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:	SB 1316
INTRODUCER:	Senator Gaetz
SUBJECT:	Health Care
DATE:	January 27, 2012
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Wilson	Stovall	HR	**Pre-meeting**
2.			BC	
3.				
4.				
5.				
6.				

I. Summary:

This bill deals generally with accountability of health care providers. It modifies existing statutory provisions relating to health care fraud, particularly in the Florida Medicaid program. Modifications include the following:

- Reducing the penalty for home health agencies that fail to timely file certain reports;
- Adding specified offenses for which persons rendering care under the Medicaid consumer-directed care program must be screened and rescreened;
- Requiring Medicaid providers to retain all medical and Medicaid-related records for 6 years rather than the current 5-year retention period;
- Requiring Medicaid providers to report a change in any principal of the provider to the Agency for Health Care Administration (AHCA) in writing no later than 30 days after the change occurs;
- Defining the term "administrative fines" for purposes of liability of parties for payment of such fines in the event of a change of ownership;
- Authorizing the AHCA to conduct onsite inspections of the service location of a provider applying for a provider agreement, before entering into a provider agreement with that provider, to determine the provider's ability to provide services in compliance with the Medicaid program and professional regulations;
- Removing certain exceptions to background screening requirements for Medicaid providers;
- Including participants in a Medicaid managed care provider network in the definition of "Medicaid provider" for purposes of oversight of the integrity of the Medicaid program;
- Authorizing the AHCA to review and analyze information from sources other than enrolled Medicaid providers in conducting investigations of potential fraud, abuse, overpayment or recipient neglect;

- Expanding the list of offenses for which the AHCA must terminate the participation of a Medicaid provider in the Medicaid program;
- Requiring the AHCA to impose the sanction of termination for cause against a provider that voluntarily relinquishes its Medicaid provider number under certain circumstances;
- Requiring the AHCA, when it is making a determination that an overpayment has occurred, to base its determination solely upon information available to it before issuance of the audit report and upon contemporaneous records;
- Removing a requirement that the AHCA pay interest at the rate of 10 percent a year on provider payments that have been withheld under suspicion of fraud or abuse, if it is determined that there was no fraud or abuse;
- Requiring overpayments and fines to be paid within 30 days after a final order;
- Clarifying the scope of the immunity from civil liability for persons who provide the state with information about fraud or suspected fraudulent acts by a Medicaid provider; and
- Modifying the grounds under which a professional board or the Department of Health (DOH) must refuse to admit a candidate to an examination and refuse to issue or renew a license, certificate, or registration of a health care practitioner.

The bill reinstates certain statutory provisions that previously were repealed. The reinstated provisions include:

- The submission by the AHCA of an annual report on adverse incidents reported by assisted living facilities;
- Medical examinations and mental health evaluations of residents of assisted living facilities who appear to need care beyond that which the facility is licensed to provide.

The bill includes the following new provisions:

- Restrictions on the techniques used by Medicaid managed care plans to manage the use of prescribed drugs by enrollees;
- A requirement for the AHCA to report on the impact of the implementation of an expansion of managed care to new populations or the provision of new items and services.

This bill substantially amends the following sections of the Florida Statutes: 400.474, 409.221, 409.907, 409.913, 409.920, 409.967, 429.23, 429.26, 456.036, 456.0635, and 456.074. The bill also creates one undesignated section of law.

II. Present Situation:

Health Care Fraud

In 2009, the Legislature passed CS/CS/CS/SB 1986, a comprehensive bill designed to address systemic health care fraud in Florida. That bill increased the Medicaid program's authority to address fraud, particularly as it relates to home health services; increased health care facility and health care practitioner licensing standards to keep fraudulent actors from obtaining a health care license in Florida; and created disincentives to commit Medicaid fraud by increasing the administrative penalties for committing Medicaid fraud, posting sanctioned and terminated

Medicaid providers on the AHCA website, and creating additional criminal felonies for committing health care fraud; among other anti-fraud provisions.[1]

With over 2 years of experience with the implementation of CS/CS/CS/SB 1986, some changes have been identified that would enhance Florida's efforts to prevent health care fraud and abuse and to effectively counter fraud and abuse that does occur. This bill addresses some of the practical effects of CS/CS/CS/SB 1986: provisions that appear to be too onerous, gaps in enforcement authority, and consumer protections that were repealed that maybe should have been retained.

Home Health Agency Regulation

Home health agencies are licensed and regulated by the AHCA under the authority of part III of ch. 400, F.S. Section 400.474, F.S., authorizes the AHCA to deny, revoke, or suspend the license of a home health agency and requires the AHCA to impose a $5,000 fine against a home health agency that commits certain acts. One of these acts is the failure of the home health agency to submit a report, within 15 days after the end of each calendar quarter, that includes the following information:

- The number of insulin dependent diabetic patients receiving insulin-injection services from the home health agency;
- The number of patients receiving both home health services from the home health agency and hospice services;
- The number of patients receiving home health services from that home health agency; and
- The names and license numbers of nurses whose primary job responsibility is to provide home health services to patients and who received remuneration from the home health agency in excess of $25,000 during the calendar quarter.

These data items help identify possible fraud, such as billing for a high number of injection visits for insulin-dependent patients who could self-inject insulin, fraudulent billing for patients who did not receive the visits, possible duplicate payment for patients receiving both hospice and home health services, and nurses earning well above the average salary that could indicate false billing. The results of each quarter's reporting are shared with the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services' Medicare Program Integrity Miami Satellite Division, the AHCA's Medicaid Program Integrity Office, and the Medicare Fraud Investigations Manager at SafeGuard Services, LLC.

