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LEGISLATIVE ACTION

Senate	.	House
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Floor: 4/AD/2R	.	
04/23/2009 05:22 PM	.	
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Senator Gaetz moved the following:

1 **Senate Amendment (with directory and title amendments)**
2
3 Delete lines 1066 - 1514
4 and insert:
5 (24) If the agency imposes an administrative sanction
6 pursuant to subsection (13), subsection (14), or subsection
7 (15), except paragraphs (15)(e) and (o), upon any provider or
8 any principal, officer, director, agent, managing employee, or
9 affiliated person of the provider ~~other person~~ who is regulated
10 by another state entity, the agency shall notify that other
11 entity of the imposition of the sanction within 5 business days.

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12 Such notification must include the provider's or person's name
13 and license number and the specific reasons for sanction.
14 (25)(a) The agency shall ~~may~~ withhold Medicaid payments, in
15 whole or in part, to a provider upon receipt of reliable
16 evidence that the circumstances giving rise to the need for a
17 withholding of payments involve fraud, willful
18 misrepresentation, or abuse under the Medicaid program, or a
19 crime committed while rendering goods or services to Medicaid
20 recipients. If it is determined that fraud, willful
21 misrepresentation, abuse, or a crime did not occur, the payments
22 withheld must be paid to the provider within 14 days after such
23 determination with interest at the rate of 10 percent a year.
24 Any money withheld in accordance with this paragraph shall be
25 placed in a suspended account, readily accessible to the agency,
26 so that any payment ultimately due the provider shall be made
27 within 14 days.
28 (b) The agency shall ~~may~~ deny payment, or require
29 repayment, if the goods or services were furnished, supervised,
30 or caused to be furnished by a person who has been suspended or
31 terminated from the Medicaid program or Medicare program by the
32 Federal Government or any state.
33 (c) Overpayments owed to the agency bear interest at the
34 rate of 10 percent per year from the date of determination of
35 the overpayment by the agency, and payment arrangements must be
36 made at the conclusion of legal proceedings. A provider who does
37 not enter into or adhere to an agreed-upon repayment schedule
38 may be terminated by the agency for nonpayment or partial
39 payment.
40 (d) The agency, upon entry of a final agency order, a

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41 judgment or order of a court of competent jurisdiction, or a
42 stipulation or settlement, may collect the moneys owed by all
43 means allowable by law, including, but not limited to, notifying
44 any fiscal intermediary of Medicare benefits that the state has
45 a superior right of payment. Upon receipt of such written
46 notification, the Medicare fiscal intermediary shall remit to
47 the state the sum claimed.
48 (e) The agency may institute amnesty programs to allow
49 Medicaid providers the opportunity to voluntarily repay
50 overpayments. The agency may adopt rules to administer such
51 programs.
52 (27) When the Agency for Health Care Administration has
53 made a probable cause determination and alleged that an
54 overpayment to a Medicaid provider has occurred, the agency,
55 after notice to the provider, shall ~~may~~:
56 (a) Withhold, and continue to withhold during the pendency
57 of an administrative hearing pursuant to chapter 120, any
58 medical assistance reimbursement payments until such time as the
59 overpayment is recovered, unless within 30 days after receiving
60 notice thereof the provider:
61 1. Makes repayment in full; or
62 2. Establishes a repayment plan that is satisfactory to the
63 Agency for Health Care Administration.
64 (b) Withhold, and continue to withhold during the pendency
65 of an administrative hearing pursuant to chapter 120, medical
66 assistance reimbursement payments if the terms of a repayment
67 plan are not adhered to by the provider.
68 (30) The agency shall ~~may~~ terminate a provider's
69 participation in the Medicaid program if the provider fails to

