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: Health Care Committee

BILL:	CS/SB 1412
INTRODUCER:	Health Care Committee
SUBJECT:	Medicaid Fraud and Abuse
DATE:	March 9, 2006
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Garner	Wilson	HE	**Fav/CS**
2.			JU	
3.			HA	
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I. Summary:

This bill requires 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, although the agency 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 the Agency for Health Care Administration (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 and 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 15 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 and provides civil liability immunity 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 chapter 626, F.S., as the provisions of this bill would be duplicative.

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 s. 409.9135, F.S., and two undesignated sections of law.

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 exceeding $1 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 AHCA's Medicaid Program Integrity Office (MPI) in cooperation with the Attorney General's 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 "provider practices that are inconsistent with generally accepted business or medical practices and that result in an

[1] National Health Care Anti-Fraud Association. (2005). *Health Care Fraud: A Serious and Costly Reality For All Americans.* http://www.nhcaa.org/pdf/all_about_hcf.pdf

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 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.

Regarding Medicaid fraud or abuse by recipients, the FDLE's Public Assistance Fraud Unit is responsible for investigating and prosecuting such cases. 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 activities that concentrate recipients in various forms of capitated managed care plans, the question becomes whether there is sufficient evidence to support the assumption that capitated managed care plans are better able to reduce fraud and abuse or whether the state needs to re-design its own efforts to oversee the activities of Medicaid managed care organization enrollees, health care providers, managed care organization networks, and their representatives in order to prevent fraud or abuse under the reform system.

Senate Interim Project Report 2006-133

Senate Health Care Committee staff were directed to review current AHCA oversight of Medicaid managed care organizations and their anti-fraud and abuse activities to answer the above question. Staff was also directed to examine 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 changes 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

[2] Section 409.913, F.S.
[3] Ibid.
[4] Ibid.

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. Since 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 their 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 4,731 cases of potential overpayments due to fraud, abuse, or error in the MediPass and fee-for-service system in a single year (FY 2002-03, the last year complete information was available). Of these cases, over 1,600 resulted in findings of overpayments.[5]

- **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.

[5] Office of Program Policy Analysis and Government Accountability. (2004). "AHCA Takes Steps to Improve Medicaid Program Integrity, But Further Actions Are Needed." Report No. 04-77.

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 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, 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:

- 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.

The law also requires insurers to develop and submit an anti-fraud plan to the Department of Financial Services (DFS) that must be updated every three years.

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 as 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:

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;
- A description or chart outlining 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 the following information with the OIG in AHCA for approval before the managed care plan implements any contracts for fraud and abuse prevention and detection:

- A copy of the written contract between the managed care organization and the contracting entity;
- Specified information about the principals of the entity with which the managed care organization has contracted; and

- A description of the qualifications of the principals of the entity with which the managed care organization has contracted.

Subsection (3) specifies that this section does not create a private right of action related to any violation of this section; authorizes the OIG, Program Integrity, AHCA's contract management staff, and the MFCU to review the records of a managed care organization to determine compliance with this section; and requires AHCA to take appropriate administrative action against a managed care organization or its subcontractors if they fail to comply with the provisions of this 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. 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.

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, AHCA's Bureau of Program Integrity, the Medicaid Fraud Control Unit in the Office of the Attorney General, or FDLE.

Upon detecting acts by providers or recipients that the managed care organization suspects are abusive, the organization must thoroughly review the acts to eliminate instances of simple error or routine anomalies. If the acts are not simple error or routine anomalies, the managed care organization must file a report of the suspected abusive acts with the OIG in AHCA within 15 days after making such determination. 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 abusive act.

The OIG in AHCA must forward reports of suspected abuse to the appropriate investigative unit, including, but not limited to, AHCA's Bureau of Program Integrity, the Medicaid Fraud Control Unit in the Office of the Attorney General, or FDLE.

Subsection (5) specifies 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 managed care organization employees or contractors whose responsibilities include the investigation and disposition of claims relating to suspected fraudulent or abusive acts to share information relating to persons suspected of committing fraudulent or abusive acts with the same or other managed care organizations' employees or contractors whose responsibilities include the investigation and disposition of claims relating to fraudulent or abusive acts. The proposed 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) specifies that a managed care organization is not liable for the fraud or abuse of an employee or agent unless its officers, directors, or managing agents actively and knowingly participated in the misconduct or negligently failed to monitor or prevent activities constituting misconduct.

Subsection (9) 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 (10) 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 misconduct. Any funds returned to a managed care organization shall exclude monetary fines, penalties, sanctions, or investigative costs.

Subsection (11) requires the MFCU, in conjunction with the managed care organizations, to track and annually publish recoveries, by providers, made under this act. This information must be submitted to the Department of Health by the provider for purposes of health care practitioner profiling.

Subsection (12) requires AHCA to develop and promulgate rules to administer this act.

Subsection (13) 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.

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:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Art. VII, s. 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Art. I, s. 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Art. III, Subsection 19(f) of the Florida Constitution.

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, these will be new costs that are indeterminate at this time.

C. Government Sector Impact:

Agency for Health Care Administration

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

Department of Health

In Special Session 2005B, the Legislature passed HB 3B (ch. 2005-358, L.O.F.), implementing the federal waiver for Medicaid reform, and naming the Division of Children's Medical Services (CMS) as a "capitated managed care plan" effective July 1, 2006.

This bill would therefore require CMS to implement specific procedures to minimize the risk of Medicaid fraud and abuse in the pilot areas of Duval and Broward Counties beginning July 1, 2006. As Medicaid reform expands to other areas in the future, those efforts would expand.

Unlike Medicaid HMOs, or PSNs, the capitation payment rate that is being developed by AHCA for CMS is not anticipated to include an administrative rate component. Because of this, there are no anticipated funds to support this additional responsibility. Added costs, regardless of whether this capacity is developed internally, or through the contracted Integrated Care Systems (ICSs), will include the need for CMS headquarters staff to compile the plans from the ICS's, or to create the plan on behalf of a CMS staffed function.

Each CMS region or contracted ICS participating in Medicaid reform will require staff to analyze claims data, recipient and provider utilization and billing information, make on-site reviews of provider's records, and interview individual recipients. This requirement will initially impact two areas but will expand eventually statewide to include the eight CMS regions.

The fiscal effect on DOH is based on implementation of the bill in two CMS regions. Implementation would require two full time equivalents' (FTE's) at headquarters to coordinate and monitor this function: 1 Operations Management Consultant (OMC) II and 1 OMC Manager. It would also require 3 staff (1 OMC Manager and 2 OMC II's) per region. In year one, the estimated cost of implementation in two regions is $440,071, and in year two, estimated cost is $501,312. In subsequent years, as Medicaid reform moves into other areas, additional fraud and abuse units will have to be added resulting in additional fiscal impact, which cannot be determined at the present time.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Summary of Amendments:

None.