1 A bill to be entitled
2 An act relating to health care fraud; amending s. 400.471,
3 F.S.; prohibiting the Agency for Health Care
4 Administration from issuing an initial license to a home
5 health agency for the purpose of opening a new home health
6 agency under certain conditions until a specified date;
7 prohibiting the agency from issuing a change-of-ownership
8 license to a home health agency under certain conditions
9 until a specified date; providing an exception; amending
10 s. 400.474, F.S.; authorizing the agency to revoke a home
11 health agency license if the applicant or any controlling
12 interest has been sanctioned for acts specified under s.
13 400.471(10), F.S.; amending s. 408.815, F.S.; revising the
14 grounds upon which the agency may deny or revoke an
15 application for an initial license, a change-of-ownership
16 license, or a licensure renewal for certain health care
17 entities listed in s. 408.802, F.S.; amending s. 409.907,
18 F.S.; extending the number of years that Medicaid
19 providers must retain Medicaid recipient records; adding
20 additional requirements to the Medicaid provider
21 agreement; revising applicability of screening
22 requirements; revising conditions under which the agency
23 is authorized to deny a Medicaid provider application;
24 amending s. 409.912, F.S.; revising requirements for
25 Medicaid prepaid, fixed-sum, and managed care contracts;
26 amending s. 409.913, F.S.; removing a required element
27 from the joint Medicaid fraud and abuse report submitted
28 by the agency and the Medicaid Fraud Control Unit of the

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29 Department of Legal Affairs; extending the number of years
30 that Medicaid providers must retain Medicaid recipient
31 records; authorizing the Medicaid program integrity staff
32 to immediately suspend or terminate a Medicaid provider
33 for engaging in specified conduct; removing a requirement
34 for the agency to hold suspended Medicaid payments in a
35 separate account; authorizing the agency to deny payment
36 or require repayment to Medicaid providers convicted of
37 certain crimes; authorizing the agency to terminate a
38 Medicaid provider if the provider fails to reimburse a
39 fine determined by a final order; authorizing the agency
40 to withhold Medicaid reimbursement to a Medicaid provider
41 that fails to pay a fine determined by a final order,
42 fails to enter into a repayment plan, or fails to comply
43 with a repayment plan or settlement agreement; amending s.
44 409.9203, F.S.; providing that certain state employees are
45 ineligible from receiving a reward for reporting Medicaid
46 fraud; amending s. 456.001, F.S.; defining the term
47 "affiliate" or "affiliated person" as it relates to health
48 professions and occupations; amending s. 456.041, F.S.;
49 requiring the Department of Health to include
50 administrative complaint, arrest, and any conviction
51 information relating to the practitioner's profile;
52 providing a disclaimer; amending s. 456.072, F.S.;
53 clarifying a ground under which disciplinary actions may
54 be taken; amending s. 456.073, F.S.; revising
55 applicability of investigations and administrative
56 complaints to include Medicaid fraud; amending s. 456.074,

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57 F.S.; authorizing the Department of Health to issue an
58 emergency order suspending the license of any person
59 licensed under ch. 456, F.S., who engages in specified
60 criminal conduct; providing an effective date.
61
62 Be It Enacted by the Legislature of the State of Florida:
63
64 Section 1. Subsection (11) of section 400.471, Florida
65 Statutes, is amended to read:
66 400.471 Application for license; fee.—
67 (11)(a) The agency may not issue an initial license to a
68 home health agency under part II of chapter 408 or this part for
69 the purpose of opening a new home health agency until July 1,
70 2012 ~~2010~~, in any county that has at least one actively licensed
71 home health agency and a population of persons 65 years of age
72 or older, as indicated in the most recent population estimates
73 published by the Executive Office of the Governor, of fewer than
74 1,200 per home health agency. In such counties, for any
75 application received by the agency prior to July 1, 2009, which
76 has been deemed by the agency to be complete except for proof of
77 accreditation, the agency may issue an initial ownership license
78 only if the applicant has applied for accreditation before May
79 1, 2009, from an accrediting organization that is recognized by
80 the agency.
81 (b) Effective October 1, 2009, the agency may not issue a
82 change of ownership license to a home health agency under part
83 II of chapter 408 or this part until July 1, 2012 ~~2010~~, in any
84 county that has at least one actively licensed home health

85 agency and a population of persons 65 years of age or older, as
86 indicated in the most recent population estimates published by
87 the Executive Office of the Governor, of fewer than 1,200 per
88 home health agency. In such counties, for any application
89 received by the agency before ~~prior to~~ October 1, 2009, which
90 has been deemed by the agency to be complete except for proof of
91 accreditation, the agency may issue a change of ownership
92 license only if the applicant has applied for accreditation
93 before August 1, 2009, from an accrediting organization that is
94 recognized by the agency. This paragraph does not apply to an
95 application for a change of ownership submitted by a home health
96 agency that is accredited, has been licensed by the state for at
97 least 5 years, and is in good standing with the agency.
98 Section 2. Subsection (8) is added to section 400.474,
99 Florida Statutes, to read:
100 400.474 Administrative penalties.—
101 (8) The agency may revoke the license of a home health
102 agency that is not be eligible for licensure renewal under s.
103 400.471(10).
104 Section 3. Subsection (4) of section 408.815, Florida
105 Statutes, is amended, and subsection (5) is added to that
106 section, to read:
107 408.815 License or application denial; revocation.—
108 (4) In addition to the grounds provided in authorizing
109 statutes, the agency shall deny an application for an initial ~~a~~
110 license or a change-of-ownership license ~~renewal~~ if the
111 applicant or a person having a controlling interest in an
112 applicant ~~has been~~:

113 (a) Has been convicted of, or enters a plea of guilty or
114 nolo contendere to, regardless of adjudication, a felony under
115 chapter 409, chapter 817, chapter 893, or a similar felony
116 offense committed in another state or jurisdiction 21 U.S.C. ss.
117 801-970, or 42 U.S.C. ss. 1395-1396, unless the sentence and any
118 subsequent period of probation for such convictions or plea
119 ended more than 15 years before prior to the date of the
120 application;
121 (b) Has been convicted of, or enters a plea of guilty or
122 nolo contendere to, regardless of adjudication, a felony under
123 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396, unless the
124 sentence and any subsequent period of probation for such
125 conviction or plea ended more than 15 years before the date of
126 the application;
127 (c)(b) Has been terminated for cause from the Florida
128 Medicaid program pursuant to s. 409.913, unless the applicant
129 has been in good standing with the Florida Medicaid program for
130 the most recent 5 years; or
131 (d)(c) Has been terminated for cause, pursuant to the
132 appeals procedures established by the state or Federal
133 Government, from the federal Medicare program or from any other
134 state Medicaid program, unless the applicant has been in good
135 standing with a state Medicaid program or the federal Medicare
136 program for the most recent 5 years and the termination occurred
137 at least 20 years before prior to the date of the application;
138 or
139 (e) Is listed on the United States Department of Health
140 and Human Services Office of Inspector General's List of

141 Excluded Individuals and Entities.
142 (5) In addition to the grounds provided in authorizing
143 statutes, the agency shall deny an application for licensure
144 renewal if the applicant or a person having a controlling
145 interest in an applicant:
146 (a) Has been convicted of, or enters a plea of guilty or
147 nolo contendere to, regardless of adjudication, a felony under
148 chapter 409, chapter 817, chapter 893, or a similar felony
149 offense committed in another state or jurisdiction since July 1,
150 2009;
151 (b) Has been convicted of, or enters a plea of guilty or
152 nolo contendere to, regardless of adjudication, a felony under
153 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 since July 1,
154 2009;
155 (c) Has been terminated for cause from the Florida
156 Medicaid program pursuant to s. 409.913, unless the applicant
157 has been in good standing with the Florida Medicaid program for
158 the most recent 5 years;
159 (d) Has been terminated for cause, pursuant to the appeals
160 procedures established by the state, from any other state
161 Medicaid program, unless the applicant has been in good standing
162 with a state Medicaid program for the most recent 5 years and
163 the termination occurred at least 20 years before the date of
164 the application; or
165 (e) Is listed on the United States Department of Health
166 and Human Services Office of Inspector General's List of
167 Excluded Individuals and Entities.
168 Section 4. Paragraph (c) of subsection (3) of section

