

By Senator Gaetz

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1                   A bill to be entitled  
2           An act relating to health care; amending s. 400.474,  
3           F.S.; revising the fine that may be imposed against a  
4           home health agency for failing to timely submit  
5           certain information to the Agency for Health Care  
6           Administration; amending s. 409.221, F.S.; revising  
7           the background screening requirements for persons  
8           rendering care in the consumer-directed care program  
9           administered by the Agency for Health Care  
10          Administration; amending s. 409.907, F.S.; extending  
11          the records-retention period for certain Medicaid  
12          provider records; revising the provider agreement to  
13          require Medicaid providers to report changes in any  
14          principal of the provider to the agency; defining the  
15          term "administrative fines" for purposes of revoking a  
16          Medicaid provider agreement due to changes of  
17          ownership; authorizing, rather than requiring, an  
18          onsite inspection of a Medicaid provider's service  
19          location before entering into a provider agreement;  
20          specifying the principals of a hospital or nursing  
21          home provider for the purposes of submitting  
22          fingerprints for background screening; removing  
23          certain providers from being subject to agency  
24          background checks; amending s. 409.913, F.S.; defining  
25          the term "Medicaid provider" or "provider" for  
26          purposes of oversight of the integrity of the Medicaid  
27          program; authorizing the agency to review and analyze  
28          information from sources other than Medicaid-enrolled  
29          providers for purposes of determining fraud, abuse,

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30 overpayment, or neglect; extending the records-  
31 retention period for certain Medicaid provider  
32 records; revising the grounds for terminating a  
33 provider from the Medicaid program; requiring the  
34 agency to base its overpayment audit reports on  
35 certain information; deleting a requirement that the  
36 agency pay interest on certain withheld Medicaid  
37 payments; requiring payment arrangements for  
38 overpayments and fines to be made within a certain  
39 time; specifying that the venue for all Medicaid  
40 program integrity cases lies in Leon County;  
41 authorizing the agency and the Medicaid Fraud Control  
42 Unit to review certain records; amending s. 409.920,  
43 F.S.; clarifying the applicability of immunity from  
44 civil liability extended to persons who provide  
45 information about fraud or suspected fraudulent acts  
46 by a Medicaid provider; amending s. 409.967, F.S.;  
47 specifying required components of a Medicaid managed  
48 care plan relating to the provisions of medications;  
49 amending s. 429.23, F.S.; requiring the agency to  
50 submit a report to the Legislature on adverse incident  
51 reports from assisted living facilities; amending s.  
52 429.26, F.S.; authorizing the agency to require a  
53 resident of an assisted living facility to undergo a  
54 physical examination if the agency questions the  
55 appropriateness of the resident's placement in that  
56 facility; authorizing release of the results of the  
57 examination to a medical review team to be used along  
58 with additional information to determine whether the

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59 resident's placement in the assisted living facility  
60 is appropriate; providing for resident notification  
61 and relocation if the resident's continued placement  
62 in the facility is not appropriate; authorizing the  
63 agency to require the evaluation of a mental health  
64 resident by a mental health professional; authorizing  
65 an assisted living facility to discharge a resident  
66 who requires more services or care than the facility  
67 is able to provide; amending s. 456.0635, F.S.;

68 revising the grounds under which the Department of  
69 Health or corresponding board is required to refuse to  
70 admit a candidate to an examination and refuse to  
71 issue or renew a license, certificate, or registration  
72 of a health care practitioner; providing an exception;  
73 amending s. 456.036, F.S.; providing that all persons  
74 who were denied renewal of licensure, certification,  
75 or registration under s. 456.0635(3), F.S., may regain  
76 licensure, certification, or registration only by  
77 completing the application process for initial  
78 licensure; providing an exception; amending s.  
79 456.074, F.S.; revising the federal offenses for which  
80 the Department of Health must issue an emergency order  
81 suspending the license of certain health care  
82 professionals; requiring the agency to prepare a  
83 report for public comment and submission to the  
84 Legislature following the expansion of services to new  
85 populations or of new services; providing effective  
86 dates.

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

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90 Section 1. Subsection (6) of section 400.474, Florida  
91 Statutes, is amended, present subsection (7) of that section is  
92 renumbered as subsection (8), and a new subsection (7) is added  
93 to that section, to read:

94 400.474 Administrative penalties.—

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

98 (a) Gives remuneration for staffing services to:

99 1. Another home health agency with which it has formal or  
100 informal patient-referral transactions or arrangements; or

101 2. A health services pool with which it has formal or  
102 informal patient-referral transactions or arrangements,

103

104 unless the home health agency has activated its comprehensive  
105 emergency management plan in accordance with s. 400.492. This  
106 paragraph does not apply to a Medicare-certified home health  
107 agency that provides fair market value remuneration for staffing  
108 services to a non-Medicare-certified home health agency that is  
109 part of a continuing care facility licensed under chapter 651  
110 for providing services to its own residents if each resident  
111 receiving home health services pursuant to this arrangement  
112 attests in writing that he or she made a decision without  
113 influence from staff of the facility to select, from a list of  
114 Medicare-certified home health agencies provided by the  
115 facility, that Medicare-certified home health agency to provide  
116 the services.

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117 (b) Provides services to residents in an assisted living  
118 facility for which the home health agency does not receive fair  
119 market value remuneration.

120 (c) Provides staffing to an assisted living facility for  
121 which the home health agency does not receive fair market value  
122 remuneration.

123 (d) Fails to provide the agency, upon request, with copies  
124 of all contracts with assisted living facilities which were  
125 executed within 5 years before the request.

126 (e) Gives remuneration to a case manager, discharge  
127 planner, facility-based staff member, or third-party vendor who  
128 is involved in the discharge planning process of a facility  
129 licensed under chapter 395, chapter 429, or this chapter from  
130 whom the home health agency receives referrals.

131 ~~(f) Fails to submit to the agency, within 15 days after the~~  
132 ~~end of each calendar quarter, a written report that includes the~~  
133 ~~following data based on data as it existed on the last day of~~  
134 ~~the quarter:~~

135 ~~1. The number of insulin-dependent diabetic patients~~  
136 ~~receiving insulin-injection services from the home health~~  
137 ~~agency;~~

138 ~~2. The number of patients receiving both home health~~  
139 ~~services from the home health agency and hospice services;~~

140 ~~3. The number of patients receiving home health services~~  
141 ~~from that home health agency; and~~

142 ~~4. The names and license numbers of nurses whose primary~~  
143 ~~job responsibility is to provide home health services to~~  
144 ~~patients and who received remuneration from the home health~~  
145 ~~agency in excess of \$25,000 during the calendar quarter.~~

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146        (f)~~(g)~~ Gives cash, or its equivalent, to a Medicare or  
147 Medicaid beneficiary.

148        (g)~~(h)~~ Has more than one medical director contract in  
149 effect at one time or more than one medical director contract  
150 and one contract with a physician-specialist whose services are  
151 mandated for the home health agency in order to qualify to  
152 participate in a federal or state health care program at one  
153 time.

