By the Committee on Health Care

587-1817-06

A bill to be entitled

An act relating to Medicaid fraud and abuse; creating s. 409.9135, F.S.; requiring that managed care organizations providing or arranging services for Medicaid recipients establish and maintain special investigative units; requiring each managed care organization to submit a plan for detecting and preventing fraud and abuse within the Medicaid program to the Agency for Health Care Administration; specifying requirements that must be met if a managed care organization contracts with another entity to conduct activities to detect and prevent fraud and abuse; providing that the act does not create a private right of action; authorizing the Office of the Inspector General in the agency, the agency's Bureau of Program Integrity, the agency's contract management staff, and the Medicaid Fraud Control Unit to review records and determine compliance with the act; requiring managed care organizations to file a report with the Office of the Inspector General if a fraudulent or abusive act is suspected; specifying the information to be included in a report of suspected fraud or abuse; providing civil immunity to any person or entity that reports suspected fraud or abuse; authorizing designated staff of a managed care organization to share information concerning suspected fraud or abuse; providing that a managed care organization is not liable

for the fraud or abuse of an employee or agent under certain circumstances; providing exceptions; requiring that any recovery of funds by the state from a Medicaid provider or recipient representing payment or payments made by a managed care organization compensated by the state by capitation be returned to the capitated managed care organization from which the payment to the Medicaid provider or recipient originated; providing exceptions; directing the Medicaid Fraud Control Unit, in conjunction with managed care organizations, to track and publish on an annual basis all Medicaid fraud recoveries made under the act; providing rulemaking authority; requiring the agency to create a system to validate information collected by a Medicaid encounter-data system; requiring that the agency report on its efforts to coordinate anti-fraud and abuse systems related to managed care organizations to the Governor and the Legislature; providing an effective date.

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

Section 1. Section 409.9135, Florida Statutes, is created to read:

409.9135 Medicaid managed care organizations' special investigative units or contracts; plans to prevent or reduce fraud and abuse.--Each managed care organization that provides or arranges for the provision of health care services to

Medicaid recipients under this chapter shall establish and maintain a special investigative unit to investigate fraudulent claims and other types of program abuse by recipients and service providers. A managed care organization may contract with another entity for the investigation of fraudulent claims and other types of program abuse by recipients and service providers. As used in this section, the terms "abuse," "fraud," and "overpayment" have the same meanings as in s. 409.913.

(1) Each managed care organization shall adopt a plan to prevent and reduce fraud and abuse and annually file that plan with the Office of the Inspector General in the agency for approval. The plan must include:

(a) A general description of the managed care organization's procedures for detecting and investigating possible acts of fraud, abuse, or overpayment;

(b) A description of the managed care organization's procedures for the mandatory reporting of possible acts of fraud or abuse to the Office of the Inspector General in the agency;

(c) A description of the managed care organization's procedures for educating and training personnel on how to detect and prevent fraud, abuse, or overpayment;

(d) The name, address, telephone number, and fax number of the individual responsible for carrying out the plan;

(e) A description or chart outlining the organizational arrangement of the managed care organization's personnel who are responsible for investigating and reporting possible acts of fraud, abuse, or overpayment;

(f) A summary of the results of investigations of fraud, abuse, or overpayment which were conducted during the past year by the managed care organization's special investigative unit or its contractor; and

(g) Provisions for maintaining the confidentiality of any patient information that is relevant to an investigation of fraud, abuse, or overpayment.

(2) If a managed care organization contracts for the investigation of fraudulent claims and other types of program abuse by recipients or service providers, the managed care organization shall file the following with the Office of the Inspector General in the agency for approval before the managed care plan implements any contracts for fraud and abuse prevention and detection:

(a) A copy of the written contract between the managed care organization and the contracting entity;

(b) The names, addresses, telephone numbers, and fax numbers of the principals of the entity with which the managed care organization has contracted; and

(c) A description of the qualifications of the principals of the entity with which the managed care organization has contracted.

(3) This section does not create a private right of action related to any violation of this section. The Office of the Inspector General in the agency, the agency's Bureau of Program Integrity, the agency's contract management staff, and the Medicaid Fraud Control Unit in the Office of the Attorney General may review the records of a managed care organization and its subcontractors to determine compliance with this section. If a managed care organization or its subcontractors fail to comply with the requirements of this section, the

agency shall take appropriate administrative action as provided in section 409.913.

