Amendment No. ___ (for drafter's use only)

CHAMBER ACTION

Senate		House
	.	

ORIGINAL STAMP BELOW

Representative(s) Wiles offered the following:

Amendment (with title amendment)

On page 7, between lines 17 and 18,

and insert:

Be It Enacted by the Legislature of the State of Florida:

Section 2. Section 16.59, Florida Statutes, is amended to read:

16.59 Medicaid fraud control.--There is created in the Department of Legal Affairs the Medicaid Fraud Control Unit, which may investigate all violations of s. 409.920 and any criminal violations discovered during the course of those investigations. The Medicaid Fraud Control Unit may refer any criminal violation so uncovered to the appropriate prosecuting authority. Offices of the Medicaid Fraud Control Unit and the offices of the Agency for Health Care Administration Medicaid program integrity program shall, to the extent possible, be collocated. The agency and the Department of Legal Affairs

1 shall conduct joint training and other joint activities
2 designed to increase communication and coordination in
3 recovering overpayments.
4 Section 3. Subsections (3), (5), and (7) of section
5 112.3187, Florida Statutes, are amended to read:
6 112.3187 Adverse action against employee for
7 disclosing information of specified nature prohibited;
8 employee remedy and relief.--
9 (3) DEFINITIONS.--As used in this act, unless
10 otherwise specified, the following words or terms shall have
11 the meanings indicated:
12 (a) "Agency" means any state, regional, county, local,
13 or municipal government entity, whether executive, judicial,
14 or legislative; any official, officer, department, division,
15 bureau, commission, authority, or political subdivision
16 therein; or any public school, community college, or state
17 university.
18 (b) "Employee" means a person who performs services
19 for, and under the control and direction of, or contracts
20 with, an agency or independent contractor for wages or other
21 remuneration.
22 (c) "Adverse personnel action" means the discharge,
23 suspension, transfer, or demotion of any employee or the
24 withholding of bonuses, the reduction in salary or benefits,
25 or any other adverse action taken against an employee within
26 the terms and conditions of employment by an agency or
27 independent contractor.
28 (d) "Independent contractor" means a person, other
29 than an agency, engaged in any business and who enters into a
30 contract or provider agreement with an agency.
31 (e) "Gross mismanagement" means a continuous pattern

1 of managerial abuses, wrongful or arbitrary and capricious
2 actions, or fraudulent or criminal conduct which may have a
3 substantial adverse economic impact.
4 (5) NATURE OF INFORMATION DISCLOSED.--The information
5 disclosed under this section must include:
6 (a) Any violation or suspected violation of any
7 federal, state, or local law, rule, or regulation committed by
8 an employee or agent of an agency or independent contractor
9 which creates and presents a substantial and specific danger
10 to the public's health, safety, or welfare.
11 (b) Any act or suspected act of gross mismanagement,
12 malfeasance, misfeasance, gross waste of public funds,
13 suspected or actual Medicaid fraud or abuse,or gross neglect
14 of duty committed by an employee or agent of an agency or
15 independent contractor.
16 (7) EMPLOYEES AND PERSONS PROTECTED.--This section
17 protects employees and persons who disclose information on
18 their own initiative in a written and signed complaint; who
19 are requested to participate in an investigation, hearing, or
20 other inquiry conducted by any agency or federal government
21 entity; who refuse to participate in any adverse action
22 prohibited by this section; or who initiate a complaint
23 through the whistle-blower's hotline or the hotline of the
24 Medicaid FRaud Control Unit of the Department of Legal
25 Affairs;or employees who file any written complaint to their
26 supervisory officials or employees who submit a complaint to
27 the Chief Inspector General in the Executive Office of the
28 Governor, to the employee designated as agency inspector
29 general under s. 112.3189(1), or to the Florida Commission on
30 Human Relations. The provisions of this section may not be
31 used by a person while he or she is under the care, custody,

1 or control of the state correctional system or, after release
2 from the care, custody, or control of the state correctional
3 system, with respect to circumstances that occurred during any
4 period of incarceration. No remedy or other protection under
5 ss. 112.3187-112.31895 applies to any person who has committed
6 or intentionally participated in committing the violation or
7 suspected violation for which protection under ss.
8 112.3187-112.31895 is being sought.
9 Section 4. Section 408.831, Florida Statutes, is
10 created to read:
11 408.831 Denial, suspension, revocation of a license,
12 registration, certificate or application.--
13 (1) In addition to any other remedies provided by law,
14 the agency may deny each application or suspend or revoke each
15 license, registration, or certificate of entities regulated or
16 licensed by it:
17 (a) If the applicant, licensee, registrant, or
18 certificateholder, or, in the case of a corporation,
19 partnership, or other business entity, if any officer,
20 director, agent, or managing employee of that business entity
21 or any affiliated person, partner, or shareholder having an
22 ownership interest equal to 5 percent or greater in that
23 business entity, has failed to pay all outstanding fines,
24 liens, or overpayments assessed by final order of the agency
25 or final order of the Centers for Medicare and Medicaid
26 Services unless a repayment plan is approved by the agency; or
27 (b) For failure to comply with any repayment plan.
28 (2) This section provides standards of enforcement
29 applicable to all entities licensed or regulated by the Agency
30 for Health Care Administration. This section controls over any
31 conflicting provisions of chapters 39, 381, 383, 390, 391,

1 393, 394, 395, 400, 408, 468, 483, and 641 or rules adopted
2 pursuant to those chapters.
3 Section 5. Section 409.902, Florida Statutes, is
4 amended to read:
5 409.902 Designated single state agency; payment
6 requirements; program title.--The Agency for Health Care
7 Administration is designated as the single state agency
8 authorized to make payments for medical assistance and related
9 services under Title XIX of the Social Security Act. These
10 payments shall be made, subject to any limitations or
11 directions provided for in the General Appropriations Act,
12 only for services included in the program, shall be made only
13 on behalf of eligible individuals, and shall be made only to
14 qualified providers in accordance with federal requirements
15 for Title XIX of the Social Security Act and the provisions of
16 state law. This program of medical assistance is designated
17 the "Medicaid program." The Department of Children and Family
18 Services is responsible for Medicaid eligibility
19 determinations, including, but not limited to, policy, rules,
20 and the agreement with the Social Security Administration for
21 Medicaid eligibility determinations for Supplemental Security
22 Income recipients, as well as the actual determination of
23 eligibility. As a condition of Medicaid eligibility, the
24 Agency for Health Care Administration and the Department of
25 Children and Family Services shall ensure that each recipient
26 of Medicaid consents to the release of her or his medical
27 records to the Agency for Health Care Administration and the
28 Medicaid Fraud Control Unit of the Department of Legal
29 Affairs.
30 Section 6. Subsections (7) and (9) of section 409.907,
31 Florida Statutes, as amended by section 6 of chapter 2001-377,

1 Laws of Florida, are amended to read:
2 409.907 Medicaid provider agreements.--The agency may
3 make payments for medical assistance and related services
4 rendered to Medicaid recipients only to an individual or
5 entity who has a provider agreement in effect with the agency,
6 who is performing services or supplying goods in accordance
7 with federal, state, and local law, and who agrees that no
8 person shall, on the grounds of handicap, race, color, or
9 national origin, or for any other reason, be subjected to
10 discrimination under any program or activity for which the
11 provider receives payment from the agency.
12 (7) The agency may require, as a condition of
13 participating in the Medicaid program and before entering into
14 the provider agreement, that the provider submit information,
15 in an initial and any required renewal applications,
16 concerning the professional, business, and personal background
17 of the provider and permit an onsite inspection of the
18 provider's service location by agency staff or other personnel
19 designated by the agency to perform this function. The agency
20 shall perform an onsite inspection, within 60 days after
21 receipt of a new provider's application, of the provider's
22 service location prior to making its first payment to the
23 provider for Medicaid services to determine the applicant's
24 ability to provide the services that the applicant is
25 proposing to provide for Medicaid reimbursement. The agency is
26 not required to perform an onsite inspection of a provider or
27 program that is licensed by the agency. As a continuing
28 condition of participation in the Medicaid program, a provider
29 shall immediately notify the agency of any current or pending
30 bankruptcy filing. Before entering into the provider
31 agreement, or as a condition of continuing participation in

