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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/15/2009	.	
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The Committee on Health and Human Services Appropriations (Gaetz) recommended the following:

Senate Amendment (with directory and title amendments)

Delete lines 908 - 1039

and insert:

the start of any investigation or created at the request of the agency.

(22) The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment. A provider may not present or elicit testimony, either on direct examination or cross-examination in any court or administrative proceeding, regarding the purchase or


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acquisition by any means of drugs, goods, or supplies; sales or divestment by any means of drugs, goods, or supplies; or inventory of drugs, goods, or supplies, unless such acquisition, sales, divestment, or inventory is documented by written invoices, written inventory records, or other competent written documentary evidence maintained in the normal course of the provider's business. Notwithstanding the applicable rules of discovery, all documentation that will be offered as evidence at an administrative hearing on a Medicaid overpayment must be exchanged by all parties at least 14 days before the administrative hearing or must be excluded from consideration. The documentation or data that a provider may rely upon or present as evidence that an overpayment has not occurred must have been created prior to the start of any agency investigation and must be made available to the agency before issuance of a final audit report, unless the documentation or data was created at the request of the agency. Documentation or data that was recreated due to extenuating circumstances beyond the provider's control, such as a disaster or the loss of records due to change of ownership, may be presented as evidence if evidence of the extenuating circumstance is also provided. This section shall not be construed to prohibit the introduction of expert witness reports regarding an overpayment or the issues addressed in the audit.

(24) If the agency imposes an administrative sanction pursuant to subsection (13), subsection (14), or subsection (15), except paragraphs (15)(e) and (o), upon any provider or any principal, officer, director, agent, managing employee, or affiliated person of the provider ~~other person~~ who is regulated

by another state entity, the agency shall notify that other entity of the imposition of the sanction within 5 business days. Such notification must include the provider's or person's name and license number and the specific reasons for sanction.

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

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

(c) Overpayments owed to the agency bear interest at the rate of 10 percent per year from the date of determination of the overpayment by the agency, and payment arrangements must be made at the conclusion of legal proceedings. A provider who does not enter into or adhere to an agreed-upon repayment schedule may be terminated by the agency for nonpayment or partial

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payment.

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

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

(27) When the Agency for Health Care Administration has made a probable cause determination and alleged that an overpayment to a Medicaid provider has occurred, the agency, after notice to the provider, shall ~~may~~:

(a) Withhold, and continue to withhold during the pendency of an administrative hearing pursuant to chapter 120, any medical assistance reimbursement payments until such time as the overpayment is recovered, unless within 30 days after receiving notice thereof the provider:

1. Makes repayment in full; or

2. Establishes a repayment plan that is satisfactory to the Agency for Health Care Administration.

(b) Withhold, and continue to withhold during the pendency of an administrative hearing pursuant to chapter 120, medical assistance reimbursement payments if the terms of a repayment plan are not adhered to by the provider.

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

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

(36) At least three times a year, the agency shall provide to each Medicaid recipient or his or her representative an explanation of benefits in the form of a letter that is mailed to the most recent address of the recipient on the record with the Department of Children and Family Services. The explanation of benefits must include the patient's name, the name of the health care provider and the address of the location where the service was provided, a description of all services billed to Medicaid in terminology that should be understood by a reasonable person, and information on how to report inappropriate or incorrect billing to the agency or other law


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enforcement entities for review or investigation. At least once a year, the letter also must include information on how to report criminal Medicaid fraud, the Medicaid Fraud Control Unit's toll-free hotline number, and information about the rewards available under s. 409.9203. The explanation of benefits may not be mailed for Medicaid independent laboratory services as described in s. 409.905(7) or for Medicaid certified match services as described in ss. 409.9071 and 1011.70.

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

(38) In order to improve the detection of health care fraud, use technology to prevent and detect fraud, and maximize the electronic exchange of health care fraud information, the agency shall:

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

(b) Develop a strategic plan to connect all databases that contain health care fraud information to facilitate the electronic exchange of health information between the agency,

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the Department of Health, the Department of Law Enforcement, and the Attorney General's Office. The plan must include recommended standard data formats, fraud identification strategies, and specifications for the technical interface between state and federal health care fraud databases;

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

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

====== D I R E C T O R Y C L A U S E A M E N D M E N T ======

And the directory clause is amended as follows:

Delete lines 679 - 682

and insert:

Section 13. Subsections (2), (7), (11), (13), (14), (15), (21), (22), (24), (25), (27), (30), (31), and (36) of section 409.913, Florida Statutes, are amended, and subsections (37) and (38) are added to that section, to read:

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

And the title is amended as follows:

Delete lines 81 - 96

and insert:

the Agency for Health Care Administration; providing an exception; requiring that the agency provide notice of certain administrative sanctions to other regulatory agencies within a


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specified period; requiring the Agency for Health Care Administration to withhold or deny Medicaid payments under certain circumstances; requiring the agency to terminate a provider's participation in the Medicaid program if the provider fails to repay certain overpayments from the Medicaid program; requiring the agency to provide at least annually information on Medicaid fraud in an explanation of benefits letter; requiring the Agency for Health Care Administration to post a list on its website of Medicaid providers and affiliated persons of providers who have been terminated or sanctioned; requiring the agency to take certain actions to improve the prevention and detection of health care fraud through the use of technology; amending s. 409.920, F.S.; defining the term "managed