Medicaid

Medicaid is the medical assistance program that provides access to health care for low-income families and individuals. Medicaid also assists aged and disabled people with the costs of nursing facility care and other medical expenses. The AHCA is responsible for Medicaid. Medicaid serves approximately 3.19 million people in Florida. Estimated Medicaid expenditures for fiscal year 2011-2012 are approximately $20.3 billion. The statutory authority for the Medicaid program is contained in part III of ch. 409, F.S.

[1] *See* ch. 2009-223, Laws of Florida.

Medicaid reimburses health care providers that have a provider agreement with the AHCA only for goods and services that are covered by the Medicaid program and only for individuals who are eligible for medical assistance from Medicaid. Section 409.907, F.S., establishes requirements for Medicaid provider agreements, which include, among other things, background screening requirements, notification requirements for change of ownership of a Medicaid provider, records retention requirements, authority for AHCA site-visits of provider service locations, and surety bond requirements.

Under s. 409.912(37), F.S., the AHCA is required to implement a Medicaid prescribed-drug spending-control program that includes a preferred drug list (PDL), which is a listing of cost-effective therapeutic options recommended by the Medicaid Pharmaceutical and Therapeutics Committee established pursuant to s. 409.91195, F.S. The PDL is used to inform clinicians of effective products that provide favorable net costs to Medicaid. The PDL educates clinicians about cost effective choices in prescribing for Medicaid recipients, but clinicians always retain the option of selecting the drug product they feel is most appropriate for their patient by calling the Therapeutic Consultation Program. If the prescriber cannot readily obtain authorization the pharmacist may dispense a 72-hour supply. The pharmacist may also use his or her professional judgment if other situations arise that would necessitate a 72-hour emergency supply.[2]

Section 409.913, F.S., outlines provisions relating to the AHCA's responsibilities for oversight of the integrity of the Medicaid program, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate.

Sections 409.920, 409.9201, 409.9203, and 409.9205, F.S., contain provisions relating specifically to Medicaid fraud. One of these is a provision that provides immunity from civil liability for a person who provides the State with information about fraud or suspected fraud by a Medicaid provider, including a managed care organization.[3]

Part IV of ch. 409, F.S., requires all Medicaid recipients to enroll in a managed care plan unless they are specifically exempted. The statewide Medicaid managed care program includes the long-term care managed care program and the managed medical assistance program. The law directs the AHCA to begin implementation of the long-term care managed care program by July 1, 2012, with full implementation in all regions of the State by October 1, 2013. By January 1, 2013, the AHCA must begin implementation of the managed medical assistance program, with full implementation in all regions of the State by October 1, 2014.

Section 409.967, F.S., establishes requirements for the accountability of managed care plans in the new statewide Medicaid managed care program, including requirements regarding coverage of prescription drugs. The AHCA is required to establish standards relating to access to care, which include the following statements regarding prescription drugs:

- The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards.

[2] Medicaid Pharmaceutical and Therapeutics Committee, Agency for Health Care Administration. Found at: <http://ahca.myflorida.com/medicaid/Prescribed_Drug/pharm_thera/index.shtml> (Last visited on January 26, 2012).
[3] *See* s. 409.920(8), F.S.

- Each managed care plan must publish any prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers.
- The plan must update the list within 24 hours after making a change.
- Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers.

These requirements will apply to all plans by October 1, 2014. Currently, operating Medicaid managed care plans may develop their own utilization and clinical protocols to manage drug costs, so long as they are ultimately no more restrictive than the Medicaid fee-for-service drug benefit. The contracts between the managed care plans and the AHCA specify requirements concerning access to the drug benefit.

Background Screening

Chapter 435, F.S., establishes standards for background screening for employment. Section 435.03, F.S., sets standards for Level 1 background screening. Level 1 background screening includes, but is not limited to, employment history checks and statewide criminal correspondence checks through the Department of Law Enforcement, and a check of the Dru Sjodin National Sex Offender Public Website, and may include local criminal records checks through local law enforcement agencies.

Level 2 background screening includes, but is not limited to, fingerprinting for statewide criminal history records checks through the Department of Law Enforcement and national criminal history records checks through the Federal Bureau of Investigation. They may also include local criminal records checks through local law enforcement agencies. Section 435.04(2), F.S., lists the offenses that will disqualify an applicant from employment.

Section 409.809, F.S., establishes background screening requirements and procedures for entities licensed by the AHCA. The AHCA must conduct Level 2 background screening for specified individuals. Each person subject to this section is subject to Level 2 background screening every 5 years. This section of law also specifies additional disqualifying offenses beyond those included in s. 435.04(2), F.S.

Florida Consumer-Directed Care Act

The Florida Consumer-Directed Care Act[4] requires the AHCA to establish the consumer-directed care program for persons with disabilities who need long-term care services and who are enrolled in one of the Medicaid home and community-based waiver programs. These types of waiver programs offer services that allow frail elders and people with disabilities to receive long-term-care services in their homes or in the community to keep them from needing care in a nursing facility or intermediate care facility for the developmentally disabled. The purpose of the consumer-directed care program is to allow enrolled persons to choose the providers of services and to direct the delivery of services, to best meet their long-term care needs.

[4] *See* s. 409.221, F.S.

