A bill to be entitled

An act relating to Medicaid provider accountability; amending s. 409.221, F.S.; requiring background screening of all persons who provide personal care or services for reimbursement under the consumer-directed care program; providing for submission of proof of compliance under certain circumstances; providing an exception to screening requirements; amending s. 409.907, F.S.; extending the period of time that a provider must retain certain medical and Medicaid-related records under provider agreements with the Agency for Health Care Administration; requiring a provider to report a change of principal in writing to the agency within a specified period of time; providing a definition; authorizing the agency to perform certain inspections before entering into a provider agreement; removing a provision that exempts certain providers and programs from agency onsite inspections; specifying applicability of background investigations with regard to principals of certain hospitals and nursing homes; revising applicability of background screening requirements; removing a provision permitting proof of compliance with background screening requirements to be retroactive; amending s. 409.913, F.S.; providing a definition; expanding agency authority with respect to conducting Medicaid fraud, abuse, overpayment, and recipient neglect reviews and investigations; extending the time

period for retention of certain records by a Medicaid provider; revising provisions relating to termination of a Medicaid provider; requiring the agency to seek a remedy provided by law for certain actions by a provider; providing additional criteria for the imposition of sanctions by the agency; requiring the agency to base a determination of overpayment to a provider on certain information available before the issuance of an audit report; removing a requirement that interest be paid on payments withheld from a provider under certain circumstances; requiring a timeframe for the establishment of payment arrangements for a provider to reimburse the agency for overpayments and fines; providing the venue for Medicaid program integrity cases; requiring the agency to terminate a provider's participation in the Medicaid program if the provider fails to reimburse an overpayment or pay a fine imposed by the agency within a specified period of time; establishing that fines are due upon issuance of a final order by the administrative law judge or hearing officer; amending s. 409.920, F.S.; expanding conditions under which a person who reports fraud or suspected fraudulent acts by a Medicaid provider may be granted immunity from civil liability; providing a definition; providing an effective date.

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

Section 1. Paragraph (i) of subsection (4) of section 409.221, Florida Statutes, is amended to read:

409.221 Consumer-directed care program.—

(4) CONSUMER-DIRECTED CARE.—

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

Section 2. Paragraph (c) of subsection (3), paragraph (a) of subsection (6), and subsections (7) and (8) of section 409.907, Florida Statutes, are amended, and paragraph (k) is added to subsection (3) of 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.

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

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

(k) Report in writing any change of any principal of the provider, including any officer, director, 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. The provider must report changes to the agency in writing no later than 30 days after the change occurs.

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

(a) In the event of a change of ownership, the transferor remains liable for all outstanding overpayments, administrative fines, and any other moneys owed to the agency before the effective date of the change of ownership. In addition to the continuing liability of the transferor, the transferee is liable to the agency for all outstanding overpayments identified by the agency on or before the effective date of the change of ownership. For purposes of this subsection, the term "outstanding overpayment" includes any amount identified in a

preliminary audit report issued to the transferor by the agency on or before the effective date of the change of ownership. For purposes of this subsection, the term "administrative fines" includes any amount identified in any notice of a monetary penalty or fine that has been issued by the agency or any other regulatory or licensing agency which governs the provider. In the event of a change of ownership for a skilled nursing facility or intermediate care facility, the Medicaid provider agreement shall be assigned to the transferee if the transferee meets all other Medicaid provider qualifications. In the event of a change of ownership involving a skilled nursing facility licensed under part II of chapter 400, liability for all outstanding overpayments, administrative fines, and any moneys owed to the agency before the effective date of the change of ownership shall be determined in accordance with s. 400.179.

(7) The agency may require, as a condition of participating in the Medicaid program and before entering into the provider agreement, that the provider submit information, in an initial and any required renewal applications, concerning the professional, business, and personal background of the provider and permit an onsite inspection of the provider's service location by agency staff or other personnel designated by the agency to perform this function. Before entering into a provider agreement, the agency is authorized to ~~shall~~ perform an ~~a random~~ onsite inspection~~, within 60 days after receipt of a fully complete new provider's application,~~ of the provider's service location ~~prior to making its first payment to the provider for Medicaid services~~ to determine the applicant's ability to

provide the services in compliance with Medicaid and professional regulations ~~that the applicant is proposing to provide for Medicaid reimbursement~~. ~~The agency is not required to perform an onsite inspection of a provider or program that is licensed by the agency, that provides services under waiver programs for home and community-based services, or that is licensed as a medical foster home by the Department of Children and Family Services.~~ As a continuing condition of participation in the Medicaid program, a provider shall immediately notify the agency of any current or pending bankruptcy filing. Before entering into the provider agreement, or as a condition of continuing participation in the Medicaid program, the agency may also require that Medicaid providers reimbursed on a fee-for-services basis or fee schedule basis which is not cost-based, post a surety bond not to exceed $50,000 or the total amount billed by the provider to the program during the current or most recent calendar year, whichever is greater. For new providers, the amount of the surety bond shall be determined by the agency based on the provider's estimate of its first year's billing. If the provider's billing during the first year exceeds the bond amount, the agency may require the provider to acquire an additional bond equal to the actual billing level of the provider. A provider's bond shall not exceed $50,000 if a physician or group of physicians licensed under chapter 458, chapter 459, or chapter 460 has a 50 percent or greater ownership interest in the provider or if the provider is an assisted living facility licensed under chapter 429. The bonds permitted by this section are in addition to the bonds

