SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

BILL: CS/CS/SB 1150

SPONSOR: Criminal Justice Committee, Health, Aging and Long-Term Care Committee and Senator Saunders

SUBJECT: Recovery of Medicaid Overpayments

DATE: February 19, 2002 REVISED: ________ ________ ________ ________

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Liem	Wilson	HC	Favorable/CS
2.	Erickson	Cannon	CJ	Favorable/CS
3.			AHS	
4.			AP	
5.			RC	
6.				

I. Summary:

The Committee Substitute for Committee Substitute for Senate Bill 1150 makes statutory changes designed to increase the state's ability to recover Medicaid overpayments. The CS:

- requires collocation of offices, if possible, and increased coordination between the offices of the Medicaid program integrity program in the Agency for Health Care Administration (AHCA or agency) and the Medicaid Fraud Control Unit (MFCU) of the Department of Legal Affairs;
- provides whistleblower protection to employees of Medicaid providers and state agencies who report Medicaid fraud and abuse;
- increases the ability of AHCA and MFCU to access records and inspect providers, manufacturers, and wholesalers to detect, investigate and prosecute overpayments;
- grants additional authority to AHCA to refuse to issue, suspend, or revoke licenses, registrations, certificates, or provider agreements of, and withhold payments to, individuals and entities which have not repaid, or made arrangements to repay, Medicaid overpayments;
- requires pro-rata distribution of Medicaid third-party liability recoveries and collections, and recoveries of overpayments to counties which are liable for making payments for medical care;
- modifies Medicaid provider application and contracting standards to require onsite visits and determinations of a provider's ability to render services;
- grants AHCA the ability to withhold payments to providers who fail to file or file erroneous cost reports;
- requires additional reporting by AHCA and the MFCU of detection, investigation and settlement activities to increase accountability to the Legislature;

- requires AHCA to impose sanctions and disincentives in the event of overpayments, unless not in the best interests of the program;
- requires review by the Attorney General and Auditor General of certain AHCA decisions in settlements and provider rate adjustments; and
- grants the Attorney General additional flexibility and duties in bringing suit under the Florida False Claims Act.

The CS amends ss. 16.59, 112.3187, 409.902, 409.907, 409.908, 409.910, 409.913, and 409.920, F.S.; and creates s. 408.831, F.S., and one undesignated section of law.

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. Under s. 409.902, F.S., 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 Florida Medicaid program spends nearly $10 billion annually providing health care. The proportion of annual health care expenditures lost to fraud and abuse remains unknown because these losses are not systematically measured. However, conventional wisdom estimates that losses to fraud and abuse may exceed 10 percent of annual Medicaid spending.

Section 409.907, F.S., establishes requirements for Medicaid provider agreements. The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency. Section 409.908, F.S., specifies conditions under which Medicaid providers may be reimbursed for Medicaid compensable services made on behalf of Medicaid eligible persons.

Section 409.913, F.S., prescribes the activities of the agency related to oversight of the integrity of the 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, and recommend administrative sanctions for providers who have abused or defrauded Medicaid. The section requires that any suspected criminal violation identified by the agency be referred to the Medicaid Fraud Control Unit of the Office of the Attorney General, and that the agency and the MFCU develop a memorandum of understanding which includes protocols for referral of cases of suspected criminal fraud and return of these cases where investigation determines that administrative action by the agency is appropriate.

Section 409.920, F.S., contains provisions related to Medicaid provider fraud, and requires the Attorney General to conduct a statewide program of Medicaid fraud control. The duties of the program include investigation of possible criminal violations pertaining to the administration of

the Medicaid program, in the provision of medical assistance, or in the activities of Medicaid providers. The Attorney General is to investigate alleged abuse or neglect of patients in health care facilities receiving Medicaid payments, and misappropriation of patient's private funds in facilities receiving Medicaid payments, in coordination with the agency. The Attorney General is required to refer all suspected abusive activities not of a criminal nature to the agency, as well as each instance of overpayment which is discovered during the course of an investigation.

