**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 Committee on Appropriations

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| BILL: | CS/CS/SB 844 |
| INTRODUCER: | Appropriations Committee (Recommended by Appropriations Subcommittee on Health and Human Services); Health Policy Committee; and Senator Grimsley |
| SUBJECT: | Medicaid Fraud |
| DATE: | April 25, 2013 REVISED: |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Lloyd | Stovall | HP | **Fav/CS** |
| 2. | Johnson | Burgess | BI | **Favorable** |
| 3. | Brown | Pigott | AHS | **Fav/CS** |
| 4. | Brown | Hansen | AP | **Fav/CS** |
| 5. | | | | |
| 6. | | | | |

## Please see Section VIII. for Additional Information:

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

## I. Summary:

CS/CS/SB 844 modifies existing statutory provisions relating to fraud and abuse, provider controls, and accountability in the Medicaid program.

The bill is expected to have an indeterminate fiscal impact on the Agency for Health Care Administration (AHCA). See Section V.

The bill:

- Provides that the AHCA may enroll as a Medicaid provider a physician located outside the state of Florida if the physician is actively licensed in Florida and interprets diagnostic testing results through telecommunications and information technology provided from a distance;
- Amends the Medicaid Third-party Liability Act to ensure compliance with federal law;
- Requires Medicaid providers to report a change in any principal of the provider to the AHCA in writing no later than 30 days after the change occurs;
- Defines "administrative fines" for purposes of liability for payment of such fines in the event of a change of ownership;

- Authorizes, rather than requires, the AHCA to perform onsite inspections of the service location of a provider applying for a provider agreement to determine that provider's ability to provide services in compliance with Medicaid regulations;
- Provides a definition for principals of a provider with a controlling interest for hospitals and nursing homes, for purposes of conducting criminal background checks;
- Removes certain exceptions to background screenings requirements for Medicaid providers;
- Expands the list of offenses for which the AHCA may terminate the participation of a Medicaid provider;
- Requires the AHCA to impose the sanction of termination for cause against providers that voluntarily relinquish their Medicaid provider numbers under certain circumstances and parameters;
- Requires that when the AHCA determines that an overpayment has been made, the AHCA must base its determination solely on the information available before the issuance of an audit report and upon contemporaneous records;
- Clarifies when the interest rate accrues on provider payments paid by the AHCA that had been withheld on a suspicion of fraud or abuse, if it is determined that there was no fraud or abuse;
- Removes the 30-day provision related to records that may be presented to contest an overpayment or sanction;
- Requires overpayments or fines be paid to the AHCA within 30 days after the date of the final order;
- Clarifies the scope of immunity from civil liability for persons who report fraudulent acts or suspected fraudulent acts;
- Amends s. 624.351, F.S., relating to the Medicaid and Public Assistance Fraud Strike Force, to authorize members or their designees to serve on the strike force and to provide that s. 624.351, F.S., is repealed effective June 30, 2014; and
- Repeals s. 624.352, F.S., relating to interagency agreements to detect and deter Medicaid and public assistance fraud, effective June 30, 2014.

The bill has an effective date of July 1, 2013.

This bill substantially amends the following sections of the Florida Statutes: 409.907, 409.913, and 409.920.

## II. Present Situation:

### Health Care Fraud

In 2009, the Legislature passed CS/CS/CS/SB 1986 to comprehensively address systematic health care fraud in Florida. That bill increased the Medicaid program's authority to address fraud, particularly as it relates to home health services and health care facility and health care practitioner standards to keep fraudulent actors from obtaining a health care license in Florida. The bill also created disincentives to commit Medicaid fraud and created additional criminal felonies for committing health care fraud.

With more than three years of history 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 in the Medicaid program. This bill addresses some of the gaps in enforcement authority, strengthens the reporting requirements by Medicaid providers and Medicaid managed care organizations, and defines the consequences for failure to comply with the requirements.

**Regulatory Authority of AHCA**

The AHCA regulates hospitals and nursing homes under the authority of chapters 395 and 400, F.S., respectively, along with dozens of other health care entities such as clinical laboratories, ambulatory surgical centers, hospices, and home health agencies. General licensing provisions for these providers are found in part II of ch. 408, F.S. The Bureau for Health Facility Regulation conducts the activities that certify and license the entities under the AHCA's jurisdiction.