All persons who render care in the program are required to undergo Level 2 background screening pursuant to ch. 435, F.S. The Florida Consumer-Directed Care Act does not currently require re-screening and authorizes persons who have been subject to background screening and who have not been unemployed for more than 90 days following such screening to not be required to be rescreened. They must attest to not having been convicted of a disqualifying offense since completing screening.

Health Care Practitioner Licensure Authority of the Department of Health

The DOH 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), and
- Chapter 491 (clinical, counseling, and psychotherapy services)

Current law[5] 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 entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under ch. 409, F.S.,[6] ch. 817, F.S.,[7] ch. 893, F.S.,[8] 21 U.S.C. ss. 801-970,[9] or

[5] *See* s. 456.0635, F.S.
[6] Ch. 409, F.S., "Social and Economic Assistance," is in Title XXX, "Social Welfare," and includes the Florida Medicaid and Kidcare programs, among other programs.
[7] ch. 817, F.S., "Fraudulent Practices," is in Title XLVI, "Crimes."
[8] ch. 893, F.S., "Drug Abuse Prevention and Control," is in Title XLVI, "Crimes."

42 U.S.C. ss. 1395-1396,[10] unless the sentence and any subsequent period of probation for such conviction or pleas ended more than 15 years prior to the date of the application;
- Terminated for cause from the Florida Medicaid program, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5 years; or
- Terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from any other state Medicaid program or the federal Medicare program, unless the applicant has been in good standing with a state Medicaid program or the federal Medicare program for the most recent 5 years and the termination occurred at least 20 years prior to the date of application.

The DOH and the medical boards must refuse to issue or renew a license, certificate, or registration if an applicant or person affiliated with that applicant has violated any of the provisions listed above. The DOH applies the denial of licensure renewals to offenses occurring after July 1, 2009, when the new provisions requiring denial of renewals went into effect. Neither the boards nor the DOH currently deny initial licensure or licensure renewal based upon termination for cause from the Medicare program, because no such termination exists in federal law. Federal law references mandatory and permissive exclusions.

Any individual who is seeking licensure must apply for licensure and meet the current requirements regardless of whether the applicant previously held a Florida license. If an applicant is required to have passed a licensure examination within a certain number of years prior to licensure, then an applicant whose test scores have "expired" would be required to re-test and pass the licensure examination. Between July 1, 2009, and November 22, 2011, 91 licensees have been denied renewal under s. 456.0635, F.S.

Regulation of Assisted Living Facilities

Assisted living facilities are regulated under part I of ch. 429, F.S. Section 429.23, F.S., requires assisted living facilities to submit to the AHCA, within 1 day after the occurrence of an adverse incident, a preliminary report concerning the incident. The assisted living facility is also required to provide a more detailed report to the AHCA within 15 days after the incident. The AHCA collects and stores the data received from the adverse incident reports. The information is currently confidential and is not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the AHCA or appropriate regulatory board. However, the AHCA does fill public record's requests for statistical information, but detailed information on an adverse incident is not provided.

Section 429.26, F.S., establishes requirements relating to the appropriateness of placements of individuals in assisted living facilities and examinations of residents in an assisted living facility. The AHCA requires that residents be examined only at admission, every 3 years, and after a "significant change." A significant change is defined in Rule 58A-35.0131(33), F.A.C.,[11] to mean a sudden or major shift in behavior or mood, or deterioration in health status such as

[9] 21 U.S.C. ss. 801-970 create the Controlled Substances Act, which regulates the registration of manufacturers, distributors, and dispensers of controlled substances at the federal level.
[10] 42 U.S.C. ss. 1395-1396 create the federal Medicare, Medicaid, and Children's Health Insurance programs.
[11] Found at: <https://www.flrules.org/gateway/RuleNo.asp?title=ASSISTED%20LIVING%20FACILITIES&ID=58A-5.0131> (Last visited on January 26, 2012).

unplanned weight change, stroke, heart condition, or stage 2, 3, or 4 pressure sores. The facility administrator is responsible for determining the appropriateness of placement. If the AHCA determines a resident is not appropriate based on observations and facility documentation, a facility is cited for the violation and required to take appropriate action to discharge the resident to a facility that can meet the resident's needs.

III. Effect of Proposed Changes:

Section 1 amends s. 400.474, F.S., to reduce the fine that the AHCA currently must impose on a home health agency that fails to submit, within 15 days after the end of each calendar quarter, the report that includes certain fraud detection information. The bill changes the penalty to a mandatory $50 per day fine, with no maximum, instead of the current permissive denial, revocation, or suspension of the home health agency's license and a mandatory fine of $5,000. Thus, the amount of the fine will be substantially less for those agencies that are only a few days late submitting the report. However, reports more than 100 days late will exceed the existing fine of $5,000.

Section 2 amends s. 409.221, F.S., to require persons who render care under the Medicaid consumer-directed care program to undergo Level 2 background screening pursuant to the provisions of s. 408.809, F.S., in addition to the provisions of ch. 435, F.S. The effect is to require persons rendering care under the consumer-directed care program to be screened for additional disqualifying offenses and to be re-screened every 5 years.

Section 3 amends s. 409.907, F.S., relating to Medicaid provider agreements, to require Medicaid providers to retain all medical and Medicaid-related records for 6 years, rather than the current statutory retention period of 5 years, consistent with Health Insurance Portability and Accountability Act (HIPAA) of 1996 administrative simplification rules.[12]

The bill requires a Medicaid provider to report in writing any change of any principal of the provider to the AHCA no later than 30 days after the change occurs. The bill specifies who is included in the term "principal."

