By Senator Gaetz

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A bill to be entitled

An act relating to health care; amending s. 400.474, F.S.; revising the fine that may be imposed against a home health agency for failing to timely submit certain information to the Agency for Health Care Administration; amending s. 409.221, F.S.; revising the background screening requirements for persons rendering care in the consumer-directed care program administered by the Agency for Health Care Administration; amending s. 409.907, F.S.; extending the records-retention period for certain Medicaid provider records; revising the provider agreement to require Medicaid providers to report changes in any principal of the provider to the agency; defining the term "administrative fines" for purposes of revoking a Medicaid provider agreement due to changes of ownership; authorizing, rather than requiring, an onsite inspection of a Medicaid provider's service location before entering into a provider agreement; specifying the principals of a hospital or nursing home provider for the purposes of submitting fingerprints for background screening; removing certain providers from being subject to agency background checks; amending s. 409.913, F.S.; defining the term "Medicaid provider" or "provider" for purposes of oversight of the integrity of the Medicaid program; authorizing the agency to review and analyze information from sources other than Medicaid-enrolled providers for purposes of determining fraud, abuse,

overpayment, or neglect; extending the records-retention period for certain Medicaid provider records; revising the grounds for terminating a provider from the Medicaid program; requiring the agency to base its overpayment audit reports on certain information; deleting a requirement that the agency pay interest on certain withheld Medicaid payments; requiring payment arrangements for overpayments and fines to be made within a certain time; specifying that the venue for all Medicaid program integrity cases lies in Leon County; authorizing the agency and the Medicaid Fraud Control Unit to review certain records; amending s. 409.920, F.S.; clarifying the applicability of immunity from civil liability extended to persons who provide information about fraud or suspected fraudulent acts by a Medicaid provider; amending s. 409.967, F.S.; specifying required components of a Medicaid managed care plan relating to the provisions of medications; amending s. 429.23, F.S.; requiring the agency to submit a report to the Legislature on adverse incident reports from assisted living facilities; amending s. 429.26, F.S.; authorizing the agency to require a resident of an assisted living facility to undergo a physical examination if the agency questions the appropriateness of the resident’s placement in that facility; authorizing release of the results of the examination to a medical review team to be used along with additional information to determine whether the

resident's placement in the assisted living facility is appropriate; providing for resident notification and relocation if the resident's continued placement in the facility is not appropriate; authorizing the agency to require the evaluation of a mental health resident by a mental health professional; authorizing an assisted living facility to discharge a resident who requires more services or care than the facility is able to provide; amending s. 456.0635, F.S.; revising the grounds under which the Department of Health or corresponding board is required to refuse to admit a candidate to an examination and refuse to issue or renew a license, certificate, or registration of a health care practitioner; providing an exception; amending s. 456.036, F.S.; providing that all persons who were denied renewal of licensure, certification, or registration under s. 456.0635(3), F.S., may regain licensure, certification, or registration only by completing the application process for initial licensure; providing an exception; amending s. 456.074, F.S.; revising the federal offenses for which the Department of Health must issue an emergency order suspending the license of certain health care professionals; requiring the agency to prepare a report for public comment and submission to the Legislature following the expansion of services to new populations or of new services; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (6) of section 400.474, Florida Statutes, is amended, present subsection (7) of that section is renumbered as subsection (8), and a new subsection (7) is added to that section, to read:

400.474 Administrative penalties.—

(6) The agency may deny, revoke, or suspend the license of a home health agency and shall impose a fine of $5,000 against a home health agency that:

(a) Gives remuneration for staffing services to:

1. Another home health agency with which it has formal or informal patient-referral transactions or arrangements; or

2. A health services pool with which it has formal or informal patient-referral transactions or arrangements,

unless the home health agency has activated its comprehensive emergency management plan in accordance with s. 400.492. This paragraph does not apply to a Medicare-certified home health agency that provides fair market value remuneration for staffing services to a non-Medicare-certified home health agency that is part of a continuing care facility licensed under chapter 651 for providing services to its own residents if each resident receiving home health services pursuant to this arrangement attests in writing that he or she made a decision without influence from staff of the facility to select, from a list of Medicare-certified home health agencies provided by the facility, that Medicare-certified home health agency to provide the services.

(b) Provides services to residents in an assisted living facility for which the home health agency does not receive fair market value remuneration.

(c) Provides staffing to an assisted living facility for which the home health agency does not receive fair market value remuneration.

(d) Fails to provide the agency, upon request, with copies of all contracts with assisted living facilities which were executed within 5 years before the request.

(e) Gives 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, chapter 429, or this chapter from whom the home health agency receives referrals.

~~(f) Fails to submit to the agency, within 15 days after the end of each calendar quarter, a written report that includes the following data based on data as it existed on the last day of the quarter:~~

~~1. The number of insulin-dependent diabetic patients receiving insulin-injection services from the home health agency;~~

~~2. The number of patients receiving both home health services from the home health agency and hospice services;~~

~~3. The number of patients receiving home health services from that home health agency; and~~

~~4. 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.~~

(f) ~~(g)~~ Gives cash, or its equivalent, to a Medicare or Medicaid beneficiary.

(g) ~~(h)~~ Has more than one medical director contract in effect at one time or more than one medical director contract and one contract with a physician-specialist whose services are mandated for the home health agency in order to qualify to participate in a federal or state health care program at one time.

