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1
2 An act relating to Medicaid recoveries; amending s.
3 409.907, F.S.; adding an additional provision relating
4 to a change in principal that must be included in a
5 Medicaid provider agreement with the Agency for Health
6 Care Administration; defining the terms
7 "administrative fines" and "outstanding overpayment";
8 revising provisions relating to the agency's onsite
9 inspection responsibilities; revising provisions
10 relating to who is subject to background screening;
11 authorizing the agency to enroll a provider who is
12 licensed in this state and provides diagnostic
13 services through telecommunications technology;
14 amending s. 409.910, F.S.; revising provisions
15 relating to settlements of Medicaid claims against
16 third parties; providing procedures for a Medicaid
17 recipient to contest the amount of recovered medical
18 expense damages; providing for certain reports to be
19 admissible as evidence to substantiate the agency's
20 claim; providing for venue; providing conditions
21 regarding attorney fees and costs; amending s.
22 409.913, F.S.; revising provisions specifying grounds
23 for terminating a provider from the program, for
24 seeking certain remedies for violations, and for
25 imposing certain sanctions; providing a limitation on
26 the information the agency may consider when making a
27 determination of overpayment; specifying the type of
28 records a provider must present to contest an



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29 overpayment; clarifying a provision regarding accrued
 30 interest on certain payments withheld from a provider;
 31 deleting the requirement that the agency place
 32 payments withheld from a provider in a suspended
 33 account and revising when a provider must reimburse
 34 overpayments; revising venue requirements; adding
 35 provisions relating to the payment of fines; amending
 36 s. 409.920, F.S.; clarifying provisions relating to
 37 immunity from liability for persons who provide
 38 information about Medicaid fraud; amending s. 624.351,
 39 F.S.; revising membership requirements for the
 40 Medicaid and Public Assistance Fraud Strike Force
 41 within the Department of Financial Services; providing
 42 for future review and repeal; amending s. 624.352,
 43 F.S., relating to interagency agreements to detect and
 44 deter Medicaid and public assistance fraud; providing
 45 for future review and repeal; providing an effective
 46 date.

47
 48 Be It Enacted by the Legislature of the State of Florida:

49
 50 Section 1. Subsections (6) through (9) of section 409.907,
 51 Florida Statutes, are amended, and paragraph (k) is added to
 52 subsection (3) of that section, to read:

53 409.907 Medicaid provider agreements.—The agency may make
 54 payments for medical assistance and related services rendered to
 55 Medicaid recipients only to an individual or entity who has a
 56 provider agreement in effect with the agency, who is performing



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57 | services or supplying goods in accordance with federal, state,
58 | and local law, and who agrees that no person shall, on the
59 | grounds of handicap, race, color, or national origin, or for any
60 | other reason, be subjected to discrimination under any program
61 | or activity for which the provider receives payment from the
62 | agency.

63 | (3) The provider agreement developed by the agency, in
64 | addition to the requirements specified in subsections (1) and
65 | (2), shall require the provider to:

66 | (k) Report a change in any principal of the provider,
67 | including any officer, director, agent, managing employee, or
68 | affiliated person, or any partner or shareholder who has an
69 | ownership interest equal to 5 percent or more in the provider,
70 | to the agency in writing within 30 days after the change occurs.
71 | For a hospital licensed under chapter 395 or a nursing home
72 | licensed under part II of chapter 400, a principal of the
73 | provider is one who meets the definition of a controlling
74 | interest under s. 408.803.

75 | (6) A Medicaid provider agreement may be revoked, at the
76 | option of the agency, due to ~~as the result of~~ a change of
77 | ownership of any facility, association, partnership, or other
78 | entity named as the provider in the provider agreement.

79 | (a) If there is ~~In the event of~~ a change of ownership, the
80 | transferor remains liable for all outstanding overpayments,
81 | administrative fines, and any other moneys owed to the agency
82 | before the effective date of the change ~~of ownership~~. ~~In~~
83 | ~~addition to the continuing liability of the transferor,~~ The
84 | transferee is also liable to the agency for all outstanding



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85 | overpayments identified by the agency on or before the effective
 86 | date of the change of ownership. ~~For purposes of this~~
 87 | ~~subsection, the term "outstanding overpayment" includes any~~
 88 | ~~amount identified in a preliminary audit report issued to the~~
 89 | ~~transferor by the agency on or before the effective date of the~~
 90 | ~~change of ownership.~~ In the event of a change of ownership for a
 91 | skilled nursing facility or intermediate care facility, the
 92 | Medicaid provider agreement shall be assigned to the transferee
 93 | if the transferee meets all other Medicaid provider
 94 | qualifications. In the event of a change of ownership involving
 95 | a skilled nursing facility licensed under part II of chapter
 96 | 400, liability for all outstanding overpayments, administrative
 97 | fines, and any moneys owed to the agency before the effective
 98 | date of the change of ownership shall be determined in
 99 | accordance with s. 400.179.

