The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Banking and Insurance Committee

BILL:	PCS/SB 8 (382480)
INTRODUCER:	Banking and Insurance Committee
SUBJECT:	Medicaid and Public Assistance Fraud Strike Force
DATE:	March 15, 2010 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Emrich	Burgess	BI	**Pre-meeting**
2.			HR	
3.			WPSC	
4.				
5.				
6.				

I. Summary:

Proposed Committee Substitute for Senate Bill 8 creates the Medicaid and Public Assistance Fraud Strike Force (Strike Force) within the Department of Financial Services (DFS) to develop a statewide strategy and coordinate state and local efforts and resources to prevent, investigate and prosecute Medicaid and public assistance fraud.[1] The Strike Force consists of 11 members and serves to advise and provide recommendations and policy alternatives to the Chief Financial Officer (CFO) including, but not limited to:

- Conducting a census of current state, local and federal Medicaid and public assistance fraud efforts;
- Developing a strategic plan targeting state and local resources to prevent, detect, and deter Medicaid and public assistance fraud;
- Creating innovative technology and data sharing among affected entities;
- Establishing a program that provides grants to state and local agencies to implement effective Medicaid and public assistance anti-fraud measures;
- Developing and promoting crime prevention services and educational programs that serve the public, including a rewards program; and
- Assisting multiagency fraud efforts to provide a Medicaid and public assistance fraud prosecutor in the Office of Statewide Prosecutor; provide assistance to state attorneys for

[1] The Strike Force includes the Chief Financial Officer (CFO) serving as chair, the Attorney General serving as vice-chair, the Executive Director of the Florida Department of Law Enforcement, secretaries of the Agency for Health Care Administration and Children and Family Services, the State Surgeon General, and five members consisting of two sheriffs, two chiefs of police, and one state attorney, who are appointed by the CFO. The Strike Force meets quarterly and its members may not designate anyone to serve in their place.

support services, or for the hiring of assistant state attorneys to prosecute this type of fraud; and provide assistance to judges for support services, or for the hiring of senior judges so that these fraud cases can be heard expeditiously.

The Strike Force is tasked to receive reports from state and local agencies, investigators, and prosecutors relating to Medicaid and public assistance fraud investigations and must annually report its activities and recommendations to the Governor and Legislature by October 1st.

The CFO is authorized to develop model interagency agreements, called "Strike Force" agreements, for the prevention, investigation, and prosecution of Medicaid and public assistance fraud.

The bill requires, to the extent possible, that the state agencies involved with Medicaid and public assistance fraud (Attorney General's Medicaid Fraud Control Unit (MFCU), Agency for Health Care Administration's (AHCA or Agency) Bureau of Medicaid Program Integrity, and the divisions of Insurance Fraud and Public Assistance Fraud within the DFS) be collocated; however, it mandates that the positions dedicated to Medicaid manage care fraud within the MFCU be collocated with the Division of Insurance Fraud. The bill requires AHCA, the Department of Legal Affairs (Attorney General), and the divisions of Insurance Fraud and Public Assistance Fraud within DFS to conduct joint training and other joint activities to increase communication and coordination in recovering overpayments.

The legislation requires the Auditor General, in consultation with the Office of Program Policy Analysis and Government Accountability (OPPAGA), to do an operational audit of AHCA's Medicaid fraud and abuse systems, including the Medicaid program integrity program. The audit's scope may include the Medicaid related programs in the various agencies involved in the program. The audit must include an evaluation of current Medicaid policies and the Medicaid fiscal agent; an analysis of all Medicaid fraud and abuse prevention and detection processes; a comprehensive evaluation of the effectiveness of current laws, rules, and contractual requirements that govern Medicaid managed care entities; and an evaluation of AHCA's Medicaid managed care oversight processes. The audit report must include recommendations for additional Medicaid fiscal agent edits, and operational and legislative recommendations to enhance the prevention and detection of fraud and abuse in the Medicaid program. The bill requires the Auditor General to submit the joint audit report to the Senate President, the Speaker of the House of Representatives, and the Governor by December 1, 2011.