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

1 suspension, termination, or other administrative action taken
2 under the Medicaid laws, rules, or regulations of this state
3 or of any other state or the Federal Government; any prior
4 violation of the laws, rules, or regulations relating to the
5 Medicare program; any prior violation of the rules or
6 regulations of any other public or private insurer; and any
7 prior violation of the laws, rules, or regulations of any
8 regulatory body of this or any other state.
9 (c) Full and accurate disclosure of any financial or
10 ownership interest that the provider, or any principal,
11 partner, or major shareholder thereof, may hold in any other
12 Medicaid provider or health care related entity or any other
13 entity that is licensed by the state to provide health or
14 residential care and treatment to persons.
15 (d) If a group provider, identification of all members
16 of the group and attestation that all members of the group are
17 enrolled in or have applied to enroll in the Medicaid program.
18 (9) Upon receipt of a completed, signed, and dated
19 application, and completion of any necessary background
20 investigation and criminal history record check, the agency
21 must either:
22 (a) Enroll the applicant as a Medicaid provider no
23 earlier than the effective date of the approval of the
24 provider application. With respect to providers who primarily
25 provide emergency medical services transportation or emergency
26 services and care pursuant to s. 401.45 or s. 395.1041, upon
27 approval of the provider application, the effective date of
28 approval is considered to be the date the agency receives the
29 provider application; or
30 (b) Deny the application if the agency finds that it
31 is in the best interest of the Medicaid program to do so. The

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1 agency may consider the factors listed in subsection (10), as
2 well as any other factor that could affect the effective and
3 efficient administration of the program, including, but not
4 limited to, the applicant's demonstrated ability to provide
5 services, conduct business, and operate a financially viable
6 concern;the current availability of medical care, services,
7 or supplies to recipients, taking into account geographic
8 location and reasonable travel time; the number of providers
9 of the same type already enrolled in the same geographic area;
10 and the credentials, experience, success, and patient outcomes
11 of the provider for the services that it is making application
12 to provide in the Medicaid program. The agency shall deny the
13 application if the agency finds that a provider; any officer,
14 director, agent, managing employee, or affiliated person; or
15 any partner or shareholder having an ownership interest equal
16 to 5 percent or greater in the provider if the provider is a
17 corporation, partnership, or other business entity, has failed
18 to pay all outstanding fines or overpayments assessed by final
19 order of the agency or final order of the Centers for Medicare
20 and Medicaid Services, unless the provider agrees to a
21 repayment plan that includes withholding Medicaid
22 reimbursement until the amount due is paid in full.
23 Section 7. Section 409.908, Florida Statutes, is
24 amended to read:
25 409.908 Reimbursement of Medicaid providers.--Subject
26 to specific appropriations, the agency shall reimburse
27 Medicaid providers, in accordance with state and federal law,
28 according to methodologies set forth in the rules of the
29 agency and in policy manuals and handbooks incorporated by
30 reference therein. These methodologies may include fee
31 schedules, reimbursement methods based on cost reporting,

1 negotiated fees, competitive bidding pursuant to s. 287.057,
2 and other mechanisms the agency considers efficient and
3 effective for purchasing services or goods on behalf of
4 recipients. If a provider is reimbursed based on cost
5 reporting and submits a cost report late and that cost report
6 would have been used to set a lower reimbursement rate for a
7 rate semester, then the provider's rate for that semester
8 shall be retroactively calculated using the new cost report,
9 and full payment at the recalculated rate shall be effected
10 retroactively. Medicare granted extensions for filing cost
11 reports, if applicable, shall also apply to Medicaid cost
12 reports.Payment for Medicaid compensable services made on
13 behalf of Medicaid eligible persons is subject to the
14 availability of moneys and any limitations or directions
15 provided for in the General Appropriations Act or chapter 216.
16 Further, nothing in this section shall be construed to prevent
17 or limit the agency from adjusting fees, reimbursement rates,
18 lengths of stay, number of visits, or number of services, or
19 making any other adjustments necessary to comply with the
20 availability of moneys and any limitations or directions
21 provided for in the General Appropriations Act, provided the
22 adjustment is consistent with legislative intent.
23 (1) Reimbursement to hospitals licensed under part I
24 of chapter 395 must be made prospectively or on the basis of
25 negotiation.
26 (a) Reimbursement for inpatient care is limited as
27 provided for in s. 409.905(5), except for:
28 1. The raising of rate reimbursement caps, excluding
29 rural hospitals.
30 2. Recognition of the costs of graduate medical
31 education.

1 3. Other methodologies recognized in the General
2 Appropriations Act.
3 4. Hospital inpatient rates shall be reduced by 6
4 percent effective July 1, 2001, and restored effective April
5 1, 2002.
6
7 During the years funds are transferred from the Department of
8 Health, any reimbursement supported by such funds shall be
9 subject to certification by the Department of Health that the
10 hospital has complied with s. 381.0403. The agency is
11 authorized to receive funds from state entities, including,
12 but not limited to, the Department of Health, local
13 governments, and other local political subdivisions, for the
14 purpose of making special exception payments, including
15 federal matching funds, through the Medicaid inpatient
16 reimbursement methodologies. Funds received from state
17 entities or local governments for this purpose shall be
18 separately accounted for and shall not be commingled with
19 other state or local funds in any manner. The agency may
20 certify all local governmental funds used as state match under
21 Title XIX of the Social Security Act, to the extent that the
22 identified local health care provider that is otherwise
23 entitled to and is contracted to receive such local funds is
24 the benefactor under the state's Medicaid program as
25 determined under the General Appropriations Act and pursuant
26 to an agreement between the Agency for Health Care
27 Administration and the local governmental entity. The local
28 governmental entity shall use a certification form prescribed
29 by the agency. At a minimum, the certification form shall
30 identify the amount being certified and describe the
31 relationship between the certifying local governmental entity

1 and the local health care provider. The agency shall prepare
2 an annual statement of impact which documents the specific
3 activities undertaken during the previous fiscal year pursuant
4 to this paragraph, to be submitted to the Legislature no later
5 than January 1, annually.
6 (b) Reimbursement for hospital outpatient care is
7 limited to $1,500 per state fiscal year per recipient, except
8 for:
9 1. Such care provided to a Medicaid recipient under
10 age 21, in which case the only limitation is medical
11 necessity.
12 2. Renal dialysis services.
13 3. Other exceptions made by the agency.
14
15 The agency is authorized to receive funds from state entities,
16 including, but not limited to, the Department of Health, the
17 Board of Regents, local governments, and other local political
18 subdivisions, for the purpose of making payments, including
19 federal matching funds, through the Medicaid outpatient
20 reimbursement methodologies. Funds received from state
21 entities and local governments for this purpose shall be
22 separately accounted for and shall not be commingled with
23 other state or local funds in any manner.
24 (c) Hospitals that provide services to a
25 disproportionate share of low-income Medicaid recipients, or
26 that participate in the regional perinatal intensive care
27 center program under chapter 383, or that participate in the
28 statutory teaching hospital disproportionate share program may
29 receive additional reimbursement. The total amount of payment
30 for disproportionate share hospitals shall be fixed by the
31 General Appropriations Act. The computation of these payments

1 must be made in compliance with all federal regulations and
2 the methodologies described in ss. 409.911, 409.9112, and
3 409.9113.
4 (d) The agency is authorized to limit inflationary
5 increases for outpatient hospital services as directed by the
6 General Appropriations Act.
7 (2)(a)1. Reimbursement to nursing homes licensed under
8 part II of chapter 400 and state-owned-and-operated
9 intermediate care facilities for the developmentally disabled
10 licensed under chapter 393 must be made prospectively.
11 2. Unless otherwise limited or directed in the General
12 Appropriations Act, reimbursement to hospitals licensed under
13 part I of chapter 395 for the provision of swing-bed nursing
14 home services must be made on the basis of the average
15 statewide nursing home payment, and reimbursement to a
16 hospital licensed under part I of chapter 395 for the
17 provision of skilled nursing services must be made on the
18 basis of the average nursing home payment for those services
19 in the county in which the hospital is located. When a
20 hospital is located in a county that does not have any
21 community nursing homes, reimbursement must be determined by
22 averaging the nursing home payments, in counties that surround
23 the county in which the hospital is located. Reimbursement to
24 hospitals, including Medicaid payment of Medicare copayments,
25 for skilled nursing services shall be limited to 30 days,
26 unless a prior authorization has been obtained from the
27 agency. Medicaid reimbursement may be extended by the agency
28 beyond 30 days, and approval must be based upon verification
29 by the patient's physician that the patient requires
30 short-term rehabilitative and recuperative services only, in
31 which case an extension of no more than 15 days may be

1 approved. Reimbursement to a hospital licensed under part I of
2 chapter 395 for the temporary provision of skilled nursing
3 services to nursing home residents who have been displaced as
4 the result of a natural disaster or other emergency may not
5 exceed the average county nursing home payment for those
6 services in the county in which the hospital is located and is
7 limited to the period of time which the agency considers
8 necessary for continued placement of the nursing home
9 residents in the hospital.
10 (b) Subject to any limitations or directions provided
11 for in the General Appropriations Act, the agency shall
12 establish and implement a Florida Title XIX Long-Term Care
13 Reimbursement Plan (Medicaid) for nursing home care in order
14 to provide care and services in conformance with the
15 applicable state and federal laws, rules, regulations, and
16 quality and safety standards and to ensure that individuals
17 eligible for medical assistance have reasonable geographic
18 access to such care.
19 1. Changes of ownership or of licensed operator do not
20 qualify for increases in reimbursement rates associated with
21 the change of ownership or of licensed operator. The agency
22 shall amend the Title XIX Long Term Care Reimbursement Plan to
23 provide that the initial nursing home reimbursement rates, for
24 the operating, patient care, and MAR components, associated
25 with related and unrelated party changes of ownership or
26 licensed operator filed on or after September 1, 2001, are
27 equivalent to the previous owner's reimbursement rate.
28 2. The agency shall amend the long-term care
29 reimbursement plan and cost reporting system to create direct
30 care and indirect care subcomponents of the patient care
31 component of the per diem rate. These two subcomponents

1 together shall equal the patient care component of the per
2 diem rate. Separate cost-based ceilings shall be calculated
3 for each patient care subcomponent. The direct care
4 subcomponent of the per diem rate shall be limited by the
5 cost-based class ceiling, and the indirect care subcomponent
6 shall be limited by the lower of the cost-based class ceiling,
7 by the target rate class ceiling, or by the individual
8 provider target. The agency shall adjust the patient care
9 component effective January 1, 2002. The cost to adjust the
10 direct care subcomponent shall be net of the total funds
11 previously allocated for the case mix add-on. The agency shall
12 make the required changes to the nursing home cost reporting
13 forms to implement this requirement effective January 1, 2002.
14 3. The direct care subcomponent shall include salaries
15 and benefits of direct care staff providing nursing services
16 including registered nurses, licensed practical nurses, and
17 certified nursing assistants who deliver care directly to
18 residents in the nursing home facility. This excludes nursing
19 administration, MDS, and care plan coordinators, staff
20 development, and staffing coordinator.
21 4. All other patient care costs shall be included in
22 the indirect care cost subcomponent of the patient care per
23 diem rate. There shall be no costs directly or indirectly
24 allocated to the direct care subcomponent from a home office
25 or management company.
26 5. On July 1 of each year, the agency shall report to
27 the Legislature direct and indirect care costs, including
28 average direct and indirect care costs per resident per
29 facility and direct care and indirect care salaries and
30 benefits per category of staff member per facility.
31 6. Under the plan, interim rate adjustments shall not

1 be granted to reflect increases in the cost of general or
2 professional liability insurance for nursing homes unless the
3 following criteria are met: have at least a 65 percent
4 Medicaid utilization in the most recent cost report submitted
5 to the agency, and the increase in general or professional
6 liability costs to the facility for the most recent policy
7 period affects the total Medicaid per diem by at least 5
8 percent. This rate adjustment shall not result in the per diem
9 exceeding the class ceiling. This provision shall be
10 implemented to the extent existing appropriations are
11 available.
12
13 It is the intent of the Legislature that the reimbursement
14 plan achieve the goal of providing access to health care for
15 nursing home residents who require large amounts of care while
16 encouraging diversion services as an alternative to nursing
17 home care for residents who can be served within the
18 community. The agency shall base the establishment of any
19 maximum rate of payment, whether overall or component, on the
20 available moneys as provided for in the General Appropriations
21 Act. The agency may base the maximum rate of payment on the
22 results of scientifically valid analysis and conclusions
23 derived from objective statistical data pertinent to the
24 particular maximum rate of payment.
25 (3) Subject to any limitations or directions provided
26 for in the General Appropriations Act, the following Medicaid
27 services and goods may be reimbursed on a fee-for-service
28 basis. For each allowable service or goods furnished in
29 accordance with Medicaid rules, policy manuals, handbooks, and
30 state and federal law, the payment shall be the amount billed
31 by the provider, the provider's usual and customary charge, or

1 the maximum allowable fee established by the agency, whichever
2 amount is less, with the exception of those services or goods
3 for which the agency makes payment using a methodology based
4 on capitation rates, average costs, or negotiated fees.
5 (a) Advanced registered nurse practitioner services.
6 (b) Birth center services.
7 (c) Chiropractic services.
8 (d) Community mental health services.
9 (e) Dental services, including oral and maxillofacial
10 surgery.
11 (f) Durable medical equipment.
12 (g) Hearing services.
13 (h) Occupational therapy for Medicaid recipients under
14 age 21.
15 (i) Optometric services.
16 (j) Orthodontic services.
17 (k) Personal care for Medicaid recipients under age
18 21.
19 (l) Physical therapy for Medicaid recipients under age
20 21.
21 (m) Physician assistant services.
22 (n) Podiatric services.
23 (o) Portable X-ray services.
24 (p) Private-duty nursing for Medicaid recipients under
25 age 21.
26 (q) Registered nurse first assistant services.
27 (r) Respiratory therapy for Medicaid recipients under
28 age 21.
29 (s) Speech therapy for Medicaid recipients under age
30 21.
31 (t) Visual services.

1 (4) Subject to any limitations or directions provided
2 for in the General Appropriations Act, alternative health
3 plans, health maintenance organizations, and prepaid health
4 plans shall be reimbursed a fixed, prepaid amount negotiated,
5 or competitively bid pursuant to s. 287.057, by the agency and
6 prospectively paid to the provider monthly for each Medicaid
7 recipient enrolled. The amount may not exceed the average
8 amount the agency determines it would have paid, based on
9 claims experience, for recipients in the same or similar
10 category of eligibility. The agency shall calculate
11 capitation rates on a regional basis and, beginning September
12 1, 1995, shall include age-band differentials in such
13 calculations. Effective July 1, 2001, the cost of exempting
14 statutory teaching hospitals, specialty hospitals, and
15 community hospital education program hospitals from
16 reimbursement ceilings and the cost of special Medicaid
17 payments shall not be included in premiums paid to health
18 maintenance organizations or prepaid health care plans. Each
19 rate semester, the agency shall calculate and publish a
20 Medicaid hospital rate schedule that does not reflect either
21 special Medicaid payments or the elimination of rate
22 reimbursement ceilings, to be used by hospitals and Medicaid
23 health maintenance organizations, in order to determine the
24 Medicaid rate referred to in ss. 409.912(16), 409.9128(5), and
25 641.513(6).
26 (5) An ambulatory surgical center shall be reimbursed
27 the lesser of the amount billed by the provider or the
28 Medicare-established allowable amount for the facility.
29 (6) A provider of early and periodic screening,
30 diagnosis, and treatment services to Medicaid recipients who
31 are children under age 21 shall be reimbursed using an

