The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	CS/SB 752
INTRODUCER:	Health Regulation Committee; and Senator Gaetz
SUBJECT:	Health Care Fraud
DATE:	March 10, 2010 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Bell	Wilson	HR	**Fav/CS**
2.			HA	
3.			RC	
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 Committee Substitute (CS) for SB 752 amends multiple sections of law relating to health care fraud. The bill provides the Agency for Health Care Administration (Agency) with additional tools to address fraudulent activity in the Medicaid program by: requiring Medicaid providers to report changes in controlling interests to the Agency, tightening the Medicaid provider background check requirement, and providing the Agency's Bureau of Medicaid Program Integrity (MPI) with additional authority to collect Medicaid overpayments and fines.

The CS increases the information the Department of Health (Department) is required to post on the online practitioner profiles for physicians and advanced registered nurse practitioners. The CS also expands the Department's authority to issue an emergency suspension order for a health care practitioner, licensed under ch. 456, F.S., who pleads guilty to, is convicted of, or who enters a plea of nolo contendere to, regardless of adjudication to a felony under ch. 812, ch. 895, or ch. 896, F.S., relating to the Medicaid program.

The CS extends the existing moratorium on the initial and change-of-ownership licensure of home health agencies in certain counties that meet specified criteria and clarifies health care facility and health care practitioner licensing standards.

This CS substantially amends ss. 400.471, 400.474, 408.815, 409.907, 409.912, 409.913, 409.9203, 456.001, 456.041, 456.0635, 456.072, 456.073, and 456.074, F.S.

The CS repeals s. 409.9122(13), F.S.

II. Present Situation:

Health Care Fraud Overview
Health care fraud is a pervasive problem for all private payors, states, and the Federal Government. The National Health Care Anti-Fraud Association estimates conservatively that 3 percent of all health care spending, approximately $68 billion, is lost to health care fraud each year. The FBI estimates that spending related to health care fraud is much higher – 10 percent of all health care spending.

Florida, particularly South Florida, has been identified by numerous federal reports and studies as one of the main epicenters of health care fraud. In 2007, the Justice Department and the Department of Health and Human Services deployed the first Medicare Strike-Force in Southern Florida. The Strike-Force continues to combat Medicare and Medicaid fraud in this state.

Historically Medicaid fraud has been a policy priority for the Florida Legislature. In 1996, the Legislature passed SB 118 in response to the Thirteenth Statewide Grand jury's findings and recommendations relating to fraud in the durable medical equipment, health clinic, adult living facility, and home health care industries. In 2002, the Legislature made significant statutory changes that included: improved tracking and accounting systems at the Agency to recover Medicaid overpayments; studies to evaluate the accuracy of Medicaid claims payments and eligibility determination; and a contract to analyze and apply sophisticated algorithms to detect unusual Medicaid drug utilization patterns.

In 2004, in response to the Seventeenth Statewide Grand Jury Report on Medicaid fraud, the Legislature passed legislation that addressed pharmaceutical practices in the Medicaid program, increasing the Agency's authority to control pharmaceutical drug prescribing in the Medicaid program. The legislation also increased Medicaid eligibility standards and provided the Agency the authority to suspend or terminate providers in the Medicaid program for fraudulent or questionable behavior.

During the 2008 Legislative Session, fraud in the home health and home medical equipment industries was addressed in CS/HB 7083. The bill substantially increased the regulatory provisions that govern the licensure of home health agencies and nurse registries to reduce Medicaid fraud and improve quality of care and industry accountability.[1] The bill also addressed home medical equipment provider fraud in the Medicaid system by authorizing the Agency for Health Care Administration to limit its network of medical equipment providers and increase its home medical equipment provider enrollment requirements.

[1] See Laws of Florida, Chapter No. 2008-246.

During the 2009 Legislative Session, Medicaid fraud was on the agenda again. The Legislature passed CS/CS/CS/SB 1986 to address systemic health care fraud.[2] Some of the provisions in the bill included:

- Additional authority for the Medicaid program to address fraud, particularly as it relates to home health services;
- Additional health care facility and health care practitioner licensing standards to keep individuals convicted of fraud from obtaining a health care license in Florida;
- Disincentives to commit Medicaid fraud;
- Incentives to report Medicaid fraud; and
- Targeted pilot projects to address Medicaid fraud in Miami-Dade County.

