1 A bill to be entitled
2 An act relating to Medicaid provider accountability;
3 amending s. 409.221, F.S.; requiring background
4 screening of all persons who provide personal care or
5 services for reimbursement under the consumer-directed
6 care program; providing for submission of proof of
7 compliance under certain circumstances; providing an
8 exception to screening requirements; amending s.
9 409.907, F.S.; extending the period of time that a
10 provider must retain certain medical and Medicaid-
11 related records under provider agreements with the
12 Agency for Health Care Administration; requiring a
13 provider to report a change of principal in writing to
14 the agency within a specified period of time;
15 providing a definition; authorizing the agency to
16 perform certain inspections before entering into a
17 provider agreement; removing a provision that exempts
18 certain providers and programs from agency onsite
19 inspections; specifying applicability of background
20 investigations with regard to principals of certain
21 hospitals and nursing homes; revising applicability of
22 background screening requirements; removing a
23 provision permitting proof of compliance with
24 background screening requirements to be retroactive;
25 amending s. 409.913, F.S.; providing a definition;
26 expanding agency authority with respect to conducting
27 Medicaid fraud, abuse, overpayment, and recipient
28 neglect reviews and investigations; extending the time

29 period for retention of certain records by a Medicaid
30 provider; revising provisions relating to termination
31 of a Medicaid provider; requiring the agency to seek a
32 remedy provided by law for certain actions by a
33 provider; providing additional criteria for the
34 imposition of sanctions by the agency; requiring the
35 agency to base a determination of overpayment to a
36 provider on certain information available before the
37 issuance of an audit report; removing a requirement
38 that interest be paid on payments withheld from a
39 provider under certain circumstances; requiring a
40 timeframe for the establishment of payment
41 arrangements for a provider to reimburse the agency
42 for overpayments and fines; providing the venue for
43 Medicaid program integrity cases; requiring the agency
44 to terminate a provider's participation in the
45 Medicaid program if the provider fails to reimburse an
46 overpayment or pay a fine imposed by the agency within
47 a specified period of time; establishing that fines
48 are due upon issuance of a final order by the
49 administrative law judge or hearing officer; amending
50 s. 409.920, F.S.; expanding conditions under which a
51 person who reports fraud or suspected fraudulent acts
52 by a Medicaid provider may be granted immunity from
53 civil liability; providing a definition; providing an
54 effective date.
55
56 Be It Enacted by the Legislature of the State of Florida:

57

58 Section 1. Paragraph (i) of subsection (4) of section
59 409.221, Florida Statutes, is amended to read:
60 409.221 Consumer-directed care program.—
61 (4) CONSUMER-DIRECTED CARE.—
62 (i) Background screening requirements.—All persons who
63 render care under this section must undergo level 2 background
64 screening pursuant to s. 408.809 and chapter 435. The agency
65 shall, as allowable, reimburse consumer-employed caregivers for
66 the cost of conducting background screening as required by this
67 section. For purposes of this section, a person who has
68 undergone screening, who is qualified for employment under this
69 section and applicable rule, and who has not been unemployed for
70 more than 90 days following such screening is not required to be
71 rescreened. Such person must attest under penalty of perjury to
72 not having been convicted of a disqualifying offense since
73 completing such screening.
74 Section 2. Paragraph (c) of subsection (3), paragraph (a)
75 of subsection (6), and subsections (7) and (8) of section
76 409.907, Florida Statutes, are amended, and paragraph (k) is
77 added to subsection (3) of that section, to read:
78 409.907 Medicaid provider agreements.—The agency may make
79 payments for medical assistance and related services rendered to
80 Medicaid recipients only to an individual or entity who has a
81 provider agreement in effect with the agency, who is performing
82 services or supplying goods in accordance with federal, state,
83 and local law, and who agrees that no person shall, on the
84 grounds of handicap, race, color, or national origin, or for any