Medicaid Fraud Control Unit

Section 16.59, F.S., creates the Medicaid Fraud Control Unit (MFCU) within the Department of Legal Affairs. The MFCU is authorized to investigate all violations of s. 409.920, F.S., relating to Medicaid provider fraud, and any criminal violations discovered during the course of those investigations. The MFCU is authorized to refer any criminal violation to the appropriate prosecuting authority.

Whistle-blower's Act

Sections 112.3187-112.31895, F.S., are the "Whistle-blower's Act." The legislative intent for the act is to prevent agencies or independent contractors from taking retaliatory action against an employee who reports to an appropriate agency violations of law on the part of a public employer or independent contractor or who discloses information to an appropriate agency alleging improper use of governmental office, gross waste of funds, or any other abuse or gross neglect of duty on the part of an agency, public officer, or employee. An agency is defined to include any state, regional, county, local or municipal government entity. An independent contractor is defined to include a person, other than an agency, engaged in any business and who enters into a contract with an agency.

OPPAGA's Justification Review of Medicaid Program Integrity Functions

In September, 2001, the Office of Program Policy and Government Accountability (OPPAGA) released a justification review of Medicaid program integrity efforts. The report did not assess operations of the Medicaid Peer Review Organization audit system or the operations of the Medicaid Fraud Control Unit. OPPAGA found a number of problems:

- Recoveries are low and probably represent a small portion of dollars lost to fraud and abuse;

- Detection methodologies are imprecise and result in too many false positives;

- Preliminary overpayment findings are subsequently reduced to final amounts;

- AHCA only rarely applies punitive sanctions available to it, such as fines or other discipline;

- Follow-up reviews are inconsistent, and there is no policy or requirement for the extent or depth of follow-up reviews;

- AHCA does not target providers with an identified history of overpayments for pre-payment review of claims;

- AHCA refers few cases to MFCU;

- Accountability is poor– there is no good measure of losses against which to judge effectiveness of MPI operations; and

- AHCA's data system did not permit an analysis of the extent to which providers are actually repaying the money they owe to the Medicaid program.

AHCA's Internal Review of the Recoupment Process

The AHCA Office of the Inspector General conducted an internal review of AHCA's process of recouping overpayments which indicated various coordination and communication problems:

- The AHCA accounts receivable system used for tracking the amount of funds a provider owes is unable to age accounts or generate collections letters. Inconsistent flow of documents between the four units involved in the recoupment process (Finance and Accounting, the General Counsel's Office, Medicaid Program Integrity, and Medicaid Program Development) results in insufficient information as to whether the amount recorded as owed is under litigation or dispute in the Office of the General Counsel. The accounts receivable system does not accurately reflect how much money is actually owed AHCA.

- There is no systematic effort to collect receivables, and collection mechanisms allowed in statute are not applied. Instances were noted in which the Office of the General Counsel (OGC) verbally requested Accounts Receivable staff to adjust receivable balances against providers or remove liens. There is confusion as to the activities of the OGC in collecting accounts which appear to be uncollectible.

- Tracking systems in Medicaid Program Integrity, the Office of the General Counsel and the Accounts Receivable section are not compatible, with the result that it is difficult to assess at what point a case is in the recovery process, whether or not a provider is complying, and what action should be taken.

- There is a lack of coordination of recovery activities between Medicaid Program Integrity, Medicaid Program Development (responsible for Medicaid policy) and the Office of the General Counsel.

TRAP Systems, Inc., Recommendations

In January, 2001, AHCA contracted with TRAP Systems, Inc., of Miami Lakes, Florida to provide enhanced fraud and abuse detection technologies. A review was conducted of AHCA's Medicaid Program Integrity operations under that contract by Malcolm Sparrow, M.A., M.P.A., PhD, of Harvard University. Dr. Sparrow made the following 7 recommendations:

- The State of Florida should conduct formal measurement studies of Medicaid overpayments on a biennial basis.