In addition, both CS/CS/SB 2658[3] and CS/SB 1658[4] addressed health care fraud during the 2009 Legislative Session.

The legislation that addressed Medicaid fraud during the last two Sessions has taken a systems approach to addressing fraud in the Medicaid program. Health care fraud negatively impacts the entire interconnected health care system. Fraud in the Medicaid program is not isolated to only the Medicaid program but spills over into the rest of the health care system and also impacts Medicare, other government sponsored health coverage, and the private insurance market. Fraud contributes to rising health care costs in all sectors.

Health care fraud prevention requires a consistent commitment from the Agency's Medicaid Program Integrity Unit, Inspector General, Medicaid Program, and Health Quality Assurance (facility licensing unit); the Department of Health's many medical boards and Medical Quality Assurance division; the Attorney General's Medicaid Fraud Control Unit; law enforcement agencies; the courts; and many other health care stake-holders. Coordination of all the interested parties is an ongoing challenge.

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 Agency is the single state agency responsible for the Florida Medicaid program.[5]

Some Medicaid services are mandatory services that must be covered by any state participating in the Medicaid program pursuant to federal law.[6] 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.[7] Similarly, some eligibility categories are mandatory[8] and some are

[2] See Laws of Florida, Chapter No. 2009-223.
[3] See Laws of Florida, Chapter No. 2009-193.
[4] See Laws of Florida, Chapter No. 2009-55.
[5] The statutory provisions for the Medicaid program appear in ss. 409.901-409.9205, F.S.
[6] These mandatory services are codified in s. 409.905, F.S.
[7] Optional services covered under the Florida Medicaid Program are codified in s. 409.906, F.S.
[8] Section 409.903, F.S.

optional.[9] 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 chapter 216, F.S. For FY 2010-2011, the Florida Medicaid Program is projected to cover 2.9 million people[10] at an estimated cost of $19.1 billion.[11]

The Agency maintains a network of Medicaid providers, including individual health care practitioners, health care facilities, and other entities to provide services to Medicaid recipients.[12] The Agency executes a provider agreement, as specified in s. 409.907, F.S., with each individual Medicaid provider. The Agency has contractual arrangements with seventeen Medicaid HMOs that provide services to over 1 million Medicaid recipients.[13] Approximately two-thirds of all Medicaid recipients are enrolled in some type of Medicaid managed care.[14]

Medicaid Managed Care Programs

The state of Florida operates a Medicaid managed care program through a federal 1915(b) waiver obtained from the Centers for Medicare and Medicaid Services in 1991. The managed care waiver provides the state with the authority to mandatorily assign eligible beneficiaries[15] and, within specific areas of the state, limit choice to approved managed care providers. The federal waiver requires Florida Medicaid recipients to be given a choice of managed care providers. The Medicaid managed care program is broken into two major categories of providers: MediPass and managed care plans. However, s. 409.91211, F.S., codifies the Medicaid reform managed care pilot program in Baker, Broward, Clay, Duval, and Nassau Counties. Eligible Medicaid recipients in these counties must enroll in a managed care plan and do not have the ability to choose the MediPass program.

The Medicaid Provider Access System (MediPass) is a primary care case management program for Medicaid recipients developed and administered by Florida Medicaid. MediPass was established in 1991 to assure adequate access to coordinated primary care while decreasing the inappropriate utilization of medical services. In MediPass, each participating Medicaid recipient selects, or is assigned, a health care provider who furnishes primary care services, 24-hour access to care, and referral and authorization for specialty services and hospital care. The primary care

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[9] Section 409.904, F.S.

[10] Social Services Estimating Conference, Medicaid Caseload, January 26, 2010. Found at: <http://edr.state.fl.us/conferences/medicaid/medcases.pdf> (Last visited on March 6, 2010).

[11] Social Services Estimating Conference, Medicaid Services Expenditures, February 12, 2010. Found at: < http://edr.state.fl.us/conferences/medicaid/medhistory.pdf> (Last visited on March 6, 2010).

[12] The Agency currently has Medicaid provider agreements with 104,004 providers statewide, including: 37,883 physicians; 44 hospices; and 650 nursing homes.

[13] Agency for Health Care Administration, Comprehensive Medicaid Managed Care Enrollment Report, February 10, 2010. Found at: <http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_data.shtml> (Last visited on March 6, 2010).

