By the Committee on Health Care

587-946-06

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; authorizing the Office of the Inspector General in the agency 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 in good faith to the agency or a law enforcement entity; authorizing designated staff of a managed care organization to share information concerning suspected fraud or abuse; 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.

(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) The Office of the Inspector General in the agency may review the records of a managed care organization in order to determine compliance with this section.

(4)(a) Upon detection of a potential or suspected fraudulent or abusive act by a provider or a recipient, the managed care organization shall file a report with the Office of the Inspector General in the agency. At a minimum, the report must contain the name of the provider or recipient, the provider's Medicaid billing number or tax identification number or the Medicaid recipient's identification number, and a description of the suspected fraudulent or abusive act.

(b) Upon receipt of the report, the Office of the Inspector General in the agency shall direct the report to the appropriate investigative unit, including 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) In the absence of fraud or bad faith, a person or managed care organization is not subject to civil liability for libel, slander, or any other relevant tort for filing a report, without malice, or furnishing other information, without malice, which is required by this section or required by the agency under the authority granted in this section, and no civil cause of action of any nature shall arise against such person or managed care organization for:

(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), persons identified as designated employees or contractors 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 other designated employees or contractors of the same or other managed care organizations whose responsibilities include the investigation and disposition of claims relating to fraudulent or abusive acts; however, the agency must have been given written notice of the names and job titles of such designated employees or contractors before the designated employees or contractors share information. Unless the designated employees or contractors of the managed care organizations act in bad faith or in reckless disregard for the rights of any recipient or provider, the managed care organization and its designated employees or contractors are not civilly liable for libel, slander, or any other relevant tort, and a civil action does

not arise against the managed care organization or its designated employees or contractors for any information related to suspected fraudulent or abusive acts which is provided to another managed care organization. The qualified immunity against civil liability conferred on any managed care organization or its designated employees or contractors shall be forfeited with respect to the publication of any defamatory information or its exchange with third persons who are not expressly authorized by this subsection to share in such information.

(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) The agency may adopt rules as necessary to administer this section.

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:

(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 November 1, 2006, 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.

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

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SENATE SUMMARY

Requires managed care organizations that provide or arrange services for Medicaid recipients to establish and maintain special investigative units. Requires managed care organizations to submit plans for detecting and preventing fraud and abuse to the Agency for Health Care Administration. Provides for the Office of the Inspector General in the agency to review records and determine compliance with the act. Requires managed care organizations to report fraud and abuse to the Office of the Inspector General. Provides that a person or entity that reports suspected fraud or abuse in good faith to the agency or a law enforcement entity is immune from civil liability. Authorizes the sharing of information concerning suspected fraud or abuse. Authorizes the agency to adopt rules. Requires that the agency create a system to validate information collected by systems for reporting encounter data concerning Medicaid recipients. Requires that the agency report to the Governor and the Legislature.