The bill requires the AHCA to issue a competitive procurement with a third-party vendor to provide a database to augment the Medicaid fiscal agent program edits and claims adjudication process. The purpose of this agreement is to decrease inaccurate payments to Medicaid providers and improve the overall efficiency of the Medicaid claims-processing system.

The bill transfers (type two transfer) the Division of Public Assistance Fraud within the Florida Department of Law Enforcement to the DFS.

The bill creates ss. 624.35 and 624.351 and amends ss. 16.59, 20.121, 411.01, 414.33, 414.39 and 943.401 of the Florida Statutes.

II. Present Situation:

Health Care Fraud Overview – Medicaid Fraud

Health care fraud is a pervasive problem for all private payors, states, and the Federal Government. The National Health Care Anti-Fraud Association estimates conservatively that 3 percent of all health care spending, approximately $68 billion, is lost to health care fraud each year. The FBI estimates that spending related to health care fraud is much higher – 10 percent of all health care spending.

Officials with the Attorney General's office assert that 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. In a February 2008 report from the Office of Program Policy Analysis and Government Accountability (OPPAGA), estimates of fraud, waste, and abuse in the state's Medicaid program ranged from five to twenty percent. Taking the average of these estimates, which is 12.5 percent, fraud, waste, and abuse in Florida's Medicaid Program amounts to at least $2.4 billion each year.[2]

Florida, particularly South Florida, has been identified by numerous federal reports and studies as one of the main epicenters of Medicare and Medicaid fraud. In 2007, the Justice Department and the Department of Health and Human Services deployed the first Medicare Strike-Force in Southern Florida. The Strike-Force continues to combat Medicare and Medicaid fraud in this state.

Historically Medicaid fraud has been a policy priority for the Florida Legislature. In 1996, the Legislature passed SB 118 in response to the Thirteenth Statewide Grand jury's findings and recommendations relating to fraud in the durable medical equipment, health clinic, adult living facility, and home health care industries.[3] In 2002, the Legislature made significant statutory changes that included: improved tracking and accounting systems at the AHCA to recover Medicaid overpayments; studies to evaluate the accuracy of Medicaid claims payments and eligibility determination; and a contract to analyze and apply sophisticated algorithms to detect unusual Medicaid drug utilization patterns.[4]

In 2004, in response to the Seventeenth Statewide Grand Jury Report on Medicaid fraud, the Legislature passed legislation that addressed pharmaceutical practices in the Medicaid program, increasing the AHCA's authority to control pharmaceutical drug prescribing in the Medicaid program.[5] The legislation also increased Medicaid eligibility standards and provided the Agency the authority to suspend or terminate providers in the Medicaid program for fraudulent or questionable behavior.

[2] The estimate is 12.5 percent of $19.1 billion. For FY 2010-2011, the Florida Medicaid Program is projected to cover 2.9 million people at an estimated cost of $19.1 billion.
[3] Ch. 1996-387, L.O.F.
[4] Ch. 2002-400, L.O.F.
[5] Ch. 2004-344, L.O.F.

During the 2008 Legislative Session, fraud in the home health and home medical equipment industries was addressed in CS/HB 7083.[6] The bill substantially increased the regulatory provisions that govern the licensure of home health agencies and nurse registries to reduce Medicaid fraud and improve quality of care and industry accountability. The bill also addressed home medical equipment provider fraud in the Medicaid system by authorizing the AHCA to limit its network of medical equipment providers and increase its home medical equipment provider enrollment requirements.

During the 2009 Legislative Session, Medicaid fraud was on the agenda again. The Legislature passed CS/CS/CS/SB 1986 to address systemic health care fraud.[7] Some of the provisions in the bill included:

- Additional authority for the Medicaid program to address fraud, particularly as it relates to home health services;
- Additional health care facility and health care practitioner licensing standards to keep individuals convicted of fraud from obtaining a health care license in Florida;
- Disincentives to commit Medicaid fraud;
- Incentives to report Medicaid fraud; and
- Targeted pilot projects to address Medicaid fraud in Miami-Dade County.

