By the Committee on Health Policy; and Senator Grimsley

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1 A bill to be entitled
2 An act relating to Medicaid fraud; amending s.
3 409.907, F.S.; increasing the number of years a
4 provider must keep records; adding an additional
5 provision relating to a change in principal that must
6 be included in a Medicaid provider agreement with the
7 Agency for Health Care Administration; adding
8 definitions for "administrative fines" and
9 "outstanding overpayment"; revising provisions
10 relating to the agency's onsite inspection
11 responsibilities; revising provisions relating to who
12 is subject to background screening; amending s.
13 409.913, F.S.; increasing the number of years a
14 provider must keep records; revising provisions
15 specifying grounds for terminating a provider from the
16 program, for seeking certain remedies for violations,
17 and for imposing certain sanctions; providing a
18 limitation on the information the agency may consider
19 when making a determination of overpayment; specifying
20 the type of records a provider must present to contest
21 an overpayment; deleting the requirement that the
22 agency place payments withheld from a provider in a
23 suspended account and revising when a provider must
24 reimburse overpayments; revising venue requirements;
25 adding provisions relating to the payment of fines;
26 amending s. 409.920, F.S.; clarifying provisions
27 relating to immunity from liability for persons who
28 provide information about Medicaid fraud; providing an
29 effective date.

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30

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

32

33 Section 1. Paragraph (c) of subsection (3) of section
34 409.907, Florida Statutes, is amended and paragraph (k) is added
35 to that subsection, and subsections (6), (7), and (8) of that
36 section are amended to read:
37 409.907 Medicaid provider agreements.—The agency may make
38 payments for medical assistance and related services rendered to
39 Medicaid recipients only to an individual or entity who has a
40 provider agreement in effect with the agency, who is performing
41 services or supplying goods in accordance with federal, state,
42 and local law, and who agrees that no person shall, on the
43 grounds of handicap, race, color, or national origin, or for any
44 other reason, be subjected to discrimination under any program
45 or activity for which the provider receives payment from the
46 agency.
47 (3) The provider agreement developed by the agency, in
48 addition to the requirements specified in subsections (1) and
49 (2), shall require the provider to:
50 (c) Retain all medical and Medicaid-related records for 6 ~~a~~
51 ~~period of 5~~ years to satisfy all necessary inquiries by the
52 agency.
53 (k) Report a change in any principal of the provider,
54 including any officer, director, agent, managing employee, or
55 affiliated person, or any partner or shareholder who has an
56 ownership interest equal to 5 percent or more in the provider,
57 to the agency in writing within 30 days after the change occurs.
58 For a hospital licensed under chapter 395 or a nursing home

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59 licensed under part II of chapter 400, a principal of the
60 provider is one who meets the definition of a controlling
61 interest under s. 408.803.
62 (6) A Medicaid provider agreement may be revoked, at the
63 option of the agency, due to ~~as the result of~~ a change of
64 ownership of any facility, association, partnership, or other
65 entity named as the provider in the provider agreement.
66 (a) If there is ~~In the event of~~ a change of ownership, the
67 transferor remains liable for all outstanding overpayments,
68 administrative fines, and any other moneys owed to the agency
69 before the effective date of the change ~~of ownership~~. ~~In~~
70 ~~addition to the continuing liability of the transferor,~~ The
71 transferee is also liable to the agency for all outstanding
72 overpayments identified by the agency on or before the effective
73 date of the change of ownership. ~~For purposes of this~~
74 ~~subsection, the term "outstanding overpayment" includes any~~
75 ~~amount identified in a preliminary audit report issued to the~~
76 ~~transferor by the agency on or before the effective date of the~~
77 ~~change of ownership.~~ In the event of a change of ownership for a
78 skilled nursing facility or intermediate care facility, the
79 Medicaid provider agreement shall be assigned to the transferee
80 if the transferee meets all other Medicaid provider
81 qualifications. In the event of a change of ownership involving
82 a skilled nursing facility licensed under part II of chapter
83 400, liability for all outstanding overpayments, administrative
84 fines, and any moneys owed to the agency before the effective
85 date of the change of ownership shall be determined in
86 accordance with s. 400.179.
87 (b) At least 60 days before the anticipated date of the