85 other reason, be subjected to discrimination under any program
86 or activity for which the provider receives payment from the
87 agency.
88 (3) The provider agreement developed by the agency, in
89 addition to the requirements specified in subsections (1) and
90 (2), shall require the provider to:
91 (c) Retain all medical and Medicaid-related records for a
92 period of 6 ~~5~~ years to satisfy all necessary inquiries by the
93 agency.
94 (k) Report in writing any change of any principal of the
95 provider, including any officer, director, agent, managing
96 employee, or affiliated person, or any partner or shareholder
97 who has an ownership interest equal to 5 percent or more in the
98 provider. The provider must report changes to the agency in
99 writing no later than 30 days after the change occurs.
100 (6) A Medicaid provider agreement may be revoked, at the
101 option of the agency, as the result of a change of ownership of
102 any facility, association, partnership, or other entity named as
103 the provider in the provider agreement.
104 (a) In the event of a change of ownership, the transferor
105 remains liable for all outstanding overpayments, administrative
106 fines, and any other moneys owed to the agency before the
107 effective date of the change of ownership. In addition to the
108 continuing liability of the transferor, the transferee is liable
109 to the agency for all outstanding overpayments identified by the
110 agency on or before the effective date of the change of
111 ownership. For purposes of this subsection, the term
112 "outstanding overpayment" includes any amount identified in a

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113 preliminary audit report issued to the transferor by the agency
114 on or before the effective date of the change of ownership. For
115 purposes of this subsection, the term "administrative fines"
116 includes any amount identified in any notice of a monetary
117 penalty or fine that has been issued by the agency or any other
118 regulatory or licensing agency which governs the provider. In
119 the event of a change of ownership for a skilled nursing
120 facility or intermediate care facility, the Medicaid provider
121 agreement shall be assigned to the transferee if the transferee
122 meets all other Medicaid provider qualifications. In the event
123 of a change of ownership involving a skilled nursing facility
124 licensed under part II of chapter 400, liability for all
125 outstanding overpayments, administrative fines, and any moneys
126 owed to the agency before the effective date of the change of
127 ownership shall be determined in accordance with s. 400.179.
128 (7) The agency may require, as a condition of
129 participating in the Medicaid program and before entering into
130 the provider agreement, that the provider submit information, in
131 an initial and any required renewal applications, concerning the
132 professional, business, and personal background of the provider
133 and permit an onsite inspection of the provider's service
134 location by agency staff or other personnel designated by the
135 agency to perform this function. Before entering into a provider
136 agreement, the agency is authorized to ~~shall~~ perform an ~~a random~~
137 onsite inspection~~, within 60 days after receipt of a fully~~
138 ~~complete new provider's application,~~ of the provider's service
139 location ~~prior to making its first payment to the provider for~~
140 ~~Medicaid services~~ to determine the applicant's ability to

141 provide the services in compliance with Medicaid and
142 professional regulations ~~that the applicant is proposing to~~
143 ~~provide for Medicaid reimbursement~~. ~~The agency is not required~~
144 ~~to perform an onsite inspection of a provider or program that is~~
145 ~~licensed by the agency, that provides services under waiver~~
146 ~~programs for home and community-based services, or that is~~
147 ~~licensed as a medical foster home by the Department of Children~~
148 ~~and Family Services.~~ As a continuing condition of participation
149 in the Medicaid program, a provider shall immediately notify the
150 agency of any current or pending bankruptcy filing. Before
151 entering into the provider agreement, or as a condition of
152 continuing participation in the Medicaid program, the agency may
153 also require that Medicaid providers reimbursed on a fee-for-
154 services basis or fee schedule basis which is not cost-based,
155 post a surety bond not to exceed $50,000 or the total amount
156 billed by the provider to the program during the current or most
157 recent calendar year, whichever is greater. For new providers,
158 the amount of the surety bond shall be determined by the agency
159 based on the provider's estimate of its first year's billing. If
160 the provider's billing during the first year exceeds the bond
161 amount, the agency may require the provider to acquire an
162 additional bond equal to the actual billing level of the
163 provider. A provider's bond shall not exceed $50,000 if a
164 physician or group of physicians licensed under chapter 458,
165 chapter 459, or chapter 460 has a 50 percent or greater
166 ownership interest in the provider or if the provider is an
167 assisted living facility licensed under chapter 429. The bonds
168 permitted by this section are in addition to the bonds

