239386

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/07/2010	.	
	.	
	.	
	.	

The Committee on Criminal Justice (Dean) recommended the following:

Senate Amendment (with title amendment)

Delete lines 881 - 1307
and insert:
information of a conviction based on patient abuse or neglect, any act prohibited by s. 409.920, or any conduct listed in subsection (13) or subsection (14). Upon termination, the agency must issue an immediate termination order, which shall state that the agency has reasonable cause to believe that the provider, person, or entity named has been convicted of patient abuse or neglect, any act prohibited by s. 409.920, or any conduct listed in subsection (13) or subsection (14). The

termination order shall provide notice of administrative hearing rights under ss. 120.569 and 120.57 and is effective immediately upon notice to the provider, person, or entity.

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

(g) ~~(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.

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

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

(j) ~~(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.

(k) ~~(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) 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.

239386

(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.

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

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

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

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

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

(18) The agency may take action to sanction, suspend, or terminate a particular provider working for a group provider, and may suspend or terminate Medicaid participation at a specific location, rather than or in addition to taking action against an entire group.

(19) The agency shall establish a process for conducting followup reviews of a sampling of providers who have a history of overpayment under the Medicaid program. This process must consider the magnitude of previous fraud or abuse and the

potential effect of continued fraud or abuse on Medicaid costs.

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

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

(22) The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment. A provider may not present or elicit testimony, either on direct examination or cross-examination in any court or administrative proceeding, regarding the purchase or acquisition by any means of drugs, goods, or supplies; sales or divestment by any means of drugs, goods, or supplies; or inventory of drugs, goods, or supplies, unless such acquisition,

sales, divestment, or inventory is documented by written invoices, written inventory records, or other competent written documentary evidence maintained in the normal course of the provider's business. Notwithstanding the applicable rules of discovery, all documentation that will be offered as evidence at an administrative hearing on a Medicaid overpayment must be exchanged by all parties at least 14 days before the administrative hearing or must be excluded from consideration.

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

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

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

(24) If the agency imposes an administrative sanction pursuant to subsection (13), subsection (14), or subsection (15), except paragraphs (15)(e) and (o), upon any provider or

any principal, officer, director, agent, managing employee, or affiliated person of the provider who is regulated by another state entity, the agency shall notify that other entity of the imposition of the sanction within 5 business days. Such notification must include the provider's or person's name and license number and the specific reasons for sanction.

(25)(a) The agency shall 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. If the provider is not paid within 14 days after the agency receives evidence ~~it is determined~~ that fraud, willful misrepresentation, abuse, or a crime did not occur, interest shall accrue at a rate of 10 percent a year ~~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 convicted of a crime under subsection (13) or who has been suspended or terminated from the Medicaid program or Medicare program by the Federal Government or any state.

(c) 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 for overpayments and fines must be made within 35 days after the date of the final order ~~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) 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 the state has a superior right of payment. Upon receipt of such written notification, the Medicare fiscal intermediary shall remit to the state the sum claimed.

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

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

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


239386

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

1. Makes repayment in full; or

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

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

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

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

(30) The agency shall terminate a provider’s participation in the Medicaid program if the provider fails to reimburse an overpayment <u>or fine</u> that has been determined by final order, not subject to further appeal, within 35 days after the date of the final order, unless the provider and the agency have entered into a repayment agreement.

(31) If a provider requests an administrative hearing pursuant to chapter 120, such hearing must be conducted within

90 days following assignment of an administrative law judge, absent exceptionally good cause shown as determined by the administrative law judge or hearing officer. Upon issuance of a final order, the outstanding balance of the amount determined to constitute the overpayment or fine shall become due. If a provider fails to make payments in full, fails to enter into a satisfactory repayment plan, or fails to comply with the terms of a repayment plan or settlement agreement, the agency shall withhold medical assistance reimbursement payments until the amount due is paid in full.

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

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

(34) To deter fraud and abuse in the Medicaid program, the agency may limit the number of Schedule II and Schedule III

239386

refill prescription claims submitted from a pharmacy provider. The agency shall limit the allowable amount of reimbursement of prescription refill claims for Schedule II and Schedule III pharmaceuticals if the agency or the Medicaid Fraud Control Unit determines that the specific prescription refill was not requested by the Medicaid recipient or authorized representative for whom the refill claim is submitted or was not prescribed by the recipient's medical provider or physician. Any such refill request must be consistent with the original prescription.

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

(36) At least three times a year, the agency shall provide to each Medicaid recipient or his or her representative an explanation of benefits in the form of a letter that is mailed to the most recent address of the recipient on the record with the Department of Children and Family Services. The explanation of benefits must include the patient's name, the name of the health care provider and the address of the location where the service was provided, a description of all services billed to Medicaid in terminology that should be understood by a reasonable person, and information on how to report inappropriate or incorrect billing to the agency or other law enforcement entities for review or investigation. At least once a year, the letter also must include information on how to

report criminal Medicaid fraud, the Medicaid Fraud Control Unit's toll-free hotline number, and information about the rewards available under s. 409.9203. The explanation of benefits may not be mailed for Medicaid independent laboratory services as described in s. 409.905(7) or for Medicaid certified match services as described in ss. 409.9071 and 1011.70.

(37) The agency shall post on its website a current list of each Medicaid provider, including any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, who has been terminated for cause from the Medicaid program or sanctioned under this section. The list must be searchable by a variety of search parameters and provide for the creation of formatted lists that may be printed or imported into other applications, including spreadsheets. The agency shall update the list at least monthly.

(38) In order to improve the detection of health care fraud, use technology to prevent and detect fraud, and maximize the electronic exchange of health care fraud information, the agency shall:

(a) Compile, maintain, and publish on its website a detailed list of all state and federal databases that contain health care fraud information and update the list at least biannually;

(b) Develop a strategic plan to connect all databases that contain health care fraud information to facilitate the electronic exchange of health information between the agency, the Department of Health, the Department of Law Enforcement, and

the Attorney General's Office. The plan must include recommended standard data formats, fraud identification strategies, and specifications for the technical interface between state and federal health care fraud databases;

(c) Monitor innovations in health information technology, specifically as it pertains to Medicaid fraud prevention and detection; and

(d) Periodically publish policy briefs that highlight available new technology to prevent or detect health care fraud and projects implemented by other states, the private sector, or the Federal Government which use technology to prevent or detect health care fraud.

Section 8. Subsection (5) is added to section 409.9203, Florida Statutes, to read:

409.9203 Rewards for reporting Medicaid fraud.—

(5) An employee of the Agency for Health Care Administration, the Department of Legal Affairs, the Department of Health, or the Department of Law Enforcement whose job responsibilities include the prevention, detection, and prosecution of Medicaid fraud is not eligible to receive a reward under this section.

Section 9. Subsection (8) is added to section 456.001, Florida Statutes, to read:

456.001 Definitions.—As used in this chapter, the term:

(8) "Affiliate" or "affiliated person" means any person who directly or indirectly manages, controls, or oversees the operation of a corporation or other business entity, regardless of whether such person is a partner, shareholder, owner, officer, director, or agent of the entity.

 239386

Section 10. Paragraph (c) of subsection (1) and subsections (2) and (3) of section 456.041, Florida Statutes, are amended, to read:

456.041 Practitioner profile; creation.—

(1)

(c) Within 30 calendar days after receiving an update of information required for the practitioner's profile, the department shall update the practitioner's profile in accordance with the requirements of subsection (8) ~~(7)~~.