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88 change of ownership, the transferor must ~~shall~~ notify the agency
89 of the intended change ~~of ownership~~ and the transferee must
90 ~~shall~~ submit to the agency a Medicaid provider enrollment
91 application. If a change of ownership occurs without compliance
92 with the notice requirements of this subsection, the transferor
93 and transferee are ~~shall be~~ jointly and severally liable for all
94 overpayments, administrative fines, and other moneys due to the
95 agency, regardless of whether the agency identified the
96 overpayments, administrative fines, or other moneys before or
97 after the effective date of the change ~~of ownership~~. The agency
98 may not approve a transferee's Medicaid provider enrollment
99 application if the transferee or transferor has not paid or
100 agreed in writing to a payment plan for all outstanding
101 overpayments, administrative fines, and other moneys due to the
102 agency. This subsection does not preclude the agency from
103 seeking any other legal or equitable remedies available to the
104 agency for the recovery of moneys owed to the Medicaid program.
105 In the event of a change of ownership involving a skilled
106 nursing facility licensed under part II of chapter 400,
107 liability for all outstanding overpayments, administrative
108 fines, and any moneys owed to the agency before the effective
109 date of the change of ownership shall be determined in
110 accordance with s. 400.179 if the Medicaid provider enrollment
111 application for change of ownership is submitted before the
112 change ~~of ownership~~.
113 (c) As used in this subsection, the term:
114 1. "Administrative fines" includes any amount identified in
115 a notice of a monetary penalty or fine which has been issued by
116 the agency or other regulatory or licensing agency that governs

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117 the provider.
118 2. “Outstanding overpayment” includes any amount identified
119 in a preliminary audit report issued to the transferor by the
120 agency on or before the effective date of a change of ownership.
121 (7) ~~The agency may require,~~ As a condition of participating
122 in the Medicaid program and before entering into the provider
123 agreement, the agency may require ~~that~~ the provider to submit
124 information, in an initial and any required renewal
125 applications, concerning the professional, business, and
126 personal background of the provider and permit an onsite
127 inspection of the provider’s service location by agency staff or
128 other personnel designated by the agency to perform this
129 function. Before entering into a provider agreement, the agency
130 may ~~shall~~ perform an ~~a random~~ onsite inspection~~, within 60 days~~
131 ~~after receipt of a fully complete new provider’s application,~~ of
132 the provider’s service location ~~prior to making its first~~
133 ~~payment to the provider for Medicaid services~~ to determine the
134 applicant’s ability to provide the services in compliance with
135 the Medicaid program and professional regulations ~~that the~~
136 ~~applicant is proposing to provide for Medicaid reimbursement~~.
137 ~~The agency is not required to perform an onsite inspection of a~~
138 ~~provider or program that is licensed by the agency, that~~
139 ~~provides services under waiver programs for home and community-~~
140 ~~based services, or that is licensed as a medical foster home by~~
141 ~~the Department of Children and Family Services.~~ As a continuing
142 condition of participation in the Medicaid program, a provider
143 must ~~shall~~ immediately notify the agency of any current or
144 pending bankruptcy filing. Before entering into the provider
145 agreement, or as a condition of continuing participation in the

