By Senator Saunders

37-1161A-04

1 A bill to be entitled
2 An act relating to Medicaid prescription fraud;
3 amending s. 16.56, F.S.; adding criminal
4 violations of s. 409.920 or s. 409.9201, F.S.,
5 to the list of specified crimes within the
6 jurisdiction of the Office of Statewide
7 Prosecution; amending s. 409.912, F.S.; giving
8 the Agency for Health Care Administration the
9 authority to require a confirmation or second
10 physician's opinion of the correct diagnosis
11 before authorizing payment for medical
12 treatment; authorizing the Agency for Health
13 Care Administration to impose mandatory
14 enrollment in drug-therapy-management or
15 disease-management programs for certain
16 categories of recipients; allowing termination
17 of certain practitioners from the Medicaid
18 program; providing that Medicaid recipients may
19 be mandated to participate in a provider
20 lock-in program; amending s. 409.913, F.S.;
21 providing specified conditions for providers to
22 meet in order to submit claims to the Medicaid
23 program; providing that claims may be denied if
24 not properly submitted; providing that the
25 agency may seek any remedy under law if a
26 provider submits specified false or erroneous
27 claims; providing that suspension or
28 termination precludes participation in the
29 Medicaid program; providing that the agency is
30 required to report administrative sanctions to
31 licensing authorities for certain violations;

1 providing that the agency may withhold payment
2 to a provider under certain circumstances;
3 providing that the agency shall deny payments
4 to terminated or suspended providers;
5 authorizing the agency to adopt rules;
6 providing for limiting, restricting, or
7 suspending Medicaid eligibility of Medicaid
8 recipients convicted of certain crimes or
9 offenses; authorizing the agency head or
10 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 an additional statement on Medicaid
21 cost reports certifying that Medicaid providers
22 are familiar with the laws and regulations
23 regarding the provision of health care services
24 under the Medicaid program; amending s.
25 409.920, F.S.; making it unlawful to knowingly
26 use or endeavor to use a Medicaid provider's or
27 a Medicaid recipient's identification number or
28 cause to be made, or aid and abet in the making
29 of, a claim for items or services that are not
30 authorized to be reimbursed under the Medicaid
31 program; defining the term "paid for"; creating

1 s. 409.9201, F.S.; providing definitions;
2 providing that a person who knowingly sells or
3 attempts to sell legend drugs obtained through
4 the Medicaid program commits a felony;
5 providing that a person who knowingly purchases
6 or attempts to purchase legend drugs obtained
7 through the Medicaid program and intended for
8 the use of another commits a felony; providing
9 that a person who knowingly makes or conspires
10 to make false representations for the purpose
11 of obtaining goods or services from the
12 Medicaid program commits a felony; providing
13 specified criminal penalties depending on the
14 value of the legend drugs or goods or services
15 obtained from the Medicaid program; amending s.
16 456.072, F.S.; providing an additional ground
17 under which a health care practitioner who
18 prescribes medicinal drugs or controlled
19 substances may be subject to discipline by the
20 Department of Health or the appropriate board
21 having jurisdiction over the health care
22 practitioner; authorizing the Department of
23 Health to initiate a disciplinary investigation
24 of prescribing practitioners under specified
25 circumstances; amending s. 465.188, F.S.;
26 deleting the requirement that the Agency for
27 Health Care Administration give pharmacists at
28 least 1 week's notice prior to an audit;
29 specifying an effective date for certain audit
30 criteria; creating s. 812.0191, F.S.; providing
31 definitions; providing that a person who

1 traffics in property paid for in whole or in
2 part by the Medicaid program, or who knowingly
3 finances, directs, or traffics in such
4 property, commits a felony; providing specified
5 criminal penalties depending on the value of
6 the property; amending s. 895.02, F.S.; adding
7 Medicaid recipient fraud to the definition of
8 the term "racketeering activity"; amending s.
9 905.34, F.S.; adding any criminal violation of
10 s. 409.920 or s. 409.9201, F.S., to the list of
11 crimes within the jurisdiction of the statewide
12 grand jury; providing an effective date.
13
14 Be It Enacted by the Legislature of the State of Florida:
15
16 Section 1. Subsection (1) of section 16.56, Florida
17 Statutes, is amended to read:
18 16.56 Office of Statewide Prosecution.--
19 (1) There is created in the Department of Legal
20 Affairs an Office of Statewide Prosecution. The office shall
21 be a separate "budget entity" as that term is defined in
22 chapter 216. The office may:
23 (a) Investigate and prosecute the offenses of:
24 1. Bribery, burglary, criminal usury, extortion,
25 gambling, kidnapping, larceny, murder, prostitution, perjury,
26 robbery, carjacking, and home-invasion robbery;
27 2. Any crime involving narcotic or other dangerous
28 drugs;
29 3. Any violation of the provisions of the Florida RICO
30 (Racketeer Influenced and Corrupt Organization) Act, including
31 any offense listed in the definition of racketeering activity

1 in s. 895.02(1)(a), providing such listed offense is
2 investigated in connection with a violation of s. 895.03 and
3 is charged in a separate count of an information or indictment
4 containing a count charging a violation of s. 895.03, the
5 prosecution of which listed offense may continue independently
6 if the prosecution of the violation of s. 895.03 is terminated
7 for any reason;
8 4. Any violation of the provisions of the Florida
9 Anti-Fencing Act;
10 5. Any violation of the provisions of the Florida
11 Antitrust Act of 1980, as amended;
12 6. Any crime involving, or resulting in, fraud or
13 deceit upon any person;
14 7. Any violation of s. 847.0135, relating to computer
15 pornography and child exploitation prevention, or any offense
16 related to a violation of s. 847.0135;
17 8. Any violation of the provisions of chapter 815; ~~or~~
18 9. Any criminal violation of part I of chapter 499; or
19 10. Any criminal violation of s. 409.920 or s.
20 409.9201;
21
22 or any attempt, solicitation, or conspiracy to commit any of
23 the crimes specifically enumerated above. The office shall
24 have such power only when any such offense is occurring, or
25 has occurred, in two or more judicial circuits as part of a
26 related transaction, or when any such offense is connected
27 with an organized criminal conspiracy affecting two or more
28 judicial circuits.
29 (b) Upon request, cooperate with and assist state
30 attorneys and state and local law enforcement officials in
31 their efforts against organized crimes.

1 (c) Request and receive from any department, division,
2 board, bureau, commission, or other agency of the state, or of
3 any political subdivision thereof, cooperation and assistance
4 in the performance of its duties.
5 Section 2. Section 409.912, Florida Statutes, is
6 amended to read:
7 409.912 Cost-effective purchasing of health care.--The
8 agency shall purchase goods and services for Medicaid
9 recipients in the most cost-effective manner consistent with
10 the delivery of quality medical care. To ensure that medical
11 services are effectively utilized, the agency may, in any
12 case, require a confirmation or second physician's opinion of
13 the correct diagnosis before authorizing payment for medical
14 treatment. Such confirmation or second opinion shall be
15 rendered in a manner approved by the agency.The agency shall
16 maximize the use of prepaid per capita and prepaid aggregate
17 fixed-sum basis services when appropriate and other
18 alternative service delivery and reimbursement methodologies,
19 including competitive bidding pursuant to s. 287.057, designed
20 to facilitate the cost-effective purchase of a case-managed
21 continuum of care. The agency shall also require providers to
22 minimize the exposure of recipients to the need for acute
23 inpatient, custodial, and other institutional care and the
24 inappropriate or unnecessary use of high-cost services. The
25 agency may mandate ~~establish~~ prior authorization, drug therapy
26 management, or disease management participation ~~requirements~~
27 for certain populations of Medicaid beneficiaries, certain
28 drug classes, or particular drugs to prevent fraud, abuse,
29 overuse, and possible dangerous drug interactions. The
30 Pharmaceutical and Therapeutics Committee shall make
31 recommendations to the agency on drugs for which prior

1 authorization is required. The agency shall inform the
2 Pharmaceutical and Therapeutics Committee of its decisions
3 regarding drugs subject to prior authorization.
4 (1) The agency shall work with the Department of
5 Children and Family Services to ensure access of children and
6 families in the child protection system to needed and
7 appropriate mental health and substance abuse services.
8 (2) The agency may enter into agreements with
9 appropriate agents of other state agencies or of any agency of
10 the Federal Government and accept such duties in respect to
11 social welfare or public aid as may be necessary to implement
12 the provisions of Title XIX of the Social Security Act and ss.
13 409.901-409.920.
14 (3) The agency may contract with health maintenance
15 organizations certified pursuant to part I of chapter 641 for
16 the provision of services to recipients.
17 (4) The agency may contract with:
18 (a) An entity that provides no prepaid health care
19 services other than Medicaid services under contract with the
20 agency and which is owned and operated by a county, county
21 health department, or county-owned and operated hospital to
22 provide health care services on a prepaid or fixed-sum basis
23 to recipients, which entity may provide such prepaid services
24 either directly or through arrangements with other providers.
25 Such prepaid health care services entities must be licensed
26 under parts I and III by January 1, 1998, and until then are
27 exempt from the provisions of part I of chapter 641. An entity
28 recognized under this paragraph which demonstrates to the
29 satisfaction of the Office of Insurance Regulation of the
30 Financial Services Commission that it is backed by the full
31

1 faith and credit of the county in which it is located may be
2 exempted from s. 641.225.
3 (b) An entity that is providing comprehensive
4 behavioral health care services to certain Medicaid recipients
5 through a capitated, prepaid arrangement pursuant to the
6 federal waiver provided for by s. 409.905(5). Such an entity
7 must be licensed under chapter 624, chapter 636, or chapter
8 641 and must possess the clinical systems and operational
9 competence to manage risk and provide comprehensive behavioral
10 health care to Medicaid recipients. As used in this paragraph,
11 the term "comprehensive behavioral health care services" means
12 covered mental health and substance abuse treatment services
13 that are available to Medicaid recipients. The secretary of
14 the Department of Children and Family Services shall approve
15 provisions of procurements related to children in the
16 department's care or custody prior to enrolling such children
17 in a prepaid behavioral health plan. Any contract awarded
18 under this paragraph must be competitively procured. In
19 developing the behavioral health care prepaid plan procurement
20 document, the agency shall ensure that the procurement
21 document requires the contractor to develop and implement a
22 plan to ensure compliance with s. 394.4574 related to services
23 provided to residents of licensed assisted living facilities
24 that hold a limited mental health license. The agency shall
25 seek federal approval to contract with a single entity meeting
26 these requirements to provide comprehensive behavioral health
27 care services to all Medicaid recipients in an AHCA area. Each
28 entity must offer sufficient choice of providers in its
29 network to ensure recipient access to care and the opportunity
30 to select a provider with whom they are satisfied. The network
31 shall include all public mental health hospitals. To ensure

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1 unimpaired access to behavioral health care services by
2 Medicaid recipients, all contracts issued pursuant to this
3 paragraph shall require 80 percent of the capitation paid to
4 the managed care plan, including health maintenance
5 organizations, to be expended for the provision of behavioral
6 health care services. In the event the managed care plan
7 expends less than 80 percent of the capitation paid pursuant
8 to this paragraph for the provision of behavioral health care
9 services, the difference shall be returned to the agency. The
10 agency shall provide the managed care plan with a
11 certification letter indicating the amount of capitation paid
12 during each calendar year for the provision of behavioral
13 health care services pursuant to this section. The agency may
14 reimburse for substance abuse treatment services on a
15 fee-for-service basis until the agency finds that adequate
16 funds are available for capitated, prepaid arrangements.
17 1. By January 1, 2001, the agency shall modify the
18 contracts with the entities providing comprehensive inpatient
19 and outpatient mental health care services to Medicaid
20 recipients in Hillsborough, Highlands, Hardee, Manatee, and
21 Polk Counties, to include substance abuse treatment services.
22 2. By July 1, 2003, the agency and the Department of
23 Children and Family Services shall execute a written agreement
24 that requires collaboration and joint development of all
25 policy, budgets, procurement documents, contracts, and
26 monitoring plans that have an impact on the state and Medicaid
27 community mental health and targeted case management programs.
28 3. By July 1, 2006, the agency and the Department of
29 Children and Family Services shall contract with managed care
30 entities in each AHCA area except area 6 or arrange to provide
31 comprehensive inpatient and outpatient mental health and