154        (h)~~(i)~~ Gives remuneration to a physician without a medical  
155 director contract being in effect. The contract must:

- 156            1. Be in writing and signed by both parties;
- 157            2. Provide for remuneration that is at fair market value  
158 for an hourly rate, which must be supported by invoices  
159 submitted by the medical director describing the work performed,  
160 the dates on which that work was performed, and the duration of  
161 that work; and
- 162            3. Be for a term of at least 1 year.

163

164 The hourly rate specified in the contract may not be increased  
165 during the term of the contract. The home health agency may not  
166 execute a subsequent contract with that physician which has an  
167 increased hourly rate and covers any portion of the term that  
168 was in the original contract.

169        (i)~~(j)~~ Gives remuneration to:

- 170            1. A physician, and the home health agency is in violation  
171 of paragraph (g) ~~(h)~~ or paragraph (h) ~~(i)~~;
- 172            2. A member of the physician's office staff; or
- 173            3. An immediate family member of the physician,

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175 if the home health agency has received a patient referral in the  
176 preceding 12 months from that physician or physician's office  
177 staff.

178 (j)~~(k)~~ Fails to provide to the agency, upon request, copies  
179 of all contracts with a medical director which were executed  
180 within 5 years before the request.

181 (k)~~(l)~~ Demonstrates a pattern of billing the Medicaid  
182 program for services to Medicaid recipients which are medically  
183 unnecessary as determined by a final order. A pattern may be  
184 demonstrated by a showing of at least two such medically  
185 unnecessary services within one Medicaid program integrity audit  
186 period.

187  
188 Paragraphs (e) and (i) do not apply to or preclude ~~Nothing in~~  
189 ~~paragraph (e) or paragraph (j) shall be interpreted as applying~~  
190 ~~to or precluding~~ any discount, compensation, waiver of payment,  
191 or payment practice permitted by 42 U.S.C. s. 1320a-7(b) or  
192 regulations adopted thereunder, including 42 C.F.R. s. 1001.952  
193 or s. 1395nn or regulations adopted thereunder.

194 (7) The agency shall impose a fine of \$50 per day against a  
195 home health agency that fails to submit to the agency, within 15  
196 days after the end of each calendar quarter, a written report  
197 that includes the following data based on data as it existed on  
198 the last day of the quarter:

199 (a) The number of patients receiving both home health  
200 services from the home health agency and hospice services;

201 (b) The number of patients receiving home health services  
202 from the home health agency;

203 (c) The number of insulin-dependent diabetic patients

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204 receiving insulin-injection services from the home health  
 205 agency; and

206 (d) The names and license numbers of nurses whose primary  
 207 job responsibility is to provide home health services to  
 208 patients and who received remuneration from the home health  
 209 agency in excess of \$25,000 during the calendar quarter.

210 Section 2. Paragraph (i) of subsection (4) of section  
 211 409.221, Florida Statutes, is amended to read:

212 409.221 Consumer-directed care program.—

213 (4) CONSUMER-DIRECTED CARE.—

214 (i) *Background screening requirements.*—All persons who  
 215 render care under this section must undergo level 2 background  
 216 screening pursuant to chapter 435 and s. 408.809. The agency  
 217 shall, as allowable, reimburse consumer-employed caregivers for  
 218 the cost of conducting such background screening ~~as required by~~  
 219 ~~this section~~. For purposes of this section, a person who has  
 220 undergone screening, who is qualified for employment under this  
 221 section and applicable rule, and who has not been unemployed for  
 222 more than 90 days following such screening is not required to be  
 223 rescreened. Such person must attest under penalty of perjury to  
 224 not having been convicted of a disqualifying offense since  
 225 completing such screening.

226 Section 3. Paragraph (c) of subsection (3) of section  
 227 409.907, Florida Statutes, is amended, paragraph (k) is added to  
 228 that subsection, and subsections (6), (7), and (8) of that  
 229 section are amended, to read:

230 409.907 Medicaid provider agreements.—The agency may make  
 231 payments for medical assistance and related services rendered to  
 232 Medicaid recipients only to an individual or entity who has a



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233 provider agreement in effect with the agency, who is performing  
234 services or supplying goods in accordance with federal, state,  
235 and local law, and who agrees that no person shall, on the  
236 grounds of handicap, race, color, or national origin, or for any  
237 other reason, be subjected to discrimination under any program  
238 or activity for which the provider receives payment from the  
239 agency.

240 (3) The provider agreement developed by the agency, in  
241 addition to the requirements specified in subsections (1) and  
242 (2), shall require the provider to:

243 (c) Retain all medical and Medicaid-related records for 6 a  
244 ~~period of 5~~ years to satisfy all necessary inquiries by the  
245 agency.

246 (k) Report a change in any principal of the provider,  
247 including any officer, director, agent, managing employee, or  
248 affiliated person, or any partner or shareholder who has an  
249 ownership interest equal to 5 percent or more in the provider,  
250 to the agency in writing no later than 30 days after the change  
251 occurs.

252 (6) A Medicaid provider agreement may be revoked, at the  
253 option of the agency, due to ~~as the result of~~ a change of  
254 ownership of any facility, association, partnership, or other  
255 entity named as the provider in the provider agreement.

256 (a) In the event of a change of ownership, the transferor  
257 remains liable for all outstanding overpayments, administrative  
258 fines, and any other moneys owed to the agency before the  
259 effective date of the change of ownership. ~~In addition to the~~  
260 ~~continuing liability of the transferor,~~ The transferee is also  
261 liable to the agency for all outstanding overpayments identified

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262 by the agency on or before the effective date of the change of  
263 ownership. ~~For purposes of this subsection, the term~~  
264 ~~"outstanding overpayment" includes any amount identified in a~~  
265 ~~preliminary audit report issued to the transferor by the agency~~  
266 ~~on or before the effective date of the change of ownership.~~ In  
267 the event of a change of ownership for a skilled nursing  
268 facility or intermediate care facility, the Medicaid provider  
269 agreement shall be assigned to the transferee if the transferee  
270 meets all other Medicaid provider qualifications. In the event  
271 of a change of ownership involving a skilled nursing facility  
272 licensed under part II of chapter 400, liability for all  
273 outstanding overpayments, administrative fines, and any moneys  
274 owed to the agency before the effective date of the change of  
275 ownership shall be determined in accordance with s. 400.179.

276 (b) At least 60 days before the anticipated date of the  
277 change of ownership, the transferor must ~~shall~~ notify the agency  
278 of the intended change of ownership and the transferee must  
279 ~~shall~~ submit to the agency a Medicaid provider enrollment  
280 application. If a change of ownership occurs without compliance  
281 with the notice requirements of this subsection, the transferor  
282 and transferee are ~~shall be~~ jointly and severally liable for all  
283 overpayments, administrative fines, and other moneys due to the  
284 agency, regardless of whether the agency identified the  
285 overpayments, administrative fines, or other moneys before or  
286 after the effective date of the change of ownership. The agency  
287 may not approve a transferee's Medicaid provider enrollment  
288 application if the transferee or transferor has not paid or  
289 agreed in writing to a payment plan for all outstanding  
290 overpayments, administrative fines, and other moneys due to the

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291 agency. This subsection does not preclude the agency from  
292 seeking any other legal or equitable remedies available to the  
293 agency for the recovery of moneys owed to the Medicaid program.  
294 In the event of a change of ownership involving a skilled  
295 nursing facility licensed under part II of chapter 400,  
296 liability for all outstanding overpayments, administrative  
297 fines, and any moneys owed to the agency before the effective  
298 date of the change of ownership shall be determined in  
299 accordance with s. 400.179 if the Medicaid provider enrollment  
300 application for change of ownership is submitted before the  
301 change of ownership.