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146 Medicaid program, the agency may also require that Medicaid
147 providers reimbursed on a fee-for-services basis or fee schedule
148 basis that ~~which~~ is not cost-based, post a surety bond not to
149 exceed $50,000 or the total amount billed by the provider to the
150 program during the current or most recent calendar year,
151 whichever is greater. For new providers, the amount of the
152 surety bond shall be determined by the agency based on the
153 provider's estimate of its first year's billing. If the
154 provider's billing during the first year exceeds the bond
155 amount, the agency may require the provider to acquire an
156 additional bond equal to the actual billing level of the
157 provider. A provider's bond need ~~shall~~ not exceed $50,000 if a
158 physician or group of physicians licensed under chapter 458,
159 chapter 459, or chapter 460 has a 50 percent or greater
160 ownership interest in the provider or if the provider is an
161 assisted living facility licensed under chapter 429. The bonds
162 permitted by this section are in addition to the bonds
163 referenced in s. 400.179(2)(d). If the provider is a
164 corporation, partnership, association, or other entity, the
165 agency may require the provider to submit information concerning
166 the background of that entity and of any principal of the
167 entity, including any partner or shareholder having an ownership
168 interest in the entity equal to 5 percent or greater, and any
169 treating provider who participates in or intends to participate
170 in Medicaid through the entity. The information must include:
171 (a) Proof of holding a valid license or operating
172 certificate, as applicable, if required by the state or local
173 jurisdiction in which the provider is located or if required by
174 the Federal Government.

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175 (b) Information concerning any prior violation, fine,
176 suspension, termination, or other administrative action taken
177 under the Medicaid laws or~~,~~ rules~~, or regulations~~ of this state
178 or of any other state or the Federal Government; any prior
179 violation of the laws or~~,~~ rules~~, or regulations~~ relating to the
180 Medicare program; any prior violation of the rules ~~or~~
181 ~~regulations~~ of any other public or private insurer; and any
182 prior violation of the laws or~~,~~ rules~~, or regulations~~ of any
183 regulatory body of this or any other state.
184 (c) Full and accurate disclosure of any financial or
185 ownership interest that the provider, or any principal, partner,
186 or major shareholder thereof, may hold in any other Medicaid
187 provider or health care related entity or any other entity that
188 is licensed by the state to provide health or residential care
189 and treatment to persons.
190 (d) If a group provider, identification of all members of
191 the group and attestation that all members of the group are
192 enrolled in or have applied to enroll in the Medicaid program.
193 (8)~~(a)~~ Each provider, or each principal of the provider if
194 the provider is a corporation, partnership, association, or
195 other entity, seeking to participate in the Medicaid program
196 must submit a complete set of his or her fingerprints to the
197 agency for the purpose of conducting a criminal history record
198 check. Principals of the provider include any officer, director,
199 billing agent, managing employee, or affiliated person, or any
200 partner or shareholder who has an ownership interest equal to 5
201 percent or more in the provider. However, for a hospital
202 licensed under chapter 395 or a nursing home licensed under
203 chapter 400, principals of the provider are those who meet the

204 definition of a controlling interest under s. 408.803. A
205 director of a not-for-profit corporation or organization is not
206 a principal for purposes of a background investigation ~~as~~
207 required by this section if the director: serves solely in a
208 voluntary capacity for the corporation or organization, does not
209 regularly take part in the day-to-day operational decisions of
210 the corporation or organization, receives no remuneration from
211 the not-for-profit corporation or organization for his or her
212 service on the board of directors, has no financial interest in
213 the not-for-profit corporation or organization, and has no
214 family members with a financial interest in the not-for-profit
215 corporation or organization; and if the director submits an
216 affidavit, under penalty of perjury, to this effect to the
217 agency and the not-for-profit corporation or organization
218 submits an affidavit, under penalty of perjury, to this effect
219 to the agency as part of the corporation's or organization's
220 Medicaid provider agreement application. Notwithstanding the
221 above, the agency may require a background check for any person
222 reasonably suspected by the agency to have been convicted of a
223 crime.
224 (a) This subsection does not apply to:
225 ~~1. A hospital licensed under chapter 395;~~
226 ~~2. A nursing home licensed under chapter 400;~~
227 ~~3. A hospice licensed under chapter 400;~~
228 ~~4. An assisted living facility licensed under chapter 429;~~
229 1.~~5.~~ A unit of local government, except that requirements
230 of this subsection apply to nongovernmental providers and
231 entities contracting with the local government to provide
232 Medicaid services. The actual cost of the state and national

