By the Committee on Health Care Services and Representative Peaden

1 A bill to be entitled
2 An act relating to Medicaid; amending s.
3 409.906, F.S.; authorizing the Agency for
4 Health Care Administration to develop a
5 certified match program for Healthy Start
6 services under certain circumstances; amending
7 s. 409.910, F.S.; providing for use of Medicare
8 standard billing formats for certain data
9 exchange purposes; creating s. 409.9101, F.S.;
10 providing a short title; providing legislative
11 intent relating to Medicaid estate recovery;
12 requiring certain notice of administration of
13 the estate of a deceased Medicaid recipient;
14 providing that receipt of Medicaid benefits
15 creates a claim and interest by the agency
16 against an estate; specifying the right of the
17 agency to amend the amount of its claim based
18 on medical claims submitted by providers
19 subsequent to the agency's initial claim
20 calculation; providing the basis of calculation
21 of the amount of the agency's claim; specifying
22 a claim's class standing; providing
23 circumstances for nonenforcement of claims;
24 providing criteria for use in considering
25 hardship requests; providing for recovery when
26 estate assets result from a claim against a
27 third party; providing for estate recovery in
28 instances involving real property; providing
29 agency rulemaking authority; amending s.
30 409.912, F.S.; eliminating requirement that a
31 Medicaid provider service network demonstration

1 project be located in Orange County; amending
2 s. 409.913, F.S.; revising provisions relating
3 to the agency's authority to withhold Medicaid
4 payments pending completion of certain legal
5 proceedings; providing for disbursement of
6 withheld Medicaid provider payments; creating
7 s. 409.9131, F.S.; providing legislative
8 findings and intent relating to integrity of
9 the Medicaid program; providing definitions;
10 authorizing onsite reviews of physician records
11 by the agency; requiring notice for such
12 reviews; requiring notice of due process rights
13 in certain circumstances; specifying procedures
14 for determinations of overpayment; requiring a
15 study of certain statistical models used by the
16 agency; requiring a report; amending ss.
17 641.261 and 641.411, F.S.; conforming
18 references and cross references; amending s.
19 733.212, F.S.; establishing the agency as a
20 reasonably ascertainable creditor with respect
21 to administration of certain estates; providing
22 an effective date.
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24 Be It Enacted by the Legislature of the State of Florida:
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26 Section 1. Subsection (11) of section 409.906, Florida
27 Statutes, 1998 Supplement, is amended to read:
28 409.906 Optional Medicaid services.--Subject to
29 specific appropriations, the agency may make payments for
30 services which are optional to the state under Title XIX of
31 the Social Security Act and are furnished by Medicaid

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1 providers to recipients who are determined to be eligible on
2 the dates on which the services were provided. Any optional
3 service that is provided shall be provided only when medically
4 necessary and in accordance with state and federal law.
5 Nothing in this section shall be construed to prevent or limit
6 the agency from adjusting fees, reimbursement rates, lengths
7 of stay, number of visits, or number of services, or making
8 any other adjustments necessary to comply with the
9 availability of moneys and any limitations or directions
10 provided for in the General Appropriations Act or chapter 216.
11 Optional services may include:
12 (11) HEALTHY START SERVICES.--The agency may pay for a
13 continuum of risk-appropriate medical and psychosocial
14 services for the Healthy Start program in accordance with a
15 federal waiver. The agency may not implement the federal
16 waiver unless the waiver permits the state to limit enrollment
17 or the amount, duration, and scope of services to ensure that
18 expenditures will not exceed funds appropriated by the
19 Legislature or available from local sources. <u>If the Health</u>
20 <u>Care Financing Administration does not approve a federal</u>
21 <u>waiver for Healthy Start services, the agency, in consultation</u>
22 <u>with the Department of Health and the Florida Association of</u>
23 <u>Healthy Start Coalitions, is authorized to establish a</u>
24 <u>Medicaid certified match program for Healthy Start services.</u>
25 <u>Participation in the Healthy Start certified match program</u>
26 <u>shall be voluntary and reimbursement shall be limited to the</u>
27 <u>federal Medicaid share to Medicaid-enrolled Healthy Start</u>
28 <u>coalitions for services provided to Medicaid recipients.</u>
29 Section 2. Subsection (21) of section 409.910, Florida
30 Statutes, 1998 Supplement, is renumbered as subsection (22),
31 and a new subsection (21) is added to said section to read:

1 409.910 Responsibility for payments on behalf of
2 Medicaid-eligible persons when other parties are liable.--
3 (21) Entities providing health insurance as defined in
4 s. 624.603, and health maintenance organizations as defined in
5 chapter 641, requiring tape or electronic billing formats from
6 the agency shall accept Medicaid billings which are prepared
7 using the current Medicare standard billing format. If the
8 insurance entity or health maintenance organization is unable
9 to utilize the agency format, the entity shall accept paper
10 claims from the agency in lieu of tape or electronic billing,
11 provided these claims are prepared using current Medicare
12 standard billing formats.
13 Section 3. Section 409.9101, Florida Statutes, is
14 created to read:
15 409.9101 Recovery for payments made on behalf of
16 Medicaid-eligible persons.--
17 (1) This section may be cited as the "Medicaid Estate
18 Recovery Act."
19 (2) It is the intent of the Legislature by this
20 section to supplement Medicaid funds which are used to provide
21 medical services to eligible persons. Medicaid estate recovery
22 shall generally be accomplished through the filing of claims
23 against the estates of deceased Medicaid recipients. The
24 recoveries shall be made pursuant to federal authority in s.
25 13612 of the Omnibus Reconciliation Act of 1993, which amends
26 s. 1917(b)(1) of the Social Security Act (42 U.S.C. s.
27 1396p(b)(1)).
28 (3) Pursuant to s. 733.212(4)(a), the personal
29 representative of the estate of the decedent shall serve the
30 agency with a copy of the notice of administration of the
31 estate within 3 months after the first publication of the

1 notice, unless the agency has already filed a claim pursuant
2 to this section.
3 (4) The acceptance of public medical assistance, as
4 defined by Title XIX (Medicaid) of the Social Security Act,
5 including mandatory and optional supplemental payments under
6 the Social Security Act, shall create a claim, as defined in
7 s. 731.201, in favor of the agency as an interested person as
8 defined in s. 731.201. The claim amount is calculated as the
9 total amount paid to or for the benefit of the recipient for
10 medical assistance on behalf of the recipient after reaching
11 55 years of age. There is no claim under this section against
12 estates of recipients who have not yet reached 55 years of
13 age.
14 (5) At the time of filing the claim, the agency may
15 reserve the right to amend the claim amounts based on medical
16 claims submitted by providers subsequent to the agency's
17 initial claim calculation.
18 (6) The claim of the agency shall be the current total
19 allowable amount of Medicaid payments as denoted in the
20 agency's provider payment processing system at the time the
21 agency's claim or amendment is filed. The agency's provider
22 processing system reports shall be admissible as prima facie
23 evidence in substantiating the agency's claim.
24 (7) The claim of the agency under this section shall
25 constitute a Class 3 claim under s. 733.707(1)(c), as provided
26 in s. 414.28(1).
27 (8) The claim created under this section shall not be
28 enforced if the recipient is survived by:
29 (a) A spouse;
30 (b) A child or children under 21 years of age; or
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1 (c) A child or children who are blind or permanently
2 and totally disabled pursuant to the eligibility requirements
3 of Title XIX of the Social Security Act.
4 (9) In accordance with s. 4, Art. X of the State
5 Constitution, no claim under this section shall be enforced
6 against any property which is determined to be the homestead
7 of the deceased Medicaid recipient and is determined to be
8 exempt from the claims of creditors of the deceased Medicaid
9 recipient.
10 (10) The state shall not recover from an estate if
11 doing so would cause undue hardship for the qualified heirs,
12 as defined in s. 731.201. The personal representative of an
13 estate and any heir may request that the agency waive recovery
14 of any or all of the debt when recovery would create a
15 hardship. A hardship does not exist solely because recovery
16 will prevent any heirs from receiving an anticipated
17 inheritance. The following criteria shall be considered by the
18 agency in reviewing a hardship request:
19 (a) The heir:
20 1. Currently resides in the residence of the decedent;
21 2. Resided there at the time of the death of the
22 decedent;
23 3. Has made the residence his or her primary residence
24 for the 12 months immediately preceding the death of the
25 decedent; and
26 4. Owns no other residence;
27 (b) The heir would be deprived of food, clothing,
28 shelter, or medical care necessary for the maintenance of life
29 or health;
30 (c) The heir can document that he or she provided
31 full-time care to the recipient which has delayed the