[14] Agency for Health Care Administration, Comprehensive Medicaid Managed Care Enrollment Report, February 10, 2010. Found at: <http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_data.shtml> (Last visited on March 9, 2010).

[15] Certain persons are ineligible for mandatory managed care enrollment. The major population groups excluded from enrolling in managed care altogether include the Medically Needy, recipients who reside in an institution, those in family planning waivers, and those who are eligible for Medicaid through the breast and cervical cancer program. Dual eligibles (persons who have both Medicaid and Medicare coverage) are excluded from enrollment in MediPass, yet the dual eligibles and others (SOBRA pregnant women and children in foster care) may voluntarily enroll in any other type of managed care plan.

providers are expected to monitor appropriateness of health care provided to their patients. MediPass providers receive a $2 monthly case management fee for each of their enrolled patients, as well as the customary reimbursement according to the Medicaid Provider Handbook for all services rendered. Currently, there are 2,482 enrolled Medicaid provider practices that include 5,087 individual providers.[16]

The second major category of provider in the Medicaid managed care program is the managed care plan. Section 409.9122, F.S., defines managed care plans as health maintenance organizations (HMOs), exclusive provider organizations (EPOs), provider service networks (PSNs), minority physician networks, the Children's Medical Services Network, and pediatric emergency department diversion programs. These plans tend to be reimbursed through a capitated payment where the plan receives a set amount per member per month and is responsible for providing all necessary Medicaid services within that capitation rate.

Depending on where an individual lives in the state and their eligibility status, Medicaid recipients are given a choice of either MediPass or a managed care plan when they enroll in the Medicaid program. Under s. 409.9122, F.S., the AHCA is required to assign all Medicaid recipients eligible for mandatory assignment into either MediPass or a managed care plan if they do not make a choice within 30 days of eligibility.

Medicaid Program Integrity

The Agency's 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.[17]

The Agency has the authority to sanction providers for a variety of offenses. When the provider is not a natural person (a corporate entity), the Agency also has authority to sanction the provider for actions of owners, officers, or agents who have engaged in sanctionable offenses. 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.[18]

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 Agency issues an audit report to the provider that includes a calculation of overpayment.

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[16] Agency for Health Care Administration, Managed Care in Florida, Presentation before the Senate Ways and Means Committee, February 17, 2010. Found at: <http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/managed_care_in_fl_medicaid_02-17-2010.pdf> (Last visited March 10, 2010).

[17] Sections 409.913 and 409.9131, F.S.

[18] Section 409.9131, F.S.

The MPI is required 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 Agency must immediately suspend a provider and issue an immediate final order under s. 120.569(2)(n), F.S., if the Agency receives information of patient abuse or neglect or of any act prohibited by s. 409.920, F.S.[20] The Agency 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 2008-2009 fiscal year, the MPI administratively sanctioned 826 Medicaid providers.[21] The sanctions included 501 provider fines, 30 suspensions, 13 Medicaid provider terminations, and 218 miscellaneous sanctions.[22] In 2009, the Legislature increased MPI's authority to address overpayments and fraudulent activity in the Medicaid program.[23]

Under federal and state law, any suspected criminal violation identified by the MPI must be referred to the Medicaid Fraud Control Unit (MFCU) in the Office of the Attorney General.[24] 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 Agency is appropriate. During FY 2008-2009, the MPI referred 183 cases to the MFCU for investigation, recovered $50.3 million in overpayments, and saved the Medicaid program an estimated $18.9 million in cost avoidance.[25]

In 2009, the Legislature created a Medicaid fraud reward program to offer a monetary reward to any person who reports original information that relates to a violation of the state Medicaid fraud laws.[26] The original information must be reported to the Office of the Attorney General, the Agency for Health Care Administration, the Department of Health, or the Department of Law Enforcement and result in a recovery of a fine, penalty, or forfeiture of property.