The legislation that addressed Medicaid fraud during the last two Sessions has taken a systemic approach to addressing fraud in the Medicaid program. Health care fraud negatively impacts the entire interconnected health care system. Fraud in the Medicaid program is not isolated to only the Medicaid program but spills over into the rest of the health care system and also impacts Medicare, other government sponsored health coverage, and the private insurance market. Fraud contributes to rising health care costs in all sectors.

Medicaid and health care fraud prevention requires a consistent commitment from the AHCA's Medicaid Program Integrity Unit, Inspector General, Medicaid Program, and Health Quality Assurance (facility licensing unit); the Department of Health's many medical boards and Medical Quality Assurance division; the Attorney General's Medicaid Fraud Control Unit; the Division of Insurance Fraud within the DFS; state and local law enforcement agencies; the courts; and many other health care stake-holders. Coordination of all the interested parties is an ongoing challenge.

Public Assistance Fraud

According to officials with the Florida Department of Law Enforcement (FDLE), 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. 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 2008-09 fiscal year, the Legislature appropriated $626 million to operate the program.[8]

[6] Ch. 2008-246, L.O.F.
[7] Ch. 2009-223, L.O.F.
[8] The PAF program is partially funded by the Federal Government.

The Division of Public Assistance Fraud (PAF) within the Florida Department of Law Enforcement (FDLE) investigates persons committing public assistance fraud which includes the following programs: aid to families with dependent children; food stamps; Medicaid (recipient fraud); school readiness; subsidized child day care; emergency financial assistance in housing; women, infants and children (WIC), and relocation assistance.[9] Fraudulent practices may involve persons not disclosing material facts when obtaining benefits or not disclosing changes in circumstances while on public assistance. The division has 63 non-sworn positions with a budget of $6,236,940, of which $3,938,663 are federal dollars. For fiscal year 2008-09, the PAF received 26,978 referrals, primarily from the Florida Department of Children and Family Services. Approximately 75 percent of these referrals involved food stamp fraud. Of the total referrals, 1,209 are pending cases, 248 are active investigations, 448 were referred for prosecution and 653 were referred for administrative sanctions. Of the remaining referrals, 25,521 were closed due to lack of staff and other resources or insufficient evidence.[10]

Florida's Medicaid Program

The state's Medicaid program is jointly funded by the federal, state, and county governments to provide medical care to families and individuals below certain income and resource levels. For FY 2010-2011, the Florida Medicaid Program is projected to cover 2.9 million people,[11] at an estimated cost of $19.1 billion.[12] Florida implemented its Medicaid program on January 1, 1970, and the AHCA is the single state agency responsible for the Florida Medicaid program.[13]

Some Medicaid services are mandatory services that must be covered by any state participating in the Medicaid program pursuant to federal law.[14] Other services are optional. A state may choose to include optional services in its state Medicaid plan, but if included, such services must be offered to all individuals statewide who meet Medicaid eligibility criteria as though they are mandatory benefits.[15] Similarly, some eligibility categories are mandatory[16] and some are optional.[17] Payments for services to individuals in the optional eligibility categories are subject to the availability of monies and any limitations established by the General Appropriations Act or ch. 216, F.S.

The AHCA maintains a network of Medicaid providers, including individual health care practitioners, health care facilities, and other entities to provide services to Medicaid recipients.[18] The AHCA executes a provider agreement, as specified in s. 409.907, F.S., with each individual Medicaid provider and has contractual arrangements with seventeen Medicaid HMOs that

