HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1245 Medicaid Provider Overpayments
SPONSOR(S): Peters
TIED BILLS: **IDEN./SIM. BILLS:** SB 1370

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	13 Y, 0 N	McElroy	Poche
2) Health Care Appropriations Subcommittee	11 Y, 0 N	Clark	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

In the Florida Medicaid program, the state has one year from the date that the Agency for Health Care Administration (AHCA) or federal Centers for Medicare & Medicaid Services (CMS) discover an overpayment to a Medicaid provider to recover or seek to recover the overpayment. After the one-year period, Florida must refund the federal share of the overpayment, regardless of whether AHCA has actually recovered payment from the Medicaid provider. Federal law provides an exemption from repayment if the Medicaid provider has gone out of business. To use this exemption, AHCA must certify that a Medicaid provider is out of business and that any overpayment cannot be collected. AHCA does not currently have statutory authority to make this certification and, as a result, Florida repays the federal share of the overpayments to out-of-business Medicaid providers. The annual repayment amount has ranged from $1.5 million to $7.3 million.

HB 1245 authorizes AHCA to certify that a Medicaid provider is out of business and that any overpayments made to the provider cannot be collected. This allows Florida to use the exemption from any mandatory repayment of the federal share for Medicaid provider overpayments.

The bill appears to have an indeterminate, positive fiscal impact on state government. There is no fiscal impact to local governments.

The bill provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Medicaid

Medicaid is a jointly funded partnership of the federal and state governments that provides access to health care for low-income families and individuals. The structure of each state's Medicaid program varies and what states must pay for is largely determined by the federal government[1], as a condition of receiving federal funds. Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states.

The Centers for Medicare & Medicaid Services (CMS), within the U.S. Department of Health and Human Services, is responsible for the administration of the Medicaid program. CMS, through its Center for Program Integrity, is tasked with identifying, prosecuting and preventing fraud, waste and abuse within the Medicaid program.[2] To accomplish this task, CMS has authority to:

- Hire contractors to review provider activities, audit claims, identify overpayments, and educate providers and others on program integrity issues;
- Provide support and assistance to states in their efforts to combat provider fraud and abuse; and
- Eliminate and recover improper payments.

Medicaid Program in Florida

The Medicaid program in Florida is administered by AHCA. Reimbursement for services provided to Medicaid recipients is established through various methodologies which may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding and other mechanisms that are efficient and effective for purchasing services or goods on behalf of recipients.[3] Reimbursement is limited to claims for services provided for covered injuries or illnesses[4] by a provider who has a valid Medicaid provider agreement.[5] Since its inception in 1970, the program has paid nearly $300 billion to Medicaid providers of goods and services.[6]

AHCA's Office of Medicaid Program Integrity (MPI) and the Medicaid Fraud Control Unit (MFCU) in the Office of the Attorney General are responsible for ensuring that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate.[7]

---

[1] The Federal Medical Assistance Percentages (FMAPs) are used to determine the amount of matching funds for state expenditures for assistance payments for certain social services, and state medical and medical insurance expenditures. The regular average state FMAP is 57%, but ranges from 50% in wealthier states up to 75% in states with lower per capita incomes (the maximum regular FMAP is 82%). *Financing & Reimbursement*, Medicaid.gov https://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/eligibility.html; https://aspe.hhs.gov/federal-medical-assistance-percentages-or-federal-financial-participation-state-assistance-expenditures (last viewed on January 20, 2016).

[2] *Program Integrity*, Medicaid.gov https://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/eligibility.html (last viewed on January 20, 2016).

[3] Section 409.908, F.S.

[4] "Covered injury or illness" means any sickness, injury, disease, disability, deformity, abnormality disease, necessary medical care, pregnancy, or death for which a third party is, may be, could be, should be, or has been liable, and for which Medicaid is, or may be, obligated to provide, or has provided, medical assistance. S. 409.901(9), F.S.

[5] Section 409.907, F.S. Medicaid provider agreements are voluntary agreements between AHCA and a provider for the provision of services to Medicaid recipients and include background screening requirements, notification requirements for change of ownership, authority for AHCA site visits of provider service locations, and surety bond requirements.

[6] Id.

[7] Section 409.913, F.S.