100 | (b) At least 60 days before the anticipated date of the
 101 | change of ownership, the transferor must ~~shall~~ notify the agency
 102 | of the intended change ~~of ownership~~ and the transferee must
 103 | ~~shall~~ submit to the agency a Medicaid provider enrollment
 104 | application. If a change of ownership occurs without compliance
 105 | with the notice requirements of this subsection, the transferor
 106 | and transferee are ~~shall be~~ jointly and severally liable for all
 107 | overpayments, administrative fines, and other moneys due to the
 108 | agency, regardless of whether the agency identified the
 109 | overpayments, administrative fines, or other moneys before or
 110 | after the effective date of the change ~~of ownership~~. The agency
 111 | may not approve a transferee's Medicaid provider enrollment
 112 | application if the transferee or transferor has not paid or



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113 | agreed in writing to a payment plan for all outstanding
 114 | overpayments, administrative fines, and other moneys due to the
 115 | agency. This subsection does not preclude the agency from
 116 | seeking any other legal or equitable remedies available to the
 117 | agency for the recovery of moneys owed to the Medicaid program.
 118 | In the event of a change of ownership involving a skilled
 119 | nursing facility licensed under part II of chapter 400,
 120 | liability for all outstanding overpayments, administrative
 121 | fines, and any moneys owed to the agency before the effective
 122 | date of the change of ownership shall be determined in
 123 | accordance with s. 400.179 if the Medicaid provider enrollment
 124 | application for change of ownership is submitted before the
 125 | change ~~of ownership~~.

126 | (c) As used in this subsection, the term:

127 | 1. "Administrative fines" includes any amount identified
 128 | in a notice of a monetary penalty or fine which has been issued
 129 | by the agency or other regulatory or licensing agency that
 130 | governs the provider.

131 | 2. "Outstanding overpayment" includes any amount
 132 | identified in a preliminary audit report issued to the
 133 | transferor by the agency on or before the effective date of a
 134 | change of ownership.

135 | (7) ~~The agency may require,~~ As a condition of
 136 | participating in the Medicaid program and before entering into
 137 | the provider agreement, the agency may require ~~that~~ the provider
 138 | to submit information, in an initial and any required renewal
 139 | applications, concerning the professional, business, and
 140 | personal background of the provider and permit an onsite



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141 inspection of the provider's service location by agency staff or
142 other personnel designated by the agency to perform this
143 function. Before entering into a provider agreement, the agency
144 may ~~shall~~ perform an ~~a random~~ onsite inspection, ~~within 60 days~~
145 ~~after receipt of a fully complete new provider's application,~~ of
146 the provider's service location ~~prior to making its first~~
147 ~~payment to the provider for Medicaid services~~ to determine the
148 applicant's ability to provide the services in compliance with
149 the Medicaid program and professional regulations ~~that the~~
150 ~~applicant is proposing to provide for Medicaid reimbursement.~~
151 ~~The agency is not required to perform an onsite inspection of a~~
152 ~~provider or program that is licensed by the agency, that~~
153 ~~provides services under waiver programs for home and community-~~
154 ~~based services, or that is licensed as a medical foster home by~~
155 ~~the Department of Children and Family Services.~~ As a continuing
156 condition of participation in the Medicaid program, a provider
157 must ~~shall~~ immediately notify the agency of any current or
158 pending bankruptcy filing. Before entering into the provider
159 agreement, or as a condition of continuing participation in the
160 Medicaid program, the agency may also require ~~that~~ Medicaid
161 providers reimbursed on a fee-for-services basis or fee schedule
162 basis that ~~which~~ is not cost-based to, post a surety bond not to
163 exceed \$50,000 or the total amount billed by the provider to the
164 program during the current or most recent calendar year,
165 whichever is greater. For new providers, the amount of the
166 surety bond shall be determined by the agency based on the
167 provider's estimate of its first year's billing. If the
168 provider's billing during the first year exceeds the bond



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169 amount, the agency may require the provider to acquire an
 170 additional bond equal to the actual billing level of the
 171 provider. A provider's bond need ~~shall~~ not exceed \$50,000 if a
 172 physician or group of physicians licensed under chapter 458,
 173 chapter 459, or chapter 460 has a 50 percent or greater
 174 ownership interest in the provider or if the provider is an
 175 assisted living facility licensed under chapter 429. The bonds
 176 permitted by this section are in addition to the bonds
 177 referenced in s. 400.179(2) (d). If the provider is a
 178 corporation, partnership, association, or other entity, the
 179 agency may require the provider to submit information concerning
 180 the background of that entity and of any principal of the
 181 entity, including any partner or shareholder having an ownership
 182 interest in the entity equal to 5 percent or greater, and any
 183 treating provider who participates in or intends to participate
 184 in Medicaid through the entity. The information must include:

185 (a) Proof of holding a valid license or operating
 186 certificate, as applicable, if required by the state or local
 187 jurisdiction in which the provider is located or if required by
 188 the Federal Government.

189 (b) Information concerning any prior violation, fine,
 190 suspension, termination, or other administrative action taken
 191 under the Medicaid laws or, ~~rules, or regulations~~ of this state
 192 or of any other state or the Federal Government; any prior
 193 violation of the laws or, ~~rules, or regulations~~ relating to the
 194 Medicare program; any prior violation of the rules ~~or~~
 195 ~~regulations~~ of any other public or private insurer; and any
 196 prior violation of the laws or, ~~rules, or regulations~~ of any

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197 regulatory body of this or any other state.

198 (c) Full and accurate disclosure of any financial or
199 ownership interest that the provider, or any principal, partner,
200 or major shareholder thereof, may hold in any other Medicaid
201 provider or health care related entity or any other entity that
202 is licensed by the state to provide health or residential care
203 and treatment to persons.

204 (d) If a group provider, identification of all members of
205 the group and attestation that all members of the group are
206 enrolled in or have applied to enroll in the Medicaid program.

207 (8)~~(a)~~ Each provider, or each principal of the provider if
208 the provider is a corporation, partnership, association, or
209 other entity, seeking to participate in the Medicaid program
210 must submit a complete set of his or her fingerprints to the
211 agency for the purpose of conducting a criminal history record
212 check. Principals of the provider include any officer, director,
213 billing agent, managing employee, or affiliated person, or any
214 partner or shareholder who has an ownership interest equal to 5
215 percent or more in the provider. However, for a hospital
216 licensed under chapter 395 or a nursing home licensed under
217 chapter 400, principals of the provider are those who meet the
218 definition of a controlling interest under s. 408.803. A
219 director of a not-for-profit corporation or organization is not
220 a principal for purposes of a background investigation ~~as~~
221 required by this section if the director: serves solely in a
222 voluntary capacity for the corporation or organization, does not
223 regularly take part in the day-to-day operational decisions of
224 the corporation or organization, receives no remuneration from



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225 | the not-for-profit corporation or organization for his or her
 226 | service on the board of directors, has no financial interest in
 227 | the not-for-profit corporation or organization, and has no
 228 | family members with a financial interest in the not-for-profit
 229 | corporation or organization; and if the director submits an
 230 | affidavit, under penalty of perjury, to this effect to the
 231 | agency and the not-for-profit corporation or organization
 232 | submits an affidavit, under penalty of perjury, to this effect
 233 | to the agency as part of the corporation's or organization's
 234 | Medicaid provider agreement application. Notwithstanding the
 235 | above, the agency may require a background check for any person
 236 | reasonably suspected by the agency to have been convicted of a
 237 | crime.

238 | (a) This subsection does not apply to:

- 239 | ~~1. A hospital licensed under chapter 395;~~
- 240 | ~~2. A nursing home licensed under chapter 400;~~
- 241 | ~~3. A hospice licensed under chapter 400;~~
- 242 | ~~4. An assisted living facility licensed under chapter 429;~~
- 243 | 1.5. A unit of local government, except that requirements
 244 | of this subsection apply to nongovernmental providers and
 245 | entities contracting with the local government to provide
 246 | Medicaid services. The actual cost of the state and national
 247 | criminal history record checks must be borne by the
 248 | nongovernmental provider or entity; or

249 | ~~2.6.~~ Any business that derives more than 50 percent of its
 250 | revenue from the sale of goods to the final consumer, and the
 251 | business or its controlling parent is required to file a form
 252 | 10-K or other similar statement with the Securities and Exchange



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253 Commission or has a net worth of \$50 million or more.

254 (b) Background screening shall be conducted in accordance
 255 with chapter 435 and s. 408.809. The cost of the state and
 256 national criminal record check shall be borne by the provider.

257 ~~(c) Proof of compliance with the requirements of level 2~~
 258 ~~screening under chapter 435 conducted within 12 months before~~
 259 ~~the date the Medicaid provider application is submitted to the~~
 260 ~~agency fulfills the requirements of this subsection.~~

261 (9) Upon receipt of a completed, signed, and dated
 262 application, and completion of any necessary background
 263 investigation and criminal history record check, the agency must
 264 either:

265 (a) Enroll the applicant as a Medicaid provider upon
 266 approval of the provider application. The enrollment effective
 267 date is ~~shall be~~ the date the agency receives the provider
 268 application. With respect to a provider that requires a Medicare
 269 certification survey, the enrollment effective date is the date
 270 the certification is awarded. With respect to a provider that
 271 completes a change of ownership, the effective date is the date
 272 the agency received the application, the date the change of
 273 ownership was complete, or the date the applicant became
 274 eligible to provide services under Medicaid, whichever date is
 275 later. With respect to a provider of emergency medical services
 276 transportation or emergency services and care, the effective
 277 date is the date the services were rendered. Payment for any
 278 claims for services provided to Medicaid recipients between the
 279 date of receipt of the application and the date of approval is
 280 contingent on applying any and all applicable audits and edits



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281 contained in the agency's claims adjudication and payment
 282 processing systems. The agency may enroll a provider located
 283 outside this ~~the~~ state ~~of Florida~~ if:

284 1. The provider's location is no more than 50 miles from
 285 the ~~Florida~~ state line;