(4)(a) Upon detecting acts by providers or recipients that the managed care organization believes are fraudulent, the managed care organization must report the acts to the Office of the Inspector General in the agency. At a minimum, the report must contain the name of the provider or recipient, the Medicaid billing number or tax identification number of the provider or the Medicaid recipient's identification number, and a description of the suspected fraudulent act. The managed care organization must report acts of suspected fraud under this section no later than 15 days after the managed care organization initially detects the suspicious fraudulent activity.

(b) The Office of the Inspector General in the agency shall forward the report of suspected fraud to the appropriate investigative unit, including, but not limited to, the Medicaid Fraud Control Unit in the Office of the Attorney General and the Department of Law Enforcement.

(c) Upon detecting acts by providers or recipients which the managed care organization suspects are abusive, the managed care organization shall thoroughly review the acts to eliminate instances of simple error or routine anomalies in billing practices or health care service delivery. If suspected abusive acts by providers or recipients are not eliminated by the review or are determined by the managed care organization not to be simple error or routine anomalies in billing practices or health care service delivery, the managed care organization shall report such acts to the Office of the Inspector General in the agency. At a minimum, the report must contain the name of the provider or recipient, the Medicaid

billing number or tax identification number of the provider or the Medicaid recipient's identification number, and a description of the suspected abusive act. The managed care organization shall provide reportable acts of suspected abuse to the Office of the Inspector General in the agency no later than 15 days after the act is determined not to be simple error or routine anomalies in billing practices or health care service delivery.

(d) The Office of the Inspector General in the agency shall forward the report of suspected abuse to the appropriate investigative unit, including, but not limited to, the agency's Bureau of Program Integrity, the Medicaid Fraud Control Unit in the Office of the Attorney General, or the Department of Law Enforcement.

(5) A person or managed care organization is not subject to civil liability of any nature absent proof by clear and convincing evidence of a specific intent to harm a person or entity that is the subject of any report or reports regarding:

(a) Any information relating to suspected fraudulent or abusive acts, or persons suspected of engaging in such acts, which is furnished to or received from law enforcement officials, their agents, or employees;

(b) Any information relating to suspected fraudulent or abusive acts, or persons suspected of engaging in such acts, which is furnished to or received from other persons subject to the provisions of this chapter;

(c) Any such information furnished in reports to the agency, the Office of the Attorney General, the Department of Law Enforcement, or any other local, state, or federal law enforcement officials or their agents or employees; or

(d) Other actions taken in cooperation with any of the agencies or individuals specified in this subsection in the lawful investigation of suspected fraudulent or abusive acts.

(6) In addition to the immunity granted in subsection (5), an employee or contractor of a managed care organization whose responsibilities include the investigation and disposition of claims relating to suspected fraudulent or abusive acts may share information relating to persons suspected of committing fraudulent or abusive acts with the employees or contractors of the same or other managed care organization whose responsibilities include the investigation and disposition of claims relating to fraudulent or abusive acts. A person or managed care organization is not subject to civil liability of any nature absent proof by clear and convincing evidence of a specific intent to harm a person or entity that is the subject of information-sharing or reporting under the provisions of this subsection.

(7) This section does not abrogate or modify in any way any common-law or statutory privilege or immunity heretofore enjoyed by any person.

(8) A managed care organization is not liable for the fraud or abuse of an employee or agent unless the officers, directors, or managing agents of the managed care organization actively and knowingly participated in the misconduct or unless the officers, directors, or managing agents of the managed care organization negligently failed to monitor and prevent activities constituting misconduct.

(9) Representatives from managed care organizations, Medicaid, the Office of the Inspector General of the agency, the Medicaid Fraud Control Unit, and the Department of Law

Enforcement shall meet at least twice each year to review and discuss fraud and abuse case studies and enforcement matters.

