HOUSE OF REPRESENTATIVES
FINAL BILL ANALYSIS

BILL #:	CS/CS/HB 939	**FINAL HOUSE FLOOR ACTION:**	
SPONSOR(S):	Health Innovation Subcommittee; Pigman	116 **Y's**	0 **N's**
COMPANION BILLS:	(CS/CS/SB 844)	**GOVERNOR'S ACTION:**	Approved

SUMMARY ANALYSIS

CS/CS/HB 939 passed the House on April 24, 2013, and subsequently passed the Senate on April 30, 2013. The bill makes statutory changes to enhance Florida's efforts to prevent fraud and abuse in the Medicaid program. The bill modifies existing statutory provisions relating to provider controls and accountability in the Medicaid program. These modifications include the following:

- Requiring Medicaid providers to report a change in any principal of the provider to the Agency for Health Care Administration (AHCA) in writing no later than 30 days after the change occurs;
- Authorizing, rather than requiring, AHCA to perform onsite inspections of the service location of a provider applying for a provider agreement before entering into a provider agreement with that provider, to determine that provider's ability to provide services in compliance with the Medicaid program and professional regulations;
- Removing certain exceptions to background screenings requirements for Medicaid providers;
- Requiring AHCA to impose the sanction of termination for cause against a provider that voluntarily relinquishes their Medicaid provider number under certain circumstances; and
- Clarifying the scope of immunity from civil liability for persons who report fraudulent acts or suspected fraudulent acts and providing a definition of fraudulent acts.

The bill amends s. 409.907(9)(a), F.S., to authorize AHCA to enroll an out-of-state health care provider in the Medicaid Program if the provider is an actively licensed Florida physician who interprets diagnostic testing results through telecommunications and information technology from a distance.

Section 409.910, F.S., provides AHCA with the right and obligation to recover Medicaid medical costs from third parties. The U.S. Supreme Court recently rendered an opinion which casts doubts on the validity of this section. The bill amends this section to comply with the Court's holding and creates a right to an administrative hearing at the Division of Administrative Hearings for Medicaid recipients to contest the amount of AHCA's recoupment of Medicaid medical costs.

The bill amends s. 624.351, F.S., and authorizes designees of the members Medicaid and Public Assistance Fraud Strike Force to serve in the same capacity as the designating member. Additionally it provides that the Strike Force will sunset on June 14, 2014. The bill amends s. 624.352, F.S., to provide that interagency agreements to detect and deter Medicaid and public assistance fraud will no longer be required after June 14, 2014.

The bill appears to have an indeterminate, negative fiscal impact on state government.

The bill was approved by the Governor on June 7, 2013, ch. 2013-150, L.O.F., and will become effective on July 1, 2013.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Present Situation

Health Care Fraud

In 2009, the Legislature passed SB 1986 to address systematic health care fraud in Florida. Over three have now passed since these anti-fraud provisions were enacted and certain changes have been identified which would enhance Florida's efforts to prevent health care fraud and abuse in Florida's Medicaid program. This bill addresses some of the gaps in enforcement authority, strengthens the reporting requirements by Medicaid providers and defines the consequences for failure to comply with these requirements.

Medicaid

Medicaid is a medical assistance program that provides access to health care for low-income families and individuals. Medicaid also assists aged and disabled people with costs of nursing facility care and other medical expenses. The Agency for Health Care Administration's (AHCA) Division of Medicaid administers the Florida Medicaid Program. The statutory authority for the Medicaid program is contained in ch. 409, F.S.

Medicaid reimburses health care providers that have a provider agreement with AHCA only for goods and services that are covered by the Medicaid program and only for individuals who are enrolled in Medicaid. Section 409.907, F.S., establishes requirements for Medicaid provider agreements, which include, among other things, background screening requirements, notification requirements for change of ownership of a Medicaid provider, authority for AHCA site visits of provider service locations and surety bond requirements. The statute does not provide for background screening for non-enrolled providers who participate in the Medicaid program as components of a Medicaid managed care network.

Medicaid Program Integrity

Under s. 409.913, F.S., AHCA, through its Office of Medicaid Program Integrity, is responsible for overseeing the integrity of the Medicaid program, to prevent and minimize fraudulent and abusive billing, and to recover overpayments and impose sanctions as appropriate. The Office of Medicaid Program Integrity reviews anti-fraud plans for all participating Medicaid plans. Additionally, under s. 626.9891, F.S., all insurance companies and managed care companies also submit their required anti-fraud plans to the Department of Financial Services, Division of Insurance Fraud for review.