169 referenced in s. 400.179(2)(d). If the provider is a
170 corporation, partnership, association, or other entity, the
171 agency may require the provider to submit information concerning
172 the background of that entity and of any principal of the
173 entity, including any partner or shareholder having an ownership
174 interest in the entity equal to 5 percent or greater, and any
175 treating provider who participates in or intends to participate
176 in Medicaid through the entity. The information must include:
177 (a) Proof of holding a valid license or operating
178 certificate, as applicable, if required by the state or local
179 jurisdiction in which the provider is located or if required by
180 the Federal Government.
181 (b) Information concerning any prior violation, fine,
182 suspension, termination, or other administrative action taken
183 under the Medicaid laws, rules, or regulations of this state or
184 of any other state or the Federal Government; any prior
185 violation of the laws, rules, or regulations relating to the
186 Medicare program; any prior violation of the rules or
187 regulations of any other public or private insurer; and any
188 prior violation of the laws, rules, or regulations of any
189 regulatory body of this or any other state.
190 (c) Full and accurate disclosure of any financial or
191 ownership interest that the provider, or any principal, partner,
192 or major shareholder thereof, may hold in any other Medicaid
193 provider or health care related entity or any other entity that
194 is licensed by the state to provide health or residential care
195 and treatment to persons.
196 (d) If a group provider, identification of all members of

197 the group and attestation that all members of the group are
198 enrolled in or have applied to enroll in the Medicaid program.
199 (8)(a) Each provider, or each principal of the provider if
200 the provider is a corporation, partnership, association, or
201 other entity, seeking to participate in the Medicaid program
202 must submit a complete set of his or her fingerprints to the
203 agency for the purpose of conducting a criminal history record
204 check. Principals of the provider include any officer, director,
205 billing agent, managing employee, or affiliated person, or any
206 partner or shareholder who has an ownership interest equal to 5
207 percent or more in the provider. However, for a hospital
208 licensed under chapter 395 or a nursing home licensed under
209 chapter 400, principals of the provider include any person or
210 entity who meets the definition of a controlling interest in s.
211 408.803(7). ~~However,~~ A director of a not-for-profit corporation
212 or organization is not a principal for purposes of a background
213 investigation as required by this section if the director:
214 serves solely in a voluntary capacity for the corporation or
215 organization, does not regularly take part in the day-to-day
216 operational decisions of the corporation or organization,
217 receives no remuneration from the not-for-profit corporation or
218 organization for his or her service on the board of directors,
219 has no financial interest in the not-for-profit corporation or
220 organization, and has no family members with a financial
221 interest in the not-for-profit corporation or organization; and
222 if the director submits an affidavit, under penalty of perjury,
223 to this effect to the agency and the not-for-profit corporation
224 or organization submits an affidavit, under penalty of perjury,

225 to this effect to the agency as part of the corporation's or
226 organization's Medicaid provider agreement application.
227 Notwithstanding the above, the agency may require a background
228 check for any person reasonably suspected by the agency to have
229 been convicted of a crime. This subsection does not apply to:
230 ~~1. A hospital licensed under chapter 395;~~
231 ~~2. A nursing home licensed under chapter 400;~~
232 ~~3. A hospice licensed under chapter 400;~~
233 ~~4. An assisted living facility licensed under chapter 429;~~
234 1.~~5.~~ A unit of local government, except that requirements
235 of this subsection apply to nongovernmental providers and
236 entities contracting with the local government to provide
237 Medicaid services. The actual cost of the state and national
238 criminal history record checks must be borne by the
239 nongovernmental provider or entity; or
240 2.~~6.~~ Any business that derives more than 50 percent of its
241 revenue from the sale of goods to the final consumer, and the
242 business or its controlling parent is required to file a form
243 10-K or other similar statement with the Securities and Exchange
244 Commission or has a net worth of $50 million or more.
245 (b) Background screening shall be conducted in accordance
246 with chapter 435 and s. 408.809. The cost of the state and
247 national criminal record check shall be borne by the provider.
248 ~~(c) Proof of compliance with the requirements of level 2~~
249 ~~screening under chapter 435 conducted within 12 months before~~
250 ~~the date the Medicaid provider application is submitted to the~~
251 ~~agency fulfills the requirements of this subsection.~~
252 Section 3. Subsections (1), (2), (9), (13), (15), (16),