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233 criminal history record checks must be borne by the
234 nongovernmental provider or entity; or
235 2.~~6.~~ Any business that derives more than 50 percent of its
236 revenue from the sale of goods to the final consumer, and the
237 business or its controlling parent is required to file a form
238 10-K or other similar statement with the Securities and Exchange
239 Commission or has a net worth of $50 million or more.
240 (b) Background screening shall be conducted in accordance
241 with chapter 435 and s. 408.809. The cost of the state and
242 national criminal record check shall be borne by the provider.
243 ~~(c) Proof of compliance with the requirements of level 2~~
244 ~~screening under chapter 435 conducted within 12 months before~~
245 ~~the date the Medicaid provider application is submitted to the~~
246 ~~agency fulfills the requirements of this subsection.~~
247 Section 2. Subsections (9), (13), (15), (16), (21), (22),
248 (25), (28), (30) and (31) of section 409.913, Florida Statutes,
249 are amended to read:
250 409.913 Oversight of the integrity of the Medicaid
251 program.—The agency shall operate a program to oversee the
252 activities of Florida Medicaid recipients, and providers and
253 their representatives, to ensure that fraudulent and abusive
254 behavior and neglect of recipients occur to the minimum extent
255 possible, and to recover overpayments and impose sanctions as
256 appropriate. Beginning January 1, 2003, and each year
257 thereafter, the agency and the Medicaid Fraud Control Unit of
258 the Department of Legal Affairs shall submit a joint report to
259 the Legislature documenting the effectiveness of the state’s
260 efforts to control Medicaid fraud and abuse and to recover
261 Medicaid overpayments during the previous fiscal year. The

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262 report must describe the number of cases opened and investigated
263 each year; the sources of the cases opened; the disposition of
264 the cases closed each year; the amount of overpayments alleged
265 in preliminary and final audit letters; the number and amount of
266 fines or penalties imposed; any reductions in overpayment
267 amounts negotiated in settlement agreements or by other means;
268 the amount of final agency determinations of overpayments; the
269 amount deducted from federal claiming as a result of
270 overpayments; the amount of overpayments recovered each year;
271 the amount of cost of investigation recovered each year; the
272 average length of time to collect from the time the case was
273 opened until the overpayment is paid in full; the amount
274 determined as uncollectible and the portion of the uncollectible
275 amount subsequently reclaimed from the Federal Government; the
276 number of providers, by type, that are terminated from
277 participation in the Medicaid program as a result of fraud and
278 abuse; and all costs associated with discovering and prosecuting
279 cases of Medicaid overpayments and making recoveries in such
280 cases. The report must also document actions taken to prevent
281 overpayments and the number of providers prevented from
282 enrolling in or reenrolling in the Medicaid program as a result
283 of documented Medicaid fraud and abuse and must include policy
284 recommendations necessary to prevent or recover overpayments and
285 changes necessary to prevent and detect Medicaid fraud. All
286 policy recommendations in the report must include a detailed
287 fiscal analysis, including, but not limited to, implementation
288 costs, estimated savings to the Medicaid program, and the return
289 on investment. The agency must submit the policy recommendations
290 and fiscal analyses in the report to the appropriate estimating

