SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based only on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/SB's 2124 and 2022

SPONSOR: Health Aging and Long-Term Care Committee, Senators Saunders and Lee

SUBJECT: Medicaid

DATE: April 21, 1999 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Liem	Wilson	HC	Favorable/CS
2.			FP	
3.				
4.				
5.				

I. Summary:

Committee Substitute for Senate Bills 2124 and 2022 addresses Medicaid funding for the Healthy Start program, Medicaid third party liability, estate recovery, provider service network demonstration projects, program integrity issues, review of physician claims, reporting by HMOs and prepaid health clinics, and notification of Medicaid by estate personal representatives.

The bill amends the section of statute relating to optional Medicaid services and the Healthy Start waiver, to enable the agency for Health Care Administration (agency) to pursue a certified match program to use local and state Healthy Start funding to draw down federal matching funds in the event that the federal government does not approve the pending Healthy Start waiver request.

The bill requires that, in the instance that health insurers and health maintenance organizations who are liable for Medicaid costs and require tape or electronic billing, the entities must, at their own expense, develop the means to use the standard tape or electronic format of the Medicare program. Entities which cannot use the tape or electronic billing format are required to accept paper claims in the Medicare format.

The bill creates the "Medicaid Estate Recovery Act," which codifies into statute Medicaid's estate recovery process. The provisions are applicable only to estates of those deceased Medicaid recipients who received Medicaid-reimbursed services after reaching the age of 55, and the agency is expressly prohibited from enforcing a claim against any homestead of a deceased Medicaid recipient. The bill requires notification of the Medicaid program of the administration of an estate by the personal representative of a deceased Medicaid recipient and creates a claim and interest in the estate on the part of the state in the amount of Medicaid assistance received by a recipient after the age of 55. The bill creates exemptions from the estate recovery process for homestead property, as well as, in the instance of a surviving spouse, a child under the age of 21 or a disabled child living in the home, a waiver provision if enforcement of the estate recovery process would create a hardship. The bill provides for a Medicaid claim against a settlement due from a third party and provides for the disposal of real property which has value exceeding the

cost of its sale, and makes the agency a reasonable ascertainable creditor where a deceased recipient has received Medicaid assistance after the age of 55.

The bill amends the section of statute relating to Medicaid provider service network demonstration projects as a cost-effective means of purchasing, to delete the requirement that one of the four demonstration projects be conducted in Orange County.

The bill modifies the agency's program integrity authority to allow Medicaid to withhold payments based on reliable evidence that a provider is engaged in fraud or abuse of the Medicaid program or a crime is being committed while rendering goods or services to Medicaid recipients.

The bill requires the agency, when preforming reviews of medical necessity for physician services, to use physicians of the same specialty as the physician under review to the extent possible. The agency is required to give advance notice to a physician when it wants to conduct onsite record reviews, use valid and accepted statistical models, and refer claims it believes are overpayments for peer review. The bill requires the agency to study its current statistical model used to calculate overpayments and advise the Legislature of any needed changes.

The bill conforms certain reporting requirements for HMOs and prepaid health clinics.

The bill amends ss. 409.906, F.S., 1998 Supplement; 409.910, F.S., 1998 Supplement; 409.912, F.S., 1998 Supplement; 409.913, F.S.; 641.261, F.S.; 641.411, F.S.; and 733.212, F.S.; and creates ss. 409.9101, F.S., and 409.9131, F.S.

II. Present Situation:

Medicaid

Medicaid is a medical assistance program that pays for health care for the poor and disabled. The program is jointly funded by the federal government, the state, and the counties. The federal government, through law and regulations, has established extensive requirements for the Medicaid program. The Agency for Health Care Administration is the single state agency responsible for the Florida Medicaid Program. The statutory provisions for the Medicaid program appear in ss. 409.901 through 409.9205, F.S.