(h) ~~(i)~~ Gives remuneration to a physician without a medical director contract being in effect. The contract must:

1. Be in writing and signed by both parties;

2. Provide for remuneration that is at fair market value for an hourly rate, which must be supported by invoices submitted by the medical director describing the work performed, the dates on which that work was performed, and the duration of that work; and

3. Be for a term of at least 1 year.

The hourly rate specified in the contract may not be increased during the term of the contract. The home health agency may not execute a subsequent contract with that physician which has an increased hourly rate and covers any portion of the term that was in the original contract.

(i) ~~(j)~~ Gives remuneration to:

1. A physician, and the home health agency is in violation of paragraph (g) ~~(h)~~ or paragraph (h) ~~(i)~~;

2. A member of the physician's office staff; or

3. An immediate family member of the physician,

if the home health agency has received a patient referral in the preceding 12 months from that physician or physician's office staff.

(j) ~~(k)~~ Fails to provide to the agency, upon request, copies of all contracts with a medical director which were executed within 5 years before the request.

(k) ~~(l)~~ Demonstrates a pattern of billing the Medicaid program for services to Medicaid recipients which are medically unnecessary as determined by a final order. A pattern may be demonstrated by a showing of at least two such medically unnecessary services within one Medicaid program integrity audit period.

Paragraphs (e) and (i) do not apply to or preclude ~~Nothing in paragraph (e) or paragraph (j) shall be interpreted as applying to or precluding~~ any discount, compensation, waiver of payment, or payment practice permitted by 42 U.S.C. s. 1320a-7(b) or regulations adopted thereunder, including 42 C.F.R. s. 1001.952 or s. 1395nn or regulations adopted thereunder.

(7) The agency shall impose a fine of $50 per day against a home health agency that fails to submit to the agency, within 15 days after the end of each calendar quarter, a written report that includes the following data based on data as it existed on the last day of the quarter:

(a) The number of patients receiving both home health services from the home health agency and hospice services;

(b) The number of patients receiving home health services from the home health agency;

(c) The number of insulin-dependent diabetic patients

receiving insulin-injection services from the home health agency; and

(d) 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.

Section 2. Paragraph (i) of subsection (4) of section 409.221, Florida Statutes, is amended to read:

409.221 Consumer-directed care program.—

(4) CONSUMER-DIRECTED CARE.—

(i) *Background screening requirements.*—All persons who render care under this section must undergo level 2 background screening pursuant to chapter 435 and s. 408.809. The agency shall, as allowable, reimburse consumer-employed caregivers for the cost of conducting such ~~background~~ screening ~~as required by this section~~. For purposes of this section, a person who has undergone screening, who is qualified for employment under this section and applicable rule, and who has not been unemployed for more than 90 days following such screening is not required to be rescreened. Such person must attest under penalty of perjury to not having been convicted of a disqualifying offense since completing such screening.

Section 3. Paragraph (c) of subsection (3) of section 409.907, Florida Statutes, is amended, paragraph (k) is added to that subsection, and subsections (6), (7), and (8) of that section are amended, to read:

409.907 Medicaid provider agreements.—The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a

provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

(3) The provider agreement developed by the agency, in addition to the requirements specified in subsections (1) and (2), shall require the provider to:

(c) Retain all medical and Medicaid-related records for 6 ~~a period of 5~~ years to satisfy all necessary inquiries by the agency.

(k) Report a change in any principal of the provider, including any officer, director, agent, managing employee, or affiliated person, or any partner or shareholder who has an ownership interest equal to 5 percent or more in the provider, to the agency in writing no later than 30 days after the change occurs.

(6) A Medicaid provider agreement may be revoked, at the option of the agency, due to ~~as the result of~~ a change of ownership of any facility, association, partnership, or other entity named as the provider in the provider agreement.

(a) In the event of a change of ownership, the transferor remains liable for all outstanding overpayments, administrative fines, and any other moneys owed to the agency before the effective date of the change of ownership. ~~In addition to the continuing liability of the transferor,~~ The transferee is also liable to the agency for all outstanding overpayments identified

by the agency on or before the effective date of the change of ownership. ~~For purposes of this subsection, the term "outstanding overpayment" includes any amount identified in a preliminary audit report issued to the transferor by the agency on or before the effective date of the change of ownership.~~ In the event of a change of ownership for a skilled nursing facility or intermediate care facility, the Medicaid provider agreement shall be assigned to the transferee if the transferee meets all other Medicaid provider qualifications. In the event of a change of ownership involving a skilled nursing facility licensed under part II of chapter 400, liability for all outstanding overpayments, administrative fines, and any moneys owed to the agency before the effective date of the change of ownership shall be determined in accordance with s. 400.179.

(b) At least 60 days before the anticipated date of the change of ownership, the transferor must ~~shall~~ notify the agency of the intended change of ownership and the transferee must ~~shall~~ submit to the agency a Medicaid provider enrollment application. If a change of ownership occurs without compliance with the notice requirements of this subsection, the transferor and transferee are ~~shall be~~ jointly and severally liable for all overpayments, administrative fines, and other moneys due to the agency, regardless of whether the agency identified the overpayments, administrative fines, or other moneys before or after the effective date of the change of ownership. The agency may not approve a transferee's Medicaid provider enrollment application if the transferee or transferor has not paid or agreed in writing to a payment plan for all outstanding overpayments, administrative fines, and other moneys due to the

agency. This subsection does not preclude the agency from seeking any other legal or equitable remedies available to the agency for the recovery of moneys owed to the Medicaid program. In the event of a change of ownership involving a skilled nursing facility licensed under part II of chapter 400, liability for all outstanding overpayments, administrative fines, and any moneys owed to the agency before the effective date of the change of ownership shall be determined in accordance with s. 400.179 if the Medicaid provider enrollment application for change of ownership is submitted before the change of ownership.