169 409.907, Florida Statutes, is amended, paragraph (k) is added to
170 that subsection, and subsection (8), paragraph (b) of subsection
171 (9), and subsection (10) of that section are amended, to read:
172 409.907 Medicaid provider agreements.—The agency may make
173 payments for medical assistance and related services rendered to
174 Medicaid recipients only to an individual or entity who has a
175 provider agreement in effect with the agency, who is performing
176 services or supplying goods in accordance with federal, state,
177 and local law, and who agrees that no person shall, on the
178 grounds of handicap, race, color, or national origin, or for any
179 other reason, be subjected to discrimination under any program
180 or activity for which the provider receives payment from the
181 agency.
182 (3) The provider agreement developed by the agency, in
183 addition to the requirements specified in subsections (1) and
184 (2), shall require the provider to:
185 (c) Retain all medical and Medicaid-related records for a
186 period of 6 ~~5~~ years to satisfy all necessary inquiries by the
187 agency.
188 (k) Report any change of any principal of the provider,
189 including any officer, director, billing agent, managing
190 employee, or affiliated person, or any partner or shareholder
191 who has an ownership interest equal to 5 percent or more in the
192 provider. The provider must report changes to the agency no
193 later than 30 days after the change occurs.
194 (8)(a) Each provider, or each principal of the provider if
195 the provider is a corporation, partnership, association, or
196 other entity, seeking to participate in the Medicaid program

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197 must submit a complete set of his or her fingerprints to the
198 agency for the purpose of conducting a criminal history record
199 check. Principals of the provider include any officer, director,
200 billing agent, managing employee, or affiliated person, or any
201 partner or shareholder who has an ownership interest equal to 5
202 percent or more in the provider. However, a director of a not-
203 for-profit corporation or organization is not a principal for
204 purposes of a background investigation as required by this
205 section if the director: serves solely in a voluntary capacity
206 for the corporation or organization, does not regularly take
207 part in the day-to-day operational decisions of the corporation
208 or organization, receives no remuneration from the not-for-
209 profit corporation or organization for his or her service on the
210 board of directors, has no financial interest in the not-for-
211 profit corporation or organization, and has no family members
212 with a financial interest in the not-for-profit corporation or
213 organization; and if the director submits an affidavit, under
214 penalty of perjury, to this effect to the agency and the not-
215 for-profit corporation or organization submits an affidavit,
216 under penalty of perjury, to this effect to the agency as part
217 of the corporation's or organization's Medicaid provider
218 agreement application. Notwithstanding the above, the agency may
219 require a background check for any person reasonably suspected
220 by the agency to have been convicted of a crime. This subsection
221 shall not apply to:
222 ~~1. A hospital licensed under chapter 395;~~
223 ~~2. A nursing home licensed under chapter 400;~~
224 ~~3. A hospice licensed under chapter 400;~~

225 ~~4. An assisted living facility licensed under chapter 429;~~
226 <u>1.</u>~~5.~~ A unit of local government, except that requirements
227 of this subsection apply to nongovernmental providers and
228 entities when contracting with the local government to provide
229 Medicaid services. The actual cost of the state and national
230 criminal history record checks must be borne by the
231 nongovernmental provider or entity; or
232 <u>2.</u>~~6.~~ Any business that derives more than 50 percent of its
233 revenue from the sale of goods to the final consumer, and the
234 business or its controlling parent either is required to file a
235 form 10-K or other similar statement with the Securities and
236 Exchange Commission or has a net worth of $50 million or more.
237 (b) <u>Background screening shall be conducted in accordance</u>
238 <u>with chapter 435 and s. 408.809.</u> ~~The agency shall submit the~~
239 ~~fingerprints to the Department of Law Enforcement. The~~
240 ~~department shall conduct a state criminal-background~~
241 ~~investigation and forward the fingerprints to the Federal Bureau~~
242 ~~of Investigation for a national criminal-history record check.~~
243 The cost of the state and national criminal record check shall
244 be borne by the provider.
245 ~~(c) The agency may permit a provider to participate in the~~
246 ~~Medicaid program pending the results of the criminal record~~
247 ~~check. However, such permission is fully revocable if the record~~
248 ~~check reveals any crime-related history as provided in~~
249 ~~subsection (10).~~
250 <u>(c)</u>~~(d)~~ Proof of compliance with the requirements of level
251 2 screening under s. 435.04 conducted within 12 months prior to
252 the date that the Medicaid provider application is submitted to

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253 the agency shall fulfill the requirements of this subsection.
254 ~~Proof of compliance with the requirements of level 1 screening~~
255 ~~under s. 435.03 conducted within 12 months prior to the date~~
256 ~~that the Medicaid provider application is submitted to the~~
257 ~~agency shall meet the requirement that the Department of Law~~
258 ~~Enforcement conduct a state criminal history record check.~~
259 (9) Upon receipt of a completed, signed, and dated
260 application, and completion of any necessary background
261 investigation and criminal history record check, the agency must
262 either:
263 (b) Deny the application if the agency finds that it is in
264 the best interest of the Medicaid program to do so. The agency
265 may consider any ~~the factors listed in subsection (10), as well~~
266 ~~as any other~~ factor that could affect the effective and
267 efficient administration of the program, including, but not
268 limited to, the applicant's demonstrated ability to provide
269 services, conduct business, and operate a financially viable
270 concern; the current availability of medical care, services, or
271 supplies to recipients, taking into account geographic location
272 and reasonable travel time; the number of providers of the same
273 type already enrolled in the same geographic area; and the
274 credentials, experience, success, and patient outcomes of the
275 provider for the services that it is making application to
276 provide in the Medicaid program. The agency shall deny the
277 application if the agency finds that a provider; any officer,
278 director, agent, managing employee, or affiliated person; or any
279 principal, partner, or shareholder having an ownership interest
280 equal to 5 percent or greater in the provider if the provider is

281 a corporation, partnership, or other business entity, has failed
282 to pay all outstanding fines or overpayments assessed by final
283 order of the agency or final order of the Centers for Medicare
284 and Medicaid Services, not subject to further appeal, unless the
285 provider agrees to a repayment plan that includes withholding
286 Medicaid reimbursement until the amount due is paid in full.
287 (10) The agency <u>shall deny the application if</u> ~~may consider~~
288 ~~whether~~ the provider, or any <u>principal,</u> officer, director,
289 agent, managing employee, or affiliated person, or any partner
290 or shareholder having an ownership interest equal to 5 percent
291 or greater in the provider if the provider is a corporation,
292 partnership, or other business entity, has <u>committed an offense</u>
293 <u>listed in s. 409.913(13), and may deny the application if one of</u>
294 <u>these persons has</u>:
295 (a) Made a false representation or omission of any
296 material fact in making the application, including the
297 submission of an application that conceals the controlling or
298 ownership interest of any <u>principal,</u> officer, director, agent,
299 managing employee, affiliated person, or partner or shareholder
300 who may not be eligible to participate;
301 (b) Been or is currently excluded, suspended, terminated
302 from, or has involuntarily withdrawn from participation in,
303 Florida's Medicaid program or any other state's Medicaid
304 program, or from participation in any other governmental or
305 private health care or health insurance program;
306 ~~(c) Been convicted of a criminal offense relating to the~~
307 ~~delivery of any goods or services under Medicaid or Medicare or~~
308 ~~any other public or private health care or health insurance~~

309 ~~program including the performance of management or~~
310 ~~administrative services relating to the delivery of goods or~~
311 ~~services under any such program;~~
312 ~~(d) Been convicted under federal or state law of a~~
313 ~~criminal offense related to the neglect or abuse of a patient in~~
314 ~~connection with the delivery of any health care goods or~~
315 ~~services;~~
316 <u>(c)</u>~~(e)~~ Been convicted under federal or state law of a
317 criminal offense relating to the unlawful manufacture,
318 distribution, prescription, or dispensing of a controlled
319 substance;
320 <u>(d)</u>~~(f)~~ Been convicted of any criminal offense relating to
321 fraud, theft, embezzlement, breach of fiduciary responsibility,
322 or other financial misconduct;
323 <u>(e)</u>~~(g)~~ Been convicted under federal or state law of a
324 crime punishable by imprisonment of a year or more which
325 involves moral turpitude;
326 <u>(f)</u>~~(h)~~ Been convicted in connection with the interference
327 or obstruction of any investigation into any criminal offense
328 listed in this subsection;
329 <u>(g)</u>~~(i)~~ Been found to have violated federal or state laws~~,~~
330 ~~rules, or regulations~~ governing Florida's Medicaid program or
331 any other state's Medicaid program, the Medicare program, or any
332 other publicly funded federal or state health care or health
333 insurance program, and been sanctioned accordingly;
334 <u>(h)</u>~~(j)~~ Been previously found by a licensing, certifying,
335 or professional standards board or agency to have violated the
336 standards or conditions relating to licensure or certification