[9] Section 943.401, F.S.
[10] One hundred and forty six open investigations were ultimately closed due to insufficient evidence.
[11] Social Services Estimating Conference, Medicaid Caseload, January 26, 2010. Found at: <http://edr.state.fl.us/conferences/medicaid/medcases.pdf> (Last visited on March 6, 2010).
[12] Social Services Estimating Conference, Medicaid Services Expenditures, February 12, 2010. Found at: < http://edr.state.fl.us/conferences/medicaid/medhistory.pdf> (Last visited on March 6, 2010).
[13] The statutory provisions for the Medicaid program appear in ss. 409.901-409.9205, F.S.
[14] These mandatory services are codified in s. 409.905, F.S.
[15] Optional services covered under the Florida Medicaid Program are codified in s. 409.906, F.S.
[16] Section 409.903, F.S.
[17] Section 409.904, F.S.
[18] The Agency currently has Medicaid provider agreements with 104,004 providers statewide, including: 37,883 physicians; 44 hospices; and 650 nursing homes.

provide services to over 1 million Medicaid recipients.[19] Approximately two-thirds of all Medicaid recipients are enrolled in some type of Medicaid managed care.[20]

Florida's Medicaid Fraud Control Unit under the Attorney General

The Medicaid Fraud Control Unit (MFCU or Unit) is within the Department of Legal Affairs (Attorney General) and is responsible for investigating criminal and civil fraud cases against the Medicaid program by service providers, and abuse, neglect, and exploitation of patients who reside in Medicaid funded facilities under s. 409.920, F.S.[21] The MFCU also investigates Medicaid managed care fraud.[22] Enforcement of these areas is designed to prevent, detect and prosecute these types of misconduct in order to protect the integrity of the Medicaid program. The Unit refers cases of abuse to the AHCA that are not criminal or fraudulent and refers criminal cases for prosecution to local state attorneys or to the Office of Statewide Prosecution. The MFCU has 217 full-time employees including 119 sworn and 98 non-sworn positions.[23] For calendar year 2009, the MFCU recovered $196,868,406. For fiscal year 2008-09, the budget for the MFCU unit was $19,317,654, of which 75 percent was federal funding and 25 percent came from general revenue. In fiscal year 2008-09, the MFCU unit recovered $168,114,241; these recoveries contributed $15,296,356 to the state General Revenue Fund. Of the $168,114,241 recovered by the MFCU, $118,895,474 was recovered from cases brought under the Florida False Claims Act.

In FY 2008-09, the MFCU received 1,238 referrals and opened 372 cases for investigation. The great majority of these referrals involved Medicaid provider fraud or abuse or exploitation of patients in Medicaid facilities. Fraudulent practices involving Medicaid range from providers who bill for services never rendered and the payment of kickbacks to other providers for client referrals, to fraud occurring at the corporate level of a managed care organization.

During FY 2008-09, the MFCU had an investigative case load of 1,157 cases (these investigations included cases from prior years) and referred 68 cases for criminal prosecution. The majority of cases the MFCU resolves involve civil, as opposed to criminal, Medicaid fraud. The largest Medicaid managed care investigation involved a joint effort by the MFCU, the FBI, and the federal prosecutor's office against Wellcare Health Plan. Ultimately, the Plan paid $40 million in restitution to the State of Florida and $40 million in forfeitures to the Federal Government. Cases involving managed care fraud, however, are a small portion of the total cases investigated or prosecuted.

Florida's Medicaid Program Integrity under the Agency for Health Care Administration

The Agency's Bureau of Medicaid Program Integrity (MPI) is responsible for preventing and detecting fraud and abuse in the Medicaid program. The duties of the MPI include:

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[19] Agency for Health Care Administration, Comprehensive Medicaid Managed Care Enrollment Report, February 10, 2010. Found at: <http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_data.shtml> (Last visited on March 6, 2010).

[20] Agency for Health Care Administration, Comprehensive Medicaid Managed Care Enrollment Report, February 10, 2010. Found at: <http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_data.shtml> (Last visited on March 9, 2010).

[21] Section 16.59, F.S.

[22] Section 409.920(2)(a)1., F.S.

[23] Thirty of these positions are not able to be filled due to budget constraints.