253 (21), (22), (25), (28), (30), and (31) of section 409.913,
254 Florida Statutes, are amended to read:
255 409.913 Oversight of the integrity of the Medicaid
256 program.—The agency shall operate a program to oversee the
257 activities of Florida Medicaid recipients, and providers and
258 their representatives, to ensure that fraudulent and abusive
259 behavior and neglect of recipients occur to the minimum extent
260 possible, and to recover overpayments and impose sanctions as
261 appropriate. Beginning January 1, 2003, and each year
262 thereafter, the agency and the Medicaid Fraud Control Unit of
263 the Department of Legal Affairs shall submit a joint report to
264 the Legislature documenting the effectiveness of the state's
265 efforts to control Medicaid fraud and abuse and to recover
266 Medicaid overpayments during the previous fiscal year. The
267 report must describe the number of cases opened and investigated
268 each year; the sources of the cases opened; the disposition of
269 the cases closed each year; the amount of overpayments alleged
270 in preliminary and final audit letters; the number and amount of
271 fines or penalties imposed; any reductions in overpayment
272 amounts negotiated in settlement agreements or by other means;
273 the amount of final agency determinations of overpayments; the
274 amount deducted from federal claiming as a result of
275 overpayments; the amount of overpayments recovered each year;
276 the amount of cost of investigation recovered each year; the
277 average length of time to collect from the time the case was
278 opened until the overpayment is paid in full; the amount
279 determined as uncollectible and the portion of the uncollectible
280 amount subsequently reclaimed from the Federal Government; the

281 number of providers, by type, that are terminated from
282 participation in the Medicaid program as a result of fraud and
283 abuse; and all costs associated with discovering and prosecuting
284 cases of Medicaid overpayments and making recoveries in such
285 cases. The report must also document actions taken to prevent
286 overpayments and the number of providers prevented from
287 enrolling in or reenrolling in the Medicaid program as a result
288 of documented Medicaid fraud and abuse and must include policy
289 recommendations necessary to prevent or recover overpayments and
290 changes necessary to prevent and detect Medicaid fraud. All
291 policy recommendations in the report must include a detailed
292 fiscal analysis, including, but not limited to, implementation
293 costs, estimated savings to the Medicaid program, and the return
294 on investment. The agency must submit the policy recommendations
295 and fiscal analyses in the report to the appropriate estimating
296 conference, pursuant to s. 216.137, by February 15 of each year.
297 The agency and the Medicaid Fraud Control Unit of the Department
298 of Legal Affairs each must include detailed unit-specific
299 performance standards, benchmarks, and metrics in the report,
300 including projected cost savings to the state Medicaid program
301 during the following fiscal year.
302 (1) For the purposes of this section, the term:
303 (a) "Abuse" means:
304 1. Provider practices that are inconsistent with generally
305 accepted business or medical practices and that result in an
306 unnecessary cost to the Medicaid program or in reimbursement for
307 goods or services that are not medically necessary or that fail
308 to meet professionally recognized standards for health care.

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309 2. Recipient practices that result in unnecessary cost to
310 the Medicaid program.
311 (b) "Complaint" means an allegation that fraud, abuse, or
312 an overpayment has occurred.
313 (c) "Fraud" means an intentional deception or
314 misrepresentation made by a person with the knowledge that the
315 deception results in unauthorized benefit to herself or himself
316 or another person. The term includes any act that constitutes
317 fraud under applicable federal or state law.
318 (d) "Medicaid provider" or "provider" means a person or
319 entity that has a Medicaid provider agreement in effect with the
320 agency and is in good standing with the agency. For purposes of
321 oversight of the integrity of the Medicaid program, the term
322 "Medicaid provider" or "provider" also includes a participant in
323 Medicaid managed care.
324 (e) ~~(d)~~ "Medical necessity" or "medically necessary" means
325 any goods or services necessary to palliate the effects of a
326 terminal condition, or to prevent, diagnose, correct, cure,
327 alleviate, or preclude deterioration of a condition that
328 threatens life, causes pain or suffering, or results in illness
329 or infirmity, which goods or services are provided in accordance
330 with generally accepted standards of medical practice. For
331 purposes of determining Medicaid reimbursement, the agency is
332 the final arbiter of medical necessity. Determinations of
333 medical necessity must be made by a licensed physician employed
334 by or under contract with the agency and must be based upon
335 information available at the time the goods or services are
336 provided.

