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 Health Policy

BILL:	SB 844
INTRODUCER:	Senator Grimsley
SUBJECT:	Medicaid Fraud
DATE:	March 4, 2013
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Pre-meeting**
2.			BI	
3.			AHS	
4.			AP	
5.				
6.				

I. Summary:

SB 844 modifies existing statutory provisions relating to fraud and abuse, provider controls and accountability in the Medicaid program. These modifications include the following:

- Increasing the length of time for retaining all medical and Medicaid related records from 5 to 6 years for Medicaid providers;
- Requiring Medicaid providers to report a change in any principal of the provider to the Agency for Health Care Administration (AHCA) in writing no later than 30 days after the change occurs;
- Defining "administrative fines" for purposes of liability for payment of such fines in the event of a change of ownership;
- Authorizing, rather than requiring, the AHCA to perform onsite inspections of the service location of a provider applying for a provider agreement before entering into a provider agreement with that provider, to determine that provider's ability to provide services in compliance with the Medicaid program and professional regulations;
- Requiring network providers under a Medicaid managed care program to also submit a complete set of fingerprints for a criminal background check in order to participate in the Medicaid program;
- Providing definition for principals of a provider with a controlling interest for hospitals and nursing homes for purposes of conducting criminal background checks;
- Removing certain exceptions to background screenings requirements for Medicaid providers;
- Requiring the Office of Medicaid Program Integrity to work with the Division of Insurance Fraud in reviewing and approving anti-fraud plans of insurers;

- Authorizing the AHCA to review and analyze information from sources other than enrolled Medicaid providers in conducting investigations;
- Expanding the list of offenses for which the AHCA may terminate the participation of a Medicaid provider in the Medicaid program;
- Requiring the AHCA to impose the sanction of termination for cause against a provider that voluntarily relinquishes their Medicaid provider number under certain circumstances;
- Requiring that when the AHCA determines that an overpayment has been made that the AHCA must base their determination solely on the information available before the issuance of an audit report and upon contemporaneous records;
- Limiting the timeframe for providers to submit records to the AHCA to 30 days after the provider has received the final audit report;
- Removing a requirement that the AHCA pay an interest rate of 10 percent a year on provider payments that have been withheld on a suspicion of fraud or abuse, if it is determined that there was no fraud or abuse;
- Requiring overpayments or fines be paid to the AHCA within 30 days after the date of the final order and are not subject to further appeal; and,
- Clarifying the scope of immunity from civil liability for persons who report fraudulent acts or suspected fraudulent acts and providing a definition of fraudulent acts.

SB 844 is not expected to have any fiscal impact on state government as AHCA reports that any workload increases can be absorbed within existing resources.

The act takes effect July 1, 2013.

This bill substantially amends, the following sections of the Florida Statutes: 409.907, 409.91212, 409.913, and 409.920.

II. Present Situation:

Health Care Fraud

In 2009, the Legislature passed CS/CS/CS/SB 1986, a comprehensive bill designed to 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; increased health care facility and health care practitioner standards to keep fraudulent actors from obtaining a health care license in Florida; and created disincentives to commit Medicaid fraud, posting sanctioned and terminated Medicaid providers on the AHCA website, and creating additional criminal felonies for committing health care fraud; among other anti-fraud provisions.

With more than 3 years experience with the implementation of CS/CS/CS/SB 1986, some changes have been identified which would enhance Florida's efforts to prevent additional health care fraud and abuse in Florida's 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.

Agency Regulatory Authority

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 people 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 goods and services that are covered by the Medicaid program 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 among other things, 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.

Currently, the Office of Medicaid Program Integrity reviews anti-fraud plans for all participating Medicaid plans. Under s. 626.9891, F.S., all insurance companies and managed care companies also submit their required anti-fraud plans to the Department of Financial Services, Division of Insurance Fraud for review resulting in duplicate reporting by Medicaid managed care companies.[1]

Under s. 409.913, F.S., the AHCA is responsible for overseeing the integrity of the Medicaid program, to ensure the fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate.

Sections 409,920, 409.9201, 409.9203, and 409.9205, F.S., contain provisions relating specifically to Medicaid fraud. 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.[2]

Part IV of ch. 409, F.S., requires all Medicaid recipients to enroll in a managed care plan unless they are specifically exempted. The statewide Medicaid managed care program includes the long-term care managed care program and the managed care medical assistance program. 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

[1] Agency for Health Care Administration, *Senate Bill 844 Analysis & Economic Impact Statement* (March 4, 2013), p.2, (on file with the Senate Health Policy Committee).
[2] *See* s. 409.920(8), F.S.

received federal approval of this program on February 1, 2013.[3] Although the AHCA has received conditional approval,[4] the AHCA is still awaiting final approval of the managed medical assistance program whose 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 5 years. This section of law also specifies additional disqualifying offenses beyond those included in s. 435.04(2), F.S.