286 2. The provider is a physician actively licensed in this
 287 state and interprets diagnostic testing results through
 288 telecommunications and information technology provided from a
 289 distance; or

290 3. The agency determines a need for that provider type to
 291 ensure adequate access to care; or

292 (b) Deny the application if the agency finds that it is in
 293 the best interest of the Medicaid program to do so. The agency
 294 may consider the factors listed in subsection (10), as well as
 295 any other factor that could affect the effective and efficient
 296 administration of the program, including, but not limited to,
 297 the applicant's demonstrated ability to provide services,
 298 conduct business, and operate a financially viable concern; the
 299 current availability of medical care, services, or supplies to
 300 recipients, taking into account geographic location and
 301 reasonable travel time; the number of providers of the same type
 302 already enrolled in the same geographic area; and the
 303 credentials, experience, success, and patient outcomes of the
 304 provider for the services that it is making application to
 305 provide in the Medicaid program. The agency shall deny the
 306 application if the agency finds that a provider; any officer,
 307 director, agent, managing employee, or affiliated person; or any
 308 partner or shareholder having an ownership interest equal to 5



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309 percent or greater in the provider if the provider is a
 310 corporation, partnership, or other business entity, has failed
 311 to pay all outstanding fines or overpayments assessed by final
 312 order of the agency or final order of the Centers for Medicare
 313 and Medicaid Services, not subject to further appeal, unless the
 314 provider agrees to a repayment plan that includes withholding
 315 Medicaid reimbursement until the amount due is paid in full.

316 Section 2. Subsection (17) of section 409.910, Florida
 317 Statutes, is amended to read:

318 409.910 Responsibility for payments on behalf of Medicaid-
 319 eligible persons when other parties are liable.-

320 (17) (a) A recipient or his or her legal representative or
 321 any person representing, or acting as agent for, a recipient or
 322 the recipient's legal representative, who has notice, excluding
 323 notice charged solely by reason of the recording of the lien
 324 pursuant to paragraph (6) (c), or who has actual knowledge of the
 325 agency's rights to third-party benefits under this section, who
 326 receives any third-party benefit or proceeds therefrom for a
 327 covered illness or injury, is required either to pay the agency,
 328 within 60 days after receipt of settlement proceeds, the full
 329 amount of the third-party benefits, but not in excess of the
 330 total medical assistance provided by Medicaid, or to place the
 331 full amount of the third-party benefits in an interest-bearing a
 332 trust account for the benefit of the agency pending an ~~judicial~~
 333 ~~or~~ administrative determination of the agency's right thereto
 334 under this subsection. Proof that any such person had notice or
 335 knowledge that the recipient had received medical assistance
 336 from Medicaid, and that third-party benefits or proceeds



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337 therefrom were in any way related to a covered illness or injury
338 for which Medicaid had provided medical assistance, and that any
339 such person knowingly obtained possession or control of, or
340 used, third-party benefits or proceeds and failed either to pay
341 the agency the full amount required by this section or to hold
342 the full amount of third-party benefits or proceeds in the
343 interest-bearing trust account pending ~~judicial or~~
344 administrative determination, unless adequately explained, gives
345 rise to an inference that such person knowingly failed to credit
346 the state or its agent for payments received from social
347 security, insurance, or other sources, pursuant to s.
348 414.39(4)(b), and acted with the intent set forth in s.
349 812.014(1).

350 (b) A recipient may contest the amount designated as
351 recovered medical expense damages payable to the agency pursuant
352 to paragraph (11)(f) by filing a petition under chapter 120
353 within 21 days after the date of payment of funds to the agency
354 or placing the full amount of the third-party benefits in the
355 trust account for the benefit of the agency pursuant to
356 paragraph (a). The petition shall be filed with the Division of
357 Administrative Hearings. For purposes of chapter 120, the
358 payment of funds to the agency or placing the full amount of the
359 third-party benefits in the trust account for the benefit of the
360 agency constitutes final agency action and notice thereof. This
361 procedure constitutes the exclusive method by which the amount
362 of third-party benefits payable to the agency may be challenged.
363 In order to successfully challenge the amount payable to the
364 agency, the recipient must prove, by clear and convincing



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365 evidence, that a lesser portion of the total recovery should be
366 allocated as reimbursement for past and future medical expenses
367 than that amount calculated by the agency pursuant to paragraph
368 (11) (f) or that Medicaid provided a lesser amount of medical
369 assistance than that determined by the agency. The Division of
370 Administrative Hearings has final order authority for
371 proceedings under this section.

372 (c) The agency's provider processing system reports are
373 admissible as prima facie evidence in substantiating the
374 agency's claim.

375 (d) Venue for all administrative proceedings pursuant to
376 paragraph (a) shall be in Leon County, at the discretion of the
377 agency. Venue for all appellate proceedings arising from the
378 administrative proceeding pursuant to paragraph (a) shall be at
379 the First District Court of Appeal, at the discretion of the
380 agency.

381 (e) Each party shall bear its own attorney fees and costs
382 for any proceeding conducted pursuant to paragraph (a) or
383 paragraph (b).

384 (f) ~~(a)~~ In cases of suspected criminal violations or
385 fraudulent activity, the agency may take any civil action
386 permitted at law or equity to recover the greatest possible
387 amount, including, without limitation, treble damages under ss.
388 772.11 and 812.035(7).

389 (g) ~~(b)~~ The agency may ~~is authorized to~~ investigate and may

390 ~~to~~ request appropriate officers or agencies of the state to

391 investigate suspected criminal violations or fraudulent activity

392 related to third-party benefits, including, without limitation,



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393 ss. 414.39 and 812.014. Such requests may be directed, without
 394 limitation, to the Medicaid Fraud Control Unit of the Office of
 395 the Attorney General, or to any state attorney. Pursuant to s.
 396 409.913, the Attorney General has primary responsibility to
 397 investigate and control Medicaid fraud.

398 (h)~~(e)~~ In carrying out duties and responsibilities related
 399 to Medicaid fraud control, the agency may subpoena witnesses or
 400 materials within or outside the state and, through any duly
 401 designated employee, administer oaths and affirmations and
 402 collect evidence for possible use in either civil or criminal
 403 judicial proceedings.

404 (i)~~(d)~~ All information obtained and documents prepared
 405 pursuant to an investigation of a Medicaid recipient, the
 406 recipient's legal representative, or any other person relating
 407 to an allegation of recipient fraud or theft is confidential and
 408 exempt from s. 119.07(1):

- 409 1. Until such time as the agency takes final agency
 410 action;
- 411 2. Until such time as the Department of Legal Affairs
 412 refers the case for criminal prosecution;
- 413 3. Until such time as an indictment or criminal
 414 information is filed by a state attorney in a criminal case; or
- 415 4. At all times if otherwise protected by law.

416 Section 3. Subsections (9), (13), (15), (16), (21), (22),
 417 (25), (28), (30) and (31) of section 409.913, Florida Statutes,
 418 are amended to read:

419 409.913 Oversight of the integrity of the Medicaid
 420 program.—The agency shall operate a program to oversee the



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421 activities of Florida Medicaid recipients, and providers and
 422 their representatives, to ensure that fraudulent and abusive
 423 behavior and neglect of recipients occur to the minimum extent
 424 possible, and to recover overpayments and impose sanctions as
 425 appropriate. Beginning January 1, 2003, and each year
 426 thereafter, the agency and the Medicaid Fraud Control Unit of
 427 the Department of Legal Affairs shall submit a joint report to
 428 the Legislature documenting the effectiveness of the state's
 429 efforts to control Medicaid fraud and abuse and to recover
 430 Medicaid overpayments during the previous fiscal year. The
 431 report must describe the number of cases opened and investigated
 432 each year; the sources of the cases opened; the disposition of
 433 the cases closed each year; the amount of overpayments alleged
 434 in preliminary and final audit letters; the number and amount of
 435 fines or penalties imposed; any reductions in overpayment
 436 amounts negotiated in settlement agreements or by other means;
 437 the amount of final agency determinations of overpayments; the
 438 amount deducted from federal claiming as a result of
 439 overpayments; the amount of overpayments recovered each year;
 440 the amount of cost of investigation recovered each year; the
 441 average length of time to collect from the time the case was
 442 opened until the overpayment is paid in full; the amount
 443 determined as uncollectible and the portion of the uncollectible
 444 amount subsequently reclaimed from the Federal Government; the
 445 number of providers, by type, that are terminated from
 446 participation in the Medicaid program as a result of fraud and
 447 abuse; and all costs associated with discovering and prosecuting
 448 cases of Medicaid overpayments and making recoveries in such



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449 cases. The report must also document actions taken to prevent
450 overpayments and the number of providers prevented from
451 enrolling in or reenrolling in the Medicaid program as a result
452 of documented Medicaid fraud and abuse and must include policy
453 recommendations necessary to prevent or recover overpayments and
454 changes necessary to prevent and detect Medicaid fraud. All
455 policy recommendations in the report must include a detailed
456 fiscal analysis, including, but not limited to, implementation
457 costs, estimated savings to the Medicaid program, and the return
458 on investment. The agency must submit the policy recommendations
459 and fiscal analyses in the report to the appropriate estimating
460 conference, pursuant to s. 216.137, by February 15 of each year.
461 The agency and the Medicaid Fraud Control Unit of the Department
462 of Legal Affairs each must include detailed unit-specific
463 performance standards, benchmarks, and metrics in the report,
464 including projected cost savings to the state Medicaid program
465 during the following fiscal year.

466 (9) A Medicaid provider shall retain medical,
467 professional, financial, and business records pertaining to
468 services and goods furnished to a Medicaid recipient and billed
469 to Medicaid for a period of 5 years after the date of furnishing
470 such services or goods. The agency may investigate, review, or
471 analyze such records, which must be made available during normal
472 business hours. However, 24-hour notice must be provided if
473 patient treatment would be disrupted. The provider must keep
474 ~~responsible for furnishing to the agency, and keeping~~ the agency
475 informed of the location of, the provider's Medicaid-related
476 records. The authority of the agency to obtain Medicaid-related



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477 records from a provider is neither curtailed nor limited during
478 a period of litigation between the agency and the provider.

