By the Committees on Criminal Justice; and Health Regulation; and Senators Gaetz and Peaden

591-04084-09 20091986c2

A bill to be entitled

An act relating to health care; providing legislative findings; designating Miami-Dade County as a health care fraud area of concern; amending s. 68.085, F.S.; allocating certain funds recovered under the Florida False Claims Act to fund rewards for persons who report and provide information relating to Medicaid fraud; amending s. 68.086, F.S.; providing that a defendant who prevails in an action under the Florida False Claims Act may be awarded attorney's fees and costs against the person bringing the action under certain circumstances; amending s. 400.471, F.S.; prohibiting the Agency for Health Care Administration from renewing a license of a home health agency in certain counties if the agency has been sanctioned for certain misconduct; amending s. 400.474, F.S.; authorizing the Agency for Health Care Administration to deny, revoke, or suspend the license of or fine a home health agency that bills the Medicaid program for medically unnecessary services; amending s. 400.506, F.S.; exempting certain items from a prohibition against providing remuneration to certain persons by a nurse registry; amending s. 408.05, F.S.; requiring the Florida Center for Health Information and Policy Analysis to take certain actions to improve the prevention and detection of health care fraud through the use of technology; creating s. 408.8065, F.S.; providing additional licensure requirements for home health agencies, home medical equipment providers, and

health care clinics; imposing criminal penalties on a person who knowingly submits misleading information to the Agency for Health Care Administration in connection with applications for certain licenses; amending s. 408.810, F.S.; requiring certain licensees to provide clients with a description of Medicaid fraud and the statewide toll-free telephone number for the central Medicaid fraud hotline; amending s. 408.815, F.S.; providing additional grounds to deny an application for a license; amending s. 409.905, F.S.; authorizing the Agency for Health Care Administration to require prior authorization of care based on utilization rates; requiring a home health agency to submit a plan of care and documentation of a recipient's medical condition to the Agency for Health Care Administration when requesting prior authorization; prohibiting the Agency for Health Care Administration from paying for home health services unless specified requirements are satisfied; amending s. 409.912, F.S.; requiring the Agency for Health Care Administration to establish norms for the utilization of Medicaid services; requiring the agency to submit a report relating to the overutilization of Medicaid services; amending s. 409.913, F.S.; requiring that the annual report submitted by the Agency for Health Care Administration and the Medicaid Fraud Control Unit of the Department of Legal Affairs recommend changes necessary to prevent and detect Medicaid fraud; requiring the Agency for Health Care

Administration to monitor patterns of overutilization of Medicaid services; requiring the agency to deny payment or require repayment for Medicaid services under certain circumstances; requiring the Agency for Health Care Administration to immediately terminate a Medicaid provider's participation in the Medicaid program as a result of certain adjudications against the provider or certain affiliated persons; requiring the Agency for Health Care Administration to suspend or terminate a Medicaid provider's participation in the Medicaid program if the provider or certain affiliated persons participating in the Medicaid program have been suspended or terminated by the Federal Government or another state; providing that a provider is subject to sanctions for violations of law as the result of actions or inactions of the provider or certain affiliated persons; requiring the Agency for Health Care Administration to use specified documents from a provider's records to calculate an overpayment by the Medicaid program; prohibiting a provider from using certain documents or data as evidence when challenging a claim of overpayment by the Agency for Health Care Administration; requiring that the agency provide notice of certain administrative sanctions to other regulatory agencies within a specified period; requiring the Agency for Health Care Administration to withhold or deny Medicaid payments under certain circumstances; requiring the agency to terminate a provider's

participation in the Medicaid program if the provider fails to repay certain overpayments from the Medicaid program; requiring the agency to provide at least annually information on Medicaid fraud in an explanation of benefits letter; requiring the Agency for Health Care Administration to post a list on its website of Medicaid providers and affiliated persons of providers who have been terminated or sanctioned; amending s. 409.920, F.S.; defining the term "managed care organization"; providing criminal penalties and fines for Medicaid fraud; granting civil immunity to certain persons who report suspected Medicaid fraud; creating s. 409.9203, F.S.; authorizing the payment of rewards to persons who report and provide information relating to Medicaid fraud; amending s. 456.004, F.S.; requiring the Department of Health to work cooperatively with the Agency for Health Care Administration and the judicial system to recover overpayments by the Medicaid program; amending s. 456.041, F.S.; requiring the Department of Health to include a statement in the practitioner profile if a practitioner has been terminated from participating in the Medicaid program; creating s. 456.0635, F.S.; prohibiting Medicaid fraud in the practice of health care professions; requiring the Department of Health or boards within the department to refuse to admit to exams and to deny licenses, permits, or certificates to certain persons who have engaged in certain acts; requiring health care practitioners to report

allegations of Medicaid fraud; specifying that acceptance of the relinquishment of a license in anticipation of charges relating to Medicaid fraud constitutes permanent revocation of a license; amending s. 456.072, F.S.; creating additional grounds for the Department of Health to take disciplinary action against certain applicants or licensees for misconduct relating to a Medicaid program or to health care fraud; amending s. 456.074, F.S.; requiring the Department of Health to issue an emergency order suspending the license of a person who engages in certain criminal conduct relating to the Medicaid program; amending s. 465.022, F.S.; authorizing partnerships and corporations to obtain pharmacy permits; requiring applicants or certain persons affiliated with an applicant for a pharmacy permit to submit a set of fingerprints for a criminal history records check and pay the costs of the criminal history records check; amending s. 465.023, F.S.; requiring the Department of Health or the Board of Pharmacy to deny an application for a pharmacy permit or take disciplinary action against a permitee for certain misconduct by the applicant, licensee, or person affiliated with the applicant or licensee; amending s. 825.103, F.S.; redefining the term "exploitation of an elderly person or disabled adult"; amending s. 921.0022, F.S.; revising the severity level ranking of Medicaid fraud under the Criminal Punishment Code; creating a pilot project to monitor

and verify the delivery of home health services and provide for electronic claims for home health services; requiring the Agency for Health Care Administration to issue a report evaluating the pilot project; creating a pilot project for home health care management in Miami-Dade County; amending ss. 400.0077 and 430.608, F.S.; conforming cross-references to changes made by the act; providing an effective date.

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

Section 1. The Legislature finds that:

(1) Immediate and proactive measures are necessary to prevent, reduce, and mitigate health care fraud, waste, and abuse and are essential to maintaining the integrity and financial viability of health care delivery systems, including those funded in whole or in part by the Medicare and Medicaid trust funds. Without these measures, health care delivery systems in this state will be depleted of necessary funds to deliver patient care, and taxpayers' dollars will be devalued and not used for their intended purposes.

(2) Sufficient justification exists for increased oversight of health care clinics, home health agencies, providers of home medical equipment, and other health care providers throughout the state, and in particular, in Miami-Dade County.

(3) The state's best interest is served by deterring health care fraud, abuse, and waste and identifying patterns of fraudulent or abusive Medicare and Medicaid activity early, especially in high-risk localities, such as Miami-Dade County,

in order to prevent inappropriate expenditures of public funds and harm to the state's residents.

