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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 636 Session of 2011

INTRODUCED BY DAVIS, DeLUCA, BARRAR, CARROLL, D. COSTA, FABRIZIO, HORNAMAN, JOSEPHS, W. KELLER, KOTIK, MANN, MATZIE, MUNDY, M. O'BRIEN, PASHINSKI, SANTARSIERO, M. SMITH AND STURLA, FEBRUARY 14, 2011

REFERRED TO COMMITTEE ON HUMAN SERVICES, FEBRUARY 14, 2011

AN ACT

Amending Title 35 (Health and Safety) of the Pennsylvania Consolidated Statutes, providing for oversight of the integrity of health care programs; and imposing penalties.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Title 35 of the Pennsylvania Consolidated Statutes is amended by adding a part to read:

PART IV

HEALTH CARE PROGRAMS

Chapter

61. Preliminary Provisions (Reserved)

63. Oversight of the Integrity of Health Care Programs

CHAPTER 61

PRELIMINARY PROVISIONS

(RESERVED)

CHAPTER 63

OVERSIGHT OF THE INTEGRITY OF HEALTH CARE PROGRAMS

Sec.

§ 6301. Scope of chapter.

This chapter relates to oversight of the integrity of health care programs.

§ 6302. Definitions.

The following words and phrases when used in this chapter shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Abuse." All of the following:

(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 an unnecessary cost to the health care program.

"AdultBasic program." The program established pursuant to chapter 13 of the act of June 26, 2001 (P.L.755, No.77), known as the Tobacco Settlement Act.

"Children's Health Insurance Program." The Children's Health Care Program established under Article XXIII of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

"Complaint." An allegation that fraud, abuse or an overpayment has occurred.

"Department." All of the following:

(1) For health care programs under the administration of the Insurance Department of the Commonwealth, the Insurance Department of the Commonwealth.

(2) For health care programs not under the administration of the Insurance Department of the Commonwealth, the executive agency of the Commonwealth charged with administering, managing or financing the health care program.

"Fraud." An intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to the person or another person. The term includes any act that constitutes fraud under applicable Federal or State law.

"Health care program." A health care program administered, managed or financed through an executive agency of the Commonwealth, such as the Children's Health Insurance Program and the adultBasic program. The term does not include the Medicaid program.

"Health care provider" or "provider." All of the following:

(1) A primary health care center or a person, including a corporation, university or other educational institution, licensed or approved by the Commonwealth to provide health care or professional medical services as a physician, a certified nurse midwife, a dentist, a pharmacist, a podiatrist, hospital, nursing home or birth center.

(2) A person receiving compensation or reimbursements from a health care program.

"Home health care agency." An organization or part thereof staffed and equipped to provide nursing and at least one therapeutic service to persons who are disabled, aged, injured or sick in their place of residence or other independent living environment.

"Insurance Company Law of 1921." The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

"Managed care plans." A company or health insurance entity licensed under the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, to issue any individual or group health, sickness or accident policy or subscriber contract or certificate or plan that provides medical or health care coverage by a health care facility or licensed health care provider that is offered or governed under this chapter or any of the following:

(1) Article XXIV of The Insurance Company Law of 1921.

(2) The act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

(3) The act of May 18, 1976 (P.L.123, No.54), known as the Individual Accident and Sickness Insurance Minimum Standards Act.

(4) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

"Medical assistance" or "Medicaid." The State program of medical assistance established under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

"Medical necessity" or "medically necessary." 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.

"Overpayment." Any amount that is not authorized to be paid by Medicaid or a health care program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistakes.

"Person." Any natural person, corporation, partnership, association, clinic, group or other entity, whether or not the person is enrolled in the Medicaid or health care program or is a provider of health care.

§ 6303. Duties of executive agency and department.

(a) Reports.--

(1) The Department of Public Welfare and the department shall operate their respective programs to oversee the activities of the Commonwealth's health care programs for the benefit of the programs' recipients, 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, 2012, and each year thereafter, the Department of Public Welfare shall submit a report to the General Assembly documenting the effectiveness of the Commonwealth's efforts to control Medicaid and health care program costs and abuse and to recover Medicaid and health care program overpayments during the previous year.

(2) The report shall describe all of the following:

(i) The number of cases opened and investigated each year.

(ii) The sources of the cases opened.

(iii) The disposition of the cases closed each year.

(iv) The amount of overpayments alleged in preliminary and final audit letters.

(v) The number and amount of fines or penalties imposed.

(vi) Any reductions in overpayment amounts negotiated in settlement agreements or by other means.

(vii) The amount of final Department of Public Welfare determinations of overpayments.

(viii) The amount deducted from Federal claiming as a result of overpayments.

(ix) The amount of overpayments recovered each year.

(x) The amount of cost of investigation recovered each year.

(xi) The average length of time to collect from the time the case was opened until the overpayment is paid in full.

(xii) The amount determined as uncollectible and the portion of the uncollectible amount subsequently

reclaimed from the Federal Government.

(xiii) The number of providers, by type, that are terminated from participation in the Medicaid and health care programs as a result of fraud and abuse.

(xiv) All costs associated with discovering and prosecuting cases of health care program overpayments and making recoveries in the cases.

(3) The report shall document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in each health care program and Medicaid as a result of documented fraud and abuse and shall include policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect fraud.

(4) All policy recommendations in the report shall include a detailed fiscal analysis, including implementation costs, estimated savings to Medicaid and each health care program and the return on investment.

(5) The Department of Public Welfare and the department shall submit the policy recommendations and fiscal analyses in the report to the President pro tempore of the Senate, the Speaker of the House of Representatives, the Banking and Insurance Committee of the Senate and the Insurance Committee of the House of Representatives by February 15 of each year.

(6) The Department of Public Welfare and the department shall each include detailed unit-specific performance standards, benchmarks and metrics in the report, including projected cost savings to each health care program during the following fiscal year.

