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LEGISLATIVE ACTION

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The Conference Committee on CS/CS/SB 1484, 1st Eng. recommended the following:

Senate Conference Committee Amendment (with title amendment)

Delete everything after the enacting clause
and insert:

Section 1. By July 1, 2010, the Agency for Health Care Administration shall begin the process of requesting an extension of the Section 1115 waiver and shall ensure that the waiver remains active and current. The agency shall report at least monthly to the Legislature on progress in negotiating for the extension of the waiver. Changes to the terms and conditions relating to the low-income pool must be approved by the


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Legislative Budget Commission.

Section 2. (1) The Agency for Health Care Administration shall develop a methodology to ensure the availability of intergovernmental transfers in any expansion of prepaid managed care in the Medicaid program. The purpose of this methodology is to support providers that have historically served Medicaid recipients, including, but not limited to, safety net providers, trauma hospitals, children's hospitals, statutory teaching hospitals, and medical and osteopathic physicians employed by or under contract with a medical school in this state. The agency may develop a supplemental capitation rate, risk pool, or incentive payment to plans that contract with these providers. The agency may develop the supplemental capitation rate to consider rates higher than the fee-for-service Medicaid rate when needed to ensure access and supported by funds provided by a locality. The agency shall evaluate the development of the rate cell to accurately reflect the underlying utilization to the maximum extent possible. The methodology may include interim rate adjustments as permitted under federal regulations. Any such methodology shall preserve federal funding to these entities and must be actuarially sound.

(2) The Secretary of Health Care Administration shall appoint members and convene a technical advisory panel to advise the agency in the study and development of intergovernmental transfer distribution methods. The panel shall include representatives from contributing hospitals, medical schools, local governments, and managed care plans. The panel shall advise the agency regarding the best methods for ensuring the continued availability of intergovernmental transfers, specific

issues to resolve in negotiations with the Centers for Medicare and Medicaid, and appropriate safeguards for appropriate implementation of any developed payment methodologies.

(3) By January 1, 2011, the agency shall provide a report to the Speaker of the House of Representatives, the President of the Senate, and the Governor on the intergovernmental transfer methodologies developed. The agency shall not implement such methodologies without express legislative authority.

Section 3. Section 624.35, Florida Statutes, is created to read:

624.35 Short title.—Sections 624.35-624.352 may be cited as the "Medicaid and Public Assistance Fraud Strike Force Act."

Section 4. Section 624.351, Florida Statutes, is created to read:

624.351 Medicaid and Public Assistance Fraud Strike Force.—

(1) LEGISLATIVE FINDINGS.—The Legislature finds that there is a need to develop and implement a statewide strategy to coordinate state and local agencies, law enforcement entities, and investigative units in order to increase the effectiveness of programs and initiatives dealing with the prevention, detection, and prosecution of Medicaid and public assistance fraud.

(2) ESTABLISHMENT.—The Medicaid and Public Assistance Fraud Strike Force is created within the department to oversee and coordinate state and local efforts to eliminate Medicaid and public assistance fraud and to recover state and federal funds. The strike force shall serve in an advisory capacity and provide recommendations and policy alternatives to the Chief Financial


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Officer.

(3) MEMBERSHIP.—The strike force shall consist of the following 11 members who may not designate anyone to serve in their place:

(a) The Chief Financial Officer, who shall serve as chair.

(b) The Attorney General, who shall serve as vice chair.

(c) The executive director of the Department of Law Enforcement.

(d) The Secretary of Health Care Administration.

(e) The Secretary of Children and Family Services.

(f) The State Surgeon General.

(g) Five members appointed by the Chief Financial Officer, consisting of two sheriffs, two chiefs of police, and one state attorney. When making these appointments, the Chief Financial Officer shall consider representation by geography, population, ethnicity, and other relevant factors in order to ensure that the membership of the strike force is representative of the state as a whole.

(4) TERMS OF MEMBERSHIP; COMPENSATION; STAFF.—

(a) The five members appointed by the Chief Financial Officer shall be appointed to 4-year terms; however, for the purpose of providing staggered terms, of the initial appointments, two members shall be appointed to a 2-year term, two members shall be appointed to a 3-year term, and one member shall be appointed to a 4-year term. Each of the remaining members is a standing member of the strike force and may not serve beyond the time he or she holds the position that was the basis for strike force membership. A vacancy shall be filled in the same manner as the original appointment but only for the

unexpired term.