The Healthy Start Program

The Healthy Start program consists of locally-based coalitions that help to identify and mitigate medical, environmental and psychosocial problems in mothers at risk for low birth weight babies. Healthy Start identifies women at risk for problem pregnancies and provides a number of "wrap-around" services designed to improve pregnancy outcomes for the at-risk mothers and their babies. Since the inception of Heathy Start, Florida has witnessed a steady drop in infant mortality and no-natal mortality rates, and ranks among the nation's leaders in terms of its marked improvement on these scores. According to the March of Dimes, Florida's overall infant mortality rate has declined from 8.9 per 1,000 births in 1991 to 6.9 per 1,000 births in 1997, with a reduction of nearly 34% for non-white mothers. While Florida's performance exceeds the national year 2000 goal, other states' performance demonstrates that further improvement is possible,

particularly in identifying and screening at-risk women and children, and providing them with services which will reduce their risk. Under the current program, at risk women are provided approximately 6 of the needed 12 contact hours per year of service.

Although nearly 80% of Healthy Start program participants are Medicaid eligible, almost all the services under the Healthy Start Program are funded from state general revenue. Many other states provide these services through Medicaid for eligible women, thereby receiving federal matching funds.

Medicaid Certified Match

The federal/state Medicaid program ordinarily pays for services at a fixed price per service - 55 percent of that cost being federal funds which are matched by 45 percent state funds. However, in the case of providers who are agencies of state government, federal law also permits the Medicaid program to pay just 55 percent of the cost of a service (i.e., the federal share), and then permits the provider/agency to certify that the other 45 percent of the payment has been provided (or matched) by state funds - without depositing those funds in a Medicaid account. This arrangement is frequently referred to as a "certified match" program.

Florida currently operates a certified match program providing outreach services in schools, and caps the amount to be paid at $50 million statewide. The program is authorized under s. 409.908 (21), F.S., 1998 Supplement. No additional expenditure of state funds is required for this program; school districts certify existing funding and programs (which meet certain minimum guidelines) to justify the draw-down of federal matching funds.

Medicaid Third Party Liability

Section 409.910, F.S., 1998 Supplement, is the "Medicaid Third-Party Liability Act," under which the agency is directed to recover the costs of goods and services delivered to a Medicaid recipient when another third party may be responsible for such costs. Subsection (20) of this section requires insurers and health maintenance organizations (HMOs) to "provide such records and information as are necessary to accomplish the purpose of this section, unless such requirement results in an unreasonable burden." Additionally, this subsection requires the agency and the Insurance Commissioner to enter a cooperative agreement for requesting and obtaining information from insurers and HMOs for purposes of the subsection, including the adoption of rules for implementing the cooperative agreement. Even though this authority for a cooperative agreement has been in statute for several years, no such agreement exists.

Each month Medicaid sends bills to about 1,000 health insurers and HMOs which are responsible for reimbursing care Medicaid has provided to persons with duplicate coverage. Although these funds are owed to the state, Medicaid staff have experienced difficulty in billing, since procedures and formats are unique to the multiple insurers and HMOs which are responsible for reimbursing the costs of services which Medicaid has provided.

Medicaid Estate Recovery

In August 1993, Congress passed the Omnibus Budget Reconciliation Act (OBRA 93) which, in part, requires state Medicaid agencies to establish and maintain estate recovery programs. The act requires states to recover the cost of medical assistance correctly paid on behalf of an eligible recipient who had reached age 55 prior to receiving services. OBRA 93 allows states to recover the costs of such benefits after the death of the recipient and after the death of the surviving spouse, dependent minor, or adult or minor handicapped children meeting the Social Security Administration definition of handicapped, if any. The agency is responsible for identifying the estates of former Medicaid recipients and recovering any funds the estate might owe the state as reimbursement for Medicaid expenditures made on behalf of the decedent. Under the provisions of Article X, Section 4, of the Florida Constitution, the homestead of the individual is exempt from estate recovery.

