts and reasons for finding an immediate danger to the public health, safety, or welfare and its reasons for concluding that the procedure used is fair under the circumstances. The agency's findings of immediate danger, necessity, and procedural fairness are judicially reviewable.<sup>39</sup> Summary suspension, restriction, or limitation may be ordered, but a suspension or revocation proceeding under ss. 120.569 and 120.57, F.S., must also be promptly instituted and acted upon.

The MPI unit has the authority to immediately suspend a Medicaid provider under s. 409.913(16)(6), F.S., if the AHCA receives information of patient abuse or neglect or any act prohibited by s. 409.920, F.S. The DOH has the authority to immediately suspend a licensed health care practitioner under s. 456.074, F.S.

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<sup>38</sup> Similar procedures are required for emergency rulemaking under the Administrative Procedure Act. See s. 120.54(4)(a), F.S.

<sup>39</sup> See also s. 120.68, F.S., which provides for immediate judicial review of final agency action.

### **Health Care Practitioner Profiles**

Section 456.039, F.S., requires each licensed medical physician, osteopathic physician, chiropractic physician, and podiatric physician to submit specified information which, beginning July 1, 1999, has been compiled into practitioner profiles to be made available to the public. The information must include: graduate medical education; hospitals at which the physician has privileges; the address at which the physician will primarily conduct his or her practice; specialty certification; year the physician began practice; faculty appointments; a description of any criminal offense committed; a description of any final disciplinary action taken within the most recent 10 years; and professional liability closed claims reported to the Office of Insurance Regulation. The professional liability claims to be published in the practitioner profiles are limited to paid claims reported within the previous 10 years that exceed specified amounts under s. 456.041(4), F.S.<sup>40</sup> In addition, the physician may submit: professional awards and publications; languages, other than English, used by the physician to communicate with patients; an indication of whether the physician participates in the Medicaid program; and relevant professional qualifications, as defined by the applicable board of the physician. Each person who applies for initial licensure as a medical physician, osteopathic physician, chiropractic physician, or podiatric physician must, at the time of application, and each medical physician, osteopathic physician, chiropractic physician, or podiatric physician must, in conjunction with the renewal of the license, submit the information required for practitioner profiles.

Section 456.042, F.S., requires each person who has submitted information under the practitioner profiling requirements to update that information in writing by notifying the DOH within 15 days after the occurrence of an event or the attainment of a status that requires reporting as part of the profiling requirements.<sup>41</sup> Persons who register to practice medicine as an intern, resident, or fellow and who apply for physician licensure are exempt from the practitioner profiling requirements. The DOH must compile the information submitted by a physician licensure applicant into a practitioner profile.

### **III. Effect of Proposed Changes:**

**Section 1.** Creates an undesignated section of law that provides for legislative findings to specify that immediate and proactive measures are necessary to prevent, reduce, and mitigate health care fraud, waste, and abuse. The bill designates Miami-Dade County as a health care fraud crisis area of concern for the purpose of increased scrutiny of home health agencies, home medical equipment providers, health care clinics, and other health care providers in Miami-Dade County in order to prevent Medicaid fraud, waste, and abuse.

**Section 2.** Amends s. 68.085, F.S., relating to prevailing actions, based on a claim of funds from the state Medicaid program, under the Florida False Claims Act and the distribution of proceeds, to provide that after the proceeds are distributed as required by law in subsections 68.085(1), (2), and (3), F.S., 10 percent of the remaining proceeds must be deposited into the Legal Affairs

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<sup>40</sup> Section 456.051(1), F.S., requires the DOH to make all reports of claims or actions for damages for personal injury available as a part of the practitioner's profile within 30 calendar days without any specified limitation on the amount of the claim or the time that the claim was incurred.

<sup>41</sup> Sections 456.039 and 456.0391, F.S., require that the written update be provided within 45 days of the occurrence of an event or the attainment of a status that requires reporting as part of the profiling requirements.

Revolving Trust Fund to fund the Medicaid fraud monetary reward program created in section fifteen of the bill, which provides rewards to persons who report valuable Medicaid fraud information. Any remaining funds are deposited into the General Revenue Fund.

**Section 3.** Amends s. 68.086, F.S., relating to the awarding of attorney's fees under the Florida False Claims Act, to make it more difficult to award attorney's fees to a False Claims Act defendant, but also to remove a disincentive for a person to bring an action. Current law specifies that if the Department of Legal Affairs or the Department of Financial Services does not proceed with an action under this act and the defendant is the prevailing party, the court shall award the defendant reasonable attorney's fees and costs against the person bringing the action.