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1 substance abuse services through capitated prepaid
2 arrangements to all Medicaid recipients who are eligible to
3 participate in such plans under federal law and regulation. In
4 AHCA areas where eligible individuals number less than
5 150,000, the agency shall contract with a single managed care
6 plan. The agency may contract with more than one plan in AHCA
7 areas where the eligible population exceeds 150,000. Contracts
8 awarded pursuant to this section shall be competitively
9 procured. Both for-profit and not-for-profit corporations
10 shall be eligible to compete.
11 4. By October 1, 2003, the agency and the department
12 shall submit a plan to the Governor, the President of the
13 Senate, and the Speaker of the House of Representatives which
14 provides for the full implementation of capitated prepaid
15 behavioral health care in all areas of the state. The plan
16 shall include provisions which ensure that children and
17 families receiving foster care and other related services are
18 appropriately served and that these services assist the
19 community-based care lead agencies in meeting the goals and
20 outcomes of the child welfare system. The plan will be
21 developed with the participation of community-based lead
22 agencies, community alliances, sheriffs, and community
23 providers serving dependent children.
24 a. Implementation shall begin in 2003 in those AHCA
25 areas of the state where the agency is able to establish
26 sufficient capitation rates.
27 b. If the agency determines that the proposed
28 capitation rate in any area is insufficient to provide
29 appropriate services, the agency may adjust the capitation
30 rate to ensure that care will be available. The agency and the
31 department may use existing general revenue to address any

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1 additional required match but may not over-obligate existing
2 funds on an annualized basis.
3 c. Subject to any limitations provided for in the
4 General Appropriations Act, the agency, in compliance with
5 appropriate federal authorization, shall develop policies and
6 procedures that allow for certification of local and state
7 funds.
8 5. Children residing in a statewide inpatient
9 psychiatric program, or in a Department of Juvenile Justice or
10 a Department of Children and Family Services residential
11 program approved as a Medicaid behavioral health overlay
12 services provider shall not be included in a behavioral health
13 care prepaid health plan pursuant to this paragraph.
14 6. In converting to a prepaid system of delivery, the
15 agency shall in its procurement document require an entity
16 providing comprehensive behavioral health care services to
17 prevent the displacement of indigent care patients by
18 enrollees in the Medicaid prepaid health plan providing
19 behavioral health care services from facilities receiving
20 state funding to provide indigent behavioral health care, to
21 facilities licensed under chapter 395 which do not receive
22 state funding for indigent behavioral health care, or
23 reimburse the unsubsidized facility for the cost of behavioral
24 health care provided to the displaced indigent care patient.
25 7. Traditional community mental health providers under
26 contract with the Department of Children and Family Services
27 pursuant to part IV of chapter 394, child welfare providers
28 under contract with the Department of Children and Family
29 Services, and inpatient mental health providers licensed
30 pursuant to chapter 395 must be offered an opportunity to
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1 accept or decline a contract to participate in any provider
2 network for prepaid behavioral health services.
3 (c) A federally qualified health center or an entity
4 owned by one or more federally qualified health centers or an
5 entity owned by other migrant and community health centers
6 receiving non-Medicaid financial support from the Federal
7 Government to provide health care services on a prepaid or
8 fixed-sum basis to recipients. Such prepaid health care
9 services entity must be licensed under parts I and III of
10 chapter 641, but shall be prohibited from serving Medicaid
11 recipients on a prepaid basis, until such licensure has been
12 obtained. However, such an entity is exempt from s. 641.225
13 if the entity meets the requirements specified in subsections
14 (15) and (16).
15 (d) A provider service network may be reimbursed on a
16 fee-for-service or prepaid basis. A provider service network
17 which is reimbursed by the agency on a prepaid basis shall be
18 exempt from parts I and III of chapter 641, but must meet
19 appropriate financial reserve, quality assurance, and patient
20 rights requirements as established by the agency. The agency
21 shall award contracts on a competitive bid basis and shall
22 select bidders based upon price and quality of care. Medicaid
23 recipients assigned to a demonstration project shall be chosen
24 equally from those who would otherwise have been assigned to
25 prepaid plans and MediPass. The agency is authorized to seek
26 federal Medicaid waivers as necessary to implement the
27 provisions of this section.
28 (e) An entity that provides comprehensive behavioral
29 health care services to certain Medicaid recipients through an
30 administrative services organization agreement. Such an entity
31 must possess the clinical systems and operational competence

1 to provide comprehensive health care to Medicaid recipients.
2 As used in this paragraph, the term "comprehensive behavioral
3 health care services" means covered mental health and
4 substance abuse treatment services that are available to
5 Medicaid recipients. Any contract awarded under this paragraph
6 must be competitively procured. The agency must ensure that
7 Medicaid recipients have available the choice of at least two
8 managed care plans for their behavioral health care services.
9 (f) An entity that provides in-home physician services
10 to test the cost-effectiveness of enhanced home-based medical
11 care to Medicaid recipients with degenerative neurological
12 diseases and other diseases or disabling conditions associated
13 with high costs to Medicaid. The program shall be designed to
14 serve very disabled persons and to reduce Medicaid reimbursed
15 costs for inpatient, outpatient, and emergency department
16 services. The agency shall contract with vendors on a
17 risk-sharing basis.
18 (g) Children's provider networks that provide care
19 coordination and care management for Medicaid-eligible
20 pediatric patients, primary care, authorization of specialty
21 care, and other urgent and emergency care through organized
22 providers designed to service Medicaid eligibles under age 18
23 and pediatric emergency departments' diversion programs. The
24 networks shall provide after-hour operations, including
25 evening and weekend hours, to promote, when appropriate, the
26 use of the children's networks rather than hospital emergency
27 departments.
28 (h) An entity authorized in s. 430.205 to contract
29 with the agency and the Department of Elderly Affairs to
30 provide health care and social services on a prepaid or
31 fixed-sum basis to elderly recipients. Such prepaid health

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1 care services entities are exempt from the provisions of part
2 I of chapter 641 for the first 3 years of operation. An entity
3 recognized under this paragraph that demonstrates to the
4 satisfaction of the Office of Insurance Regulation that it is
5 backed by the full faith and credit of one or more counties in
6 which it operates may be exempted from s. 641.225.
7 (i) A Children's Medical Services network, as defined
8 in s. 391.021.
9 (5) By October 1, 2003, the agency and the department
10 shall, to the extent feasible, develop a plan for implementing
11 new Medicaid procedure codes for emergency and crisis care,
12 supportive residential services, and other services designed
13 to maximize the use of Medicaid funds for Medicaid-eligible
14 recipients. The agency shall include in the agreement
15 developed pursuant to subsection (4) a provision that ensures
16 that the match requirements for these new procedure codes are
17 met by certifying eligible general revenue or local funds that
18 are currently expended on these services by the department
19 with contracted alcohol, drug abuse, and mental health
20 providers. The plan must describe specific procedure codes to
21 be implemented, a projection of the number of procedures to be
22 delivered during fiscal year 2003-2004, and a financial
23 analysis that describes the certified match procedures, and
24 accountability mechanisms, projects the earnings associated
25 with these procedures, and describes the sources of state
26 match. This plan may not be implemented in any part until
27 approved by the Legislative Budget Commission. If such
28 approval has not occurred by December 31, 2003, the plan shall
29 be submitted for consideration by the 2004 Legislature.
30 (6) The agency may contract with any public or private
31 entity otherwise authorized by this section on a prepaid or

1 fixed-sum basis for the provision of health care services to
2 recipients. An entity may provide prepaid services to
3 recipients, either directly or through arrangements with other
4 entities, if each entity involved in providing services:
5 (a) Is organized primarily for the purpose of
6 providing health care or other services of the type regularly
7 offered to Medicaid recipients;
8 (b) Ensures that services meet the standards set by
9 the agency for quality, appropriateness, and timeliness;
10 (c) Makes provisions satisfactory to the agency for
11 insolvency protection and ensures that neither enrolled
12 Medicaid recipients nor the agency will be liable for the
13 debts of the entity;
14 (d) Submits to the agency, if a private entity, a
15 financial plan that the agency finds to be fiscally sound and
16 that provides for working capital in the form of cash or
17 equivalent liquid assets excluding revenues from Medicaid
18 premium payments equal to at least the first 3 months of
19 operating expenses or $200,000, whichever is greater;
20 (e) Furnishes evidence satisfactory to the agency of
21 adequate liability insurance coverage or an adequate plan of
22 self-insurance to respond to claims for injuries arising out
23 of the furnishing of health care;
24 (f) Provides, through contract or otherwise, for
25 periodic review of its medical facilities and services, as
26 required by the agency; and
27 (g) Provides organizational, operational, financial,
28 and other information required by the agency.
29 (7) The agency may contract on a prepaid or fixed-sum
30 basis with any health insurer that:
31

1 (a) Pays for health care services provided to enrolled
2 Medicaid recipients in exchange for a premium payment paid by
3 the agency;
4 (b) Assumes the underwriting risk; and
5 (c) Is organized and licensed under applicable
6 provisions of the Florida Insurance Code and is currently in
7 good standing with the Office of Insurance Regulation.
8 (8) The agency may contract on a prepaid or fixed-sum
9 basis with an exclusive provider organization to provide
10 health care services to Medicaid recipients provided that the
11 exclusive provider organization meets applicable managed care
12 plan requirements in this section, ss. 409.9122, 409.9123,
13 409.9128, and 627.6472, and other applicable provisions of
14 law.
15 (9) The Agency for Health Care Administration may
16 provide cost-effective purchasing of chiropractic services on
17 a fee-for-service basis to Medicaid recipients through
18 arrangements with a statewide chiropractic preferred provider
19 organization incorporated in this state as a not-for-profit
20 corporation. The agency shall ensure that the benefit limits
21 and prior authorization requirements in the current Medicaid
22 program shall apply to the services provided by the
23 chiropractic preferred provider organization.
24 (10) The agency shall not contract on a prepaid or
25 fixed-sum basis for Medicaid services with an entity which
26 knows or reasonably should know that any officer, director,
27 agent, managing employee, or owner of stock or beneficial
28 interest in excess of 5 percent common or preferred stock, or
29 the entity itself, has been found guilty of, regardless of
30 adjudication, or entered a plea of nolo contendere, or guilty,
31 to:

1 (a) Fraud;
2 (b) Violation of federal or state antitrust statutes,
3 including those proscribing price fixing between competitors
4 and the allocation of customers among competitors;
5 (c) Commission of a felony involving embezzlement,
6 theft, forgery, income tax evasion, bribery, falsification or
7 destruction of records, making false statements, receiving
8 stolen property, making false claims, or obstruction of
9 justice; or
10 (d) Any crime in any jurisdiction which directly
11 relates to the provision of health services on a prepaid or
12 fixed-sum basis.
13 (11) The agency, after notifying the Legislature, may
14 apply for waivers of applicable federal laws and regulations
15 as necessary to implement more appropriate systems of health
16 care for Medicaid recipients and reduce the cost of the
17 Medicaid program to the state and federal governments and
18 shall implement such programs, after legislative approval,
19 within a reasonable period of time after federal approval.
20 These programs must be designed primarily to reduce the need
21 for inpatient care, custodial care and other long-term or
22 institutional care, and other high-cost services.
23 (a) Prior to seeking legislative approval of such a
24 waiver as authorized by this subsection, the agency shall
25 provide notice and an opportunity for public comment. Notice
26 shall be provided to all persons who have made requests of the
27 agency for advance notice and shall be published in the
28 Florida Administrative Weekly not less than 28 days prior to
29 the intended action.
30 (b) Notwithstanding s. 216.292, funds that are
31 appropriated to the Department of Elderly Affairs for the

1 Assisted Living for the Elderly Medicaid waiver and are not
2 expended shall be transferred to the agency to fund
3 Medicaid-reimbursed nursing home care.
4 (12) The agency shall establish a postpayment
5 utilization control program designed to identify recipients
6 who may inappropriately overuse or underuse Medicaid services
7 and shall provide methods to correct such misuse.
8 (13) The agency shall develop and provide coordinated
9 systems of care for Medicaid recipients and may contract with
10 public or private entities to develop and administer such
11 systems of care among public and private health care providers
12 in a given geographic area.
13 (14) The agency shall operate or contract for the
14 operation of utilization management and incentive systems
15 designed to encourage cost-effective use services.
16 (15)(a) The agency shall operate the Comprehensive
17 Assessment and Review (CARES) nursing facility preadmission
18 screening program to ensure that Medicaid payment for nursing
19 facility care is made only for individuals whose conditions
20 require such care and to ensure that long-term care services
21 are provided in the setting most appropriate to the needs of
22 the person and in the most economical manner possible. The
23 CARES program shall also ensure that individuals participating
24 in Medicaid home and community-based waiver programs meet
25 criteria for those programs, consistent with approved federal
26 waivers.
27 (b) The agency shall operate the CARES program through
28 an interagency agreement with the Department of Elderly
29 Affairs.
30 (c) Prior to making payment for nursing facility
31 services for a Medicaid recipient, the agency must verify that

