By Senator Gaetz

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1 A bill to be entitled
2 An act relating to Medicaid; amending s. 409.913,
3 F.S.; authorizing the Agency for Health Care
4 Administration to immediately terminate participation
5 of a corporate Medicaid provider for actions or
6 inactions of an officer, director, affiliated person,
7 or other person having an ownership interest;
8 requiring the agency to issue a final order under ch.
9 120, F.S., in order to terminate a provider's
10 participation in the Medicaid program; authorizing the
11 agency to terminate or suspend a corporate Medicaid
12 provider's participation in this state's Medicaid
13 program if its participation has been terminated or
14 suspended in another state or by the Federal
15 Government; authorizing the agency to sanction a
16 corporate Medicaid provider for specified violations;
17 clarifying that the agency's calculation of
18 overpayment in its audit report is based on
19 documentation created contemporaneously with the goods
20 or services rendered and made available to the agency
21 before the issuance of the audit report; prohibiting a
22 Medicaid provider from relying upon or presenting
23 evidence of documentation or data that was not created
24 contemporaneously with the goods or services rendered
25 and made available to the agency before the issuance
26 of its audit report; providing an effective date.
27
28 Be It Enacted by the Legislature of the State of Florida:
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30 Section 1. Subsections (13), (14), (15), (21), and (22) of
31 section 409.913, Florida Statutes, are amended to read:
32 409.913 Oversight of the integrity of the Medicaid
33 program.—The agency shall operate a program to oversee the
34 activities of Florida Medicaid recipients, and providers and
35 their representatives, to ensure that fraudulent and abusive
36 behavior and neglect of recipients occur to the minimum extent
37 possible, and to recover overpayments and impose sanctions as
38 appropriate. Beginning January 1, 2003, and each year
39 thereafter, the agency and the Medicaid Fraud Control Unit of
40 the Department of Legal Affairs shall submit a joint report to
41 the Legislature documenting the effectiveness of the state's
42 efforts to control Medicaid fraud and abuse and to recover
43 Medicaid overpayments during the previous fiscal year. The
44 report must describe the number of cases opened and investigated
45 each year; the sources of the cases opened; the disposition of
46 the cases closed each year; the amount of overpayments alleged
47 in preliminary and final audit letters; the number and amount of
48 fines or penalties imposed; any reductions in overpayment
49 amounts negotiated in settlement agreements or by other means;
50 the amount of final agency determinations of overpayments; the
51 amount deducted from federal claiming as a result of
52 overpayments; the amount of overpayments recovered each year;
53 the amount of cost of investigation recovered each year; the
54 average length of time to collect from the time the case was
55 opened until the overpayment is paid in full; the amount
56 determined as uncollectible and the portion of the uncollectible
57 amount subsequently reclaimed from the Federal Government; the
58 number of providers, by type, that are terminated from

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59 participation in the Medicaid program as a result of fraud and
60 abuse; and all costs associated with discovering and prosecuting
61 cases of Medicaid overpayments and making recoveries in such
62 cases. The report must also document actions taken to prevent
63 overpayments and the number of providers prevented from
64 enrolling in or reenrolling in the Medicaid program as a result
65 of documented Medicaid fraud and abuse and must recommend
66 changes necessary to prevent or recover overpayments.
67 (13) The agency may immediately terminate participation of
68 a Medicaid provider in the Medicaid program and may seek civil
69 remedies or impose other administrative sanctions against a
70 Medicaid provider, if the provider, or if the provider is not a
71 natural person, any principal, officer, director, agent,
72 managing employee, affiliated person, or any partner or
73 shareholder having an ownership interest in the provider equal
74 to 5 percent or greater, has been:
75 (a) Convicted of a criminal offense related to the delivery
76 of any health care goods or services, including the performance
77 of management or administrative functions relating to the
78 delivery of health care goods or services;
79 (b) Convicted of a criminal offense under federal law or
80 the law of any state relating to the practice of the provider's
81 profession; or
82 (c) Found by a court of competent jurisdiction to have
83 neglected or physically abused a patient in connection with the
84 delivery of health care goods or services.
85
86 If the agency effects a termination under this subsection as an
87 immediate termination, the agency shall issue an immediate final

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88 order under s. 120.569(2).
89 (14) If the provider, or if the provider is not a natural
90 person, any principal, officer, director, agent, managing
91 employee, affiliated person, or any partner or shareholder
92 having an ownership interest in the provider equal to 5 percent
93 or greater, has been suspended or terminated from participation
94 in the Medicaid program or the Medicare program by the Federal
95 Government or any state, the agency must immediately suspend or
96 terminate, as appropriate, the provider's participation in this
97 state's ~~the Florida~~ Medicaid program for a period no less than
98 that imposed by the Federal Government or any other state, and
99 may not enroll such provider in this state's ~~the Florida~~
100 Medicaid program while such foreign suspension or termination
101 remains in effect. This sanction is in addition to all other
102 remedies provided by law.
103 (15) The agency may seek any remedy provided by law,
104 including, but not limited to, the remedies provided in
105 subsections (13) and (16) and s. 812.035, if:
106 (a) The provider's license has not been renewed, or has
107 been revoked, suspended, or terminated, for cause, by the
108 licensing agency of any state;
109 (b) The provider has failed to make available or has
110 refused access to Medicaid-related records to an auditor,
111 investigator, or other authorized employee or agent of the
112 agency, the Attorney General, a state attorney, or the Federal
113 Government;
114 (c) The provider has not furnished or has failed to make
115 available such Medicaid-related records as the agency has found
116 necessary to determine whether Medicaid payments are or were due