III. Effect of Proposed Changes:

Section 1 amends s. 409.907, F.S. relating to Medicaid provider agreements, to require Medicaid providers to retain all medical and Medicaid-related records for 6 years, rather than the current statutory retention period of 5 years, consistent with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 administrative simplification rules.[5]

The bill requires a Medicaid provider to report in writing any change of any principal of the provider whose ownership interest is equal to 5 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:

- The applicant or licensee,

[3] 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).
[4] 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).
[5] *See* 45 CFR 164.316(b)(2). Found at: <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=be9877c2440a17a8ebe3b02b0948a06a&rgn=div8&view=text&node=45:1.0.1.3.79.3.27.8&idno=45> (Last visited on March 1, 2013).

- A person or entity that serves as an officer of, is on the board or has a 5 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 5 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 Family Services, since the selection of providers for onsite inspections is no longer a random selection, but is left up to the discretion of the AHCA under the bill.

The bill amends existing surety bond requirements for certain Medicaid providers to clarify 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 elected.

The bill amends requirements for criminal history background checks and fingerprinting to include providers in Medicaid managed care networks.

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.

Section 2 amends s. 409.91212, F.S., relating to Medicaid managed care fraud, to require the AHCA's Office of Medicaid Program Integrity to enter into an interagency agreement with the Division of Insurance Fraud in the Department of Financial Services to delineate the responsibilities of the two agencies in reviewing and approving anti-fraud plans of insurers under s. 626.9891, F.S., to avoid duplication of responsibilities.

The bill also extends the length of time before an administrative fine is assessed for failure to timely report an incidence of overpayment, abuse or fraud from 15 days to 60 days after detection.

Section 3 amends s. 409.913, F.S., relating to oversight of the integrity of the Medicaid program. The bill authorizes the AHCA, as part of its fraud and abuse detection efforts, to review and analyze information from sources, other than enrolled Medicaid providers. Medicaid providers are required to retain medical, professional, financial, and business records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid for 6 years, rather than the current statutory retention period of 5 years.

The bill amends subsection (13) of s. 409.913, F.S., to remove a requirement that the AHCA *immediately* terminate participation of a Medicaid provider that has been convicted of certain offenses. In order to immediately terminate a provider, the AHCA must show an immediate harm to the public health, which is not always possible. The AHCA still must terminate a Medicaid provider from participation in the Medicaid program, unless the AHCA determines that the provider did not participate or acquiesce in the offense. The change will resolve a current conflict with the Administrative Procedures Act.[6]

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;

[6] *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 1 year or more which involves moral turpitude;
- Being convicted in connection with the interference or obstruction of any investigation into any criminal offense listed above;
- Violation of federal or state laws, rules, or regulations governing any Medicaid program, the Medicare program, or any other publicly funded federal or state health care or health insurance program, if they have been sanctioned accordingly;
- Violation of the standards or conditions relating to professional licensure or certification or the quality of services provided; or
- Failure to pay fines and overpayments under the Medicaid program.

- An offense listed in s. 408.809(4), F.S., relating to background screening of licensees, which includes the following offenses or any similar offense of another jurisdiction:
  - Any authorizing statutes, if the offense was a felony;
  - Chapter 408, F.S., if the offense was a felony;
  - Section 409.920, F.S., relating to Medicaid provider fraud;
  - Section 409.9201, F.S., relating to Medicaid fraud;
  - Section 741.28, F.S., relating to domestic violence;
  - Section 817.034, F.S., relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems;
  - Section 817.234, F.S., relating to false and fraudulent insurance claims;
  - Section 817.505, F.S., relating to patient brokering;
  - Section 817.568, F.S., relating to criminal use of personal identification information;
  - Section 817.60, F.S., relating to obtaining a credit card through fraudulent means;
  - Section 817.61, F.S., relating to fraudulent use of credit cards, if the offense was a felony;
  - Section 831.01, F.S., relating to forgery;
  - Section 831.02, F.S., relating to uttering forged instruments;
  - Section 831.07, F.S., relating to forging bank bills, checks, drafts, or promissory notes;
  - Section 831.09, F.S., relating to uttering forged bank bills, checks, drafts, or promissory notes;
  - Section 831.30, F.S., relating to fraud in obtaining medicinal drugs; or
  - Section 831.31, F.S., relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.
- An offense listed in s. 435.04(2), F.S., relating to employee background screening, which includes the following offenses or any similar offense of another jurisdiction:
  - Section 393.135, F.S., relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct;
  - Section 394.4593, F.S., relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct;
  - Section 415.111, F.S., relating to adult abuse, neglect, or exploitation of aged persons or disabled adults;

