Committee on Health Policy

CS/CS/HB 939 — Medicaid Recoveries

by Health and Human Services Committee; Health Innovation Subcommittee; and Rep. Pigman and others (CS/CS/SB 844 by Appropriations Committee; Health Policy Committee; and Senator Grimsley)

The bill modifies existing statutory provisions relating to fraud and abuse, provider controls, and accountability in the Medicaid program. This bill includes the following provisions:

- Requires a Medicaid provider to report a change in any principal of the provider to the Agency for Health Care Administration (AHCA) within 30 days after the change occurs;
- Provides a definition for "administrative fines" for purposes of liability for payment of such fines in the event of a change of ownership;
- Authorizes, rather than requires, the AHCA to perform an onsite inspection of a provider before entering a provider agreement to ensure that the entity complies with the Medicaid program and professional regulations;
- Modifies provider's surety bond requirements to provide that the amount of the bond need not exceed $50,000, if the physician or group of physicians licensed under ch. 458, ch. 459 or ch. 460, F.S., has a 50 percent or greater ownership interest in the provider or if the provider is an assisted living facility under ch. 429, F.S.;
- Provides a definition for principals of a provider with a controlling interest for hospitals and nursing homes, for purposes of conducting criminal background checks to be consistent with the definition for licensure;
- Removes exceptions to the background screenings requirements for hospices or assisted living facilities that are Medicaid providers;
- Permits enrollment of an out-of-state provider if the provider is located within 50 miles of the state line; the provider is a physician actively licensed in the state and interprets diagnostic testing results through telecommunications and information technology from a distance; or the AHCA determines a need for that provider type to ensure adequate access to care;
- Amends the Medicaid Third Party Liability Act with respect to procedures for challenging certain recovered medical expenses to ensure compliance with federal law;
- Expands the list of criminal offenses for which the AHCA may terminate the participation of a Medicaid provider;

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- Requires the AHCA to impose the sanction of termination for cause against providers that voluntarily relinquish their Medicaid provider numbers after being notified that an audit, survey, or inspection that could result in the sanction of suspension or termination is underway or has been conducted;

- Requires that when the AHCA determines that an overpayment has been made, the AHCA must base its determination solely on the information available before the issuance of an audit report and upon contemporaneous records. The AHCA may consider addenda and modifications to a note made contemporaneously with the patient care episode if the addenda is germane to the care;

- Requires overpayments or fines to be paid to the AHCA within 30 days after the date of the final order;

- Clarifies the scope of immunity from civil liability for persons who report fraudulent acts or suspected fraudulent acts;

- Amends the membership of the Medicaid and Public Assistance Fraud Strike Force to allow members to utilize designees and repeals the Strike Force effective June 30, 2014; and,

- Repeals s. 624.352, F.S., relating to interagency agreements to detect and deter Medicaid and public assistance fraud effective June 30, 2014.

The AHCA will primarily oversee the implementation of the bill relating to Medicaid in coordination with the Chief Financial Officer and other state agencies involved in Medicaid and public assistance fraud activities.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 38-0; House 116-0

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