302 (c) As used in this subsection, the term:

303 1. "Administrative fines" includes any amount identified in  
304 a notice of a monetary penalty or fine which has been issued by  
305 the agency or other regulatory or licensing agency that governs  
306 the provider.

307 2. "Outstanding overpayment" includes any amount identified  
308 in a preliminary audit report issued to the transferor by the  
309 agency on or before the effective date of a change of ownership.

310 ~~(7) The agency may require,~~ As a condition of participating  
311 in the Medicaid program and before entering into the provider  
312 agreement, the agency may require that the provider to submit  
313 information, in an initial and any required renewal  
314 applications, concerning the professional, business, and  
315 personal background of the provider and permit an onsite  
316 inspection of the provider's service location by agency staff or  
317 other personnel designated by the agency to perform this  
318 function. Before entering into a provider agreement, the agency  
319 may shall perform an a random onsite inspection, ~~within 60 days~~

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320 ~~after receipt of a fully complete new provider's application, of~~  
321 ~~the provider's service location prior to making its first~~  
322 ~~payment to the provider for Medicaid services to determine the~~  
323 ~~applicant's ability to provide the services in compliance with~~  
324 ~~the Medicaid program and professional regulations that the~~  
325 ~~applicant is proposing to provide for Medicaid reimbursement.~~  
326 ~~The agency is not required to perform an onsite inspection of a~~  
327 ~~provider or program that is licensed by the agency, that~~  
328 ~~provides services under waiver programs for home and community-~~  
329 ~~based services, or that is licensed as a medical foster home by~~  
330 ~~the Department of Children and Family Services. As a continuing~~  
331 ~~condition of participation in the Medicaid program, a provider~~  
332 ~~must shall immediately notify the agency of any current or~~  
333 ~~pending bankruptcy filing. Before entering into the provider~~  
334 ~~agreement, or as a condition of continuing participation in the~~  
335 ~~Medicaid program, the agency may also require that Medicaid~~  
336 ~~providers reimbursed on a fee-for-services basis or fee schedule~~  
337 ~~basis that ~~which~~ is not cost-based, post a surety bond not to~~  
338 ~~exceed \$50,000 or the total amount billed by the provider to the~~  
339 ~~program during the current or most recent calendar year,~~  
340 ~~whichever is greater. For new providers, the amount of the~~  
341 ~~surety bond shall be determined by the agency based on the~~  
342 ~~provider's estimate of its first year's billing. If the~~  
343 ~~provider's billing during the first year exceeds the bond~~  
344 ~~amount, the agency may require the provider to acquire an~~  
345 ~~additional bond equal to the actual billing level of the~~  
346 ~~provider. A provider's bond may ~~shall~~ not exceed \$50,000 if a~~  
347 ~~physician or group of physicians licensed under chapter 458,~~  
348 ~~chapter 459, or chapter 460 has a 50 percent or greater~~

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349 ownership interest in the provider or if the provider is an  
350 assisted living facility licensed under chapter 429. The bonds  
351 permitted by this section are in addition to the bonds  
352 referenced in s. 400.179(2)(d). If the provider is a  
353 corporation, partnership, association, or other entity, the  
354 agency may require the provider to submit information concerning  
355 the background of that entity and of any principal of the  
356 entity, including any partner or shareholder having an ownership  
357 interest in the entity equal to 5 percent or greater, and any  
358 treating provider who participates in or intends to participate  
359 in Medicaid through the entity. The information must include:

360 (a) Proof of holding a valid license or operating  
361 certificate, as applicable, if required by the state or local  
362 jurisdiction in which the provider is located or if required by  
363 the Federal Government.

364 (b) Information concerning any prior violation, fine,  
365 suspension, termination, or other administrative action taken  
366 under the Medicaid laws, rules, or regulations of this state or  
367 of any other state or the Federal Government; any prior  
368 violation of the laws, rules, or regulations relating to the  
369 Medicare program; any prior violation of the rules or  
370 regulations of any other public or private insurer; and any  
371 prior violation of the laws, rules, or regulations of any  
372 regulatory body of this or any other state.

373 (c) Full and accurate disclosure of any financial or  
374 ownership interest that the provider, or any principal, partner,  
375 or major shareholder thereof, may hold in any other Medicaid  
376 provider or health care related entity or any other entity that  
377 is licensed by the state to provide health or residential care

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378 and treatment to persons.

379 (d) If a group provider, identification of all members of  
380 the group and attestation that all members of the group are  
381 enrolled in or have applied to enroll in the Medicaid program.

382 (8)~~(a)~~ Each provider, or each principal of the provider if  
383 the provider is a corporation, partnership, association, or  
384 other entity, seeking to participate in the Medicaid program  
385 must submit a complete set of his or her fingerprints to the  
386 agency for the purpose of conducting a criminal history record  
387 check. Principals of the provider include any officer, director,  
388 billing agent, managing employee, or affiliated person, or any  
389 partner or shareholder who has an ownership interest equal to 5  
390 percent or more in the provider. However, for a hospital  
391 licensed under chapter 395 or a nursing home licensed under  
392 chapter 400, principals of the provider are those who meet the  
393 definition of a controlling interest under s. 408.803. A  
394 director of a not-for-profit corporation or organization is not  
395 a principal for purposes of a background investigation as  
396 required by this section if the director: serves solely in a  
397 voluntary capacity for the corporation or organization, does not  
398 regularly take part in the day-to-day operational decisions of  
399 the corporation or organization, receives no remuneration from  
400 the not-for-profit corporation or organization for his or her  
401 service on the board of directors, has no financial interest in  
402 the not-for-profit corporation or organization, and has no  
403 family members with a financial interest in the not-for-profit  
404 corporation or organization; and if the director submits an  
405 affidavit, under penalty of perjury, to this effect to the  
406 agency and the not-for-profit corporation or organization

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407 submits an affidavit, under penalty of perjury, to this effect  
408 to the agency as part of the corporation's or organization's  
409 Medicaid provider agreement application.

410 (a) Notwithstanding the above, the agency may require a  
411 background check for any person reasonably suspected by the  
412 agency to have been convicted of a crime. This subsection does  
413 not apply to:

- 414 ~~1. A hospital licensed under chapter 395;~~
- 415 ~~2. A nursing home licensed under chapter 400;~~
- 416 ~~3. A hospice licensed under chapter 400;~~
- 417 ~~4. An assisted living facility licensed under chapter 429;~~

418 1.5. A unit of local government, except that requirements  
419 of this subsection apply to nongovernmental providers and  
420 entities contracting with the local government to provide  
421 Medicaid services. The actual cost of the state and national  
422 criminal history record checks must be borne by the  
423 nongovernmental provider or entity; or

424 2.6. Any business that derives more than 50 percent of its  
425 revenue from the sale of goods to the final consumer, and the  
426 business or its controlling parent is required to file a form  
427 10-K or other similar statement with the Securities and Exchange  
428 Commission or has a net worth of \$50 million or more.