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70 reimburse an overpayment that has been determined by final
71 order, not subject to further appeal, within 35 days after the
72 date of the final order, unless the provider and the agency have
73 entered into a repayment agreement.
74 (31) If a provider requests an administrative hearing
75 pursuant to chapter 120, such hearing must be conducted within
76 90 days following assignment of an administrative law judge,
77 absent exceptionally good cause shown as determined by the
78 administrative law judge or hearing officer. Upon issuance of a
79 final order, the outstanding balance of the amount determined to
80 constitute the overpayment shall become due. If a provider fails
81 to make payments in full, fails to enter into a satisfactory
82 repayment plan, or fails to comply with the terms of a repayment
83 plan or settlement agreement, the agency shall ~~may~~ withhold
84 medical assistance reimbursement payments until the amount due
85 is paid in full.
86 (36) At least three times a year, the agency shall provide
87 to each Medicaid recipient or his or her representative an
88 explanation of benefits in the form of a letter that is mailed
89 to the most recent address of the recipient on the record with
90 the Department of Children and Family Services. The explanation
91 of benefits must include the patient’s name, the name of the
92 health care provider and the address of the location where the
93 service was provided, a description of all services billed to
94 Medicaid in terminology that should be understood by a
95 reasonable person, and information on how to report
96 inappropriate or incorrect billing to the agency or other law
97 enforcement entities for review or investigation. At least once
98 a year, the letter also must include information on how to

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99 report criminal Medicaid fraud, the Medicaid Fraud Control
100 Unit’s toll-free hotline number, and information about the
101 rewards available under s. 409.9203. The explanation of benefits
102 may not be mailed for Medicaid independent laboratory services
103 as described in s. 409.905(7) or for Medicaid certified match
104 services as described in ss. 409.9071 and 1011.70.
105 (37) The agency shall post on its website a current list of
106 each Medicaid provider, including any principal, officer,
107 director, agent, managing employee, or affiliated person of the
108 provider, or any partner or shareholder having an ownership
109 interest in the provider equal to 5 percent or greater, who has
110 been terminated for cause from the Medicaid program or
111 sanctioned under this section. The list must be searchable by a
112 variety of search parameters and provide for the creation of
113 formatted lists that may be printed or imported into other
114 applications, including spreadsheets. The agency shall update
115 the list at least monthly.
116 (38) In order to improve the detection of health care
117 fraud, use technology to prevent and detect fraud, and maximize
118 the electronic exchange of health care fraud information, the
119 agency shall:
120 (a) Compile, maintain, and publish on its website a
121 detailed list of all state and federal databases that contain
122 health care fraud information and update the list at least
123 biannually;
124 (b) Develop a strategic plan to connect all databases that
125 contain health care fraud information to facilitate the
126 electronic exchange of health information between the agency,
127 the Department of Health, the Department of Law Enforcement, and

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128 the Attorney General's Office. The plan must include recommended
129 standard data formats, fraud-identification strategies, and
130 specifications for the technical interface between state and
131 federal health care fraud databases;
132 (c) Monitor innovations in health information technology,
133 specifically as it pertains to Medicaid fraud prevention and
134 detection; and
135 (d) Periodically publish policy briefs that highlight
136 available new technology to prevent or detect health care fraud
137 and projects implemented by other states, the private sector, or
138 the Federal Government which use technology to prevent or detect
139 health care fraud.
140 Section 14. Subsections (1) and (2) of section 409.920,
141 Florida Statutes, are amended, present subsections (8) and (9)
142 of that section are renumbered as subsections (9) and (10),
143 respectively, and a new subsection (8) is added to that section,
144 to read:
145 409.920 Medicaid provider fraud.—
146 (1) For the purposes of this section, the term:
147 (a) "Agency" means the Agency for Health Care
148 Administration.
149 (b) "Fiscal agent" means any individual, firm, corporation,
150 partnership, organization, or other legal entity that has
151 contracted with the agency to receive, process, and adjudicate
152 claims under the Medicaid program.
153 (c) "Item or service" includes:
154 1. Any particular item, device, medical supply, or service
155 claimed to have been provided to a recipient and listed in an
156 itemized claim for payment; or

