

1 A bill to be entitled
2 An act relating to the recovery of Medicaid
3 overpayments; amending s. 16.59, F.S.;
4 specifying additional requirements for the
5 Medicaid Fraud Control Unit of the Department
6 of Legal Affairs and the Medicaid program
7 integrity program; amending s. 112.3187, F.S.;
8 extending whistle-blower protection to
9 employees of Medicaid providers reporting
10 Medicaid fraud or abuse; amending s. 400.179,
11 F.S.; providing exceptions to bond
12 requirements; creating s. 408.831, F.S.;
13 allowing the Agency for Health Care
14 Administration to take action against a
15 licensee in certain circumstances; amending s.
16 409.907, F.S.; prescribing additional
17 requirements with respect to provider
18 enrollment; requiring that the Agency for
19 Health Care Administration deny a provider's
20 application under certain circumstances;
21 amending s. 409.908, F.S.; providing additional
22 requirements for cost-reporting; amending s.
23 409.910, F.S.; revising requirements for the
24 distribution of funds recovered from third
25 parties that are liable for making payments for
26 medical care furnished to Medicaid recipients
27 and in the case of recoveries of overpayments;
28 amending s. 409.913, F.S.; requiring that the
29 agency and Medicaid Fraud Control Unit annually
30 submit a report to the Legislature; defining
31 the term "complaint"; specifying additional

1 requirements for the Medicaid program integrity
2 program and the Medicaid Fraud Control Unit of
3 the Department of Legal Affairs; requiring
4 imposition of sanctions or disincentives,
5 except under certain circumstances; providing
6 additional sanctions and disincentives;
7 providing additional grounds under which the
8 agency may terminate a provider's participation
9 in the Medicaid program; providing additional
10 requirements for administrative hearings;
11 providing additional grounds for withholding
12 payments to a provider; authorizing the agency
13 and the Medicaid Fraud Control Unit to review
14 certain records; requiring review by the
15 Attorney General of certain settlements;
16 requiring review by the Auditor General of
17 certain cost reports; requiring that the agency
18 refund to a county any recovery of Medicaid
19 overpayment received for hospital inpatient and
20 nursing home services; providing a formula for
21 calculating the credit; amending s. 409.920,
22 F.S.; providing additional duties of the
23 Medicaid Fraud Control Unit; requiring
24 recommendations to the Legislature; repealing
25 s. 414.41(5), F.S., relating to interest
26 imposed upon the recovery amount of medical
27 assistance overpayments; providing an effective
28 date.

29
30 Be It Enacted by the Legislature of the State of Florida:
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1 Section 1. Section 16.59, Florida Statutes, is amended
2 to read:

3 16.59 Medicaid fraud control.--There is created in the
4 Department of Legal Affairs the Medicaid Fraud Control Unit,
5 which may investigate all violations of s. 409.920 and any
6 criminal violations discovered during the course of those
7 investigations. The Medicaid Fraud Control Unit may refer any
8 criminal violation so uncovered to the appropriate prosecuting
9 authority. Offices of the Medicaid Fraud Control Unit and the
10 offices of the Agency for Health Care Administration Medicaid
11 program integrity program shall, to the extent possible, be
12 collocated. The agency and the Department of Legal Affairs
13 shall conduct joint training and other joint activities
14 designed to increase communication and coordination in
15 recovering overpayments.

16 Section 2. Subsections (3), (5), and (7) of section
17 112.3187, Florida Statutes, are amended to read:

18 112.3187 Adverse action against employee for
19 disclosing information of specified nature prohibited;
20 employee remedy and relief.--

21 (3) DEFINITIONS.--As used in this act, unless
22 otherwise specified, the following words or terms shall have
23 the meanings indicated:

24 (a) "Agency" means any state, regional, county, local,
25 or municipal government entity, whether executive, judicial,
26 or legislative; any official, officer, department, division,
27 bureau, commission, authority, or political subdivision
28 therein; or any public school, community college, or state
29 university.

30 (b) "Employee" means a person who performs services
31 for, and under the control and direction of, or contracts

1 with, an agency or independent contractor for wages or other
2 remuneration.

3 (c) "Adverse personnel action" means the discharge,
4 suspension, transfer, or demotion of any employee or the
5 withholding of bonuses, the reduction in salary or benefits,
6 or any other adverse action taken against an employee within
7 the terms and conditions of employment by an agency or
8 independent contractor.

9 (d) "Independent contractor" means a person, other
10 than an agency, engaged in any business and who enters into a
11 contract or provider agreement with an agency.

12 (e) "Gross mismanagement" means a continuous pattern
13 of managerial abuses, wrongful or arbitrary and capricious
14 actions, or fraudulent or criminal conduct which may have a
15 substantial adverse economic impact.

16 (5) NATURE OF INFORMATION DISCLOSED.--The information
17 disclosed under this section must include:

18 (a) Any violation or suspected violation of any
19 federal, state, or local law, rule, or regulation committed by
20 an employee or agent of an agency or independent contractor
21 which creates and presents a substantial and specific danger
22 to the public's health, safety, or welfare.

23 (b) Any act or suspected act of gross mismanagement,
24 malfeasance, misfeasance, gross waste of public funds,
25 suspected or actual Medicaid fraud or abuse, or gross neglect
26 of duty committed by an employee or agent of an agency or
27 independent contractor.

28 (7) EMPLOYEES AND PERSONS PROTECTED.--This section
29 protects employees and persons who disclose information on
30 their own initiative in a written and signed complaint; who
31 are requested to participate in an investigation, hearing, or

1 other inquiry conducted by any agency or federal government
2 entity; who refuse to participate in any adverse action
3 prohibited by this section; or who initiate a complaint
4 through the whistle-blower's hotline or the hotline of the
5 Medicaid FRAud Control Unit of the Department of Legal
6 Affairs; or employees who file any written complaint to their
7 supervisory officials or employees who submit a complaint to
8 the Chief Inspector General in the Executive Office of the
9 Governor, to the employee designated as agency inspector
10 general under s. 112.3189(1), or to the Florida Commission on
11 Human Relations. The provisions of this section may not be
12 used by a person while he or she is under the care, custody,
13 or control of the state correctional system or, after release
14 from the care, custody, or control of the state correctional
15 system, with respect to circumstances that occurred during any
16 period of incarceration. No remedy or other protection under
17 ss. 112.3187-112.31895 applies to any person who has committed
18 or intentionally participated in committing the violation or
19 suspected violation for which protection under ss.
20 112.3187-112.31895 is being sought.

21 Section 3. Paragraph (d) of subsection (5) of section
22 400.179, Florida Statutes, is amended to read:

23 400.179 Sale or transfer of ownership of a nursing
24 facility; liability for Medicaid underpayments and
25 overpayments.--

26 (5) Because any transfer of a nursing facility may
27 expose the fact that Medicaid may have underpaid or overpaid
28 the transferor, and because in most instances, any such
29 underpayment or overpayment can only be determined following a
30 formal field audit, the liabilities for any such underpayments
31 or overpayments shall be as follows:

1 (d) Where the transfer involves a facility that has
2 been leased by the transferor:

3 1. The transferee shall, as a condition to being
4 issued a license by the agency, acquire, maintain, and provide
5 proof to the agency of a bond with a term of 30 months,
6 renewable annually, in an amount not less than the total of 3
7 months Medicaid payments to the facility computed on the basis
8 of the preceding 12-month average Medicaid payments to the
9 facility.

10 2. The leasehold operator may meet the bond
11 requirement through other arrangements acceptable to the
12 department.

13 3. All existing nursing facility licensees, operating
14 the facility as a leasehold, shall acquire, maintain, and
15 provide proof to the agency of the 30-month bond required in
16 subparagraph 1., above, on and after July 1, 1993, for each
17 license renewal.

18 4. It shall be the responsibility of all nursing
19 facility operators, operating the facility as a leasehold, to
20 renew the 30-month bond and to provide proof of such renewal
21 to the agency annually at the time of application for license
22 renewal.

23 5. Any failure of the nursing facility operator to
24 acquire, maintain, renew annually, or provide proof to the
25 agency shall be grounds for the agency to deny, cancel,
26 revoke, or suspend the facility license to operate such
27 facility and to take any further action, including, but not
28 limited to, enjoining the facility, asserting a moratorium, or
29 applying for a receiver, deemed necessary to ensure compliance
30 with this section and to safeguard and protect the health,
31 safety, and welfare of the facility's residents.

1 6. Notwithstanding other provisions of this section, a
2 lease agreement required as a condition of bond financing or
3 refinancing under s. 154.213 by a health facilities authority
4 or under s. 159.30 by a county or municipality is not
5 considered as a leasehold and therefore, is not subject to the
6 bond requirement of this paragraph.

