

SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: Judiciary Committee

BILL: CS/CS/SB 1412

INTRODUCER: Judiciary Committee, Health Care Committee and Health Care Committee

SUBJECT: Medicaid Fraud and Abuse

DATE: March 30, 2006

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	<u>Garner</u>	<u>Wilson</u>	<u>HE</u>	<u>Fav/CS</u>
2.	<u>Luczynski</u>	<u>Maclure</u>	<u>JU</u>	<u>Fav/CS</u>
3.	_____	_____	<u>HA</u>	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

I. Summary:

This bill requires each managed care organization, with the exception of the Children's Medical Services (CMS) Program, that provides or arranges for the provision of health care services to Medicaid recipients to 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 these services, although the Agency for Health Care Administration (AHCA) must approve such contracts.

The bill requires each Medicaid managed care organization to adopt a plan to prevent and reduce fraud and abuse. The plan must be filed with the Office of the Inspector General (OIG) in AHCA for approval. Each plan must be filed on an annual basis and must include specified information. The bill also specifies information that must be provided to AHCA if the managed care organization contracts with another entity for investigation of fraud and abuse. The bill authorizes the OIG, AHCA, and the Medicaid Fraud Control Unit (MFCU) in the Office of the Attorney General to access records to ensure compliance with the provisions of the bill.

The bill specifies that this new section of law does not create a private right of action against managed care organizations that are in violation of the requirements of the bill. It also requires Medicaid managed care organizations to file a report of suspected fraud or abuse with the OIG in AHCA within 15 days after identifying suspected fraudulent acts or within 30 days after determining that suspected abusive acts are not simple errors or billing anomalies. The bill specifies that the OIG must direct the report to the appropriate investigative unit in the state. The bill also authorizes specific individuals within the managed care organization to share information about suspected fraud or abuse with the state, law enforcement, and other specified persons in other managed care organizations. Immunity from civil liability is provided to

individuals and entities if they report or share information about suspected fraud or abuse as required in this bill. The bill requires AHCA to take appropriate administrative action against a managed care organization or its subcontractors if they do not file required reports of suspected fraud or abuse.

The bill requires the agency to return recovered funds from a fraud or abuse investigation to the managed care organization from which the payments originated, unless the managed care organization's employees or subcontractors were involved in the misconduct. The bill requires AHCA to adopt rules. The bill exempts a managed care organization's Medicaid line of business from the anti-fraud and abuse requirements for insurance plans in ch. 626, F.S., as the provisions of this bill would be duplicative. The bill provides that the Children's Medical Services (CMS) Program is exempt from the requirements of the section of this bill requiring the establishment of a special investigative unit to investigate fraudulent claims and other types of program abuse. However, CMS would be required to coordinate activities related to the identification and reporting of suspected fraud, abuse, or overpayment with the OIG in AHCA.

The bill also requires AHCA to develop and implement a methodology to validate specified information collected by any encounter-data-reporting system used for tracking services provided to Medicaid recipients through managed care organizations. The bill requires AHCA to 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 bill creates section 409.9135, Florida Statutes. This bill creates unnumbered sections of the Florida Statutes.

II. Present Situation:

Anti-Fraud and Abuse Activities in Florida's Medicaid Program

Fraud and abuse in the overall health care system is a serious concern. The National Health Care Anti-Fraud Association estimates that for all private and public health expenditures in 2003, between 3 percent and 10 percent of these expenditures were lost to fraud alone. With total national health care expenditures of \$1.7 trillion in 2003, this would equal losses of between \$51 billion and \$170 billion to fraud.¹

Like the overall health care system, Florida's Medicaid program is subject to the threats of fraud and abuse. Medicaid fraud and abuse can be committed by any of the stakeholders in the Medicaid system including physicians, health plans, providers of ancillary services, or recipients.

Over the years, the state has committed significant resources to the prevention, detection, and recovery of Medicaid funds lost to fraud and abuse. These prevention, detection, and recovery activities are primarily conducted by the Agency for Health Care Administration's (AHCA or agency) Medicaid Program Integrity Office (MPI) in cooperation with the Attorney General's

¹ National Health Care Anti-Fraud Association. *Health Care Fraud: A Serious and Costly Reality For All Americans*, at http://www.nhcaa.org/about_health_care_fraud/310.cfm (last visited Mar. 23, 2006).

Medicaid Fraud Control Unit (MFCU) and the Florida Department of Law Enforcement (FDLE). Each of these units has a specific role in the system depending on whether the suspected activity is considered fraud or abuse.

The MPI office is responsible for identifying and recovering Medicaid funds lost to abuse and simple billing error. Medicaid abuse is defined in statute as “[p]rovider 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 If MPI determines that a provider has committed abuse, the office has a wide range of actions that it may take, from providing education and training, to assessing fines.

