CHAPTER 97-290

Committee Substitute for Senate Bill No. 508

An act relating to Medicaid provider agreements; amending s. 409.907, F.S.; requiring state and national criminal-history checks of those who apply to be providers; providing an exemption from a criminal history record check for directors of certain not-for-profit corporations or organizations and for certain businesses; allowing the Agency for Health Care Administration to permit an applicant to become a provider pending the results of such checks, and to revoke permission in specified circumstances; providing exemptions from the background-screening requirements for certain providers and under certain circumstances; amending s. 409.920, F.S.; increasing the penalty for knowingly submitting false or misleading information to Medicaid for purposes of being accepted as a Medicaid provider; amending s. 409.9122, F.S.; providing visits to certain providers for MediPass patients without prior authorization; amending s. 143 of ch. 95-418, Laws of Florida; exempting from certificate-of-need review the establishment of Medicare-certified home health agencies, contingent upon specified future actions; repealing s. 409.912(31), F.S., relating to Medicaid recipient selection of provider entities; providing an effective date.

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

Section 1. Present subsections (9) and (10) of section 409.907, Florida Statutes, 1996 Supplement, are redesignated as subsections (10) and (11), respectively, present subsection (8) of that section is redesignated as subsection (9) and amended, and a new subsection (8) is added to that section, 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.

(8)(a) Each provider, or each principal of the provider if the provider is a corporation, partnership, association, or other entity, seeking to participate in the Medicaid program must submit a complete set of his or her fingerprints to the agency for the purpose of conducting a criminal history record check. Principals of the provider include any officer, director, billing agent, managing employee, or affiliated person, or any partner or shareholder who has an ownership interest equal to 5 percent or more in the provider. However, a director of a not-for-profit corporation or organization is not a principal for purposes of a background investigation as required by

CODING: Words ~~striken~~ are deletions; words underlined are additions.

this section if the director: serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration from the not-for-profit corporation or organization for his or her service on the board of directors, has no financial interest in the not-for-profit corporation or organization, and has no family members with a financial interest in the not-for-profit corporation or organization; and if the director submits an affidavit, under penalty of perjury, to this effect to the agency and the not-for-profit corporation or organization submits an affidavit, under penalty of perjury, to this effect to the agency as part of the corporation's or organization's Medicaid provider agreement application. Notwithstanding the above, the agency may require a background check for any person reasonably suspected by the agency to have been convicted of a crime. This subsection shall not apply to:

1. A hospital licensed under chapter 395;

2. A nursing home licensed under chapter 400;

3. A hospice licensed under chapter 400;

4. An assisted living facility licensed under chapter 400.

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

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

(b) The agency shall submit the fingerprints to the Department of Law Enforcement. The department shall conduct a state criminal-background investigation and forward the fingerprints to the Federal Bureau of Investigation for a national criminal-history record check. The cost of the state and national criminal record check shall be borne by the provider.

(c) The agency may permit a provider to participate in the Medicaid program pending the results of the criminal record check. However, such permission is fully revocable if the record check reveals any crime-related history as provided in subsection (10).

(d) Proof of compliance with the requirements of level 2 screening under s. 435.04 conducted within 12 months prior to the date that the Medicaid provider application is submitted to the agency shall fulfill the requirements of this subsection. Proof of compliance with the requirements of level 1 screening under s. 435.03 conducted within 12 months prior to the date that the Medicaid provider application is submitted to the agency shall meet the requirement that the Department of Law Enforcement conduct a state criminal history record check.

~~(9)~~(8) Upon receipt of a completed, signed, and dated application, and completion of ~~after~~ any necessary background investigation and criminal history record check ~~by the agency, which may include Florida Department of Law Enforcement background checks~~, the agency must either:

(a) Enroll the applicant as a Medicaid provider; or

(b) Deny the application if, based on the grounds listed in subsection (10), ~~(9)~~ it is in the best interest of the Medicaid program to do so, specifying the reasons for denial.

Section 2. Section 409.920, Florida Statutes, 1996 Supplement, is amended to read:

409.920 Medicaid provider fraud.—

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

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

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

(c) "Item or service" includes:

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

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

(d) "Knowingly" means done by a person who is aware or should be aware of the nature of his or her conduct and that his or her conduct is substantially certain to cause the intended result.