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157 2. In the case of a claim based on costs, any entry in the
158 cost report, books of account, or other documents supporting
159 such claim.
160 (d) "Knowingly" means that the act was done voluntarily and
161 intentionally and not because of mistake or accident. As used in
162 this section, the term "knowingly" also includes the word
163 "willfully" or "willful" which, as used in this section, means
164 that an act was committed voluntarily and purposely, with the
165 specific intent to do something that the law forbids, and that
166 the act was committed with bad purpose, either to disobey or
167 disregard the law.
168 (e) "Managed care plans" means a health insurer authorized
169 under chapter 624, an exclusive provider organization authorized
170 under chapter 627, a health maintenance organization authorized
171 under chapter 641, the Children's Medical Services Network
172 authorized under chapter 391, a prepaid health plan authorized
173 under chapter 409, a provider service network authorized under
174 chapter 409, a minority physician network authorized under
175 chapter 409, and an emergency department diversion program
176 authorized under chapter 409 or the General Appropriations Act,
177 providing health care services pursuant to a contract with the
178 Medicaid program.
179 (2)(a) A person may not ~~It is unlawful to~~:
180 1.~~(a)~~ Knowingly make, cause to be made, or aid and abet in
181 the making of any false statement or false representation of a
182 material fact, by commission or omission, in any claim submitted
183 to the agency or its fiscal agent or a managed care plan for
184 payment.
185 2.~~(b)~~ Knowingly make, cause to be made, or aid and abet in

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186 the making of a claim for items or services that are not
187 authorized to be reimbursed by the Medicaid program.
188 3.~~(c)~~ Knowingly charge, solicit, accept, or receive
189 anything of value, other than an authorized copayment from a
190 Medicaid recipient, from any source in addition to the amount
191 legally payable for an item or service provided to a Medicaid
192 recipient under the Medicaid program or knowingly fail to credit
193 the agency or its fiscal agent for any payment received from a
194 third-party source.
195 4.~~(d)~~ Knowingly make or in any way cause to be made any
196 false statement or false representation of a material fact, by
197 commission or omission, in any document containing items of
198 income and expense that is or may be used by the agency to
199 determine a general or specific rate of payment for an item or
200 service provided by a provider.
201 5.~~(e)~~ Knowingly solicit, offer, pay, or receive any
202 remuneration, including any kickback, bribe, or rebate, directly
203 or indirectly, overtly or covertly, in cash or in kind, in
204 return for referring an individual to a person for the
205 furnishing or arranging for the furnishing of any item or
206 service for which payment may be made, in whole or in part,
207 under the Medicaid program, or in return for obtaining,
208 purchasing, leasing, ordering, or arranging for or recommending,
209 obtaining, purchasing, leasing, or ordering any goods, facility,
210 item, or service, for which payment may be made, in whole or in
211 part, under the Medicaid program.
212 6.~~(f)~~ Knowingly submit false or misleading information or
213 statements to the Medicaid program for the purpose of being
214 accepted as a Medicaid provider.

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215 7. ~~(g)~~ Knowingly use or endeavor to use a Medicaid
216 provider's identification number or a Medicaid recipient's
217 identification number to make, cause to be made, or aid and abet
218 in the making of a claim for items or services that are not
219 authorized to be reimbursed by the Medicaid program.
220 (b)1. A person who violates this subsection and receives or
221 endeavors to receive anything of value of:
222 a. Ten thousand dollars or less commits a felony of the
223 third degree, punishable as provided in s. 775.082, s. 775.083,
224 or s. 775.084.
225 b. More than $10,000, but less than $50,000, commits a
226 felony of the second degree, punishable as provided in s.
227 775.082, s. 775.083, or s. 775.084.
228 c. Fifty thousand dollars or more commits a felony of the
229 first degree, punishable as provided in s. 775.082, s. 775.083,
230 or s. 775.084.
231 2. The value of separate funds, goods, or services that a
232 person received or attempted to receive pursuant to a scheme or
233 course of conduct may be aggregated in determining the degree of
234 the offense.
235 3. In addition to the sentence authorized by law, a person
236 who is convicted of a violation of this subsection shall pay a
237 fine in an amount equal to five times the pecuniary gain
238 unlawfully received or the loss incurred by the Medicaid program
239 or managed care organization, whichever is greater.
240 (8) A person who provides the state, any state agency, any
241 of the state's political subdivisions, or any agency of the
242 state's political subdivisions with information about fraud or
243 suspected fraud by a Medicaid provider, including a managed care

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244 organization, is immune from civil liability for providing the
245 information unless the person acted with knowledge that the
246 information was false or with reckless disregard for the truth
247 or falsity of the information.
248 Section 15. Section 409.9203, Florida Statutes, is created
249 to read:
250 409.9203 Rewards for reporting Medicaid fraud.—
251 (1) The Department of Law Enforcement or director of the
252 Medicaid Fraud Control Unit shall, subject to availability of
253 funds, pay a reward to a person who furnishes original
254 information relating to and reports a violation of the state's
255 Medicaid fraud laws, unless the person declines the reward, if
256 the information and report:
257 (a) Is made to the Office of the Attorney General, the
258 Agency for Health Care Administration, the Department of Health,
259 or the Department of Law Enforcement;
260 (b) Relates to criminal fraud upon Medicaid funds or a
261 criminal violation of Medicaid laws by another person; and
262 (c) Leads to a recovery of a fine, penalty, or forfeiture
263 of property.
264 (2) The reward may not exceed the lesser of 25 percent of
265 the amount recovered or $500,000 in a single case.
266 (3) The reward shall be paid from the Legal Affairs
267 Revolving Trust Fund from moneys collected pursuant to s.
268 68.085.
269 (4) A person who receives a reward pursuant to this section
270 is not eligible to receive any funds pursuant to the Florida
271 False Claims Act for Medicaid fraud for which a reward is
272 received pursuant to this section.

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273 Section 16. Subsection (11) is added to section 456.004,
274 Florida Statutes, to read:
275 456.004 Department; powers and duties.—The department, for
276 the professions under its jurisdiction, shall:
277 (11) Work cooperatively with the Agency for Health Care
278 Administration and the judicial system to recover Medicaid
279 overpayments by the Medicaid program. The department shall
280 investigate and prosecute health care practitioners who have not
281 remitted amounts owed to the state for an overpayment from the
282 Medicaid program pursuant to a final order, judgment, or
283 stipulation or settlement.
284 Section 17. Present subsections (6) through (10) of section
285 456.041, Florida Statutes, are renumbered as subsections (7)
286 through (11), respectively, and a new subsection (6) is added to
287 that section, to read:
288 456.041 Practitioner profile; creation.—
289 (6) The Department of Health shall provide in each
290 practitioner profile for every physician or advanced registered
291 nurse practitioner terminated for cause from participating in
292 the Medicaid program, pursuant to s. 409.913, or sanctioned by
293 the Medicaid program a statement that the practitioner has been
294 terminated from participating in the Florida Medicaid program or
295 sanctioned by the Medicaid program.
296 Section 18. Paragraph (o) of subsection (3) of section
297 456.053, Florida Statutes, is amended to read:
298 456.053 Financial arrangements between referring health
299 care providers and providers of health care services.—
300 (3) DEFINITIONS.—For the purpose of this section, the word,
301 phrase, or term:

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302 (o) “Referral” means any referral of a patient by a health
303 care provider for health care services, including, without
304 limitation:
305 1. The forwarding of a patient by a health care provider to
306 another health care provider or to an entity which provides or
307 supplies designated health services or any other health care
308 item or service; or
309 2. The request or establishment of a plan of care by a
310 health care provider, which includes the provision of designated
311 health services or other health care item or service.
312 3. The following orders, recommendations, or plans of care
313 shall not constitute a referral by a health care provider:
314 a. By a radiologist for diagnostic-imaging services.
315 b. By a physician specializing in the provision of
316 radiation therapy services for such services.
317 c. By a medical oncologist for drugs and solutions to be
318 prepared and administered intravenously to such oncologist’s
319 patient, as well as for the supplies and equipment used in
320 connection therewith to treat such patient for cancer and the
321 complications thereof.
322 d. By a cardiologist for cardiac catheterization services.
323 e. By a pathologist for diagnostic clinical laboratory
324 tests and pathological examination services, if furnished by or
325 under the supervision of such pathologist pursuant to a
326 consultation requested by another physician.
327 f. By a health care provider who is the sole provider or
328 member of a group practice for designated health services or
329 other health care items or services that are prescribed or
330 provided solely for such referring health care provider’s or

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331 group practice’s own patients, and that are provided or
332 performed by or under the direct supervision of such referring
333 health care provider or group practice; provided, however, that
334 effective July 1, 1999, a physician licensed pursuant to chapter
335 458, chapter 459, chapter 460, or chapter 461 may refer a
336 patient to a sole provider or group practice for diagnostic
337 imaging services, excluding radiation therapy services, for
338 which the sole provider or group practice billed both the
339 technical and the professional fee for or on behalf of the
340 patient, if the referring physician has no investment interest
341 in the practice. The diagnostic imaging service referred to a
342 group practice or sole provider must be a diagnostic imaging
343 service normally provided within the scope of practice to the
344 patients of the group practice or sole provider. The group
345 practice or sole provider may accept no more than 15 percent of
346 their patients receiving diagnostic imaging services from
347 outside referrals, excluding radiation therapy services.
348 g. By a health care provider for services provided by an
349 ambulatory surgical center licensed under chapter 395.
350 h. By a urologist for lithotripsy services.
351 i. By a dentist for dental services performed by an
352 employee of or health care provider who is an independent
353 contractor with the dentist or group practice of which the
354 dentist is a member.
355 j. By a physician for infusion therapy services to a
356 patient of that physician or a member of that physician’s group
357 practice.
358 k. By a nephrologist for renal dialysis services and
359 supplies, except laboratory services.

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360 l. By a health care provider whose principal professional
361 practice consists of treating patients in their private
362 residences for services to be rendered in such private
363 residences, except for services rendered by a home health agency
364 licensed under chapter 400. For purposes of this sub-
365 subparagraph, the term "private residences" includes patient's
366 private homes, independent living centers, and assisted living
367 facilities, but does not include skilled nursing facilities.
368 m. By a health care provider for sleep related testing.
369 Section 19. Section 456.0635, Florida Statutes, is created
370 to read:
371 456.0635 Medicaid fraud; disqualification for license,
372 certificate, or registration.—
373 (1) Medicaid fraud in the practice of a health care
374 profession is prohibited.
375 (2) Each board within the jurisdiction of the department,
376 or the department if there is no board, shall refuse to admit a
377 candidate to any examination and refuse to issue or renew a
378 license, certificate, or registration to any applicant if the
379 candidate or applicant or any principle, officer, agent,
380 managing employee, or affiliated person of the applicant, has
381 been:
382 (a) Convicted of, or entered a plea of guilty or nolo
383 contendere to, regardless of adjudication, a felony under
384 chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or
385 42 U.S.C. ss. 1395-1396, unless the sentence and any subsequent
386 period of probation for such conviction or pleas ended more than
387 fifteen years prior to the date of the application;
388 (b) Terminated for cause from the Florida Medicaid program