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337 or the quality of services provided; or
338 (i) ~~(k)~~ Failed to pay any fine or overpayment properly
339 assessed under the Medicaid program in which no appeal is
340 pending or after resolution of the proceeding by stipulation or
341 agreement, unless the agency has issued a specific letter of
342 forgiveness or has approved a repayment schedule to which the
343 provider agrees to adhere.
344 Section 5. Subsections (10) and (32) of section 409.912,
345 Florida Statutes, are amended to read:
346 409.912 Cost-effective purchasing of health care.—The
347 agency shall purchase goods and services for Medicaid recipients
348 in the most cost-effective manner consistent with the delivery
349 of quality medical care. To ensure that medical services are
350 effectively utilized, the agency may, in any case, require a
351 confirmation or second physician's opinion of the correct
352 diagnosis for purposes of authorizing future services under the
353 Medicaid program. This section does not restrict access to
354 emergency services or poststabilization care services as defined
355 in 42 C.F.R. part 438.114. Such confirmation or second opinion
356 shall be rendered in a manner approved by the agency. The agency
357 shall maximize the use of prepaid per capita and prepaid
358 aggregate fixed-sum basis services when appropriate and other
359 alternative service delivery and reimbursement methodologies,
360 including competitive bidding pursuant to s. 287.057, designed
361 to facilitate the cost-effective purchase of a case-managed
362 continuum of care. The agency shall also require providers to
363 minimize the exposure of recipients to the need for acute
364 inpatient, custodial, and other institutional care and the

365 inappropriate or unnecessary use of high-cost services. The
366 agency shall contract with a vendor to monitor and evaluate the
367 clinical practice patterns of providers in order to identify
368 trends that are outside the normal practice patterns of a
369 provider's professional peers or the national guidelines of a
370 provider's professional association. The vendor must be able to
371 provide information and counseling to a provider whose practice
372 patterns are outside the norms, in consultation with the agency,
373 to improve patient care and reduce inappropriate utilization.
374 The agency may mandate prior authorization, drug therapy
375 management, or disease management participation for certain
376 populations of Medicaid beneficiaries, certain drug classes, or
377 particular drugs to prevent fraud, abuse, overuse, and possible
378 dangerous drug interactions. The Pharmaceutical and Therapeutics
379 Committee shall make recommendations to the agency on drugs for
380 which prior authorization is required. The agency shall inform
381 the Pharmaceutical and Therapeutics Committee of its decisions
382 regarding drugs subject to prior authorization. The agency is
383 authorized to limit the entities it contracts with or enrolls as
384 Medicaid providers by developing a provider network through
385 provider credentialing. The agency may competitively bid single-
386 source-provider contracts if procurement of goods or services
387 results in demonstrated cost savings to the state without
388 limiting access to care. The agency may limit its network based
389 on the assessment of beneficiary access to care, provider
390 availability, provider quality standards, time and distance
391 standards for access to care, the cultural competence of the
392 provider network, demographic characteristics of Medicaid

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393 beneficiaries, practice and provider-to-beneficiary standards,
394 appointment wait times, beneficiary use of services, provider
395 turnover, provider profiling, provider licensure history,
396 previous program integrity investigations and findings, peer
397 review, provider Medicaid policy and billing compliance records,
398 clinical and medical record audits, and other factors. Providers
399 shall not be entitled to enrollment in the Medicaid provider
400 network. The agency shall determine instances in which allowing
401 Medicaid beneficiaries to purchase durable medical equipment and
402 other goods is less expensive to the Medicaid program than long-
403 term rental of the equipment or goods. The agency may establish
404 rules to facilitate purchases in lieu of long-term rentals in
405 order to protect against fraud and abuse in the Medicaid program
406 as defined in s. 409.913. The agency may seek federal waivers
407 necessary to administer these policies.
408 (10) The agency shall not contract on a prepaid or fixed-
409 sum basis for Medicaid services with an entity which knows or
410 reasonably should know that any principal, officer, director,
411 agent, managing employee, or owner of stock or beneficial
412 interest in excess of 5 percent common or preferred stock, or
413 the entity itself, has been found guilty of, regardless of
414 adjudication, or entered a plea of nolo contendere, or guilty,
415 to:
416 (a) An offense listed in s. 408.809, s. 409.913(13), or s.
417 435.04 ~~Fraud~~;
418 (b) Violation of federal or state antitrust statutes,
419 including those proscribing price fixing between competitors and
420 the allocation of customers among competitors;

421 (c) Commission of a felony involving embezzlement, theft,
422 forgery, income tax evasion, bribery, falsification or
423 destruction of records, making false statements, receiving
424 stolen property, making false claims, or obstruction of justice;
425 or
426 (d) Any crime in any jurisdiction which directly relates
427 to the provision of health services on a prepaid or fixed-sum
428 basis.
429 (32) Each managed care plan that is under contract with
430 the agency to provide health care services to Medicaid
431 recipients shall annually conduct a background check with the
432 Florida Department of Law Enforcement of all persons with
433 ownership interest of 5 percent or more or executive management
434 responsibility for the managed care plan and shall submit to the
435 agency information concerning any such person who has been found
436 guilty of, regardless of adjudication, or has entered a plea of
437 nolo contendere or guilty to, any of the offenses listed in s.
438 408.809, s. 409.913(13), or s. 435.04 ~~s. 435.03~~.
439 Section 6. Section 409.913, Florida Statutes, is amended
440 to read:
441 409.913 Oversight of the integrity of the Medicaid
442 program.—The agency shall operate a program to oversee the
443 activities of Florida Medicaid recipients, and providers and
444 their representatives, to ensure that fraudulent and abusive
445 behavior and neglect of recipients occur to the minimum extent
446 possible, and to recover overpayments and impose sanctions as
447 appropriate. Beginning January 1, 2003, and each year
448 thereafter, the agency and the Medicaid Fraud Control Unit of

449 the Department of Legal Affairs shall submit a joint report to
450 the Legislature documenting the effectiveness of the state's
451 efforts to control Medicaid fraud and abuse and to recover
452 Medicaid overpayments during the previous fiscal year. The
453 report must describe the number of cases opened and investigated
454 each year; the sources of the cases opened; the disposition of
455 the cases closed each year; the amount of overpayments alleged
456 in preliminary and final audit letters; the number and amount of
457 fines or penalties imposed; any reductions in overpayment
458 amounts negotiated in settlement agreements or by other means;
459 the amount of final agency determinations of overpayments; the
460 amount deducted from federal claiming as a result of
461 overpayments; the amount of overpayments recovered each year;
462 the amount of cost of investigation recovered each year; the
463 average length of time to collect from the time the case was
464 opened until the overpayment is paid in full; the amount
465 determined as uncollectible and the portion of the uncollectible
466 amount subsequently reclaimed from the Federal Government; the
467 number of providers, by type, that are terminated from
468 participation in the Medicaid program as a result of fraud and
469 abuse; and all costs associated with discovering and prosecuting
470 cases of Medicaid overpayments and making recoveries in such
471 cases. The report must also document actions taken to prevent
472 overpayments and the number of providers prevented from
473 enrolling in or reenrolling in the Medicaid program as a result
474 of documented Medicaid fraud and abuse and must include policy
475 recommendations necessary to prevent or recover overpayments and
476 changes necessary to prevent and detect Medicaid fraud. All

