442428

LEGISLATIVE ACTION

| Senate | . | House |
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| Floor: 1/AD/3R | . | |
| 04/26/2010 10:33 AM | . | |
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Senator Negron moved the following:

1 **Senate Amendment (with directory and title amendments)**
2
3 Between lines 358 and 359
4 insert:
5 Section 10. Section 409.91212, Florida Statutes, is created
6 to read:
7 409.91212 Medicaid managed care fraud.—
8 (1) Each managed care plan, as defined in s. 409.920(1)(e),
9 shall adopt an anti-fraud plan addressing the detection and
10 prevention of overpayments, abuse, and fraud relating to the
11 provision of and payment for Medicaid services and submit the
12 plan to the Office of the Inspector General within the agency
13 for approval. At a minimum, the anti-fraud plan must include:

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14 (a) A written description or chart outlining the
15 organizational arrangement of the plan’s personnel who are
16 responsible for the investigation and reporting of possible
17 overpayment, abuse, or fraud;
18 (b) A description of the plan’s procedures for detecting
19 and investigating possible acts of fraud, abuse, and
20 overpayment;
21 (c) A description of the plan’s procedures for the
22 mandatory reporting of possible overpayment, abuse, or fraud to
23 the Office of the Inspector General within the agency;
24 (d) A description of the plan’s program and procedures for
25 educating and training personnel on how to detect and prevent
26 fraud, abuse, and overpayment;
27 (e) The name, address, telephone number, e-mail address,
28 and fax number of the individual responsible for carrying out
29 the anti-fraud plan; and
30 (f) A summary of the results of the investigations of
31 fraud, abuse, or overpayment which were conducted during the
32 previous year by the managed care organization’s fraud
33 investigative unit.
34 (2) A managed care plan that provides Medicaid services
35 shall:
36 (a) Establish and maintain a fraud investigative unit to
37 investigate possible acts of fraud, abuse, and overpayment; or
38 (b) Contract for the investigation of possible fraudulent
39 or abusive acts by Medicaid recipients, persons providing
40 services to Medicaid recipients, or any other persons.
41 (3) If a managed care plan contracts for the investigation
42 of fraudulent claims and other types of program abuse by

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43 recipients or service providers, the managed care plan shall
44 file the following with the Office of the Inspector General
45 within the agency for approval before the plan executes any
46 contracts for fraud and abuse prevention and detection:
47 (a) A copy of the written contract between the plan and the
48 contracting entity;
49 (b) The names, addresses, telephone numbers, e-mail
50 addresses, and fax numbers of the principals of the entity with
51 which the managed care plan has contracted; and
52 (c) A description of the qualifications of the principals
53 of the entity with which the managed care plan has contracted.
54 (4) On or before September 1 of each year, each managed
55 care plan shall report to the Office of the Inspector General
56 within the agency on its experience in implementing an anti-
57 fraud plan, as provided under subsection (1), and, if
58 applicable, conducting or contracting for investigations of
59 possible fraudulent or abusive acts as provided under this
60 section for the prior state fiscal year. The report must
61 include, at a minimum:
62 (a) The dollar amount of losses and recoveries attributable
63 to overpayment, abuse, and fraud.
64 (b) The number of referrals to the Office of the Inspector
65 General during the prior year.
66 (5) If a managed care plan fails to timely submit a final
67 acceptable anti-fraud plan, fails to timely submit its annual
68 report, fails to implement its anti-fraud plan or investigative
69 unit, if applicable, or otherwise refuses to comply with this
70 section, the agency shall impose:
71 (a) An administrative fine of $2,000 per calendar day for

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72 failure to submit an acceptable anti-fraud plan or report until
73 the agency deems the managed care plan or report to be in
74 compliance;
75 (b) An administrative fine of not more than $10,000 for
76 failure by a managed care plan to implement an anti-fraud plan
77 or investigative unit, as applicable; or
78 (c) The administrative fines pursuant to paragraphs (a) and
79 (b).
80 (6) Each managed care plan shall report all suspected or
81 confirmed instances of provider or recipient fraud or abuse
82 within 15 calendar days after detection to the Office of the
83 Inspector General within the agency. At a minimum the report
84 must contain the name of the provider or recipient, the Medicaid
85 billing number or tax identification number, and a description
86 of the fraudulent or abusive act. The Office of the Inspector
87 General in the agency shall forward the report of suspected
88 overpayment, abuse, or fraud to the appropriate investigative
89 unit, including, but not limited to, the Bureau of Medicaid
90 program integrity, the Medicaid fraud control unit, the Division
91 of Public Assistance Fraud, the Division of Insurance Fraud, or
92 the Department of Law Enforcement.
93 (a) Failure to timely report shall result in an
94 administrative fine of $1,000 per calendar day after the 15th
95 day of detection.
96 (b) Failure to timely report may result in additional
97 administrative, civil, or criminal penalties.
98 (7) The agency may adopt rules to administer this section.
99
100 ====== D I R E C T O R Y C L A U S E A M E N D M E N T ======

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101 And the directory clause is amended as follows:
102 Delete lines 411 - 413
103 and insert:
104 Section 14. Except for sections 10 and 11 of this act and
105 this section, which shall take effect upon this act becoming a
106 law, this act shall take effect January 1, 2011.
107
108 ================= T I T L E A M E N D M E N T ================
109 And the title is amended as follows:
110 Delete line 30
111 and insert:
112 to investigate public assistance fraud; creating s.
113 409.91212, F.S.; requiring Medicaid managed care plans
114 to adopt an anti-fraud plan relating to the provision
115 of health care services; requiring certain managed
116 care plans to also establish an investigative unit or
117 contract for the investigation of fraudulent or
118 abusive activity; requiring an annual report;
119 providing administrative penalties for noncompliance;
120 authorizing the Agency for Health Care Administration
121 to adopt rules; directing the