- The State of Florida should adopt a proactive media and public relations posture with respect to fraud and abuse control, aggressively publicizing Medicaid billing abuses; the administration should seek to win back support from legitimate providers and their professional associations by explicitly linking control of abuses within particular segments to increases in reimbursement rates within those segments.

- The State of Florida should authorize and fund an aggressive program of growth for the Medicaid Program Integrity function, to bring investments into line with the scale of the fraud and abuse problem.

- AHCA should establish a cross-functional "Fraud and Abuse Control Committee," under the chairmanship of the Inspector General (or his designee), to provide a forum for the development and implementation of coordinated responses to major non-compliance issues.

- The systems AHCA uses to recover overpayments, and their performance in this regard, should be systematically reviewed. Managerial and legislative attention should be paid to the collections rate, the extent to which overpayments are negotiated, reduced, or settled; AHCA's use of sanctions and penalties; and the overall incentives for compliance that result.

- Program Integrity, in order to progress towards delivering a more results-oriented performance account, should develop a system of performance tracking and reporting that uses three categories: Category (1) relates to outputs and activity counts after improper bills have been submitted and paid; Category (2) relates to Medicaid cost-savings achieved where improper bills have been submitted but not paid – capturing the value of pre-payment controls introduced as a result of discovery and analysis of improper billing patterns; and Category (3) relates to major billing problems (each costing Medicaid a minimum of $500,000 per year) identified, accurately described, and then mitigated through a formal problem-solving process, employing whatever methods and tactics are deemed relevant to the particular billing pattern.

- Once the algorithm development process (AHCA has a contract with TRAP Systems to develop new pattern-recognition algorithms to detect fraud and abuse) is reasonably established, MFCU should be invited to participate.

Medicaid Third-party Liability

Federal law governing Medicaid provides that a state must commit to take all reasonable measures to ascertain the legal liability of third parties (including health insurers, group health plans, service benefit plans, and health maintenance organizations) to pay for care and services available under the program. Further, a state must commit to seek reimbursement in situations where a legal liability is found to exist after medical assistance has been made available and where the likely recovery will exceed the costs of securing such recovery. Section 409.910, F.S.,

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.

The Select Subcommittee on Recovery of Medicaid Overpayments

On January 2, 2002, the chairman of the Senate Committee on Health, Aging and Long-Term Care appointed a Select Subcommittee on Recovery of Medicaid Overpayments to investigate the manner in which the Agency for Health Care Administration determines whether overpayments have been made to Medicaid providers, how effective the state's recovery efforts have been, and how to improve the state's recovery of Medicaid funds that have been improperly spent. The investigation involved both the Office of Medicaid Program Integrity and the Medicaid Fraud Control Unit within the Department of Legal Affairs.

The Select Subcommittee held two hearings. The first hearing was on January 10, 2002, from 1:00 to 4:00 p.m., and the second hearing was January 24, 2002, from 12:15 to 1:45 p.m.

At the January 24th meeting, committee staff presented 16 proposed statutory changes for the Select Subcommittee to consider. The Select Subcommittee adopted 14 of these proposals for submission to the full committee. The Select Subcommittee requested that staff develop additional proposals based on testimony received during the meeting, and requested that staff work with the Agency for Health Care Administration and the office of the Attorney General to develop actual bill language for consideration by the full committee. This CS is the result of these activities.

III. Effect of Proposed Changes:

Section 1. Amends s. 16.59, F.S., to require that the offices of the Medicaid Fraud Control Unit and the offices of AHCA's Medicaid program integrity program be collocated to the extent possible, and that the agency and the Department of Legal Affairs conduct joint training and other activities designed to increase communication and coordination in recovering overpayments.