(2) It is unlawful to:

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

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

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

(d) Knowingly make or in any way cause to be made any false statement or false representation of a material fact, by commission or omission, in any document containing items of income and expense that is or may be used by the agency to determine a general or specific rate of payment for an item or service provided by a provider.

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

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

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

~~(3) A person who knowingly submits false or misleading information or statements to the Medicaid program for the purpose of being accepted as a Medicaid provider commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.~~

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

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

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

(6)~~(7)~~ Proof of submission to the agency or its fiscal agent of a document containing items of income and expense, which document is used or that may be used by the agency or its fiscal agent to determine a general or

specific rate of payment and which document contains a false statement or a false representation of a material fact, by commission or omission, unless satisfactorily explained, gives rise to the inference that the person who signed the certification of the document had knowledge of the false statement or representation. This subsection applies whether the signature appears on the document by means of handwriting, typewriting, facsimile signature stamp, electronic transmission, initials, or otherwise.

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

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

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

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

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

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

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

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

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

(a) Enter upon the premises of any health care provider, excluding a physician, participating in the Medicaid program to examine all accounts and records that may, in any manner, be relevant in determining the existence of fraud in the Medicaid program, to investigate alleged abuse or neglect of patients, or to investigate alleged misappropriation of patients' private funds. A participating physician is required to make available any accounts or records that may, in any manner, be relevant in determining the existence of fraud in the Medicaid program. The accounts or records of a non-Medicaid patient may not be reviewed by, or turned over to, the Attorney General without the patient's written consent.

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

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

Section 3. Subsections (6) through (11) of section 409.9122, Florida Statutes, 1996 Supplement, are redesignated as subsections (7) through (12), respectively, and a new subsection (6) is added to that section to read:

409.9122 Mandatory Medicaid managed care enrollment; programs and procedures.—

(6) MediPass enrolled recipients may receive up to 10 visits of reimbursable services by participating Medicaid physicians licensed under chapter 460 and up to four visits of reimbursable services by participating Medicaid physicians licensed under chapter 461. Any further visits must be by prior authorization by the MediPass primary care provider. However, nothing in this subsection may be construed to increase the total number of visits or the total amount of dollars per year per person under current Medicaid rules, unless otherwise provided for in the General Appropriations Act.

Section 4. Section 143 of chapter 95-418, Laws of Florida, is amended to read:

Section 143. Effective upon this act becoming a law and notwithstanding any provision of law to the contrary, the provisions of section 19 of chapter 93-214, Laws of Florida, and section 4 of chapter 94-206, Laws of Florida, shall not become effective on July 1, 1995, but shall take effect on July 1, 1997, except that paragraph (f) of subsection (1) and paragraph (h) of subsection (3) of section 408.036, Florida Statutes, as amended by section 19 of chapter 93-214, Laws of Florida, shall not take effect on July 1, 1997, but shall take effect 90 days after the adjournment sine die of the next regular session of the Legislature occurring after the legislative session in which the Legislature receives a report from the Director of Health Care Administration certifying that the federal Health Care Financing Administration has implemented a per-episode prospective pay system for Medicare-certified home health agencies; however, a certificate of need shall not be required for the establishment of a Medicare-certified home health agency by a facility certified under chapter 651, Florida Statutes, a retirement community as defined in s. 400.404(2)(e), Florida Statutes, or a residential facility that serves only retired military personnel, their dependents and the surviving dependents of deceased military personnel. Medicare-reimbursed home health services provided through such agency shall be offered exclusively to residents of the facility or retirement community or to residents of facilities or retirement communities owned, operated, or managed by the same corporate entity. Each visit made to deliver Medicare-reimbursable home health services to a home health patient who, at the time of service, is not a resident of the facility or retirement community shall be a deceptive and unfair trade

practice and constitutes a violation of the Florida Deceptive and Unfair Trade Practices Act.

Section 5. Subsection (31) of section 409.912, Florida Statutes, 1996 Supplement, is repealed.

Section 6. This act shall take effect July 1, 1997.

Became a law without the Governor's approval June 1, 1997.

Filed in Office Secretary of State May 30, 1997.