1 the nursing facility preadmission screening program has
2 determined that the individual requires nursing facility care
3 and that the individual cannot be safely served in
4 community-based programs. The nursing facility preadmission
5 screening program shall refer a Medicaid recipient to a
6 community-based program if the individual could be safely
7 served at a lower cost and the recipient chooses to
8 participate in such program.
9 (d) By January 1 of each year, the agency shall submit
10 a report to the Legislature and the Office of Long-Term-Care
11 Policy describing the operations of the CARES program. The
12 report must describe:
13 1. Rate of diversion to community alternative
14 programs;
15 2. CARES program staffing needs to achieve additional
16 diversions;
17 3. Reasons the program is unable to place individuals
18 in less restrictive settings when such individuals desired
19 such services and could have been served in such settings;
20 4. Barriers to appropriate placement, including
21 barriers due to policies or operations of other agencies or
22 state-funded programs; and
23 5. Statutory changes necessary to ensure that
24 individuals in need of long-term care services receive care in
25 the least restrictive environment.
26 (16)(a) The agency shall identify health care
27 utilization and price patterns within the Medicaid program
28 which are not cost-effective or medically appropriate and
29 assess the effectiveness of new or alternate methods of
30 providing and monitoring service, and may implement such
31 methods as it considers appropriate. Such methods may include

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1 disease management initiatives, an integrated and systematic
2 approach for managing the health care needs of recipients who
3 are at risk of or diagnosed with a specific disease by using
4 best practices, prevention strategies, clinical-practice
5 improvement, clinical interventions and protocols, outcomes
6 research, information technology, and other tools and
7 resources to reduce overall costs and improve measurable
8 outcomes.
9 (b) The responsibility of the agency under this
10 subsection shall include the development of capabilities to
11 identify actual and optimal practice patterns; patient and
12 provider educational initiatives; methods for determining
13 patient compliance with prescribed treatments; fraud, waste,
14 and abuse prevention and detection programs; and beneficiary
15 case management programs.
16 1. The practice pattern identification program shall
17 evaluate practitioner prescribing patterns based on national
18 and regional practice guidelines, comparing practitioners to
19 their peer groups. The agency and its Drug Utilization Review
20 Board shall consult with the Department of Health and a panel
21 of practicing health care professionals consisting of the
22 following: the Speaker of the House of Representatives and the
23 President of the Senate shall each appoint three physicians
24 licensed under chapter 458 or chapter 459; and the Governor
25 shall appoint two pharmacists licensed under chapter 465 and
26 one dentist licensed under chapter 466 who is an oral surgeon.
27 Terms of the panel members shall expire at the discretion of
28 the appointing official. The panel shall begin its work by
29 August 1, 1999, regardless of the number of appointments made
30 by that date. The advisory panel shall be responsible for
31 evaluating treatment guidelines and recommending ways to

1 incorporate their use in the practice pattern identification
2 program. Practitioners who are prescribing inappropriately or
3 inefficiently, as determined by the agency, may have their
4 prescribing of certain drugs subject to prior authorization or
5 may be terminated from all participation in the Medicaid
6 program.
7 2. The agency shall also develop educational
8 interventions designed to promote the proper use of
9 medications by providers and beneficiaries.
10 3. The agency shall implement a pharmacy fraud, waste,
11 and abuse initiative that may include a surety bond or letter
12 of credit requirement for participating pharmacies, enhanced
13 provider auditing practices, the use of additional fraud and
14 abuse software, recipient management programs for
15 beneficiaries inappropriately using their benefits, and other
16 steps that will eliminate provider and recipient fraud, waste,
17 and abuse. The initiative shall address enforcement efforts to
18 reduce the number and use of counterfeit prescriptions.
19 4. By September 30, 2002, the agency shall contract
20 with an entity in the state to implement a wireless handheld
21 clinical pharmacology drug information database for
22 practitioners. The initiative shall be designed to enhance the
23 agency's efforts to reduce fraud, abuse, and errors in the
24 prescription drug benefit program and to otherwise further the
25 intent of this paragraph.
26 5. The agency may apply for any federal waivers needed
27 to implement this paragraph.
28 (17) An entity contracting on a prepaid or fixed-sum
29 basis shall, in addition to meeting any applicable statutory
30 surplus requirements, also maintain at all times in the form
31 of cash, investments that mature in less than 180 days

1 allowable as admitted assets by the Office of Insurance
2 Regulation, and restricted funds or deposits controlled by the
3 agency or the Office of Insurance Regulation, a surplus amount
4 equal to one-and-one-half times the entity's monthly Medicaid
5 prepaid revenues. As used in this subsection, the term
6 "surplus" means the entity's total assets minus total
7 liabilities. If an entity's surplus falls below an amount
8 equal to one-and-one-half times the entity's monthly Medicaid
9 prepaid revenues, the agency shall prohibit the entity from
10 engaging in marketing and preenrollment activities, shall
11 cease to process new enrollments, and shall not renew the
12 entity's contract until the required balance is achieved. The
13 requirements of this subsection do not apply:
14 (a) Where a public entity agrees to fund any deficit
15 incurred by the contracting entity; or
16 (b) Where the entity's performance and obligations are
17 guaranteed in writing by a guaranteeing organization which:
18 1. Has been in operation for at least 5 years and has
19 assets in excess of $50 million; or
20 2. Submits a written guarantee acceptable to the
21 agency which is irrevocable during the term of the contracting
22 entity's contract with the agency and, upon termination of the
23 contract, until the agency receives proof of satisfaction of
24 all outstanding obligations incurred under the contract.
25 (18)(a) The agency may require an entity contracting
26 on a prepaid or fixed-sum basis to establish a restricted
27 insolvency protection account with a federally guaranteed
28 financial institution licensed to do business in this state.
29 The entity shall deposit into that account 5 percent of the
30 capitation payments made by the agency each month until a
31 maximum total of 2 percent of the total current contract

1 amount is reached. The restricted insolvency protection
2 account may be drawn upon with the authorized signatures of
3 two persons designated by the entity and two representatives
4 of the agency. If the agency finds that the entity is
5 insolvent, the agency may draw upon the account solely with
6 the two authorized signatures of representatives of the
7 agency, and the funds may be disbursed to meet financial
8 obligations incurred by the entity under the prepaid contract.
9 If the contract is terminated, expired, or not continued, the
10 account balance must be released by the agency to the entity
11 upon receipt of proof of satisfaction of all outstanding
12 obligations incurred under this contract.
13 (b) The agency may waive the insolvency protection
14 account requirement in writing when evidence is on file with
15 the agency of adequate insolvency insurance and reinsurance
16 that will protect enrollees if the entity becomes unable to
17 meet its obligations.
18 (19) An entity that contracts with the agency on a
19 prepaid or fixed-sum basis for the provision of Medicaid
20 services shall reimburse any hospital or physician that is
21 outside the entity's authorized geographic service area as
22 specified in its contract with the agency, and that provides
23 services authorized by the entity to its members, at a rate
24 negotiated with the hospital or physician for the provision of
25 services or according to the lesser of the following:
26 (a) The usual and customary charges made to the
27 general public by the hospital or physician; or
28 (b) The Florida Medicaid reimbursement rate
29 established for the hospital or physician.
30 (20) When a merger or acquisition of a Medicaid
31 prepaid contractor has been approved by the Office of

1 Insurance Regulation pursuant to s. 628.4615, the agency shall
2 approve the assignment or transfer of the appropriate Medicaid
3 prepaid contract upon request of the surviving entity of the
4 merger or acquisition if the contractor and the other entity
5 have been in good standing with the agency for the most recent
6 12-month period, unless the agency determines that the
7 assignment or transfer would be detrimental to the Medicaid
8 recipients or the Medicaid program. To be in good standing,
9 an entity must not have failed accreditation or committed any
10 material violation of the requirements of s. 641.52 and must
11 meet the Medicaid contract requirements. For purposes of this
12 section, a merger or acquisition means a change in controlling
13 interest of an entity, including an asset or stock purchase.
14 (21) Any entity contracting with the agency pursuant
15 to this section to provide health care services to Medicaid
16 recipients is prohibited from engaging in any of the following
17 practices or activities:
18 (a) Practices that are discriminatory, including, but
19 not limited to, attempts to discourage participation on the
20 basis of actual or perceived health status.
21 (b) Activities that could mislead or confuse
22 recipients, or misrepresent the organization, its marketing
23 representatives, or the agency. Violations of this paragraph
24 include, but are not limited to:
25 1. False or misleading claims that marketing
26 representatives are employees or representatives of the state
27 or county, or of anyone other than the entity or the
28 organization by whom they are reimbursed.
29 2. False or misleading claims that the entity is
30 recommended or endorsed by any state or county agency, or by
31

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1 any other organization which has not certified its endorsement
2 in writing to the entity.
3 3. False or misleading claims that the state or county
4 recommends that a Medicaid recipient enroll with an entity.
5 4. Claims that a Medicaid recipient will lose benefits
6 under the Medicaid program, or any other health or welfare
7 benefits to which the recipient is legally entitled, if the
8 recipient does not enroll with the entity.
9 (c) Granting or offering of any monetary or other
10 valuable consideration for enrollment, except as authorized by
11 subsection (22).
12 (d) Door-to-door solicitation of recipients who have
13 not contacted the entity or who have not invited the entity to
14 make a presentation.
15 (e) Solicitation of Medicaid recipients by marketing
16 representatives stationed in state offices unless approved and
17 supervised by the agency or its agent and approved by the
18 affected state agency when solicitation occurs in an office of
19 the state agency. The agency shall ensure that marketing
20 representatives stationed in state offices shall market their
21 managed care plans to Medicaid recipients only in designated
22 areas and in such a way as to not interfere with the
23 recipients' activities in the state office.
24 (f) Enrollment of Medicaid recipients.
25 (22) The agency may impose a fine for a violation of
26 this section or the contract with the agency by a person or
27 entity that is under contract with the agency. With respect
28 to any nonwillful violation, such fine shall not exceed $2,500
29 per violation. In no event shall such fine exceed an
30 aggregate amount of $10,000 for all nonwillful violations
31 arising out of the same action. With respect to any knowing

1 and willful violation of this section or the contract with the
2 agency, the agency may impose a fine upon the entity in an
3 amount not to exceed $20,000 for each such violation. In no
4 event shall such fine exceed an aggregate amount of $100,000
5 for all knowing and willful violations arising out of the same
6 action.
7 (23) A health maintenance organization or a person or
8 entity exempt from chapter 641 that is under contract with the
9 agency for the provision of health care services to Medicaid
10 recipients may not use or distribute marketing materials used
11 to solicit Medicaid recipients, unless such materials have
12 been approved by the agency. The provisions of this subsection
13 do not apply to general advertising and marketing materials
14 used by a health maintenance organization to solicit both
15 non-Medicaid subscribers and Medicaid recipients.
16 (24) Upon approval by the agency, health maintenance
17 organizations and persons or entities exempt from chapter 641
18 that are under contract with the agency for the provision of
19 health care services to Medicaid recipients may be permitted
20 within the capitation rate to provide additional health
21 benefits that the agency has found are of high quality, are
22 practicably available, provide reasonable value to the
23 recipient, and are provided at no additional cost to the
24 state.
25 (25) The agency shall utilize the statewide health
26 maintenance organization complaint hotline for the purpose of
27 investigating and resolving Medicaid and prepaid health plan
28 complaints, maintaining a record of complaints and confirmed
29 problems, and receiving disenrollment requests made by
30 recipients.
31

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(26) The agency shall require the publication of the health maintenance organization's and the prepaid health plan's consumer services telephone numbers and the "800" telephone number of the statewide health maintenance organization complaint hotline on each Medicaid identification card issued by a health maintenance organization or prepaid health plan contracting with the agency to serve Medicaid recipients and on each subscriber handbook issued to a Medicaid recipient.