(4) The Legislature designates Miami-Dade County as a health care fraud crisis area for purposes of implementing increased scrutiny of home health agencies, home medical equipment providers, health care clinics, and other health care providers in Miami-Dade County in order to assist the state's efforts to prevent Medicaid fraud, waste, and abuse in the county and throughout the state.

Section 2. Section 68.085, Florida Statutes, is amended to read:

68.085 Awards to plaintiffs bringing action.—

(1) If the department proceeds with and prevails in an action brought by a person under this act, except as provided in subsection (2), the court shall order the distribution to the person of at least 15 percent but not more than 25 percent of the proceeds recovered under any judgment obtained by the department in an action under s. 68.082 or of the proceeds of any settlement of the claim, depending upon the extent to which the person substantially contributed to the prosecution of the action.

(2) If the department proceeds with an action which the court finds to be based primarily on disclosures of specific information, other than that provided by the person bringing the action, relating to allegations or transactions in a criminal, civil, or administrative hearing; a legislative, administrative, inspector general, or auditor general report, hearing, audit, or investigation; or from the news media, the court may award such sums as it considers appropriate, but in no case more than 10

percent of the proceeds recovered under a judgment or received in settlement of a claim under this act, taking into account the significance of the information and the role of the person bringing the action in advancing the case to litigation.

(3) If the department does not proceed with an action under this section, the person bringing the action or settling the claim shall receive an amount which the court decides is reasonable for collecting the civil penalty and damages. The amount shall be not less than 25 percent and not more than 30 percent of the proceeds recovered under a judgment rendered in an action under this act or in settlement of a claim under this act.

(4) Following any distributions under subsection (1), subsection (2), or subsection (3), the agency injured by the submission of a false or fraudulent claim shall be awarded an amount not to exceed its compensatory damages. If the action was based on a claim of funds from the state Medicaid program, 10 percent of any remaining proceeds shall be deposited into the Legal Affairs Revolving Trust Fund to fund rewards for persons who report and provide information relating to Medicaid fraud pursuant to s. 409.9203. Any remaining proceeds, including civil penalties awarded under s. 68.082, shall be deposited in the General Revenue Fund.

(5) Any payment under this section to the person bringing the action shall be paid only out of the proceeds recovered from the defendant.

(6) Whether or not the department proceeds with the action, if the court finds that the action was brought by a person who planned and initiated the violation of s. 68.082 upon which the

action was brought, the court may, to the extent the court considers appropriate, reduce the share of the proceeds of the action which the person would otherwise receive under this section, taking into account the role of the person in advancing the case to litigation and any relevant circumstances pertaining to the violation. If the person bringing the action is convicted of criminal conduct arising from his or her role in the violation of s. 68.082, the person shall be dismissed from the civil action and shall not receive any share of the proceeds of the action. Such dismissal shall not prejudice the right of the department to continue the action.

Section 3. Section 68.086, Florida Statutes, is amended to read:

68.086 Expenses; attorney's fees and costs.—

(1) If the department initiates an action under this act or assumes control of an action brought by a person under this act, the department shall be awarded its reasonable attorney's fees, expenses, and costs.

(2) If the court awards the person bringing the action proceeds under this act, the person shall also be awarded an amount for reasonable attorney's fees and costs. Payment for reasonable attorney's fees and costs shall be made from the recovered proceeds before the distribution of any award.

(3) If the department does not proceed with an action under this act and the person bringing the action conducts the action ~~defendant is the prevailing party~~, the court may ~~shall~~ award to the defendant its reasonable attorney's fees and costs if the defendant prevails in the action and the court finds that the claim of ~~against~~ the person bringing the action was clearly

frivolous, clearly vexatious, or brought primarily for purposes of harassment.

(4) No liability shall be incurred by the state government, the affected agency, or the department for any expenses, attorney's fees, or other costs incurred by any person in bringing or defending an action under this act.

Section 4. Subsection (10) is added to section 400.471, Florida Statutes, to read:

400.471 Application for license; fee.—

(10) The agency may not issue a renewal license for a home health agency in any county having at least one licensed home health agency and that has more than one home health agency per 5,000 persons, as indicated by the most recent population estimates published by the Legislature's Office of Economic and Demographic Research, if the applicant or any controlling interest has been administratively sanctioned within the last calendar year by the agency for one or more of the following acts:

(a) An intentional, reckless, or negligent act that materially affects the health or safety of a patient;

(b) Knowingly providing home health services in an unlicensed assisted living facility or unlicensed adult family-care home, unless the home health agency or employee reports the unlicensed facility or home to the agency within 72 hours after providing the services;

(c) Preparing or maintaining fraudulent patient records, such as, but not limited to, charting ahead, recording vital signs or symptoms which were not personally obtained or observed by the home health agency's staff at the time indicated,

borrowing patients or patient records from other home health agencies to pass a survey or inspection, or falsifying signatures;

(d) Failing to provide at least one service directly to a patient for a period of 60 days;

(e) Demonstrating a pattern of falsifying documents relating to the training of home health aides or certified nursing assistants or demonstrating a pattern of falsifying health statements for staff who provide direct care to patients. A pattern may be demonstrated by a showing of at least three fraudulent entries or documents;

(f) Demonstrating a pattern of billing any payor for services not provided. A pattern may be demonstrated by a showing of at least three billings for services not provided within a 12-month period;

(g) Demonstrating a pattern of failing to provide a service specified in the home health agency's written agreement with a patient or the patient's legal representative, or the plan of care for that patient, unless a reduction in service is mandated by Medicare, Medicaid, or a state program or as provided in s. 400.492(3). A pattern may be demonstrated by a showing of at least three incidents, regardless of the patient or service, in which the home health agency did not provide a service specified in a written agreement or plan of care during a 3-month period;

(h) Giving remuneration to a case manager, discharge planner, facility-based staff member, or third-party vendor who is involved in the discharge planning process of a facility licensed under chapter 395 or this chapter from whom the home health agency receives referrals;

(i) Giving cash, or its equivalent, to a Medicare or Medicaid beneficiary; or

(j) Demonstrating a pattern of billing the Medicaid program for services to Medicaid recipients which are medically unnecessary. A pattern may be demonstrated by a showing of at least three fraudulent entries or documents.

Section 5. Paragraph (l) is added to subsection (6) of section 400.474, Florida Statutes, to read:

400.474 Administrative penalties.—

(6) The agency may deny, revoke, or suspend the license of a home health agency and shall impose a fine of $5,000 against a home health agency that:

(l) Demonstrates a pattern of billing the Medicaid program for services to Medicaid recipients that are medically unnecessary. A pattern may be demonstrated by a showing of at least three medically unnecessary services.

Section 6. Paragraph (a) of subsection (15) of section 400.506, Florida Statutes, is amended to read:

400.506 Licensure of nurse registries; requirements; penalties.—

(15)(a) The agency may deny, suspend, or revoke the license of a nurse registry and shall impose a fine of $5,000 against a nurse registry that:

1. Provides services to residents in an assisted living facility for which the nurse registry does not receive fair market value remuneration.

2. Provides staffing to an assisted living facility for which the nurse registry does not receive fair market value remuneration.

3. Fails to provide the agency, upon request, with copies of all contracts with assisted living facilities which were executed within the last 5 years.