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117 and the amounts thereof;
118 (d) The provider has failed to maintain medical records
119 made at the time of service, or prior to service if prior
120 authorization is required, demonstrating the necessity and
121 appropriateness of the goods or services rendered;
122 (e) The provider is not in compliance with provisions of
123 Medicaid provider publications that have been adopted by
124 reference as rules in the Florida Administrative Code; with
125 provisions of state or federal laws, rules, or regulations; with
126 provisions of the provider agreement between the agency and the
127 provider; or with certifications found on claim forms or on
128 transmittal forms for electronically submitted claims that are
129 submitted by the provider or authorized representative, as such
130 provisions apply to the Medicaid program;
131 (f) The provider or person who ordered or prescribed the
132 care, services, or supplies has furnished, or ordered the
133 furnishing of, goods or services to a recipient which are
134 inappropriate, unnecessary, excessive, or harmful to the
135 recipient or are of inferior quality;
136 (g) The provider has demonstrated a pattern of failure to
137 provide goods or services that are medically necessary;
138 (h) The provider or an authorized representative of the
139 provider, or a person who ordered or prescribed the goods or
140 services, has submitted or caused to be submitted false or a
141 pattern of erroneous Medicaid claims;
142 (i) The provider or an authorized representative of the
143 provider, or a person who has ordered or prescribed the goods or
144 services, has submitted or caused to be submitted a Medicaid
145 provider enrollment application, a request for prior

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146 authorization for Medicaid services, a drug exception request,
147 or a Medicaid cost report that contains materially false or
148 incorrect information;
149 (j) The provider or an authorized representative of the
150 provider has collected from or billed a recipient or a
151 recipient's responsible party improperly for amounts that should
152 not have been so collected or billed by reason of the provider's
153 billing the Medicaid program for the same service;
154 (k) The provider or an authorized representative of the
155 provider has included in a cost report costs that are not
156 allowable under a Florida Title XIX reimbursement plan, after
157 the provider or authorized representative had been advised in an
158 audit exit conference or audit report that the costs were not
159 allowable;
160 (l) The provider is charged by information or indictment
161 with fraudulent billing practices. The sanction applied for this
162 reason is limited to suspension of the provider's participation
163 in the Medicaid program for the duration of the indictment
164 unless the provider is found guilty pursuant to the information
165 or indictment;
166 (m) The provider or a person who has ordered, or prescribed
167 the goods or services is found liable for negligent practice
168 resulting in death or injury to the provider's patient;
169 (n) The provider fails to demonstrate that it had available
170 during a specific audit or review period sufficient quantities
171 of goods, or sufficient time in the case of services, to support
172 the provider's billings to the Medicaid program;
173 (o) The provider has failed to comply with the notice and
174 reporting requirements of s. 409.907;

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175 (p) The agency has received reliable information of patient
176 abuse or neglect or of any act prohibited by s. 409.920; or
177 (q) The provider has failed to comply with an agreed-upon
178 repayment schedule.
179
180 If the violation involves any action or inaction by a provider,
181 or if the provider is not a natural person, by any principal,
182 officer, director, agent, managing employee, affiliated person,
183 or any partner or shareholder having an ownership interest equal
184 to 5 percent or greater in the provider, such action or inaction
185 constitutes a violation of this subsection and the provider may
186 be sanctioned.
187 (21) When making a determination that an overpayment has
188 occurred, the agency shall prepare and issue an audit report to
189 the provider showing the calculation of overpayments. If the
190 agency's determination that an overpayment has occurred is based
191 upon a review of the provider's records, the calculation of
192 overpayment shall be based upon documentation created
193 contemporaneously with the goods or services rendered and made
194 available to the agency before the issuance of the audit report.
195 (22) The audit report, supported by agency work papers,
196 showing an overpayment to a provider constitutes evidence of the
197 overpayment. A provider may not present or elicit testimony,
198 either on direct examination or cross-examination in any court
199 or administrative proceeding, regarding the purchase or
200 acquisition by any means of drugs, goods, or supplies; sales or
201 divestment by any means of drugs, goods, or supplies; or
202 inventory of drugs, goods, or supplies, unless such acquisition,
203 sales, divestment, or inventory is documented by written

204 invoices, written inventory records, or other competent written
205 documentary evidence maintained in the normal course of the
206 provider's business. Notwithstanding the applicable rules of
207 discovery, all documentation that will be offered as evidence at
208 an administrative hearing on a Medicaid overpayment must be
209 exchanged by all parties at least 14 days before the
210 administrative hearing or must be excluded from consideration. A
211 provider may not rely upon or present evidence of documentation
212 or data that was not created contemporaneously with the goods or
213 services rendered and made available to the agency before
214 issuance of the audit report.
215 Section 2. This act shall take effect July 1, 2009.