(b) Reviews.--

(1) The Department of Public Welfare shall conduct 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. At least 5% of all audits shall be conducted on a random basis. As part of its ongoing fraud detection activities, the Department of Public Welfare shall identify and monitor patterns of overutilization of health care services based on State averages. The Department of Public Welfare shall track health care provider prescription and billing patterns and evaluate them against Medicaid medical necessity criteria and coverage and limitation guidelines adopted by rule. The Department of Public Welfare 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. For purposes of determining Medicaid reimbursement, the Department of Public Welfare 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 Department of Public Welfare and must be based upon information available at the time the goods or services are provided.

(2) The department shall conduct reviews, investigations, analyses, audits or any combination thereof to determine possible fraud, abuse or waste in health care programs and shall report the findings in the report required

under this section.

(c) Prepayment review.--

(1) The Department of Public Welfare may conduct prepayment review of provider claims to:

(i) Ensure cost-effective purchasing.

(ii) Ensure that billing by a provider to the Department of Public Welfare is in accordance with applicable provisions of rules, regulations, handbooks and policies and in accordance with Federal and State law.

(iii) Ensure that appropriate care is rendered to Medicaid recipients.

(2) Prepayment reviews may be conducted as determined appropriate by the Department of Public Welfare, without any suspicion or allegation of fraud, abuse or neglect and may last for up to one year. Unless the Department of Public Welfare has reliable evidence of fraud, misrepresentation, abuse or neglect, claims shall be adjudicated for denial or payment within 90 days after receipt of complete documentation by the Department of Public Welfare for review. If there is reliable evidence of fraud, misrepresentation, abuse or neglect, claims shall be adjudicated for denial of payment within 180 days after receipt of complete documentation by the Department of Public Welfare for review.

(d) Referrals to the Office of Attorney General.--Any suspected criminal violation identified by the Department of Public Welfare or by the department shall be referred to the Office of Attorney General for investigation. The Department of Public Welfare and the department shall periodically conduct joint training and other joint activities with the Office of

Attorney General designed to increase communication and coordination in recovering overpayments.

(e) Peer review.--A health care provider is subject to having goods and services that are paid for by Medicaid or a health care program reviewed by an appropriate peer-review organization designated by the Department of Public Welfare or the department. The written findings of the peer-review organization shall be admissible in any court or administrative proceeding as evidence of medical necessity or the lack of medical necessity.

(f) Notice of peer review.--Any notice required to be given to a provider under this section shall be presumed to be sufficient notice if sent to the address last shown on the provider enrollment file. It is the responsibility of the provider to furnish and keep the Department of Public Welfare informed of the provider's current address. United States Postal Service proof of mailing or certified or registered mailing of the notice to the provider at the address shown on the provider enrollment file shall constitute sufficient proof of notice. Any notice required to be given to the Department of Public Welfare under this section must be sent to the Department of Public Welfare at an address designated by rule.

(g) Payments.--When presenting a claim for payment under Medicaid or a health care program, a provider shall have an affirmative duty to supervise the provision of, and be responsible for, goods and services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for goods and services that:

(1) Have actually been furnished to the recipient by the

provider prior to submitting the claim.

(2) Are covered goods or services under the health care program and that are medically necessary.

(3) Are of a quality comparable to those furnished to the general public by the provider's peers.

(4) Have not been billed in whole or in part to a recipient or a recipient's responsible party, except for the copayments, coinsurance or deductibles as are authorized by the Department of Public Welfare.

(5) Are provided in accord with applicable provisions of all health care program rules, regulations, handbooks and policies and in accordance with Federal and State law.

(6) Are documented by records made at the time the goods or services were provided, demonstrating the medical necessity for the goods or services rendered. Medicaid and health care program goods or services shall be considered excessive or not medically necessary unless both the medical basis and the specific need for them are fully and properly documented in the recipient's medical record.

(7) Medicaid and the Department of Public Welfare shall deny payment or require repayment for goods or services that are not presented as required under this section.

(h) Denial of payments.--The Department of Public Welfare shall not reimburse any person or entity for any prescription for medications, medical supplies or medical services if the prescription was written by a physician or other prescribing practitioner who is not enrolled in the health care program. This section shall not apply:

(1) In instances involving bona fide emergency medical conditions as determined by the Department of Public Welfare.

(2) To a provider of medical services to a patient in a hospital emergency department, hospital inpatient or outpatient setting or nursing home.

(3) To bona fide pro bono services by preapproved non-Medicaid providers as determined by the Department of Public Welfare.

(4) To prescribing physicians who are board-certified specialists treating Medicaid recipients referred for treatment by a treating physician who is enrolled in the health care program.

(5) To prescriptions written for duly eligible Medicare beneficiaries by an authorized Medicare provider who is not enrolled in the Medicaid program.

(6) To other physicians who are not enrolled in the Medicaid program but who provide a medically necessary service or prescription not otherwise reasonably available from a Medicaid-enrolled physician.

(i) Retention.--

(1) A health care program provider shall retain medical, professional, financial and business records pertaining to services and goods furnished to Medicaid or a health care program recipient and billed to Medicaid or the health care program for a period of five years after the date of furnishing the services or goods.

(2) The Department of Public Welfare or department may investigate, review or analyze the records, which must be made available during normal business hours, except that 24-hour notice must be provided if patient treatment would be disrupted. The provider shall be responsible for furnishing to the Department of Public Welfare or the department, and

keeping the Department of Public Welfare or the department informed of the location of, the provider's Medicaid and health care program-related records.

(3) The authority of the Department of Public Welfare to obtain Medicaid or health care program-related records from a provider shall not be curtailed nor limited during a period of litigation between the Department of Public Welfare and the provider or the department and the provider.

(j) Billing payments.--Payments for the services of billing agents or persons participating in the preparation of a Medicaid or health care program claim shall not be based on amounts for which they bill nor based on the amount a provider receives from Medicaid or the health care program.

