Amendment No.

CHAMBER ACTION

Senate House

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Representative Flores offered the following:

Amendment (with title amendment)

Between lines 1833 and 1834, insert:

Section 31. Subsection (5) of section 409.907, Florida Statutes, is amended to read:

409.907 Medicaid provider agreements.—The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

(5) The agency:

(a) Is required to make timely payment at the established rate for services or goods furnished to a recipient by the provider upon receipt of a properly completed claim form. The claim form shall require certification that the services or goods have been completely furnished to the recipient and that, with the exception of those services or goods specified by the agency, the amount billed does not exceed the provider's usual and customary charge for the same services or goods.

(b) Is prohibited from demanding repayment from the provider in any instance in which the Medicaid overpayment is attributable to error of the department in the determination of eligibility of a recipient.

(c) May adopt, and include in the provider agreement, such other requirements and stipulations on either party as the agency finds necessary to properly and efficiently administer the Medicaid program.

(d) May enroll entities as Medicare crossover-only providers for payment and claims processing purposes only. The provider agreement shall:

1. Require that the provider is an eligible Medicare provider, has a current provider agreement in place with the Centers for Medicare and Medicaid Services, and provides verification that the provider is currently in good standing with the agency.

2. Require that the provider notify the agency immediately, in writing, upon being suspended or disenrolled as a Medicare provider. If a provider does not provide such

notification within 5 business days after suspension or disenrollment, sanctions may be imposed pursuant to this chapter and the provider may be required to return funds paid to the provider during the period of time that the provider was suspended or disenrolled as a Medicare provider.

3. Require that all records pertaining to health care services provided to each of the provider's recipients be kept for a minimum of 5 years. The agreement shall also require that records and information relating to payments claimed by the provider for services under the agreement be delivered to the agency or the Office of the Attorney General Medicaid Fraud Control Unit when requested. If a provider does not provide such records and information when requested, sanctions may be imposed pursuant to this chapter.

4. Disclose that the agreement is for the purposes of paying and processing Medicare crossover claims only.

This paragraph pertains solely to Medicare crossover-only providers. In order to become a standard Medicaid provider, the other requirements of this section and applicable rules must be met.

Section 32. Subsection (24) is added to section 409.908, Florida Statutes, to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein.

These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(24) If a provider fails to notify the agency within 5 business days after suspension or disenrollment from Medicare, sanctions may be imposed pursuant to this chapter and the provider may be required to return funds paid to the provider

during the period of time that the provider was suspended or disenrolled as a Medicare provider.

T I T L E A M E N D M E N T

Remove line 181 and insert:

certain purposes; amending s. 409.907, F.S.; authorizing the Agency for Health Care Administration to enroll entities as Medicare crossover-only providers for payment and claims processing purposes only; specifying requirements for Medicare crossover-only agreements; amending s. 409.908, F.S.; providing penalties for providers that fail to report suspension or disenrollment from Medicare within a specified time; providing an effective date.