- Section 782.04, F.S., relating to murder;
- Section 782.07, F.S., relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child;
- Section 782.071, F.S., relating to vehicular homicide;
- Section 782.09, F.S., relating to killing of an unborn quick child by injury to the mother;
- Chapter 784, F.S., relating to assault, battery, and culpable negligence, if the offense was a felony;
- Section 784.011, F.S., relating to assault, if the victim of the offense was a minor;
- Section 784.03, F.S., relating to battery, if the victim of the offense was a minor;
- Section 787.01, F.S., relating to kidnapping;
- Section 787.02, F.S., relating to false imprisonment;
- Section 787.025, F.S., relating to luring or enticing a child;
- Section 787.04(2), F.S., relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings;
- Section 787.04(3), F.S., relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person;
- Section 790.115(1), F.S., relating to exhibiting firearms or weapons within 1,000 feet of a school;
- Section 790.115(2)(b), F.S., relating to possessing an electric weapon or device, destructive device, or other weapon on school property;
- Section 794.011, F.S., relating to sexual battery;
- Former s. 794.041, F.S., relating to prohibited acts of persons in familial or custodial authority;
- Section 794.05, F.S., relating to unlawful sexual activity with certain minors;
- Chapter 796, F.S., relating to prostitution;
- Section 798.02, F.S., relating to lewd and lascivious behavior;
- Chapter 800, F.S., relating to lewdness and indecent exposure;
- Section 806.01, F.S., relating to arson;
- Section 810.02, F.S., relating to burglary;
- Section 810.14, F.S., relating to voyeurism, if the offense is a felony;
- Section 810.145, F.S., relating to video voyeurism, if the offense is a felony;
- Chapter 812, F.S., relating to theft, robbery, and related crimes, if the offense is a felony;
- Section 817.563, F.S., relating to fraudulent sale of controlled substances, only if the offense was a felony;
- Section 825.102, F.S., relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult;
- Section 825.1025, F.S., relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult;
- Section 825.103, F.S., relating to exploitation of an elderly person or disabled adult, if the offense was a felony;
- Section 826.04, F.S., relating to incest;
- Section 827.03, F.S., relating to child abuse, aggravated child abuse, or neglect of a child;
- Section 827.04, F.S., relating to contributing to the delinquency or dependency of a child;
- Former s. 827.05, F.S., relating to negligent treatment of children;
- Section 827.071, F.S., relating to sexual performance by a child;
- Section 843.01, F.S., relating to resisting arrest with violence;

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

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

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

The bill amends subsection (21) of s. 409.913, F.S., to specify that when the AHCA is making a determination that an overpayment has occurred, the determination must be based solely upon information available to it before it issues the audit report and, in the case of documentation obtained to substantiate claims for Medicaid reimbursement, based solely upon contemporaneous records. Subsection (22) is amended to specify that testimony or evidence that is not based upon

contemporaneous records and that was not furnished to the AHCA within 30 days after the provider received the final audit report is inadmissible in an administrative hearing on a Medicaid overpayment or an administrative sanction. Also, all documentation to be offered as evidence in an administrative hearing on an administrative sanction (in addition to Medicaid overpayments) must be exchanged by all parties at least 14 days before the administrative hearing or excluded from consideration.

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

The bill amends subsection (28) of s. 409.913, F.S., to make Leon County the venue for all Medicaid program integrity cases, not just overpayment cases. However, the AHCA has discretion concerning venue.

Subsection (29) is amended to authorize the AHCA and the Medicaid Fraud Control Unit of the Department of Legal Affairs to review a *person's*, in addition to a provider's, Medicaid-related and non-Medicaid-related records in order to determine the total output of a provider's practice to reconcile quantities of goods or services billed to Medicaid with quantities of goods or services used in the provider's total practice.

Subsection (30) of s. 409.913, F.S., is amended to require the AHCA to terminate a provider's participation in the Medicaid program if the provider fails to 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. Subsection (31) is amended to include fines, as well as overpayments, that are due upon the issuance of a final order at the conclusion of a requested administrative hearing.

Section 4 amends s. 409.920, F.S., relating to Medicaid provider fraud, to clarify that the existing immunity from civil liability extended to persons who provide information about fraud or suspected fraudulent acts is for civil liability for libel, slander, or any other relevant tort. The bill defines "fraudulent acts" for purposes of 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 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. Health care providers who do not participate in the Medicaid program under fee-for-service but become a member of a Medicaid managed care provider network will be required to undergo background screening.

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-$16 for electronic screening, depending on the provider. The cost of the screening is borne by the individual provider.[7]

C. Government Sector Impact:

The agency reports no fiscal impact. Medicaid contract management believes there may be a spike in initial screenings of registered treating providers, but does not believe this will have a fiscal impact on the agency.[8]

The Department of Children and Families did not report any fiscal impact.

The Department of Financial Services also reports no fiscal impact as the legislation will alleviate duplication in reviewing anti-fraud plans submitted by managed care plans as required by s. 626.9891 and s. 409.91212, F.S.[9]

[7] Agency for Health Care Administration, *supra*, note 1 at 6.
[8] Agency for Health Care Administration, *supra*, note 1 at 5.
[9] Department of Financial Services, *Senate Bill 844 Bill Analysis and Fiscal Impact Statement* (Feb. 28, 2013), p.2, (on file with the Senate Health Policy Committee).

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, additional costs may be incurred to comply with this requirement.

VI. Technical Deficiencies:

There is an inconsistency in dates between line 292 and the detection of fraud and abuse time frame to the Office of the Inspector General of 15 calendar days and the proposed revision to 60 days in line 305. The agency recommends that these two timeframes be made consistent at 60 days.

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.)

None.

B. Amendments:

None.