429 (b) Background screening shall be conducted in accordance  
430 with chapter 435 and s. 408.809. The cost of the state and  
431 national criminal record check shall be borne by the provider.

432 ~~(c) Proof of compliance with the requirements of level 2~~  
433 ~~screening under chapter 435 conducted within 12 months before~~  
434 ~~the date the Medicaid provider application is submitted to the~~  
435 ~~agency fulfills the requirements of this subsection.~~

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436 Section 4. Present paragraphs (e) and (f) of subsection (1)  
437 of section 409.913, Florida Statutes, are redesignated as  
438 paragraphs (f) and (g), respectively, a new paragraph (e) is  
439 added to that subsection, and subsections (2), (9), (13), (15),  
440 (16), (21), (22), (25), (28), (29), (30), and (31) of that  
441 section are amended, to read:

442 409.913 Oversight of the integrity of the Medicaid  
443 program.—The agency shall operate a program to oversee the  
444 activities of Florida Medicaid recipients, and providers and  
445 their representatives, to ensure that fraudulent and abusive  
446 behavior and neglect of recipients occur to the minimum extent  
447 possible, and to recover overpayments and impose sanctions as  
448 appropriate. Beginning January 1, 2003, and each year  
449 thereafter, the agency and the Medicaid Fraud Control Unit of  
450 the Department of Legal Affairs shall submit a joint report to  
451 the Legislature documenting the effectiveness of the state's  
452 efforts to control Medicaid fraud and abuse and to recover  
453 Medicaid overpayments during the previous fiscal year. The  
454 report must describe the number of cases opened and investigated  
455 each year; the sources of the cases opened; the disposition of  
456 the cases closed each year; the amount of overpayments alleged  
457 in preliminary and final audit letters; the number and amount of  
458 fines or penalties imposed; any reductions in overpayment  
459 amounts negotiated in settlement agreements or by other means;  
460 the amount of final agency determinations of overpayments; the  
461 amount deducted from federal claiming as a result of  
462 overpayments; the amount of overpayments recovered each year;  
463 the amount of cost of investigation recovered each year; the  
464 average length of time to collect from the time the case was



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465 opened until the overpayment is paid in full; the amount  
466 determined as uncollectible and the portion of the uncollectible  
467 amount subsequently reclaimed from the Federal Government; the  
468 number of providers, by type, that are terminated from  
469 participation in the Medicaid program as a result of fraud and  
470 abuse; and all costs associated with discovering and prosecuting  
471 cases of Medicaid overpayments and making recoveries in such  
472 cases. The report must also document actions taken to prevent  
473 overpayments and the number of providers prevented from  
474 enrolling in or reenrolling in the Medicaid program as a result  
475 of documented Medicaid fraud and abuse and must include policy  
476 recommendations necessary to prevent or recover overpayments and  
477 changes necessary to prevent and detect Medicaid fraud. All  
478 policy recommendations in the report must include a detailed  
479 fiscal analysis, including, but not limited to, implementation  
480 costs, estimated savings to the Medicaid program, and the return  
481 on investment. The agency must submit the policy recommendations  
482 and fiscal analyses in the report to the appropriate estimating  
483 conference, pursuant to s. 216.137, by February 15 of each year.  
484 The agency and the Medicaid Fraud Control Unit of the Department  
485 of Legal Affairs each must include detailed unit-specific  
486 performance standards, benchmarks, and metrics in the report,  
487 including projected cost savings to the state Medicaid program  
488 during the following fiscal year.

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

490 (e) "Medicaid provider" or "provider" has the same meaning  
491 as provided in s. 409.901 and, for purposes of oversight of the  
492 integrity of the Medicaid program, also includes a participant  
493 in a Medicaid managed care provider network.

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494 (2) The agency shall conduct, or cause to be conducted by  
495 contract or otherwise, reviews, investigations, analyses,  
496 audits, or any combination thereof, to determine possible fraud,  
497 abuse, overpayment, or recipient neglect in the Medicaid program  
498 and ~~shall~~ report the findings of any overpayments in audit  
499 reports as appropriate. At least 5 percent of all audits must  
500 ~~shall~~ be conducted on a random basis. As part of its ongoing  
501 fraud detection activities, the agency shall identify and  
502 monitor, by contract or otherwise, patterns of overutilization  
503 of Medicaid services based on state averages. The agency shall  
504 track Medicaid provider prescription and billing patterns and  
505 evaluate them against Medicaid medical necessity criteria and  
506 coverage and limitation guidelines adopted by rule. Medical  
507 necessity determination requires that service be consistent with  
508 symptoms or confirmed diagnosis of illness or injury under  
509 treatment and not in excess of the patient's needs. The agency  
510 shall conduct reviews of provider exceptions to peer group norms  
511 and ~~shall~~, using statistical methodologies, provider profiling,  
512 and analysis of billing patterns, detect and investigate  
513 abnormal or unusual increases in billing or payment of claims  
514 for Medicaid services and medically unnecessary provision of  
515 services. The agency may review and analyze information from  
516 sources other than enrolled Medicaid providers in conducting its  
517 activities under this subsection.

518 (9) A Medicaid provider shall retain medical, professional,  
519 financial, and business records pertaining to services and goods  
520 furnished to a Medicaid recipient and billed to Medicaid for 6 a  
521 ~~period of 5~~ years after the date of furnishing such services or  
522 goods. The agency may investigate, review, or analyze such

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523 records, which must be made available during normal business  
524 hours. However, 24-hour notice must be provided if patient  
525 treatment would be disrupted. The provider is responsible for  
526 furnishing to the agency, and keeping the agency informed of the  
527 location of, the provider's Medicaid-related records. The  
528 authority of the agency to obtain Medicaid-related records from  
529 a provider is neither curtailed nor limited during a period of  
530 litigation between the agency and the provider.

531 (13) The agency shall ~~immediately~~ terminate participation  
532 of a Medicaid provider in the Medicaid program and may seek  
533 civil remedies or impose other administrative sanctions against  
534 a Medicaid provider, if the provider or any principal, officer,  
535 director, agent, managing employee, or affiliated person of the  
536 provider, or any partner or shareholder having an ownership  
537 interest in the provider equal to 5 percent or greater, has been  
538 convicted of a criminal offense under federal law or the law of  
539 any state relating to the practice of the provider's profession,  
540 or an offense listed under s. 409.907(10), s. 408.809(4), or s.  
541 435.04(2) has been:

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

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

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

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552 determines that the a provider did not participate or acquiesce  
553 in the an offense ~~specified in paragraph (a), paragraph (b), or~~  
554 ~~paragraph (c)~~, termination will not be imposed. If the agency  
555 effects a termination under this subsection, the agency shall  
556 issue an immediate final order pursuant to s. 120.569(2)(n).