The bill amends the statutory provisions relating to the liability of Medicaid providers in a change of ownership for outstanding overpayments, administrative fines, and any other moneys owed to the AHCA. The bill defines "administrative fines" to include any amount identified in any notice of a monetary penalty or fine that has been issued by the AHCA or any other regulatory or licensing agency which governs the provider.

The requirement for the AHCA to conduct random onsite inspections of Medicaid providers' service locations within 60 days after receipt of a fully complete new provider's application and prior to making the first payment to the provider for Medicaid services is amended to authorize, rather than require, the AHCA to perform onsite inspections. The inspection would be conducted prior to the AHCA entering into a Medicaid provider agreement with the provider and would be used to determine the applicant's ability to provide services in compliance with the Medicaid

[12] *See* 45 CFR 164.316(b)(2). Found at: <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=be9877c2440a17a8ebe3b02b0948a06a&rgn=div8&view=text&node=45:1.0.1.3.79.3.27.8&idno=45> (Last visited on January 26, 2012).

program and professional regulations. The law currently only requires the AHCA to determine the applicant's ability to provide the services for which they will seek Medicaid payment. The bill also removes an exception to the current onsite-inspection requirement for a provider or program that is licensed by the AHCA, that provides services under waiver programs for home and community-based services, or that is licensed as a medical foster home by the Department of Children and Family Services, since the selection of providers for onsite inspections is no longer a random selection, but is left up to the discretion of the AHCA under the bill.

The bill amends the requirements for a criminal history record check of each Medicaid provider, or each principal of the provider, to remove an exemption from such checks for hospitals, nursing homes, hospices, and assisted living facilities. The bill specifies that for hospitals and nursing homes the principals of the provider are those who meet the definition of a controlling interest in s. 408.803, F.S.

The bill removes the provision that proof of compliance with Level 2 background screening under ch. 435, F.S., conducted within 12 months before the date the Medicaid provider application is submitted to the AHCA satisfies the requirements for a criminal history background check. This conforms to screening provisions in ch. 435, F.S., and ch. 408, F.S.

Section 4 amends s. 409.913, F.S., which relates to oversight of the integrity of the Medicaid program. The bill defines "Medicaid provider" or "provider" to include not only persons or entities that have a Medicaid provider agreement in effect with the AHCA and that are in good standing with the AHCA, but also, for purposes of oversight of the integrity of the Medicaid program, participants in a Medicaid managed care provider network.

The bill authorizes the AHCA, as part of its fraud and abuse detection efforts, to review and analyze information from sources other than enrolled Medicaid providers. Medicaid providers are required to retain medical, professional, financial, and business records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid for 6 years, rather than the current statutory retention period of 5 years.

The bill amends subsection (13) of s. 409.913, F.S., to remove a requirement that the AHCA *immediately* terminate participation of a Medicaid provider that has been convicted of certain offenses. In order to immediately terminate a provider, the AHCA must show an immediate harm to the public health, which is not always possible. The AHCA still must terminate a Medicaid provider from participation in the Medicaid program, unless the AHCA determines that the provider did not participate or acquiesce in the offense, and may seek civil remedies or impose administrative sanctions if a provider *has been convicted* of any of the following offenses.

- A criminal offense under federal law or the law of any state relating to the practice of the provider's profession.
- An offense listed in s. 409.907(10), F.S., relating to factors the AHCA may consider when reviewing an application for a Medicaid provider agreement, which includes:
    - Making a false representation or omission of any material fact in making an application for a provider agreement;
    - Exclusion, suspension, termination, or involuntary withdrawal from participation in any Medicaid program or other governmental or private health care or health insurance program;

- Being convicted of a criminal offense relating to the delivery of any goods or services under Medicaid or Medicare or any other public or private health care or health insurance program including the performance of management or administrative services relating to the delivery of goods or services under any such program;
- Being convicted of a criminal offense under federal or state law related to the neglect or abuse of a patient in connection with the delivery of any health care goods or services;
- Being convicted of a criminal offense under federal or state law related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance;
- Being convicted of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;
- Being convicted of a criminal offense under federal or state law punishable by imprisonment of 1 year or more which involves moral turpitude;
- Being convicted in connection with the interference or obstruction of any investigation into any criminal offense listed above;
- Violation of federal or state laws, rules, or regulations governing any Medicaid program, the Medicare program, or any other publicly funded federal or state health care or health insurance program, if they have been sanctioned accordingly;
- Violation of the standards or conditions relating to professional licensure or certification or the quality of services provided; or
- Failure to pay fines and overpayments under the Medicaid program.