**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 persons with costs of nursing facility care and other medical expenses. The AHCA is designated as the single state agency responsible for Medicaid. Medicaid serves approximately 3.3 million people in Florida. The statutory authority for the Medicaid program is contained in ch. 409, F.S.

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

Under s. 409.913, F.S., the AHCA is responsible for overseeing the integrity of the Medicaid program, to ensure that fraudulent and abusive behavior and neglect of recipients is minimized, 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. A person who provides the state with information about fraud or suspected fraud by a Medicaid provider, including a managed care organization, is immune from civil liability for providing that information unless the person knew the information was false or acted with reckless disregard for the truth or falsity of the information.[1]

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 (SMMC) program includes a long-term care managed care component and a managed medical assistance component. The law directs the AHCA to begin implementation of the long-term managed care program by July 1, 2012, with full implementation in all regions of the State by October 1, 2013. The state received federal approval of this component on February 1, 2013.[2] Although the

[1] *See* s. 409.920(8), F.S.
[2] Agency for Health Care Administration, *February 1, 2013 Waiver Approval Letter*, http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Signed_approval_FL0962_new_1915c_02-01-2013.pdf (Last visited on March 4, 2013).

AHCA has received conditional approval,[3] the AHCA is still awaiting final approval of the managed medical assistance program; full implementation is anticipated by October 1, 2014.

**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 screenings 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 408.809, 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 five years. This section of law also specifies additional disqualifying offenses beyond those included in s. 435.04(2), F.S.

**Medicaid and Third-party Recovery in Florida**

Section 409.910, F.S. is known as the Medicaid Third-Party Liability Act (Act). Pursuant to the Act, third-party benefits for medical services are primary to any medical assistance provided to a recipient by Medicaid. As such, a Medicaid recipient who receives a settlement, award, or judgment in a third-party tort action is required to reimburse the ACHA for any related Medicaid medical costs. The medical costs are calculated as the lesser of 37.5 percent of the total recovery or the total amount of medical assistance paid by Medicaid. The recipient cannot contest the amount designated by the ACHA as recovered medical expense damages.

The U.S Supreme Court, in *Wos v. E.M.A.*, recently invalidated a North Carolina statute that authorized the recovery of third-party benefits from Medicaid recipients.[4] North Carolina's Medicaid third-party liability statute provides that the state will be paid from a tort settlement or judgment the lesser of the total amount expended on the recipient's behalf by Medicaid or 33 percent of the total settlement or judgment amount.[5] The Court held that North Carolina's statute was preempted by the federal anti-lien provision due to the fact that the state statute created an irrebuttable, one-size-fits-all statutory presumption that one-third of a tort recovery is attributable to medical expenses. Such an irrebuttable presumption was found to be incompatible with the

[3] Agency for Health Care Administration, *February 20, 2013 Agreement in Principle Letter*, http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/Letter_from_CMS_re_Agreement_in_Principal_2013-02-20.pdf (Last visited on March 4, 2013).
[4] *Wos v. E.M.A. ex rel. Johnson*, ___ U.S. ___, 2013 WL 1131709 (U.S. March 20, 2013).
[5] N.C. Gen. Stat. Ann. s. 108A-57(a).

federal Medicaid Act's mandate that a state may not demand any portion of a beneficiary's tort recovery except the share that is attributable to medical expenses.[6]

**Medicaid and Public Assistance Fraud Strike Force**

In 2010 the Legislature found that there was a need to develop and implement a statewide strategy to coordinate state and local agencies, law enforcement entities, and investigative units in order to increase the effectiveness of programs and initiatives dealing with the prevention, detection, and prosecution of Medicaid and public assistance fraud.[7] Interagency agreements for the coordination of prevention, investigation, and prosecution of Medicaid and public assistance fraud were executed by various agencies.[8] Thus, the Medicaid and Public Assistance Fraud Strike Force was created within the Department of Financial Services to oversee and coordinate state and local efforts to eliminate Medicaid and public assistance fraud and to recover state and federal funds.