(k) Denial of payments.--The Department of Public Welfare or the department shall deny payment or require repayment for inappropriate, medically unnecessary or excessive goods or services from the person furnishing them, the person under whose supervision they were furnished or the person causing them to be furnished.

(l) Confidentiality.--The complaint and all information obtained pursuant to an investigation of a health care provider, or the authorized representative or agent of a provider, relating to an allegation of fraud, abuse or neglect are confidential and shall be exempt from the act of February 14, 2008 (P.L.6, No.3), known as the Right-to-Know Law, under the following circumstances:

(1) Until the Department of Public Welfare or the department takes final Department of Public Welfare action with respect to the provider and requires repayment of any overpayment or imposes an administrative sanction.

(2) Until the Attorney General refers the case for criminal prosecution.

(3) Until ten days after the complaint is determined without merit.

(4) At any time if the complaint or information is otherwise protected by law.

§ 6304. Termination and sanctions.

(a) Termination of participation.--The Department of Public Welfare or the department shall immediately terminate participation of a health care program provider in the Medicaid or health care program and may seek civil remedies or impose other administrative sanctions against a 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 at least 5%, has been:

(1) 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.

(2) Convicted of a criminal offense under Federal law or the law of any state relating to the practice of the provider's profession.

(3) 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.

(b) Termination for foreign suspension.--If the provider has been suspended or terminated from participation in the Medicaid program or the Medicare program by the Federal Government or any state, the Department of Public Welfare shall immediately

suspend or terminate the provider's participation in the Commonwealth's Medicaid program for a period no less than that imposed by the Federal Government or any other state, and may not enroll the provider in the Commonwealth's Medicaid program while the foreign suspension or termination remains in effect. The Department of Public Welfare shall immediately suspend or terminate, as appropriate, a provider's participation in the Commonwealth's Medicaid program if the provider participated or acquiesced in any action for which 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 at least 5%, was suspended or terminated from participating in the Medicaid program or the Medicare program by the Federal Government or any state. The sanction under this subsection shall be in addition to any other remedies provided by law.

(c) Remedies.--The Department of Public Welfare shall seek any remedy provided by law, including any remedy provided under this chapter if any of the following apply:

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

(2) The provider has failed to make available or has refused access to Medicaid or health care program-related records to an auditor, investigator or other authorized employee or agent of the Department of Public Welfare, the Attorney General or the Federal Government.

(3) The provider has not furnished or has failed to make available Medicaid or health care program-related records as the Department of Public Welfare or the department has found

necessary to determine whether Medicaid or health care program payments are or were due and the amounts of the payments.

(4) 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.

(5) The provider is not in compliance with the provisions applicable to the health care program of any of the following:

(i) Provisions of Medicaid provider publications.

(ii) Federal or State laws, rules or regulations.

(iii) Provisions of the provider agreement between the Department of Public Welfare and the provider.

(iv) Certifications found on claim forms or on transmittal forms for electronically submitted claims that are submitted by the provider or authorized representative.

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

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

(8) The provider, 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 or health care program claims.

(9) The provider, an authorized representative of the

provider or a person who has ordered or prescribed the goods or services has submitted or caused to be submitted a health care provider enrollment application, a request for prior authorization for Medicaid services, a drug exception request or a health care program or Medicaid cost report that contains materially false or incorrect information.

(10) 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 collected or billed by reason of the provider's billing of the Medicaid or health care program for the same service.

(11) The provider is charged by information or indictment with fraudulent billing practices. The sanction under this paragraph shall be limited to suspension of the provider's participation in the Medicaid or health care program for the duration of the indictment unless the provider is found guilty pursuant to the information or indictment.

(12) 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.

(13) The provider fails to demonstrate that the provider 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 or health care program.

(14) The Department of Public Welfare has received reliable information of patient abuse or neglect or of any

act prohibited by 18 Pa.C.S. (relating to crimes and offenses).

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

(d) Sanctions.--A provider is subject to sanctions for violations of subsections (a) and (b) as the result of actions or inactions of the provider, or actions or inactions of any principal, officer, director, agent, managing employee, affiliated person of the provider or any partner or shareholder having an ownership interest in the provider equal to at least 5% or greater, in which the provider participated or acquiesced.

(e) Imposition of sanctions.--The Department of Public Welfare or the department shall impose any of the following sanctions or disincentives on a provider or a person for any of the acts described under subsection (a) or (b):

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

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

(3) (i) 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 or health care program-related records or refusing access to records, is considered, for the purposes of this section, to be a separate violation.

(ii) Each instance of improper billing of a Medicaid or health care program recipient, each instance of furnishing a Medicaid or health care program 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 or health care program provider enrollment application, request for prior authorization for health care program services, drug exception request or cost report, each instance of the inappropriate prescribing of drugs for a Medicaid or health care program recipient as determined by competent peer judgment and each false or erroneous health care provider claim leading to an overpayment to a provider is considered, for the purposes of this section, to be a separate violation.

(4) Immediate suspension, if the Department of Public Welfare or the department has received information of patient abuse or neglect or of any act prohibited by companion criminal law. Upon suspension, the Department of Public Welfare must issue an immediate final order appealable to a court of competent jurisdiction.

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

(6) Imposition of liens against provider assets,

including financial assets and real property, not to exceed the amount of fines or recoveries sought, upon entry of an order determining that the moneys are due or recoverable.

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

(8) Comprehensive follow-up reviews of providers every six months to ensure that they are billing the Medicaid and health care programs correctly.

(9) Corrective-action plans that would remain in effect for providers for up to three years and that would be monitored by the Department of Public Welfare or the department every six months while in effect.

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

(f) Discretion.--The Department of Public Welfare or department head charged with responsibility for administering Medicaid or each health care program may make a determination that imposition of a sanction or disincentive is not in the best interest of the Medicaid or health care program, in which case a sanction or disincentive shall not be imposed.

