By the Committee on Health, Aging, and Long-Term Care; and Senators Saunders, Aronberg and Fasano

317-1972-04

A bill to be entitled

An act relating to Medicaid; amending s. 16.56, F.S.; adding criminal violations of s. 409.920 or s. 409.9201, F.S., to the list of specified crimes within the jurisdiction of the Office of Statewide Prosecution; amending s. 400.408, F.S.; including the Medicaid Fraud Control Unit of the Department of Legal Affairs in the Agency for Health Care Administration's local coordinating workgroups for identifying unlicensed assisted living facilities; amending s. 400.434, F.S.; giving the Medicaid Fraud Control Unit of the Department of Legal Affairs the authority to enter and inspect facilities licensed under part III of ch. 400, F.S.; amending s. 409.912, F.S.; giving the Agency for Health Care Administration the authority to require a confirmation or second physician's opinion of the correct diagnosis before authorizing payment for medical treatment; authorizing the Agency for Health Care Administration to impose mandatory enrollment in drug-therapy-management or disease-management programs for certain categories of recipients; requiring that the Agency for Health Care Administration and the Drug Utilization Review Board consult with the Department of Health; allowing termination of certain practitioners from the Medicaid program; providing that Medicaid recipients may be mandated to participate in a provider

lock-in program; amending s. 409.913, F.S.; providing specified conditions for providers to meet in order to submit claims to the Medicaid program; providing that claims may be denied if not properly submitted; providing that the agency may seek any remedy under law if a provider submits specified false or erroneous claims; providing that suspension or termination precludes participation in the Medicaid program; providing that the agency is required to report administrative sanctions to licensing authorities for certain violations; providing that the agency may withhold payment to a provider under certain circumstances; providing that the agency may deny payments to terminated or suspended providers; authorizing the agency to implement amnesty programs for providers to voluntarily repay overpayments; authorizing the agency to adopt rules; providing for limiting, restricting, or suspending Medicaid eligibility of Medicaid recipients convicted of certain crimes or offenses; authorizing the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs to review non-Medicaid-related records in order to determine reconciliation of a provider's records; authorizing the agency head or designee to limit, restrict, or suspend Medicaid eligibility for a period not to exceed 1 year if a recipient is convicted of a federal health care crime; authorizing the Agency for

Health Care Administration to limit the number of certain types of prescription claims submitted by pharmacy providers; requiring the agency to limit the allowable amount of certain types of prescriptions under specified circumstances; amending s. 409.9131, F.S.; redefining the term "peer review"; providing for peer review for purposes of determining a potential overpayment if the medical necessity or quality of care is evaluated; requiring an additional statement on Medicaid cost reports certifying that Medicaid providers are familiar with the laws and regulations regarding the provision of health care services under the Medicaid program; amending s. 409.920, F.S.; redefining the term "knowingly" to include "willfully" or "willful"; making it unlawful to knowingly use or endeavor to use a Medicaid provider's or a Medicaid recipient's identification number or cause to be made, or aid and abet in the making of, a claim for items or services that are not authorized to be reimbursed under the Medicaid program; defining the term "paid for"; expanding the authority of the Attorney General to examine patient records; creating s. 409.9201, F.S.; providing definitions; providing that a person who knowingly sells or attempts to sell legend drugs obtained through the Medicaid program commits a felony; providing that a person who knowingly purchases or attempts to purchase

legend drugs obtained through the Medicaid program and intended for the use of another commits a felony; providing that a person who knowingly makes or conspires to make false representations for the purpose of obtaining goods or services from the Medicaid program commits a felony; providing specified criminal penalties depending on the value of the legend drugs or goods or services obtained from the Medicaid program; amending s. 456.072, F.S.; providing an additional ground under which a health care practitioner who prescribes medicinal drugs or controlled substances may be subject to discipline by the Department of Health or the appropriate board having jurisdiction over the health care practitioner; authorizing the Department of Health to initiate a disciplinary investigation of prescribing practitioners under specified circumstances; amending s. 465.188, F.S.; deleting the requirement that the Agency for Health Care Administration give pharmacists at least 1 week's notice prior to an audit; specifying an effective date for certain audit criteria; creating s. 812.0191, F.S.; providing definitions; providing that a person who traffics in property paid for in whole or in part by the Medicaid program, or who knowingly finances, directs, or traffics in such property, commits a felony; providing specified criminal penalties depending on the value of

the property; amending s. 895.02, F.S.; adding Medicaid recipient fraud to the definition of the term "racketeering activity"; amending s. 905.34, F.S.; adding any criminal violation of s. 409.920 or s. 409.9201, F.S., to the list of crimes within the jurisdiction of the statewide grand jury; amending s. 932.701, F.S.; expanding the definition of "contraband article"; amending s. 932.7055, F.S.; requiring that proceeds collected under the Florida Contraband Forfeiture Act be deposited in the Agency for Health Care Administration's Grants and Donations Trust Fund; providing an effective date.

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

Section 1. Subsection (1) of section 16.56, Florida Statutes, is amended to read:

16.56 Office of Statewide Prosecution.--

(1) There is created in the Department of Legal Affairs an Office of Statewide Prosecution. The office shall be a separate "budget entity" as that term is defined in chapter 216. The office may:

(a) Investigate and prosecute the offenses of:

1. Bribery, burglary, criminal usury, extortion, gambling, kidnapping, larceny, murder, prostitution, perjury, robbery, carjacking, and home-invasion robbery;

2. Any crime involving narcotic or other dangerous drugs;

3. Any violation of the provisions of the Florida RICO (Racketeer Influenced and Corrupt Organization) Act, including any offense listed in the definition of racketeering activity in s. 895.02(1)(a), providing such listed offense is investigated in connection with a violation of s. 895.03 and is charged in a separate count of an information or indictment containing a count charging a violation of s. 895.03, the prosecution of which listed offense may continue independently if the prosecution of the violation of s. 895.03 is terminated for any reason;

4. Any violation of the provisions of the Florida Anti-Fencing Act;

5. Any violation of the provisions of the Florida Antitrust Act of 1980, as amended;

6. Any crime involving, or resulting in, fraud or deceit upon any person;

7. Any violation of s. 847.0135, relating to computer pornography and child exploitation prevention, or any offense related to a violation of s. 847.0135;

8. Any violation of the provisions of chapter 815; ~~or~~

9. Any criminal violation of part I of chapter 499; or

10. Any criminal violation of s. 409.920 or s. 409.9201.

or any attempt, solicitation, or conspiracy to commit any of the crimes specifically enumerated above. The office shall have such power only when any such offense is occurring, or has occurred, in two or more judicial circuits as part of a related transaction, or when any such offense is connected with an organized criminal conspiracy affecting two or more judicial circuits.

(b) Upon request, cooperate with and assist state attorneys and state and local law enforcement officials in their efforts against organized crimes.

(c) Request and receive from any department, division, board, bureau, commission, or other agency of the state, or of any political subdivision thereof, cooperation and assistance in the performance of its duties.

Section 2. Paragraph (i) of subsection (1) of section 400.408, Florida Statutes, is amended to read:

400.408 Unlicensed facilities; referral of person for residency to unlicensed facility; penalties; verification of licensure status.--

(1)

(i) Each field office of the Agency for Health Care Administration shall establish a local coordinating workgroup which includes representatives of local law enforcement agencies, state attorneys, the Medicaid Fraud Control Unit of the Department of Legal Affairs, local fire authorities, the Department of Children and Family Services, the district long-term care ombudsman council, and the district human rights advocacy committee to assist in identifying the operation of unlicensed facilities and to develop and implement a plan to ensure effective enforcement of state laws relating to such facilities. The workgroup shall report its findings, actions, and recommendations semiannually to the Director of Health Facility Regulation of the agency.

Section 3. Section 400.434, Florida Statutes, is amended to read:

400.434 Right of entry and inspection.--Any duly designated officer or employee of the department, the Department of Children and Family Services, the agency, the

Medicaid Fraud Control Unit of the Department of Legal Affairs, the state or local fire marshal, or a member of the state or local long-term care ombudsman council shall have the right to enter unannounced upon and into the premises of any facility licensed pursuant to this part in order to determine the state of compliance with the provisions of this part and of rules or standards in force pursuant thereto. The right of entry and inspection shall also extend to any premises which the agency has reason to believe is being operated or maintained as a facility without a license; but no such entry or inspection of any premises may be made without the permission of the owner or person in charge thereof, unless a warrant is first obtained from the circuit court authorizing such entry. The warrant requirement shall extend only to a facility which the agency has reason to believe is being operated or maintained as a facility without a license. Any application for a license or renewal thereof made pursuant to this part shall constitute permission for, and complete acquiescence in, any entry or inspection of the premises for which the license is sought, in order to facilitate verification of the information submitted on or in connection with the application; to discover, investigate, and determine the existence of abuse or neglect; or to elicit, receive, respond to, and resolve complaints. Any current valid license shall constitute unconditional permission for, and complete acquiescence in, any entry or inspection of the premises by authorized personnel. The agency shall retain the right of entry and inspection of facilities that have had a license revoked or suspended within the previous 24 months, to ensure that the facility is not operating unlawfully. However, before entering the facility, a statement of probable cause must be

filed with the director of the agency, who must approve or disapprove the action within 48 hours. Probable cause shall include, but is not limited to, evidence that the facility holds itself out to the public as a provider of personal care services or the receipt of a complaint by the long-term care ombudsman council about the facility. Data collected by the state or local long-term care ombudsman councils or the state or local advocacy councils may be used by the agency in investigations involving violations of regulatory standards.

Section 4. Section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis before authorizing payment for medical treatment. Such confirmation or second opinion shall be rendered in a manner approved by the agency.The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency may mandate ~~establish~~ prior authorization, drug therapy management, or disease management participation ~~requirements~~

for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization.

(1) The agency shall work with the Department of Children and Family Services to ensure access of children and families in the child protection system to needed and appropriate mental health and substance abuse services.

(2) The agency may enter into agreements with appropriate agents of other state agencies or of any agency of the Federal Government and accept such duties in respect to social welfare or public aid as may be necessary to implement the provisions of Title XIX of the Social Security Act and ss. 409.901-409.920.

(3) The agency may contract with health maintenance organizations certified pursuant to part I of chapter 641 for the provision of services to recipients.

(4) The agency may contract with:

(a) An entity that provides no prepaid health care services other than Medicaid services under contract with the agency and which is owned and operated by a county, county health department, or county-owned and operated hospital to provide health care services on a prepaid or fixed-sum basis to recipients, which entity may provide such prepaid services either directly or through arrangements with other providers. Such prepaid health care services entities must be licensed under parts I and III by January 1, 1998, and until then are

exempt from the provisions of part I of chapter 641. An entity recognized under this paragraph which demonstrates to the satisfaction of the Office of Insurance Regulation of the Financial Services Commission that it is backed by the full faith and credit of the county in which it is located may be exempted from s. 641.225.