4. Gives remuneration to a case manager, discharge planner, facility-based staff member, or third-party vendor who is involved in the discharge planning process of a facility licensed under chapter 395 or this chapter and from whom the nurse registry receives referrals. However, this subparagraph does not prohibit a nurse registry from providing promotional items or promotional products, food, or beverages. The cumulative value of these items may not exceed $50 for a single event. The cumulative value of these items may not exceed $100 in a calendar year for all persons specified in this subparagraph who are affiliated with a facility.

5. Gives remuneration to a physician, a member of the physician's office staff, or an immediate family member of the physician, and the nurse registry received a patient referral in the last 12 months from that physician or the physician's office staff. However, this subparagraph does not prohibit a nurse registry from providing promotional items or promotional products, food, or beverages. The cumulative value of these items may not exceed $50 for a single event. The cumulative value of these items may not exceed $100 in a calendar year for all persons specified in this subparagraph who are affiliated with a physician's office.

Section 7. Present subsections (4) through (9) of section 408.05, Florida Statutes, are renumbered as subsections (5) through (10), respectively, and a new subsection (4) is added to that section, to read:

408.05 Florida Center for Health Information and Policy Analysis.—

(4) MEDICAID FRAUD DETECTION.—In order to improve the detection of health care fraud, use technology to prevent and detect fraud, and maximize the electronic exchange of health care fraud information, the center shall:

(a) Compile, maintain, and publish on its website a detailed list of all state and federal databases that contain health care fraud information and update the list at least biannually;

(b) Develop a strategic plan to connect all databases that contain health care fraud information to facilitate the electronic exchange of health information between the agency, the Department of Health, the Department of Law Enforcement, and the Attorney General's Office. The plan must include recommended standard data formats, fraud identification strategies, and specifications for the technical interface between state and federal health care fraud databases;

(c) Monitor innovations in health information technology, specifically as it pertains to Medicaid fraud prevention and detection; and

(d) Periodically publish policy briefs that highlight available new technology to prevent or detect health care fraud and projects implemented by other states, the private sector, or the Federal Government which use technology to prevent or detect health care fraud.

Section 8. Section 408.8065, Florida Statutes, is created to read:

408.8065 Additional licensure requirements for home health

agencies, home medical equipment providers, and health care clinics.—

(1) An applicant for initial licensure, or initial licensure due to a change of ownership, as a home health agency, home medical equipment provider, or health care clinic shall:

(a) Demonstrate financial ability to operate, as required under s. 408.810(8);

(b)1. Submit pro forma financial statements, including a balance sheet and an income and expense statement, for the first year of operation which provides evidence that the applicant has sufficient assets, credit, and projected revenues to cover liabilities and expenses; or

2. Demonstrate the financial ability to operate if the applicant's assets, credit, and projected revenues do not meet or exceed projected liabilities and expenses; and

(c) Submit a statement of the applicant's estimated startup costs and sources of funds through the break-even point in operations demonstrating that the applicant has the ability to fund all startup costs. The statement must show that the applicant has a minimum amount of operating funds equal to 3 months of average projected expenses. The applicant must provide documented proof that these funds will be available as needed.

All documents required under this subsection must be prepared in accordance with generally accepted accounting principles and may be in a compilation form. The financial statements must be signed by a certified public accountant.

(2) In addition to the penalties provided in s. 408.812, any person offering services requiring licensure under part III,

part VII, or part X of chapter 400, who knowingly files a false or misleading license or license renewal application or who submits false or misleading information related to such application; and any person who violates or conspires to violate this section commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 9. Paragraph (a) of subsection (5) of section 408.810, Florida Statutes, is amended to read:

408.810 Minimum licensure requirements.—In addition to the licensure requirements specified in this part, authorizing statutes, and applicable rules, each applicant and licensee must comply with the requirements of this section in order to obtain and maintain a license.

(5)(a) On or before the first day services are provided to a client, a licensee must inform the client and his or her immediate family or representative, if appropriate, of the right to report:

1. Complaints. The statewide toll-free telephone number for reporting complaints to the agency must be provided to clients in a manner that is clearly legible and must include the words: "To report a complaint regarding the services you receive, please call toll-free (phone number)."

2. Abusive, neglectful, or exploitative practices. The statewide toll-free telephone number for the central abuse hotline must be provided to clients in a manner that is clearly legible and must include the words: "To report abuse, neglect, or exploitation, please call toll-free (phone number)."

3. Medicaid fraud. A written description of Medicaid fraud in layman's terms and the statewide toll-free telephone number

for the central Medicaid fraud hotline must be provided to clients in a manner that is clearly legible and must include the words: "To report suspected Medicaid fraud, please call toll-free (phone number)."

The agency shall publish a minimum of a 90-day advance notice of a change in the toll-free telephone numbers.

Section 10. Subsection (4) is added to section 408.815, Florida Statutes, to read:

408.815 License or application denial; revocation.—

(4) In addition to the grounds provided in authorizing statutes, the agency shall deny an application for a license or license renewal if the applicant or a person having a controlling interest in an applicant has been:

(a) Convicted of, or enters a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396; or

(b) Terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from any state Medicaid program or the federal Medicare program.

Section 11. Subsection (4) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically

necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(4) HOME HEALTH CARE SERVICES.—The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home. An entity that provides services pursuant to this subsection shall be licensed under part III of chapter 400. These services, equipment, and supplies, or reimbursement therefor, may be limited as provided in the General Appropriations Act and do not include services, equipment, or supplies provided to a person residing in a hospital or nursing facility.

(a) In providing home health care services, the agency may require prior authorization of care based on diagnosis or utilization rates. The agency shall require prior authorization for visits for home health services that are not associated with a skilled nursing visit when the home health agency utilization rates exceed the state average by 50 percent or more. The home health agency must submit the recipient's plan of care and documentation that supports the recipient's diagnosis to the agency when requesting prior authorization.

(b) The agency shall implement a comprehensive utilization

management program that requires prior authorization of all private duty nursing services, an individualized treatment plan that includes information about medication and treatment orders, treatment goals, methods of care to be used, and plans for care coordination by nurses and other health professionals. The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. The assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule regarding work, school, sleep, and care for other family dependents. When implemented, the private duty nursing utilization management program shall replace the current authorization program used by the Agency for Health Care Administration and the Children's Medical Services program of the Department of Health. The agency may competitively bid on a contract to select a qualified organization to provide utilization management of private duty nursing services. The agency is authorized to seek federal waivers to implement this initiative.

(c) The agency may not pay for home health services, unless the services are medically necessary, and:

1. The services are ordered by a physician.

2. The written prescription for the services is signed and dated by the recipient's physician before the development of a plan of care and before any request requiring prior authorization.

3. The physician ordering the services is not employed, under contract with, or otherwise affiliated with the home

health agency rendering the services.

4. The physician ordering the services has examined the recipient within the 30 days preceding the initial request for the services and biannually thereafter.

5. The written prescription for the services includes the recipient's acute or chronic medical condition or diagnosis; the home health service required, including the minimum skill level required to perform the service; and the frequency and duration of the services.

6. The national provider identifier, Medicaid identification number, or medical practitioner license number of the physician ordering the services is listed on the written prescription for the services, the claim for home health reimbursement, and the prior authorization request.

