HOUSE OF REPRESENTATIVES
FINAL BILL ANALYSIS

BILL #:	CS/HB 1245	**FINAL HOUSE FLOOR ACTION:**	
SPONSOR(S):	Health & Human Services Committee; Peters	118 **Y's**	0 **N's**
COMPANION BILLS:	CS/SB 1370	**GOVERNOR'S ACTION:**	Approved

SUMMARY ANALYSIS

CS/HB 1245 passed the House on March 2, 2016, and subsequently passed the Senate on March 4, 2016.

Federal law requires each state to detect and investigate Medicaid fraud and abuse. This includes overpayments to Medicaid providers and fraudulent billing practices by home health agencies.

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 the overpayment to the Medicaid provider. Federal law provides an exemption from repayment if the Medicaid provider has gone out of business. To qualify for 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 overpayments to out-of-business Medicaid providers. The annual repayment amount has ranged from $1.5 million to $7.3 million.

CS/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. Such certification exempts Florida from mandatory repayment of the federal share of any Medicaid overpayments to the provider.

Section 409.9132, F.S., requires AHCA to telephonically verify the use and delivery of home health services in pilot project counties through the use of voice biometrics. The bill deletes the telephone only requirement and authorizes AHCA to verify use and delivery of home health services using any technology that is effective for identifying delivery of services and deterring fraudulent or abusive billing.

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

The bill was approved by the Governor on March 24, 2016, ch. 2016-103, L.O.F., and will become effective on July 1, 2016.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF 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, administers the Medicaid program with the states. 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 Agency for Health Care Administration (AHCA) administers the Florida Medicaid program. AHCA establishes reimbursement for services provided to Medicaid recipients through various methodologies which may include fee schedules, cost-based reimbursement, negotiated fees, competitive procurement 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]

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[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 March 4, 2016).

[2] *Program Integrity*, Medicaid.gov https://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/eligibility.html (last viewed on March 4, 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] Agency for Health Care Administration and the Department of Legal Affairs, *The State's Efforts to Control Medicaid Fraud and Abuse, FY 2013-14*, December 15, 2015, page 34, available at http://ahca.myflorida.com/medicaid/recent_presentations/TheStatesEffortstoCombatMedicaidFraud2013-14.pdf (last viewed March 4, 2016).

Federal regulation requires each state to detect and investigate Medicaid fraud and abuse.[7] 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 for recovering overpayments and imposing sanctions as appropriate.[8]

MPI is statutorily required to develop statistical methodologies to identify providers who exhibit aberrant billing patterns.[9] MPI utilizes these methodologies to perform comprehensive audits and generalized analyses of Medicaid providers.[10] Overpayments identified through these audits are referred to AHCA's Division of Operations, Bureau of Financial Services (Financial Services) for collection.[11] Financial Services collects the overpayments through either direct payment or through withholding payment to the provider.[12]

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.[13]

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.[14]

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.[15] Overpayments can be discovered in a variety of ways, including audits performed by AHCA or CMS under their program integrity offices.[16] The state has one year from the date that AHCA or CMS discover an overpayment to recover or seek to recover the overpayment.[17] After one year, the state must refund the federal share of the overpayment, regardless of whether AHCA has actually recovered payment from the provider.[18]

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.[19] To prove the provider is out of business, a state must:[20]

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[7] 42 CFR 455.1.
[8] Section 409.913, F.S.
[9] Id.
[10] 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 March 4, 2016).
[11] Id.
[12] Id.
[13] Id.
[14] Id.
[15] 42 C.F.R. 433.304.
[16] Section 409.913, F.S.; Section 1936 of the Social Security Act.
[17] 42 C.F.R. 433.312(a)(1).
[18] 42 C.F.R. 433.312(a)(2).
[19] 42 C.F.R. 433.318(d)(1).
[20] 42 C.F.R. 433.318(d)(2)(i) and (ii).

- Document its efforts to locate the party and its assets;[21] 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. No state law provision authorizes AHCA to certify that a provider is out of business and that the overpayment cannot be collected, so the federal exemption from mandatory repayment does not apply in Florida. As a result, Florida refunded 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 that it would not have had to refund if Florida had such a statutory provision.[22]

Home Health Agencies

Home health agencies provide home health services and staffing services and are licensed by AHCA under Part III of chapter 400, F.S.[23] Home health services are health and medical services and medical supplies furnished to an individual in the individual's home or place of residence, including:[24]

- Nursing care;
- Physical, occupational, respiratory, or speech therapy;
- Home health aide services;
- Dietetics and nutrition practice and nutrition counseling; and
- Medical supplies, restricted to drugs and biologicals prescribed by a physician.