(g) Factors affecting sanctions.--In determining the appropriate administrative sanction to be applied, or the duration of any suspension or termination, the Department of Public Welfare or department head shall consider:

(1) The seriousness and extent of the violation or violations.

(2) Any prior history of violations by the provider relating to the delivery of health care programs which resulted in either a criminal conviction or in administrative sanction or penalty.

(3) Evidence of continued violation within the provider's management control of the health care program's statutes, rules, regulations or policies after written notification to the provider of improper practice or instance of violation.

(4) The effect, if any, on the quality of medical care provided to Medicaid or health care program recipients as a result of the acts of the provider.

(5) Any action by a licensing agency respecting the provider in any state in which the provider operates or has operated.

(6) The apparent impact on access by recipients to health care program services if the provider is suspended or terminated, in the best judgment of the Department of Public Welfare or the department.

(h) Documentation.--The Department of Public Welfare and the department shall document the basis for all sanctioning actions and recommendations.

(i) Limiting participation.--The Department of Public Welfare or the department may take action to sanction, suspend or terminate a particular provider working for a group provider and may suspend or terminate participation in the health care program at a specific location, rather than or in addition to taking action against an entire group.

(j) Follow-up review process.--The Department of Public Welfare or the department shall establish a process for conducting follow-up reviews of a sampling of providers who have a history of overpayment under the Medicaid or health care program. This process shall consider the magnitude of previous fraud or abuse and the potential effect of continued fraud or

abuse on Medicaid or health care program costs.

(k) Overpayment determinations.--In making a determination of overpayment to a provider, the Department of Public Welfare or the department shall use accepted and valid auditing, accounting, analytical, statistical or peer-review methods or combinations thereof. Appropriate statistical methods may include sampling and extension to the population, parametric and nonparametric statistics, tests of hypotheses and other generally accepted statistical methods. Appropriate analytical methods may include reviews to determine variances between the quantities of products that a provider had on hand and available to be purveyed to health care program recipients during the review period and the quantities of the same products paid for by Medicaid or the health care program for the same period, taking into appropriate consideration sales of the same products to non-Medicaid or nonhealth care program customers during the same period. In meeting its burden of proof in any administrative or court proceeding, the Department of Public Welfare or the department may introduce the results of the statistical methods as evidence of overpayment.

(l) Audit reports.--When making a determination that an overpayment has occurred, the Department of Public Welfare or the department shall prepare and issue an audit report to the provider showing the calculation of overpayments.

(m) Audit reports on overpayments.--The audit report, supported by Department of Public Welfare or department 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 the acquisition, sales, divestment or inventory is documented by written invoices, written inventory records or other competent written documentary evidence maintained in the normal course of the provider's business. Notwithstanding the applicable rules of discovery, all documentation that will be offered as evidence at an administrative hearing on a Medicaid or health care program overpayment must be exchanged by all parties at least 14 days before the administrative hearing or must be excluded from consideration.

(n) Audit expenses.--In an audit or investigation of a violation committed by a provider which is conducted under this section, the Department of Public Welfare or the department is entitled to recover all investigative, legal and expert witness costs if the Department of Public Welfare's or department's findings were not contested by the provider or, if contested, the Department of Public Welfare or the department ultimately prevailed.

(o) Burden of proof for audit expenses.--The Department of Public Welfare or the department shall have the burden of documenting the costs, which include salaries and employee benefits and out-of-pocket expenses. The amount of costs that may be recovered must be reasonable in relation to the seriousness of the violation and must be set taking into consideration the financial resources, earning ability and needs of the provider, who has the burden of demonstrating the factors.

(p) Periodic payment of audit expenses.--The provider may

pay the costs over a period to be determined by the Department of Public Welfare or the department if the Department of Public Welfare or the department determines that an extreme hardship would result to the provider from immediate full payment. Any default in payment of costs may be collected by any means authorized by law.

(q) Notification.--If the Department of Public Welfare or the department imposes an administrative sanction under subsection (c), except paragraphs (5) and (15) or subsection (m), upon any provider or any principal, officer, director, agent, managing employee or affiliated person of the provider who is regulated by another state entity, the Department of Public Welfare or the department shall notify the other entity of the imposition of the sanction within five business days. The notification shall include the provider's or person's name and license number and the specific reasons for sanction.

(r) Withholding payment.--

(1) The Department of Public Welfare or the department shall withhold Medicaid or health care program 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 or health care program, or a crime committed while rendering goods or services to Medicaid or the health care program recipients.

(2) The Department of Public Welfare or the department 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 health care program or the Medicare program by the

Federal Government or any state.

(3) Overpayments owed to the Department of Public Welfare shall bear interest at the rate calculated under section 806 of act of April 9, 1929 (P.L.343, No.176), known as The Fiscal Code, from the date of determination of the overpayment by the Department of Public Welfare. Payment arrangements shall be made at the conclusion of legal proceedings. A provider who does not enter into or adhere to an agreed-upon repayment schedule may be terminated by the Department of Public Welfare for nonpayment or partial payment.

(s) Collection on judgments.--The Department of Public Welfare, upon entry of a final Department of Public Welfare order, a judgment or order of a court of competent jurisdiction, or a stipulation or settlement, may collect the money owed by all means allowable by law, including notifying any fiscal intermediary of health care program benefits that the State has a superior right of payment. Upon receipt of the written notification, the Medicare fiscal intermediary shall remit to the State the sum claimed.

(t) Administrative sanctions.--The Department of Public Welfare may impose administrative sanctions against a Medicaid recipient or may seek any other remedy provided by law if the Department of Public Welfare finds that a recipient has abused the Medicaid program.