1 recipient's entry into a nursing home. The heir must be either
2 the decedent's sibling or the son or daughter of the decedent
3 and must have resided with the recipient for at least 1 year
4 prior to the recipient's death; or
5 (d) The cost involved in the sale of the property
6 would be equal to or greater than the value of the property.
7 (11) Instances arise in Medicaid estate recovery cases
8 where the assets include a settlement of a claim against a
9 liable third party. The agency's claim under s. 409.910 must
10 be satisfied prior to including the settlement proceeds as
11 estate assets. The remaining settlement proceeds shall be
12 included in the estate and be available to satisfy the
13 Medicaid estate recovery claim. The Medicaid estate recovery
14 share shall be one-half of the settlement proceeds included in
15 the estate. Nothing in this subsection is intended to limit
16 the agency's rights against other assets in the estate not
17 related to the settlement. However, in no circumstances shall
18 the agency's recovery exceed the total amount of Medicaid
19 medical assistance provided to the recipient.
20 (12) In instances where there are no liquid assets to
21 satisfy the Medicaid estate recovery claim, if there is
22 nonhomestead real property and the costs of sale will not
23 exceed the proceeds, the property shall be sold to satisfy the
24 Medicaid estate recovery claim. Real property shall not be
25 transferred to the agency in any instance.
26 (13) The agency is authorized to adopt rules to
27 implement the provisions of this section pursuant to federal
28 requirements.
29 Section 4. Paragraph (d) of subsection (3) of section
30 409.912, Florida Statutes, 1998 Supplement, is amended to
31 read:

1 409.912 Cost-effective purchasing of health care.--The
2 agency shall purchase goods and services for Medicaid
3 recipients in the most cost-effective manner consistent with
4 the delivery of quality medical care. The agency shall
5 maximize the use of prepaid per capita and prepaid aggregate
6 fixed-sum basis services when appropriate and other
7 alternative service delivery and reimbursement methodologies,
8 including competitive bidding pursuant to s. 287.057, designed
9 to facilitate the cost-effective purchase of a case-managed
10 continuum of care. The agency shall also require providers to
11 minimize the exposure of recipients to the need for acute
12 inpatient, custodial, and other institutional care and the
13 inappropriate or unnecessary use of high-cost services.
14 (3) The agency may contract with:
15 (d) No more than four provider service networks for
16 demonstration projects to test Medicaid direct contracting.
17 ~~One demonstration project must be located in Orange County.~~
18 The demonstration projects may be reimbursed on a
19 fee-for-service or prepaid basis. A provider service network
20 which is reimbursed by the agency on a prepaid basis shall be
21 exempt from parts I and III of chapter 641, but must meet
22 appropriate financial reserve, quality assurance, and patient
23 rights requirements as established by the agency. The agency
24 shall award contracts on a competitive bid basis and shall
25 select bidders based upon price and quality of care. Medicaid
26 recipients assigned to a demonstration project shall be chosen
27 equally from those who would otherwise have been assigned to
28 prepaid plans and MediPass. The agency is authorized to seek
29 federal Medicaid waivers as necessary to implement the
30 provisions of this section. A demonstration project awarded
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pursuant to this paragraph shall be for 2 years from the date of implementation.

Section 5. Paragraph (a) of subsection (24) of section 409.913, Florida Statutes, is amended to read:

409.913 Oversight of the integrity of the Medicaid program.--The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate.

(24)(a) The agency may withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud or willful misrepresentation under the Medicaid program, or a crime committed while rendering goods or services to Medicaid recipients, ~~up to the amount of the overpayment as determined by final agency audit report,~~ pending completion of legal proceedings ~~under this section~~. ~~If the agency withholds payments under this section, the Medicaid payment may not be reduced by more than 10 percent.~~ If it is ~~has been~~ determined that fraud, willful misrepresentation, or a crime did not occur ~~an overpayment has not occurred~~, the payments withheld must be paid to the provider within 60 days after such determination with interest at the rate of 10 percent a year. Any money withheld in accordance with this paragraph shall be placed in a suspended account, readily accessible to the agency, so that any payment ultimately due the provider shall be made within 10 days. Furthermore, the authority to withhold payments under this paragraph shall not apply to physicians