Medicaid's estate recovery efforts operate under the general provisions relating to public assistance. While specifying Medicaid estate recovery provisions in law, the Legislature has taken steps in the past to enhance the state's estate recovery efforts. For example, ch. 98-91, L.O.F., amended s. 198.30, F.S., relating to estate recovery, to require that circuit judges provide the agency with a copy of a monthly report containing the estate information of all decedents whose wills have been or will be probated before the court judge. This 1998 measure also amended s. 414.28, F.S., relating to public assistance debts, to raise public assistance recovery debts from Class 7 (debts acquired after death) to Class 3 (debts and taxes with preferences under federal law).

Section 733.212, F.S., relates to notices of administration and the filing of claims against estates of decedents. The notice requirements currently do not involve any notice to the agency for estates of decedents who may have been Medicaid recipients.

The primary source of information for estate recoveries comes from monthly Clerk of Court reports that detail estates opened in that county during that month. Letters of Administration submitted by personal representatives or attorneys also serve as leads for the recoveries, but are inconsistently provided to the agency. When a lead is received, research is conducted to determine if the individual was a Medicaid recipient and the estate meets criteria for an estate recovery. The claim history is reviewed to determine a lien amount to file against the estate. This lien amount may be amended as Medicaid providers file additional claims on the recipient.

In June 1996, the agency awarded the contract for estate recovery activities to Public Consulting Group. The contract will expire in April, 1999, however the agency plans to exercise one of its renewal options to extend the contract through October 31, 1999. The estate recovery program collected $1,175,590 in 1995, $3,955,840 in 1996, $3,511,365 in 1997, and $6,024,165 in 1998.

Provider Sponsored Networks

Section 409.912, Florida Statutes, directs the agency to purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. Towards that end, the agency is authorized to utilize a number of different purchasing strategies. Section 409.912(3)(d), F.S., 1998 Supplement, provides authorization for the agency to conduct

no more than 4 Medicaid provider service network (PSN) demonstration projects, with the stipulation that one of the projects be conducted in Orange County.

These projects will test a direct, risk-shared partnership between the agency and historically high-volume health care providers which are either Florida physician group practices or 51 percent owned by a Florida hospital or a combination of these two provider types. Each applicant must serve an entire county and all counties served must be served in their entirety. The PSNs will offer recipients a choice of an integrated system of care delivered through physicians, physician specialists, hospitals and other health care providers.

After releasing its Invitation to Negotiate, Medicaid had only one bidder from Orange County. During the course of negotiations, this sole bidder decided not to participate in the demonstration project. The Orange County stipulation in the statute precludes Medicaid from going elsewhere for a demonstration project. At the present time Medicaid has potential bidders in the Fort Meyers and Palm Beach areas.

Medicaid Program Integrity

More than $1 trillion is spent on health care each year in the United States. The proportion of annual health care expenditures lost to fraud and abuse remains unknown because these losses are not systematically measured. Conventional wisdom, supported by relatively recent Medicare studies undertaken by multiple federal agencies, estimates that losses to fraud and abuse may exceed 10 percent of annual health care spending.

Section 409.913, F.S., provides for the oversight of the integrity of the Florida Medicaid Program. Staff of the Medicaid Program Integrity section develop and use statistical methodologies to identify providers who exhibit aberrant billing patterns, conduct investigations and audits of these providers, calculate provider overpayments, initiate recovery of overpayments in instances of provider abuse, recommend administrative sanctions for providers who have abused or defrauded Medicaid, and refer cases of suspected fraud to the Medicaid Fraud Control Unit in the Attorney General's Office.

Currently the agency may only withhold payments from a Medicaid provider during the pendency of an administrative hearing to determine an overpayment. The agency is allowed by s. 409.913 (24)(a), F.S., to withhold 10 percent of a provider's billing during the pendency of the proceeding. This statute originated during a time when the only means available to the Medicaid program to recover overpayments were administrative hearings at the Division of Administrative Hearings. The agency now has authority to pursue recoupment under the civil theft statues (which require intent to defraud) and the False Claims Act. These two provisions are used in the instance of serious, intentional over billing. Since these are criminal prosecutions, the language allowing withholding 10 percent of billings does not apply. Consequently, during the pendency of these criminal proceedings, the agency has no authority to stop payments while the over billing is prosecuted. The agency reports that cases being prosecuted often involve large sums of money, and that recoupments are very difficult once the money has been paid out. It is therefore very important to the agency's program integrity efforts to be able to stop the flow of money to providers who the agency believes are deliberately taking money to which they are not entitled.

