By the Committee on Health, Aging and Long-Term Care; and Senator Saunders

317-2164A-99

A bill to be entitled

An act relating to Medicaid; amending s. 409.906, F.S.; authorizing the Agency for Health Care Administration to develop a certified-match program for Healthy Start services under certain circumstances; amending s. 409.910, F.S.; providing for use of Medicare standard billing formats for certain data-exchange purposes; creating s. 409.9101, F.S.; providing a short title; providing legislative intent relating to Medicaid estate recovery; requiring certain notice of administration of the estate of a deceased Medicaid recipient; providing that receipt of Medicaid benefits creates a claim and interest by the agency against an estate; specifying the right of the agency to amend the amount of its claim based on medical claims submitted by providers subsequent to the agency's initial claim calculation; providing the basis of calculation of the amount of the agency's claim; specifying a claim's class standing; providing circumstances for nonenforcement of claims; providing criteria for use in considering hardship requests; providing for recovery when estate assets result from a claim against a third party; providing for estate recovery in instances involving real property; providing agency rulemaking authority; amending s. 409.912, F.S.; eliminating a requirement that a Medicaid provider service network

demonstration project be located in Orange County; amending s. 409.913, F.S.; revising provisions relating to the agency's authority to withhold Medicaid payments pending completion of certain legal proceedings; providing for disbursement of withheld Medicaid provider payments; creating s. 409.9131, F.S.; providing legislative findings and intent relating to integrity of the Medicaid program; providing definitions; authorizing onsite reviews of physician records by the agency; requiring notice for such reviews; requiring notice of due process rights in certain circumstances; specifying procedures for determinations of overpayment; requiring a study of certain statistical models used by the agency; requiring a report; amending ss. 641.261 and 641.411, F.S.; conforming references and cross-references; amending s. 733.212, F.S.; establishing the agency as a reasonably ascertainable creditor with respect to administration of certain estates; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (11) of section 409.906, Florida Statutes, 1998 Supplement, is amended to read:

409.906 Optional Medicaid services.--Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of

the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Optional services may include:

(11) HEALTHY START SERVICES.--The agency may pay for a continuum of risk-appropriate medical and psychosocial services for the Healthy Start program in accordance with a federal waiver. The agency may not implement the federal waiver unless the waiver permits the state to limit enrollment or the amount, duration, and scope of services to ensure that expenditures will not exceed funds appropriated by the Legislature or available from local sources. If the Health Care Financing Administration does not approve a federal waiver for Healthy Start services, the agency, in consultation with the Department of Health and the Florida Association of Healthy Start Coalitions, is authorized to establish a Medicaid certified-match program for Healthy Start services. Participation in the Healthy Start certified-match program shall be voluntary and reimbursement shall be limited to the federal Medicaid share to Medicaid-enrolled Healthy Start coalitions for services provided to Medicaid recipients. The agency shall take no action to implement a certified-match

program without ensuring that the amendment and review requirements of ss. 216.177 and 216.181 have been met.

Section 2. Subsection (21) of section 409.910, Florida Statutes, 1998 Supplement, is renumbered as subsection (22), and a new subsection (21) is added to that section to read:

409.910 Responsibility for payments on behalf of Medicaid-eligible persons when other parties are liable.--

(21) Entities providing health insurance as defined in s. 624.603, and health maintenance organizations as defined in chapter 641, requiring tape or electronic billing formats from the agency shall accept Medicaid billings that are prepared using the current Medicare standard billing format. If the insurance entity or health maintenance organization is unable to use the agency format, the entity shall accept paper claims from the agency in lieu of tape or electronic billing, provided that these claims are prepared using current Medicare standard billing formats.

Section 3. Section 409.9101, Florida Statutes, is created to read:

409.9101 Recovery for payments made on behalf of Medicaid-eligible persons.--

(1) This section may be cited as the "Medicaid Estate Recovery Act."

(2) It is the intent of the Legislature by this section to supplement Medicaid funds that are used to provide medical services to eligible persons. Medicaid estate recovery shall generally be accomplished through the filing of claims against the estates of deceased Medicaid recipients. The recoveries shall be made pursuant to federal authority in s. 13612 of the Omnibus Budget Reconciliation Act of 1993, which

amends s. 1917(b)(1) of the Social Security Act (42 U.S.C. s. 1396p(b)(1)).