(u) Overpayments.--If the Department of Public Welfare has made a probable cause determination and alleged that an overpayment to a health care provider has occurred, the Department of Public Welfare, after notice to the provider, shall:

(1) Withhold, during the pendency of an administrative hearing under 2 Pa.C.S. (relating to administrative law and procedure), any medical assistance reimbursement payments until the time as the overpayment is recovered, unless within 30 days after receiving notice of the overpayment, the provider:

(i) makes repayment in full; or

(ii) establishes a repayment plan that is satisfactory to the Department of Public Welfare.

(2) Withhold, during the pendency of an administrative hearing under 2 Pa.C.S., medical assistance reimbursement payments if the terms of a repayment plan are not adhered to by the provider.

(v) Records review.--Notwithstanding any other provision of law, the Department of Public Welfare may review a provider's Medicaid, health care program-related and nonhealth care program-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.

(w) Termination of participation in health care program.--The Department of Public Welfare or the department shall terminate a provider's participation in the Medicaid or health care program if the provider fails to reimburse an overpayment that has been determined by final order, not subject to further appeal, within 35 days after the date of the final order, unless the provider and the Department of Public Welfare have entered into a repayment agreement.

(x) Administrative hearing.--If a provider requests an administrative hearing, the hearing must be conducted within 90

days following assignment of an administrative law judge, absent exceptionally good cause, shown as determined by the hearing officer. Upon issuance of a final order, the outstanding balance of the amount determined to constitute the overpayment shall become due. If a provider fails to make payments in full, fails to enter into a satisfactory repayment plan or fails to comply with the terms of a repayment plan or settlement agreement, the Department of Public Welfare shall withhold medical assistance reimbursement payments until the amount due is paid in full.

(y) Inspections.--Duly authorized agents and employees of the Department of Public Welfare shall have the power to inspect, during normal business hours, the records of any pharmacy, wholesale establishment or manufacturer, or any other place in which drugs and medical supplies are manufactured, packed, packaged, made, stored, sold or kept for sale, for the purpose of verifying the amount of drugs and medical supplies ordered, delivered or purchased by a provider. The Department of Public Welfare shall provide at least two business days' prior notice of any inspection. The notice shall identify the provider whose records will be inspected and the inspection shall include only records specifically related to that provider.

(z) Internet website posting.--The Department of Public Welfare shall post on its Internet website a current list of each health care provider, including any principal, officer, director, agent, managing employee or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to at least 5%, who has been terminated for cause from the Medicaid or health care program or sanctioned under this section. The list shall be searchable by a variety of search parameters and provide for the creation of

formatted lists that may be printed or imported into other applications, including spreadsheets. The Department of Public Welfare shall update the list at least monthly.

(aa) Use of technology.--In order to improve the detection of health care fraud, use technology to prevent and detect fraud and maximize the electronic exchange of health care fraud information, the Department of Public Welfare shall:

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

(2) Develop a strategic plan to connect all databases that contain health care fraud information to facilitate the electronic exchange of health information between the Department of Public Welfare, the department, the Department of Health and the Office of Attorney General. The plan must include recommended standard data formats, fraud identification strategies and specifications for the technical interface between Federal and State health care fraud databases.

(3) Monitor innovations in health information technology, specifically as it pertains to Medicaid and health care program fraud prevention and detection.

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

§ 6305. Recipient and prescription refill fraud.

(a) Recipient fraud.--In accordance with Federal law,

Medicaid recipients convicted of a crime under section 1128B of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1320a-7b) may be limited, restricted or suspended from other health care program eligibility for a period not to exceed one year, as determined by the Department of Public Welfare head or designee.

(b) Prescription refill fraud.--To deter fraud and abuse in a health care program, the Department of Public Welfare may limit the number of Schedule II and Schedule III refill prescription claims submitted from a pharmacy provider. The Department of Public Welfare shall limit the allowable amount of reimbursement of prescription refill claims for Schedule II and Schedule III pharmaceuticals if the Department of Public Welfare determines that the specific prescription refill was not requested by the Medicaid recipient or authorized representative for whom the refill claim is submitted or was not prescribed by the recipient's medical provider or physician. Any refill request must be consistent with the original prescription.

(c) Recipient explanation of benefits.--At least three times a year, the Department of Public Welfare shall provide to each Medicaid recipient or the recipient's representative an explanation of benefits in the form of a letter that is mailed to the most recent address of the recipient on the record with the Department of Public Welfare. The explanation of benefits shall include the patient's name, the name of the health care provider and the address of the location where the service was provided, a description of all services billed to Medicaid in terminology that should be understood by a reasonable person and information on how to report inappropriate or incorrect billing to the Department of Public Welfare or other law enforcement entities for review or investigation. At least once a year, the

Department of Public Welfare and the department shall by letter notify Medicaid and health care program recipients of information on how to report criminal health care provider fraud and the Department of Public Welfare's toll-free hotline telephone number.

§ 6306. Duties of the Office of Attorney General.

(a) Statewide Medicaid fraud prevention program.--The Office of Attorney General shall conduct a Statewide program of Medicaid and health care program fraud control. To accomplish this purpose, the Attorney General shall:

(1) Investigate the possible criminal violation of any State law pertaining to fraud in the administration of a health care program or the Medicaid program, in the provision of medical assistance or in the activities of providers of health care under the Medicaid or health care program.

(2) Investigate the alleged abuse or neglect of patients in health care facilities receiving payments under the Medicaid program, in coordination with the Department of Public Welfare.

(3) Investigate the alleged misappropriation of patients' private funds in health care facilities receiving payments under the Medicaid program.

(4) Refer to the Department of Public Welfare or the department all suspected abusive activities not of a criminal or fraudulent nature.

(5) Safeguard the privacy rights of all individuals and provide safeguards to prevent the use of patient medical records for any reason beyond the scope of a specific investigation for fraud or abuse, or both, without the patient's written consent.

(6) Publicize to State employees and the public the ability of persons to bring suit under 18 Pa.C.S. (relating to crimes and offenses) and the potential for the persons bringing a civil action under 18 Pa.C.S. to obtain a monetary award.