- Ensuring that Medicaid recipients are not subject to fraud, abuse, or neglect;
- Preventing fraud in the Medicaid system;
- Recovering overpayments from Medicaid providers; and
- Sanctioning or terminating providers from the Medicaid program, as appropriate.[24]

The Agency has the authority to sanction providers for a variety of offenses. When the provider is not a natural person (a corporate entity), the Agency also has authority to sanction the provider for actions of owners, officers, or agents who have engaged in sanctionable offenses. Existing law provides definitions, provides the authority for the MPI to conduct Medicaid provider onsite medical records reviews, and specifies the process for Medicaid overpayment determination.[25]

The MPI staff develop and use statistical methodologies to identify providers who exhibit aberrant billing patterns, conduct investigations and audits of these providers, calculate provider overpayments, initiate recovery of overpayments in instances of provider abuse, and recommend administrative sanctions for providers who have abused or defrauded Medicaid. When the MPI determines that Medicaid has overpaid a provider, the Agency issues an audit report to the provider that includes a calculation of overpayment.

The MPI is required to impose sanctions on a provider for various violations.[26] These sanctions include suspending or terminating Medicaid providers for specified periods of time and fining Medicaid providers. The Agency must immediately suspend a provider and issue an immediate final order under s. 120.569(2)(n), F.S., if the Agency receives information of patient abuse or neglect or of any act prohibited by s. 409.920, F.S.[27] The Agency has indicated that it is unclear whether the Agency has the authority to impose the sanction of an immediate termination followed by an immediate final order under s. 409.913(13), F.S.

During the 2008-2009 fiscal year, the MPI administratively sanctioned 826 Medicaid providers.[28] The sanctions included 501 provider fines, 30 suspensions, 13 Medicaid provider terminations, and 218 miscellaneous sanctions.[29] In 2009, the Legislature increased MPI's authority to address overpayments and fraudulent activity in the Medicaid program.[30]

Under federal and state law, any suspected criminal violation identified by the MPI must be referred to the Medicaid Fraud Control Unit (MFCU) in the Office of the Attorney General.[31] The MPI and the MFCU are required to develop a memorandum of understanding, which

[24] Sections 409.913 and 409.9131, F.S.
[25] Section 409.9131, F.S.
[26] Section 409.913(13)-(16), F.S.
[27] Section 409.913(16)(d), F.S.
[28] The Agency for Health Care Administration and the Medicaid Fraud Control Unit, Department of Legal Affairs, The State's Efforts to Control Medicaid Fraud and Abuse, FY 2008-2009. Found at: <http://ahca.myflorida.com/Executive/Inspector_General/docs/The_States_Efforts%20to_Control_Medicaid_Fraud_and_Abuse_FY2008_09_signed.pdf> (Last visited on March 6, 2010).
[29] The Agency for Health Care Administration and the Medicaid Fraud Control Unit, Department of Legal Affairs, The State's Efforts to Control Medicaid Fraud and Abuse, FY 2008-2009. Found at: <http://ahca.myflorida.com/Executive/Inspector_General/docs/The_States_Efforts%20to_Control_Medicaid_Fraud_and_Abuse_FY2008_09_signed.pdf> (Last visited on March 6, 2010).
[30] See Laws of Florida, Chapter No. 2009-223.
[31] See 42 C.F.R. 455.21 and s. 409.913(4), F.S.

includes protocols for referral of cases of suspected criminal fraud and return of those cases when investigation determines that administrative action by the Agency is appropriate. During FY 2008-2009, the MPI referred 183 cases to the MFCU for investigation, recovered $50.3 million in overpayments, and saved the Medicaid program an estimated $18.9 million in cost avoidance.[32]

In 2009, the Legislature created a Medicaid fraud reward program to offer a monetary reward to any person who reports original information that relates to a violation of the state Medicaid fraud laws.[33] The original information must be reported to the Office of the Attorney General, the AHCA, the Department of Health, or the Department of Law Enforcement and result in a recovery of a fine, penalty, or forfeiture of property.

The Medicaid program covers 2.7 million people at an estimated annual cost of almost $19 billion, yet fraud permeates the program and costs the state and Federal government millions of dollars every year.