337 (f) ~~(e)~~ "Overpayment" includes any amount that is not
338 authorized to be paid by the Medicaid program whether paid as a
339 result of inaccurate or improper cost reporting, improper
340 claiming, unacceptable practices, fraud, abuse, or mistake.
341 (g) ~~(f)~~ "Person" means any natural person, corporation,
342 partnership, association, clinic, group, or other entity,
343 whether or not such person is enrolled in the Medicaid program
344 or is a provider of health care.
345 (2) The agency shall conduct, or cause to be conducted by
346 contract or otherwise, reviews, investigations, analyses,
347 audits, or any combination thereof, to determine possible fraud,
348 abuse, overpayment, or recipient neglect in the Medicaid program
349 and shall report the findings of any overpayments in audit
350 reports as appropriate. At least 5 percent of all audits shall
351 be conducted on a random basis. As part of its ongoing fraud
352 detection activities, the agency shall identify and monitor, by
353 contract or otherwise, patterns of overutilization of Medicaid
354 services based on state averages. The agency shall track
355 Medicaid provider prescription and billing patterns and evaluate
356 them against Medicaid medical necessity criteria and coverage
357 and limitation guidelines adopted by rule. Medical necessity
358 determination requires that service be consistent with symptoms
359 or confirmed diagnosis of illness or injury under treatment and
360 not in excess of the patient's needs. The agency shall conduct
361 reviews of provider exceptions to peer group norms and shall,
362 using statistical methodologies, provider profiling, and
363 analysis of billing patterns, detect and investigate abnormal or
364 unusual increases in billing or payment of claims for Medicaid

365 services and medically unnecessary provision of services. The
366 agency is not limited to the review or analysis of Medicaid-
367 enrolled providers when conducting, or causing to be conducted,
368 fraud, abuse, overpayment, or recipient neglect activities.
369 (9) A Medicaid provider shall retain medical,
370 professional, financial, and business records pertaining to
371 services and goods furnished to a Medicaid recipient and billed
372 to Medicaid for a period of 6 ~~5~~ years after the date of
373 furnishing such services or goods. The agency may investigate,
374 review, or analyze such records, which must be made available
375 during normal business hours. However, 24-hour notice must be
376 provided if patient treatment would be disrupted. The provider
377 is responsible for furnishing to the agency, and keeping the
378 agency informed of the location of, the provider's Medicaid-
379 related records. The authority of the agency to obtain Medicaid-
380 related records from a provider is neither curtailed nor limited
381 during a period of litigation between the agency and the
382 provider.
383 (13) The agency shall ~~immediately~~ terminate participation
384 of a Medicaid provider in the Medicaid program and may seek
385 civil remedies or impose other administrative sanctions against
386 a Medicaid provider, if the provider or any principal, officer,
387 director, agent, managing employee, or affiliated person of the
388 provider, or any partner or shareholder having an ownership
389 interest in the provider equal to 5 percent or greater, is no
390 longer in compliance with the background screening requirements
391 of s. 408.809 or chapter 435, or has been:
392 (a) Convicted of a criminal offense related to the

393 delivery of any health care goods or services, including the
394 performance of management or administrative functions relating
395 to the delivery of health care goods or services;
396 (b) Convicted of a criminal offense under federal law or
397 the law of any state relating to the practice of the provider's
398 profession; ~~or~~
399 (c) Found by a court of competent jurisdiction to have
400 neglected or physically abused a patient in connection with the
401 delivery of health care goods or services; or
402 (d) Convicted of any offense set forth in s. 409.907(10).
403
404 If the agency determines a provider did not participate or
405 acquiesce in an offense specified in paragraph (a), paragraph
406 (b), ~~or~~ paragraph (c), or paragraph (d), termination will not be
407 imposed. If the agency effects a termination under this
408 subsection, the agency shall issue an immediate final order
409 pursuant to s. 120.569(2)(n).
410 (15) The agency shall seek a remedy provided by law,
411 including, but not limited to, any remedy provided in
412 subsections (13) and (16) and s. 812.035, if:
413 (a) The provider's license has not been renewed, or has
414 been revoked, suspended, or terminated, for cause, by the
415 licensing agency of any state;
416 (b) The provider has failed to make available or has
417 refused access to Medicaid-related records to an auditor,
418 investigator, or other authorized employee or agent of the
419 agency, the Attorney General, a state attorney, or the Federal
420 Government;

