HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 421 Reimbursement of Medicaid Providers
SPONSOR(S): Trumbull
TIED BILLS: **IDEN./SIM. BILLS:** SB 526

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

SUMMARY ANALYSIS

In the Medicaid program, to determine the appropriate reimbursement to a provider for services rendered to a recipient, the Agency for Health Care Administration (AHCA) pays the amount billed by the provider, the provider's usual and customary charge, or the maximum allowable fee established by AHCA, whichever amount is less. AHCA is required to make timely payment for services or goods to a provider upon receipt of a claim form from the provider. Among other requirements, the claim form certifies that the services or goods were completely furnished to the recipient and that the amount billed does not exceed the provider's usual and customary charge for the same services or goods.

"Usual and customary" is a common payment methodology utilized in various sections of Florida law, including the Medicaid statutes. However, despite its prevalent use, the term is not defined in law. This potentially creates uncertainty of interpretation of the term and, as least in the Medicaid program, has resulted in litigation.

HB 421 amends s. 409.901, F.S., to define "usual and customary", for the purposes of the Medicaid program, as the amount routinely billed by a provider or supplier to an uninsured consumer for services or goods before application of any discount, rebate, or supplemental plan. The term does not include free or discounted charges for services or goods based upon a person's insured or financial status. The bill expressly states that the definition is remedial in nature and, based on existing case law, demonstrates the intent for retroactive application of the definition.

The bill does not appear to have a fiscal impact on state or local governments.

The bill provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families, the Agency for Persons with Disabilities, and the Department of Elderly Affairs.

The structure of each state's Medicaid program varies and what states must pay for is largely determined by the federal government, as a condition of receiving federal funds. Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states: some populations are entitled to enroll in the program and enrollees are entitled to certain benefits.

The federal government sets the minimum mandatory benefits to be covered in every state Medicaid program. These benefits include physician services, hospital services, home health services, and family planning.[1] States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, dental services, and dialysis.[2]

Statewide Medicaid Managed Care[3]

In 2011, the Legislature established the Statewide Medicaid Managed Care (SMMC) program as Part IV of Chapter 409, F.S. The SMMC program is an integrated managed care program which provides all mandatory and optional Medicaid benefits to enrollees. Within the SMMC program, the Managed Medical Assistance (MMA) program provides primary and acute medical assistance and related services, including dental services.[4] In the SMMC program, each Medicaid recipient has one managed care organization to coordinate all health care services, rather than various entities.[5]

In December 2012, AHCA released an Invitation to Negotiate (ITN) to competitively procure managed care plans on a regional basis for the MMA program.[6] AHCA selected 19 managed care plans and executed 5-year contracts in February 2014. The MMA program was fully implemented statewide as of August 1, 2014.

Medicaid Provider Reimbursement- Usual and Customary

[1] S. 409.905, F.S.
[2] S. 409.906, F.S.
[3] The delivery of Medicaid services through managed care is not expressly authorized by federal law. If a state wants to use a managed care delivery system, it must seek a waiver of certain requirements of Title XIX of the Social Security Act (Medicaid). To implement the SMMC program, AHCA applied for and obtained section 1115 waiver authority.
[4] The other component of the SMMC program is the Long-Term Care Managed Care Program.
[5] This comprehensive coordinated system of care was successfully implemented in the 5-county Medicaid reform pilot program, 2006-2014.
[6] AHCA Invitation to Negotiate, *Statewide Medicaid Managed Care*, *Addendum 2,* Solicitations Number: AHCA ITN 017-12/13; dated February 26, 2013 http://www.govcb.com/Statewide-Medicaid-Managed-Care-ADP136192735200011 82.htm (last visited on January 4, 2016); AHCA Invitation to Negotiate, *Statewide Medicaid Managed Care*, Solicitation Number: AHCA ITN 017-12/13; dated December 28, 2012 http://www.govcb.com/Statewide-Medicaid-Managed-Care-ADP136192735200011 82.htm (last visited on January 4, 2016).

AHCA is required to reimburse Medicaid providers in accordance with state and federal law.[7] Requirements for reimbursement are established according to methodologies set forth in AHCA's administrative rules and in policy manuals and handbooks incorporated by reference.[8]

Medicaid reimbursement methodologies differ based upon what type of services or goods are being provided; however, these methodologies often include a prohibition against reimbursement in excess of the provider's usual and customary rate for the service or good. In fact, with some exceptions, for each allowable service or good furnished in accordance with applicable law, the reimbursement is the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee, whichever is less.[9] Further, in order to be eligible to receive payment from AHCA, a provider must certify that the service or good has been completely furnished to the Medicaid recipient and that the amount billed does not exceed the provider's usual and customary charge.[10] However, despite its prevalent use, the term is not defined in Florida law.[11]

Reimbursement for Laboratory Services- Qui Tam Action against Certain Providers[12]

"Qui tam" is a Latin abbreviation for "he who sues in this matter for the king as well as for himself".[13] Qui tam actions are commonly referred to as whistle blower lawsuits and involve a private citizen suing a person or corporation on behalf of the federal or state government. The private citizen plaintiff is authorized to prosecute the lawsuit from start to finish; however, the government may intervene and assume primary responsibility for the lawsuit. The private citizen plaintiff is entitled to a percentage of any amount recovered for the government.