(2) Beginning July 1, 2010, on the profile published under subsection (1), the department shall include ~~indicate if~~ the information provided under s. 456.039(1)(a)7. or s. 456.0391(1)(a)7. and indicate if the information is or is not corroborated by a criminal history records check conducted according to this subsection. The department must include in each practitioner's profile the following statement: "The criminal history information, if any exists, may be incomplete. Federal criminal history information is not available to the public." ~~The department, or the board having regulatory authority over the practitioner acting on behalf of the department, shall investigate any information received by the department or the board.~~

(3) Beginning July 1, 2010, the department shall include in each practitioner's profile any open administrative complaint filed with the department against the practitioner in which probable cause has been found. ~~The Department of Health shall include in each practitioner's practitioner profile that criminal information that directly relates to the practitioner's ability to competently practice his or her profession. The~~

 239386

~~department must include in each practitioner's practitioner profile the following statement: "The criminal history information, if any exists, may be incomplete; federal criminal history information is not available to the public."~~ The department shall provide in each practitioner profile, for every final disciplinary action taken against the practitioner, an easy-to-read narrative description that explains the administrative complaint filed against the practitioner and the final disciplinary action imposed on the practitioner. The department shall include a hyperlink to each final order listed in its website report of dispositions of recent disciplinary actions taken against practitioners.

Section 11. Section 456.0635, Florida Statutes, is amended to read:

456.0635 Health care ~~Medicaid~~ fraud; disqualification for license, certificate, or registration.—

(1) ~~Medicaid~~ Fraud in the practice of a health care profession is prohibited.

(2) Each board within the jurisdiction of the department, or the department if there is no board, shall refuse to admit a candidate to any examination and refuse to issue ~~or renew~~ a license, certificate, or registration to any applicant if the candidate or applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant~~, has been~~:

(a) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, chapter 893, or a similar felony offense committed in another state or jurisdiction ~~21 U.S.C. ss.~~


239386

~~801-970, or 42 U.S.C. ss. 1395-1396~~, unless the sentence and any subsequent period of probation for such conviction or plea ~~pleas~~ ended: ~~more than 15 years prior to the date of the application;~~

1. For felonies of the first or second degree more than 15 years before the date of application.

2. For felonies of the third degree more than 10 years before the date of application, except for felonies of the third degree under s. 893.13(6)(a).

3. For felonies of the third degree under s. 893.13(6)(a), more than 5 years before the date of application.

4. For felonies in which the defendant entered a plea of guilty or nolo contendere in an agreement with the court to enter a pretrial intervention or drug diversion program, the department shall not approve or deny the application for a license, certificate, or registration until the final resolution of the case.

(b) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, unless the sentence and any subsequent period of probation for such conviction or plea ended more than 15 years before the date of the application;

(c) ~~(b)~~ Has been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5 years;

(d) ~~(c)~~ Has been terminated for cause, pursuant to the appeals procedures established by the state ~~or Federal Government~~, from any other state Medicaid program ~~or the federal~~

 239386

~~Medicare program~~, unless the applicant has been in good standing with a state Medicaid program ~~or the federal Medicare program~~ for the most recent 5 years and the termination occurred at least 20 years before ~~prior to~~ the date of the application; or~~.~~

(e) Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

(f) This subsection does not apply to applicants for initial licensure or certification who were enrolled in an educational or training program on or before July 1, 2009, which was recognized by a board or, if there is no board, recognized by the department, and who applied for licensure after July 1, 2009.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete lines 51 - 66

and insert:

repayment plan or settlement agreement; requiring the Office of Program Policy Analysis and Government Accountability biennial review of Medicaid fraud and abuse to include the Medicaid Fraud Control Unit within the Department of Legal Affairs; amending s. 409.9203, F.S.; providing that certain state employees are ineligible from receiving a reward for reporting Medicaid fraud; amending s. 456.001, F.S.; defining the term "affiliate" or "affiliated person" as it relates to health professions and occupations; amending s. 456.041, F.S.; requiring the Department of


239386

Health to include administrative complaint and any conviction information relating to the practitioner's profile; providing a disclaimer; amending s. 456.0635, F.S.; revising the grounds under which the Department of Health or corresponding board is required to refuse to admit a candidate to an examination and refuse to issue or renew a license, certificate, or registration of a health care practitioner; providing an exception; amending s. 456.072, F.S.; clarifying a