421 (c) The provider has not furnished or has failed to make
422 available such Medicaid-related records as the agency has found
423 necessary to determine whether Medicaid payments are or were due
424 and the amounts thereof;
425 (d) The provider has failed to maintain medical records
426 made at the time of service, or prior to service if prior
427 authorization is required, demonstrating the necessity and
428 appropriateness of the goods or services rendered;
429 (e) The provider is not in compliance with provisions of
430 Medicaid provider publications that have been adopted by
431 reference as rules in the Florida Administrative Code; with
432 provisions of state or federal laws, rules, or regulations; with
433 provisions of the provider agreement between the agency and the
434 provider; or with certifications found on claim forms or on
435 transmittal forms for electronically submitted claims that are
436 submitted by the provider or authorized representative, as such
437 provisions apply to the Medicaid program;
438 (f) The provider or person who ordered or prescribed the
439 care, services, or supplies has furnished, ~~or~~ ordered, or
440 authorized the furnishing of~~,~~ goods or services to a recipient
441 which are inappropriate, unnecessary, excessive, or harmful to
442 the recipient or are of inferior quality;
443 (g) The provider has demonstrated a pattern of failure to
444 provide goods or services that are medically necessary;
445 (h) The provider or an authorized representative of the
446 provider, or a person who ordered or prescribed the goods or
447 services, has submitted or caused to be submitted false or a
448 pattern of erroneous Medicaid claims;

449 (i) The provider or an authorized representative of the
450 provider, or a person who has ordered, authorized, or prescribed
451 the goods or services, has submitted or caused to be submitted a
452 Medicaid provider enrollment application, a request for prior
453 authorization for Medicaid services, a drug exception request,
454 or a Medicaid cost report that contains materially false or
455 incorrect information;
456 (j) The provider or an authorized representative of the
457 provider has collected from or billed a recipient or a
458 recipient's responsible party improperly for amounts that should
459 not have been so collected or billed by reason of the provider's
460 billing the Medicaid program for the same service;
461 (k) The provider or an authorized representative of the
462 provider has included in a cost report costs that are not
463 allowable under a Florida Title XIX reimbursement plan, after
464 the provider or authorized representative had been advised in an
465 audit exit conference or audit report that the costs were not
466 allowable;
467 (l) The provider is charged by information or indictment
468 with fraudulent billing practices or any of the offenses set
469 forth in subsection (13). The sanction applied for this reason
470 is limited to suspension of the provider's participation in the
471 Medicaid program for the duration of the indictment unless the
472 provider is found guilty pursuant to the information or
473 indictment;
474 (m) The provider or a person who has ordered or prescribed
475 the goods or services is found liable for negligent practice
476 resulting in death or injury to the provider's patient;

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477 (n) The provider fails to demonstrate that it had
478 available during a specific audit or review period sufficient
479 quantities of goods, or sufficient time in the case of services,
480 to support the provider's billings to the Medicaid program;
481 (o) The provider has failed to comply with the notice and
482 reporting requirements of s. 409.907;
483 (p) The agency has received reliable information of
484 patient abuse or neglect or of any act prohibited by s. 409.920;
485 or
486 (q) The provider has failed to comply with an agreed-upon
487 repayment schedule.
488
489 A provider is subject to sanctions for violations of this
490 subsection as the result of actions or inactions of the
491 provider, or actions or inactions of any principal, officer,
492 director, agent, managing employee, or affiliated person of the
493 provider, or any partner or shareholder having an ownership
494 interest in the provider equal to 5 percent or greater, in which
495 the provider participated or acquiesced.
496 (16) The agency shall impose any of the following
497 sanctions or disincentives on a provider or a person for any of
498 the acts described in subsection (15):
499 (a) Suspension for a specific period of time of not more
500 than 1 year. Suspension shall preclude participation in the
501 Medicaid program, which includes any action that results in a
502 claim for payment to the Medicaid program as a result of
503 furnishing, supervising a person who is furnishing, or causing a
504 person to furnish goods or services.