477 policy recommendations in the report must include a detailed
478 fiscal analysis, including, but not limited to, implementation
479 costs, estimated savings to the Medicaid program, and the return
480 on investment. The agency must submit the policy recommendations
481 and fiscal analyses in the report to the appropriate estimating
482 conference, pursuant to s. 216.137, by February 15 of each year.
483 The agency and the Medicaid Fraud Control Unit of the Department
484 of Legal Affairs each must include detailed unit-specific
485 performance standards, benchmarks, and metrics in the report~~,~~
486 ~~including projected cost savings to the state Medicaid program~~
487 ~~during the following fiscal year~~.
488 (1) For the purposes of this section, the term:
489 (a) "Abuse" means:
490 1. Provider practices that are inconsistent with generally
491 accepted business or medical practices and that result in an
492 unnecessary cost to the Medicaid program or in reimbursement for
493 goods or services that are not medically necessary or that fail
494 to meet professionally recognized standards for health care.
495 2. Recipient practices that result in unnecessary cost to
496 the Medicaid program.
497 (b) "Complaint" means an allegation that fraud, abuse, or
498 an overpayment has occurred.
499 (c) "Fraud" means an intentional deception or
500 misrepresentation made by a person with the knowledge that the
501 deception results in unauthorized benefit to herself or himself
502 or another person. The term includes any act that constitutes
503 fraud under applicable federal or state law.
504 (d) "Medical necessity" or "medically necessary" means any

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505 goods or services necessary to palliate the effects of a
506 terminal condition, or to prevent, diagnose, correct, cure,
507 alleviate, or preclude deterioration of a condition that
508 threatens life, causes pain or suffering, or results in illness
509 or infirmity, which goods or services are provided in accordance
510 with generally accepted standards of medical practice. For
511 purposes of determining Medicaid reimbursement, the agency is
512 the final arbiter of medical necessity. Determinations of
513 medical necessity must be made by a licensed physician employed
514 by or under contract with the agency and must be based upon
515 information available at the time the goods or services are
516 provided.
517 (e) "Overpayment" includes any amount that is not
518 authorized to be paid by the Medicaid program whether paid as a
519 result of inaccurate or improper cost reporting, improper
520 claiming, unacceptable practices, fraud, abuse, or mistake.
521 (f) "Person" means any natural person, corporation,
522 partnership, association, clinic, group, or other entity,
523 whether or not such person is enrolled in the Medicaid program
524 or is a provider of health care.
525 (2) The agency shall conduct, or cause to be conducted by
526 contract or otherwise, reviews, investigations, analyses,
527 audits, or any combination thereof, to determine possible fraud,
528 abuse, overpayment, or recipient neglect in the Medicaid program
529 and shall report the findings of any overpayments in audit
530 reports as appropriate. At least 5 percent of all audits shall
531 be conducted on a random basis. As part of its ongoing fraud
532 detection activities, the agency shall identify and monitor, by

533 contract or otherwise, patterns of overutilization of Medicaid
534 services based on state averages. The agency shall track
535 Medicaid provider prescription and billing patterns and evaluate
536 them against Medicaid medical necessity criteria and coverage
537 and limitation guidelines adopted by rule. Medical necessity
538 determination requires that service be consistent with symptoms
539 or confirmed diagnosis of illness or injury under treatment and
540 not in excess of the patient's needs. The agency shall conduct
541 reviews of provider exceptions to peer group norms and shall,
542 using statistical methodologies, provider profiling, and
543 analysis of billing patterns, detect and investigate abnormal or
544 unusual increases in billing or payment of claims for Medicaid
545 services and medically unnecessary provision of services.
546 (3) The agency may conduct, or may contract for,
547 prepayment review of provider claims to ensure cost-effective
548 purchasing; to ensure that billing by a provider to the agency
549 is in accordance with applicable provisions of all Medicaid
550 rules, regulations, handbooks, and policies and in accordance
551 with federal, state, and local law; and to ensure that
552 appropriate care is rendered to Medicaid recipients. Such
553 prepayment reviews may be conducted as determined appropriate by
554 the agency, without any suspicion or allegation of fraud, abuse,
555 or neglect, and may last for up to 1 year. Unless the agency has
556 reliable evidence of fraud, misrepresentation, abuse, or
557 neglect, claims shall be adjudicated for denial or payment
558 within 90 days after receipt of complete documentation by the
559 agency for review. If there is reliable evidence of fraud,
560 misrepresentation, abuse, or neglect, claims shall be

561 adjudicated for denial of payment within 180 days after receipt
562 of complete documentation by the agency for review.
563 (4) Any suspected criminal violation identified by the
564 agency must be referred to the Medicaid Fraud Control Unit of
565 the Office of the Attorney General for investigation. The agency
566 and the Attorney General shall enter into a memorandum of
567 understanding, which must include, but need not be limited to, a
568 protocol for regularly sharing information and coordinating
569 casework. The protocol must establish a procedure for the
570 referral by the agency of cases involving suspected Medicaid
571 fraud to the Medicaid Fraud Control Unit for investigation, and
572 the return to the agency of those cases where investigation
573 determines that administrative action by the agency is
574 appropriate. Offices of the Medicaid program integrity program
575 and the Medicaid Fraud Control Unit of the Department of Legal
576 Affairs, shall, to the extent possible, be collocated. The
577 agency and the Department of Legal Affairs shall periodically
578 conduct joint training and other joint activities designed to
579 increase communication and coordination in recovering
580 overpayments.
581 (5) A Medicaid provider is subject to having goods and
582 services that are paid for by the Medicaid program reviewed by
583 an appropriate peer-review organization designated by the
584 agency. The written findings of the applicable peer-review
585 organization are admissible in any court or administrative
586 proceeding as evidence of medical necessity or the lack thereof.
587 (6) Any notice required to be given to a provider under
588 this section is presumed to be sufficient notice if sent to the

589 address last shown on the provider enrollment file. It is the
590 responsibility of the provider to furnish and keep the agency
591 informed of the provider's current address. United States Postal
592 Service proof of mailing or certified or registered mailing of
593 such notice to the provider at the address shown on the provider
594 enrollment file constitutes sufficient proof of notice. Any
595 notice required to be given to the agency by this section must
596 be sent to the agency at an address designated by rule.
597 (7) When presenting a claim for payment under the Medicaid
598 program, a provider has an affirmative duty to supervise the
599 provision of, and be responsible for, goods and services claimed
600 to have been provided, to supervise and be responsible for
601 preparation and submission of the claim, and to present a claim
602 that is true and accurate and that is for goods and services
603 that:
604 (a) Have actually been furnished to the recipient by the
605 provider prior to submitting the claim.
606 (b) Are Medicaid-covered goods or services that are
607 medically necessary.
608 (c) Are of a quality comparable to those furnished to the
609 general public by the provider's peers.
610 (d) Have not been billed in whole or in part to a
611 recipient or a recipient's responsible party, except for such
612 copayments, coinsurance, or deductibles as are authorized by the
613 agency.
614 (e) Are provided in accord with applicable provisions of
615 all Medicaid rules, regulations, handbooks, and policies and in
616 accordance with federal, state, and local law.

617 (f) Are documented by records made at the time the goods
618 or services were provided, demonstrating the medical necessity
619 for the goods or services rendered. Medicaid goods or services
620 are excessive or not medically necessary unless both the medical
621 basis and the specific need for them are fully and properly
622 documented in the recipient's medical record.
623
624 The agency shall deny payment or require repayment for goods or
625 services that are not presented as required in this subsection.
626 (8) The agency shall not reimburse any person or entity
627 for any prescription for medications, medical supplies, or
628 medical services if the prescription was written by a physician
629 or other prescribing practitioner who is not enrolled in the
630 Medicaid program. This section does not apply:
631 (a) In instances involving bona fide emergency medical
632 conditions as determined by the agency;
633 (b) To a provider of medical services to a patient in a
634 hospital emergency department, hospital inpatient or outpatient
635 setting, or nursing home;
636 (c) To bona fide pro bono services by preapproved non-
637 Medicaid providers as determined by the agency;
638 (d) To prescribing physicians who are board-certified
639 specialists treating Medicaid recipients referred for treatment
640 by a treating physician who is enrolled in the Medicaid program;
641 (e) To prescriptions written for dually eligible Medicare
642 beneficiaries by an authorized Medicare provider who is not
643 enrolled in the Medicaid program;
644 (f) To other physicians who are not enrolled in the