There was a dramatic increase, especially in south Florida, of the number of home health agencies following the repeal of the certificate of need (CON) regulation of such agencies. In August 1999, prior to the repeal of the CON regulation, there were 1,186 licensed home health agencies in the state.[25] The CON regulation was repealed in 2000, and by 2007 there had been a 57 percent increase in the number of licensed home health agencies in the state (1,865).[26] Nearly three quarters of this growth occurred in south Florida with the number of home health agencies in Miami-Dade County increasing by 200 percent (216 to 651) and in Broward County increasing 40 percent (153 to 214).[27]

Associated with this growth was a substantial increase in Medicaid and Medicare fraud. Typical fraudulent activities included:[28]

- Kickbacks to physicians to sign plans of treatment;
- Recruiting recipients to fake or exaggerate symptoms to qualify for home health services;
- Paying recipients for participating in billing of unnecessary or non-rendered services; and
- Collaborative arrangements between Medicare and Medicaid certified home health agencies to pass off some services, primarily home health aide services, provided to dually eligible recipients to providers enrolled in Medicaid.

The majority of the fraud cases during this time were associated with Miami-Dade Medicaid providers.[29]

A 2009 report by the United States Government Accountability Office (GAO) identified Florida as one of the states experiencing the highest growth in Medicare home health spending and utilization,

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[21] These efforts must be consistent with applicable state policies and procedures.
[22] Agency for Health Care Administration, *2016 Agency Legislative Bill Analysis for HB 1245*, January 23, 2016 (on file with the Health and Human Services Committee staff).
[23] Section 400.462(12), F.S.
[24] Section 400.462(14), F.S.
[25] Committee on Health Regulation, Fla. Senate, *Review Regulatory Requirements for Home Health Agencies*, (Interim Report 2008-135) (Nov. 2007) http://www.flsenate.gov/data/Publications/2008/Senate/reports/interim_reports/pdf/2008-135hr.pdf (last viewed March 4, 2016).
[26] Id.
[27] Id.
[28] Id.
[29] Id.

specifically in home health services.[30] Medicare home health spending in Florida increased by 90 percent from 2002 to 2006, although the number of Medicare beneficiaries only grew by 28 percent during the same time period.[31] The GAO report found that the increase in Medicare home health spending and utilization was due in part to upcoding of Medicare claims by billing for outlier cases that qualified for additional payment.[32] Miami-Dade County was cited in the report as an example of an unusually high number of outlier cases indicating fraudulent upcoding of Medicare home health claims.[33]

In 2009, the Legislature created a pilot project in Miami-Dade County to reduce and eliminate home health fraud in the Medicaid program.[34] The pilot project requires AHCA, through its vendor,[35] to verify the utilization and delivery of home health services and to provide an electronic billing interface.[36] Verification occurs telephonically through the use of voice biometrics.[37] This is accomplished by the home health service provider contacting the vendor from the patient's telephone upon both arrival and departure from the patient's home.

In 2012, the pilot project was expanded statewide with the exception of counties where AHCA determined the program would not be cost-effective.[38] As of July 1, 2015, the pilot project is limited to eight counties.[39]

Effect of Proposed Changes

CS/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. Such certification exempts Florida from mandatory repayment of the federal share of any Medicaid overpayments to such providers and allows the state to retain those funds.

Section 409.9132, F.S., requires AHCA to telephonically verify the use and delivery of home health services in pilot project counties through the use of voice biometrics. The bill removes the telephone only requirement and authorizes AHCA to verify use and delivery of home health services using any technology that is effective for identifying delivery of services and deterring fraudulent or abusive billing.

[30] United States Government Accountability Office, *Medicare, Improvements Needed to Address Improper Payments in Home Health, U.S. Government Accountability Office* (Feb. 2009), http://www.gao.gov/new.items/d09185.pdf (last viewed March 4, 2016).
[31] Id.
[32] Id.
[33] Id.
[34] Section 409. 9132, F.S.
[35] AHCA is currently contracted with Sandata Technologies to provide these services.
[36] Footnote 33, *supra.*
[37] Id.
[38] Id.
[39] Broward, Duval, Hillsborough, Lee, Miami-Dade, Orange, Palm Beach, and Pinellas. AHCA, *Florida Medicaid Health Care Alert May 2015: Revised Program Counties for the Telephonic Home Health Service DMV Project*. http://www.sandataflorida.com/Default.aspx (last viewed March 4, 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 not have to refund 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.[40]

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.

[40] Footnote 22, *supra*.