**Telemedicine**

Telemedicine utilizes various advances in communication technology to provide healthcare services through a variety of electronic mediums. Telemedicine is not a separate medical specialty and does not change what constitutes proper medical treatment and services. According to the American Telemedicine Association, services provided through telemedicine include:[9]

- **Primary Care and Specialist Referral Services** – Telemedicine in this context involves a primary care or allied health professional providing consultation with a patient or a specialist assisting the primary care physician with a diagnosis. The process may involve live interactive video or the use of store and forward transmission of diagnostic images, vital signs and/or video clips with patient data for later review.
- **Remote patient monitoring** – Telemedicine in this context includes home health services and uses devices to remotely collect and send data to home health agencies or remote diagnostic testing facilities.
- **Consumer medical and health information** – In this context, telemedicine offers consumers specialized health information and on-line discussion groups for peer-to-peer support.
- **Medical education** – In this context, telemedicine provides continuing medical education credits.

[6] The federal Medicaid Act requires states to have in effect laws pursuant to which states have the right to recover third party benefits for medical assistance provided by the state Medicaid program. *See* 42 U.S.C. § 1396a(a)(25)(H). Federal law also mandates that state Medicaid programs must require recipients to assign to the state any rights the recipient has to benefits from third parties related to medical care. *See* 42 U.S.C. § 1396k(a)(1)(A). Notwithstanding the foregoing provisions, the Medicaid Act's "anti-lien provision" prohibits states from imposing a lien on the property of a recipient prior to his death on account of medical assistance provided by the state's Medicaid program. *See* 42 U.S.C. § 1396p(a)(1).
[7] *See* s. 624.351, F.S.
[8] *See* s. 624.352, F.S.
[9] American Telemedicine Association, *What is Telemedicine*, http://www.americantelemed.org/learn/what-is-telemedicine (last visited Mar. 26, 2013).

**Telemedicine Services in Florida**

Since 2006, the Children's Medical Services Network (CMS Network) has provided specified telemedicine services under Florida's 1915(b) Medicaid Managed Care Waiver in compliance with federal and state regulations. Authorized CMS Network telemedicine services include certain evaluation and consultation services already covered by the Medicaid state plan.

The Child Protection Team (CPT) program under Children's Medical Services also utilizes a telemedicine network. The CPT is a medically directed multi-disciplinary program that works with local sheriffs offices and the Department of Children and Families in cases of child abuse and neglect to supplement investigative activities.[10] The telemedicine network connects the child in one location ("remote site") where a registered nurse greets the child and assists with the examination by the health care professionals in another location ("hub site").[11] The hub site is a comprehensive medical facility with a wide range of medical and interdisciplinary staff that can assist with the exam and review. Special equipment allows for live assessments between the remote and hub sites, including professional participation from multiple locations.[12]

The use of telemedicine for the CPTs is further defined under rule at Rule 64C-8.001, F.A.C. Rule 64C-8.003, F.A.C, allows medical diagnosis and evaluation to be conducted in person or through telemedicine. However, the use of telemedicine specifically requires the presence of a CMS-approved physician or advanced registered nurse practitioner at the hub site and a registered nurse at the remote site.

In December 2010, Florida Medicaid submitted a state plan amendment to the federal Centers for Medicare and Medicaid Services to allow for the provision of specified physician, dental, mental health, and substance abuse telemedicine services. The amendment was requested because the program had been reimbursing only the physician rendering services using telemedicine, not the provider physically with the patient. The state plan amendment specifies that covered telemedicine services under Medicaid must include, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the Medicaid recipient and the health care practitioner.[13] Telephone conversations, chart review, electronic mail messages or facsimile transmissions are not considered telemedicine.[14]

Only a specific list of provider types are eligible for Medicaid reimbursement for telemedicine services and such providers or entities must be licensed under chs. 394, 397, 458, 459, 464, 466, 490, or 491, F.S.[15] The state plan amendment was approved in March 2011 and was retroactively effective to October 1, 2010. The 2012-2015 Model Contracts with Medicaid Managed Care

[10] Florida Department of Health, *Child Protection Teams*, http://www.cms-kids.com/families/child_protection_safety/child_protection_teams.html (last visited Mar. 26, 2013).
[11] Florida Department of Health, *CPT Telemedicine and Telehealth Network*, http://www.cms-kids.com/families/child_protection_safety/cpt_telemedicine.html (last visited Mar. 26, 2013).
[12] Florida Department of Health, *Child Protection Team Telemedicine Network Fact Sheet*, http://www.cms-kids.com/families/child_protection_safety/documents/cpt_telemedicine_fact_sheet.pdf (last visited Mar. 26. 2013).
[13] Florida Medicaid State Plan, Attachment 3.1-B, Page 11.
[14] Ibid.
[15] The eligible provider types are: physicians, dentists, psychiatric nurses, registered nurses, advanced registered nurse practitioners, physician's assistants, clinical social workers, mental health counselors, marriage and family therapists, masters level certified addiction professionals (CAP) and psychologists.

Organizations, however, limit telemedicine services to behavioral health care and dental services.[16,17]

The contract language specifically excludes reimbursement for telephone conversations, video cell phone interactions, electronic mail messages, facsimile transmission, telecommunications with the enrollee at a location other than a "spoke site," which is the provider office location where an approved service is being furnished.[18] Reimbursement is also excluded for "store and forward" visits and consultations that are transmitted after the Medicaid recipient is no longer available.[19] Medicaid does not reimburse for the costs or fees of any of the equipment necessary to provide the services.

Fee-for-service (FFS) Medicaid providers may provide telemedicine services within the requirements of the current Medicaid Services Coverage and Limitations Handbook.[20] Currently, the approved FFS providers are physicians, dental providers, and behavioral health care providers.[21] The managed care contracts are currently being amended to include the provision of telemedicine services by physicians.[22]

Florida law allows the Florida Board of Medicine (Board) to establish by rule standards of practice and standards of care for particular practice settings, including, but not limited to, education and training, equipment and supplies, medications including anesthetics, assistance of and delegation to other personnel, transfer agreements, sterilization, records, performance of complex or multiple procedures, informed consent, and policy and procedures manuals. In 2003, the Board adopted Rule 64B8-9.014, F.A.C., "Standards for Telemedicine Prescribing Practice." The rule prohibits prescribing based solely on an electronic questionnaire. The rule permits a doctor to provide treatment recommendations, include issuing a prescription based on a documented patient evaluation, discussion between the patient and physician regarding treatment, and treatment options and maintenance of appropriate medical records.

## III. Effect of Proposed Changes:

**Section 1** of the bill amends s. 409.907, F.S., relating to Medicaid provider agreements, to require a Medicaid provider to report in writing any change of any principal of the provider whose ownership interest is equal to five percent or more to the AHCA no later than 30 days after the change occurs. The bill specifies who is included in the term "principal." The definition of a controlling interest is already defined by statute under s. 408.803(7), F.S., and includes:

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[16] According to the February 17, 2010 minutes of a Medicaid Medical Advisory Committee meeting, Medicaid reimburses telemedicine dental services for oral prophylaxis, topical fluoride application, oral hygiene instructions when a dental hygienists performs these services via video teleconferencing with a supervising licensed dentist.
[17] Agency for Health Care Administration, *House Bill 499/Senate Bill 898 Bill Analysis and Economic Impact Statement,* p. 2, (Mar. 27, 2013) (on file with the Senate Health Policy Committee).
[18] Ibid.
[19] Agency for Health Care Administration, 2012-2015 Health Plan Model Contract Attachment II – Core Contract Provisions, Paragraph 22, http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/docs/contract/1215_Contract/2012-2015/Jan2013/2012-15_HP-ContractAtt-II_GEN-AMEND1-JAN-2013-CLEAN.pdf (last visited Mar. 26, 2013).
[20] Agency for Health Care Administration, *supra*, note 9, at 2.
[21] Ibid.
[22] Agency for Health Care Administration, *supra*, note 9, at 2.

- The applicant or licensee;
- A person or entity that serves as an officer of, is on the board or has a five percent or greater ownership interest in the applicant or licensee; or
- A person or entity that serves as an officer of, is on the board, or has a five percent or greater management interest in the management company or other entity, related or unrelated, that the applicant or licensee contracts with to manage the provider.
- The term does not include a voluntary board member.

The bill clarifies 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 that 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 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 Families, 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 existing surety bond requirements for certain Medicaid providers. The bill clarifies that the additional bond required by the AHCA, if a provider's billing during the first year exceeds the bond amount, need not exceed $50,000 for certain providers. A provider could have a bond greater than $50,000, if the provider so elects.

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., under the general licensing provisions for health care facilities regulated by the AHCA.

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.

The bill provides that the AHCA may enroll as a Medicaid provider a physician located outside the state of Florida if the physician is actively licensed in Florida and interprets diagnostic testing results through telecommunications and information technology provided from a distance.