557 (15) The agency shall seek a remedy provided by law,  
558 including, but not limited to, any remedy provided in  
559 subsections (13) and (16) and s. 812.035, if:

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

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

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

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

576 (e) The provider is not in compliance with provisions of  
577 Medicaid provider publications that have been adopted by  
578 reference as rules in the Florida Administrative Code; with  
579 provisions of state or federal laws, rules, or regulations; with  
580 provisions of the provider agreement between the agency and the

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581 provider; or with certifications found on claim forms or on  
582 transmittal forms for electronically submitted claims that are  
583 submitted by the provider or authorized representative, as such  
584 provisions apply to the Medicaid program;

585 (f) The provider or person who ordered or prescribed the  
586 care, services, or supplies has furnished, ~~or~~ ordered, or  
587 authorized the furnishing of ~~7~~ goods or services to a recipient  
588 which are inappropriate, unnecessary, excessive, or harmful to  
589 the recipient or are of inferior quality;

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

592 (h) The provider or an authorized representative of the  
593 provider, or a person who ordered or prescribed the goods or  
594 services, has submitted or caused to be submitted false or a  
595 pattern of erroneous Medicaid claims;

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

603 (j) The provider or an authorized representative of the  
604 provider has collected from or billed a recipient or a  
605 recipient's responsible party improperly for amounts that should  
606 not have been so collected or billed by reason of the provider's  
607 billing the Medicaid program for the same service;

608 (k) The provider or an authorized representative of the  
609 provider has included in a cost report costs that are not

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610 allowable under a Florida Title XIX reimbursement plan, after  
611 the provider or authorized representative had been advised in an  
612 audit exit conference or audit report that the costs were not  
613 allowable;

614 (l) The provider is charged by information or indictment  
615 with fraudulent billing practices or any offense referenced in  
616 subsection (13). The sanction applied for this reason is limited  
617 to suspension of the provider's participation in the Medicaid  
618 program for the duration of the indictment unless the provider  
619 is found guilty pursuant to the information or indictment;

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

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

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

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

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

633

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

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

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

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

650 (b) Termination for a specific period of time of from more  
651 than 1 year to 20 years. Termination precludes ~~shall preclude~~  
652 participation in the Medicaid program, which includes any action  
653 that results in a claim for payment to the Medicaid program as a  
654 result of furnishing, supervising a person who is furnishing, or  
655 causing a person to furnish goods or services.

656 (c) Imposition of a fine of up to \$5,000 for each  
657 violation. Each day that an ongoing violation continues, such as  
658 refusing to furnish Medicaid-related records or refusing access  
659 to records, is considered, for the purposes of this section, to  
660 be a separate violation. Each instance of improper billing of a  
661 Medicaid recipient; each instance of including an unallowable  
662 cost on a hospital or nursing home Medicaid cost report after  
663 the provider or authorized representative has been advised in an  
664 audit exit conference or previous audit report of the cost  
665 unallowability; each instance of furnishing a Medicaid recipient  
666 goods or professional services that are inappropriate or of  
667 inferior quality as determined by competent peer judgment; each

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668 instance of knowingly submitting a materially false or erroneous  
669 Medicaid provider enrollment application, request for prior  
670 authorization for Medicaid services, drug exception request, or  
671 cost report; each instance of inappropriate prescribing of drugs  
672 for a Medicaid recipient as determined by competent peer  
673 judgment; and each false or erroneous Medicaid claim leading to  
674 an overpayment to a provider is considered, for the purposes of  
675 this section, to be a separate violation.

676 (d) Immediate suspension, if the agency has received  
677 information of patient abuse or neglect or of any act prohibited  
678 by s. 409.920. Upon suspension, the agency must issue an  
679 immediate final order under s. 120.569(2)(n).

680 (e) A fine, not to exceed \$10,000, for a violation of  
681 paragraph (15)(i).

682 (f) Imposition of liens against provider assets, including,  
683 but not limited to, financial assets and real property, not to  
684 exceed the amount of fines or recoveries sought, upon entry of  
685 an order determining that such moneys are due or recoverable.

686 (g) Prepayment reviews of claims for a specified period of  
687 time.

688 (h) Comprehensive followup reviews of providers every 6  
689 months to ensure that they are billing Medicaid correctly.

690 (i) Corrective-action plans that ~~would~~ remain in effect ~~for~~  
691 ~~providers~~ for up to 3 years and that are ~~would be~~ monitored by  
692 the agency every 6 months while in effect.

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

695  
696 If a provider voluntarily relinquishes its Medicaid provider



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697 number after receiving written notice that the agency is  
698 conducting, or has conducted, an audit or investigation and the  
699 sanction of suspension or termination will be imposed for  
700 noncompliance discovered as a result of the audit or  
701 investigation, the agency shall impose the sanction of  
702 termination for cause against the provider. The Secretary of  
703 Health Care Administration may make a determination that  
704 imposition of a sanction or disincentive is not in the best  
705 interest of the Medicaid program, in which case a sanction or  
706 disincentive may ~~shall~~ not be imposed.

707 (21) When making a determination that an overpayment has  
708 occurred, the agency shall prepare and issue an audit report to  
709 the provider showing the calculation of overpayments. The  
710 agency's determination shall be based solely upon information  
711 available to it before issuance of the audit report and, in the  
712 case of documentation obtained to substantiate claims for  
713 Medicaid reimbursement, based solely upon contemporaneous  
714 records.

715 (22) The audit report, supported by agency work papers,  
716 showing an overpayment to a provider constitutes evidence of the  
717 overpayment. A provider may not present or elicit testimony,  
718 ~~either~~ on direct examination or cross-examination in any court  
719 or administrative proceeding, regarding the purchase or  
720 acquisition by any means of drugs, goods, or supplies; sales or  
721 divestment by any means of drugs, goods, or supplies; or  
722 inventory of drugs, goods, or supplies, unless such acquisition,  
723 sales, divestment, or inventory is documented by written  
724 invoices, written inventory records, or other competent written  
725 documentary evidence maintained in the normal course of the

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726 provider's business. Testimony or evidence that is not based  
727 upon contemporaneous records or that was not furnished to the  
728 agency within 21 days after the issuance of the audit report is  
729 inadmissible in an administrative hearing on a Medicaid  
730 overpayment or an administrative sanction. Notwithstanding the  
731 applicable rules of discovery, all documentation to that will be  
732 offered as evidence at an administrative hearing on a Medicaid  
733 overpayment or an administrative sanction must be exchanged by  
734 all parties at least 14 days before the administrative hearing  
735 or ~~must be~~ excluded from consideration.

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

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

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755 (c) Overpayments owed to the agency bear interest at the  
756 rate of 10 percent per year from the date of determination of  
757 the overpayment by the agency, and payment arrangements  
758 regarding overpayments and fines must be made within 30 days  
759 after the date of the final order and are not subject to further  
760 appeal at the conclusion of legal proceedings. ~~A provider who~~  
761 ~~does not enter into or adhere to an agreed-upon repayment~~  
762 ~~schedule may be terminated by the agency for nonpayment or~~  
763 ~~partial payment.~~

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

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

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

779 (29) Notwithstanding other provisions of law, the agency  
780 and the Medicaid Fraud Control Unit of the Department of Legal  
781 Affairs may review a person's or provider's Medicaid-related and  
782 non-Medicaid-related records in order to determine the total  
783 output of a provider's practice to reconcile quantities of goods

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784 or services billed to Medicaid with quantities of goods or  
785 services used in the provider's total practice.