291 conference, pursuant to s. 216.137, by February 15 of each year.
292 The agency and the Medicaid Fraud Control Unit of the Department
293 of Legal Affairs each must include detailed unit-specific
294 performance standards, benchmarks, and metrics in the report,
295 including projected cost savings to the state Medicaid program
296 during the following fiscal year.
297 (9) A Medicaid provider shall retain medical, professional,
298 financial, and business records pertaining to services and goods
299 furnished to a Medicaid recipient and billed to Medicaid for 6 ~~a~~
300 ~~period of 5~~ years after the date of furnishing such services or
301 goods. The agency may investigate, review, or analyze such
302 records, which must be made available during normal business
303 hours. However, 24-hour notice must be provided if patient
304 treatment would be disrupted. The provider must keep ~~is~~
305 ~~responsible for furnishing to the agency, and keeping~~ the agency
306 informed of the location of, the provider's Medicaid-related
307 records. The authority of the agency to obtain Medicaid-related
308 records from a provider is neither curtailed nor limited during
309 a period of litigation between the agency and the provider.
310 (13) The agency shall ~~immediately~~ terminate participation
311 of a Medicaid provider in the Medicaid program and may seek
312 civil remedies or impose other administrative sanctions against
313 a Medicaid provider, if the provider or any principal, officer,
314 director, agent, managing employee, or affiliated person of the
315 provider, or any partner or shareholder having an ownership
316 interest in the provider equal to 5 percent or greater, has been
317 convicted of a criminal offense under federal law or the law of
318 any state relating to the practice of the provider's profession,
319 or a criminal offense listed under s. 409.907(10), s.

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320 408.809(4), or s. 435.04(2) ~~has been:~~
321 ~~(a) Convicted of a criminal offense related to the delivery~~
322 ~~of any health care goods or services, including the performance~~
323 ~~of management or administrative functions relating to the~~
324 ~~delivery of health care goods or services;~~
325 ~~(b) Convicted of a criminal offense under federal law or~~
326 ~~the law of any state relating to the practice of the provider's~~
327 ~~profession; or~~
328 ~~(c) Found by a court of competent jurisdiction to have~~
329 ~~neglected or physically abused a patient in connection with the~~
330 ~~delivery of health care goods or services~~. If the agency
331 determines that the ~~a~~ provider did not participate or acquiesce
332 in the ~~an~~ offense ~~specified in paragraph (a), paragraph (b), or~~
333 ~~paragraph (c),~~ termination will not be imposed. If the agency
334 effects a termination under this subsection, the agency shall
335 take final agency action ~~issue an immediate final order pursuant~~
336 ~~to s. 120.569(2)(n)~~.
337 (15) The agency shall seek a remedy provided by law,
338 including, but not limited to, any remedy provided in
339 subsections (13) and (16) and s. 812.035, if:
340 (a) The provider's license has not been renewed, or has
341 been revoked, suspended, or terminated, for cause, by the
342 licensing agency of any state;
343 (b) The provider has failed to make available or has
344 refused access to Medicaid-related records to an auditor,
345 investigator, or other authorized employee or agent of the
346 agency, the Attorney General, a state attorney, or the Federal
347 Government;
348 (c) The provider has not furnished or has failed to make

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349 available such Medicaid-related records as the agency has found
350 necessary to determine whether Medicaid payments are or were due
351 and the amounts thereof;
352 (d) The provider has failed to maintain medical records
353 made at the time of service, or prior to service if prior
354 authorization is required, demonstrating the necessity and
355 appropriateness of the goods or services rendered;
356 (e) The provider is not in compliance with provisions of
357 Medicaid provider publications that have been adopted by
358 reference as rules in the Florida Administrative Code; with
359 provisions of state or federal laws, rules, or regulations; with
360 provisions of the provider agreement between the agency and the
361 provider; or with certifications found on claim forms or on
362 transmittal forms for electronically submitted claims that are
363 submitted by the provider or authorized representative, as such
364 provisions apply to the Medicaid program;
365 (f) The provider or person who ordered, authorized, or
366 prescribed the care, services, or supplies has furnished, or
367 ordered or authorized the furnishing of, goods or services to a
368 recipient which are inappropriate, unnecessary, excessive, or
369 harmful to the recipient or are of inferior quality;
370 (g) The provider has demonstrated a pattern of failure to
371 provide goods or services that are medically necessary;
372 (h) The provider or an authorized representative of the
373 provider, or a person who ordered, authorized, or prescribed the
374 goods or services, has submitted or caused to be submitted false
375 or a pattern of erroneous Medicaid claims;
376 (i) The provider or an authorized representative of the
377 provider, or a person who has ordered, authorized, or prescribed