(b) An entity that is providing comprehensive behavioral health care services to certain Medicaid recipients through a capitated, prepaid arrangement pursuant to the federal waiver provided for by s. 409.905(5). Such an entity must be licensed under chapter 624, chapter 636, or chapter 641 and must possess the clinical systems and operational competence to manage risk and provide comprehensive behavioral health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. The secretary of the Department of Children and Family Services shall approve provisions of procurements related to children in the department's care or custody prior to enrolling such children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. The agency shall seek federal approval to contract with a single entity meeting these requirements to provide comprehensive behavioral health care services to all Medicaid recipients in an AHCA area. Each

entity must offer sufficient choice of providers in its network to ensure recipient access to care and the opportunity to select a provider with whom they are satisfied. The network shall include all public mental health hospitals. To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph shall require 80 percent of the capitation paid to the managed care plan, including health maintenance organizations, to be expended for the provision of behavioral health care services. In the event the managed care plan expends less than 80 percent of the capitation paid pursuant to this paragraph for the provision of behavioral health care services, the difference shall be returned to the agency. The agency shall provide the managed care plan with a certification letter indicating the amount of capitation paid during each calendar year for the provision of behavioral health care services pursuant to this section. The agency may reimburse for substance abuse treatment services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.

1. By January 1, 2001, the agency shall modify the contracts with the entities providing comprehensive inpatient and outpatient mental health care services to Medicaid recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk Counties, to include substance abuse treatment services.

2. By July 1, 2003, the agency and the Department of Children and Family Services shall execute a written agreement that requires collaboration and joint development of all policy, budgets, procurement documents, contracts, and monitoring plans that have an impact on the state and Medicaid community mental health and targeted case management programs.

3. By July 1, 2006, the agency and the Department of Children and Family Services shall contract with managed care entities in each AHCA area except area 6 or arrange to provide comprehensive inpatient and outpatient mental health and substance abuse services through capitated prepaid arrangements to all Medicaid recipients who are eligible to participate in such plans under federal law and regulation. In AHCA areas where eligible individuals number less than 150,000, the agency shall contract with a single managed care plan. The agency may contract with more than one plan in AHCA areas where the eligible population exceeds 150,000. Contracts awarded pursuant to this section shall be competitively procured. Both for-profit and not-for-profit corporations shall be eligible to compete.

4. By October 1, 2003, the agency and the department shall submit a plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives which provides for the full implementation of capitated prepaid behavioral health care in all areas of the state. The plan shall include provisions which ensure that children and families receiving foster care and other related services are appropriately served and that these services assist the community-based care lead agencies in meeting the goals and outcomes of the child welfare system. The plan will be developed with the participation of community-based lead agencies, community alliances, sheriffs, and community providers serving dependent children.

a. Implementation shall begin in 2003 in those AHCA areas of the state where the agency is able to establish sufficient capitation rates.

b. If the agency determines that the proposed capitation rate in any area is insufficient to provide appropriate services, the agency may adjust the capitation rate to ensure that care will be available. The agency and the department may use existing general revenue to address any additional required match but may not over-obligate existing funds on an annualized basis.

c. Subject to any limitations provided for in the General Appropriations Act, the agency, in compliance with appropriate federal authorization, shall develop policies and procedures that allow for certification of local and state funds.

5. Children residing in a statewide inpatient psychiatric program, or in a Department of Juvenile Justice or a Department of Children and Family Services residential program approved as a Medicaid behavioral health overlay services provider shall not be included in a behavioral health care prepaid health plan pursuant to this paragraph.

6. In converting to a prepaid system of delivery, the agency shall in its procurement document require an entity providing comprehensive behavioral health care services to prevent the displacement of indigent care patients by enrollees in the Medicaid prepaid health plan providing behavioral health care services from facilities receiving state funding to provide indigent behavioral health care, to facilities licensed under chapter 395 which do not receive state funding for indigent behavioral health care, or reimburse the unsubsidized facility for the cost of behavioral health care provided to the displaced indigent care patient.

7. Traditional community mental health providers under contract with the Department of Children and Family Services

pursuant to part IV of chapter 394, child welfare providers under contract with the Department of Children and Family Services, and inpatient mental health providers licensed pursuant to chapter 395 must be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid behavioral health services.

(c) A federally qualified health center or an entity owned by one or more federally qualified health centers or an entity owned by other migrant and community health centers receiving non-Medicaid financial support from the Federal Government to provide health care services on a prepaid or fixed-sum basis to recipients. Such prepaid health care services entity must be licensed under parts I and III of chapter 641, but shall be prohibited from serving Medicaid recipients on a prepaid basis, until such licensure has been obtained. However, such an entity is exempt from s. 641.225 if the entity meets the requirements specified in subsections (15) and (16).

(d) A provider service network may be reimbursed on a fee-for-service or prepaid basis. A provider service network which is reimbursed by the agency on a prepaid basis shall be exempt from parts I and III of chapter 641, but must meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency. The agency shall award contracts on a competitive bid basis and shall select bidders based upon price and quality of care. Medicaid recipients assigned to a demonstration project shall be chosen equally from those who would otherwise have been assigned to prepaid plans and MediPass. The agency is authorized to seek federal Medicaid waivers as necessary to implement the provisions of this section.

(e) An entity that provides comprehensive behavioral health care services to certain Medicaid recipients through an administrative services organization agreement. Such an entity must possess the clinical systems and operational competence to provide comprehensive health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. Any contract awarded under this paragraph must be competitively procured. The agency must ensure that Medicaid recipients have available the choice of at least two managed care plans for their behavioral health care services.

(f) An entity that provides in-home physician services to test the cost-effectiveness of enhanced home-based medical care to Medicaid recipients with degenerative neurological diseases and other diseases or disabling conditions associated with high costs to Medicaid. The program shall be designed to serve very disabled persons and to reduce Medicaid reimbursed costs for inpatient, outpatient, and emergency department services. The agency shall contract with vendors on a risk-sharing basis.

(g) Children's provider networks that provide care coordination and care management for Medicaid-eligible pediatric patients, primary care, authorization of specialty care, and other urgent and emergency care through organized providers designed to service Medicaid eligibles under age 18 and pediatric emergency departments' diversion programs. The networks shall provide after-hour operations, including evening and weekend hours, to promote, when appropriate, the use of the children's networks rather than hospital emergency departments.

(h) An entity authorized in s. 430.205 to contract with the agency and the Department of Elderly Affairs to provide health care and social services on a prepaid or fixed-sum basis to elderly recipients. Such prepaid health care services entities are exempt from the provisions of part I of chapter 641 for the first 3 years of operation. An entity recognized under this paragraph that demonstrates to the satisfaction of the Office of Insurance Regulation that it is backed by the full faith and credit of one or more counties in which it operates may be exempted from s. 641.225.

(i) A Children's Medical Services network, as defined in s. 391.021.

(5) By October 1, 2003, the agency and the department shall, to the extent feasible, develop a plan for implementing new Medicaid procedure codes for emergency and crisis care, supportive residential services, and other services designed to maximize the use of Medicaid funds for Medicaid-eligible recipients. The agency shall include in the agreement developed pursuant to subsection (4) a provision that ensures that the match requirements for these new procedure codes are met by certifying eligible general revenue or local funds that are currently expended on these services by the department with contracted alcohol, drug abuse, and mental health providers. The plan must describe specific procedure codes to be implemented, a projection of the number of procedures to be delivered during fiscal year 2003-2004, and a financial analysis that describes the certified match procedures, and accountability mechanisms, projects the earnings associated with these procedures, and describes the sources of state match. This plan may not be implemented in any part until approved by the Legislative Budget Commission. If such

approval has not occurred by December 31, 2003, the plan shall be submitted for consideration by the 2004 Legislature.

(6) The agency may contract with any public or private entity otherwise authorized by this section on a prepaid or fixed-sum basis for the provision of health care services to recipients. An entity may provide prepaid services to recipients, either directly or through arrangements with other entities, if each entity involved in providing services:

(a) Is organized primarily for the purpose of providing health care or other services of the type regularly offered to Medicaid recipients;

(b) Ensures that services meet the standards set by the agency for quality, appropriateness, and timeliness;

(c) Makes provisions satisfactory to the agency for insolvency protection and ensures that neither enrolled Medicaid recipients nor the agency will be liable for the debts of the entity;

(d) Submits to the agency, if a private entity, a financial plan that the agency finds to be fiscally sound and that provides for working capital in the form of cash or equivalent liquid assets excluding revenues from Medicaid premium payments equal to at least the first 3 months of operating expenses or $200,000, whichever is greater;

(e) Furnishes evidence satisfactory to the agency of adequate liability insurance coverage or an adequate plan of self-insurance to respond to claims for injuries arising out of the furnishing of health care;

(f) Provides, through contract or otherwise, for periodic review of its medical facilities and services, as required by the agency; and

(g) Provides organizational, operational, financial, and other information required by the agency.

(7) The agency may contract on a prepaid or fixed-sum basis with any health insurer that:

(a) Pays for health care services provided to enrolled Medicaid recipients in exchange for a premium payment paid by the agency;

(b) Assumes the underwriting risk; and

(c) Is organized and licensed under applicable provisions of the Florida Insurance Code and is currently in good standing with the Office of Insurance Regulation.

(8) The agency may contract on a prepaid or fixed-sum basis with an exclusive provider organization to provide health care services to Medicaid recipients provided that the exclusive provider organization meets applicable managed care plan requirements in this section, ss. 409.9122, 409.9123, 409.9128, and 627.6472, and other applicable provisions of law.

(9) The Agency for Health Care Administration may provide cost-effective purchasing of chiropractic services on a fee-for-service basis to Medicaid recipients through arrangements with a statewide chiropractic preferred provider organization incorporated in this state as a not-for-profit corporation. The agency shall ensure that the benefit limits and prior authorization requirements in the current Medicaid program shall apply to the services provided by the chiropractic preferred provider organization.

(10) The agency shall not contract on a prepaid or fixed-sum basis for Medicaid services with an entity which knows or reasonably should know that any officer, director, agent, managing employee, or owner of stock or beneficial

interest in excess of 5 percent common or preferred stock, or the entity itself, has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty, to:

(a) Fraud;

(b) Violation of federal or state antitrust statutes, including those proscribing price fixing between competitors and the allocation of customers among competitors;

(c) Commission of a felony involving embezzlement, theft, forgery, income tax evasion, bribery, falsification or destruction of records, making false statements, receiving stolen property, making false claims, or obstruction of justice; or

(d) Any crime in any jurisdiction which directly relates to the provision of health services on a prepaid or fixed-sum basis.

(11) The agency, after notifying the Legislature, may apply for waivers of applicable federal laws and regulations as necessary to implement more appropriate systems of health care for Medicaid recipients and reduce the cost of the Medicaid program to the state and federal governments and shall implement such programs, after legislative approval, within a reasonable period of time after federal approval. These programs must be designed primarily to reduce the need for inpatient care, custodial care and other long-term or institutional care, and other high-cost services.

(a) Prior to seeking legislative approval of such a waiver as authorized by this subsection, the agency shall provide notice and an opportunity for public comment. Notice shall be provided to all persons who have made requests of the agency for advance notice and shall be published in the

Florida Administrative Weekly not less than 28 days prior to the intended action.

(b) Notwithstanding s. 216.292, funds that are appropriated to the Department of Elderly Affairs for the Assisted Living for the Elderly Medicaid waiver and are not expended shall be transferred to the agency to fund Medicaid-reimbursed nursing home care.

(12) The agency shall establish a postpayment utilization control program designed to identify recipients who may inappropriately overuse or underuse Medicaid services and shall provide methods to correct such misuse.

(13) The agency shall develop and provide coordinated systems of care for Medicaid recipients and may contract with public or private entities to develop and administer such systems of care among public and private health care providers in a given geographic area.