III. Effect of Proposed Changes:

Section 1. Amends s. 409.906, F.S., 1998 Supplement, to establish a certified match program for Healthy Start services which will allow draw-down of additional federal Medicaid matching dollars for services which are provided to Medicaid-eligible Healthy Start clients. The bill prohibits implementation by the agency without ensuring that the amendment and review requirements of ss. 216.177 and 216.181, F.S., have been met.

Section 2. Amends s. 409.910, F.S., 1998 Supplement, to require that, in the instance that health insurers and health maintenance organizations who are liable for Medicaid costs and require tape or electronic billing, the entities must, at their own expense, develop the means to use the standard Medicare format. Entities which cannot use the agency's format are required to accept paper claims in the Medicare format.

Section 3. Creates s. 409.9101, F.S., to create the "Medicaid Estate Recovery Act," which codifies into statute Medicaid's estate recovery process. The section imposes the requirement of providing a copy of a notice of administration of an estate to the agency by estate personal representatives under s. 733.212(4)(a), F.S., within three months after the first publication of the notice of administration. An exemption is provided if Medicaid has already filed a claim under the section. The section states that acceptance of Medicaid assistance creates a claim and interest, as defined in s. 731.201(4) and (21), F.S., of the probate code, in favor of the agency, in the amount of assistance received by a Medicaid recipient after the recipient has reached the age of 55. The agency is allowed to amend its claim based on provider claims received after the initial determination of the amount of the claim. The section clarifies that the claim against the estate is a class (3) claim as provided in s. 414.28 (1), F.S., 1998 Supplement.

In the section, the claim created is unenforceable if the recipient is survived by a spouse, a child under 21, a child who is living in the home who is blind or permanently or totally disabled pursuant to Title XIX of the Social Security Act. The claim is also unenforceable against any property which is determined to be the homestead of the deceased recipient, in accordance with section 4, Article X, State Constitution.

The section provides an exemption from enforcement of these provisions in circumstances in which doing so would create an undue hardship for the qualified heirs. Criteria are specified for determination of a hardship. The criteria relate to residency issues, basic needs issues, care history issues, and property settlement cost considerations.

The section requires that, in the instance that the estate of the deceased includes as an asset a settlement against a third party, the agency's claim must be satisfied before the third party settlement proceeds are included as estate assets. Proceeds remaining must be included in the estate and available to settle the agency's claim.

In the instance that there are no liquid assets to satisfy Medicaid's claim and there is real property which can be sold for more than the costs of a sale, the section requires that the property be sold to satisfy the Medicaid claim. The title to real estate cannot be transferred to the agency.

The agency may adopt rules to administer the section.

Section 4. Amends s. 409.912, F.S., 1998 Supplement, to delete the requirement that one of the four Medicaid provider service network demonstration projects be conducted in Orange County.

Section 5. Amends s. 409.913, F.S., to authorize the agency to withhold payments, in whole or in part, based on reliable evidence of fraud, willful misrepresentation, or criminal activities associated with the delivery of Medicaid goods or services; and delete existing limitations that the agency may only reduce payments up to 10 percent of the amount owed, or up to $25,000 per month when an overpayment by the agency exceeds $75,000. The agency reports that reliable evidence will equate to probable cause such as the issuance of a warrant, an arrest, or charges being filed against a provider. The agency will have to defend its actions, and will have to produce substantial evidence that the criminal action has occurred. If the provider is ultimately cleared, the funds will be returned to the provider within 14 days with interest paid at the rate of 10 percent per year.