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378 the goods or services, has submitted or caused to be submitted a
379 Medicaid provider enrollment application, a request for prior
380 authorization for Medicaid services, a drug exception request,
381 or a Medicaid cost report that contains materially false or
382 incorrect information;
383 (j) The provider or an authorized representative of the
384 provider has collected from or billed a recipient or a
385 recipient's responsible party improperly for amounts that should
386 not have been so collected or billed by reason of the provider's
387 billing the Medicaid program for the same service;
388 (k) The provider or an authorized representative of the
389 provider has included in a cost report costs that are not
390 allowable under a Florida Title XIX reimbursement plan~~,~~ after
391 the provider or authorized representative had been advised in an
392 audit exit conference or audit report that the costs were not
393 allowable;
394 (l) The provider is charged by information or indictment
395 with fraudulent billing practices or an offense referenced in
396 subsection (13). The sanction applied for this reason is limited
397 to suspension of the provider's participation in the Medicaid
398 program for the duration of the indictment unless the provider
399 is found guilty pursuant to the information or indictment;
400 (m) The provider or a person who ~~has~~ ordered, authorized,
401 or prescribed the goods or services is found liable for
402 negligent practice resulting in death or injury to the
403 provider's patient;
404 (n) The provider fails to demonstrate that it had available
405 during a specific audit or review period sufficient quantities
406 of goods, or sufficient time in the case of services, to support

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407 the provider’s billings to the Medicaid program;
408 (o) The provider has failed to comply with the notice and
409 reporting requirements of s. 409.907;
410 (p) The agency has received reliable information of patient
411 abuse or neglect or of any act prohibited by s. 409.920; or
412 (q) The provider has failed to comply with an agreed-upon
413 repayment schedule.
414
415 A provider is subject to sanctions for violations of this
416 subsection as the result of actions or inactions of the
417 provider, or actions or inactions of any principal, officer,
418 director, agent, managing employee, or affiliated person of the
419 provider, or any partner or shareholder having an ownership
420 interest in the provider equal to 5 percent or greater, in which
421 the provider participated or acquiesced.
422 (16) The agency shall impose any of the following sanctions
423 or disincentives on a provider or a person for any of the acts
424 described in subsection (15):
425 (a) Suspension for a specific period of time of not more
426 than 1 year. Suspension precludes ~~shall preclude~~ participation
427 in the Medicaid program, which includes any action that results
428 in a claim for payment to the Medicaid program for ~~as a result~~
429 ~~of~~ furnishing, supervising a person who is furnishing, or
430 causing a person to furnish goods or services.
431 (b) Termination for a specific period of time ranging ~~of~~
432 from more than 1 year to 20 years. Termination precludes ~~shall~~
433 ~~preclude~~ participation in the Medicaid program, which includes
434 any action that results in a claim for payment to the Medicaid
435 program for ~~as a result of~~ furnishing, supervising a person who

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436 is furnishing, or causing a person to furnish goods or services.
437 (c) Imposition of a fine of up to $5,000 for each
438 violation. Each day that an ongoing violation continues, such as
439 refusing to furnish Medicaid-related records or refusing access
440 to records, is considered~~, for the purposes of this section, to~~
441 ~~be~~ a separate violation. Each instance of improper billing of a
442 Medicaid recipient; each instance of including an unallowable
443 cost on a hospital or nursing home Medicaid cost report after
444 the provider or authorized representative has been advised in an
445 audit exit conference or previous audit report of the cost
446 unallowability; each instance of furnishing a Medicaid recipient
447 goods or professional services that are inappropriate or of
448 inferior quality as determined by competent peer judgment; each
449 instance of knowingly submitting a materially false or erroneous
450 Medicaid provider enrollment application, request for prior
451 authorization for Medicaid services, drug exception request, or
452 cost report; each instance of inappropriate prescribing of drugs
453 for a Medicaid recipient as determined by competent peer
454 judgment; and each false or erroneous Medicaid claim leading to
455 an overpayment to a provider is considered~~, for the purposes of~~
456 ~~this section, to be~~ a separate violation.
457 (d) Immediate suspension, if the agency has received
458 information of patient abuse or neglect or of any act prohibited
459 by s. 409.920. Upon suspension, the agency must issue an
460 immediate final order under s. 120.569(2)(n).
461 (e) A fine, not to exceed $10,000, for a violation of
462 paragraph (15)(i).
463 (f) Imposition of liens against provider assets, including,
464 but not limited to, financial assets and real property, not to