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

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

1. Written quality assurance program descriptions.

2. Responsibilities of the governing body for monitoring, evaluating, and making improvements to care.

3. An active quality assurance committee.

4. Quality assurance program supervision.

5. Requiring the program to have adequate resources to effectively carry out its specified activities.

6. Provider participation in the quality assurance program.

7. Delegation of quality assurance program activities.

8. Credentialing and recredentialing.

9. Enrollee rights and responsibilities.

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1 10. Availability and accessibility to services and
2 care.
3 11. Ambulatory care facilities.
4 12. Accessibility and availability of medical records,
5 as well as proper recordkeeping and process for record review.
6 13. Utilization review.
7 14. A continuity of care system.
8 15. Quality assurance program documentation.
9 16. Coordination of quality assurance activity with
10 other management activity.
11 17. Delivering care to pregnant women and infants; to
12 elderly and disabled recipients, especially those who are at
13 risk of institutional placement; to persons with developmental
14 disabilities; and to adults who have chronic, high-cost
15 medical conditions.
16 (b) Guidelines which require the entities to conduct
17 quality-of-care studies which:
18 1. Target specific conditions and specific health
19 service delivery issues for focused monitoring and evaluation.
20 2. Use clinical care standards or practice guidelines
21 to objectively evaluate the care the entity delivers or fails
22 to deliver for the targeted clinical conditions and health
23 services delivery issues.
24 3. Use quality indicators derived from the clinical
25 care standards or practice guidelines to screen and monitor
26 care and services delivered.
27 (c) Guidelines for external quality review of each
28 contractor which require: focused studies of patterns of care;
29 individual care review in specific situations; and followup
30 activities on previous pattern-of-care study findings and
31 individual-care-review findings. In designing the external

1 quality review function and determining how it is to operate
2 as part of the state's overall quality improvement system, the
3 agency shall construct its external quality review
4 organization and entity contracts to address each of the
5 following:
6 1. Delineating the role of the external quality review
7 organization.
8 2. Length of the external quality review organization
9 contract with the state.
10 3. Participation of the contracting entities in
11 designing external quality review organization review
12 activities.
13 4. Potential variation in the type of clinical
14 conditions and health services delivery issues to be studied
15 at each plan.
16 5. Determining the number of focused pattern-of-care
17 studies to be conducted for each plan.
18 6. Methods for implementing focused studies.
19 7. Individual care review.
20 8. Followup activities.
21 (28) In order to ensure that children receive health
22 care services for which an entity has already been
23 compensated, an entity contracting with the agency pursuant to
24 this section shall achieve an annual Early and Periodic
25 Screening, Diagnosis, and Treatment (EPSDT) Service screening
26 rate of at least 60 percent for those recipients continuously
27 enrolled for at least 8 months. The agency shall develop a
28 method by which the EPSDT screening rate shall be calculated.
29 For any entity which does not achieve the annual 60 percent
30 rate, the entity must submit a corrective action plan for the
31 agency's approval. If the entity does not meet the standard

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

1 (30) Any lists of providers made available to Medicaid
2 recipients, MediPass enrollees, or managed care plan enrollees
3 shall be arranged alphabetically showing the provider's name
4 and specialty and, separately, by specialty in alphabetical
5 order.
6 (31) The agency shall establish an enhanced managed
7 care quality assurance oversight function, to include at least
8 the following components:
9 (a) At least quarterly analysis and followup,
10 including sanctions as appropriate, of managed care
11 participant utilization of services.
12 (b) At least quarterly analysis and followup,
13 including sanctions as appropriate, of quality findings of the
14 Medicaid peer review organization and other external quality
15 assurance programs.
16 (c) At least quarterly analysis and followup,
17 including sanctions as appropriate, of the fiscal viability of
18 managed care plans.
19 (d) At least quarterly analysis and followup,
20 including sanctions as appropriate, of managed care
21 participant satisfaction and disenrollment surveys.
22 (e) The agency shall conduct regular and ongoing
23 Medicaid recipient satisfaction surveys.
24
25 The analyses and followup activities conducted by the agency
26 under its enhanced managed care quality assurance oversight
27 function shall not duplicate the activities of accreditation
28 reviewers for entities regulated under part III of chapter
29 641, but may include a review of the finding of such
30 reviewers.
31

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1 (32) Each managed care plan that is under contract
2 with the agency to provide health care services to Medicaid
3 recipients shall annually conduct a background check with the
4 Florida Department of Law Enforcement of all persons with
5 ownership interest of 5 percent or more or executive
6 management responsibility for the managed care plan and shall
7 submit to the agency information concerning any such person
8 who has been found guilty of, regardless of adjudication, or
9 has entered a plea of nolo contendere or guilty to, any of the
10 offenses listed in s. 435.03.
11 (33) The agency shall, by rule, develop a process
12 whereby a Medicaid managed care plan enrollee who wishes to
13 enter hospice care may be disenrolled from the managed care
14 plan within 24 hours after contacting the agency regarding
15 such request. The agency rule shall include a methodology for
16 the agency to recoup managed care plan payments on a pro rata
17 basis if payment has been made for the enrollment month when
18 disenrollment occurs.
19 (34) The agency and entities which contract with the
20 agency to provide health care services to Medicaid recipients
21 under this section or s. 409.9122 must comply with the
22 provisions of s. 641.513 in providing emergency services and
23 care to Medicaid recipients and MediPass recipients.
24 (35) All entities providing health care services to
25 Medicaid recipients shall make available, and encourage all
26 pregnant women and mothers with infants to receive, and
27 provide documentation in the medical records to reflect, the
28 following:
29 (a) Healthy Start prenatal or infant screening.
30 (b) Healthy Start care coordination, when screening or
31 other factors indicate need.

1 (c) Healthy Start enhanced services in accordance with
2 the prenatal or infant screening results.
3 (d) Immunizations in accordance with recommendations
4 of the Advisory Committee on Immunization Practices of the
5 United States Public Health Service and the American Academy
6 of Pediatrics, as appropriate.
7 (e) Counseling and services for family planning to all
8 women and their partners.
9 (f) A scheduled postpartum visit for the purpose of
10 voluntary family planning, to include discussion of all
11 methods of contraception, as appropriate.
12 (g) Referral to the Special Supplemental Nutrition
13 Program for Women, Infants, and Children (WIC).
14 (36) Any entity that provides Medicaid prepaid health
15 plan services shall ensure the appropriate coordination of
16 health care services with an assisted living facility in cases
17 where a Medicaid recipient is both a member of the entity's
18 prepaid health plan and a resident of the assisted living
19 facility. If the entity is at risk for Medicaid targeted case
20 management and behavioral health services, the entity shall
21 inform the assisted living facility of the procedures to
22 follow should an emergent condition arise.
23 (37) The agency may seek and implement federal waivers
24 necessary to provide for cost-effective purchasing of home
25 health services, private duty nursing services,
26 transportation, independent laboratory services, and durable
27 medical equipment and supplies through competitive bidding
28 pursuant to s. 287.057. The agency may request appropriate
29 waivers from the federal Health Care Financing Administration
30 in order to competitively bid such services. The agency may
31

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1 exclude providers not selected through the bidding process
2 from the Medicaid provider network.
3 (38) The Agency for Health Care Administration is
4 directed to issue a request for proposal or intent to
5 negotiate to implement on a demonstration basis an outpatient
6 specialty services pilot project in a rural and urban county
7 in the state. As used in this subsection, the term
8 "outpatient specialty services" means clinical laboratory,
9 diagnostic imaging, and specified home medical services to
10 include durable medical equipment, prosthetics and orthotics,
11 and infusion therapy.
12 (a) The entity that is awarded the contract to provide
13 Medicaid managed care outpatient specialty services must, at a
14 minimum, meet the following criteria:
15 1. The entity must be licensed by the Office of
16 Insurance Regulation under part II of chapter 641.
17 2. The entity must be experienced in providing
18 outpatient specialty services.
19 3. The entity must demonstrate to the satisfaction of
20 the agency that it provides high-quality services to its
21 patients.
22 4. The entity must demonstrate that it has in place a
23 complaints and grievance process to assist Medicaid recipients
24 enrolled in the pilot managed care program to resolve
25 complaints and grievances.
26 (b) The pilot managed care program shall operate for a
27 period of 3 years. The objective of the pilot program shall
28 be to determine the cost-effectiveness and effects on
29 utilization, access, and quality of providing outpatient
30 specialty services to Medicaid recipients on a prepaid,
31 capitated basis.

1 (c) The agency shall conduct a quality assurance
2 review of the prepaid health clinic each year that the
3 demonstration program is in effect. The prepaid health clinic
4 is responsible for all expenses incurred by the agency in
5 conducting a quality assurance review.
6 (d) The entity that is awarded the contract to provide
7 outpatient specialty services to Medicaid recipients shall
8 report data required by the agency in a format specified by
9 the agency, for the purpose of conducting the evaluation
10 required in paragraph (e).
11 (e) The agency shall conduct an evaluation of the
12 pilot managed care program and report its findings to the
13 Governor and the Legislature by no later than January 1, 2001.
14 (39) The agency shall enter into agreements with
15 not-for-profit organizations based in this state for the
16 purpose of providing vision screening.
17 (40)(a) The agency shall implement a Medicaid
18 prescribed-drug spending-control program that includes the
19 following components:
20 1. Medicaid prescribed-drug coverage for brand-name
21 drugs for adult Medicaid recipients is limited to the
22 dispensing of four brand-name drugs per month per recipient.
23 Children are exempt from this restriction. Antiretroviral
24 agents are excluded from this limitation. No requirements for
25 prior authorization or other restrictions on medications used
26 to treat mental illnesses such as schizophrenia, severe
27 depression, or bipolar disorder may be imposed on Medicaid
28 recipients. Medications that will be available without
29 restriction for persons with mental illnesses include atypical
30 antipsychotic medications, conventional antipsychotic
31 medications, selective serotonin reuptake inhibitors, and

1 other medications used for the treatment of serious mental
2 illnesses. The agency shall also limit the amount of a
3 prescribed drug dispensed to no more than a 34-day supply. The
4 agency shall continue to provide unlimited generic drugs,
5 contraceptive drugs and items, and diabetic supplies. Although
6 a drug may be included on the preferred drug formulary, it
7 would not be exempt from the four-brand limit. The agency may
8 authorize exceptions to the brand-name-drug restriction based
9 upon the treatment needs of the patients, only when such
10 exceptions are based on prior consultation provided by the
11 agency or an agency contractor, but the agency must establish
12 procedures to ensure that:
13 a. There will be a response to a request for prior
14 consultation by telephone or other telecommunication device
15 within 24 hours after receipt of a request for prior
16 consultation;
17 b. A 72-hour supply of the drug prescribed will be
18 provided in an emergency or when the agency does not provide a
19 response within 24 hours as required by sub-subparagraph a.;
20 and
21 c. Except for the exception for nursing home residents
22 and other institutionalized adults and except for drugs on the
23 restricted formulary for which prior authorization may be
24 sought by an institutional or community pharmacy, prior
25 authorization for an exception to the brand-name-drug
26 restriction is sought by the prescriber and not by the
27 pharmacy. When prior authorization is granted for a patient in
28 an institutional setting beyond the brand-name-drug
29 restriction, such approval is authorized for 12 months and
30 monthly prior authorization is not required for that patient.
31

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1 2. Reimbursement to pharmacies for Medicaid prescribed
2 drugs shall be set at the average wholesale price less 13.25
3 percent.
4 3. The agency shall develop and implement a process
5 for managing the drug therapies of Medicaid recipients who are
6 using significant numbers of prescribed drugs each month. The
7 management process may include, but is not limited to,
8 comprehensive, physician-directed medical-record reviews,
9 claims analyses, and case evaluations to determine the medical
10 necessity and appropriateness of a patient's treatment plan
11 and drug therapies. The agency may contract with a private
12 organization to provide drug-program-management services. The
13 Medicaid drug benefit management program shall include
14 initiatives to manage drug therapies for HIV/AIDS patients,
15 patients using 20 or more unique prescriptions in a 180-day
16 period, and the top 1,000 patients in annual spending.
17 4. The agency may limit the size of its pharmacy
18 network based on need, competitive bidding, price
19 negotiations, credentialing, or similar criteria. The agency
20 shall give special consideration to rural areas in determining
21 the size and location of pharmacies included in the Medicaid
22 pharmacy network. A pharmacy credentialing process may include
23 criteria such as a pharmacy's full-service status, location,
24 size, patient educational programs, patient consultation,
25 disease-management services, and other characteristics. The
26 agency may impose a moratorium on Medicaid pharmacy enrollment
27 when it is determined that it has a sufficient number of
28 Medicaid-participating providers.
29 5. The agency shall develop and implement a program
30 that requires Medicaid practitioners who prescribe drugs to
31 use a counterfeit-proof prescription pad for Medicaid

1 prescriptions. The agency shall require the use of
2 standardized counterfeit-proof prescription pads by
3 Medicaid-participating prescribers or prescribers who write
4 prescriptions for Medicaid recipients. The agency may
5 implement the program in targeted geographic areas or
6 statewide.
7 6. The agency may enter into arrangements that require
8 manufacturers of generic drugs prescribed to Medicaid
9 recipients to provide rebates of at least 15.1 percent of the
10 average manufacturer price for the manufacturer's generic
11 products. These arrangements shall require that if a
12 generic-drug manufacturer pays federal rebates for
13 Medicaid-reimbursed drugs at a level below 15.1 percent, the
14 manufacturer must provide a supplemental rebate to the state
15 in an amount necessary to achieve a 15.1-percent rebate level.
16 7. The agency may establish a preferred drug formulary
17 in accordance with 42 U.S.C. s. 1396r-8, and, pursuant to the
18 establishment of such formulary, it is authorized to negotiate
19 supplemental rebates from manufacturers that are in addition
20 to those required by Title XIX of the Social Security Act and
21 at no less than 10 percent of the average manufacturer price
22 as defined in 42 U.S.C. s. 1936 on the last day of a quarter
23 unless the federal or supplemental rebate, or both, equals or
24 exceeds 25 percent. There is no upper limit on the
25 supplemental rebates the agency may negotiate. The agency may
26 determine that specific products, brand-name or generic, are
27 competitive at lower rebate percentages. Agreement to pay the
28 minimum supplemental rebate percentage will guarantee a
29 manufacturer that the Medicaid Pharmaceutical and Therapeutics
30 Committee will consider a product for inclusion on the
31 preferred drug formulary. However, a pharmaceutical

manufacturer is not guaranteed placement on the formulary by simply paying the minimum supplemental rebate. Agency decisions will be made on the clinical efficacy of a drug and recommendations of the Medicaid Pharmaceutical and Therapeutics Committee, as well as the price of competing products minus federal and state rebates. The agency is authorized to contract with an outside agency or contractor to conduct negotiations for supplemental rebates. For the purposes of this section, the term "supplemental rebates" may include, at the agency's discretion, cash rebates and other program benefits that offset a Medicaid expenditure. Such other program benefits may include, but are not limited to, disease management programs, drug product donation programs, drug utilization control programs, prescriber and beneficiary counseling and education, fraud and abuse initiatives, and other services or administrative investments with guaranteed savings to the Medicaid program in the same year the rebate reduction is included in the General Appropriations Act. The agency is authorized to seek any federal waivers to implement this initiative.