**Section 2** of the bill amends s. 409.910, F.S., to address the recent U.S. Supreme Court ruling in *Wos v. E.M.A.* Section 409.910, F.S., creates an irrebuttable presumption that the amount that the ACHA is entitled to from a Medicaid recipient's judgment, award, or settlement in a tort action is the lesser of 37.5 percent of the total recovery or the total amount of medical assistance paid by Medicaid. This provision is similar to the North Carolina provision recently struck down by the Court. To ensure compliance with federal law, the bill amends this section to create a presumption of accuracy as to the ACHA's determination of the reimbursement amount but allows this determination to be rebutted by clear and convincing evidence. The bill establishes the mechanism for these challenges by providing Medicaid recipients with the right to an administrative hearing at the Division of Administrative Hearings (DOAH) to contest the amount of AHCA's recoupment. The bill establishes Leon County as venue for these hearings and the First District Court of Appeal as venue for any related appeals. The bill also provides that each party is to bear its own attorney fees and costs.

**Section 3** of the bill amends s. 409.913, F.S., relating to oversight of the integrity of the Medicaid program. The bill deletes a requirement that the AHCA *immediately* terminate participation of a Medicaid provider that has been convicted of certain offenses. In order to terminate a provider immediately, 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. The change will resolve a current conflict with the Administrative Procedure Act.[23]

The AHCA 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;

[23] *See* s. 120.569(2)(n), F.S. which requires that "if any agency head finds that an immediate danger to the public health , safety, or welfare requires an immediate final order, it shall recite with particularity the facts underlying such finding in the final order, which shall be appealable or enjoinable from the date ordered."

  - 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 one 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 provisions 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 authorizes the AHCA to sanction a provider if the provider is charged by information or indictment with any offense listed above. The AHCA may impose sanctions if the provider or certain persons affiliated with the provider participated or acquiesced in the proscribed activity.

The bill provides 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, subject to challenge under ch. 120, F.S. Under current law, if a Medicaid provider receives notification that it is going to be suspended or terminated, the provider is able to voluntarily terminate its contract. By doing so, 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. Current law gives the secretary of the AHCA 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 specifies that when the AHCA is making a determination that an overpayment has occurred, the determination must be based solely upon information available before it issues the audit report and, in the case of documentation obtained to substantiate claims for Medicaid reimbursement, based solely upon contemporaneous records. The bill authorizes the AHCA to consider addenda or modifications to a note made contemporaneously with the patient care episode if the addenda or modifications are germane to the note.

In addition, the bill provides that a provider may not present records to contest an overpayment or sanction unless the records are contemporaneous and, if requested during the audit process, were provided to the AHCA or its agent. This limitation does not apply to Medicaid cost report audits and does not preclude consideration by the AHCA of audits or modifications to a note if the addenda or modifications were made before the notification of the audit and are germane to a note that was made contemporaneously with a patient care episode. 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.

The bill clarifies when interest will accrue on provider payments withheld by the AHCA based on suspected fraud or criminal activity, if it is determined later that there was no fraud or that a crime did not occur. Interest on provider payments to be paid after an investigation will accrue at 10 percent a year, beginning after the 14th day after the determination. A provision relating to the placement of funds in a suspended account held by the AHCA is deleted and a payment deadline of 14 days to the provider is removed. 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 requires the AHCA to terminate a provider's participation in the Medicaid program if the provider fails to pay 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. The bill requires that fines, as well as overpayments, are due upon the issuance of a final order at the conclusion of a requested administrative hearing.

**Section 4** of the bill 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 pertains to civil liability for libel, slander, or any other relevant tort. The bill defines "fraudulent acts" for purposes of immunity from civil liability to include actual or suspected fraud and abuse, insurance fraud, licensure fraud, or public insurance fraud; 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, including forums, and incorporates 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 5** of the bill amends s. 624.351, F.S., relating to the Medicaid and Public Assistance Fraud Strike Force, to authorize members or their designees to serve on the strike force and to provide that s. 624.351, F.S., is repealed effective June 30, 2014.

**Section 6** of the bill amends s. 624.352, F.S., relating to interagency agreements to detect and deter Medicaid and public assistance fraud, to provide that the section is repealed effective June 30, 2014.