Sections 409,920, 409.9201, 409.9203, and 409.9205, F.S., contain provisions relating specifically to Medicaid fraud. A person who provides the State with information about fraud or suspected fraud by a Medicaid provider, including a managed care organization, is immune from civil liability for providing that information unless the person knew the information was false or acted with reckless disregard for the truth or falsity of the information.[1]

Background Screening

Chapter 435, F.S., establishes standards for background screening for employment. Section 435.03, F.S., sets standards for Level 1 background screening. Level 1 background screenings include, but are not limited to, employment history checks and statewide criminal correspondence checks through the

[1] See s. 409.920(8), F.S.

Department of Law Enforcement and a check of the Dru Sjodin National Sex Offender Public Website, and may include local criminal records checks through local law enforcement agencies.

Level 2 background screenings include, but are not limited to, fingerprinting for statewide criminal history records checks through the Department of Law Enforcement and national criminal history records checks through the Federal Bureau of Investigation. They may also include local criminal records checks through local law enforcement agencies. Section 435.04(2), F.S., lists the offenses that will disqualify an applicant from employment.

Section 408.809, F.S., establishes background screening requirements and procedures for entities licensed by the AHCA. The AHCA must conduct Level 2 background screening for specified individuals. Each person subject to this section is subject to Level 2 background screening every 5 years. This section of law also specifies additional disqualifying offenses beyond those included in s. 435.04(2), F.S.

Medicaid and Public Assistance Strike Force

In 2010 the Legislature found that there was 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] The Medicaid and Public Assistance Fraud Strike Force was created within the Department of Financial Services to oversee and coordinate state and local efforts to eliminate Medicaid and public assistance fraud and to recover state and federal funds to address this need. The strike force consists of eleven members who may not designate anyone to serve in their place.[3] The eleven members are as follows:

- The Chief Financial Officer, who shall serve as chair;
- The Attorney General, who shall serve as vice chair;
- The executive director of the Department of Law Enforcement;
- The Secretary of Health Care Administration;
- The Secretary of Children and Family Services;
- The State Surgeon General; and
- Five members appointed by the Chief Financial Officer, consisting of two sheriffs, two chiefs of police, and one state attorney.[4]

Interagency agreements for the coordination of prevention, investigation, and prosecution of Medicaid and public assistance fraud were executed by various agencies to effectuate the purpose of the strike force.[5]

Medicaid and Third-Party Recovery in Florida

Section 409.910, F.S. is the Medicaid Third-Party Liability Act (Act). Pursuant to the Act, third-party benefits for medical services are primary to any medical assistance provided to a recipient by Medicaid. As such, a Medicaid recipient who receives a settlement, award or judgment in a third-party tort action is required to reimburse the AHCA for any related Medicaid medical costs.[6] The medical costs are calculated as the lesser of 37.5% of the total recovery or the total amount of medical assistance paid by Medicaid.[7] The recipient cannot contest the amount designated by AHCA as recovered medical

[2] S. 624.351, F.S.
[3] Id.
[4] Id.
[5] S. 624.352, F.S.
[6] S. 409.910, F.S. As an alternative to this payment, a recipient can place the full amount of the third-party benefits in a trust account for the benefit of ACHA pending judicial or administrative determination of ACHA's right to the third-party benefits.
[7] Id.

expense damages.[8] Thus, this section creates an irrebuttable presumption that the amount that AHCA is entitled to from a Medicaid recipient's judgment, award or settlement in a tort action is the lesser of 37.5% of the total recovery or the total amount of medical assistance paid by Medicaid. A North Carolina statute which created a similar irrebutable presumption was recently struck down by the Supreme Court in *Wos v. E.M.A.*

The U.S Supreme Court, in *Wos v. E.M.A.,* recently invalidated a North Carolina statute which authorized the recovery of third-party benefits from Medicaid recipients.[9] North Carolina's Medicaid third-party liability statute provides that the state will be paid from a tort settlement or judgment the lesser of the total amount expended on the recipient's behalf by Medicaid or 33% of the total settlement or judgment amount.[10] The Supreme Court held that North Carolina's statute was preempted by the federal anti-lien provision due to the fact that the state statute created an irrebuttable, one-size-fits-all statutory presumption that one-third of a tort recovery is attributable to medical expenses.[11] Such an irrebuttable presumption was found to be incompatible with the Medicaid Act's clear mandate that a state may not demand any portion of a beneficiary's tort recovery except the share that is attributable to medical expenses.[12]

Effect of Proposed Changes

The bill makes various changes to Medicaid provider contracting requirements and program integrity functions to improve fraud and abusive billing prevention and recoupment.