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389 pursuant to s. 409.913, unless the applicant has been in good
390 standing with the Florida Medicaid program for the most recent
391 five years;
392 (c) Terminated for cause, pursuant to the appeals
393 procedures established by the state or Federal Government, from
394 any other state Medicaid program or the federal Medicare
395 program, unless the applicant has been in good standing with a
396 state Medicaid program or the federal Medicare program for the
397 most recent five years and the termination occurred at least 20
398 years prior to the date of the application.
399 (3) Licensed health care practitioners shall report
400 allegations of Medicaid fraud to the department, regardless of
401 the practice setting in which the alleged Medicaid fraud
402 occurred.
403 (4) The acceptance by a licensing authority of a
404 candidate’s relinquishment of a license which is offered in
405 response to or anticipation of the filing of administrative
406 charges alleging Medicaid fraud or similar charges constitutes
407 the permanent revocation of the license.
408 Section 20. Paragraphs (ii), (jj), (kk), and (ll) are added
409 to subsection (1) of section 456.072, Florida Statutes, to read:
410 456.072 Grounds for discipline; penalties; enforcement.—
411 (1) The following acts shall constitute grounds for which
412 the disciplinary actions specified in subsection (2) may be
413 taken:
414 (ii) Being convicted of, or entering a plea of guilty or
415 nolo contendere to, any misdemeanor or felony, regardless of
416 adjudication, under 18 U.S.C. s. 669, ss. 285-287, s. 371, s.
417 1001, s. 1035, s. 1341, s. 1343, s. 1347, s. 1349, or s. 1518,

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418 or 42 U.S.C. ss. 1320a-7b, relating to the Medicaid program.
419 (jj) Failing to remit the sum owed to the state for an
420 overpayment from the Medicaid program pursuant to a final order,
421 judgment, or stipulation or settlement.
422 (kk) Being terminated from the state Medicaid program
423 pursuant to s. 409.913, any other state Medicaid program, or the
424 federal Medicare program, unless eligibility to participate in
425 the program from which the practitioner was terminated has been
426 restored.
427 (ll) Being convicted of, or entering a plea of guilty or
428 nolo contendere to, any misdemeanor or felony, regardless of
429 adjudication, a crime in any jurisdiction which relates to
430 health care fraud.
431 Section 21. Subsection (1) of section 456.074, Florida
432 Statutes, is amended to read:
433 456.074 Certain health care practitioners; immediate
434 suspension of license.—
435 (1) The department shall issue an emergency order
436 suspending the license of any person licensed under chapter 458,
437 chapter 459, chapter 460, chapter 461, chapter 462, chapter 463,
438 chapter 464, chapter 465, chapter 466, or chapter 484 who pleads
439 guilty to, is convicted or found guilty of, or who enters a plea
440 of nolo contendere to, regardless of adjudication, to:
441 (a) A felony under chapter 409, chapter 817, or chapter 893
442 or under 21 U.S.C. ss. 801-970 or under 42 U.S.C. ss. 1395-1396;
443 or.
444 (b) A misdemeanor or felony under 18 U.S.C. s. 669, ss.
445 285-287, s. 371, s. 1001, s. 1035, s. 1341, s. 1343, s. 1347, s.
446 1349, or s. 1518 or 42 U.S.C. ss. 1320a-7b, relating to the

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447 Medicaid program.
448 Section 22. Subsections (2) and (3) of section 465.022,
449 Florida Statutes, are amended, present subsections (4), (5),
450 (6), and (7) of that section are renumbered as subsections (5),
451 (6), (7), and (8), respectively, and a new subsection (4) is
452 added to that section, to read:
453 465.022 Pharmacies; general requirements; fees.—
454 (2) A pharmacy permit shall be issued only to a person who
455 is at least 18 years of age, a partnership whose partners are
456 all at least 18 years of age, or to a corporation that ~~which~~ is
457 registered pursuant to chapter 607 or chapter 617 whose
458 officers, directors, and shareholders are at least 18 years of
459 age.
460 (3) Any person, partnership, or corporation before engaging
461 in the operation of a pharmacy shall file with the board a sworn
462 application on forms provided by the department.
463 (a) An application for a pharmacy permit must include a set
464 of fingerprints from each person having an ownership interest of
465 5 percent or greater and from any person who, directly or
466 indirectly, manages, oversees, or controls the operation of the
467 applicant, including officers and members of the board of
468 directors of an applicant that is a corporation. The applicant
469 must provide payment in the application for the cost of state
470 and national criminal history records checks.
471 1. For corporations having more than $100 million of
472 business taxable assets in this state, in lieu of these
473 fingerprint requirements, the department shall require the
474 prescription department manager who will be directly involved in
475 the management and operation of the pharmacy to submit a set of

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476 fingerprints.
477 2. A representative of a corporation described in
478 subparagraph 1. satisfies the requirement to submit a set of his
479 or her fingerprints if the fingerprints are on file with the
480 department or the Agency for Health Care Administration, meet
481 the fingerprint specifications for submission by the Department
482 of Law Enforcement, and are available to the department.
483 (b) The department shall submit the fingerprints provided
484 by the applicant to the Department of Law Enforcement for a
485 state criminal history records check. The Department of Law
486 Enforcement shall forward the fingerprints to the Federal Bureau
487 of Investigation for a national criminal history records check.
488 (4) The department or board shall deny an application for a
489 pharmacy permit if the applicant or an affiliated person,
490 partner, officer, director, or prescription department manager
491 of the applicant has:
492 (a) Obtained a permit by misrepresentation or fraud;
493 (b) Attempted to procure, or has procured, a permit for any
494 other person by making, or causing to be made, any false
495 representation;
496 (c) Been convicted of, or entered a plea of guilty or nolo
497 contendere to, regardless of adjudication, a crime in any
498 jurisdiction which relates to the practice of, or the ability to
499 practice, the profession of pharmacy;
500 (d) Been convicted of, or entered a plea of guilty or nolo
501 contendere to, regardless of adjudication, a crime in any
502 jurisdiction which relates to health care fraud;
503 (e) Been terminated for cause, pursuant to the appeals
504 procedures established by the state or Federal Government, from

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505 any state Medicaid program or the federal Medicare program,
506 unless the applicant has been in good standing with a state
507 Medicaid program or the federal Medicare program for the most
508 recent five years and the termination occurred at least 20 years
509 ago; or
510
511 ====== D I R E C T O R Y C L A U S E A M E N D M E N T ======
512 And the directory clause is amended as follows:
513 Delete line 832
514 and insert:
515 (24), (25), (27), (30), (31), and (36) of section
516
517 ================= T I T L E A M E N D M E N T ================
518 And the title is amended as follows:
519 Delete lines 76 - 106
520 and insert:
521 affiliated persons; requiring that the agency provide notice of
522 certain administrative sanctions to other regulatory agencies
523 within a specified period; requiring the Agency for Health Care
524 Administration to withhold or deny Medicaid payments under
525 certain circumstances; requiring the agency to terminate a
526 provider’s participation in the Medicaid program if the provider
527 fails to repay certain overpayments from the Medicaid program;
528 requiring the agency to provide at least annually information on
529 Medicaid fraud in an explanation of benefits letter; requiring
530 the Agency for Health Care Administration to post a list on its
531 website of Medicaid providers and affiliated persons of
532 providers who have been terminated or sanctioned; requiring the
533 agency to take certain actions to improve the prevention and

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534 detection of health care fraud through the use of technology;
535 amending s. 409.920, F.S.; defining the term “managed care
536 organization”; providing criminal penalties and fines for
537 Medicaid fraud; granting civil immunity to certain persons who
538 report suspected Medicaid fraud; creating s. 409.9203, F.S.;
539 authorizing the payment of rewards to persons who report and
540 provide information relating to Medicaid fraud; amending s.
541 456.004, F.S.; amending s. 456.053, F.S.; excluding referrals to
542 a sleep care provider for sleep related testing to the
543 definition of a referral; requiring the