645 Medicaid program but who provide a medically necessary service
646 or prescription not otherwise reasonably available from a
647 Medicaid-enrolled physician; or
648 (9) A Medicaid provider shall retain medical,
649 professional, financial, and business records pertaining to
650 services and goods furnished to a Medicaid recipient and billed
651 to Medicaid for a period of 6 ~~5~~ years after the date of
652 furnishing such services or goods. The agency may investigate,
653 review, or analyze such records, which must be made available
654 during normal business hours. However, 24-hour notice must be
655 provided if patient treatment would be disrupted. The provider
656 is responsible for furnishing to the agency, and keeping the
657 agency informed of the location of, the provider's Medicaid-
658 related records. The authority of the agency to obtain Medicaid-
659 related records from a provider is neither curtailed nor limited
660 during a period of litigation between the agency and the
661 provider.
662 (10) Payments for the services of billing agents or
663 persons participating in the preparation of a Medicaid claim
664 shall not be based on amounts for which they bill nor based on
665 the amount a provider receives from the Medicaid program.
666 (11) The agency shall deny payment or require repayment
667 for inappropriate, medically unnecessary, or excessive goods or
668 services from the person furnishing them, the person under whose
669 supervision they were furnished, or the person causing them to
670 be furnished.
671 (12) The complaint and all information obtained pursuant
672 to an investigation of a Medicaid provider, or the authorized

673 representative or agent of a provider, relating to an allegation
674 of fraud, abuse, or neglect are confidential and exempt from the
675 provisions of s. 119.07(1):
676 (a) Until the agency takes final agency action with
677 respect to the provider and requires repayment of any
678 overpayment, or imposes an administrative sanction;
679 (b) Until the Attorney General refers the case for
680 criminal prosecution;
681 (c) Until 10 days after the complaint is determined
682 without merit; or
683 (d) At all times if the complaint or information is
684 otherwise protected by law.
685 (13) The agency shall immediately terminate participation
686 of a Medicaid provider in the Medicaid program and may seek
687 civil remedies or impose other administrative sanctions against
688 a Medicaid provider, if the provider or any principal, officer,
689 director, agent, managing employee, or affiliated person of the
690 provider, or any partner or shareholder having an ownership
691 interest in the provider equal to 5 percent or greater, has
692 been:
693 (a) Convicted of a criminal offense related to the
694 delivery of any health care goods or services, including the
695 performance of management or administrative functions relating
696 to the delivery of health care goods or services;
697 (b) Convicted of a criminal offense under federal law or
698 the law of any state relating to the practice of the provider's
699 profession; or
700 (c) Found by a court of competent jurisdiction to have

701 neglected or physically abused a patient in connection with the
702 delivery of health care goods or services.
703
704 If the agency determines a provider did not participate or
705 acquiesce in an offense specified in paragraph (a), paragraph
706 (b), or paragraph (c), termination will not be imposed. If the
707 agency effects a termination under this subsection, the agency
708 shall issue an immediate termination ~~final~~ order as provided in
709 subsection (16) ~~pursuant to s. 120.569(2)(n)~~.
710 (14) If the provider has been suspended or terminated from
711 participation in the Medicaid program or the Medicare program by
712 the Federal Government or any state, the agency must immediately
713 suspend or terminate, as appropriate, the provider's
714 participation in this state's Medicaid program for a period no
715 less than that imposed by the Federal Government or any other
716 state, and may not enroll such provider in this state's Medicaid
717 program while such foreign suspension or termination remains in
718 effect. The agency shall also immediately suspend or terminate,
719 as appropriate, a provider's participation in this state's
720 Medicaid program if the provider participated or acquiesced in
721 any action for which any principal, officer, director, agent,
722 managing employee, or affiliated person of the provider, or any
723 partner or shareholder having an ownership interest in the
724 provider equal to 5 percent or greater, was suspended or
725 terminated from participating in the Medicaid program or the
726 Medicare program by the Federal Government or any state. This
727 sanction is in addition to all other remedies provided by law.
728 If the agency suspends or terminates a provider's participation

729 in the state's Medicaid program under this subsection, the
730 agency shall issue an immediate suspension or immediate
731 termination order as provided in subsection (16).
732 (15) The agency shall seek a remedy provided by law,
733 including, but not limited to, any remedy provided in
734 subsections (13) and (16) and s. 812.035, if:
735 (a) The provider's license has not been renewed, or has
736 been revoked, suspended, or terminated, for cause, by the
737 licensing agency of any state;
738 (b) The provider has failed to make available or has
739 refused access to Medicaid-related records to an auditor,
740 investigator, or other authorized employee or agent of the
741 agency, the Attorney General, a state attorney, or the Federal
742 Government;
743 (c) The provider has not furnished or has failed to make
744 available such Medicaid-related records as the agency has found
745 necessary to determine whether Medicaid payments are or were due
746 and the amounts thereof;
747 (d) The provider has failed to maintain medical records
748 made at the time of service, or prior to service if prior
749 authorization is required, demonstrating the necessity and
750 appropriateness of the goods or services rendered;
751 (e) The provider is not in compliance with provisions of
752 Medicaid provider publications that have been adopted by
753 reference as rules in the Florida Administrative Code; with
754 provisions of state or federal laws, rules, or regulations; with
755 provisions of the provider agreement between the agency and the
756 provider; or with certifications found on claim forms or on

757 transmittal forms for electronically submitted claims that are
758 submitted by the provider or authorized representative, as such
759 provisions apply to the Medicaid program;
760 (f) The provider or person who ordered or prescribed the
761 care, services, or supplies has furnished, or ordered the
762 furnishing of, goods or services to a recipient which are
763 inappropriate, unnecessary, excessive, or harmful to the
764 recipient or are of inferior quality;
765 (g) The provider has demonstrated a pattern of failure to
766 provide goods or services that are medically necessary;
767 (h) The provider or an authorized representative of the
768 provider, or a person who ordered or prescribed the goods or
769 services, has submitted or caused to be submitted false or a
770 pattern of erroneous Medicaid claims;
771 (i) The provider or an authorized representative of the
772 provider, or a person who has ordered or prescribed the goods or
773 services, has submitted or caused to be submitted a Medicaid
774 provider enrollment application, a request for prior
775 authorization for Medicaid services, a drug exception request,
776 or a Medicaid cost report that contains materially false or
777 incorrect information;
778 (j) The provider or an authorized representative of the
779 provider has collected from or billed a recipient or a
780 recipient's responsible party improperly for amounts that should
781 not have been so collected or billed by reason of the provider's
782 billing the Medicaid program for the same service;
783 (k) The provider or an authorized representative of the
784 provider has included in a cost report costs that are not

785 allowable under a Florida Title XIX reimbursement plan, after
786 the provider or authorized representative had been advised in an
787 audit exit conference or audit report that the costs were not
788 allowable;
789 (l) The provider is charged by information or indictment
790 with fraudulent billing practices or an offense under subsection
791 (13). The sanction applied for this reason is limited to
792 suspension of the provider's participation in the Medicaid
793 program for the duration of the indictment unless the provider
794 is found guilty pursuant to the information or indictment;
795 (m) The provider or a person who has ordered or prescribed
796 the goods or services is found liable for negligent practice
797 resulting in death or injury to the provider's patient;
798 (n) The provider fails to demonstrate that it had
799 available during a specific audit or review period sufficient
800 quantities of goods, or sufficient time in the case of services,
801 to support the provider's billings to the Medicaid program;
802 (o) The provider has failed to comply with the notice and
803 reporting requirements of s. 409.907;
804 (p) The agency has received reliable information of
805 patient abuse or neglect or of any act prohibited by s. 409.920;
806 or
807 (q) The provider has failed to comply with an agreed-upon
808 repayment schedule.
809
810 A provider is subject to sanctions for violations of this
811 subsection as the result of actions or inactions of the
812 provider, or actions or inactions of any principal, officer,