The bill specifies that if the defendant is the prevailing party in a False Claims Act case, the court *may* award attorney's fees if the court finds that the action was clearly frivolous, clearly vexatious, or brought primarily for the purposes of harassment.

This statutory change should conform the Florida False Claims Act to the Federal False Claims Act and qualify Florida to keep an additional 10 percent of the federal portion of Medicaid recoveries.

**Section 4.** Amends s. 400.471, F.S., to prohibit the AHCA from renewing a home health agency license, if the applicant is located in a county that has at least one home health agency and the county has more than one home health agency per 5,000 persons, based on the most recent population estimates published by the Executive Office of the Governor, *and* the applicant, or any controlling interest, has been administratively sanctioned by the agency for one or more of the following actions:

- An intentional, reckless, or negligent act that materially affects the health or safety of a patient;
- Knowingly providing home health services in an unlicensed assisted living facility or unlicensed adult family-care home, unless the home health agency or employee reports the unlicensed facility or home to the agency within 72 hours after providing the services;
- Preparing or maintaining fraudulent patient records, such as, but not limited to, charting ahead, recording vital signs or symptoms that were not personally obtained or observed by the home health agency's staff at the time indicated, borrowing patients or patient records from other home health agencies to pass a survey or inspection, or falsifying signatures;
- Failing to provide at least one service directly to a patient for a period of 60 days;
- Demonstrating a pattern of falsifying documents of training for home health aides or certified nursing assistants; or health statements for staff providing direct care to patients. A pattern may be demonstrated by a showing of at least three fraudulent entries or documents;
- Demonstrating a pattern of billing any payor for services not provided. A pattern may be demonstrated by a showing of at least three billings for services not provided within a 12-month period;
- Demonstrating a pattern of failing to provide a service specified in the home health agency's written agreement with a patient or the patient's legal representative, or the plan of care for that patient, unless a reduction in service is mandated by Medicare, Medicaid, or a state program or as provided in s. 400.492(3), F.S. A pattern may be demonstrated by a showing of at least three incidences, regardless of the patient or service, where the home health

agency did not provide a service specified in a written agreement or plan of care during a 3-month period;

- Giving remuneration to a case manager, discharge planner, facility-based staff member, or third-party vendor who is involved in the discharge planning process of a facility licensed under chapter 395 or chapter 400, F.S., from whom the home health agency receives referrals;
- Giving cash, or its equivalent, to a Medicare or Medicaid beneficiary; or
- Demonstrating a pattern of billing the Medicaid program for services to a Medicaid recipient that are medically unnecessary. A pattern may be demonstrated by a showing of at least three fraudulent entries or documents.

**Section 5.** Amends s. 400.474, F.S., to create an additional administrative penalty for home health agencies. The bill gives the AHCA the authority to deny, revoke, or suspend the license of a home health agency and requires the AHCA to impose a fine of \$5,000 against a home health agency that demonstrates a pattern of billing the Medicaid program for services to a Medicaid recipient that are medically unnecessary. A pattern may be demonstrated by a showing of at least three medically unnecessary services.

**Section 6.** Amends s. 400.506, F.S., to allow a nurse registry to provide promotional items, including products, food, and beverages, to the staff responsible for facility discharge planning and to staff associated with a physician office, from which the nurse registry has received a referral in the last 12 months. The bill limits the cumulative value of the promotion items allowed in the bill to \$50 for a single event. The cumulative value of all items to the persons affiliated with a facility or a physician office may not exceed \$100 in a calendar year.

**Section 7.** Amends s. 408.05, F.S., to require the Florida Center for Health Information and Policy Analysis within the AHCA to:

- Compile, maintain, and publish on its website a detailed list of all state and federal databases that contain health care fraud information and update the list at least biannually;
- Develop a strategic plan to connect all databases that contain health care fraud information;
- Monitor innovations in health information technology, specifically as it pertains to Medicaid fraud prevention and detection; and
- Periodically publish policy briefs that highlight available new technology to prevent or detect health care fraud and projects implemented by other states, the private sector, or the Federal Government which use technology to prevent or detect health care fraud.

**Section 8.** Creates s. 408.8065, F.S., to establish additional licensure requirements for home health agencies, home medical equipment providers, and health care clinics. The bill requires applicants for initial licensure or initial licensure due to change of ownership, as a home health agency, home medical equipment provider, or health care clinic to demonstrate their financial ability to operate, as required under s. 408.810(8), F.S., and:

- Submit pro forma financial statements, including a balance sheet and an income and expense statement, for the first year of operation to provide evidence that the applicant has sufficient assets, credit, and projected revenues to cover liabilities and expenses; *or* demonstrate the financial ability to operate if the applicant's assets, credit, and projected revenues do not meet or exceed projected liabilities and expenses; and

- Submit a statement of the applicant's estimated startup costs and sources of funds through the break-even point in operations to demonstrate that the applicant has the ability to fund all startup costs. The statement must show that the applicant has a minimum amount of operating funds that equals at least 3 months of average projected expenses. The applicant must provide documented proof that these funds will be available, as needed.