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

792 (31) If a provider requests an administrative hearing  
793 pursuant to chapter 120, such hearing must be conducted within  
794 90 days following assignment of an administrative law judge,  
795 absent exceptionally good cause shown as determined by the  
796 administrative law judge or hearing officer. Upon issuance of a  
797 final order, the outstanding balance of the amount determined to  
798 constitute the overpayment and fines is ~~shall become~~ due. If a  
799 provider fails to make payments in full, fails to enter into a  
800 satisfactory repayment plan, or fails to comply with the terms  
801 of a repayment plan or settlement agreement, the agency shall  
802 withhold ~~medical assistance~~ reimbursement payments for Medicaid  
803 services until the amount due is paid in full.

804 Section 5. Subsection (8) of section 409.920, Florida  
805 Statutes, is amended to read:

806 409.920 Medicaid provider fraud.—

807 (8) A person who provides the state, any state agency, any  
808 of the state's political subdivisions, or any agency of the  
809 state's political subdivisions with information about fraud or  
810 suspected fraudulent acts ~~fraud~~ by a Medicaid provider,  
811 including a managed care organization, is immune from civil  
812 liability for libel, slander, or any other relevant tort for

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813 providing any ~~the~~ information about fraud or suspected  
814 fraudulent acts, unless the person acted with knowledge that the  
815 information was false or with reckless disregard for the truth  
816 or falsity of the information. For purposes of this subsection,  
817 the term "fraudulent acts" includes actual or suspected fraud,  
818 abuse, or overpayment, including any fraud-related matters that  
819 a provider or health plan is required to report to the agency or  
820 a law enforcement agency. The immunity from civil liability  
821 extends to reports of fraudulent acts conveyed to the agency in  
822 any manner, including any forum and with any audience as  
823 directed by the agency, and includes all discussions subsequent  
824 to the report and subsequent inquiries from the agency, unless  
825 the person acted with knowledge that the information was false  
826 or with reckless disregard for the truth or falsity of the  
827 information.

828 Section 6. Paragraph (c) of subsection (2) of section  
829 409.967, Florida Statutes, is amended to read:

830 409.967 Managed care plan accountability.—

831 (2) The agency shall establish such contract requirements  
832 as are necessary for the operation of the statewide managed care  
833 program. In addition to any other provisions the agency may deem  
834 necessary, the contract must require:

835 (c) Access.—

836 1. Providers.—The agency shall establish specific standards  
837 for the number, type, and regional distribution of providers in  
838 managed care plan networks to ensure access to care for both  
839 adults and children. Each plan must maintain a regionwide  
840 network of providers in sufficient numbers to meet the access  
841 standards for specific medical services for all recipients

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842 enrolled in the plan. The exclusive use of mail-order pharmacies  
843 ~~is may~~ not be sufficient to meet network access standards.  
844 Consistent with the standards established by the agency,  
845 provider networks may include providers located outside the  
846 region. A plan may contract with a new hospital facility before  
847 the date the hospital becomes operational if the hospital has  
848 commenced construction, will be licensed and operational by  
849 January 1, 2013, and a final order has issued in any civil or  
850 administrative challenge. Each plan shall establish and maintain  
851 an accurate and complete electronic database of contracted  
852 providers, including information about licensure or  
853 registration, locations and hours of operation, specialty  
854 credentials and other certifications, specific performance  
855 indicators, and such other information as the agency deems  
856 necessary. The database must be available online to both the  
857 agency and the public and have the capability to compare the  
858 availability of providers to network adequacy standards and to  
859 accept and display feedback from each provider's patients. Each  
860 plan shall submit quarterly reports to the agency identifying  
861 the number of enrollees assigned to each primary care provider.

862 2. Prescribed drugs.—

863 a. If establishing a prescribed drug formulary or preferred  
864 drug list, a managed care plan must:

865 (I) Provide coverage for drugs in categories and classes  
866 for all disease states and provide a broad range of therapeutic  
867 options for all therapeutic categories;

868 (II) Include coverage for each drug newly approved by the  
869 federal Food and Drug Administration until the plan's  
870 Pharmaceutical and Therapeutics Committee reviews such drug for

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871 inclusion on the formulary;

872 (III) Provide a response within 24 hours after receipt of  
873 all necessary information for a request for prior authorization  
874 or override of other medical management tools; and

875 (IV) Report all denials to the agency on a quarterly basis.  
876 For each nonformulary drug, the plan must report the total  
877 number of requests and the total number of denials.

878 b. Each managed care plan shall ~~must~~ publish any prescribed  
879 drug formulary or preferred drug list on the plan's website in a  
880 manner that is accessible to and searchable by enrollees and  
881 providers. The plan must update the list within 24 hours after  
882 making a change. ~~Each plan must ensure that the prior~~  
883 ~~authorization process for prescribed drugs is readily accessible~~  
884 ~~to health care providers, including posting appropriate contact~~  
885 ~~information on its website and providing timely responses to~~  
886 ~~providers.~~

887 c. The managed care plan must continue to permit an  
888 enrollee who was receiving a prescription drug that was on the  
889 plan's formulary and subsequently removed or changed to continue  
890 to receive that drug if requested by the enrollee and prescriber  
891 for as long as the enrollee is a member of the plan.

892 d. A managed care plan that imposes a step-therapy or a  
893 fail-first protocol must do so in accordance with the following:

894 (I) If prescribed drugs for the treatment of a medical  
895 condition are restricted for use by the plan through a step-  
896 therapy or fail-first protocol, the plan must provide the  
897 prescriber with access to a clear and convenient process to  
898 expeditiously request an override of such restriction from the  
899 insurer.

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900       (II) An override of the restriction must be expeditiously  
901 granted by the plan if the prescriber can demonstrate to the  
902 plan that the preferred treatment required under the step-  
903 therapy or fail-first protocol:

904       (A) Has been ineffective in the treatment of the enrollee's  
905 disease or medical condition;

906       (B) Is reasonably expected to be ineffective based on the  
907 known relevant physical or mental characteristics and medical  
908 history of the enrollee and known characteristics of the drug  
909 regimen; or

910       (C) Will cause or will likely cause an adverse reaction or  
911 other physical harm to the enrollee.

912       (III) The maximum duration of a step-therapy or fail-first  
913 protocol requirement may not be longer than the customary period  
914 for the prescribed drug if such treatment is demonstrated by the  
915 prescriber to be clinically ineffective. If the plan can  
916 demonstrate, through sound clinical evidence, that the  
917 originally prescribed drug is likely to require more than the  
918 customary period for such drug to provide any relief or  
919 amelioration to the enrollee, the step-therapy or fail-first  
920 protocol may be extended, but no longer than the original  
921 customary period for the drug, after which time the prescriber  
922 may deem such treatment as clinically ineffective for the  
923 enrollee. Once the prescriber deems the treatment to be  
924 clinically ineffective, the plan must dispense and cover the  
925 originally prescribed drug recommended by the prescriber.