813 director, agent, managing employee, or affiliated person of the
814 provider, or any partner or shareholder having an ownership
815 interest in the provider equal to 5 percent or greater, in which
816 the provider participated or acquiesced. If the agency suspends
817 or terminates a provider under this subsection, the agency shall
818 issue an immediate suspension or immediate termination order as
819 provided in subsection (16).
820 (16) The agency shall impose any of the following
821 sanctions or disincentives on a provider or a person for any of
822 the acts described in subsection (15):
823 (a) Suspension for a specific period of time of not more
824 than 1 year. Suspension shall preclude participation in the
825 Medicaid program, which includes any action that results in a
826 claim for payment to the Medicaid program as a result of
827 furnishing, supervising a person who is furnishing, or causing a
828 person to furnish goods or services.
829 (b) Termination for a specific period of time of from more
830 than 1 year to 20 years. Termination shall preclude
831 participation in the Medicaid program, which includes any action
832 that results in a claim for payment to the Medicaid program as a
833 result of furnishing, supervising a person who is furnishing, or
834 causing a person to furnish goods or services.
835 (c) Imposition of a fine of up to $5,000 for each
836 violation. Each day that an ongoing violation continues, such as
837 refusing to furnish Medicaid-related records or refusing access
838 to records, is considered, for the purposes of this section, to
839 be a separate violation. Each instance of improper billing of a
840 Medicaid recipient; each instance of including an unallowable

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841 cost on a hospital or nursing home Medicaid cost report after
842 the provider or authorized representative has been advised in an
843 audit exit conference or previous audit report of the cost
844 unallowability; each instance of furnishing a Medicaid recipient
845 goods or professional services that are inappropriate or of
846 inferior quality as determined by competent peer judgment; each
847 instance of knowingly submitting a materially false or erroneous
848 Medicaid provider enrollment application, request for prior
849 authorization for Medicaid services, drug exception request, or
850 cost report; each instance of inappropriate prescribing of drugs
851 for a Medicaid recipient as determined by competent peer
852 judgment; and each false or erroneous Medicaid claim leading to
853 an overpayment to a provider is considered, for the purposes of
854 this section, to be a separate violation.
855 (d) Immediate suspension, if the agency has received
856 information of patient abuse or neglect, ~~or of~~ any act
857 prohibited by s. 409.920, or any conduct listed in subsection
858 (13) or subsection (14). Upon suspension, the agency must issue
859 an immediate suspension ~~final~~ order, which shall state that the
860 agency has reasonable cause to believe that the provider,
861 person, or entity named is engaging in or has engaged in patient
862 abuse or neglect, any act prohibited by s. 409.920, or any
863 conduct listed in subsection (13) or subsection (14). The order
864 shall provide notice of administrative hearing rights under ss.
865 120.569 and 120.57 and is effective immediately upon notice to
866 the provider, person, or entity ~~under s. 120.569(2)(n)~~.
867 (e) Immediate termination, if the agency has received
868 information of a conviction of patient abuse or neglect, any act

869 prohibited by s. 409.920, or any conduct listed in subsection
870 (13) or subsection (14). Upon termination, the agency must issue
871 an immediate termination order, which shall state that the
872 agency has reasonable cause to believe that the provider,
873 person, or entity named has been convicted of patient abuse or
874 neglect, any act prohibited by s. 409.920, or any conduct listed
875 in subsection (13) or subsection (14). The termination order
876 shall provide notice of administrative hearing rights under ss.
877 120.569 and 120.57 and is effective immediately upon notice to
878 the provider, person, or entity.
879 (f)(e) A fine, not to exceed $10,000, for a violation of
880 paragraph (15)(i).
881 (g)(f) Imposition of liens against provider assets,
882 including, but not limited to, financial assets and real
883 property, not to exceed the amount of fines or recoveries
884 sought, upon entry of an order determining that such moneys are
885 due or recoverable.
886 (h)(g) Prepayment reviews of claims for a specified period
887 of time.
888 (i)(h) Comprehensive followup reviews of providers every 6
889 months to ensure that they are billing Medicaid correctly.
890 (j)(i) Corrective-action plans that would remain in effect
891 for providers for up to 3 years and that would be monitored by
892 the agency every 6 months while in effect.
893 (k)(j) Other remedies as permitted by law to effect the
894 recovery of a fine or overpayment.
895
896 The Secretary of Health Care Administration may make a

897 determination that imposition of a sanction or disincentive is
898 not in the best interest of the Medicaid program, in which case
899 a sanction or disincentive shall not be imposed.
900 (17) In determining the appropriate administrative
901 sanction to be applied, or the duration of any suspension or
902 termination, the agency shall consider:
903 (a) The seriousness and extent of the violation or
904 violations.
905 (b) Any prior history of violations by the provider
906 relating to the delivery of health care programs which resulted
907 in either a criminal conviction or in administrative sanction or
908 penalty.
909 (c) Evidence of continued violation within the provider's
910 management control of Medicaid statutes, rules, regulations, or
911 policies after written notification to the provider of improper
912 practice or instance of violation.
913 (d) The effect, if any, on the quality of medical care
914 provided to Medicaid recipients as a result of the acts of the
915 provider.
916 (e) Any action by a licensing agency respecting the
917 provider in any state in which the provider operates or has
918 operated.
919 (f) The apparent impact on access by recipients to
920 Medicaid services if the provider is suspended or terminated, in
921 the best judgment of the agency.
922
923 The agency shall document the basis for all sanctioning actions
924 and recommendations.

925 (18) The agency may take action to sanction, suspend, or
926 terminate a particular provider working for a group provider,
927 and may suspend or terminate Medicaid participation at a
928 specific location, rather than or in addition to taking action
929 against an entire group.
930 (19) The agency shall establish a process for conducting
931 followup reviews of a sampling of providers who have a history
932 of overpayment under the Medicaid program. This process must
933 consider the magnitude of previous fraud or abuse and the
934 potential effect of continued fraud or abuse on Medicaid costs.
935 (20) In making a determination of overpayment to a
936 provider, the agency must use accepted and valid auditing,
937 accounting, analytical, statistical, or peer-review methods, or
938 combinations thereof. Appropriate statistical methods may
939 include, but are not limited to, sampling and extension to the
940 population, parametric and nonparametric statistics, tests of
941 hypotheses, and other generally accepted statistical methods.
942 Appropriate analytical methods may include, but are not limited
943 to, reviews to determine variances between the quantities of
944 products that a provider had on hand and available to be
945 purveyed to Medicaid recipients during the review period and the
946 quantities of the same products paid for by the Medicaid program
947 for the same period, taking into appropriate consideration sales
948 of the same products to non-Medicaid customers during the same
949 period. In meeting its burden of proof in any administrative or
950 court proceeding, the agency may introduce the results of such
951 statistical methods as evidence of overpayment.
952 (21) When making a determination that an overpayment has

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953 occurred, the agency shall prepare and issue an audit report to
954 the provider showing the calculation of overpayments.
955 (22) The audit report, supported by agency work papers,
956 showing an overpayment to a provider constitutes evidence of the
957 overpayment. A provider may not present or elicit testimony,
958 either on direct examination or cross-examination in any court
959 or administrative proceeding, regarding the purchase or
960 acquisition by any means of drugs, goods, or supplies; sales or
961 divestment by any means of drugs, goods, or supplies; or
962 inventory of drugs, goods, or supplies, unless such acquisition,
963 sales, divestment, or inventory is documented by written
964 invoices, written inventory records, or other competent written
965 documentary evidence maintained in the normal course of the
966 provider's business. Notwithstanding the applicable rules of
967 discovery, all documentation that will be offered as evidence at
968 an administrative hearing on a Medicaid overpayment must be
969 exchanged by all parties at least 14 days before the
970 administrative hearing or must be excluded from consideration.
971 (23)(a) In an audit or investigation of a violation
972 committed by a provider which is conducted pursuant to this
973 section, the agency is entitled to recover all investigative,
974 legal, and expert witness costs if the agency's findings were
975 not contested by the provider or, if contested, the agency
976 ultimately prevailed.
977 (b) The agency has the burden of documenting the costs,
978 which include salaries and employee benefits and out-of-pocket
979 expenses. The amount of costs that may be recovered must be
980 reasonable in relation to the seriousness of the violation and