The required financial statements are required to be signed by a certified public accountant and prepared in accordance with generally accepted accounting principles.

This bill creates a third degree felony offense, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, F.S., for a person licensed under part III (home health agencies and nurse registries), part VII (home medical equipment providers), or part X (health care clinics) of chapter 400, F.S., who knowingly files a false or misleading license or license renewal application or who submits false or misleading information related to such application. This is in addition to penalties provided under ch. 408, F.S.

**Section 9.** Amends s. 408.810, F.S., to require all facilities licensed under part II of chapter 408, F.S., to inform each client, or his or her representative, of the right to report Medicaid fraud and provide each such person a clearly written description of what constitutes Medicaid fraud with the statewide toll-free number for the central Medicaid fraud hotline.

**Section 10.** Amends s. 408.815, F.S., to direct the AHCA to deny the licensure application for any facility licensed under part II of chapter 408, F.S, if the applicant, or a person having a controlling interest in the applicant, has been:

- Convicted of, or enters a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, F. S., chapter 817, F.S., chapter 893, F.S., 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396; or
- Terminated *for cause*, pursuant to the appeals procedures established by the state or federal government, from any state Medicaid program or the federal Medicare program.

**Section 11.** Amends s. 409.905(4), F.S., relating to home health services in the Medicaid program, to require home health agencies that exceed the statewide home health services utilization rate by 50 percent, to undergo prior authorization for Medicaid home health service visits not associated with a skilled nursing visit. The bill specifies that prior authorization includes the submission of a Medicaid recipient's plan of care and documentation that supports the recipient's diagnosis to the AHCA.

The bill requires that Medicaid home health services must be ordered by a physician and meet the following requirements:

- The written prescription for service must be signed and dated by the recipient's physician before the development of a plan of care or any request requiring prior authorization;
- The physician ordering the home health services must not be employed by, under contract with, or otherwise affiliated with the home health agency rendering services;
- The physician ordering the services must have examined the recipient no more than 30 days before the initial request for home health services and biannually thereafter;

- The written prescription for the services must include the recipient's acute or chronic medical condition or diagnosis, the home health service required, including the minimum skill level required to perform the service, and the frequency and duration of the services; and
- The national provider identifier, Medicaid identification number, or medical practitioner license number of the physician who ordered the services must be listed on the written prescription for home health services, the claim for home health reimbursement, and the home health service prior authorization request.

**Section 12.** Amends s. 409.912, F.S., to direct the AHCA to eliminate any overutilization of Medicaid services that are medically unnecessary in the Medicaid program. The bill requires the AHCA to:

- Establish Medicaid service utilization norms that are risk-adjusted for patient acuity;
- Track Medicaid provider prescribing and treatment patterns and develop Medicaid treatment norms;
- Refer providers that demonstrate a pattern of submitting claims for medically unnecessary services to the Medicaid program integrity unit for investigation; and
- Submit a report on the establishment of Medicaid service utilization norms in the Medicaid program to the Governor, the President of the Senate, and the Speaker of the House of Representatives, by February 1, 2010.

**Section 13.** Amends s. 409.913, F.S., relating to the responsibilities of the Medicaid program integrity (MPI) unit to add requirements to the AHCA and the MFCU of the Department of Legal Affairs' annual report that documents the effectiveness of the state's efforts to control Medicaid fraud and abuse and recover Medicaid overpayments during the previous fiscal year. The additional reporting requirements include:

- Policy recommendations to prevent and detect Medicaid fraud;
- All policy recommendations or changes recommended in the report must include a detailed fiscal analysis; and
- Unit specific performance standards, benchmarks, and metrics that include a projected cost savings to the Medicaid program in the following fiscal year.

In addition, the policy recommendations in the report must be submitted to the appropriate estimating conference by February 15 of each year.

The bill requires the MPI to identify and monitor patterns of overutilization of Medicaid services based on state averages, as part of its ongoing fraud detection activities. The AHCA may meet this requirement by contract.

The bill *requires* the AHCA to deny reimbursement or require repayment for Medicaid goods and services that do not meet the following criteria:

- Are furnished to the recipient prior to submission of a claim for reimbursement;
- Are Medicaid-covered goods or services that are medically necessary;
- Are of comparable quality to those furnished to the general public by the provider's peers;
- Have not been billed in whole or in part to a recipient or a recipient's responsible party, except for copayments, coinsurance, or deductibles as authorized by the AHCA;

- Are provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law; and
- Are documented by records that demonstrate medical necessity and that are made at the time the goods or services were provided.