(b) The Legislature finds that the strike force serves a legitimate state, county, and municipal purpose and that service on the strike force is consistent with a member's principal service in a public office or employment. Therefore membership on the strike force does not disqualify a member from holding any other public office or from being employed by a public entity, except that a member of the Legislature may not serve on the strike force.

(c) Members of the strike force shall serve without compensation, but are entitled to reimbursement for per diem and travel expenses pursuant to s. 112.061. Reimbursements may be paid from appropriations provided to the department by the Legislature for the purposes of this section.

(d) The Chief Financial Officer shall appoint a chief of staff for the strike force who must have experience, education, and expertise in the fields of law, prosecution, or fraud investigations and shall serve at the pleasure of the Chief Financial Officer. The department shall provide the strike force with staff necessary to assist the strike force in the performance of its duties.

(5) MEETINGS.—The strike force shall hold its organizational session by March 1, 2011. Thereafter, the strike force shall meet at least four times per year. Additional meetings may be held if the chair determines that extraordinary circumstances require an additional meeting. Members may appear by electronic means. A majority of the members of the strike force constitutes a quorum.

(6) STRIKE FORCE DUTIES.—The strike force shall provide

advice and make recommendations, as necessary, to the Chief Financial Officer.

(a) The strike force may advise the Chief Financial Officer on initiatives that include, but are not limited to:

1. Conducting a census of local, state, and federal efforts to address Medicaid and public assistance fraud in this state, including fraud detection, prevention, and prosecution, in order to discern overlapping missions, maximize existing resources, and strengthen current programs.

2. Developing a strategic plan for coordinating and targeting state and local resources for preventing and prosecuting Medicaid and public assistance fraud. The plan must identify methods to enhance multiagency efforts that contribute to achieving the state’s goal of eliminating Medicaid and public assistance fraud.

3. Identifying methods to implement innovative technology and data sharing in order to detect and analyze Medicaid and public assistance fraud with speed and efficiency.

4. Establishing a program to provide grants to state and local agencies that develop and implement effective Medicaid and public assistance fraud prevention, detection, and investigation programs, which are evaluated by the strike force and ranked by their potential to contribute to achieving the state’s goal of eliminating Medicaid and public assistance fraud. The grant program may also provide startup funding for new initiatives by local and state law enforcement or administrative agencies to combat Medicaid and public assistance fraud.

5. Developing and promoting crime prevention services and educational programs that serve the public, including, but not

limited to, a well-publicized rewards program for the apprehension and conviction of criminals who perpetrate Medicaid and public assistance fraud.

6. Providing grants, contingent upon appropriation, for multiagency or state and local Medicaid and public assistance fraud efforts, which include, but are not limited to:

a. Providing for a Medicaid and public assistance fraud prosecutor in the Office of the Statewide Prosecutor.

b. Providing assistance to state attorneys for support services or equipment, or for the hiring of assistant state attorneys, as needed, to prosecute Medicaid and public assistance fraud cases.

c. Providing assistance to judges for support services or for the hiring of senior judges, as needed, so that Medicaid and public assistance fraud cases can be heard expeditiously.

(b) The strike force shall receive periodic reports from state agencies, law enforcement officers, investigators, prosecutors, and coordinating teams regarding Medicaid and public assistance criminal and civil investigations. Such reports may include discussions regarding significant factors and trends relevant to a statewide Medicaid and public assistance fraud strategy.

(7) REPORTS.—The strike force shall annually prepare and submit a report on its activities and recommendations, by October 1, to the President of the Senate, the Speaker of the House of Representatives, the Governor, and the chairs of the House of Representatives and Senate committees that have substantive jurisdiction over Medicaid and public assistance fraud.