(c) As used in this subsection, the term:

1. "Administrative fines" includes any amount identified in a notice of a monetary penalty or fine which has been issued by the agency or other regulatory or licensing agency that governs the provider.

2. "Outstanding overpayment" includes any amount identified in a preliminary audit report issued to the transferor by the agency on or before the effective date of a change of ownership.

(7) ~~The agency may require,~~ As a condition of participating in the Medicaid program and before entering into the provider agreement, the agency may require ~~that~~ the provider to submit information, in an initial and any required renewal applications, concerning the professional, business, and personal background of the provider and permit an onsite inspection of the provider's service location by agency staff or other personnel designated by the agency to perform this function. Before entering into a provider agreement, the agency may ~~shall~~ perform an ~~a random~~ onsite inspection~~, within 60 days~~

~~after receipt of a fully complete new provider's application,~~ of the provider's service location ~~prior to making its first payment to the provider for Medicaid services~~ to determine the applicant's ability to provide ~~the~~ services in compliance with the Medicaid program and professional regulations ~~that the applicant is proposing to provide for Medicaid reimbursement~~. ~~The agency is not required to perform an onsite inspection of a provider or program that is licensed by the agency, 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.~~ As a continuing condition of participation in the Medicaid program, a provider must ~~shall~~ immediately notify the agency of any current or pending bankruptcy filing. Before entering into the provider agreement, or as a condition of continuing participation in the Medicaid program, the agency may also require that Medicaid providers reimbursed on a fee-for-services basis or fee schedule basis that ~~which~~ is not cost-based, post a surety bond not to exceed $50,000 or the total amount billed by the provider to the program during the current or most recent calendar year, whichever is greater. For new providers, the amount of the surety bond shall be determined by the agency based on the provider's estimate of its first year's billing. If the provider's billing during the first year exceeds the bond amount, the agency may require the provider to acquire an additional bond equal to the actual billing level of the provider. A provider's bond may ~~shall~~ not exceed $50,000 if a physician or group of physicians licensed under chapter 458, chapter 459, or chapter 460 has a 50 percent or greater

ownership interest in the provider or if the provider is an assisted living facility licensed under chapter 429. The bonds permitted by this section are in addition to the bonds referenced in s. 400.179(2)(d). If the provider is a corporation, partnership, association, or other entity, the agency may require the provider to submit information concerning the background of that entity and of any principal of the entity, including any partner or shareholder having an ownership interest in the entity equal to 5 percent or greater, and any treating provider who participates in or intends to participate in Medicaid through the entity. The information must include:

(a) Proof of holding a valid license or operating certificate, as applicable, if required by the state or local jurisdiction in which the provider is located or if required by the Federal Government.

(b) Information concerning any prior violation, fine, suspension, termination, or other administrative action taken under the Medicaid laws, rules, or regulations of this state or of any other state or the Federal Government; any prior violation of the laws, rules, or regulations relating to the Medicare program; any prior violation of the rules or regulations of any other public or private insurer; and any prior violation of the laws, rules, or regulations of any regulatory body of this or any other state.

(c) Full and accurate disclosure of any financial or ownership interest that the provider, or any principal, partner, or major shareholder thereof, may hold in any other Medicaid provider or health care related entity or any other entity that is licensed by the state to provide health or residential care

and treatment to persons.

(d) If a group provider, identification of all members of the group and attestation that all members of the group are enrolled in or have applied to enroll in the Medicaid program.

(8)~~(a)~~ Each provider, or each principal of the provider if the provider is a corporation, partnership, association, or other entity, seeking to participate in the Medicaid program must submit a complete set of his or her fingerprints to the agency for the purpose of conducting a criminal history record check. Principals of the provider include any officer, director, billing agent, managing employee, or affiliated person, or any partner or shareholder who has an ownership interest equal to 5 percent or more in the provider. However, for a hospital licensed under chapter 395 or a nursing home licensed under chapter 400, principals of the provider are those who meet the definition of a controlling interest under s. 408.803. A director of a not-for-profit corporation or organization is not a principal for purposes of a background investigation as required by this section if the director: serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration from the not-for-profit corporation or organization for his or her service on the board of directors, has no financial interest in the not-for-profit corporation or organization, and has no family members with a financial interest in the not-for-profit corporation or organization; and if the director submits an affidavit, under penalty of perjury, to this effect to the agency and the not-for-profit corporation or organization

submits an affidavit, under penalty of perjury, to this effect to the agency as part of the corporation's or organization's Medicaid provider agreement application.