Section 12. Subsection (14) of 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 for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. 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 shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation 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. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without

limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers shall not be entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(14)(a) The agency shall operate or contract for the operation of utilization management and incentive systems designed to encourage cost-effective use <u>of</u> services <u>and to eliminate overutilization of Medicaid services that are medically unnecessary</u>. <u>The agency shall establish norms for the utilization of Medicaid services which are risk-adjusted for patient acuity. The agency shall also track Medicaid provider prescription and treatment patterns and develop utilization norms. Providers that demonstrate a pattern of submitting claims</u>

for medically unnecessary services shall be referred to the Medicaid program integrity unit for investigation. By February 1, 2010, the agency shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the utilization of Medicaid services and the establishment of utilization norms in the Medicaid program. The report must include a definition of overutilization and gross overutilization of Medicaid services and recommendations to decrease the overutilization of Medicaid services in the Medicaid program.

(b) The agency shall develop a procedure for determining whether health care providers and service vendors can provide the Medicaid program using a business case that demonstrates whether a particular good or service can offset the cost of providing the good or service in an alternative setting or through other means and therefore should receive a higher reimbursement. The business case must include, but need not be limited to:

1. A detailed description of the good or service to be provided, a description and analysis of the agency's current performance of the service, and a rationale documenting how providing the service in an alternative setting would be in the best interest of the state, the agency, and its clients.

2. A cost-benefit analysis documenting the estimated specific direct and indirect costs, savings, performance improvements, risks, and qualitative and quantitative benefits involved in or resulting from providing the service. The cost-benefit analysis must include a detailed plan and timeline identifying all actions that must be implemented to realize

expected benefits. The Secretary of Health Care Administration shall verify that all costs, savings, and benefits are valid and achievable.

(c) If the agency determines that the increased reimbursement is cost-effective, the agency shall recommend a change in the reimbursement schedule for that particular good or service. If, within 12 months after implementing any rate change under this procedure, the agency determines that costs were not offset by the increased reimbursement schedule, the agency may revert to the former reimbursement schedule for the particular good or service.

Section 13. Subsections (2), (7), (11), (13), (14), (15), (21), (22), (24), (25), (27), (30), (31), and (36) of section 409.913, Florida Statutes, are amended, and subsection (37) is added to that section, 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 include policy recommendations ~~recommend changes~~ necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud. All policy recommendations in the report must include a detailed fiscal analysis, including, but not limited to, implementation costs, estimated savings to the Medicaid program, and the return on investment. The agency must submit the policy recommendations and fiscal analyses in the report to the appropriate estimating conference, pursuant to s. 216.137, by February 15 of each year. The agency and the Medicaid Fraud

Control Unit of the Department of Legal Affairs each must include detailed unit-specific performance standards, benchmarks, and metrics in the report, including projected costs savings to the state Medicaid program during the following fiscal year.

(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. At least 5 percent of all audits shall be conducted on a random basis. As part of its ongoing fraud-detection activities, the agency shall identify and monitor, by contract or otherwise, patterns of overutilization of Medicaid services based on state averages. The agency shall use the scope and frequency of services by diagnosis to establish utilization norms.

(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 shall ~~may~~ deny payment or require repayment for goods or services that are not presented as required in this subsection.

(11) The agency shall ~~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.

(13) The agency shall immediately ~~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 or any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or

greater, 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.

If the agency effects a termination under this subsection, the agency shall issue an immediate final order pursuant to s. 120.569(2)(n).

(14) 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 this state's ~~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 this state's ~~the Florida~~ Medicaid program while such foreign suspension or termination remains in effect. The agency shall also immediately suspend or terminate, as appropriate, a provider's participation in this state's Medicaid program if the provider participated or acquiesced in any action for which any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder

having an ownership interest in the provider equal to 5 percent or greater, was suspended or terminated from participating in the Medicaid program or the Medicare program by the Federal Government or any state. This sanction is in addition to all other remedies provided by law.

(15) The agency shall ~~may~~ seek a ~~any~~ remedy provided by law, including, but not limited to, any remedy ~~the remedies~~ provided in subsections (13) and (16) 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;

(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.

A provider is subject to sanctions for violations of this subsection as the result of actions or inactions of the provider, or actions or inactions of any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership

interest in the provider equal to 5 percent or greater, in which the provider participated or acquiesced.

(21) 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. If the agency's determination that an overpayment has occurred is based upon a review of the provider's records, the calculation of the overpayment shall be based upon documentation created prior to the start of any investigation.

(22) 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. The documentation or data that a provider may rely upon or present as evidence that an overpayment has not occurred must have been created prior to the start of any agency investigation, and must be made available to the agency before

issuance of a final audit report.

(24) If the agency imposes an administrative sanction pursuant to subsection (13), subsection (14), or subsection (15), except paragraphs (15)(e) and (o), upon any provider or any principal, officer, director, agent, managing employee, or affiliated person of the provider ~~other person~~ who is regulated by another state entity, the agency shall notify that other entity of the imposition of the sanction within 5 business days. Such notification must include the provider's or person's name and license number and the specific reasons for sanction.

(25)(a) The agency shall ~~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. 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 shall ~~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) 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) 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.

(27) 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, shall ~~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.

(30) The agency shall ~~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) 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 shall ~~may~~ withhold medical assistance reimbursement payments until the amount due is paid in full.

(36) At least three times a year, the agency shall provide to each Medicaid recipient or his or her representative an explanation of benefits in the form of a letter that is mailed to the most recent address of the recipient on the record with the Department of Children and Family Services. The explanation

of benefits must include the patient's name, the name of the health care provider and the address of the location where the service was provided, a description of all services billed to Medicaid in terminology that should be understood by a reasonable person, and information on how to report inappropriate or incorrect billing to the agency or other law enforcement entities for review or investigation. At least once a year, the letter also must include information on how to report criminal Medicaid fraud, the Medicaid Fraud Control Unit's toll-free hotline number, and information about the rewards available under s. 409.9203. The explanation of benefits may not be mailed for Medicaid independent laboratory services as described in s. 409.905(7) or for Medicaid certified match services as described in ss. 409.9071 and 1011.70.

(37) The agency shall post on its website a current list of each Medicaid provider, including any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, who has been terminated from the Medicaid program or sanctioned under this section. The list must be searchable by a variety of search parameters and provide for the creation of formatted lists that may be printed or imported into other applications, including spreadsheets. The agency shall update the list at least monthly.

Section 14. Subsections (1) and (2) of section 409.920, Florida Statutes, are amended, present subsections (8) and (9) of that section are renumbered as subsections (9) and (10), respectively, and a new subsection (8) is added to that section, 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.

(e) "Managed care organization" means a private insurance carrier, health care cooperative or alliance, health maintenance organization, insurer, organization, entity, association, affiliation, or person that contracts with the agency to provide, or is reimbursed by the agency for goods and services provided, which are a required benefit of a state or federally

funded health care benefit program. The term includes a person who provides or contracts to provide goods and services to a managed care organization.

(2)(a) A person may not ~~It is unlawful to~~:

1.~~(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 or a managed care organization for payment.

2.~~(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.

3.~~(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.

4.~~(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.

5.~~(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.

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

7.~~(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.

(b)1. A person who violates this subsection and receives or endeavors to receive anything of value of:

a. Ten thousand dollars or less commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

b. More than $10,000, but less than $50,000, commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

c. Fifty thousand dollars or more commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. The value of separate funds, goods, or services that a person received or attempted to receive pursuant to a scheme or course of conduct may be aggregated in determining the degree of

the offense.

3. In addition to the sentence authorized by law, a person who is convicted of a violation of this subsection shall pay a fine in an amount equal to five times the pecuniary gain unlawfully received or the loss incurred by the Medicaid program or managed care organization, whichever is greater.

(8) A person who provides the state, any state agency, any of the state's political subdivisions, or any agency of the state's political subdivisions with information about fraud or suspected fraud by a Medicaid provider, including a managed care organization, is immune from civil liability for providing the information unless the person acted with knowledge that the information was false or with reckless disregard for the truth or falsity of the information.

Section 15. Section 409.9203, Florida Statutes, is created to read:

409.9203 Rewards for reporting Medicaid fraud.—

(1) The Department of Law Enforcement or director of the Medicaid Fraud Control Unit shall, subject to availability of funds, pay a reward to a person who furnishes original information relating to and reports a violation of the state's Medicaid fraud laws, unless the person declines the reward, if the information and report:

(a) Is made to the Office of the Attorney General, the Agency for Health Care Administration, the Department of Health, or the Department of Law Enforcement;

(b) Relates to criminal fraud upon Medicaid funds or a criminal violation of Medicaid laws by another person; and

(c) Leads to a recovery of a fine, penalty, or forfeiture

of property.

(2) The reward may not exceed the lesser of 25 percent of the amount recovered or $500,000 in a single case.

(3) The reward shall be paid from the Legal Affairs Revolving Trust Fund from moneys collected pursuant to s. 68.085.

(4) A person who receives a reward pursuant to this section is not eligible to receive any funds pursuant to the Florida False Claims Act for Medicaid fraud for which a reward is received pursuant to this section.

Section 16. Subsection (11) is added to section 456.004, Florida Statutes, to read:

456.004 Department; powers and duties.—The department, for the professions under its jurisdiction, shall:

(11) Work cooperatively with the Agency for Health Care Administration and the judicial system to recover Medicaid overpayments by the Medicaid program. The department shall investigate and prosecute health care practitioners who have not remitted amounts owed to the state for an overpayment from the Medicaid program pursuant to a final order, judgment, or stipulation or settlement.

Section 17. Present subsections (6) through (10) of section 456.041, Florida Statutes, are renumbered as subsections (7) through (11), respectively, and a new subsection (6) is added to that section, to read:

456.041 Practitioner profile; creation.—

(6) The Department of Health shall provide in each practitioner profile for every physician or advanced registered nurse practitioner terminated from participating in the Medicaid

program, pursuant to s. 409.913, or sanctioned by the Medicaid program a statement that the practitioner has been terminated from participating in the Florida Medicaid program or sanctioned by the Medicaid program.

Section 18. Section 456.0635, Florida Statutes, is created to read:

456.0635 Medicaid fraud; disqualification for license, certificate, or registration.—

(1) Medicaid fraud in the practice of a health care profession is prohibited.

(2) Each board within the jurisdiction of the department, or the department if there is no board, shall refuse to admit a candidate to any examination and refuse to issue or renew a license, certificate, or registration to any applicant if the candidate or applicant or any principle, officer, agent, managing employee, or affiliated person of the applicant, has been:

(a) Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396; or

(b) Terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from any state Medicaid program or the federal Medicare program.

(3) Licensed health care practitioners shall report allegations of Medicaid fraud to the department, regardless of the practice setting in which the alleged Medicaid fraud occurred.

(4) The acceptance by a licensing authority of a

candidate's relinquishment of a license which is offered in response to or anticipation of the filing of administrative charges alleging Medicaid fraud or similar charges constitutes the permanent revocation of the license.

Section 19. Paragraphs (ii), (jj), (kk), and (ll) are 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:

(ii) Being convicted of, or entering a plea of guilty or nolo contendere to, any misdemeanor or felony, regardless of adjudication, under 18 U.S.C. s. 669, ss. 285-287, s. 371, s. 1001, s. 1035, s. 1341, s. 1343, s. 1347, s. 1349, or s. 1518, or 42 U.S.C. ss. 1320a-7b, relating to the Medicaid program.

(jj) Failing to remit the sum owed to the state for an overpayment from the Medicaid program pursuant to a final order, judgment, or stipulation or settlement.

(kk) Being terminated from the state Medicaid program pursuant to s. 409.913, any other state Medicaid program, or the federal Medicare program.

(ll) Being convicted of, or entering a plea of guilty or nolo contendere to, any misdemeanor or felony, regardless of adjudication, a crime in any jurisdiction which relates to health care fraud.

Section 20. Subsection (1) of section 456.074, Florida Statutes, is amended to read:

456.074 Certain health care practitioners; immediate suspension of license.—

(1) The department shall issue an emergency order suspending the license of any person licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 464, chapter 465, chapter 466, or chapter 484 who pleads guilty to, is convicted or found guilty of, or who enters a plea of nolo contendere to, regardless of adjudication, to:

(a) A felony under chapter 409, chapter 817, or chapter 893 or under 21 U.S.C. ss. 801-970 or under 42 U.S.C. ss. 1395-1396; or.

(b) A misdemeanor or felony under 18 U.S.C. s. 669, ss. 285-287, s. 371, s. 1001, s. 1035, s. 1341, s. 1343, s. 1347, s. 1349, or s. 1518 or 42 U.S.C. ss. 1320a-7b, relating to the Medicaid program.

Section 21. Subsections (2) and (3) of section 465.022, Florida Statutes, are amended to read:

465.022 Pharmacies; general requirements; fees.—

(2) A pharmacy permit shall be issued only to a person who is at least 18 years of age, a partnership whose partners are all at least 18 years of age, or to a corporation that ~~which~~ is registered pursuant to chapter 607 or chapter 617 whose officers, directors, and shareholders are at least 18 years of age and have an ownership interest of 5 percent or greater.

(3) Any person, partnership, or corporation before engaging in the operation of a pharmacy shall file with the board a sworn application on forms provided by the department.

(a) An application for a pharmacy permit must include a set of fingerprints from each person having an ownership interest of 5 percent or greater and from any person who, directly or indirectly, manages, oversees, or controls the operation of the

applicant, including officers and members of the board of directors of an applicant that is a corporation. The applicant must provide payment in the application for the cost of state and national criminal history records checks.

1. For corporations having more than $100 million of business taxable assets in this state, the department shall require each person who will be directly involved in the management and operation of the pharmacy to submit a set of fingerprints.

2. A representative of a corporation described in subparagraph 1. satisfies the requirement to submit a set of his or her fingerprints if the fingerprints are on file with a state agency and available to the department.

(b) The department shall submit the fingerprints provided by the applicant to the Department of Law Enforcement for a state criminal history records check. The Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for a national criminal history records check.