7 Section 4. Section 408.831, Florida Statutes, is
8 created to read:

9 408.831 Denial, suspension, revocation of a license,
10 registration, certificate or application.--

11 (1) In addition to any other remedies provided by law,
12 the agency may deny each application or suspend or revoke each
13 license, registration, or certificate of entities regulated or
14 licensed by it:

15 (a) If the applicant, licensee, registrant, or
16 certificateholder, or, in the case of a corporation,
17 partnership, or other business entity, if any officer,
18 director, agent, or managing employee of that business entity
19 or any affiliated person, partner, or shareholder having an
20 ownership interest equal to 5 percent or greater in that
21 business entity, has failed to pay all outstanding fines,
22 liens, or overpayments assessed by final order of the agency
23 or final order of the Centers for Medicare and Medicaid
24 Services unless a repayment plan is approved by the agency; or

25 (b) For failure to comply with any repayment plan.

26 (2) This section provides standards of enforcement
27 applicable to all entities licensed or regulated by the Agency
28 for Health Care Administration. This section controls over any
29 conflicting provisions of chapters 39, 381, 383, 390, 391,
30 393, 394, 395, 400, 408, 468, 483, and 641 or rules adopted
31 pursuant to those chapters.

1 Section 5. Section 409.902, Florida Statutes, is
2 amended to read:

3 409.902 Designated single state agency; payment
4 requirements; program title.--The Agency for Health Care
5 Administration is designated as the single state agency
6 authorized to make payments for medical assistance and related
7 services under Title XIX of the Social Security Act. These
8 payments shall be made, subject to any limitations or
9 directions provided for in the General Appropriations Act,
10 only for services included in the program, shall be made only
11 on behalf of eligible individuals, and shall be made only to
12 qualified providers in accordance with federal requirements
13 for Title XIX of the Social Security Act and the provisions of
14 state law. This program of medical assistance is designated
15 the "Medicaid program." The Department of Children and Family
16 Services is responsible for Medicaid eligibility
17 determinations, including, but not limited to, policy, rules,
18 and the agreement with the Social Security Administration for
19 Medicaid eligibility determinations for Supplemental Security
20 Income recipients, as well as the actual determination of
21 eligibility. As a condition of Medicaid eligibility, the
22 Agency for Health Care Administration and the Department of
23 Children and Family Services shall ensure that each recipient
24 of Medicaid consents to the release of her or his medical
25 records to the Agency for Health Care Administration and the
26 Medicaid Fraud Control Unit of the Department of Legal
27 Affairs.

28 Section 6. Subsections (7) and (9) of section 409.907,
29 Florida Statutes, as amended by section 6 of chapter 2001-377,
30 Laws of Florida, are amended to read:

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1 409.907 Medicaid provider agreements.--The agency may
2 make payments for medical assistance and related services
3 rendered to Medicaid recipients only to an individual or
4 entity who has a provider agreement in effect with the agency,
5 who is performing services or supplying goods in accordance
6 with federal, state, and local law, and who agrees that no
7 person shall, on the grounds of handicap, race, color, or
8 national origin, or for any other reason, be subjected to
9 discrimination under any program or activity for which the
10 provider receives payment from the agency.

11 (7) The agency may require, as a condition of
12 participating in the Medicaid program and before entering into
13 the provider agreement, that the provider submit information,
14 in an initial and any required renewal applications,
15 concerning the professional, business, and personal background
16 of the provider and permit an onsite inspection of the
17 provider's service location by agency staff or other personnel
18 designated by the agency to perform this function. The agency
19 shall perform a random onsite inspection, within 60 days after
20 receipt of a fully complete new provider's application, of the
21 provider's service location prior to making its first payment
22 to the provider for Medicaid services to determine the
23 applicant's ability to provide the services that the applicant
24 is proposing to provide for Medicaid reimbursement. The agency
25 is not required to perform an onsite inspection of a provider
26 or program that is licensed by the agency, that provides
27 services under waiver programs for home and community-based
28 services, or that is licensed as a medical foster home by the
29 Department of Children and Family Services.As a continuing
30 condition of participation in the Medicaid program, a provider
31 shall immediately notify the agency of any current or pending

1 bankruptcy filing. Before entering into the provider
2 agreement, or as a condition of continuing participation in
3 the Medicaid program, the agency may also require that
4 Medicaid providers reimbursed on a fee-for-services basis or
5 fee schedule basis which is not cost-based, post a surety bond
6 not to exceed \$50,000 or the total amount billed by the
7 provider to the program during the current or most recent
8 calendar year, whichever is greater. For new providers, the
9 amount of the surety bond shall be determined by the agency
10 based on the provider's estimate of its first year's billing.
11 If the provider's billing during the first year exceeds the
12 bond amount, the agency may require the provider to acquire an
13 additional bond equal to the actual billing level of the
14 provider. A provider's bond shall not exceed \$50,000 if a
15 physician or group of physicians licensed under chapter 458,
16 chapter 459, or chapter 460 has a 50 percent or greater
17 ownership interest in the provider or if the provider is an
18 assisted living facility licensed under part III of chapter
19 400. The bonds permitted by this section are in addition to
20 the bonds referenced in s. 400.179(4)(d). If the provider is a
21 corporation, partnership, association, or other entity, the
22 agency may require the provider to submit information
23 concerning the background of that entity and of any principal
24 of the entity, including any partner or shareholder having an
25 ownership interest in the entity equal to 5 percent or
26 greater, and any treating provider who participates in or
27 intends to participate in Medicaid through the entity. The
28 information must include:

29 (a) Proof of holding a valid license or operating
30 certificate, as applicable, if required by the state or local
31

1 jurisdiction in which the provider is located or if required
2 by the Federal Government.

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

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

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

21 (9) Upon receipt of a completed, signed, and dated
22 application, and completion of any necessary background
23 investigation and criminal history record check, the agency
24 must either:

25 (a) Enroll the applicant as a Medicaid provider no
26 earlier than the effective date of the approval of the
27 provider application. With respect to providers who were
28 recently granted a change of ownership and those who primarily
29 provide emergency medical services transportation or emergency
30 services and care pursuant to s. 401.45 or s. 395.1041,
31 including out-of-state providers, upon approval of the

1 provider application, the effective date of approval is
2 considered to be the date the agency receives the provider
3 application; or

4 (b) Deny the application if the agency finds that it
5 is in the best interest of the Medicaid program to do so. The
6 agency may consider the factors listed in subsection (10), as
7 well as any other factor that could affect the effective and
8 efficient administration of the program, including, but not
9 limited to, the applicant's demonstrated ability to provide
10 services, conduct business, and operate a financially viable
11 concern; the current availability of medical care, services,
12 or supplies to recipients, taking into account geographic
13 location and reasonable travel time; the number of providers
14 of the same type already enrolled in the same geographic area;
15 and the credentials, experience, success, and patient outcomes
16 of the provider for the services that it is making application
17 to provide in the Medicaid program. The agency shall deny the
18 application if the agency finds that a provider; any officer,
19 director, agent, managing employee, or affiliated person; or
20 any partner or shareholder having an ownership interest equal
21 to 5 percent or greater in the provider if the provider is a
22 corporation, partnership, or other business entity, has failed
23 to pay all outstanding fines or overpayments assessed by final
24 order of the agency or final order of the Centers for Medicare
25 and Medicaid Services, unless the provider agrees to a
26 repayment plan that includes withholding Medicaid
27 reimbursement until the amount due is paid in full.

28 Section 7. Section 409.908, Florida Statutes, is
29 amended to read:

30 409.908 Reimbursement of Medicaid providers.--Subject
31 to specific appropriations, the agency shall reimburse

1 Medicaid providers, in accordance with state and federal law,
2 according to methodologies set forth in the rules of the
3 agency and in policy manuals and handbooks incorporated by
4 reference therein. These methodologies may include fee
5 schedules, reimbursement methods based on cost reporting,
6 negotiated fees, competitive bidding pursuant to s. 287.057,
7 and other mechanisms the agency considers efficient and
8 effective for purchasing services or goods on behalf of
9 recipients. If a provider is reimbursed based on cost
10 reporting and submits a cost report late and that cost report
11 would have been used to set a lower reimbursement rate for a
12 rate semester, then the provider's rate for that semester
13 shall be retroactively calculated using the new cost report,
14 and full payment at the recalculated rate shall be effected
15 retroactively. Medicare granted extensions for filing cost
16 reports, if applicable, shall also apply to Medicaid cost
17 reports. Payment for Medicaid compensable services made on
18 behalf of Medicaid eligible persons is subject to the
19 availability of moneys and any limitations or directions
20 provided for in the General Appropriations Act or chapter 216.
21 Further, nothing in this section shall be construed to prevent
22 or limit the agency from adjusting fees, reimbursement rates,
23 lengths of stay, number of visits, or number of services, or
24 making any other adjustments necessary to comply with the
25 availability of moneys and any limitations or directions
26 provided for in the General Appropriations Act, provided the
27 adjustment is consistent with legislative intent.

28 (1) Reimbursement to hospitals licensed under part I
29 of chapter 395 must be made prospectively or on the basis of
30 negotiation.

31

1 (a) Reimbursement for inpatient care is limited as
2 provided for in s. 409.905(5), except for:

3 1. The raising of rate reimbursement caps, excluding
4 rural hospitals.