Currently, the AHCA has the *option* to deny payment or require repayment for claims that do not meet the criteria listed above, but is not *required* to deny payment or require repayment. The bill *requires* the AHCA to deny payment or require repayment for inappropriate, medically unnecessary, or excessive goods or services.

The bill *requires* the AHCA to *immediately* terminate a provider from participating in the Medicaid program, if the provider has been:

- Convicted of a criminal offense related to the delivery of any health care goods or services, including the performance of management or administration functions relating to the delivery of health care goods or services;
- Convicted of a criminal offense under federal law or the law of any state relating to the practice of the provider's profession; or
- Found by a court of competent jurisdiction to have neglected or physically abused a patient in connection with the delivery of goods or services.

Currently, the AHCA has the *option* to terminate providers for these offenses, but it is unclear if the AHCA's termination authority includes an immediate final order under s. 120.596(2)(n), F.S. The bill *requires* the AHCA to immediately terminate the provider for the offenses listed above.

The bill clarifies that providers subject to immediate termination under this subsection include persons connected with corporations or other business entities that are Medicaid providers including any principal, officer, director, agent, managing employee, affiliated person, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater.

The bill requires the AHCA to immediately suspend or terminate, as appropriate, a provider from participation in the Florida Medicaid program if the provider participated or acquiesced in any action for which a principal, officer, director, agent, managing employee, affiliated person, or partner or shareholder with a 5 percent or greater ownership interest was suspended or terminated from participating in the Medicaid program or the Medicare program by the federal government or any state.

The bill *requires* the AHCA to seek all remedies provided in law if a provider violates any of the offenses enumerated in s. 409.913(15), F.S. Currently, the AHCA has the *option* to exercise this authority but it is not *required* to do so. The bill also clarifies that violations may involve action or inaction by the provider. The bill also subjects the provider to sanctions for actions or inactions in violation of s. 409.913(15), F.S., by a principal, officer, director, agent, managing employee, affiliated person, or partner or shareholder with a 5 percent or greater ownership interest if the provider participated or acquiesced in the actions or inactions.

The bill specifies that when the AHCA finds evidence of overpayment while reviewing a Medicaid provider's records, calculation of the overpayment must be based on the documentation created prior to the start of any investigation.

The bill requires that any documentation or data relied upon or presented as evidence by a provider in a court or administrative procedure to contest an overpayment claim must have been created prior to the start of any AHCA investigation. Such documentation or data must also be provided to the AHCA before issuance of the final audit report.

The bill specifies that when the AHCA administratively sanctions a provider or controlling interest under sections (13), (14), and (15) of s. 409.913, F.S., excluding paragraphs (15)(e) and (o), that is regulated by another entity, it must notify the regulatory authority of the provider, *within five working days*. The bill specifies that the notification requirement applies to controlling interests of the provider and that the notification must occur within five working days.

The bill *requires* the AHCA to withhold Medicaid payments when it receives reliable evidence that a provider was involved in fraud, willful misrepresentation, abuse, or a crime while providing Medicaid services to a Medicaid recipient. If the provider is cleared of the allegation the AHCA must reimburse the provider with a 10 percent interest rate within 14 days of the determination. The bill also *requires* the AHCA to withhold Medicaid payments if the Medicaid goods or services were furnished or supervised by a person who has been terminated from any state Medicaid program or federal Medicare program. Currently, the AHCA has the *option* to exercise these authorities but the bill *requires* the AHCA to exercise its authority.

The bill *requires* the AHCA to exercise its authority to withhold reimbursement from a provider when the AHCA has made a probable cause determination and alleged that an overpayment to a Medicaid provider has occurred and the provider has been notified until:

- The results of an administrative hearing under chapter 120, F.S.; or
- In the 30 days after notification, the provider makes payment in full or establishes an agreed upon payment plan with the AHCA.

Currently the AHCA has the *option* to exercise this authority, but the bill *requires* the AHCA to exercise its authority.

The bill *requires* the AHCA to terminate a provider's participation in the Medicaid program if the provider does not reimburse an overpayment within 35 days after a final order, unless the provider and the AHCA have entered into a repayment agreement.

The bill *requires* that the letter sent to Medicaid recipients that explains their benefits must once a year include information on how to report criminal Medicaid fraud, the Medicaid Fraud Control Unit's toll-free hotline number, and the reward program created in the bill.

The bill *requires* the AHCA to post a list of all Medicaid providers, including controlling interests, that have been sanctioned or terminated from the Medicaid program. The list must be updated at least monthly, and must be searchable, printable, and available for download.