Section 5. Section 624.352, Florida Statutes, is created to read:

624.352 Interagency agreements to detect and deter Medicaid and public assistance fraud.—

(1) The Chief Financial Officer shall prepare model interagency agreements for the coordination of prevention, investigation, and prosecution of Medicaid and public assistance fraud to be known as "Strike Force" agreements. Parties to such agreements may include any agency that is headed by a Cabinet officer, the Governor, the Governor and Cabinet, a collegial body, or any federal, state, or local law enforcement agency.

(2) The agreements must include, but are not limited to:

(a) Establishing the agreement's purpose, mission, authority, organizational structure, procedures, supervision, operations, deputations, funding, expenditures, property and equipment, reports and records, assets and forfeitures, media policy, liability, and duration.

(b) Requiring that parties to an agreement have appropriate powers and authority relative to the purpose and mission of the agreement.

Section 6. Section 16.59, Florida Statutes, is amended to read:

16.59 Medicaid fraud control.—The Medicaid Fraud Control Unit ~~There~~ is created in the Department of Legal Affairs to ~~the Medicaid Fraud Control Unit, which may~~ investigate all violations of s. 409.920 and any criminal violations discovered during the course of those investigations. The Medicaid Fraud Control Unit may refer any criminal violation so uncovered to the appropriate prosecuting authority. The offices of the

Medicaid Fraud Control Unit, ~~and~~ the ~~offices of the~~ Agency for Health Care Administration Medicaid program integrity program, and the Divisions of Insurance Fraud and Public Assistance Fraud within the Department of Financial Services shall, to the extent possible, be collocated; however, positions dedicated to Medicaid managed care fraud within the Medicaid Fraud Control Unit shall be collocated with the Division of Insurance Fraud. The Agency for Health Care Administration, ~~and~~ the Department of Legal Affairs, and the Divisions of Insurance Fraud and Public Assistance Fraud within the Department of Financial Services shall conduct joint training and other joint activities designed to increase communication and coordination in recovering overpayments.

Section 7. Paragraph (o) is added to subsection (2) of section 20.121, Florida Statutes, to read:

20.121 Department of Financial Services.—There is created a Department of Financial Services.

(2) DIVISIONS.—The Department of Financial Services shall consist of the following divisions:

(o) The Division of Public Assistance Fraud.

Section 8. Paragraph (b) of subsection (7) of section 411.01, Florida Statutes, is amended to read:

411.01 School readiness programs; early learning coalitions.—

(7) PARENTAL CHOICE.—

(b) If it is determined that a provider has provided any cash to the beneficiary in return for receiving the purchase order, the early learning coalition or its fiscal agent shall refer the matter to the Department of Financial Services


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pursuant to s. 414.411 ~~Division of Public Assistance Fraud~~ for investigation.

Section 9. Subsection (2) of section 414.33, Florida Statutes, is amended to read:

414.33 Violations of food stamp program.—

(2) In addition, the department shall establish procedures for referring ~~to the Department of Law Enforcement~~ any case that involves a suspected violation of federal or state law or rules governing the administration of the food stamp program to the Department of Financial Services pursuant to s. 414.411.

Section 10. Subsection (9) of section 414.39, Florida Statutes, is amended to read:

414.39 Fraud.—

(9) All records relating to investigations of public assistance fraud in the custody of the department and the Agency for Health Care Administration are available for examination by the Department of Financial Services ~~Law Enforcement~~ pursuant to s. 414.411 ~~943.401~~ and are admissible into evidence in proceedings brought under this section as business records within the meaning of s. 90.803(6).

Section 11. Section 943.401, Florida Statutes, is transferred, renumbered as section 414.411, Florida Statutes, and amended to read:

414.411 ~~943.401~~ Public assistance fraud.—

(1)~~(a)~~ The Department of Financial Services ~~Law Enforcement~~ shall investigate all public assistance provided to residents of the state or provided to others by the state. In the course of such investigation the department ~~of Law Enforcement~~ shall examine all records, including electronic benefits transfer


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records and make inquiry of all persons who may have knowledge as to any irregularity incidental to the disbursement of public moneys, food stamps, or other items or benefits authorizations to recipients.

~~(b)~~ All public assistance recipients, as a condition precedent to qualification for public assistance ~~received and as defined~~ under ~~the provisions of~~ chapter 409, chapter 411, or this chapter ~~414~~, must ~~shall~~ first give in writing, to the Agency for Health Care Administration, the Department of Health, the Agency for Workforce Innovation, and the Department of Children and Family Services, as appropriate, and to the Department of Financial Services ~~Law Enforcement~~, consent to make inquiry of past or present employers and records, financial or otherwise.

(2) In the conduct of such investigation the Department of Financial Services ~~Law Enforcement~~ may employ persons having such qualifications as are useful in the performance of this duty.

(3) The results of such investigation shall be reported by the Department of Financial Services ~~Law Enforcement~~ to the appropriate legislative committees, the Agency for Health Care Administration, the Department of Health, the Agency for Workforce Innovation, and the Department of Children and Family Services, and to such others as the department ~~of Law Enforcement~~ may determine.

(4) The Department of Health and the Department of Children and Family Services shall report to the Department of Financial Services ~~Law Enforcement~~ the final disposition of all cases wherein action has been taken pursuant to s. 414.39, based upon


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information furnished by the Department of Financial Services ~~Law Enforcement~~.

(5) All lawful fees and expenses of officers and witnesses, expenses incident to taking testimony and transcripts of testimony and proceedings are a proper charge to the Department of Financial Services ~~Law Enforcement~~.

(6) The provisions of this section shall be liberally construed in order to carry out effectively the purposes of this section in the interest of protecting public moneys and other public property.

Section 12. Section 409.91212, Florida Statutes, is created to read:

409.91212 Medicaid managed care fraud.—

(1) Each managed care plan, as defined in s. 409.920(1)(e), shall adopt an anti-fraud plan addressing the detection and prevention of overpayments, abuse, and fraud relating to the provision of and payment for Medicaid services and submit the plan to the Office of Medicaid Program Integrity within the agency for approval. At a minimum, the anti-fraud plan must include:

(a) A written description or chart outlining the organizational arrangement of the plan's personnel who are responsible for the investigation and reporting of possible overpayment, abuse, or fraud;

(b) A description of the plan's procedures for detecting and investigating possible acts of fraud, abuse, and overpayment;

(c) A description of the plan's procedures for the mandatory reporting of possible overpayment, abuse, or fraud to

the Office of Medicaid Program Integrity within the agency;

(d) A description of the plan's program and procedures for educating and training personnel on how to detect and prevent fraud, abuse, and overpayment;

(e) The name, address, telephone number, e-mail address, and fax number of the individual responsible for carrying out the anti-fraud plan; and

(f) A summary of the results of the investigations of fraud, abuse, or overpayment which were conducted during the previous year by the managed care organization's fraud investigative unit.

(2) A managed care plan that provides Medicaid services shall:

(a) Establish and maintain a fraud investigative unit to investigate possible acts of fraud, abuse, and overpayment; or

(b) Contract for the investigation of possible fraudulent or abusive acts by Medicaid recipients, persons providing services to Medicaid recipients, or any other persons.

(3) If a managed care plan contracts for the investigation of fraudulent claims and other types of program abuse by recipients or service providers, the managed care plan shall file the following with the Office of Medicaid Program Integrity within the agency for approval before the plan executes any contracts for fraud and abuse prevention and detection:

(a) A copy of the written contract between the plan and the contracting entity;

(b) The names, addresses, telephone numbers, e-mail addresses, and fax numbers of the principals of the entity with which the managed care plan has contracted; and

(c) A description of the qualifications of the principals of the entity with which the managed care plan has contracted.

(4) On or before September 1 of each year, each managed care plan shall report to the Office of Medicaid Program Integrity within the agency on its experience in implementing an anti-fraud plan, as provided under subsection (1), and, if applicable, conducting or contracting for investigations of possible fraudulent or abusive acts as provided under this section for the prior state fiscal year. The report must include, at a minimum:

(a) The dollar amount of losses and recoveries attributable to overpayment, abuse, and fraud.

(b) The number of referrals to the Office of Medicaid Program Integrity during the prior year.