Section 2. Amends subsections (3), (5), and (7) of s. 112.3187, F.S., to extend whistleblower protection to employees of Medicaid providers who report suspected or actual Medicaid fraud or abuse, and extends whistleblower protection to individuals who initiate a complaint through the hotline of the Medicaid Fraud Control Unit.

Section 3. Creates s. 408.831, F.S., to allow AHCA to deny, suspend, or revoke a license, registration, or certificate if the applicant or licensee, registrant or certificate holder has failed to pay or has failed to comply with a repayment plan for all outstanding fines, liens, or overpayments assessed by final order of the agency or the Centers for Medicare and Medicaid Services, unless a repayment plan is approved by the agency. The agency may take these same actions in the instance of a corporation, partnership, or other business entity if any officer, director, agent, managing employee, or affiliated person, partner or shareholder having an ownership interest of 5 percent or greater has failed to pay fines, liens or overpayments; does not have an approved repayment plan; or has failed to comply with a repayment plan.

This section is applicable to all entities licensed or regulated by the agency and controls in the event of a conflict with specified regulatory chapters.

Section 4. Amends s. 409.902, F.S., to require that AHCA and the Department of Children and Family Services ensure that each recipient of Medicaid, as a condition of Medicaid eligibility, consents to release of his or her medical records to AHCA and the Medicaid Fraud Control unit of the Department of Legal Affairs.

Section 5. Amends subsections (7) and (9) of s. 409.907, F.S., to require that AHCA perform an onsite inspection of a new provider applicant's service location, within 60 days after the receipt of the application, to determine the applicant's ability to provide the services the applicant is proposing to provide for Medicaid reimbursement. AHCA is not required to perform an onsite inspection of a provider or program which is licensed by the agency. The CS allows AHCA to consider the applicant's demonstrated ability to provide services, conduct business, and operate a financially viable concern as a factor (in addition to other factors currently in statute) when determining whether or not to enroll a provider. With respect to providers who primarily provide emergency medical services transportation or emergency services, the effective date of an approved application is the date the agency receives the provider application.

The agency is required to deny a provider application when it determines that the applicant has failed to pay all outstanding fines or overpayments assessed by final order of the agency or the Centers for Medicare and Medicaid Services, unless the provider agrees to a repayment plan that includes withholding Medicaid reimbursement until the amount is paid in full. This restriction also applies in the instance of a corporation, partnership, or other business entity if any officer, director, agent, managing employee, or affiliated person, partner or shareholder having an ownership interest of 5 percent or greater has failed to pay these fines or liens.

Section 6. Amends s. 409.908, F.S., to provide that if the Medicaid provider submits a late cost report and that report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester is retroactively calculated using the new cost report, and full payment of the recalculated rate is retroactively effected. Additionally, Medicare granted extensions of time for filing costs reports, if applicable, also apply to Medicaid cost reports.

Section 7. Amends paragraph (b) of subsection (7) of s. 409.410, F.S., to include a requirement for a pro-rata distribution (or an offset in the instance in which a county has been billed but has not paid the amount due) of Medicaid third-party liability recoveries and collections, and recoveries of overpayments to counties which are liable for making payments for medical care. In the instance of a county with a special taxing district or authority, the county must proportionately divide any refund or offset in accordance with the proration that has been established.

Section 8. Amends s. 409.913, F.S., to:

- require AHCA and the Medicaid Fraud Control Unit of the Department of Legal Affairs to annually submit a joint report on the effectiveness of the state's efforts to control

Medicaid fraud and abuse and to recover Medicaid overpayments. The report must include specified information;

- define the term "complaint" as used in this section to mean an allegation that fraud, abuse or an overpayment has occurred;

- require that the offices of the Medicaid Fraud Control Unit and the offices of AHCA's Medicaid program integrity program be collocated to the extent possible, and that the agency and the Department of Legal Affairs conduct joint training and other activities designed to increase communication and coordination in recovering overpayments;

- allow AHCA to impose penalties on a Medicaid provider who has failed to comply with an agreed-upon repayment schedule;