Division of Insurance Fraud

The agency established to investigate insurance fraud in Florida is the Division of Insurance Fraud (DIF or "Division") within the Department of Financial Services (DFS). Created by the Legislature in 1976,[34] the DIF employs 197 persons including 151 sworn law enforcement officers who are located in Tallahassee and in 10 regional field offices.[35] The Division's sworn personnel are tasked with investigating criminal activities ranging from fraudulent insurance acts,[36] false and fraudulent insurance claims,[37] unauthorized insurance activities,[38] health care fraud, willful violations of the insurance code,[39] and deceptive trade practices.[40]

There are currently seven insurance fraud assistant state attorneys and seven paralegals that are dedicated to prosecuting insurance fraud cases (primarily personal injury protection or PIP fraud) in the following State Attorney offices: two in Dade, and one each in Broward, Palm Beach,

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[32] The Agency for Health Care Administration and the Medicaid Fraud Control Unit, Department of Legal Affairs, The State's Efforts to Control Medicaid Fraud and Abuse, FY 2008-2009. Found at: <http://ahca.myflorida.com/Executive/Inspector_General/docs/The_States_Efforts%20to_Control_Medicaid_Fraud_and_Abuse_FY2008_09_signed.pdf> (Last visited on March 6, 2010).

[33] Section 409.9203, F.S.

[34] Ch. 76-266, L.O.F., creating s. 626.989, F.S.

[35] The offices are in Pensacola, Tallahassee, Jacksonville, Orlando, Tampa, St. Petersburg, Ft. Myers, Miami, Plantation, and West Palm Beach.

[36] Section 626.989(1), F.S. A person commits a "fraudulent insurance act" if the person knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, self-insurer, self-insurance fund, servicing corporation, purported insurer, broker, or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of, any insurance policy, or a claim for payment or other benefit pursuant to any insurance policy, which the person knows to contain materially false information concerning any fact material thereto or if the person conceals, for the purpose of misleading another, information concerning any fact material thereto.

[37] Section 817.234, F.S.

[38] Section 626.901-626.939, F.S.

[39] Section 624.15, F.S.

[40] Section 626.9541, F.S.

Orange, Hillsborough, and Duval counties.[41] Two dedicated workers' compensation assistant state attorneys and two paralegals have been assigned to the following counties: one prosecutor and paralegal in Dade County and one prosecutor and paralegal in Orange County.

During 2008-09, the DIF received 12,084 fraud referrals, opened 1,971 cases for investigation, presented 982 cases for prosecution, made 834 arrests and secured 532 convictions.[42] The amount of court ordered restitution to victims totaled $34.6 million. The vast majority of these referrals were from insurer special investigative units[43] and the number of referrals have increased by 22 percent over the prior year. According to DIF officials, PIP fraud and motor vehicle fraud constituted the largest percentage of cases investigated by the agency and accounted for 42 percent of the its referrals, 45 percent of cases presented for prosecution, 47 percent of arrests, and 40 percent of convictions in 2008-2009. Workers' compensation fraud[44] constituted the second largest percentage of fraud cases investigated by the DIF followed by other types of criminal activity including healthcare, homeowners, licensee (e.g., agents, public adjustors),[45] life and health insurance, marine, and unauthorized entities fraud. The DIF refers any Medicaid fraud referrals it receives to the Medicaid Fraud Control Unit.

III. Effect of Proposed Changes:

The bill makes findings describing the extent of Medicaid and public assistance fraud occurring in Florida and describes the need to implement a statewide strategy to coordinate state and local agencies, law enforcement, and investigative entities to focus resources on the prevention, detection and prosecution of Medicaid and public assistance fraud.

Section 1. Creates s. 624.35, F.S., to provide that ss. 624.35-624.352, F.S., may be cited as the "Medicaid and Public Assistance Fraud Strike Force Act."