Health Facility Licensure

The Agency is also 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

[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, The State's Efforts to Control Medicaid Fraud and Abuse, FY 2008-2009. Found at: <http://ahca.myflorida.com/Executive/Inspector_General/docs/The_States_Efforts%20to_Control_Medicaid_Fraud_and_Abuse_FY2008_09_signed.pdf> (Last visited on March 6, 2010).
[22] The Agency for Health Care Administration and the Medicaid Fraud Control Unit, Department of Legal Affairs, The State's Efforts to Control Medicaid Fraud and Abuse, FY 2008-2009. Found at: <http://ahca.myflorida.com/Executive/Inspector_General/docs/The_States_Efforts%20to_Control_Medicaid_Fraud_and_Abuse_FY2008_09_signed.pdf> (Last visited on March 6, 2010).
[23] See Laws of Florida, Chapter No. 2009-223.
[24] See 42 C.F.R. 455.21 and s. 409.913(4), F.S.
[25] The Agency for Health Care Administration and the Medicaid Fraud Control Unit, Department of Legal Affairs, The State's Efforts to Control Medicaid Fraud and Abuse, FY 2008-2009. Found at: <http://ahca.myflorida.com/Executive/Inspector_General/docs/The_States_Efforts%20to_Control_Medicaid_Fraud_and_Abuse_FY2008_09_signed.pdf> (Last visited on March 6, 2010).
[26] Section 409.9203, F.S.

Center for Health 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 (ALFs);
- Birth Centers;
- Clinical Laboratories;
- Commercial HMOs/PHCs/EPOs;
- Comprehensive Outpatient Rehabilitation Facilities;
- Crisis Stabilization Units and Short Term Residential Treatment Facilities;
- Diagnostic Imaging Services;
- Drug-free Workplace Laboratories;
- Extended Congregate Care (ALFs);
- 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 (ALFs);
- Limited Nursing Services (ALFs);
- 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; and
- Transitional Living Facilities.

Core Licensure Provisions

In addition to specific authorizing statutes that provide the regulatory structure for these health care facilities, providers, or programs, part II of chapter 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.[27]

Part II of chapter 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 Agency to impose administrative fines and pursue other regulatory and enforcement actions.

[27] Section 408.801, F.S.

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 activities of 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.[28] The licensure requirements for home health agencies are found in the general provisions of part II of 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.

In 2008, the Legislature significantly strengthened the home health agency licensure requirements to address fraud and abuse in the Medicaid and Medicare programs. Prior to 2008, the Agency saw significant growth in the number of applications and new licenses of home health agencies.[29] The Agency 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 Agency, the new accreditation requirement created in 2008 has slowed the growth in new licensees, but the Agency continues to receive a high volume of applications.

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.

In 2009, the Legislature further strengthened the home health agency licensure requirements to address primarily fraud and abuse in the Medicaid program.[30] The new provisions included a moratorium on the licensure of new home health agencies in counties that meet certain specifications.[31] The Agency is prohibited from issuing an initial or change of ownership home health agency license in any county where this is at least one actively licensed home health agency and the population of persons 65 and older, as indicated by the most recent population

[28] Section 400.462(14), F.S.
[29] Committee on Health Regulation, Fla. Senate, *Review Regulatory Requirements for Home Health Agencies*, Interim Report 2008-135, November, 2007. Found at: <http://www.flsenate.gov/data/Publications/2008/Senate/reports/interim_reports/pdf/2008-135hr.pdf> (Last visited on March 6, 2010).
[30] See Laws of Florida, Chapter No. 2009-223.
[31] Section 400.471(11), F.S.

estimates published by the Executive Office of the Governor, is fewer than 1,200 per home health agency.

The home health agency licensure moratorium is in effect in Miami-Dade County and Broward County. Miami-Dade County has 380 persons 65 or older per licensed home health agency, and Broward County has 1,010 persons 65 or older per licensed home health agency.[32] Currently, Miami-Dade county has 943 licensed home health agencies and Broward county has 279 licensed home health agencies.

Currently, the Agency is also prohibited 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 Agency 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 Agency 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;

[32] Agency for Health Care Administration, Regulatory Update Presentation, including changes in state law effective July 1, 2009. Found at: <http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Home_Care/Home_Health_Agency.shtml> (Last visited on March 6, 2010).

- 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.