1 all-inclusive rate stipulated in a fee schedule established by
2 the agency. A provider of the visual, dental, and hearing
3 components of such services shall be reimbursed the lesser of
4 the amount billed by the provider or the Medicaid maximum
5 allowable fee established by the agency.
6 (7) A provider of family planning services shall be
7 reimbursed the lesser of the amount billed by the provider or
8 an all-inclusive amount per type of visit for physicians and
9 advanced registered nurse practitioners, as established by the
10 agency in a fee schedule.
11 (8) A provider of home-based or community-based
12 services rendered pursuant to a federally approved waiver
13 shall be reimbursed based on an established or negotiated rate
14 for each service. These rates shall be established according
15 to an analysis of the expenditure history and prospective
16 budget developed by each contract provider participating in
17 the waiver program, or under any other methodology adopted by
18 the agency and approved by the Federal Government in
19 accordance with the waiver. Effective July 1, 1996, privately
20 owned and operated community-based residential facilities
21 which meet agency requirements and which formerly received
22 Medicaid reimbursement for the optional intermediate care
23 facility for the mentally retarded service may participate in
24 the developmental services waiver as part of a
25 home-and-community-based continuum of care for Medicaid
26 recipients who receive waiver services.
27 (9) A provider of home health care services or of
28 medical supplies and appliances shall be reimbursed on the
29 basis of competitive bidding or for the lesser of the amount
30 billed by the provider or the agency's established maximum
31 allowable amount, except that, in the case of the rental of

1 durable medical equipment, the total rental payments may not
2 exceed the purchase price of the equipment over its expected
3 useful life or the agency's established maximum allowable
4 amount, whichever amount is less.
5 (10) A hospice shall be reimbursed through a
6 prospective system for each Medicaid hospice patient at
7 Medicaid rates using the methodology established for hospice
8 reimbursement pursuant to Title XVIII of the federal Social
9 Security Act.
10 (11) A provider of independent laboratory services
11 shall be reimbursed on the basis of competitive bidding or for
12 the least of the amount billed by the provider, the provider's
13 usual and customary charge, or the Medicaid maximum allowable
14 fee established by the agency.
15 (12)(a) A physician shall be reimbursed the lesser of
16 the amount billed by the provider or the Medicaid maximum
17 allowable fee established by the agency.
18 (b) The agency shall adopt a fee schedule, subject to
19 any limitations or directions provided for in the General
20 Appropriations Act, based on a resource-based relative value
21 scale for pricing Medicaid physician services. Under this fee
22 schedule, physicians shall be paid a dollar amount for each
23 service based on the average resources required to provide the
24 service, including, but not limited to, estimates of average
25 physician time and effort, practice expense, and the costs of
26 professional liability insurance. The fee schedule shall
27 provide increased reimbursement for preventive and primary
28 care services and lowered reimbursement for specialty services
29 by using at least two conversion factors, one for cognitive
30 services and another for procedural services. The fee
31 schedule shall not increase total Medicaid physician

1 expenditures unless moneys are available, and shall be phased
2 in over a 2-year period beginning on July 1, 1994. The Agency
3 for Health Care Administration shall seek the advice of a
4 16-member advisory panel in formulating and adopting the fee
5 schedule. The panel shall consist of Medicaid physicians
6 licensed under chapters 458 and 459 and shall be composed of
7 50 percent primary care physicians and 50 percent specialty
8 care physicians.
9 (c) Notwithstanding paragraph (b), reimbursement fees
10 to physicians for providing total obstetrical services to
11 Medicaid recipients, which include prenatal, delivery, and
12 postpartum care, shall be at least $1,500 per delivery for a
13 pregnant woman with low medical risk and at least $2,000 per
14 delivery for a pregnant woman with high medical risk. However,
15 reimbursement to physicians working in Regional Perinatal
16 Intensive Care Centers designated pursuant to chapter 383, for
17 services to certain pregnant Medicaid recipients with a high
18 medical risk, may be made according to obstetrical care and
19 neonatal care groupings and rates established by the agency.
20 Nurse midwives licensed under part I of chapter 464 or
21 midwives licensed under chapter 467 shall be reimbursed at no
22 less than 80 percent of the low medical risk fee. The agency
23 shall by rule determine, for the purpose of this paragraph,
24 what constitutes a high or low medical risk pregnant woman and
25 shall not pay more based solely on the fact that a caesarean
26 section was performed, rather than a vaginal delivery. The
27 agency shall by rule determine a prorated payment for
28 obstetrical services in cases where only part of the total
29 prenatal, delivery, or postpartum care was performed. The
30 Department of Health shall adopt rules for appropriate
31 insurance coverage for midwives licensed under chapter 467.

1 Prior to the issuance and renewal of an active license, or
2 reactivation of an inactive license for midwives licensed
3 under chapter 467, such licensees shall submit proof of
4 coverage with each application.
5 (13) Medicare premiums for persons eligible for both
6 Medicare and Medicaid coverage shall be paid at the rates
7 established by Title XVIII of the Social Security Act. For
8 Medicare services rendered to Medicaid-eligible persons,
9 Medicaid shall pay Medicare deductibles and coinsurance as
10 follows:
11 (a) Medicaid shall make no payment toward deductibles
12 and coinsurance for any service that is not covered by
13 Medicaid.
14 (b) Medicaid's financial obligation for deductibles
15 and coinsurance payments shall be based on Medicare allowable
16 fees, not on a provider's billed charges.
17 (c) Medicaid will pay no portion of Medicare
18 deductibles and coinsurance when payment that Medicare has
19 made for the service equals or exceeds what Medicaid would
20 have paid if it had been the sole payor. The combined payment
21 of Medicare and Medicaid shall not exceed the amount Medicaid
22 would have paid had it been the sole payor. The Legislature
23 finds that there has been confusion regarding the
24 reimbursement for services rendered to dually eligible
25 Medicare beneficiaries. Accordingly, the Legislature clarifies
26 that it has always been the intent of the Legislature before
27 and after 1991 that, in reimbursing in accordance with fees
28 established by Title XVIII for premiums, deductibles, and
29 coinsurance for Medicare services rendered by physicians to
30 Medicaid eligible persons, physicians be reimbursed at the
31 lesser of the amount billed by the physician or the Medicaid

1 maximum allowable fee established by the Agency for Health
2 Care Administration, as is permitted by federal law. It has
3 never been the intent of the Legislature with regard to such
4 services rendered by physicians that Medicaid be required to
5 provide any payment for deductibles, coinsurance, or
6 copayments for Medicare cost sharing, or any expenses incurred
7 relating thereto, in excess of the payment amount provided for
8 under the State Medicaid plan for such service. This payment
9 methodology is applicable even in those situations in which
10 the payment for Medicare cost sharing for a qualified Medicare
11 beneficiary with respect to an item or service is reduced or
12 eliminated. This expression of the Legislature is in
13 clarification of existing law and shall apply to payment for,
14 and with respect to provider agreements with respect to, items
15 or services furnished on or after the effective date of this
16 act. This paragraph applies to payment by Medicaid for items
17 and services furnished before the effective date of this act
18 if such payment is the subject of a lawsuit that is based on
19 the provisions of this section, and that is pending as of, or
20 is initiated after, the effective date of this act.
21 (d) Notwithstanding paragraphs (a)-(c):
22 1. Medicaid payments for Nursing Home Medicare part A
23 coinsurance shall be the lesser of the Medicare coinsurance
24 amount or the Medicaid nursing home per diem rate.
25 2. Medicaid shall pay all deductibles and coinsurance
26 for Medicare-eligible recipients receiving freestanding end
27 stage renal dialysis center services.
28 3. Medicaid payments for general hospital inpatient
29 services shall be limited to the Medicare deductible per spell
30 of illness. Medicaid shall make no payment toward coinsurance
31 for Medicare general hospital inpatient services.

1 4. Medicaid shall pay all deductibles and coinsurance
2 for Medicare emergency transportation services provided by
3 ambulances licensed pursuant to chapter 401.
4 (14) A provider of prescribed drugs shall be
5 reimbursed the least of the amount billed by the provider, the
6 provider's usual and customary charge, or the Medicaid maximum
7 allowable fee established by the agency, plus a dispensing
8 fee. The agency is directed to implement a variable dispensing
9 fee for payments for prescribed medicines while ensuring
10 continued access for Medicaid recipients. The variable
11 dispensing fee may be based upon, but not limited to, either
12 or both the volume of prescriptions dispensed by a specific
13 pharmacy provider and the volume of prescriptions dispensed to
14 an individual recipient. The agency is authorized to limit
15 reimbursement for prescribed medicine in order to comply with
16 any limitations or directions provided for in the General
17 Appropriations Act, which may include implementing a
18 prospective or concurrent utilization review program.
19 (15) A provider of primary care case management
20 services rendered pursuant to a federally approved waiver
21 shall be reimbursed by payment of a fixed, prepaid monthly sum
22 for each Medicaid recipient enrolled with the provider.
23 (16) A provider of rural health clinic services and
24 federally qualified health center services shall be reimbursed
25 a rate per visit based on total reasonable costs of the
26 clinic, as determined by the agency in accordance with federal
27 regulations.
28 (17) A provider of targeted case management services
29 shall be reimbursed pursuant to an established fee, except
30 where the Federal Government requires a public provider be
31 reimbursed on the basis of average actual costs.