Section 2. Creates s. 624.351, F.S., to establish the Medicaid and Public Assistance Fraud Strike Force (Strike Force) within the Department of Financial Services (DFS) consisting of 11 members including the Chief Financial Officer (CFO) serving as chair, the Attorney General serving as vice-chair, the Executive Director of the Florida Department of Law Enforcement, secretaries of the Agency for Health Care Administration and Children and Family Services, the State Surgeon General, and five members consisting of two sheriffs, two chiefs of police, and one state attorney, who are appointed by the CFO. The Strike Force meets quarterly, its members may not designate anyone to serve in their place, and serves to advise and provide recommendations and policy alternatives to the Chief Financial Officer (CFO) including, but not limited to:

[41] The Legislature appropriated $1,016,043 for FY 2009-2010 from the Insurance Regulatory Trust Fund (IRTF) to the Justice Administration Commission (JAC). The proviso states that "these funds may not be used for any purpose other than the funding of positions and activities that prosecute crimes of insurance fraud." An insurance fraud prosecutor (and a paralegal) were initially authorized by the Legislature in FY 2005-06 for Dade County.
[42] Annual Report for the Division of Insurance Fraud.
[43] Other cases are referred to the division by law enforcement entities, state agencies, fraud bureaus, e.g., National Insurance Crime Bureau, and individuals.
[44] Thirty-six investigators are assigned to workers' compensation fraud investigations and 61are assigned to investigate all other types of insurance fraud.
[45] For example, insurance agents pocketing premiums or title agents committing mortgage fraud.

- Conducting a census of current state, local and federal Medicaid and public assistance fraud efforts;
- Developing a strategic plan targeting state and local resources to prevent, detect, and deter Medicaid and public assistance fraud;
- Developing innovative technology and data sharing among affected entities;
- Establishing a program that provides grants to state and local agencies to implement effective Medicaid and public assistance anti-fraud measures;
- Developing and promoting crime prevention services and educational programs that serve the public, including a rewards program; and
- Providing grants, contingent upon an appropriation, for multiagency Medicaid and public assistance fraud efforts to include providing a prosecutor in the Office of Statewide Prosecutor; providing assistance to state attorneys for support services, or for the hiring of assistant state attorneys to prosecute this type of fraud; and providing assistance to judges for support services, or for the hiring of senior judges so that these fraud cases can be heard expeditiously.

The Strike Force is tasked to receive reports from state and local agencies, investigators, and prosecutors relating to Medicaid and public assistance fraud investigations and must annually report its activities and recommendations to the Governor and Legislature on October 1st.

Section 3. Creates s. 624.352, F.S., which directs the CFO to develop model interagency agreements, called "Strike Force" agreements, among agencies for the prevention, investigation, and prosecution of Medicaid and public assistance fraud. Parties to the agreements may include any agency headed by a Cabinet officer, the Governor and Cabinet, a collegial body, or any federal, state, or local law enforcement agency. The bill lists the provisions which must be included in a model Strike Force agreement including its purpose, structure, procedures, funding, reports and records, assets and forfeitures, liability, and duration.

Section 4. Amends s. 16.59, F.S., relating to Medicaid fraud control, to require, to the extent possible, that the state agencies involved with Medicaid and public assistance fraud (Attorney General's Medicaid Fraud Control Unit (MFCU), Agency for Health Care Administration's (AHCA) Bureau of Medicaid Program Integrity, and the divisions of Insurance Fraud and Public Assistance Fraud within the DFS) be collocated; however, the bill mandates that the positions dedicated to Medicaid manage care fraud within the MFCU be collocated with the Division of Insurance Fraud. The bill requires AHCA, the Department of Legal Affairs (Attorney General), and the divisions of Insurance Fraud and Public Assistance Fraud within DFS to conduct joint training and other joint activities to increase communication and coordination in recovering overpayments.

Section 5. Amends s. 20.121, F.S., relating to the DFS, to include the Division of Public Assistance Fraud as a division within the department.

Section 6. Amends s. 411.01, F.S., pertaining to the school readiness programs, to specify the DFS is to receive referrals for investigations involving the public assistance fraud division.

Section 7. Amends s. 414.33, F.S., relating to food stamp violations, specifying the DFS and not the Florida Department of Law Enforcement, as the agency receiving referrals for suspected food stamp violations.