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

1 9. The Agency for Health Care Administration shall
2 expand home delivery of pharmacy products. To assist Medicaid
3 patients in securing their prescriptions and reduce program
4 costs, the agency shall expand its current mail-order-pharmacy
5 diabetes-supply program to include all generic and brand-name
6 drugs used by Medicaid patients with diabetes. Medicaid
7 recipients in the current program may obtain nondiabetes drugs
8 on a voluntary basis. This initiative is limited to the
9 geographic area covered by the current contract. The agency
10 may seek and implement any federal waivers necessary to
11 implement this subparagraph.
12 (b) The agency shall implement this subsection to the
13 extent that funds are appropriated to administer the Medicaid
14 prescribed-drug spending-control program. The agency may
15 contract all or any part of this program to private
16 organizations.
17 (c) The agency shall submit quarterly reports to the
18 Governor, the President of the Senate, and the Speaker of the
19 House of Representatives which must include, but need not be
20 limited to, the progress made in implementing this subsection
21 and its effect on Medicaid prescribed-drug expenditures.
22 (41) Notwithstanding the provisions of chapter 287,
23 the agency may, at its discretion, renew a contract or
24 contracts for fiscal intermediary services one or more times
25 for such periods as the agency may decide; however, all such
26 renewals may not combine to exceed a total period longer than
27 the term of the original contract.
28 (42) The agency shall provide for the development of a
29 demonstration project by establishment in Miami-Dade County of
30 a long-term-care facility licensed pursuant to chapter 395 to
31 improve access to health care for a predominantly minority,

1 medically underserved, and medically complex population and to
2 evaluate alternatives to nursing home care and general acute
3 care for such population. Such project is to be located in a
4 health care condominium and colocated with licensed facilities
5 providing a continuum of care. The establishment of this
6 project is not subject to the provisions of s. 408.036 or s.
7 408.039. The agency shall report its findings to the
8 Governor, the President of the Senate, and the Speaker of the
9 House of Representatives by January 1, 2003.
10 (43) The agency shall develop and implement a
11 utilization management program for Medicaid-eligible
12 recipients for the management of occupational, physical,
13 respiratory, and speech therapies. The agency shall establish
14 a utilization program that may require prior authorization in
15 order to ensure medically necessary and cost-effective
16 treatments. The program shall be operated in accordance with a
17 federally approved waiver program or state plan amendment. The
18 agency may seek a federal waiver or state plan amendment to
19 implement this program. The agency may also competitively
20 procure these services from an outside vendor on a regional or
21 statewide basis.
22 (44) The agency may contract on a prepaid or fixed-sum
23 basis with appropriately licensed prepaid dental health plans
24 to provide dental services.
25 (45) The agency may mandate a recipient's
26 participation in a provider lock-in program limiting the
27 receipt of goods or services to a single specified provider.
28 The lock-in programs shall include, but are not limited to,
29 pharmacies. The agency shall seek any federal waivers
30 necessary to implement this subsection.
31

1 Section 3. Section 409.913, Florida Statutes, is
2 amended to read:
3 409.913 Oversight of the integrity of the Medicaid
4 program.--The agency shall operate a program to oversee the
5 activities of Florida Medicaid recipients, and providers and
6 their representatives, to ensure that fraudulent and abusive
7 behavior and neglect of recipients occur to the minimum extent
8 possible, and to recover overpayments and impose sanctions as
9 appropriate. Beginning January 1, 2003, and each year
10 thereafter, the agency and the Medicaid Fraud Control Unit of
11 the Department of Legal Affairs shall submit a joint report to
12 the Legislature documenting the effectiveness of the state's
13 efforts to control Medicaid fraud and abuse and to recover
14 Medicaid overpayments during the previous fiscal year. The
15 report must describe the number of cases opened and
16 investigated each year; the sources of the cases opened; the
17 disposition of the cases closed each year; the amount of
18 overpayments alleged in preliminary and final audit letters;
19 the number and amount of fines or penalties imposed; any
20 reductions in overpayment amounts negotiated in settlement
21 agreements or by other means; the amount of final agency
22 determinations of overpayments; the amount deducted from
23 federal claiming as a result of overpayments; the amount of
24 overpayments recovered each year; the amount of cost of
25 investigation recovered each year; the average length of time
26 to collect from the time the case was opened until the
27 overpayment is paid in full; the amount determined as
28 uncollectible and the portion of the uncollectible amount
29 subsequently reclaimed from the Federal Government; the number
30 of providers, by type, that are terminated from participation
31 in the Medicaid program as a result of fraud and abuse; and

1 all costs associated with discovering and prosecuting cases of
2 Medicaid overpayments and making recoveries in such cases. The
3 report must also document actions taken to prevent
4 overpayments and the number of providers prevented from
5 enrolling in or reenrolling in the Medicaid program as a
6 result of documented Medicaid fraud and abuse and must
7 recommend changes necessary to prevent or recover
8 overpayments. For the 2001-2002 fiscal year, the agency shall
9 prepare a report that contains as much of this information as
10 is available to it.
11 (1) For the purposes of this section, the term:
12 (a) "Abuse" means:
13 1. Provider practices that are inconsistent with
14 generally accepted business or medical practices and that
15 result in an unnecessary cost to the Medicaid program or in
16 reimbursement for goods or services that are not medically
17 necessary or that fail to meet professionally recognized
18 standards for health care.
19 2. Recipient practices that result in unnecessary cost
20 to the Medicaid program.
21 (b) "Complaint" means an allegation that fraud, abuse,
22 or an overpayment has occurred.
23 (c) "Fraud" means an intentional deception or
24 misrepresentation made by a person with the knowledge that the
25 deception results in unauthorized benefit to herself or
26 himself or another person. The term includes any act that
27 constitutes fraud under applicable federal or state law.
28 (d) "Medical necessity" or "medically necessary" means
29 any goods or services necessary to palliate the effects of a
30 terminal condition, or to prevent, diagnose, correct, cure,
31 alleviate, or preclude deterioration of a condition that

threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

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

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

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

(3) The agency may conduct, or may contract for, prepayment review of provider claims to ensure cost-effective purchasing; to ensure that~~,~~billing by a provider to the agency is in accordance with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law;~~,~~and to ensure that appropriate ~~provision of~~ care is rendered to Medicaid recipients. Such prepayment reviews may be conducted as

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1 determined appropriate by the agency, without any suspicion or
2 allegation of fraud, abuse, or neglect, and may last for up to
3 1 year. Unless the agency has reliable evidence of fraud,
4 misrepresentation, abuse, or neglect, claims shall be
5 adjudicated for denial or payment within 90 days after the
6 date complete documentation is received by the agency for
7 review. If there is reliable evidence of fraud,
8 misrepresentation, abuse, or neglect, claims shall be
9 adjudicated for denial or payment within 180 days after the
10 date complete documentation is received by the agency for
11 review.
12 (4) Any suspected criminal violation identified by the
13 agency must be referred to the Medicaid Fraud Control Unit of
14 the Office of the Attorney General for investigation. The
15 agency and the Attorney General shall enter into a memorandum
16 of understanding, which must include, but need not be limited
17 to, a protocol for regularly sharing information and
18 coordinating casework. The protocol must establish a
19 procedure for the referral by the agency of cases involving
20 suspected Medicaid fraud to the Medicaid Fraud Control Unit
21 for investigation, and the return to the agency of those cases
22 where investigation determines that administrative action by
23 the agency is appropriate. Offices of the Medicaid program
24 integrity program and the Medicaid Fraud Control Unit of the
25 Department of Legal Affairs, shall, to the extent possible, be
26 collocated. The agency and the Department of Legal Affairs
27 shall periodically conduct joint training and other joint
28 activities designed to increase communication and coordination
29 in recovering overpayments.
30 (5) A Medicaid provider is subject to having goods and
31 services that are paid for by the Medicaid program reviewed by

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1 an appropriate peer-review organization designated by the
2 agency. The written findings of the applicable peer-review
3 organization are admissible in any court or administrative
4 proceeding as evidence of medical necessity or the lack
5 thereof.
6 (6) Any notice required to be given to a provider
7 under this section is presumed to be sufficient notice if sent
8 to the address last shown on the provider enrollment file. It
9 is the responsibility of the provider to furnish and keep the
10 agency informed of the provider's current address. United
11 States Postal Service proof of mailing or certified or
12 registered mailing of such notice to the provider at the
13 address shown on the provider enrollment file constitutes
14 sufficient proof of notice. Any notice required to be given to
15 the agency by this section must be sent to the agency at an
16 address designated by rule.
17 (7) When presenting a claim for payment under the
18 Medicaid program, a provider has an affirmative duty to
19 supervise the provision of, and be responsible for, goods and
20 services claimed to have been provided, to supervise and be
21 responsible for preparation and submission of the claim, and
22 to present a claim that is true and accurate and that is for
23 goods and services that:
24 (a) Have actually been furnished to the recipient by
25 the provider prior to submitting the claim.
26 (b) Are Medicaid-covered goods or services that are
27 medically necessary.
28 (c) Are of a quality comparable to those furnished to
29 the general public by the provider's peers.
30 (d) Have not been billed in whole or in part to a
31 recipient or a recipient's responsible party, except for such

1 copayments, coinsurance, or deductibles as are authorized by
2 the agency.
3 (e) Are provided in accord with applicable provisions
4 of all Medicaid rules, regulations, handbooks, and policies
5 and in accordance with federal, state, and local law.
6 (f) Are documented by records made at the time the
7 goods or services were provided, demonstrating the medical
8 necessity for the goods or services rendered. Medicaid goods
9 or services are excessive or not medically necessary unless
10 both the medical basis and the specific need for them are
11 fully and properly documented in the recipient's medical
12 record.
13
14 The agency may deny payment or require repayment for goods or
15 services that are not presented as required in this
16 subsection.
17 (8) The agency shall not reimburse any person or
18 entity for any prescription for medications, medical supplies,
19 or medical services if the prescription was written by a
20 physician or other prescribing practitioner who is not
21 enrolled in the Medicaid program. This section does not apply:
22 (a) In instances involving bona fide emergency medical
23 conditions as determined by the agency;
24 (b) To a provider of medical services to a patient in
25 a hospital emergency department;
26 (c) To bono fide pro bono services by preapproved
27 non-Medicaid providers as determined by the agency;
28 (d) To prescribing physicians who are board-certified
29 specialists treating Medicaid recipients referred for
30 treatment by a treating physician who is enrolled in the
31 Medicaid program; or