However, if a provider is suspected of committing Medicaid fraud, the case is required to be referred to the MFCU in the Attorney General’s Office for investigation. Medicaid fraud is defined as “an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.”³ A Medicaid provider convicted of fraud may face both criminal and/or civil fines and penalties.

The FDLE’s Public Assistance Fraud Unit is responsible for investigating and prosecuting cases concerning Medicaid fraud or abuse by recipients. Florida Statutes define Medicaid recipient abuse as “practices that result in unnecessary cost to the Medicaid program.”⁴

Florida’s Medicaid Reform Initiative: Moving Toward More Managed Care

In general, the state’s anti-fraud and abuse efforts have focused on the fee-for-service aspects of the Medicaid program. This policy is based on the assumption that capitated managed care plans have a financial incentive to identify and prevent fraud and abuse. It is also assumed that managed care plans are better able to control fraud and abuse through contract arrangements and other techniques used in the private sector. However, as Florida moves forward with Medicaid reform and more recipients are concentrated in various forms of capitated managed care plans, it is not clear whether the managed care plans or the state is best able to reduce fraud and abuse. If the state is to prevent and reduce fraud and abuse under Medicaid reform, then the state needs to redesign its own efforts to oversee the activities of Medicaid managed care organization enrollees, health care providers, managed care organization networks, and their representatives.

Senate Interim Project Report 2006-133⁵

Senate Health Care Committee staff was directed to review current AHCA oversight of Medicaid managed care organizations and their anti-fraud and abuse activities to determine the ability of managed care plans to adequately prevent fraud and abuse. Staff was also directed to examine

² Section 409.913(1)(a)1., F.S.

³ Section 409.913(1)(c), F.S.

⁴ Section 409.9.13(1)(a)2., F.S.

⁵ Comm. on Health Care, The Fla. Senate, *Identification and Prevention of Fraud and Abuse in Medicaid Managed Care*, Interim Project Report 2006-133 (Nov. 2005), at

http://www.flsenate.gov/data/Publications/2006/Senate/reports/interim_reports/pdf/2006-133he.pdf.

best practices in states with significant Medicaid managed care programs to identify if there were activities that should be considered for Florida's Medicaid program. Senate Interim Project Report 2006-133 contains the findings and recommendations from this study. These findings include the following:

- **Medicaid fraud and abuse still occur in capitated managed care plans; however, fraud and abuse change form from that seen in traditional, fee-for-service payment systems.** One of the core arguments for supporting the movement of Medicaid recipients into capitated managed care plans is that the plans are fiscally at-risk, and not the state, if they fail to control fraud and abuse. Furthermore, proponents of managed care systems argue that these private managed care plans have greater flexibility in addressing problem providers under federal and state Medicaid laws than AHCA. However, staff found that experts in Medicaid and Medicare fraud disagree with these assumptions, and the federal government has published guidelines for state Medicaid programs on how to identify and address Medicaid fraud and abuse in managed care systems because it still occurs, just in different forms.
- **Current Medicaid managed care fraud and abuse oversight in Florida is primarily a contract management activity.** Federal law and regulations require specific anti-fraud and abuse policies and procedures for managed care plans participating in Medicare and Medicaid. Because Florida has not codified most of these requirements in Florida Statutes, the federal regulations are the governing authority. These regulations are primarily enforced through the Medicaid health maintenance organization (HMO) contract approval and monitoring process conducted by AHCA's Bureau of Managed Health Care.

In addition to these federal regulations, Florida's Medicaid HMO contracts include other fraud prevention policies and procedures that have additional reporting and credentialing requirements. The agency's Bureau of Managed Health Care uses these criteria to approve new Medicaid HMOs and in its annual monitoring of current Medicaid HMOs. Agency staff report that these activities constitute most of the oversight activity regarding fraud and abuse in managed care plans. In interviews, all parties reported limited involvement of MPI or MFCU. This is a concern because during the course of the interim project review, and in previous work conducted by the Office of Program Policy Analysis and Government Accountability, staff found limited examples of current Medicaid HMOs reporting suspected fraud and/or abuse.

In response to a request for the number of cases referred to AHCA by the current Medicaid HMOs over the last five years, the agency identified 47 cases, of which most had only been received over the past few months almost exclusively from two HMOs. In comparison, MPI investigated 2,556 cases of potential overpayments due to fraud, abuse,

or error in the MediPass and fee-for-service system in a single year (FY 2004-05).⁶ Of these cases, overpayment was identified in 849 cases.⁷

- **There are opportunities to improve fraud and abuse oversight of managed care plans in Florida's Medicaid program.** In interviews and focus groups with representatives of the Medicaid HMO industry, AHCA staff, and Medicaid administrators in other states, several ideas were provided to Senate staff to improve the fraud and abuse oversight of managed care entities, especially under the Medicaid reform initiative. Most of these ideas for improving oversight included the themes of coordination of information among managed care organizations and the state, and the use of better encounter information to monitor actual service delivery in the managed care plans.