(a) Notwithstanding the above, the agency may require a background check for any person reasonably suspected by the agency to have been convicted of a crime. This subsection does not apply to:

~~1. A hospital licensed under chapter 395;~~

~~2. A nursing home licensed under chapter 400;~~

~~3. A hospice licensed under chapter 400;~~

~~4. An assisted living facility licensed under chapter 429;~~

1.~~5.~~ A unit of local government, except that requirements of this subsection apply to nongovernmental providers and entities contracting with the local government to provide Medicaid services. The actual cost of the state and national criminal history record checks must be borne by the nongovernmental provider or entity; or

2.~~6.~~ Any business that derives more than 50 percent of its revenue from the sale of goods to the final consumer, and the business or its controlling parent is required to file a form 10-K or other similar statement with the Securities and Exchange Commission or has a net worth of $50 million or more.

(b) Background screening shall be conducted in accordance with chapter 435 and s. 408.809. The cost of the state and national criminal record check shall be borne by the provider.

~~(c) Proof of compliance with the requirements of level 2 screening under chapter 435 conducted within 12 months before the date the Medicaid provider application is submitted to the agency fulfills the requirements of this subsection.~~

Section 4. Present paragraphs (e) and (f) of subsection (1) of section 409.913, Florida Statutes, are redesignated as paragraphs (f) and (g), respectively, a new paragraph (e) is added to that subsection, and subsections (2), (9), (13), (15), (16), (21), (22), (25), (28), (29), (30), and (31) of that section are amended, to read:

409.913 Oversight of the integrity of the Medicaid program.—The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, 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. Beginning January 1, 2003, and each year thereafter, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit a joint report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report must describe the number of cases opened and investigated each year; the sources of the cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was

opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must include policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud. All policy recommendations in the report must include a detailed fiscal analysis, including, but not limited to, implementation costs, estimated savings to the Medicaid program, and the return on investment. The agency must submit the policy recommendations and fiscal analyses in the report to the appropriate estimating conference, pursuant to s. 216.137, by February 15 of each year. The agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs each must include detailed unit-specific performance standards, benchmarks, and metrics in the report, including projected cost savings to the state Medicaid program during the following fiscal year.

(1) For the purposes of this section, the term:

(e) "Medicaid provider" or "provider" has the same meaning as provided in s. 409.901 and, for purposes of oversight of the integrity of the Medicaid program, also includes a participant in a Medicaid managed care provider network.

(2) The agency shall conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and ~~shall~~ report the findings of any overpayments in audit reports as appropriate. At least 5 percent of all audits must ~~shall~~ be conducted on a random basis. As part of its ongoing fraud detection activities, the agency shall identify and monitor, by contract or otherwise, patterns of overutilization of Medicaid services based on state averages. The agency shall track Medicaid provider prescription and billing patterns and evaluate them against Medicaid medical necessity criteria and coverage and limitation guidelines adopted by rule. Medical necessity determination requires that service be consistent with symptoms or confirmed diagnosis of illness or injury under treatment and not in excess of the patient's needs. The agency shall conduct reviews of provider exceptions to peer group norms and ~~shall~~, using statistical methodologies, provider profiling, and analysis of billing patterns, detect and investigate abnormal or unusual increases in billing or payment of claims for Medicaid services and medically unnecessary provision of services. The agency may review and analyze information from sources other than enrolled Medicaid providers in conducting its activities under this subsection.

(9) A Medicaid provider shall retain medical, professional, financial, and business records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid for 6 ~~a period of 5~~ years after the date of furnishing such services or goods. The agency may investigate, review, or analyze such

records, which must be made available during normal business hours. However, 24-hour notice must be provided if patient treatment would be disrupted. The provider is responsible for furnishing to the agency, and keeping the agency informed of the location of, the provider's Medicaid-related records. The authority of the agency to obtain Medicaid-related records from a provider is neither curtailed nor limited during a period of litigation between the agency and the provider.

(13) The agency shall ~~immediately~~ terminate participation of a Medicaid provider in the Medicaid program and may seek civil remedies or impose other administrative sanctions against a Medicaid provider, if the provider or any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, has been convicted of a criminal offense under federal law or the law of any state relating to the practice of the provider's profession, or an offense listed under s. 409.907(10), s. 408.809(4), or s. 435.04(2) ~~has been:~~

~~(a) Convicted of a criminal offense related to the delivery of any health care goods or services, including the performance of management or administrative functions relating to the delivery of health care goods or services;~~

~~(b) Convicted of a criminal offense under federal law or the law of any state relating to the practice of the provider's profession; or~~

~~(c) Found by a court of competent jurisdiction to have neglected or physically abused a patient in connection with the delivery of health care goods or services~~. If the agency

determines that the ~~a~~ provider did not participate or acquiesce in the ~~an~~ offense ~~specified in paragraph (a), paragraph (b), or paragraph (c)~~, termination will not be imposed. If the agency effects a termination under this subsection, the agency shall issue an immediate final order pursuant to s. 120.569(2)(n).