5 2. Recognition of the costs of graduate medical
6 education.

7 3. Other methodologies recognized in the General
8 Appropriations Act.

9 4. Hospital inpatient rates shall be reduced by 6
10 percent effective July 1, 2001, and restored effective April
11 1, 2002.

12

13 During the years funds are transferred from the Department of
14 Health, any reimbursement supported by such funds shall be
15 subject to certification by the Department of Health that the
16 hospital has complied with s. 381.0403. The agency is
17 authorized to receive funds from state entities, including,
18 but not limited to, the Department of Health, local
19 governments, and other local political subdivisions, for the
20 purpose of making special exception payments, including
21 federal matching funds, through the Medicaid inpatient
22 reimbursement methodologies. Funds received from state
23 entities or local governments for this purpose shall be
24 separately accounted for and shall not be commingled with
25 other state or local funds in any manner. The agency may
26 certify all local governmental funds used as state match under
27 Title XIX of the Social Security Act, to the extent that the
28 identified local health care provider that is otherwise
29 entitled to and is contracted to receive such local funds is
30 the benefactor under the state's Medicaid program as
31 determined under the General Appropriations Act and pursuant

1 to an agreement between the Agency for Health Care
2 Administration and the local governmental entity. The local
3 governmental entity shall use a certification form prescribed
4 by the agency. At a minimum, the certification form shall
5 identify the amount being certified and describe the
6 relationship between the certifying local governmental entity
7 and the local health care provider. The agency shall prepare
8 an annual statement of impact which documents the specific
9 activities undertaken during the previous fiscal year pursuant
10 to this paragraph, to be submitted to the Legislature no later
11 than January 1, annually.

12 (b) Reimbursement for hospital outpatient care is
13 limited to \$1,500 per state fiscal year per recipient, except
14 for:

- 15 1. Such care provided to a Medicaid recipient under
16 age 21, in which case the only limitation is medical
17 necessity.
 - 18 2. Renal dialysis services.
 - 19 3. Other exceptions made by the agency.
- 20

21 The agency is authorized to receive funds from state entities,
22 including, but not limited to, the Department of Health, the
23 Board of Regents, local governments, and other local political
24 subdivisions, for the purpose of making payments, including
25 federal matching funds, through the Medicaid outpatient
26 reimbursement methodologies. Funds received from state
27 entities and local governments for this purpose shall be
28 separately accounted for and shall not be commingled with
29 other state or local funds in any manner.

30 (c) Hospitals that provide services to a
31 disproportionate share of low-income Medicaid recipients, or

1 that participate in the regional perinatal intensive care
2 center program under chapter 383, or that participate in the
3 statutory teaching hospital disproportionate share program may
4 receive additional reimbursement. The total amount of payment
5 for disproportionate share hospitals shall be fixed by the
6 General Appropriations Act. The computation of these payments
7 must be made in compliance with all federal regulations and
8 the methodologies described in ss. 409.911, 409.9112, and
9 409.9113.

10 (d) The agency is authorized to limit inflationary
11 increases for outpatient hospital services as directed by the
12 General Appropriations Act.

13 (2)(a)1. Reimbursement to nursing homes licensed under
14 part II of chapter 400 and state-owned-and-operated
15 intermediate care facilities for the developmentally disabled
16 licensed under chapter 393 must be made prospectively.

17 2. Unless otherwise limited or directed in the General
18 Appropriations Act, reimbursement to hospitals licensed under
19 part I of chapter 395 for the provision of swing-bed nursing
20 home services must be made on the basis of the average
21 statewide nursing home payment, and reimbursement to a
22 hospital licensed under part I of chapter 395 for the
23 provision of skilled nursing services must be made on the
24 basis of the average nursing home payment for those services
25 in the county in which the hospital is located. When a
26 hospital is located in a county that does not have any
27 community nursing homes, reimbursement must be determined by
28 averaging the nursing home payments, in counties that surround
29 the county in which the hospital is located. Reimbursement to
30 hospitals, including Medicaid payment of Medicare copayments,
31 for skilled nursing services shall be limited to 30 days,

1 unless a prior authorization has been obtained from the
2 agency. Medicaid reimbursement may be extended by the agency
3 beyond 30 days, and approval must be based upon verification
4 by the patient's physician that the patient requires
5 short-term rehabilitative and recuperative services only, in
6 which case an extension of no more than 15 days may be
7 approved. Reimbursement to a hospital licensed under part I of
8 chapter 395 for the temporary provision of skilled nursing
9 services to nursing home residents who have been displaced as
10 the result of a natural disaster or other emergency may not
11 exceed the average county nursing home payment for those
12 services in the county in which the hospital is located and is
13 limited to the period of time which the agency considers
14 necessary for continued placement of the nursing home
15 residents in the hospital.

16 (b) Subject to any limitations or directions provided
17 for in the General Appropriations Act, the agency shall
18 establish and implement a Florida Title XIX Long-Term Care
19 Reimbursement Plan (Medicaid) for nursing home care in order
20 to provide care and services in conformance with the
21 applicable state and federal laws, rules, regulations, and
22 quality and safety standards and to ensure that individuals
23 eligible for medical assistance have reasonable geographic
24 access to such care.

25 1. Changes of ownership or of licensed operator do not
26 qualify for increases in reimbursement rates associated with
27 the change of ownership or of licensed operator. The agency
28 shall amend the Title XIX Long Term Care Reimbursement Plan to
29 provide that the initial nursing home reimbursement rates, for
30 the operating, patient care, and MAR components, associated
31 with related and unrelated party changes of ownership or

1 licensed operator filed on or after September 1, 2001, are
2 equivalent to the previous owner's reimbursement rate.

3 2. The agency shall amend the long-term care
4 reimbursement plan and cost reporting system to create direct
5 care and indirect care subcomponents of the patient care
6 component of the per diem rate. These two subcomponents
7 together shall equal the patient care component of the per
8 diem rate. Separate cost-based ceilings shall be calculated
9 for each patient care subcomponent. The direct care
10 subcomponent of the per diem rate shall be limited by the
11 cost-based class ceiling, and the indirect care subcomponent
12 shall be limited by the lower of the cost-based class ceiling,
13 by the target rate class ceiling, or by the individual
14 provider target. The agency shall adjust the patient care
15 component effective January 1, 2002. The cost to adjust the
16 direct care subcomponent shall be net of the total funds
17 previously allocated for the case mix add-on. The agency shall
18 make the required changes to the nursing home cost reporting
19 forms to implement this requirement effective January 1, 2002.

20 3. The direct care subcomponent shall include salaries
21 and benefits of direct care staff providing nursing services
22 including registered nurses, licensed practical nurses, and
23 certified nursing assistants who deliver care directly to
24 residents in the nursing home facility. This excludes nursing
25 administration, MDS, and care plan coordinators, staff
26 development, and staffing coordinator.

27 4. All other patient care costs shall be included in
28 the indirect care cost subcomponent of the patient care per
29 diem rate. There shall be no costs directly or indirectly
30 allocated to the direct care subcomponent from a home office
31 or management company.

1 5. On July 1 of each year, the agency shall report to
2 the Legislature direct and indirect care costs, including
3 average direct and indirect care costs per resident per
4 facility and direct care and indirect care salaries and
5 benefits per category of staff member per facility.

6 6. Under the plan, interim rate adjustments shall not
7 be granted to reflect increases in the cost of general or
8 professional liability insurance for nursing homes unless the
9 following criteria are met: have at least a 65 percent
10 Medicaid utilization in the most recent cost report submitted
11 to the agency, and the increase in general or professional
12 liability costs to the facility for the most recent policy
13 period affects the total Medicaid per diem by at least 5
14 percent. This rate adjustment shall not result in the per diem
15 exceeding the class ceiling. This provision shall be
16 implemented to the extent existing appropriations are
17 available.

18
19 It is the intent of the Legislature that the reimbursement
20 plan achieve the goal of providing access to health care for
21 nursing home residents who require large amounts of care while
22 encouraging diversion services as an alternative to nursing
23 home care for residents who can be served within the
24 community. The agency shall base the establishment of any
25 maximum rate of payment, whether overall or component, on the
26 available moneys as provided for in the General Appropriations
27 Act. The agency may base the maximum rate of payment on the
28 results of scientifically valid analysis and conclusions
29 derived from objective statistical data pertinent to the
30 particular maximum rate of payment.

31

1 (3) Subject to any limitations or directions provided
2 for in the General Appropriations Act, the following Medicaid
3 services and goods may be reimbursed on a fee-for-service
4 basis. For each allowable service or goods furnished in
5 accordance with Medicaid rules, policy manuals, handbooks, and
6 state and federal law, the payment shall be the amount billed
7 by the provider, the provider's usual and customary charge, or
8 the maximum allowable fee established by the agency, whichever
9 amount is less, with the exception of those services or goods
10 for which the agency makes payment using a methodology based
11 on capitation rates, average costs, or negotiated fees.

12 (a) Advanced registered nurse practitioner services.

13 (b) Birth center services.

14 (c) Chiropractic services.