Based on the findings in the interim project review, staff determined that the assertion that managed care organizations adequately prevent and detect fraud and abuse is not supported. Under managed care, fraud and abuse activities change form, requiring changes in how the state conducts its anti-fraud and abuse activities. As such, the report provided the following recommendations:

- All Medicaid managed care organizations, including those under the Governor's reform initiative, should be required to have a comprehensive fraud and abuse prevention and identification system within their corporate structure as a condition of participating in Florida's Medicaid program. These systems should work in partnership with the state's anti-fraud and abuse activities.
- The state should develop a system of information sharing between Medicaid program management and the managed care organizations that allows each to become aware of providers with suspicious practice/billing patterns. This system should include a method of providing protections for managed care organizations from civil liability if they are reporting suspicious provider practice/billing patterns in good faith.
- AHCA should be required to develop a system to validate the information collected through the encounter-data-reporting system currently being developed to collect utilization information from providers (in lieu of claims data).
- AHCA should evaluate how its internal anti-fraud and abuse prevention and detection systems are coordinating in regards to managed care plans and develop a more systematic method to obtain and share fraud and abuse referrals from managed care organizations.

General Requirements for Special Investigative Units in Insurance Plans

Section 626.9891(1), F.S., requires that every insurer admitted to do business in this state who in the previous calendar year, at any time during that year, had \$10 million or more in direct premiums written shall:

⁶ Office of Program Policy Analysis & Government Accountability, Fla. Legislature, *Enhanced Detection and Stronger Use of Sanctions Could Improve AHCA's Ability to Detect and Deter Overpayments to Providers*, Report No. 06-23, at 9 (Mar. 2006) <http://www.oppaga.state.fl.us/reports/pdf/0623rpt.pdf> (last visited Mar. 25, 2006).

⁷ *Id.*

- Establish and maintain a unit or division within the company to investigate possible fraudulent claims by insureds or by persons making claims for services or repairs against policies held by insureds; or
- Contract with others to investigate possible fraudulent claims for services or repairs against policies held by insureds.

Section 626.9891(2), F.S., requires that every insurer admitted to do business in this state, who in the previous calendar year had less than \$10 million in direct premiums written, must adopt an anti-fraud plan and file it with the Department of Financial Services (DFS) or, in the alternative, to comply with s. 626.9891(1), F.S.

However, DFS has only recently published a proposed rule to implement this provision and, if adopted, it would not apply to all managed care plans in the Medicaid reform demonstration sites because Provider Service Networks (PSNs) (a provider-formed managed care plan authorized under Medicaid reform) are not regulated under ch. 626, F.S.

III. Effect of Proposed Changes:

This bill requires each managed care organization in Florida serving Medicaid recipients, with the exception of the Children's Medical Services (CMS) Program, to establish fraud and abuse investigative units and file annual fraud and abuse prevention plans. It requires managed care organizations to file a report with the Office of the Inspector General (OIG) if a fraudulent or abusive act is suspected and authorizes designated personnel to share information related to suspected fraud and abuse. The bill requires the Agency for Health Care Administration (AHCA) to establish a system to validate encounter data used to track services provided to Medicaid recipients through managed care organizations. In addition, the bill requires AHCA to report to the Legislature on its internal efforts to prevent and detect fraud and abuse in managed care and how it coordinates and shares information among managed care organizations and other government entities with similar responsibilities.

Section 1. Creates s. 409.9135, F.S., requiring each managed care organization that provides or arranges for the provision of health care services to Medicaid recipients to 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 these services.

Subsection (1) requires each managed care organization to adopt a plan to prevent and reduce fraud and abuse. The plan must be filed with the OIG in AHCA for approval. Each plan must be filed on an annual basis and must include:

- A general description of the managed care organization's procedures for detecting and investigating possible acts of fraud, abuse, or overpayment;
- A description of the managed care organization's procedures for the mandatory reporting of possible acts of fraud or abuse to the OIG in AHCA;
- A description of the managed care organization's procedures for educating and training personnel on how to detect and prevent fraud, abuse, or overpayment;
- Specified information about the individual responsible for carrying out the plan;

- The organizational arrangement of the managed care organization's personnel responsible for investigating and reporting possible acts of fraud, abuse, or overpayment;
- A summary of the results of investigations of fraud, abuse, or overpayment conducted during the past year by the managed care organization's special investigative unit or its contractor; and
- Provisions for maintaining the confidentiality of any patient information relevant to an investigation of fraud, abuse, or overpayment.