(15) The agency shall seek a remedy provided by law, including, but not limited to, any remedy provided in subsections (13) and (16) and s. 812.035, if:

(a) The provider's license has not been renewed, or has been revoked, suspended, or terminated, for cause, by the licensing agency of any state;

(b) The provider has failed to make available or has refused access to Medicaid-related records to an auditor, investigator, or other authorized employee or agent of the agency, the Attorney General, a state attorney, or the Federal Government;

(c) The provider has not furnished or has failed to make available such Medicaid-related records as the agency has found necessary to determine whether Medicaid payments are or were due and the amounts thereof;

(d) The provider has failed to maintain medical records made at the time of service, or prior to service if prior authorization is required, demonstrating the necessity and appropriateness of the goods or services rendered;

(e) The provider is not in compliance with provisions of Medicaid provider publications that have been adopted by reference as rules in the Florida Administrative Code; with provisions of state or federal laws, rules, or regulations; with provisions of the provider agreement between the agency and the

provider; or with certifications found on claim forms or on transmittal forms for electronically submitted claims that are submitted by the provider or authorized representative, as such provisions apply to the Medicaid program;

(f) The provider or person who ordered or prescribed the care, services, or supplies has furnished, ~~or~~ ordered, or authorized the furnishing of~~,~~ goods or services to a recipient which are inappropriate, unnecessary, excessive, or harmful to the recipient or are of inferior quality;

(g) The provider has demonstrated a pattern of failure to provide goods or services that are medically necessary;

(h) The provider or an authorized representative of the provider, or a person who ordered or prescribed the goods or services, has submitted or caused to be submitted false or a pattern of erroneous Medicaid claims;

(i) The provider or an authorized representative of the provider, or a person who has ordered, authorized, or prescribed the goods or services, has submitted or caused to be submitted a Medicaid provider enrollment application, a request for prior authorization for Medicaid services, a drug exception request, or a Medicaid cost report that contains materially false or incorrect information;

(j) The provider or an authorized representative of the provider has collected from or billed a recipient or a recipient's responsible party improperly for amounts that should not have been so collected or billed by reason of the provider's billing the Medicaid program for the same service;

(k) The provider or an authorized representative of the provider has included in a cost report costs that are not

allowable under a Florida Title XIX reimbursement plan~~,~~ after the provider or authorized representative had been advised in an audit exit conference or audit report that the costs were not allowable;

(l) The provider is charged by information or indictment with fraudulent billing practices or any offense referenced in subsection (13). The sanction applied for this reason is limited to suspension of the provider's participation in the Medicaid program for the duration of the indictment unless the provider is found guilty pursuant to the information or indictment;

(m) The provider or a person who has ordered or prescribed the goods or services is found liable for negligent practice resulting in death or injury to the provider's patient;

(n) The provider fails to demonstrate that it had available during a specific audit or review period sufficient quantities of goods, or sufficient time in the case of services, to support the provider's billings to the Medicaid program;

(o) The provider has failed to comply with the notice and reporting requirements of s. 409.907;

(p) The agency has received reliable information of patient abuse or neglect or of any act prohibited by s. 409.920; or

(q) The provider has failed to comply with an agreed-upon repayment schedule.

A provider is subject to sanctions for violations of this subsection as the result of actions or inactions of the provider, or actions or inactions of any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership

interest in the provider equal to 5 percent or greater, in which the provider participated or acquiesced.

(16) The agency shall impose any of the following sanctions or disincentives on a provider or a person for any of the acts described in subsection (15):

(a) Suspension for a specific period of time of not more than 1 year. Suspension precludes ~~shall preclude~~ participation in the Medicaid program, which includes any action that results in a claim for payment to the Medicaid program as a result of furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services.

(b) Termination for a specific period of time of from more than 1 year to 20 years. Termination precludes ~~shall preclude~~ participation in the Medicaid program, which includes any action that results in a claim for payment to the Medicaid program as a result of furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services.

(c) Imposition of a fine of up to $5,000 for each violation. Each day that an ongoing violation continues, such as refusing to furnish Medicaid-related records or refusing access to records, is considered, for the purposes of this section, to be a separate violation. Each instance of improper billing of a Medicaid recipient; each instance of including an unallowable cost on a hospital or nursing home Medicaid cost report after the provider or authorized representative has been advised in an audit exit conference or previous audit report of the cost unallowability; each instance of furnishing a Medicaid recipient goods or professional services that are inappropriate or of inferior quality as determined by competent peer judgment; each

instance of knowingly submitting a materially false or erroneous Medicaid provider enrollment application, request for prior authorization for Medicaid services, drug exception request, or cost report; each instance of inappropriate prescribing of drugs for a Medicaid recipient as determined by competent peer judgment; and each false or erroneous Medicaid claim leading to an overpayment to a provider is considered, for the purposes of this section, to be a separate violation.

(d) Immediate suspension, if the agency has received information of patient abuse or neglect or of any act prohibited by s. 409.920. Upon suspension, the agency must issue an immediate final order under s. 120.569(2)(n).

(e) A fine, not to exceed $10,000, for a violation of paragraph (15)(i).

(f) Imposition of liens against provider assets, including, but not limited to, financial assets and real property, not to exceed the amount of fines or recoveries sought, upon entry of an order determining that such moneys are due or recoverable.

(g) Prepayment reviews of claims for a specified period of time.

(h) Comprehensive followup reviews of providers every 6 months to ensure that they are billing Medicaid correctly.

(i) Corrective-action plans that ~~would~~ remain in effect ~~for providers~~ for up to 3 years and that are ~~would be~~ monitored by the agency every 6 months while in effect.

(j) Other remedies as permitted by law to effect the recovery of a fine or overpayment.

If a provider voluntarily relinquishes its Medicaid provider

number after receiving written notice that the agency is conducting, or has conducted, an audit or investigation and the sanction of suspension or termination will be imposed for noncompliance discovered as a result of the audit or investigation, the agency shall impose the sanction of termination for cause against the provider. The Secretary of Health Care Administration may make a determination that imposition of a sanction or disincentive is not in the best interest of the Medicaid program, in which case a sanction or disincentive may ~~shall~~ not be imposed.