981 must be set taking into consideration the financial resources,
982 earning ability, and needs of the provider, who has the burden
983 of demonstrating such factors.
984 (c) The provider may pay the costs over a period to be
985 determined by the agency if the agency determines that an
986 extreme hardship would result to the provider from immediate
987 full payment. Any default in payment of costs may be collected
988 by any means authorized by law.
989 (24) If the agency imposes an administrative sanction
990 pursuant to subsection (13), subsection (14), or subsection
991 (15), except paragraphs (15)(e) and (o), upon any provider or
992 any principal, officer, director, agent, managing employee, or
993 affiliated person of the provider who is regulated by another
994 state entity, the agency shall notify that other entity of the
995 imposition of the sanction within 5 business days. Such
996 notification must include the provider's or person's name and
997 license number and the specific reasons for sanction.
998 (25)(a) The agency shall withhold Medicaid payments, in
999 whole or in part, to a provider upon receipt of reliable
1000 evidence that the circumstances giving rise to the need for a
1001 withholding of payments involve fraud, willful
1002 misrepresentation, or abuse under the Medicaid program, or a
1003 crime committed while rendering goods or services to Medicaid
1004 recipients. If the provider is not paid within 14 days after the
1005 provider receives such evidence, interest shall accrue at a rate
1006 of 10 percent a year. ~~If it is determined that fraud, willful~~
1007 ~~misrepresentation, abuse, or a crime did not occur, the payments~~
1008 ~~withheld must be paid to the provider within 14 days after such~~

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1009 ~~determination with interest at the rate of 10 percent a year.~~
1010 ~~Any money withheld in accordance with this paragraph shall be~~
1011 ~~placed in a suspended account, readily accessible to the agency,~~
1012 ~~so that any payment ultimately due the provider shall be made~~
1013 ~~within 14 days.~~
1014 (b) The agency shall deny payment, or require repayment,
1015 if the goods or services were furnished, supervised, or caused
1016 to be furnished by a person who has been convicted of a crime
1017 under subsection (13) or who has been suspended or terminated
1018 from the Medicaid program or Medicare program by the Federal
1019 Government or any state.
1020 (c) Overpayments owed to the agency bear interest at the
1021 rate of 10 percent per year from the date of determination of
1022 the overpayment by the agency, and payment arrangements
1023 regarding overpayments and fines must be made within 35 days
1024 after the date of the termination or suspension order ~~at the~~
1025 ~~conclusion of legal proceedings. A provider who does not enter~~
1026 ~~into or adhere to an agreed-upon repayment schedule may be~~
1027 ~~terminated by the agency for nonpayment or partial payment~~.
1028 (d) The agency, upon entry of a final agency order, a
1029 judgment or order of a court of competent jurisdiction, or a
1030 stipulation or settlement, may collect the moneys owed by all
1031 means allowable by law, including, but not limited to, notifying
1032 any fiscal intermediary of Medicare benefits that the state has
1033 a superior right of payment. Upon receipt of such written
1034 notification, the Medicare fiscal intermediary shall remit to
1035 the state the sum claimed.
1036 (e) The agency may institute amnesty programs to allow

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1037 Medicaid providers the opportunity to voluntarily repay
1038 overpayments. The agency may adopt rules to administer such
1039 programs.
1040 (26) The agency may impose administrative sanctions
1041 against a Medicaid recipient, or the agency may seek any other
1042 remedy provided by law, including, but not limited to, the
1043 remedies provided in s. 812.035, if the agency finds that a
1044 recipient has engaged in solicitation in violation of s. 409.920
1045 or that the recipient has otherwise abused the Medicaid program.
1046 (27) When the Agency for Health Care Administration has
1047 made a probable cause determination and alleged that an
1048 overpayment to a Medicaid provider has occurred, the agency,
1049 after notice to the provider, shall:
1050 (a) Withhold, and continue to withhold during the pendency
1051 of an administrative hearing pursuant to chapter 120, any
1052 medical assistance reimbursement payments until such time as the
1053 overpayment is recovered, unless within 30 days after receiving
1054 notice thereof the provider:
1055 1. Makes repayment in full; or
1056 2. Establishes a repayment plan that is satisfactory to
1057 the Agency for Health Care Administration.
1058 (b) Withhold, and continue to withhold during the pendency
1059 of an administrative hearing pursuant to chapter 120, medical
1060 assistance reimbursement payments if the terms of a repayment
1061 plan are not adhered to by the provider.
1062 (28) Venue for all Medicaid program integrity overpayment
1063 cases shall lie in Leon County, at the discretion of the agency.
1064 (29) Notwithstanding other provisions of law, the agency

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1065 and the Medicaid Fraud Control Unit of the Department of Legal
1066 Affairs may review a provider's Medicaid-related and non-
1067 Medicaid-related records in order to determine the total output
1068 of a provider's practice to reconcile quantities of goods or
1069 services billed to Medicaid with quantities of goods or services
1070 used in the provider's total practice.
1071 (30) The agency shall terminate a provider's participation
1072 in the Medicaid program if the provider fails to reimburse an
1073 overpayment or fine that has been determined by termination or
1074 suspension ~~final~~ order, not subject to further appeal, within 35
1075 days after the date of the termination or suspension ~~final~~
1076 order, unless the provider and the agency have entered into a
1077 repayment agreement.
1078 (31) If a provider requests an administrative hearing
1079 pursuant to chapter 120, such hearing must be conducted within
1080 90 days following assignment of an administrative law judge,
1081 absent exceptionally good cause shown as determined by the
1082 administrative law judge or hearing officer. Upon issuance of a
1083 termination or suspension ~~final~~ order, the outstanding balance
1084 of the amount determined to constitute the overpayment or fine
1085 shall become due. If a provider fails to make payments in full,
1086 fails to enter into a satisfactory repayment plan, or fails to
1087 comply with the terms of a repayment plan or settlement
1088 agreement, the agency shall withhold medical assistance
1089 reimbursement payments until the amount due is paid in full.
1090 (32) Duly authorized agents and employees of the agency
1091 shall have the power to inspect, during normal business hours,
1092 the records of any pharmacy, wholesale establishment, or

1093 manufacturer, or any other place in which drugs and medical
1094 supplies are manufactured, packed, packaged, made, stored, sold,
1095 or kept for sale, for the purpose of verifying the amount of
1096 drugs and medical supplies ordered, delivered, or purchased by a
1097 provider. The agency shall provide at least 2 business days'
1098 prior notice of any such inspection. The notice must identify
1099 the provider whose records will be inspected, and the inspection
1100 shall include only records specifically related to that
1101 provider.
1102 (33) In accordance with federal law, Medicaid recipients
1103 convicted of a crime pursuant to 42 U.S.C. s. 1320a-7b may be
1104 limited, restricted, or suspended from Medicaid eligibility for
1105 a period not to exceed 1 year, as determined by the agency head
1106 or designee.
1107 (34) To deter fraud and abuse in the Medicaid program, the
1108 agency may limit the number of Schedule II and Schedule III
1109 refill prescription claims submitted from a pharmacy provider.
1110 The agency shall limit the allowable amount of reimbursement of
1111 prescription refill claims for Schedule II and Schedule III
1112 pharmaceuticals if the agency or the Medicaid Fraud Control Unit
1113 determines that the specific prescription refill was not
1114 requested by the Medicaid recipient or authorized representative
1115 for whom the refill claim is submitted or was not prescribed by
1116 the recipient's medical provider or physician. Any such refill
1117 request must be consistent with the original prescription.
1118 (35) The Office of Program Policy Analysis and Government
1119 Accountability shall provide a report to the President of the
1120 Senate and the Speaker of the House of Representatives on a

1121 biennial basis, beginning January 31, 2006, on the agency's
1122 efforts to prevent, detect, and deter, as well as recover funds
1123 lost to, fraud and abuse in the Medicaid program.
1124 (36) At least three times a year, the agency shall provide
1125 to each Medicaid recipient or his or her representative an
1126 explanation of benefits in the form of a letter that is mailed
1127 to the most recent address of the recipient on the record with
1128 the Department of Children and Family Services. The explanation
1129 of benefits must include the patient's name, the name of the
1130 health care provider and the address of the location where the
1131 service was provided, a description of all services billed to
1132 Medicaid in terminology that should be understood by a
1133 reasonable person, and information on how to report
1134 inappropriate or incorrect billing to the agency or other law
1135 enforcement entities for review or investigation. At least once
1136 a year, the letter also must include information on how to
1137 report criminal Medicaid fraud, the Medicaid Fraud Control
1138 Unit's toll-free hotline number, and information about the
1139 rewards available under s. 409.9203. The explanation of benefits
1140 may not be mailed for Medicaid independent laboratory services
1141 as described in s. 409.905(7) or for Medicaid certified match
1142 services as described in ss. 409.9071 and 1011.70.
1143 (37) The agency shall post on its website a current list
1144 of each Medicaid provider, including any principal, officer,
1145 director, agent, managing employee, or affiliated person of the
1146 provider, or any partner or shareholder having an ownership
1147 interest in the provider equal to 5 percent or greater, who has
1148 been terminated for cause from the Medicaid program or