(14) The agency shall operate or contract for the operation of utilization management and incentive systems designed to encourage cost-effective use services.

(15)(a) The agency shall operate the Comprehensive Assessment and Review (CARES) nursing facility preadmission screening program to ensure that Medicaid payment for nursing facility care is made only for individuals whose conditions require such care and to ensure that long-term care services are provided in the setting most appropriate to the needs of the person and in the most economical manner possible. The CARES program shall also ensure that individuals participating in Medicaid home and community-based waiver programs meet criteria for those programs, consistent with approved federal waivers.

(b) The agency shall operate the CARES program through an interagency agreement with the Department of Elderly Affairs.

(c) Prior to making payment for nursing facility services for a Medicaid recipient, the agency must verify that the nursing facility preadmission screening program has determined that the individual requires nursing facility care and that the individual cannot be safely served in community-based programs. The nursing facility preadmission screening program shall refer a Medicaid recipient to a community-based program if the individual could be safely served at a lower cost and the recipient chooses to participate in such program.

(d) By January 1 of each year, the agency shall submit a report to the Legislature and the Office of Long-Term-Care Policy describing the operations of the CARES program. The report must describe:

1. Rate of diversion to community alternative programs;

2. CARES program staffing needs to achieve additional diversions;

3. Reasons the program is unable to place individuals in less restrictive settings when such individuals desired such services and could have been served in such settings;

4. Barriers to appropriate placement, including barriers due to policies or operations of other agencies or state-funded programs; and

5. Statutory changes necessary to ensure that individuals in need of long-term care services receive care in the least restrictive environment.

(16)(a) The agency shall identify health care utilization and price patterns within the Medicaid program which are not cost-effective or medically appropriate and assess the effectiveness of new or alternate methods of providing and monitoring service, and may implement such methods as it considers appropriate. Such methods may include disease management initiatives, an integrated and systematic approach for managing the health care needs of recipients who are at risk of or diagnosed with a specific disease by using best practices, prevention strategies, clinical-practice improvement, clinical interventions and protocols, outcomes research, information technology, and other tools and resources to reduce overall costs and improve measurable outcomes.

(b) The responsibility of the agency under this subsection shall include the development of capabilities to identify actual and optimal practice patterns; patient and provider educational initiatives; methods for determining patient compliance with prescribed treatments; fraud, waste, and abuse prevention and detection programs; and beneficiary case management programs.

1. The practice pattern identification program shall evaluate practitioner prescribing patterns based on national and regional practice guidelines, comparing practitioners to their peer groups. The agency and its Drug Utilization Review Board shall consult with <u>the Department of Health and</u> a panel of practicing health care professionals consisting of the following: the Speaker of the House of Representatives and the President of the Senate shall each appoint three physicians licensed under chapter 458 or chapter 459; and the Governor shall appoint two pharmacists licensed under chapter 465 and

one dentist licensed under chapter 466 who is an oral surgeon. Terms of the panel members shall expire at the discretion of the appointing official. The panel shall begin its work by August 1, 1999, regardless of the number of appointments made by that date. The advisory panel shall be responsible for evaluating treatment guidelines and recommending ways to incorporate their use in the practice pattern identification program. Practitioners who are prescribing inappropriately or inefficiently, as determined by the agency, may have their prescribing of certain drugs subject to prior authorization or may be terminated from all participation in the Medicaid program.

2. The agency shall also develop educational interventions designed to promote the proper use of medications by providers and beneficiaries.

3. The agency shall implement a pharmacy fraud, waste, and abuse initiative that may include a surety bond or letter of credit requirement for participating pharmacies, enhanced provider auditing practices, the use of additional fraud and abuse software, recipient management programs for beneficiaries inappropriately using their benefits, and other steps that will eliminate provider and recipient fraud, waste, and abuse. The initiative shall address enforcement efforts to reduce the number and use of counterfeit prescriptions.

4. By September 30, 2002, the agency shall contract with an entity in the state to implement a wireless handheld clinical pharmacology drug information database for practitioners. The initiative shall be designed to enhance the agency's efforts to reduce fraud, abuse, and errors in the prescription drug benefit program and to otherwise further the intent of this paragraph.

5. The agency may apply for any federal waivers needed to implement this paragraph.

(17) An entity contracting on a prepaid or fixed-sum basis shall, in addition to meeting any applicable statutory surplus requirements, also maintain at all times in the form of cash, investments that mature in less than 180 days allowable as admitted assets by the Office of Insurance Regulation, and restricted funds or deposits controlled by the agency or the Office of Insurance Regulation, a surplus amount equal to one-and-one-half times the entity's monthly Medicaid prepaid revenues. As used in this subsection, the term "surplus" means the entity's total assets minus total liabilities. If an entity's surplus falls below an amount equal to one-and-one-half times the entity's monthly Medicaid prepaid revenues, the agency shall prohibit the entity from engaging in marketing and preenrollment activities, shall cease to process new enrollments, and shall not renew the entity's contract until the required balance is achieved. The requirements of this subsection do not apply:

(a) Where a public entity agrees to fund any deficit incurred by the contracting entity; or

(b) Where the entity's performance and obligations are guaranteed in writing by a guaranteeing organization which:

1. Has been in operation for at least 5 years and has assets in excess of $50 million; or

2. Submits a written guarantee acceptable to the agency which is irrevocable during the term of the contracting entity's contract with the agency and, upon termination of the contract, until the agency receives proof of satisfaction of all outstanding obligations incurred under the contract.

(18)(a) The agency may require an entity contracting on a prepaid or fixed-sum basis to establish a restricted insolvency protection account with a federally guaranteed financial institution licensed to do business in this state. The entity shall deposit into that account 5 percent of the capitation payments made by the agency each month until a maximum total of 2 percent of the total current contract amount is reached. The restricted insolvency protection account may be drawn upon with the authorized signatures of two persons designated by the entity and two representatives of the agency. If the agency finds that the entity is insolvent, the agency may draw upon the account solely with the two authorized signatures of representatives of the agency, and the funds may be disbursed to meet financial obligations incurred by the entity under the prepaid contract. If the contract is terminated, expired, or not continued, the account balance must be released by the agency to the entity upon receipt of proof of satisfaction of all outstanding obligations incurred under this contract.

(b) The agency may waive the insolvency protection account requirement in writing when evidence is on file with the agency of adequate insolvency insurance and reinsurance that will protect enrollees if the entity becomes unable to meet its obligations.

(19) An entity that contracts with the agency on a prepaid or fixed-sum basis for the provision of Medicaid services shall reimburse any hospital or physician that is outside the entity's authorized geographic service area as specified in its contract with the agency, and that provides services authorized by the entity to its members, at a rate

negotiated with the hospital or physician for the provision of services or according to the lesser of the following:

(a) The usual and customary charges made to the general public by the hospital or physician; or

(b) The Florida Medicaid reimbursement rate established for the hospital or physician.

(20) When a merger or acquisition of a Medicaid prepaid contractor has been approved by the Office of Insurance Regulation pursuant to s. 628.4615, the agency shall approve the assignment or transfer of the appropriate Medicaid prepaid contract upon request of the surviving entity of the merger or acquisition if the contractor and the other entity have been in good standing with the agency for the most recent 12-month period, unless the agency determines that the assignment or transfer would be detrimental to the Medicaid recipients or the Medicaid program. To be in good standing, an entity must not have failed accreditation or committed any material violation of the requirements of s. 641.52 and must meet the Medicaid contract requirements. For purposes of this section, a merger or acquisition means a change in controlling interest of an entity, including an asset or stock purchase.

(21) Any entity contracting with the agency pursuant to this section to provide health care services to Medicaid recipients is prohibited from engaging in any of the following practices or activities:

(a) Practices that are discriminatory, including, but not limited to, attempts to discourage participation on the basis of actual or perceived health status.

(b) Activities that could mislead or confuse recipients, or misrepresent the organization, its marketing

representatives, or the agency. Violations of this paragraph include, but are not limited to:

1. False or misleading claims that marketing representatives are employees or representatives of the state or county, or of anyone other than the entity or the organization by whom they are reimbursed.

2. False or misleading claims that the entity is recommended or endorsed by any state or county agency, or by any other organization which has not certified its endorsement in writing to the entity.

3. False or misleading claims that the state or county recommends that a Medicaid recipient enroll with an entity.

4. Claims that a Medicaid recipient will lose benefits under the Medicaid program, or any other health or welfare benefits to which the recipient is legally entitled, if the recipient does not enroll with the entity.

(c) Granting or offering of any monetary or other valuable consideration for enrollment, except as authorized by subsection (22).

(d) Door-to-door solicitation of recipients who have not contacted the entity or who have not invited the entity to make a presentation.

(e) Solicitation of Medicaid recipients by marketing representatives stationed in state offices unless approved and supervised by the agency or its agent and approved by the affected state agency when solicitation occurs in an office of the state agency. The agency shall ensure that marketing representatives stationed in state offices shall market their managed care plans to Medicaid recipients only in designated areas and in such a way as to not interfere with the recipients' activities in the state office.

(f) Enrollment of Medicaid recipients.

(22) The agency may impose a fine for a violation of this section or the contract with the agency by a person or entity that is under contract with the agency. With respect to any nonwillful violation, such fine shall not exceed $2,500 per violation. In no event shall such fine exceed an aggregate amount of $10,000 for all nonwillful violations arising out of the same action. With respect to any knowing and willful violation of this section or the contract with the agency, the agency may impose a fine upon the entity in an amount not to exceed $20,000 for each such violation. In no event shall such fine exceed an aggregate amount of $100,000 for all knowing and willful violations arising out of the same action.

(23) A health maintenance organization or a person or entity exempt from chapter 641 that is under contract with the agency for the provision of health care services to Medicaid recipients may not use or distribute marketing materials used to solicit Medicaid recipients, unless such materials have been approved by the agency. The provisions of this subsection do not apply to general advertising and marketing materials used by a health maintenance organization to solicit both non-Medicaid subscribers and Medicaid recipients.

(24) Upon approval by the agency, health maintenance organizations and persons or entities exempt from chapter 641 that are under contract with the agency for the provision of health care services to Medicaid recipients may be permitted within the capitation rate to provide additional health benefits that the agency has found are of high quality, are practicably available, provide reasonable value to the

recipient, and are provided at no additional cost to the state.

(25) The agency shall utilize the statewide health maintenance organization complaint hotline for the purpose of investigating and resolving Medicaid and prepaid health plan complaints, maintaining a record of complaints and confirmed problems, and receiving disenrollment requests made by recipients.

(26) The agency shall require the publication of the health maintenance organization's and the prepaid health plan's consumer services telephone numbers and the "800" telephone number of the statewide health maintenance organization complaint hotline on each Medicaid identification card issued by a health maintenance organization or prepaid health plan contracting with the agency to serve Medicaid recipients and on each subscriber handbook issued to a Medicaid recipient.