Miami-Dade County currently has one home health agency per 2,782 persons (all ages) and is subject to this provision.[33]

Department of Health – Health Care Practitioner Licensure

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

- Chapter 457 (acupuncture);
- Chapter 458 (medical practice);
- Chapter 459 (osteopathic medicine);
- Chapter 460 (chiropractic medicine);
- Chapter 461 (podiatric medicine);
- Chapter 462 (naturopathy);
- Chapter 463 (optometry);
- Chapter 464 (nursing);
- Chapter 465 (pharmacy);
- Chapter 466 (dentistry);
- Chapter 467 (midwifery);
- Part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468 (speech-language pathology and audiology; nursing home administration; occupational therapy; respiratory therapy; dietetics and nutrition practice; athletic trainers; and orthotics, prosthetics, and pedorthics);
- Chapter 478 (electrolysis);
- Chapter 480 (massage practice);
- Part III or part IV of chapter 483 (clinical laboratory personnel and medical physicists);
- Chapter 484 (dispensing of optical devices and hearing aids);
- Chapter 486 (physical therapy practice);
- Chapter 490 (psychological services); 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 Department contain provisions establishing grounds for which disciplinary action may be taken against licensed health care practitioners.[34]

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[33] Agency for Health Care Administration, Regulatory Update Presentation, including changes in state law effective July 1, 2009. Found at: <http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Home_Care/Home_Health_Agency.shtml> (Last visited: March 6, 2010).

[34] 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.

Health Care Practitioner Disciplinary Proceedings

Section 456.073, F.S., sets forth procedures the Department must follow in order to conduct disciplinary proceedings against practitioners under its jurisdiction. The Department, 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 Department, at its discretion, may continue its investigation of the complaint. The Department may investigate anonymous, written complaints or complaints filed by confidential informants if the complaints are legally sufficient and the Department has reason to believe after a preliminary inquiry that the alleged violations are true. If the Department 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 Department's jurisdiction are determined to be complete and legally sufficient, the Department 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 Department 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 Department if there is no board or if the board has delegated the probable cause determination to the Department.

The boards within the Department 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.

In 2009, the Legislature created additional grounds for health care practitioner discipline directly relating to crimes relating to the Medicaid or Medicare program, failing to remit a sum owed to the state for a Medicaid overpayment after a final order, and being convicted of a crime relating to health care fraud.[35]

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.[36] 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;

[35] Section 456.072(1)(ii), F.S. – Section 456.072(1)(ll), F.S.

[36] 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.[37] 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.

In 2009, the Legislature expanded the Department's authority to immediately suspend the license of a practitioner 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.[38]

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.[39] 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.[40]

In 2009, the Legislature required the Department to include Medicaid sanction and termination information on the practitioner profiles.[41]

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.

[37] See also s. 120.68, F.S., which provides for immediate judicial review of final agency action.
[38] Section 456.074, F.S.
[39] Section 456.039, F.S.
[40] Section 456.051(1), F.S., requires the Department 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.
[41] Section 456.041, F.S.

Section 456.0391, F.S., requires advanced registered nurse practitioners to also submit information to be published on the Department's practitioner profile website.

Each person who has submitted information under the practitioner profiling requirements is required to update that information in writing by notifying the Department within 15 days after the occurrence of an event or the attainment of a status that requires reporting as part of the profiling requirements.[42] 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

III. Effect of Proposed Changes:

Section 1. Amends s. 400.471, F.S., to extend the current moratorium on the licensure (initial and change of ownership) of home health agencies in counties that have a population of persons 65 years of age or older of fewer than 1,200 per home health agency until July 1, 2012.

The bill allows a home health agency subject to the moratorium to submit a change of ownership application if:

- The home health agency is accredited;
- Has been licensed by the state for at least 5 years; and
- Is in good standing with the Agency.

Section 2. Amends s. 400.474, F.S., to authorize the Agency to revoke the license of a home health agency that would not be eligible for licensure renewal under s. 400.471(10), F.S.

Subsection 400.471(10), F.S., prohibits the Agency from renewing a home health agency license, if the renewal 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 controlling interest has been administratively sanctioned by the Agency in the last 2 years for one or more specified violations.

Miami-Dade County currently has 1 home health agency per 2,782 persons (all ages) and is the only county that meets this population criteria.[43] The Agency has denied two home health agency renewal applications and has four home health agency renewal application denials pending.[44]

Section 3. Amends s. 408.815, F.S., to direct the Agency to deny the licensure application for any facility licensed under part II of ch. 408, F.S., if the applicant, or person having a controlling interest in the applicant:

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[42] 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.

[43] Agency for Health Care Administration, Regulatory Update Presentation, including changes in state law effective July 1, 2009. Found at: <http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Home_Care/Home_Health_Agency.shtml> (Last visited on March 6, 2010).