**Section 14.** Amends s. 409.920, F.S., related to Medicaid provider fraud, to add a definition of a *managed care organization* to this section of law and to specify that a person may not make, cause to be made, or aid and abet in the making of any false statement or false representation of a



material fact, by commission or omission, in any claim submitted to the agency, its fiscal agent or a managed care organization for payment.

The bill provides immunity from civil liability for any person who provides the state with information about fraud or suspected fraud by a Medicaid provider, including a managed care organization, unless the person acted with knowledge that the information was false or with reckless disregard for the truth or falsity of the information. Current law provides immunity from civil liability for persons who report workers' compensation fraud under s. 440.1051, F.S.; persons who report any violation of chapter 560, F.S.; and persons who provide information about the financial condition of an insurer under s. 624.3102, F.S.

The bill increases penalties for any violation of subsection 409.920(2), F.S., which provides that a person may not knowingly:

- Make, cause to be made, or aid and abet in the making of any false statement or false representation of a material fact, by commission or omission, in any claim submitted to the AHCA or its fiscal agent or a managed care organization for payment<sup>42</sup>;
- Make, cause to be made, or aid and abet in the making of a claim for items or services that are not authorized for reimbursement by Medicaid;
- Charge, solicit, accept, or receive anything of value, other than an authorized copayment from a Medicaid recipient, from any sources in addition to the amount legally payable for an item or service provided to a Medicaid recipient under the Medicaid program or fail to credit the AHCA or its fiscal agent for any of the payments received from a third-party source;
- Make, or in any way cause to be made, any false statement or false representation of a material fact, by commission or omission, in any document containing items of income and expense that is or may be used by the AHCA to determine a general or specific rate of payment for an item or service provided by a provider;
- Solicit, offer, pay or receive any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in case or in kind, in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made, in whole or in part, under the Medicaid program, or in return for obtaining, purchasing, leasing, ordering, or arranging for or recommending, obtaining, purchasing, leasing, or ordering any goods, facility item, or service, for which payment may be made, in whole or in part, under the Medicaid program;
- Submit false or misleading information or statements to the Medicaid program for the purpose of being accepted as a Medicaid provider; or
- Use or endeavor to use a Medicaid provider's identification number or any 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.

The bill provides that a person who violates of any of the provisions listed above and receives or endeavors to receive anything of value commits a felony. The degree of the felony is determined by the dollar value of the fraud as follows:

- \$10,000 or less – third degree felony, punishable by imprisonment for up to 5 years and a fine of up to \$5000;

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<sup>42</sup> The bill adds claims made to a managed care organization, which are not currently included in s. 409.920(2)(a), F.S.

- More than \$10,000 but less than \$50,000 – second degree felony, punishable by imprisonment for up to 15 years and a fine of up to \$10,000; or
- \$50,000 or more – first degree felony, punishable by imprisonment for up to 30 years and a fine of up to \$10,000.

Section 23 of the bill adds these penalties to the Criminal Punishment Code that is used in conjunction with the Criminal Punishment Code worksheet, codified in s. 921.0024, F.S., to compute the sentence score for each felony offender. The offense severity ranking chart has 10 offense levels, with level 1 offenses the least severe and level 10 offenses the most severe. The third- and second-degree felonies in the bill are added to the level 7 severity ranking chart, and the first-degree felony is added to the level 9 severity ranking chart.

The bill provides that the value of all the separate funds, goods, or services the person received or attempted to receive in a scheme or course of conduct may be aggregated to determine the degree of the offense.

The bill requires persons convicted under subsection 409.920(2), F.S., to pay a fine that is equal to five times the money unlawfully received or the loss incurred by the Medicaid program or managed care organization, whichever is greater, in addition to any criminal sentence that is imposed.

Current law provides only for a third-degree felony for any violation of s. 409.920(2), F.S., and does not link the penalty to a dollar amount. The penalty scheme created in the bill is similar to the penalty provisions for Medicaid fraud as it relates to prescription drugs, codified in s. 409.9201, F.S.

**Section 15.** Creates s. 409.9203, F.S., to offer a monetary reward to any person who reports original information that relates to a violation of the state Medicaid fraud laws. The information must be reported to the Office of the Attorney General, the AHCA, the DOH, or the Department of Law Enforcement and result in a recovery of a fine, penalty, or forfeiture of property.

The reward monies will be collected from proceeds recovered under the Florida False Claims Act, pursuant to s. 68.085, F.S., as amended in section 2 of this bill. The amount of each award will be 25 percent of the monies recovered or \$500,000, whichever is smaller.