15 (d) Community mental health services.

16 (e) Dental services, including oral and maxillofacial
17 surgery.

18 (f) Durable medical equipment.

19 (g) Hearing services.

20 (h) Occupational therapy for Medicaid recipients under
21 age 21.

22 (i) Optometric services.

23 (j) Orthodontic services.

24 (k) Personal care for Medicaid recipients under age
25 21.

26 (l) Physical therapy for Medicaid recipients under age
27 21.

28 (m) Physician assistant services.

29 (n) Podiatric services.

30 (o) Portable X-ray services.

31

1 (p) Private-duty nursing for Medicaid recipients under
2 age 21.

3 (q) Registered nurse first assistant services.

4 (r) Respiratory therapy for Medicaid recipients under
5 age 21.

6 (s) Speech therapy for Medicaid recipients under age
7 21.

8 (t) Visual services.

9 (4) Subject to any limitations or directions provided
10 for in the General Appropriations Act, alternative health
11 plans, health maintenance organizations, and prepaid health
12 plans shall be reimbursed a fixed, prepaid amount negotiated,
13 or competitively bid pursuant to s. 287.057, by the agency and
14 prospectively paid to the provider monthly for each Medicaid
15 recipient enrolled. The amount may not exceed the average
16 amount the agency determines it would have paid, based on
17 claims experience, for recipients in the same or similar
18 category of eligibility. The agency shall calculate
19 capitation rates on a regional basis and, beginning September
20 1, 1995, shall include age-band differentials in such
21 calculations. Effective July 1, 2001, the cost of exempting
22 statutory teaching hospitals, specialty hospitals, and
23 community hospital education program hospitals from
24 reimbursement ceilings and the cost of special Medicaid
25 payments shall not be included in premiums paid to health
26 maintenance organizations or prepaid health care plans. Each
27 rate semester, the agency shall calculate and publish a
28 Medicaid hospital rate schedule that does not reflect either
29 special Medicaid payments or the elimination of rate
30 reimbursement ceilings, to be used by hospitals and Medicaid
31 health maintenance organizations, in order to determine the

1 Medicaid rate referred to in ss. 409.912(16), 409.9128(5), and
2 641.513(6).

3 (5) An ambulatory surgical center shall be reimbursed
4 the lesser of the amount billed by the provider or the
5 Medicare-established allowable amount for the facility.

6 (6) A provider of early and periodic screening,
7 diagnosis, and treatment services to Medicaid recipients who
8 are children under age 21 shall be reimbursed using an
9 all-inclusive rate stipulated in a fee schedule established by
10 the agency. A provider of the visual, dental, and hearing
11 components of such services shall be reimbursed the lesser of
12 the amount billed by the provider or the Medicaid maximum
13 allowable fee established by the agency.

14 (7) A provider of family planning services shall be
15 reimbursed the lesser of the amount billed by the provider or
16 an all-inclusive amount per type of visit for physicians and
17 advanced registered nurse practitioners, as established by the
18 agency in a fee schedule.

19 (8) A provider of home-based or community-based
20 services rendered pursuant to a federally approved waiver
21 shall be reimbursed based on an established or negotiated rate
22 for each service. These rates shall be established according
23 to an analysis of the expenditure history and prospective
24 budget developed by each contract provider participating in
25 the waiver program, or under any other methodology adopted by
26 the agency and approved by the Federal Government in
27 accordance with the waiver. Effective July 1, 1996, privately
28 owned and operated community-based residential facilities
29 which meet agency requirements and which formerly received
30 Medicaid reimbursement for the optional intermediate care
31 facility for the mentally retarded service may participate in

1 the developmental services waiver as part of a
2 home-and-community-based continuum of care for Medicaid
3 recipients who receive waiver services.

4 (9) A provider of home health care services or of
5 medical supplies and appliances shall be reimbursed on the
6 basis of competitive bidding or for the lesser of the amount
7 billed by the provider or the agency's established maximum
8 allowable amount, except that, in the case of the rental of
9 durable medical equipment, the total rental payments may not
10 exceed the purchase price of the equipment over its expected
11 useful life or the agency's established maximum allowable
12 amount, whichever amount is less.

13 (10) A hospice shall be reimbursed through a
14 prospective system for each Medicaid hospice patient at
15 Medicaid rates using the methodology established for hospice
16 reimbursement pursuant to Title XVIII of the federal Social
17 Security Act.

18 (11) A provider of independent laboratory services
19 shall be reimbursed on the basis of competitive bidding or for
20 the least of the amount billed by the provider, the provider's
21 usual and customary charge, or the Medicaid maximum allowable
22 fee established by the agency.

23 (12)(a) A physician shall be reimbursed the lesser of
24 the amount billed by the provider or the Medicaid maximum
25 allowable fee established by the agency.

26 (b) The agency shall adopt a fee schedule, subject to
27 any limitations or directions provided for in the General
28 Appropriations Act, based on a resource-based relative value
29 scale for pricing Medicaid physician services. Under this fee
30 schedule, physicians shall be paid a dollar amount for each
31 service based on the average resources required to provide the

1 service, including, but not limited to, estimates of average
2 physician time and effort, practice expense, and the costs of
3 professional liability insurance. The fee schedule shall
4 provide increased reimbursement for preventive and primary
5 care services and lowered reimbursement for specialty services
6 by using at least two conversion factors, one for cognitive
7 services and another for procedural services. The fee
8 schedule shall not increase total Medicaid physician
9 expenditures unless moneys are available, and shall be phased
10 in over a 2-year period beginning on July 1, 1994. The Agency
11 for Health Care Administration shall seek the advice of a
12 16-member advisory panel in formulating and adopting the fee
13 schedule. The panel shall consist of Medicaid physicians
14 licensed under chapters 458 and 459 and shall be composed of
15 50 percent primary care physicians and 50 percent specialty
16 care physicians.

17 (c) Notwithstanding paragraph (b), reimbursement fees
18 to physicians for providing total obstetrical services to
19 Medicaid recipients, which include prenatal, delivery, and
20 postpartum care, shall be at least \$1,500 per delivery for a
21 pregnant woman with low medical risk and at least \$2,000 per
22 delivery for a pregnant woman with high medical risk. However,
23 reimbursement to physicians working in Regional Perinatal
24 Intensive Care Centers designated pursuant to chapter 383, for
25 services to certain pregnant Medicaid recipients with a high
26 medical risk, may be made according to obstetrical care and
27 neonatal care groupings and rates established by the agency.
28 Nurse midwives licensed under part I of chapter 464 or
29 midwives licensed under chapter 467 shall be reimbursed at no
30 less than 80 percent of the low medical risk fee. The agency
31 shall by rule determine, for the purpose of this paragraph,

1 what constitutes a high or low medical risk pregnant woman and
2 shall not pay more based solely on the fact that a caesarean
3 section was performed, rather than a vaginal delivery. The
4 agency shall by rule determine a prorated payment for
5 obstetrical services in cases where only part of the total
6 prenatal, delivery, or postpartum care was performed. The
7 Department of Health shall adopt rules for appropriate
8 insurance coverage for midwives licensed under chapter 467.
9 Prior to the issuance and renewal of an active license, or
10 reactivation of an inactive license for midwives licensed
11 under chapter 467, such licensees shall submit proof of
12 coverage with each application.

13 (13) Medicare premiums for persons eligible for both
14 Medicare and Medicaid coverage shall be paid at the rates
15 established by Title XVIII of the Social Security Act. For
16 Medicare services rendered to Medicaid-eligible persons,
17 Medicaid shall pay Medicare deductibles and coinsurance as
18 follows:

19 (a) Medicaid shall make no payment toward deductibles
20 and coinsurance for any service that is not covered by
21 Medicaid.

22 (b) Medicaid's financial obligation for deductibles
23 and coinsurance payments shall be based on Medicare allowable
24 fees, not on a provider's billed charges.

25 (c) Medicaid will pay no portion of Medicare
26 deductibles and coinsurance when payment that Medicare has
27 made for the service equals or exceeds what Medicaid would
28 have paid if it had been the sole payor. The combined payment
29 of Medicare and Medicaid shall not exceed the amount Medicaid
30 would have paid had it been the sole payor. The Legislature
31 finds that there has been confusion regarding the

1 reimbursement for services rendered to dually eligible
2 Medicare beneficiaries. Accordingly, the Legislature clarifies
3 that it has always been the intent of the Legislature before
4 and after 1991 that, in reimbursing in accordance with fees
5 established by Title XVIII for premiums, deductibles, and
6 coinsurance for Medicare services rendered by physicians to
7 Medicaid eligible persons, physicians be reimbursed at the
8 lesser of the amount billed by the physician or the Medicaid
9 maximum allowable fee established by the Agency for Health
10 Care Administration, as is permitted by federal law. It has
11 never been the intent of the Legislature with regard to such
12 services rendered by physicians that Medicaid be required to
13 provide any payment for deductibles, coinsurance, or
14 copayments for Medicare cost sharing, or any expenses incurred
15 relating thereto, in excess of the payment amount provided for
16 under the State Medicaid plan for such service. This payment
17 methodology is applicable even in those situations in which
18 the payment for Medicare cost sharing for a qualified Medicare
19 beneficiary with respect to an item or service is reduced or
20 eliminated. This expression of the Legislature is in
21 clarification of existing law and shall apply to payment for,
22 and with respect to provider agreements with respect to, items
23 or services furnished on or after the effective date of this
24 act. This paragraph applies to payment by Medicaid for items
25 and services furnished before the effective date of this act
26 if such payment is the subject of a lawsuit that is based on
27 the provisions of this section, and that is pending as of, or
28 is initiated after, the effective date of this act.