[44] Agency for Health Care Administration, Update on SB 1986, February 24, 2010. (On file with the Senate Health Regulation Committee).

- Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under ch. 409, ch. 817, or ch. 893, F.S., or a similar felony offense committed in another jurisdiction;
- Has been convicted of or enters a plea of nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396;
- Has been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, F.S., unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5 years;
- Has been terminated for cause, pursuant to the appeals procedures established by the state government, from any other state Medicaid program; or
- Is listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

An applicant for initial or change of ownership licensure that has been convicted of, or entered a plea of guilty or nolo contendere to any of the felonies listed in the first two items in the bulleted list above will not be disqualified from licensure if the sentence and any subsequent period of probation for such convictions or plea ended more than 15 years before the date of the application.

The CS clarifies that an applicant for *renewal* licensure that has been convicted of, or entered a plea of guilty or nolo contendere to any crimes listed in the first two items in the bulleted list above will not be disqualified from licensure if the conviction or plea occurred before July 1, 2009.

Section 4. Amends s. 409.907, F.S., relating to Medicaid provider agreements, to require all Medicaid providers to retain all medical and Medicaid-related records for a period of six years. Currently, the Medicaid provider agreement requires Medicaid providers to retain records for five years. This change conforms state law to the Federal Health Insurance Portability and Accountability Act of 1996 that requires health records to be retained for six years.

The CS creates an additional reporting requirement for Medicaid providers as a condition of the Medicaid provider agreement. Medicaid providers must report the change of any principle of the provider including any officer, director, agent, managing employee, or affiliated person, or any partner or shareholder who has an ownership interest equal to 5 percent or more in the provider. Medicaid providers have 30 days to report changes to the Agency after the change occurs.

The CS removes an exemption from background screening for Medicaid provider enrollment of hospitals licensed under chapter 395, F.S.; nursing homes licensed under ch. 400, F.S.; hospices licensed under ch. 400, F.S.; and assisted living facilities licensed under ch. 429, F.S. The CS clarifies that all Medicaid provider background screenings will be conducted in accordance with ch. 435, F.S., and s. 408.809, F.S.

The CS removes an obsolete provision that allowed the Agency to provisionally enroll a Medicaid provider while background screening results were pending.

The CS provides the Agency with additional authority to deny a Medicaid provider application, if the provider or any controlling interest of the provider has committed certain specified crimes.

Section 5. Amends s. 409.912, F.S., to clarify which fraud crimes prohibit the Agency from contracting with an entity on a prepaid basis for Medicaid services, if the entity or any controlling interest of the entity has been found guilty of those specified crimes.

The CS requires Medicaid managed care plans to notify the Agency if any person that has executive management responsibilities for the managed care plan or if any individual that has a 5 percent or more controlling interest in the plan has committed certain criminal offenses.

Section 6. Repeals s. 409.9122(13), F.S., to remove a provision that authorized the Agency to adjust the Medicaid managed care enrollee assignment process to provide those Medicaid managed prepaid health plans operating in Miami-Dade, that have executed a contract with the Agency for at least 8-consecutive years, a minimum enrollment level of 15,000 enrollees.

Section 7. Amends s. 409.913, F.S., to provide the Medicaid program integrity unit additional authority to immediately suspend a Medicaid provider from participation in the Medicaid program and to immediately terminate a Medicaid provider from participation in the Medicaid program if the provider engages in certain conduct.

The CS also:
- Removes a requirement for the Agency to hold suspended Medicaid payments in a separate account;
- Authorizes the Agency to deny payment to or require repayment from Medicaid providers convicted of certain crimes;
- Authorizes the Agency to terminate a Medicaid provider if the provider fails to reimburse a fine determined by a final order; and
- Authorizes the Agency to withhold Medicaid reimbursement to a Medicaid provider that fails to pay a fine determine by a final order, fails to enter into a repayment plan, or fails to comply with a repayment plan or settlement agreement.

Section 8. Amends s. 409.9203, F.S., to exclude employees of the Agency, the Department of Legal Affairs, the Department of Health, or the Department of Law Enforcement whose job responsibilities include the prevention, detection, and prosecution of Medicaid fraud from eligibility to receive a reward, authorized in this section, for reporting original Medicaid fraud information.

