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 Judiciary Committee

BILL:	CS/CS/SB 2286
INTRODUCER:	Judiciary Committee, Health Regulation Committee, and Senator Gardiner
SUBJECT:	Health Care
DATE:	April 23, 2009 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Stovall	Wilson	HR	**Fav/CS**
2.	Maclure	Maclure	JU	**Fav/CS**
3.			HA	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

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

I. Summary:

The bill amends multiple sections of law to address systemic health care fraud and decrease health facility regulation. The bill increases the Medicaid program's authority to address fraud, particularly as it relates to home health services. Health care facility and health care practitioner licensing standards are increased to keep fraudulent actors from obtaining a health care license in Florida. The bill creates disincentives to commit Medicaid fraud by: increasing the administrative penalties for committing Medicaid fraud; posting sanctioned and terminated Medicaid providers on the Agency for Health Care Administration (AHCA) website; and creating additional criminal felonies for committing health care fraud. The bill creates incentives for persons to report incidents of Medicaid fraud by: offering monetary rewards for persons who report Medicaid fraud to the authorities; removing a disincentive to pursue an action under the Florida False Claims Act; and providing civil immunity for persons who report suspected Medicaid fraud.

Miami-Dade County is designated as a health care fraud crisis area in the bill. The AHCA is directed to implement two pilot projects in Miami-Dade County to prevent the overutilization of home health services and control, verify, and monitor the delivery of home health services in the Medicaid program.

Senate Bill 2600, the proposed General Appropriations Bill for Fiscal Year 2009-2010, provides 5 positions, $1,607,796 from the General Revenue Fund, and $1,607,797 from trust funds and savings of $4,567,836 from general revenue funds and $9,547,851 from trust funds for the expansions of fraud and abuse recoupment initiatives in the Medicaid program.

The bill also reduces duplicative and unnecessary regulation of providers licensed or registered by the AHCA by:

- Eliminating duplicative reporting, certain annual reports, and a multi-agency workgroup;
- Revising conditions which qualify as an adverse event that must be reported to nursing homes and assisted living facilities. Abuse, neglect, or exploitation is no longer classified as an adverse incident and is required to be reported to the AHCA within 5 days and immediately to the central abuse hotline;
- Providing additional uniform provisions for facilities licensed by the AHCA;
- Designating additional disqualifying offenses for persons who work with facilities licensed by the AHCA; and
- Authorizing access to certain information electronically or from the AHCA's internet website.

This bill substantially amends sections 68.085, 68.086, 395.405, 400.0077, 400.0712, 400.141, 400.147, 400.162, 400.191, 400.195, 400.23, 400.471, 400.474, 400.506, 400.9905, 400.9935, 400.995, 408.803, 408.806, 408.808, 408.809, 408.810, 408.811, 408.813 408.815, 408.820, 408.831, 408.918, 409.221, 409.901, 409.905, 409.907, 409.912, 409.913, 409.920, 429.08, 429.14, 429.19, 429.23, 430.608, 430.80, 435.04, 435.05, 456.004, 456.041, 456.072, 456.074, 465.022, 465.023, 483.031, 483.041, 483.172, 627.4239, 651.105, 651.118, 825.103, and 921.0022, F.S.

The bill repeals sections 395.0199, 400.118(2), 429.071, 429.26(9), and 483.106, F.S.

The bill creates sections 408.8065, 408.821, 409.9203, and 456.0635, F.S.

The bill creates three undesignated sections of law.

II. Present Situation:

National Recognition of Health Care Fraud in Florida

In a recent report by the United States Government Accountability Office (GAO), Florida was identified as one of the states experiencing the highest growth in Medicare home health spending and utilization, specifically in home health services.[1] Medicare home health spending in Florida increased by 90 percent from 2002 to 2006, while the number of Medicare beneficiaries only grew by 28 percent during the same time period. The GAO report found that the increase in Medicare home health spending and utilization was due in part to upcoding of Medicare claims by billing for outlier cases that qualified for additional payment. Miami-Dade County was cited

[1] United States Government Accountability Office, *Medicare, Improvements Needed to Address Improper Payments in Home Health, U.S. Government Accountability Office* (Feb. 2009), *available at* http://www.gao.gov/new.items/d09185.pdf (last visited Mar. 30, 2009).

in the report as an example of an unusually high number of outlier cases indicating fraudulent upcoding of Medicare home health claims.

In the 2007 U.S. Department of Health and Human Services and U.S. Department of Justice Health Care Fraud and Abuse Control Program Annual Report, there are descriptions of several projects to discourage fraud in Florida.[2] The report describes the successful Medicare Fraud Strike Force that collaborated with local staff in Miami to target improper billing of durable Medical equipment and HIV infusion therapy services, which resulted in 74 indictments involving charges filed against 120 defendants, who collectively billed the Medicare program more than $400 million. The other Florida specific fraud cases included the federal conviction of the owner of Florida Pharmacy and F&M Medical for conspiring to defraud the government, submitting false claims, and receiving kickbacks. Additionally, three subjects were sentenced for their roles in a scheme to submit false claims in Medicare for medically unnecessary durable medical equipment (DME) in Florida.

In 2007, the Department of Health and Human Services, Office of the Inspector General, published "Aberrant Billing in South Florida for Beneficiaries with HIV/AIDS," to identify claim patterns associated with HIV/AIDS infusion therapy that may indicate fraudulent or abusive activity in three South Florida counties, and to assess the effectiveness of past and current efforts to control inappropriate payments to infusion therapy providers in three South Florida counties.[3] The report found that in the last half of 2006, three South Florida counties accounted for half the amount, and 79 percent of the amount for drugs billed nationally for Medicare beneficiaries with HIV/AIDS; that other metropolitan areas exhibit patterns of billing similar to South Florida, but to a lesser extent; and that the Centers for Medicare and Medicaid Services (CMS) has had limited success in controlling aberrant billing practices of South Florida infusion therapy providers.

The federal government is responsible for the administration of the Medicare program. The states are primarily responsible for policing fraud in the Medicaid program. The CMS provides technical assistance, guidance, and oversight in these efforts. Fraud schemes often cross state lines, and the CMS strives to improve information sharing among the Medicaid programs and other stakeholders.

Legislative Action to Combat Medicaid Fraud in Florida

In response to findings and recommendations of the Thirteenth Statewide Grand Jury relating to durable medical equipment, clinics, adult living facilities, and home health care, the Legislature passed SB118 (ch. 96-387, Laws of Florida) in 1996, relating to Medicaid fraud and abuse. In 2002, the Chair of the Senate Health, Aging, and Long-Term Care Committee appointed a Select

[2] Department of Health and Human Services and Department of Justice, *Health Care Fraud and Abuse Control Program, Annual Report for FY 2007* (Nov. 2008), *available at* http://www.oig.hhs.gov/publications/docs/hcfac/hcfacreport2007.pdf (last visited Mar. 30, 2009).

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[3] Department of Health and Human Services, Office of Inspector General, *Aberrant Billing in South Florida for Beneficiaries with HIV/AIDS, available at* http://www.oig.hhs.gov/oei/reports/oei-09-07-00030.pdf (last visited Mar. 30, 2009).

Subcommittee on the Recovery of Medicaid Overpayments. The committee investigated whether overpayments had been made to Medicaid providers, how the Agency for Health Care Administration (AHCA) determined overpayments, the effectiveness of Medicaid overpayment recoveries, and how to improve the state's recovery of Medicaid overpayments. During the 2002 legislative session, significant statutory changes were passed that included:

- Improved tracking and accounting systems in the AHCA for recovery of Medicaid overpayments;
- Studies of the accuracy of Medicaid claims payments and eligibility determination;
- A contract with Heritage Information Systems to analyze and apply sophisticated drug algorithms to detect unusual drug utilization patterns and assist the AHCA in determining the cause; and
- A contract with Gold Standard Multimedia to provide handheld, wireless personal digital assistants (PDAs) to Medicaid-prescribing physicians.

Since the first Senate Select Subcommittee in 2002, the Legislature has passed legislation almost every year to address some component of Medicaid fraud. In 2003, the Florida Auditor General's audit report recommended more improvements to the Medicaid Fraud Control Unit (MFCU) in the Department of Legal Affairs.

In 2004, the Chair of the Senate Health, Aging, and Long-term Care Committee appointed another select subcommittee on prescription drug over-prescribing in the Medicaid program. The committee was assigned to investigate the over-prescribing of narcotics. The Seventeenth Statewide Grand Jury Report on Recipient Fraud in the Medicaid Program found that corrupt doctors and clinics work with willing Medicaid recipients to defraud Medicaid, and in many instances, doctors no longer affiliated with the Medicaid program are still able to prescribe medication that is then billed by pharmacies to the program. In 2004, the Legislature passed CS/CS/SB 1064, which made substantial statutory changes to Medicaid recipient eligibility, dramatically increased the AHCA's authority to control pharmaceutical drug prescribing in the Medicaid program, authorized the AHCA to limit its Medicaid provider network, and increased the AHCA's authority to suspend or terminate providers in the Medicaid program for fraudulent or questionable behavior.

Most recently, during the 2008 legislative session, the Legislature passed CS/HB 7083, which substantially increased the regulatory provisions that govern the licensure of home health agencies and nurse registries to reduce Medicaid fraud and improve quality and accountability. The bill also specifically addressed home medical equipment fraud in the Medicaid system, allowing the AHCA to limit its network of home medical equipment providers and increased its home medical equipment Medicaid provider enrollment requirements.

Medicaid Fraud OPPAGA Reports

Chapter 2004-344, Laws of Florida, required the Office of Program Policy Analysis and Government Accountability (OPPAGA) to report biennially on the AHCA's efforts to prevent, detect, and deter, as well as recover funds lost to, fraud and abuse in the Medicaid program. The OPPAGA has published three reports that address the AHCA's ability to address Medicaid fraud: AHCA Takes Steps to Improve Medicaid Program Integrity, But Further Actions Are

Needed, in 2004;[4] Enhanced Detection and Stronger Use of Sanctions Could Improve AHCA's Ability to Detect and Deter Overpayments to Providers, in 2006;[5] and AHCA Making Progress But Stronger Detection, Sanctions, and Managed Care Oversight Needed, in 2008.[6]

The 2008 report recommends that the AHCA:

- Expand Florida's capabilities to detect Medicaid fraud, abuse, and overbillings by developing advanced detection models;
- Establish minimum fine amounts based on the amount of a provider's overpayments; and
- Expand the oversight of Medicaid managed care organizations to detect and deter corporate fraud and abuse.

Since the report, the AHCA has promulgated a new administrative rule to increase fines as recommended by the OPPAGA.[7] The next OPPAGA report will be published in January 2010.

Federal Medicaid Fraud and Abuse Requirements

Federal law requires each state to have a Medicaid program integrity unit within the Medicaid state agency to detect and investigate Medicaid fraud and abuse. State Medicaid program integrity units must meet the requirements in federal law, which include: methods for the identification, investigation, and referral of Medicaid fraud; fraud and abuse reporting requirements; and collaboration with state and federal law enforcement.[8] The AHCA Bureau of Medicaid Program Integrity (MPI) is responsible for oversight of the Florida Medicaid program, as it pertains to these issues of fraud and abuse.

Federal law also requires a state to establish and operate a state Medicaid Fraud Control Unit (MFCU) to conduct a statewide program for the investigation and prosecution of health care providers that defraud the Medicaid program.[9] State MFCUs are certified by the Secretary of the U.S. Department of Health and Human Services annually. In addition, state MFCUs review complaints of abuse or neglect of nursing home residents. The MFCUs receive referrals from the Medicaid state agency and are responsible for collecting any overpayments it identifies. Under federal law, state MFCUs must be separate and distinct from the state agency responsible for administering the Medicaid program.[10] The Florida MFCU is located in the Office of the Attorney General.

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[4] The Office of Program Policy Analysis & Government Accountability, *AHCA Takes Steps to Improve Medicaid Program Integrity, But Further Actions Are Needed*, Report No. 04-77 (Nov. 2004), *available at* http://www.oppaga.state.fl.us/Summary.aspx?reportNum=04-77.

[5] The Office of Program Policy Analysis & Government Accountability, *Enhanced Detection and Stronger Use of Sanctions Could Improve AHCA's Ability to Detect and Deter Overpayments to Providers*, Report No. 06-23 (Mar. 2006), *available at* http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/0623rpt.pdf.

[6] The Office of Program Policy Analysis & Government Accountability, *AHCA Making Progress But Stronger Detection, Sanctions, and Managed Care Oversight Needed*, Report No. 08-08 (Feb. 2008), *available at* http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/0808rpt.pdf.

[7] 59G-9.070, F.A.C.

[8] 42 C.F.R. s. 455.

[9] 42 U.S.C. s. 1396.

[10] 42 U.S.C. s 1396.

Florida Medicaid Program

Florida's Medicaid program is jointly funded by the federal, state, and county governments to provide medical care to eligible individuals. Florida implemented its Medicaid program on January 1, 1970, to provide medical services to indigent people. The AHCA is the single state agency responsible for the Florida Medicaid program.[11]

Some Medicaid services are mandatory services that must be covered by any state participating in the Medicaid program pursuant to federal law.[12] Other services are optional. A state may choose to include optional services in its state Medicaid plan, but if included, such services must be offered to all individuals statewide who meet Medicaid eligibility criteria as though they are mandatory benefits.[13] Similarly, some eligibility categories are mandatory[14] and some are optional.[15] Payments for services to individuals in the optional eligibility categories are subject to the availability of monies and any limitations established by the General Appropriations Act or ch. 216, F.S. For FY 2009-2010, the Florida Medicaid Program is projected to cover 2.6 million people[16] at an estimated cost of $16.3 billion.[17]

Florida Medicaid Program Integrity

The AHCA Bureau of Medicaid Program Integrity (MPI) is responsible for preventing and detecting fraud and abuse in the Medicaid program. The duties of the MPI include:

- Ensuring that Medicaid recipients are not subject to fraud, abuse, or neglect;
- Preventing fraud in the Medicaid system;
- Recovering overpayments from Medicaid providers; and
- Sanctioning or terminating providers from the Medicaid program, as appropriate.[18]

The AHCA has the authority to sanction providers for a variety of offenses; however, when the provider is not a natural person (a corporate entity), the AHCA's authority to sanction the provider for actions of owners, officers, or agents who have engaged in sanctionable offenses is unclear.