479 (13) The agency shall ~~immediately~~ terminate participation
480 of a Medicaid provider in the Medicaid program and may seek
481 civil remedies or impose other administrative sanctions against
482 a Medicaid provider, if the provider or any principal, officer,
483 director, agent, managing employee, or affiliated person of the
484 provider, or any partner or shareholder having an ownership
485 interest in the provider equal to 5 percent or greater, has been
486 convicted of a criminal offense under federal law or the law of
487 any state relating to the practice of the provider's profession,
488 or a criminal offense listed under s. 408.809(4), s.
489 409.907(10), or s. 435.04(2) has been:

490 ~~(a) Convicted of a criminal offense related to the~~
491 ~~delivery of any health care goods or services, including the~~
492 ~~performance of management or administrative functions relating~~
493 ~~to the delivery of health care goods or services;~~

494 ~~(b) Convicted of a criminal offense under federal law or~~
495 ~~the law of any state relating to the practice of the provider's~~
496 ~~profession; or~~

497 ~~(c) Found by a court of competent jurisdiction to have~~
498 ~~neglected or physically abused a patient in connection with the~~
499 ~~delivery of health care goods or services. If the agency~~
500 determines that the a provider did not participate or acquiesce
501 in the an offense specified in paragraph (a), paragraph (b), or
502 ~~paragraph (c),~~ termination will not be imposed. If the agency
503 effects a termination under this subsection, the agency shall
504 take final agency action ~~issue an immediate final order pursuant~~



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505 ~~to s. 120.569(2)(n).~~

506 (15) The agency shall seek a remedy provided by law,
507 including, but not limited to, any remedy provided in
508 subsections (13) and (16) and s. 812.035, if:

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

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

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

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

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



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533 provisions apply to the Medicaid program;

534 (f) The provider or person who ordered, authorized, or
535 prescribed the care, services, or supplies has furnished, or
536 ordered or authorized the furnishing of, goods or services to a
537 recipient which are inappropriate, unnecessary, excessive, or
538 harmful to the recipient or are of inferior quality;

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

541 (h) The provider or an authorized representative of the
542 provider, or a person who ordered, authorized, or prescribed the
543 goods or services, has submitted or caused to be submitted false
544 or a pattern of erroneous Medicaid claims;

545 (i) The provider or an authorized representative of the
546 provider, or a person who has ordered, authorized, or prescribed
547 the goods or services, has submitted or caused to be submitted a
548 Medicaid provider enrollment application, a request for prior
549 authorization for Medicaid services, a drug exception request,
550 or a Medicaid cost report that contains materially false or
551 incorrect information;

552 (j) The provider or an authorized representative of the
553 provider has collected from or billed a recipient or a
554 recipient's responsible party improperly for amounts that should
555 not have been so collected or billed by reason of the provider's
556 billing the Medicaid program for the same service;

557 (k) The provider or an authorized representative of the
558 provider has included in a cost report costs that are not
559 allowable under a Florida Title XIX reimbursement plan, after
560 the provider or authorized representative had been advised in an



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561 | audit exit conference or audit report that the costs were not
562 | allowable;

563 | (1) The provider is charged by information or indictment
564 | with fraudulent billing practices or an offense referenced in
565 | subsection (13). The sanction applied for this reason is limited
566 | to suspension of the provider's participation in the Medicaid
567 | program for the duration of the indictment unless the provider
568 | is found guilty pursuant to the information or indictment;

569 | (m) The provider or a person who ~~has~~ ordered, authorized,
570 | or prescribed the goods or services is found liable for
571 | negligent practice resulting in death or injury to the
572 | provider's patient;

573 | (n) The provider fails to demonstrate that it had
574 | available during a specific audit or review period sufficient
575 | quantities of goods, or sufficient time in the case of services,
576 | to support the provider's billings to the Medicaid program;

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

579 | (p) The agency has received reliable information of
580 | patient abuse or neglect or of any act prohibited by s. 409.920;
581 | or

582 | (q) The provider has failed to comply with an agreed-upon
583 | repayment schedule.

584 |
585 | A provider is subject to sanctions for violations of this
586 | subsection as the result of actions or inactions of the
587 | provider, or actions or inactions of any principal, officer,
588 | director, agent, managing employee, or affiliated person of the



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589 provider, or any partner or shareholder having an ownership
590 interest in the provider equal to 5 percent or greater, in which
591 the provider participated or acquiesced.

592 (16) The agency shall impose any of the following
593 sanctions or disincentives on a provider or a person for any of
594 the acts described in subsection (15):

595 (a) Suspension for a specific period of time of not more
596 than 1 year. Suspension precludes ~~shall preclude~~ participation
597 in the Medicaid program, which includes any action that results
598 in a claim for payment to the Medicaid program for ~~as a result~~
599 ~~of~~ furnishing, supervising a person who is furnishing, or
600 causing a person to furnish goods or services.