Section 9. Amends s. 456.001, F.S., to define "affiliate" or "affiliated person." The CS defines, "affiliate" or "affiliated person" as any person who directly or indirectly manages, controls, or oversees the operations of a corporation or other business entity, regardless of whether that person is a partner, shareholder, owner, officer, director, or agent of the entity.

Section 10. Amends s. 456.041, F.S., to require the Department to include additional information on the physician and advanced registered nurse practitioner online profiles beginning July 1, 2010. The new information required to be posted on the practitioner profile includes:
- All criminal history information reported to the Department;
- Any administrative complaint filed with the Department in which probable cause was found; and

- Detailed arrest information.

Section 11. Amends s. 456.0635, F.S., to prohibit the Department, and the medical boards within the Department, from allowing any person to sit for an examination, or issuing a new license, certificate, or registration to any applicant if the applicant:

- Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under ch. 409, ch. 817, or ch. 893, F.S., or a similar felony offense committed in another state or jurisdiction, unless the sentence and any subsequent period of probation for such conviction or plea ended:
  - For felonies of the first or second degree more than 15 years before the date of application;
  - For felonies of the third degree more than 10 years before the date of application, except for felonies of the third degree under s. 893.13(6)(a), F.S.; and
  - For felonies of the third degree under s. 893.13(6)(a), F.S., more than five years before the date of application.
- Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, unless the sentence and any subsequent period of probation for such convictions or plea ended more than 15 years before the date of application;
- Has been terminated for cause, pursuant to the appeals procedures established by the state from any state Medicaid program; or
- Is listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

The CS clarifies that the Department and the medical boards must refuse to renew a license, certificate, or registration of an applicant, or person affiliated with that applicant, who has violated any of the provisions listed in the first bulleted item above since July 1, 2009.

The CS allows the Department to hold pending a license, certification or registration application, if the applicant entered a plea of guilty or nolo contendere to a disqualifying felony in an agreement with the court to enter a pre-trail intervention or drug diversion program, until the final resolution of the case.

The CS provides the Department with rulemaking authority to administer the denial of licensure renewal.

Section 12. Amends s. 456.072, F.S., to clarify that exclusion from participation in the federal Medicare program is grounds for discipline for health care practitioners.

Section 13. Amends s. 456.073, F.S., to allow an administrative complaint to be filed against a health care practitioner licensee more than six years after the incident or occurrence, if the incident or occurrence involved fraud related to the Medicaid program.

Section 14. Amends s. 456.074, F.S., to provide the Department additional authority to immediately suspend the license of a person licensed in a profession defined in ch. 456, F.S., who pleads guilty of, or who enters a plea of nolo contendere to, regardless of adjudication to a felony under ch. 812, ch. 895, or ch. 896, F.S.

Section 15. The effective date of the CS is July 1, 2010.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this CS 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 this CS 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 CS 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:

Hospitals, hospices, assisted living facilities, and nursing homes may incur additional background check costs as part of the Medicaid provider application process.

C. Government Sector Impact:

The Department of Health has indicated that it will require additional budget authority and .five FTEs to implement the new practitioner profile requirements in the CS. The additional workload will be to scan, redact, quality check and publish administrative complaints to the practitioner profile and to quality check arrest information and publish on the practitioner profile.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

CS by Health Regulation on March 9, 2010:
Adds additional requirements to the Medicaid provider agreement;

- Requires Medicaid providers to report changes in controlling interests to the Agency;
- Provides the Agency's Bureau of Medicaid Program Integrity (MPI) with additional authority to collect Medicaid overpayments and fines;
- Tightens the Medicaid provider background check requirements;
- Requires Medicaid providers to maintain medical records for 6 years;
- Repeals a provision that allows the Agency to adjust its Medicaid managed care enrollment process to provide those Medicaid prepaid health plans in Miami-Dade, that have executed a contract with the Agency for 8 consecutive years, a minimum enrollment of 15,000 members-per-month**;**
- Increases the information the Department is requires to post on the online practitioner profiles for physicians and advanced registered nurse practitioners;
- Expands the Department's authority to issues an emergency suspension order for a health care practitioner licensed under ch. 456, F.S., for certain Medicaid related crimes;
- Extends the existing moratorium on the initial or change-of-ownership licensure of home health agencies in certain counties that meet specified criteria; and
- Clarifies health care facility and health care practitioner licensing standards.

B. Amendments:

None.