Reward recipients are not eligible to receive monies under the Florida False Claims Act for the same information reported pursuant to this section. The bill allows individuals to decline a reward.

**Section 16.** Amends s. 456.004, F.S., to direct the DOH to work cooperatively with the AHCA and the judicial system to recover Medicaid overpayments. The bill requires the DOH to investigate and prosecute health care practitioners who, after a final order, judgment, stipulation, or settlement, have not remitted amounts owed to the state for an overpayment from the Medicaid program.

**Section 17.** Amends s. 456.041, F.S., to require the DOH to include a statement that indicates that the practitioner has been terminated from participating in the state Medicaid program or

sanctioned by the Medicaid program, in the practitioner profiles of the physicians and advanced registered nurse practitioners who have been terminated from participating in the state Medicaid program or sanctioned by the Medicaid program.

**Section 18.** Creates s. 456.0635, F.S., to prohibit fraud in the practice of a health care profession. The bill prohibits the DOH and the medical boards within the DOH from allowing any person to sit for an examination, who has been:

- Convicted of, or enters a plea of guilty or nolo contendere to, regardless of adjudication, a felony under ch. 409, F.S., ch. 817, F.S, ch. 893, F.S., 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396; or
- Terminated *for cause*, pursuant to the appeals procedures established by the state or Federal Government, from any state Medicaid program or the federal Medicare program.

The DOH and the medical boards must refuse to issue or renew a license, certificate, or registration to an applicant, or person affiliated with that applicant, who has violated any of the same provisions.

The bill directs health care practitioners to report allegations of Medicaid fraud to the DOH, regardless of the practice setting.

**Section 19.** Amends s. 456.072, F.S., to provide that these acts are grounds for discipline:

- Being convicted of, or entering a plea of guilty or nolo contendere to, any misdemeanor or felony, regardless of adjudication, under 18 U.S.C. s. 669, ss. 285-287, s. 371, s. 1001, s. 1035, s. 1341, s. 1343, s. 1347, s. 1349, or s. 1518, or 42 U.S.C. ss. 1320a-7b, relating to the Medicaid program;
- Failing to remit the sum owed to the state for an overpayment from the Medicaid program pursuant to a final order, judgment, or stipulation or settlement;
- Being terminated from the state Medicaid program pursuant to s. 409.913, F.S., any other state Medicaid program, or the federal Medicare program; and
- Being convicted of, or entering a plea of guilty or nolo contendere to, any misdemeanor or felony, regardless of adjudication, a crime in any jurisdiction which relates to health care fraud.

**Section 20.** Amends s. 456.074, F.S., to expand the DOH's authority to immediately suspend the license of a practitioner licensed under chapter 458, 459, 460, 461, 462, 463, 464, 465, 466, or 484, F.S., who pleads guilty to, is convicted of, or who enters a plea of nolo contendere to, regardless of adjudication, to certain crimes, to include a misdemeanor or felony under 18 U.S.C. s. 669, ss. 285-287, s. 371, s. 1001, s. 1035, s. 1341, s. 1343, s. 1347, s. 1349, or s. 1518 or 42 U.S.C. ss. 1320a-7b, relating to the Medicaid program.

**Section 21.** Amends s. 465.022, F.S., to increase the pharmacy permit requirements.

The bill provides that a pharmacy permit may be issued to a partnership, provided the partners are at least 18 years of age.

The bill requires pharmacy permit applications submitted by a corporation to include a set of fingerprints from each person that has an ownership interest in the corporation of 5 percent or

greater and from any person who directly, or indirectly, manages, oversees, or controls the operations of the applicant, including officers and members of the board of directors, unless the person has a set of fingerprints on file with another state agency and the fingerprints are available to the DOH. The fingerprints will be submitted to the Department of Law Enforcement for a state criminal history records check and forwarded to the Federal Bureau of Investigation for a national criminal history records check. Corporate pharmacy permit applicants must submit payment for the background checks along with their application.

The bill requires the DOH to limit the fingerprint requirement, for corporations that have more than \$100 million in business taxable assets in this state to the persons who will be directly involved in the management of the pharmacy.

**Section 22.** Amends s. 465.023, F.S., to require the DOH or the Board of Pharmacy to deny a pharmacy permit application, to require pharmacy permittees to be disciplined for certain violations, and to supplement the list of violations.