1 whose alleged overpayments are being determined by
2 administrative proceedings pursuant to chapter 120.If the
3 amount of the alleged overpayment exceeds $75,000, the agency
4 may reduce the Medicaid payments by up to $25,000 per month.
5 Section 6. Section 409.9131, Florida Statutes, is
6 created to read:
7 409.9131 Special provisions relating to integrity of
8 the Medicaid program.--
9 (1) LEGISLATIVE FINDINGS AND INTENT.--It is the intent
10 of the Legislature that physicians, as defined in this
11 section, be subject to Medicaid fraud and abuse investigations
12 in accordance with the provisions set forth in this section as
13 a supplement to the provisions contained in s. 409.913. If a
14 conflict exists between the provisions of this section and s.
15 409.913, it is the intent of the Legislature that the
16 provisions of this section shall control.
17 (2) DEFINITIONS.--For purposes of this section, the
18 term:
19 (a) "Active practice" means a physician must have
20 regularly provided medical care and treatment to patients
21 within the past 2 years.
22 (b) "Medical necessity" or "medically necessary" means
23 any goods or services necessary to palliate the effects of a
24 terminal condition or to prevent, diagnose, correct, cure,
25 alleviate, or preclude deterioration of a condition that
26 threatens life, causes pain or suffering, or results in
27 illness or infirmity, which goods or services are provided in
28 accordance with generally accepted standards of medical
29 practice. For purposes of determining Medicaid reimbursement,
30 the agency is the final arbiter of medical necessity. In
31 making determinations of medical necessity, the agency must,

1 to the maximum extent possible, use a physician in active
2 practice, either employed by or under contract with the
3 agency, of the same specialty or subspecialty as the physician
4 under review. Such determination must be based upon the
5 information available at the time the goods or services were
6 provided.
7 (c) "Peer" means a Florida licensed physician who is,
8 to the maximum extent possible, of the same specialty or
9 subspecialty, licensed under the same chapter, and in active
10 practice.
11 (d) "Peer review" means an evaluation of the
12 professional practices of a Medicaid physician provider by a
13 peer or peers in order to assess the medical necessity,
14 appropriateness, and quality of care provided, as such care is
15 compared to that customarily furnished by the physician's
16 peers and to recognized health care standards, and to
17 determine whether the documentation in the physician's records
18 is adequate.
19 (e) "Physician" means a person licensed to practice
20 medicine under chapter 458 or a person licensed to practice
21 osteopathic medicine under chapter 459.
22 (f) "Professional services" means procedures provided
23 to a Medicaid recipient, either directly by or under the
24 supervision of a physician who is a registered provider for
25 the Medicaid program.
26 (3) ONSITE RECORDS REVIEW.--As specified in s.
27 409.913(8), the agency may investigate, review, or analyze a
28 physician's medical records of Medicaid patients. The
29 physician must make such records available to the agency
30 during normal business hours. The agency must provide notice
31 to the physician at least 24 hours before such visit. The

1 agency and physician shall make every effort to set a mutually
2 agreeable time for the agency's visit during normal business
3 hours and within the 24-hour period. If such a time cannot be
4 agreed upon, the agency may set the time.
5 (4) NOTICE OF DUE PROCESS RIGHTS REQUIRED.--Whenever
6 the agency seeks an administrative remedy against a physician
7 pursuant to this section or s. 409.913, the physician must be
8 advised of his or her rights to due process under chapter 120.
9 This provision shall not limit or hinder the agency's ability
10 to pursue any remedy available to it under s. 409.913 or other
11 applicable law.
12 (5) DETERMINATIONS OF OVERPAYMENT.--In making a
13 determination of overpayment to a physician, the agency must:
14 (a) Use accepted and valid auditing, accounting,
15 analytical, statistical, or peer-review methods, or
16 combinations thereof. Appropriate statistical methods may
17 include, but are not limited to, sampling and extension to the
18 population, parametric and nonparametric statistics, tests of
19 hypotheses, other generally accepted statistical methods,
20 review of medical records, and a consideration of the
21 physician's client case mix. Before performing a review of the
22 physician's Medicaid records, however, the agency shall make
23 every effort to consider the physician's patient case mix,
24 including, but not limited to, patient age and whether
25 individual patients are clients of the Children's Medical
26 Services network established in chapter 391. In meeting its
27 burden of proof in any administrative or court proceeding, the
28 agency may introduce the results of such statistical methods
29 and its other audit findings as evidence of overpayment.
30 (b) Refer all physician service claims for peer review
31 when the agency's preliminary analysis indicates a potential

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overpayment, and before any formal proceedings are initiated against the physician, except as required by s. 409.913.