- An offense listed in s. 408.809(4), F.S., relating to background screening of licensees, which includes the following offenses or any similar offense of another jurisdiction:
  - Any authorizing statutes, if the offense was a felony;
  - Chapter 408, F.S., if the offense was a felony;
  - Section 409.920, F.S., relating to Medicaid provider fraud;
  - Section 409.9201, F.S., relating to Medicaid fraud;
  - Section 741.28, F.S., relating to domestic violence;
  - Section 817.034, F.S., relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems;
  - Section 817.234, F.S., relating to false and fraudulent insurance claims;
  - Section 817.505, F.S., relating to patient brokering;
  - Section 817.568, F.S., relating to criminal use of personal identification information;
  - Section 817.60, F.S., relating to obtaining a credit card through fraudulent means;
  - Section 817.61, F.S., relating to fraudulent use of credit cards, if the offense was a felony;
  - Section 831.01, F.S., relating to forgery;
  - Section 831.02, F.S., relating to uttering forged instruments;
  - Section 831.07, F.S., relating to forging bank bills, checks, drafts, or promissory notes;
  - Section 831.09, F.S., relating to uttering forged bank bills, checks, drafts, or promissory notes;
  - Section 831.30, F.S., relating to fraud in obtaining medicinal drugs; or
  - Section 831.31, F.S., relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.
- An offense listed in s. 435.04(2), F.S., relating to employee background screening, which includes the following offenses or any similar offense of another jurisdiction:
  - Section 393.135, F.S., relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct;

- Section 394.4593, F.S., relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct;
- Section 415.111, F.S., relating to adult abuse, neglect, or exploitation of aged persons or disabled adults;
- Section 782.04, F.S., relating to murder;
- Section 782.07, F.S., relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child;
- Section 782.071, F.S., relating to vehicular homicide;
- Section 782.09, F.S., relating to killing of an unborn quick child by injury to the mother;
- Chapter 784, F.S., relating to assault, battery, and culpable negligence, if the offense was a felony;
- Section 784.011, F.S., relating to assault, if the victim of the offense was a minor;
- Section 784.03, F.S., relating to battery, if the victim of the offense was a minor;
- Section 787.01, F.S., relating to kidnapping;
- Section 787.02, F.S., relating to false imprisonment;
- Section 787.025, F.S., relating to luring or enticing a child;
- Section 787.04(2), F.S., relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings;
- Section 787.04(3), F.S., relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person;
- Section 790.115(1), F.S., relating to exhibiting firearms or weapons within 1,000 feet of a school;
- Section 790.115(2)(b), F.S., relating to possessing an electric weapon or device, destructive device, or other weapon on school property;
- Section 794.011, F.S., relating to sexual battery;
- Former s. 794.041, F.S., relating to prohibited acts of persons in familial or custodial authority;
- Section 794.05, F.S., relating to unlawful sexual activity with certain minors;
- Chapter 796, F.S., relating to prostitution;
- Section 798.02, F.S., relating to lewd and lascivious behavior;
- Chapter 800, F.S., relating to lewdness and indecent exposure;
- Section 806.01, F.S., relating to arson;
- Section 810.02, F.S., relating to burglary;
- Section 810.14, F.S., relating to voyeurism, if the offense is a felony;
- Section 810.145, F.S., relating to video voyeurism, if the offense is a felony;
- Chapter 812, F.S., relating to theft, robbery, and related crimes, if the offense is a felony;
- Section 817.563, F.S., relating to fraudulent sale of controlled substances, only if the offense was a felony;
- Section 825.102, F.S., relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult;
- Section 825.1025, F.S., relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult;
- Section 825.103, F.S., relating to exploitation of an elderly person or disabled adult, if the offense was a felony;
- Section 826.04, F.S., relating to incest;
- Section 827.03, F.S., relating to child abuse, aggravated child abuse, or neglect of a child;

- Section 827.04, F.S., relating to contributing to the delinquency or dependency of a child;
- Former s. 827.05, F.S., relating to negligent treatment of children;
- Section 827.071, F.S., relating to sexual performance by a child;
- Section 843.01, F.S., relating to resisting arrest with violence;
- Section 843.025, F.S., relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication;
- Section 843.12, F.S., relating to aiding in an escape;
- Section 843.13, F.S., relating to aiding in the escape of juvenile inmates in correctional institutions;
- Chapter 847, F.S., relating to obscene literature;
- Section 874.05(1), F.S., relating to encouraging or recruiting another to join a criminal gang;
- Chapter 893, F.S., relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor;
- Section 916.1075, F.S., relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct;
- Section 944.35(3), F.S., relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm;
- Section 944.40, F.S., relating to escape;
- Section 944.46, F.S., relating to harboring, concealing, or aiding an escaped prisoner;
- Section 944.47, F.S., relating to introduction of contraband into a correctional facility;
- Section 985.701, F.S., relating to sexual misconduct in juvenile justice programs; or
- Section 985.711, F.S., relating to contraband introduced into detention facilities.

The bill amends subsection (15) of s. 409.913, F.S., relating to noncriminal actions of Medicaid providers for which the AHCA may impose sanctions, to include the act of *authorizing* certain services that are inappropriate, unnecessary, excessive, or harmful to the recipient or are of inferior quality, or *authorizing* certain requests and reports that contain materially false or incorrect information. The bill also adds that the AHCA may sanction a provider if the provider is charged by information or indictment with any offense referenced in subsection (13). (See above for a listing of the offenses.) The AHCA may impose sanctions under this subsection if the provider or certain persons affiliated with the provider participated or acquiesced in the proscribed activity.

Subsection (16) of s. 409.913, F.S., relating to sanctions the AHCA may impose for the acts listed in subsection (15), is amended to state that, if a Medicaid provider voluntarily relinquishes its Medicaid provider number after receiving notice of an audit or investigation for which the sanction of suspension or termination will be imposed, the AHCA must impose the sanction of termination for cause against the provider. Currently, if a Medicaid provider receives notification that they are going to be suspended or terminated, they are able to voluntarily terminate their contract. By doing this, a provider has the ability to avoid sanctions of suspension or termination, which would affect the ability of the provider to reenter the program in the future. Existing language in this subsection gives the Secretary of AHCA the authority to make a determination that imposition of a sanction is not in the best interest of the Medicaid program, in which case a sanction may not be imposed.