Medicaid Program Integrity

The bill requires a Medicaid provider to report, in writing, any change of any principal of the provider to AHCA within 30 days after the change occurs. "Principal" includes any officer, director, agent, managing employee, affiliated person or any partner or shareholder who has a 5% or greater interest in the provider.

The bill defines "administrative fines" and "outstanding overpayment". This functions to clarify the statutory provisions relating to the liability of Medicaid providers in a change of ownership for outstanding overpayments, administrative fines, and any other moneys owed to AHCA.

Section 409.907(7), F.S., requires AHCA to conduct random onsite inspections of Medicaid providers' service locations within 60 days after receipt of a fully complete new provider's application and prior to making the first payment to the provider for Medicaid services. The bill removes the 60 day time period, as well as the requirement for random inspections. This provides AHCA with greater flexibility in performing its onsite inspections prior to entering into a provider agreement. The bill also removes the exception to random onsite-inspections granted to certain providers as the inspections are conducted at the discretion of AHCA.

Section 409.913(13), F.S., requires AHCA to immediately terminate participation of a Medicaid provider that has been convicted of certain identified offenses. However, in order to immediately terminate a provider, AHCA must show an immediate harm to the public health, which is not always possible. The

[8] Id.
[9] *Wos v. E.M.A. ex rel. Johnson*, ___ U.S. ____, 2013 WL 1131709 (U.S. March 20, 2013).
[10] N. C. Gen. Stat. Ann. §108A–57(a).
[11] *Supra* fn 9.
[12] The federal Medicaid Act requires states to have in effect laws pursuant to which states have the right to recover third party benefits for medical assistance provided by the state Medicaid program. *See* 42 U.S.C. § 1396a(a)(25)(H). Federal law also mandates that state Medicaid programs must require recipients to assign to the state any rights the recipient has to benefits from third parties related to medical care. *See* 42 U.S.C. § 1396k(a)(1)(A). Notwithstanding the foregoing provisions, the Medicaid Act's "anti-lien provision" prohibits states from imposing a lien on the property of a recipient prior to his death on account of medical assistance provided by the state's Medicaid program. *See* 42 U.S.C. § 1396p(a)(1).

bill removes “immediately” from the requirement the provision. AHCA still must terminate a Medicaid provider from participation in the Medicaid program but the termination is no longer in conflict with the Administrative Procedures Act.[13] The bill additionally amends this section to clarify the instances of provider disqualification from participation on the Medicaid program.

Section 409.913, F.S., delineates the noncriminal actions of Medicaid providers for which AHCA may impose sanctions. The section provides penalties for the individual or provider who participated or acquiesced in the proscribed activity. The bill adds individuals or providers who “authorized” to those who may be sanctioned under this section. The bill also adds that AHCA may sanction a provider if the provider is charged by information or indictment with any offense referenced in subsection (13).

Currently, if a Medicaid provider receives notification that it is going to be suspended or terminated, the provider is able to voluntarily terminate its contract. By doing this, a provider has the ability to avoid sanctions of suspension or termination, which would affect the ability of the provider to reenter the program in the future. The bill amends s. 409.913(16), F.S., to state that, if a Medicaid provider voluntarily relinquishes its Medicaid provider number after receiving notice of an audit or investigation for which the sanction of suspension or termination will be imposed, AHCA must impose the sanction of termination for cause against the provider. However, AHCA’s termination with cause is subject to hearing rights as may be provided under chapter 120. The bill also amends this section to give the Secretary of AHCA discretionary authority to make a determination to refrain from imposing a sanction if it is not in the best interest of the Medicaid program.

The bill amends s. 409.913(21), F.S., to specify that when AHCA is making a determination that an overpayment has occurred, the determination must be based solely upon information available to it before it issues the audit report and, in the case of documentation obtained to substantiate claims for Medicaid reimbursement, based solely upon contemporaneous records. AHCA may also consider addenda or modifications to a note that was made contemporaneously with the patient care episode if the addenda or modifications are germane to the note.