926       e. For enrollees ~~Medicaid recipients~~ diagnosed with  
927 hemophilia who have been prescribed anti-hemophilic-factor  
928 replacement products, the agency shall provide for those



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929 products and hemophilia overlay services through the agency's  
930 hemophilia disease management program.

931 3. Prior authorization.-

932 a. Each managed care plan must ensure that the prior  
933 authorization process for prescribed drugs is readily accessible  
934 to health care providers, including posting appropriate contact  
935 information on its website and providing timely responses to  
936 providers.

937 b. If a drug, determined to be medically necessary and  
938 prescribed for an enrollee by a physician using sound clinical  
939 judgment, is subject to prior authorization, the managed care  
940 plan must provide payment to the pharmacist for dispensing such  
941 drug without seeking prior authorization if the pharmacist  
942 confirms that:

943 (I) The prescription is a refill or renewal of the same  
944 drug for the same beneficiary written by the same prescriber; or

945 (II) If the drug is generally prescribed for an indication  
946 that is treated on an ongoing basis by continuous medication or  
947 as-needed, the enrollee for whom the drug is prescribed has  
948 filled a prescription for the same drug within the preceding 30  
949 to 90 days.

950 c. If a prescribed drug requires prior authorization, the  
951 managed care plan shall reimburse the pharmacist for dispensing  
952 a 72-hour supply to the enrollee and process the prior  
953 authorization request and send a response to the requesting  
954 pharmacist within 24 hours after receiving the pharmacist's  
955 request for prior authorization.

956 d.3. Managed care plans, and their fiscal agents or  
957 intermediaries, must accept prior authorization requests for any

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958 service electronically.

959 Section 7. Subsection (11) is added to section 429.23,  
960 Florida Statutes, to read:

961 429.23 Internal risk management and quality assurance  
962 program; adverse incidents and reporting requirements.—

963 (11) The agency shall annually submit a report to the  
964 Legislature on adverse incident reports by assisted living  
965 facilities. The report must include the following information  
966 arranged by county:

967 (a) A total number of adverse incidents;

968 (b) A listing, by category, of the type of adverse  
969 incidents occurring within each category and the type of staff  
970 involved;

971 (c) A listing, by category, of the types of injuries, if  
972 any, and the number of injuries occurring within each category;

973 (d) Types of liability claims filed based on an adverse  
974 incident report or reportable injury; and

975 (e) Disciplinary action taken against staff, categorized by  
976 the type of staff involved.

977 Section 8. Present subsections (9), (10), and (11) of  
978 section 429.26, Florida Statutes, are renumbered as subsections  
979 (12), (13), and (14), respectively, and new subsections (9),  
980 (10), and (11) are added to that section, to read:

981 429.26 Appropriateness of placements; examinations of  
982 residents.—

983 (9) If, at any time after admission to a facility, agency  
984 personnel question whether a resident needs care beyond that  
985 which the facility is licensed to provide, the agency may  
986 require the resident to be physically examined by a licensed

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987 physician, licensed physician assistant, or certified nurse  
988 practitioner. To the extent possible, the examination must be  
989 performed by the resident's preferred physician, physician  
990 assistant, or nurse practitioner and paid for by the resident  
991 with personal funds, except as provided in s. 429.18(2). This  
992 subsection does not preclude the agency from imposing sanctions  
993 for violations of subsection (1).

994 (a) Following examination, the examining physician,  
995 physician assistant, or nurse practitioner shall complete and  
996 sign a medical form provided by the agency. The completed  
997 medical form must be submitted to the agency within 30 days  
998 after the date the facility owner or administrator was notified  
999 by the agency that a physical examination is required.

1000 (b) A medical review team designated by the agency shall  
1001 determine whether the resident is appropriately residing in the  
1002 facility based on the completed medical form and, if necessary,  
1003 consultation with the physician, physician assistant, or nurse  
1004 practitioner who performed the examination. Members of the  
1005 medical review team making the determination may not include the  
1006 agency personnel who initially questioned the appropriateness of  
1007 the resident's placement. The medical review team shall base its  
1008 decision on a comprehensive review of the resident's physical  
1009 and functional status. A determination that the resident's  
1010 placement is not appropriate is final and binding upon the  
1011 facility and the resident.

1012 (c) A resident who is determined by the medical review team  
1013 to be inappropriately residing in a facility shall be given 30  
1014 days' written notice to relocate by the owner or administrator,  
1015 unless the resident's continued residence in the facility

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1016 presents an imminent danger to the health, safety, or welfare of  
 1017 the resident or a substantial probability exists that death or  
 1018 serious physical harm to the resident would result if the  
 1019 resident is allowed to remain in the facility.

1020 (10) If a mental health resident appears to have needs in  
 1021 addition to those identified in the community living support  
 1022 plan, the agency may require an evaluation by a mental health  
 1023 professional, as determined by the Department of Children and  
 1024 Family Services.

1025 (11) A facility may not be required to retain a resident  
 1026 who requires more services or care than the facility is able to  
 1027 provide in accordance with its policies and criteria for  
 1028 admission and continued residency.

1029 Section 9. Effective July 1, 2012, section 456.0635,  
 1030 Florida Statutes, is amended to read:

1031 456.0635 Health care ~~Medicaid~~ fraud; disqualification for  
 1032 license, certificate, or registration.—

1033 (1) Health care ~~Medicaid~~ fraud in the practice of a health  
 1034 care profession is prohibited.

1035 (2) Each board under ~~within~~ the jurisdiction of the  
 1036 department, or the department if there is no board, shall refuse  
 1037 to admit a candidate to an ~~any~~ examination and refuse to issue  
 1038 ~~or renew~~ a license, certificate, or registration to an ~~any~~  
 1039 applicant if the candidate or applicant or any principal,  
 1040 officer, agent, managing employee, or affiliated person of the  
 1041 applicant, ~~has been~~:

1042 (a) Has been convicted of, or entered a plea of guilty or  
 1043 nolo contendere to, regardless of adjudication, a felony under  
 1044 chapter 409, chapter 817, or chapter 893, or a similar felony

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1045 offense committed in another state or jurisdiction, unless the  
1046 candidate or applicant has successfully completed a pretrial  
1047 intervention or drug diversion program for that felony. Any such  
1048 conviction or plea excludes the applicant or candidate from  
1049 licensure, examination, certification, or registration 21 U.S.C.  
1050 ss. 801-970, or 42 U.S.C. ss. 1395-1396, unless the sentence and  
1051 any subsequent period of probation for such conviction or plea  
1052 pleas ended: more than 15 years prior to the date of the  
1053 application;

1054 1. For felonies of the first or second degree, more than 15  
1055 years before the date of application.

1056 2. For felonies of the third degree, more than 10 years  
1057 before the date of application, except for felonies of the third  
1058 degree under s. 893.13(6)(a).

1059 3. For felonies of the third degree under s. 893.13(6)(a),  
1060 more than 5 years before the date of application.