The bill amends subsection (21) of s. 409.913, F.S., to specify that when the AHCA is making a determination that an overpayment has occurred, the determination must be based solely upon information available to it before it issues the audit report and, in the case of documentation obtained to substantiate claims for Medicaid reimbursement, based solely upon contemporaneous records. Subsection (22) is amended to specify that testimony or evidence that is not based upon contemporaneous records or that was not furnished to the AHCA within 21 days after the issuance of the audit report is inadmissible in an administrative hearing on a Medicaid overpayment or an administrative sanction. Also, all documentation to be offered as evidence in an administrative hearing on an administrative sanction (in addition to Medicaid overpayments) must be exchanged by all parties at least 14 days before the administrative hearing or excluded from consideration.

Subsection (25) of s. 409.913, F.S., is amended to remove the requirement that the AHCA pay, interest at the rate of 10 percent a year on Medicaid payments that have been withheld from a provider based on suspected fraud or criminal activity, if it is determined that there was no fraud or that a crime did not occur. Also, payment arrangements for overpayments and fines owed to the AHCA must be made within 30 days after the date of the final order and are not subject to further appeal.

The bill amends subsection (28) of s. 409.913, F.S., to make Leon County the venue for all Medicaid program integrity cases, not just overpayment cases. However, the AHCA has discretion concerning venue. Subsection (29) is amended to authorize the AHCA and the Medicaid Fraud Control Unit of the Department of Legal Affairs to review a *person's*, in addition to a provider's, Medicaid-related and non-Medicaid-related records in order to determine the total output of a provider's practice to reconcile quantities of goods or services billed to Medicaid with quantities of goods or services used in the provider's total practice.

Subsection (30) of s. 409.913, F.S., is amended to require the AHCA to terminate a provider's participation in the Medicaid program if the provider fails to reimburse a fine within 30 days after the date of the final order imposing the fine. The time within which a provider must reimburse an overpayment is reduced from 35 to 30 days after the date of the final order. Subsection (31) is amended to include fines, as well as overpayments, that are due upon the issuance of a final order at the conclusion of a requested administrative hearing.

Section 5 amends s. 409.920, F.S., relating to Medicaid provider fraud, to clarify that the existing immunity from civil liability extended to persons who provide information about fraud or suspected fraudulent acts is for civil liability for libel, slander, or any other relevant tort. The bill defines "fraudulent acts" for purposes of the immunity from civil liability to include actual or suspected fraud, abuse, or overpayment, including any fraud-related matters that a provider or health plan is required to report to the AHCA or a law enforcement agency. The immunity from civil liability extends to reports conveyed to the AHCA in any manner and includes all discussions subsequent to the report and subsequent inquiries from the AHCA, unless the person reporting acted with knowledge that the information was false or with reckless disregard for the truth or falsity of the information.

Section 6 amends s. 409.967, F.S., relating to Medicaid managed care plan accountability, to establish requirements for managed care plans relating to coverage of prescribed drugs, which do

not currently exist for the Medicaid fee-for-service drug program or Medicaid managed care plans. With regard to standards for managed care plan networks, the bill states that exclusive use of mail-order pharmacies *is not sufficient* to meet network access standards. Current law states that exclusive use of mail-order pharmacies *may not be sufficient*. The effect is that managed care plans will be required to use some pharmacies that are not mail-order pharmacies.

The bill establishes the following requirements for managed care plans that use a prescribed drug formulary or preferred drug list. The plan must:

- Provide coverage for drugs in categories and classes for all disease states and provide a broad range of therapeutic options for all therapeutic categories;
- Include coverage for each new drug approved by the federal Food and Drug Administration until the plan's Pharmaceutical and Therapeutics Committee reviews the drug for inclusion on its formulary;
- Provide a response within 24 hours after receipt of all necessary information for a request for prior authorization or override of other medical management tools; and
- Report all denials to the AHCA on a quarterly basis. For each nonformulary drug, the plan must report the total number of requests and the total number of denials.

The bill requires a managed care plan to continue to permit an enrollee who was receiving a prescription drug that was on the plan's formulary and subsequently removed or changed to continue to receive that drug if requested by the enrollee and the prescriber for as long as the enrollee is a member of the plan.

The bill establishes requirements for the use of step-therapy or fail-first protocols by managed care plans. Plans that impose step-therapy or a fail-first protocol must:

- Provide the prescriber with access to a clear and convenient process to expeditiously request an override of a restriction;
- Expeditiously grant an override of a restriction if the prescriber can demonstrate to the plan that the preferred treatment required under the step-therapy or fail-first protocol:
  - Has been ineffective in the treatment of the enrollee's disease or medical condition;
  - Is reasonably expected to be ineffective based on the known relevant physical or mental characteristics and medical history of the enrollee and known characteristics of the drug regimen; or
  - Will cause or will likely cause an adverse reaction or other physical harm to the enrollee.
- Limit the maximum duration of a step-therapy or fail-first protocol requirement so that it is no longer than the customary period for the prescribed drug if the treatment is demonstrated by the prescriber to be clinically ineffective. (The bill authorizes a plan, under specified circumstances, to extend the step-therapy or fail-first protocol.) Once the prescriber deems the treatment to be clinically ineffective, the plan must dispense and cover the originally prescribed drug.