29 (d) Notwithstanding paragraphs (a)-(c):
30
31

1 1. Medicaid payments for Nursing Home Medicare part A
2 coinsurance shall be the lesser of the Medicare coinsurance
3 amount or the Medicaid nursing home per diem rate.

4 2. Medicaid shall pay all deductibles and coinsurance
5 for Medicare-eligible recipients receiving freestanding end
6 stage renal dialysis center services.

7 3. Medicaid payments for general hospital inpatient
8 services shall be limited to the Medicare deductible per spell
9 of illness. Medicaid shall make no payment toward coinsurance
10 for Medicare general hospital inpatient services.

11 4. Medicaid shall pay all deductibles and coinsurance
12 for Medicare emergency transportation services provided by
13 ambulances licensed pursuant to chapter 401.

14 (14) A provider of prescribed drugs shall be
15 reimbursed the least of the amount billed by the provider, the
16 provider's usual and customary charge, or the Medicaid maximum
17 allowable fee established by the agency, plus a dispensing
18 fee. The agency is directed to implement a variable dispensing
19 fee for payments for prescribed medicines while ensuring
20 continued access for Medicaid recipients. The variable
21 dispensing fee may be based upon, but not limited to, either
22 or both the volume of prescriptions dispensed by a specific
23 pharmacy provider and the volume of prescriptions dispensed to
24 an individual recipient. The agency is authorized to limit
25 reimbursement for prescribed medicine in order to comply with
26 any limitations or directions provided for in the General
27 Appropriations Act, which may include implementing a
28 prospective or concurrent utilization review program.

29 (15) A provider of primary care case management
30 services rendered pursuant to a federally approved waiver
31

1 shall be reimbursed by payment of a fixed, prepaid monthly sum
2 for each Medicaid recipient enrolled with the provider.

3 (16) A provider of rural health clinic services and
4 federally qualified health center services shall be reimbursed
5 a rate per visit based on total reasonable costs of the
6 clinic, as determined by the agency in accordance with federal
7 regulations.

8 (17) A provider of targeted case management services
9 shall be reimbursed pursuant to an established fee, except
10 where the Federal Government requires a public provider be
11 reimbursed on the basis of average actual costs.

12 (18) Unless otherwise provided for in the General
13 Appropriations Act, a provider of transportation services
14 shall be reimbursed the lesser of the amount billed by the
15 provider or the Medicaid maximum allowable fee established by
16 the agency, except when the agency has entered into a direct
17 contract with the provider, or with a community transportation
18 coordinator, for the provision of an all-inclusive service, or
19 when services are provided pursuant to an agreement negotiated
20 between the agency and the provider. The agency, as provided
21 for in s. 427.0135, shall purchase transportation services
22 through the community coordinated transportation system, if
23 available, unless the agency determines a more cost-effective
24 method for Medicaid clients. Nothing in this subsection shall
25 be construed to limit or preclude the agency from contracting
26 for services using a prepaid capitation rate or from
27 establishing maximum fee schedules, individualized
28 reimbursement policies by provider type, negotiated fees,
29 prior authorization, competitive bidding, increased use of
30 mass transit, or any other mechanism that the agency considers
31 efficient and effective for the purchase of services on behalf

1 of Medicaid clients, including implementing a transportation
2 eligibility process. The agency shall not be required to
3 contract with any community transportation coordinator or
4 transportation operator that has been determined by the
5 agency, the Department of Legal Affairs Medicaid Fraud Control
6 Unit, or any other state or federal agency to have engaged in
7 any abusive or fraudulent billing activities. The agency is
8 authorized to competitively procure transportation services or
9 make other changes necessary to secure approval of federal
10 waivers needed to permit federal financing of Medicaid
11 transportation services at the service matching rate rather
12 than the administrative matching rate.

13 (19) County health department services may be
14 reimbursed a rate per visit based on total reasonable costs of
15 the clinic, as determined by the agency in accordance with
16 federal regulations under the authority of 42 C.F.R. s.
17 431.615.

18 (20) A renal dialysis facility that provides dialysis
19 services under s. 409.906(9) must be reimbursed the lesser of
20 the amount billed by the provider, the provider's usual and
21 customary charge, or the maximum allowable fee established by
22 the agency, whichever amount is less.

23 (21) The agency shall reimburse school districts which
24 certify the state match pursuant to ss. 236.0812 and 409.9071
25 for the federal portion of the school district's allowable
26 costs to deliver the services, based on the reimbursement
27 schedule. The school district shall determine the costs for
28 delivering services as authorized in ss. 236.0812 and 409.9071
29 for which the state match will be certified. Reimbursement of
30 school-based providers is contingent on such providers being
31 enrolled as Medicaid providers and meeting the qualifications

1 contained in 42 C.F.R. s. 440.110, unless otherwise waived by
2 the federal Health Care Financing Administration. Speech
3 therapy providers who are certified through the Department of
4 Education pursuant to rule 6A-4.0176, Florida Administrative
5 Code, are eligible for reimbursement for services that are
6 provided on school premises. Any employee of the school
7 district who has been fingerprinted and has received a
8 criminal background check in accordance with Department of
9 Education rules and guidelines shall be exempt from any agency
10 requirements relating to criminal background checks.

11 (22) The agency shall request and implement Medicaid
12 waivers from the federal Health Care Financing Administration
13 to advance and treat a portion of the Medicaid nursing home
14 per diem as capital for creating and operating a
15 risk-retention group for self-insurance purposes, consistent
16 with federal and state laws and rules.

17 Section 8. Paragraph (b) of subsection (7) of section
18 409.910, Florida Statutes, is amended to read:

19 409.910 Responsibility for payments on behalf of
20 Medicaid-eligible persons when other parties are liable.--

21 (7) The agency shall recover the full amount of all
22 medical assistance provided by Medicaid on behalf of the
23 recipient to the full extent of third-party benefits.

24 (b) Upon receipt of any recovery or other collection
25 pursuant to this section, the agency shall distribute the
26 amount collected as follows:

27 1. To itself, an amount equal to the state Medicaid
28 expenditures for the recipient plus any incentive payment made
29 in accordance with paragraph (14)(a). From this share the
30 agency shall credit a county on its county billing invoice the
31 county's proportionate share of Medicaid third-party

1 recoveries in the areas of estate recoveries and casualty
2 claims, minus the agency's cost of recovering the third-party
3 payments, based on the county's percentage of the sum of total
4 county billing divided by total Medicaid expenditures.
5 However, if a county has been billed for its participation but
6 has not paid the amount due, the agency shall offset that
7 amount and notify the county of the amount of the offset. If
8 the county has divided its financial responsibility between
9 the county and a special taxing district or authority as
10 contemplated in s. 409.915(6), the county must proportionately
11 divide any refund or offset in accordance with the proration
12 that it has established.

13 2. To the Federal Government, the federal share of the
14 state Medicaid expenditures minus any incentive payment made
15 in accordance with paragraph (14)(a) and federal law, and
16 minus any other amount permitted by federal law to be
17 deducted.

18 3. To the recipient, after deducting any known amounts
19 owed to the agency for any related medical assistance or to
20 health care providers, any remaining amount. This amount shall
21 be treated as income or resources in determining eligibility
22 for Medicaid.

23
24 The provisions of this subsection do not apply to any proceeds
25 received by the state, or any agency thereof, pursuant to a
26 final order, judgment, or settlement agreement, in any matter
27 in which the state asserts claims brought on its own behalf,
28 and not as a subrogee of a recipient, or under other theories
29 of liability. The provisions of this subsection do not apply
30 to any proceeds received by the state, or an agency thereof,
31 pursuant to a final order, judgment, or settlement agreement,

1 in any matter in which the state asserted both claims as a
2 subrogee and additional claims, except as to those sums
3 specifically identified in the final order, judgment, or
4 settlement agreement as reimbursements to the recipient as
5 expenditures for the named recipient on the subrogation claim.