(21) When making a determination that an overpayment has occurred, the agency shall prepare and issue an audit report to the provider showing the calculation of overpayments. The agency's determination shall be based solely upon information available to it before issuance of the audit report and, in the case of documentation obtained to substantiate claims for Medicaid reimbursement, based solely upon contemporaneous records.

(22) The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment. A provider may not present or elicit testimony, ~~either~~ on direct examination or cross-examination in any court or administrative proceeding, regarding the purchase or acquisition by any means of drugs, goods, or supplies; sales or divestment by any means of drugs, goods, or supplies; or inventory of drugs, goods, or supplies, unless such acquisition, sales, divestment, or inventory is documented by written invoices, written inventory records, or other competent written documentary evidence maintained in the normal course of the

provider's business. Testimony or evidence that is not based upon contemporaneous records or that was not furnished to the agency within 21 days after the issuance of the audit report is inadmissible in an administrative hearing on a Medicaid overpayment or an administrative sanction. Notwithstanding the applicable rules of discovery, all documentation to ~~that will~~ be offered as evidence at an administrative hearing on a Medicaid overpayment or an administrative sanction must be exchanged by all parties at least 14 days before the administrative hearing or ~~must be~~ excluded from consideration.

(25)(a) The agency shall withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud, willful misrepresentation, or abuse under the Medicaid program, or a crime committed while rendering goods or services to Medicaid recipients. If it is determined that fraud, willful misrepresentation, abuse, or a crime did not occur, the payments withheld must be paid to the provider within 14 days after such determination ~~with interest at the rate of 10 percent a year~~. ~~Any money withheld in accordance with this paragraph shall be placed in a suspended account, readily accessible to the agency, so that any payment ultimately due the provider shall be made within 14 days.~~

(b) The agency shall deny payment, or require repayment, if the goods or services were furnished, supervised, or caused to be furnished by a person who has been suspended or terminated from the Medicaid program or Medicare program by the Federal Government or any state.

(c) Overpayments owed to the agency bear interest at the rate of 10 percent per year from the date of determination of the overpayment by the agency, and payment arrangements regarding overpayments and fines must be made within 30 days after the date of the final order and are not subject to further appeal ~~at the conclusion of legal proceedings~~. ~~A provider who does not enter into or adhere to an agreed-upon repayment schedule may be terminated by the agency for nonpayment or partial payment.~~

(d) The agency, upon entry of a final agency order, a judgment or order of a court of competent jurisdiction, or a stipulation or settlement, may collect the moneys owed by all means allowable by law, including, but not limited to, notifying any fiscal intermediary of Medicare benefits that the state has a superior right of payment. Upon receipt of such written notification, the Medicare fiscal intermediary shall remit to the state the sum claimed.

(e) The agency may institute amnesty programs to allow Medicaid providers the opportunity to voluntarily repay overpayments. The agency may adopt rules to administer such programs.

(28) Venue for all Medicaid program integrity ~~overpayment~~ cases lies ~~shall lie~~ in Leon County, at the discretion of the agency.

(29) Notwithstanding other provisions of law, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs may review a person's or 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.

(30) The agency shall terminate a provider's participation in the Medicaid program if the provider fails to reimburse an overpayment or fine that has been determined by final order, not subject to further appeal, within 30 ~~35~~ days after the date of the final order, unless the provider and the agency have entered into a repayment agreement.

(31) If a provider requests an administrative hearing pursuant to chapter 120, such hearing must be conducted within 90 days following assignment of an administrative law judge, absent exceptionally good cause shown as determined by the administrative law judge or hearing officer. Upon issuance of a final order, the outstanding balance of the amount determined to constitute the overpayment and fines is ~~shall become~~ due. If a provider fails to make payments in full, fails to enter into a satisfactory repayment plan, or fails to comply with the terms of a repayment plan or settlement agreement, the agency shall withhold ~~medical assistance~~ reimbursement payments for Medicaid services until the amount due is paid in full.

Section 5. Subsection (8) of section 409.920, Florida Statutes, is amended to read:

409.920 Medicaid provider fraud.—

(8) A person who provides the state, any state agency, any of the state's political subdivisions, or any agency of the state's political subdivisions with information about fraud or suspected fraudulent acts ~~fraud~~ by a Medicaid provider, including a managed care organization, is immune from civil liability for libel, slander, or any other relevant tort for

providing any ~~the~~ information about fraud or suspected fraudulent acts, unless the person acted with knowledge that the information was false or with reckless disregard for the truth or falsity of the information. For purposes of this subsection, the term "fraudulent acts" includes actual or suspected fraud, abuse, or overpayment, including any fraud-related matters that a provider or health plan is required to report to the agency or a law enforcement agency. The immunity from civil liability extends to reports of fraudulent acts conveyed to the agency in any manner, including any forum and with any audience as directed by the agency, and includes all discussions subsequent to the report and subsequent inquiries from the agency, unless the person acted with knowledge that the information was false or with reckless disregard for the truth or falsity of the information.

