1 A bill to be entitled
2 An act relating to Medicaid providers; amending s.
3 409.901; amending s. 409.907; amending s. 409.912;
4 providing an effective date.
5
6 Be It Enacted by the Legislature of the State of Florida:
7
8 Section 1. Subsections (5), (6), (7), (8), (9), (10),
9 (11), (12), (13), (14), (15), (16), (17), (18), (19), (20),
10 (22), (23), (24), (25), (26), and (27) of section 409.901,
11 Florida Statutes, are renumbered as subsections (6), (7), (8),
12 (9), (10), (11), (12), (13), (14), (15), (16), (17), (18), (19),
13 (20), (22), (23), (24), (25), (26), (27) and (28), respectively,
14 and a new subsection (5) is added to that section to read:
15 409.901 Definitions; ss. 409.901-409.920.--As used in ss.
16 409.901-409.920, except as otherwise specifically provided, the
17 term:
18 (5) "Change of ownership" means an event in which the
19 provider changes to a different legal entity or in which 45
20 percent or more of the ownership, voting shares, or controlling
21 interest in a corporation whose shares are not publicly traded
22 on a recognized stock exchange is transferred or assigned,
23 including the final transfer or assignment of multiple transfers
24 or assignments over a 2-year period that cumulatively total 45
25 percent or greater. A change solely in the management company or
26 board of directors is not a change of ownership.
27 Section 2. Subsection (6), and subsection (9) of section
28 409.907, Florida Statutes, are amended to read:

29 409.907 Medicaid provider agreements.--The agency may make
30 payments for medical assistance and related services rendered to
31 Medicaid recipients only to an individual or entity who has a
32 provider agreement in effect with the agency, who is performing
33 services or supplying goods in accordance with federal, state,
34 and local law, and who agrees that no person shall, on the
35 grounds of handicap, race, color, or national origin, or for any
36 other reason, be subjected to discrimination under any program
37 or activity for which the provider receives payment from the
38 agency.
39 (6) A Medicaid provider agreement may be revoked, at the
40 option of the agency, as the result of a change of ownership of
41 any facility, association, partnership, or other entity named as
42 the provider in the provider agreement. ~~A provider shall give~~
43 ~~the agency 60 days' notice before making any change in ownership~~
44 ~~of the entity named in the provider agreement as the provider.~~
45 (a) In the event of a change of ownership, the transferor
46 shall remain liable for all outstanding overpayments,
47 administrative fines, and any other moneys owed to the agency
48 prior to the effective date of the change of ownership. In
49 addition to the continuing liability of the transferor, the
50 transferee shall be liable to the agency for all outstanding
51 overpayments identified by the agency on or before the effective
52 date of the change of ownership. For purposes of this
53 subsection, the term "outstanding overpayment" includes any
54 amount identified in a preliminary audit report issued to the
55 transferor by the agency on or before the effective date of the
56 change of ownership. In the event of a change of ownership for

57 a skilled nursing facility or intermediate care facility, the
58 Medicaid provider agreement shall be assigned to the transferee
59 if the transferee meets all other Medicaid provider
60 qualifications.
61 (b) At least 60 days prior to the anticipated date of the
62 change of ownership, the transferor shall notify the agency of
63 the intended change of ownership and the transferee shall submit
64 to the agency a Medicaid provider enrollment application. In the
65 event a change of ownership occurs without compliance with the
66 notice requirements of this subsection, the transferor and
67 transferee shall be jointly and severally liable for all
68 overpayments, administrative fines, and any other moneys due to
69 the agency, regardless of whether the agency identified the
70 overpayments, administrative fines, or other moneys before or
71 after the effective date of the change of ownership. The agency
72 shall not approve a transferee's Medicaid provider enrollment
73 application if the transferee or transferor has not paid or
74 agreed in writing to a payment plan for all outstanding
75 overpayments, administrative fines, and other moneys due to the
76 agency. Nothing in this subsection is intended to preclude the
77 agency from seeking any other legal or equitable remedies
78 available to the agency for the recovery of moneys owed to the
79 Medicaid program.
80 (9) Upon receipt of a completed, signed, and dated
81 application, and completion of any necessary background
82 investigation and criminal history record check, the agency must
83 either:

84 (a) Enroll the applicant as a Medicaid provider upon
85 approval of the provider application. The enrollment effective
86 date shall be the date the agency receives the provider
87 application. With respect to a provider that requires a Medicare
88 certification survey, the enrollment effective date shall be the
89 date the certification is awarded. With respect to a provider
90 that completes a change of ownership, the effective date will be
91 the date the agency received the application, the date the
92 change of ownership was complete, or the date the applicant
93 became eligible to provide services under Medicaid, whichever
94 date is later. With respect to a provider of emergency medical
95 services transportation or emergency services and care, the
96 effective date is the date the services were rendered. Payment
97 for any claims for services provided to Medicaid recipients
98 between the date of receipt of the application and the date of
99 approval is contingent on applying any and all applicable audits
100 and edits contained in the agency's claims adjudication and
101 payment processing systems; or
102 (b) Deny the application if the agency finds that it is in
103 the best interest of the Medicaid program to do so. The agency
104 may consider the factors listed in subsection (10), as well as
105 any other factor that could affect the effective and efficient
106 administration of the program, including, but not limited to,
107 the applicant's demonstrated ability to provide services,
108 conduct business, and operate a financially viable concern; the
109 current availability of medical care, services, or supplies to
110 recipients, taking into account geographic location and
111 reasonable travel time; the number of providers of the same type

112 already enrolled in the same geographic area; and the
113 credentials, experience, success, and patient outcomes of the
114 provider for the services that it is making application to
115 provide in the Medicaid program. The agency shall deny the
116 application if the agency finds that a provider; any officer,
117 director, agent, managing employee, or affiliated person; or any
118 partner or shareholder having an ownership interest equal to 5
119 percent or greater in the provider if the provider is a
120 corporation, partnership, or other business entity, has failed
121 to pay all outstanding fines or overpayments assessed by final
122 order of the agency or final order of the Centers for Medicare
123 and Medicaid Services, not subject to further appeal, unless the
124 provider agrees to a repayment plan that includes withholding
125 Medicaid reimbursement until the amount due is paid in full.
126 Section 3. Subsection (48) of section 409.912, Florida
127 Statutes, is amended to read:
128 409.912 Cost-effective purchasing of health care.--The
129 agency shall purchase goods and services for Medicaid recipients
130 in the most cost-effective manner consistent with the delivery
131 of quality medical care. To ensure that medical services are
132 effectively utilized, the agency may, in any case, require a
133 confirmation or second physician's opinion of the correct
134 diagnosis for purposes of authorizing future services under the
135 Medicaid program. This section does not restrict access to
136 emergency services or poststabilization care services as defined
137 in 42 C.F.R. part 438.114. Such confirmation or second opinion
138 shall be rendered in a manner approved by the agency. The agency
139 shall maximize the use of prepaid per capita and prepaid

140 aggregate fixed-sum basis services when appropriate and other
141 alternative service delivery and reimbursement methodologies,
142 including competitive bidding pursuant to s. 287.057, designed
143 to facilitate the cost-effective purchase of a case-managed
144 continuum of care. The agency shall also require providers to
145 minimize the exposure of recipients to the need for acute
146 inpatient, custodial, and other institutional care and the
147 inappropriate or unnecessary use of high-cost services. The
148 agency shall contract with a vendor to monitor and evaluate the
149 clinical practice patterns of providers in order to identify
150 trends that are outside the normal practice patterns of a
151 provider's professional peers or the national guidelines of a
152 provider's professional association. The vendor must be able to
153 provide information and counseling to a provider whose practice
154 patterns are outside the norms, in consultation with the agency,
155 to improve patient care and reduce inappropriate utilization.
156 The agency may mandate prior authorization, drug therapy
157 management, or disease management participation for certain
158 populations of Medicaid beneficiaries, certain drug classes, or
159 particular drugs to prevent fraud, abuse, overuse, and possible
160 dangerous drug interactions. The Pharmaceutical and Therapeutics
161 Committee shall make recommendations to the agency on drugs for
162 which prior authorization is required. The agency shall inform
163 the Pharmaceutical and Therapeutics Committee of its decisions
164 regarding drugs subject to prior authorization. The agency is
165 authorized to limit the entities it contracts with or enrolls as
166 Medicaid providers by developing a provider network through
167 provider credentialing. The agency may competitively bid single-