1 (e) To prescriptions written for dually eligible
2 Medicare beneficiaries by an authorized Medicare provider who
3 is not enrolled in the Medicaid program.
4 (9)~~(8)~~ A Medicaid provider shall retain medical,
5 professional, financial, and business records pertaining to
6 services and goods furnished to a Medicaid recipient and
7 billed to Medicaid for a period of 5 years after the date of
8 furnishing such services or goods. The agency may investigate,
9 review, or analyze such records, which must be made available
10 during normal business hours. However, 24-hour notice must be
11 provided if patient treatment would be disrupted. The provider
12 is responsible for furnishing to the agency, and keeping the
13 agency informed of the location of, the provider's
14 Medicaid-related records. The authority of the agency to
15 obtain Medicaid-related records from a provider is neither
16 curtailed nor limited during a period of litigation between
17 the agency and the provider.
18 (10)~~(9)~~ Payments for the services of billing agents or
19 persons participating in the preparation of a Medicaid claim
20 shall not be based on amounts for which they bill nor based on
21 the amount a provider receives from the Medicaid program.
22 (11)~~(10)~~ The agency may deny payment or require
23 repayment for inappropriate, medically unnecessary, or
24 excessive goods or services from the person furnishing them,
25 the person under whose supervision they were furnished, or the
26 person causing them to be furnished.
27 (12)~~(11)~~ The complaint and all information obtained
28 pursuant to an investigation of a Medicaid provider, or the
29 authorized representative or agent of a provider, relating to
30 an allegation of fraud, abuse, or neglect are confidential and
31 exempt from the provisions of s. 119.07(1):

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1 (a) Until the agency takes final agency action with
2 respect to the provider and requires repayment of any
3 overpayment, or imposes an administrative sanction;
4 (b) Until the Attorney General refers the case for
5 criminal prosecution;
6 (c) Until 10 days after the complaint is determined
7 without merit; or
8 (d) At all times if the complaint or information is
9 otherwise protected by law.
10 (13)~~(12)~~ The agency may terminate participation of a
11 Medicaid provider in the Medicaid program and may seek civil
12 remedies or impose other administrative sanctions against a
13 Medicaid provider, if the provider has been:
14 (a) Convicted of a criminal offense related to the
15 delivery of any health care goods or services, including the
16 performance of management or administrative functions relating
17 to the delivery of health care goods or services;
18 (b) Convicted of a criminal offense under federal law
19 or the law of any state relating to the practice of the
20 provider's profession; or
21 (c) Found by a court of competent jurisdiction to have
22 neglected or physically abused a patient in connection with
23 the delivery of health care goods or services.
24 (14)~~(13)~~ If the provider has been suspended or
25 terminated from participation in the Medicaid program or the
26 Medicare program by the Federal Government or any state, the
27 agency must immediately suspend or terminate, as appropriate,
28 the provider's participation in the Florida Medicaid program
29 for a period no less than that imposed by the Federal
30 Government or any other state, and may not enroll such
31 provider in the Florida Medicaid program while such foreign

suspension or termination remains in effect. This sanction is in addition to all other remedies provided by law.

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

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

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

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

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

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

1 (f) The provider or person who ordered or prescribed
2 the care, services, or supplies has furnished, or ordered the
3 furnishing of, goods or services to a recipient which are
4 inappropriate, unnecessary, excessive, or harmful to the
5 recipient or are of inferior quality;
6 (g) The provider has demonstrated a pattern of failure
7 to provide goods or services that are medically necessary;
8 (h) The provider or an authorized representative of
9 the provider, or a person who ordered or prescribed the goods
10 or services, has submitted or caused to be submitted false or
11 a pattern of erroneous Medicaid claims ~~that have resulted in~~
12 ~~overpayments to a provider or that exceed those to which the~~
13 ~~provider was entitled under the Medicaid program~~;
14 (i) The provider or an authorized representative of
15 the provider, or a person who has ordered or prescribed the
16 goods or services, has submitted or caused to be submitted a
17 Medicaid provider enrollment application, a request for prior
18 authorization for Medicaid services, a drug exception request,
19 or a Medicaid cost report that contains materially false or
20 incorrect information;
21 (j) The provider or an authorized representative of
22 the provider has collected from or billed a recipient or a
23 recipient's responsible party improperly for amounts that
24 should not have been so collected or billed by reason of the
25 provider's billing the Medicaid program for the same service;
26 (k) The provider or an authorized representative of
27 the provider has included in a cost report costs that are not
28 allowable under a Florida Title XIX reimbursement plan, after
29 the provider or authorized representative had been advised in
30 an audit exit conference or audit report that the costs were
31 not allowable;

1 (l) The provider is charged by information or
2 indictment with fraudulent billing practices. The sanction
3 applied for this reason is limited to suspension of the
4 provider's participation in the Medicaid program for the
5 duration of the indictment unless the provider is found guilty
6 pursuant to the information or indictment;
7 (m) The provider or a person who has ordered, or
8 prescribed the goods or services is found liable for negligent
9 practice resulting in death or injury to the provider's
10 patient;
11 (n) The provider fails to demonstrate that it had
12 available during a specific audit or review period sufficient
13 quantities of goods, or sufficient time in the case of
14 services, to support the provider's billings to the Medicaid
15 program;
16 (o) The provider has failed to comply with the notice
17 and reporting requirements of s. 409.907;
18 (p) The agency has received reliable information of
19 patient abuse or neglect or of any act prohibited by s.
20 409.920; or
21 (q) The provider has failed to comply with an
22 agreed-upon repayment schedule.
23 (16)~~(15)~~ The agency shall impose any of the following
24 sanctions or disincentives on a provider or a person for any
25 of the acts described in subsection(15)~~(14)~~:
26 (a) Suspension for a specific period of time of not
27 more than 1 year. Suspension shall preclude participation in
28 the Medicaid program, which includes any action that results
29 in a claim for payment to the Medicaid program as a result of
30 furnishing, supervising a person who is furnishing, or causing
31 a person to furnish goods or services.

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1 (b) Termination for a specific period of time of from
2 more than 1 year to 20 years. Termination shall preclude
3 participation in the Medicaid program, which includes any
4 action that results in a claim for payment to the Medicaid
5 program as a result of furnishing, supervising a person who is
6 furnishing, or causing a person to furnish goods or services.
7 (c) Imposition of a fine of up to $5,000 for each
8 violation. Each day that an ongoing violation continues, such
9 as refusing to furnish Medicaid-related records or refusing
10 access to records, is considered, for the purposes of this
11 section, to be a separate violation. Each instance of
12 improper billing of a Medicaid recipient; each instance of
13 including an unallowable cost on a hospital or nursing home
14 Medicaid cost report after the provider or authorized
15 representative has been advised in an audit exit conference or
16 previous audit report of the cost unallowability; each
17 instance of furnishing a Medicaid recipient goods or
18 professional services that are inappropriate or of inferior
19 quality as determined by competent peer judgment; each
20 instance of knowingly submitting a materially false or
21 erroneous Medicaid provider enrollment application, request
22 for prior authorization for Medicaid services, drug exception
23 request, or cost report; each instance of inappropriate
24 prescribing of drugs for a Medicaid recipient as determined by
25 competent peer judgment; and each false or erroneous Medicaid
26 claim leading to an overpayment to a provider is considered,
27 for the purposes of this section, to be a separate violation.
28 (d) Immediate suspension, if the agency has received
29 information of patient abuse or neglect or of any act
30 prohibited by s. 409.920. Upon suspension, the agency must
31 issue an immediate final order under s. 120.569(2)(n).

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

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

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

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

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

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

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

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

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

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

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1 (c) Evidence of continued violation within the
2 provider's management control of Medicaid statutes, rules,
3 regulations, or policies after written notification to the
4 provider of improper practice or instance of violation.
5 (d) The effect, if any, on the quality of medical care
6 provided to Medicaid recipients as a result of the acts of the
7 provider.
8 (e) Any action by a licensing agency respecting the
9 provider in any state in which the provider operates or has
10 operated.
11 (f) The apparent impact on access by recipients to
12 Medicaid services if the provider is suspended or terminated,
13 in the best judgment of the agency.
14
15 The agency shall document the basis for all sanctioning
16 actions and recommendations.
17 (18)~~(17)~~ The agency may take action to sanction,
18 suspend, or terminate a particular provider working for a
19 group provider, and may suspend or terminate Medicaid
20 participation at a specific location, rather than or in
21 addition to taking action against an entire group.
22 (19)~~(18)~~ The agency shall establish a process for
23 conducting followup reviews of a sampling of providers who
24 have a history of overpayment under the Medicaid program.
25 This process must consider the magnitude of previous fraud or
26 abuse and the potential effect of continued fraud or abuse on
27 Medicaid costs.
28 (20)~~(19)~~ In making a determination of overpayment to a
29 provider, the agency must use accepted and valid auditing,
30 accounting, analytical, statistical, or peer-review methods,
31 or combinations thereof. Appropriate statistical methods may

1 include, but are not limited to, sampling and extension to the
2 population, parametric and nonparametric statistics, tests of
3 hypotheses, and other generally accepted statistical methods.
4 Appropriate analytical methods may include, but are not
5 limited to, reviews to determine variances between the
6 quantities of products that a provider had on hand and
7 available to be purveyed to Medicaid recipients during the
8 review period and the quantities of the same products paid for
9 by the Medicaid program for the same period, taking into
10 appropriate consideration sales of the same products to
11 non-Medicaid customers during the same period. In meeting its
12 burden of proof in any administrative or court proceeding, the
13 agency may introduce the results of such statistical methods
14 as evidence of overpayment.
15 (21)~~(20)~~ When making a determination that an
16 overpayment has occurred, the agency shall prepare and issue
17 an audit report to the provider showing the calculation of
18 overpayments.
19 (22)~~(21)~~ The audit report, supported by agency work
20 papers, showing an overpayment to a provider constitutes
21 evidence of the overpayment. A provider may not present or
22 elicit testimony, either on direct examination or
23 cross-examination in any court or administrative proceeding,
24 regarding the purchase or acquisition by any means of drugs,
25 goods, or supplies; sales or divestment by any means of drugs,
26 goods, or supplies; or inventory of drugs, goods, or supplies,
27 unless such acquisition, sales, divestment, or inventory is
28 documented by written invoices, written inventory records, or
29 other competent written documentary evidence maintained in the
30 normal course of the provider's business. Notwithstanding the
31 applicable rules of discovery, all documentation that will be

1 offered as evidence at an administrative hearing on a Medicaid
2 overpayment must be exchanged by all parties at least 14 days
3 before the administrative hearing or must be excluded from
4 consideration.
5 (23)~~(22)~~(a) In an audit or investigation of a
6 violation committed by a provider which is conducted pursuant
7 to this section, the agency is entitled to recover all
8 investigative, legal, and expert witness costs if the agency's
9 findings were not contested by the provider or, if contested,
10 the agency ultimately prevailed.
11 (b) The agency has the burden of documenting the
12 costs, which include salaries and employee benefits and
13 out-of-pocket expenses. The amount of costs that may be
14 recovered must be reasonable in relation to the seriousness of
15 the violation and must be set taking into consideration the
16 financial resources, earning ability, and needs of the
17 provider, who has the burden of demonstrating such factors.
18 (c) The provider may pay the costs over a period to be
19 determined by the agency if the agency determines that an
20 extreme hardship would result to the provider from immediate
21 full payment. Any default in payment of costs may be
22 collected by any means authorized by law.
23 (24)~~(23)~~ If the agency imposes an administrative
24 sanction pursuant to subsection (13), subsection (14), or
25 subsection (15), except paragraphs (15)(e) and (o),~~under this~~
26 ~~section~~ upon any provider or other person who is regulated by
27 another state entity, the agency shall notify that other
28 entity of the imposition of the sanction. Such notification
29 must include the provider's or person's name and license
30 number and the specific reasons for sanction.
31

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

(b) The agency shall deny payment, or require repayment, if the goods or services were furnished, supervised, or caused to be furnished by a person who has been suspended or terminated from the Medicaid program or Medicare program by the Federal Government or any state.