Section 22. Subsection (1) of section 465.023, Florida Statutes, is amended to read:

465.023 Pharmacy permittee; disciplinary action.—

(1) The department or the board shall deny an application for a pharmacy permit, ~~may~~ revoke or suspend the permit of any pharmacy permittee, and ~~may~~ fine, place on probation, or otherwise discipline any pharmacy permittee if an affiliated person, partner, officer, director, or agent of an applicant or permittee ~~who~~ has:

(a) Obtained a permit by misrepresentation or fraud or through an error of the department or the board;

(b) Attempted to procure, or has procured, a permit for any other person by making, or causing to be made, any false representation;

(c) Violated any of the requirements of this chapter or any of the rules of the Board of Pharmacy; of chapter 499, known as the "Florida Drug and Cosmetic Act"; of 21 U.S.C. ss. 301-392, known as the "Federal Food, Drug, and Cosmetic Act"; of 21 U.S.C. ss. 821 et seq., known as the Comprehensive Drug Abuse Prevention and Control Act; or of chapter 893;

(d) Been convicted or found guilty, regardless of adjudication, of a felony or any other crime involving moral turpitude in any of the courts of this state, of any other state, or of the United States; ~~or~~

(e) Been convicted or disciplined by a regulatory agency of the Federal Government or a regulatory agency of another state for any offense that would constitute a violation of this chapter;

(f) Been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to the practice of, or the ability to practice, the profession of pharmacy;

(g) Been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to health care fraud; or

(h) ~~(e)~~ Dispensed any medicinal drug based upon a communication that purports to be a prescription as defined by s. 465.003(14) or s. 893.02 when the pharmacist knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship that includes a

documented patient evaluation, including history and a physical examination adequate to establish the diagnosis for which any drug is prescribed and any other requirement established by board rule under chapter 458, chapter 459, chapter 461, chapter 463, chapter 464, or chapter 466.

Section 23. Section 825.103, Florida Statutes, is amended to read:

825.103 Exploitation of an elderly person or disabled adult; penalties.—

(1) "Exploitation of an elderly person or disabled adult" means:

(a) Knowingly, by deception or intimidation, obtaining or using, or endeavoring to obtain or use, an elderly person's or disabled adult's funds, assets, or property with the intent to temporarily or permanently deprive the elderly person or disabled adult of the use, benefit, or possession of the funds, assets, or property, or to benefit someone other than the elderly person or disabled adult, by a person who:

1. Stands in a position of trust and confidence with the elderly person or disabled adult; or

2. Has a business relationship with the elderly person or disabled adult; ~~or~~

(b) Obtaining or using, endeavoring to obtain or use, or conspiring with another to obtain or use an elderly person's or disabled adult's funds, assets, or property with the intent to temporarily or permanently deprive the elderly person or disabled adult of the use, benefit, or possession of the funds, assets, or property, or to benefit someone other than the elderly person or disabled adult, by a person who knows or

reasonably should know that the elderly person or disabled adult lacks the capacity to consent; or.

(c) Breach of a fiduciary duty to an elderly person or disabled adult by the person's guardian or agent under a power of attorney which results in an unauthorized appropriation, sale, or transfer of property.

(2)(a) If the funds, assets, or property involved in the exploitation of the elderly person or disabled adult is valued at $100,000 or more, the offender commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) If the funds, assets, or property involved in the exploitation of the elderly person or disabled adult is valued at $20,000 or more, but less than $100,000, the offender commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) If the funds, assets, or property involved in the exploitation of an elderly person or disabled adult is valued at less than $20,000, the offender commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 24. Paragraphs (g) and (i) of subsection (3) of section 921.0022, Florida Statutes, are amended to read:

921.0022 Criminal Punishment Code; offense severity ranking chart.—

(3) OFFENSE SEVERITY RANKING CHART

(g) LEVEL 7

Florida Statute	Felony Degree	Description

316.027(1)(b)	1st	Accident involving death, failure to stop; leaving scene.
316.193(3)(c)2.	3rd	DUI resulting in serious bodily injury.
316.1935(3)(b)	1st	Causing serious bodily injury or death to another person; driving at high speed or with wanton disregard for safety while fleeing or attempting to elude law enforcement officer who is in a patrol vehicle with siren and lights activated.
327.35(3)(c)2.	3rd	Vessel BUI resulting in serious bodily injury.
402.319(2)	2nd	Misrepresentation and negligence or intentional act resulting in great bodily harm, permanent disfiguration, permanent disability, or death.
409.920(2)(b)1.a.	3rd	Medicaid provider fraud; $10,000 or less.
409.920(2)(b)1.b.	2nd	Medicaid provider fraud; more than $10,000, but less than $50,000.

456.065(2)	3rd	Practicing a health care profession without a license.
456.065(2)	2nd	Practicing a health care profession without a license which results in serious bodily injury.
458.327(1)	3rd	Practicing medicine without a license.
459.013(1)	3rd	Practicing osteopathic medicine without a license.
460.411(1)	3rd	Practicing chiropractic medicine without a license.
461.012(1)	3rd	Practicing podiatric medicine without a license.
462.17	3rd	Practicing naturopathy without a license.
463.015(1)	3rd	Practicing optometry without a license.
464.016(1)	3rd	Practicing nursing without a license.
465.015(2)	3rd	Practicing pharmacy without a license.

466.026(1)	3rd	Practicing dentistry or dental hygiene without a license.
467.201	3rd	Practicing midwifery without a license.
468.366	3rd	Delivering respiratory care services without a license.
483.828(1)	3rd	Practicing as clinical laboratory personnel without a license.
483.901(9)	3rd	Practicing medical physics without a license.
484.013(1)(c)	3rd	Preparing or dispensing optical devices without a prescription.
484.053	3rd	Dispensing hearing aids without a license.
494.0018(2)	1st	Conviction of any violation of ss. 494.001-494.0077 in which the total money and property unlawfully obtained exceeded $50,000 and there were five or more victims.
560.123(8)(b)1.	3rd	Failure to report currency or payment

		instruments exceeding $300 but less than $20,000 by a money services business.
560.125(5)(a)	3rd	Money services business by unauthorized person, currency or payment instruments exceeding $300 but less than $20,000.
655.50(10)(b)1.	3rd	Failure to report financial transactions exceeding $300 but less than $20,000 by financial institution.
775.21(10)(a)	3rd	Sexual predator; failure to register; failure to renew driver's license or identification card; other registration violations.
775.21(10)(b)	3rd	Sexual predator working where children regularly congregate.
775.21(10)(g)	3rd	Failure to report or providing false information about a sexual predator; harbor or conceal a sexual predator.
782.051(3)	2nd	Attempted felony murder of a person by a person other than the perpetrator or the perpetrator of an

		attempted felony.
782.07(1)	2nd	Killing of a human being by the act, procurement, or culpable negligence of another (manslaughter).
782.071	2nd	Killing of a human being or viable fetus by the operation of a motor vehicle in a reckless manner (vehicular homicide).
782.072	2nd	Killing of a human being by the operation of a vessel in a reckless manner (vessel homicide).
784.045(1)(a)1.	2nd	Aggravated battery; intentionally causing great bodily harm or disfigurement.
784.045(1)(a)2.	2nd	Aggravated battery; using deadly weapon.
784.045(1)(b)	2nd	Aggravated battery; perpetrator aware victim pregnant.
784.048(4)	3rd	Aggravated stalking; violation of injunction or court order.
784.048(7)	3rd	Aggravated stalking; violation of

		court order.
784.07(2)(d)	1st	Aggravated battery on law enforcement officer.
784.074(1)(a)	1st	Aggravated battery on sexually violent predators facility staff.
784.08(2)(a)	1st	Aggravated battery on a person 65 years of age or older.
784.081(1)	1st	Aggravated battery on specified official or employee.
784.082(1)	1st	Aggravated battery by detained person on visitor or other detainee.
784.083(1)	1st	Aggravated battery on code inspector.
790.07(4)	1st	Specified weapons violation subsequent to previous conviction of s. 790.07(1) or (2).
790.16(1)	1st	Discharge of a machine gun under specified circumstances.
790.165(2)	2nd	Manufacture, sell, possess, or deliver hoax bomb.