Section 6. Paragraph (c) of subsection (2) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(c) *Access.*—

1. Providers.—The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients

enrolled in the plan. The exclusive use of mail-order pharmacies is ~~may~~ not ~~be~~ sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. A plan may contract with a new hospital facility before the date the hospital becomes operational if the hospital has commenced construction, will be licensed and operational by January 1, 2013, and a final order has issued in any civil or administrative challenge. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider.

2. Prescribed drugs.—

a. If establishing a prescribed drug formulary or preferred drug list, a managed care plan must:

(I) Provide coverage for drugs in categories and classes for all disease states and provide a broad range of therapeutic options for all therapeutic categories;

(II) Include coverage for each drug newly approved by the federal Food and Drug Administration until the plan's Pharmaceutical and Therapeutics Committee reviews such drug for

inclusion on the formulary;

(III) 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

(IV) Report all denials to the agency on a quarterly basis. For each nonformulary drug, the plan must report the total number of requests and the total number of denials.

b. Each managed care plan shall ~~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.~~

c. The managed care plan must 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 prescriber for as long as the enrollee is a member of the plan.

d. A managed care plan that imposes a step-therapy or a fail-first protocol must do so in accordance with the following:

(I) If prescribed drugs for the treatment of a medical condition are restricted for use by the plan through a step-therapy or fail-first protocol, the plan must provide the prescriber with access to a clear and convenient process to expeditiously request an override of such restriction from the insurer.

(II) An override of the restriction must be expeditiously granted by the plan if the prescriber can demonstrate to the plan that the preferred treatment required under the step-therapy or fail-first protocol:

(A) Has been ineffective in the treatment of the enrollee's disease or medical condition;

(B) 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

(C) Will cause or will likely cause an adverse reaction or other physical harm to the enrollee.

(III) The maximum duration of a step-therapy or fail-first protocol requirement may not be longer than the customary period for the prescribed drug if such treatment is demonstrated by the prescriber to be clinically ineffective. If the plan can demonstrate, through sound clinical evidence, that the originally prescribed drug is likely to require more than the customary period for such drug to provide any relief or amelioration to the enrollee, the step-therapy or fail-first protocol may be extended, but no longer than the original customary period for the drug, after which time the prescriber may deem such treatment as clinically ineffective for the enrollee. Once the prescriber deems the treatment to be clinically ineffective, the plan must dispense and cover the originally prescribed drug recommended by the prescriber.

e. For enrollees ~~Medicaid recipients~~ diagnosed with hemophilia who have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those

products and hemophilia overlay services through the agency's hemophilia disease management program.

3. Prior authorization.—

a. Each managed care 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.

b. If a drug, determined to be medically necessary and prescribed for an enrollee by a physician using sound clinical judgment, is subject to prior authorization, the managed care plan must provide payment to the pharmacist for dispensing such drug without seeking prior authorization if the pharmacist confirms that:

(I) The prescription is a refill or renewal of the same drug for the same beneficiary written by the same prescriber; or

(II) 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.

c. If a prescribed drug requires prior authorization, the managed care plan shall 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.

d.~~3.~~ Managed care plans, and their fiscal agents or intermediaries, must accept prior authorization requests for any

service electronically.

Section 7. Subsection (11) is added to section 429.23, Florida Statutes, to read:

429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.—

(11) The agency shall annually submit a report to the Legislature on adverse incident reports by assisted living facilities. The report must include the following information arranged by county:

(a) A total number of adverse incidents;

(b) A listing, by category, of the type of adverse incidents occurring within each category and the type of staff involved;

(c) A listing, by category, of the types of injuries, if any, and the number of injuries occurring within each category;

(d) Types of liability claims filed based on an adverse incident report or reportable injury; and

(e) Disciplinary action taken against staff, categorized by the type of staff involved.

Section 8. Present subsections (9), (10), and (11) of section 429.26, Florida Statutes, are renumbered as subsections (12), (13), and (14), respectively, and new subsections (9), (10), and (11) are added to that section, to read:

429.26 Appropriateness of placements; examinations of residents.—

(9) If, at any time after admission to a facility, agency personnel question whether a resident needs care beyond that which the facility is licensed to provide, the agency 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 the resident's preferred physician, physician assistant, or nurse practitioner and paid for by the resident with personal funds, except as provided in s. 429.18(2). This subsection does not preclude the agency from imposing sanctions for violations of subsection (1).

(a) Following examination, the examining physician, physician assistant, or nurse practitioner shall complete and sign a medical form provided by the agency. The completed medical form must be submitted to the agency within 30 days after the date the facility owner or administrator was notified by the agency that a physical examination is required.

(b) A medical review team designated by the agency shall determine whether the resident is appropriately residing in the facility based on the completed medical form and, if necessary, consultation with the physician, physician assistant, or nurse practitioner who performed the examination. Members of the medical review team making the determination may not include the agency personnel who initially questioned the appropriateness of the resident's placement. The medical review team shall base its decision on a comprehensive review of the resident's physical and functional status. A determination that the resident's placement is not appropriate is final and binding upon the facility and the resident.

(c) A resident who is determined by the medical review team to be inappropriately residing in a facility shall be given 30 days' written notice to relocate by the owner or administrator, 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.

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

(11) 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. Effective July 1, 2012, section 456.0635, Florida Statutes, is amended to read:

456.0635 Health care ~~Medicaid~~ fraud; disqualification for license, certificate, or registration.—

(1) Health care ~~Medicaid~~ fraud in the practice of a health care profession is prohibited.