MPI is statutorily required to develop statistical methodologies to identify providers who exhibit aberrant billing patterns.[8] MPI utilizes these methodologies to perform comprehensive audits and generalized analyses of Medicaid providers.[9] Overpayments identified through these audits are referred to AHCA's Division of Operations, Bureau of Financial Services (Financial Services) for collection.[10] Financial Services collects the overpayments through either direct payment or through withholding payment to the provider.[11]

Any suspected criminal violation identified by AHCA is referred to the MFCU. MFCU is responsible for investigating and prosecuting provider fraud within the Medicaid program which commonly involves fraud related to providers' billing practices, including billing for services that were not provided, overcharging for services that were provided and billing for services that were not medically necessary.[12] AHCA and MFCU are required to submit an annual joint report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year.[13]

Reimbursement of Medicaid Overpayment

Federal law requires the state to refund the federal share of any overpayment made to a Medicaid provider. An overpayment occurs when a Medicaid provider is paid in an amount in excess of the Medicaid established allowable amount for the service.[14] Overpayments can be discovered in a variety of ways, including audits performed by AHCA or CMS under their program integrity offices.[15] The state has one year from the date that AHCA or CMS discover an overpayment to recover or seek to recover the overpayment.[16] After one year, the state must refund the federal share of the overpayment, regardless of whether AHCA has actually recovered payment from the provider.[17]

Federal law also provides an exception to the mandatory federal share repayment provision. Audits are not always performed contemporaneously with payment and may occur several years after the overpayment to the Medicaid provider. Sometimes, the provider has gone out of business prior to the discovery of the overpayment. A state is not required to refund the federal portion of the overpayment if the provider is out of business on the date of discovery of the overpayment or if the provider goes out of business before the end of the one year period following discovery.[18] To prove the provider is out of business, a state must:[19]

- Document its efforts to locate the party and its assets;[20] and
- Provide an affidavit or certification from the appropriate state legal authority establishing that the provider is out of business and that the overpayment cannot be collected under state law and procedures, and citing the effective date of that determination.

Florida is currently required to repay the federal share of an overpayment when a provider is out business. There are no state law provisions that authorize AHCA to certify that a provider is out of business and that the overpayment cannot be collected, so the exemption from mandatory repayment is not available. As a result, Florida refunded the federal government $7.3 million in FY 2011-12, $1.5

[8] Id.
[9] Agency for Health Care Administration and the Department of Legal Affairs, *The State's Efforts to Control Medicaid Fraud and Abuse, FY 2014-15*, December 15, 2015, available at https://ahca.myflorida.com/Executive/Inspector_General/docs/Medicaid_Fraud_Abuse_Annual_Reports/2014-15_MedicaidFraudandAbuseAnnualReport.pdf (last viewed January 23, 2016).
[10] Id.
[11] Id.
[12] Id.
[13] Id.
[14] 42 C.F.R. 433.304
[15] Section 409.913, F.S.; Section 1936 of the Social Security Act.
[16] 42 C.F.R. 433.312(a)(1).
[17] 42 C.F.R. 433.312(a)(2).
[18] 42 C.F.R. 433.318(d)(1).
[19] 42 C.F.R. 433.318(d)(2)(i) and (ii).
[20] These efforts must be consistent with applicable state policies and procedures.

million in FY 2012-13 and $2.8 million in FY 2013-14 for the federal share of Medicaid provider overpayments that it could have otherwise retained.[21]

Effect of Proposed Changes

HB 1245 authorizes AHCA to certify that a Medicaid provider is out of business and that any overpayments made to the provider cannot be collected under state law and procedures. This allows Florida to qualify for the exemption from mandatory federal share repayment for Medicaid provider overpayments, and retain those funds.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.908, F.S., relating to reimbursement of Medicaid providers.
Section 2: Reenacts s. 409.8132, F.S., relating to Medikids program component.
Section 3: Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   Florida refunded to the federal government $7.3 million in FY 2011-12, $1.5 million in FY 2012-13 and $2.8 million in FY 2013-14 for the federal share of Medicaid provider overpayments. The bill permits AHCA to certify that a provider is out-of-business and that overpayments cannot be collected. As a result, Florida will retain the federal share of future Medicaid overpayments to providers who are certified as out-of-business, which AHCA estimates will total between $1 and $3 million per fiscal year.[22]

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

[21] Agency for Health Care Administration, *2016 Agency Legislative Bill Analysis for HB 1245*, January 23, 2016 (on file with the Health Care Appropriations Subcommittee staff).
[22] Id.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES