

1                                   A bill to be entitled  
2           An act relating to Medicaid; amending s. 16.56,  
3           F.S.; adding criminal violations of s. 409.920  
4           or s. 409.9201, F.S., to the list of specified  
5           crimes within the jurisdiction of the Office of  
6           Statewide Prosecution; amending s. 400.408,  
7           F.S.; including the Medicaid Fraud Control Unit  
8           of the Department of Legal Affairs in the  
9           Agency for Health Care Administration's local  
10          coordinating workgroups for identifying  
11          unlicensed assisted living facilities; amending  
12          s. 400.434, F.S.; giving the Medicaid Fraud  
13          Control Unit of the Department of Legal Affairs  
14          the authority to enter and inspect facilities  
15          licensed under part III of ch. 400, F.S.;  
16          creating s. 409.9021, F.S.; requiring a  
17          Medicaid applicant to agree to forfeiture of  
18          all entitlements under the Medicaid program  
19          upon a judicial or administrative finding of  
20          fraud within a specified period; amending s.  
21          409.912, F.S.; authorizing the Agency for  
22          Health Care Administration to require a  
23          confirmation or second physician's opinion of  
24          the correct diagnosis for purposes of  
25          authorizing future services under the Medicaid  
26          program; authorizing the Agency for Health Care  
27          Administration to impose mandatory enrollment  
28          in drug-therapy-management or  
29          disease-management programs for certain  
30          categories of recipients; requiring that the  
31          Agency for Health Care Administration and the

1 Drug Utilization Review Board consult with the  
2 Department of Health; allowing termination of  
3 certain practitioners from the Medicaid  
4 program; providing that Medicaid recipients may  
5 be required to participate in a provider  
6 lock-in program for not less than 1 year and up  
7 to the duration of the time the recipient  
8 participates in the program; requiring the  
9 agency to seek a federal waiver to terminate  
10 eligibility; requiring the agency to conduct a  
11 study of electronic verification systems;  
12 authorizing the agency to use credentialing  
13 criteria for the purpose of including providers  
14 in the Medicaid program; amending s. 409.913,  
15 F.S.; providing specified conditions for  
16 providers to meet in order to submit claims to  
17 the Medicaid program; providing that claims may  
18 be denied if not properly submitted; providing  
19 that the agency may seek any remedy under law  
20 if a provider submits specified false or  
21 erroneous claims; providing that suspension or  
22 termination precludes participation in the  
23 Medicaid program; providing that the agency is  
24 required to report administrative sanctions to  
25 licensing authorities for certain violations;  
26 providing that the agency may withhold payment  
27 to a provider under certain circumstances;  
28 providing that the agency may deny payments to  
29 terminated or suspended providers; authorizing  
30 the agency to implement amnesty programs for  
31 providers to voluntarily repay overpayments;

1 authorizing the agency to adopt rules;  
2 providing for limiting, restricting, or  
3 suspending Medicaid eligibility of Medicaid  
4 recipients convicted of certain crimes or  
5 offenses; authorizing the agency and the  
6 Medicaid Fraud Control Unit of the Department  
7 of Legal Affairs to review non-Medicaid-related  
8 records in order to determine reconciliation of  
9 a provider's records; authorizing the agency  
10 head or designee to limit, restrict, or suspend  
11 Medicaid eligibility for a period not to exceed  
12 1 year if a recipient is convicted of a federal  
13 health care crime; authorizing the Agency for  
14 Health Care Administration to limit the number  
15 of certain types of prescription claims  
16 submitted by pharmacy providers; requiring the  
17 agency to limit the allowable amount of certain  
18 types of prescriptions under specified  
19 circumstances; amending s. 409.9131, F.S.;  
20 requiring that the Office of Program Policy  
21 Analysis and Government Accountability report  
22 to the Legislature on the agency's fraud and  
23 abuse prevention, deterrence, detection, and  
24 recovery efforts; redefining the term "peer  
25 review"; providing for peer review for purposes  
26 of determining a potential overpayment if the  
27 medical necessity or quality of care is  
28 evaluated; requiring an additional statement on  
29 Medicaid cost reports certifying that Medicaid  
30 providers are familiar with the laws and  
31 regulations regarding the provision of health

1 care services under the Medicaid program;  
2 amending s. 409.920, F.S.; redefining the term  
3 "knowingly" to include "willfully" or  
4 "willful"; making it unlawful to knowingly use  
5 or endeavor to use a Medicaid provider's or a  
6 Medicaid recipient's identification number or  
7 cause to be made, or aid and abet in the making  
8 of, a claim for items or services that are not  
9 authorized to be reimbursed under the Medicaid  
10 program; defining the term "paid for"; creating  
11 s. 409.9201, F.S.; providing definitions;  
12 providing that a person who knowingly sells or  
13 attempts to sell legend drugs obtained through  
14 the Medicaid program commits a felony;  
15 providing that a person who knowingly purchases  
16 or attempts to purchase legend drugs obtained  
17 through the Medicaid program and intended for  
18 the use of another commits a felony; providing  
19 that a person who knowingly makes or conspires  
20 to make false representations for the purpose  
21 of obtaining goods or services from the  
22 Medicaid program commits a felony; providing  
23 specified criminal penalties depending on the  
24 value of the legend drugs or goods or services  
25 obtained from the Medicaid program; amending s.  
26 456.072, F.S.; providing an additional ground  
27 under which a health care practitioner who  
28 prescribes medicinal drugs or controlled  
29 substances may be subject to discipline by the  
30 Department of Health or the appropriate board  
31 having jurisdiction over the health care

1 practitioner; authorizing the Department of  
2 Health to initiate a disciplinary investigation  
3 of prescribing practitioners under specified  
4 circumstances; amending s. 465.188, F.S.;  
5 deleting the requirement that the Agency for  
6 Health Care Administration give pharmacists at  
7 least 1 week's notice prior to an audit;  
8 specifying an effective date for certain audit  
9 criteria; providing that the specified Medicaid  
10 audit procedures do not apply to any  
11 investigative audit conducted by the agency  
12 when the agency has reliable evidence that the  
13 claim that is the subject of the audit involves  
14 fraud, willful misrepresentation, or abuse  
15 under the Medicaid program; prohibiting the  
16 accounting practice of extrapolation for  
17 calculating penalties for Medicaid audits;  
18 creating s. 812.0191, F.S.; providing  
19 definitions; providing that a person who  
20 traffics in property paid for in whole or in  
21 part by the Medicaid program, or who knowingly  
22 finances, directs, or traffics in such  
23 property, commits a felony; providing specified  
24 criminal penalties depending on the value of  
25 the property; amending s. 895.02, F.S.; adding  
26 Medicaid recipient fraud to the definition of  
27 the term "racketeering activity"; amending s.  
28 905.34, F.S.; adding any criminal violation of  
29 s. 409.920 or s. 409.9201, F.S., to the list of  
30 crimes within the jurisdiction of the statewide  
31 grand jury; amending s. 932.701, F.S.;

1 expanding the definition of "contraband  
2 article"; amending s. 932.7055, F.S.; requiring  
3 that proceeds collected under the Florida  
4 Contraband Forfeiture Act be deposited in the  
5 Department of Legal Affairs' Grants and  
6 Donations Trust Fund; amending ss. 394.9082,  
7 400.0077, 409.9065, 409.9071, 409.908,  
8 409.91196, 409.9122, 409.9131, 430.608,  
9 636.0145, 641.225, and 641.386, F.S.;  
10 correcting cross-references; reenacting s.  
11 921.0022(3)(g), F.S., relating to the offense  
12 severity ranking chart of the Criminal  
13 Punishment Code, to incorporate the amendment  
14 to s. 409.920, F.S., in a reference thereto;  
15 reenacting s. 705.101(6), F.S., relating to  
16 unclaimed evidence, to incorporate the  
17 amendment to s. 932.701, F.S., in a reference  
18 thereto; reenacting s. 932.703(4), F.S.,  
19 relating to forfeiture of contraband articles,  
20 to incorporate the amendment to s. 932.701,  
21 F.S., in a reference thereto; providing an  
22 appropriation and authorizing positions;  
23 providing an effective date.

24  
25 Be It Enacted by the Legislature of the State of Florida:

26  
27 Section 1. Subsection (1) of section 16.56, Florida  
28 Statutes, is amended to read:

29 16.56 Office of Statewide Prosecution.--

30 (1) There is created in the Department of Legal  
31 Affairs an Office of Statewide Prosecution. The office shall

1 be a separate "budget entity" as that term is defined in  
2 chapter 216. The office may:

3 (a) Investigate and prosecute the offenses of:

4 1. Bribery, burglary, criminal usury, extortion,  
5 gambling, kidnapping, larceny, murder, prostitution, perjury,  
6 robbery, carjacking, and home-invasion robbery;

7 2. Any crime involving narcotic or other dangerous  
8 drugs;

9 3. Any violation of the provisions of the Florida RICO  
10 (Racketeer Influenced and Corrupt Organization) Act, including  
11 any offense listed in the definition of racketeering activity  
12 in s. 895.02(1)(a), providing such listed offense is  
13 investigated in connection with a violation of s. 895.03 and  
14 is charged in a separate count of an information or indictment  
15 containing a count charging a violation of s. 895.03, the  
16 prosecution of which listed offense may continue independently  
17 if the prosecution of the violation of s. 895.03 is terminated  
18 for any reason;

19 4. Any violation of the provisions of the Florida  
20 Anti-Fencing Act;

21 5. Any violation of the provisions of the Florida  
22 Antitrust Act of 1980, as amended;

23 6. Any crime involving, or resulting in, fraud or  
24 deceit upon any person;

25 7. Any violation of s. 847.0135, relating to computer  
26 pornography and child exploitation prevention, or any offense  
27 related to a violation of s. 847.0135;

28 8. Any violation of the provisions of chapter 815; ~~or~~  
29 9. Any criminal violation of part I of chapter 499; or  
30 10. Any criminal violation of s. 409.920 or s.  
31 409.9201.

1  
2 or any attempt, solicitation, or conspiracy to commit any of  
3 the crimes specifically enumerated above. The office shall  
4 have such power only when any such offense is occurring, or  
5 has occurred, in two or more judicial circuits as part of a  
6 related transaction, or when any such offense is connected  
7 with an organized criminal conspiracy affecting two or more  
8 judicial circuits.

9 (b) Upon request, cooperate with and assist state  
10 attorneys and state and local law enforcement officials in  
11 their efforts against organized crimes.

12 (c) Request and receive from any department, division,  
13 board, bureau, commission, or other agency of the state, or of  
14 any political subdivision thereof, cooperation and assistance  
15 in the performance of its duties.

16 Section 2. Paragraph (i) of subsection (1) of section  
17 400.408, Florida Statutes, is amended to read:

18 400.408 Unlicensed facilities; referral of person for  
19 residency to unlicensed facility; penalties; verification of  
20 licensure status.--

21 (1)

22 (i) Each field office of the Agency for Health Care  
23 Administration shall establish a local coordinating workgroup  
24 which includes representatives of local law enforcement  
25 agencies, state attorneys, the Medicaid Fraud Control Unit of  
26 the Department of Legal Affairs, local fire authorities, the  
27 Department of Children and Family Services, the district  
28 long-term care ombudsman council, and the district human  
29 rights advocacy committee to assist in identifying the  
30 operation of unlicensed facilities and to develop and  
31 implement a plan to ensure effective enforcement of state laws



1 relating to such facilities. The workgroup shall report its  
2 findings, actions, and recommendations semiannually to the  
3 Director of Health Facility Regulation of the agency.

4 Section 3. Section 400.434, Florida Statutes, is  
5 amended to read:

6 400.434 Right of entry and inspection.--Any duly  
7 designated officer or employee of the department, the  
8 Department of Children and Family Services, the agency, the  
9 Medicaid Fraud Control Unit of the Department of Legal  
10 Affairs, the state or local fire marshal, or a member of the  
11 state or local long-term care ombudsman council shall have the  
12 right to enter unannounced upon and into the premises of any  
13 facility licensed pursuant to this part in order to determine  
14 the state of compliance with the provisions of this part and  
15 of rules or standards in force pursuant thereto. The right of  
16 entry and inspection shall also extend to any premises which  
17 the agency has reason to believe is being operated or  
18 maintained as a facility without a license; but no such entry  
19 or inspection of any premises may be made without the  
20 permission of the owner or person in charge thereof, unless a  
21 warrant is first obtained from the circuit court authorizing  
22 such entry. The warrant requirement shall extend only to a  
23 facility which the agency has reason to believe is being  
24 operated or maintained as a facility without a license. Any  
25 application for a license or renewal thereof made pursuant to  
26 this part shall constitute permission for, and complete  
27 acquiescence in, any entry or inspection of the premises for  
28 which the license is sought, in order to facilitate  
29 verification of the information submitted on or in connection  
30 with the application; to discover, investigate, and determine  
31 the existence of abuse or neglect; or to elicit, receive,

1 respond to, and resolve complaints. Any current valid license  
2 shall constitute unconditional permission for, and complete  
3 acquiescence in, any entry or inspection of the premises by  
4 authorized personnel. The agency shall retain the right of  
5 entry and inspection of facilities that have had a license  
6 revoked or suspended within the previous 24 months, to ensure  
7 that the facility is not operating unlawfully. However, before  
8 entering the facility, a statement of probable cause must be  
9 filed with the director of the agency, who must approve or  
10 disapprove the action within 48 hours. Probable cause shall  
11 include, but is not limited to, evidence that the facility  
12 holds itself out to the public as a provider of personal care  
13 services or the receipt of a complaint by the long-term care  
14 ombudsman council about the facility. Data collected by the  
15 state or local long-term care ombudsman councils or the state  
16 or local advocacy councils may be used by the agency in  
17 investigations involving violations of regulatory standards.

18 Section 4. Section 409.9021, Florida Statutes, is  
19 created to read:

20 409.9021 Forfeiture of eligibility agreement.--As a  
21 condition of Medicaid eligibility, subject to federal  
22 approval, a Medicaid applicant shall agree in writing to  
23 forfeit all entitlements to any goods or services provided  
24 through the Medicaid program if he or she has been found to  
25 have committed fraud, through judicial or administrative  
26 determination, two times in a period of five years. This  
27 provision applies only to the Medicaid recipient found to have  
28 committed or participated in the fraud and does not apply to  
29 any family member of the recipient who was not involved in the  
30 fraud.

31

1 Section 5. Section 409.912, Florida Statutes, is  
2 amended to read:

3 409.912 Cost-effective purchasing of health care.--The  
4 agency shall purchase goods and services for Medicaid  
5 recipients in the most cost-effective manner consistent with  
6 the delivery of quality medical care. To ensure that medical  
7 services are effectively utilized, the agency may, in any  
8 case, require a confirmation or second physician's opinion of  
9 the correct diagnosis for purposes of authorizing future  
10 services under the Medicaid program. This section does not  
11 restrict access to emergency services or poststabilization  
12 care services as defined in 42 C.F.R. part 438.114. Such  
13 confirmation or second opinion shall be rendered in a manner  
14 approved by the agency.The agency shall maximize the use of  
15 prepaid per capita and prepaid aggregate fixed-sum basis  
16 services when appropriate and other alternative service  
17 delivery and reimbursement methodologies, including  
18 competitive bidding pursuant to s. 287.057, designed to  
19 facilitate the cost-effective purchase of a case-managed  
20 continuum of care. The agency shall also require providers to  
21 minimize the exposure of recipients to the need for acute  
22 inpatient, custodial, and other institutional care and the  
23 inappropriate or unnecessary use of high-cost services. The  
24 agency may mandate ~~establish~~ prior authorization, drug therapy  
25 management, or disease management participation requirements  
26 for certain populations of Medicaid beneficiaries, certain  
27 drug classes, or particular drugs to prevent fraud, abuse,  
28 overuse, and possible dangerous drug interactions. The  
29 Pharmaceutical and Therapeutics Committee shall make  
30 recommendations to the agency on drugs for which prior  
31 authorization is required. The agency shall inform the

1 Pharmaceutical and Therapeutics Committee of its decisions  
2 regarding drugs subject to prior authorization.

3 (1) The agency shall work with the Department of  
4 Children and Family Services to ensure access of children and  
5 families in the child protection system to needed and  
6 appropriate mental health and substance abuse services.

7 (2) The agency may enter into agreements with  
8 appropriate agents of other state agencies or of any agency of  
9 the Federal Government and accept such duties in respect to  
10 social welfare or public aid as may be necessary to implement  
11 the provisions of Title XIX of the Social Security Act and ss.  
12 409.901-409.920.

13 (3) The agency may contract with health maintenance  
14 organizations certified pursuant to part I of chapter 641 for  
15 the provision of services to recipients.

16 (4) The agency may contract with:

17 (a) An entity that provides no prepaid health care  
18 services other than Medicaid services under contract with the  
19 agency and which is owned and operated by a county, county  
20 health department, or county-owned and operated hospital to  
21 provide health care services on a prepaid or fixed-sum basis  
22 to recipients, which entity may provide such prepaid services  
23 either directly or through arrangements with other providers.  
24 Such prepaid health care services entities must be licensed  
25 under parts I and III by January 1, 1998, and until then are  
26 exempt from the provisions of part I of chapter 641. An entity  
27 recognized under this paragraph which demonstrates to the  
28 satisfaction of the Office of Insurance Regulation of the  
29 Financial Services Commission that it is backed by the full  
30 faith and credit of the county in which it is located may be  
31 exempted from s. 641.225.

1 (b) An entity that is providing comprehensive  
2 behavioral health care services to certain Medicaid recipients  
3 through a capitated, prepaid arrangement pursuant to the  
4 federal waiver provided for by s. 409.905(5). Such an entity  
5 must be licensed under chapter 624, chapter 636, or chapter  
6 641 and must possess the clinical systems and operational  
7 competence to manage risk and provide comprehensive behavioral  
8 health care to Medicaid recipients. As used in this paragraph,  
9 the term "comprehensive behavioral health care services" means  
10 covered mental health and substance abuse treatment services  
11 that are available to Medicaid recipients. The secretary of  
12 the Department of Children and Family Services shall approve  
13 provisions of procurements related to children in the  
14 department's care or custody prior to enrolling such children  
15 in a prepaid behavioral health plan. Any contract awarded  
16 under this paragraph must be competitively procured. In  
17 developing the behavioral health care prepaid plan procurement  
18 document, the agency shall ensure that the procurement  
19 document requires the contractor to develop and implement a  
20 plan to ensure compliance with s. 394.4574 related to services  
21 provided to residents of licensed assisted living facilities  
22 that hold a limited mental health license. The agency shall  
23 seek federal approval to contract with a single entity meeting  
24 these requirements to provide comprehensive behavioral health  
25 care services to all Medicaid recipients in an AHCA area. Each  
26 entity must offer sufficient choice of providers in its  
27 network to ensure recipient access to care and the opportunity  
28 to select a provider with whom they are satisfied. The network  
29 shall include all public mental health hospitals. To ensure  
30 unimpaired access to behavioral health care services by  
31 Medicaid recipients, all contracts issued pursuant to this

1 paragraph shall require 80 percent of the capitation paid to  
2 the managed care plan, including health maintenance  
3 organizations, to be expended for the provision of behavioral  
4 health care services. In the event the managed care plan  
5 expends less than 80 percent of the capitation paid pursuant  
6 to this paragraph for the provision of behavioral health care  
7 services, the difference shall be returned to the agency. The  
8 agency shall provide the managed care plan with a  
9 certification letter indicating the amount of capitation paid  
10 during each calendar year for the provision of behavioral  
11 health care services pursuant to this section. The agency may  
12 reimburse for substance abuse treatment services on a  
13 fee-for-service basis until the agency finds that adequate  
14 funds are available for capitated, prepaid arrangements.

15       1. By January 1, 2001, the agency shall modify the  
16 contracts with the entities providing comprehensive inpatient  
17 and outpatient mental health care services to Medicaid  
18 recipients in Hillsborough, Highlands, Hardee, Manatee, and  
19 Polk Counties, to include substance abuse treatment services.

20       2. By July 1, 2003, the agency and the Department of  
21 Children and Family Services shall execute a written agreement  
22 that requires collaboration and joint development of all  
23 policy, budgets, procurement documents, contracts, and  
24 monitoring plans that have an impact on the state and Medicaid  
25 community mental health and targeted case management programs.

26       3. By July 1, 2006, the agency and the Department of  
27 Children and Family Services shall contract with managed care  
28 entities in each AHCA area except area 6 or arrange to provide  
29 comprehensive inpatient and outpatient mental health and  
30 substance abuse services through capitated prepaid  
31 arrangements to all Medicaid recipients who are eligible to

1 participate in such plans under federal law and regulation. In  
2 AHCA areas where eligible individuals number less than  
3 150,000, the agency shall contract with a single managed care  
4 plan. The agency may contract with more than one plan in AHCA  
5 areas where the eligible population exceeds 150,000. Contracts  
6 awarded pursuant to this section shall be competitively  
7 procured. Both for-profit and not-for-profit corporations  
8 shall be eligible to compete.

9           4. By October 1, 2003, the agency and the department  
10 shall submit a plan to the Governor, the President of the  
11 Senate, and the Speaker of the House of Representatives which  
12 provides for the full implementation of capitated prepaid  
13 behavioral health care in all areas of the state. The plan  
14 shall include provisions which ensure that children and  
15 families receiving foster care and other related services are  
16 appropriately served and that these services assist the  
17 community-based care lead agencies in meeting the goals and  
18 outcomes of the child welfare system. The plan will be  
19 developed with the participation of community-based lead  
20 agencies, community alliances, sheriffs, and community  
21 providers serving dependent children.

22           a. Implementation shall begin in 2003 in those AHCA  
23 areas of the state where the agency is able to establish  
24 sufficient capitation rates.

25           b. If the agency determines that the proposed  
26 capitation rate in any area is insufficient to provide  
27 appropriate services, the agency may adjust the capitation  
28 rate to ensure that care will be available. The agency and the  
29 department may use existing general revenue to address any  
30 additional required match but may not over-obligate existing  
31 funds on an annualized basis.

1           c. Subject to any limitations provided for in the  
2 General Appropriations Act, the agency, in compliance with  
3 appropriate federal authorization, shall develop policies and  
4 procedures that allow for certification of local and state  
5 funds.

6           5. Children residing in a statewide inpatient  
7 psychiatric program, or in a Department of Juvenile Justice or  
8 a Department of Children and Family Services residential  
9 program approved as a Medicaid behavioral health overlay  
10 services provider shall not be included in a behavioral health  
11 care prepaid health plan pursuant to this paragraph.

12           6. In converting to a prepaid system of delivery, the  
13 agency shall in its procurement document require an entity  
14 providing comprehensive behavioral health care services to  
15 prevent the displacement of indigent care patients by  
16 enrollees in the Medicaid prepaid health plan providing  
17 behavioral health care services from facilities receiving  
18 state funding to provide indigent behavioral health care, to  
19 facilities licensed under chapter 395 which do not receive  
20 state funding for indigent behavioral health care, or  
21 reimburse the unsubsidized facility for the cost of behavioral  
22 health care provided to the displaced indigent care patient.

23           7. Traditional community mental health providers under  
24 contract with the Department of Children and Family Services  
25 pursuant to part IV of chapter 394, child welfare providers  
26 under contract with the Department of Children and Family  
27 Services, and inpatient mental health providers licensed  
28 pursuant to chapter 395 must be offered an opportunity to  
29 accept or decline a contract to participate in any provider  
30 network for prepaid behavioral health services.

31



1           (c) A federally qualified health center or an entity  
2 owned by one or more federally qualified health centers or an  
3 entity owned by other migrant and community health centers  
4 receiving non-Medicaid financial support from the Federal  
5 Government to provide health care services on a prepaid or  
6 fixed-sum basis to recipients. Such prepaid health care  
7 services entity must be licensed under parts I and III of  
8 chapter 641, but shall be prohibited from serving Medicaid  
9 recipients on a prepaid basis, until such licensure has been  
10 obtained. However, such an entity is exempt from s. 641.225  
11 if the entity meets the requirements specified in subsections  
12 (15) and (16).

13           (d) A provider service network may be reimbursed on a  
14 fee-for-service or prepaid basis. A provider service network  
15 which is reimbursed by the agency on a prepaid basis shall be  
16 exempt from parts I and III of chapter 641, but must meet  
17 appropriate financial reserve, quality assurance, and patient  
18 rights requirements as established by the agency. The agency  
19 shall award contracts on a competitive bid basis and shall  
20 select bidders based upon price and quality of care. Medicaid  
21 recipients assigned to a demonstration project shall be chosen  
22 equally from those who would otherwise have been assigned to  
23 prepaid plans and MediPass. The agency is authorized to seek  
24 federal Medicaid waivers as necessary to implement the  
25 provisions of this section.

26           (e) An entity that provides comprehensive behavioral  
27 health care services to certain Medicaid recipients through an  
28 administrative services organization agreement. Such an entity  
29 must possess the clinical systems and operational competence  
30 to provide comprehensive health care to Medicaid recipients.  
31 As used in this paragraph, the term "comprehensive behavioral

1 health care services" means covered mental health and  
2 substance abuse treatment services that are available to  
3 Medicaid recipients. Any contract awarded under this paragraph  
4 must be competitively procured. The agency must ensure that  
5 Medicaid recipients have available the choice of at least two  
6 managed care plans for their behavioral health care services.

7 (f) An entity that provides in-home physician services  
8 to test the cost-effectiveness of enhanced home-based medical  
9 care to Medicaid recipients with degenerative neurological  
10 diseases and other diseases or disabling conditions associated  
11 with high costs to Medicaid. The program shall be designed to  
12 serve very disabled persons and to reduce Medicaid reimbursed  
13 costs for inpatient, outpatient, and emergency department  
14 services. The agency shall contract with vendors on a  
15 risk-sharing basis.

16 (g) Children's provider networks that provide care  
17 coordination and care management for Medicaid-eligible  
18 pediatric patients, primary care, authorization of specialty  
19 care, and other urgent and emergency care through organized  
20 providers designed to service Medicaid eligibles under age 18  
21 and pediatric emergency departments' diversion programs. The  
22 networks shall provide after-hour operations, including  
23 evening and weekend hours, to promote, when appropriate, the  
24 use of the children's networks rather than hospital emergency  
25 departments.

26 (h) An entity authorized in s. 430.205 to contract  
27 with the agency and the Department of Elderly Affairs to  
28 provide health care and social services on a prepaid or  
29 fixed-sum basis to elderly recipients. Such prepaid health  
30 care services entities are exempt from the provisions of part  
31 I of chapter 641 for the first 3 years of operation. An entity

1 recognized under this paragraph that demonstrates to the  
2 satisfaction of the Office of Insurance Regulation that it is  
3 backed by the full faith and credit of one or more counties in  
4 which it operates may be exempted from s. 641.225.

5 (i) A Children's Medical Services network, as defined  
6 in s. 391.021.

7 (5) By October 1, 2003, the agency and the department  
8 shall, to the extent feasible, develop a plan for implementing  
9 new Medicaid procedure codes for emergency and crisis care,  
10 supportive residential services, and other services designed  
11 to maximize the use of Medicaid funds for Medicaid-eligible  
12 recipients. The agency shall include in the agreement  
13 developed pursuant to subsection (4) a provision that ensures  
14 that the match requirements for these new procedure codes are  
15 met by certifying eligible general revenue or local funds that  
16 are currently expended on these services by the department  
17 with contracted alcohol, drug abuse, and mental health  
18 providers. The plan must describe specific procedure codes to  
19 be implemented, a projection of the number of procedures to be  
20 delivered during fiscal year 2003-2004, and a financial  
21 analysis that describes the certified match procedures, and  
22 accountability mechanisms, projects the earnings associated  
23 with these procedures, and describes the sources of state  
24 match. This plan may not be implemented in any part until  
25 approved by the Legislative Budget Commission. If such  
26 approval has not occurred by December 31, 2003, the plan shall  
27 be submitted for consideration by the 2004 Legislature.

28 (6) The agency may contract with any public or private  
29 entity otherwise authorized by this section on a prepaid or  
30 fixed-sum basis for the provision of health care services to  
31 recipients. An entity may provide prepaid services to

1 recipients, either directly or through arrangements with other  
2 entities, if each entity involved in providing services:

3 (a) Is organized primarily for the purpose of  
4 providing health care or other services of the type regularly  
5 offered to Medicaid recipients;

6 (b) Ensures that services meet the standards set by  
7 the agency for quality, appropriateness, and timeliness;

8 (c) Makes provisions satisfactory to the agency for  
9 insolvency protection and ensures that neither enrolled  
10 Medicaid recipients nor the agency will be liable for the  
11 debts of the entity;

12 (d) Submits to the agency, if a private entity, a  
13 financial plan that the agency finds to be fiscally sound and  
14 that provides for working capital in the form of cash or  
15 equivalent liquid assets excluding revenues from Medicaid  
16 premium payments equal to at least the first 3 months of  
17 operating expenses or \$200,000, whichever is greater;

18 (e) Furnishes evidence satisfactory to the agency of  
19 adequate liability insurance coverage or an adequate plan of  
20 self-insurance to respond to claims for injuries arising out  
21 of the furnishing of health care;

22 (f) Provides, through contract or otherwise, for  
23 periodic review of its medical facilities and services, as  
24 required by the agency; and

25 (g) Provides organizational, operational, financial,  
26 and other information required by the agency.

27 (7) The agency may contract on a prepaid or fixed-sum  
28 basis with any health insurer that:

29 (a) Pays for health care services provided to enrolled  
30 Medicaid recipients in exchange for a premium payment paid by  
31 the agency;

1 (b) Assumes the underwriting risk; and

2 (c) Is organized and licensed under applicable  
3 provisions of the Florida Insurance Code and is currently in  
4 good standing with the Office of Insurance Regulation.

5 (8) The agency may contract on a prepaid or fixed-sum  
6 basis with an exclusive provider organization to provide  
7 health care services to Medicaid recipients provided that the  
8 exclusive provider organization meets applicable managed care  
9 plan requirements in this section, ss. 409.9122, 409.9123,  
10 409.9128, and 627.6472, and other applicable provisions of  
11 law.

12 (9) The Agency for Health Care Administration may  
13 provide cost-effective purchasing of chiropractic services on  
14 a fee-for-service basis to Medicaid recipients through  
15 arrangements with a statewide chiropractic preferred provider  
16 organization incorporated in this state as a not-for-profit  
17 corporation. The agency shall ensure that the benefit limits  
18 and prior authorization requirements in the current Medicaid  
19 program shall apply to the services provided by the  
20 chiropractic preferred provider organization.

21 (10) The agency shall not contract on a prepaid or  
22 fixed-sum basis for Medicaid services with an entity which  
23 knows or reasonably should know that any officer, director,  
24 agent, managing employee, or owner of stock or beneficial  
25 interest in excess of 5 percent common or preferred stock, or  
26 the entity itself, has been found guilty of, regardless of  
27 adjudication, or entered a plea of nolo contendere, or guilty,  
28 to:

29 (a) Fraud;  
30  
31

1 (b) Violation of federal or state antitrust statutes,  
2 including those proscribing price fixing between competitors  
3 and the allocation of customers among competitors;

4 (c) Commission of a felony involving embezzlement,  
5 theft, forgery, income tax evasion, bribery, falsification or  
6 destruction of records, making false statements, receiving  
7 stolen property, making false claims, or obstruction of  
8 justice; or

9 (d) Any crime in any jurisdiction which directly  
10 relates to the provision of health services on a prepaid or  
11 fixed-sum basis.

12 (11) The agency, after notifying the Legislature, may  
13 apply for waivers of applicable federal laws and regulations  
14 as necessary to implement more appropriate systems of health  
15 care for Medicaid recipients and reduce the cost of the  
16 Medicaid program to the state and federal governments and  
17 shall implement such programs, after legislative approval,  
18 within a reasonable period of time after federal approval.  
19 These programs must be designed primarily to reduce the need  
20 for inpatient care, custodial care and other long-term or  
21 institutional care, and other high-cost services.

22 (a) Prior to seeking legislative approval of such a  
23 waiver as authorized by this subsection, the agency shall  
24 provide notice and an opportunity for public comment. Notice  
25 shall be provided to all persons who have made requests of the  
26 agency for advance notice and shall be published in the  
27 Florida Administrative Weekly not less than 28 days prior to  
28 the intended action.

29 (b) Notwithstanding s. 216.292, funds that are  
30 appropriated to the Department of Elderly Affairs for the  
31 Assisted Living for the Elderly Medicaid waiver and are not

1 expended shall be transferred to the agency to fund  
2 Medicaid-reimbursed nursing home care.

3 (12) The agency shall establish a postpayment  
4 utilization control program designed to identify recipients  
5 who may inappropriately overuse or underuse Medicaid services  
6 and shall provide methods to correct such misuse.

7 (13) The agency shall develop and provide coordinated  
8 systems of care for Medicaid recipients and may contract with  
9 public or private entities to develop and administer such  
10 systems of care among public and private health care providers  
11 in a given geographic area.

12 (14) The agency shall operate or contract for the  
13 operation of utilization management and incentive systems  
14 designed to encourage cost-effective use services.

15 (15)(a) The agency shall operate the Comprehensive  
16 Assessment and Review (CARES) nursing facility preadmission  
17 screening program to ensure that Medicaid payment for nursing  
18 facility care is made only for individuals whose conditions  
19 require such care and to ensure that long-term care services  
20 are provided in the setting most appropriate to the needs of  
21 the person and in the most economical manner possible. The  
22 CARES program shall also ensure that individuals participating  
23 in Medicaid home and community-based waiver programs meet  
24 criteria for those programs, consistent with approved federal  
25 waivers.

26 (b) The agency shall operate the CARES program through  
27 an interagency agreement with the Department of Elderly  
28 Affairs.

29 (c) Prior to making payment for nursing facility  
30 services for a Medicaid recipient, the agency must verify that  
31 the nursing facility preadmission screening program has

1 determined that the individual requires nursing facility care  
2 and that the individual cannot be safely served in  
3 community-based programs. The nursing facility preadmission  
4 screening program shall refer a Medicaid recipient to a  
5 community-based program if the individual could be safely  
6 served at a lower cost and the recipient chooses to  
7 participate in such program.

8 (d) By January 1 of each year, the agency shall submit  
9 a report to the Legislature and the Office of Long-Term-Care  
10 Policy describing the operations of the CARES program. The  
11 report must describe:

- 12 1. Rate of diversion to community alternative  
13 programs;
- 14 2. CARES program staffing needs to achieve additional  
15 diversions;
- 16 3. Reasons the program is unable to place individuals  
17 in less restrictive settings when such individuals desired  
18 such services and could have been served in such settings;
- 19 4. Barriers to appropriate placement, including  
20 barriers due to policies or operations of other agencies or  
21 state-funded programs; and
- 22 5. Statutory changes necessary to ensure that  
23 individuals in need of long-term care services receive care in  
24 the least restrictive environment.

25 (16)(a) The agency shall identify health care  
26 utilization and price patterns within the Medicaid program  
27 which are not cost-effective or medically appropriate and  
28 assess the effectiveness of new or alternate methods of  
29 providing and monitoring service, and may implement such  
30 methods as it considers appropriate. Such methods may include  
31 disease management initiatives, an integrated and systematic



1 approach for managing the health care needs of recipients who  
2 are at risk of or diagnosed with a specific disease by using  
3 best practices, prevention strategies, clinical-practice  
4 improvement, clinical interventions and protocols, outcomes  
5 research, information technology, and other tools and  
6 resources to reduce overall costs and improve measurable  
7 outcomes.

8 (b) The responsibility of the agency under this  
9 subsection shall include the development of capabilities to  
10 identify actual and optimal practice patterns; patient and  
11 provider educational initiatives; methods for determining  
12 patient compliance with prescribed treatments; fraud, waste,  
13 and abuse prevention and detection programs; and beneficiary  
14 case management programs.

15 1. The practice pattern identification program shall  
16 evaluate practitioner prescribing patterns based on national  
17 and regional practice guidelines, comparing practitioners to  
18 their peer groups. The agency and its Drug Utilization Review  
19 Board shall consult with the Department of Health and a panel  
20 of practicing health care professionals consisting of the  
21 following: the Speaker of the House of Representatives and the  
22 President of the Senate shall each appoint three physicians  
23 licensed under chapter 458 or chapter 459; and the Governor  
24 shall appoint two pharmacists licensed under chapter 465 and  
25 one dentist licensed under chapter 466 who is an oral surgeon.  
26 Terms of the panel members shall expire at the discretion of  
27 the appointing official. The panel shall begin its work by  
28 August 1, 1999, regardless of the number of appointments made  
29 by that date. The advisory panel shall be responsible for  
30 evaluating treatment guidelines and recommending ways to  
31 incorporate their use in the practice pattern identification

1 program. Practitioners who are prescribing inappropriately or  
2 inefficiently, as determined by the agency, may have their  
3 prescribing of certain drugs subject to prior authorization or  
4 may be terminated from all participation in the Medicaid  
5 program.

6           2. The agency shall also develop educational  
7 interventions designed to promote the proper use of  
8 medications by providers and beneficiaries.

9           3. The agency shall implement a pharmacy fraud, waste,  
10 and abuse initiative that may include a surety bond or letter  
11 of credit requirement for participating pharmacies, enhanced  
12 provider auditing practices, the use of additional fraud and  
13 abuse software, recipient management programs for  
14 beneficiaries inappropriately using their benefits, and other  
15 steps that will eliminate provider and recipient fraud, waste,  
16 and abuse. The initiative shall address enforcement efforts to  
17 reduce the number and use of counterfeit prescriptions.

18           4. By September 30, 2002, the agency shall contract  
19 with an entity in the state to implement a wireless handheld  
20 clinical pharmacology drug information database for  
21 practitioners. The initiative shall be designed to enhance the  
22 agency's efforts to reduce fraud, abuse, and errors in the  
23 prescription drug benefit program and to otherwise further the  
24 intent of this paragraph.

25           5. The agency may apply for any federal waivers needed  
26 to implement this paragraph.

27           (17) An entity contracting on a prepaid or fixed-sum  
28 basis shall, in addition to meeting any applicable statutory  
29 surplus requirements, also maintain at all times in the form  
30 of cash, investments that mature in less than 180 days  
31 allowable as admitted assets by the Office of Insurance

1 Regulation, and restricted funds or deposits controlled by the  
2 agency or the Office of Insurance Regulation, a surplus amount  
3 equal to one-and-one-half times the entity's monthly Medicaid  
4 prepaid revenues. As used in this subsection, the term  
5 "surplus" means the entity's total assets minus total  
6 liabilities. If an entity's surplus falls below an amount  
7 equal to one-and-one-half times the entity's monthly Medicaid  
8 prepaid revenues, the agency shall prohibit the entity from  
9 engaging in marketing and preenrollment activities, shall  
10 cease to process new enrollments, and shall not renew the  
11 entity's contract until the required balance is achieved. The  
12 requirements of this subsection do not apply:

13 (a) Where a public entity agrees to fund any deficit  
14 incurred by the contracting entity; or

15 (b) Where the entity's performance and obligations are  
16 guaranteed in writing by a guaranteeing organization which:

17 1. Has been in operation for at least 5 years and has  
18 assets in excess of \$50 million; or

19 2. Submits a written guarantee acceptable to the  
20 agency which is irrevocable during the term of the contracting  
21 entity's contract with the agency and, upon termination of the  
22 contract, until the agency receives proof of satisfaction of  
23 all outstanding obligations incurred under the contract.

24 (18)(a) The agency may require an entity contracting  
25 on a prepaid or fixed-sum basis to establish a restricted  
26 insolvency protection account with a federally guaranteed  
27 financial institution licensed to do business in this state.  
28 The entity shall deposit into that account 5 percent of the  
29 capitation payments made by the agency each month until a  
30 maximum total of 2 percent of the total current contract  
31 amount is reached. The restricted insolvency protection

1 account may be drawn upon with the authorized signatures of  
2 two persons designated by the entity and two representatives  
3 of the agency. If the agency finds that the entity is  
4 insolvent, the agency may draw upon the account solely with  
5 the two authorized signatures of representatives of the  
6 agency, and the funds may be disbursed to meet financial  
7 obligations incurred by the entity under the prepaid contract.  
8 If the contract is terminated, expired, or not continued, the  
9 account balance must be released by the agency to the entity  
10 upon receipt of proof of satisfaction of all outstanding  
11 obligations incurred under this contract.

12 (b) The agency may waive the insolvency protection  
13 account requirement in writing when evidence is on file with  
14 the agency of adequate insolvency insurance and reinsurance  
15 that will protect enrollees if the entity becomes unable to  
16 meet its obligations.

17 (19) An entity that contracts with the agency on a  
18 prepaid or fixed-sum basis for the provision of Medicaid  
19 services shall reimburse any hospital or physician that is  
20 outside the entity's authorized geographic service area as  
21 specified in its contract with the agency, and that provides  
22 services authorized by the entity to its members, at a rate  
23 negotiated with the hospital or physician for the provision of  
24 services or according to the lesser of the following:

25 (a) The usual and customary charges made to the  
26 general public by the hospital or physician; or

27 (b) The Florida Medicaid reimbursement rate  
28 established for the hospital or physician.

29 (20) When a merger or acquisition of a Medicaid  
30 prepaid contractor has been approved by the Office of  
31 Insurance Regulation pursuant to s. 628.4615, the agency shall

1 approve the assignment or transfer of the appropriate Medicaid  
2 prepaid contract upon request of the surviving entity of the  
3 merger or acquisition if the contractor and the other entity  
4 have been in good standing with the agency for the most recent  
5 12-month period, unless the agency determines that the  
6 assignment or transfer would be detrimental to the Medicaid  
7 recipients or the Medicaid program. To be in good standing,  
8 an entity must not have failed accreditation or committed any  
9 material violation of the requirements of s. 641.52 and must  
10 meet the Medicaid contract requirements. For purposes of this  
11 section, a merger or acquisition means a change in controlling  
12 interest of an entity, including an asset or stock purchase.

13 (21) Any entity contracting with the agency pursuant  
14 to this section to provide health care services to Medicaid  
15 recipients is prohibited from engaging in any of the following  
16 practices or activities:

17 (a) Practices that are discriminatory, including, but  
18 not limited to, attempts to discourage participation on the  
19 basis of actual or perceived health status.

20 (b) Activities that could mislead or confuse  
21 recipients, or misrepresent the organization, its marketing  
22 representatives, or the agency. Violations of this paragraph  
23 include, but are not limited to:

24 1. False or misleading claims that marketing  
25 representatives are employees or representatives of the state  
26 or county, or of anyone other than the entity or the  
27 organization by whom they are reimbursed.

28 2. False or misleading claims that the entity is  
29 recommended or endorsed by any state or county agency, or by  
30 any other organization which has not certified its endorsement  
31 in writing to the entity.

1           3. False or misleading claims that the state or county  
2 recommends that a Medicaid recipient enroll with an entity.

3           4. Claims that a Medicaid recipient will lose benefits  
4 under the Medicaid program, or any other health or welfare  
5 benefits to which the recipient is legally entitled, if the  
6 recipient does not enroll with the entity.

7           (c) Granting or offering of any monetary or other  
8 valuable consideration for enrollment, except as authorized by  
9 subsection (22).

10          (d) Door-to-door solicitation of recipients who have  
11 not contacted the entity or who have not invited the entity to  
12 make a presentation.

13          (e) Solicitation of Medicaid recipients by marketing  
14 representatives stationed in state offices unless approved and  
15 supervised by the agency or its agent and approved by the  
16 affected state agency when solicitation occurs in an office of  
17 the state agency. The agency shall ensure that marketing  
18 representatives stationed in state offices shall market their  
19 managed care plans to Medicaid recipients only in designated  
20 areas and in such a way as to not interfere with the  
21 recipients' activities in the state office.

22          (f) Enrollment of Medicaid recipients.

23          (22) The agency may impose a fine for a violation of  
24 this section or the contract with the agency by a person or  
25 entity that is under contract with the agency. With respect  
26 to any nonwillful violation, such fine shall not exceed \$2,500  
27 per violation. In no event shall such fine exceed an  
28 aggregate amount of \$10,000 for all nonwillful violations  
29 arising out of the same action. With respect to any knowing  
30 and willful violation of this section or the contract with the  
31 agency, the agency may impose a fine upon the entity in an

1 amount not to exceed \$20,000 for each such violation. In no  
2 event shall such fine exceed an aggregate amount of \$100,000  
3 for all knowing and willful violations arising out of the same  
4 action.

5 (23) A health maintenance organization or a person or  
6 entity exempt from chapter 641 that is under contract with the  
7 agency for the provision of health care services to Medicaid  
8 recipients may not use or distribute marketing materials used  
9 to solicit Medicaid recipients, unless such materials have  
10 been approved by the agency. The provisions of this subsection  
11 do not apply to general advertising and marketing materials  
12 used by a health maintenance organization to solicit both  
13 non-Medicaid subscribers and Medicaid recipients.

14 (24) Upon approval by the agency, health maintenance  
15 organizations and persons or entities exempt from chapter 641  
16 that are under contract with the agency for the provision of  
17 health care services to Medicaid recipients may be permitted  
18 within the capitation rate to provide additional health  
19 benefits that the agency has found are of high quality, are  
20 practicably available, provide reasonable value to the  
21 recipient, and are provided at no additional cost to the  
22 state.

23 (25) The agency shall utilize the statewide health  
24 maintenance organization complaint hotline for the purpose of  
25 investigating and resolving Medicaid and prepaid health plan  
26 complaints, maintaining a record of complaints and confirmed  
27 problems, and receiving disenrollment requests made by  
28 recipients.

29 (26) The agency shall require the publication of the  
30 health maintenance organization's and the prepaid health  
31 plan's consumer services telephone numbers and the "800"

1 telephone number of the statewide health maintenance  
2 organization complaint hotline on each Medicaid identification  
3 card issued by a health maintenance organization or prepaid  
4 health plan contracting with the agency to serve Medicaid  
5 recipients and on each subscriber handbook issued to a  
6 Medicaid recipient.

7 (27) The agency shall establish a health care quality  
8 improvement system for those entities contracting with the  
9 agency pursuant to this section, incorporating all the  
10 standards and guidelines developed by the Medicaid Bureau of  
11 the Health Care Financing Administration as a part of the  
12 quality assurance reform initiative. The system shall  
13 include, but need not be limited to, the following:

14 (a) Guidelines for internal quality assurance  
15 programs, including standards for:

- 16 1. Written quality assurance program descriptions.
- 17 2. Responsibilities of the governing body for  
18 monitoring, evaluating, and making improvements to care.
- 19 3. An active quality assurance committee.
- 20 4. Quality assurance program supervision.
- 21 5. Requiring the program to have adequate resources to  
22 effectively carry out its specified activities.
- 23 6. Provider participation in the quality assurance  
24 program.
- 25 7. Delegation of quality assurance program activities.
- 26 8. Credentialing and recredentialing.
- 27 9. Enrollee rights and responsibilities.
- 28 10. Availability and accessibility to services and  
29 care.
- 30 11. Ambulatory care facilities.

31



1           12. Accessibility and availability of medical records,  
2 as well as proper recordkeeping and process for record review.

3           13. Utilization review.

4           14. A continuity of care system.

5           15. Quality assurance program documentation.

6           16. Coordination of quality assurance activity with  
7 other management activity.

8           17. Delivering care to pregnant women and infants; to  
9 elderly and disabled recipients, especially those who are at  
10 risk of institutional placement; to persons with developmental  
11 disabilities; and to adults who have chronic, high-cost  
12 medical conditions.

13           (b) Guidelines which require the entities to conduct  
14 quality-of-care studies which:

15           1. Target specific conditions and specific health  
16 service delivery issues for focused monitoring and evaluation.

17           2. Use clinical care standards or practice guidelines  
18 to objectively evaluate the care the entity delivers or fails  
19 to deliver for the targeted clinical conditions and health  
20 services delivery issues.

21           3. Use quality indicators derived from the clinical  
22 care standards or practice guidelines to screen and monitor  
23 care and services delivered.

24           (c) Guidelines for external quality review of each  
25 contractor which require: focused studies of patterns of care;  
26 individual care review in specific situations; and followup  
27 activities on previous pattern-of-care study findings and  
28 individual-care-review findings. In designing the external  
29 quality review function and determining how it is to operate  
30 as part of the state's overall quality improvement system, the  
31 agency shall construct its external quality review

1 organization and entity contracts to address each of the  
2 following:

- 3 1. Delineating the role of the external quality review  
4 organization.
- 5 2. Length of the external quality review organization  
6 contract with the state.
- 7 3. Participation of the contracting entities in  
8 designing external quality review organization review  
9 activities.
- 10 4. Potential variation in the type of clinical  
11 conditions and health services delivery issues to be studied  
12 at each plan.
- 13 5. Determining the number of focused pattern-of-care  
14 studies to be conducted for each plan.
- 15 6. Methods for implementing focused studies.
- 16 7. Individual care review.
- 17 8. Followup activities.

18 (28) In order to ensure that children receive health  
19 care services for which an entity has already been  
20 compensated, an entity contracting with the agency pursuant to  
21 this section shall achieve an annual Early and Periodic  
22 Screening, Diagnosis, and Treatment (EPSDT) Service screening  
23 rate of at least 60 percent for those recipients continuously  
24 enrolled for at least 8 months. The agency shall develop a  
25 method by which the EPSDT screening rate shall be calculated.  
26 For any entity which does not achieve the annual 60 percent  
27 rate, the entity must submit a corrective action plan for the  
28 agency's approval. If the entity does not meet the standard  
29 established in the corrective action plan during the specified  
30 timeframe, the agency is authorized to impose appropriate  
31 contract sanctions. At least annually, the agency shall

1 publicly release the EPSDT Services screening rates of each  
2 entity it has contracted with on a prepaid basis to serve  
3 Medicaid recipients.

4 (29) The agency shall perform enrollments and  
5 disenrollments for Medicaid recipients who are eligible for  
6 MediPass or managed care plans. Notwithstanding the  
7 prohibition contained in paragraph (19)(f), managed care plans  
8 may perform preenrollments of Medicaid recipients under the  
9 supervision of the agency or its agents. For the purposes of  
10 this section, "preenrollment" means the provision of marketing  
11 and educational materials to a Medicaid recipient and  
12 assistance in completing the application forms, but shall not  
13 include actual enrollment into a managed care plan. An  
14 application for enrollment shall not be deemed complete until  
15 the agency or its agent verifies that the recipient made an  
16 informed, voluntary choice. The agency, in cooperation with  
17 the Department of Children and Family Services, may test new  
18 marketing initiatives to inform Medicaid recipients about  
19 their managed care options at selected sites. The agency shall  
20 report to the Legislature on the effectiveness of such  
21 initiatives. The agency may contract with a third party to  
22 perform managed care plan and MediPass enrollment and  
23 disenrollment services for Medicaid recipients and is  
24 authorized to adopt rules to implement such services. The  
25 agency may adjust the capitation rate only to cover the costs  
26 of a third-party enrollment and disenrollment contract, and  
27 for agency supervision and management of the managed care plan  
28 enrollment and disenrollment contract.

29 (30) Any lists of providers made available to Medicaid  
30 recipients, MediPass enrollees, or managed care plan enrollees  
31 shall be arranged alphabetically showing the provider's name

1 and specialty and, separately, by specialty in alphabetical  
2 order.

3 (31) The agency shall establish an enhanced managed  
4 care quality assurance oversight function, to include at least  
5 the following components:

6 (a) At least quarterly analysis and followup,  
7 including sanctions as appropriate, of managed care  
8 participant utilization of services.

9 (b) At least quarterly analysis and followup,  
10 including sanctions as appropriate, of quality findings of the  
11 Medicaid peer review organization and other external quality  
12 assurance programs.

13 (c) At least quarterly analysis and followup,  
14 including sanctions as appropriate, of the fiscal viability of  
15 managed care plans.

16 (d) At least quarterly analysis and followup,  
17 including sanctions as appropriate, of managed care  
18 participant satisfaction and disenrollment surveys.

19 (e) The agency shall conduct regular and ongoing  
20 Medicaid recipient satisfaction surveys.

21

22 The analyses and followup activities conducted by the agency  
23 under its enhanced managed care quality assurance oversight  
24 function shall not duplicate the activities of accreditation  
25 reviewers for entities regulated under part III of chapter  
26 641, but may include a review of the finding of such  
27 reviewers.

28 (32) Each managed care plan that is under contract  
29 with the agency to provide health care services to Medicaid  
30 recipients shall annually conduct a background check with the  
31 Florida Department of Law Enforcement of all persons with

1 ownership interest of 5 percent or more or executive  
2 management responsibility for the managed care plan and shall  
3 submit to the agency information concerning any such person  
4 who has been found guilty of, regardless of adjudication, or  
5 has entered a plea of nolo contendere or guilty to, any of the  
6 offenses listed in s. 435.03.

7 (33) The agency shall, by rule, develop a process  
8 whereby a Medicaid managed care plan enrollee who wishes to  
9 enter hospice care may be disenrolled from the managed care  
10 plan within 24 hours after contacting the agency regarding  
11 such request. The agency rule shall include a methodology for  
12 the agency to recoup managed care plan payments on a pro rata  
13 basis if payment has been made for the enrollment month when  
14 disenrollment occurs.

15 (34) The agency and entities which contract with the  
16 agency to provide health care services to Medicaid recipients  
17 under this section or s. 409.9122 must comply with the  
18 provisions of s. 641.513 in providing emergency services and  
19 care to Medicaid recipients and MediPass recipients.

20 (35) All entities providing health care services to  
21 Medicaid recipients shall make available, and encourage all  
22 pregnant women and mothers with infants to receive, and  
23 provide documentation in the medical records to reflect, the  
24 following:

25 (a) Healthy Start prenatal or infant screening.

26 (b) Healthy Start care coordination, when screening or  
27 other factors indicate need.

28 (c) Healthy Start enhanced services in accordance with  
29 the prenatal or infant screening results.

30 (d) Immunizations in accordance with recommendations  
31 of the Advisory Committee on Immunization Practices of the

1 United States Public Health Service and the American Academy  
2 of Pediatrics, as appropriate.

3 (e) Counseling and services for family planning to all  
4 women and their partners.

5 (f) A scheduled postpartum visit for the purpose of  
6 voluntary family planning, to include discussion of all  
7 methods of contraception, as appropriate.

8 (g) Referral to the Special Supplemental Nutrition  
9 Program for Women, Infants, and Children (WIC).

10 (36) Any entity that provides Medicaid prepaid health  
11 plan services shall ensure the appropriate coordination of  
12 health care services with an assisted living facility in cases  
13 where a Medicaid recipient is both a member of the entity's  
14 prepaid health plan and a resident of the assisted living  
15 facility. If the entity is at risk for Medicaid targeted case  
16 management and behavioral health services, the entity shall  
17 inform the assisted living facility of the procedures to  
18 follow should an emergent condition arise.

19 (37) The agency may seek and implement federal waivers  
20 necessary to provide for cost-effective purchasing of home  
21 health services, private duty nursing services,  
22 transportation, independent laboratory services, and durable  
23 medical equipment and supplies through competitive bidding  
24 pursuant to s. 287.057. The agency may request appropriate  
25 waivers from the federal Health Care Financing Administration  
26 in order to competitively bid such services. The agency may  
27 exclude providers not selected through the bidding process  
28 from the Medicaid provider network.

29 (38) The Agency for Health Care Administration is  
30 directed to issue a request for proposal or intent to  
31 negotiate to implement on a demonstration basis an outpatient

1 specialty services pilot project in a rural and urban county  
2 in the state. As used in this subsection, the term  
3 "outpatient specialty services" means clinical laboratory,  
4 diagnostic imaging, and specified home medical services to  
5 include durable medical equipment, prosthetics and orthotics,  
6 and infusion therapy.

7 (a) The entity that is awarded the contract to provide  
8 Medicaid managed care outpatient specialty services must, at a  
9 minimum, meet the following criteria:

10 1. The entity must be licensed by the Office of  
11 Insurance Regulation under part II of chapter 641.

12 2. The entity must be experienced in providing  
13 outpatient specialty services.

14 3. The entity must demonstrate to the satisfaction of  
15 the agency that it provides high-quality services to its  
16 patients.

17 4. The entity must demonstrate that it has in place a  
18 complaints and grievance process to assist Medicaid recipients  
19 enrolled in the pilot managed care program to resolve  
20 complaints and grievances.

21 (b) The pilot managed care program shall operate for a  
22 period of 3 years. The objective of the pilot program shall  
23 be to determine the cost-effectiveness and effects on  
24 utilization, access, and quality of providing outpatient  
25 specialty services to Medicaid recipients on a prepaid,  
26 capitated basis.

27 (c) The agency shall conduct a quality assurance  
28 review of the prepaid health clinic each year that the  
29 demonstration program is in effect. The prepaid health clinic  
30 is responsible for all expenses incurred by the agency in  
31 conducting a quality assurance review.

1           (d) The entity that is awarded the contract to provide  
2 outpatient specialty services to Medicaid recipients shall  
3 report data required by the agency in a format specified by  
4 the agency, for the purpose of conducting the evaluation  
5 required in paragraph (e).

6           (e) The agency shall conduct an evaluation of the  
7 pilot managed care program and report its findings to the  
8 Governor and the Legislature by no later than January 1, 2001.

9           (39) The agency shall enter into agreements with  
10 not-for-profit organizations based in this state for the  
11 purpose of providing vision screening.

12           (40)(a) The agency shall implement a Medicaid  
13 prescribed-drug spending-control program that includes the  
14 following components:

15           1. Medicaid prescribed-drug coverage for brand-name  
16 drugs for adult Medicaid recipients is limited to the  
17 dispensing of four brand-name drugs per month per recipient.  
18 Children are exempt from this restriction. Antiretroviral  
19 agents are excluded from this limitation. No requirements for  
20 prior authorization or other restrictions on medications used  
21 to treat mental illnesses such as schizophrenia, severe  
22 depression, or bipolar disorder may be imposed on Medicaid  
23 recipients. Medications that will be available without  
24 restriction for persons with mental illnesses include atypical  
25 antipsychotic medications, conventional antipsychotic  
26 medications, selective serotonin reuptake inhibitors, and  
27 other medications used for the treatment of serious mental  
28 illnesses. The agency shall also limit the amount of a  
29 prescribed drug dispensed to no more than a 34-day supply. The  
30 agency shall continue to provide unlimited generic drugs,  
31 contraceptive drugs and items, and diabetic supplies. Although



1 a drug may be included on the preferred drug formulary, it  
2 would not be exempt from the four-brand limit. The agency may  
3 authorize exceptions to the brand-name-drug restriction based  
4 upon the treatment needs of the patients, only when such  
5 exceptions are based on prior consultation provided by the  
6 agency or an agency contractor, but the agency must establish  
7 procedures to ensure that:

8 a. There will be a response to a request for prior  
9 consultation by telephone or other telecommunication device  
10 within 24 hours after receipt of a request for prior  
11 consultation;

12 b. A 72-hour supply of the drug prescribed will be  
13 provided in an emergency or when the agency does not provide a  
14 response within 24 hours as required by sub-subparagraph a.;  
15 and

16 c. Except for the exception for nursing home residents  
17 and other institutionalized adults and except for drugs on the  
18 restricted formulary for which prior authorization may be  
19 sought by an institutional or community pharmacy, prior  
20 authorization for an exception to the brand-name-drug  
21 restriction is sought by the prescriber and not by the  
22 pharmacy. When prior authorization is granted for a patient in  
23 an institutional setting beyond the brand-name-drug  
24 restriction, such approval is authorized for 12 months and  
25 monthly prior authorization is not required for that patient.

26 2. Reimbursement to pharmacies for Medicaid prescribed  
27 drugs shall be set at the average wholesale price less 13.25  
28 percent.

29 3. The agency shall develop and implement a process  
30 for managing the drug therapies of Medicaid recipients who are  
31 using significant numbers of prescribed drugs each month. The

1 management process may include, but is not limited to,  
2 comprehensive, physician-directed medical-record reviews,  
3 claims analyses, and case evaluations to determine the medical  
4 necessity and appropriateness of a patient's treatment plan  
5 and drug therapies. The agency may contract with a private  
6 organization to provide drug-program-management services. The  
7 Medicaid drug benefit management program shall include  
8 initiatives to manage drug therapies for HIV/AIDS patients,  
9 patients using 20 or more unique prescriptions in a 180-day  
10 period, and the top 1,000 patients in annual spending. The  
11 agency shall enroll any Medicaid recipient in the drug benefit  
12 management program if he or she meets the specifications of  
13 this provision and is not enrolled in a Medicaid health  
14 maintenance organization.

15 4. The agency may limit the size of its pharmacy  
16 network based on need, competitive bidding, price  
17 negotiations, credentialing, or similar criteria. The agency  
18 shall give special consideration to rural areas in determining  
19 the size and location of pharmacies included in the Medicaid  
20 pharmacy network. A pharmacy credentialing process may include  
21 criteria such as a pharmacy's full-service status, location,  
22 size, patient educational programs, patient consultation,  
23 disease-management services, and other characteristics. The  
24 agency may impose a moratorium on Medicaid pharmacy enrollment  
25 when it is determined that it has a sufficient number of  
26 Medicaid-participating providers.

27 5. The agency shall develop and implement a program  
28 that requires Medicaid practitioners who prescribe drugs to  
29 use a counterfeit-proof prescription pad for Medicaid  
30 prescriptions. The agency shall require the use of  
31 standardized counterfeit-proof prescription pads by

1 Medicaid-participating prescribers or prescribers who write  
2 prescriptions for Medicaid recipients. The agency may  
3 implement the program in targeted geographic areas or  
4 statewide.

5           6. The agency may enter into arrangements that require  
6 manufacturers of generic drugs prescribed to Medicaid  
7 recipients to provide rebates of at least 15.1 percent of the  
8 average manufacturer price for the manufacturer's generic  
9 products. These arrangements shall require that if a  
10 generic-drug manufacturer pays federal rebates for  
11 Medicaid-reimbursed drugs at a level below 15.1 percent, the  
12 manufacturer must provide a supplemental rebate to the state  
13 in an amount necessary to achieve a 15.1-percent rebate level.

14           7. The agency may establish a preferred drug formulary  
15 in accordance with 42 U.S.C. s. 1396r-8, and, pursuant to the  
16 establishment of such formulary, it is authorized to negotiate  
17 supplemental rebates from manufacturers that are in addition  
18 to those required by Title XIX of the Social Security Act and  
19 at no less than 10 percent of the average manufacturer price  
20 as defined in 42 U.S.C. s. 1936 on the last day of a quarter  
21 unless the federal or supplemental rebate, or both, equals or  
22 exceeds 25 percent. There is no upper limit on the  
23 supplemental rebates the agency may negotiate. The agency may  
24 determine that specific products, brand-name or generic, are  
25 competitive at lower rebate percentages. Agreement to pay the  
26 minimum supplemental rebate percentage will guarantee a  
27 manufacturer that the Medicaid Pharmaceutical and Therapeutics  
28 Committee will consider a product for inclusion on the  
29 preferred drug formulary. However, a pharmaceutical  
30 manufacturer is not guaranteed placement on the formulary by  
31 simply paying the minimum supplemental rebate. Agency

1 decisions will be made on the clinical efficacy of a drug and  
2 recommendations of the Medicaid Pharmaceutical and  
3 Therapeutics Committee, as well as the price of competing  
4 products minus federal and state rebates. The agency is  
5 authorized to contract with an outside agency or contractor to  
6 conduct negotiations for supplemental rebates. For the  
7 purposes of this section, the term "supplemental rebates" may  
8 include, at the agency's discretion, cash rebates and other  
9 program benefits that offset a Medicaid expenditure. Such  
10 other program benefits may include, but are not limited to,  
11 disease management programs, drug product donation programs,  
12 drug utilization control programs, prescriber and beneficiary  
13 counseling and education, fraud and abuse initiatives, and  
14 other services or administrative investments with guaranteed  
15 savings to the Medicaid program in the same year the rebate  
16 reduction is included in the General Appropriations Act. The  
17 agency is authorized to seek any federal waivers to implement  
18 this initiative.

19       8. The agency shall establish an advisory committee  
20 for the purposes of studying the feasibility of using a  
21 restricted drug formulary for nursing home residents and other  
22 institutionalized adults. The committee shall be comprised of  
23 seven members appointed by the Secretary of Health Care  
24 Administration. The committee members shall include two  
25 physicians licensed under chapter 458 or chapter 459; three  
26 pharmacists licensed under chapter 465 and appointed from a  
27 list of recommendations provided by the Florida Long-Term Care  
28 Pharmacy Alliance; and two pharmacists licensed under chapter  
29 465.

30       9. The Agency for Health Care Administration shall  
31 expand home delivery of pharmacy products. To assist Medicaid

1 patients in securing their prescriptions and reduce program  
2 costs, the agency shall expand its current mail-order-pharmacy  
3 diabetes-supply program to include all generic and brand-name  
4 drugs used by Medicaid patients with diabetes. Medicaid  
5 recipients in the current program may obtain nondiabetes drugs  
6 on a voluntary basis. This initiative is limited to the  
7 geographic area covered by the current contract. The agency  
8 may seek and implement any federal waivers necessary to  
9 implement this subparagraph.

10 (b) The agency shall implement this subsection to the  
11 extent that funds are appropriated to administer the Medicaid  
12 prescribed-drug spending-control program. The agency may  
13 contract all or any part of this program to private  
14 organizations.

15 (c) The agency shall submit quarterly reports to the  
16 Governor, the President of the Senate, and the Speaker of the  
17 House of Representatives which must include, but need not be  
18 limited to, the progress made in implementing this subsection  
19 and its effect on Medicaid prescribed-drug expenditures.

20 (41) Notwithstanding the provisions of chapter 287,  
21 the agency may, at its discretion, renew a contract or  
22 contracts for fiscal intermediary services one or more times  
23 for such periods as the agency may decide; however, all such  
24 renewals may not combine to exceed a total period longer than  
25 the term of the original contract.

26 (42) The agency shall provide for the development of a  
27 demonstration project by establishment in Miami-Dade County of  
28 a long-term-care facility licensed pursuant to chapter 395 to  
29 improve access to health care for a predominantly minority,  
30 medically underserved, and medically complex population and to  
31 evaluate alternatives to nursing home care and general acute

1 care for such population. Such project is to be located in a  
2 health care condominium and colocated with licensed facilities  
3 providing a continuum of care. The establishment of this  
4 project is not subject to the provisions of s. 408.036 or s.  
5 408.039. The agency shall report its findings to the  
6 Governor, the President of the Senate, and the Speaker of the  
7 House of Representatives by January 1, 2003.

8 (43) The agency shall develop and implement a  
9 utilization management program for Medicaid-eligible  
10 recipients for the management of occupational, physical,  
11 respiratory, and speech therapies. The agency shall establish  
12 a utilization program that may require prior authorization in  
13 order to ensure medically necessary and cost-effective  
14 treatments. The program shall be operated in accordance with a  
15 federally approved waiver program or state plan amendment. The  
16 agency may seek a federal waiver or state plan amendment to  
17 implement this program. The agency may also competitively  
18 procure these services from an outside vendor on a regional or  
19 statewide basis.

20 (44) The agency may contract on a prepaid or fixed-sum  
21 basis with appropriately licensed prepaid dental health plans  
22 to provide dental services.

23 (45) Subject to the availability of funds, the agency  
24 shall mandate a recipient's participation in a provider  
25 lock-in program, when appropriate, if a recipient is found by  
26 the agency to have used Medicaid goods or services at a  
27 frequency or amount not medically necessary, limiting the  
28 receipt of goods or services to medically necessary providers  
29 after the 21-day appeal process has ended, for a period of not  
30 less than 1 year. The lock-in programs shall include, but are  
31 not limited to, pharmacies, medical doctors, and infusion

1 clinics. The limitation does not apply to emergency services  
2 and care provided to the recipient in a hospital emergency  
3 department. The agency shall seek any federal waivers  
4 necessary to implement this subsection. The agency shall adopt  
5 any rules necessary to comply with or administer this  
6 subsection.

7 (46) The agency shall seek a federal waiver for  
8 permission to terminate the eligibility of a Medicaid  
9 recipient who has been found to have committed fraud, through  
10 judicial or administrative determination, two times in a  
11 period of five years.

12 (47) The agency shall conduct a study of available  
13 electronic systems for the purpose of verifying the identity  
14 and eligibility of a Medicaid recipient. The agency shall  
15 recommend to the Legislature a plan to implement an electronic  
16 verification system for Medicaid recipients by January 31,  
17 2005.

18 (48) A provider is not entitled to enrollment in the  
19 Medicaid provider network. The agency may implement a Medicaid  
20 fee for service provider network controls, including, but not  
21 limited to, competitive procurement and provider  
22 credentialing. If a credentialing process is used, the agency  
23 may limit its provider network based upon the following  
24 considerations: beneficiary access to care, provider  
25 availability, provider quality standards and quality assurance  
26 processes, cultural competency, demographic characteristics of  
27 beneficiaries, practice standards, service wait times,  
28 provider turnover, provider licensure and accreditation  
29 history, program integrity history, peer review, Medicaid  
30 policy and billing compliance records, clinical and medical  
31 record audit findings, and such other areas that are

1 considered necessary by the agency to ensure the integrity of  
2 the program.

3 Section 6. Section 409.913, Florida Statutes, is  
4 amended to read:

5 409.913 Oversight of the integrity of the Medicaid  
6 program.--The agency shall operate a program to oversee the  
7 activities of Florida Medicaid recipients, and providers and  
8 their representatives, to ensure that fraudulent and abusive  
9 behavior and neglect of recipients occur to the minimum extent  
10 possible, and to recover overpayments and impose sanctions as  
11 appropriate. Beginning January 1, 2003, and each year  
12 thereafter, the agency and the Medicaid Fraud Control Unit of  
13 the Department of Legal Affairs shall submit a joint report to  
14 the Legislature documenting the effectiveness of the state's  
15 efforts to control Medicaid fraud and abuse and to recover  
16 Medicaid overpayments during the previous fiscal year. The  
17 report must describe the number of cases opened and  
18 investigated each year; the sources of the cases opened; the  
19 disposition of the cases closed each year; the amount of  
20 overpayments alleged in preliminary and final audit letters;  
21 the number and amount of fines or penalties imposed; any  
22 reductions in overpayment amounts negotiated in settlement  
23 agreements or by other means; the amount of final agency  
24 determinations of overpayments; the amount deducted from  
25 federal claiming as a result of overpayments; the amount of  
26 overpayments recovered each year; the amount of cost of  
27 investigation recovered each year; the average length of time  
28 to collect from the time the case was opened until the  
29 overpayment is paid in full; the amount determined as  
30 uncollectible and the portion of the uncollectible amount  
31 subsequently reclaimed from the Federal Government; the number



1 of providers, by type, that are terminated from participation  
2 in the Medicaid program as a result of fraud and abuse; and  
3 all costs associated with discovering and prosecuting cases of  
4 Medicaid overpayments and making recoveries in such cases. The  
5 report must also document actions taken to prevent  
6 overpayments and the number of providers prevented from  
7 enrolling in or reenrolling in the Medicaid program as a  
8 result of documented Medicaid fraud and abuse and must  
9 recommend changes necessary to prevent or recover  
10 overpayments. ~~For the 2001-2002 fiscal year, the agency shall~~  
11 ~~prepare a report that contains as much of this information as~~  
12 ~~is available to it.~~

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

14 (a) "Abuse" means:

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

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

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

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

30 (d) "Medical necessity" or "medically necessary" means  
31 any goods or services necessary to palliate the effects of a

1 terminal condition, or to prevent, diagnose, correct, cure,  
2 alleviate, or preclude deterioration of a condition that  
3 threatens life, causes pain or suffering, or results in  
4 illness or infirmity, which goods or services are provided in  
5 accordance with generally accepted standards of medical  
6 practice. For purposes of determining Medicaid reimbursement,  
7 the agency is the final arbiter of medical necessity.  
8 Determinations of medical necessity must be made by a licensed  
9 physician employed by or under contract with the agency and  
10 must be based upon information available at the time the goods  
11 or services are provided.

12 (e) "Overpayment" includes any amount that is not  
13 authorized to be paid by the Medicaid program whether paid as  
14 a result of inaccurate or improper cost reporting, improper  
15 claiming, unacceptable practices, fraud, abuse, or mistake.

16 (f) "Person" means any natural person, corporation,  
17 partnership, association, clinic, group, or other entity,  
18 whether or not such person is enrolled in the Medicaid program  
19 or is a provider of health care.

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

26 (3) The agency may conduct, or may contract for,  
27 prepayment review of provider claims to ensure cost-effective  
28 purchasing; to ensure that, billing by a provider to the  
29 agency is in accordance with applicable provisions of all  
30 Medicaid rules, regulations, handbooks, and policies and in  
31 accordance with federal, state, and local law; and to ensure

1 that appropriate ~~provision of~~ care is rendered 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, and may last for up to  
5 1 year. Unless the agency has reliable evidence of fraud,  
6 misrepresentation, abuse, or neglect, claims shall be  
7 adjudicated for denial or payment within 90 days after receipt  
8 of complete documentation by the agency for review. If there  
9 is reliable evidence of fraud, misrepresentation, abuse, or  
10 neglect, claims shall be adjudicated for denial of payment  
11 within 180 days after receipt of complete documentation by the  
12 agency for review.

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

31

1           (5) A Medicaid provider is subject to having goods and  
2 services that are paid for by the Medicaid program reviewed by  
3 an appropriate peer-review organization designated by the  
4 agency. The written findings of the applicable peer-review  
5 organization are admissible in any court or administrative  
6 proceeding as evidence of medical necessity or the lack  
7 thereof.

8           (6) Any notice required to be given to a provider  
9 under this section is presumed to be sufficient notice if sent  
10 to the address last shown on the provider enrollment file. It  
11 is the responsibility of the provider to furnish and keep the  
12 agency informed of the provider's current address. United  
13 States Postal Service proof of mailing or certified or  
14 registered mailing of such notice to the provider at the  
15 address shown on the provider enrollment file constitutes  
16 sufficient proof of notice. Any notice required to be given to  
17 the agency by this section must be sent to the agency at an  
18 address designated by rule.

19           (7) When presenting a claim for payment under the  
20 Medicaid program, a provider has an affirmative duty to  
21 supervise the provision of, and be responsible for, goods and  
22 services claimed to have been provided, to supervise and be  
23 responsible for preparation and submission of the claim, and  
24 to present a claim that is true and accurate and that is for  
25 goods and services that:

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

28           (b) Are Medicaid-covered goods or services that are  
29 medically necessary.

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

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

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

8 (f) Are documented by records made at the time the  
9 goods or services were provided, demonstrating the medical  
10 necessity for the goods or services rendered. Medicaid goods  
11 or services are excessive or not medically necessary unless  
12 both the medical basis and the specific need for them are  
13 fully and properly documented in the recipient's medical  
14 record.

15  
16 The agency may deny payment or require repayment for goods or  
17 services that are not presented as required in this  
18 subsection.

19 (8) The agency shall not reimburse any person or  
20 entity for any prescription for medications, medical supplies,  
21 or medical services if the prescription was written by a  
22 physician or other prescribing practitioner who is not  
23 enrolled in the Medicaid program. This section does not apply:

24 (a) In instances involving bona fide emergency medical  
25 conditions as determined by the agency;

26 (b) To a provider of medical services to a patient in  
27 a hospital emergency department, hospital inpatient or  
28 outpatient setting, or nursing home;

29 (c) To bono fide pro bono services by preapproved  
30 non-Medicaid providers as determined by the agency;

31

1           (d) To prescribing physicians who are board-certified  
2 specialists treating Medicaid recipients referred for  
3 treatment by a treating physician who is enrolled in the  
4 Medicaid program;

5           (e) To prescriptions written for dually eligible  
6 Medicare beneficiaries by an authorized Medicare provider who  
7 is not enrolled in the Medicaid program;

8           (f) To other physicians who are not enrolled in the  
9 Medicaid program but who provide a medically necessary service  
10 or prescription not otherwise reasonably available from a  
11 Medicaid-enrolled physician; or

12           (g) In instances where the agency cannot practically  
13 notify a pharmacy at the point of sale that a prescription  
14 will be approved for processing under paragraphs (a)-(f). This  
15 paragraph shall expire July 1, 2005.

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

30           ~~(10)(9)~~ Payments for the services of billing agents or  
31 persons participating in the preparation of a Medicaid claim

1 shall not be based on amounts for which they bill nor based on  
2 the amount a provider receives from the Medicaid program.

3 (11)~~(10)~~ The agency may deny payment or require  
4 repayment for inappropriate, medically unnecessary, or  
5 excessive goods or services from the person furnishing them,  
6 the person under whose supervision they were furnished, or the  
7 person causing them to be furnished.

8 (12)~~(11)~~ The complaint and all information obtained  
9 pursuant to an investigation of a Medicaid provider, or the  
10 authorized representative or agent of a provider, relating to  
11 an allegation of fraud, abuse, or neglect are confidential and  
12 exempt from the provisions of s. 119.07(1):

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

16 (b) Until the Attorney General refers the case for  
17 criminal prosecution;

18 (c) Until 10 days after the complaint is determined  
19 without merit; or

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

22 (13)~~(12)~~ The agency may terminate participation of a  
23 Medicaid provider in the Medicaid program and may seek civil  
24 remedies or impose other administrative sanctions against a  
25 Medicaid provider, if the provider has been:

26 (a) Convicted of a criminal offense related to the  
27 delivery of any health care goods or services, including the  
28 performance of management or administrative functions relating  
29 to the delivery of health care goods or services;

30  
31

1 (b) Convicted of a criminal offense under federal law  
2 or the law of any state relating to the practice of the  
3 provider's profession; or

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

7 (14)~~(13)~~ If the provider has been suspended or  
8 terminated from participation in the Medicaid program or the  
9 Medicare program by the Federal Government or any state, the  
10 agency must immediately suspend or terminate, as appropriate,  
11 the provider's participation in the Florida Medicaid program  
12 for a period no less than that imposed by the Federal  
13 Government or any other state, and may not enroll such  
14 provider in the Florida Medicaid program while such foreign  
15 suspension or termination remains in effect. This sanction is  
16 in addition to all other remedies provided by law.

17 (15)~~(14)~~ The agency may seek any remedy provided by  
18 law, including, but not limited to, the remedies provided in  
19 subsections (13)~~(12)~~ and (16)~~(15)~~ and s. 812.035, if:

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

23 (b) The provider has failed to make available or has  
24 refused access to Medicaid-related records to an auditor,  
25 investigator, or other authorized employee or agent of the  
26 agency, the Attorney General, a state attorney, or the Federal  
27 Government;

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



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

5 (e) The provider is not in compliance with provisions  
6 of Medicaid provider publications that have been adopted by  
7 reference as rules in the Florida Administrative Code; with  
8 provisions of state or federal laws, rules, or regulations;  
9 with provisions of the provider agreement between the agency  
10 and the provider; or with certifications found on claim forms  
11 or on transmittal forms for electronically submitted claims  
12 that are submitted by the provider or authorized  
13 representative, as such provisions apply to the Medicaid  
14 program;

15 (f) The provider or person who ordered or prescribed  
16 the care, services, or supplies has furnished, or ordered the  
17 furnishing of, goods or services to a recipient which are  
18 inappropriate, unnecessary, excessive, or harmful to the  
19 recipient or are of inferior quality;

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

22 (h) The provider or an authorized representative of  
23 the provider, or a person who ordered or prescribed the goods  
24 or services, has submitted or caused to be submitted false or  
25 a pattern of erroneous Medicaid claims ~~that have resulted in~~  
26 ~~overpayments to a provider or that exceed those to which the~~  
27 ~~provider was entitled under the Medicaid program;~~

28 (i) The provider or an authorized representative of  
29 the provider, or a person who has ordered or prescribed the  
30 goods or services, has submitted or caused to be submitted a  
31 Medicaid provider enrollment application, a request for prior

1 authorization for Medicaid services, a drug exception request,  
2 or a Medicaid cost report that contains materially false or  
3 incorrect information;

4 (j) The provider or an authorized representative of  
5 the provider has collected from or billed a recipient or a  
6 recipient's responsible party improperly for amounts that  
7 should not have been so collected or billed by reason of the  
8 provider's billing the Medicaid program for the same service;

9 (k) The provider or an authorized representative of  
10 the provider has included in a cost report costs that are not  
11 allowable under a Florida Title XIX reimbursement plan, after  
12 the provider or authorized representative had been advised in  
13 an audit exit conference or audit report that the costs were  
14 not allowable;

15 (l) The provider is charged by information or  
16 indictment with fraudulent billing practices. The sanction  
17 applied for this reason is limited to suspension of the  
18 provider's participation in the Medicaid program for the  
19 duration of the indictment unless the provider is found guilty  
20 pursuant to the information or indictment;

21 (m) The provider or a person who has ordered, or  
22 prescribed the goods or services is found liable for negligent  
23 practice resulting in death or injury to the provider's  
24 patient;

25 (n) The provider fails to demonstrate that it had  
26 available during a specific audit or review period sufficient  
27 quantities of goods, or sufficient time in the case of  
28 services, to support the provider's billings to the Medicaid  
29 program;

30 (o) The provider has failed to comply with the notice  
31 and reporting requirements of s. 409.907;

1 (p) The agency has received reliable information of  
2 patient abuse or neglect or of any act prohibited by s.  
3 409.920; or

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

6 ~~(16)~~~~(15)~~ The agency shall impose any of the following  
7 sanctions or disincentives on a provider or a person for any  
8 of the acts described in subsection~~(15)~~~~(14)~~:

9 (a) Suspension for a specific period of time of not  
10 more than 1 year. Suspension shall preclude participation in  
11 the Medicaid program, which includes any action that results  
12 in a claim for payment to the Medicaid program as a result of  
13 furnishing, supervising a person who is furnishing, or causing  
14 a person to furnish goods or services.

15 (b) Termination for a specific period of time of from  
16 more than 1 year to 20 years. Termination shall preclude  
17 participation in the Medicaid program, which includes any  
18 action that results in a claim for payment to the Medicaid  
19 program as a result of furnishing, supervising a person who is  
20 furnishing, or causing a person to furnish goods or services.

21 (c) Imposition of a fine of up to \$5,000 for each  
22 violation. Each day that an ongoing violation continues, such  
23 as refusing to furnish Medicaid-related records or refusing  
24 access to records, is considered, for the purposes of this  
25 section, to be a separate violation. Each instance of  
26 improper billing of a Medicaid recipient; each instance of  
27 including an unallowable cost on a hospital or nursing home  
28 Medicaid cost report after the provider or authorized  
29 representative has been advised in an audit exit conference or  
30 previous audit report of the cost unallowability; each  
31 instance of furnishing a Medicaid recipient goods or

1 professional services that are inappropriate or of inferior  
2 quality as determined by competent peer judgment; each  
3 instance of knowingly submitting a materially false or  
4 erroneous Medicaid provider enrollment application, request  
5 for prior authorization for Medicaid services, drug exception  
6 request, or cost report; each instance of inappropriate  
7 prescribing of drugs for a Medicaid recipient as determined by  
8 competent peer judgment; and each false or erroneous Medicaid  
9 claim leading to an overpayment to a provider is considered,  
10 for the purposes of this section, to be a separate violation.

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

15 (e) A fine, not to exceed \$10,000, for a violation of  
16 paragraph (15)(i) ~~(14)(i)~~.

17 (f) Imposition of liens against provider assets,  
18 including, but not limited to, financial assets and real  
19 property, not to exceed the amount of fines or recoveries  
20 sought, upon entry of an order determining that such moneys  
21 are due or recoverable.

22 (g) Prepayment reviews of claims for a specified  
23 period of time.

24 (h) Comprehensive followup reviews of providers every  
25 6 months to ensure that they are billing Medicaid correctly.

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

29 (j) Other remedies as permitted by law to effect the  
30 recovery of a fine or overpayment.

31

1 The Secretary of Health Care Administration may make a  
2 determination that imposition of a sanction or disincentive is  
3 not in the best interest of the Medicaid program, in which  
4 case a sanction or disincentive shall not be imposed.

5 (17)~~(16)~~ In determining the appropriate administrative  
6 sanction to be applied, or the duration of any suspension or  
7 termination, the agency shall consider:

8 (a) The seriousness and extent of the violation or  
9 violations.

10 (b) Any prior history of violations by the provider  
11 relating to the delivery of health care programs which  
12 resulted in either a criminal conviction or in administrative  
13 sanction or penalty.

14 (c) Evidence of continued violation within the  
15 provider's management control of Medicaid statutes, rules,  
16 regulations, or policies after written notification to the  
17 provider of improper practice or instance of violation.

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

21 (e) Any action by a licensing agency respecting the  
22 provider in any state in which the provider operates or has  
23 operated.

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

27  
28 The agency shall document the basis for all sanctioning  
29 actions and recommendations.

30 (18)~~(17)~~ The agency may take action to sanction,  
31 suspend, or terminate a particular provider working for a

1 group provider, and may suspend or terminate Medicaid  
2 participation at a specific location, rather than or in  
3 addition to taking action against an entire group.

4 (19)~~(18)~~ The agency shall establish a process for  
5 conducting followup reviews of a sampling of providers who  
6 have a history of overpayment under the Medicaid program.  
7 This process must consider the magnitude of previous fraud or  
8 abuse and the potential effect of continued fraud or abuse on  
9 Medicaid costs.

10 (20)~~(19)~~ In making a determination of overpayment to a  
11 provider, the agency must use accepted and valid auditing,  
12 accounting, analytical, statistical, or peer-review methods,  
13 or combinations thereof. Appropriate statistical methods may  
14 include, but are not limited to, sampling and extension to the  
15 population, parametric and nonparametric statistics, tests of  
16 hypotheses, and other generally accepted statistical methods.  
17 Appropriate analytical methods may include, but are not  
18 limited to, reviews to determine variances between the  
19 quantities of products that a provider had on hand and  
20 available to be purveyed to Medicaid recipients during the  
21 review period and the quantities of the same products paid for  
22 by the Medicaid program for the same period, taking into  
23 appropriate consideration sales of the same products to  
24 non-Medicaid customers during the same period. In meeting its  
25 burden of proof in any administrative or court proceeding, the  
26 agency may introduce the results of such statistical methods  
27 as evidence of overpayment.

28 (21)~~(20)~~ When making a determination that an  
29 overpayment has occurred, the agency shall prepare and issue  
30 an audit report to the provider showing the calculation of  
31 overpayments.

1           (22)~~(21)~~ The audit report, supported by agency work  
2 papers, showing an overpayment to a provider constitutes  
3 evidence of the overpayment. A provider may not present or  
4 elicit testimony, either on direct examination or  
5 cross-examination in any court or administrative proceeding,  
6 regarding the purchase or acquisition by any means of drugs,  
7 goods, or supplies; sales or divestment by any means of drugs,  
8 goods, or supplies; or inventory of drugs, goods, or supplies,  
9 unless such acquisition, sales, divestment, or inventory is  
10 documented by written invoices, written inventory records, or  
11 other competent written documentary evidence maintained in the  
12 normal course of the provider's business. Notwithstanding the  
13 applicable rules of discovery, all documentation that will be  
14 offered as evidence at an administrative hearing on a Medicaid  
15 overpayment must be exchanged by all parties at least 14 days  
16 before the administrative hearing or must be excluded from  
17 consideration.

18           (23)~~(22)~~(a) In an audit or investigation of a  
19 violation committed by a provider which is conducted pursuant  
20 to this section, the agency is entitled to recover all  
21 investigative, legal, and expert witness costs if the agency's  
22 findings were not contested by the provider or, if contested,  
23 the agency ultimately prevailed.

24           (b) The agency has the burden of documenting the  
25 costs, which includes salaries and employee benefits and  
26 out-of-pocket expenses. The amount of costs that may be  
27 recovered must be reasonable in relation to the seriousness of  
28 the violation and must be set taking into consideration the  
29 financial resources, earning ability, and needs of the  
30 provider, who has the burden of demonstrating such factors.

31

1 (c) The provider may pay the costs over a period to be  
2 determined by the agency if the agency determines that an  
3 extreme hardship would result to the provider from immediate  
4 full payment. Any default in payment of costs may be  
5 collected by any means authorized by law.

6 ~~(24)(23)~~ If the agency imposes an administrative  
7 sanction pursuant to subsection (13), subsection (14), or  
8 subsection (15), except paragraphs (15)(e) and (o),~~under this~~  
9 ~~section~~ upon any provider or other person who is regulated by  
10 another state entity, the agency shall notify that other  
11 entity of the imposition of the sanction. Such notification  
12 must include the provider's or person's name and license  
13 number and the specific reasons for sanction.

14 ~~(25)(24)~~(a) The agency may withhold Medicaid payments,  
15 in whole or in part, to a provider upon receipt of reliable  
16 evidence that the circumstances giving rise to the need for a  
17 withholding of payments involve fraud, willful  
18 misrepresentation, or abuse under the Medicaid program, or a  
19 crime committed while rendering goods or services to Medicaid  
20 recipients, ~~pending completion of legal proceedings~~. If it is  
21 determined that fraud, willful misrepresentation, abuse, or a  
22 crime did not occur, the payments withheld must be paid to the  
23 provider within 14 days after such determination with interest  
24 at the rate of 10 percent a year. Any money withheld in  
25 accordance with this paragraph shall be placed in a suspended  
26 account, readily accessible to the agency, so that any payment  
27 ultimately due the provider shall be made within 14 days.

28 (b) The agency may deny payment, or require repayment,  
29 if the goods or services were furnished, supervised, or caused  
30 to be furnished by a person who has been suspended or  
31



1 terminated from the Medicaid program or Medicare program by  
2 the Federal Government or any state.

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

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

18 (e) The agency may institute amnesty programs to allow  
19 Medicaid providers the opportunity to voluntarily repay  
20 overpayments. The agency may adopt rules to administer such  
21 programs.

22 (26)(25) The agency may impose administrative  
23 sanctions against a Medicaid recipient, or the agency may seek  
24 any other remedy provided by law, including, but not limited  
25 to, the remedies provided in s. 812.035, if the agency finds  
26 that a recipient has engaged in solicitation in violation of  
27 s. 409.920 or that the recipient has otherwise abused the  
28 Medicaid program.

29 (27)(26) When the Agency for Health Care  
30 Administration has made a probable cause determination and  
31

1 alleged that an overpayment to a Medicaid provider has  
2 occurred, the agency, 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 (28)~~(27)~~ Venue for all Medicaid program integrity  
16 overpayment cases shall lie in Leon County, at the discretion  
17 of the agency.

18 (29)~~(28)~~ Notwithstanding other provisions of law, the  
19 agency and the Medicaid Fraud Control Unit of the Department  
20 of Legal Affairs may review a provider's Medicaid-related and  
21 non-Medicaid-related records in order to determine the total  
22 output of a provider's practice to reconcile quantities of  
23 goods or services billed to Medicaid with ~~against~~ quantities  
24 of goods or services used in the provider's total practice.

25 (30)~~(29)~~ The agency may terminate a provider's  
26 participation in the Medicaid program if the provider fails to  
27 reimburse an overpayment that has been determined by final  
28 order, not subject to further appeal, within 35 days after the  
29 date of the final order, unless the provider and the agency  
30 have entered into a repayment agreement.

31

1           ~~(31)(30)~~ If a provider requests an administrative  
2 hearing pursuant to chapter 120, such hearing must be  
3 conducted within 90 days following assignment of an  
4 administrative law judge, absent exceptionally good cause  
5 shown as determined by the administrative law judge or hearing  
6 officer. Upon issuance of a final order, the outstanding  
7 balance of the amount determined to constitute the overpayment  
8 shall become due. If a provider fails to make payments in  
9 full, fails to enter into a satisfactory repayment plan, or  
10 fails to comply with the terms of a repayment plan or  
11 settlement agreement, the agency may withhold medical  
12 assistance reimbursement payments until the amount due is paid  
13 in full.

14           ~~(32)(31)~~ Duly authorized agents and employees of the  
15 agency shall have the power to inspect, during normal business  
16 hours, the records of any pharmacy, wholesale establishment,  
17 or manufacturer, or any other place in which drugs and medical  
18 supplies are manufactured, packed, packaged, made, stored,  
19 sold, or kept for sale, for the purpose of verifying the  
20 amount of drugs and medical supplies ordered, delivered, or  
21 purchased by a provider. The agency shall provide at least 2  
22 business days' prior notice of any such inspection. The notice  
23 must identify the provider whose records will be inspected,  
24 and the inspection shall include only records specifically  
25 related to that provider.

26           (33) In accordance with federal law, Medicaid  
27 recipients convicted of a crime pursuant to 42 U.S.C. 1320a-7b  
28 may be limited, restricted, or suspended from Medicaid  
29 eligibility for a period not to exceed 1 year, as determined  
30 by the agency head or designee.

31

1           (34) To deter fraud and abuse in the Medicaid program,  
2 the agency may limit the number of Schedule II and Schedule  
3 III refill prescription claims submitted from a pharmacy  
4 provider. The agency shall limit the allowable amount of  
5 reimbursement of prescription refill claims for Schedule II  
6 and Schedule III pharmaceuticals if the agency or the Medicaid  
7 Fraud Control Unit determines that the specific prescription  
8 refill was not requested by the Medicaid recipient or  
9 authorized representative for whom the refill claim is  
10 submitted or was not prescribed by the recipient's medical  
11 provider or physician. Any such refill request must be  
12 consistent with the original prescription.

13           (35) The Office of Program Policy Analysis and  
14 Government Accountability shall provide a report to the  
15 President of the Senate and the Speaker of the House of  
16 Representatives on a biennial basis, beginning January 31,  
17 2006, on the agency's efforts to prevent, detect, and deter,  
18 as well as recover funds lost to, fraud and abuse in the  
19 Medicaid program.

20           Section 7. Paragraph (d) of subsection (2) and  
21 paragraph (b) of subsection (5) of section 409.9131, Florida  
22 Statutes, are amended, and subsection (6) is added to that  
23 section, to read:

24           409.9131 Special provisions relating to integrity of  
25 the Medicaid program.--

26           (2) DEFINITIONS.--For purposes of this section, the  
27 term:

28           (d) "Peer review" means an evaluation of the  
29 professional practices of a Medicaid physician provider by a  
30 peer or peers in order to assess the medical necessity,  
31 appropriateness, and quality of care provided, as such care is

1 compared to that customarily furnished by the physician's  
2 peers and to recognized health care standards, and, in cases  
3 involving determination of medical necessity, to determine  
4 whether the documentation in the physician's records is  
5 adequate.

6 (5) DETERMINATIONS OF OVERPAYMENT.--In making a  
7 determination of overpayment to a physician, the agency must:

8 (b) Refer all physician service claims for peer review  
9 when the agency's preliminary analysis indicates that an  
10 evaluation of the medical necessity, appropriateness, and  
11 quality of care needs to be undertaken to determine a  
12 potential overpayment, and before any formal proceedings are  
13 initiated against the physician, except as required by s.  
14 409.913.

15 (6) COST REPORTS.--For any Medicaid provider  
16 submitting a cost report to the agency by any method, and in  
17 addition to any other certification, the following statement  
18 must immediately precede the dated signature of the provider's  
19 administrator or chief financial officer on such cost report:

20 "I certify that I am familiar with the laws and  
21 regulations regarding the provision of health  
22 care services under the Florida Medicaid  
23 program, including the laws and regulations  
24 relating to claims for Medicaid reimbursements  
25 and payments, and that the services identified  
26 in this cost report were provided in compliance  
27 with such laws and regulations."

28 Section 8. Section 409.920, Florida Statutes, is  
29 amended to read:

30 409.920 Medicaid provider fraud.--

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

1 (a) "Agency" means the Agency for Health Care  
2 Administration.

3 (b) "Fiscal agent" means any individual, firm,  
4 corporation, partnership, organization, or other legal entity  
5 that has contracted with the agency to receive, process, and  
6 adjudicate claims under the Medicaid program.

7 (c) "Item or service" includes:

8 1. Any particular item, device, medical supply, or  
9 service claimed to have been provided to a recipient and  
10 listed in an itemized claim for payment; or

11 2. In the case of a claim based on costs, any entry in  
12 the cost report, books of account, or other documents  
13 supporting such claim.

14 (d) "Knowingly" means that the act was done  
15 voluntarily and intentionally and not because of mistake or  
16 accident. As used in this section, the term "knowingly" also  
17 includes the word "willfully" or "willful" which, as used in  
18 this section, means that an act was committed voluntarily and  
19 purposely, with the specific intent to do something that the  
20 law forbids, and that the act was committed with bad purpose,  
21 either to disobey or disregard the law done by a person who is  
22 ~~aware or should be aware of the nature of his or her conduct~~  
23 ~~and that his or her conduct is substantially certain to cause~~  
24 ~~the intended result.~~

25 (2) It is unlawful to:

26 (a) Knowingly make, cause to be made, or aid and abet  
27 in the making of any false statement or false representation  
28 of a material fact, by commission or omission, in any claim  
29 submitted to the agency or its fiscal agent for payment.  
30  
31

1           (b) Knowingly make, cause to be made, or aid and abet  
2 in the making of a claim for items or services that are not  
3 authorized to be reimbursed by the Medicaid program.

4           (c) Knowingly charge, solicit, accept, or receive  
5 anything of value, other than an authorized copayment from a  
6 Medicaid recipient, from any source in addition to the amount  
7 legally payable for an item or service provided to a Medicaid  
8 recipient under the Medicaid program or knowingly fail to  
9 credit the agency or its fiscal agent for any payment received  
10 from a third-party source.

11           (d) Knowingly make or in any way cause to be made any  
12 false statement or false representation of a material fact, by  
13 commission or omission, in any document containing items of  
14 income and expense that is or may be used by the agency to  
15 determine a general or specific rate of payment for an item or  
16 service provided by a provider.

17           (e) Knowingly solicit, offer, pay, or receive any  
18 remuneration, including any kickback, bribe, or rebate,  
19 directly or indirectly, overtly or covertly, in cash or in  
20 kind, in return for referring an individual to a person for  
21 the furnishing or arranging for the furnishing of any item or  
22 service for which payment may be made, in whole or in part,  
23 under the Medicaid program, or in return for obtaining,  
24 purchasing, leasing, ordering, or arranging for or  
25 recommending, obtaining, purchasing, leasing, or ordering any  
26 goods, facility, item, or service, for which payment may be  
27 made, in whole or in part, under the Medicaid program.

28           (f) Knowingly submit false or misleading information  
29 or statements to the Medicaid program for the purpose of being  
30 accepted as a Medicaid provider.

31

1           (g) Knowingly use or endeavor to use a Medicaid  
2 provider's identification number or a Medicaid recipient's  
3 identification number to make, cause to be made, or aid and  
4 abet in the making of a claim for items or services that are  
5 not authorized to be reimbursed by the Medicaid program.

6  
7 A person who violates this subsection commits a felony of the  
8 third degree, punishable as provided in s. 775.082, s.  
9 775.083, or s. 775.084.

10           (3) The repayment of Medicaid payments wrongfully  
11 obtained, or the offer or endeavor to repay Medicaid funds  
12 wrongfully obtained, does not constitute a defense to, or a  
13 ground for dismissal of, criminal charges brought under this  
14 section.

15           (4) Property "paid for" includes all property  
16 furnished to or intended to be furnished to any recipient of  
17 benefits under the Medicaid program, regardless of whether  
18 reimbursement is ever actually made by the program.

19           ~~(5)(4)~~ All records in the custody of the agency or its  
20 fiscal agent which relate to Medicaid provider fraud are  
21 business records within the meaning of s. 90.803(6).

22           ~~(6)(5)~~ Proof that a claim was submitted to the agency  
23 or its fiscal agent which contained a false statement or a  
24 false representation of a material fact, by commission or  
25 omission, unless satisfactorily explained, gives rise to an  
26 inference that the person whose signature appears as the  
27 provider's authorizing signature on the claim form, or whose  
28 signature appears on an agency electronic claim submission  
29 agreement submitted for claims made to the fiscal agent by  
30 electronic means, had knowledge of the false statement or  
31 false representation. This subsection applies whether the



1 signature appears on the claim form or the electronic claim  
2 submission agreement by means of handwriting, typewriting,  
3 facsimile signature stamp, computer impulse, initials, or  
4 otherwise.

5 (7)~~(6)~~ Proof of submission to the agency or its fiscal  
6 agent of a document containing items of income and expense,  
7 which document is used or that may be used by the agency or  
8 its fiscal agent to determine a general or specific rate of  
9 payment and which document contains a false statement or a  
10 false representation of a material fact, by commission or  
11 omission, unless satisfactorily explained, gives rise to the  
12 inference that the person who signed the certification of the  
13 document had knowledge of the false statement or  
14 representation. This subsection applies whether the signature  
15 appears on the document by means of handwriting, typewriting,  
16 facsimile signature stamp, electronic transmission, initials,  
17 or otherwise.

18 (8)~~(7)~~ The Attorney General shall conduct a statewide  
19 program of Medicaid fraud control. To accomplish this purpose,  
20 the Attorney General shall:

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

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

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

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

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

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

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

16 (9)~~(8)~~ In carrying out the duties and responsibilities  
17 under this section, the Attorney General may:

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

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

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

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

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

16 Section 9. Section 409.9201, Florida Statutes, is  
17 created to read:

18 409.9201 Medicaid fraud.--

19 (1) As used in this section, the term:

20 (a) "Legend drug" means any drug, including, but not  
21 limited to, finished dosage forms or active ingredients that  
22 are subject to, defined by, or described by s. 503(b) of the  
23 Federal Food, Drug, and Cosmetic Act or by s. 465.003(8), s.  
24 499.007(12), or s. 499.0122(1)(b) or (c).

25 (b) "Value" means the amount billed to the Medicaid  
26 program for the property dispensed or the market value of a  
27 legend drug or goods or services at the time and place of the  
28 offense. If the market value cannot be determined, the term  
29 means the replacement cost of the legend drug or goods or  
30 services within a reasonable time after the offense.

31

1           (2) Any person who knowingly sells, who knowingly  
2 attempts or conspires to sell, or who knowingly causes any  
3 other person to sell or attempt or conspire to sell a legend  
4 drug that was paid for by the Medicaid program commits a  
5 felony.

6           (a) If the value of the legend drug involved is less  
7 than \$20,000, the crime is a felony of the third degree,  
8 punishable as provided in s. 775.082, s. 775.083, or s.  
9 775.084.

10           (b) If the value of the legend drug involved is  
11 \$20,000 or more but less than \$100,000, the crime is a felony  
12 of the second degree, punishable as provided in s. 775.082, s.  
13 775.083, or s. 775.084.

14           (c) If the value of the legend drug involved is  
15 \$100,000 or more, the crime is a felony of the first degree,  
16 punishable as provided in s. 775.082, s. 775.083, or s.  
17 775.084.

18           (3) Any person who knowingly purchases, or who  
19 knowingly attempts or conspires to purchase, a legend drug  
20 that was paid for by the Medicaid program and intended for use  
21 by another person commits a felony.

22           (a) If the value of the legend drug is less than  
23 \$20,000, the crime is a felony of the third degree, punishable  
24 as provided in s. 775.082, s. 775.083, or s. 775.084.

25           (b) If the value of the legend drug is \$20,000 or more  
26 but less than \$100,000, the crime is a felony of the second  
27 degree, punishable as provided in s. 775.082, s. 775.083, or  
28 s. 775.084.

29           (c) If the value of the legend drug is \$100,000 or  
30 more, the crime is a felony of the first degree, punishable as  
31 provided in s. 775.082, s. 775.083, or s. 775.084.

1           (4) Any person who knowingly makes or knowingly causes  
2 to be made, or who attempts or conspires to make, any false  
3 statement or representation to any person for the purpose of  
4 obtaining goods or services from the Medicaid program commits  
5 a felony.

6           (a) If the value of the goods or services is less than  
7 \$20,000, the crime is a felony of the third degree, punishable  
8 as provided in s. 775.082, s. 775.083, or s. 775.084.

9           (b) If the value of the goods or services is \$20,000  
10 or more but less than \$100,000, the crime is a felony of the  
11 second degree, punishable as provided in s. 775.082, s.  
12 775.083, or s. 775.084.

13           (c) If the value of the goods or services involved is  
14 \$100,000 or more, the crime is a felony of the first degree,  
15 punishable as provided in s. 775.082, s. 775.083, or s.  
16 775.084.

17  
18 The value of individual items of the legend drugs or goods or  
19 services involved in distinct transactions committed during a  
20 single scheme or course of conduct, whether involving a single  
21 person or several persons, may be aggregated when determining  
22 the punishment for the offense.

23           Section 10. Paragraph (ff) is added to subsection (1)  
24 of section 456.072, Florida Statutes, to read:

25           456.072 Grounds for discipline; penalties;  
26 enforcement.--

27           (1) The following acts shall constitute grounds for  
28 which the disciplinary actions specified in subsection (2) may  
29 be taken:

30           (ff) Engaging in a pattern of practice when  
31 prescribing medicinal drugs or controlled substances which

1 demonstrates a lack of reasonable skill or safety to patients,  
2 a violation of any provision of this chapter, a violation of  
3 the applicable practice act, or a violation of any rules  
4 adopted pursuant to this chapter or the applicable practice  
5 act of the prescribing practitioner. Notwithstanding s.  
6 456.073(13), the department may initiate an investigation and  
7 establish such a pattern from billing records, data, or any  
8 other information obtained by the department.

9 Section 11. Subsection (1) of section 465.188, Florida  
10 Statutes, is amended, and subsection (4) is added to that  
11 section, to read:

12 465.188 Medicaid audits of pharmacies.--

13 (1) Notwithstanding any other law, when an audit of  
14 the Medicaid-related records of a pharmacy licensed under  
15 chapter 465 is conducted, such audit must be conducted as  
16 provided in this section.

17 (a) The agency conducting the audit must give the  
18 pharmacist at least 1 week's prior notice of the initial audit  
19 for each audit cycle.

20 (b) An audit must be conducted by a pharmacist  
21 licensed in this state.

22 (c) Any clerical or recordkeeping error, such as a  
23 typographical error, scrivener's error, or computer error  
24 regarding a document or record required under the Medicaid  
25 program does not constitute a willful violation and is not  
26 subject to criminal penalties without proof of intent to  
27 commit fraud.

28 (d) A pharmacist may use the physician's record or  
29 other order for drugs or medicinal supplies written or  
30 transmitted by any means of communication for purposes of  
31

1 validating the pharmacy record with respect to orders or  
2 refills of a legend or narcotic drug.

3 (e) A finding of an overpayment or underpayment must  
4 be based on the actual overpayment or underpayment and may not  
5 be a projection based on the number of patients served having  
6 a similar diagnosis or on the number of similar orders or  
7 refills for similar drugs.

8 (f) Each pharmacy shall be audited under the same  
9 standards and parameters.

10 (g) A pharmacist must be allowed at least 10 days in  
11 which to produce documentation to address any discrepancy  
12 found during an audit.

13 (h) The period covered by an audit may not exceed 1  
14 calendar year.

15 (i) An audit may not be scheduled during the first 5  
16 days of any month due to the high volume of prescriptions  
17 filled during that time.

18 (j) The audit report must be delivered to the  
19 pharmacist within 90 days after conclusion of the audit. A  
20 final audit report shall be delivered to the pharmacist within  
21 6 months after receipt of the preliminary audit report or  
22 final appeal, as provided for in subsection (2), whichever is  
23 later.

24 (k) The audit criteria set forth in this section  
25 applies only to audits of claims submitted for payment  
26 subsequent to July 11, 2003. Notwithstanding any other  
27 provision in this section, the agency conducting the audit  
28 shall not use the accounting practice of extrapolation in  
29 calculating penalties for Medicaid audits.

30 (4) This section does not apply to any investigative  
31 audit conducted by the Agency for Health Care Administration

1 when the agency has reliable evidence that the claim that is  
2 the subject of the audit involves fraud, willful  
3 misrepresentation, or abuse under the Medicaid program.

4 Section 12. Section 812.0191, Florida Statutes, is  
5 created to read:

6 812.0191 Dealing in property paid for in whole or in  
7 part by the Medicaid program.--

8 (1) As used in this section, the term:

9 (a) "Property paid for in whole or in part by the  
10 Medicaid program" means any devices, goods, services, drugs,  
11 or any other property furnished or intended to be furnished to  
12 a recipient of benefits under the Medicaid program.

13 (b) "Value" means the amount billed to Medicaid for  
14 the property dispensed or the market value of the devices,  
15 goods, services, or drugs at the time and place of the  
16 offense. If the market value cannot be determined, the term  
17 means the replacement cost of the devices, goods, services, or  
18 drugs within a reasonable time after the offense.

19 (2) Any person who traffics in, or endeavors to  
20 traffic in, property that he or she knows or should have known  
21 was paid for in whole or in part by the Medicaid program  
22 commits a felony.

23 (a) If the value of the property involved is less than  
24 \$20,000, the crime is a felony of the third degree, punishable  
25 as provided in s. 775.082, s. 775.083, or s. 775.084.

26 (b) If the value of the property involved is \$20,000  
27 or more but less than \$100,000, the crime is a felony of the  
28 second degree, punishable as provided in s. 775.082, s.  
29 775.083, or s. 775.084.

30  
31



1           (c) If the value of the property involved is \$100,000  
2 or more, the crime is a felony of the first degree, punishable  
3 as provided in s. 775.082, s. 775.083, or s. 775.084.

4  
5 The value of individual items of the devices, goods, services,  
6 drugs, or other property involved in distinct transactions  
7 committed during a single scheme or course of conduct, whether  
8 involving a single person or several persons, may be  
9 aggregated when determining the punishment for the offense.

10           (3) Any person who knowingly initiates, organizes,  
11 plans, finances, directs, manages, or supervises the obtaining  
12 of property paid for in whole or in part by the Medicaid  
13 program and who traffics in, or endeavors to traffic in, such  
14 property commits a felony of the first degree, punishable as  
15 provided in s. 775.082, s. 775.083, or s. 775.084.

16           Section 13. Paragraph (a) of subsection (1) of section  
17 895.02, Florida Statutes, is amended to read:

18           895.02 Definitions.--As used in ss. 895.01-895.08, the  
19 term:

20           (1) "Racketeering activity" means to commit, to  
21 attempt to commit, to conspire to commit, or to solicit,  
22 coerce, or intimidate another person to commit:

23           (a) Any crime which is chargeable by indictment or  
24 information under the following provisions of the Florida  
25 Statutes:

26           1. Section 210.18, relating to evasion of payment of  
27 cigarette taxes.

28           2. Section 403.727(3)(b), relating to environmental  
29 control.

30           3. Section 414.39, relating to public assistance  
31 fraud.

- 1           4. Section 409.920 or s. 409.9201, relating to  
2 Medicaid ~~provider~~ fraud.
- 3           5. Section 440.105 or s. 440.106, relating to workers'  
4 compensation.
- 5           6. Sections 499.0051, 499.0052, 499.0053, 499.0054,  
6 and 499.0691, relating to crimes involving contraband and  
7 adulterated drugs.
- 8           7. Part IV of chapter 501, relating to telemarketing.
- 9           8. Chapter 517, relating to sale of securities and  
10 investor protection.
- 11          9. Section 550.235, s. 550.3551, or s. 550.3605,  
12 relating to dogracing and horseracing.
- 13          10. Chapter 550, relating to jai alai frontons.
- 14          11. Chapter 552, relating to the manufacture,  
15 distribution, and use of explosives.
- 16          12. Chapter 560, relating to money transmitters, if  
17 the violation is punishable as a felony.
- 18          13. Chapter 562, relating to beverage law enforcement.
- 19          14. Section 624.401, relating to transacting insurance  
20 without a certificate of authority, s. 624.437(4)(c)1.,  
21 relating to operating an unauthorized multiple-employer  
22 welfare arrangement, or s. 626.902(1)(b), relating to  
23 representing or aiding an unauthorized insurer.
- 24          15. Section 655.50, relating to reports of currency  
25 transactions, when such violation is punishable as a felony.
- 26          16. Chapter 687, relating to interest and usurious  
27 practices.
- 28          17. Section 721.08, s. 721.09, or s. 721.13, relating  
29 to real estate timeshare plans.
- 30          18. Chapter 782, relating to homicide.
- 31          19. Chapter 784, relating to assault and battery.