1 (18) Unless otherwise provided for in the General
2 Appropriations Act, a provider of transportation services
3 shall be reimbursed the lesser of the amount billed by the
4 provider or the Medicaid maximum allowable fee established by
5 the agency, except when the agency has entered into a direct
6 contract with the provider, or with a community transportation
7 coordinator, for the provision of an all-inclusive service, or
8 when services are provided pursuant to an agreement negotiated
9 between the agency and the provider. The agency, as provided
10 for in s. 427.0135, shall purchase transportation services
11 through the community coordinated transportation system, if
12 available, unless the agency determines a more cost-effective
13 method for Medicaid clients. Nothing in this subsection shall
14 be construed to limit or preclude the agency from contracting
15 for services using a prepaid capitation rate or from
16 establishing maximum fee schedules, individualized
17 reimbursement policies by provider type, negotiated fees,
18 prior authorization, competitive bidding, increased use of
19 mass transit, or any other mechanism that the agency considers
20 efficient and effective for the purchase of services on behalf
21 of Medicaid clients, including implementing a transportation
22 eligibility process. The agency shall not be required to
23 contract with any community transportation coordinator or
24 transportation operator that has been determined by the
25 agency, the Department of Legal Affairs Medicaid Fraud Control
26 Unit, or any other state or federal agency to have engaged in
27 any abusive or fraudulent billing activities. The agency is
28 authorized to competitively procure transportation services or
29 make other changes necessary to secure approval of federal
30 waivers needed to permit federal financing of Medicaid
31 transportation services at the service matching rate rather

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1 than the administrative matching rate.
2 (19) County health department services may be
3 reimbursed a rate per visit based on total reasonable costs of
4 the clinic, as determined by the agency in accordance with
5 federal regulations under the authority of 42 C.F.R. s.
6 431.615.
7 (20) A renal dialysis facility that provides dialysis
8 services under s. 409.906(9) must be reimbursed the lesser of
9 the amount billed by the provider, the provider's usual and
10 customary charge, or the maximum allowable fee established by
11 the agency, whichever amount is less.
12 (21) The agency shall reimburse school districts which
13 certify the state match pursuant to ss. 236.0812 and 409.9071
14 for the federal portion of the school district's allowable
15 costs to deliver the services, based on the reimbursement
16 schedule. The school district shall determine the costs for
17 delivering services as authorized in ss. 236.0812 and 409.9071
18 for which the state match will be certified. Reimbursement of
19 school-based providers is contingent on such providers being
20 enrolled as Medicaid providers and meeting the qualifications
21 contained in 42 C.F.R. s. 440.110, unless otherwise waived by
22 the federal Health Care Financing Administration. Speech
23 therapy providers who are certified through the Department of
24 Education pursuant to rule 6A-4.0176, Florida Administrative
25 Code, are eligible for reimbursement for services that are
26 provided on school premises. Any employee of the school
27 district who has been fingerprinted and has received a
28 criminal background check in accordance with Department of
29 Education rules and guidelines shall be exempt from any agency
30 requirements relating to criminal background checks.
31 (22) The agency shall request and implement Medicaid

waivers from the federal Health Care Financing Administration to advance and treat a portion of the Medicaid nursing home per diem as capital for creating and operating a risk-retention group for self-insurance purposes, consistent with federal and state laws and rules.

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

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

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

(b) Upon receipt of any recovery or other collection pursuant to this section, s. 409.913 or s. 409.920 the agency shall distribute the amount collected as follows:

1. To itself and to any county that has responsibility for certain items of care and service as mandated in s. 409.915, amounts equal to a pro rata distribution of the county's contribution and the state's respective Medicaid expenditures ~~an amount equal to the state Medicaid expenditures~~ for the recipient plus any incentive payment made in accordance with paragraph (14)(a). However, if a county has been billed for its participation but has not paid the amount due, the agency shall offset that amount and notify the county of the amount of the offset. If the county has divided its financial responsibility between the county and a special taxing district or authority as contemplated in s. 409.915(6), the county must proportionately divide any refund or offset in accordance with the proration that it has established.

2. To the Federal Government, the federal share of the state Medicaid expenditures minus any incentive payment made

1 in accordance with paragraph (14)(a) and federal law, and
2 minus any other amount permitted by federal law to be
3 deducted.
4 3. To the recipient, after deducting any known amounts
5 owed to the agency for any related medical assistance or to
6 health care providers, any remaining amount. This amount shall
7 be treated as income or resources in determining eligibility
8 for Medicaid.
9
10 The provisions of this subsection do not apply to any proceeds
11 received by the state, or any agency thereof, pursuant to a
12 final order, judgment, or settlement agreement, in any matter
13 in which the state asserts claims brought on its own behalf,
14 and not as a subrogee of a recipient, or under other theories
15 of liability. The provisions of this subsection do not apply
16 to any proceeds received by the state, or an agency thereof,
17 pursuant to a final order, judgment, or settlement agreement,
18 in any matter in which the state asserted both claims as a
19 subrogee and additional claims, except as to those sums
20 specifically identified in the final order, judgment, or
21 settlement agreement as reimbursements to the recipient as
22 expenditures for the named recipient on the subrogation claim.
23 Section 9. Section 409.913, Florida Statutes, as
24 amended by section 12 of chapter 2001-377, Laws of Florida, is
25 amended to read:
26 409.913 Oversight of the integrity of the Medicaid
27 program.--The agency shall operate a program to oversee the
28 activities of Florida Medicaid recipients, and providers and
29 their representatives, to ensure that fraudulent and abusive
30 behavior and neglect of recipients occur to the minimum extent
31 possible, and to recover overpayments and impose sanctions as

1 appropriate. Beginning January 1, 2003, and each year
2 thereafter, the agency and the Medicaid Fraud Control Unit of
3 the Department of Legal Affairs shall submit a joint report to
4 the Legislature documenting the effectiveness of the state's
5 efforts to control Medicaid fraud and abuse and to recover
6 Medicaid overpayments during the previous fiscal year. The
7 report must describe the number of cases opened and
8 investigated each year; the sources of the cases opened; the
9 disposition of the cases closed each year; the amount of
10 overpayments alleged in preliminary and final audit letters;
11 the number and amount of fines or penalties imposed; any
12 reductions in overpayment amounts negotiated in settlement
13 agreements or by other means; the amount of final agency
14 determinations of overpayments; the amount deducted from
15 federal claiming as a result of overpayments; the amount of
16 overpayments recovered each year; the amount of cost of
17 investigation recovered each year; the average length of time
18 to collect from the time the case was opened until the
19 overpayment is paid in full; the amount determined as
20 uncollectible and the portion of the uncollectible amount
21 subsequently reclaimed from the Federal Government; the number
22 of providers, by type, that are terminated from participation
23 in the Medicaid program as a result of fraud and abuse; and
24 all costs associated with discovering and prosecuting cases of
25 Medicaid overpayments and making recoveries in such cases. The
26 report must also document actions taken to prevent
27 overpayments and the number of providers prevented from
28 enrolling in or reenrolling in the Medicaid program as a
29 result of documented Medicaid fraud and abuse and must
30 recommend changes necessary to prevent or recover
31 overpayments. For the 2001-2002 fiscal year, the agency shall

prepare a report that contains as much of this information as is available to it.

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

(a) "Abuse" means:

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

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

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

(c)~~(b)~~ "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.

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

1 or services are provided.
2 (e)~~(d)~~ "Overpayment" includes any amount that is not
3 authorized to be paid by the Medicaid program whether paid as
4 a result of inaccurate or improper cost reporting, improper
5 claiming, unacceptable practices, fraud, abuse, or mistake.
6 (f)~~(e)~~ "Person" means any natural person, corporation,
7 partnership, association, clinic, group, or other entity,
8 whether or not such person is enrolled in the Medicaid program
9 or is a provider of health care.
10 (2) The agency shall conduct, or cause to be conducted
11 by contract or otherwise, reviews, investigations, analyses,
12 audits, or any combination thereof, to determine possible
13 fraud, abuse, overpayment, or recipient neglect in the
14 Medicaid program and shall report the findings of any
15 overpayments in audit reports as appropriate.
16 (3) The agency may conduct, or may contract for,
17 prepayment review of provider claims to ensure cost-effective
18 purchasing, billing, and provision of care to Medicaid
19 recipients. Such prepayment reviews may be conducted as
20 determined appropriate by the agency, without any suspicion or
21 allegation of fraud, abuse, or neglect.
22 (4) Any suspected criminal violation identified by the
23 agency must be referred to the Medicaid Fraud Control Unit of
24 the Office of the Attorney General for investigation. The
25 agency and the Attorney General shall enter into a memorandum
26 of understanding, which must include, but need not be limited
27 to, a protocol for regularly sharing information and
28 coordinating casework. The protocol must establish a
29 procedure for the referral by the agency of cases involving
30 suspected Medicaid fraud to the Medicaid Fraud Control Unit
31 for investigation, and the return to the agency of those cases

1 where investigation determines that administrative action by
2 the agency is appropriate. Offices of the Medicaid program
3 integrity program and the Medicaid Fraud Control Unit of the
4 Department of Legal Affairs, shall, to the extent possible, be
5 collocated. The agency and the Department of Legal Affairs
6 shall periodically conduct joint training and other joint
7 activities designed to increase communication and coordination
8 in recovering overpayments.
9 (5) A Medicaid provider is subject to having goods and
10 services that are paid for by the Medicaid program reviewed by
11 an appropriate peer-review organization designated by the
12 agency. The written findings of the applicable peer-review
13 organization are admissible in any court or administrative
14 proceeding as evidence of medical necessity or the lack
15 thereof.
16 (6) Any notice required to be given to a provider
17 under this section is presumed to be sufficient notice if sent
18 to the address last shown on the provider enrollment file. It
19 is the responsibility of the provider to furnish and keep the
20 agency informed of the provider's current address. United
21 States Postal Service proof of mailing or certified or
22 registered mailing of such notice to the provider at the
23 address shown on the provider enrollment file constitutes
24 sufficient proof of notice. Any notice required to be given to
25 the agency by this section must be sent to the agency at an
26 address designated by rule.
27 (7) When presenting a claim for payment under the
28 Medicaid program, a provider has an affirmative duty to
29 supervise the provision of, and be responsible for, goods and
30 services claimed to have been provided, to supervise and be
31 responsible for preparation and submission of the claim, and

1 to present a claim that is true and accurate and that is for
2 goods and services that:
3 (a) Have actually been furnished to the recipient by
4 the provider prior to submitting the claim.
5 (b) Are Medicaid-covered goods or services that are
6 medically necessary.
7 (c) Are of a quality comparable to those furnished to
8 the general public by the provider's peers.
9 (d) Have not been billed in whole or in part to a
10 recipient or a recipient's responsible party, except for such
11 copayments, coinsurance, or deductibles as are authorized by
12 the agency.
13 (e) Are provided in accord with applicable provisions
14 of all Medicaid rules, regulations, handbooks, and policies
15 and in accordance with federal, state, and local law.
16 (f) Are documented by records made at the time the
17 goods or services were provided, demonstrating the medical
18 necessity for the goods or services rendered. Medicaid goods
19 or services are excessive or not medically necessary unless
20 both the medical basis and the specific need for them are
21 fully and properly documented in the recipient's medical
22 record.
23 (8) A Medicaid provider shall retain medical,
24 professional, financial, and business records pertaining to
25 services and goods furnished to a Medicaid recipient and
26 billed to Medicaid for a period of 5 years after the date of
27 furnishing such services or goods. The agency may investigate,
28 review, or analyze such records, which must be made available
29 during normal business hours. However, 24-hour notice must be
30 provided if patient treatment would be disrupted. The provider
31 is responsible for furnishing to the agency, and keeping the

1 agency informed of the location of, the provider's
2 Medicaid-related records. The authority of the agency to
3 obtain Medicaid-related records from a provider is neither
4 curtailed nor limited during a period of litigation between
5 the agency and the provider.
6 (9) Payments for the services of billing agents or
7 persons participating in the preparation of a Medicaid claim
8 shall not be based on amounts for which they bill nor based on
9 the amount a provider receives from the Medicaid program.
10 (10) The agency may require repayment for
11 inappropriate, medically unnecessary, or excessive goods or
12 services from the person furnishing them, the person under
13 whose supervision they were furnished, or the person causing
14 them to be furnished.
15 (11) The complaint and all information obtained
16 pursuant to an investigation of a Medicaid provider, or the
17 authorized representative or agent of a provider, relating to
18 an allegation of fraud, abuse, or neglect are confidential and
19 exempt from the provisions of s. 119.07(1):
20 (a) Until the agency takes final agency action with
21 respect to the provider and requires repayment of any
22 overpayment, or imposes an administrative sanction;
23 (b) Until the Attorney General refers the case for
24 criminal prosecution;
25 (c) Until 10 days after the complaint is determined
26 without merit; or
27 (d) At all times if the complaint or information is
28 otherwise protected by law.
29 (12) The agency may terminate participation of a
30 Medicaid provider in the Medicaid program and may seek civil
31 remedies or impose other administrative sanctions against a

1 Medicaid provider, if the provider has been:
2 (a) Convicted of a criminal offense related to the
3 delivery of any health care goods or services, including the
4 performance of management or administrative functions relating
5 to the delivery of health care goods or services;
6 (b) Convicted of a criminal offense under federal law
7 or the law of any state relating to the practice of the
8 provider's profession; or
9 (c) Found by a court of competent jurisdiction to have
10 neglected or physically abused a patient in connection with
11 the delivery of health care goods or services.
12 (13) If the provider has been suspended or terminated
13 from participation in the Medicaid program or the Medicare
14 program by the Federal Government or any state, the agency
15 must immediately suspend or terminate, as appropriate, the
16 provider's participation in the Florida Medicaid program for a
17 period no less than that imposed by the Federal Government or
18 any other state, and may not enroll such provider in the
19 Florida Medicaid program while such foreign suspension or
20 termination remains in effect. This sanction is in addition
21 to all other remedies provided by law.
22 (14) The agency may seek any remedy provided by law,
23 including, but not limited to, the remedies provided in
24 subsections (12) and (15) and s. 812.035, if:
25 (a) The provider's license has not been renewed, or
26 has been revoked, suspended, or terminated, for cause, by the
27 licensing agency of any state;
28 (b) The provider has failed to make available or has
29 refused access to Medicaid-related records to an auditor,
30 investigator, or other authorized employee or agent of the
31 agency, the Attorney General, a state attorney, or the Federal

1 Government;
2 (c) The provider has not furnished or has failed to
3 make available such Medicaid-related records as the agency has
4 found necessary to determine whether Medicaid payments are or
5 were due and the amounts thereof;
6 (d) The provider has failed to maintain medical
7 records made at the time of service, or prior to service if
8 prior authorization is required, demonstrating the necessity
9 and appropriateness of the goods or services rendered;
10 (e) The provider is not in compliance with provisions
11 of Medicaid provider publications that have been adopted by
12 reference as rules in the Florida Administrative Code; with
13 provisions of state or federal laws, rules, or regulations;
14 with provisions of the provider agreement between the agency
15 and the provider; or with certifications found on claim forms
16 or on transmittal forms for electronically submitted claims
17 that are submitted by the provider or authorized
18 representative, as such provisions apply to the Medicaid
19 program;
20 (f) The provider or person who ordered or prescribed
21 the care, services, or supplies has furnished, or ordered the
22 furnishing of, goods or services to a recipient which are
23 inappropriate, unnecessary, excessive, or harmful to the
24 recipient or are of inferior quality;
25 (g) The provider has demonstrated a pattern of failure
26 to provide goods or services that are medically necessary;
27 (h) The provider or an authorized representative of
28 the provider, or a person who ordered or prescribed the goods
29 or services, has submitted or caused to be submitted false or
30 a pattern of erroneous Medicaid claims that have resulted in
31 overpayments to a provider or that exceed those to which the