Current law gives the DOH or the board of pharmacy the authority to revoke or suspend a permit, or to fine, place on probation, or discipline a pharmacy permittee for the violations listed below, but does not require them to do so. The bill specifies that there are grounds to deny a license or discipline a current permittee if a pharmacy permittee, or an officer, director, or agent of an applicant or permittee has:

- Obtained a permit by misrepresentation or fraud or through an error of the department or the board;
- Attempted to procure, or has procured, a permit for any other person by making, or causing to be made, any false representation;
- Violated any of the requirements of this chapter or any of the rules of the Board of Pharmacy; of chapter 499, F.S., known as the “Florida Drug and Cosmetic Act,” of 21 U.S.C. ss. 301-392, known as the “Federal Food, Drug, and Cosmetic Act,” of 21 U.S.C. ss. 821, F.S., et seq., known as the Comprehensive Drug Abuse Prevention and Control Act; or of chapter 893, F.S.;
- Been convicted or found guilty, regardless of adjudication, of a felony or any other crime involving moral turpitude in any of the courts of this state, of any other state, or of the United States; or
- Dispensed any medicinal drug based upon a communication that purports to be a prescription as defined by s. 465.003(14), F.S., or s. 893.02, F.S., when the pharmacist knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship that includes a documented patient evaluation, including history and a physical examination adequate to establish the diagnosis for which any drug is prescribed and any other requirement established by board rule under chapter 458, chapter 459, chapter 461, chapter 463, chapter 464, or chapter 466, F.S.

The bill creates additional grounds to deny a pharmacy permit application or take disciplinary action against a permittee, if the applicant, permittee, or controlling interest has:

- Been convicted of or disciplined by a regulatory agency of the Federal Government or a regulatory agency of another state for any offense that would constitute a violation of chapter 465, F.S.;

- Been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to the practice of, or the ability to practice, the profession of pharmacy; or
- Been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to health care fraud.

The bill *requires* disciplinary action for all these violations.

**Section 23.** Amends s. 825.103, F.S., to expand the definition of “exploitation of an elderly person or disabled adult” to include the breach of a fiduciary duty to an elderly person or disabled adult by the person’s guardian or agent under a power of attorney which results in the unauthorized appropriation, sale, or transfer of property.

The investigation of abuse, neglect, and exploitation of patients that reside in Medicaid funded facilities is under the purview of the MFCU. The MFCU suggested supplementing the definition of what constitutes exploitation of an elderly person or disabled adult to address the unlawful spend-down of an elderly or disabled adult’s assets by the guardian or agent under power of attorney, that often qualifies the elderly or disabled person for Medicaid.

**Section 24.** Amends s. 921.0022, F.S., to add the offenses created in section thirteen of the bill to the offense severity ranking chart of the Criminal Punishment Code.

**Section 25 and Section 26.** Create undesignated sections of law that require the AHCA to implement two pilot projects.

The first pilot project requires the AHCA to develop and implement a home health agency monitoring pilot project in Miami-Dade County by January 1, 2010. The bill requires the AHCA to contract with a vendor to verify the utilization and delivery of the home health services and provide an electronic billing interface for home health service reimbursement. The pilot project must telephonically verify the delivery of home health services using voice biometrics. The bill requires the AHCA to submit a report evaluating the pilot project by February 1, 2011, to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Oklahoma, Indiana, Tennessee, and South Carolina have all integrated voice authentication systems into various components of their Medicaid programs, usually to verify services to homebound patients. An evaluation of the Oklahoma pilot concluded that: home health providers in the pilot were reimbursed more quickly by the state; utilization of home health services declined by 8 percent among the recipients served in the pilot; and average cost of home health care services per member per month declined among the pilot population.<sup>43</sup>

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<sup>43</sup> Oklahoma Department of Human Services, Interactive Voice Response/Authentication: A Pilot Study, Office of Planning, Research and Statistics, June 2008. Found at: <http://www.crossroads.odl.state.ok.us/cgi-bin/showfile.exe?CISOROOT=/stgovpub&CISOPTR=6466&filename=6681.pdf#search=%22pilot%22> (last visited March 24, 2009).

At the March 16, 2009, Medicaid Impact Conference, the AHCA estimated that this pilot project would generate an annualized net savings of \$5,781,238, that includes \$1,870,809 in general revenue savings and \$3,910,429 in federal savings.<sup>44</sup>

The second pilot project requires the AHCA to implement a comprehensive home health care management pilot project by January 1, 2010, that includes face-to-face assessments by a licensed nurse, consultations with prescribing physicians to substantiate the medical necessity of services, and on-site or desk reviews of recipient medical records. The AHCA is directed to implement the pilot in an area of the state that has demonstrated an aberration in the utilization of Medicaid home health services.

At the March 16, 2009, Medicaid Impact Conference, the AHCA presented a Medicaid fraud policy proposal that included this pilot project and estimated savings to the state. However, specific estimates of fiscal savings related directly to the pilot project were not presented.<sup>45</sup>

The bill provides the AHCA with the authority to amend the Medicaid state plan and apply for federal waivers as necessary to implement the pilot projects.