Section 6. Creates section 409.9131, F.S., providing additional requirements for program integrity activities of the Medicaid program related to records review, audit, and recoupment of overpayments involving physician providers. The section states the legislative intent that provisions in the section are a supplement to the provisions of s. 409.913, F.S., and control when there is a conflict between the two sections.

The term "active practice" is defined to mean that a physician must have regularly provided medical care and treatment to patients within the past two years. The terms "medical necessity" and "medically necessary" are modified from the definition in 409.913(1)(c) to require that, in making determinations of medical necessity, the agency must use a physician in active practice, of the same specialty or subspecialty, as the physician under review.

The term "peer" is defined as a physician licensed in Florida who is, whenever possible, of the same specialty or subspecialty and who is licensed under the same chapter as the physician under review and in active practice. "Peer review" is defined as an evaluation of a Medicaid physician provider by a peer or peers in order to assess the medical necessity, appropriateness, and quality of care provided, as such care is compared to that customarily furnished by peers and to recognized health care standards. The section defines "physician" as a person licensed to practice medicine under chapter 458, F.S., or a person licensed to practice osteopathic medicine under chapter 459, F.S. "Professional services" are defined as procedures provided to a Medicaid recipient either directly or under the supervision of a physician registered as a Medicaid provider.

The agency is required to provide notice to the physician at least 24 hours prior to an onsite review of physician records, and requires that the physician and the agency make every effort to set a mutually agreed time for the visit. If a time cannot be agreed upon, the agency sets the time. The section requires the agency to notify a physician against whom the agency is seeking an administrative remedy of his or her due process rights under the Administrative Procedure Act, but specifies that this provision shall not hinder the agency's ability to pursue any remedy under s. 409.913, F.S., or other applicable law.

The section requires the agency, when it is determining an overpayment, to use accepted and valid auditing, accounting, analytical and statistical models which, to the maximum extent possible, compare physicians of the same specialty or subspecialty, if applicable, take into consideration the

physician's case mix, and which have at least a 95 percent confidence level. The section requires that all physician claims being investigated for overpayment be referred for peer review, except for claims referred as criminal violations. The agency is allowed to limit administrative sanctions to the amount of the sample overpayment.

The section requires that by March 1, 2000 the agency study and report to the legislature on its current statistical model used to calculate overpayments, and advise the legislature of changes or modifications which should be made. The study shall include a review of the appropriateness of including physician specialty and case-mix parameters within the model.

Sections 7. and 8. Amend ss. 641.261 and 641.411, F.S., to conform with the current s. 409.910, F.S., and to replace an obsolete reference to the Department of Health and Rehabilitative Services.

Section 9. Amends s. 733.212, F.S., to specify that Medicaid is considered a reasonably ascertainable creditor for purposes of the requirement that a personal representative of an estate serve a copy of the notice of administration of an estate on creditors of the decedent who are reasonably ascertainable. This provision applies to a decedent who had received Medicaid assistance for Medical care after the age of 55.

Section 10. The effective date of the bill is July 1, 1999.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Subsections 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

There may be a cost to insurers and HMOs to develop software to accept electronic and tape billings in the Medicare format.

Those with a stake in the estate of a deceased Medicaid recipient may see the estate reduced by a Medicaid claim against the estate. Those with a stake in the estate of a deceased Medicaid recipient, and an estate administrator, will have a better understanding of the parameters of the agency's authority in the estate recovery process.

The agency reports that the bill would be a potential benefit to physicians as a group because they would not be subject to the same recoupment and sanction actions on the first audit as would other providers.

C. Government Sector Impact:

Addition of a certified match program under Healthy Start would increase the funding for prenatal and perinatal programs by an estimated $28,639,606 in federal funds. There would be no additional state funds required.

To the extent that a clearer estate recovery process results from the creation of parameters in statute for this process, the agency may recover additional estate revenue.

The ability to halt the flow of funds to providers who are intentionally over billing the Medicaid program will produce savings to the state.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.

This Senate staff analysis does not reflect the intent or official position of the bill's sponsor or the Florida Senate.