The bill establishes prior authorization requirements relating to prescribed drugs.

- Each managed care plan must ensure that the prior authorization process is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers. (This is an existing statutory requirement that is being relocated.)

- If a drug is subject to prior authorization, the managed care plan must provide payment to the pharmacist for dispensing the drug without seeking prior authorization if the pharmacist confirms that:
  - The prescription is a refill or renewal of the same drug for the same beneficiary written by the same prescriber; or
  - If the drug is generally prescribed for an indication that is treated on an ongoing basis by continuous medication or as-needed, the enrollee for whom the drug is prescribed has filled a prescription for the same drug within the preceding 30 to 90 days.
- If a prescribed drug requires prior authorization, the managed care plan must reimburse the pharmacist for dispensing a 72-hour supply to the enrollee and process the prior authorization request and send a response to the requesting pharmacist within 24 hours after receiving the pharmacist's request for prior authorization.

Section 7 amends s. 429.23, F.S., relating to adverse incident reporting requirements for assisted living facilities, to reestablish a requirement for the AHCA to annually submit a report on adverse incident reports by assisted living facilities. The requirement for an annual report was repealed July 1, 2009 (s. 63 of ch. 2009-223, L.O.F.). The AHCA will once again be required to submit an annual report to the Legislature containing certain information, by county, about reported adverse incidents in assisted living facilities.

Section 8 amends s. 429.26, F.S., relating to appropriateness of placement of residents of assisted living facilities, to reestablish a requirement for physical examination or mental health evaluation of residents who appear to need care beyond that which the assisted living facility is licensed to provide. The requirement for such examinations or evaluations was repealed July 1, 2009 (s. 64 of ch. 2009-223, L.O.F.).

If personnel of the AHCA question whether a resident needs care beyond that which the facility is licensed to provide, the AHCA may require the resident to be physically examined by a licensed physician, licensed physician assistant, or certified nurse practitioner. To the extent possible, the examination must be performed by a health care provider who is preferred by the resident. The cost of the examination must be paid for by the resident with personal funds, except for certain low-income residents. The requirement for the AHCA to have such an examination conducted does not preclude the AHCA from imposing sanctions against an assisted living facility for violating its duty to determine the continuing appropriateness of placement of its residents.

Following the physical examination and based on a completed medical form submitted to the AHCA by the examining health care provider, a medical team designated by the AHCA must determine if the resident is appropriately residing in the facility. The AHCA may consult with the examining provider if necessary. A determination by the medical team that the resident's placement is not appropriate is final and binding upon the facility and the resident. A resident who is determined to be inappropriately residing in a facility must be given 30 days' written notice to relocate, unless the resident's continued residence in the facility presents an imminent danger to the health, safety, or welfare of the resident or a substantial probability exists that death or serious physical harm to the resident would result if the resident is allowed to remain in the facility.

If a mental health resident appears to have needs in addition to those identified in the community living support plan, the AHCA may require an evaluation by a mental health professional, as determined by the Department of Children and Family Services.

A facility may not be required to retain a resident who requires more services or care than the facility is able to provide in accordance with its policies and criteria for admission and continued residency.

Section 9 amends s. 456.0635, F.S., effective July 1, 2012, relating to disqualification for licensure, certification, or registration of health care practitioners for Medicaid fraud. The catch line is changed from "Medicaid fraud; disqualification for license, certificate, or registration," to "Health care fraud; disqualification for license, certificate, or registration." Other references in the statute to the general subject of "Medicaid fraud" are changed to "health care fraud." References to "candidate" vs. "candidate or applicant" are also standardized.

The bill separates the disqualifications for initial licensure, certification, or registration from those relating to licensure renewal into two different statutory subsections.

The bill requires a board or the DOH to refuse to admit a candidate to any examination and to refuse to issue a license to any applicant who has been convicted of, or entered 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., *or similar felony offenses committed in another state or jurisdiction*. The bill deletes the provision in current law that nullifies the prohibition if the sentence and probation period ended more than 15 years prior to the date of application, and replaces it with the following provisions:

- For felonies of the first or second degree, the prohibition expires when the sentence and probation period have ended more than 15 years before the date of application.
- For felonies of the third degree, the prohibition expires when the sentence and probation period have ended more than 10 years before the date of application, except for felonies of the third degree under s. 893.13(6)(a), F.S.[13]
- For felonies of the third degree under s. 893.13(6)(a), F.S., the prohibition expires when the sentence and probation period have ended more than 5 years before the date of application.

An applicant or candidate who has been convicted of or pled guilty or nolo contendere to any state felony listed above is eligible for initial licensure without any prohibition if he or she successfully completes a pretrial intervention or drug diversion program for that felony.

The bill moves into a new paragraph the requirement for a board or the DOH to refuse to admit a candidate to any examination and to refuse to issue a license to any applicant who has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a

[13] Section 893.13(6)(a), F.S., makes it unlawful for any person to be in actual or constructive possession of a controlled substance unless such controlled substance was lawfully obtained from a practitioner or pursuant to a valid prescription or order of a practitioner while acting in the course of his or her professional practice, or to be in actual or constructive possession of a controlled substance except as otherwise authorized by ch. 893, F.S.

felony under 21 U.S.C. ss. 801-970[14] or 42 U.S.C. ss. 1395-1396,[15] unless the sentence and any probation period for such conviction or plea ended more than 15 years before the date of the application.