(2) Each board under ~~within~~ the jurisdiction of the department, or the department if there is no board, shall refuse to admit a candidate to an ~~any~~ examination and refuse to issue ~~or renew~~ a license, certificate, or registration to an ~~any~~ applicant if the candidate or applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant~~, has been~~:

(a) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, or chapter 893, or a similar felony

offense committed in another state or jurisdiction, unless the candidate or applicant has successfully completed a pretrial intervention or drug diversion program for that felony. Any such conviction or plea excludes the applicant or candidate from licensure, examination, certification, or registration ~~21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396,~~ unless the sentence and any subsequent period of probation for such conviction or plea ~~pleas~~ ended: ~~more than 15 years prior to the date of the application;~~

1. For felonies of the first or second degree, more than 15 years before the date of application.

2. For felonies of the third degree, more than 10 years before the date of application, except for felonies of the third degree under s. 893.13(6)(a).

3. For felonies of the third degree under s. 893.13(6)(a), more than 5 years before the date of application.

(b) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396, unless the sentence and any subsequent period of probation for such conviction or plea ended more than 15 years before the date of the application.

(c) ~~(b)~~ Has been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the candidate or applicant has been in good standing with the Florida Medicaid program for the most recent 5 years.~~;~~

(d) ~~(c)~~ Has been 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 candidate or applicant has been in good standing with that ~~a~~ state Medicaid program ~~or the federal Medicare program~~ for the most recent 5 years and the termination occurred at least 20 years before ~~prior to~~ the date of the application.

(e) Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

This subsection does not apply to candidates or applicants for initial licensure or certification who were enrolled in an educational or training program on or before July 1, 2009, which was recognized by a board or, if there is no board, recognized by the department, and who applied for licensure after July 1, 2012.

(3) The department shall refuse to renew a license, certificate, or registration of any applicant if the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant:

(a) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, or chapter 893, or a similar felony offense committed in another state or jurisdiction since July 1, 2009, unless the applicant is currently enrolled in or has successfully completed a pretrial intervention or drug diversion program for that felony. Any such conviction or plea excludes the applicant from renewal of licensure, certification, or registration unless the sentence and any subsequent period of probation for such conviction or plea ended:

1. For felonies of the first or second degree, more than 15 years before the date of application.

2. For felonies of the third degree, more than 10 years before the date of application, except for felonies of the third degree under s. 893.13(6)(a).

3. For felonies of the third degree under s. 893.13(6)(a), more than 5 years before the date of application.

(b) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 since July 1, 2009, unless the sentence and any subsequent period of probation for such conviction or plea ended more than 15 years before the date of the application.

(c) Has been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5 years.

(d) Has been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program, unless the applicant has been in good standing with that state Medicaid program for the most recent 5 years and the termination occurred at least 20 years before the date of the application.

(e) Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

(4) ~~(3)~~ Licensed health care practitioners shall report allegations of health care ~~Medicaid~~ fraud to the department, regardless of the practice setting in which the alleged health

care ~~Medicaid~~ fraud occurred.

(5)~~(4)~~ The acceptance by a licensing authority of a licensee's ~~candidate's~~ relinquishment of a license which is offered in response to or anticipation of the filing of administrative charges alleging health care ~~Medicaid~~ fraud or similar charges constitutes the permanent revocation of the license.

Section 10. Effective July 1, 2012, present subsections (14) and (15) of section 456.036, Florida Statutes, are renumbered as subsections (15) and (16), respectively, and a new subsection (14) is added to that section, to read:

456.036 Licenses; active and inactive status; delinquency.—

(14) A person who has been denied license renewal, certification, or registration under s. 456.0635(3) may regain licensure, certification, or registration only by meeting the qualifications and completing the application process for initial licensure as defined by the board, or the department if there is no board. However, a person who was denied renewal of licensure, certification, or registration under s. 24 of chapter 2009-223, Laws of Florida, between July 1, 2009, and June 30, 2012, is not required to retake and pass examinations applicable for initial licensure, certification, or registration.

Section 11. Subsection (1) of section 456.074, Florida Statutes, is amended to read:

456.074 Certain health care practitioners; immediate suspension of license.—

(1) The department shall issue an emergency order suspending the license of any person licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463,

chapter 464, chapter 465, chapter 466, or chapter 484 who pleads guilty to, is convicted or found guilty of, or who enters a plea of nolo contendere to, regardless of adjudication~~, to~~:

(a) A felony under chapter 409, chapter 817, or chapter 893 or under 21 U.S.C. ss. 801-970 or ~~under~~ 42 U.S.C. ss. 1395-1396; or

(b) 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 12. The Agency for Health Care Administration shall 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 agency shall post a draft of the report on its website and provide an opportunity for public comment. The final report shall be submitted to the Legislature, along with a description of the process for public input. The report must include an assessment of:

(1) The impact of managed care on patient access to care, including an evaluation of any new barriers to the use of services and prescription drugs, created by the use of medical management or cost-containment tools.

(2) The impact of the increased managed care expansion on the utilization of services, quality of care, and patient outcomes.

(3) The use of prior authorization and other utilization management tools, including an assessment of whether these tools pose an undue administrative burden for health care providers or create barriers to needed care.

Section 13. Except as otherwise expressly provided in this act, this act shall take effect upon becoming a law.