601 (b) Termination for a specific period of time ranging ~~of~~
602 from more than 1 year to 20 years. Termination precludes ~~shall~~
603 ~~preclude~~ participation in the Medicaid program, which includes
604 any action that results in a claim for payment to the Medicaid
605 program for ~~as a result of~~ furnishing, supervising a person who
606 is furnishing, or causing a person to furnish goods or services.

607 (c) Imposition of a fine of up to \$5,000 for each
608 violation. Each day that an ongoing violation continues, such as
609 refusing to furnish Medicaid-related records or refusing access
610 to records, is considered, ~~for the purposes of this section, to~~
611 ~~be~~ a separate violation. Each instance of improper billing of a
612 Medicaid recipient; each instance of including an unallowable
613 cost on a hospital or nursing home Medicaid cost report after
614 the provider or authorized representative has been advised in an
615 audit exit conference or previous audit report of the cost
616 unallowability; each instance of furnishing a Medicaid recipient



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617 goods or professional services that are inappropriate or of
 618 inferior quality as determined by competent peer judgment; each
 619 instance of knowingly submitting a materially false or erroneous
 620 Medicaid provider enrollment application, request for prior
 621 authorization for Medicaid services, drug exception request, or
 622 cost report; each instance of inappropriate prescribing of drugs
 623 for a Medicaid recipient as determined by competent peer
 624 judgment; and each false or erroneous Medicaid claim leading to
 625 an overpayment to a provider is considered, ~~for the purposes of~~
 626 ~~this section, to be~~ a separate violation.

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

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

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

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

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

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

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

647
648 If a provider voluntarily relinquishes its Medicaid provider
649 number or an associated license, or allows the associated
650 licensure to expire after receiving written notice that the
651 agency is conducting, or has conducted, an audit, survey,
652 inspection, or investigation and that a sanction of suspension
653 or termination will or would be imposed for noncompliance
654 discovered as a result of the audit, survey, inspection, or
655 investigation, the agency shall impose the sanction of
656 termination for cause against the provider. The agency's
657 termination with cause is subject to hearing rights as may be
658 provided under chapter 120. The Secretary of Health Care
659 Administration may make a determination that imposition of a
660 sanction or disincentive is not in the best interest of the
661 Medicaid program, in which case a sanction or disincentive may
662 shall not be imposed.

663 (21) When making a determination that an overpayment has
664 occurred, the agency shall prepare and issue an audit report to
665 the provider showing the calculation of overpayments. The
666 agency's determination must be based solely upon information
667 available to it before issuance of the audit report and, in the
668 case of documentation obtained to substantiate claims for
669 Medicaid reimbursement, based solely upon contemporaneous
670 records. The agency may consider addenda or modifications to a
671 note that was made contemporaneously with the patient care
672 episode if the addenda or modifications are germane to the note.



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673 (22) The audit report, supported by agency work papers,
674 showing an overpayment to a provider constitutes evidence of the
675 overpayment. A provider may not present or elicit testimony,
676 ~~either~~ on direct examination or cross-examination in any court
677 or administrative proceeding, regarding the purchase or
678 acquisition by any means of drugs, goods, or supplies; sales or
679 divestment by any means of drugs, goods, or supplies; or
680 inventory of drugs, goods, or supplies, unless such acquisition,
681 sales, divestment, or inventory is documented by written
682 invoices, written inventory records, or other competent written
683 documentary evidence maintained in the normal course of the
684 provider's business. A provider may not present records to
685 contest an overpayment or sanction unless such records are
686 contemporaneous and, if requested during the audit process, were
687 furnished to the agency or its agent upon request. This
688 limitation does not apply to Medicaid cost report audits. This
689 limitation does not preclude consideration by the agency of
690 addenda or modifications to a note if the addenda or
691 modifications are made before notification of the audit, the
692 addenda or modifications are germane to the note, and the note
693 was made contemporaneously with a patient care episode.
694 Notwithstanding the applicable rules of discovery, all
695 documentation to that ~~will~~ be offered as evidence at an
696 administrative hearing on a Medicaid overpayment or an
697 administrative sanction must be exchanged by all parties at
698 least 14 days before the administrative hearing or ~~must~~ be
699 excluded from consideration.

700 (25) (a) The agency shall withhold Medicaid payments, in



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701 whole or in part, to a provider upon receipt of reliable
 702 evidence that the circumstances giving rise to the need for a
 703 withholding of payments involve fraud, willful
 704 misrepresentation, or abuse under the Medicaid program, or a
 705 crime committed while rendering goods or services to Medicaid
 706 recipients. If it is determined that fraud, willful
 707 misrepresentation, abuse, or a crime did not occur, the payments
 708 withheld must be paid to the provider within 14 days after such
 709 determination. Amounts not paid within 14 days accrue with
 710 interest at the rate of 10 percent per a year, beginning after
 711 the 14th day. ~~Any money withheld in accordance with this~~
 712 ~~paragraph shall be placed in a suspended account, readily~~
 713 ~~accessible to the agency, so that any payment ultimately due the~~
 714 ~~provider shall be made within 14 days.~~