790.165(3)	2nd	Possessing, displaying, or threatening to use any hoax bomb while committing or attempting to commit a felony.
790.166(3)	2nd	Possessing, selling, using, or attempting to use a hoax weapon of mass destruction.
790.166(4)	2nd	Possessing, displaying, or threatening to use a hoax weapon of mass destruction while committing or attempting to commit a felony.
790.23	1st,PBL	Possession of a firearm by a person who qualifies for the penalty enhancements provided for in s. 874.04.
794.08(4)	3rd	Female genital mutilation; consent by a parent, guardian, or a person in custodial authority to a victim younger than 18 years of age.
796.03	2nd	Procuring any person under 16 years for prostitution.
800.04(5)(c)1.	2nd	Lewd or lascivious molestation; victim less than 12 years of age;

		offender less than 18 years.
800.04(5)(c)2.	2nd	Lewd or lascivious molestation; victim 12 years of age or older but less than 16 years; offender 18 years or older.
806.01(2)	2nd	Maliciously damage structure by fire or explosive.
810.02(3)(a)	2nd	Burglary of occupied dwelling; unarmed; no assault or battery.
810.02(3)(b)	2nd	Burglary of unoccupied dwelling; unarmed; no assault or battery.
810.02(3)(d)	2nd	Burglary of occupied conveyance; unarmed; no assault or battery.
810.02(3)(e)	2nd	Burglary of authorized emergency vehicle.
812.014(2)(a)1.	1st	Property stolen, valued at $100,000 or more or a semitrailer deployed by a law enforcement officer; property stolen while causing other property damage; 1st degree grand theft.
812.014(2)(b)2.	2nd	Property stolen, cargo valued at less

		than $50,000, grand theft in 2nd degree.
812.014(2)(b)3.	2nd	Property stolen, emergency medical equipment; 2nd degree grand theft.
812.014(2)(b)4.	2nd	Property stolen, law enforcement equipment from authorized emergency vehicle.
812.0145(2)(a)	1st	Theft from person 65 years of age or older; $50,000 or more.
812.019(2)	1st	Stolen property; initiates, organizes, plans, etc., the theft of property and traffics in stolen property.
812.131(2)(a)	2nd	Robbery by sudden snatching.
812.133(2)(b)	1st	Carjacking; no firearm, deadly weapon, or other weapon.
817.234(8)(a)	2nd	Solicitation of motor vehicle accident victims with intent to defraud.
817.234(9)	2nd	Organizing, planning, or participating in an intentional motor

		vehicle collision.
817.234(11)(c)	1st	Insurance fraud; property value $100,000 or more.
817.2341(2)(b) & (3)(b)	1st	Making false entries of material fact or false statements regarding property values relating to the solvency of an insuring entity which are a significant cause of the insolvency of that entity.
825.102(3)(b)	2nd	Neglecting an elderly person or disabled adult causing great bodily harm, disability, or disfigurement.
825.103(2)(b)	2nd	Exploiting an elderly person or disabled adult and property is valued at $20,000 or more, but less than $100,000.
827.03(3)(b)	2nd	Neglect of a child causing great bodily harm, disability, or disfigurement.
827.04(3)	3rd	Impregnation of a child under 16 years of age by person 21 years of age or older.

837.05(2)	3rd	Giving false information about alleged capital felony to a law enforcement officer.
838.015	2nd	Bribery.
838.016	2nd	Unlawful compensation or reward for official behavior.
838.021(3)(a)	2nd	Unlawful harm to a public servant.
838.22	2nd	Bid tampering.
847.0135(3)	3rd	Solicitation of a child, via a computer service, to commit an unlawful sex act.
847.0135(4)	2nd	Traveling to meet a minor to commit an unlawful sex act.
872.06	2nd	Abuse of a dead human body.
874.10	1st,PBL	Knowingly initiates, organizes, plans, finances, directs, manages, or supervises criminal gang-related activity.
893.13(1)(c)1.	1st	Sell, manufacture, or deliver cocaine (or other drug prohibited under s.

		893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4.) within 1,000 feet of a child care facility, school, or state, county, or municipal park or publicly owned recreational facility or community center.
893.13(1)(e)1.	1st	Sell, manufacture, or deliver cocaine or other drug prohibited under s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4., within 1,000 feet of property used for religious services or a specified business site.
893.13(4)(a)	1st	Deliver to minor cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4. drugs).
893.135(1)(a)1.	1st	Trafficking in cannabis, more than 25 lbs., less than 2,000 lbs.
893.135(1)(b)1.a.	1st	Trafficking in cocaine, more than 28 grams, less than 200 grams.
893.135(1)(c)1.a.	1st	Trafficking in illegal drugs, more than 4 grams, less than 14 grams.

893.135(1)(d)1.	1st	Trafficking in phencyclidine, more than 28 grams, less than 200 grams.
893.135(1)(e)1.	1st	Trafficking in methaqualone, more than 200 grams, less than 5 kilograms.
893.135(1)(f)1.	1st	Trafficking in amphetamine, more than 14 grams, less than 28 grams.
893.135(1)(g)1.a.	1st	Trafficking in flunitrazepam, 4 grams or more, less than 14 grams.
893.135(1)(h)1.a.	1st	Trafficking in gamma-hydroxybutyric acid (GHB), 1 kilogram or more, less than 5 kilograms.
893.135(1)(j)1.a.	1st	Trafficking in 1,4-Butanediol, 1 kilogram or more, less than 5 kilograms.
893.135(1)(k)2.a.	1st	Trafficking in Phenethylamines, 10 grams or more, less than 200 grams.
893.1351(2)	2nd	Possession of place for trafficking in or manufacturing of controlled substance.
896.101(5)(a)	3rd	Money laundering, financial

		transactions exceeding $300 but less than $20,000.
896.104(4)(a)1.	3rd	Structuring transactions to evade reporting or registration requirements, financial transactions exceeding $300 but less than $20,000.
943.0435(4)(c)	2nd	Sexual offender vacating permanent residence; failure to comply with reporting requirements.
943.0435(8)	2nd	Sexual offender; remains in state after indicating intent to leave; failure to comply with reporting requirements.
943.0435(9)(a)	3rd	Sexual offender; failure to comply with reporting requirements.
943.0435(13)	3rd	Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.
943.0435(14)	3rd	Sexual offender; failure to report and reregister; failure to respond to address verification.
944.607(9)	3rd	Sexual offender; failure to comply

		with reporting requirements.
944.607(10)(a)	3rd	Sexual offender; failure to submit to the taking of a digitized photograph.
944.607(12)	3rd	Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.
944.607(13)	3rd	Sexual offender; failure to report and reregister; failure to respond to address verification.
985.4815(10)	3rd	Sexual offender; failure to submit to the taking of a digitized photograph.
985.4815(12)	3rd	Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.
985.4815(13)	3rd	Sexual offender; failure to report and reregister; failure to respond to address verification.