The bill deletes reference to "terminated for cause" from the federal Medicare program as grounds for which a board or the DOH is required to deny a license and creates a new standard to exclude applicants currently listed on the U.S. Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

The bill specifies that the prohibitions above relating to examination, licensure, certification, or registration do not apply to applicants for initial licensure or certification who were enrolled in a DOH- or board-recognized educational or training program on or before July 1, 2009, and who applied for licensure after July 1, 2012.

The bill creates a new statutory subsection relating to license *renewal* that requires a board or the DOH to deny renewal to applicants who, after July 1, 2009, have been convicted of or pled guilty or nolo contendere to the same felony offenses listed under the subsection on initial licensure. The same 5, 10, and 15-year prohibition periods apply concerning eligibility for relicensure after a felony as for initial licensure after a felony. Applicants who have been convicted of or pled guilty or nolo contendere to specified state felonies are eligible for license renewal without any prohibition period if they are currently enrolled in or have successfully completed a pretrial intervention or drug diversion program for that felony.

The bill also includes the same provisions for denying licensure renewal as those described above for initial examination, licensure, certification, and registration, relative to exclusion from the Medicare program and termination from Medicaid programs in Florida or in other states.

Section 10 amends s. 456.036, F.S., effective July 1, 2012, to authorize any person who has been denied renewal of licensure, certification, or registration under s. 456.0635(3), F.S., to regain licensure, certification, or registration by undergoing the procedure for initial licensure as defined by a board or the department. However, a person who was denied renewal between July 1, 2009 and June 30, 2012, is not required to retake any examinations which would otherwise be necessary for initial licensure.

Section 11 amends s. 456.074, F.S., relating to the immediate suspension of the license of certain health care practitioners who plead guilty to, are convicted or found guilty of, or who enter a plea of nolo contendere to, regardless of adjudication, certain offenses. The bill removes the limiting clause "relating to the Medicaid program" as it modifies a list of federal misdemeanor or felony offenses. The effect would be that the listed health care practitioners would be subject to immediate suspension of their license for the misdemeanor or felony offenses, whether or not the offense related to the Medicaid program.

[14] 21 U.S.C. ss. 801-970 relates to drug abuse prevention and control. It regulates the registration of manufacturers, distributors, and dispensers of controlled substances; provides for offenses and penalties; and regulates the import and export of controlled substances.
[15] 42 U.S.C. ss. 1395-1396 contain provisions relating to Medicare, Medicaid, and the Children's Health Insurance Program.

Section 12 creates a new undesignated section of law to require the AHCA to prepare a report within 18 months after the implementation of an expansion of managed care to new populations or the provision of new items and services. The AHCA must post a draft of the report on its website and provide an opportunity for public comment. The final report must be submitted to the Legislature, along with a description of the process for public input. The report must include an assessment of:

- The impact of managed care on patient access to care, including any new barriers to the use of services or prescription drugs created by the use of medical management or cost-containment tools.
- The impact of managed care expansion on the utilization of services, quality of care, and patient outcomes.
- The use of prior authorization and other utilization management tools, including whether these tools pose an undue administrative burden for health care providers or create barriers to needed care.

Section 13 provides that the bill will take effect upon becoming a law, except that sections 9 and 10 take effect on July 1, 2012.

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 the 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.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The change in the fine imposed on home health agencies will result in a reduction in the amount of the fines assessed, but the fiscal impact is indeterminate.

A resident in an assisted living facility may incur the cost of a medical examination if the AHCA questions whether a resident needs care beyond that which the facility is licensed to provide.

C. Government Sector Impact:

Department of Health
The DOH will experience recurring and non-recurring increases in workload to implement the provisions of this bill, but current resources and budget authority are adequate to absorb the costs of these increases.

Agency for Health Care Administration
The AHCA indicates that the bill has no fiscal impact on the agency.

VI. Technical Deficiencies:

The word "authorized" should be included after the word "ordered" on lines 585, 593, and 620.

On line 788, the underlined language should be "or pay a fine" since fines are not reimbursed to the AHCA.

On line 899, the word "insurer" should be "plan."

On line 900, the word "expeditiously" does not establish a clear time period within which the override must be granted.

Lines 912 -923 should be reworded to make clear what "customary period" means and what "original customary period" means.

On line 944, the word "beneficiary" should be changed to "enrollee."

VII. Related Issues:

It is not clear whether the intent of lines 537 through 541 is to terminate a Medicaid provider's participation in the Medicaid program only if the provider has been convicted of criminal offenses in the enumerated sections of statute or whether noncriminal actions in those sections of statute would also be grounds for termination from the Medicaid program.

On lines 866 and 867, the bill uses the phrase "a broad range of therapeutic options for all therapeutic categories." It is not clear how the word "broad" should be interpreted. For some therapeutic categories this might mean that the plan would have to cover all therapeutic options, or all drugs available for that therapeutic category.

According to the AHCA, the requirement in Section 12 for the AHCA to prepare a report within 18 months after implementation of an expansion of managed care is a duplication of federal requirements for the Section 1915(b) Long Term Care Managed Care Waiver and Section 1115

Research and Demonstration Waiver. The AHCA suggests that Section 12 is not necessary and should either be removed or revised to accurately reflect the federal requirements for waivers.[16]

VIII. Additional Information:

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

None.

B. Amendments:

None.

[16] *See* Agency for Health Care Administration 2012 Bill Analysis and Economic Impact Statement for SB 1316 – on file with the Senate Health Regulation Committee.