(3) Pursuant to s. 733.212(4)(a), the personal representative of the estate of the decedent shall serve the agency with a copy of the notice of administration of the estate within 3 months after the first publication of the notice, unless the agency has already filed a claim pursuant to this section.

(4) The acceptance of public medical assistance, as defined by Title XIX (Medicaid) of the Social Security Act, including mandatory and optional supplemental payments under the Social Security Act, shall create a claim, as defined in s. 731.201, in favor of the agency as an interested person as defined in s. 731.201. The claim amount is calculated as the total amount paid to or for the benefit of the recipient for medical assistance on behalf of the recipient after he or she reached 55 years of age. There is no claim under this section against estates of recipients who had not yet reached 55 years of age.

(5) At the time of filing the claim, the agency may reserve the right to amend the claim amounts based on medical claims submitted by providers subsequent to the agency's initial claim calculation.

(6) The claim of the agency shall be the current total allowable amount of Medicaid payments as denoted in the agency's provider payment processing system at the time the agency's claim or amendment is filed. The agency's provider processing system reports shall be admissible as prima facie evidence in substantiating the agency's claim.

(7) The claim of the agency under this section shall constitute a Class 3 claim under s. 733.707(1)(c), as provided in s. 414.28(1).

(8) The claim created under this section shall not be enforced if the recipient is survived by:

(a) A spouse;

(b) A child or children under 21 years of age; or

(c) A child or children who are blind or permanently and totally disabled pursuant to the eligibility requirements of Title XIX of the Social Security Act.

(9) In accordance with s. 4, Art. X of the State Constitution, no claim under this section shall be enforced against any property that is determined to be the homestead of the deceased Medicaid recipient and is determined to be exempt from the claims of creditors of the deceased Medicaid recipient.

(10) The agency shall not recover from an estate if doing so would cause undue hardship for the qualified heirs, as defined in s. 731.201. The personal representative of an estate and any heir may request that the agency waive recovery of any or all of the debt when recovery would create a hardship. A hardship does not exist solely because recovery will prevent any heirs from receiving an anticipated inheritance. The following criteria shall be considered by the agency in reviewing a hardship request:

(a) The heir:

1. Currently resides in the residence of the decedent;

2. Resided there at the time of the death of the decedent;

3. Has made the residence his or her primary residence for the 12 months immediately preceding the death of the decedent; and

4. Owns no other residence;

(b) The heir would be deprived of food, clothing, shelter, or medical care necessary for the maintenance of life or health;

(c) The heir can document that he or she provided full-time care to the recipient which delayed the recipient's entry into a nursing home. The heir must be either the decedent's sibling or the son or daughter of the decedent and must have resided with the recipient for at least 1 year prior to the recipient's death; or

(d) The cost involved in the sale of the property would be equal to or greater than the value of the property.

(11) Instances arise in Medicaid estate-recovery cases where the assets include a settlement of a claim against a liable third party. The agency's claim under s. 409.910 must be satisfied prior to including the settlement proceeds as estate assets. The remaining settlement proceeds shall be included in the estate and be available to satisfy the Medicaid estate-recovery claim. The Medicaid estate-recovery share shall be one-half of the settlement proceeds included in the estate. Nothing in this subsection is intended to limit the agency's rights against other assets in the estate not related to the settlement. However, in no circumstances shall the agency's recovery exceed the total amount of Medicaid medical assistance provided to the recipient.

(12) In instances where there are no liquid assets to satisfy the Medicaid estate-recovery claim, if there is nonhomestead real property and the costs of sale will not

exceed the proceeds, the property shall be sold to satisfy the Medicaid estate-recovery claim. Real property shall not be transferred to the agency in any instance.

(13) The agency is authorized to adopt rules to implement the provisions of this section.

Section 4. Paragraph (d) of subsection (3) of section 409.912, Florida Statutes, 1998 Supplement, is amended to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services.

(3) The agency may contract with:

(d) No more than four provider service networks for demonstration projects to test Medicaid direct contracting. ~~One demonstration project must be located in Orange County.~~ The demonstration projects may be reimbursed on a fee-for-service or prepaid basis. A provider service network which is reimbursed by the agency on a prepaid basis shall be exempt from parts I and III of chapter 641, but must meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency. The agency

shall award contracts on a competitive bid basis and shall select bidders based upon price and quality of care. Medicaid recipients assigned to a demonstration project shall be chosen equally from those who would otherwise have been assigned to prepaid plans and MediPass. The agency is authorized to seek federal Medicaid waivers as necessary to implement the provisions of this section. A demonstration project awarded pursuant to this paragraph shall be for 2 years from the date of implementation.