(b) Discretionary actions.--In carrying out the duties and responsibilities under this section, the Office of Attorney General may:

(1) Enter upon the premises of any health care provider, excluding a physician, participating in the Medicaid program or health care program to examine all accounts and records that may be relevant in determining the existence of fraud in the Medicaid or health care program, to investigate alleged abuse or neglect of patients or to investigate alleged misappropriation of patients' private funds. A participating physician shall make available any accounts or records that may be relevant in determining the existence of fraud in the Medicaid or health care program, alleged abuse or neglect of patients or alleged misappropriation of patients' private funds. The accounts or records of a non-Medicaid or nonhealth care program patient may not be reviewed by, or turned over to, the Attorney General without the patient's written consent.

(2) Subpoena witnesses or materials, including medical records relating to Medicaid and health care program recipients, within or outside of this Commonwealth and, through any duly designated employee, administer oaths and affirmations and collect evidence for possible use in either civil or criminal judicial proceedings.

(3) Request and receive the assistance of any district

attorney or law enforcement agency in the investigation and prosecution of any violation of this section.

(4) Take all actions necessary for the collection of overpayments to a provider of health care under the Medicaid program.

(5) Seek any other civil remedies permitted by law.

§ 6307. Initial service provision to a Medicaid or health care program recipient.

(a) Initial notice.--

(1) On or before the first day services are provided to a client, a health care provider shall inform the client and his immediate family or representative, if appropriate, of the right to report:

(i) Complaints. The Statewide toll-free telephone number for reporting complaints to the licensing agency shall be provided to clients in a manner that is clearly legible and shall include the following language:

To report a complaint regarding the services you receive, please call toll-free (telephone number).

(ii) Abusive, neglectful or exploitative practices. The Statewide toll-free telephone number for the central abuse hotline shall be provided to clients in a manner that is clearly legible and shall include the following language:

To report abuse, neglect or exploitation, please call toll-free (telephone number).

(iii) Medicaid or health care program fraud. Any licensing agency description of Medicaid or health care program fraud and the Statewide toll-free telephone number for the central Medicaid fraud hotline shall be

provided to clients in a manner that is clearly legible and shall include the following language:

To report suspected Medicaid or health care program fraud, please call toll-free (telephone number).

(2) The licensing agency shall publish a minimum of a 90-day advance notice of a change in the toll-free telephone numbers.

(b) Procedures and policies.--Each licensee shall establish appropriate policies and procedures for providing notice to clients.

(c) Proof of right to occupancy.--An applicant must provide the Department of Public Welfare with proof of the applicant's legal right to occupy the property before a license may be issued. Proof may include copies of warranty deeds, lease or rental agreements, contracts for deeds, quitclaim deeds or other similar documentation.

(d) Initial application.--Upon application for initial licensure or change of ownership licensure, the applicant shall furnish satisfactory proof of the applicant's financial ability to operate in accordance with the requirements of this chapter, statute and applicable rules. The licensing agency shall establish standards for this purpose, including information concerning the applicant's controlling interests. The licensing agency shall also establish documentation requirements, to be completed by each applicant, that show anticipated provider revenues and expenditures, the basis for financing the anticipated cash-flow requirements of the provider and an applicant's access to contingency financing. A current certificate of authority, issued by a licensing agency, may be provided as proof of financial ability to operate. The licensing

agency may require a licensee to provide proof of financial ability to operate at any time if there is evidence of financial instability, including unpaid expenses necessary for the basic operations of the provider.

(e) Evidence of financial stability.--A controlling interest may not withhold from the Department of Public Welfare any evidence of financial instability, including checks returned due to insufficient funds, delinquent accounts, nonpayment of withholding taxes, unpaid utility expenses, nonpayment for essential services or adverse court action concerning the financial viability of the provider that is under the control of the controlling interest. Any person who violates this subsection commits a misdemeanor of the second degree. Each day of continuing violation constitutes a separate offense.

§ 6308. Home health care agencies.

(a) License suspension or revocation.--A licensing agency may deny, revoke and suspend a license and impose an administrative fine.

(b) Disciplinary action.--In addition to the grounds provided under other statutes or regulations, any of the following actions by a home health care agency or its employee shall be grounds for disciplinary action by the Department of Health:

(1) Violation of this chapter or any other act or applicable rules or regulations promulgated under this chapter or any other act.

(2) An intentional, reckless or negligent act that materially affects the health or safety of a patient.

(3) Knowingly providing home health care services in an unlicensed assisted living facility or unlicensed adult

family-care home, unless the home health care agency or employee reports the unlicensed facility or home to the Department of Public Welfare within 72 hours after providing the services.

(4) Preparing or maintaining fraudulent patient records, such as charting ahead, recording vital signs or symptoms that were not personally obtained or observed by the home health care agency's staff at the time indicated, borrowing patients or patient records from other home health agencies to pass a survey or inspection, or falsifying signatures.

(5) Failing to provide at least one service directly to a patient for a period of 60 days.

(c) Fines.--

(1) The Department of Health shall impose a fine of $1,000 against a home health care agency that demonstrates a pattern of falsifying:

(i) Documents of training for home health care aides or certified nursing assistants.

(ii) Health statements for staff providing direct care to patients.

(2) A pattern under paragraph (1) may be demonstrated by a showing of at least three fraudulent entries or documents. The fine shall be imposed for each fraudulent document or, if multiple staff members are included on one document, for each fraudulent entry on the document.

(d) Additional fine for pattern of false billing.--The Department of Health shall impose a fine of $5,000 against a home health care agency that demonstrates a pattern of billing any payor for services not provided. A pattern may be demonstrated by a showing of at least three billings for

services not provided within a 12-month period. The fine shall be imposed for each incident that is falsely billed. The Department of Health may also:

(1) require payback of all funds;

(2) issue a temporary license suspension under section 6311 (relating to temporary suspension); and

(3) revoke the license.