The MPI staff develop and use statistical methodologies to identify providers who exhibit aberrant billing patterns, conduct investigations and audits of these providers, calculate provider overpayments, initiate recovery of overpayments in instances of provider abuse, and recommend administrative sanctions for providers who have abused or defrauded Medicaid. When the MPI determines that Medicaid has overpaid a provider, the AHCA issues an audit report to the

[11] The statutory provisions for the Medicaid program appear in ss. 409.901-409.9205, F.S.
[12] These mandatory services are codified in s. 409.905, F.S.
[13] Optional services covered under the Florida Medicaid Program are codified in s. 409.906, F.S.
[14] Section 409.903, F.S.
[15] Section 409.904, F.S.
[16] Social Services Estimating Conference, *Basic Medicaid Caseloads, Historical and Forecasted Average Monthly Caseloads by Fiscal Year, FY 2002-2003 to FY 2012-1, available at* http://edr.state.fl.us/conferences/medicaid/medcases.pdf (last visited on Mar. 30, 2009).
[17] Social Services Estimating Conference, *Medicaid Services Expenditures* (Feb. 13, 2009), *available at* http://edr.state.fl.us/conferences/medicaid/medhistory.pdf (last visited on Mar. 30, 2009).
[18] Sections 409.913 and 409.9131, F.S.

provider that includes a calculation of overpayment. The AHCA reports that providers send documentation on repeated occasions (duplications of prior documentation), newly discovered documents, or documents created after the issuance of a final audit report.

The MPI is authorized to impose sanctions on a provider for various violations.[19] These sanctions include suspending or terminating Medicaid providers for specified periods of time and fining Medicaid providers. The AHCA may immediately suspend a provider and issue an immediate final order under s. 120.569(2)(n), F.S., if the AHCA receives information of patient abuse or neglect or of any act prohibited by s. 409.920, F.S.[20] The AHCA has indicated that it is unclear whether the agency has the authority to impose the sanction of an immediate termination followed by an immediate final order under s. 409.913(13), F.S. During the 2007-2008 fiscal year, the MPI administratively sanctioned 472 Medicaid providers. The sanctions included 155 provider fines, six suspensions, 10 Medicaid provider terminations, and several acknowledgement statements.[21]

Existing law provides definitions, provides the authority for the MPI to conduct Medicaid provider onsite medical records reviews, and specifies the process for Medicaid overpayment determination.[22]

Under federal and state law, any suspected criminal violation identified by the MPI must be referred to the MFCU in the Office of the Attorney General.[23] The MPI and the MFCU are required to develop a memorandum of understanding, which includes protocols for referral of cases of suspected criminal fraud and return of those cases when investigation determines that administrative action by the AHCA is appropriate. During FY 2007-2008, the MPI referred 218 cases to the MFCU for investigation, identified $28.9 million in overpayments, and saved the Medicaid program an estimated $21.5 million in cost avoidance.[24]

Florida Medicaid Fraud Control Unit

The MFCU is within the Department of Legal Affairs and is responsible for the criminal and civil enforcement of fraud perpetrated against the Medicaid program by Medicaid providers.[25] In addition, the MFCU investigates abuse, neglect, and exploitation of patients who reside in Medicaid funded facilities. The MFCU is also directed to investigate the alleged misappropriation of patients' private funds in health care facilities receiving payments under the Medicaid program, refer all cases of abuse to the AHCA that are not criminal or fraudulent, publicize the Florida False Claims Act, and refer criminal cases to the Office of Statewide Prosecution.[26]

[19] Section 409.913(13)-(16), F.S.
[20] Section 409.913(16)(d), F.S.
[21] The Agency for Health Care Administration and the Medicaid Fraud Control Unit, Department of Legal Affairs, *Annual Report on the State's Efforts to Control Medicaid Fraud and Abuse, FY 2007-2008* (Dec. 2008), *available at* http://www.fdhc.state.fl.us/docs/2008_Fraud_and_%20Abuse%20Binder_signed.pdf (last visited Mar. 30, 2009).
[22] Section 409.9131, F.S.
[23] See 42 C.F.R. 455.21 and s. 409.913(4), F.S.
[24] Agency for Health Care Administration, s*upra* note 21.
[25] Section 16.59, F.S.
[26] Section 409.920, F.S.

The MFCU has 232 full-time employees, and in fiscal year 2007-08 the budget for the MFCU unit was $18,360,869, of which 75 percent was federal funding and 25 percent came from general revenue.[27] In fiscal year 2007-08, the MFCU unit recovered $56,722,698; these recoveries contributed $5,684,855 to the state General Revenue Fund.

Of the $56,722,698 recovered by the MFCU in the 2007-08 fiscal year, $51,120,765 was recovered from cases brought under the Florida False Claims Act.

Florida False Claims Act

The Florida False Claims Act (FFCA)[28] authorizes civil actions by individuals and the state against persons who file false claims for payment or approval with a state agency. The FFCA is modeled after the Federal False Claims Act that was enacted during the Civil War in response to widespread fraud among defense contractors.[29] Actions brought by private entities on behalf of the state are called *qui tam* actions.[30]

The FFCA has often been used to combat health care, nursing home, Medicaid, and Medicare fraud. An action under the FFCA can be brought either by the state itself or by a private individual on behalf of the state. The Department of Legal Affairs and then the Department of Financial Services are responsible for investigating and litigating actions brought under the FFCA. In addition to Florida, 22 states, the District of Columbia, New York City, and Chicago have a False Claims Act with *qui tam* provisions.[31]

Current law provides that when a *qui tam* action is filed in the circuit court of the Second Judicial Circuit, in and for Leon County, a copy of the complaint and disclosure of all material evidence must be served on the Attorney General, as head of the Department of Legal Affairs, and the Chief Financial Officer, as head of the Department of Financial Services.[32]

When a private individual brings a potential claim to the attention of the Department of Legal Affairs or the Department of Financial Services, these departments have 60 days to decide whether they are going to intervene, and take over litigating the FFCA action from the private individual.[33]

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[27] Agency for Health Care Administration, *supra* note 21.
[28] Sections 68.081-68.09, F.S.
[29] *False Claims Amendments Act of 1986*, S. Rep. No. 99-345, at 8 (1986), reprinted in 1986 U.S.C.C.A.N 5266, 5273 ("The Claims Act was adopted in 1863 and signed into law by President Abraham Lincoln in order to combat rampant fraud in Civil War defense contracts."); see also *Rainwater v. United States*, 356 U.S. 590, 592 (1958) ("The Act was originally passed in 1863 after disclosure of widespread fraud against the Government during the War Between the States.").
[30] *Qui tam* cases usually arise from an employee of an institution such as a health care provider who discovers that violations of the FFCA are occurring. This is a type of whistleblower action. In a *qui tam* action under the FFCA, the employee will sue on behalf of the state to collect money that was illegally defrauded from the state. A private entity that brings a successful FFCA action on behalf of the state will receive an amount that the court decides is reasonable for collecting the civil penalty and damages. The amount must not be less than 25 percent and not more than 30 percent of the proceeds recovered under a judgment. Section 68.085(3), F.S.
[31] *See* The False Claims Act Legal Center, Taxpayers Against Fraud Education Fund, *State False Claims Acts*, *available at* http://www.taf.org/statefca.htm (last visited Mar. 30, 2009).
[32] Section 68.083(3), F.S.
[33] *Id*.

Actions that violate the FFCA include:

- Submitting a false claim for payment or approval;
- Making or using a false record to get a false or fraudulent claim paid or approved;
- Conspiring to make a false claim or to deceive an agency to get a false or fraudulent claim allowed or paid; or
- Making or using a false record to conceal, avoid, or decrease payments owed to the state government.[34]

The penalty for violating the FFCA is $5,500 to $11,000 per claim, plus three times the amount of damages to the state government for FFCA violations.

As enacted by section 6031 of the Deficit Reduction Act of 2005, section 1909 of the Social Security Act (Act) provides a financial incentive for states to enact false claims acts that establish liability to the state for the submission of false or fraudulent claims to the state's Medicaid program. If a state false claims act is determined to meet certain enumerated requirements, the state is entitled to an increase of 10 percentage points in the state medical assistance percentage, as determined by section 1905(b) of the Social Security Act, with respect to any amounts recovered under a state action brought under such a law.

Under section 1909(b) of the Act, the federal Office of the Inspector General (OIG) is required to determine, in consultation with the Attorney General of the United States, whether a state has in effect a law relating to false or fraudulent claims submitted to a State Medicaid program that is at least as effective as the Federal False Claims Act. The FFCA is very similar to the Federal False Claims Act, but Florida does not receive the 10-percent increase in recovered Medicaid monies.

In 2007, the Legislature passed CS/SB 2312 to amend the FFCA, to conform to the Federal False Claims Act. Despite these changes, in July 2008, the OIG ruled that the FFCA does not qualify because, under Florida law, when the state does not proceed with the action, the court must award the defendant reasonable attorney's fees and costs against the relator if the defendant is the prevailing party.[35] In contrast, under the Federal False Claims Act, the court *may* award the defendant reasonable attorney's fees and expenses if the defendant prevails in the action *and* the court finds that the relator's claim was clearly frivolous, clearly vexatious, or brought primarily for purposes of harassment.[36]

Agency for Health Care Administration

The AHCA is the chief health policy and planning entity for the state. The AHCA is the designated Medicaid state agency that is responsible for the administration of the Medicaid program. It is responsible for health facility licensure, inspection, and regulatory enforcement; investigation of consumer complaints related to health care facilities and managed care plans; the implementation of the certificate-of-need program; the operation of the Florida Center for Health

[34] Section 68.082(2), F.S.
[35] Correspondence to Richard E. Lober, Director of Medicaid Fraud, from Daniel R. Levinson, Inspector General, U.S. Department of Health and Human Resources (July 24, 2008), *available at* http://www.oig.hhs.gov/fraud/docs/falseclaimsact/Florida.pdf (last visited Mar. 24, 2009). *See* s. 68.086(3), F.S.
[36] 31 U.S.C. s. 3730(d)(4).

Information and Policy Analysis; the administration of the Florida Healthy Kids Corporation contracts; the certification of health maintenance organizations and prepaid health clinics; and other duties prescribed by statute or agreement.

The agency is responsible for licensing, certifying, or registering the following health care facilities, providers, or programs:

- Abortion Clinics;
- Adult Day Care Centers;
- Adult Family Care Homes;
- Ambulatory Surgical Centers;
- Assisted Living Facilities;
- Birth Centers;
- Clinical Laboratories;
- Commercial HMOs/PHCs/EPOs;
- Comprehensive Outpatient Rehabilitation Facilities;
- Certificate of Need/Financial Analysis (CON/FA);
- Crisis Stabilization Units and Short Term Residential Treatment Facilities;
- Diagnostic Imaging Services;
- Drug-free Workplace Laboratories;
- Extended Congregate Care;
- Health Care Clinics;
- Health Care Services Pools;
- Health Flex Plan Programs;
- Homes for Special Services;
- Home Health Aides;
- Home Health Agencies;
- Homemaker/Companion Organizations;
- Home Medical Equipment Providers;
- Hospices;
- Hospitals;
- Intermediate Care Facilities for the Developmentally Disabled;
- Limited Mental Health;
- Limited Nursing Services;
- Medicaid HMOs;
- Multiphasic Health Testing Centers;
- Nurse Registries;
- Nursing Homes;
- Organ, Tissue and Eye Procurement Organizations;
- Partial Hospitalization Programs;
- Portable X-rays;
- Prescribed Pediatric Extended Care Centers;
- Rehabilitation Agencies;
- Residential Treatment Centers for Children and Adolescents;
- Residential Treatment Facilities;

- Risk Management and Patient Safety;
- Risk Managers;
- Rural Health Clinics;
- Transitional Living Facilities; and
- Utilization Review.

Core Licensure Provisions

In addition to specific authorizing statutes that provide the regulatory structure for these activities, part II of ch. 408, F.S., provides general licensing provisions. The purpose of this part is to provide a streamlined and consistent set of basic licensing requirements for all providers licensed by the agency in order to minimize confusion, standardize terminology, and include issues that are otherwise not adequately addressed in the Florida Statutes pertaining to specific providers.[37]

Part II of ch. 408, F.S.:

- Provides definitions; the license application process; procedures for a change of ownership; general information about background screening; minimum licensure requirements and agency action with respect to approving, denying, or suspending licenses; inspection authority; and rulemaking authority;
- Prohibits unlicensed activity; and
- Authorizes the AHCA to impose administrative fines and pursue other regulatory and enforcement actions.

Home Health Agencies

Home health agencies are organizations that provide home health services and staffing services. Home health services are health and medical services and medical supplies furnished to an individual in the individual's home or place of residence. The services include: nursing care; physical, occupational, respiratory, or speech therapy; home health aide services (assistance with daily living such as bathing, dressing, eating, personal hygiene, and ambulation); dietetics and nutrition practice and nutrition counseling; and medical supplies, restricted to drugs and biologicals prescribed by a physician.[38]

Home health agency personnel are employed by or under contract with a home health agency. Staffing services are provided to health care facilities or other business entities on a temporary basis by licensed health care personnel and by certified nursing assistants and home health aides who are employed by, or work under the auspices of, a licensed home health agency.[39]

Home health agencies are organizations licensed and regulated by AHCA. The licensure requirements for home health agencies are found in the general provisions of part II of

[37] Section 408.801, F.S.
[38] Section 400.462(14), F.S.
[39] Section 400.462(29), F.S.

ch. 408, F.S., the specific home health agency provisions of part III of ch. 400, F.S., and ch. 59A-8, Florida Administrative Code.