(27) The agency shall establish a health care quality improvement system for those entities contracting with the agency pursuant to this section, incorporating all the standards and guidelines developed by the Medicaid Bureau of the Health Care Financing Administration as a part of the quality assurance reform initiative. The system shall include, but need not be limited to, the following:

(a) Guidelines for internal quality assurance programs, including standards for:

1. Written quality assurance program descriptions.

2. Responsibilities of the governing body for monitoring, evaluating, and making improvements to care.

3. An active quality assurance committee.

4. Quality assurance program supervision.

5. Requiring the program to have adequate resources to effectively carry out its specified activities.

6. Provider participation in the quality assurance program.

7. Delegation of quality assurance program activities.

8. Credentialing and recredentialing.

9. Enrollee rights and responsibilities.

10. Availability and accessibility to services and care.

11. Ambulatory care facilities.

12. Accessibility and availability of medical records, as well as proper recordkeeping and process for record review.

13. Utilization review.

14. A continuity of care system.

15. Quality assurance program documentation.

16. Coordination of quality assurance activity with other management activity.

17. Delivering care to pregnant women and infants; to elderly and disabled recipients, especially those who are at risk of institutional placement; to persons with developmental disabilities; and to adults who have chronic, high-cost medical conditions.

(b) Guidelines which require the entities to conduct quality-of-care studies which:

1. Target specific conditions and specific health service delivery issues for focused monitoring and evaluation.

2. Use clinical care standards or practice guidelines to objectively evaluate the care the entity delivers or fails to deliver for the targeted clinical conditions and health services delivery issues.

3. Use quality indicators derived from the clinical care standards or practice guidelines to screen and monitor care and services delivered.

(c) Guidelines for external quality review of each contractor which require: focused studies of patterns of care; individual care review in specific situations; and followup activities on previous pattern-of-care study findings and individual-care-review findings. In designing the external quality review function and determining how it is to operate as part of the state's overall quality improvement system, the agency shall construct its external quality review organization and entity contracts to address each of the following:

1. Delineating the role of the external quality review organization.

2. Length of the external quality review organization contract with the state.

3. Participation of the contracting entities in designing external quality review organization review activities.

4. Potential variation in the type of clinical conditions and health services delivery issues to be studied at each plan.

5. Determining the number of focused pattern-of-care studies to be conducted for each plan.

6. Methods for implementing focused studies.

7. Individual care review.

8. Followup activities.

(28) In order to ensure that children receive health care services for which an entity has already been compensated, an entity contracting with the agency pursuant to

this section shall achieve an annual Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Service screening rate of at least 60 percent for those recipients continuously enrolled for at least 8 months. The agency shall develop a method by which the EPSDT screening rate shall be calculated. For any entity which does not achieve the annual 60 percent rate, the entity must submit a corrective action plan for the agency's approval. If the entity does not meet the standard established in the corrective action plan during the specified timeframe, the agency is authorized to impose appropriate contract sanctions. At least annually, the agency shall publicly release the EPSDT Services screening rates of each entity it has contracted with on a prepaid basis to serve Medicaid recipients.

(29) The agency shall perform enrollments and disenrollments for Medicaid recipients who are eligible for MediPass or managed care plans. Notwithstanding the prohibition contained in paragraph (19)(f), managed care plans may perform preenrollments of Medicaid recipients under the supervision of the agency or its agents. For the purposes of this section, "preenrollment" means the provision of marketing and educational materials to a Medicaid recipient and assistance in completing the application forms, but shall not include actual enrollment into a managed care plan. An application for enrollment shall not be deemed complete until the agency or its agent verifies that the recipient made an informed, voluntary choice. The agency, in cooperation with the Department of Children and Family Services, may test new marketing initiatives to inform Medicaid recipients about their managed care options at selected sites. The agency shall report to the Legislature on the effectiveness of such

initiatives. The agency may contract with a third party to perform managed care plan and MediPass enrollment and disenrollment services for Medicaid recipients and is authorized to adopt rules to implement such services. The agency may adjust the capitation rate only to cover the costs of a third-party enrollment and disenrollment contract, and for agency supervision and management of the managed care plan enrollment and disenrollment contract.

(30) Any lists of providers made available to Medicaid recipients, MediPass enrollees, or managed care plan enrollees shall be arranged alphabetically showing the provider's name and specialty and, separately, by specialty in alphabetical order.

(31) The agency shall establish an enhanced managed care quality assurance oversight function, to include at least the following components:

(a) At least quarterly analysis and followup, including sanctions as appropriate, of managed care participant utilization of services.

(b) At least quarterly analysis and followup, including sanctions as appropriate, of quality findings of the Medicaid peer review organization and other external quality assurance programs.

(c) At least quarterly analysis and followup, including sanctions as appropriate, of the fiscal viability of managed care plans.

(d) At least quarterly analysis and followup, including sanctions as appropriate, of managed care participant satisfaction and disenrollment surveys.

(e) The agency shall conduct regular and ongoing Medicaid recipient satisfaction surveys.

The analyses and followup activities conducted by the agency under its enhanced managed care quality assurance oversight function shall not duplicate the activities of accreditation reviewers for entities regulated under part III of chapter 641, but may include a review of the finding of such reviewers.

(32) Each managed care plan that is under contract with the agency to provide health care services to Medicaid recipients shall annually conduct a background check with the Florida Department of Law Enforcement of all persons with ownership interest of 5 percent or more or executive management responsibility for the managed care plan and shall submit to the agency information concerning any such person who has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any of the offenses listed in s. 435.03.

(33) The agency shall, by rule, develop a process whereby a Medicaid managed care plan enrollee who wishes to enter hospice care may be disenrolled from the managed care plan within 24 hours after contacting the agency regarding such request. The agency rule shall include a methodology for the agency to recoup managed care plan payments on a pro rata basis if payment has been made for the enrollment month when disenrollment occurs.

(34) The agency and entities which contract with the agency to provide health care services to Medicaid recipients under this section or s. 409.9122 must comply with the provisions of s. 641.513 in providing emergency services and care to Medicaid recipients and MediPass recipients.

(35) All entities providing health care services to Medicaid recipients shall make available, and encourage all pregnant women and mothers with infants to receive, and provide documentation in the medical records to reflect, the following:

(a) Healthy Start prenatal or infant screening.

(b) Healthy Start care coordination, when screening or other factors indicate need.

(c) Healthy Start enhanced services in accordance with the prenatal or infant screening results.

(d) Immunizations in accordance with recommendations of the Advisory Committee on Immunization Practices of the United States Public Health Service and the American Academy of Pediatrics, as appropriate.

(e) Counseling and services for family planning to all women and their partners.

(f) A scheduled postpartum visit for the purpose of voluntary family planning, to include discussion of all methods of contraception, as appropriate.

(g) Referral to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

(36) Any entity that provides Medicaid prepaid health plan services shall ensure the appropriate coordination of health care services with an assisted living facility in cases where a Medicaid recipient is both a member of the entity's prepaid health plan and a resident of the assisted living facility. If the entity is at risk for Medicaid targeted case management and behavioral health services, the entity shall inform the assisted living facility of the procedures to follow should an emergent condition arise.

(37) The agency may seek and implement federal waivers necessary to provide for cost-effective purchasing of home health services, private duty nursing services, transportation, independent laboratory services, and durable medical equipment and supplies through competitive bidding pursuant to s. 287.057. The agency may request appropriate waivers from the federal Health Care Financing Administration in order to competitively bid such services. The agency may exclude providers not selected through the bidding process from the Medicaid provider network.

(38) The Agency for Health Care Administration is directed to issue a request for proposal or intent to negotiate to implement on a demonstration basis an outpatient specialty services pilot project in a rural and urban county in the state. As used in this subsection, the term "outpatient specialty services" means clinical laboratory, diagnostic imaging, and specified home medical services to include durable medical equipment, prosthetics and orthotics, and infusion therapy.

(a) The entity that is awarded the contract to provide Medicaid managed care outpatient specialty services must, at a minimum, meet the following criteria:

1. The entity must be licensed by the Office of Insurance Regulation under part II of chapter 641.

2. The entity must be experienced in providing outpatient specialty services.

3. The entity must demonstrate to the satisfaction of the agency that it provides high-quality services to its patients.

4. The entity must demonstrate that it has in place a complaints and grievance process to assist Medicaid recipients

enrolled in the pilot managed care program to resolve complaints and grievances.

(b) The pilot managed care program shall operate for a period of 3 years. The objective of the pilot program shall be to determine the cost-effectiveness and effects on utilization, access, and quality of providing outpatient specialty services to Medicaid recipients on a prepaid, capitated basis.

(c) The agency shall conduct a quality assurance review of the prepaid health clinic each year that the demonstration program is in effect. The prepaid health clinic is responsible for all expenses incurred by the agency in conducting a quality assurance review.

(d) The entity that is awarded the contract to provide outpatient specialty services to Medicaid recipients shall report data required by the agency in a format specified by the agency, for the purpose of conducting the evaluation required in paragraph (e).

(e) The agency shall conduct an evaluation of the pilot managed care program and report its findings to the Governor and the Legislature by no later than January 1, 2001.

(39) The agency shall enter into agreements with not-for-profit organizations based in this state for the purpose of providing vision screening.

(40)(a) The agency shall implement a Medicaid prescribed-drug spending-control program that includes the following components:

1. Medicaid prescribed-drug coverage for brand-name drugs for adult Medicaid recipients is limited to the dispensing of four brand-name drugs per month per recipient. Children are exempt from this restriction. Antiretroviral

agents are excluded from this limitation. No requirements for prior authorization or other restrictions on medications used to treat mental illnesses such as schizophrenia, severe depression, or bipolar disorder may be imposed on Medicaid recipients. Medications that will be available without restriction for persons with mental illnesses include atypical antipsychotic medications, conventional antipsychotic medications, selective serotonin reuptake inhibitors, and other medications used for the treatment of serious mental illnesses. The agency shall also limit the amount of a prescribed drug dispensed to no more than a 34-day supply. The agency shall continue to provide unlimited generic drugs, contraceptive drugs and items, and diabetic supplies. Although a drug may be included on the preferred drug formulary, it would not be exempt from the four-brand limit. The agency may authorize exceptions to the brand-name-drug restriction based upon the treatment needs of the patients, only when such exceptions are based on prior consultation provided by the agency or an agency contractor, but the agency must establish procedures to ensure that:

a. There will be a response to a request for prior consultation by telephone or other telecommunication device within 24 hours after receipt of a request for prior consultation;

b. A 72-hour supply of the drug prescribed will be provided in an emergency or when the agency does not provide a response within 24 hours as required by sub-subparagraph a.; and

c. Except for the exception for nursing home residents and other institutionalized adults and except for drugs on the restricted formulary for which prior authorization may be

sought by an institutional or community pharmacy, prior authorization for an exception to the brand-name-drug restriction is sought by the prescriber and not by the pharmacy. When prior authorization is granted for a patient in an institutional setting beyond the brand-name-drug restriction, such approval is authorized for 12 months and monthly prior authorization is not required for that patient.

2. Reimbursement to pharmacies for Medicaid prescribed drugs shall be set at the average wholesale price less 13.25 percent.

3. The agency shall develop and implement a process for managing the drug therapies of Medicaid recipients who are using significant numbers of prescribed drugs each month. The management process may include, but is not limited to, comprehensive, physician-directed medical-record reviews, claims analyses, and case evaluations to determine the medical necessity and appropriateness of a patient's treatment plan and drug therapies. The agency may contract with a private organization to provide drug-program-management services. The Medicaid drug benefit management program shall include initiatives to manage drug therapies for HIV/AIDS patients, patients using 20 or more unique prescriptions in a 180-day period, and the top 1,000 patients in annual spending.