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1149 sanctioned under this section. The list must be searchable by a
1150 variety of search parameters and provide for the creation of
1151 formatted lists that may be printed or imported into other
1152 applications, including spreadsheets. The agency shall update
1153 the list at least monthly.
1154 (38) In order to improve the detection of health care
1155 fraud, use technology to prevent and detect fraud, and maximize
1156 the electronic exchange of health care fraud information, the
1157 agency shall:
1158 (a) Compile, maintain, and publish on its website a
1159 detailed list of all state and federal databases that contain
1160 health care fraud information and update the list at least
1161 biannually;
1162 (b) Develop a strategic plan to connect all databases that
1163 contain health care fraud information to facilitate the
1164 electronic exchange of health information between the agency,
1165 the Department of Health, the Department of Law Enforcement, and
1166 the Attorney General's Office. The plan must include recommended
1167 standard data formats, fraud identification strategies, and
1168 specifications for the technical interface between state and
1169 federal health care fraud databases;
1170 (c) Monitor innovations in health information technology,
1171 specifically as it pertains to Medicaid fraud prevention and
1172 detection; and
1173 (d) Periodically publish policy briefs that highlight
1174 available new technology to prevent or detect health care fraud
1175 and projects implemented by other states, the private sector, or
1176 the Federal Government which use technology to prevent or detect

1177 health care fraud.
1178 Section 7. Subsection (5) is added to section 409.9203,
1179 Florida Statutes, to read:
1180 409.9203 Rewards for reporting Medicaid fraud.—
1181 (5) An employee of the Agency for Health Care
1182 Administration, the Department of Legal Affairs, the Department
1183 of Health, or the Department of Law Enforcement whose job
1184 responsibilities include the prevention, detection, and
1185 prosecution of Medicaid fraud is not eligible to receive a
1186 reward under this section.
1187 Section 8. Subsection (8) is added to section 456.001,
1188 Florida Statutes, to read:
1189 456.001 Definitions.—As used in this chapter, the term:
1190 (8) "Affiliate" or "affiliated person" means any person
1191 who directly or indirectly manages, controls, or oversees the
1192 operation of a corporation or other business entity, regardless
1193 of whether that person is a partner, shareholder, owner,
1194 officer, director, or agent of the entity.
1195 Section 9. Subsections (7) through (11) of section
1196 456.041, Florida Statutes, are renumbered as subsections (8)
1197 through (12), respectively, a new subsection (7) is added to
1198 that section, and paragraph (c) of subsection (1) and
1199 subsections (2) and (3) of that section are amended, to read:
1200 456.041 Practitioner profile; creation.—
1201 (1)
1202 (c) Within 30 calendar days after receiving an update of
1203 information required for the practitioner's profile, the
1204 department shall update the practitioner's profile in accordance

1205 with the requirements of subsection (9) ~~(7)~~.
1206 (2) Beginning July 1, 2010, on the profile published under
1207 subsection (1), the department shall include ~~indicate if~~ the
1208 information provided under s. 456.039(1)(a)7. or s.
1209 456.0391(1)(a)7. and indicate if the information is or is not
1210 corroborated by a criminal history records check conducted
1211 according to this subsection. The department must include in
1212 each practitioner's profile the following statement: "The
1213 criminal history information, if any exists, may be incomplete.
1214 Federal criminal history information is not available to the
1215 public." ~~The department, or the board having regulatory~~
1216 ~~authority over the practitioner acting on behalf of the~~
1217 ~~department, shall investigate any information received by the~~
1218 ~~department or the board.~~
1219 (3) Beginning July 1, 2010, the department shall include
1220 in each practitioner's profile any administrative complaint
1221 filed with the department against the practitioner in which
1222 probable cause has been found and the status of the complaint.
1223 ~~The Department of Health shall include in each practitioner's~~
1224 ~~practitioner profile that criminal information that directly~~
1225 ~~relates to the practitioner's ability to competently practice~~
1226 ~~his or her profession. The department must include in each~~
1227 ~~practitioner's practitioner profile the following statement:~~
1228 ~~"The criminal history information, if any exists, may be~~
1229 ~~incomplete; federal criminal history information is not~~
1230 ~~available to the public."~~ The department shall provide in each
1231 practitioner profile, for every final disciplinary action taken
1232 against the practitioner, an easy-to-read narrative description

1233 that explains the administrative complaint filed against the
1234 practitioner and the final disciplinary action imposed on the
1235 practitioner. The department shall include a hyperlink to each
1236 final order listed in its website report of dispositions of
1237 recent disciplinary actions taken against practitioners.
1238 (7) Beginning July 1, 2010, the department shall include
1239 in each practitioner's profile detailed information about each
1240 arrest related to that practitioner. The department must include
1241 in each practitioner's profile the following statement: "The
1242 arrest information, if any exists, may be incomplete."
1243 Section 10. Paragraph (kk) of subsection (1) of section
1244 456.072, Florida Statutes, is amended to read:
1245 456.072 Grounds for discipline; penalties; enforcement.—
1246 (1) The following acts shall constitute grounds for which
1247 the disciplinary actions specified in subsection (2) may be
1248 taken:
1249 (kk) Being terminated from the state Medicaid program
1250 pursuant to s. 409.913 or~~,~~ any other state Medicaid program~~,~~ or
1251 excluded from the federal Medicare program, unless eligibility
1252 to participate in the program from which the practitioner was
1253 terminated has been restored.
1254 Section 11. Subsection (13) of section 456.073, Florida
1255 Statutes, is amended to read:
1256 456.073 Disciplinary proceedings.—Disciplinary proceedings
1257 for each board shall be within the jurisdiction of the
1258 department.
1259 (13) Notwithstanding any provision of law to the contrary,
1260 an administrative complaint against a licensee shall be filed

1261 within 6 years after the time of the incident or occurrence
1262 giving rise to the complaint against the licensee. If such
1263 incident or occurrence involved fraud related to the Medicaid
1264 program, criminal actions, diversion of controlled substances,
1265 sexual misconduct, or impairment by the licensee, this
1266 subsection does not apply to bar initiation of an investigation
1267 or filing of an administrative complaint beyond the 6-year
1268 timeframe. In those cases covered by this subsection in which it
1269 can be shown that fraud, concealment, or intentional
1270 misrepresentation of fact prevented the discovery of the
1271 violation of law, the period of limitations is extended forward,
1272 but in no event to exceed 12 years after the time of the
1273 incident or occurrence.
1274 Section 12. Subsection (1) of section 456.074, Florida
1275 Statutes, is amended to read:
1276 456.074 Certain health care practitioners; immediate
1277 suspension of license.—
1278 (1) The department shall issue an emergency order
1279 suspending the license of any person licensed in a profession as
1280 defined in chapter 456 ~~under chapter 458, chapter 459, chapter~~
1281 ~~460, chapter 461, chapter 462, chapter 463, chapter 464, chapter~~
1282 ~~465, chapter 466, or chapter 484~~ who pleads guilty to, is
1283 convicted or found guilty of, or who enters a plea of nolo
1284 contendere to, regardless of adjudication, to:
1285 (a) A felony under chapter 409, chapter 812, chapter 817,
1286 ~~or~~ chapter 893, chapter 895, chapter 896, ~~or under~~ 21 U.S.C. ss.
1287 801-970, or ~~under~~ 42 U.S.C. ss. 1395-1396; or
1288 (b) A misdemeanor or felony under 18 U.S.C. s. 669, ss.

1289 285-287, s. 371, s. 1001, s. 1035, s. 1341, s. 1343, s. 1347, s.
1290 1349, or s. 1518 or 42 U.S.C. ss. 1320a-7b, relating to the
1291 Medicaid program.
1292 Section 13. This act shall take effect July 1, 2010.

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