(10) Any funds recovered by the state from a Medicaid provider or recipient representing payment or payments made by a managed care organization compensated by the state by capitation shall be returned to the capitated managed care organization from which the payment to the Medicaid provider or recipient originated, including interest, if any. The agency, the Medicaid Fraud Control Unit, and the Department of Law Enforcement may not return recovered funds associated with a fraudulent or abusive act committed by an employee or agent of the managed care organization if the officers, directors, or managing agents of the managed care organization actively and knowingly participated in the misconduct or negligently failed to monitor and prevent activities constituting misconduct. Any funds returned to a managed care organization may not include monetary fines, penalties, or sanctions imposed by the agency, the Medicaid Fraud Control Unit, or the Department of Law Enforcement under s. 409.913 which do not represent payment or payments made by a managed care organization. The agency, the Medicaid Fraud Control Unit, and the Department of Law Enforcement may recover investigative, legal, and expert witness costs, if any, under s. 409.913 which are separate and apart from recovery of payment or payments made by a managed care organization.

(11) The agency and the Medicaid Fraud Control Unit, in conjunction with managed care organizations, must track and publish on an annual basis all Medicaid fraud recoveries by providers made under this section. Such information shall be submitted to the Department of Health by the provider pursuant to the procedures under s. 456.039.

(12) The agency shall develop and adopt rules to administer this section.

(13) Notwithstanding other provisions of law to the contrary, health maintenance organizations under contract with the agency under s. 409.912 or s. 409.91211 are exempt from ss. 626.989 and 626.9891 for Medicaid lines of business.

Section 2. The Agency for Health Care Administration shall develop and implement a methodology to validate the information that is collected by any encounter-data-reporting system and used for tracking the services provided to Medicaid recipients through managed care organizations. This validation methodology shall assess whether the encounter-data-reporting system accurately reflects, at a minimum, the following items:

(1) The demographic characteristics of the patient.

(2) The principal, secondary, and tertiary diagnosis.

(3) The procedure performed.

(4) The date and location where the procedure was performed.

(5) The payment for the procedure, if any.

(6) If applicable, the health care practitioner's universal identification number.

(7) If the health care practitioner rendering the service is a dependent practitioner, the modifiers appropriate to indicate that the service was delivered by the dependent practitioner.

(8) Prescription drugs for each type of patient encounter.

(9) Appropriate information related to health care costs and utilization from managed care plans.

Section 3. The Agency for Health Care Administration shall report to the Governor, the President of the Senate, and

the Speaker of the House of Representatives by January 1, 2007, on how the agency is coordinating its internal anti-fraud and abuse-prevention and detection systems as they apply to managed care organizations. This report must include a description of how information is coordinated and shared among managed care organizations, the agency, and other governmental entities that are responsible for preventing, detecting, and prosecuting Medicaid provider and recipient fraud or abuse. The agency may include the content of this section in its annual report to the Legislature concerning Medicaid fraud and its abuse-prevention and detection activities as required by s. 409.913, Florida Statutes, in lieu of a separate report.

Section 4. This act shall take effect July 1, 2006.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
Senate Bill 1412

The Committee Substitute:

-- Specifies that the failure of a Medicaid managed care organization to comply with the provisions of the bill does not create a private right of action;

-- Clarifies that the Agency for Health Care Administration (AHCA) and the Medicaid Fraud Control Unit (MFCU) may access the records of managed care plans and their subcontractors to investigate incidents of suspected fraud and abuse;

-- Requires the agency to take appropriate administrative actions if a managed care organization or its subcontractors fail to comply with the provisions of the bill;

-- Clarifies when and how a managed care organization must report suspected fraud or abuse;

-- Simplifies the civil immunity protection language for managed care organizations that report suspected fraud and abuse as required by this bill;

-- Specifies that a managed care organization is not liable for fraud or abuse committed by its employees or agents unless the officers, directors, or managing agents knowingly participated in the activity or negligently failed to monitor and prevent misconduct;

-- Requires representatives of Medicaid managed care organizations, AHCA, MFCU, and the Florida Department of Law Enforcement to meet at least twice a year to discuss anti-fraud and abuse initiatives;

-- Requires recovered funds associated with a capitated payment to be returned to the managed care organization of origin;

-- Requires MFCU, in conjunction with the managed care organizations, to track and report fraud recoveries by provider on an annual basis and that such information must be provided to the Department of Health pursuant to the procedures under s. 456.039, F.S.; and,

-- Exempts an HMO's Medicaid line of business from similar anti-fraud and abuse requirements found in chapter 626, F.S., so that the Medicaid HMOs only have to comply with the provisions of this bill.