505 (b) Termination for a specific period of time of from more
506 than 1 year to 20 years. Termination shall preclude
507 participation in the Medicaid program, which includes any action
508 that results in a claim for payment to the Medicaid program as a
509 result of furnishing, supervising a person who is furnishing, or
510 causing a person to furnish goods or services.
511 (c) Imposition of a fine of up to $5,000 for each
512 violation. Each day that an ongoing violation continues, such as
513 refusing to furnish Medicaid-related records or refusing access
514 to records, is considered, for the purposes of this section, to
515 be a separate violation. Each instance of improper billing of a
516 Medicaid recipient; each instance of including an unallowable
517 cost on a hospital or nursing home Medicaid cost report after
518 the provider or authorized representative has been advised in an
519 audit exit conference or previous audit report of the cost
520 unallowability; each instance of furnishing a Medicaid recipient
521 goods or professional services that are inappropriate or of
522 inferior quality as determined by competent peer judgment; each
523 instance of knowingly submitting a materially false or erroneous
524 Medicaid provider enrollment application, request for prior
525 authorization for Medicaid services, drug exception request, or
526 cost report; each instance of inappropriate prescribing of drugs
527 for a Medicaid recipient as determined by competent peer
528 judgment; and each false or erroneous Medicaid claim leading to
529 an overpayment to a provider is considered, for the purposes of
530 this section, to be a separate violation.
531 (d) Immediate suspension, if the agency has received
532 information of patient abuse or neglect or of any act prohibited

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533 by s. 409.920. Upon suspension, the agency must issue an
534 immediate final order under s. 120.569(2)(n).
535 (e) A fine, not to exceed $10,000, for a violation of
536 paragraph (15)(i).
537 (f) Imposition of liens against provider assets,
538 including, but not limited to, financial assets and real
539 property, not to exceed the amount of fines or recoveries
540 sought, upon entry of an order determining that such moneys are
541 due or recoverable.
542 (g) Prepayment reviews of claims for a specified period of
543 time.
544 (h) Comprehensive followup reviews of providers every 6
545 months to ensure that they are billing Medicaid correctly.
546 (i) Corrective-action plans that would remain in effect
547 for providers for up to 3 years and that would be monitored by
548 the agency every 6 months while in effect.
549 (j) Other remedies as permitted by law to effect the
550 recovery of a fine or overpayment.
551
552 If a provider seeks to voluntarily relinquish its Medicaid
553 provider number after receiving written notice that the agency
554 has initiated an audit or investigation, when the sanction of
555 suspension or termination would have been imposed for any
556 noncompliance discovered, the agency shall impose the sanction
557 of termination for cause against the provider. The Secretary of
558 Health Care Administration may make a determination that
559 imposition of a sanction or disincentive is not in the best
560 interest of the Medicaid program, in which case a sanction or

561 disincentive shall not be imposed.
562 (21) When making a determination that an overpayment has
563 occurred, the agency shall prepare and issue an audit report to
564 the provider showing the calculation of overpayments. The
565 agency's determination shall be based solely upon information
566 available to the agency before the audit report is issued and,
567 in the case of documentation obtained to substantiate the claims
568 for Medicaid reimbursement, shall be based solely upon
569 contemporaneous records.
570 (22) The audit report, supported by agency work papers,
571 showing an overpayment to a provider constitutes evidence of the
572 overpayment. A provider may not present or elicit testimony,
573 either on direct examination or cross-examination in any court
574 or administrative proceeding, regarding the purchase or
575 acquisition by any means of drugs, goods, or supplies; sales or
576 divestment by any means of drugs, goods, or supplies; or
577 inventory of drugs, goods, or supplies, unless such acquisition,
578 sales, divestment, or inventory is documented by written
579 invoices, written inventory records, or other competent written
580 documentary evidence maintained in the normal course of the
581 provider's business. Furthermore, a provider may present
582 evidence of documentation or data based upon contemporaneous
583 records. Notwithstanding the applicable rules of discovery, all
584 documentation that will be offered as evidence at an
585 administrative hearing on a Medicaid overpayment or
586 administrative sanction must be exchanged by all parties at
587 least 14 days before the administrative hearing or must be
588 excluded from consideration.