- 1           20. Chapter 787, relating to kidnapping.  
2           21. Chapter 790, relating to weapons and firearms.  
3           22. Section 796.03, s. 796.04, s. 796.05, or s.  
4 796.07, relating to prostitution.  
5           23. Chapter 806, relating to arson.  
6           24. Section 810.02(2)(c), relating to specified  
7 burglary of a dwelling or structure.  
8           25. Chapter 812, relating to theft, robbery, and  
9 related crimes.  
10          26. Chapter 815, relating to computer-related crimes.  
11          27. Chapter 817, relating to fraudulent practices,  
12 false pretenses, fraud generally, and credit card crimes.  
13          28. Chapter 825, relating to abuse, neglect, or  
14 exploitation of an elderly person or disabled adult.  
15          29. Section 827.071, relating to commercial sexual  
16 exploitation of children.  
17          30. Chapter 831, relating to forgery and  
18 counterfeiting.  
19          31. Chapter 832, relating to issuance of worthless  
20 checks and drafts.  
21          32. Section 836.05, relating to extortion.  
22          33. Chapter 837, relating to perjury.  
23          34. Chapter 838, relating to bribery and misuse of  
24 public office.  
25          35. Chapter 843, relating to obstruction of justice.  
26          36. Section 847.011, s. 847.012, s. 847.013, s.  
27 847.06, or s. 847.07, relating to obscene literature and  
28 profanity.  
29          37. Section 849.09, s. 849.14, s. 849.15, s. 849.23,  
30 or s. 849.25, relating to gambling.  
31          38. Chapter 874, relating to criminal street gangs.

1           39. Chapter 893, relating to drug abuse prevention and  
2 control.

3           40. Chapter 896, relating to offenses related to  
4 financial transactions.

5           41. Sections 914.22 and 914.23, relating to tampering  
6 with a witness, victim, or informant, and retaliation against  
7 a witness, victim, or informant.

8           42. Sections 918.12 and 918.13, relating to tampering  
9 with jurors and evidence.

10           Section 14. Section 905.34, Florida Statutes, is  
11 amended to read:

12           905.34 Powers and duties; law applicable.--The  
13 jurisdiction of a statewide grand jury impaneled under this  
14 chapter shall extend throughout the state. The subject matter  
15 jurisdiction of the statewide grand jury shall be limited to  
16 the offenses of:

17           (1) Bribery, burglary, carjacking, home-invasion  
18 robbery, criminal usury, extortion, gambling, kidnapping,  
19 larceny, murder, prostitution, perjury, and robbery;

20           (2) Crimes involving narcotic or other dangerous  
21 drugs;

22           (3) Any violation of the provisions of the Florida  
23 RICO (Racketeer Influenced and Corrupt Organization) Act,  
24 including any offense listed in the definition of racketeering  
25 activity in s. 895.02(1)(a), providing such listed offense is  
26 investigated in connection with a violation of s. 895.03 and  
27 is charged in a separate count of an information or indictment  
28 containing a count charging a violation of s. 895.03, the  
29 prosecution of which listed offense may continue independently  
30 if the prosecution of the violation of s. 895.03 is terminated  
31 for any reason;

1           (4) Any violation of the provisions of the Florida  
2 Anti-Fencing Act;

3           (5) Any violation of the provisions of the Florida  
4 Antitrust Act of 1980, as amended;

5           (6) Any violation of the provisions of chapter 815;

6           (7) Any crime involving, or resulting in, fraud or  
7 deceit upon any person;

8           (8) Any violation of s. 847.0135, s. 847.0137, or s.  
9 847.0138 relating to computer pornography and child  
10 exploitation prevention, or any offense related to a violation  
11 of s. 847.0135, s. 847.0137, or s. 847.0138; ~~or~~

12           (9) Any criminal violation of part I of chapter 499;  
13 or

14           (10) Any criminal violation of s. 409.920 or s.  
15 409.9201;

16

17 or any attempt, solicitation, or conspiracy to commit any  
18 violation of the crimes specifically enumerated above, when  
19 any such offense is occurring, or has occurred, in two or more  
20 judicial circuits as part of a related transaction or when any  
21 such offense is connected with an organized criminal  
22 conspiracy affecting two or more judicial circuits. The  
23 statewide grand jury may return indictments and presentments  
24 irrespective of the county or judicial circuit where the  
25 offense is committed or triable. If an indictment is  
26 returned, it shall be certified and transferred for trial to  
27 the county where the offense was committed. The powers and  
28 duties of, and law applicable to, county grand juries shall  
29 apply to a statewide grand jury except when such powers,  
30 duties, and law are inconsistent with the provisions of ss.  
31 905.31-905.40.

1           Section 15. Paragraph (a) of subsection (2) of section  
2 932.701, Florida Statutes, is amended to read:

3           932.701 Short title; definitions.--

4           (2) As used in the Florida Contraband Forfeiture Act:

5           (a) "Contraband article" means:

6           1. Any controlled substance as defined in chapter 893  
7 or any substance, device, paraphernalia, or currency or other  
8 means of exchange that was used, was attempted to be used, or  
9 was intended to be used in violation of any provision of  
10 chapter 893, if the totality of the facts presented by the  
11 state is clearly sufficient to meet the state's burden of  
12 establishing probable cause to believe that a nexus exists  
13 between the article seized and the narcotics activity, whether  
14 or not the use of the contraband article can be traced to a  
15 specific narcotics transaction.

16           2. Any gambling paraphernalia, lottery tickets, money,  
17 currency, or other means of exchange which was used, was  
18 attempted, or intended to be used in violation of the gambling  
19 laws of the state.

20           3. Any equipment, liquid or solid, which was being  
21 used, is being used, was attempted to be used, or intended to  
22 be used in violation of the beverage or tobacco laws of the  
23 state.

24           4. Any motor fuel upon which the motor fuel tax has  
25 not been paid as required by law.

26           5. Any personal property, including, but not limited  
27 to, any vessel, aircraft, item, object, tool, substance,  
28 device, weapon, machine, vehicle of any kind, money,  
29 securities, books, records, research, negotiable instruments,  
30 or currency, which was used or was attempted to be used as an  
31 instrumentality in the commission of, or in aiding or abetting

1 in the commission of, any felony, whether or not comprising an  
2 element of the felony, or which is acquired by proceeds  
3 obtained as a result of a violation of the Florida Contraband  
4 Forfeiture Act.

5           6. Any real property, including any right, title,  
6 leasehold, or other interest in the whole of any lot or tract  
7 of land, which was used, is being used, or was attempted to be  
8 used as an instrumentality in the commission of, or in aiding  
9 or abetting in the commission of, any felony, or which is  
10 acquired by proceeds obtained as a result of a violation of  
11 the Florida Contraband Forfeiture Act.

12           7. Any personal property, including, but not limited  
13 to, equipment, money, securities, books, records, research,  
14 negotiable instruments, currency, or any vessel, aircraft,  
15 item, object, tool, substance, device, weapon, machine, or  
16 vehicle of any kind in the possession of or belonging to any  
17 person who takes aquaculture products in violation of s.  
18 812.014(2)(c).

19           8. Any motor vehicle offered for sale in violation of  
20 s. 320.28.

21           9. Any motor vehicle used during the course of  
22 committing an offense in violation of s. 322.34(9)(a).

23           10. Any real property, including any right, title,  
24 leasehold, or other interest in the whole of any lot or tract  
25 of land, which is acquired by proceeds obtained as a result of  
26 Medicaid fraud under s. 409.920 or s. 409.9201; any personal  
27 property, including, but not limited to, equipment, money,  
28 securities, books, records, research, negotiable instruments,  
29 or currency; or any vessel, aircraft, item, object, tool,  
30 substance, device, weapon, machine, or vehicle of any kind in  
31 the possession of or belonging to any person which is acquired

1 by proceeds obtained as a result of Medicaid fraud under s.  
2 409.920 or s. 409.9201.

3 Section 16. Paragraph (1) is added to subsection (5)  
4 of section 932.7055, Florida Statutes, to read:

5 932.7055 Disposition of liens and forfeited  
6 property.--

7 (5) If the seizing agency is a state agency, all  
8 remaining proceeds shall be deposited into the General Revenue  
9 Fund. However, if the seizing agency is:

10 (1) The Medicaid Fraud Control Unit of the Department  
11 of Legal Affairs, the proceeds accrued pursuant to the  
12 provisions of the Florida Contraband Forfeiture Act shall be  
13 deposited into the Department of Legal Affairs Grants and  
14 Donations Trust Fund to be used for investigation and  
15 prosecution of Medicaid fraud, abuse, neglect, and other  
16 related cases by the Medicaid Fraud Control Unit.

17 Section 17. Paragraphs (a), (b), and (e) of subsection  
18 (4) of section 394.9082, Florida Statutes, are amended to  
19 read:

20 394.9082 Behavioral health service delivery  
21 strategies.--

22 (4) CONTRACT FOR SERVICES.--

23 (a) The Department of Children and Family Services and  
24 the Agency for Health Care Administration may contract for the  
25 provision or management of behavioral health services with a  
26 managing entity in at least two geographic areas. Both the  
27 Department of Children and Family Services and the Agency for  
28 Health Care Administration must contract with the same  
29 managing entity in any distinct geographic area where the  
30 strategy operates. This managing entity shall be accountable  
31 at a minimum for the delivery of behavioral health services



1 specified and funded by the department and the agency. The  
2 geographic area must be of sufficient size in population and  
3 have enough public funds for behavioral health services to  
4 allow for flexibility and maximum efficiency. Notwithstanding  
5 the provisions of s. 409.912(4)~~(3)~~(b)1. and 2., at least one  
6 service delivery strategy must be in one of the service  
7 districts in the catchment area of G. Pierce Wood Memorial  
8 Hospital.

9 (b) Under one of the service delivery strategies, the  
10 Department of Children and Family Services may contract with a  
11 prepaid mental health plan that operates under s. 409.912 to  
12 be the managing entity. Under this strategy, the Department of  
13 Children and Family Services is not required to competitively  
14 procure those services and, notwithstanding other provisions  
15 of law, may employ prospective payment methodologies that the  
16 department finds are necessary to improve client care or  
17 institute more efficient practices. The Department of Children  
18 and Family Services may employ in its contract any provision  
19 of the current prepaid behavioral health care plan authorized  
20 under s. 409.912(4)~~(3)~~(a) and (b), or any other provision  
21 necessary to improve quality, access, continuity, and price.  
22 Any contracts under this strategy in Area 6 of the Agency for  
23 Health Care Administration or in the prototype region under s.  
24 20.19(7) of the Department of Children and Family Services may  
25 be entered with the existing substance abuse treatment  
26 provider network if an administrative services organization is  
27 part of its network. In Area 6 of the Agency for Health Care  
28 Administration or in the prototype region of the Department of  
29 Children and Family Services, the Department of Children and  
30 Family Services and the Agency for Health Care Administration  
31 may employ alternative service delivery and financing

1 methodologies, which may include prospective payment for  
2 certain population groups. The population groups that are to  
3 be provided these substance abuse services would include at a  
4 minimum: individuals and families receiving family safety  
5 services; Medicaid-eligible children, adolescents, and adults  
6 who are substance-abuse-impaired; or current recipients and  
7 persons at risk of needing cash assistance under Florida's  
8 welfare reform initiatives.

9 (e) The cost of the managing entity contract shall be  
10 funded through a combination of funds from the Department of  
11 Children and Family Services and the Agency for Health Care  
12 Administration. To operate the managing entity, the Department  
13 of Children and Family Services and the Agency for Health Care  
14 Administration may not expend more than 10 percent of the  
15 annual appropriations for mental health and substance abuse  
16 treatment services prorated to the geographic areas and must  
17 include all behavioral health Medicaid funds, including  
18 psychiatric inpatient funds. This restriction does not apply  
19 to a prepaid behavioral health plan that is authorized under  
20 s. 409.912(4)~~(3)~~(a) and (b).

21 Section 18. Subsection (6) of section 400.0077,  
22 Florida Statutes, is amended to read:

23 400.0077 Confidentiality.--

24 (6) This section does not limit the subpoena power of  
25 the Attorney General pursuant to s. 409.920(9)~~(8)~~(b).

26 Section 19. Paragraph (a) of subsection (4) of section  
27 409.9065, Florida Statutes, is amended to read:

28 409.9065 Pharmaceutical expense assistance.--

29 (4) ADMINISTRATION.--The pharmaceutical expense  
30 assistance program shall be administered by the agency, in  
31

1 collaboration with the Department of Elderly Affairs and the  
2 Department of Children and Family Services.

3 (a) The agency shall, by rule, establish for the  
4 pharmaceutical expense assistance program eligibility  
5 requirements; limits on participation; benefit limitations,  
6 including copayments; a requirement for generic drug  
7 substitution; and other program parameters comparable to those  
8 of the Medicaid program. Individuals eligible to participate  
9 in this program are not subject to the limit of four brand  
10 name drugs per month per recipient as specified in s.

11 409.912(40)~~(38)~~(a). There shall be no monetary limit on  
12 prescription drugs purchased with discounts of less than 51  
13 percent unless the agency determines there is a risk of a  
14 funding shortfall in the program. If the agency determines  
15 there is a risk of a funding shortfall, the agency may  
16 establish monetary limits on prescription drugs which shall  
17 not be less than \$160 worth of prescription drugs per month.

18 Section 20. Subsection (1) of section 409.9071,  
19 Florida Statutes, is amended to read:

20 409.9071 Medicaid provider agreements for school  
21 districts certifying state match.--

22 (1) The agency shall submit a state plan amendment by  
23 September 1, 1997, for the purpose of obtaining federal  
24 authorization to reimburse school-based services as provided  
25 in former s. 236.0812 pursuant to the rehabilitative services  
26 option provided under 42 U.S.C. s. 1396d(a)(13). For purposes  
27 of this section, billing agent consulting services shall be  
28 considered billing agent services, as that term is used in s.  
29 409.913(10)~~(9)~~, and, as such, payments to such persons shall  
30 not be based on amounts for which they bill nor based on the  
31 amount a provider receives from the Medicaid program. This

1 provision shall not restrict privatization of Medicaid  
2 school-based services. Subject to any limitations provided for  
3 in the General Appropriations Act, the agency, in compliance  
4 with appropriate federal authorization, shall develop policies  
5 and procedures and shall allow for certification of state and  
6 local education funds which have been provided for  
7 school-based services as specified in s. 1011.70 and  
8 authorized by a physician's order where required by federal  
9 Medicaid law. Any state or local funds certified pursuant to  
10 this section shall be for children with specified disabilities  
11 who are eligible for both Medicaid and part B or part H of the  
12 Individuals with Disabilities Education Act (IDEA), or the  
13 exceptional student education program, or who have an  
14 individualized educational plan.

15 Section 21. Subsection (4) of section 409.908, Florida  
16 Statutes, is amended to read:

17 409.908 Reimbursement of Medicaid providers.--Subject  
18 to specific appropriations, the agency shall reimburse  
19 Medicaid providers, in accordance with state and federal law,  
20 according to methodologies set forth in the rules of the  
21 agency and in policy manuals and handbooks incorporated by  
22 reference therein. These methodologies may include fee  
23 schedules, reimbursement methods based on cost reporting,  
24 negotiated fees, competitive bidding pursuant to s. 287.057,  
25 and other mechanisms the agency considers efficient and  
26 effective for purchasing services or goods on behalf of  
27 recipients. If a provider is reimbursed based on cost  
28 reporting and submits a cost report late and that cost report  
29 would have been used to set a lower reimbursement rate for a  
30 rate semester, then the provider's rate for that semester  
31 shall be retroactively calculated using the new cost report,

1 and full payment at the recalculated rate shall be affected  
2 retroactively. Medicare-granted extensions for filing cost  
3 reports, if applicable, shall also apply to Medicaid cost  
4 reports. Payment for Medicaid compensable services made on  
5 behalf of Medicaid eligible persons is subject to the  
6 availability of moneys and any limitations or directions  
7 provided for in the General Appropriations Act or chapter 216.  
8 Further, nothing in this section shall be construed to prevent  
9 or limit the agency from adjusting fees, reimbursement rates,  
10 lengths of stay, number of visits, or number of services, or  
11 making any other adjustments necessary to comply with the  
12 availability of moneys and any limitations or directions  
13 provided for in the General Appropriations Act, provided the  
14 adjustment is consistent with legislative intent.

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

1 organizations or prepaid health care plans. Each rate  
2 semester, the agency shall calculate and publish a Medicaid  
3 hospital rate schedule that does not reflect either special  
4 Medicaid payments or the elimination of rate reimbursement  
5 ceilings, to be used by hospitals and Medicaid health  
6 maintenance organizations, in order to determine the Medicaid  
7 rate referred to in ss. 409.912(19)(~~17~~), 409.9128(5), and  
8 641.513(6).

9 Section 22. Subsections (1) and (2) of section  
10 409.91196, Florida Statutes, are amended to read:

11 409.91196 Supplemental rebate agreements;  
12 confidentiality of records and meetings.--

13 (1) Trade secrets, rebate amount, percent of rebate,  
14 manufacturer's pricing, and supplemental rebates which are  
15 contained in records of the Agency for Health Care  
16 Administration and its agents with respect to supplemental  
17 rebate negotiations and which are prepared pursuant to a  
18 supplemental rebate agreement under s. 409.912(40)(~~38~~)(a)7.  
19 are confidential and exempt from s. 119.07 and s. 24(a), Art.  
20 I of the State Constitution.

21 (2) Those portions of meetings of the Medicaid  
22 Pharmaceutical and Therapeutics Committee at which trade  
23 secrets, rebate amount, percent of rebate, manufacturer's  
24 pricing, and supplemental rebates are disclosed for discussion  
25 or negotiation of a supplemental rebate agreement under s.  
26 409.912(40)(~~38~~)(a)7. are exempt from s. 286.011 and s. 24(b),  
27 Art. I of the State Constitution.