Section 8. Amends s. 414.39, F.S., relating to fraud, specifying the DFS and not the Florida Department of Law Enforcement, as the agency examining records of public assistance fraud investigations.

Section 9. Amends s. 943.401, F.S., relating to public assistance fraud, specifying that the section is transferred and renumbered as s. 414.411, F.S. The provision specifies that the DFS and not the Florida Department of Law Enforcement, is the agency authorized to investigate all public assistance provided to Florida residents.

Section 10. The legislation mandates that the Auditor General, in consultation with the Office of Program Policy Analysis and Government Accountability (OPPAGA), conduct an operational audit of the AHCA's Medicaid fraud and abuse systems, including the Medicaid program integrity program. The audit's scope may include the MFCU within the Attorney General's Office, and Medicaid related programs in the Department of Health, Department of Elderly Affairs, the Agency for Persons with Disabilities, and the Department of Children and Family Services. The audit must include, but is not limited to, an evaluation of current Medicaid policies and the Medicaid fiscal agent; an analysis of all Medicaid fraud and abuse prevention and detection processes; a comprehensive evaluation of the effectiveness of current laws, rules, and contractual requirements that govern Medicaid managed care entities; and an evaluation of AHCA's Medicaid managed care oversight processes.

The audit report must include, but is not limited to, recommendations for additional Medicaid fiscal agent edits to increase the efficiency of the Medicaid program, and operational and legislative recommendations to enhance the prevention and detection of fraud and abuse in the Medicaid program, including the Medicaid managed care program, in order to manage the program in a more cost-effective manner. The bill provides that the Auditor General's Office and OPPAGA may contract with technical consultants to assist in the performance of the audit. Finally, the bill requires the Auditor General to submit the joint audit report to the Senate President, the Speaker of the House of Representatives, and the Governor by December 1, 2011.

Section 11. The bill establishes the Medicaid claims adjudication project and requires the AHCA to issue a competitive procurement under ch. 287, F.S., with a third-party vendor to provide a database to augment the Medicaid fiscal agent program edits and claims adjudication process. The purpose of this agreement is to decrease inaccurate payments to Medicaid providers and improve the overall efficiency of the Medicaid claims-processing system.

Section 12. The legislation provides that all powers, duties, property, administrative authority, rules, contracts, 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), F.S., to the Division of Public Assistance Fraud within the DFS.[46]

[46] A type two transfer is the merging into another agency of an existing agency or program under s. 20.06(2), F.S.

Section 13. Provides that the act takes effect January 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The provisions of the proposed committee substitute that promote crime prevention services, educational programs that serve the public, and a rewards program should help reduce incidents of Medicaid and public assistance fraud and abuse.

C. Government Sector Impact:

The proposed committee substitute should greatly facilitate the coordination among state and local agencies and law enforcement entities involved in investigating and prosecuting Medicaid and public assistance fraud. The creation of the Strike Force will likely focus agency resources and ultimately reduce the costs associated with this type of fraud.

The estimate below is provided by the professional staff with the General Government Appropriations Committee.

I. General Revenue Funding for the Medicaid and Public Assistance Fraud Program: New Positions

Agency	FTE	Total GR	Recurring GR	Non-Recurring GR	Trust Funds	Total Issue
DFS	6.00	$1,062,328	$1,019,551	$42,777		$1,062,328
DLA	5.00	89,854	77,957	11,897	$269,560	359,414
SubTotal:		**$1,152,182**	**$1,097,508**	**$54,674**	**$269,560**	**$1,421,742**

II. Transfer of Division of Public Assistance Fraud from FDLE to DFS:

Agency	FTE	Total GR	Recurring GR	Non-Recurring GR	Trust Funds	Total Issue
FDLE	63.00	$2,298,277	$2,298,277	0	$3,938,663	$6,236,940
Total:	**74.00**	**$3,450,459**	**$3,395,785**	**$54,674**	**$4,208,223**	**$7,658,682**

Note, the $4,208,223 under the "Trust Fund" category are funds from the Federal Government.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.