FOR CONSIDERATION By the Committee on Health Care

587-946-06

1 A bill to be entitled
2 An act relating to Medicaid fraud and abuse;
3 creating s. 409.9135, F.S.; requiring that
4 managed care organizations providing or
5 arranging services for Medicaid recipients
6 establish and maintain special investigative
7 units; requiring each managed care organization
8 to submit a plan for detecting and preventing
9 fraud and abuse within the Medicaid program to
10 the Agency for Health Care Administration;
11 specifying requirements that must be met if a
12 managed care organization contracts with
13 another entity to conduct activities to detect
14 and prevent fraud and abuse; authorizing the
15 Office of the Inspector General in the agency
16 to review records and determine compliance with
17 the act; requiring managed care organizations
18 to file a report with the Office of the
19 Inspector General if a fraudulent or abusive
20 act is suspected; specifying the information to
21 be included in a report of suspected fraud or
22 abuse; providing civil immunity to any person
23 or entity that reports suspected fraud or abuse
24 in good faith to the agency or a law
25 enforcement entity; authorizing designated
26 staff of a managed care organization to share
27 information concerning suspected fraud or
28 abuse; providing rulemaking authority;
29 requiring the agency to create a system to
30 validate information collected by a Medicaid
31 encounter-data system; requiring that the

1 agency report on its efforts to coordinate
2 anti-fraud and abuse systems related to managed
3 care organizations to the Governor and the
4 Legislature; providing an effective date.
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6 Be It Enacted by the Legislature of the State of Florida:
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8 Section 1. Section 409.9135, Florida Statutes, is
9 created to read:
10 409.9135 Medicaid managed care organizations' special
11 investigative units or contracts; plans to prevent or reduce
12 fraud and abuse.--Each managed care organization that provides
13 or arranges for the provision of health care services to
14 Medicaid recipients under this chapter shall establish and
15 maintain a special investigative unit to investigate
16 fraudulent claims and other types of program abuse by
17 recipients and service providers. A managed care organization
18 may contract with another entity for the investigation of
19 fraudulent claims and other types of program abuse by
20 recipients and service providers. As used in this section, the
21 terms "abuse," "fraud," and "overpayment" have the same
22 meanings as in s. 409.913.
23 (1) Each managed care organization shall adopt a plan
24 to prevent and reduce fraud and abuse and annually file that
25 plan with the Office of the Inspector General in the agency
26 for approval. The plan must include:
27 (a) A general description of the managed care
28 organization's procedures for detecting and investigating
29 possible acts of fraud, abuse, or overpayment;
30 (b) A description of the managed care organization's
31 procedures for the mandatory reporting of possible acts of