4. The agency may limit the size of its pharmacy network based on need, competitive bidding, price negotiations, credentialing, or similar criteria. The agency shall give special consideration to rural areas in determining the size and location of pharmacies included in the Medicaid pharmacy network. A pharmacy credentialing process may include criteria such as a pharmacy's full-service status, location, size, patient educational programs, patient consultation,

disease-management services, and other characteristics. The agency may impose a moratorium on Medicaid pharmacy enrollment when it is determined that it has a sufficient number of Medicaid-participating providers.

5. The agency shall develop and implement a program that requires Medicaid practitioners who prescribe drugs to use a counterfeit-proof prescription pad for Medicaid prescriptions. The agency shall require the use of standardized counterfeit-proof prescription pads by Medicaid-participating prescribers or prescribers who write prescriptions for Medicaid recipients. The agency may implement the program in targeted geographic areas or statewide.

6. The agency may enter into arrangements that require manufacturers of generic drugs prescribed to Medicaid recipients to provide rebates of at least 15.1 percent of the average manufacturer price for the manufacturer's generic products. These arrangements shall require that if a generic-drug manufacturer pays federal rebates for Medicaid-reimbursed drugs at a level below 15.1 percent, the manufacturer must provide a supplemental rebate to the state in an amount necessary to achieve a 15.1-percent rebate level.

7. The agency may establish a preferred drug formulary in accordance with 42 U.S.C. s. 1396r-8, and, pursuant to the establishment of such formulary, it is authorized to negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the Social Security Act and at no less than 10 percent of the average manufacturer price as defined in 42 U.S.C. s. 1936 on the last day of a quarter unless the federal or supplemental rebate, or both, equals or exceeds 25 percent. There is no upper limit on the

supplemental rebates the agency may negotiate. The agency may determine that specific products, brand-name or generic, are competitive at lower rebate percentages. Agreement to pay the minimum supplemental rebate percentage will guarantee a manufacturer that the Medicaid Pharmaceutical and Therapeutics Committee will consider a product for inclusion on the preferred drug formulary. However, a pharmaceutical manufacturer is not guaranteed placement on the formulary by simply paying the minimum supplemental rebate. Agency decisions will be made on the clinical efficacy of a drug and recommendations of the Medicaid Pharmaceutical and Therapeutics Committee, as well as the price of competing products minus federal and state rebates. The agency is authorized to contract with an outside agency or contractor to conduct negotiations for supplemental rebates. For the purposes of this section, the term "supplemental rebates" may include, at the agency's discretion, cash rebates and other program benefits that offset a Medicaid expenditure. Such other program benefits may include, but are not limited to, disease management programs, drug product donation programs, drug utilization control programs, prescriber and beneficiary counseling and education, fraud and abuse initiatives, and other services or administrative investments with guaranteed savings to the Medicaid program in the same year the rebate reduction is included in the General Appropriations Act. The agency is authorized to seek any federal waivers to implement this initiative.

8. The agency shall establish an advisory committee for the purposes of studying the feasibility of using a restricted drug formulary for nursing home residents and other institutionalized adults. The committee shall be comprised of

seven members appointed by the Secretary of Health Care Administration. The committee members shall include two physicians licensed under chapter 458 or chapter 459; three pharmacists licensed under chapter 465 and appointed from a list of recommendations provided by the Florida Long-Term Care Pharmacy Alliance; and two pharmacists licensed under chapter 465.

9. The Agency for Health Care Administration shall expand home delivery of pharmacy products. To assist Medicaid patients in securing their prescriptions and reduce program costs, the agency shall expand its current mail-order-pharmacy diabetes-supply program to include all generic and brand-name drugs used by Medicaid patients with diabetes. Medicaid recipients in the current program may obtain nondiabetes drugs on a voluntary basis. This initiative is limited to the geographic area covered by the current contract. The agency may seek and implement any federal waivers necessary to implement this subparagraph.

(b) The agency shall implement this subsection to the extent that funds are appropriated to administer the Medicaid prescribed-drug spending-control program. The agency may contract all or any part of this program to private organizations.

(c) The agency shall submit quarterly reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives which must include, but need not be limited to, the progress made in implementing this subsection and its effect on Medicaid prescribed-drug expenditures.

(41) Notwithstanding the provisions of chapter 287, the agency may, at its discretion, renew a contract or contracts for fiscal intermediary services one or more times

for such periods as the agency may decide; however, all such renewals may not combine to exceed a total period longer than the term of the original contract.

(42) The agency shall provide for the development of a demonstration project by establishment in Miami-Dade County of a long-term-care facility licensed pursuant to chapter 395 to improve access to health care for a predominantly minority, medically underserved, and medically complex population and to evaluate alternatives to nursing home care and general acute care for such population. Such project is to be located in a health care condominium and colocated with licensed facilities providing a continuum of care. The establishment of this project is not subject to the provisions of s. 408.036 or s. 408.039. The agency shall report its findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2003.

(43) The agency shall develop and implement a utilization management program for Medicaid-eligible recipients for the management of occupational, physical, respiratory, and speech therapies. The agency shall establish a utilization program that may require prior authorization in order to ensure medically necessary and cost-effective treatments. The program shall be operated in accordance with a federally approved waiver program or state plan amendment. The agency may seek a federal waiver or state plan amendment to implement this program. The agency may also competitively procure these services from an outside vendor on a regional or statewide basis.

(44) The agency may contract on a prepaid or fixed-sum basis with appropriately licensed prepaid dental health plans to provide dental services.

(45) The agency may mandate a recipient's participation in a provider lock-in program limiting the receipt of goods or services to a single specified provider. The lock-in programs shall include, but are not limited to, pharmacies. The agency shall seek any federal waivers necessary to implement this subsection.

Section 5. Section 409.913, Florida Statutes, is 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. Beginning January 1, 2003, and each year thereafter, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit a joint 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 recommend changes necessary to prevent or recover overpayments. For the 2001-2002 fiscal year, the agency shall prepare a report that contains as much of this information as is available to it.

(1) For the purposes of this section, the term:

(a) "Abuse" means:

1. Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care.

2. Recipient practices that result in unnecessary cost to the Medicaid program.

(b) "Complaint" means an allegation that fraud, abuse, or an overpayment has occurred.

(c) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or

himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.

(d) "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

(e) "Overpayment" includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

(f) "Person" means any natural person, corporation, partnership, association, clinic, group, or other entity, whether or not such person is enrolled in the Medicaid program or is a provider of health care.

(2) 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.

(3) The agency may conduct, or may contract for, prepayment review of provider claims to ensure cost-effective

purchasing; to ensure that, billing by a provider to the agency is in accordance with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law;, and to ensure that appropriate ~~provision of~~ care is rendered to Medicaid recipients. Such prepayment reviews may be conducted as determined appropriate by the agency, without any suspicion or allegation of fraud, abuse, or neglect, and may last for up to 1 year. Unless the agency has reliable evidence of fraud, misrepresentation, abuse, or neglect, claims shall be adjudicated for denial or payment within 90 days after the date complete documentation is received by the agency for review. If there is reliable evidence of fraud, misrepresentation, abuse, or neglect, claims shall be adjudicated for denial or payment within 180 days after the date complete documentation is received by the agency for review.

(4) Any suspected criminal violation identified by the agency must be referred to the Medicaid Fraud Control Unit of the Office of the Attorney General for investigation. The agency and the Attorney General shall enter into a memorandum of understanding, which must include, but need not be limited to, a protocol for regularly sharing information and coordinating casework. The protocol must establish a procedure for the referral by the agency of cases involving suspected Medicaid fraud to the Medicaid Fraud Control Unit for investigation, and the return to the agency of those cases where investigation determines that administrative action by the agency is appropriate. Offices of the Medicaid program integrity program and the Medicaid Fraud Control Unit of the Department of Legal Affairs, shall, to the extent possible, be

collocated. The agency and the Department of Legal Affairs shall periodically conduct joint training and other joint activities designed to increase communication and coordination in recovering overpayments.

(5) A Medicaid provider is subject to having goods and services that are paid for by the Medicaid program reviewed by an appropriate peer-review organization designated by the agency. The written findings of the applicable peer-review organization are admissible in any court or administrative proceeding as evidence of medical necessity or the lack thereof.

(6) Any notice required to be given to a provider under this section is presumed to be sufficient notice if sent to the address last shown on the provider enrollment file. It is the responsibility of the provider to furnish and keep the agency informed of the provider's current address. United States Postal Service proof of mailing or certified or registered mailing of such notice to the provider at the address shown on the provider enrollment file constitutes sufficient proof of notice. Any notice required to be given to the agency by this section must be sent to the agency at an address designated by rule.

(7) When presenting a claim for payment under the Medicaid program, a provider has an affirmative duty to supervise the provision of, and be responsible for, goods and services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for goods and services that:

(a) Have actually been furnished to the recipient by the provider prior to submitting the claim.

(b) Are Medicaid-covered goods or services that are medically necessary.

(c) Are of a quality comparable to those furnished to the general public by the provider's peers.

(d) Have not been billed in whole or in part to a recipient or a recipient's responsible party, except for such copayments, coinsurance, or deductibles as are authorized by the agency.

(e) Are provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law.

(f) Are documented by records made at the time the goods or services were provided, demonstrating the medical necessity for the goods or services rendered. Medicaid goods or services are excessive or not medically necessary unless both the medical basis and the specific need for them are fully and properly documented in the recipient's medical record.

The agency may deny payment or require repayment for goods or services that are not presented as required in this subsection.

(8) The agency shall not reimburse any person or entity for any prescription for medications, medical supplies, or medical services if the prescription was written by a physician or other prescribing practitioner who is not enrolled in the Medicaid program. This section does not apply:

(a) In instances involving bona fide emergency medical conditions as determined by the agency;

(b) To a provider of medical services to a patient in a hospital emergency department;

(c) To bono fide pro bono services by preapproved non-Medicaid providers as determined by the agency;

(d) To prescribing physicians who are board-certified specialists treating Medicaid recipients referred for treatment by a treating physician who is enrolled in the Medicaid program; or

(e) To prescriptions written for dually eligible Medicare beneficiaries by an authorized Medicare provider who is not enrolled in the Medicaid program.

(9)~~(8)~~ A Medicaid provider shall retain medical, professional, financial, and business records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid for a period of 5 years after the date of furnishing such services or goods. The agency may investigate, review, or analyze such records, which must be made available during normal business hours. However, 24-hour notice must be provided if patient treatment would be disrupted. The provider is responsible for furnishing to the agency, and keeping the agency informed of the location of, the provider's Medicaid-related records. The authority of the agency to obtain Medicaid-related records from a provider is neither curtailed nor limited during a period of litigation between the agency and the provider.

(10)~~(9)~~ Payments for the services of billing agents or persons participating in the preparation of a Medicaid claim shall not be based on amounts for which they bill nor based on the amount a provider receives from the Medicaid program.

(11)~~(10)~~ The agency may deny payment or require repayment for inappropriate, medically unnecessary, or excessive goods or services from the person furnishing them,

the person under whose supervision they were furnished, or the person causing them to be furnished.

(12)~~(11)~~ The complaint and all information obtained pursuant to an investigation of a Medicaid provider, or the authorized representative or agent of a provider, relating to an allegation of fraud, abuse, or neglect are confidential and exempt from the provisions of s. 119.07(1):

(a) Until the agency takes final agency action with respect to the provider and requires repayment of any overpayment, or imposes an administrative sanction;

(b) Until the Attorney General refers the case for criminal prosecution;

(c) Until 10 days after the complaint is determined without merit; or

(d) At all times if the complaint or information is otherwise protected by law.

(13)~~(12)~~ The agency may terminate participation of a Medicaid provider in the Medicaid program and may seek civil remedies or impose other administrative sanctions against a Medicaid provider, if the provider has been:

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

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

(c) Found by a court of competent jurisdiction to have neglected or physically abused a patient in connection with the delivery of health care goods or services.

(14)~~(13)~~ If the provider has been suspended or terminated from participation in the Medicaid program or the Medicare program by the Federal Government or any state, the agency must immediately suspend or terminate, as appropriate, the provider's participation in the Florida Medicaid program for a period no less than that imposed by the Federal Government or any other state, and may not enroll such provider in the Florida Medicaid program while such foreign suspension or termination remains in effect. This sanction is in addition to all other remedies provided by law.

(15)~~(14)~~ The agency may seek any remedy provided by law, including, but not limited to, the remedies provided in subsections(13)~~(12)~~and(16)~~(15)~~and s. 812.035, if:

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

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

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

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

(e) The provider is not in compliance with provisions of Medicaid provider publications that have been adopted by

reference as rules in the Florida Administrative Code; with provisions of state or federal laws, rules, or regulations; with provisions of the provider agreement between the agency and the provider; or with certifications found on claim forms or on transmittal forms for electronically submitted claims that are submitted by the provider or authorized representative, as such provisions apply to the Medicaid program;

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

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

(h) The provider or an authorized representative of the provider, or a person who ordered or prescribed the goods or services, has submitted or caused to be submitted false or a pattern of erroneous Medicaid claims ~~that have resulted in overpayments to a provider or that exceed those to which the provider was entitled under the Medicaid program~~;

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

(j) The provider or an authorized representative of the provider has collected from or billed a recipient or a recipient's responsible party improperly for amounts that

should not have been so collected or billed by reason of the provider's billing the Medicaid program for the same service;

(k) The provider or an authorized representative of the provider has included in a cost report costs that are not allowable under a Florida Title XIX reimbursement plan, after the provider or authorized representative had been advised in an audit exit conference or audit report that the costs were not allowable;

(l) The provider is charged by information or indictment with fraudulent billing practices. The sanction applied for this reason is limited to suspension of the provider's participation in the Medicaid program for the duration of the indictment unless the provider is found guilty pursuant to the information or indictment;

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

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

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

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

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

(16)~~(15)~~ The agency shall impose any of the following sanctions or disincentives on a provider or a person for any of the acts described in subsection(15)~~(14)~~:

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

(b) Termination for a specific period of time of from more than 1 year to 20 years. Termination shall preclude participation in the Medicaid program, which includes any action that results in a claim for payment to the Medicaid program as a result of 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, for the purposes of this section, to be 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, for the purposes of this section, to be 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) ~~(14)(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 would remain in effect for providers for up to 3 years and that would be monitored by the agency every 6 months while in effect.

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

The Secretary of Health Care Administration may make a determination that imposition of a sanction or disincentive is not in the best interest of the Medicaid program, in which case a sanction or disincentive shall not be imposed.

(17)~~(16)~~ In determining the appropriate administrative sanction to be applied, or the duration of any suspension or termination, the agency shall consider:

(a) The seriousness and extent of the violation or violations.

(b) Any prior history of violations by the provider relating to the delivery of health care programs which resulted in either a criminal conviction or in administrative sanction or penalty.

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

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

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

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

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

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

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

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

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

(22)~~(21)~~ The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment. A provider may not present or

elicit testimony, either on direct examination or cross-examination in any court or administrative proceeding, regarding the purchase or acquisition by any means of drugs, goods, or supplies; sales or divestment by any means of drugs, goods, or supplies; or inventory of drugs, goods, or supplies, unless such acquisition, sales, divestment, or inventory is documented by written invoices, written inventory records, or other competent written documentary evidence maintained in the normal course of the provider's business. Notwithstanding the applicable rules of discovery, all documentation that will be offered as evidence at an administrative hearing on a Medicaid overpayment must be exchanged by all parties at least 14 days before the administrative hearing or must be excluded from consideration.

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

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

(c) The provider may pay the costs over a period to be determined by the agency if the agency determines that an extreme hardship would result to the provider from immediate

full payment. Any default in payment of costs may be collected by any means authorized by law.

(24)~~(23)~~ If the agency imposes an administrative sanction pursuant to subsection (13), subsection (14), or subsection (15), except paragraphs (15)(e) and (o),~~under this section~~ upon any provider or other person who is regulated by another state entity, the agency shall notify that other entity of the imposition of the sanction. Such notification must include the provider's or person's name and license number and the specific reasons for sanction.

(25)~~(24)~~(a) The agency may withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud, willful misrepresentation, or abuse under the Medicaid program, or a crime committed while rendering goods or services to Medicaid recipients~~, pending completion of legal proceedings~~. If it is determined that fraud, willful misrepresentation, abuse, or a crime did not occur, the payments withheld must be paid to the provider within 14 days after such determination with interest at the rate of 10 percent a year. Any money withheld in accordance with this paragraph shall be placed in a suspended account, readily accessible to the agency, so that any payment ultimately due the provider shall be made within 14 days.

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

(c)~~(b)~~ Overpayments owed to the agency bear interest at the rate of 10 percent per year from the date of

determination of the overpayment by the agency, and payment arrangements must be made at the conclusion of legal proceedings. A provider who does not enter into or adhere to an agreed-upon repayment schedule may be terminated by the agency for nonpayment or partial payment.

(d)~~(c)~~ The agency, upon entry of a final agency order, a judgment or order of a court of competent jurisdiction, or a stipulation or settlement, may collect the moneys owed by all means allowable by law, including, but not limited to, notifying any fiscal intermediary of Medicare benefits that the state has a superior right of payment. Upon receipt of such written notification, the Medicare fiscal intermediary shall remit to the state the sum claimed.

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

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

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

(a) Withhold, and continue to withhold during the pendency of an administrative hearing pursuant to chapter 120, any medical assistance reimbursement payments until such time

as the overpayment is recovered, unless within 30 days after receiving notice thereof the provider:

1. Makes repayment in full; or

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

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

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

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

(30)~~(29)~~ The agency may terminate a provider's participation in the Medicaid program if the provider fails to reimburse an overpayment that has been determined by final order, not subject to further appeal, within 35 days after the date of the final order, unless the provider and the agency have entered into a repayment agreement.

(31)~~(30)~~ If a provider requests an administrative hearing pursuant to chapter 120, such hearing must be conducted within 90 days following assignment of an administrative law judge, absent exceptionally good cause shown as determined by the administrative law judge or hearing officer. Upon issuance of a final order, the outstanding

balance of the amount determined to constitute the overpayment shall become due. If a provider fails to make payments in full, fails to enter into a satisfactory repayment plan, or fails to comply with the terms of a repayment plan or settlement agreement, the agency may withhold medical assistance reimbursement payments until the amount due is paid in full.

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

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

(34) To deter fraud and abuse in the Medicaid program, the agency may limit the number of Schedule II and Schedule III refill prescription claims submitted from a pharmacy provider. The agency shall limit the allowable amount of reimbursement of prescription refill claims for Schedule II and Schedule III pharmaceuticals if the agency or the Medicaid Fraud Control Unit determines that the specific prescription

refill was not requested by the Medicaid recipient or authorized representative for whom the refill claim is submitted or was not prescribed by the recipient's medical provider or physician. Any such refill request must be consistent with the original prescription.

Section 6. Paragraph (d) of subsection (2) and paragraph (b) of subsection (5) of section 409.9131, Florida Statutes, are amended, and subsection (6) is added to that section, to read:

409.9131 Special provisions relating to integrity of the Medicaid program.--

(2) DEFINITIONS.--For purposes of this section, the term:

(d) "Peer review" means an evaluation of the professional practices of a Medicaid physician provider by a peer or peers in order to assess the medical necessity, appropriateness, and quality of care provided, as such care is compared to that customarily furnished by the physician's peers and to recognized health care standards, and, in cases involving determination of medical necessity, to determine whether the documentation in the physician's records is adequate.

(5) DETERMINATIONS OF OVERPAYMENT.--In making a determination of overpayment to a physician, the agency must:

(b) Refer all physician service claims for peer review when the agency's preliminary analysis indicates that an evaluation of the medical necessity, appropriateness, and quality of care needs to be undertaken to determine a potential overpayment, and before any formal proceedings are initiated against the physician, except as required by s. 409.913.

(6) COST REPORTS.--For any Medicaid provider submitting a cost report to the agency by any method, and in addition to any other certification, the following statement must immediately precede the dated signature of the provider's administrator or chief financial officer on such cost report:

"I certify that I am familiar with the laws and regulations regarding the provision of health care services under the Florida Medicaid program, including the laws and regulations relating to claims for Medicaid reimbursements and payments, and that the services identified in this cost report were provided in compliance with such laws and regulations."

Section 7. Section 409.920, Florida Statutes, is amended to read:

409.920 Medicaid provider fraud.--

(1) For the purposes of this section, the term:

(a) "Agency" means the Agency for Health Care Administration.

(b) "Fiscal agent" means any individual, firm, corporation, partnership, organization, or other legal entity that has contracted with the agency to receive, process, and adjudicate claims under the Medicaid program.

(c) "Item or service" includes:

1. Any particular item, device, medical supply, or service claimed to have been provided to a recipient and listed in an itemized claim for payment; or

2. In the case of a claim based on costs, any entry in the cost report, books of account, or other documents supporting such claim.

(d) "Knowingly" means that the act was done voluntarily and intentionally and not because of mistake or accident. As used in this section, the term "knowingly" also includes the word "willfully" or "willful" which, as used in this section, means that an act was committed voluntarily and purposely, with the specific intent to do something that the law forbids, and that the act was committed with bad purpose, either to disobey or disregard the law ~~done by a person who is aware or should be aware of the nature of his or her conduct and that his or her conduct is substantially certain to cause the intended result~~.

(2) It is unlawful to:

(a) Knowingly make, cause to be made, or aid and abet in the making of any false statement or false representation of a material fact, by commission or omission, in any claim submitted to the agency or its fiscal agent for payment.

(b) Knowingly make, cause to be made, or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed by the Medicaid program.

(c) Knowingly charge, solicit, accept, or receive anything of value, other than an authorized copayment from a Medicaid recipient, from any source in addition to the amount legally payable for an item or service provided to a Medicaid recipient under the Medicaid program or knowingly fail to credit the agency or its fiscal agent for any payment received from a third-party source.

(d) Knowingly make or in any way cause to be made any false statement or false representation of a material fact, by commission or omission, in any document containing items of income and expense that is or may be used by the agency to

determine a general or specific rate of payment for an item or service provided by a provider.

(e) Knowingly solicit, offer, pay, or receive any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made, in whole or in part, under the Medicaid program, or in return for obtaining, purchasing, leasing, ordering, or arranging for or recommending, obtaining, purchasing, leasing, or ordering any goods, facility, item, or service, for which payment may be made, in whole or in part, under the Medicaid program.

(f) Knowingly submit false or misleading information or statements to the Medicaid program for the purpose of being accepted as a Medicaid provider.