(5) If a managed care plan fails to timely submit a final acceptable anti-fraud plan, fails to timely submit its annual report, fails to implement its anti-fraud plan or investigative unit, if applicable, or otherwise refuses to comply with this section, the agency shall impose:

(a) An administrative fine of $2,000 per calendar day for failure to submit an acceptable anti-fraud plan or report until the agency deems the managed care plan or report to be in compliance;

(b) An administrative fine of not more than $10,000 for failure by a managed care plan to implement an anti-fraud plan or investigative unit, as applicable; or

(c) The administrative fines pursuant to paragraphs (a) and (b).

(6) Each managed care plan shall report all suspected or


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confirmed instances of provider or recipient fraud or abuse within 15 calendar days after detection to the Office of Medicaid Program Integrity within the agency. At a minimum the report must contain the name of the provider or recipient, the Medicaid billing number or tax identification number, and a description of the fraudulent or abusive act. The Office of Medicaid Program Integrity in the agency shall forward the report of suspected overpayment, abuse, or fraud to the appropriate investigative unit, including, but not limited to, the Bureau of Medicaid program integrity, the Medicaid fraud control unit, the Division of Public Assistance Fraud, the Division of Insurance Fraud, or the Department of Law Enforcement.

(a) Failure to timely report shall result in an administrative fine of $1,000 per calendar day after the 15th day of detection.

(b) Failure to timely report may result in additional administrative, civil, or criminal penalties.

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

Section 13. Review of the Medicaid fraud and abuse processes.—

(1) The Auditor General and the Office of Program Policy Analysis and Government Accountability shall review and evaluate the Agency for Health Care Administration’s Medicaid fraud and abuse systems, including the Medicaid program integrity program. The reviewers may access Medicaid-related information and data from the Attorney General’s Medicaid Fraud Control Unit, the Department of Health, the Department of Elderly Affairs, the Agency for Persons with Disabilities, and the Department of

Children and Family Services, as necessary, to conduct the review. The review must include, but is not limited to:

(a) An evaluation of current Medicaid policies and the Medicaid fiscal agent;

(b) An analysis of the Medicaid fraud and abuse prevention and detection processes, including agency contracts, Medicaid databases, and internal control risk assessments;

(c) A comprehensive evaluation of the effectiveness of the current laws, rules, and contractual requirements that govern Medicaid managed care entities;

(d) An evaluation of the agency's Medicaid managed care oversight processes;

(e) Recommendations to improve the Medicaid claims adjudication process, to increase the overall efficiency of the Medicaid program, and to reduce Medicaid overpayments; and

(f) Operational and legislative recommendations to improve the prevention and detection of fraud and abuse in the Medicaid managed care program.

(2) The Auditor General's Office and the Office of Program Policy Analysis and Government Accountability may contract with technical consultants to assist in the performance of the review. The Auditor General and the Office of Program Policy Analysis and Government Accountability shall report to the President of the Senate, the Speaker of the House of Representatives, and the Governor by December 1, 2011.

Section 14. Medicaid claims adjudication project.—The Agency for Health Care Administration shall issue a competitive procurement pursuant to chapter 287, Florida Statutes, with a third-party vendor, at no cost to the state, to provide a real-

time, front-end database to augment the Medicaid fiscal agent program edits and claims adjudication process. The vendor shall provide an interface with the Medicaid fiscal agent to decrease inaccurate payment to Medicaid providers and improve the overall efficiency of the Medicaid claims-processing system.

Section 15. Effective July 1, 2010, paragraph (b) of subsection (4) of section 409.912, Florida Statutes, is amended, and paragraph (d) of that subsection is republished, to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician’s opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the


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clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history,

previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers shall not be entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(4) The agency may contract with:

(b) An entity that is providing comprehensive behavioral health care services to certain Medicaid recipients through a capitated, prepaid arrangement pursuant to the federal waiver provided for by s. 409.905(5). Such entity must be licensed under chapter 624, chapter 636, or chapter 641, or authorized under paragraph (c) or paragraph (d), and must possess the clinical systems and operational competence to manage risk and provide comprehensive behavioral health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. The secretary of the Department of Children and Family Services shall approve provisions of procurements related to children in the department's care or custody before enrolling such children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively


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procured. In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. Except as provided in subparagraph 8., and except in counties where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211, the agency shall seek federal approval to contract with a single entity meeting these requirements to provide comprehensive behavioral health care services to all Medicaid recipients not enrolled in a Medicaid managed care plan authorized under s. 409.91211, a provider service network authorized under paragraph (d), or a Medicaid health maintenance organization in an AHCA area. In an AHCA area where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and are subject to this paragraph. Each entity must offer a sufficient choice of providers in its network to ensure recipient access to care and the opportunity to select a provider with whom they are satisfied. The network shall include all public mental health hospitals. To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph must require 80 percent of the capitation paid to the managed care plan, including health maintenance organizations and capitated provider service networks, to be expended for the provision of

behavioral health care services. If the managed care plan expends less than 80 percent of the capitation paid for the provision of behavioral health care services, the difference shall be returned to the agency. The agency shall provide the plan with a certification letter indicating the amount of capitation paid during each calendar year for behavioral health care services pursuant to this section. The agency may reimburse for substance abuse treatment services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.

1. By January 1, 2001, the agency shall modify the contracts with the entities providing comprehensive inpatient and outpatient mental health care services to Medicaid recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk Counties, to include substance abuse treatment services.

2. By July 1, 2003, the agency and the Department of Children and Family Services shall execute a written agreement that requires collaboration and joint development of all policy, budgets, procurement documents, contracts, and monitoring plans that have an impact on the state and Medicaid community mental health and targeted case management programs.

3. Except as provided in subparagraph 8., by July 1, 2006, the agency and the Department of Children and Family Services shall contract with managed care entities in each AHCA area except area 6 or arrange to provide comprehensive inpatient and outpatient mental health and substance abuse services through capitated prepaid arrangements to all Medicaid recipients who are eligible to participate in such plans under federal law and regulation. In AHCA areas where eligible individuals number less


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than 150,000, the agency shall contract with a single managed care plan to provide comprehensive behavioral health services to all recipients who are not enrolled in a Medicaid health maintenance organization, a provider service network authorized under paragraph (d), or a Medicaid capitated managed care plan authorized under s. 409.91211. The agency may contract with more than one comprehensive behavioral health provider to provide care to recipients who are not enrolled in a Medicaid capitated managed care plan authorized under s. 409.91211, a provider service network authorized under paragraph (d), or a Medicaid health maintenance organization in AHCA areas where the eligible population exceeds 150,000. In an AHCA area where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and shall be subject to this paragraph. Contracts for comprehensive behavioral health providers awarded pursuant to this section shall be competitively procured. Both for-profit and not-for-profit corporations are eligible to compete. Managed care plans contracting with the agency under subsection (3) or paragraph (d), shall provide and receive payment for the same comprehensive behavioral health benefits as provided in AHCA rules, including handbooks incorporated by reference. In AHCA area 11, the agency shall contract with at least two comprehensive behavioral health care providers to provide behavioral health care to recipients in that area who are enrolled in, or assigned to, the MediPass program. One of the behavioral health care contracts must be with the existing

provider service network pilot project, as described in paragraph (d), for the purpose of demonstrating the cost-effectiveness of the provision of quality mental health services through a public hospital-operated managed care model. Payment shall be at an agreed-upon capitated rate to ensure cost savings. Of the recipients in area 11 who are assigned to MediPass under s. 409.9122(2)(k), a minimum of 50,000 of those MediPass-enrolled recipients shall be assigned to the existing provider service network in area 11 for their behavioral care.

4. By October 1, 2003, the agency and the department shall submit a plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives which provides for the full implementation of capitated prepaid behavioral health care in all areas of the state.

a. Implementation shall begin in 2003 in those AHCA areas of the state where the agency is able to establish sufficient capitation rates.

b. If the agency determines that the proposed capitation rate in any area is insufficient to provide appropriate services, the agency may adjust the capitation rate to ensure that care will be available. The agency and the department may use existing general revenue to address any additional required match but may not over-obligate existing funds on an annualized basis.

c. Subject to any limitations provided in the General Appropriations Act, the agency, in compliance with appropriate federal authorization, shall develop policies and procedures that allow for certification of local and state funds.

