A bill to be entitled

An act relating to patient referrals by Medicaid managed care organizations and managed care plans; amending s. 409.913, F.S.; authorizing the Agency for Health Care Administration to conduct or cause to be conducted reviews, investigations, analyses, audits, and combinations thereof, to determine if managed care organizations, managed care plans, and their subcontractors violate the Medicaid program integrity in their patient referrals; providing penalties; amending s. 409.967, F.S.; prohibiting managed care organizations, managed care plans, and their subcontractors from violating the Medicaid program integrity by referring Medicaid recipients, for treatments and services, to entities having certain financial relationships and arrangements with the organizations, plans, and their subcontractors; providing an effective date.

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

Section 1. Subsections (2) and (16) of section 409.913, Florida Statutes, are amended to read:

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

activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. Each January 15, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit a report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report must describe the number of cases opened and investigated each year; the sources of the cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a

result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must include policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud. All policy recommendations in the report must include a detailed fiscal analysis, including, but not limited to, implementation costs, estimated savings to the Medicaid program, and the return on investment. The agency must submit the policy recommendations and fiscal analyses in the report to the appropriate estimating conference, pursuant to s. 216.137, by February 15 of each year. The agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs each must include detailed unit-specific performance standards, benchmarks, and metrics in the report, including projected cost savings to the state Medicaid program during the following fiscal year.

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

reports as appropriate. At least 5 percent of all audits shall be conducted on a random basis. As part of its ongoing fraud detection activities, the agency shall identify and monitor, by contract or otherwise, patterns of overutilization of Medicaid services based on state averages. The agency shall track Medicaid provider prescription and billing patterns and evaluate them against Medicaid medical necessity criteria and coverage and limitation guidelines adopted by rule. Medical necessity determination requires that service be consistent with symptoms or confirmed diagnosis of illness or injury under treatment and not in excess of the patient's needs. The agency shall conduct reviews of provider exceptions to peer group norms and shall, using statistical methodologies, provider profiling, and analysis of billing patterns, detect and investigate abnormal or unusual increases in billing or payment of claims for Medicaid services and medically unnecessary provision of services.

(b) The agency may conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine if a managed care organization or managed care plan, or its subcontractor, has violated the program integrity under s. 409.967(2)(g)2. by referring a Medicaid recipient for a covered treatment or service rendered by or in the office of a provider, another subcontractor, or a third-party entity that is owned or partially owned by the managed care organization or managed care

plan, or the subcontractor, or that has a profit-sharing arrangement with the managed care organization or managed care plan, or the subcontractor.

(16) The agency shall impose any of the following sanctions or disincentives on a provider or a person for any of the acts described in paragraph (2)(b) or subsection (15):

(a) Suspension for a specific period of time of not more than 1 year. Suspension precludes participation in the Medicaid program, which includes any action that results in a claim for payment to the Medicaid program for furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services.

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

(c) Imposition of a fine of up to $5,000 for each violation. Each day that an ongoing violation continues, such as refusing to furnish Medicaid-related records or refusing access to records, is considered a separate violation. Each instance of improper billing of a Medicaid recipient; each instance of including an unallowable cost on a hospital or nursing home Medicaid cost report after the provider or authorized

representative has been advised in an audit exit conference or previous audit report of the cost unallowability; each instance of furnishing a Medicaid recipient goods or professional services that are inappropriate or of inferior quality as determined by competent peer judgment; each instance of knowingly submitting a materially false or erroneous Medicaid provider enrollment application, request for prior authorization for Medicaid services, drug exception request, or cost report; each instance of inappropriate prescribing of drugs for a Medicaid recipient as determined by competent peer judgment; and each false or erroneous Medicaid claim leading to an overpayment to a provider is considered a separate violation.

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

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

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

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

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

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

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

If a provider voluntarily relinquishes its Medicaid provider number or an associated license, or allows the associated licensure to expire after receiving written notice that the agency is conducting, or has conducted, an audit, survey, inspection, or investigation and that a sanction of suspension or termination will or would be imposed for noncompliance discovered as a result of the audit, survey, inspection, or investigation, the agency shall impose the sanction of termination for cause against the provider. The agency's termination with cause is subject to hearing rights as may be provided under chapter 120. 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 may not be imposed.

Section 2. Paragraph (g) of subsection (2) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(g) Program integrity.—

1. Each managed care plan shall establish program integrity functions and activities to reduce the incidence of fraud and abuse, including, at a minimum:

a.~~1.~~ A provider credentialing system and ongoing provider monitoring, including maintenance of written provider credentialing policies and procedures which comply with federal and agency guidelines;

b.~~2.~~ An effective prepayment and postpayment review process including, but not limited to, data analysis, system editing, and auditing of network providers;

c.~~3.~~ Procedures for reporting instances of fraud and abuse pursuant to chapter 641;

d.~~4.~~ Administrative and management arrangements or procedures, including a mandatory compliance plan, designed to prevent fraud and abuse; and

e.~~5.~~ Designation of a program integrity compliance officer.

2. Each managed care organization or managed care plan, or its subcontractor, may not refer a Medicaid recipient for a

covered treatment or service rendered by or in the office of a provider, another subcontractor, or a third-party entity if the managed care organization or managed care plan, or its subcontractor, has any ownership or profit-sharing arrangement with the provider, the other subcontractor, or the third-party entity.

Section 3. This act shall take effect July 1, 2025.