HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 939 Medicaid Fraud
SPONSOR(S): Pigman
TIED BILLS: **IDEN./SIM. BILLS:** SB 844

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		McElroy	Shaw
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

HB 939 modifies existing statutory provisions relating to fraud and abuse, provider controls and accountability in the Medicaid program. These modifications include the following:

- Increasing the length of time for retaining all medical and Medicaid related records from 5 to 6 years for Medicaid providers;
- Requiring Medicaid providers to report a change in any principal of the provider to the Agency for Health Care Administration (AHCA or the Agency) in writing no later than 30 days after the change occurs;
- Defining "administrative fines" and "outstanding overpayment" for purposes of liability for payment of such fines in the event of a change of ownership;
- Authorizing, rather than requiring, the AHCA to perform onsite inspections of the service location of a provider applying for a provider agreement before entering into a provider agreement with that provider, to determine that provider's ability to provide services in compliance with the Medicaid program and professional regulations;
- Extending the length of time before an administrative fine is assessed for failure to timely report an incidence of overpayment, abuse or fraud from 15 days to 60 days after detection.
- Requiring network providers under a Medicaid managed care program to submit a complete set of fingerprints for a criminal background check in order to participate in the Medicaid program;
- Requiring the Office of Medicaid Program Integrity to work with the Division of Insurance Fraud in reviewing and approving anti-fraud plans of insurers;
- Authorizing the AHCA to review and analyze information from sources other than enrolled Medicaid providers in conducting investigations;
- Requiring the AHCA to impose the sanction of termination for cause against a provider that voluntarily relinquishes their Medicaid provider number under certain circumstances;
- Limiting the timeframe for providers to submit records to the AHCA to 30 days after the provider has received the final audit report; Removing a requirement that the AHCA pay an interest rate of 10 percent a year on provider payments that have been withheld on a suspicion of fraud or abuse, if it is determined that there was no fraud or abuse;
- Clarifying the scope of immunity from civil liability for persons who report fraudulent acts or suspected fraudulent acts and providing a definition of fraudulent acts.

The bill does not appear to fiscal impact on state or local government.

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Health Care Fraud

In 2009, the Legislature passed CS/CS/CS/SB 1986 to address systematic health care fraud in Florida. Over three have now passed since these anti-fraud provisions were enacted and certain changes have been identified which would enhance Florida's efforts to prevent health care fraud and abuse in Florida's Medicaid program. This bill addresses some of the gaps in enforcement authority, strengthens the reporting requirements by Medicaid providers and Medicaid managed care organizations and defines the consequences for failure to comply with these requirements.

Medicaid

Medicaid is a medical assistance program that provides access to health care for low-income families and individuals. Medicaid also assists aged and disabled people with costs of nursing facility care and other medical expenses. The ACHA's Division of Medicaid administers the Florida Medicaid Program. The statutory authority for the Medicaid program is contained in ch. 409, F.S.

Medicaid reimburses health care providers that have a provider agreement with the AHCA only for goods and services that are covered by the Medicaid program and only for individuals who are eligible for Medicaid assistance from Medicaid. Section 409.907, F.S., establishes requirements for Medicaid provider agreements, which include among other things, background screening requirements, notification requirements for change of ownership of a Medicaid provider, authority for AHCA site visits of provider service locations and surety bond requirements. The statute does not provide for background screening for non-enrolled providers who participate in the Medicaid program as components of a Medicaid managed care network.

Currently, the Office of Medicaid Program Integrity reviews anti-fraud plans for all participating Medicaid plans. Additionally, under s. 626.9891, F.S., all insurance companies and managed care companies also submit their required anti-fraud plans to the Department of Financial Services, Division of Insurance Fraud for review.

Under s. 409.913, F.S., the AHCA is responsible for overseeing the integrity of the Medicaid program, to ensure the fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate.

Sections 409,920, 409.9201, 409.9203, and 409.9205, F.S., contain provisions relating specifically to Medicaid fraud. A person who provides the State with information about fraud or suspected fraud by a Medicaid provider, including a managed care organization, is immune from civil liability for providing that information unless the person knew the information was false or acted with reckless disregard for the truth or falsity of the information.[1]

Part IV of ch. 409, F.S., requires all Medicaid recipients to enroll in a managed care plan unless they are specifically exempted. The statewide Medicaid managed care program includes the long-term care managed care program and the managed care medical assistance program. The law directs the AHCA to begin implementation of the long term managed care program by July 1, 2012, with full implementation in all regions of the State by October 1, 2013. The State received federal approval of

[1] See s. 409.920(8), F.S.

this program on February 1, 2013.[2] Although the AHCA has received conditional approval,[3] the AHCA is still awaiting final approval of the managed medical assistance program whose full implementation is anticipated by October 1, 2014.