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

(d)~~(c)~~ The agency, upon entry of a final agency order, a judgment or order of a court of competent jurisdiction, or a stipulation or settlement, may collect the moneys owed by all means allowable by law, including, but not limited to, notifying any fiscal intermediary of Medicare benefits that

1 the state has a superior right of payment. Upon receipt of
2 such written notification, the Medicare fiscal intermediary
3 shall remit to the state the sum claimed.
4 (26)~~(25)~~ The agency may impose administrative
5 sanctions against a Medicaid recipient, or the agency may seek
6 any other remedy provided by law, including, but not limited
7 to, the remedies provided in s. 812.035, if the agency finds
8 that a recipient has engaged in solicitation in violation of
9 s. 409.920 or that the recipient has otherwise abused the
10 Medicaid program.
11 (27)~~(26)~~ When the Agency for Health Care
12 Administration has made a probable cause determination and
13 alleged that an overpayment to a Medicaid provider has
14 occurred, the agency, after notice to the provider, may:
15 (a) Withhold, and continue to withhold during the
16 pendency of an administrative hearing pursuant to chapter 120,
17 any medical assistance reimbursement payments until such time
18 as the overpayment is recovered, unless within 30 days after
19 receiving notice thereof the provider:
20 1. Makes repayment in full; or
21 2. Establishes a repayment plan that is satisfactory
22 to the Agency for Health Care Administration.
23 (b) Withhold, and continue to withhold during the
24 pendency of an administrative hearing pursuant to chapter 120,
25 medical assistance reimbursement payments if the terms of a
26 repayment plan are not adhered to by the provider.
27 (28)~~(27)~~ Venue for all Medicaid program integrity
28 overpayment cases shall lie in Leon County, at the discretion
29 of the agency.
30 (29)~~(28)~~ Notwithstanding other provisions of law, the
31 agency and the Medicaid Fraud Control Unit of the Department

1 of Legal Affairs may review a provider's Medicaid-related
2 records in order to determine the total output of a provider's
3 practice to reconcile quantities of goods or services billed
4 to Medicaid with ~~against~~ quantities of goods or services used
5 in the provider's total practice.
6 (30)~~(29)~~ The agency may terminate a provider's
7 participation in the Medicaid program if the provider fails to
8 reimburse an overpayment that has been determined by final
9 order, not subject to further appeal, within 35 days after the
10 date of the final order, unless the provider and the agency
11 have entered into a repayment agreement.
12 (31)~~(30)~~ If a provider requests an administrative
13 hearing pursuant to chapter 120, such hearing must be
14 conducted within 90 days following assignment of an
15 administrative law judge, absent exceptionally good cause
16 shown as determined by the administrative law judge or hearing
17 officer. Upon issuance of a final order, the outstanding
18 balance of the amount determined to constitute the overpayment
19 shall become due. If a provider fails to make payments in
20 full, fails to enter into a satisfactory repayment plan, or
21 fails to comply with the terms of a repayment plan or
22 settlement agreement, the agency may withhold medical
23 assistance reimbursement payments until the amount due is paid
24 in full.
25 (32)~~(31)~~ Duly authorized agents and employees of the
26 agency shall have the power to inspect, during normal business
27 hours, the records of any pharmacy, wholesale establishment,
28 or manufacturer, or any other place in which drugs and medical
29 supplies are manufactured, packed, packaged, made, stored,
30 sold, or kept for sale, for the purpose of verifying the
31 amount of drugs and medical supplies ordered, delivered, or

1 purchased by a provider. The agency shall provide at least 2
2 business days' prior notice of any such inspection. The notice
3 must identify the provider whose records will be inspected,
4 and the inspection shall include only records specifically
5 related to that provider.
6 (33) In accordance with federal law, Medicaid
7 recipients convicted of a crime pursuant to 42 U.S.C. 1320a-7b
8 may be limited, restricted, or suspended from Medicaid
9 eligibility for a period not to exceed 1 year, as determined
10 by the agency head or designee.
11 (34) To deter fraud and abuse in the Medicaid program,
12 the agency may limit the number of Schedule II and Schedule
13 III refill prescription claims submitted from a pharmacy
14 provider. The agency shall limit the allowable amount of
15 reimbursement of prescription refill claims for Schedule II
16 and Schedule III pharmaceuticals if the agency or the Medicaid
17 Fraud Control Unit determines that the specific prescription
18 refill was not requested by the Medicaid recipient or
19 authorized representative for whom the refill claim is
20 submitted or was not prescribed by the recipient's medical
21 provider or physician. Any such refill request must be
22 consistent with the original prescription.
23 Section 4. Subsection (6) is added to section
24 409.9131, Florida Statutes, to read:
25 409.9131 Special provisions relating to integrity of
26 the Medicaid program.--
27 (6) COST REPORTS.--For any Medicaid provider
28 submitting a cost report to the agency by any method, and in
29 addition to any other certification, the following statement
30 must immediately precede the dated signature of the provider's
31 administrator or chief financial officer on such cost report:

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1 "I certify that I am familiar with the laws and
2 regulations regarding the provision of health
3 care services under the Florida Medicaid
4 program, including the laws and regulations
5 relating to claims for Medicaid reimbursements
6 and payments, and that the services identified
7 in this cost report were provided in compliance
8 with such laws and regulations."
9 Section 5. Section 409.920, Florida Statutes, is
10 amended to read:
11 409.920 Medicaid provider fraud.--
12 (1) For the purposes of this section, the term:
13 (a) "Agency" means the Agency for Health Care
14 Administration.
15 (b) "Fiscal agent" means any individual, firm,
16 corporation, partnership, organization, or other legal entity
17 that has contracted with the agency to receive, process, and
18 adjudicate claims under the Medicaid program.
19 (c) "Item or service" includes:
20 1. Any particular item, device, medical supply, or
21 service claimed to have been provided to a recipient and
22 listed in an itemized claim for payment; or
23 2. In the case of a claim based on costs, any entry in
24 the cost report, books of account, or other documents
25 supporting such claim.
26 (d) "Knowingly" means done by a person who is aware or
27 should be aware of the nature of his or her conduct and that
28 his or her conduct is substantially certain to cause the
29 intended result.
30 (2) It is unlawful to:
31

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1 (a) Knowingly make, cause to be made, or aid and abet
2 in the making of any false statement or false representation
3 of a material fact, by commission or omission, in any claim
4 submitted to the agency or its fiscal agent for payment.
5 (b) Knowingly make, cause to be made, or aid and abet
6 in the making of a claim for items or services that are not
7 authorized to be reimbursed by the Medicaid program.
8 (c) Knowingly charge, solicit, accept, or receive
9 anything of value, other than an authorized copayment from a
10 Medicaid recipient, from any source in addition to the amount
11 legally payable for an item or service provided to a Medicaid
12 recipient under the Medicaid program or knowingly fail to
13 credit the agency or its fiscal agent for any payment received
14 from a third-party source.
15 (d) Knowingly make or in any way cause to be made any
16 false statement or false representation of a material fact, by
17 commission or omission, in any document containing items of
18 income and expense that is or may be used by the agency to
19 determine a general or specific rate of payment for an item or
20 service provided by a provider.
21 (e) Knowingly solicit, offer, pay, or receive any
22 remuneration, including any kickback, bribe, or rebate,
23 directly or indirectly, overtly or covertly, in cash or in
24 kind, in return for referring an individual to a person for
25 the furnishing or arranging for the furnishing of any item or
26 service for which payment may be made, in whole or in part,
27 under the Medicaid program, or in return for obtaining,
28 purchasing, leasing, ordering, or arranging for or
29 recommending, obtaining, purchasing, leasing, or ordering any
30 goods, facility, item, or service, for which payment may be
31 made, in whole or in part, under the Medicaid program.

1 (f) Knowingly submit false or misleading information
2 or statements to the Medicaid program for the purpose of being
3 accepted as a Medicaid provider.
4 (g) Knowingly use or endeavor to use a Medicaid
5 provider's identification number or a Medicaid recipient's
6 identification number to make, cause to be made, or aid and
7 abet in the making of a claim for items or services that are
8 not authorized to be reimbursed by the Medicaid program.
9
10 A person who violates this subsection commits a felony of the
11 third degree, punishable as provided in s. 775.082, s.
12 775.083, or s. 775.084.
13 (3) The repayment of Medicaid payments wrongfully
14 obtained, or the offer or endeavor to repay Medicaid funds
15 wrongfully obtained, does not constitute a defense to, or a
16 ground for dismissal of, criminal charges brought under this
17 section.
18 (4) Property "paid for" includes all property
19 furnished to or intended to be furnished to any recipient of
20 benefits under the Medicaid program, regardless of whether
21 reimbursement is ever actually made by the program.
22 (5)~~(4)~~ All records in the custody of the agency or its
23 fiscal agent which relate to Medicaid provider fraud are
24 business records within the meaning of s. 90.803(6).
25 (6)~~(5)~~ Proof that a claim was submitted to the agency
26 or its fiscal agent which contained a false statement or a
27 false representation of a material fact, by commission or
28 omission, unless satisfactorily explained, gives rise to an
29 inference that the person whose signature appears as the
30 provider's authorizing signature on the claim form, or whose
31 signature appears on an agency electronic claim submission

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1 agreement submitted for claims made to the fiscal agent by
2 electronic means, had knowledge of the false statement or
3 false representation. This subsection applies whether the
4 signature appears on the claim form or the electronic claim
5 submission agreement by means of handwriting, typewriting,
6 facsimile signature stamp, computer impulse, initials, or
7 otherwise.
8 (7)~~(6)~~ Proof of submission to the agency or its fiscal
9 agent of a document containing items of income and expense,
10 which document is used or that may be used by the agency or
11 its fiscal agent to determine a general or specific rate of
12 payment and which document contains a false statement or a
13 false representation of a material fact, by commission or
14 omission, unless satisfactorily explained, gives rise to the
15 inference that the person who signed the certification of the
16 document had knowledge of the false statement or
17 representation. This subsection applies whether the signature
18 appears on the document by means of handwriting, typewriting,
19 facsimile signature stamp, electronic transmission, initials,
20 or otherwise.
21 (8)~~(7)~~ The Attorney General shall conduct a statewide
22 program of Medicaid fraud control. To accomplish this purpose,
23 the Attorney General shall:
24 (a) Investigate the possible criminal violation of any
25 applicable state law pertaining to fraud in the administration
26 of the Medicaid program, in the provision of medical
27 assistance, or in the activities of providers of health care
28 under the Medicaid program.
29 (b) Investigate the alleged abuse or neglect of
30 patients in health care facilities receiving payments under
31 the Medicaid program, in coordination with the agency.

1 (c) Investigate the alleged misappropriation of
2 patients' private funds in health care facilities receiving
3 payments under the Medicaid program.
4 (d) Refer to the Office of Statewide Prosecution or
5 the appropriate state attorney all violations indicating a
6 substantial potential for criminal prosecution.
7 (e) Refer to the agency all suspected abusive
8 activities not of a criminal or fraudulent nature.
9 (f) Safeguard the privacy rights of all individuals
10 and provide safeguards to prevent the use of patient medical
11 records for any reason beyond the scope of a specific
12 investigation for fraud or abuse, or both, without the
13 patient's written consent.
14 (g) Publicize to state employees and the public the
15 ability of persons to bring suit under the provisions of the
16 Florida False Claims Act and the potential for the persons
17 bringing a civil action under the Florida False Claims Act to
18 obtain a monetary award.
19 (9)~~(8)~~ In carrying out the duties and responsibilities
20 under this section, the Attorney General may:
21 (a) Enter upon the premises of any health care
22 provider, excluding a physician, participating in the Medicaid
23 program to examine all accounts and records that may, in any
24 manner, be relevant in determining the existence of fraud in
25 the Medicaid program, to investigate alleged abuse or neglect
26 of patients, or to investigate alleged misappropriation of
27 patients' private funds. A participating physician is required
28 to make available any accounts or records that may, in any
29 manner, be relevant in determining the existence of fraud in
30 the Medicaid program. The accounts or records of a
31 non-Medicaid patient may not be reviewed by, or turned over

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1 to, the Attorney General without the patient's written
2 consent.
3 (b) Subpoena witnesses or materials, including medical
4 records relating to Medicaid recipients, within or outside the
5 state and, through any duly designated employee, administer
6 oaths and affirmations and collect evidence for possible use
7 in either civil or criminal judicial proceedings.
8 (c) Request and receive the assistance of any state
9 attorney or law enforcement agency in the investigation and
10 prosecution of any violation of this section.
11 (d) Seek any civil remedy provided by law, including,
12 but not limited to, the remedies provided in ss. 68.081-68.092
13 and 812.035 and this chapter.
14 (e) Refer to the agency for collection each instance
15 of overpayment to a provider of health care under the Medicaid
16 program which is discovered during the course of an
17 investigation.
18 Section 6. Section 409.9201, Florida Statutes, is
19 created to read:
20 409.9201 Medicaid fraud.--
21 (1) As used in this section, the term:
22 (a) "Legend drug" means any drug, including, but not
23 limited to, finished dosage forms or active ingredients that
24 are subject to, defined by, or described by s. 503(b) of the
25 Federal Food, Drug, and Cosmetic Act or by s. 465.003(8), s.
26 499.007(12), or s. 499.0122(1)(b) or (c).
27 (b) "Value" means the amount billed to the Medicaid
28 program for the property dispensed or the market value of a
29 legend drug or goods or services at the time and place of the
30 offense. If the market value cannot be determined, the term
31

