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.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	CS/SB 2658
INTRODUCER:	Health Regulation Committee and Senator Baker
SUBJECT:	Licensure of Home Health Agencies, Home Medical Equipment Providers, and Health Care Clinics
DATE:	April 2, 2009 REVISED:

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

Please see Section VIII. for Additional Information:

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

I. Summary:

The bill designates Miami-Dade County a special area of concern for health care fraud. The bill increases the requirements for applicants for licensure as home health agencies, home medical equipment providers, and health care clinics to include: additional financial documentation and a $500,000 surety bond for U.S. residents who have not been in the U.S. for at least 5 years. The bill creates a moratorium on new home health agency licenses in counties that meet certain criteria until July 1, 2010. The bill also creates new third-degree felony offenses.

The bill creates one undesignated section of law and s. 408.8065, F.S.

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.[1] 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.[2] 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 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 Florida Counties.[3] 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.

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[1] 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 on March 29, 2009).
[2] 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 on March 29, 2009).
[3] Found at:< http://www.oig.hhs.gov/oei/reports/oei-09-07-00030.pdf> (Last visited on March 29, 2009).

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 SB 118 (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 Agency for Health Care Administration (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 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 and 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.[4] The next OPPAGA report will be published in January 2010.

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.

Core Licensure Provisions

In addition to specific authorizing statutes that provide the regulatory structure for licensing of health care facilities and services, 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 AHCA in order to minimize confusion, standardize terminology, and include issues that are otherwise not adequately addressed in the Florida Statutes pertaining to specific providers.[5]

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; inspectional authority; and rulemaking authority;
- Prohibits unlicensed activity; and

[4] 59G-9.070, Florida Administrative Code.
[5] s. 408.801, F.S.

- Authorizes the AHCA to impose administrative fines and pursue other regulatory and enforcement actions.

Licensure of Home Health Agencies

Home health agencies are organizations licensed and regulated by the 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:[6]

- 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
- 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.[7]

[6] s. 408.806, 408.810, and 400.471, F.S., respectively.
[7] s. 400.471(2)(f), F.S.

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.[8]

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.[9] Unlicensed activity is a second degree misdemeanor.[10] In addition, a controlling interest that withholds any evidence of financial instability commits a second-degree misdemeanor.[11]

Prior to 2008, the AHCA saw significant growth in the number of applications and new licenses for home health agencies.[12] 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 were from Miami-Dade County. As of December 31, 2008, there were 2,225 licensed home health agencies in the state.[13] 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.

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.[14] However, there are numerous exceptions to the clinics, which 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:[15]

- 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;

[8] s. 400.471, F.S.
[9] s. 400.464, F.S.
[10] s. 400.464, F.S.
[11] s. 408.810, F.S.
[12] 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> (Last visited on March 29, 2009).
[13] Source: AHCA Home Care Unit, Bureau of Health Facility Regulation.
[14] s. 400.9905(4), F.S.
[15] s. 400.991, F.S.

- 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.

Under s. 409.991(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 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 ch. 400, F.S., and part II of ch. 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 Centers 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.

III. Effect of Proposed Changes:

The bill creates an undesignated section of law that designates Miami-Dade County as a special area of concern for health care fraud, for the purpose of increased scrutiny of home health agencies, home medical equipment providers, and health care clinics.

The bill creates s. 408.8065, F.S., to establish additional licensure requirements for home health agencies, home medical equipment providers, and health care clinics. Applicants for initial, renewal, or change of ownership licensure are required to:

- Be a legal resident of the United States for at least 5 years before becoming an applicant or controlling interest in a health care clinic, home health agency, or home health medical equipment provider, unless a surety bond of $500,000 is provided.
- Demonstrate the financial ability to operate by complying with the requirements of s. 408.810(8), F.S., and by:
    - Submitting a financial statement, including a balance sheet and an income and expense statement, and a statement of cash flow for the first two years of operation, to provide evidence that the applicant has sufficient assets, credit, and projected revenues to cover liabilities and expenses;
    - Providing documented proof that the applicant has the ability to fund all startup costs through the point of break-even in operational costs by submitting a statement of estimated startup costs and any source of funds; and
    - Providing documented proof that any of the funds necessary for start-up, working capital, and contingency financing will be available, as needed.
- The required financial documents must be prepared in accordance with generally accepted accounting principles and the required financial statement must be signed by a certified public accountant.

The bill creates a moratorium on the licensure of new home health agencies in a county that meets certain criteria until July 1, 2010. The bill prohibits the AHCA from issuing a new home health agency license in any county where there is at least one actively licensed home health agency and the population of persons 65 years of age and older, as indicated in the most recent population estimates published by the Executive Office of the Governor, is fewer than 1,200 per home health agency. The AHCA may continue and process a license to a home health agency if the agency has received accreditation before May 1, 2009.

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 who:

- Offers services that require licensure under part III, part VII, or part X of chapter 400, F.S., without obtaining a valid license;
- Knowingly files a false or misleading license or license renewal application or provides false or misleading information related to the application or agency rule; and
- Violates or conspires to violate this section.

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.

D. Other Constitutional Issues:

The licensure prohibition created in the bill that applies only to legal residents of the United States, who have been legal residents for less than 5 years, may violate the 14th Amendment of the U.S. Constitution that provides that:

"No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The new licensure requirements for health care clinics, home health agencies, and providers of home medical equipment may require applicants for initial, renewal, or change of ownership licensure to incur additional costs.

Legal US residents that have been in the United States for less than 5 years would be required to provide a surety bond of $500,000 to apply for a license or become a controlling interest in a home health agency, health care clinic, or home medical equipment provider.

C. Government Sector Impact:

The bill creates a third-degree felony. The Criminal Justice Impact Conference has not established the impact of the additional felony.

VI. Technical Deficiencies:

None.

VII. Related Issues:

There may be an inconsistency among the core licensure provisions in part II of ch. 408, F.S., part III of ch. 400, F.S., part VII of ch. 400, F.S., part X of ch. 400, F.S., and the new licensure requirements created in the bill. If conflicts exist, it is unclear which provisions would control licensure requirements.

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 Health Regulation Committee on April 1, 2009:
The committee substitute substantially changed the bill in the following ways:

- Decreases the home health agency licensure moratorium for new home health agency applicants that meet certain criteria from 3 years to 1 year.
- Specifies that the new licensure requirements for home health agencies, home medical equipment providers, and health care clinics apply to initial, renewal, and change of ownership licensure.
- Requires the financial documents to include a statement of cash flow for the first 2 years; and
- Removes the AHCA's rule-making authority.

B. Amendments:

None.