Subsection (2) requires that, if a managed care organization contracts for investigative services, the managed care organization must file certain information with the OIG in AHCA for approval before the managed care plan implements any contracts for fraud and abuse prevention and detection.

Subsection (3) specifies that this section does not create a private right of action related to any violation of this section; authorizes the OIG, AHCA's Medicaid Program Integrity Office (MPI), AHCA's contract management staff, and the Medicaid Fraud Control Unit (MFCU) to review the records of a managed care organization to determine compliance with this section. It also requires AHCA to take appropriate administrative action for failure to comply with the provisions of the bill.

Subsection (4) requires managed care organizations to file a report with the OIG in AHCA within 15 days after initial detection of suspected fraudulent acts by a provider or a recipient. It specifies the minimum reporting requirements.

Upon receipt of the report of suspected fraud, the OIG in AHCA must direct the report to the appropriate investigative unit, including, but not limited to, the MFCU and the Florida Department of Law Enforcement (FDLE).

Upon suspicion of acts of abuse by providers or recipients, the managed care organization must review the acts to eliminate instances of simple error or routine anomalies and, if not eliminated, file a report of the suspected abusive acts with the OIG in AHCA within 30 days after making such determination. The bill specifies the minimum reporting requirements.

The OIG in AHCA must forward reports of suspected abuse to the appropriate investigative unit, including, but not limited to, the MPI, the MFCU, or FDLE.

Subsection (5) specifies certain conditions when a person or managed care organization is not subject to civil liability. This section provides that 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:

- Any information relating to suspected fraudulent or abusive acts or persons suspected of engaging in such acts furnished to or received from law enforcement officials, their agents, or employees;
- Any information relating to suspected fraudulent or abusive acts or persons suspected of engaging in such acts furnished to or received from other persons subject to the provisions of this chapter;

- Any such information furnished in reports to AHCA, the Office of the Attorney General, FDLE, or any other local, state, or federal enforcement officials or their agents or employees; or
- Other actions taken in cooperation with any of the agencies or individuals specified in this paragraph in the lawful investigation of suspected fraudulent or abusive acts.

Subsection (6) authorizes certain managed care organization employees or contractors to share information relating to persons suspected of committing fraudulent or abusive acts with the same or other managed care organizations' employees or contractors in certain circumstances. The bill provides qualified immunity against civil liability to managed care organizations and their designated employees or contractors for sharing this information.

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

Subsection (8) requires representatives from managed care organizations, Medicaid, AHCA's OIG, the MFCU, and FDLE to meet at least twice a year to review and discuss case studies and enforcement matters.

Subsection (9) requires that funds recovered from a fraud or abuse investigation shall be returned to the managed care organization from which the claim originated, unless the managed care organization was involved in the fraud or abuse. Any funds returned to a managed care organization shall exclude monetary fines, penalties, sanctions, or investigative costs.

Subsection (10) requires the MFCU, in conjunction with the managed care organizations, to track and annually publish fraud recoveries, by providers, made under this act. This information must be submitted to the Department of Health (DOH) by the provider as required by law in order that DOH can publish the information on the physician's profile.

Subsection (11) requires AHCA to develop and promulgate rules to administer this act.

Subsection (12) exempts health maintenance organizations under contract with the agency under ss. 409.912 and 409.91211, F.S., from ss. 626.989 and 626.9891, F.S., for Medicaid lines of business. As previously mentioned, the provisions of this bill would be duplicative of ss. 626.989 and 626.9891, F.S.

Subsection (13) provides that the CMS Program is exempt from the requirements of the section of this bill requiring the establishment of a special investigative unit to investigate fraudulent claims and other types of program abuse. However, CMS would be required to coordinate activities related to the identification and reporting of suspected fraud, abuse, or overpayment with the OIG in AHCA.

Section 2. Requires AHCA to develop and implement a methodology to validate specified information collected by any encounter-data-reporting system used for tracking services provided to Medicaid recipients through managed care organizations.

Section 3. Requires AHCA to 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 government entities responsible for the prevention, detection, and prosecution of Medicaid provider and recipient fraud or abuse. The report may be included in the annual report to the Legislature required under s. 409.913, F.S., in lieu of a separate report.

Section 4. Specifies that the act shall take effect July 1, 2006.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

This bill requires the establishment of a special investigative unit within each Medicaid managed care organization, although it does not specify any minimal level of staffing or resources. To the extent that a managed care organization does not have a special investigative unit, there should be new costs, but they are indeterminate at this time.

C. Government Sector Impact:

Agency for Health Care Administration

The Agency for Health Care Administration (AHCA) reports no fiscal effects associated with the bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

This Senate staff analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

VIII. Summary of Amendments:

None.

This Senate staff analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.