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

720 (c) Overpayments owed to the agency bear interest at the
 721 rate of 10 percent per year from the date of final determination
 722 of the overpayment by the agency, and payment arrangements must
 723 be made within 30 days after the date of the final order, which
 724 is not subject to further appeal ~~at the conclusion of legal~~
 725 ~~proceedings. A provider who does not enter into or adhere to an~~
 726 ~~agreed upon repayment schedule may be terminated by the agency~~
 727 ~~for nonpayment or partial payment.~~

728 (d) The agency, upon entry of a final agency order, a



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729 judgment or order of a court of competent jurisdiction, or a
 730 stipulation or settlement, may collect the moneys owed by all
 731 means allowable by law, including, but not limited to, notifying
 732 any fiscal intermediary of Medicare benefits that the state has
 733 a superior right of payment. Upon receipt of such written
 734 notification, the Medicare fiscal intermediary shall remit to
 735 the state the sum claimed.

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

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

743 (30) The agency shall terminate a provider's participation
 744 in the Medicaid program if the provider fails to reimburse an
 745 overpayment or pay an agency-imposed fine that has been
 746 determined by final order, not subject to further appeal, within
 747 30 ~~35~~ days after the date of the final order, unless the
 748 provider and the agency have entered into a repayment agreement.

749 (31) If a provider requests an administrative hearing
 750 pursuant to chapter 120, such hearing must be conducted within
 751 90 days following assignment of an administrative law judge,
 752 absent exceptionally good cause shown as determined by the
 753 administrative law judge or hearing officer. Upon issuance of a
 754 final order, the outstanding balance of the amount determined to
 755 constitute the overpayment and fines is ~~shall become~~ due. If a
 756 provider fails to make payments in full, fails to enter into a



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757 satisfactory repayment plan, or fails to comply with the terms
 758 of a repayment plan or settlement agreement, the agency shall
 759 withhold ~~medical assistance~~ reimbursement payments for Medicaid
 760 services until the amount due is paid in full.

761 Section 4. Subsection (8) of section 409.920, Florida
 762 Statutes, is amended to read:

763 409.920 Medicaid provider fraud.—

764 (8) A person who provides the state, any state agency, any
 765 of the state's political subdivisions, or any agency of the
 766 state's political subdivisions with information about fraud or
 767 suspected fraudulent acts ~~fraud~~ by a Medicaid provider,
 768 including a managed care organization, is immune from civil
 769 liability for libel, slander, or any other relevant tort for
 770 providing ~~the~~ information about fraud or suspected fraudulent
 771 acts unless the person acted with knowledge that the information
 772 was false or with reckless disregard for the truth or falsity of
 773 the information. Such immunity extends to reports of fraudulent
 774 acts or suspected fraudulent acts conveyed to or from the agency
 775 in any manner, including any forum and with any audience as
 776 directed by the agency, and includes all discussions subsequent
 777 to the report and subsequent inquiries from the agency, unless
 778 the person acted with knowledge that the information was false
 779 or with reckless disregard for the truth or falsity of the
 780 information. For purposes of this subsection, the term
 781 "fraudulent acts" includes actual or suspected fraud and abuse,
 782 insurance fraud, licensure fraud, or public assistance fraud,
 783 including any fraud-related matters that a provider or health
 784 plan is required to report to the agency or a law enforcement



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785 agency.

786 Section 5. Subsection (3) of section 624.351, Florida
787 Statutes, is amended, and subsection (8) is added to that
788 section, to read:

789 624.351 Medicaid and Public Assistance Fraud Strike
790 Force.—

791 (3) MEMBERSHIP.—The strike force shall consist of the
792 following 11 members or their designees. A designee shall serve
793 in the same capacity as the designating member ~~who may not~~
794 ~~designate anyone to serve in their place:~~

795 (a) The Chief Financial Officer, who shall serve as chair.

796 (b) The Attorney General, who shall serve as vice chair.

797 (c) The executive director of the Department of Law
798 Enforcement.

799 (d) The Secretary of Health Care Administration.

800 (e) The Secretary of Children and Family Services.

801 (f) The State Surgeon General.

802 (g) Five members appointed by the Chief Financial Officer,
803 consisting of two sheriffs, two chiefs of police, and one state
804 attorney. When making these appointments, the Chief Financial
805 Officer shall consider representation by geography, population,
806 ethnicity, and other relevant factors in order to ensure that
807 the membership of the strike force is representative of the
808 state as a whole.

809 (8) This section is repealed June 30, 2014, unless
810 reviewed and reenacted by the Legislature before that date.

811 Section 6. Subsection (3) is added to section 624.352,
812 Florida Statutes, to read:



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813 | 624.352 Interagency agreements to detect and deter
 814 | Medicaid and public assistance fraud.—
 815 | (3) This section is repealed June 30, 2014, unless
 816 | reviewed and reenacted by the Legislature before that date.
 817 | Section 7. This act shall take effect July 1, 2013.