The bill amends s. 409.913(22), F.S., to state that a provider may not present records to contest an overpayment or sanction unless such records are contemporaneous and, if requested during the audit process, were furnished to AHCA or its agent upon request. Also, all documentation to be offered as evidence in an administrative hearing on an administrative sanction (in addition to Medicaid overpayments) must be exchanged by all parties at least 14 days before the administrative hearing or otherwise must be excluded from consideration. This limitation does not preclude consideration by AHCA of addenda or modifications to a note if the addenda or modifications are made before notification of the audit, the addenda or modifications are germane to the note, and the note was made contemporaneously with a patient care episode.

Section 409.913(25), F.S., requires AHCA to reimburse providers within 14 days for all Medicaid payments that have been withheld from a provider based on suspected fraud or criminal activity, if it is determined that there was no fraud or that a crime did not occur. Any withheld funds accrue interest rate of 10 percent per year. The bill removes the requirement that these funds be held in a suspended account and clarifies that interest does not begin accruing until after the 14th day. Also, payment arrangements for overpayments and fines owed to AHCA must be made within 30 days after the date of the final order, which is not subject to further appeal.

Section 409.913(28), F.S., provides that venue for all Medicaid program integrity overpayments cases shall lie in Leon County. This creates questions as to whether venue for all administrative fines cases also lie in Leon County. The bill amends s. 409.913(28), F.S., to make Leon County the proper venue for all Medicaid program integrity cases.

[13] See s. 120.569(2)(n), F.S. which requires that “if any agency head finds that an immediate danger to the public health , safety, or welfare requires an immediate final order, it shall recite with particularity the facts underlying such finding in the final order, which shall be appealable or enjoinable from the date ordered.”

Section 409.913(30), F.S., requires AHCA to terminate a provider's participation in the Medicaid program if the provider fails to reimburse an overpayment within 35 days after the date of the final order. The bill expands this requirement to include payment of an agency fine and reduces the time period for reimbursement and/or payment to 30 days after the date of the final order.

The bill amends s. 409.913(31), F.S., to include fines, as well as overpayments, to the outstanding balance due upon the issuance of a final order at the conclusion of a requested administrative hearing.

The bill amends s. 409.920, F.S., to clarify that the existing immunity from civil liability extended to persons who provide information about fraud or suspected fraudulent acts is for civil liability for libel, slander, or any other relevant tort. The bill defines "fraudulent acts" for purposes of immunity from civil liability to include actual or suspected fraud and abuse, insurance fraud, licensure fraud or public insurance fraud; including any fraud-related matters that a provider or health plan is required to report to AHCA or a law enforcement agency. The immunity from civil liability extends to reports conveyed to AHCA in any manner, including forums, and incorporates all discussions subsequent to the report and subsequent inquiries from AHCA.

Background Screening

Currently, only enrolled Medicaid providers are contractually required to submit a complete set of fingerprints to AHCA for criminal history screening. The bill amends the statute to require persons who meet the definition of controlling interest for certain hospitals and nursing homes to submit a full set of fingerprints to AHCA.

The bill removes the provision that proof of compliance with Level 2 background screening under ch. 435, F.S., conducted within 12 months before the date the Medicaid provider application is submitted to the AHCA satisfies the requirements for a criminal history background check. This conforms to screening provisions in ch. 435, F.S., and ch. 408, F.S.

The bill amends s. 409.907(9)(a), F.S., to authorize the AHCA to enroll an out-of-state health care provider in the Medicaid Program if the provider is an actively licensed Florida physician who interprets diagnostic testing results through telecommunications and information technology from a distance.

Medicaid and Public Assistance Strike Force

The bill amends s. 624.351, F.S., to allow designees to serve in the same capacity as the designating member of the Medicaid and Public Assistance Fraud Strike Force. It additionally provides that this section will be repealed on June 14, 2014, unless reviewed and reenacted by the Legislature before that date.

The bill amends s. 624.352, F.S., and provides that express authority for interagency agreements to detect and deter Medicaid and public assistance fraud will be repealed on June 14, 2014, unless reviewed and reenacted by the Legislature before that date.