1 provider was entitled under the Medicaid program;
2 (i) The provider or an authorized representative of
3 the provider, or a person who has ordered or prescribed the
4 goods or services, has submitted or caused to be submitted a
5 Medicaid provider enrollment application, a request for prior
6 authorization for Medicaid services, a drug exception request,
7 or a Medicaid cost report that contains materially false or
8 incorrect information;
9 (j) The provider or an authorized representative of
10 the provider has collected from or billed a recipient or a
11 recipient's responsible party improperly for amounts that
12 should not have been so collected or billed by reason of the
13 provider's billing the Medicaid program for the same service;
14 (k) The provider or an authorized representative of
15 the provider has included in a cost report costs that are not
16 allowable under a Florida Title XIX reimbursement plan, after
17 the provider or authorized representative had been advised in
18 an audit exit conference or audit report that the costs were
19 not allowable;
20 (l) The provider is charged by information or
21 indictment with fraudulent billing practices. The sanction
22 applied for this reason is limited to suspension of the
23 provider's participation in the Medicaid program for the
24 duration of the indictment unless the provider is found guilty
25 pursuant to the information or indictment;
26 (m) The provider or a person who has ordered, or
27 prescribed the goods or services is found liable for negligent
28 practice resulting in death or injury to the provider's
29 patient;
30 (n) The provider fails to demonstrate that it had
31 available during a specific audit or review period sufficient

1 quantities of goods, or sufficient time in the case of
2 services, to support the provider's billings to the Medicaid
3 program;
4 (o) The provider has failed to comply with the notice
5 and reporting requirements of s. 409.907; ~~or~~
6 (p) The agency has received reliable information of
7 patient abuse or neglect or of any act prohibited by s.
8 409.920; or~~.~~
9 (q) The provider has failed to comply with an
10 agreed-upon repayment schedule.
11 (15) The agency shall ~~may~~ impose any of the following
12 sanctions or disincentives on a provider or a person for any
13 of the acts described in subsection (14):
14 (a) Suspension for a specific period of time of not
15 more than 1 year.
16 (b) Termination for a specific period of time of from
17 more than 1 year to 20 years.
18 (c) Imposition of a fine of up to $5,000 for each
19 violation. Each day that an ongoing violation continues, such
20 as refusing to furnish Medicaid-related records or refusing
21 access to records, is considered, for the purposes of this
22 section, to be a separate violation. Each instance of
23 improper billing of a Medicaid recipient; each instance of
24 including an unallowable cost on a hospital or nursing home
25 Medicaid cost report after the provider or authorized
26 representative has been advised in an audit exit conference or
27 previous audit report of the cost unallowability; each
28 instance of furnishing a Medicaid recipient goods or
29 professional services that are inappropriate or of inferior
30 quality as determined by competent peer judgment; each
31 instance of knowingly submitting a materially false or

1 erroneous Medicaid provider enrollment application, request
2 for prior authorization for Medicaid services, drug exception
3 request, or cost report; each instance of inappropriate
4 prescribing of drugs for a Medicaid recipient as determined by
5 competent peer judgment; and each false or erroneous Medicaid
6 claim leading to an overpayment to a provider is considered,
7 for the purposes of this section, to be a separate violation.
8 (d) Immediate suspension, if the agency has received
9 information of patient abuse or neglect or of any act
10 prohibited by s. 409.920. Upon suspension, the agency must
11 issue an immediate final order under s. 120.569(2)(n).
12 (e) A fine, not to exceed $10,000, for a violation of
13 paragraph (14)(i).
14 (f) Imposition of liens against provider assets,
15 including, but not limited to, financial assets and real
16 property, not to exceed the amount of fines or recoveries
17 sought, upon entry of an order determining that such moneys
18 are due or recoverable.
19 (g) Prepayment reviews of claims for a specified
20 period of time.
21 (h) Comprehensive follow-up reviews of providers every
22 6 months to ensure that they are billing Medicaid correctly.
23 (i) Corrective-action plans that would remain in
24 effect for providers for up to 3 years and that would be
25 monitored by the agency every 6 months while in effect.
26 (j)~~(g)~~ Other remedies as permitted by law to effect
27 the recovery of a fine or overpayment.
28
29 The Secretary of Health Care Administration may make a
30 determination that imposition of a sanction or disincentive is
31 not in the best interest of the Medicaid program, in which

1 case a sanction or disincentive shall not be imposed.
2 (16) In determining the appropriate administrative
3 sanction to be applied, or the duration of any suspension or
4 termination, the agency shall consider:
5 (a) The seriousness and extent of the violation or
6 violations.
7 (b) Any prior history of violations by the provider
8 relating to the delivery of health care programs which
9 resulted in either a criminal conviction or in administrative
10 sanction or penalty.
11 (c) Evidence of continued violation within the
12 provider's management control of Medicaid statutes, rules,
13 regulations, or policies after written notification to the
14 provider of improper practice or instance of violation.
15 (d) The effect, if any, on the quality of medical care
16 provided to Medicaid recipients as a result of the acts of the
17 provider.
18 (e) Any action by a licensing agency respecting the
19 provider in any state in which the provider operates or has
20 operated.
21 (f) The apparent impact on access by recipients to
22 Medicaid services if the provider is suspended or terminated,
23 in the best judgment of the agency.
24
25 The agency shall document the basis for all sanctioning
26 actions and recommendations.
27 (17) The agency may take action to sanction, suspend,
28 or terminate a particular provider working for a group
29 provider, and may suspend or terminate Medicaid participation
30 at a specific location, rather than or in addition to taking
31 action against an entire group.

1 (18) The agency shall establish a process for
2 conducting followup reviews of a sampling of providers who
3 have a history of overpayment under the Medicaid program.
4 This process must consider the magnitude of previous fraud or
5 abuse and the potential effect of continued fraud or abuse on
6 Medicaid costs.
7 (19) In making a determination of overpayment to a
8 provider, the agency must use accepted and valid auditing,
9 accounting, analytical, statistical, or peer-review methods,
10 or combinations thereof. Appropriate statistical methods may
11 include, but are not limited to, sampling and extension to the
12 population, parametric and nonparametric statistics, tests of
13 hypotheses, and other generally accepted statistical methods.
14 Appropriate analytical methods may include, but are not
15 limited to, reviews to determine variances between the
16 quantities of products that a provider had on hand and
17 available to be purveyed to Medicaid recipients during the
18 review period and the quantities of the same products paid for
19 by the Medicaid program for the same period, taking into
20 appropriate consideration sales of the same products to
21 non-Medicaid customers during the same period. In meeting its
22 burden of proof in any administrative or court proceeding, the
23 agency may introduce the results of such statistical methods
24 as evidence of overpayment.
25 (20) When making a determination that an overpayment
26 has occurred, the agency shall prepare and issue an audit
27 report to the provider showing the calculation of
28 overpayments.
29 (21) The audit report, supported by agency work
30 papers, showing an overpayment to a provider constitutes
31 evidence of the overpayment. A provider may not present or

1 elicit testimony, either on direct examination or
2 cross-examination in any court or administrative proceeding,
3 regarding the purchase or acquisition by any means of drugs,
4 goods, or supplies; sales or divestment by any means of drugs,
5 goods, or supplies; or inventory of drugs, goods, or supplies,
6 unless such acquisition, sales, divestment, or inventory is
7 documented by written invoices, written inventory records, or
8 other competent written documentary evidence maintained in the
9 normal course of the provider's business. Notwithstanding the
10 applicable rules of discovery, all documentation that will be
11 offered as evidence at an administrative hearing on a Medicaid
12 overpayment must be exchanged by all parties at least 14 days
13 before the administrative hearing or must be excluded from
14 consideration.
15 (22)(a) In an audit or investigation of a violation
16 committed by a provider which is conducted pursuant to this
17 section, the agency is entitled to recover all investigative,
18 legal, and expert witness costs if the agency's findings were
19 not contested by the provider or, if contested, the agency
20 ultimately prevailed.
21 (b) The agency has the burden of documenting the
22 costs, which include salaries and employee benefits and
23 out-of-pocket expenses. The amount of costs that may be
24 recovered must be reasonable in relation to the seriousness of
25 the violation and must be set taking into consideration the
26 financial resources, earning ability, and needs of the
27 provider, who has the burden of demonstrating such factors.
28 (c) The provider may pay the costs over a period to be
29 determined by the agency if the agency determines that an
30 extreme hardship would result to the provider from immediate
31 full payment. Any default in payment of costs may be