465 exceed the amount of fines or recoveries sought, upon entry of
466 an order determining that such moneys are due or recoverable.
467 (g) Prepayment reviews of claims for a specified period of
468 time.
469 (h) Comprehensive followup reviews of providers every 6
470 months to ensure that they are billing Medicaid correctly.
471 (i) Corrective-action plans that ~~would~~ remain in effect ~~for~~
472 ~~providers~~ for up to 3 years and that are ~~would be~~ monitored by
473 the agency every 6 months while in effect.
474 (j) Other remedies as permitted by law to effect the
475 recovery of a fine or overpayment.
476
477 If a provider voluntarily relinquishes its Medicaid provider
478 number or an associated license, or allows the associated
479 licensure to expire after receiving written notice that the
480 agency is conducting, or has conducted, an audit, survey,
481 inspection, or investigation and that a sanction of suspension
482 or termination will or would be imposed for noncompliance
483 discovered as a result of the audit, survey, inspection, or
484 investigation, the agency shall impose the sanction of
485 termination for cause against the provider. The Secretary of
486 Health Care Administration may make a determination that
487 imposition of a sanction or disincentive is not in the best
488 interest of the Medicaid program, in which case a sanction or
489 disincentive may ~~shall~~ not be imposed.
490 (21) When making a determination that an overpayment has
491 occurred, the agency shall prepare and issue an audit report to
492 the provider showing the calculation of overpayments. The
493 agency’s determination must be based solely upon information

494 available to it before issuance of the audit report and, in the
495 case of documentation obtained to substantiate claims for
496 Medicaid reimbursement, based solely upon contemporaneous
497 records.
498 (22) The audit report, supported by agency work papers,
499 showing an overpayment to a provider constitutes evidence of the
500 overpayment. A provider may not present or elicit testimony,
501 either on direct examination or cross-examination in any court
502 or administrative proceeding, regarding the purchase or
503 acquisition by any means of drugs, goods, or supplies; sales or
504 divestment by any means of drugs, goods, or supplies; or
505 inventory of drugs, goods, or supplies, unless such acquisition,
506 sales, divestment, or inventory is documented by written
507 invoices, written inventory records, or other competent written
508 documentary evidence maintained in the normal course of the
509 provider's business. A provider may not present records to
510 contest an overpayment or sanction unless such records are
511 contemporaneous and, if requested during the audit process, were
512 furnished to the agency or its agent upon request. This
513 limitation does not apply to Medicaid cost report audits.
514 Notwithstanding the applicable rules of discovery, all
515 documentation to that will be offered as evidence at an
516 administrative hearing on a Medicaid overpayment or an
517 administrative sanction must be exchanged by all parties at
518 least 14 days before the administrative hearing or must be
519 excluded from consideration.
520 (25)(a) The agency shall withhold Medicaid payments, in
521 whole or in part, to a provider upon receipt of reliable
522 evidence that the circumstances giving rise to the need for a

