A bill to be entitled

An act relating to Medicaid and public assistance fraud; creating s. 624.35, F.S.; providing a short title; creating s. 624.351, F.S.; providing legislative intent; 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 can 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 Medicaid managed care plans to adopt an anti-fraud plan relating to the provision of health care services; requiring certain managed care plans to also establish an investigative unit or contract for the investigation of fraudulent or abusive activity; requiring an annual report; providing administrative penalties for noncompliance; authorizing the Agency for Health Care Administration 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; transferring activities relating to public assistance fraud from the 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.

WHEREAS, Florida's Medicaid program is one of the largest in the country, serving approximately 2.7 million persons each month. The program provides health care benefits to families and individuals below certain income and resource levels. For the

2008-2009 fiscal year, the Legislature appropriated $18.81 billion to operate the Medicaid program which is funded from general revenue, trust funds that include federal matching funds, and other state funds, and

WHEREAS, Medicaid fraud in Florida is epidemic, far-reaching, and costs the state and the Federal Government billions of dollars annually. Medicaid fraud not only drives up the cost of health care and reduces the availability of funds to support needed services, but undermines the long-term solvency of both health care providers and the state's Medicaid program, and

WHEREAS, the state's public assistance programs serve approximately 1.8 million Floridians each month by providing benefits for food, cash assistance for needy families, home health care for disabled adults, and grants to individuals and communities affected by natural disasters. For the 2008-2009 fiscal year, the Legislature appropriated $626 million to operate public assistance programs, and

WHEREAS, public assistance fraud costs taxpayers millions of dollars annually, which significantly and negatively impacts the various assistance programs by taking dollars that could be used to provide services for those people who have a legitimate need for assistance, and

WHEREAS, both Medicaid and public assistance programs are vulnerable to fraudulent practices that can take many forms. For Medicaid, these practices range from providers who bill for services never rendered and who pay kickbacks to other providers for client referrals, to fraud occurring at the corporate level of a managed care organization. Fraudulent practices involving

public assistance involve persons not disclosing material facts when obtaining assistance or not disclosing changes in circumstances while on public assistance, and

WHEREAS, ridding the system of perpetrators who prey on the state's Medicaid and public assistance programs helps reduce the state's skyrocketing costs, makes more funds available for essential services, and improves the quality of care and the health status of our residents, and

WHEREAS, aggressive and comprehensive measures are needed at the state level to investigate and prosecute Medicaid and public assistance fraud and to recover dollars stolen from these programs, and

WHEREAS, new statewide initiatives and coordinated efforts are necessary to focus resources in order to aid law enforcement and investigative agencies in detecting and deterring this type of fraudulent activity, NOW, THEREFORE,

Be It Enacted by the Legislature of the State of Florida:

Section 1. 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 2. 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 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 will serve 4-year terms; however, for the purpose of providing staggered terms, of the initial appointments, two members will be appointed to a 2-year term, two members will be appointed to a 3-year term, and one member will be appointed to a 4-year term. The remaining members are standing members 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 3. 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 4. 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 5. 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 6. 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 pursuant to s. 414.411 ~~Division of Public Assistance Fraud~~ for investigation.

Section 7. 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 8. 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 9. 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 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 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 10. 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 the Inspector General 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 the Inspector General 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 the Inspector General 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 the Inspector General 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 the Inspector General 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 confirmed instances of provider or recipient fraud or abuse within 15 calendar days after detection to the Office of the Inspector General 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 the Inspector General 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 11. 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 12. 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 13. 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 14. Except for sections 10 and 11 of this act and this section, which shall take effect upon this act becoming a law, this act shall take effect January 1, 2011.