6 Section 9. Section 409.913, Florida Statutes, as
7 amended by section 12 of chapter 2001-377, Laws of Florida, is
8 amended to read:

9 409.913 Oversight of the integrity of the Medicaid
10 program.--The agency shall operate a program to oversee the
11 activities of Florida Medicaid recipients, and providers and
12 their representatives, to ensure that fraudulent and abusive
13 behavior and neglect of recipients occur to the minimum extent
14 possible, and to recover overpayments and impose sanctions as
15 appropriate. Beginning January 1, 2003, and each year
16 thereafter, the agency and the Medicaid Fraud Control Unit of
17 the Department of Legal Affairs shall submit a joint report to
18 the Legislature documenting the effectiveness of the state's
19 efforts to control Medicaid fraud and abuse and to recover
20 Medicaid overpayments during the previous fiscal year. The
21 report must describe the number of cases opened and
22 investigated each year; the sources of the cases opened; the
23 disposition of the cases closed each year; the amount of
24 overpayments alleged in preliminary and final audit letters;
25 the number and amount of fines or penalties imposed; any
26 reductions in overpayment amounts negotiated in settlement
27 agreements or by other means; the amount of final agency
28 determinations of overpayments; the amount deducted from
29 federal claiming as a result of overpayments; the amount of
30 overpayments recovered each year; the amount of cost of
31 investigation recovered each year; the average length of time

1 to collect from the time the case was opened until the
2 overpayment is paid in full; the amount determined as
3 uncollectible and the portion of the uncollectible amount
4 subsequently reclaimed from the Federal Government; the number
5 of providers, by type, that are terminated from participation
6 in the Medicaid program as a result of fraud and abuse; and
7 all costs associated with discovering and prosecuting cases of
8 Medicaid overpayments and making recoveries in such cases. The
9 report must also document actions taken to prevent
10 overpayments and the number of providers prevented from
11 enrolling in or reenrolling in the Medicaid program as a
12 result of documented Medicaid fraud and abuse and must
13 recommend changes necessary to prevent or recover
14 overpayments. For the 2001-2002 fiscal year, the agency shall
15 prepare a report that contains as much of this information as
16 is available to it.

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

18 (a) "Abuse" means:

19 1. Provider practices that are inconsistent with
20 generally accepted business or medical practices and that
21 result in an unnecessary cost to the Medicaid program or in
22 reimbursement for goods or services that are not medically
23 necessary or that fail to meet professionally recognized
24 standards for health care.

25 2. Recipient practices that result in unnecessary cost
26 to the Medicaid program.

27 (b) "Complaint" means an allegation that fraud, abuse
28 or an overpayment has occurred.

29 (c)~~(b)~~ "Fraud" means an intentional deception or
30 misrepresentation made by a person with the knowledge that the
31 deception results in unauthorized benefit to herself or

1 himself or another person. The term includes any act that
2 constitutes fraud under applicable federal or state law.

3 (d)~~(c)~~ "Medical necessity" or "medically necessary"
4 means any goods or services necessary to palliate the effects
5 of a terminal condition, or to prevent, diagnose, correct,
6 cure, alleviate, or preclude deterioration of a condition that
7 threatens life, causes pain or suffering, or results in
8 illness or infirmity, which goods or services are provided in
9 accordance with generally accepted standards of medical
10 practice. For purposes of determining Medicaid reimbursement,
11 the agency is the final arbiter of medical necessity.
12 Determinations of medical necessity must be made by a licensed
13 physician employed by or under contract with the agency and
14 must be based upon information available at the time the goods
15 or services are provided.

16 (e)~~(d)~~ "Overpayment" includes any amount that is not
17 authorized to be paid by the Medicaid program whether paid as
18 a result of inaccurate or improper cost reporting, improper
19 claiming, unacceptable practices, fraud, abuse, or mistake.

20 (f)~~(e)~~ "Person" means any natural person, corporation,
21 partnership, association, clinic, group, or other entity,
22 whether or not such person is enrolled in the Medicaid program
23 or is a provider of health care.

24 (2) The agency shall conduct, or cause to be conducted
25 by contract or otherwise, reviews, investigations, analyses,
26 audits, or any combination thereof, to determine possible
27 fraud, abuse, overpayment, or recipient neglect in the
28 Medicaid program and shall report the findings of any
29 overpayments in audit reports as appropriate.

30 (3) The agency may conduct, or may contract for,
31 prepayment review of provider claims to ensure cost-effective

1 purchasing, billing, and provision of care to Medicaid
2 recipients. Such prepayment reviews may be conducted as
3 determined appropriate by the agency, without any suspicion or
4 allegation of fraud, abuse, or neglect.

5 (4) Any suspected criminal violation identified by the
6 agency must be referred to the Medicaid Fraud Control Unit of
7 the Office of the Attorney General for investigation. The
8 agency and the Attorney General shall enter into a memorandum
9 of understanding, which must include, but need not be limited
10 to, a protocol for regularly sharing information and
11 coordinating casework. The protocol must establish a
12 procedure for the referral by the agency of cases involving
13 suspected Medicaid fraud to the Medicaid Fraud Control Unit
14 for investigation, and the return to the agency of those cases
15 where investigation determines that administrative action by
16 the agency is appropriate. Offices of the Medicaid program
17 integrity program and the Medicaid Fraud Control Unit of the
18 Department of Legal Affairs, shall, to the extent possible, be
19 collocated. The agency and the Department of Legal Affairs
20 shall periodically conduct joint training and other joint
21 activities designed to increase communication and coordination
22 in recovering overpayments.

23 (5) A Medicaid provider is subject to having goods and
24 services that are paid for by the Medicaid program reviewed by
25 an appropriate peer-review organization designated by the
26 agency. The written findings of the applicable peer-review
27 organization are admissible in any court or administrative
28 proceeding as evidence of medical necessity or the lack
29 thereof.

30 (6) Any notice required to be given to a provider
31 under this section is presumed to be sufficient notice if sent

1 to the address last shown on the provider enrollment file. It
2 is the responsibility of the provider to furnish and keep the
3 agency informed of the provider's current address. United
4 States Postal Service proof of mailing or certified or
5 registered mailing of such notice to the provider at the
6 address shown on the provider enrollment file constitutes
7 sufficient proof of notice. Any notice required to be given to
8 the agency by this section must be sent to the agency at an
9 address designated by rule.

10 (7) When presenting a claim for payment under the
11 Medicaid program, a provider has an affirmative duty to
12 supervise the provision of, and be responsible for, goods and
13 services claimed to have been provided, to supervise and be
14 responsible for preparation and submission of the claim, and
15 to present a claim that is true and accurate and that is for
16 goods and services that:

17 (a) Have actually been furnished to the recipient by
18 the provider prior to submitting the claim.

19 (b) Are Medicaid-covered goods or services that are
20 medically necessary.

21 (c) Are of a quality comparable to those furnished to
22 the general public by the provider's peers.

23 (d) Have not been billed in whole or in part to a
24 recipient or a recipient's responsible party, except for such
25 copayments, coinsurance, or deductibles as are authorized by
26 the agency.

27 (e) Are provided in accord with applicable provisions
28 of all Medicaid rules, regulations, handbooks, and policies
29 and in accordance with federal, state, and local law.

30 (f) Are documented by records made at the time the
31 goods or services were provided, demonstrating the medical

1 necessity for the goods or services rendered. Medicaid goods
2 or services are excessive or not medically necessary unless
3 both the medical basis and the specific need for them are
4 fully and properly documented in the recipient's medical
5 record.

6 (8) A Medicaid provider shall retain medical,
7 professional, financial, and business records pertaining to
8 services and goods furnished to a Medicaid recipient and
9 billed to Medicaid for a period of 5 years after the date of
10 furnishing such services or goods. The agency may investigate,
11 review, or analyze such records, which must be made available
12 during normal business hours. However, 24-hour notice must be
13 provided if patient treatment would be disrupted. The provider
14 is responsible for furnishing to the agency, and keeping the
15 agency informed of the location of, the provider's
16 Medicaid-related records. The authority of the agency to
17 obtain Medicaid-related records from a provider is neither
18 curtailed nor limited during a period of litigation between
19 the agency and the provider.

20 (9) Payments for the services of billing agents or
21 persons participating in the preparation of a Medicaid claim
22 shall not be based on amounts for which they bill nor based on
23 the amount a provider receives from the Medicaid program.

24 (10) The agency may require repayment for
25 inappropriate, medically unnecessary, or excessive goods or
26 services from the person furnishing them, the person under
27 whose supervision they were furnished, or the person causing
28 them to be furnished.

29 (11) The complaint and all information obtained
30 pursuant to an investigation of a Medicaid provider, or the
31 authorized representative or agent of a provider, relating to

1 an allegation of fraud, abuse, or neglect are confidential and
2 exempt from the provisions of s. 119.07(1):

3 (a) Until the agency takes final agency action with
4 respect to the provider and requires repayment of any
5 overpayment, or imposes an administrative sanction;

6 (b) Until the Attorney General refers the case for
7 criminal prosecution;

8 (c) Until 10 days after the complaint is determined
9 without merit; or

10 (d) At all times if the complaint or information is
11 otherwise protected by law.

12 (12) The agency may terminate participation of a
13 Medicaid provider in the Medicaid program and may seek civil
14 remedies or impose other administrative sanctions against a
15 Medicaid provider, if the provider has been:

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

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

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

26 (13) If the provider has been suspended or terminated
27 from participation in the Medicaid program or the Medicare
28 program by the Federal Government or any state, the agency
29 must immediately suspend or terminate, as appropriate, the
30 provider's participation in the Florida Medicaid program for a
31 period no less than that imposed by the Federal Government or

1 any other state, and may not enroll such provider in the
2 Florida Medicaid program while such foreign suspension or
3 termination remains in effect. This sanction is in addition
4 to all other remedies provided by law.