referenced in s. 400.179(2)(d). If the provider is a corporation, partnership, association, or other entity, the agency may require the provider to submit information concerning the background of that entity and of any principal of the entity, including any partner or shareholder having an ownership interest in the entity equal to 5 percent or greater, and any treating provider who participates in or intends to participate in Medicaid through the entity. The information must include:

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

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

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

(d) If a group provider, identification of all members of

the group and attestation that all members of the group are enrolled in or have applied to enroll in the Medicaid program.

(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, for a hospital licensed under chapter 395 or a nursing home licensed under chapter 400, principals of the provider include any person or entity who meets the definition of a controlling interest in s. 408.803(7). ~~However,~~ A director of a not-for-profit corporation or organization is not a principal for purposes of a background investigation as required by 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 does 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 429;~~

1.~~5.~~ A unit of local government, except that requirements of this subsection apply to nongovernmental providers and entities 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

2.~~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 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) Background screening shall be conducted in accordance with chapter 435 and s. 408.809. The cost of the state and national criminal record check shall be borne by the provider.

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

Section 3. Subsections (1), (2), (9), (13), (15), (16),

(21), (22), (25), (28), (30), and (31) of section 409.913, Florida Statutes, are amended to read:

409.913 Oversight of the integrity of the Medicaid program.—The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. Beginning January 1, 2003, and each year thereafter, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit a joint report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report must describe the number of cases opened and investigated each year; the sources of the cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the

number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must include policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud. All policy recommendations in the report must include a detailed fiscal analysis, including, but not limited to, implementation costs, estimated savings to the Medicaid program, and the return on investment. The agency must submit the policy recommendations and fiscal analyses in the report to the appropriate estimating conference, pursuant to s. 216.137, by February 15 of each year. The agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs each must include detailed unit-specific performance standards, benchmarks, and metrics in the report, including projected cost savings to the state Medicaid program during the following fiscal year.

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

(a) "Abuse" means:

1. Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care.

2. Recipient practices that result in unnecessary cost to the Medicaid program.

(b) "Complaint" means an allegation that fraud, abuse, or an overpayment has occurred.

(c) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.

(d) "Medicaid provider" or "provider" means a person or entity that has a Medicaid provider agreement in effect with the agency and is in good standing with the agency. For purposes of oversight of the integrity of the Medicaid program, the term "Medicaid provider" or "provider" also includes a participant in Medicaid managed care.

(e) ~~(d)~~ "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

(f) ~~(e)~~ "Overpayment" includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

(g) ~~(f)~~ "Person" means any natural person, corporation, partnership, association, clinic, group, or other entity, whether or not such person is enrolled in the Medicaid program or is a provider of health care.

(2) The agency shall conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and shall report the findings of any overpayments in audit reports as appropriate. At least 5 percent of all audits shall be conducted on a random basis. As part of its ongoing fraud detection activities, the agency shall identify and monitor, by contract or otherwise, patterns of overutilization of Medicaid services based on state averages. The agency shall track Medicaid provider prescription and billing patterns and evaluate them against Medicaid medical necessity criteria and coverage and limitation guidelines adopted by rule. Medical necessity determination requires that service be consistent with symptoms or confirmed diagnosis of illness or injury under treatment and not in excess of the patient's needs. The agency shall conduct reviews of provider exceptions to peer group norms and shall, using statistical methodologies, provider profiling, and analysis of billing patterns, detect and investigate abnormal or unusual increases in billing or payment of claims for Medicaid

services and medically unnecessary provision of services. The agency is not limited to the review or analysis of Medicaid-enrolled providers when conducting, or causing to be conducted, fraud, abuse, overpayment, or recipient neglect activities.

(9) A Medicaid provider shall retain medical, professional, financial, and business records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid for a period of 6 ~~5~~ years after the date of furnishing such services or goods. The agency may investigate, review, or analyze such records, which must be made available during normal business hours. However, 24-hour notice must be provided if patient treatment would be disrupted. The provider is responsible for furnishing to the agency, and keeping the agency informed of the location of, the provider's Medicaid-related records. The authority of the agency to obtain Medicaid-related records from a provider is neither curtailed nor limited during a period of litigation between the agency and the provider.