(e) Additional fine for pattern of false billing of services.--The Department of Health shall impose a fine of $5,000 against a home health care agency that demonstrates a pattern of failing to provide a service specified in the home health care agency's written agreement with a patient or the patient's legal representative, or the plan of care for that patient, unless a reduction in service is mandated by Medicare, Medicaid or a State program. A pattern may be demonstrated by a showing of at least three incidences, regardless of the patient or service, where the home health care agency did not provide a service specified in a written agreement or plan of care during a three-month period. The Department of Health shall impose the fine for each occurrence. The Department of Health may also impose an additional administrative fine for the direct or indirect harm to a patient, or deny, revoke or suspend the license of the home health care agency for a pattern of failing to provide a service specified in the home health care agency's written agreement with a patient or the plan of care for that patient.

(f) License action.--Notwithstanding any other law, the Department of Health may deny, revoke or suspend the license of a home health care agency and shall impose a fine of $5,000 against a home health care agency that:

(1) Gives remuneration for staffing services to another home health care agency with which it has formal or informal patient-referral transactions or arrangements.

(2) Gives remuneration for staffing services to a health services pool with which it has formal or informal patient-referral transactions or arrangements.

(3) Provides services to residents in an assisted living facility for which the home health care agency does not receive fair market value remuneration.

(4) Provides staffing to an assisted living facility for which the home health care agency does not receive fair market value remuneration.

(5) Fails to provide the licensing agency, upon request, with copies of all contracts with assisted living facilities which were executed within five years before the request.

(6) Gives remuneration to a case manager, discharge planner, facility-based staff member or third-party vendor who is involved in the discharge planning process of a facility from whom the home health care agency receives referrals.

(7) Fails to submit to the licensing agency, within 15 days after the end of each calendar quarter, a written report that includes the following data based on data as it existed on the last day of the quarter:

(i) The number of insulin-dependent diabetic patients receiving insulin-injection services from the home health care agency.

(ii) The number of patients receiving both home health care services from the home health care agency and hospice services.

(iii) The number of patients receiving home health care services from that home health care agency.

(iv) The names and license numbers of nurses whose primary job responsibility is to provide home health care services to patients and who received remuneration from the home health care agency in excess of $25,000 during the calendar quarter.

(8) Gives cash, or its equivalent, to a Medicare or Medicaid beneficiary.

(9) Has more than one medical director contract in effect at one time or more than one medical director contract and one contract with a physician-specialist whose services are mandated for the home health care agency in order to qualify to participate in a Federal or State health care program at one time.

(10) Fails to provide to the Department of Public Welfare, upon request, copies of all contracts with a medical director which were executed within five years before the request.

(11) Demonstrates a pattern of billing the Medicaid program for services to Medicaid recipients which are medically unnecessary as determined by a final order. A pattern may be demonstrated by a showing of at least two medically unnecessary services within one Medicaid program integrity audit period.

(g) Interpretation.--Nothing in this chapter shall be interpreted as applying to or precluding any discount, compensation, waiver of payment or payment practice permitted under section 1128B of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1320a-7b).

(h) Additional criminal law violation.--In addition to any requirements under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act, any person, partnership or corporation that operates an unlicensed home and that previously operated a licensed home health care agency or concurrently operates both a licensed home health care agency and an unlicensed home health care agency commits a felony of the third degree.

(i) Fraud referral.--If any home health care agency is found to be operating without a license and that home health care agency has received any government reimbursement for services, the Department of Public Welfare shall make a fraud referral to the appropriate government reimbursement program.

§ 6309. Medicaid fraud, disqualification for license, certificate or registration.

(a) General.--Medicaid fraud in the practice of a health care profession is prohibited.

(b) Disqualification.--In addition to the grounds provided under other statutes or regulations, each licensing authority shall refuse to admit a candidate to any examination and refuse to issue or renew a license, certificate or registration to any applicant if the candidate or applicant or any principal, officer, agent, managing employee or affiliated person of the applicant has been:

(1) Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 18 Pa.C.S. (relating to crimes and offenses) or 21 U.S.C. §§ 801-970, unless the sentence and any subsequent period of probation for the conviction or pleas ended more than 15 years prior to the date of the application.

(2) Terminated for cause from the Medicaid program under section 6304 (relating to termination and sanctions), unless the applicant has been in good standing with the Medicaid program for the most recent five years.

(3) Terminated for cause, pursuant to the appeals procedures established by the Federal Government or the Commonwealth, from any state Medicaid program, a health care program or the Federal Medicare program, unless the applicant has been in good standing with a state Medicaid program or the Federal Medicare program for the most recent five years and the termination occurred at least 20 years prior to the date of the application.

(c) Report.--Licensed health care practitioners shall report allegations of Medicaid fraud to the Department of Public Welfare, regardless of the practice setting in which the alleged Medicaid fraud occurred.

(d) Acceptance.--The acceptance by a licensing authority of a candidate's relinquishment of a license which is offered in response to or anticipation of the filing of administrative charges alleging Medicaid or health care program fraud or similar charges constitutes the permanent revocation of the license.

§ 6310. Executive agencies regulation of health care providers activities.

(a) Denial of license.--In addition to the grounds provided under other statutes or regulations, grounds that may be used by the licensing agency for denying and revoking a license or change of ownership application include any of the following actions by a controlling interest:

(1) False representation of a material fact in the

license application or omission of any material fact from the application.

(2) An intentional or negligent act materially affecting the health or safety of a client of the provider.

(3) A violation of this chapter, other statutes or applicable rules.

(4) A demonstrated pattern of deficient performance.

(5) A current exclusion, suspension or termination of the applicant, licensee or controlling interest from participation in the State Medicaid program, the Medicaid program of any other state, the Medicare program or a health care program.