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523 withholding of payments involve fraud, willful
524 misrepresentation, or abuse under the Medicaid program, or a
525 crime committed while rendering goods or services to Medicaid
526 recipients. If it is determined that fraud, willful
527 misrepresentation, abuse, or a crime did not occur, the payments
528 withheld must be paid to the provider within 14 days after such
529 determination ~~with interest at the rate of 10 percent a year.~~
530 ~~Any money withheld in accordance with this paragraph shall be~~
531 ~~placed in a suspended account, readily accessible to the agency,~~
532 ~~so that any payment ultimately due the provider shall be made~~
533 ~~within 14 days~~. Amounts not paid within 14 days accrue interest
534 at the rate of 10 percent a year, beginning after the 14th day.
535 (b) The agency shall deny payment, or require repayment, if
536 the goods or services were furnished, supervised, or caused to
537 be furnished by a person who has been suspended or terminated
538 from the Medicaid program or Medicare program by the Federal
539 Government or any state.
540 (c) Overpayments owed to the agency bear interest at the
541 rate of 10 percent per year from the date of final determination
542 of the overpayment by the agency, and payment arrangements must
543 be made within 30 days after the date of the final order, which
544 is not subject to further appeal ~~at the conclusion of legal~~
545 ~~proceedings~~. ~~A provider who does not enter into or adhere to an~~
546 ~~agreed-upon repayment schedule may be terminated by the agency~~
547 ~~for nonpayment or partial payment.~~
548 (d) The agency, upon entry of a final agency order, a
549 judgment or order of a court of competent jurisdiction, or a
550 stipulation or settlement, may collect the moneys owed by all
551 means allowable by law, including, but not limited to, notifying

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

552 any fiscal intermediary of Medicare benefits that the state has
553 a superior right of payment. Upon receipt of such written
554 notification, the Medicare fiscal intermediary shall remit to
555 the state the sum claimed.
556 (e) The agency may institute amnesty programs to allow
557 Medicaid providers the opportunity to voluntarily repay
558 overpayments. The agency may adopt rules to administer such
559 programs.
560 (28) Venue for all Medicaid program integrity ~~overpayment~~
561 cases lies ~~shall lie~~ in Leon County, at the discretion of the
562 agency.
563 (30) The agency shall terminate a provider's participation
564 in the Medicaid program if the provider fails to reimburse an
565 overpayment or pay an agency-imposed fine that has been
566 determined by final order, not subject to further appeal, within
567 30 ~~35~~ days after the date of the final order, unless the
568 provider and the agency have entered into a repayment agreement.
569 (31) If a provider requests an administrative hearing
570 pursuant to chapter 120, such hearing must be conducted within
571 90 days following assignment of an administrative law judge,
572 absent exceptionally good cause shown as determined by the
573 administrative law judge or hearing officer. Upon issuance of a
574 final order, the outstanding balance of the amount determined to
575 constitute the overpayment and fines is ~~shall become~~ due. If a
576 provider fails to make payments in full, fails to enter into a
577 satisfactory repayment plan, or fails to comply with the terms
578 of a repayment plan or settlement agreement, the agency shall
579 withhold ~~medical assistance~~ reimbursement payments for Medicaid
580 services until the amount due is paid in full.

581 Section 3. Subsection (8) of section 409.920, Florida
582 Statutes, is amended to read:
583 409.920 Medicaid provider fraud.—
584 (8) A person who provides the state, any state agency, any
585 of the state’s political subdivisions, or any agency of the
586 state’s political subdivisions with information about fraud or
587 suspected fraudulent acts ~~fraud~~ by a Medicaid provider,
588 including a managed care organization, is immune from civil
589 liability for libel, slander, or any other relevant tort for
590 providing ~~the~~ information about fraud or suspected fraudulent
591 acts, unless the person acted with knowledge that the
592 information was false or with reckless disregard for the truth
593 or falsity of the information. Such immunity extends to reports
594 of fraudulent acts or suspected fraudulent acts conveyed to or
595 from the agency in any manner, including any forum and with any
596 audience as directed by the agency, and includes all discussions
597 subsequent to the report and subsequent inquiries from the
598 agency, unless the person acted with knowledge that the
599 information was false or with reckless disregard for the truth
600 or falsity of the information. For purposes of this subsection,
601 the term “fraudulent acts” includes actual or suspected fraud
602 and abuse, insurance fraud, licensure fraud, or public
603 assistance fraud, including any fraud-related matters that a
604 provider or health plan is required to report to the agency or a
605 law enforcement agency.
606 Section 4. This act shall take effect July 1, 2013.