168 source-provider contracts if procurement of goods or services
169 results in demonstrated cost savings to the state without
170 limiting access to care. The agency may limit its network based
171 on the assessment of beneficiary access to care, provider
172 availability, provider quality standards, time and distance
173 standards for access to care, the cultural competence of the
174 provider network, demographic characteristics of Medicaid
175 beneficiaries, practice and provider-to-beneficiary standards,
176 appointment wait times, beneficiary use of services, provider
177 turnover, provider profiling, provider licensure history,
178 previous program integrity investigations and findings, peer
179 review, provider Medicaid policy and billing compliance records,
180 clinical and medical record audits, and other factors. Providers
181 shall not be entitled to enrollment in the Medicaid provider
182 network. The agency shall determine instances in which allowing
183 Medicaid beneficiaries to purchase durable medical equipment and
184 other goods is less expensive to the Medicaid program than long-
185 term rental of the equipment or goods. The agency may establish
186 rules to facilitate purchases in lieu of long-term rentals in
187 order to protect against fraud and abuse in the Medicaid program
188 as defined in s. 409.913. The agency may seek federal waivers
189 necessary to administer these policies.
190 (48) (a) A provider is not entitled to enrollment in the
191 Medicaid provider network. The agency may implement a Medicaid
192 fee-for-service provider network controls, including, but not
193 limited to, competitive procurement and provider credentialing.
194 If a credentialing process is used, the agency may limit its
195 provider network based upon the following considerations:


CODING: Words stricken are deletions; words underlined are additions.

V

196 beneficiary access to care, provider availability, provider
197 quality standards and quality assurance processes, cultural
198 competency, demographic characteristics of beneficiaries,
199 practice standards, service wait times, provider turnover,
200 provider licensure and accreditation history, program integrity
201 history, peer review, Medicaid policy and billing compliance
202 records, clinical and medical record audit findings, and such
203 other areas that are considered necessary by the agency to
204 ensure the integrity of the program.
205 (b) The agency shall limit its network of durable medical
206 equipment and medical supply providers. For dates of service
207 after January 1, 2009, the agency shall limit payment for
208 durable medical equipment and supplies to providers that meet
209 all the requirements of this subsection.
210 1. Providers must be accredited by a Centers for Medicare
211 and Medicaid Deemed Accreditation Organization for suppliers of
212 durable medical equipment, prosthetics, orthotics and supplies.
213 The provider must maintain accreditation and shall be subject to
214 unannounced reviews by the accrediting organization.
215 2. Providers must provide the services or supplies
216 directly to the Medicaid recipient or caregiver at the provider
217 location or sent directly to the recipient's residence with
218 receipt of mailed delivery. Subcontracting or consignment of
219 the service or supply to a third party is prohibited.
220 3. Providers must have a physical business location
221 clearly identified as a business that furnishes durable medical
222 equipment or medical supplies by signage which can be read from
223 20 feet away. The location must be readily accessible to the

224 public during normal, scheduled, posted business hours and must
225 operate no less than five (5) hours per day and no less than
226 five (5) days per week, with the exception of scheduled and
227 posted holidays, and must have a functional landline business
228 phone. The location shall not be located within or at the same
229 numbered street address as another enrolled Medicaid durable
230 medical equipment or medical supply provider or as an enrolled
231 Medicaid pharmacy that is also enrolled as a durable medical
232 equipment provider. The location shall be within the state of
233 Florida or no more than fifty (50) miles from the Florida state
234 line. The agency may make exceptions for providers of durable
235 medical equipment or supplies not otherwise available from other
236 enrolled providers located within the state.
237 4. Providers must maintain a stock of durable medical
238 equipment and medical supplies on site that is readily available
239 to meet the needs of the durable medical equipment business
240 location's customers.
241 5. Providers must provide a $50,000 surety bond for each
242 provider location, up to a maximum of five (5) bonds statewide
243 or an aggregate bond of $250,000 statewide as identified per
244 Federal Employer Identification Number. Providers who post a
245 statewide or an aggregate bond must identify all of their
246 locations in any Medicaid durable medical equipment and medical
247 supply provider enrollment application or bond renewal. Each
248 provider location's surety bond must be renewed annually and the
249 provider must submit proof of renewal even if the original bond
250 is a continuous bond.

251 6. Providers must obtain a Level Two background screening,
252 as described in section 435.04, for each provider employee in
253 direct contact with or providing direct services to recipients
254 of durable medical equipment and medical supplies in their
255 homes. This requirement includes, but is not limited to, repair
256 and service technicians, fitters and delivery staff. The cost
257 of the background screening shall be borne by the provider.
258 7. The following providers are exempt from the
259 requirements of paragraphs 1. and 5.:
260 a. Durable medical equipment providers owned and operated
261 by a government entity.
262 b. Durable medical equipment providers that are operating
263 within a pharmacy that is currently enrolled as a Medicaid
264 pharmacy provider.
265 c. Active, Medicaid-enrolled orthopedic physician groups,
266 primarily owned by physicians, providing only orthotic and
267 prosthetic devices.
268 Section 4. This act shall take effect July 1, 2008.