(g) Knowingly use or endeavor to use a Medicaid provider's identification number or a Medicaid recipient's identification number to make, cause to be made, or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed by the Medicaid program.

A person who violates this subsection commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(3) The repayment of Medicaid payments wrongfully obtained, or the offer or endeavor to repay Medicaid funds wrongfully obtained, does not constitute a defense to, or a ground for dismissal of, criminal charges brought under this section.

(4) Property "paid for" includes all property furnished to or intended to be furnished to any recipient of benefits under the Medicaid program, regardless of whether reimbursement is ever actually made by the program.

(5)~~(4)~~ All records in the custody of the agency or its fiscal agent which relate to Medicaid provider fraud are business records within the meaning of s. 90.803(6).

(6)~~(5)~~ Proof that a claim was submitted to the agency or its fiscal agent which contained a false statement or a false representation of a material fact, by commission or omission, unless satisfactorily explained, gives rise to an inference that the person whose signature appears as the provider's authorizing signature on the claim form, or whose signature appears on an agency electronic claim submission agreement submitted for claims made to the fiscal agent by electronic means, had knowledge of the false statement or false representation. This subsection applies whether the signature appears on the claim form or the electronic claim submission agreement by means of handwriting, typewriting, facsimile signature stamp, computer impulse, initials, or otherwise.

(7)~~(6)~~ Proof of submission to the agency or its fiscal agent of a document containing items of income and expense, which document is used or that may be used by the agency or its fiscal agent to determine a general or specific rate of payment and which document contains a false statement or a false representation of a material fact, by commission or omission, unless satisfactorily explained, gives rise to the inference that the person who signed the certification of the document had knowledge of the false statement or representation. This subsection applies whether the signature

appears on the document by means of handwriting, typewriting, facsimile signature stamp, electronic transmission, initials, or otherwise.

(8)~~(7)~~ The Attorney General shall conduct a statewide program of Medicaid fraud control. To accomplish this purpose, the Attorney General shall:

(a) Investigate the possible criminal violation of any applicable state law pertaining to fraud in the administration of the Medicaid program, in the provision of medical assistance, or in the activities of providers of health care under the Medicaid program.

(b) Investigate the alleged abuse or neglect of patients in health care facilities receiving payments under the Medicaid program, in coordination with the agency.

(c) Investigate the alleged misappropriation of patients' private funds in health care facilities receiving payments under the Medicaid program.

(d) Refer to the Office of Statewide Prosecution or the appropriate state attorney all violations indicating a substantial potential for criminal prosecution.

(e) Refer to the agency all suspected abusive activities not of a criminal or fraudulent nature.

(f) Safeguard the privacy rights of all individuals and provide safeguards to prevent the use of patient medical records for any reason beyond the scope of a specific investigation for fraud or abuse, or both, without the patient's written consent.

(g) Publicize to state employees and the public the ability of persons to bring suit under the provisions of the Florida False Claims Act and the potential for the persons

bringing a civil action under the Florida False Claims Act to obtain a monetary award.

(9)~~(8)~~ In carrying out the duties and responsibilities under this section, the Attorney General may:

(a) Enter upon the premises of any health care provider, excluding a physician, participating in the Medicaid program to examine all accounts and records that may, in any manner, be relevant in determining the existence of fraud in the Medicaid program, to investigate alleged abuse or neglect of patients, or to investigate alleged misappropriation of patients' private funds. A participating physician is required to make available any accounts or records that may, in any manner, be relevant in determining the existence of fraud in the Medicaid program, to investigate alleged abuse or neglect of patients, or to investigate alleged misappropriation of patients' private funds. Subject only to applicable federal statutes, but notwithstanding any other provision of law, the accounts or records of a non-Medicaid patient may be reviewed by the Medicaid Fraud Control Unit without the patient's consent, pursuant to an investigation of suspected Medicaid fraud, in order to determine consistency in the quality and appropriateness of treatment provided to Medicaid recipients as compared to non-Medicaid recipients ~~not be reviewed by, or turned over to, the Attorney General without the patient's written consent~~.

(b) Subpoena witnesses or materials, including medical records relating to Medicaid recipients, within or outside the state and, through any duly designated employee, administer oaths and affirmations and collect evidence for possible use in either civil or criminal judicial proceedings.

(c) Request and receive the assistance of any state attorney or law enforcement agency in the investigation and prosecution of any violation of this section.

(d) Seek any civil remedy provided by law, including, but not limited to, the remedies provided in ss. 68.081-68.092 and 812.035 and this chapter.

(e) Refer to the agency for collection each instance of overpayment to a provider of health care under the Medicaid program which is discovered during the course of an investigation.

Section 8. Section 409.9201, Florida Statutes, is created to read:

409.9201 Medicaid fraud.--

(1) As used in this section, the term:

(a) "Legend drug" means any drug, including, but not limited to, finished dosage forms or active ingredients that are subject to, defined by, or described by s. 503(b) of the Federal Food, Drug, and Cosmetic Act or by s. 465.003(8), s. 499.007(12), or s. 499.0122(1)(b) or (c).

(b) "Value" means the amount billed to the Medicaid program for the property dispensed or the market value of a legend drug or goods or services at the time and place of the offense. If the market value cannot be determined, the term means the replacement cost of the legend drug or goods or services within a reasonable time after the offense.

(2) Any person who knowingly sells, who knowingly attempts or conspires to sell, or who knowingly causes any other person to sell or attempt or conspire to sell a legend drug that was paid for by the Medicaid program commits a felony.

(a) If the value of the legend drug involved is less than $20,000, the crime is a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) If the value of the legend drug involved is $20,000 or more but less than $100,000, the crime is a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) If the value of the legend drug involved is $100,000 or more, the crime is a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(3) Any person who knowingly purchases, or who knowingly attempts or conspires to purchase, a legend drug that was paid for by the Medicaid program and intended for use by another person commits a felony.

(a) If the value of the legend drug is less than $20,000, the crime is a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) If the value of the legend drug is $20,000 or more but less than $100,000, the crime is a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) If the value of the legend drug is $100,000 or more, the crime is a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(4) Any person who knowingly makes or knowingly causes to be made, or who attempts or conspires to make, any false statement or representation to any person for the purpose of obtaining goods or services from the Medicaid program commits a felony.

(a) If the value of the goods or services is less than $20,000, the crime is a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) If the value of the goods or services is $20,000 or more but less than $100,000, the crime is a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) If the value of the goods or services involved is $100,000 or more, the crime is a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

The value of individual items of the legend drugs or goods or services involved in distinct transactions committed during a single scheme or course of conduct, whether involving a single person or several persons, may be aggregated when determining the punishment for the offense.

Section 9. Paragraph (ff) is added to subsection (1) of section 456.072, Florida Statutes, to read:

456.072 Grounds for discipline; penalties; enforcement.--

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(ff) Engaging in a pattern of practice when prescribing medicinal drugs or controlled substances which demonstrates a lack of reasonable skill or safety to patients, a violation of any provision of this chapter, a violation of the applicable practice act, or a violation of any rules adopted pursuant to this chapter or the applicable practice act of the prescribing practitioner. Notwithstanding s.

456.073(13), the department may initiate an investigation and establish such a pattern from billing records, data, or any other information obtained by the department.

Section 10. Subsection (1) of section 465.188, Florida Statutes, is amended to read:

465.188 Medicaid audits of pharmacies.--

(1) Notwithstanding any other law, when an audit of the Medicaid-related records of a pharmacy licensed under chapter 465 is conducted, such audit must be conducted as provided in this section.

~~(a) The agency conducting the audit must give the pharmacist at least 1 week's prior notice of the audit.~~

(a)~~(b)~~ An audit must be conducted by a pharmacist licensed in this state.

(b)~~(c)~~ Any clerical or recordkeeping error, such as a typographical error, scrivener's error, or computer error regarding a document or record required under the Medicaid program does not constitute a willful violation and is not subject to criminal penalties without proof of intent to commit fraud.

(c)~~(d)~~ A pharmacist may use the physician's record or other order for drugs or medicinal supplies written or transmitted by any means of communication for purposes of validating the pharmacy record with respect to orders or refills of a legend or narcotic drug.

(d)~~(e)~~ A finding of an overpayment or underpayment must be based on the actual overpayment or underpayment and may not be a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs.

(e)~~(f)~~ Each pharmacy shall be audited under the same standards and parameters.

(f)~~(g)~~ A pharmacist must be allowed at least 10 days in which to produce documentation to address any discrepancy found during an audit.

(g)~~(h)~~ The period covered by an audit may not exceed 1 calendar year.

(h)~~(i)~~ An audit may not be scheduled during the first 5 days of any month due to the high volume of prescriptions filled during that time.

(i)~~(j)~~ The audit report must be delivered to the pharmacist within 90 days after conclusion of the audit. A final audit report shall be delivered to the pharmacist within 6 months after receipt of the preliminary audit report or final appeal, as provided for in subsection (2), whichever is later.

(j) The audit criteria set forth in this section applies only to audits of claims submitted for payment subsequent to July 11, 2003.

Section 11. Section 812.0191, Florida Statutes, is created to read:

812.0191 Dealing in property paid for in whole or in part by the Medicaid program.--

(1) As used in this section, the term:

(a) "Property paid for in whole or in part by the Medicaid program" means any devices, goods, services, drugs, or any other property furnished or intended to be furnished to a recipient of benefits under the Medicaid program.

(b) "Value" means the amount billed to Medicaid for the property dispensed or the market value of the devices, goods, services, or drugs at the time and place of the

offense. If the market value cannot be determined, the term means the replacement cost of the devices, goods, services, or drugs within a reasonable time after the offense.

(2) Any person who traffics in, or endeavors to traffic in, property that he or she knows or should have known was paid for in whole or in part by the Medicaid program commits a felony.

(a) If the value of the property involved is less than $20,000, the crime is a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) If the value of the property involved is $20,000 or more but less than $100,000, the crime is a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) If the value of the property involved is $100,000 or more, the crime is a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

The value of individual items of the devices, goods, services, drugs, or other property involved in distinct transactions committed during a single scheme or course of conduct, whether involving a single person or several persons, may be aggregated when determining the punishment for the offense.

(3) Any person who knowingly initiates, organizes, plans, finances, directs, manages, or supervises the obtaining of property paid for in whole or in part by the Medicaid program and who traffics in, or endeavors to traffic in, such property commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 12. Paragraph (a) of subsection (1) of section 895.02, Florida Statutes, is amended to read:

895.02 Definitions.--As used in ss. 895.01-895.08, the term:

(1) "Racketeering activity" means to commit, to attempt to commit, to conspire to commit, or to solicit, coerce, or intimidate another person to commit:

(a) Any crime which is chargeable by indictment or information under the following provisions of the Florida Statutes:

1. Section 210.18, relating to evasion of payment of cigarette taxes.

2. Section 403.727(3)(b), relating to environmental control.

3. Section 414.39, relating to public assistance fraud.

4. Section 409.920, relating to Medicaid provider fraud and s. 409.9201, relating to Medicaid recipient fraud.

5. Section 440.105 or s. 440.106, relating to workers' compensation.

6. Sections 499.0051, 499.0052, 499.0053, 499.0054, and 499.0691, relating to crimes involving contraband and adulterated drugs.

7. Part IV of chapter 501, relating to telemarketing.

8. Chapter 517, relating to sale of securities and investor protection.

9. Section 550.235, s. 550.3551, or s. 550.3605, relating to dogracing and horseracing.

10. Chapter 550, relating to jai alai frontons.

11. Chapter 552, relating to the manufacture, distribution, and use of explosives.

12. Chapter 560, relating to money transmitters, if the violation is punishable as a felony.

13. Chapter 562, relating to beverage law enforcement.

14. Section 624.401, relating to transacting insurance without a certificate of authority, s. 624.437(4)(c)1., relating to operating an unauthorized multiple-employer welfare arrangement, or s. 626.902(1)(b), relating to representing or aiding an unauthorized insurer.

15. Section 655.50, relating to reports of currency transactions, when such violation is punishable as a felony.

16. Chapter 687, relating to interest and usurious practices.

17. Section 721.08, s. 721.09, or s. 721.13, relating to real estate timeshare plans.

18. Chapter 782, relating to homicide.

19. Chapter 784, relating to assault and battery.

20. Chapter 787, relating to kidnapping.

21. Chapter 790, relating to weapons and firearms.

22. Section 796.03, s. 796.04, s. 796.05, or s. 796.07, relating to prostitution.

23. Chapter 806, relating to arson.

24. Section 810.02(2)(c), relating to specified burglary of a dwelling or structure.

25. Chapter 812, relating to theft, robbery, and related crimes.

26. Chapter 815, relating to computer-related crimes.

27. Chapter 817, relating to fraudulent practices, false pretenses, fraud generally, and credit card crimes.

28. Chapter 825, relating to abuse, neglect, or exploitation of an elderly person or disabled adult.

29. Section 827.071, relating to commercial sexual exploitation of children.

30. Chapter 831, relating to forgery and counterfeiting.

31. Chapter 832, relating to issuance of worthless checks and drafts.

32. Section 836.05, relating to extortion.

33. Chapter 837, relating to perjury.

34. Chapter 838, relating to bribery and misuse of public office.

35. Chapter 843, relating to obstruction of justice.

36. Section 847.011, s. 847.012, s. 847.013, s. 847.06, or s. 847.07, relating to obscene literature and profanity.

37. Section 849.09, s. 849.14, s. 849.15, s. 849.23, or s. 849.25, relating to gambling.

38. Chapter 874, relating to criminal street gangs.

39. Chapter 893, relating to drug abuse prevention and control.

40. Chapter 896, relating to offenses related to financial transactions.

41. Sections 914.22 and 914.23, relating to tampering with a witness, victim, or informant, and retaliation against a witness, victim, or informant.

42. Sections 918.12 and 918.13, relating to tampering with jurors and evidence.

Section 13. Section 905.34, Florida Statutes, is amended to read:

905.34 Powers and duties; law applicable.--The jurisdiction of a statewide grand jury impaneled under this chapter shall extend throughout the state. The subject matter jurisdiction of the statewide grand jury shall be limited to the offenses of:

(1) Bribery, burglary, carjacking, home-invasion robbery, criminal usury, extortion, gambling, kidnapping, larceny, murder, prostitution, perjury, and robbery;

(2) Crimes involving narcotic or other dangerous drugs;

(3) Any violation of the provisions of the Florida RICO (Racketeer Influenced and Corrupt Organization) Act, including any offense listed in the definition of racketeering activity in s. 895.02(1)(a), providing such listed offense is investigated in connection with a violation of s. 895.03 and is charged in a separate count of an information or indictment containing a count charging a violation of s. 895.03, the prosecution of which listed offense may continue independently if the prosecution of the violation of s. 895.03 is terminated for any reason;

(4) Any violation of the provisions of the Florida Anti-Fencing Act;

(5) Any violation of the provisions of the Florida Antitrust Act of 1980, as amended;

(6) Any violation of the provisions of chapter 815;

(7) Any crime involving, or resulting in, fraud or deceit upon any person;

(8) Any violation of s. 847.0135, s. 847.0137, or s. 847.0138 relating to computer pornography and child exploitation prevention, or any offense related to a violation of s. 847.0135, s. 847.0137, or s. 847.0138; ~~or~~

(9) Any criminal violation of part I of chapter 499; or

(10) Any criminal violation of s. 409.920 or s. 409.9201;

or any attempt, solicitation, or conspiracy to commit any violation of the crimes specifically enumerated above, when any such offense is occurring, or has occurred, in two or more judicial circuits as part of a related transaction or when any such offense is connected with an organized criminal conspiracy affecting two or more judicial circuits. The statewide grand jury may return indictments and presentments irrespective of the county or judicial circuit where the offense is committed or triable. If an indictment is returned, it shall be certified and transferred for trial to the county where the offense was committed. The powers and duties of, and law applicable to, county grand juries shall apply to a statewide grand jury except when such powers, duties, and law are inconsistent with the provisions of ss. 905.31-905.40.

Section 14. Paragraph (a) of subsection (2) of section 932.701, Florida Statutes, is amended to read:

932.701 Short title; definitions.--

(2) As used in the Florida Contraband Forfeiture Act:

(a) "Contraband article" means:

1. Any controlled substance as defined in chapter 893 or any substance, device, paraphernalia, or currency or other means of exchange that was used, was attempted to be used, or was intended to be used in violation of any provision of chapter 893, if the totality of the facts presented by the state is clearly sufficient to meet the state's burden of establishing probable cause to believe that a nexus exists between the article seized and the narcotics activity, whether or not the use of the contraband article can be traced to a specific narcotics transaction.

2. Any gambling paraphernalia, lottery tickets, money, currency, or other means of exchange which was used, was attempted, or intended to be used in violation of the gambling laws of the state.

3. Any equipment, liquid or solid, which was being used, is being used, was attempted to be used, or intended to be used in violation of the beverage or tobacco laws of the state.

4. Any motor fuel upon which the motor fuel tax has not been paid as required by law.

5. Any personal property, including, but not limited to, any vessel, aircraft, item, object, tool, substance, device, weapon, machine, vehicle of any kind, money, securities, books, records, research, negotiable instruments, or currency, which was used or was attempted to be used as an instrumentality in the commission of, or in aiding or abetting in the commission of, any felony, whether or not comprising an element of the felony, or which is acquired by proceeds obtained as a result of a violation of the Florida Contraband Forfeiture Act.

6. Any real property, including any right, title, leasehold, or other interest in the whole of any lot or tract of land, which was used, is being used, or was attempted to be used as an instrumentality in the commission of, or in aiding or abetting in the commission of, any felony, or which is acquired by proceeds obtained as a result of a violation of the Florida Contraband Forfeiture Act.

7. Any personal property, including, but not limited to, equipment, money, securities, books, records, research, negotiable instruments, currency, or any vessel, aircraft, item, object, tool, substance, device, weapon, machine, or

vehicle of any kind in the possession of or belonging to any person who takes aquaculture products in violation of s. 812.014(2)(c).

8. Any motor vehicle offered for sale in violation of s. 320.28.

9. Any motor vehicle used during the course of committing an offense in violation of s. 322.34(9)(a).

10. Any real property, including any right, title, leasehold, or other interest in the whole of any lot or tract of land, which is acquired by proceeds obtained as a result of Medicaid provider fraud under s. 409.920; any personal property, including, but not limited to, equipment, money, securities, books, records, research, negotiable instruments, or currency; or any vessel, aircraft, item, object, tool, substance, device, weapon, machine, or vehicle of any kind in the possession of or belonging to any person which is acquired by proceeds obtained as a result of Medicaid provider fraud under s. 409.920.

Section 15. Paragraph (l) is added to subsection (5) of section 932.7055, Florida Statutes, to read:

932.7055 Disposition of liens and forfeited property.--

(5) If the seizing agency is a state agency, all remaining proceeds shall be deposited into the General Revenue Fund. However, if the seizing agency is:

(l) The Medicaid Fraud Control Unit of the Department of Legal Affairs, the state share of the proceeds accrued pursuant to the provisions of the Florida Contraband Forfeiture Act shall be deposited into the Grants and Donations Trust Fund as provided in s. 409.916, as applicable.

Section 16. This act shall take effect July 1, 2004.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
Senate Bill 1064

The committee substitute makes the following changes to SB 1064:

Authorizes the Office of Statewide Prosecution to investigate and prosecute any criminal violation of s. 409.920 or s. 409.9201, F.S., and provides that the Statewide Grand Jury's jurisdiction includes any criminal violation of s. 409.920 or s. 409.9201, F.S.

Includes MFCU in the AHCA local coordinating workgroups for identifying unlicensed assisted living facilities and gives MFCU the authority to enter and inspect facilities licensed under part III of ch. 400, F.S.

Gives AHCA the authority to require a confirmation or second physician's opinion of the correct diagnosis before authorizing payment for medical treatment.

Requires AHCA and the Drug Utilization Review Board to consult with the Department of Health under the practice pattern identification program.

Specifies that AHCA can conduct or contract for prepayment review of provider claims to ensure that billing by a provider is in accordance with applicable Medicaid rules, regulations, handbooks, and policies and in accordance with all state and federal laws, and to ensure that appropriate care is rendered to Medicaid recipients.

Clarifies that suspension or termination from the Medicaid program precludes participation in Medicaid during that period, which includes any action that results in a claim for payment to the Medicaid program as a result of furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services.

Authorizes AHCA to limit, restrict, or suspend Medicaid eligibility for a period of up to one year for those recipients convicted of a fraudulent act under or against a federal health care program.

Further specifies a provider's obligation with regard to submitting claims to the Medicaid progrqam by providing that AHCA shall not reimburse any person or entity for any prescription for medications, medical supplies, or medical services if the prescription was written by a physician or other prescribing practitioner who is not enrolled in the Medicaid program, and provides certain exemptions.

Authorizes AHCA to limit the number of Schedule II and Schedule III refill prescription claims submitted from pharmacy providers.

Requires AHCA to limit the allowable amount of reimbursement of prescription refill claims for Schedule II and Schedule III pharmaceuticals if AHCA or MFCU determines that the specific

prescription refill was not requested by the Medicaid recipient or authorized representative for whom the refill claim is submitted, or was not prescribed by the recipient's medical provider or physician.

Redefines the term "knowingly" as an act done voluntarily and intentionally and not because of mistake or accident. "Knowingly" also includes the word "willfully" or "willful". Makes it unlawful to knowingly use or endeavor to use a Medicaid provider's or recipient's identification number or cause to be made, or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed under the Medicaid program.

Authorizes AHCA and MFCU to review a provider's non-Medicaid-related records, without the patient's consent, pursuant to an investigation of suspected Medicaid fraud in or to determine consistency in the quality and appropriateness of treatment provided to Medicaid recipients as compared to non-Medicaid recipients.

Provides an additional ground under which a health care practitioner who prescribes medicinal drugs or controlled substances may be subject to discipline by the Department of Health or the appropriate board having jurisdiction over the health care practitioner.

Deletes the requirement that AHCA give pharmacists at least 1 week's notice prior to a pharmacy audit, specifying an effective date for the audit criteria in the section.

Creates new felony violations for various Medicaid fraud activities.

Expands the definition of "racketeering activity" to include crimes committed under s. 409.9201, F.S., relating to Medicaid recipient fraud. Expands the definition of "contraband article." Requires that proceeds collected under the Contraband Forfeiture Act be deposited in AHCA's Grants and Donations Trust Fund.