**Section 7** of the bill provides an effective date of July 1, 2013.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Entities and individual health care providers under Medicaid currently exempt from background checks will be required to complete the same requirements as other Medicaid providers.

The total fee for a Level 2 background screening is $64.50 ($24.00 for the state portion, $16.50 for the national portion, and $24.00 for retention). There is an additional fee of $11-to-$16 for electronic screening, depending on the provider. The cost of the screening is borne by the individual provider.[24]

C. Government Sector Impact:

To the extent that the bill deters fraud and abuse in the Medicaid program, the bill will have an indeterminate positive fiscal impact.

The bill also creates an indeterminate negative fiscal impact. From March 2012 to February 2013, the ACHA's Third Party Liability (TPL) vendor closed 302 cases and made recoveries based on the current provisions of s. 409.910, F.S. The ACHA recovered $4.9 million from these cases, approximately $2 million of which is utilized by the Legislature to fund Medicaid administrative activities. Under Section 2 of the bill, the ACHA's ability to recover Medicaid medical costs from third parties will likely be reduced as a result the recovery amount hearings caused by the decision in *Wos v. E.M.S.* The amount of this reduction is indeterminate. However, the amount of any reduction will likely be mitigated by the bill's standard of proof for overcoming the presumption.

[24] Agency for Health Care Administration, *supra*, note 1 at 6.

In addition to the fiscal impact of reduced collections, the AHCA will incur a negative fiscal impact for providing recipients with hearings on the recovery amounts under Section 2 of the bill. The TPL vendor staffed 62 hearings in circuit court contesting the ACHA's entitlement to Medicaid recovery during the last 12 months with a cost of approximately $5,000 per hearing. Due to the loss of the irrebuttable presumption, the ACHA anticipates there will be a substantial increase in the number of hearings to determine the Medicaid recovery allocation. The bill mitigates those costs by requiring the hearings to be brought in the DOAH, requiring the venue to be in Leon County, and setting a burden of proof (clear and convincing evidence), but the amount of that mitigation is indeterminate.

The ACHA and the DOAH may experience a workload increase under Section 2 of the bill. The ACHA is not requesting additional resources but plans to review the workload impacts and make a Legislative Budget Request for fiscal year 2014-2015 if the workload cannot be absorbed within existing resources.

The AHCA reports that Section 3 of the bill may result in an increase in initial background screenings of registered treating providers performed by AHCA staff, but any potential increase in workload under the bill can be absorbed within existing resources.

To the extent that a governmental entity has providers or is a provider that are not currently required to provide a completed background checks prior to Medicaid provider enrollment and not otherwise exempt, additional costs may be incurred to comply with this requirement.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Additional Information:

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

**CS/CS by Appropriations on April 23, 2013:**
The CS removes from the bill provisions that would increase the records retention time for all medical and Medicaid-related records from five to six years for Medicaid providers. The CS provides that the AHCA may enroll as a Medicaid provider a physician located outside the state of Florida if the physician is actively licensed in Florida and interprets diagnostic testing results through telecommunications technology at a distance. The CS provides that an action by the AHCA to terminate for cause a provider that voluntarily relinquishes its Medicaid provider number is subject to challenge under ch. 120, F.S. The CS clarifies parameters relating to documentation that

the AHCA may consider during certain audits. The CS amends the Medicaid Third-party Liability Act to ensure compliance with federal law. The CS amends s. 624.351, F.S., relating to the Medicaid and Public Assistance Fraud Strike Force, to authorize members or their designees to serve on the strike force and to provide that s. 624.351, F.S., is repealed effective June 30, 2014. The CS repeals s. 624.352, F.S., relating to interagency agreements to detect and deter Medicaid and public assistance fraud, effective June 30, 2014.

**CS by Health Policy on March 7, 2013**
The CS deletes a separate requirement for Level 2 background checks of providers under contract with Medicaid managed care networks. All Medicaid providers participating under fee for service must still comply with this requirement. The CS removed a provision relating to the coordination of anti-fraud report reviews between the Department of Financial Services and the AHCA. The CS does not include the provision allowing the AHCA to consider information from non-Medicaid providers during an investigation. The CS also removed the 30-day provision related to records that may be presented to contest an overpayment or sanction. Interest payments to the providers that had been withheld are reinstated and the timeframe for when interest is applied is clarified.

B. Amendments:

None.