5 (14) The agency may seek any remedy provided by law,
6 including, but not limited to, the remedies provided in
7 subsections (12) and (15) and s. 812.035, if:

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

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

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

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

24 (e) The provider is not in compliance with provisions
25 of Medicaid provider publications that have been adopted by
26 reference as rules in the Florida Administrative Code; with
27 provisions of state or federal laws, rules, or regulations;
28 with provisions of the provider agreement between the agency
29 and the provider; or with certifications found on claim forms
30 or on transmittal forms for electronically submitted claims
31 that are submitted by the provider or authorized

1 representative, as such provisions apply to the Medicaid
2 program;

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

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

10 (h) The provider or an authorized representative of
11 the provider, or a person who ordered or prescribed the goods
12 or services, has submitted or caused to be submitted false or
13 a pattern of erroneous Medicaid claims that have resulted in
14 overpayments to a provider or that exceed those to which the
15 provider was entitled under the Medicaid program;

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

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

28 (k) The provider or an authorized representative of
29 the provider has included in a cost report costs that are not
30 allowable under a Florida Title XIX reimbursement plan, after
31 the provider or authorized representative had been advised in

1 an audit exit conference or audit report that the costs were
2 not allowable;

3 (l) The provider is charged by information or
4 indictment with fraudulent billing practices. The sanction
5 applied for this reason is limited to suspension of the
6 provider's participation in the Medicaid program for the
7 duration of the indictment unless the provider is found guilty
8 pursuant to the information or indictment;

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

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

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

20 (p) The agency has received reliable information of
21 patient abuse or neglect or of any act prohibited by s.
22 409.920; ~~or-~~

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

25 (15) The agency shall ~~may~~ impose any of the following
26 sanctions or disincentives on a provider or a person for any
27 of the acts described in subsection (14):

28 (a) Suspension for a specific period of time of not
29 more than 1 year.

30 (b) Termination for a specific period of time of from
31 more than 1 year to 20 years.

1 (c) Imposition of a fine of up to \$5,000 for each
2 violation. Each day that an ongoing violation continues, such
3 as refusing to furnish Medicaid-related records or refusing
4 access to records, is considered, for the purposes of this
5 section, to be a separate violation. Each instance of
6 improper billing of a Medicaid recipient; each instance of
7 including an unallowable cost on a hospital or nursing home
8 Medicaid cost report after the provider or authorized
9 representative has been advised in an audit exit conference or
10 previous audit report of the cost unallowability; each
11 instance of furnishing a Medicaid recipient goods or
12 professional services that are inappropriate or of inferior
13 quality as determined by competent peer judgment; each
14 instance of knowingly submitting a materially false or
15 erroneous Medicaid provider enrollment application, request
16 for prior authorization for Medicaid services, drug exception
17 request, or cost report; each instance of inappropriate
18 prescribing of drugs for a Medicaid recipient as determined by
19 competent peer judgment; and each false or erroneous Medicaid
20 claim leading to an overpayment to a provider is considered,
21 for the purposes of this section, to be a separate violation.

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

26 (e) A fine, not to exceed \$10,000, for a violation of
27 paragraph (14)(i).

28 (f) Imposition of liens against provider assets,
29 including, but not limited to, financial assets and real
30 property, not to exceed the amount of fines or recoveries

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1 sought, upon entry of an order determining that such moneys
2 are due or recoverable.

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

5 (h) Comprehensive follow-up reviews of providers every
6 6 months to ensure that they are billing Medicaid correctly.

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

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

12
13 The Secretary of Health Care Administration may make a
14 determination that imposition of a sanction or disincentive is
15 not in the best interest of the Medicaid program, in which
16 case a sanction or disincentive shall not be imposed.

17 (16) In determining the appropriate administrative
18 sanction to be applied, or the duration of any suspension or
19 termination, the agency shall consider:

20 (a) The seriousness and extent of the violation or
21 violations.

22 (b) Any prior history of violations by the provider
23 relating to the delivery of health care programs which
24 resulted in either a criminal conviction or in administrative
25 sanction or penalty.

26 (c) Evidence of continued violation within the
27 provider's management control of Medicaid statutes, rules,
28 regulations, or policies after written notification to the
29 provider of improper practice or instance of violation.

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1 (d) The effect, if any, on the quality of medical care
2 provided to Medicaid recipients as a result of the acts of the
3 provider.

4 (e) Any action by a licensing agency respecting the
5 provider in any state in which the provider operates or has
6 operated.

7 (f) The apparent impact on access by recipients to
8 Medicaid services if the provider is suspended or terminated,
9 in the best judgment of the agency.

10
11 The agency shall document the basis for all sanctioning
12 actions and recommendations.

13 (17) The agency may take action to sanction, suspend,
14 or terminate a particular provider working for a group
15 provider, and may suspend or terminate Medicaid participation
16 at a specific location, rather than or in addition to taking
17 action against an entire group.

18 (18) The agency shall establish a process for
19 conducting followup reviews of a sampling of providers who
20 have a history of overpayment under the Medicaid program.
21 This process must consider the magnitude of previous fraud or
22 abuse and the potential effect of continued fraud or abuse on
23 Medicaid costs.

24 (19) In making a determination of overpayment to a
25 provider, the agency must use accepted and valid auditing,
26 accounting, analytical, statistical, or peer-review methods,
27 or combinations thereof. Appropriate statistical methods may
28 include, but are not limited to, sampling and extension to the
29 population, parametric and nonparametric statistics, tests of
30 hypotheses, and other generally accepted statistical methods.
31 Appropriate analytical methods may include, but are not

1 limited to, reviews to determine variances between the
2 quantities of products that a provider had on hand and
3 available to be purveyed to Medicaid recipients during the
4 review period and the quantities of the same products paid for
5 by the Medicaid program for the same period, taking into
6 appropriate consideration sales of the same products to
7 non-Medicaid customers during the same period. In meeting its
8 burden of proof in any administrative or court proceeding, the
9 agency may introduce the results of such statistical methods
10 as evidence of overpayment.

11 (20) When making a determination that an overpayment
12 has occurred, the agency shall prepare and issue an audit
13 report to the provider showing the calculation of
14 overpayments.

15 (21) The audit report, supported by agency work
16 papers, showing an overpayment to a provider constitutes
17 evidence of the overpayment. A provider may not present or
18 elicit testimony, either on direct examination or
19 cross-examination in any court or administrative proceeding,
20 regarding the purchase or acquisition by any means of drugs,
21 goods, or supplies; sales or divestment by any means of drugs,
22 goods, or supplies; or inventory of drugs, goods, or supplies,
23 unless such acquisition, sales, divestment, or inventory is
24 documented by written invoices, written inventory records, or
25 other competent written documentary evidence maintained in the
26 normal course of the provider's business. Notwithstanding the
27 applicable rules of discovery, all documentation that will be
28 offered as evidence at an administrative hearing on a Medicaid
29 overpayment must be exchanged by all parties at least 14 days
30 before the administrative hearing or must be excluded from
31 consideration.

1 (22)(a) In an audit or investigation of a violation
2 committed by a provider which is conducted pursuant to this
3 section, the agency is entitled to recover all investigative,
4 legal, and expert witness costs if the agency's findings were
5 not contested by the provider or, if contested, the agency
6 ultimately prevailed.

7 (b) The agency has the burden of documenting the
8 costs, which include salaries and employee benefits and
9 out-of-pocket expenses. The amount of costs that may be
10 recovered must be reasonable in relation to the seriousness of
11 the violation and must be set taking into consideration the
12 financial resources, earning ability, and needs of the
13 provider, who has the burden of demonstrating such factors.

14 (c) The provider may pay the costs over a period to be
15 determined by the agency if the agency determines that an
16 extreme hardship would result to the provider from immediate
17 full payment. Any default in payment of costs may be
18 collected by any means authorized by law.

19 (23) If the agency imposes an administrative sanction
20 under this section upon any provider or other person who is
21 regulated by another state entity, the agency shall notify
22 that other entity of the imposition of the sanction. Such
23 notification must include the provider's or person's name and
24 license number and the specific reasons for sanction.

25 (24)(a) The agency may withhold Medicaid payments, in
26 whole or in part, to a provider upon receipt of reliable
27 evidence that the circumstances giving rise to the need for a
28 withholding of payments involve fraud, willful
29 misrepresentation, or abuse under the Medicaid program, or a
30 crime committed while rendering goods or services to Medicaid
31 recipients, pending completion of legal proceedings. If it is

1 determined that fraud, willful misrepresentation, abuse, or a
2 crime did not occur, the payments withheld must be paid to the
3 provider within 14 days after such determination with interest
4 at the rate of 10 percent a year. Any money withheld in
5 accordance with this paragraph shall be placed in a suspended
6 account, readily accessible to the agency, so that any payment
7 ultimately due the provider shall be made within 14 days.