1 collected by any means authorized by law.
2 (23) If the agency imposes an administrative sanction
3 under this section upon any provider or other person who is
4 regulated by another state entity, the agency shall notify
5 that other entity of the imposition of the sanction. Such
6 notification must include the provider's or person's name and
7 license number and the specific reasons for sanction.
8 (24)(a) The agency may withhold Medicaid payments, in
9 whole or in part, to a provider upon receipt of reliable
10 evidence that the circumstances giving rise to the need for a
11 withholding of payments involve fraud, willful
12 misrepresentation, or abuse under the Medicaid program, or a
13 crime committed while rendering goods or services to Medicaid
14 recipients, pending completion of legal proceedings. If it is
15 determined that fraud, willful misrepresentation, abuse, or a
16 crime did not occur, the payments withheld must be paid to the
17 provider within 14 days after such determination with interest
18 at the rate of 10 percent a year. Any money withheld in
19 accordance with this paragraph shall be placed in a suspended
20 account, readily accessible to the agency, so that any payment
21 ultimately due the provider shall be made within 14 days.
22 (b) Overpayments owed to the agency bear interest at
23 the rate of 10 percent per year from the date of determination
24 of the overpayment by the agency, and payment arrangements
25 must be made at the conclusion of legal proceedings. A
26 provider who does not enter into or adhere to an agreed-upon
27 repayment schedule may be terminated by the agency for
28 nonpayment or partial payment.
29 (c) The agency, upon entry of a final agency order, a
30 judgment or order of a court of competent jurisdiction, or a
31 stipulation or settlement, may collect the moneys owed by all

means allowable by law, including, but not limited to, notifying any fiscal intermediary of Medicare benefits that the state has a superior right of payment. Upon receipt of such written notification, the Medicare fiscal intermediary shall remit to the state the sum claimed.

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

(26) When the Agency for Health Care Administration has made a probable cause determination and alleged that an overpayment to a Medicaid provider has occurred, the agency, after notice to the provider, may:

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

1. Makes repayment in full; or

2. Establishes a repayment plan that is satisfactory to the Agency for Health Care Administration.

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

~~If a provider requests an administrative hearing pursuant to chapter 120, such hearing must be conducted within 90 days~~

~~following receipt by the provider of the final audit report, absent exceptionally good cause shown as determined by the administrative law judge or hearing officer. Upon issuance of a final order, the balance outstanding of the amount determined to constitute the overpayment shall become due. Any withholding of payments by the Agency for Health Care Administration pursuant to this section shall be limited so that the monthly medical assistance payment is not reduced by more than 10 percent.~~

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

(28) Notwithstanding other provisions of law, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs may review a provider's Medicaid-related records in order to determine the total output of a provider's practice to reconcile quantities of goods or services billed to Medicaid against quantities of goods or services used in the provider's total practice.

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

(30) If a provider requests an administrative hearing pursuant to chapter 120, such hearing must be conducted within 90 days following assignment of an administrative law judge, absent exceptionally good cause shown as determined by the administrative law judge or hearing officer. Upon issuance of

1 a final order, the outstanding balance of the amount
2 determined to constitute the overpayment shall become due. If
3 a provider fails to make payments in full, fails to enter into
4 a satisfactory repayment plan, or fails to comply with the
5 terms of a repayment plan or settlement agreement, the agency
6 may withhold medical-assistance-reimbursement payments until
7 the amount due is paid in full.
8 (31) Duly authorized agents and employees of the
9 agency and the Medicaid Fraud Control Unit of the Department
10 of Legal Affairs shall have the power to inspect, at all
11 reasonable hours and upon proper notice, the records of any
12 pharmacy, wholesale establishment, or manufacturer, or any
13 other place in the state in which drugs and medical supplies
14 are manufactured, packed, packaged, made, stored, sold, or
15 kept for sale, for the purpose of verifying the amount of
16 drugs and medical supplies ordered, delivered, or purchased by
17 a provider.
18 (32) The agency shall request that the Attorney
19 General review any settlement of an overpayment in which the
20 agency reduces the amount due to the state by $10,000 or more.
21 (33) The agency shall request that the Auditor General
22 review any provider rate adjustment not supported by a cost
23 report or with respect to which there are disagreements
24 concerning the application of accounting interpretations and
25 the financial benefit to the provider exceeds $10,000.
26 Section 10. Subsections (7) and (8) of section
27 409.920, Florida Statutes, are amended to read:
28 409.920 Medicaid provider fraud.--
29 (7) The Attorney General shall conduct a statewide
30 program of Medicaid fraud control. To accomplish this purpose,
31 the Attorney General shall:

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

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

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

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

~~(e) Refer to the agency all suspected abusive activities not of a criminal nature.~~

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

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

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

(8) In carrying out the duties and responsibilities

under this section ~~subsection~~, the Attorney General may:

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

(b) Subpoena witnesses or materials, including medical records relating to Medicaid recipients, within or outside the state and, through any duly designated employee, administer oaths and affirmations and collect evidence for possible use in either civil or criminal judicial proceedings.

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

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

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

(f) Refer to the agency suspected abusive activities not of a criminal nature.

1 Section 11. By January 1, 2003, the Agency for Health
2 Care Administration shall make recommendations to the
3 Legislature as to limits in the amount of home office
4 management and administrative fees which should be allowable
5 for reimbursement for providers whose rates are set on a
6 cost-reimbursement basis.
7
8
9 =============== T I T L E   A M E N D M E N T ===============
10 And the title is amended as follows:
11 On page 1, line 26,
12 remove: all of said line
13
14 and insert:
15 amending s. 16.59,F.S.; specifying additional
16 requirements for the Medicaid Fraud Control
17 Unit of the Department of Legal Affairs and the
18 Medicaid program integrity program; amending s.
19 112.3187, F.S.; extending whistle-blower
20 protection to employees of Medicaid providers
21 reporting Medicaid fraud or abuse; creating s.
22 408.831, F.S.; allowing the Agency for Health
23 Care Administration to take action against a
24 licensee in certain circumstances; amending s.
25 409.907, F.S.; prescribing additional
26 requirements with respect to provider
27 enrollment; requiring that the Agency for
28 Health Care Administration deny a provider's
29 application under certain circumstances;
30 amending s. 409.908, F.S.; providing additional
31 requirements for cost-reporting; amending s.

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1 409.910, F.S.; revising requirements for the
2 distribution of funds recovered from third
3 parties that are liable for making payments for
4 medical care furnished to Medicaid recipients
5 and in the case of recoveries of overpayments;
6 amending s. 409.913, F.S.; requiring that the
7 agency and Medicaid Fraud Control Unit annually
8 submit a report to the Legislature; defining
9 the term "complaint"; specifying additional
10 requirements for the Medicaid program integrity
11 program and the Medicaid Fraud Control Unit of
12 the Department of Legal Affairs; requiring
13 imposition of sanctions or disincentives,
14 except under certain circumstances; providing
15 additional sanctions and disincentives;
16 providing additional grounds under which the
17 agency may terminate a provider's participation
18 in the Medicaid program; providing additional
19 requirements for administrative hearings;
20 providing additional grounds for withholding
21 payments to a provider; authorizing the agency
22 and the Medicaid Fraud Control Unit to review
23 certain records; requiring review by the
24 Attorney General of certain settlements;
25 requiring review by the Auditor General of
26 certain cost reports; amending s. 409.920,
27 F.S.; providing additional duties of the
28 Medicaid Fraud Control Unit; requiring
29 recommendations to the Legislature; providing
30 an effective date.
31