Section 5. Paragraph (a) of subsection (24) of section 409.913, Florida Statutes, is amended to read:

409.913 Oversight of the integrity of the Medicaid program.--The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate.

(24)(a) The agency may withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud or willful misrepresentation under the Medicaid program, or a crime committed while rendering goods or services to Medicaid recipients, ~~up to the amount of the overpayment as determined by final agency audit report,~~ pending completion of legal proceedings ~~under this section~~. ~~If the agency withholds payments under this section, the Medicaid payment may not be reduced by more than 10 percent.~~ If it is ~~has been~~ determined that fraud, willful misrepresentation, or a crime did not occur ~~an overpayment has not occurred~~, the payments withheld

must be paid to the provider within 14 ~~60~~ days after such determination with interest at the rate of 10 percent a year. Any money withheld in accordance with this paragraph shall be placed in a suspended account, readily accessible to the agency, so that any payment ultimately due the provider shall be made within 14 days. Furthermore, the authority to withhold payments under this paragraph shall not apply to physicians whose alleged overpayments are being determined by administrative proceedings pursuant to chapter 120.~~If the amount of the alleged overpayment exceeds $75,000, the agency may reduce the Medicaid payments by up to $25,000 per month.~~

Section 6. Section 409.9131, Florida Statutes, is created to read:

409.9131 Special provisions relating to integrity of the Medicaid program.--

(1) LEGISLATIVE FINDINGS AND INTENT.--It is the intent of the Legislature that physicians, as defined in this section, be subject to Medicaid fraud and abuse investigations in accordance with the provisions set forth in this section as a supplement to the provisions contained in s. 409.913. If a conflict exists between the provisions of this section and s. 409.913, it is the intent of the Legislature that the provisions of this section shall control.

(2) DEFINITIONS.--For purposes of this section, the term:

(a) "Active practice" means a physician must have regularly provided medical care and treatment to patients within the past 2 years.

(b) "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition or to prevent, diagnose, correct, cure,

alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. In making determinations of medical necessity, the agency must, to the maximum extent possible, use a physician in active practice, either employed by or under contract with the agency, of the same specialty or subspecialty as the physician under review. Such determination must be based upon the information available at the time the goods or services were provided.

(c) "Peer" means a Florida licensed physician who is, to the maximum extent possible, of the same specialty or subspecialty, licensed under the same chapter, and in active practice.

(d) "Peer review" means an evaluation of the professional practices 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 the physician's peers and to recognized health care standards, and to determine whether the documentation in the physician's records is adequate.

(e) "Physician" means a person licensed to practice medicine under chapter 458 or a person licensed to practice osteopathic medicine under chapter 459.

(f) "Professional services" means procedures provided to a Medicaid recipient, either directly by or under the

supervision of a physician who is a registered provider for the Medicaid program.

(3) ONSITE RECORDS REVIEW.--As specified in s. 409.913(8), the agency may investigate, review, or analyze a physician's medical records concerning Medicaid patients. The physician must make such records available to the agency during normal business hours. The agency must provide notice to the physician at least 24 hours before such visit. The agency and physician shall make every effort to set a mutually agreeable time for the agency's visit during normal business hours and within the 24-hour period. If such a time cannot be agreed upon, the agency may set the time.

(4) NOTICE OF DUE PROCESS RIGHTS REQUIRED.--Whenever the agency seeks an administrative remedy against a physician pursuant to this section or s. 409.913, the physician must be advised of his or her rights to due process under chapter 120. This provision shall not limit or hinder the agency's ability to pursue any remedy available to it under s. 409.913 or other applicable law.

