A bill to be entitled

An act relating to Medicaid fraud; amending s. 409.907, F.S.; increasing the number of years a provider must keep records; adding an additional provision relating to a change in principal that must be included in a Medicaid provider agreement with the Agency for Health Care Administration; adding definitions for "administrative fines" and "outstanding overpayment"; revising provisions relating to the agency's onsite inspection responsibilities; revising provisions relating to who is subject to background screening; amending s. 409.91212, F.S.; requiring the agency to enter into an interagency agreement with the Division of Insurance Fraud regarding anti-fraud plans by managed care plans; revising the time period in which a managed care plan must report fraud or abuse; delaying the imposition of certain fines for failing to report; amending s. 409.913, F.S.; authorizing the agency to review and analyze sources other than providers in order to carry out its duties with respect to its Medicaid oversight responsibilities; increasing the number of years a provider must keep records; revising provisions specifying grounds for terminating a provider from the program, for seeking certain remedies for violations, and for imposing certain sanctions; providing a limitation on the information the agency may consider when making a determination of

overpayment; specifying the type of records a provider must present to contest an overpayment; deleting the requirement that the agency pay interest on certain payments withheld from a provider and revising when a provider must reimburse overpayments; revising venue requirements; adding provisions relating to the payment of fines; amending s. 409.920, F.S.; clarifying provisions relating to immunity from liability for persons who provide information about Medicaid fraud; providing an effective date.

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

Section 1. Paragraph (c) of subsection (3) of section 409.907, Florida Statutes, is amended and paragraph (k) is added to that subsection, and subsections (6), (7), and (8) of that section are amended 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 6 ~~a period of 5~~ years to satisfy all necessary inquiries by the agency.

(k) Report a change in 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, to the agency in writing within 30 days after the change occurs. For a hospital licensed under chapter 395 or a nursing home licensed under part II of chapter 400, a principal of the provider is one who meets the definition of a controlling interest under s. 408.803.

(6) A Medicaid provider agreement may be revoked, at the option of the agency, due to ~~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) If there is ~~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 also 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.~~ 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.

(b) At least 60 days before the anticipated date of the change of ownership, the transferor must ~~shall~~ notify the agency of the intended change ~~of ownership~~ and the transferee must ~~shall~~ submit to the agency a Medicaid provider enrollment application. If a change of ownership occurs without compliance with the notice requirements of this subsection, the transferor and transferee are ~~shall be~~ jointly and severally liable for all overpayments, administrative fines, and other moneys due to the agency, regardless of whether the agency identified the overpayments, administrative fines, or other moneys before or after the effective date of the change ~~of ownership~~. The agency may not approve a transferee's Medicaid provider enrollment application if the transferee or transferor has not paid or agreed in writing to a payment plan for all outstanding overpayments, administrative fines, and other moneys due to the agency. This subsection does not preclude the agency from seeking any other legal or equitable remedies available to the

agency for the recovery of moneys owed to the Medicaid program. 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 if the Medicaid provider enrollment application for change of ownership is submitted before the change ~~of ownership~~.

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

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

2. "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 a change of ownership.

(7) ~~The agency may require,~~ As a condition of participating in the Medicaid program and before entering into the provider agreement, the agency may require ~~that~~ the provider to 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 may ~~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 the Medicaid program 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 must ~~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 that ~~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 need ~~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 or~~,~~ rules~~, or regulations~~ of this state or of any other state or the Federal Government; any prior violation of the laws or~~,~~ 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 or~~,~~ 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, including Medicaid managed care network providers, 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 are those who meet the definition of a controlling interest under s. 408.803. 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.

(a) 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 2. Subsections (1) and (6) of section 409.91212, Florida Statutes, are amended to read:

409.91212 Medicaid managed care fraud.—

(1) Each managed care plan, as defined in s. 409.920(1)(e), shall adopt an anti-fraud plan addressing the detection and prevention of overpayments, abuse, and fraud relating to the provision of and payment for Medicaid services and submit the plan to the Office of Medicaid Program Integrity within the agency for approval. The office shall enter into an interagency agreement with the Division of Insurance Fraud in the Department of Financial Services which delineates the responsibilities of the agency in reviewing and approving anti-fraud plans for entities that are also required to submit anti-fraud plans under s. 626.9891. At a minimum, the anti-fraud plan must include:

(a) A written description or chart outlining the organizational arrangement of the plan's personnel who are responsible for the investigation and reporting of possible overpayment, abuse, or fraud;

(b) A description of the plan's procedures for detecting and investigating possible acts of fraud, abuse, and overpayment;

(c) A description of the plan's procedures for the

mandatory reporting of possible overpayment, abuse, or fraud to the Office of Medicaid Program Integrity within the agency;

(d) A description of the plan's program and procedures for educating and training personnel on how to detect and prevent fraud, abuse, and overpayment;

(e) The name, address, telephone number, e-mail address, and fax number of the individual responsible for carrying out the anti-fraud plan; and

(f) A summary of the results of the investigations of fraud, abuse, or overpayment which were conducted during the previous year by the managed care organization's fraud investigative unit.