**Section 27 and Section 28.** Amend ss. 400.0077 and 430.608, F.S., to conform cross-references.

**Section 29.** The effective date of the bill is July 1, 2009.

#### **IV. Constitutional Issues:**

##### **A. Municipality/County Mandates Restrictions:**

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

##### **B. Public Records/Open Meetings Issues:**

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

##### **C. Trust Funds Restrictions:**

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

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<sup>44</sup> Medicaid Impact Conference, March 16, 2009. Found at: <http://edr.state.fl.us/conferences/medicaid/Impact/impact%20conference%20results%20Mar16.pdf> (last visited March 24, 2009).

<sup>45</sup> Medicaid Impact Conference, March 16, 2009. Found at: <http://edr.state.fl.us/conferences/medicaid/Impact/impact%20conference%20results%20Mar16.pdf> (last visited March 24, 2009).

**V. Fiscal Impact Statement:****A. Tax/Fee Issues:**

None.

**B. Private Sector Impact:**

The bill may decrease the number of individuals who qualify for health care practitioner licensure and health care facility licensure. Some current licensees may face disciplinary action or have their licenses revoked as result of the bill.

The bill requires pharmacy permit applicants to submit a set of fingerprints and pay for the cost of a state and federal background check. According to the DOH, this will cost pharmacy permit applicants \$47 for each required background check.

**C. Government Sector Impact:**

At the March 16, 2009, Medicaid Impact Conference, the AHCA estimated that the provisions in sections 10, 25, and 26 of the bill would generate an annualized savings of at least \$15 million that includes \$4,854,000 in general revenue savings, and \$10,146,000 in federal savings.<sup>46</sup>

Section 3 of the bill should qualify Florida to keep an additional 10 percent of the federal portion of Medicaid recoveries under the Florida False Claims Act. The amount of money recovered by the FFCA varies each year. According to the MFCU, an additional 10 percent of recoveries would have provided the state an extra \$2,429,654 in FY 2006-2007, \$4,281, 209 in FY 2007-2008, and \$2,766,246 so far this year.

The bill creates several felonies. The Criminal Justice Estimating Conference has not established the impact of the additional felonies.

**VI. Technical Deficiencies:**

None.

**VII. Related Issues:**

In several sections of the bill the AHCA is *required* to take an action, whereas currently the AHCA is *allowed* to take certain actions, specifically in regard to Medicaid provider overpayments and terminations. The AHCA has expressed concerns that it needs flexibility to apply Medicaid provider exclusions to only those providers terminated for reasons having to do with Medicaid fraud or documented patterns of abusive billing.

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<sup>46</sup> Medicaid Impact Conference, March 16, 2009. Found at: <http://edr.state.fl.us/conferences/medicaid/Impact/impact%20conference%20results%20Mar16.pdf> >(last visited March 25, 2009).

**VIII. Additional Information:**

- A. **Committee Substitute – Statement of Substantial Changes:**  
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

**CS by Criminal Justice Committee on April 1, 2009:**

The committee substitute substantially changes the bill in the following ways:

- Requires the AHCA to develop utilization norms rather than treatment norms;
- Requires the AHCA to sanction a provider for the actions or inactions of a principal, officer, director, agent, managing employee, affiliated person, or partner or shareholder with a 5 percent or greater ownership only if the provider participated or acquiesced in the person's misconduct;
- Specifies that when the AHCA finds evidence of overpayment while reviewing a Medicaid provider's records, calculation of the overpayment must be based on documentation created prior to the start of any investigation; and
- Requires that any documentation or data relied upon or presented as evidence by a provider in a court or administrative procedure to contest an overpayment claim must have been created prior to the start of any AHCA investigation.

**CS by Health Regulation Committee on March 25, 2009:**

The committee substitute substantially changes the bill in the following ways:

- Increases regulatory authority for the Medicaid program, the Agency for Health Care Administration as the licensing authority for health care facilities, and the Department of Health as the licensing authority for health care practitioners, to address Medicaid fraud directly and indirectly;
- Creates incentives for persons to report incidents of Medicaid fraud;
- Increases the penalties for fraud in the Medicaid program and increases licensure standards to keep fraudulent actors from obtaining a health care practitioner license or a health care facility license;
- Increases licensure requirements for home health agencies, health care clinics, and home medical equipment providers;
- Designates Miami-Dade County as a health care fraud crisis area; and
- Directs the Agency for Health Care Administration to implement two pilot projects in Miami-Dade County to prevent the overutilization of home health services and to control, verify, and monitor the delivery of home health services in the Medicaid program.

- B. **Amendments:**

None.