To obtain a home health agency license, an applicant must:[40]

- Submit an application under oath which includes the name, address, social security number and federal employer identification number or taxpayer identification number of the applicant and each controlling interest, and the name of the person who will manage the provider;
- Submit information identifying the service areas and counties to be served;
- Submit proof of professional and commercial liability insurance of not less than $250,000 per claim; and
- Submit proof of financial ability to operate, or a $50,000 surety bond;
- Submit a licensure fee of $1,660; and
- Pass a survey by the AHCA inspectors.

In 2008, the Legislature significantly strengthened the home health agency licensure requirements to address fraud and abuse in the Medicaid and Medicare programs. Effective July 1, 2008, applicants must also:

- Submit a business plan detailing the agency's methods to obtain patients and recruit and maintain staff;
- Provide evidence of contingency funding equivalent to one month's average operating expenses;
- Submit a balance sheet, income and expense statement, and statement of cash flows for the first two years of operation which shows sufficient assets, credit, and projected revenues to cover liabilities and expenses;
- Disclose all ownership interests in other health care entities held by controlling interests; and
- Be accredited by an organization recognized by the AHCA.

The applicant has demonstrated financial ability to operate if the applicant's assets, credit, and projected revenues meet or exceed projected liabilities and expenses. An applicant may not project an operating margin of 15 percent or greater for any month in the first year of operation. All required documents must be prepared in accordance with generally accepted accounting principles and compiled and signed by a certified public accountant.[41]

In addition, the 2008 changes prohibit licensure of an applicant that shares common controlling interest with a home health agency in the same county and within 10 miles of the applicant.[42]

Florida law prohibits unlicensed activity, authorizes the AHCA to fine unlicensed providers $500 for each day of noncompliance, and authorizes state attorneys and the AHCA to enjoin unlicensed providers.[43] Unlicensed activity is a second-degree misdemeanor for the first offense,

[40] Sections 408.806, 408.810, and 400.471, F.S., respectively.
[41] Section 400.471(2)(f), F.S.
[42] Section 400.471, F.S.
[43] Section 400.464(4), F.S.

and a first-degree misdemeanor for each subsequent offense.[44] In addition, a controlling interest that withholds any evidence of financial instability commits a second-degree misdemeanor.[45]

Prior to 2008, the AHCA saw significant growth in the number of applications and new licenses of home health care agencies.[46] The AHCA received 431 new licensure applications for home health agencies during 2007. Two hundred fifty-two (58.5 percent) of those were for new home health agency licenses in Miami-Dade County. According to the AHCA, the new accreditation requirement has slowed the growth in new licensees, but the AHCA continues to receive a high volume of applications. Since July 1, 2008, the AHCA received 331 applications, most of which were from Miami-Dade County. As of December 31, 2008, there were 2,225 licensed home health agencies in the state.[47] In Miami-Dade County, the number of licensed home health agencies increased from 216 in August 1999, to 895 as of March 6, 2009, which is a 75-percent increase in licensees in that county.

According to a project conducted by the MPI, home health agency Medicaid reimbursement for home health aide services unassociated with a skilled nursing service increased substantially in Miami-Dade County between 2005 and 2007. In coordination with the MFCU and the federal government, the MPI participated in a project to target home health agencies in Miami-Dade County. Some of the questionable home health practices that were discovered include:

- Home health aides reporting that they worked 20-25 hour days;
- Patient brokering by aides;
- Alteration of records;
- Billing for skilled nursing services that were not provided;
- Payment of physicians by referrals;
- Payment to patients;
- Patients receiving services that are not medically necessary; and
- Physicians with financial interests in the agencies referring to those entities.

Home Medical Equipment Providers

Durable medical equipment and medical supply providers are licensed and regulated by the AHCA, as home medical equipment providers, under part VII of ch. 400, F.S., and part II of ch. 408, F.S. Home medical equipment includes any products defined as home medical equipment by the Federal Food and Drug Administration, reimbursed under Medicare part B durable medical equipment benefits, or reimbursed under the Florida Medicaid durable medical equipment program.

[44] Section 400.464(4), F.S.
[45] Section 408.810(9), F.S.
[46] Committee on Health Regulation, Fla. Senate, *Review Regulatory Requirements for Home Health Agencies*, (Interim Report 2008-135) (Nov. 2007), *available at* http://www.flsenate.gov/data/Publications/2008/Senate/reports/interim_reports/pdf/2008-135hr.pdf (last visited April 30, 2009).
[47] Source: AHCA Home Care Unit, Bureau of Health Facility Regulation.

Home medical equipment includes:

- Oxygen and related breathing equipment;
- Manual, motorized, or customized wheelchairs and related seating and positioning, but does not include prosthetics or orthotics or any splints, braces, or aids custom fabricated by a licensed health care practitioner;
- Motorized scooters;
- Personal transfer systems; and
- Specialty beds, such as a hospital bed.

In 2008, the Legislature added requirements for a home medical equipment provider to enroll as a Medicaid provider and obtain a Medicaid provider contract. The Medicaid home medical equipment providers must:

- Be licensed by the local government agency as a business or merchant or provide documentation from the city or county authority that no licensure is required;
- Be licensed by the Department of Health, Board of Orthotics and Prosthetics, if providing orthotics and prosthetic devices;
- Hold a Home Medical Equipment Provider license under part III of ch. 400, F.S.;
- Comply with all applicable laws relating to qualifications or licensure;
- Have an in-state business location or be located not more than 50 miles from the Florida state line;
- Meet all the general Medicaid provider requirements and qualifications;
- Be fully operational;
- Submit a surety bond as part of the enrollment application unless the provider is owned and operated by a governmental entity. One $50,000 bond is required for each provider location up to a maximum of five bonds statewide or an aggregate bond of $250,000;
- Pass a site visit unless the applicant is associated with a pharmacy or rural health clinic, or provides only orthotic or prosthetic devices and is licensed by the Board of Orthotics and Prosthetics;
- Be accredited and maintain accreditation by a Center for Medicare and Medicaid Services (CMS) Deemed Accreditation Organization for suppliers of durable medical equipment, prosthetics, orthotics, and supplies;
- Provide services or supplies directly to the Medicaid recipient or caregiver, or provide the services or supplies by mail, and may not subcontract or consign the function to a third party (with certain exceptions);
    - Have a physical business location that meets criteria regarding signage, public accessibility, telephone access, location within Florida, and co-location, with certain exceptions;
    - Maintain a stock of equipment and supplies readily available to meet the needs of customers; and
    - Obtain a level 2 background screening for staff in direct contact with or providing direct services to recipients.

Health Care Clinics

Certain health care clinics are licensed by the AHCA under part X of ch. 400, F.S. A clinic is defined as an entity at which health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider.[48] However, there are numerous exceptions to the clinics that must be licensed and subject to regulation under this part. Each clinic subject to licensure must appoint a medical director or clinic director. Each licensed clinic engaged in magnetic resonance imaging services must be accredited and maintain accreditation by the Joint Commission on Accreditation of Healthcare Organizations, the American College of Radiology, or the Accreditation Association for Ambulatory Health Care within one year after licensure. However, a clinic may request a single, six-month extension.

A health care clinic licensure applicant must:[49]

- Submit an application including information on the identity of the owners, the number and profession of medical providers employed, and the medical director;
- Submit proof of financial ability to operate a clinic or a $500,000 surety bond;
- Pass a level 2 background screening; and
- Have a medical director or clinic director who agrees in writing to accept legal responsibility pursuant to s. 400.9935, F.S., for various activities on behalf of the clinic, including ensuring billing is not fraudulent, taking corrective action if unlawful charges are discovered, and ensuring that the AHCA has full access to the clinic and its billing records.

Under s. 400.991(5), F.S., a clinic license may not be granted to an applicant who has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening in ch. 435, F.S., or a violation of insurance fraud under s. 817.234, F.S., within the past five years. The AHCA may deny, revoke, or suspend a health care clinic license and impose administrative fines of up to $5,000 per violation pursuant to s 400.995, F.S.

Health Care Clinic Exemptions

Section 400.9905(4), F.S., contains a listing of entities that are not considered a "clinic" for purposes of licensure, including:
• Entities licensed or registered by the state under one or more of the specified practice acts and that only provide services within the scope of their license;
• Entities that own, directly or indirectly, an entity licensed or registered by the state under one or more of the specified practice acts and that only provide services within the scope of their license;
• Entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state under one or more of the specified practice acts and only provides services within the scope of their license.
• Entities that are exempt from federal taxation under 26 U.S.C. sec. 501(c)(3) or sec. 501(c)(4);

[48] Section 400.9905(4), F.S.
[49] Section 409.991, F.S.

• A community college or university clinic;
• Entities owned or operated by the federal or state government, including agencies, subdivisions and municipalities;
• Clinical facilities affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows;
• Entities that provide only oncology or radiation therapy services by physicians licensed under chs. 458 or 459, F.S.; and
• Clinical facilities affiliated with a college of chiropractic accredited by the Council on Chiropractic Education at which training is provided for chiropractic students.

Clinical Laboratories

Certain clinical laboratories are licensed by the AHCA under part I of ch. 483, F.S. This part applies to all clinical laboratories within the state except a clinical laboratory:

- Operated by the United States government;
- That performs only waived tests and has received a certificate of exemption from the AHCA under s. 483.106, F.S., or
- Operated and maintained exclusively for research and teaching purposes that does not involve patient or public health service.

A waived test is a test that the federal government has determined qualifies for a certificate of waiver under the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA), and the federal rules adopted thereunder.[50] Waived tests include finger sticks for glucose, swabs for strep throat, and pregnancy tests. Laboratories performing waived tests are generally located in physicians' offices or in otherwise licensed health care providers such as nursing homes or home health agencies. Approximately 8,500 of the 12,800 licensed clinical laboratories perform only waived tests.[51]

Nursing Home Licensure

Nursing homes are licensed and regulated by the AHCA under part II of ch. 400, F.S., part II of ch. 408, F.S., and Chapter 59A-4, Florida Administrative Code (F.A.C.). Nursing homes provide long term and sub-acute care to persons in need of 24-hour nursing services or significant supportive services. Nursing home residents are generally frail, physically and psychosocially compromised, heavily dependent upon others for basic care and sustenance, and in some cases near the end of their lives. When residents live in an environment where they are totally dependent on others, they are especially vulnerable to abuse, neglect, and exploitation.

Nursing home deficiencies are classified according to the nature and scope of the deficiency as follows[52]:

[50] s. 483.041(10), F.S.
[51] Data received from the Agency.
[52] s. 400.23, F.S.

- Class I is a deficiency that the AHCA determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility.
- Class II is a deficiency that the AHCA determines has compromised a resident's ability to maintain or reach his or her highest practicable physical, mental, and psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.
- Class III is a deficiency that the AHCA determines will result in no more than minimal physical, mental, or psychosocial discomfort to a resident or has the potential to compromise a resident's ability to maintain or reach his or her highest practical physical, mental, or psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.
- Class IV is a deficiency that the AHCA determines has the potential for causing no more than a minor negative impact on a resident.

Assisted Living Facilities

Assisted Living Facilities (ALFs) are licensed and regulated by the AHCA under part I of ch. 429, F.S., part II of ch. 408, F.S., and Chapter 59A-5, F.A.C.

The ALFs provide housing, meals, personal care services, and supportive services to older persons and disabled adults who are unable to live independently. They are intended to be an alternative to more restrictive, institutional settings for individuals who need housing and supportive services, but who do not need 24-hour nursing supervision. Generally, the ALFs provide supervision, assistance with personal care services, such as bathing, dressing, eating, and assistance with or administration of medications.

The ALFs are licensed to provide routine personal care services under a standard license, or more specific services under the authority of various specialty licenses. The purpose of specialty licenses is to allow individuals to "age in place" in familiar surroundings that can adequately and safely meet their continuing health care needs.

Utilization Review Agents

This program consists of registration of an agent who performs utilization review services for third-party payers on a contractual basis for hospital (outpatient or inpatient) services. The registration process does not include full-time employees, personnel, or staff of health insurers, health maintenance organizations, or hospitals, or wholly owned subsidiaries thereof or affiliates under common ownership, when performing utilization review for their respective hospitals, health maintenance organizations, or insurers of the same insurance group. Agents contracted with the federal or state government that perform utilization review of Medicare or Medicaid claims or reviewing workers' compensation claims do not have to be registered under this section. Also, self-insurance funds or service organizations performing reviews of claims pursuant to chapter 440, F.S., or part VII of chapter 626, F.S., are not required to be registered under this section.

The AHCA indicates that utilization review agents are not inspected and have no regulatory penalties. There are currently 111 registered agents, 75 of whom are located in other states.

Adverse Incident Reporting

Nursing Homes
Chapter 2001-45, L.O.F., established the internal risk management and quality assurance program for nursing homes. The purpose of this program is to assess patient care practices; review facility quality indicators, facility incident reports, deficiencies cited by the AHCA, shared risk agreements, and resident grievances; and to develop plans of action to correct and respond quickly to identified quality deficiencies. Adverse incident reporting is one component of this program.

An adverse incident is defined in s. 400.147(5), F.S., as:

- An event over which facility personnel could exercise control and which is associated in whole or in part with the facility's intervention, rather than the condition for which such intervention occurred, and which results in one of the following:
  - Death,
  - Brain or spinal damage,
  - Permanent disfigurement,
  - Fracture or dislocation of bones or joints,
  - A limitation of neurological, physical, or sensory function,
  - Any condition that required medical attention to which the resident has not given his or her informed consent, including failure to honor advanced directives, or
  - Any condition that required the transfer of the resident, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the resident's condition prior to the adverse incident;
- Abuse, neglect, or exploitation as defined in s. 415.102, F.S.;
- Abuse, neglect and harm as defined in s. 39.01, F.S.;
- Resident elopement; or
- An event that is reported to law enforcement.

