**STORAGE NAME**: h2239.hcs
**DATE**: April 15, 1999

**HOUSE OF REPRESENTATIVES**
**COMMITTEE ON**
**HEALTH CARE SERVICES**
**ANALYSIS**

**BILL #**: HB 2239 (PCB HCS 99-06)

**RELATING TO**: Medicaid

**SPONSOR(S)**: Committee on Health Care Services and Rep. Peaden

**COMPANION BILL(S)**:

**ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE**:
(1) HEALTH CARE SERVICES YEAS 14 NAYS 0
(2)
(3)
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I. SUMMARY:

HB 2239 addresses the following Medicaid issues:

-Amends the section of statute relating to optional Medicaid services and the Healthy Start waiver authorized thereunder, to enable the Agency for Health Care Administration 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.

-Amends the section of statute relating to Medicaid third-party liability to require health insurers and health maintenance organizations to develop the capability for tape matches for purposes of Medicaid file matches, using the Medicare standard billing format, to determine if Medicaid recipients might have any applicable insurance coverage.

-Creates the “Medicaid Estate Recovery Act,” which codifies into statute Medicaid’s estate recovery process. The provisions are only applicable to estates of those deceased Medicaid recipients above age 55, and the Agency for Health Care Administration is expressly prohibited from enforcement against any homestead of a deceased Medicaid recipient when it is determined that the homestead be exempt from creditors. Conforming related provisions are incorporated into the provision of statute relating to administration of estates, and notices thereof.

-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.

-Amends the section of statute relating to the withholding of payments as part of Medicaid program integrity activity to authorize the Agency for Health Care Administration to withhold payments in whole or in part based on evidence of fraud, willful misrepresentation, or criminal activities associated with the delivery of Medicaid goods or services. Deletes existing limitations that the agency may only reduce payments up to 10 percent of amounts owed, or up to $25,000 per month when an overpayment by the agency exceeds $75,000. Provides for prompt payment of withheld payments to providers once withholding disputes are settled.

-Creates a new section of statute that specifically addresses Medicaid program integrity issues in the context of Medicaid physician providers. Specifically addressed are: findings and intent; definitions; notice of due process; and determination of overpayment, including review of medical records, consideration of physician case mix and peer review, and an Agency for Health Care Administration study of its overpayment calculation methodology.

-Incorporates conforming agency name and cross-reference changes into related sections of statute.

The bill’s effective date is July 1, 1999.

The bill has no direct fiscal impact.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

**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 for Health Care Administration 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. 98-191, L.O.F., amended s. 198.30, F.S., relating to estate recovery, to require that circuit judges provide 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 to AHCA. 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).

The primary source of information for estate recoveries comes from monthly Clerk of Court reports that are to detail every estate that was 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 AHCA. When a lead is received, research is conducted to determine if the individual was a Medicaid recipient and meets all the criteria for an estate recovery. Once the information has been verified, the recipient's 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.

The Agency for Health Care Administration contracted with a private attorney to conduct the state's Estate Recovery Program from January 1994 until December 1995. The agency competitively procured a contractor to conduct the estate recovery program and, in June 1996, AHCA awarded the contract 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 has been very successful in recoveries. Collection figures based on state fiscal years are as follows:

| Year | Collection Amount |
|---|---|
| 1995 | $1,175,590 |
| 1996 | $3,955,840 |
| 1997 | $3,511,365 |
| 1998 | $6,024,165 |

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

**Medicaid Third-Party Liability**

Section 409.910, F.S., 1998 Supplement, is the "Medicaid Third-Party Liability Act," under which AHCA is to seek to recover the cost of goods and services delivered to a Medicaid recipient when another third party may be responsible for such costs of services. 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 AHCA 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.

**Medicaid Program Integrity/Fraud and Abuse**

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 such 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. Given this degree of fraudulent activity, Florida has taken a number of steps in the past few years to avoid and detect fraud and abuse in the Medicaid Program. As a result of initiatives on the part of AHCA, the Legislature, the Attorney General's Medicaid Fraud Control Unit, and the Grand Jury convened by the Statewide Prosecutor, much has been accomplished to keep "bad" providers out of the Medicaid Program. What remains to be reviewed is how to make sure that the remaining "good" providers are not unnecessarily burdened by program integrity reviews within the Medicaid Program, while at the same time guarding against any provider abuses of the program.

Section 409.913, F.S., provides for the oversight of the integrity of the Florida Medicaid Program. Staff of Medicaid Program Integrity developed 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.

**Medicaid Healthy Start Waiver Authorization**

Section 1 of ch. 98-288, L.O.F., directed the Agency for Health Care Administration, working in consultation with the Department of Health and the Florida Association of Healthy Start Coalitions, to seek a federal waiver to secure federal Medicaid matching funds for Healthy Start services. Section 52 of the 1998 act also amended s. 409.906, F.S., to create a new subsection (11) which authorized Healthy Start services as an optional Medicaid service, pursuant to a waiver of federal requirements relating to amount, duration, and scope of services. The intent of these revisions was to use existing state and local funds to draw down matching federal Medicaid funding for Healthy Start's continuum of risk-appropriate medical and psychological services. The Agency for Health Care Administration has applied for the waiver, and is still awaiting final federal approval of the waiver.

**Medicaid Provider Service Network Demonstration Projects**

Section 10 of ch. 97-260, L.O.F., and s. 15 of ch. 97-263, L.O.F, codified as s. 409.912(3)(d), F.S., provided authorization for the Agency for Health Care Administration to conduct no more than 4 provider service network demonstration projects, with the stipulation that one of the projects be conducted in Orange County. After releasing its Invitation to Negotiate, AHCA 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 AHCA from going elsewhere for a demonstration project.

B. EFFECT OF PROPOSED CHANGES:

The bill will create the "Medicaid Estate Recovery Act," which codifies into statute Medicaid's estate recovery process. Conforming related provisions will be incorporated into the provision of statute relating to administration of estates.

The bill will enable the Agency for Health Care Administration to pursue a Medicaid certified match program to use local and state Healthy Start funding to draw down federal Medicaid matching funds, in the event that the federal government does not approve a pending Healthy Start Medicaid waiver.

The bill will amend the section of statute relating to Medicaid third-party liability to require health insurers and health maintenance organizations to develop the capability for tape matches for

purposes of Medicaid file matches, using the current Medicare standard billing format, to determine if Medicaid recipients might have any applicable insurance coverage.

The bill will delete the requirement that one of the four Medicaid provider service network demonstration projects be conducted in Orange County.

The bill will also authorize AHCA to withhold payments, in whole or in part, based on evidence of fraud, willful misrepresentation, or criminal activities associated with the delivery of Medicaid goods or services; 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; and provide for prompt payment of withheld payments to providers once withholding disputes are settled.

Finally, the bill will create a new section of statute that specifically addresses Medicaid program integrity issues in the context of Medicaid physician providers. Specifically addressed are: findings and intent, definitions, notice of due process, determination of overpayment; and an Agency for Health Care Administration study of its overpayment calculation methodology.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

Physician providers under Medicaid will have an opportunity to request an educational review of their Medicaid billing activities. This process is not an option currently.

Attorneys and families of deceased Medicaid recipients will have a better understanding of AHCA's estate recovery authority, what AHCA can and cannot do in cases involving impacted estates.

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

No.

(3) any entitlement to a government service or benefit?

No.

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

N/A

(2) what is the cost of such responsibility at the new level/agency?

N/A

(3) how is the new agency accountable to the people governed?

N/A

2. Lower Taxes:

   a. Does the bill increase anyone's taxes?

      N/A

   b. Does the bill require or authorize an increase in any fees?

      N/A

   c. Does the bill reduce total taxes, both rates and revenues?

      N/A

   d. Does the bill reduce total fees, both rates and revenues?

      N/A

   e. Does the bill authorize any fee or tax increase by any local government?

      N/A

3. Personal Responsibility:

   a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

      The bill clarifies AHCA's authority with regard to the state's ability to recover Medicaid-related costs from the estate of a deceased Medicaid recipient.

   b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

      Those physicians who seek an educational review of their Medicaid billing practices may be asked by AHCA to pay a nominal amount for such services.

4. Individual Freedom:

   a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

      N/A

   b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

      N/A

5. Family Empowerment:

   a. If the bill purports to provide services to families or children:

      (1) Who evaluates the family's needs?

          N/A

      (2) Who makes the decisions?

          N/A

(3) Are private alternatives permitted?

N/A

(4) Are families required to participate in a program?

N/A

(5) Are families penalized for not participating in a program?

N/A

b. Does the bill directly affect the legal rights and obligations between family members?

Family members involved in the adjudication of an estate of a recipient of Medicaid services will have a better understanding of their rights and responsibilities, and a better understanding of AHCA's estate recovery authority.

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

Sections 409.906(11), 409.910, 409.9101, 409.912(3)(d), 409.913(24)(a), 409.9131, 641.261, 641.411, and 733.212(4)(a), F.S.

E. SECTION-BY-SECTION ANALYSIS:

**Section 1.** Amends s. 409.906(11), F.S., 1998 Supplement, relating to optional Medicaid services and the Healthy Start waiver authorized thereunder, to enable the Agency for Health Care Administration 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.

**Section 2.** Amends s. 409.910, F.S., relating to Medicaid third-party liability, to add as a new subsection (21) the requirement that health insurers and health maintenance organizations develop the capability for tape matches for purposes of Medicaid file matches, using current Medicare standard billing formats, to determine if Medicaid recipients might have any applicable insurance coverage. Existing subsection (21) is renumbered as (22).

**Section 3.** Creates s. 409.9101, F.S., relating to recovery for payments made on behalf of Medicaid-eligible persons. This section codifies into statute Medicaid's estate recovery process. This new section contains the following subsections:

Subsection (1) provides the short title, the "Medicaid Estate Recovery Act."

Subsection (2) provides legislative findings and intent.