- require, rather than permit AHCA to impose a variety of sanctions or disincentives, and add to the list of sanctions: prepayment reviews of claims for a specified period of time, comprehensive follow-up reviews every 6 months, and corrective action plans of up to 3 years duration which would be monitored every 6 months; with a provision that the Secretary may make a determination that imposition of a sanction or disincentive is not in the best interests of Medicaid, in which case a sanction or disincentive is not to be imposed;

- allow the agency to terminate a provider who does not enter into an agreed-upon repayment schedule;

- allow the agency and MFCU to review a provider's Medicaid-related records in order to reconcile quantities of goods or services billed to Medicaid against quantities of goods and services used in the provider's total practice;

- allow the agency to terminate a provider's participation in Medicaid for failure to reimburse an overpayment which has been determined by final order within 35 days unless the provider and the agency have entered into a repayment agreement, and requiring reinstatement if the final order is overturned on appeal;

- require that administrative hearings pursuant to chapter 120 be conducted within 90 days following assignment of an administrative law judge and specifying that upon issuance of a final order that the balance outstanding becomes due;

- allow the agency to withhold medical assistance payments to a provider until the amount due is repaid in full if a provider fails to make payments in full, or comply with the terms of a repayment plan or settlement agreement;

- delete a provision which restricted withholding of provider payments to no more than 10 percent of a provider's monthly payments from the agency;

- allow agents and employees of the agency and MFCU to inspect the records of a pharmacy, wholesale establishment, manufacturer, or other place in the state where drugs and medical supplies are manufactured, packed, stored, sold, or kept for sale, for the purpose of verifying the amount of drugs and medical supplies ordered, delivered or purchased by a provider;

- require that the agency request the Attorney General to review any settlement of an overpayment in which the agency reduces the amount due the state by the amount of $10,000 or greater; and

- require that the agency request the Auditor General to review any provider rate adjustment not supported by a cost report or in which there are disagreements concerning the application of accounting interpretations and where the financial benefit to the provider exceeds $10,000.

Section 9. Amends subsections (7) and (8) of s. 409.920, F.S., to:

- delete a requirement that the Attorney General refer to the Agency for Health Care Administration all cases of suspected abuse of the Medicaid program that are not criminal in nature and each instance of Medicaid overpayments to a provider which is discovered in the course of an investigation;

- permit the Attorney General to seek any civil remedy, including, but not limited to, those in the Florida False Claims Act, the civil recovery section of the Florida Anti-Fencing Act, or ch. 409, F.S.;

- permit a referral to the agency for collection in any case of overpayment to a provider discovered during the course of an investigation; and to refer to the agency any case of suspected abusive activity not of a criminal nature;

- clarify that the investigatory powers granted in subsection (8) are available to the Attorney General in carrying out the responsibilities delineated in other subsections of s. 409.920, F.S.; and

- require the Attorney General to publicize the ability of persons to bring suit under the provisions of the Florida False Claims Act and the potential for the persons bringing a civil suit under that act to obtain a monetary award.

Section 10. Requires the agency to make recommendations to the Legislature as to limits in the amount of home office management and administrative fees which should be allowable for reimbursement for providers whose rates are set on a cost-reimbursement basis.

Section 11. Provides an effective date of upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this CS have no impact on municipalities and the counties under the requirements of Art. VII, s. 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

The provisions of this CS have no impact on the trust fund restrictions under the requirements of Art. III, s. 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The CS gives AHCA and the Attorney General additional powers and remedies to recover Medicaid overpayments, potentially resulting in additional penalties to providers who improperly bill Medicaid.

C. Government Sector Impact:

The CS may result in additional recoveries of Medicaid funds for the state in the instance of providers who have been overpaid by the Medicaid program. Historically, the return on investment in Medicaid recovery activities has ranged from approximately $2.50 to $4.90 for each dollar spent.

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.