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1 means the replacement cost of the legend drug or goods or
2 services within a reasonable time after the offense.
3 (2) Any person who knowingly sells, who knowingly
4 attempts or conspires to sell, or who knowingly causes any
5 other person to sell or attempt or conspire to sell a legend
6 drug that was paid for by the Medicaid program commits a
7 felony.
8 (a) If the value of the legend drug involved is less
9 than $20,000, the crime is a felony of the third degree,
10 punishable as provided in s. 775.082, s. 775.083, or s.
11 775.084.
12 (b) If the value of the legend drug involved is
13 $20,000 or more but less than $100,000, the crime is a felony
14 of the second degree, punishable as provided in s. 775.082, s.
15 775.083, or s. 775.084.
16 (c) If the value of the legend drug involved is
17 $100,000 or more, the crime is a felony of the first degree,
18 punishable as provided in s. 775.082, s. 775.083, or s.
19 775.084.
20 (3) Any person who knowingly purchases, or who
21 knowingly attempts or conspires to purchase, a legend drug
22 that was paid for by the Medicaid program and intended for use
23 by another person commits a felony.
24 (a) If the value of the legend drug is less than
25 $20,000, the crime is a felony of the third degree, punishable
26 as provided in s. 775.082, s. 775.083, or s. 775.084.
27 (b) If the value of the legend drug is $20,000 or more
28 but less than $100,000, the crime is a felony of the second
29 degree, punishable as provided in s. 775.082, s. 775.083, or
30 s. 775.084.
31

1 (c) If the value of the legend drug is $100,000 or
2 more, the crime is a felony of the first degree, punishable as
3 provided in s. 775.082, s. 775.083, or s. 775.084.
4 (4) Any person who knowingly makes or knowingly causes
5 to be made, or who attempts or conspires to make, any false
6 statement or representation to any person for the purpose of
7 obtaining goods or services from the Medicaid program commits
8 a felony.
9 (a) If the value of the goods or services is less than
10 $20,000, the crime is a felony of the third degree, punishable
11 as provided in s. 775.082, s. 775.083, or s. 775.084.
12 (b) If the value of the goods or services is $20,000
13 or more but less than $100,000, the crime is a felony of the
14 second degree, punishable as provided in s. 775.082, s.
15 775.083, or s. 775.084.
16 (c) If the value of the goods or services involved is
17 $100,000 or more, the crime is a felony of the first degree,
18 punishable as provided in s. 775.082, s. 775.083, or s.
19 775.084.
20
21 The value of individual items of the legend drugs or goods or
22 services involved in distinct transactions committed during a
23 single scheme or course of conduct, whether involving a single
24 person or several persons, may be aggregated when determining
25 the punishment for the offense.
26 Section 7. Paragraph (ff) is added to subsection (1)
27 of section 456.072, Florida Statutes, to read:
28 456.072 Grounds for discipline; penalties;
29 enforcement.--
30
31

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

(ff) Engaging in a pattern of practice when prescribing medicinal drugs or controlled substances which demonstrates a lack of reasonable skill or safety to patients, a violation of any provision of this chapter, a violation of the applicable practice act, or a violation of any rules adopted pursuant to this chapter or the applicable practice act of the prescribing practitioner. Notwithstanding s. 456.073(13), the department may initiate an investigation and establish such a pattern from billing records, data, or any other information obtained by the department.

Section 8. Subsection (1) of section 465.188, Florida Statutes, is amended to read:

465.188 Medicaid audits of pharmacies.--

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

~~(a) The agency conducting the audit must give the pharmacist at least 1 week's prior notice of the audit.~~

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

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

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(c)~~(d)~~ A pharmacist may use the physician's record or other order for drugs or medicinal supplies written or transmitted by any means of communication for purposes of validating the pharmacy record with respect to orders or refills of a legend or narcotic drug.

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

(e)~~(f)~~ Each pharmacy shall be audited under the same standards and parameters.

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

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

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

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

(j) The audit criteria set forth in this section applies only to audits of claims submitted for payment subsequent to July 11, 2003.

Section 9. Section 812.0191, Florida Statutes, is created to read:

1 812.0191 Dealing in property paid for in whole or in
2 part by the Medicaid program.--
3 (1) As used in this section, the term:
4 (a) "Property paid for in whole or in part by the
5 Medicaid program" means any devices, goods, services, drugs,
6 or any other property furnished or intended to be furnished to
7 a recipient of benefits under the Medicaid program.
8 (b) "Value" means the amount billed to Medicaid for
9 the property dispensed or the market value of the devices,
10 goods, services, or drugs at the time and place of the
11 offense. If the market value cannot be determined, the term
12 means the replacement cost of the devices, goods, services, or
13 drugs within a reasonable time after the offense.
14 (2) Any person who traffics in, or endeavors to
15 traffic in, property that he or she knows or should have known
16 was paid for in whole or in part by the Medicaid program
17 commits a felony.
18 (a) If the value of the property involved is less than
19 $20,000, the crime is a felony of the third degree, punishable
20 as provided in s. 775.082, s. 775.083, or s. 775.084.
21 (b) If the value of the property involved is $20,000
22 or more but less than $100,000, the crime is a felony of the
23 second degree, punishable as provided in s. 775.082, s.
24 775.083, or s. 775.084.
25 (c) If the value of the property involved is $100,000
26 or more, the crime is a felony of the first degree, punishable
27 as provided in s. 775.082, s. 775.083, or s. 775.084.
28
29 The value of individual items of the devices, goods, services,
30 drugs, or other property involved in distinct transactions
31 committed during a single scheme or course of conduct, whether

1 involving a single person or several persons, may be
2 aggregated when determining the punishment for the offense.
3 (3) Any person who knowingly initiates, organizes,
4 plans, finances, directs, manages, or supervises the obtaining
5 of property paid for in whole or in part by the Medicaid
6 program and who traffics in, or endeavors to traffic in, such
7 property commits a felony of the first degree, punishable as
8 provided in s. 775.082, s. 775.083, or s. 775.084.
9 Section 10. Paragraph (a) of subsection (1) of section
10 895.02, Florida Statutes, is amended to read:
11 895.02 Definitions.--As used in ss. 895.01-895.08, the
12 term:
13 (1) "Racketeering activity" means to commit, to
14 attempt to commit, to conspire to commit, or to solicit,
15 coerce, or intimidate another person to commit:
16 (a) Any crime which is chargeable by indictment or
17 information under the following provisions of the Florida
18 Statutes:
19 1. Section 210.18, relating to evasion of payment of
20 cigarette taxes.
21 2. Section 403.727(3)(b), relating to environmental
22 control.
23 3. Section 414.39, relating to public assistance
24 fraud.
25 4. Section 409.920, relating to Medicaid provider
26 fraud and s. 409.9201, relating to Medicaid recipient fraud.
27 5. Section 440.105 or s. 440.106, relating to workers'
28 compensation.
29 6. Sections 499.0051, 499.0052, 499.0053, 499.0054,
30 and 499.0691, relating to crimes involving contraband and
31 adulterated drugs.

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1 7. Part IV of chapter 501, relating to telemarketing.
2 8. Chapter 517, relating to sale of securities and
3 investor protection.
4 9. Section 550.235, s. 550.3551, or s. 550.3605,
5 relating to dogracing and horseracing.
6 10. Chapter 550, relating to jai alai frontons.
7 11. Chapter 552, relating to the manufacture,
8 distribution, and use of explosives.
9 12. Chapter 560, relating to money transmitters, if
10 the violation is punishable as a felony.
11 13. Chapter 562, relating to beverage law enforcement.
12 14. Section 624.401, relating to transacting insurance
13 without a certificate of authority, s. 624.437(4)(c)1.,
14 relating to operating an unauthorized multiple-employer
15 welfare arrangement, or s. 626.902(1)(b), relating to
16 representing or aiding an unauthorized insurer.
17 15. Section 655.50, relating to reports of currency
18 transactions, when such violation is punishable as a felony.
19 16. Chapter 687, relating to interest and usurious
20 practices.
21 17. Section 721.08, s. 721.09, or s. 721.13, relating
22 to real estate timeshare plans.
23 18. Chapter 782, relating to homicide.
24 19. Chapter 784, relating to assault and battery.
25 20. Chapter 787, relating to kidnapping.
26 21. Chapter 790, relating to weapons and firearms.
27 22. Section 796.03, s. 796.04, s. 796.05, or s.
28 796.07, relating to prostitution.
29 23. Chapter 806, relating to arson.
30 24. Section 810.02(2)(c), relating to specified
31 burglary of a dwelling or structure.

1 25. Chapter 812, relating to theft, robbery, and
2 related crimes.
3 26. Chapter 815, relating to computer-related crimes.
4 27. Chapter 817, relating to fraudulent practices,
5 false pretenses, fraud generally, and credit card crimes.
6 28. Chapter 825, relating to abuse, neglect, or
7 exploitation of an elderly person or disabled adult.
8 29. Section 827.071, relating to commercial sexual
9 exploitation of children.
10 30. Chapter 831, relating to forgery and
11 counterfeiting.
12 31. Chapter 832, relating to issuance of worthless
13 checks and drafts.
14 32. Section 836.05, relating to extortion.
15 33. Chapter 837, relating to perjury.
16 34. Chapter 838, relating to bribery and misuse of
17 public office.
18 35. Chapter 843, relating to obstruction of justice.
19 36. Section 847.011, s. 847.012, s. 847.013, s.
20 847.06, or s. 847.07, relating to obscene literature and
21 profanity.
22 37. Section 849.09, s. 849.14, s. 849.15, s. 849.23,
23 or s. 849.25, relating to gambling.
24 38. Chapter 874, relating to criminal street gangs.
25 39. Chapter 893, relating to drug abuse prevention and
26 control.
27 40. Chapter 896, relating to offenses related to
28 financial transactions.
29 41. Sections 914.22 and 914.23, relating to tampering
30 with a witness, victim, or informant, and retaliation against
31 a witness, victim, or informant.

1 42. Sections 918.12 and 918.13, relating to tampering
2 with jurors and evidence.
3 Section 11. Section 905.34, Florida Statutes, is
4 amended to read:
5 905.34 Powers and duties; law applicable.--The
6 jurisdiction of a statewide grand jury impaneled under this
7 chapter shall extend throughout the state. The subject matter
8 jurisdiction of the statewide grand jury shall be limited to
9 the offenses of:
10 (1) Bribery, burglary, carjacking, home-invasion
11 robbery, criminal usury, extortion, gambling, kidnapping,
12 larceny, murder, prostitution, perjury, and robbery;
13 (2) Crimes involving narcotic or other dangerous
14 drugs;
15 (3) Any violation of the provisions of the Florida
16 RICO (Racketeer Influenced and Corrupt Organization) Act,
17 including any offense listed in the definition of racketeering
18 activity in s. 895.02(1)(a), providing such listed offense is
19 investigated in connection with a violation of s. 895.03 and
20 is charged in a separate count of an information or indictment
21 containing a count charging a violation of s. 895.03, the
22 prosecution of which listed offense may continue independently
23 if the prosecution of the violation of s. 895.03 is terminated
24 for any reason;
25 (4) Any violation of the provisions of the Florida
26 Anti-Fencing Act;
27 (5) Any violation of the provisions of the Florida
28 Antitrust Act of 1980, as amended;
29 (6) Any violation of the provisions of chapter 815;
30 (7) Any crime involving, or resulting in, fraud or
31 deceit upon any person;

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

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

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

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

Section 12. This act shall take effect July 1, 2004.

1 **

2 SENATE SUMMARY

Adds certain criminal violations to the list of specified crimes within the jurisdiction of the Office of Statewide Prosecution. Authorizes the Agency for Health Care Administration to require a confirmation or second physician's opinion of the correct diagnosis before authorizing payment for medical treatment. Authorizes the agency to order certain categories of Medicaid recipients to enroll in drug-therapy-management or disease-management programs. Provides that Medicaid recipients may be mandated to participate in a provider lock-in program. Provides specified conditions for providers to meet in order to submit claims to the Medicaid program and provides that claims may be denied if not properly submitted. Provides that the agency may seek any remedy under law if a provider submits specified false or erroneous claims. Requires the agency to report administrative sanctions to licensing authorities for certain violations. Permits the agency to withhold payment to a provider under certain circumstances. Restricts or suspends Medicaid eligibility of recipients convicted of certain crimes or offenses. Authorizes the agency to limit the number of certain types of prescription claims submitted by pharmacy providers. Makes it unlawful to knowingly use a Medicaid provider's or a Medicaid recipient's identification number to submit false claims. Provides that a person who sells legend drugs obtained through the Medicaid program commits a felony. Provides that a health care practitioner who prescribes medicinal drugs or controlled substances may be subject to discipline by the Department of Health or the appropriate board having jurisdiction over the health care practitioner. Authorizes the Department of Health to initiate a disciplinary investigation of prescribing practitioners under specified circumstances. Provides that a person who traffics in property paid for in whole or in part by the Medicaid program commits a felony. (See bill for details.)

3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31