A facility must initiate an investigation and notify the AHCA of minimal information about an incident within one business day after the risk manager has received an incident report from a health care provider, agent, or employee of the nursing home. The minimal information reported includes, but is not limited to, whether the events causing or resulting in the adverse incident represent a potential risk to any other resident. The facility is to complete an investigation into the incident and submit an adverse incident report to the AHCA for each adverse incident within 15 calendar days after the occurrence. If, after investigation, the risk manager determines that the incident was not an adverse incident as defined, this determination must be reported to the AHCA.

Based on adverse incident reports submitted during 2006, 77.1 percent of the 1-day notifications were subsequently reported by the facility as not meeting the definition of adverse incident upon completing the 15-day investigation. The AHCA investigates a portion of the 1-day adverse incident notifications and two such investigations found serious deficiencies; however, both incidents were reported to the AHCA as part of a 5-day Federal reporting requirement for

mistreatment, neglect, abuse, including injuries of unknown source, and misappropriation of resident property required by federal law.[53]

Assisted Living Facilities
Section 429.23, F.S., provides a similar definition of "adverse incident" for assisted living facilities and has similar reporting requirements, but does not require an assisted living facility to employ a licensed risk manager.

AHCA Reporting to the Legislature
The AHCA is required to report annually to the Legislature on adverse incidents in nursing homes and assisted living facilities.[54] The report must include the following information arranged by county:

- A total number of adverse incidents;
- A listing, by category, of the types of adverse incidents occurring within each category and the type of staff involved;
- A listing, by category, of the types of injuries, if any, and the number of injuries occurring within each category,
- Types of liability claims filed based on an adverse incident report or reportable injury; and
- Disciplinary action taken against staff, categorized by the type of staff involved.

Department of Health

The Department of Health (DOH) is responsible for the licensure of most health care practitioners in the state. Chapter 456, F.S., provides general provisions for the regulation of health care professions in addition to the regulatory authority in specific practice acts for each profession or occupation. Section 456.001, F.S., defines "health care practitioner" as any person licensed under:

- Chapter 457 (acupuncture);
- Chapter 458 (medical practice);
- Chapter 459 (osteopathic medicine);
- Chapter 460 (chiropractic medicine);
- Chapter 461 (podiatric medicine);
- Chapter 462 (naturopathy);
- Chapter 463 (optometry);
- Chapter 464 (nursing);
- Chapter 465 (pharmacy);
- Chapter 466 (dentistry);
- Chapter 467 (midwifery);
- Part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468 (speech-language pathology and audiology; nursing home administration; occupational therapy; respiratory therapy; dietetics and nutrition practice; athletic trainers; and orthotics, prosthetics, and pedorthics);
- Chapter 478 (electrolysis);

[53] 42 C.F.R. §13(c).
[54] See s. 400.147(14), F.S., for nursing homes and s. 429.23(6), F.S., for assisted living facilities.

- Chapter 480 (massage practice);
- Part III or part IV of chapter 483 (clinical laboratory personnel and medical physicists);
- Chapter 484 (dispensing of optical devices and hearing aids);
- Chapter 486 (physical therapy practice);
- Chapter 490 (psychological services); or
- Chapter 491 (clinical, counseling, and psychotherapy services).

Section 456.072, F.S., and various practice acts regulating health care professions under the regulatory jurisdiction of the DOH contain provisions establishing grounds for which disciplinary action may be taken against licensed health care practitioners.[55]

Health Care Practitioner Disciplinary Proceedings

Section 456.073, F.S., sets forth procedures the DOH must follow in order to conduct disciplinary proceedings against practitioners under its jurisdiction. The DOH, for the boards under its jurisdiction, must investigate all written complaints filed with it that are legally sufficient. Complaints are legally sufficient if they contain facts, which, if true, show that a licensee has violated any applicable regulations governing the licensee's profession or occupation. Even if the original complainant withdraws or otherwise indicates a desire that the complaint not be investigated or prosecuted to its completion, the DOH, at its discretion, may continue its investigation of the complaint. The DOH may investigate anonymous, written complaints or complaints filed by confidential informants if the complaints are legally sufficient and the DOH has reason to believe after a preliminary inquiry that the alleged violations are true. If the DOH has reasonable cause to believe that a licensee has violated any applicable regulations governing the licensee's profession, it may initiate an investigation on its own.

When investigations of licensees within the DOH's jurisdiction are determined to be complete and legally sufficient, the DOH is required to prepare and submit to a probable cause panel of the appropriate board, if there is a board, an investigative report along with a recommendation of the DOH regarding the existence of probable cause. A board has discretion over whether to delegate the responsibility of determining probable cause to the department or to retain the responsibility to do so by appointing a probable cause panel for the board. The determination as to whether probable cause exists must be made by majority vote of a probable cause panel of the appropriate board, or by the DOH if there is no board or if the board has delegated the probable cause determination to the DOH.

The subject of the complaint must be notified regarding the DOH's investigation of alleged violations that may subject the licensee to disciplinary action. When the DOH investigates a complaint, it must provide to the subject of the complaint or her or his attorney a copy of the complaint or document that resulted in the initiation of the investigation. Except for cases involving physicians, within 20 days after the service of the complaint, the subject of the complaint may submit a written response to the information contained in the complaint. The

[55] The following sections of law provide grounds for which discipline may be imposed by boards for licensed health care practitioners under the Division of Medical Quality Assurance within the Department of Health: ss. 457.109, 458.331, 459.015, 460.413, 461.013, 462.14, 463.016, 464.018, 465.016, 466.028, 467.203, 468.1295, 468.1755, 468.217, 468.365, 468.518, 468.719, 468.811, 478.52, 480.046, 483.825, 483.901, 484.014, 484.056, 486.125, 490.009, and 491.009, F.S.

DOH may conduct an investigation without notification to the subject if the act under investigation is a criminal offense. If the department's secretary or her or his designee and the chair of its probable cause panel agree, in writing, that notification to the subject of the investigation would be detrimental to the investigation, then the DOH may withhold notification of the subject.

If the subject of the complaint makes a written request and agrees to maintain the confidentiality of the information, the subject may review the DOH's complete investigative file. The licensee may respond within 20 days of the licensee's review of the investigative file to information in the file before it is considered by the probable cause panel. Complaints and information obtained by the DOH during its investigations are exempt from the public records law until 10 days after probable cause has been found to exist by the probable cause panel or the DOH, or until the subject of the investigation waives confidentiality. If no probable cause is found to exist, the complaints and information remain confidential in perpetuity.

When the DOH presents its recommendations regarding the existence of probable cause to the probable cause panel of the appropriate board, the panel may find that probable cause exists or does not exist, or it may find that additional investigative information is necessary in order to make its findings regarding probable cause. Probable cause proceedings are exempt from the noticing requirements of ch. 120, F.S. After the panel convenes and receives the DOH's final investigative report, the panel may make additional requests for investigative information. Time limits are specified within which the probable cause panel may request additional investigative information from the DOH and within which the probable cause panel must make a determination regarding the existence of probable cause.[56] Within 30 days of receiving the final investigative report, the DOH or the appropriate probable cause panel must make a determination regarding the existence of probable cause. The secretary of the DOH may grant an extension of the 15-day and 30-day time limits outlined in s. 456.073(4), F.S. If the panel does not issue a letter of guidance or find probable cause within the 30-day time limit as extended, the DOH must make a determination regarding the existence of probable cause within 10 days after the time limit has elapsed.

Instead of making a finding of probable cause, the probable cause panel may issue a letter of guidance to the subject of a disciplinary complaint. Letters of guidance do not constitute discipline. If the panel finds that probable cause exists, it must direct the DOH to file a formal administrative complaint against the licensee under the provisions of ch. 120, F.S. The DOH has the option of not prosecuting the complaint if it finds that probable cause has been improvidently found by the probable cause panel. In the event the DOH does not prosecute the complaint on the grounds that probable cause was improvidently found, it must refer the complaint back to the board, which then may independently prosecute the complaint. The DOH must report to the appropriate board any investigation or disciplinary proceeding not before the Division of Administrative Hearings under ch. 120, F.S., or otherwise not completed within one year of the filing of the complaint. The appropriate probable cause panel then has the option to retain independent legal counsel, employ investigators, and continue the investigation, as it deems necessary.

[56] Section 456.073(4), F.S.

When an administrative complaint is filed against a subject based on an alleged disciplinary violation, the subject of the complaint is informed of her or his right to request an informal hearing if there are no disputed issues of material fact, or a formal hearing if there are disputed issues of material fact or the subject disputes the allegations of the complaint. The subject may waive her or his rights to object to the allegations of the complaint, which allows the DOH to proceed with the prosecution of the case without the licensee's involvement. Once the administrative complaint has been filed, the licensee has 21 days to respond to the DOH. If the subject of the complaint and the DOH do not agree in writing that there are no disputed issues of material fact, s. 456.073(5), F.S., requires a formal hearing before a hearing officer of the Division of Administrative Hearings under ch. 120, F.S.

The hearing provides a forum for the licensee to dispute the allegations of the administrative complaint. At any point before an administrative hearing is held, the licensee and the DOH may reach a settlement. The settlement is prepared by the prosecuting attorney and sent to the appropriate board. The board may accept, reject, or modify the settlement offer. If accepted, the board may issue a final order to dispose of the complaint. If rejected or modified by the board, the licensee and DOH may renegotiate a settlement or the licensee may request a formal hearing. If a hearing is held, the hearing officer makes findings of fact and conclusions of law that are placed in a recommended order. The licensee and the DOH's prosecuting attorney may file exceptions to the hearing officer's findings of facts. The boards resolve the exceptions to the hearing officer's findings of facts when they issue a final order for the disciplinary action.

The boards within the DOH have the status of an agency for certain administrative actions, including licensee discipline. A board may issue an order imposing discipline on any licensee under its jurisdiction as authorized by the profession's practice act and the provisions of ch. 456, F.S. Typically, boards are authorized to impose the following disciplinary penalties against licensees:

- Refusal to certify, or to certify with restrictions, an application for a license;
- Suspension or permanent revocation of a license;
- Restriction of practice or license;
- Imposition of an administrative fine for each count or separate offense;
- Issuance of a reprimand or letter of concern;
- Placement of the licensee on probation for a specified period of time and subject to specified conditions; or
- Corrective action.

Emergency Suspension of a License

An agency is authorized to take emergency action against a license if the agency finds that immediate serious danger to the public health, safety, or welfare requires emergency suspension, restriction, or limitation of a license.[57] The agency may take such action by any procedure that is fair under the circumstances if:

- The procedure provides at least the same procedural protection as is given by other statutes, the Florida Constitution, or the United States Constitution;

[57] Similar procedures are required for emergency rulemaking under the Administrative Procedure Act. See s. 120.54(4)(a), F.S.

- The agency takes only that action necessary to protect the public interest under the emergency procedure; and
- The agency states in writing at the time of, or prior to, its action the specific facts and reasons for finding an immediate danger to the public health, safety, or welfare and its reasons for concluding that the procedure used is fair under the circumstances.

The agency's findings of immediate danger, necessity, and procedural fairness are judicially reviewable.[58] Summary suspension, restriction, or limitation may be ordered, but a suspension or revocation proceeding under ss. 120.569 and 120.57, F.S., must also be promptly instituted and acted upon.

The MPI unit has the authority to immediately suspend a Medicaid provider under s. 409.913(16)(6), F.S., if the AHCA receives information of patient abuse or neglect or any act prohibited by s. 409.920, F.S. The DOH has the authority to immediately suspend a licensed health care practitioner under s. 456.074, F.S.

Health Care Practitioner Profiles

Each licensed medical physician, osteopathic physician, chiropractic physician, and podiatric physician is required to submit specified information that, beginning July 1, 1999, has been compiled into practitioner profiles to be made available to the public.[59] The information must include: graduate medical education; hospitals at which the physician has privileges; the address at which the physician will primarily conduct his or her practice; specialty certification; year the physician began practice; faculty appointments; a description of any criminal offense committed; a description of any final disciplinary action taken within the most recent 10 years; and professional liability closed claims reported to the Office of Insurance Regulation. The professional liability claims to be published in the practitioner profiles are limited to paid claims reported within the previous 10 years that exceed specified amounts under s. 456.041(4), F.S.[60]

In addition, the physician may submit: professional awards and publications; languages, other than English, used by the physician to communicate with patients; an indication of whether the physician participates in the Medicaid program; and relevant professional qualifications, as defined by the applicable board of the physician. Each person who applies for initial licensure as a medical physician, osteopathic physician, chiropractic physician, or podiatric physician must, at the time of application, and each medical physician, osteopathic physician, chiropractic physician, or podiatric physician must, in conjunction with the renewal of the license, submit the information required for practitioner profiles.

Each person who has submitted information under the practitioner profiling requirements is required to update that information in writing by notifying the DOH within 15 days after the occurrence of an event or the attainment of a status that requires reporting as part of the profiling

[58] See also s. 120.68, F.S., which provides for immediate judicial review of final agency action.
[59] Section 456.039, F.S.
[60] Section 456.051(1), F.S., requires the DOH to make all reports of claims or actions for damages for personal injury available as a part of the practitioner's profile within 30 calendar days without any specified limitation on the amount of the claim or the time that the claim was incurred.

requirements.[61] Persons who register to practice medicine as an intern, resident, or fellow and who apply for physician licensure are exempt from the practitioner profiling requirements. The DOH must compile the information submitted by a physician licensure applicant into a practitioner profile.