Subsection (3) imposes the requirement of serving of a notice of administration to AHCA by estate personal representatives under s. 733.212(4)(a), F.S.

Subsection (4) provides a statement of the fact that acceptance of Medicaid services creates a claim in favor of AHCA as an interested person, in those instances involving a deceased Medicaid recipient who has reached age 55.

Subsection (5) provides AHCA with authority to amend claim amounts based on receipt of reimbursement requests from providers subsequent to filing the claim.

Subsection (6) specifies the process for determining an estate claim amount based on AHCA's provider payment processing system, and provides for such system reports to be considered prima facie evidence in AHCA's claim.

Subsection (7) specifies that a claim against an estate is a Class 3 claim, in conformity with the current public assistance claim standing.

Subsection (8) stipulates that a claim against an estate will not be enforced if the decedent is survived by a spouse, a child under age 21, or a child meeting the federal definition of disabled.

Subsection (9) indicates that no claim will be made against a homestead determined to be exempt from the claims of creditors, in conformity with the Florida Constitution.

Subsection (10) provides an exemption from enforcement of these provisions in circumstances in which doing so would create a hardship. Criteria are specified for determination of a hardship, and relate to residency issues, basic needs issues, care history issues, and property settlement cost considerations.

Subsection (11) provides guidance in cases involving settlement proceeds from liable third parties.

Subsection (12) provides guidance in situations involving non-liquid real property.

Subsection (13) authorizes AHCA to adopt rules pursuant to federal requirements.

**Section 4.** Amends s. 409.912(3)(d), F.S., 1998 Supplement, relating to Medicaid provider service network demonstration projects as a cost-effective means of purchasing Medicaid services, to delete the requirement that one of the four demonstration projects be conducted in Orange County. (The sole bidder there to the Agency for Health Care Administration's Invitation to Negotiate decided not to participate as a demonstration project.)

**Section 5.** Amends s. 409.913(24)(a), F.S., relating to the withholding of payments as part of Medicaid program integrity activity, to authorize AHCA to withhold payments, in whole or in part, based on evidence of fraud, willful misrepresentation, or criminal activities associated with the delivery of Medicaid goods or services. Deletes existing limitations that the agency may only reduce payments by up to 10 percent of the amount due, and up to $25,000 per month when an overpayment by the agency exceeds $75,000. (The agency indicates that it is not currently adhering to this latter limitation due to federal withholding requirements.) A stipulation is added that withheld amounts be placed in a suspended account, readily accessible for payment to providers within 10 days of the settlement of the withheld amount.

**Section 6.** Creates s. 409.9131, F.S., addressing Medicaid program integrity issues (fraud and abuse) in the context of Medicaid physician providers. Specifically addressed are: findings and intent; definitions of 6 specific terms; on-site records review, including prior notice provisions; notice of due process; and determination of overpayment. These new provisions address a review of medical records, consideration of physician case-mix, including patient age and whether the physician's patients include Children's Medical Services Network patients, and peer review as part of determination of any physician provider overpayments. In addition, the Agency for Health Care Administration is directed to study and report to the Legislature its methodology for overpayment calculations, including the appropriateness of using physician specialty and case-mix parameters in the methodology.

**Section 7.** Amends s. 641.261, F.S., relating to other reporting requirements for health maintenance organizations, to update reference to the Agency for Health Care Administration and to incorporate conforming cross-reference revisions.

**Section 8.** Amends s. 641.411, F.S., relating to other reporting requirements for prepaid health plans, to update reference to the Agency for Health Care Administration and to incorporate conforming cross-reference revisions.

**Section 9.** Amends s. 733.212(4)(a), F.S., relating to administration of estates and notice requirements thereof, to require estate administrators to consider AHCA a creditor in instances where the decedent received Medicaid services after age 55.

**Section 10.** Provides for a July 1, 1999, effective date.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

None.

2. Recurring Effects:

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

3. Long Run Effects Other Than Normal Growth:

None.

4. Total Revenues and Expenditures:

Unknown.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

None.

2. Recurring Effects:

None.

3. Long Run Effects Other Than Normal Growth:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

Those with a stake in the estate of a deceased Medicaid recipient may see the estate reduced by any Medicaid claim against the estate.

2. Direct Private Sector Benefits:

   Those with a stake in the estate of a deceased Medicaid recipient, and any estate administrator, will have a much better understanding of the parameters of AHCA's authority in the estate recovery process.

3. Effects on Competition, Private Enterprise and Employment Markets:

   N/A

D. FISCAL COMMENTS:

None.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

The bill does not reduce the authority that municipalities or counties have to raise revenue in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

The bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

As amended by the Committee on Health Care Services on April 5, 1999, section 5 of the bill, requires withheld provider payments to be paid by the Agency for Health Care Administration to the provider from whom the agency withheld payment within 10 days of dispute settlement. This 10-day requirement may be too short for the agency to be able to comply, based on internal administrative functions. A more reasonable time frame would be 15 or 21 days.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

N/A

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

| Prepared by: | Staff Director: |
| --- | --- |
| Phil E. Williams | Phil E. Williams |