(b) Licensure pending litigation.--If a licensee lawfully continues to operate while a denial or revocation is pending in litigation, the licensee shall continue to meet all other requirements of this chapter, other statutes and applicable rules and shall file subsequent renewal applications for licensure and pay all licensure fees. No other law applying to a particular health care provider shall apply to renewal applications filed during the time period in which the litigation of the denial or revocation is pending until that litigation is final.

(c) Grounds for denial.--An action under section 6311 (relating to temporary suspension) or a denial of the license of the transferor may be grounds for denial of a change of ownership application of the transferee.

(d) Additional grounds for denial.--The licensing agency shall deny an application for a license or license renewal if the applicant or a person having a controlling interest in an applicant has been:

(1) Convicted of, or enters a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 18 Pa.C.S. (relating to crimes and offenses) or 21 U.S.C. §§ 801-970, unless the sentence and any subsequent period of probation for the convictions or plea ended more than 15 years prior to the date of the application.

(2) Terminated for cause from a health care program or the State Medicaid program, unless the applicant has been in good standing with the State Medicaid program for the most recent five years.

(3) Terminated for cause, pursuant to the appeals procedures established by the Federal Government or the Commonwealth, from the Federal Medicare program, a health care program or from any other state Medicaid program, unless the applicant has been in good standing with a state Medicaid program or the Federal Medicare program for the most recent five years and the termination occurred at least 20 years prior to the date of the application.

§ 6311. Temporary suspension.

A license or certificate issued under any act may be temporarily suspended for a violation of this chapter as the General Assembly declares a violation of this chapter to be an immediate and clear danger to the public health and safety. The licensing agency shall issue an order to that effect without a hearing, but upon due notice, to the licensee or certificate holder concerned at his last known address, which shall include a written statement of all allegations against the licensee or certificate holder. The provisions of section 9 of the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985, or similar legislation shall not apply to

a temporary suspension. The licensing agency shall commence formal action to suspend, revoke or restrict the license or certificate of the person concerned as otherwise provided for under this chapter. All actions shall be taken promptly and without delay. Within 30 days following the issuance of an order temporarily suspending a license, the licensing agency shall conduct or cause to be conducted a preliminary hearing to determine that there is a prima facie case supporting the suspension. The licensee or certificate holder whose license or certificate has been temporarily suspended may be present at the preliminary hearing and may be represented by counsel, cross-examine witnesses, inspect physical evidence, call witnesses, offer evidence and testimony and make a record of the proceedings. If it is determined that there is not a prima facie case, the suspended license shall be immediately restored. The temporary suspension shall remain in effect until vacated by the licensing agency, but in no event longer than 180 days, unless agreed to by the licensee or certificate holder.

§ 6312. Antifraud plans.

(a) Purpose.--The purpose of this section is to require the development of an antifraud plan by the Department of Public Welfare, the department and their respective employees, and to encourage the prevention, detection, investigation and reporting of Medicaid and health care program insurance fraud.

(b) Antifraud plans.--

(1) The Department of Public Welfare shall develop, implement, disseminate and maintain written procedures to prevent, detect, investigate and report suspected Medicaid and health care program fraud.

(2) The written antifraud procedures shall at a minimum

provide for the:

(i) Education of the Department of Public Welfare's employees, contractors and business partners as to the Commonwealth's antifraud effort and requirements.

(ii) Written policies, procedures and standards of conduct to prevent and detect inappropriate behavior.

(iii) Detection of fraud or other criminal acts occurring within or affecting the Department of Public Welfare's policyholder services, vendor relations, provider relations, claims or claim payment areas.

(iv) Designation of a chief compliance officer and other appropriate bodies charged with the responsibility of operating and monitoring the compliance program and who report directly to high-level personnel and the governing body.

(v) Reporting of claims information to appropriate database systems permitting access to the information by law enforcement.

(vi) Establishment of a fraud investigation unit, employing or contracting with persons qualified by education and experience to do the Department of Public Welfare's investigation of Medicaid program fraud.

(vii) Use of reasonable efforts not to include any individual in the substantial authority personnel whom the organization knew or should have known has engaged in illegal activities or other conduct inconsistent with an effective compliance and ethics program.

(viii) Reporting of Medicaid fraud to Federal, State or local criminal law enforcement authorities for consideration of investigation and prosecution.

(ix) Department of Public Welfare's cooperation with Federal, State or local criminal law enforcement agencies in investigation and prosecution of Medicaid and health care program fraud.

(x) Release to Federal, State or local criminal law enforcement agencies upon their request of all information relating to reported Medicaid or health care program fraud.

(xi) Pursuit of civil recovery of fraud-related costs and expenses.

(xii) Maintenance of a process, such as a toll-free hotline or dedicated and secure e-mail account, to receive complaints and the adoption of procedures to protect the anonymity of complainants and to protect whistleblowers from retaliation.

(xiii) Establishment of processes and procedures for the suspension of Medicaid and health care program payments to health care providers consistent with Federal and State law requirements.

(3) Plans developed under this section are confidential and exempt from the act of February 14, 2008 (P.L.6, No.3), known as the Right-to-Know Law.

Section 2. The following shall apply:

(1) Rules and regulations in effect on the effective date of this section applicable to health care facilities not clearly inconsistent with the provisions of 35 Pa.C.S. Ch. 63 shall remain in effect until replaced, revised or amended.

(2) All health care providers and home health care agencies licensed on the effective date of this section to establish, maintain or operate a health care facility shall

be licensed for the period remaining on the license.

(3) Notwithstanding any other law, all departments under the jurisdiction of the Governor, the Office of Attorney General and the Auditor General shall cooperate with the agencies in the implementation and ongoing administration of 35 Pa.C.S. Ch. 63.

Section 3. Agencies and departments charged with duties and responsibilities under this chapter may promulgate all rules and regulations necessary to implement 35 Pa.C.S. Ch. 63.

Section 4. This act shall take effect in 60 days.