5. Children residing in a statewide inpatient psychiatric

program, or in a Department of Juvenile Justice or a Department of Children and Family Services residential program approved as a Medicaid behavioral health overlay services provider may not be included in a behavioral health care prepaid health plan or any other Medicaid managed care plan pursuant to this paragraph.

6. In converting to a prepaid system of delivery, the agency shall in its procurement document require an entity providing only comprehensive behavioral health care services to prevent the displacement of indigent care patients by enrollees in the Medicaid prepaid health plan providing behavioral health care services from facilities receiving state funding to provide indigent behavioral health care, to facilities licensed under chapter 395 which do not receive state funding for indigent behavioral health care, or reimburse the unsubsidized facility for the cost of behavioral health care provided to the displaced indigent care patient.

7. Traditional community mental health providers under contract with the Department of Children and Family Services pursuant to part IV of chapter 394, child welfare providers under contract with the Department of Children and Family Services in areas 1 and 6, and inpatient mental health providers licensed pursuant to chapter 395 must be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid behavioral health services.

8. All Medicaid-eligible children, except children in area 1 and children in Highlands County, Hardee County, Polk County, or Manatee County of area 6, that are open for child welfare services in the HomeSafeNet system, shall receive their behavioral health care services through a specialty prepaid plan

operated by community-based lead agencies through a single agency or formal agreements among several agencies. The specialty prepaid plan must result in savings to the state comparable to savings achieved in other Medicaid managed care and prepaid programs. Such plan must provide mechanisms to maximize state and local revenues. The specialty prepaid plan shall be developed by the agency and the Department of Children and Family Services. The agency may seek federal waivers to implement this initiative. Medicaid-eligible children whose cases are open for child welfare services in the HomeSafeNet system and who reside in AHCA area 10 are exempt from the specialty prepaid plan upon the development of a service delivery mechanism for children who reside in area 10 as specified in s. 409.91211(3)(dd).

(d) A provider service network may be reimbursed on a fee-for-service or prepaid basis. A provider service network which is reimbursed by the agency on a prepaid basis shall be exempt from parts I and III of chapter 641, but must comply with the solvency requirements in s. 641.2261(2) and meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency. Medicaid recipients assigned to a provider service network shall be chosen equally from those who would otherwise have been assigned to prepaid plans and MediPass. The agency is authorized to seek federal Medicaid waivers as necessary to implement the provisions of this section. Any contract previously awarded to a provider service network operated by a hospital pursuant to this subsection shall remain in effect for a period of 3 years following the current contract expiration date, regardless of

any contractual provisions to the contrary. A provider service network is a network established or organized and operated by a health care provider, or group of affiliated health care providers, including minority physician networks and emergency room diversion programs that meet the requirements of s. 409.91211, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the provider service network organization.

Section 16. Effective July 1, 2010, paragraphs (e) and (dd) of subsection (3) of section 409.91211, Florida Statutes, are amended to read:

409.91211 Medicaid managed care pilot program.—

(3) The agency shall have the following powers, duties, and responsibilities with respect to the pilot program:

(e) To implement policies and guidelines for phasing in financial risk for approved provider service networks that, for purposes of this paragraph, include the Children's Medical Services Network, over the ~~a 5-year~~ period of the waiver and the extension thereof. These policies and guidelines must include an option for a provider service network to be paid fee-for-service rates. For any provider service network established in a managed


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care pilot area, the option to be paid fee-for-service rates must include a savings-settlement mechanism that is consistent with s. 409.912(44). This model must be converted to a risk-adjusted capitated rate by the beginning of the final ~~sixth~~ year of operation under the waiver extension, and may be converted earlier at the option of the provider service network. Federally qualified health centers may be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid primary care services.