589 (25)(a) The agency shall withhold Medicaid payments, in
590 whole or in part, to a provider upon receipt of reliable
591 evidence that the circumstances giving rise to the need for a
592 withholding of payments involve fraud, willful
593 misrepresentation, or abuse under the Medicaid program, or a
594 crime committed while rendering goods or services to Medicaid
595 recipients. If it is determined that fraud, willful
596 misrepresentation, abuse, or a crime did not occur, the payments
597 withheld must be paid to the provider within 14 days after such
598 determination ~~with interest at the rate of 10 percent a year.~~
599 ~~Any money withheld in accordance with this paragraph shall be~~
600 ~~placed in a suspended account, readily accessible to the agency,~~
601 ~~so that any payment ultimately due the provider shall be made~~
602 ~~within 14 days~~.
603 (b) The agency shall deny payment, or require repayment,
604 if the goods or services were furnished, supervised, or caused
605 to be furnished by a person who has been suspended or terminated
606 from the Medicaid program or Medicare program by the Federal
607 Government or any state.
608 (c) Overpayments owed to the agency bear interest at the
609 rate of 10 percent per year from the date of determination of
610 the overpayment by the agency, and payment arrangements
611 regarding overpayments and fines must be made within 30 days
612 after the date of the final order, not subject to further appeal
613 ~~at the conclusion of legal proceedings~~. ~~A provider who does not~~
614 ~~enter into or adhere to an agreed-upon repayment schedule may be~~
615 ~~terminated by the agency for nonpayment or partial payment.~~
616 (d) The agency, upon entry of a final agency order, a

617 judgment or order of a court of competent jurisdiction, or a
618 stipulation or settlement, may collect the moneys owed by all
619 means allowable by law, including, but not limited to, notifying
620 any fiscal intermediary of Medicare benefits that the state has
621 a superior right of payment. Upon receipt of such written
622 notification, the Medicare fiscal intermediary shall remit to
623 the state the sum claimed.
624 (e) The agency may institute amnesty programs to allow
625 Medicaid providers the opportunity to voluntarily repay
626 overpayments. The agency may adopt rules to administer such
627 programs.
628 (28) Venue for all Medicaid program integrity ~~overpayment~~
629 cases shall lie in Leon County, at the discretion of the agency.
630 (30) The agency shall terminate a provider's participation
631 in the Medicaid program if the provider fails to reimburse an
632 overpayment or pay a fine that has been determined by final
633 order, not subject to further appeal, within 30 ~~35~~ days after
634 the date of the final order, unless the provider and the agency
635 have entered into a repayment agreement.
636 (31) If a provider requests an administrative hearing
637 pursuant to chapter 120, such hearing must be conducted within
638 90 days following assignment of an administrative law judge,
639 absent exceptionally good cause shown as determined by the
640 administrative law judge or hearing officer. Upon issuance of a
641 final order, the outstanding balance of the amount determined to
642 constitute the overpayment and any fines shall become due. If a
643 provider fails to make payments in full, fails to enter into a
644 satisfactory repayment plan, or fails to comply with the terms

645 of a repayment plan or settlement agreement, the agency shall
646 withhold medical assistance reimbursement payments until the
647 amount due is paid in full.
648 Section 4. Subsection (8) of section 409.920, Florida
649 Statutes, is amended to read:
650 409.920 Medicaid provider fraud; fraudulent acts.—
651 (8) A person who provides the state, any state agency, any
652 of the state's political subdivisions, or any agency of the
653 state's political subdivisions with information about fraud or
654 suspected fraudulent acts ~~fraud~~ by a Medicaid provider,
655 including a managed care organization, is immune from civil
656 liability for libel, slander, or any other relevant tort for
657 providing any ~~the~~ information about fraud or suspected
658 fraudulent acts, unless the person acted with knowledge that the
659 information was false or with reckless disregard for the truth
660 or falsity of the information. For purposes of this subsection,
661 the term "fraudulent acts" includes actual or suspected fraud,
662 abuse, or overpayments, including any fraud-related matters a
663 provider or health plan is required to report to the agency or
664 law enforcement. The immunity from civil liability extends to
665 reports of fraudulent acts conveyed to the state in any manner,
666 including any forum and with any audience as directed by the
667 state, and includes all discussions subsequent to the report and
668 subsequent inquiries from the state, unless the person acted
669 with knowledge that the information was false or with reckless
670 disregard for the truth or falsity of the information.
671 Section 5. This act shall take effect July 1, 2012.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.