(5) DETERMINATIONS OF OVERPAYMENT.--In making a determination of overpayment to a physician, the agency must:

(a) Use accepted and valid auditing, accounting, analytical, statistical, or peer-review methods, or combinations thereof. Appropriate statistical methods may include, but are not limited to, sampling and extension to the population, parametric and nonparametric statistics, tests of hypotheses, other generally accepted statistical methods, review of medical records, and a consideration of the physician's client case mix. Before performing a review of the physician's Medicaid records, however, the agency shall make every effort to consider the physician's patient case mix,

including, but not limited to, patient age and whether individual patients are clients of the Children's Medical Services network established in chapter 391. In meeting its burden of proof in any administrative or court proceeding, the agency may introduce the results of such statistical methods and its other audit findings as evidence of overpayment.

(b) Refer all physician service claims for peer review when the agency's preliminary analysis indicates a potential overpayment, and before any formal proceedings are initiated against the physician, except as required by s. 409.913.

(c) By March 1, 2000, the agency shall study and report to the Legislature on its current statistical model used to calculate overpayments and advise the Legislature what, if any, changes, improvements, or other modifications should be made to the statistical model. Such review shall include, but not be limited to, a review of the appropriateness of including physician specialty and case-mix parameters within the statistical model.

Section 7. Section 641.261, Florida Statutes, is amended to read:

641.261 Other reporting requirements.--

(1) Each authorized health maintenance organization shall provide records and information to the Agency for Health Care Administration ~~Department of Health and Rehabilitative Services~~ pursuant to s. 409.910(20) and (21)~~(22)~~for the sole purpose of identifying potential coverage for claims filed with the agency ~~Department of Health and Rehabilitative Services~~ and its fiscal agents for payment of medical services under the Medicaid program.

(2) Any information provided by a health maintenance organization under this section to the agency ~~Department of~~

~~Health and Rehabilitative Services~~ shall not be considered a violation of any right of confidentiality or contract that the health maintenance organization may have with covered persons. The health maintenance organization is immune from any liability that it may otherwise incur through its release of information to the agency ~~Department of Health and Rehabilitative Services~~ under this section.

Section 8. Section 641.411, Florida Statutes, is amended to read:

641.411 Other reporting requirements.--

(1) Each prepaid health clinic shall provide records and information to the Agency for Health Care Administration ~~Department of Health and Rehabilitative Services~~ pursuant to s. 409.910(20) and (21)~~(22)~~for the sole purpose of identifying potential coverage for claims filed with the agency ~~Department of Health and Rehabilitative Services~~ and its fiscal agents for payment of medical services under the Medicaid program.

(2) Any information provided by a prepaid health clinic under this section to the agency ~~Department of Health and Rehabilitative Services~~ shall not be considered a violation of any right of confidentiality or contract that the prepaid health clinic may have with covered persons. The prepaid health clinic is immune from any liability that it may otherwise incur through its release of information to the agency ~~Department of Health and Rehabilitative Services~~ under this section.

Section 9. Paragraph (a) of subsection (4) of section 733.212, Florida Statutes, is amended to read:

733.212 Notice of administration; filing of objections and claims.--

(4)(a) The personal representative shall promptly make a diligent search to determine the names and addresses of creditors of the decedent who are reasonably ascertainable and shall serve on those creditors a copy of the notice within 3 months after the first publication of the notice. Under s. 409.9101, the Agency for Health Care Administration is considered a reasonably ascertainable creditor in instances where the decedent had received Medicaid assistance for medical care after reaching 55 years of age.Impracticable and extended searches are not required. Service is not required on any creditor who has filed a claim as provided in this part; a creditor whose claim has been paid in full; or a creditor whose claim is listed in a personal representative's timely proof of claim if the personal representative notified the creditor of that listing.

Section 10. This act shall take effect July 1, 1999.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
Senate Bills 2124 and 2022

The bill combines the provisions of Senate Bill 2124 and Senate Bill 2022. The bill enables 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; requires that heath insurers and health maintenance organizations who are liable for Medicaid costs use the standard tape or electronic format or paper claims in the Medicare program format; creates the "Medicaid Estate Recovery Act"; deletes the requirement that one of the four provider service network demonstration projects be conducted in Orange County; enables the agency 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; provides standards for the return of withheld funds; requires the agency, when performing reviews of medical necessity for physician services, to use physicians of the same specialty as the physician under review to the extent possible; requires the agency to give advance notice, use valid and accepted statistical models, and refer claims it believes are overpayments for peer review when it is trying to recover overpayments to physicians; requires a study of the agency's overpayment calculation methodology; and conforms certain reporting requirements for HMOs and prepaid health clinics.