(13) The agency shall ~~immediately~~ terminate participation of a Medicaid provider in the Medicaid program and may seek civil remedies or impose other administrative sanctions against a Medicaid provider, if the provider or 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, is no longer in compliance with the background screening requirements of s. 408.809 or chapter 435, or has been:

(a) Convicted of a criminal offense related to the

delivery of any health care goods or services, including the performance of management or administrative functions relating to the delivery of health care goods or services;

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

(c) Found by a court of competent jurisdiction to have neglected or physically abused a patient in connection with the delivery of health care goods or services; or

(d) Convicted of any offense set forth in s. 409.907(10).

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

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

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

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

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

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

(e) The provider is not in compliance with provisions of Medicaid provider publications that have been adopted by reference as rules in the Florida Administrative Code; with provisions of state or federal laws, rules, or regulations; with provisions of the provider agreement between the agency and the provider; or with certifications found on claim forms or on transmittal forms for electronically submitted claims that are submitted by the provider or authorized representative, as such provisions apply to the Medicaid program;

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

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

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

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

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

(k) The provider or an authorized representative of the provider has included in a cost report costs that are not allowable under a Florida Title XIX reimbursement plan, after the provider or authorized representative had been advised in an audit exit conference or audit report that the costs were not allowable;

(l) The provider is charged by information or indictment with fraudulent billing practices or any of the offenses set forth in subsection (13). The sanction applied for this reason is limited to suspension of the provider's participation in the Medicaid program for the duration of the indictment unless the provider is found guilty pursuant to the information or indictment;

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

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

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

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

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

A provider is subject to sanctions for violations of this subsection as the result of actions or inactions of the provider, or actions or inactions of 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, in which the provider participated or acquiesced.

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

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

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

(c) Imposition of a fine of up to $5,000 for each violation. Each day that an ongoing violation continues, such as refusing to furnish Medicaid-related records or refusing access to records, is considered, for the purposes of this section, to be a separate violation. Each instance of improper billing of a Medicaid recipient; each instance of including an unallowable cost on a hospital or nursing home Medicaid cost report after the provider or authorized representative has been advised in an audit exit conference or previous audit report of the cost unallowability; each instance of furnishing a Medicaid recipient goods or professional services that are inappropriate or of inferior quality as determined by competent peer judgment; each instance of knowingly submitting a materially false or erroneous Medicaid provider enrollment application, request for prior authorization for Medicaid services, drug exception request, or cost report; each instance of inappropriate prescribing of drugs for a Medicaid recipient as determined by competent peer judgment; and each false or erroneous Medicaid claim leading to an overpayment to a provider is considered, for the purposes of this section, to be a separate violation.

(d) Immediate suspension, if the agency has received information of patient abuse or neglect or of any act prohibited

by s. 409.920. Upon suspension, the agency must issue an immediate final order under s. 120.569(2)(n).

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

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

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

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

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

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

If a provider seeks to voluntarily relinquish its Medicaid provider number after receiving written notice that the agency has initiated an audit or investigation, when the sanction of suspension or termination would have been imposed for any noncompliance discovered, the agency shall impose the sanction of termination for cause against the provider. The Secretary of Health Care Administration may make a determination that imposition of a sanction or disincentive is not in the best interest of the Medicaid program, in which case a sanction or

disincentive shall not be imposed.

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

(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 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. Furthermore, a provider may present evidence of documentation or data based upon contemporaneous records. Notwithstanding the applicable rules of discovery, all documentation that will be offered as evidence at an administrative hearing on a Medicaid overpayment or administrative sanction must be exchanged by all parties at least 14 days before the administrative hearing or must be excluded from consideration.

(25)(a) The agency shall 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 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 regarding overpayments and fines must be made within 30 days after the date of the final order, not subject to further appeal ~~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 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.

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

(30) The agency shall terminate a provider's participation in the Medicaid program if the provider fails to reimburse an overpayment or pay a fine that has been determined by final order, not subject to further appeal, within 30 ~~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 and any fines 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 withhold medical assistance reimbursement payments until the amount due is paid in full.

Section 4. Subsection (8) of section 409.920, Florida Statutes, is amended to read:

409.920 Medicaid provider fraud; fraudulent acts.—

(8) A person who provides the state, any state agency, any of the state's political subdivisions, or any agency of the state's political subdivisions with information about fraud or suspected fraudulent acts ~~fraud~~ by a Medicaid provider, including a managed care organization, is immune from civil liability for libel, slander, or any other relevant tort for providing any ~~the~~ information about fraud or suspected fraudulent acts, unless the person acted with knowledge that the information was false or with reckless disregard for the truth or falsity of the information. For purposes of this subsection, the term "fraudulent acts" includes actual or suspected fraud, abuse, or overpayments, including any fraud-related matters a provider or health plan is required to report to the agency or law enforcement. The immunity from civil liability extends to reports of fraudulent acts conveyed to the state in any manner, including any forum and with any audience as directed by the state, and includes all discussions subsequent to the report and subsequent inquiries from the state, unless the person acted with knowledge that the information was false or with reckless disregard for the truth or falsity of the information.

Section 5. This act shall take effect July 1, 2012.