(i) LEVEL 9

Florida Statute	Felony Degree	Description
316.193(3)(c)3.b.	1st	DUI manslaughter; failing to render

		aid or give information.
327.35(3)(c)3.b.	1st	BUI manslaughter; failing to render aid or give information.
<u>409.920(2)(b)1.c.</u>	<u>1st</u>	<u>Medicaid provider fraud; $50,000 or more.</u>
499.0051(9)	1st	Knowing sale or purchase of contraband prescription drugs resulting in great bodily harm.
560.123(8)(b)3.	1st	Failure to report currency or payment instruments totaling or exceeding $100,000 by money transmitter.
560.125(5)(c)	1st	Money transmitter business by unauthorized person, currency, or payment instruments totaling or exceeding $100,000.
655.50(10)(b)3.	1st	Failure to report financial transactions totaling or exceeding $100,000 by financial institution.
775.0844	1st	Aggravated white collar crime.
782.04(1)	1st	Attempt, conspire, or solicit to commit premeditated murder.

782.04(3)	1st,PBL	Accomplice to murder in connection with arson, sexual battery, robbery, burglary, and other specified felonies.
782.051(1)	1st	Attempted felony murder while perpetrating or attempting to perpetrate a felony enumerated in s. 782.04(3).
782.07(2)	1st	Aggravated manslaughter of an elderly person or disabled adult.
787.01(1)(a)1.	1st,PBL	Kidnapping; hold for ransom or reward or as a shield or hostage.
787.01(1)(a)2.	1st,PBL	Kidnapping with intent to commit or facilitate commission of any felony.
787.01(1)(a)4.	1st,PBL	Kidnapping with intent to interfere with performance of any governmental or political function.
787.02(3)(a)	1st	False imprisonment; child under age 13; perpetrator also commits aggravated child abuse, sexual battery, or lewd or lascivious battery, molestation, conduct, or exhibition.

790.161	1st	Attempted capital destructive device offense.
790.166(2)	1st,PBL	Possessing, selling, using, or attempting to use a weapon of mass destruction.
794.011(2)	1st	Attempted sexual battery; victim less than 12 years of age.
794.011(2)	Life	Sexual battery; offender younger than 18 years and commits sexual battery on a person less than 12 years.
794.011(4)	1st	Sexual battery; victim 12 years or older, certain circumstances.
794.011(8)(b)	1st	Sexual battery; engage in sexual conduct with minor 12 to 18 years by person in familial or custodial authority.
794.08(2)	1st	Female genital mutilation; victim younger than 18 years of age.
800.04(5)(b)	Life	Lewd or lascivious molestation; victim less than 12 years; offender 18 years or older.

812.13(2)(a)	1st,PBL	Robbery with firearm or other deadly weapon.
812.133(2)(a)	1st,PBL	Carjacking; firearm or other deadly weapon.
812.135(2)(b)	1st	Home-invasion robbery with weapon.
817.568(7)	2nd,PBL	Fraudulent use of personal identification information of an individual under the age of 18 by his or her parent, legal guardian, or person exercising custodial authority.
827.03(2)	1st	Aggravated child abuse.
847.0145(1)	1st	Selling, or otherwise transferring custody or control, of a minor.
847.0145(2)	1st	Purchasing, or otherwise obtaining custody or control, of a minor.
859.01	1st	Poisoning or introducing bacteria, radioactive materials, viruses, or chemical compounds into food, drink, medicine, or water with intent to kill or injure another person.
893.135	1st	Attempted capital trafficking offense.

893.135(1)(a)3.	1st	Trafficking in cannabis, more than 10,000 lbs.
893.135(1)(b)1.c.	1st	Trafficking in cocaine, more than 400 grams, less than 150 kilograms.
893.135(1)(c)1.c.	1st	Trafficking in illegal drugs, more than 28 grams, less than 30 kilograms.
893.135(1)(d)1.c.	1st	Trafficking in phencyclidine, more than 400 grams.
893.135(1)(e)1.c.	1st	Trafficking in methaqualone, more than 25 kilograms.
893.135(1)(f)1.c.	1st	Trafficking in amphetamine, more than 200 grams.
893.135(1)(h)1.c.	1st	Trafficking in gamma-hydroxybutyric acid (GHB), 10 kilograms or more.
893.135(1)(j)1.c.	1st	Trafficking in 1,4-Butanediol, 10 kilograms or more.
893.135(1)(k)2.c.	1st	Trafficking in Phenethylamines, 400 grams or more.
896.101(5)(c)	1st	Money laundering, financial instruments

		totaling or exceeding $100,000.
896.104(4)(a)3.	1st	Structuring transactions to evade reporting or registration requirements, financial transactions totaling or exceeding $100,000.

Section 25. Pilot project to monitor home health services.—The Agency for Health Care Administration shall develop and implement a home health agency monitoring pilot project in Miami-Dade County by January 1, 2010. The agency shall contract with a vendor to verify the utilization and delivery of home health services and provide an electronic billing interface for home health services. The contract must require the creation of a program to submit claims electronically for the delivery of home health services. The program must verify telephonically visits for the delivery of home health services using voice biometrics. The agency may seek amendments to the Medicaid state plan and waivers of federal laws, as necessary, to implement the pilot project. Notwithstanding s. 287.057(5)(f), Florida Statutes, the agency must award the contract through the competitive solicitation process. The agency shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives evaluating the pilot project by February 1, 2011.

Section 26. Pilot project for home health care management.—The Agency for Health Care Administration shall implement a comprehensive care management pilot project for home health services by January 1, 2010, which includes face-to-face

assessments by a nurse licensed pursuant to chapter 464, Florida Statutes, consultation with physicians ordering services to substantiate the medical necessity for services, and on-site or desk reviews of recipients' medical records in Miami-Dade County. The agency may enter into a contract with a qualified organization to implement the pilot project. The agency may seek amendments to the Medicaid state plan and waivers of federal laws, as necessary, to implement the pilot project.

Section 27. Subsection (6) of section 400.0077, Florida Statutes, is amended to read:

400.0077 Confidentiality.—

(6) This section does not limit the subpoena power of the Attorney General pursuant to s. 409.920(10)(b) ~~s. 409.920(9)(b)~~.

Section 28. Subsection (2) of section 430.608, Florida Statutes, is amended to read:

430.608 Confidentiality of information.—

(2) This section does not, however, limit the subpoena authority of the Medicaid Fraud Control Unit of the Department of Legal Affairs pursuant to s. 409.920(10)(b) ~~s. 409.920(9)(b)~~.

Section 29. This act shall take effect July 1, 2009.