Florida 211 Network

A Florida 211 Network provider is an information and referral organization whose primary purpose is to maintain information about human service resources in the community, supply descriptive information about the agencies or organizations that offer services, and assist consumers in accessing appropriate providers.[62] As of December 17, 2008, there are 16 active 211 Network providers throughout the state.[63] A number of agencies provide similar services in rural areas but do not have sufficient funding to meet the requirements of AIRS for accreditation. As a result, they operate using regular seven digit numbers rather than 211.

The FLAIRS is a statewide association of agencies and individuals committed to the provision of quality information, referral and hotline services. FLAIRS is the state chapter of the national Alliance of Information and Referral Systems (AIRS). Members include United Ways, crises hotlines, libraries, military service centers, elder hotlines, child care resource and referral providers, and other who provide hotline and information services.

The Agency conducts an on-site visit as a part of the certification process unless the provider is accredited by the AIRS. The Standards for Professional Information & Referral: Requirement for AIRS Accreditation and Operating 211 Systems[64] defines the national standards for information and referral programs and systems.

Currently the Florida 211 Network receives no general revenue funds. It is funded through various sources including the United Way, local government, nonprofit agencies, corporations, private grants, and private donations.

Florida Motor Vehicle No-Fault Law

In Florida, motorists are required to maintain personal injury protection (PIP) coverage and property damage liability coverage.[65] PIP provides $10,000 of coverage for the following: payment of 80 percent of reasonable medical expenses, 60 percent of loss of income, and a death benefit of $5,000 or the remainder of the unused PIP benefits, whichever is less, for bodily injury sustained in a motor vehicle accident, without regard to fault. PIP covers the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in the insured motor vehicle, and persons struck by the motor vehicle. This coverage also

[61] Section 456.042, F.S. Sections 456.039 and 456.0391, F.S., require that the written update be provided within 45 days of the occurrence of an event or the attainment of a status that requires reporting as part of the profiling requirements.
[62] Rule 59G-11.002, F.A.C.
[63] FLAIRS 211 Network Plan available at: <http://flairs.org/pdf/fl211providers.pdf>, (Last visited on February 27, 2009).
[64] Published by the Alliance of Information and Referral Systems is available at: <http://211canada.typepad.com/informcanada/files/airs_standards_version_5.2_Canadian%20English.pdf>, (Last visited on February 27, 2009).
[65] Section 627.7275, F.S.

provides the policyholder with immunity from liability for economic damages (medical expenses) up to the $10,000 policy limits and for non-economic damages (pain and suffering) for most injuries.

The most common types of PIP fraud are health care clinic fraud and staged accidents.[66] In fiscal year 2007/2008, nearly half of the Division of Insurance Fraud's convictions involved fraudulent claims for PIP benefits and there were 1,176 complaints of fraudulent activity committed by health care providers.

Continuing Care Retirement Communities

Continuing Care Retirement Communities (CCRC) allow seniors to "age in place," with flexible accommodations that are designed to meet their health and housing needs as these needs change over time. Residents entering CCRCs sign a long-term contract that provides for housing, services and nursing care, usually all in one location, enabling seniors to remain in a familiar setting as they grow older. CCRC are regulated by the Office of Insurance Regulation under chapter 651, F.S. Florida law provides that CCRCs must meet the financial, contractual, resident standards, advertising limitations, and other specifications in law to receive a certificate of authority. The Office of Insurance Regulation must inspect the business of any CCRC applicant or any provider providing care for a CCRC under contract at least once every 3 years but has the authority to examine a certified CCRC anytime. According to the Office of Insurance Regulation website, there are currently 117 certified CCRCs in Florida.

III. Effect of Proposed Changes:

Section 1 creates an undesignated section of law that provides for legislative findings to specify that immediate and proactive measures are necessary to prevent, reduce, and mitigate health care fraud, waste, and abuse. The bill designates Miami-Dade County as a health care fraud crisis area of concern for the purpose of increased scrutiny of home health agencies, home medical equipment providers, health care clinics, and other health care providers in Miami-Dade County in order to prevent Medicaid fraud, waste, and abuse.

Section 2 amends s. 68.085, F.S., relating to prevailing actions, based on a claim of funds from the state Medicaid program, under the Florida False Claims Act and the distribution of proceeds, to provide that after the proceeds are distributed as required by law in subsections (1), (2), and (3) of that section, 10 percent of the remaining proceeds must be deposited into the Legal Affairs Revolving Trust Fund to fund the Medicaid fraud monetary reward program created in section 15 of the bill, which provides rewards to persons who report valuable Medicaid fraud information. Any remaining funds are deposited into the General Revenue Fund.

Section 3 amends s. 68.086, F.S., relating to the awarding of attorney's fees under the Florida False Claims Act, to make it more difficult to award attorney's fees to a False Claims Act defendant, but also to remove a disincentive for a person to bring an action. Current law specifies that if the Department of Legal Affairs or the Department of Financial Services does not proceed

[66] See Senate Interim Report Number 2006-102, *Florida's Motor Vehicle No-Fault Law*, Found at: http://www.flsenate.gov/data/publications/2006/senate/reports/interim_reports/pdf/2006-102bilong.pdf (Last visted April 21, 2009).

with an action under this act and the defendant is the prevailing party, the court shall award the defendant reasonable attorney's fees and costs against the person bringing the action.

The bill specifies that if the defendant is the prevailing party in a False Claims Act case, the court *may* award attorney's fees if the court finds that the action was clearly frivolous, clearly vexatious, or brought primarily for the purposes of harassment. This statutory change should conform the Florida False Claims Act to the Federal False Claims Act and qualify Florida to keep an additional 10 percent of the federal portion of Medicaid recoveries.

Section 4 amends s. 400.471, F.S., to prohibit the AHCA from renewing a home health agency license, if the applicant is located in a county that has at least one home health agency and the county has more than one home health agency per 5,000 persons, based on the most recent population estimates published by the Legislature's Office of Economic and Demographic Research, *and* the applicant, or any controlling interest, has been administratively sanctioned by the AHCA since the last approved licensure renewal application for one or more of the following actions:

- An intentional or negligent act that materially affects the health or safety of a client of the provider;
- Knowingly providing home health services in an unlicensed assisted living facility or unlicensed adult family-care home, unless the home health agency or employee reports the unlicensed facility or home to the AHCA within 72 hours after providing the services;
- Preparing or maintaining fraudulent patient records, such as, but not limited to, charting ahead, recording vital signs or symptoms that were not personally obtained or observed by the home health agency's staff at the time indicated, borrowing patients or patient records from other home health agencies to pass a survey or inspection, or falsifying signatures;
- Failing to provide at least one service directly to a patient for a period of 60 days;
- Demonstrating a pattern of falsifying documents of training for home health aides or certified nursing assistants; or health statements for staff providing direct care to patients. A pattern may be demonstrated by a showing of at least three fraudulent entries or documents;
- Demonstrating a pattern of billing any payor for services not provided. A pattern may be demonstrated by a showing of at least three billings for services not provided within a 12-month period;
- Demonstrating a pattern of failing to provide a service specified in the home health agency's written agreement with a patient or the patient's legal representative, or the plan of care for that patient, unless a reduction in service is mandated by Medicare, Medicaid, or a state program or as provided in s. 400.492(3), F.S. A pattern may be demonstrated by a showing of at least three incidences, regardless of the patient or service, where the home health agency did not provide a service specified in a written agreement or plan of care during a three-month period;
- Giving 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 ch. 395, ch. 429, or ch. 400, F.S., from whom the home health agency receives referrals;
- Giving cash, or its equivalent, to a Medicare or Medicaid beneficiary;

- Demonstrating a pattern of billing the Medicaid program for services to a Medicaid recipient that are medically unnecessary. A pattern may be demonstrated by a showing of at least two fraudulent entries or documents;
- Providing services to residents in an assisted living facility for which the home health agency does not receive fair market value remuneration; or
- Providing staffing to an assisted living facility for which the home health agency does not receive fair market value remuneration.

Section 5 amends s. 400.474, F.S., to create an additional administrative penalty for home health agencies. The bill gives the AHCA the authority to deny, revoke, or suspend the license of a home health agency and requires the AHCA to impose a fine of $5,000 against a home health agency that demonstrates a pattern of billing the Medicaid program for services to a Medicaid recipient that are medically unnecessary. A pattern may be demonstrated by a showing of at least two medically unnecessary services. The bill also specifies that the AHCA may sanction a home health agency that provides remuneration to persons involved in the discharge planning process for facilities licensed under ch. 429, F.S. (assisted care communities).

The bill specifies that a home health agencies that provides discounts, compensation, payment waivers, or reimbursement under certain federal laws[67] cannot be construed by the AHCA as:

- Giving 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, 429, or 400, F.S., from whom the home health receives referrals; or
- Giving remuneration to a physician while also violating the home health agency contract provisions in s. 400.474(6)(h), F.S., or s. 400.474(6)(i), F.S.; giving remuneration to a member of the physician's office staff; or 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.

Section 6 amends s. 400.506, F.S., to allow a nurse registry to provide promotional items, including products, food, and beverages, to the staff responsible for facility discharge planning and to staff associated with a physician office, from which the nurse registry has received a referral in the last 12 months. The bill limits the cumulative value of the promotional items allowed in the bill to $50 for a single event. The cumulative value of all items to the persons affiliated with a facility or a physician office may not exceed $100 in a calendar year.

Section 7 creates s. 408.8065, F.S., to establish additional licensure requirements for home health agencies, home medical equipment providers, and health care clinics. The bill requires applicants for initial licensure, or initial licensure due to change of ownership, as a home health agency, home medical equipment provider, or health care clinic to demonstrate their financial ability to operate, as required under s. 408.810(8), F.S., and:

- Submit pro forma financial statements, including a balance sheet, income and expense statement, and statement of cash flows for the first two years of operation to provide evidence that the applicant has sufficient assets, credit, and projected revenues to cover liabilities and expenses; and

[67] 52 U.S.C. s. 1320a-7b(b), 42 C.F.R s. 1001.952, or by 42 U.S.C. s. 1395nn.

- Submit a statement of the applicant's estimated startup costs and sources of funds through the break-even point in operations to demonstrate that the applicant has the ability to fund all startup costs. The statement must show that the applicant has at a minimum 3 months of average projected expenses to cover startup costs, working capital, and contingency financing. The minimum amount for contingency funding shall not be less than one month of average projected expenses.

The bill specifies that an applicant will have demonstrated the financial ability to operate if the applicant's assets, credit, and projected revenues meet or exceed projected liabilities and expenses and the applicant has provided independent evidence that the funds necessary for startup costs, working capital, and contingency financing exist and are available. The required financial statements are required to be signed by a certified public accountant and prepared in accordance with generally accepted accounting principles.

This bill creates a third-degree felony offense, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, F.S., for a person licensed under part III (home health agencies and nurse registries), part VII (home medical equipment providers), or part X (health care clinics) of ch. 400, F.S., who knowingly files a false or misleading license or license renewal application or who submits false or misleading information related to such application. This is in addition to penalties provided under ch. 408, F.S.

Section 8 amends s. 408.810, F.S., to revise the general licensing provisions for all facilities licensed by the AHCA to require that, unless otherwise specified, any information required to be reported to the AHCA must be submitted within 21 calendar days after the report period or effective date of the information, *whichever occurs earlier* and specifies that this includes, but is not limited to any change of information contained in the most recent application for licensure and required insurance or bonds.

The bill requires all facilities licensed under part II of ch. 408, F.S., to inform each client, or his or her representative, on or before the first day services are provided, of the right to report Medicaid fraud and provide each person an AHCA written description of what constitutes Medicaid fraud with the statewide toll-free number for the central Medicaid fraud hotline.

Section 9 amends s. 408.815, F.S., to direct the AHCA to deny the licensure application for any facility licensed under part II of ch. 408, F.S, if the applicant, or a person having a controlling interest in the applicant, has been:

- Convicted of, or enters a plea of guilty or nolo contendere to, regardless of adjudication, a felony under ch. 409, F.S., ch. 817, F.S., ch. 893, F.S., 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396; or
- Terminated *for cause*, pursuant to the appeals procedures established by the state or federal government, from any state Medicaid program or the federal Medicare program.

Section 10 amends s. 409.905(4), F.S., relating to home health services in the Medicaid program, to require home health agencies that exceed the statewide home health services utilization rate by 50 percent to undergo prior authorization for Medicaid home health service visits not associated with a skilled nursing visit. The bill specifies that prior authorization includes the submission of

a Medicaid recipient's plan of care and documentation that supports the recipient's diagnosis to the AHCA.

The bill requires that Medicaid home health services must be ordered by a physician and meet all of the following requirements:

- The written prescription for service must be signed and dated by the recipient's physician before the development of a plan of care or any request requiring prior authorization.
- The physician ordering the home health services must not be employed by, under contract with, or otherwise affiliated with the home health agency rendering services. The bill creates an exemption for this requirements for home health agency or agencies that are affiliated with a retirement community, of which the parent corporation or related legal entity owns a rural health clinic certified under part II of ch. 400, F.S., and apartments and single family homes for independent living.
- The physician ordering the services must have examined the recipient no more than 30 days before the initial request for home health services and biannually thereafter.
- The written prescription for the services must include the recipient's acute or chronic medical condition or diagnosis, the home health service required, and for skilled nursing services the frequency and duration of the services.
- The national provider identifier, Medicaid identification number, or medical practitioner license number of the physician who ordered the services must be listed on the written prescription for home health services, the claim for home health reimbursement, and the home health service prior authorization request.

Section 11 amends s. 409.907, F.S., to authorize the AHCA to enroll Medicaid providers that are located up to 50 miles from the Florida state line when the AHCA determines a need for that provider type to ensure adequate access to care.