(6) Each managed care plan shall report all suspected or confirmed instances of provider or recipient fraud or abuse within 60 ~~15~~ calendar days after detection to the Office of Medicaid Program Integrity within the agency. At a minimum the report must contain the name of the provider or recipient, the Medicaid billing number or tax identification number, and a description of the fraudulent or abusive act. The office ~~of Medicaid Program Integrity in the agency~~ shall forward the report of suspected overpayment, abuse, or fraud to the appropriate investigative unit, including, but not limited to, the Bureau of Medicaid program integrity, the Medicaid fraud control unit, the Division of Public Assistance Fraud, the Division of Insurance Fraud, or the Department of Law Enforcement.

(a) Failure to timely report shall result in an administrative fine of $1,000 per calendar day after the 60th

~~15th~~ day of detection.

(b) Failure to timely report may result in additional administrative, civil, or criminal penalties.

Section 3. Subsections (2), (9), (13), (15), (16), (21), (22), (25), (28), (29), (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.

(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 must ~~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, shall detect and investigate abnormal or unusual increases in billing or payment of claims for Medicaid services and medically unnecessary provision of services. The agency may review and analyze information from sources other than enrolled Medicaid providers in conducting its activities under this subsection.

(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 6 ~~a period of 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 must keep ~~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, has been convicted of a criminal offense under federal law or the law of any state relating to the practice of the provider's profession, or a criminal offense listed under s. 409.907(10), s. 408.809(4), or s. 435.04(2) ~~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~~. If the agency

determines that the ~~a~~ provider did not participate or acquiesce in the ~~an~~ offense ~~specified in paragraph (a), paragraph (b), or paragraph (c),~~ termination will not be imposed. If the agency effects a termination under this subsection, the agency shall take final action ~~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, authorized, 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, authorized, 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 an offense referenced 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, authorized, 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 precludes ~~shall preclude~~ participation in the Medicaid program, which includes any action that results in a claim for payment to the Medicaid program for ~~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 ranging ~~of~~ from more than 1 year to 20 years. Termination precludes ~~shall preclude~~ participation in the Medicaid program, which includes any action that results in a claim for payment to the Medicaid program for ~~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 are ~~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 voluntarily relinquishes its Medicaid provider number or an associated license, or allows the associated licensure to expire after receiving written notice that the agency is conducting, or has conducted, an audit, survey, inspection, or investigation and that a sanction of suspension or termination will or would be imposed for noncompliance discovered as a result of the audit, survey, inspection, or investigation, 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 may ~~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 must be based solely upon information available to it before issuance of the audit report and, in the case of documentation obtained to substantiate claims for Medicaid reimbursement, 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. A provider may not present records to contest an overpayment or sanction unless such records are contemporaneous and, if requested during the audit process, were furnished to the agency or its agent upon request or were furnished within 30 days after the provider received the final audit report. This limitation does not apply to Medicaid cost report audits. Notwithstanding the applicable rules of discovery, all documentation to ~~that will~~ be offered as evidence at an administrative hearing on a Medicaid overpayment or an 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 must be made within 30 days after the date of the final order and are 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 lies ~~shall lie~~ in Leon County, at the discretion of the agency.

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

(30) The agency shall terminate a provider's participation in the Medicaid program if the provider fails to reimburse an overpayment or pay an agency-imposed 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 fines is ~~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 for Medicaid services 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.—

(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 ~~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. Such immunity extends to reports of fraudulent acts or suspected fraudulent acts conveyed to or from the agency in any manner, including any forum and with any audience as directed by the agency, and includes all discussions subsequent to the report and subsequent inquiries from the agency, 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

and abuse, insurance fraud, licensure fraud, or public assistance fraud, including any fraud-related matters that a provider or health plan is required to report to the agency or a law enforcement agency.

Section 5. This act shall take effect July 1, 2013.