(c) By March 1, 2000, the agency shall study and report to the Legislature on its current statistical model used to calculate overpayments and advise the Legislature what, if any, changes, improvements, or other modifications should be made to the statistical model. Such review shall include, but not be limited to, a review of the appropriateness of including physician specialty and case-mix parameters within the statistical model.

Section 7. Section 641.261, Florida Statutes, is amended to read:

641.261 Other reporting requirements.--

(1) Each authorized health maintenance organization shall provide records and information to the Agency for Health Care Administration ~~Department of Health and Rehabilitative Services~~ pursuant to s. 409.910(20) and (21)~~(22)~~for the sole purpose of identifying potential coverage for claims filed with the agency ~~Department of Health and Rehabilitative Services~~ and its fiscal agents for payment of medical services under the Medicaid program.

(2) Any information provided by a health maintenance organization under this section to the agency ~~Department of Health and Rehabilitative Services~~ shall not be considered a violation of any right of confidentiality or contract that the health maintenance organization may have with covered persons. The health maintenance organization is immune from any liability that it may otherwise incur through its release of information to the agency ~~Department of Health and Rehabilitative Services~~ under this section.

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Section 8. Section 641.411, Florida Statutes, is amended to read:

641.411 Other reporting requirements.--

(1) Each prepaid health clinic shall provide records and information to the Agency for Health Care Administration ~~Department of Health and Rehabilitative Services~~ pursuant to s. 409.910(20) and (21)~~(22)~~for the sole purpose of identifying potential coverage for claims filed with the agency ~~Department of Health and Rehabilitative Services~~ and its fiscal agents for payment of medical services under the Medicaid program.

(2) Any information provided by a prepaid health clinic under this section to the agency ~~Department of Health and Rehabilitative Services~~ shall not be considered a violation of any right of confidentiality or contract that the prepaid health clinic may have with covered persons. The prepaid health clinic is immune from any liability that it may otherwise incur through its release of information to the agency ~~Department of Health and Rehabilitative Services~~ under this section.

Section 9. Paragraph (a) of subsection (4) of section 733.212, Florida Statutes, is amended to read:

733.212 Notice of administration; filing of objections and claims.--

(4)(a) The personal representative shall promptly make a diligent search to determine the names and addresses of creditors of the decedent who are reasonably ascertainable and shall serve on those creditors a copy of the notice within 3 months after the first publication of the notice. Under s. 409.9101, the Agency for Health Care Administration is considered a reasonably ascertainable creditor in instances

1 where the decedent had received Medicaid assistance for
2 medical care after reaching 55 years of age.Impracticable and
3 extended searches are not required. Service is not required
4 on any creditor who has filed a claim as provided in this
5 part; a creditor whose claim has been paid in full; or a
6 creditor whose claim is listed in a personal representative's
7 timely proof of claim if the personal representative notified
8 the creditor of that listing.
9 Section 10. This act shall take effect July 1, 1999.
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11 ***
12 HOUSE SUMMARY
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14 Authorizes the Agency for Health Care Administration to establish a certified match program for Healthy Start services if a federal waiver for such services is not approved. Requires insurance entities and health maintenance organizations responsible for payments for Medicaid-eligible persons to accept agency claims using Medicare standard billing formats. Creates the "Medicaid Estate Recovery Act." Provides for notice to the agency of administration of the estate of a deceased Medicaid recipient. Provides procedure for calculation and enforcement of Medicaid recovery claims against such estates. Provides for consideration of hardship requests by qualified heirs. Provides agency rulemaking authority. Eliminates requirement for a Medicaid provider service network demonstration project in Orange County. Limits authority of the agency to withhold Medicaid provider payments, pending the outcome of legal proceedings, to circumstances involving fraud, willful misrepresentation, or a crime. Revises provisions relating to disbursement of payments withheld. Establishes additional procedures and requirements for Medicaid physician fraud and abuse investigations. Authorizes the agency to perform onsite physician record reviews. Requires certain notice of reviews and of due process rights. Provides agency procedures for determinations of overpayment. Requires the agency to conduct a study of its statistical model for calculating overpayments and to report to the Legislature by March 1, 2000.
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