Section 12 amends s. 409.912, F.S., to direct the AHCA to eliminate any overutilization of Medicaid services that are medically unnecessary in the Medicaid program. The bill requires the AHCA to:

- Track Medicaid provider prescription and billing patterns and evaluate them against Medicaid medical necessity criteria and coverage and limitation guidelines promulgated in rule;
- Conduct reviews of provider exceptions to peer group norms and will detect and investigate abnormal or unusual increases in billing or payment of claims for Medicaid services, using statistical methodologies, provider profiling and analysis of billing patterns;
- Refer providers that demonstrate a pattern of submitting claims for medically unnecessary services to the Medicaid program integrity unit for investigation; and
- Report on the AHCA efforts to control overutilization of Medicaid services in the MPI and MFCU annual report required in s. 409.913, F.S.

Section 13 amends s. 409.913, F.S., relating to the responsibilities of the MPI unit to add requirements to the MPI and the MFCU of the Department of Legal Affairs' annual report that documents the effectiveness of the state's efforts to control Medicaid fraud and abuse and

recover Medicaid overpayments during the previous fiscal year. The additional reporting requirements include:

- Policy recommendations to prevent and detect Medicaid fraud;
- All policy recommendations or changes recommended in the report must include a detailed fiscal analysis; and
- Unit specific performance standards, benchmarks, and metrics that include a projected cost savings to the Medicaid program in the following fiscal year.

In addition, the policy recommendations in the report must be submitted to the appropriate estimating conference by February 15 of each year.

The bill requires the MPI to identify and monitor patterns of utilization of Medicaid services based on peer group norms.

The bill requires the AHCA to deny reimbursement or require repayment for Medicaid goods and services that do not meet the following criteria:

- Are furnished to the recipient prior to submission of a claim for reimbursement;
- Are Medicaid-covered goods or services that are medically necessary;
- Are of comparable quality to those furnished to the general public by the provider's peers;
- Have not been billed in whole or in part to a recipient or a recipient's responsible party, except for copayments, coinsurance, or deductibles as authorized by the AHCA;
- Are provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law; and
- Are documented by records that demonstrate medical necessity and that are made at the time the goods or services were provided.

Currently, the AHCA has the option to deny payment or require repayment for claims that do not meet the criteria listed above, but is not required to deny payment or require repayment. The bill requires the AHCA to deny payment or require repayment for inappropriate, medically unnecessary, or excessive goods or services.

The bill requires the AHCA to immediately terminate a provider from participating in the Medicaid program, if the provider or an affiliated person of the provider has been:

- Convicted of a criminal offense related to the delivery of any health care goods or services, including the performance of management or administration functions relating to the delivery of health care goods or services;
- Convicted of a criminal offense under federal law or the law of any state relating to the practice of the provider's profession; or
- Found by a court of competent jurisdiction to have neglected or physically abused a patient in connection with the delivery of goods or services.

Currently, the AHCA has the option to terminate providers for these offenses, but it is unclear if the AHCA's termination authority includes an immediate final order under s. 120.596(2)(n), F.S. The bill requires the AHCA to immediately terminate the provider for the offenses listed above, unless the AHCA determines a provider did not participate or acquiesce the offense.

The bill clarifies that providers subject to immediate termination under this subsection include persons connected with corporations or other business entities that are Medicaid providers including any principal, officer, director, agent, managing employee, affiliated person, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater.

The bill requires the AHCA to immediately suspend or terminate, as appropriate, a provider from participation in the Florida Medicaid program if the provider participated or acquiesced in any action for which a principal, officer, director, agent, managing employee, affiliated person, or partner or shareholder with a 5 percent or greater ownership interest was suspended or terminated from participating in the Medicaid program or the Medicare program by the federal government or any state.

The bill requires the AHCA to seek all remedies provided in law if a provider violates any of the offenses enumerated in s. 409.913(15), F.S. Currently, the AHCA has the *option* to exercise this authority but it is not required to do so. The bill also clarifies that violations may involve action or inaction by the provider. The bill also subjects the provider to sanctions for actions or inactions in violation of s. 409.913(15), F.S., by a principal, officer, director, agent, managing employee, affiliated person, or partner or shareholder with a 5 percent or greater ownership interest if the provider participated or acquiesced in the actions or inactions.

The bill specifies that when the AHCA finds evidence of overpayment while reviewing a Medicaid provider's records, calculation of the overpayment must be based on the documentation created prior to the start of any investigation or documentation created at the request of the AHCA.

The bill requires that any documentation or data relied upon or presented as evidence by a provider in a court or administrative procedure to contest an overpayment claim must have been created prior to the start of any AHCA investigation or created at the request of the AHCA. Such documentation or data must also be provided to the AHCA before issuance of the final audit report. The bill authorizes providers to submit documentation or data that was recreated due to extenuating circumstances beyond the provider's control if evidence of the circumstances are also provided.

The bill specifies that when the AHCA administratively sanctions a provider or controlling interest under sections (13), (14), and (15) of s. 409.913, F.S., excluding paragraphs (15)(e) and (o), which is regulated by another entity, it must notify the regulatory authority of the provider, within five working days. The bill specifies that the notification requirement applies to controlling interests of the provider and that the notification must occur within five working days.

The bill requires the AHCA to withhold Medicaid payments when it receives reliable evidence that a provider was involved in fraud, willful misrepresentation, abuse, or a crime while providing Medicaid services to a Medicaid recipient. If the provider is cleared of the allegation, the AHCA must reimburse the provider with a 10 percent interest rate within 14 days of the determination. The bill also requires the AHCA to withhold Medicaid payments if the Medicaid goods or services were furnished or supervised by a person who has been terminated from any

state Medicaid program or federal Medicare program. Currently, the AHCA has the option to exercise these authorities but the bill requires the AHCA to exercise its authority.

The bill requires the AHCA to exercise its authority to withhold reimbursement from a provider when the AHCA has made a probable cause determination and alleged that an overpayment to a Medicaid provider has occurred and the provider has been notified until:

- The results of an administrative hearing under ch. 120, F.S.; or
- In the 30 days after notification, the provider makes payment in full or establishes an agreed upon payment plan with the AHCA.

Currently, the AHCA has the option to exercise this authority, but the bill requires the AHCA to exercise its authority.

The bill requires the AHCA to terminate a provider's participation in the Medicaid program if the provider does not reimburse an overpayment within 35 days after a final order, unless the provider and the AHCA have entered into a repayment agreement.

The bill requires that the letter sent to Medicaid recipients that explains their benefits must once a year include information on how to report criminal Medicaid fraud, the Medicaid Fraud Control Unit's toll-free hotline number, and the reward program created in the bill. The bill requires the AHCA to post a list of all Medicaid providers, including controlling interests, that have been sanctioned or terminated from the Medicaid program. The list must be updated at least monthly, and must be searchable, printable, and available for download.

The bill requires the AHCA to:

- Compile, maintain, and publish on its website a detailed list of all state and federal databases that contain health care fraud information and update the list at least biannually;
- Develop a strategic plan to connect all databases that contain health care fraud information;
- Monitor innovations in health information technology, specifically as it pertains to Medicaid fraud prevention and detection; and
- Periodically publish policy briefs that highlight available new technology to prevent or detect health care fraud and projects implemented by other states, the private sector, or the Federal Government which use technology to prevent or detect health care fraud.

Section 14 amends s. 409.920, F.S., related to Medicaid provider fraud, to add a definition of a "managed care organization" to this section of law and to specify that a person may not make, cause to be made, or aid and abet in the making of any false statement or false representation of a material fact, by commission or omission, in any claim submitted to the agency, its fiscal agent, or a managed care organization for payment.

The bill provides immunity from civil liability for any person who provides the state with information about fraud or suspected fraud by a Medicaid provider, including a managed care organization, unless the person acted with knowledge that the information was false or with reckless disregard for the truth or falsity of the information. Current law provides immunity from civil liability for persons who report workers' compensation fraud under s. 440.1051, F.S., persons who report any violation of ch. 560, F.S., and persons who provide information about the financial condition of an insurer under s. 624.3102, F.S.

The bill increases penalties for any violation of s. 409.920(2), F.S., which provides that a person may not knowingly:

- Make, cause to be made, or aid and abet in the making of any false statement or false representation of a material fact, by commission or omission, in any claim submitted to the AHCA or its fiscal agent or a managed care organization for payment;[68]
- Make, cause to be made, or aid and abet in the making of a claim for items or services that are not authorized for reimbursement by Medicaid;
- Charge, solicit, accept, or receive anything of value, other than an authorized copayment from a Medicaid recipient, from any sources in addition to the amount legally payable for an item or service provided to a Medicaid recipient under the Medicaid program or fail to credit the AHCA or its fiscal agent for any of the payments received from a third-party source;
- Make, or in any way cause to be made, any false statement or false representation of a material fact, by commission or omission, in any document containing items of income and expense that is or may be used by the AHCA to determine a general or specific rate of payment for an item or service provided by a provider;
- Solicit, offer, pay or receive any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in case or in kind, in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made, in whole or in part, under the Medicaid program, or in return for obtaining, purchasing, leasing, ordering, or arranging for or recommending, obtaining, purchasing, leasing, or ordering any goods, facility item, or service, for which payment may be made, in whole or in part, under the Medicaid program;
- Submit false or misleading information or statements to the Medicaid program for the purpose of being accepted as a Medicaid provider; or
- Use or endeavor to use a Medicaid provider's identification number or any Medicaid recipient's identification number to make, cause to be made, or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed by the Medicaid program.

The bill provides that a person who violates of any of the provisions listed above and receives or endeavors to receive anything of value commits a felony. The degree of the felony is determined by the dollar value of the fraud as follows:

- $10,000 or less – third-degree felony, punishable by imprisonment for up to five years and a fine of up to $5000;
- More than $10,000 but less than $50,000 – second-degree felony, punishable by imprisonment for up to 15 years and a fine of up to $10,000; or
- $50,000 or more – first-degree felony, punishable by imprisonment for up to 30 years and a fine of up to $10,000.

Section 24 of the bill adds these penalties to the Criminal Punishment Code that is used in conjunction with the Criminal Punishment Code worksheet, codified in s. 921.0024, F.S., to compute the sentence score for each felony offender. The offense severity ranking chart has 10 offense levels, with level 1 offenses the least severe and level 10 offenses the most severe.

[68] The bill adds claims made to a managed care organization, which are not currently included in s. 409.920(2)(a), F.S.

The third- and second-degree felonies in the bill are added to the level 7 severity ranking chart, and the first-degree felony is added to the level 9 severity ranking chart.

The bill provides that the value of all the separate funds, goods, or services the person received or attempted to receive in a scheme or course of conduct may be aggregated to determine the degree of the offense.

The bill requires persons convicted under subsection 409.920(2), F.S., to pay a fine that is equal to five times the money unlawfully received or the loss incurred by the Medicaid program or managed care organization, whichever is greater, in addition to any criminal sentence that is imposed.

Current law provides only for a third-degree felony for any violation of s. 409.920(2), F.S., and does not link the penalty to a dollar amount. The penalty scheme created in the bill is similar to the penalty provisions for Medicaid fraud as it relates to prescription drugs, codified in s. 409.9201, F.S.

Section 15 creates s. 409.9203, F.S., to offer a monetary reward to any person who reports original information that relates to a violation of the state Medicaid fraud laws. The information must be reported to the Office of the Attorney General, the AHCA, the DOH, or the Department of Law Enforcement and result in a recovery of a fine, penalty, or forfeiture of property. The bill does not define "original information."

The reward monies will be collected from proceeds recovered under the Florida False Claims Act, pursuant to s. 68.085, F.S., as amended in section 2 of this bill. The amount of each award will be 25 percent of the monies recovered or $500,000, whichever is smaller.

Reward recipients are not eligible to receive monies under the Florida False Claims Act for the same information reported pursuant to this section. The bill allows individuals to decline a reward.

Section 16 amends s. 456.004, F.S., to direct the Department of Health (DOH) to work cooperatively with the AHCA and the judicial system to recover Medicaid overpayments. The bill requires the DOH to investigate and prosecute health care practitioners who, after a final order, judgment, stipulation, or settlement, have not remitted amounts owed to the state for an overpayment from the Medicaid program.

Section 17 amends s. 456.041, F.S., to require the DOH to include a statement that indicates that the practitioner has been terminated from participating in the state Medicaid program or sanctioned by the Medicaid program in the practitioner profiles of the physicians and advanced registered nurse practitioners who have been terminated from participating in the state Medicaid program or sanctioned by the Medicaid program.

Section 18 creates s. 456.0635, F.S., to prohibit fraud in the practice of a health care profession. The bill prohibits the DOH and the medical boards within the DOH from allowing any person to sit for an examination, who has been:

- Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under ch. 409, F.S., ch. 817, F.S, ch. 893, F.S., 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396; or
- Terminated *for cause*, pursuant to the appeals procedures established by the state or Federal Government, from any state Medicaid program or the federal Medicare program.

The DOH and the medical boards must refuse to issue or renew a license, certificate, or registration to an applicant, or person affiliated with that applicant, who has violated any of the same provisions.

The bill directs health care practitioners to report allegations of Medicaid fraud to the DOH, regardless of the practice setting.

Section 19 amends s. 456.072, F.S., to provide that the following acts are grounds for discipline:
- Being convicted of, or entering a plea of guilty or nolo contendere to, any misdemeanor or felony, regardless of adjudication, 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;
- Failing to remit the sum owed to the state for an overpayment from the Medicaid program pursuant to a final order, judgment, or stipulation or settlement;
- Being terminated from the state Medicaid program pursuant to s. 409.913, F.S., any other state Medicaid program, or the federal Medicare program; and
- Being convicted of, or entering a plea of guilty or nolo contendere to, any misdemeanor or felony, regardless of adjudication, a crime in any jurisdiction which relates to health care fraud.

Section 20 amends s. 456.074, F.S., to expand the DOH's authority to immediately suspend the license of a practitioner licensed under ch. 458, 459, 460, 461, 462, 463, 464, 465, 466, or 484, F.S., who pleads guilty to, is convicted of, or who enters a plea of nolo contendere to, regardless of adjudication, certain crimes, to include 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 21 amends s. 465.022, F.S., to increase the pharmacy permit requirements.