28 Section 23. Paragraph (f) of subsection (2) of section  
29 409.9122, Florida Statutes, is amended to read:

30 409.9122 Mandatory Medicaid managed care enrollment;  
31 programs and procedures.--

1 (2)

2 (f) When a Medicaid recipient does not choose a  
3 managed care plan or MediPass provider, the agency shall  
4 assign the Medicaid recipient to a managed care plan or  
5 MediPass provider. Medicaid recipients who are subject to  
6 mandatory assignment but who fail to make a choice shall be  
7 assigned to managed care plans until an enrollment of 40  
8 percent in MediPass and 60 percent in managed care plans is  
9 achieved. Once this enrollment is achieved, the assignments  
10 shall be divided in order to maintain an enrollment in  
11 MediPass and managed care plans which is in a 40 percent and  
12 60 percent proportion, respectively. Thereafter, assignment of  
13 Medicaid recipients who fail to make a choice shall be based  
14 proportionally on the preferences of recipients who have made  
15 a choice in the previous period. Such proportions shall be  
16 revised at least quarterly to reflect an update of the  
17 preferences of Medicaid recipients. The agency shall  
18 disproportionately assign Medicaid-eligible recipients who are  
19 required to but have failed to make a choice of managed care  
20 plan or MediPass, including children, and who are to be  
21 assigned to the MediPass program to children's networks as  
22 described in s. 409.912(4)~~(3)~~(g), Children's Medical Services  
23 network as defined in s. 391.021, exclusive provider  
24 organizations, provider service networks, minority physician  
25 networks, and pediatric emergency department diversion  
26 programs authorized by this chapter or the General  
27 Appropriations Act, in such manner as the agency deems  
28 appropriate, until the agency has determined that the networks  
29 and programs have sufficient numbers to be economically  
30 operated. For purposes of this paragraph, when referring to  
31 assignment, the term "managed care plans" includes health

1 maintenance organizations, exclusive provider organizations,  
2 provider service networks, minority physician networks,  
3 Children's Medical Services network, and pediatric emergency  
4 department diversion programs authorized by this chapter or  
5 the General Appropriations Act. When making assignments, the  
6 agency shall take into account the following criteria:

7         1. A managed care plan has sufficient network capacity  
8 to meet the need of members.

9         2. The managed care plan or MediPass has previously  
10 enrolled the recipient as a member, or one of the managed care  
11 plan's primary care providers or MediPass providers has  
12 previously provided health care to the recipient.

13         3. The agency has knowledge that the member has  
14 previously expressed a preference for a particular managed  
15 care plan or MediPass provider as indicated by Medicaid  
16 fee-for-service claims data, but has failed to make a choice.

17         4. The managed care plan's or MediPass primary care  
18 providers are geographically accessible to the recipient's  
19 residence.

20         Section 24. Subsection (3) of section 409.9131,  
21 Florida Statutes, is amended to read:

22         409.9131 Special provisions relating to integrity of  
23 the Medicaid program.--

24         (3) ONSITE RECORDS REVIEW.--As specified in s.  
25 409.913(9)~~(8)~~, the agency may investigate, review, or analyze  
26 a physician's medical records concerning Medicaid patients.  
27 The physician must make such records available to the agency  
28 during normal business hours. The agency must provide notice  
29 to the physician at least 24 hours before such visit. The  
30 agency and physician shall make every effort to set a mutually  
31 agreeable time for the agency's visit during normal business



1 hours and within the 24-hour period. If such a time cannot be  
2 agreed upon, the agency may set the time.

3 Section 25. Subsection (2) of section 430.608, Florida  
4 Statutes, is amended to read:

5 430.608 Confidentiality of information.--

6 (2) This section does not, however, limit the subpoena  
7 authority of the Medicaid Fraud Control Unit of the Department  
8 of Legal Affairs pursuant to s. 409.920(9)~~(8)~~(b).

9 Section 26. Section 636.0145, Florida Statutes, is  
10 amended to read:

11 636.0145 Certain entities contracting with  
12 Medicaid.--Notwithstanding the requirements of s.  
13 409.912(4)~~(3)~~(b), an entity that is providing comprehensive  
14 inpatient and outpatient mental health care services to  
15 certain Medicaid recipients in Hillsborough, Highlands,  
16 Hardee, Manatee, and Polk Counties through a capitated,  
17 prepaid arrangement pursuant to the federal waiver provided  
18 for in s. 409.905(5) must become licensed under chapter 636 by  
19 December 31, 1998. Any entity licensed under this chapter  
20 which provides services solely to Medicaid recipients under a  
21 contract with Medicaid shall be exempt from ss. 636.017,  
22 636.018, 636.022, 636.028, and 636.034.

23 Section 27. Subsection (3) of section 641.225, Florida  
24 Statutes, is amended to read:

25 641.225 Surplus requirements.--

26 (3)(a) An entity providing prepaid capitated services  
27 which is authorized under s. 409.912(4)~~(3)~~(a) and which  
28 applies for a certificate of authority is subject to the  
29 minimum surplus requirements set forth in subsection (1),  
30 unless the entity is backed by the full faith and credit of  
31 the county in which it is located.

1 (b) An entity providing prepaid capitated services  
 2 which is authorized under s. 409.912(4)~~(3)~~(b) or (c), and  
 3 which applies for a certificate of authority is subject to the  
 4 minimum surplus requirements set forth in s. 409.912.

5 Section 28. Subsection (4) of section 641.386, Florida  
 6 Statutes, is amended to read:

7 641.386 Agent licensing and appointment required;  
 8 exceptions.--

9 (4) All agents and health maintenance organizations  
 10 shall comply with and be subject to the applicable provisions  
 11 of ss. 641.309 and 409.912(21)~~(19)~~, and all companies and  
 12 entities appointing agents shall comply with s. 626.451, when  
 13 marketing for any health maintenance organization licensed  
 14 pursuant to this part, including those organizations under  
 15 contract with the Agency for Health Care Administration to  
 16 provide health care services to Medicaid recipients or any  
 17 private entity providing health care services to Medicaid  
 18 recipients pursuant to a prepaid health plan contract with the  
 19 Agency for Health Care Administration.

20 Section 29. For the purposes of incorporating the  
 21 amendment to section 409.920, Florida Statutes, in a reference  
 22 thereto, paragraph (g) of subsection (3) of section 921.0022,  
 23 Florida Statutes, is reenacted to read:

24 921.0022 Criminal Punishment Code; offense severity  
 25 ranking chart.--

26 (3) OFFENSE SEVERITY RANKING CHART

27  
 28 Florida Felony  
 29 Statute Degree Description  
 30  
 31

1			(g) LEVEL 7
2	316.027(1)(b)	2nd	Accident involving death, failure
3			to stop; leaving scene.
4	316.193(3)(c)2.	3rd	DUI resulting in serious bodily
5			injury.
6	327.35(3)(c)2.	3rd	Vessel BUI resulting in serious
7			bodily injury.
8	402.319(2)	2nd	Misrepresentation and negligence
9			or intentional act resulting in
10			great bodily harm, permanent
11			disfiguration, permanent
12			disability, or death.
13	409.920(2)	3rd	Medicaid provider fraud.
14	456.065(2)	3rd	Practicing a health care
15			profession without a license.
16	456.065(2)	2nd	Practicing a health care
17			profession without a license
18			which results in serious bodily
19			injury.
20	458.327(1)	3rd	Practicing medicine without a
21			license.
22	459.013(1)	3rd	Practicing osteopathic medicine
23			without a license.
24	460.411(1)	3rd	Practicing chiropractic medicine
25			without a license.
26	461.012(1)	3rd	Practicing podiatric medicine
27			without a license.
28	462.17	3rd	Practicing naturopathy without a
29			license.
30	463.015(1)	3rd	Practicing optometry without a
31			license.

1	464.016(1)	3rd	Practicing nursing without a
2			license.
3	465.015(2)	3rd	Practicing pharmacy without a
4			license.
5	466.026(1)	3rd	Practicing dentistry or dental
6			hygiene without a license.
7	467.201	3rd	Practicing midwifery without a
8			license.
9	468.366	3rd	Delivering respiratory care
10			services without a license.
11	483.828(1)	3rd	Practicing as clinical laboratory
12			personnel without a license.
13	483.901(9)	3rd	Practicing medical physics
14			without a license.
15	484.013(1)(c)	3rd	Preparing or dispensing optical
16			devices without a prescription.
17	484.053	3rd	Dispensing hearing aids without a
18			license.
19	494.0018(2)	1st	Conviction of any violation of
20			ss. 494.001-494.0077 in which the
21			total money and property
22			unlawfully obtained exceeded
23			\$50,000 and there were five or
24			more victims.
25	560.123(8)(b)1.	3rd	Failure to report currency or
26			payment instruments exceeding
27			\$300 but less than \$20,000 by
28			money transmitter.
29			
30			
31			

1	560.125(5)(a)	3rd	Money transmitter business by
2			unauthorized person, currency or
3			payment instruments exceeding
4			\$300 but less than \$20,000.
5	655.50(10)(b)1.	3rd	Failure to report financial
6			transactions exceeding \$300 but
7			less than \$20,000 by financial
8			institution.
9	782.051(3)	2nd	Attempted felony murder of a
10			person by a person other than the
11			perpetrator or the perpetrator of
12			an attempted felony.
13	782.07(1)	2nd	Killing of a human being by the
14			act, procurement, or culpable
15			negligence of another
16			(manslaughter).
17	782.071	2nd	Killing of human being or viable
18			fetus by the operation of a motor
19			vehicle in a reckless manner
20			(vehicular homicide).
21	782.072	2nd	Killing of a human being by the
22			operation of a vessel in a
23			reckless manner (vessel
24			homicide).
25	784.045(1)(a)1.	2nd	Aggravated battery; intentionally
26			causing great bodily harm or
27			disfigurement.
28	784.045(1)(a)2.	2nd	Aggravated battery; using deadly
29			weapon.
30	784.045(1)(b)	2nd	Aggravated battery; perpetrator
31			aware victim pregnant.

1	784.048(4)	3rd	Aggravated stalking; violation of
2			injunction or court order.
3	784.07(2)(d)	1st	Aggravated battery on law
4			enforcement officer.
5	784.074(1)(a)	1st	Aggravated battery on sexually
6			violent predators facility staff.
7	784.08(2)(a)	1st	Aggravated battery on a person 65
8			years of age or older.
9	784.081(1)	1st	Aggravated battery on specified
10			official or employee.
11	784.082(1)	1st	Aggravated battery by detained
12			person on visitor or other
13			detainee.
14	784.083(1)	1st	Aggravated battery on code
15			inspector.
16	790.07(4)	1st	Specified weapons violation
17			subsequent to previous conviction
18			of s. 790.07(1) or (2).
19	790.16(1)	1st	Discharge of a machine gun under
20			specified circumstances.
21	790.165(2)	2nd	Manufacture, sell, possess, or
22			deliver hoax bomb.
23	790.165(3)	2nd	Possessing, displaying, or
24			threatening to use any hoax bomb
25			while committing or attempting to
26			commit a felony.
27	790.166(3)	2nd	Possessing, selling, using, or
28			attempting to use a hoax weapon
29			of mass destruction.
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1	790.166(4)	2nd	Possessing, displaying, or
2			threatening to use a hoax weapon
3			of mass destruction while
4			committing or attempting to
5			commit a felony.
6	796.03	2nd	Procuring any person under 16
7			years for prostitution.
8	800.04(5)(c)1.	2nd	Lewd or lascivious molestation;
9			victim less than 12 years of age;
10			offender less than 18 years.
11	800.04(5)(c)2.	2nd	Lewd or lascivious molestation;
12			victim 12 years of age or older
13			but less than 16 years; offender
14			18 years or older.
15	806.01(2)	2nd	Maliciously damage structure by
16			fire or explosive.
17	810.02(3)(a)	2nd	Burglary of occupied dwelling;
18			unarmed; no assault or battery.
19	810.02(3)(b)	2nd	Burglary of unoccupied dwelling;
20			unarmed; no assault or battery.
21	810.02(3)(d)	2nd	Burglary of occupied conveyance;
22			unarmed; no assault or battery.
23	812.014(2)(a)	1st	Property stolen, valued at
24			\$100,000 or more; cargo stolen
25			valued at \$50,000 or more;
26			property stolen while causing
27			other property damage; 1st degree
28			grand theft.
29	812.014(2)(b)3.	2nd	Property stolen, emergency
30			medical equipment; 2nd degree
31			grand theft.

1	812.0145(2)(a)	1st	Theft from person 65 years of age
2			or older; \$50,000 or more.
3	812.019(2)	1st	Stolen property; initiates,
4			organizes, plans, etc., the theft
5			of property and traffics in
6			stolen property.
7	812.131(2)(a)	2nd	Robbery by sudden snatching.
8	812.133(2)(b)	1st	Carjacking; no firearm, deadly
9			weapon, or other weapon.
10	817.234(8)(a)	2nd	Solicitation of motor vehicle
11			accident victims with intent to
12			defraud.
13	817.234(9)	2nd	Organizing, planning, or
14			participating in an intentional
15			motor vehicle collision.
16	817.234(11)(c)	1st	Insurance fraud; property value
17			\$100,000 or more.
18	817.2341(2)(b)&		
19	(3)(b)	1st	Making false entries of material
20			fact or false statements
21			regarding property values
22			relating to the solvency of an
23			insuring entity which are a
24			significant cause of the
25			insolvency of that entity.
26	825.102(3)(b)	2nd	Neglecting an elderly person or
27			disabled adult causing great
28			bodily harm, disability, or
29			disfigurement.
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1	825.103(2)(b)	2nd	Exploiting an elderly person or
2			disabled adult and property is
3			valued at \$20,000 or more, but
4			less than \$100,000.
5	827.03(3)(b)	2nd	Neglect of a child causing great
6			bodily harm, disability, or
7			disfigurement.
8	827.04(3)	3rd	Impregnation of a child under 16
9			years of age by person 21 years
10			of age or older.
11	837.05(2)	3rd	Giving false information about
12			alleged capital felony to a law
13			enforcement officer.
14	838.015	2nd	Bribery.
15	838.016	2nd	Unlawful compensation or reward
16			for official behavior.
17	838.021(3)(a)	2nd	Unlawful harm to a public
18			servant.
19	838.22	2nd	Bid tampering.
20	872.06	2nd	Abuse of a dead human body.
21	893.13(1)(c)1.	1st	Sell, manufacture, or deliver
22			cocaine (or other drug prohibited
23			under s. 893.03(1)(a), (1)(b),
24			(1)(d), (2)(a), (2)(b), or
25			(2)(c)4.) within 1,000 feet of a
26			child care facility, school, or
27			state, county, or municipal park
28			or publicly owned recreational
29			facility or community center.
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1	893.13(1)(e)1.	1st	Sell, manufacture, or deliver
2			cocaine or other drug prohibited
3			under s. 893.03(1)(a), (1)(b),
4			(1)(d), (2)(a), (2)(b), or
5			(2)(c)4., within 1,000 feet of
6			property used for religious
7			services or a specified business
8			site.
9	893.13(4)(a)	1st	Deliver to minor cocaine (or
10			other s. 893.03(1)(a), (1)(b),
11			(1)(d), (2)(a), (2)(b), or
12			(2)(c)4. drugs).
13	893.135(1)(a)1.	1st	Trafficking in cannabis, more
14			than 25 lbs., less than 2,000
15			lbs.
16	893.135		
17	(1)(b)1.a.	1st	Trafficking in cocaine, more than
18			28 grams, less than 200 grams.
19	893.135		
20	(1)(c)1.a.	1st	Trafficking in illegal drugs,
21			more than 4 grams, less than 14
22			grams.
23	893.135		
24	(1)(d)1.	1st	Trafficking in phencyclidine,
25			more than 28 grams, less than 200
26			grams.
27	893.135(1)(e)1.	1st	Trafficking in methaqualone, more
28			than 200 grams, less than 5
29			kilograms.
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1	893.135(1)(f)1.	1st	Trafficking in amphetamine, more
2			than 14 grams, less than 28
3			grams.
4	893.135		
5	(1)(g)1.a.	1st	Trafficking in flunitrazepam, 4
6			grams or more, less than 14
7			grams.
8	893.135		
9	(1)(h)1.a.	1st	Trafficking in
10			gamma-hydroxybutyric acid (GHB),
11			1 kilogram or more, less than 5
12			kilograms.
13	893.135		
14	(1)(j)1.a.	1st	Trafficking in 1,4-Butanediol, 1
15			kilogram or more, less than 5
16			kilograms.
17	893.135		
18	(1)(k)2.a.	1st	Trafficking in Phenethylamines,
19			10 grams or more, less than 200
20			grams.
21	896.101(5)(a)	3rd	Money laundering, financial
22			transactions exceeding \$300 but
23			less than \$20,000.
24	896.104(4)(a)1.	3rd	Structuring transactions to evade
25			reporting or registration
26			requirements, financial
27			transactions exceeding \$300 but
28			less than \$20,000.

29 Section 30. For the purpose of incorporating the  
 30 amendment to section 932.701, Florida Statutes, in a reference  
 31

1 thereto, subsection (6) of section 705.101, Florida Statutes,  
2 is reenacted to read:

3 705.101 Definitions.--As used in this chapter:

4 (6) "Unclaimed evidence" means any tangible personal  
5 property, including cash, not included within the definition  
6 of "contraband article," as provided in s. 932.701(2), which  
7 was seized by a law enforcement agency, was intended for use  
8 in a criminal or quasi-criminal proceeding, and is retained by  
9 the law enforcement agency or the clerk of the county or  
10 circuit court for 60 days after the final disposition of the  
11 proceeding and to which no claim of ownership has been made.

12 Section 31. For the purpose of incorporating the  
13 amendment to section 932.701, Florida Statutes, in references  
14 thereto, subsection (4) of section 932.703, Florida Statutes,  
15 is reenacted to read:

16 932.703 Forfeiture of contraband article;  
17 exceptions.--

18 (4) In any incident in which possession of any  
19 contraband article defined in s. 932.701(2)(a) constitutes a  
20 felony, the vessel, motor vehicle, aircraft, other personal  
21 property, or real property in or on which such contraband  
22 article is located at the time of seizure shall be contraband  
23 subject to forfeiture. It shall be presumed in the manner  
24 provided in s. 90.302(2) that the vessel, motor vehicle,  
25 aircraft, other personal property, or real property in which  
26 or on which such contraband article is located at the time of  
27 seizure is being used or was attempted or intended to be used  
28 in a manner to facilitate the transportation, carriage,  
29 conveyance, concealment, receipt, possession, purchase, sale,  
30 barter, exchange, or giving away of a contraband article  
31 defined in s. 932.701(2).

1           Section 32. The Agency for Health Care Administration  
2 shall report to the President of the Senate and the Speaker of  
3 the House of Representatives, by January 1, 2005, on the  
4 feasibility of creating a database of valid prescriber  
5 information for the purpose of notifying pharmacies of  
6 prescribers qualified to write prescriptions for Medicaid  
7 beneficiaries, or in the alternative, of prescribers not  
8 qualified to write prescriptions for Medicaid beneficiaries.  
9 The report shall include information on the system changes  
10 necessary to implement this paragraph, as well as the cost of  
11 implementing the changes.

12           Section 33. The sum of \$262,087 is appropriated from  
13 the Medical Quality Assurance Trust Fund to the Department of  
14 Health, and four full-time equivalent positions are  
15 authorized, for the purpose of implementing the provisions of  
16 this act during the 2004-2005 fiscal year.

17           Section 34. This act shall take effect July 1, 2004.  
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