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1 fraud or abuse to the Office of the Inspector General in the
2 agency;
3 (c) A description of the managed care organization's
4 procedures for educating and training personnel on how to
5 detect and prevent fraud, abuse, or overpayment;
6 (d) The name, address, telephone number, and fax
7 number of the individual responsible for carrying out the
8 plan;
9 (e) A description or chart outlining the
10 organizational arrangement of the managed care organization's
11 personnel who are responsible for investigating and reporting
12 possible acts of fraud, abuse, or overpayment;
13 (f) A summary of the results of investigations of
14 fraud, abuse, or overpayment which were conducted during the
15 past year by the managed care organization's special
16 investigative unit or its contractor; and
17 (g) Provisions for maintaining the confidentiality of
18 any patient information that is relevant to an investigation
19 of fraud, abuse, or overpayment.
20 (2) If a managed care organization contracts for the
21 investigation of fraudulent claims and other types of program
22 abuse by recipients or service providers, the managed care
23 organization shall file the following with the Office of the
24 Inspector General in the agency.
25 (a) A copy of the written contract between the managed
26 care organization and the contracting entity;
27 (b) The names, addresses, telephone numbers, and fax
28 numbers of the principals of the entity with which the managed
29 care organization has contracted; and
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1 (c) A description of the qualifications of the
2 principals of the entity with which the managed care
3 organization has contracted.
4 (3) The Office of the Inspector General in the agency
5 may review the records of a managed care organization in order
6 to determine compliance with this section.
7 (4)(a) Upon detection of a potential or suspected
8 fraudulent or abusive act by a provider or a recipient, the
9 managed care organization shall file a report with the Office
10 of the Inspector General in the agency. At a minimum, the
11 report must contain the name of the provider or recipient, the
12 provider's Medicaid billing number or tax identification
13 number or the Medicaid recipient's identification number, and
14 a description of the suspected fraudulent or abusive act.
15 (b) Upon receipt of the report, the Office of the
16 Inspector General in the agency shall direct the report to the
17 appropriate investigative unit, including the agency's Bureau
18 of Program Integrity, the Medicaid Fraud Control Unit in the
19 Office of the Attorney General, or the Department of Law
20 Enforcement.
21 (5) In the absence of fraud or bad faith, a person or
22 managed care organization is not subject to civil liability
23 for libel, slander, or any other relevant tort for filing a
24 report, without malice, or furnishing other information,
25 without malice, which is required by this section or required
26 by the agency under the authority granted in this section, and
27 no civil cause of action of any nature shall arise against
28 such person or managed care organization for:
29 (a) Any information relating to suspected fraudulent
30 or abusive acts, or persons suspected of engaging in such
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1 acts, which is furnished to or received from law enforcement
2 officials, their agents, or employees;
3 (b) Any information relating to suspected fraudulent
4 or abusive acts, or persons suspected of engaging in such
5 acts, which is furnished to or received from other persons
6 subject to the provisions of this chapter;
7 (c) Any such information furnished in reports to the
8 agency, the Office of the Attorney General, the Department of
9 Law Enforcement, or any other local, state, or federal law
10 enforcement officials or their agents or employees; or
11 (d) Other actions taken in cooperation with any of the
12 agencies or individuals specified in this subsection in the
13 lawful investigation of suspected fraudulent or abusive acts.
14 (6) In addition to the immunity granted in subsection
15 (5), persons identified as designated employees or contractors
16 whose responsibilities include the investigation and
17 disposition of claims relating to suspected fraudulent or
18 abusive acts may share information relating to persons
19 suspected of committing fraudulent or abusive acts with other
20 designated employees or contractors of the same or other
21 managed care organizations whose responsibilities include the
22 investigation and disposition of claims relating to fraudulent
23 or abusive acts; however, the agency must have been given
24 written notice of the names and job titles of such designated
25 employees or contractors before the designated employees or
26 contractors share information. Unless the designated employees
27 or contractors of the managed care organizations act in bad
28 faith or in reckless disregard for the rights of any recipient
29 or provider, the managed care organization and its designated
30 employees or contractors are not civilly liable for libel,
31 slander, or any other relevant tort, and a civil action does

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1 not arise against the managed care organization or its
2 designated employees or contractors for any information
3 related to suspected fraudulent or abusive acts which is
4 provided to another managed care organization. The qualified
5 immunity against civil liability conferred on any managed care
6 organization or its designated employees or contractors shall
7 be forfeited with respect to the publication of any defamatory
8 information or its exchange with third persons who are not
9 expressly authorized by this subsection to share in such
10 information.
11 (7) This section does not abrogate or modify in any
12 way any common-law or statutory privilege or immunity
13 heretofore enjoyed by any person.
14 (8) The agency may adopt rules as necessary to
15 administer this section.
16 Section 2. The Agency for Health Care Administration
17 shall develop and implement a methodology to validate the
18 information that is collected by any encounter-data-reporting
19 system and used for tracking the services provided to Medicaid
20 recipients through managed care organizations. This validation
21 methodology shall assess whether the encounter-data-reporting
22 system accurately reflects:
23 (1) The demographic characteristics of the patient.
24 (2) The principal, secondary, and tertiary diagnosis.
25 (3) The procedure performed.
26 (4) The date and location where the procedure was
27 performed.
28 (5) The payment for the procedure, if any.
29 (6) If applicable, the health care practitioner's
30 universal identification number.
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1 (7) If the health care practitioner rendering the
2 service is a dependent practitioner, the modifiers appropriate
3 to indicate that the service was delivered by the dependent
4 practitioner.
5 (8) Prescription drugs for each type of patient
6 encounter.
7 (9) Appropriate information related to health care
8 costs and utilization from managed care plans.
9 Section 3. The Agency for Health Care Administration
10 shall report to the Governor, the President of the Senate, and
11 the Speaker of the House of Representatives by November 1,
12 2006, on how the agency is coordinating its internal
13 anti-fraud and abuse-prevention and detection systems as they
14 apply to managed care organizations. This report must include
15 a description of how information is coordinated and shared
16 among managed care organizations, the agency, and other
17 governmental entities that are responsible for preventing,
18 detecting, and prosecuting Medicaid provider and recipient
19 fraud or abuse.
20 Section 4. This act shall take effect July 1, 2006.
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2 SENATE SUMMARY

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

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