The bill provides that a pharmacy permit may be issued to a partnership, if the partners are at least 18 years of age.

The bill requires pharmacy permit applications submitted by a corporation to include a set of fingerprints from each person who has an ownership interest in the corporation of 5 percent or greater and from any person who directly, or indirectly, manages, oversees, or controls the operations of the applicant, including officers and members of the board of directors. The fingerprints will be submitted to the Department of Law Enforcement for a state criminal history records check and forwarded to the Federal Bureau of Investigation for a national criminal history records check. Permit applicants must submit payment for the background checks along with their application. Pharmacy permit applicants may meet the fingerprint requirement if the applicant has fingerprints on file with the DOH or the AHCA, the fingerprints meet the

Department of Law Enforcement's specifications for submission, and the fingerprints are available to the DOH.

The bill requires the DOH to limit the fingerprint requirement, for corporations that have more than $100 million in business taxable assets in this state, to the prescription department manager who will be directly involved in the management of the pharmacy.

The bill requires the DOH or the Board of Pharmacy to deny a pharmacy permit application if the applicant or any person affiliated with the applicant has:

- Obtained a permit by misrepresentation or fraud;
- Attempted to procure, or has procured, a permit for any other person by making, or causing to be made, any false representation;
- Been convicted or found guilty, regardless of adjudication, of a felony or any other crime involving moral turpitude in any of the courts of this state, of any other state, or of the United States; or
- Dispensed any medicinal drug based upon a communication that purports to be a prescription as defined by s. 465.003(14), F.S., or s. 893.02, F.S., when the pharmacist knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship that includes a documented patient evaluation, including history and a physical examination adequate to establish the diagnosis for which any drug is prescribed and any other requirement established by board rule under chs. 458, 459, 461, 463, 464, or 466, F.S.

Current law does not give the DOH or the Board of Pharmacy the authority to deny a pharmacy permit application.

Section 22 amends s. 465.023, F.S., to create additional authority for the DOH or Board of Pharmacy to revoke or suspend the permit of any pharmacy permittee, or discipline a pharmacy permittee, if a permittee, or a person affiliated with the permittee has:

- Been convicted of or disciplined by a regulatory agency of the Federal Government or a regulatory agency of another state for any offense that would constitute a violation of ch. 465, F.S.;
- Been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to the practice of, or the ability to practice, the profession of pharmacy; or
- Been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to health care fraud.

Current law gives the DOH or the board of pharmacy the authority to revoke or suspend a permit, or to fine, place on probation, or discipline a pharmacy permittee for the violations listed below.

- Obtained a permit by misrepresentation or fraud or through an error of the department or the board;
- Attempted to procure, or has procured, a permit for any other person by making, or causing to be made, any false representation;

- Been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to the practice of, or the ability to practice, the profession of pharmacy;
- Been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to health care fraud;
- Been terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from any state Medicaid program or the federal Medicare program; or
- Dispensed any medicinal drug based upon a communication that purports to be a prescription as defined by s. 465.003(14), F.S., or s. 893.02, F.S., when the pharmacist knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship that includes a documented patient evaluation, including history and a physical examination adequate to establish the diagnosis for which any drug is prescribed and any other requirement established by board rule under Chapters. 458, 459, 461, 463, 464, or 466, F.S.

Section 23 amends s. 825.103, F.S., to expand the definition of "exploitation of an elderly person or disabled adult" to include the breach of a fiduciary duty to an elderly person or disabled adult by the person's guardian or agent under a power of attorney which results in the unauthorized appropriation, sale, or transfer of property.

The investigation of abuse, neglect, and exploitation of patients that reside in Medicaid funded facilities is under the purview of the MFCU. The MFCU suggested supplementing the definition of what constitutes exploitation of an elderly person or disabled adult to address the unlawful spend-down of an elderly or disabled adult's assets by the guardian or agent under power of attorney, that often qualifies the elderly or disabled person for Medicaid.

Section 24 amends s. 921.0022, F.S., to add the offenses created in section 14 of the bill to the offense severity ranking chart of the Criminal Punishment Code.

Sections 25 requires the AHCA to develop and implement a home health agency monitoring pilot project in Miami-Dade County by January 1, 2010. The bill requires the AHCA to contract with a vendor to verify the utilization and delivery of the home health services and provide an electronic billing interface for home health service reimbursement. The pilot project must telephonically verify the delivery of home health services using voice biometrics. The bill requires the AHCA to submit a report evaluating the pilot project by February 1, 2011, to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Sections 26 requires the AHCA to implement a comprehensive home health care management pilot project by January 1, 2010, which includes face-to-face assessments by a licensed nurse, consultations with prescribing physicians to substantiate the medical necessity of services, and on-site or desk reviews of recipient medical records. The AHCA is directed to implement the pilot in an area of the state that has demonstrated an aberration in the utilization of Medicaid home health services.

Sections 27 and 28 amend ss. 400.0077 and 430.608, F.S., respectively, to conform cross-references.

Section 29 repeals s. 395.0199, F.S., related to private utilization review and the registration of private utilization review agents.

Section 30 amends s. 395.405, F.S., to delete the authorization for the DOH to adopt rules related to s. 395.0199, F.S., which is repealed in section 29 of the bill.

Section 31 amends s. 400.0712, F.S., to delete a reference to s. 408.831(4), F.S., which is repealed in section 50 of the bill. The substantive legislation, authorizing an inactive license under certain circumstances, is amended into s. 408.821, F.S., in section 48 of the bill.

Section 32 repeals s. 400.118(2), F.S., to eliminate the quality-of-care monitors for nursing homes.

Section 33 amends s. 400.141, F.S., to eliminate the requirement for a nursing home to report monthly the number of vacant beds in the facility which are available for resident occupancy on the day the information is reported and to renumber the subsections and paragraphs.

Section 34 amends s. 400.147, F.S., related to the requirement for a nursing home to report adverse incidents to the AHCA, to amend the definition of an adverse incident to include an event over which the nursing home personnel could exercise control and that is reported to a law enforcement agency or its personnel for investigation. All resident elopements are not required to be reported, only those in which the elopement places the resident at risk of harm or injury. A nursing home is no longer required to report as an adverse incident all instances of abuse, neglect, or exploitation as defined in s. 415.102, F.S., related to adult protective services or abuse, neglect and harm as defined in s. 39.01, F.S., addressing proceedings relating to children. Instead, the committee substitute requires abuse, neglect, or exploitation to be reported to the the AHCA as required by 42 C.F.R. s. 483.13(c) (within five working days after the incident) and to the Department of Children and Family Services as required by ch. 39, F.S., (proceedings related to children) and ch. 415, F.S., (adult protective services) immediately to the Central Abuse Hotline.

In addition, the bill eliminates the requirement for the AHCA to submit a report on adverse incidents in nursing homes to the Legislature, annually.

Section 35 amends s. 400.162, F.S., to require a nursing home to provide a copy of the policy pertaining to minimizing the risk of theft or loss of the personal property of residents to the resident's representative, if appropriate, and to provide a copy of the policy when revised to every employee, resident and resident's representative. The facility is no longer required to post this policy in places accessible to residents.

Section 36 amends s. 400.191, F.S., to eliminate the requirement for the AHCA to annually publish the Nursing Home Guide in printed form. The bill also removes the requirement for the Nursing home guide to include facility deficiency data, nursing home care alternatives, a list of all nursing home facilities in the state, and other nursing home facility data.

Section 37 amends s. 400.195, F.S., related to the AHCA's reporting requirements to the Governor and Legislature regarding nursing homes to conform a cross-reference.

Section 38 amends s. 400.23, F.S., to eliminate the rulemaking authority granted to the AHCA regarding nursing home staff providing residents with eating assistance.

Sections 39 and 40 amend ss. 400.9905 and 400.9935, F.S., related to licensed health care clinics to:

- Authorize an accredited clinic, or one that is within the original year after licensure, that replaces its core magnetic resonance imaging equipment 1 year after the equipment is replaced to attain accreditation;
- Require a clinic that files a change-of-ownership application to comply with the original accreditation time requirements of the transferor, otherwise the AHCA must deny the application; and
- Require that if the accreditation agency requires new accreditation because a clinic has added, replaced, or modified equipment for magnetic resonance imaging, then the clinic must be accredited within 1 year after the addition, replacement, or modification, unless it receives a single 6-month extension from the AHCA based on evidence of good cause.

The bill also exempts all health care clinic licensing requirements for all providers who are not reimbursed, "for medical services paid pursuant to personal injury protection [PIP] coverage required by s. 627.736, bodily injury liability coverage, personal liability umbrella coverage, or uninsured motorist coverage." In addition, the bill expands an existing health care clinic licensing exemption to include pediatric cardiological or perinatological clinical facilities that are publicly traded corporations or that are wholly owned, directly or indirectly, by a publicly traded corporation.[69]

Section 41 amends s. 400.995(6), F.S., to require the AHCA to make a reasonable attempt, during an inspection, to discuss each violation at a health care clinic with the owner, medical director, or clinic director. The bill also eliminates a provision authorizing the AHCA to request a plan of corrective action rather than requiring a date certain for compliance with standards to conform with section 45 of the committee substitute which amends the general licensing provisions for facilities licensed by the AHCA to authorize the AHCA to require an applicant or licensee to submit a plan of correction for deficiencies.

Section 42 amends amends s. 408.803, F.S., to revise the definition of "change of ownership" in the general licensing provisions for all facilities licensed by the AHCA to mean:

- An event in which the licensee sells or otherwise transfers its ownership to a different individual or other entity as evidenced by a change in federal employer identification number or taxpayer identification number; or
- An event in which 51 percent or more of the ownership, shares, membership, or controlling interest of a licensee is in any manner transferred or otherwise assigned. This paragraph does not apply to a licensee that is publicly traded on a recognized stock exchange.

[69] In s. 400.9905(4)(l), F.S., a publicly traded corporation is a corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange.

A change solely in the management company or board of directors is not a change of ownership. In addition, the bill eliminates the requirement for a voluntary board member and not-for-profit corporation or organization to submit a statement affirming the that the board member or officer conforms to the definition of voluntary board member.

Section 43 amends s. 408.806, F.S., to revise the general licensing provisions for all facilities licensed by the AHCA. In addition to information that is currently required, an application for licensure must include the name, address, and social security number of the administrator or a similarly titled person who is responsible for the day-to-day operation of the provider and the financial officer or similarly titled person who is responsible for the financial operation of the provider. The AHCA is required to return a renewal licensure application or any other application or request that is submitted more than 120 days before expiration of the current license or the requested effective date. A licensed adult family-care home is added to the list of facilities that does not require an unannounced inspection. The bill authorizes the AHCA to provide electronic access to information or documents as opposed to sending documents.

Section 44. amends s. 408.808, F.S., to revise the general licensing provisions for all facilities licensed by the AHCA to authorize the AHCA to issue a provisional license for a limited duration, not to exceed a period of 12 months, to an applicant submitting an application for a change of ownership.

Section 45 amends s. 408.809, F.S., to revise the general licensing provisions for all facilities licensed by the AHCA to require:

- The employer's annual affidavit of compliance with the background screening requirements and annual updates of covered employees to be submitted at the time of license renewal, and
- Effective October 1, 2009, employees required to undergo background screening for employment must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to an offense prohibited by law or any similar statute of another jurisdiction identified in:
  - Any authorizing statute, if the offense was a felony,
  - Chapter 408, F.S., relating to healthcare administration, if the offense was a felony, or
  - An additional 17 statutory sections or chapters.

The bill exempts a person who serves as a controlling interest of or is employed by a licensee on September 30, 2009, from rescreening for these offenses if the person has been screened and qualified under the standards specified in s. 435.03 or s. 435.04, relating to level I and level II background screening, and authorizes such a person to apply for an exemption before September 30, 2009, and continue working, upon agreement by the employer, pending the AHCA's decision on the exemption request.

This section of the bill also deletes the exemption from background screening requirements for clinical laboratories applying for a certificate of exemption to conform to the repeal of the application for certificate of exemption provisions in section 64 of the committee substitute.

Section 46 amends s. 408.811, F.S., to revise the general licensing provisions for all facilities licensed by the AHCA to:

- Authorize an inspection conducted in conjunction with a comparable licensure requirement or a recognized or approved accreditation organization to be accepted in lieu of a complete licensure inspection;
- Require a licensee to send to the AHCA, upon request, copies of all provider records required during an inspection or other review at no cost to the AHCA, including records requested during an off-site review;
- Require a licensee to correct deficiencies within 30 calendar days after the last day of an inspection unless an alternative timeframe is required or approved by the AHCA;
- Authorize the AHCA to require an applicant or licensee to submit a plan of correction for deficiencies within 10 calendar days after notification unless an alternative timeframe is required.

Section 47 amends s. 408.813, F.S., to revise the general licensing provisions for all facilities licensed by the AHCA to provide for a uniform classification ranking for violations of requirements imposed by law or rule on a licensee. Violations are classified according to the nature of the violation and the gravity of its probable effect on clients. The scope may be cited as isolated, patterned, or widespread. The violations are classified ranging from a class I violation, which is the most severe, to a class IV violation.

Section 48 amends s. 408.820, F.S., to revise the general licensing provisions for all facilities licensed by the AHCA to:

- Remove the exemptions related to private review agents to conform to the repeal of private review agents in section 29 of the bill;
- Exempt a nursing home from the general provisions relating to administrative fines since the authorizing statutes specify administrative fines and other penalties;
- Exempt a health care risk manager from minimum licensure requirements that relate to operation of a provider and providing services to a client rather than all licensure requirements. As a result, a health care risk manager is required to comply with background screening requirements; provide an explanation of any exclusions, suspensions, or terminations from Medicare or Medicaid; and comply with reporting deadlines;
- Require transitional living facilities to comply with insurance provisions, if proof of insurance is required by the authorizing statutes. Currently proof of insurance is not a statutory requirement in part V of ch. 400, F.S., for transitional living facilities; and
- Subject health care clinics to the background screening provisions in s. 408.809, F.S., which are more comprehensive than the background screening provisions in part X of ch. 400, F.S., specifically related to health care clinics.