Medicaid and Third-Party Recovery in Florida

Section 409.910, F.S. creates an irrebuttable presumption that the amount that AHCA is entitled to from a Medicaid recipient's judgment, award or settlement in a tort action is the lesser of 37.5% of the total recovery or the total amount of medical assistance paid by Medicaid. This provision is similar to the North Carolina provision recently struck down by the Supreme Court in *Wos v. E.M.A.* To ensure compliance with federal law, the bill amends this section to create a presumption of accuracy as to the AHCA's determination of the reimbursement amount but allows this determination to be rebutted by clear and convincing evidence. The bill establishes the mechanism for these challenges by providing Medicaid recipients with the right to an administrative hearing at the Department of Administrative

Hearings (DOAH) to contest the amount of AHCA's recoupment. The bill establishes Leon County as venue for these hearings and the First District Court of Appeal as venue for any related appeals. The bill also provides that each party is to bear its own attorney fees and costs.

The bill provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

Indeterminate.

The bill appears to have an indeterminate, negative fiscal impact due to the amendment of s. 409.910, F.S.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Entities and individual health care providers under Medicaid currently exempt from background checks will be required to meet the same requirements as other Medicaid providers. Health care providers who do not participate in the Medicaid program on a fee-for-service basis but become a member of a Medicaid managed care provider network will be required to undergo background screening.

The total fee for a Level 2 background screening is $64.50 ($24.00 for the state portion, $16.50 for the national portion, and $24.00 for retention). There is an additional fee of $11-$16 for electronic screening, depending on the provider. The cost of the screening is borne by the individual provider.[14]

D. FISCAL COMMENTS:

Section 409.910, F.S., creates an irrebuttable presumption for the amount of Medicaid Medical costs that the AHCA may recover from third parties. This amount is calculated by statutory formula: the lesser of 37.5% of the total recovery of third party benefits or the total amount of medical assistance paid by Medicaid.[15] The holding in *Wos v. E.M.A* casts doubt on the validity of the irrebuttable presumption and requires Medicaid programs to give recipients an opportunity to contest the amount of recovery. Without specific statutory direction, that hearing process would take place adjunct to the recipients' original negligence lawsuits in circuit courts statewide. To ensure compliance with the court decision

[14] Agency for Health Care Administration, *House Bill 944 Analysis & Economic Impact Statement* (March 14, 2013).
[15] Section 409.910(11)(f), F.S

the bill amends s. 409.910, F.S., to give Medicaid recipients the right to an administrative hearing at DOAH to contest the amount of AHCA's recoupment, effectively making the statutory presumption rebuttable. The bill also establishes a standard of proof: the recipient must rebut the presumption with clear and convincing evidence.

From March 2012 to February 2013, AHCA's Third Party Liability (TPL) vendor closed 302 cases based upon calculations derived from the statutory formula.[16] AHCA recovered $4.9 million from these cases, approximately $2 million of which is utilized by the Legislature to fund Medicaid administrative activities.[17] However, AHCA's ability to recover Medicaid medical costs from third parties will likely be reduced as a result the recovery amount hearings caused by the decision in *Wos v. E.M.S.* The amount of this reduction is unknown. However, the amount of any reduction will likely be mitigated by the bill's standard of proof for overcoming the presumption.

In addition to the fiscal impact of reduced collections, AHCA will incur a negative fiscal impact for providing recipients hearings on the recovery amount. The TPL vendor staffed 62 hearings in circuit court contesting the AHCA's entitlement to Medicaid recovery during the last 12 months with a cost of approximately $5,000 per hearing. Although the exact number is unknown, due to the loss of the irrebuttable presumption, AHCA anticipates there will be a substantial increase in the number of hearings to determine the Medicaid recovery allocation.[18] The bill mitigates those costs by requiring the hearings to be brought in DOAH, having venue in Leon County, and setting a burden of proof (clear and convincing evidence). The amount of that mitigation is indeterminate.

AHCA and the DOAH may experience a workload increase. AHCA is not requesting additional resources. AHCA plans to review the workload impacts and request a Legislative Budget Request for Fiscal Year 2014-2015 if the workload cannot be absorbed within existing resources.

[16] Agency for Health Care Administration, *Bill Analysis Relating to Proposed Amendment of Section 409.910(17), Florida Statutes* (April 11, 2013) on file with the Health and Human Services Committee staff.
[17] Id. The federal portion of these recoveries (57.73%) is returned to the Federal Government with the remainder is retained by the state.
[18] Id.