(dd) To implement service delivery mechanisms within a specialty plan in area 10 ~~capitated managed care plans~~ to provide behavioral health care services ~~Medicaid services as specified in ss. 409.905 and 409.906~~ to Medicaid-eligible children whose cases are open for child welfare services in the HomeSafeNet system. These services must be coordinated with community-based care providers as specified in s. 409.1671, where available, and be sufficient to meet the ~~medical,~~ developmental, behavioral, and emotional needs of these children. Children in area 10 who have an open case in the HomeSafeNet system shall be enrolled into the specialty plan. These service delivery mechanisms must be implemented no later than July 1, 2011 ~~2008~~, in AHCA area 10 in order for the children in AHCA area 10 to remain exempt from the statewide plan under s. 409.912(4)(b)8. An administrative fee may be paid to the specialty plan for the coordination of services based on the receipt of the state share of that fee being provided through intergovernmental transfers.

Section 17. All powers, duties, functions, records, offices, personnel, property, pending issues and existing

contracts, administrative authority, administrative rules, and unexpended balances of appropriations, allocations, and other funds relating to public assistance fraud in the Department of Law Enforcement are transferred by a type two transfer, as defined in s. 20.06(2), Florida Statutes, to the Division of Public Assistance Fraud in the Department of Financial Services.

Section 18. Except as otherwise expressly provided in this act and except for sections 1, 2, 12, 13, and 14 of this act and this section, which shall take effect upon this act becoming a law, this act shall take effect January 1, 2011.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to Medicaid; requiring that the Agency for Health Care Administration request an extension of a specified federal waiver; requiring the agency to report each month to the Legislature; requiring that certain changes of terms and conditions relating to the low-income pool be approved by the Legislative Budget Commission; requiring that the agency develop a methodology for intergovernmental transfers in any expansion of prepaid managed care in the Medicaid program; requiring that the secretary appoint a technical advisory panel; requiring a report to the Governor and Legislature; creating s. 624.35, F.S.; providing a short title; creating s. 624.351, F.S.;

providing legislative findings; establishing the Medicaid and Public Assistance Fraud Strike Force within the Department of Financial Services to coordinate efforts to eliminate Medicaid and public assistance fraud; providing for membership; providing for meetings; specifying duties; requiring an annual report to the Legislature and Governor; creating s. 624.352, F.S.; directing the Chief Financial Officer to prepare model interagency agreements that address Medicaid and public assistance fraud; specifying which agencies may be a party to such agreements; amending s. 16.59, F.S.; conforming provisions to changes made by the act; requiring the Divisions of Insurance Fraud and Public Assistance Fraud in the Department of Financial Services to be collocated with the Medicaid Fraud Control Unit if possible; requiring positions dedicated to Medicaid managed care fraud to be collocated with the Division of Insurance Fraud; amending s. 20.121, F.S.; establishing the Division of Public Assistance Fraud within the Department of Financial Services; amending ss. 411.01, 414.33, and 414.39, F.S.; conforming provisions to changes made by the act; transferring, renumbering, and amending s. 943.401, F.S.; directing the Department of Financial Services rather than the Department of Law Enforcement to investigate public assistance fraud; creating s. 409.91212, F.S.; requiring that each managed care plan adopt an anti-fraud plan; specifying requirements for the plan; requiring that a managed care plan providing

Medicaid services to establish and maintain a fraud investigative unit or contract for such services; providing requirements for reports to the Office of Medicaid Program Integrity; authorizing the agency to impose fines against a managed care plan that fails to submit an anti-fraud plan or make certain reports; authorizing the agency to adopt rules; directing the Auditor General and the Office of Program Policy Analysis and Government Accountability to review the Medicaid fraud and abuse processes in the Agency for Health Care Administration; requiring a report to the Legislature and Governor by a certain date; establishing the Medicaid claims adjudication project in the Agency for Health Care Administration to decrease the incidence of inaccurate payments and to improve the efficiency of the Medicaid claims processing system; amending s. 409.912, F.S.; authorizing the Agency for Health Care Administration to contract with an entity that provides comprehensive behavioral health care services to certain Medicaid recipients who are not enrolled in a Medicaid managed care plan or a Medicaid provider service network under certain circumstances; amending s. 409.91211, F.S.; revising certain provisions governing the Medicaid managed care pilot program to conform to the extension of the federal waiver; authorizing an administrative fee to be paid to the specialty plan for the coordination of services; transferring activities relating to public assistance fraud from the


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Department of Law Enforcement to the Division of Public Assistance Fraud in the Department of Financial Services by a type two transfer; providing effective dates.