Background Screening

Chapter 435, F.S., establishes standards for background screening for employment. Section 435.03, F.S., sets standards for Level 1 background screening. Level 1 background screenings include, but are not limited to, employment history checks and statewide criminal correspondence checks through the Department of Law Enforcement and a check of the Dru Sjodin National Sex Offender Public Website, and may include local criminal records checks through local law enforcement agencies.

Level 2 background screenings include, but are not limited to, fingerprinting for statewide criminal history records checks through the Department of Law Enforcement and national criminal history records checks through the Federal Bureau of Investigation. They may also include local criminal records checks through local law enforcement agencies. Section 435.04(2), F.S., lists the offenses that will disqualify an applicant from employment.

Section 408.809, F.S., establishes background screening requirements and procedures for entities licensed by the AHCA. The AHCA must conduct Level 2 background screening for specified individuals. Each person subject to this section is subject to Level 2 background screening every 5 years. This section of law also specifies additional disqualifying offenses beyond those included in s. 435.04(2), F.S.

Effects of the bill

Section 409.907(3)(c), F.S. requires Medicaid providers to retain all medical and Medicaid-related records for 5 years. The bill extends the retention period to 6 years, which is consistent with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 administrative simplification rules.[4]

The bill requires a Medicaid provider to report, in writing, any change of any principal of the provider to AHCA within 30 days after the change occurs. “Principal” includes any officer, director, agent, managing employee, affiliated person or any partner or shareholder who has a 5% or greater interest in the provider.

The bill defines “administrative fines” and “outstanding overpayment”. This functions to clarify the statutory provisions relating to the liability of Medicaid providers in a change of ownership for outstanding overpayments, administrative fines, and any other moneys owed to the AHCA.

Section 409.907(7) requires the AHCA to conduct random onsite inspections of Medicaid providers’ service locations within 60 days after receipt of a fully complete new provider’s application and prior to making the first payment to the provider for Medicaid services. The bill removes the 60 day time period, as well as the requirement for random inspections. This provides the ACHA with greater flexibility in performing its onsite inspections prior to entering into a provider agreement. The bill also removes the exception to random onsite-inspections granted to certain providers as the inspections are conducted at the discretion of the ACHA.

Currently, only enrolled Medicaid providers are contractually required to submit a complete set of fingerprints to the ACHA for criminal history screening. The bill amends the statute to require Medicaid

[2] Agency for Health Care Administration, February 1, 2013 Waiver Approval Letter, http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Signed_approval_FL0962_new_1915c_02-01-2013.pdf (last visited on March 14, 2013).
[3] Agency for Health Care Administration, *February 20, 2013 Agreement in Principle Letter*, http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/Letter_from_CMS_re_Agreement_in_Principal_2013-02-20.pdf (Last visited on March1 4, 2013).
[4] See 45 CFR 164.316(b)(2).

managed care network providers, and persons who meet the definition of controlling interest for certain hospitals and nursing homes to submit a full set of fingerprints to the ACHA.

Section 409.91212, F.S., requires AHCA to review anti-fraud plans of all Medicaid managed care organizations and Medicaid provider service networks. Anti-fraud plans for all insurance companies and managed care companies are also required to be submitted to the Department of Financial Services, Division of Insurance Fraud under s. 626. 9891, F.S. The bill amends this section to eliminate the duplicative submissions required under the statutes. Specifically, the bill amends this section and requires the AHCA to enter into an interagency agreement with the Division of Insurance Fraud in the Department of Financial Services to delineate the responsibilities of the two agencies in reviewing and approving anti-fraud plans of insurers under s. 626.9891, F.S.

The bill extends the length of time before an administrative fine is assessed against a managed care plan for failure to timely report an incidence of overpayment, abuse or fraud from 15 days to 60 days after detection. This change gives the managed care plan more time to conduct an internal investigation of the allegations.

Pursuant to s. 409.913, F.S., the ACHA may only review and analyze information from enrolled providers in its investigation of fraud, abuse, overpayment and/or recipient neglect in the Medicaid program. The bill authorizes the ACHA to review and analyze information from sources other than enrolled Medicaid providers when investigating or auditing a Medicaid provider.

Section 409.913(13), F.S., requires the AHCA to immediately terminate participation of a Medicaid provider that has been convicted of certain identified offenses. However, in order to immediately terminate a provider, the AHCA must show an immediate harm to the public health, which is not always possible. The bill removes “immediately” from the requirement the provision. The AHCA still must terminate a Medicaid provider from participation in the Medicaid program but the termination is no longer in conflict with the Administrative Procedures Act.[5] The bill additionally amends this section to clarify the instances of provider disqualification from participation on the Medicaid program.

Section. 409.913, F.S., delineates the noncriminal actions of Medicaid providers for which the AHCA may impose sanctions. The section provides penalties for the individual or provider who participated or acquiesced in the proscribed activity. The bill adds individuals or providers who “authorized” to those who may be sanctioned under this section. The bill also adds that the AHCA may sanction a provider if the provider is charged by information or indictment with any offense referenced in subsection (13).

Currently, if a Medicaid provider receives notification that it is going to be suspended or terminated, the provider is able to voluntarily terminate their contract. By doing this, a provider has the ability to avoid sanctions of suspension or termination, which would affect the ability of the provider to reenter the program in the future. The bill amends s. 409.913(16), F.S., to state that, if a Medicaid provider voluntarily relinquishes its Medicaid provider number after receiving notice of an audit or investigation for which the sanction of suspension or termination will be imposed, the AHCA must impose the sanction of termination for cause against the provider. The bill also amends this section to give the Secretary of the AHCA discretionary authority to make a determination to refrain from imposing a sanction if it is not in the best interest of the Medicaid program.

The bill amends s. 409.913(21), F.S., to specify that when the AHCA is making a determination that an overpayment has occurred, the determination must be based solely upon information available to it before it issues the audit report and, in the case of documentation obtained to substantiate claims for Medicaid reimbursement, based solely upon contemporaneous records.

The bill amends s. 409.913(22), F.S., to state that a provider may not present records to contest an overpayment or sanction unless such records are contemporaneous and, if requested during the audit

[5] See s. 120.569(2)(n), F.S. which requires that “if any agency head finds that an immediate danger to the public health , safety, or welfare requires an immediate final order, it shall recite with particularity the facts underlying such finding in the final order, which shall be appealable or enjoinable from the date ordered.”

process, were furnished to the AHCA within 30 days after the provider received the final audit report. Also, all documentation to be offered as evidence in an administrative hearing on an administrative sanction (in addition to Medicaid overpayments) must be exchanged by all parties at least 14 days before the administrative hearing or otherwise it will be excluded from consideration.

The bill amends s. 409.913(25), F.S., to remove the requirement that the AHCA pay interest at the rate of 10 percent a year on Medicaid payments that have been withheld from a provider based on suspected fraud or criminal activity, if it is determined that there was no fraud or that a crime did not occur. Also, payment arrangements for overpayments and fines owed to the AHCA must be made within 30 days after the date of the final order and are not subject to further appeal.

Section 409.913(28), F.S., provides that venue for all Medicaid program integrity overpayments cases shall lie in Leon County. This creates questions as to whether venue for all administrative fines cases also lie in Leon County. The bill amends s. 409.913(28), F.S., to make Leon County the proper venue for all Medicaid program integrity cases.

The bill amends s. 409.913(29), F.S., to authorize the AHCA and the Medicaid Fraud Control Unit of the Department of Legal Affairs to review a *person's*, in addition to a provider's, Medicaid-related and non-Medicaid-related records in order to determine the total output of a provider's practice to reconcile quantities of goods or services billed to Medicaid with quantities of goods or services used in the provider's total practice.

Section 409.913(30), F.S., requires the AHCA to terminate a provider's participation in the Medicaid program if the provider fails to pay a fine within 35 days after the date of the final order imposing the fine. The bill amends this section to reduce the time within which a provider must reimburse an overpayment to 30 days after the date of the final order.

The bill amends s. 409.913(31), F.S., to include fines, as well as overpayments, to the outstanding balance due upon the issuance of a final order at the conclusion of a requested administrative hearing.

The bill amends s. 409.920, F.S., to clarify that the existing immunity from civil liability extended to persons who provide information about fraud or suspected fraudulent acts is for civil liability for libel, slander, or any other relevant tort. The bill defines "fraudulent acts" for purposes of immunity from civil liability to include actual or suspected fraud and abuse, insurance fraud, licensure fraud or public insurance fraud; including any fraud-related matters that a provider or health plan is required to report to the AHCA or a law enforcement agency. The immunity from civil liability extends to reports conveyed to the AHCA in any manner, including forums, and incorporates all discussions subsequent to the report and subsequent inquiries from the AHCA.

The bill provides an effective date of July 1, 2013.

B. SECTION DIRECTORY:

Section 1 amends s. 409.07, F.S., relating to Medicaid provider agreements.

Section 2 amends s. 409.91212, F.S., relating to Medicaid managed care fraud.

Section 3 amends s. 409.913, F.S., relating to oversight of the integrity of the Medicaid program.

Section 4 amends s. 409.920, F.S., relating to Medicaid provider fraud.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Entities and individual health care providers under Medicaid currently exempt from background checks will be required to complete the same requirements as other Medicaid providers. Health care providers who do not participate in the Medicaid program under fee-for-service but become a member of a Medicaid managed care provider network will be required to undergo background screening.

The total fee for a Level 2 background screening is $64.50 ($24.00 for the state portion, $16.50 for the national portion, and $24.00 for retention). There is an additional fee of $11-$16 for electronic screening, depending on the provider. The cost of the screening is borne by the individual provider.[6]

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[6] Agency for Health Care Administration, *House Bill 944 Analysis & Economic Impact Statement* (March 14, 2013).