1061 (b) Has been convicted of, or entered a plea of guilty or  
1062 nolo contendere to, regardless of adjudication, a felony under  
1063 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396, unless the  
1064 sentence and any subsequent period of probation for such  
1065 conviction or plea ended more than 15 years before the date of  
1066 the application.

1067 (c) ~~(b)~~ Has been terminated for cause from the Florida  
1068 Medicaid program pursuant to s. 409.913, unless the candidate or  
1069 applicant has been in good standing with the Florida Medicaid  
1070 program for the most recent 5 years.

1071 (d) ~~(c)~~ Has been terminated for cause, pursuant to the  
1072 appeals procedures established by the state ~~or Federal~~  
1073 Government, from any other state Medicaid program ~~or the federal~~

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1074 ~~Medicare program~~, unless the candidate or applicant has been in  
1075 good standing with that a state Medicaid program ~~or the federal~~  
1076 ~~Medicare program~~ for the most recent 5 years and the termination  
1077 occurred at least 20 years before ~~prior to~~ the date of the  
1078 application.

1079 (e) Is currently listed on the United States Department of  
1080 Health and Human Services Office of Inspector General's List of  
1081 Excluded Individuals and Entities.

1082  
1083 This subsection does not apply to candidates or applicants for  
1084 initial licensure or certification who were enrolled in an  
1085 educational or training program on or before July 1, 2009, which  
1086 was recognized by a board or, if there is no board, recognized  
1087 by the department, and who applied for licensure after July 1,  
1088 2012.

1089 (3) The department shall refuse to renew a license,  
1090 certificate, or registration of any applicant if the applicant  
1091 or any principal, officer, agent, managing employee, or  
1092 affiliated person of the applicant:

1093 (a) Has been convicted of, or entered a plea of guilty or  
1094 nolo contendere to, regardless of adjudication, a felony under  
1095 chapter 409, chapter 817, or chapter 893, or a similar felony  
1096 offense committed in another state or jurisdiction since July 1,  
1097 2009, unless the applicant is currently enrolled in or has  
1098 successfully completed a pretrial intervention or drug diversion  
1099 program for that felony. Any such conviction or plea excludes  
1100 the applicant from renewal of licensure, certification, or  
1101 registration unless the sentence and any subsequent period of  
1102 probation for such conviction or plea ended:

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1103 1. For felonies of the first or second degree, more than 15  
1104 years before the date of application.

1105 2. For felonies of the third degree, more than 10 years  
1106 before the date of application, except for felonies of the third  
1107 degree under s. 893.13(6) (a).

1108 3. For felonies of the third degree under s. 893.13(6) (a),  
1109 more than 5 years before the date of application.

1110 (b) Has been convicted of, or entered a plea of guilty or  
1111 nolo contendere to, regardless of adjudication, a felony under  
1112 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 since July 1,  
1113 2009, unless the sentence and any subsequent period of probation  
1114 for such conviction or plea ended more than 15 years before the  
1115 date of the application.

1116 (c) Has been terminated for cause from the Florida Medicaid  
1117 program pursuant to s. 409.913, unless the applicant has been in  
1118 good standing with the Florida Medicaid program for the most  
1119 recent 5 years.

1120 (d) Has been terminated for cause, pursuant to the appeals  
1121 procedures established by the state, from any other state  
1122 Medicaid program, unless the applicant has been in good standing  
1123 with that state Medicaid program for the most recent 5 years and  
1124 the termination occurred at least 20 years before the date of  
1125 the application.

1126 (e) Is currently listed on the United States Department of  
1127 Health and Human Services Office of Inspector General's List of  
1128 Excluded Individuals and Entities.

1129 (4) ~~(3)~~ Licensed health care practitioners shall report  
1130 allegations of health care Medicaid fraud to the department,  
1131 regardless of the practice setting in which the alleged health

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1132 care ~~Medicaid~~ fraud occurred.

1133 (5)~~(4)~~ The acceptance by a licensing authority of a  
1134 licensee's candidate's relinquishment of a license which is  
1135 offered in response to or anticipation of the filing of  
1136 administrative charges alleging health care ~~Medicaid~~ fraud or  
1137 similar charges constitutes the permanent revocation of the  
1138 license.

1139 Section 10. Effective July 1, 2012, present subsections  
1140 (14) and (15) of section 456.036, Florida Statutes, are  
1141 renumbered as subsections (15) and (16), respectively, and a new  
1142 subsection (14) is added to that section, to read:

1143 456.036 Licenses; active and inactive status; delinquency.-  
1144 (14) A person who has been denied license renewal,  
1145 certification, or registration under s. 456.0635(3) may regain  
1146 licensure, certification, or registration only by meeting the  
1147 qualifications and completing the application process for  
1148 initial licensure as defined by the board, or the department if  
1149 there is no board. However, a person who was denied renewal of  
1150 licensure, certification, or registration under s. 24 of chapter  
1151 2009-223, Laws of Florida, between July 1, 2009, and June 30,  
1152 2012, is not required to retake and pass examinations applicable  
1153 for initial licensure, certification, or registration.

1154 Section 11. Subsection (1) of section 456.074, Florida  
1155 Statutes, is amended to read:

1156 456.074 Certain health care practitioners; immediate  
1157 suspension of license.-

1158 (1) The department shall issue an emergency order  
1159 suspending the license of any person licensed under chapter 458,  
1160 chapter 459, chapter 460, chapter 461, chapter 462, chapter 463,



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1161 chapter 464, chapter 465, chapter 466, or chapter 484 who pleads  
1162 guilty to, is convicted or found guilty of, or who enters a plea  
1163 of nolo contendere to, regardless of adjudication,~~te:~~

1164 (a) A felony under chapter 409, chapter 817, or chapter 893  
1165 or under 21 U.S.C. ss. 801-970 or ~~under~~ 42 U.S.C. ss. 1395-1396;  
1166 or

1167 (b) A misdemeanor or felony under 18 U.S.C. s. 669, ss.  
1168 285-287, s. 371, s. 1001, s. 1035, s. 1341, s. 1343, s. 1347, s.  
1169 1349, or s. 1518 or 42 U.S.C. ss. 1320a-7b, ~~relating to the~~  
1170 ~~Medicaid program.~~

1171 Section 12. The Agency for Health Care Administration shall  
1172 prepare a report within 18 months after the implementation of an  
1173 expansion of managed care to new populations or the provision of  
1174 new items and services. The agency shall post a draft of the  
1175 report on its website and provide an opportunity for public  
1176 comment. The final report shall be submitted to the Legislature,  
1177 along with a description of the process for public input. The  
1178 report must include an assessment of:

1179 (1) The impact of managed care on patient access to care,  
1180 including an evaluation of any new barriers to the use of  
1181 services and prescription drugs, created by the use of medical  
1182 management or cost-containment tools.

1183 (2) The impact of the increased managed care expansion on  
1184 the utilization of services, quality of care, and patient  
1185 outcomes.

1186 (3) The use of prior authorization and other utilization  
1187 management tools, including an assessment of whether these tools  
1188 pose an undue administrative burden for health care providers or  
1189 create barriers to needed care.

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1190           Section 13. Except as otherwise expressly provided in this  
1191 act, this act shall take effect upon becoming a law.