8 (b) Overpayments owed to the agency bear interest at
9 the rate of 10 percent per year from the date of determination
10 of the overpayment by the agency, and payment arrangements
11 must be made at the conclusion of legal proceedings. A
12 provider who does not enter into or adhere to an agreed-upon
13 repayment schedule may be terminated by the agency for
14 nonpayment or partial payment.

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

23 (25) The agency may impose administrative sanctions
24 against a Medicaid recipient, or the agency may seek any other
25 remedy provided by law, including, but not limited to, the
26 remedies provided in s. 812.035, if the agency finds that a
27 recipient has engaged in solicitation in violation of s.
28 409.920 or that the recipient has otherwise abused the
29 Medicaid program.

30 (26) When the Agency for Health Care Administration
31 has made a probable cause determination and alleged that an

1 overpayment to a Medicaid provider has occurred, the agency,
2 after notice to the provider, may:

3 (a) Withhold, and continue to withhold during the
4 pendency of an administrative hearing pursuant to chapter 120,
5 any medical assistance reimbursement payments until such time
6 as the overpayment is recovered, unless within 30 days after
7 receiving notice thereof the provider:

- 8 1. Makes repayment in full; or
- 9 2. Establishes a repayment plan that is satisfactory
10 to the Agency for Health Care Administration.

11 (b) Withhold, and continue to withhold during the
12 pendency of an administrative hearing pursuant to chapter 120,
13 medical assistance reimbursement payments if the terms of a
14 repayment plan are not adhered to by the provider.

15
~~16 If a provider requests an administrative hearing pursuant to
17 chapter 120, such hearing must be conducted within 90 days
18 following receipt by the provider of the final audit report,
19 absent exceptionally good cause shown as determined by the
20 administrative law judge or hearing officer. Upon issuance of
21 a final order, the balance outstanding of the amount
22 determined to constitute the overpayment shall become due. Any
23 withholding of payments by the Agency for Health Care
24 Administration pursuant to this section shall be limited so
25 that the monthly medical assistance payment is not reduced by
26 more than 10 percent.~~

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

30 (28) Notwithstanding other provisions of law, the
31 agency and the Medicaid Fraud Control Unit of the Department

1 of Legal Affairs may review a provider's Medicaid-related
2 records in order to determine the total output of a provider's
3 practice to reconcile quantities of goods or services billed
4 to Medicaid against quantities of goods or services used in
5 the provider's total practice.

6 (29) The agency may terminate a provider's
7 participation in the Medicaid program if the provider fails to
8 reimburse an overpayment that has been determined by final
9 order within 35 days after the date of the final order, unless
10 the provider and the agency have entered into a repayment
11 agreement. If the final order is overturned on appeal, the
12 provider shall be reinstated.

13 (30) If a provider requests an administrative hearing
14 pursuant to chapter 120, such hearing must be conducted within
15 90 days following assignment of an administrative law judge,
16 absent exceptionally good cause shown as determined by the
17 administrative law judge or hearing officer. Upon issuance of
18 a final order, the outstanding balance of the amount
19 determined to constitute the overpayment shall become due. If
20 a provider fails to make payments in full, fails to enter into
21 a satisfactory repayment plan, or fails to comply with the
22 terms of a repayment plan or settlement agreement, the agency
23 may withhold medical-assistance-reimbursement payments until
24 the amount due is paid in full.

25 (31) Duly authorized agents and employees of the
26 agency shall have the power to inspect, during normal business
27 hours, the records of any pharmacy, wholesale establishment,
28 or manufacturer, or any other place in which drugs and medical
29 supplies are manufactured, packed, packaged, made, stored,
30 sold, or kept for sale, for the purpose of verifying the
31 amount of drugs and medical supplies ordered, delivered, or

1 purchased by a provider. The agency shall provide at least 2
2 business days' prior notice of any such inspection. The notice
3 must identify the provider whose records will be inspected,
4 and the inspection shall include only records specifically
5 related to that provider.

6 (32) The agency shall request that the Attorney
7 General review any settlement of an overpayment in which the
8 agency reduces the amount due to the state by \$10,000 or more.

9 (33) With respect to recoveries of Medicaid
10 overpayments collected by the agency, by September 30 each
11 year the agency shall credit a county on its county billing
12 invoices for the county's proportionate share of Medicaid
13 overpayments recovered during the previous fiscal year from
14 hospitals for inpatient services and from nursing homes.
15 However, if a county has been billed for its participation but
16 has not paid the amount due, the agency shall offset that
17 amount and notify the county of the amount of the offset. If
18 the county has divided its financial responsibility between
19 the county and a special taxing district or authority as
20 provided in s. 409.915(6), the county must proportionately
21 divide any credit or offset in accordance with the proration
22 that it has established. The credit or offset shall be
23 calculated separately for inpatient and nursing home services
24 as follows:

25 (a) The stateshare of the amount recovered from
26 hospitals for inpatient services and from nursing homes for
27 which the county has not previously received credit;

28 (b) Less the state share of the agency's cost of
29 recovering such payment; and

30 (c) Multiplied by the total county share. The total
31 county share shall be calculated as the sum of total county

1 billing for inpatient services and nursing home services,
2 respectively, divided by the state share of Medicaid
3 expenditures for inpatient services and nursing home services,
4 respectively.

5
6 The credit given to each county shall be its proportionate
7 share of the total county share calculated under paragraph
8 (c).

9 Section 10. Subsections (7) and (8) of section
10 409.920, Florida Statutes, are amended to read:

11 409.920 Medicaid provider fraud.--

12 (7) The Attorney General shall conduct a statewide
13 program of Medicaid fraud control. To accomplish this purpose,
14 the Attorney General shall:

15 (a) Investigate the possible criminal violation of any
16 applicable state law pertaining to fraud in the administration
17 of the Medicaid program, in the provision of medical
18 assistance, or in the activities of providers of health care
19 under the Medicaid program.

20 (b) Investigate the alleged abuse or neglect of
21 patients in health care facilities receiving payments under
22 the Medicaid program, in coordination with the agency.

23 (c) Investigate the alleged misappropriation of
24 patients' private funds in health care facilities receiving
25 payments under the Medicaid program.

26 (d) Refer to the Office of Statewide Prosecution or
27 the appropriate state attorney all violations indicating a
28 substantial potential for criminal prosecution.

29 (e) Refer to the agency all suspected abusive
30 activities not of a criminal or fraudulent nature.

31

1 ~~(f) Refer to the agency for collection each instance~~
2 ~~of overpayment to a provider of health care under the Medicaid~~
3 ~~program which is discovered during the course of an~~
4 ~~investigation.~~

5 (f)~~(g)~~ Safeguard the privacy rights of all individuals
6 and provide safeguards to prevent the use of patient medical
7 records for any reason beyond the scope of a specific
8 investigation for fraud or abuse, or both, without the
9 patient's written consent.

10 (g) Publicize to state employees and the public the
11 ability of persons to bring suit under the provisions of the
12 Florida False Claims Act and the potential for the persons
13 bring a civil action under the Florida False Claims Act to
14 obtain a monetary award.

15 (8) In carrying out the duties and responsibilities
16 under this section ~~subsection~~, the Attorney General may:

17 (a) Enter upon the premises of any health care
18 provider, excluding a physician, participating in the Medicaid
19 program to examine all accounts and records that may, in any
20 manner, be relevant in determining the existence of fraud in
21 the Medicaid program, to investigate alleged abuse or neglect
22 of patients, or to investigate alleged misappropriation of
23 patients' private funds. A participating physician is required
24 to make available any accounts or records that may, in any
25 manner, be relevant in determining the existence of fraud in
26 the Medicaid program. The accounts or records of a
27 non-Medicaid patient may not be reviewed by, or turned over
28 to, the Attorney General without the patient's written
29 consent.

30 (b) Subpoena witnesses or materials, including medical
31 records relating to Medicaid recipients, within or outside the

1 state and, through any duly designated employee, administer
2 oaths and affirmations and collect evidence for possible use
3 in either civil or criminal judicial proceedings.

4 (c) Request and receive the assistance of any state
5 attorney or law enforcement agency in the investigation and
6 prosecution of any violation of this section.

7 (d) Seek any civil remedy provided by law, including,
8 but not limited to, the remedies provided in ss.
9 68.081-68.092, s. 812.035, and this chapter.

10 (e) Refer to the agency for collection each instance
11 of overpayment to a provider of health care under the Medicaid
12 program which is discovered during the course of an
13 investigation.

14 Section 11. By January 1, 2003, the Agency for Health
15 Care Administration shall make recommendations to the
16 Legislature as to limits in the amount of home office
17 management and administrative fees which should be allowable
18 for reimbursement for providers whose rates are set on a
19 cost-reimbursement basis.

20 Section 12. Subsection (5) of section 414.41, Florida
21 Statutes, is repealed.

22 Section 13. This act shall take effect upon becoming a
23 law.

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