Section 49 creates s. 408.821, F.S., within the general licensing provisions for all facilities licensed by the AHCA to address emergency management planning, emergency operations, and inactive licensure status. Specifically this section:

- Requires a licensee that is required to have an emergency operations plan to designate a liaison officer to serve as primary contact related to emergency operations;
- Authorizes a licensee to exceed its licensed capacity to act as a receiving provider, in accordance with an approved emergency operations plan, for up to 15 days. This period may be extended upon AHCA approval of a request providing satisfactory justification and need. This provision is moved from s. 408.831(3), F.S., which is repealed in section 49 of the bill;

- Authorizes the AHCA to issue an inactive license when a provider is located in a geographic area where a state of emergency was declared by the Governor and certain other conditions are met. An inactive license may be issued for a period not to exceed 12 months, and may be renewed by the AHCA for up to an additional 12 months. This provision is moved from s. 408.831(4), F.S., which is repealed in section 22 of this committee substitute; and
- Authorizes the AHCA to adopt rules related to emergency management planning, communications, and operations.

Section 50 amends s. 408.831, F.S., to delete provisions regarding a licensee exceeding its licensed capacity and the issuance of an inactive license during a state of emergency. The substance of these provisions is re-enacted in s. 408.821, F.S., in section 48 of the bill.

Section 51 amends s. 408.918, F.S., to remove the requirement for the AHCA to certify Florida 211 Network providers. The bill requires 211 providers to be fully accredited by the National Alliance for Information and Referral Service or received approval to operate by the Florida Alliance of Information and Referral Services. The bill specifies the Florida Alliance of Information and Referral Services as the Florida 211 collaboration organization for the state and is responsible for studying, designing, implementing, supporting, and coordinating the Florida 211 Network and for receiving federal grants.

Section 52 amends s. 409.221, F.S., related to consumer-directed care to conform a cross-reference.

Section 53 amends s. 409.901, F.S., to revise the definition for "change of ownership" related to the Medicaid program. "Change in ownership" means:

- An event in which the provider ownership changes to a different individual entity as evidenced by a change in federal employer identification number or taxpayer identification number;
- An event in which 51 percent or more of the ownership, shares, membership, or controlling interest of the provider is in any manner transferred or otherwise assigned. This paragraph does not apply to a licensee that is publicly traded on a recognized stock exchange; or
- When the provider is licensed or registered by the AHCA, an event considered a change of ownership for licensure as defined in s. 408.803, F.S.

A change solely in the management company or board of directors is not a change of ownership.

Section 54 repeals s. 429.071, F.S., related to a pilot program enacted in 2005 for intergenerational respite care assisted living facilities.

Section 55 amends s. 429.08, F.S., to authorize the AHCA to publish certain information related to ALFs electronically and to eliminate the requirement for a local coordinating workgroup of various state agencies, ombudsman councils, and advisory committees charged with identifying unlicensed ALFs. The bill also removes the non-criminal penalty and fine for knowingly referring a person to an ALF that does not have a valid and unencumbered license; expands the prohibition of knowingly discharging a patient or client to an unlicensed ALF to all providers as defined in the general licensing provisions; and eliminates requirements that the AHCA must provide to various persons information regarding licensed ALFs.

Section 56 amends s. 429.14, F.S., to conform language related to administrative penalties and deficiencies.

Section 57 amends s. 429.19, F.S., to delete the definitions of a class I, class II, class III, and class IV violation related to ALFs and refer to the definition of these classes of violations in the general licensing provisions for all facilities licensed by the AHCA in section 19 of this committee substitute, which amends s. 408.813, F.S. The administrative fines associated with these classes of violations remain unchanged, within this section. The AHCA is required to make a reasonable attempt to discuss, during an inspection, each violation and the requirement for the AHCA to recommend corrective action has been removed from the law. Potential corrective action is deleted from this section since this provision is included within section 45 of the bill, which amends s. 408.811, F.S.

Section 58 amends s. 429.23, F.S., related to the requirement for an ALF to report adverse incidents to the AHCA. An adverse incident is amended to include an event over which the ALF personnel could exercise control and that is reported to a law enforcement AHCA or its personnel for investigation. All resident elopements are not required to be reported, only those in which the elopement places the resident at risk of harm or injury. An ALF is no longer required to report as an adverse incident all instances of abuse, neglect, or exploitation as defined in s. 415.102, F.S., related to adult protective services or abuse, neglect and harm as defined in s. 39.01, F.S., addressing proceedings relating to children. Instead, the bill requires abuse, neglect, or exploitation to be reported to the AHCA as required by 42 C.F.R. s. 483.13(c) (within five working days after the incident) and to the Department of Children and Family Services as required by ch. 39, F.S., (proceedings related to children) and ch. 415, F.S., (adult protective services) immediately to the Central Abuse Hotline.

In addition, this committee substitute eliminates the requirement for the AHCA to annually submit to the Legislature a report on adverse incidents in ALFs.

Section 59 repeals s. 429.26(9), F.S., that requires a medical assessment of a resident in an ALF when the resident appears to need care beyond that which the facility is licensed to provide and the determination by a medical review team of the appropriateness of the resident's continued placement in that facility.

Section 60 amends s. 430.80, F.S., to revise the definition of a teaching nursing home by reducing the minimum number of licensed nursing home beds that the facility contains from 400 to 275 and expanding the definition to include a facility that operates a geriatric research center in lieu of having a contractual relationship with a federally funded accredited geriatric research center. The criteria to be designated as a teaching nursing home is expanded to include a nursing home that possesses a Gold Seal Award and eliminates the requirement for the nursing home to have a formalized contractual relationship with a designated teaching hospital. The bill also conforms a cross-reference.

Section 61 amends s. 435.04, F.S., to allow employers of employees who are in positions of trust or responsibility and are subject to background screening as a part of being licensed or registered by a state AHCA to submit to the licensing AHCA, either annually or *at the time of license renewal,* an affidavit of compliance with the requirement that the employees attest to meeting the

requirement for qualifying for employment and agree to inform the employer immediately if convicted of any disqualifying offenses while employed by the employer.

Section 62 amends s. 435.05, F.S., to allow each employer that is required to conduct level 2 background screening to sign an affidavit annually *or at the time of license renewal*, stating that all covered employees have been screened or are newly hired and are awaiting the results of the required screening checks.

Section 63 amends s. 483.031, F.S., to conform a provision related to a clinical laboratory to reflect the repeal of the certificate of exemption in section 64 of this committee substitute.

Section 64 amends s. 483.041, F.S., to substitute "Centers for Medicare and Medicaid Services" for Health Care Financing Administration in a definition related to clinical laboratories.

Section 65 repeals s. 483.106, F.S., to eliminate the requirement for a certificate of exemption for a clinical laboratory that performs only waived tests.

Section 66 amends s. 483.172, F.S., to remove the biennial license fee of $100 for a certificate of exemption to conform to the repeal of the certificate of exemption in section 64 of the bill.

Section 67 amends s. 627.4239, F.S., to update the definition of "standard reference compendium," as it relates drugs used to treat cancer.

Section 68 amends s. 651.105, F.S., to decrease the minimum frequency that the Office of Insurance Regulation must inspect Continuing Care Communities to 5 years, in lieu of the current 3 year requirements.

Section 69 amends s. 651.118, F.S., related to certificates of need to conform a cross-reference.

Section 70 provides that the bill is effective July 1, 2009.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of the bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill may decrease the number of individuals who qualify for health care practitioner licensure and health care facility licensure. Some current licensees may face disciplinary action or have their licenses revoked as result of the bill.

The bill requires pharmacy permit applicants to submit a set of fingerprints and pay for the cost of a state and federal background check. According to the Department of Health, this will cost pharmacy permit applicants $47 for each required background check.

In addition, certain individuals who report violations of state Medicaid laws may receive a monetary reward.

The Agency indicates that elimination of the:

- Registration of private utilization review agents will save the 111 providers currently registered approximately $57,054 based on a $514 biennial registration fee; and
- Certification of waived labs will save providers between $800,000 and $900,000 in fees every two years and avoid duplication of federal requirements and litigation costs for late or "failed to renew" applicants, which are numerous.

C. Government Sector Impact:

Senate Bill 2600, the proposed General Appropriations Bill for Fiscal Year 2009-2010, provides 5 positions, $1,607,796 from the General Revenue Fund, and $1,607,797 from trust funds and savings of $4,567,836 from general revenue funds and $9,547,851 from trust funds for the expansions of fraud and abuse recoupment initiatives in the Medicaid program.

The provisions of Section 3 of the bill should enable Florida to qualify to keep an additional 10 percent of the federal portion of Medicaid recoveries under the Florida False Claims Act. The amount of money recovered by the Florida False Claims Act varies each year. According to the Medicaid Fraud Control Unit, the additional 10 percent of recoveries would have provided the state with the following amounts: $2,429,654 in Fiscal Year 2006-2007; $4,281,209 in Fiscal Year 2007-2008; and $2,766,246 for Fiscal Year 2008-2009 year-to-date.

The bill creates several felonies. The Criminal Justice Estimating Conference has established the additional felonies would create an insignificant, or very small additional bed impact to the state.[70]

[70] Criminal Justice Estimating Conference, April 13, 2009. Found at: http://edr.state.fl.us/conferences/criminaljustice/Impact/2009/CJIC_09.pdf (Last visited: April 16, 2009).

According to the AHCA, the elimination of the interagency workgroup in section 54 of the bill will provide for greater efficiency and use of limited staff resources.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Lines 2584 through 2588 create an additional exemption for health clinic licensure that appears to be unenforceable by the AHCA because the exemption standard is not verifiable. The AHCA nor the Office of Insurance Regulation do not collect any data that verifies entities' acceptance of personal injury payments (PIP), and insurance companies are not required to report personal injury protection payments.

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 Judiciary on April 21, 2009:
The committee substitute replaces the contents of the bill with essentially the contents of CS/CS/CS/SB 1986, an act relating to health care, which amends multiple sections of law to address systemic health care fraud and decrease health facility regulation. In addition to that substantial change, the committee substitute:

- Specifies that a home health agencies that provides discounts, compensation, payment waivers, or reimbursement under certain federal laws cannot be construed by the AHCA as:
  - Giving 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, 429, or 400, F.S., from whom the home health receives referrals; or
  - Giving remuneration to a physician while also violating the home health agency contract provisions in s. 400.474(6)(h), F.S. or s. 400.474(6)(i), F.S.; giving remuneration to a member of the physician's office staff; or 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.
- Amends s. 430.80, F.S., to revise the definition of a teaching nursing home by reducing the minimum number of licensed nursing home beds that the facility contains from 400 to 275 and expanding the definition to include a facility that operates a geriatric research center in lieu of having a contractual relationship with a federally funded accredited geriatric research center. The criteria to be designated as a teaching nursing home is expanded to include a nursing home that possesses a Gold Seal Award and eliminates the requirement for the nursing home to have a formalized contractual relationship with a designated teaching hospital.

- Amends section 651.105, F.S. to decrease the minimum frequency that the Office of Insurance Regulation must inspect Continuing Care Communities to 5 years, in lieu of the current 3 year requirements.
- Exempts all health care clinic licensing requirements, under the Health Care Clinic Act, for all providers who are not reimbursed "for medical services paid pursuant to personal injury protection (PIP) coverage required by s. 627.736, bodily injury liability coverage, personal liability umbrella coverage, or uninsured motorist coverage." In addition, the bill expands an existing health care clinic licensing exemption to include pediatric cardiological or perinatological clinical facilities that are publicly traded corporations or that are wholly owned, directly or indirectly, by a publicly traded corporation.

CS by Health Regulation on March 25, 2009:
The committee substitute makes the following substantive changes:

- Eliminates the quality-of-care monitors for nursing homes;
- Requires a nursing home to provide a copy of the policy pertaining to minimizing the risk of theft or loss of the personal property of residents to the resident's representative, if appropriate, and to provide a copy of the policy when revised to every employee, resident and resident's representative. The facility is no longer required to post this policy in places accessible to residents;
- Eliminates the rulemaking authority granted to the Agency regarding nursing home staff providing residents with eating assistance;
- Provides an exception to the prohibition against nurse registries giving remuneration to persons involved in discharge planning or to physicians and their staff for a nurse registry that does not participate in the Medicaid or Medicare program;
- Reinstates the requirement that homemaker and companion organizations register with the Agency;
- Reinstates the prohibition on a medical director referring a patient to the licensed clinic if the clinic performs magnetic resonance imaging or related types of testing;
- Reinstates the requirement for the Agency to discuss with appropriate management at a licensed medical clinic or ALF each violation noted during an inspection;
- Revises the (revised) definition of a change of ownership in the general licensing provisions and under Medicaid;
- Eliminates the proposed requirement that an applicant for a change in ownership provide the Agency with the effective date of the change and final closing documents;
- Extends the period of time for a provisional license related to a change in ownership from 6 months to 12 months;
- Substitutes "a person who serves as a controlling interest of a licensee" for "a person affiliated with a licensee" in the provisions related to exemption requests for new disqualifying offenses;
- Eliminates the requirement for the Agency to consult with the Department of Community Affairs when it adopts rules relating to emergency management planning, communications, and operations;
- Expands the prohibition of knowingly discharging a patient or client to an unlicensed ALF to all providers as defined in the general licensing provisions;

- Eliminates requirements that the Agency must provide to various persons information regarding licensed ALFs; and
- Eliminates the section of the bill revising the criminal offenses related to clinical laboratories.

B. Amendments:

None.