In 2007, Hunter Labs and Chris Riedel filed a qui tam action under the Florida False Claims Act in the circuit court in Leon County, alleging that LabCorp and Quest Diagnostics (LabCorp/Quest) defrauded the state by overcharging the Medicaid program for laboratory services provided to recipients. In 2013, the Attorney General (AG) intervened in the above lawsuit alleging that LabCorp/Quest defrauded the state by failing to charge the Medicaid program its lowest charge to any other third party payer for providing laboratory services.[14]

LabCorp/Quest filed an administrative petition with the Division of Administrative Hearings (DOAH) against AHCA challenging the validity of the "lowest charge" rule.[15] Ultimately, AHCA agreed that the rule was invalid and a Consent Order was entered in March 2014, formally striking down the rule. This litigation, although related to the circuit court case, was separate and distinct from the qui tam action.

In light of the Consent Order entered into in the DOAH hearing, the AG is pursuing an alternative legal theory against LabCorp/Quest in the qui tam action. The AG alleges that LabCorp/Quest defrauded the state by charging more than their usual and customary charge. For purposes of the litigation, it is the AG's position that the term "usual and customary" is defined as any amount accepted by LabCorp/Quest as payment from any other third-party payer.

In August 2014, AHCA proposed a rule that would have codified the AG's interpretation of usual and customary charge. Medicaid providers objected to the rule and the interpretation, arguing that the

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[7] S. 409.908, F.S. Reimbursement is subject to specific appropriations.
[8] Id.
[9] Id; see also s. 409.912(8)(a), F.S.; s. 409.9128(5), F.S.; s. 409.967, F.S.; 42 C.F.R. 447.512; Florida Medicaid Provider General Handbook, as promulgated in Rule 59G-5.020, F.A.C.; and Florida Medicaid Prescribed Drug Services Handbook, as promulgated in Rule 59G-4.250, F.A.C.,
[10] S. 409.907(5)(a), F.S.
[11] Usual and customary is identified as a payment methodology in chapters 394, 400, 409, 440, 627, 641, and 817; however, the term is not defined.
[12] State of Florida ex rel. Hunter Laboratories, LLC and Chris Riedel v. Quest Diagnostics, Incorporated, et al, in the Circuit Court for the Second Judicial Circuit in and for Leon County, case number 2007-CA-003549.
[13] Qui Tam: An Abbreviated Look at the False Claims Act and Related Federal Statutes, Congressional Research Service, Charles Doyle, August 6, 2009, available at: http://webcache.googleusercontent.com/search?q=cache:INZp35Nhq5EJ:https://www.fas.org/sgp/crs/misc/R40786.pdf+&cd=5&hl=en&ct=clnk&gl=us (last viewed January 7, 2016).
[14] Rule 59G-5.110(2), F.A.C.
[15] The petition was filed against AHCA because AHCA developed and adopted the rule.

proposed definition was contrary to the long understood meaning of the term, and the term had never been interpreted in that manner. LabCorp/Quest filed an administrative petition with DOAH, challenging the proposed rule as an invalid exercise of delegated legislative authority. This litigation, although related the circuit court case, was separate and distinct from the qui tam action. AHCA subsequently withdrew the proposed rule and stipulated that it had never previously interpreted "usual and customary charge" according to the "accepted payment" standard in the proposed rule and that it would not rely on that interpretation moving forward.

Although litigation of the administrative petitions with DOAH has resolved, the qui tam action against LabCorp/Quest is currently ongoing.

Retroactive and Remedial Application of Law

Newly enacted legislation is presumed to apply prospectively absent clear legislative intent to the contrary.[16] However, the intent for retrospective application of enacted legislation can be established through the express language of the statute or by analyzing the practical effect of the statute. If the intent for retrospective application is established, then it must be determined whether such application of the statute is constitutionally permissible.[17] Retroactive application is unconstitutional, and thereby prohibited, if:[18]

- Vested rights are adversely affected or destroyed;[19]
- A new obligation or duty is created or imposed; or
- An additional disability is established.

The Florida Supreme Court previously ruled that retroactive application of a remedial statute is constitutionally permissible and should occur to achieve the intended purpose of the statute.[20] Remedial statutes operate to further a remedy or confirm existing rights and do not create new obligations or adversely affect vested rights.[21] Further, when an amendment to a statute is enacted soon after controversies as to the interpretation of the original statute arise, a court may consider that amendment as legislative interpretation of the original law and not a substantive change of the law.[22]

Effect of Proposed Changes

The term “usual and customary” is not defined for purposes of determining reimbursement of Medicaid providers in Florida. HB 421 amends s. 409.901, F.S., and defines “usual and customary” as the amount routinely billed by a provider or supplier to an uninsured consumer for services or goods before application of any discount, rebate, or supplemental plan. The term does not include free or discounted charges for services or goods based upon a person's insured or financial status. The definition applies to the entire Medicaid program, through sections 409.901 through 409.920, F.S., unless expressly stated otherwise. The bill expressly states that the definition is remedial in nature and, based upon existing case law, demonstrates intent for retrospective application of the definition.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.901, F.S., relating to definitions; ss. 409.901-409.920.
Section 2: Creates an unnumbered section of law stating that changes made by the act to s. 409.901, F.S., are intended to clarify existing law and are remedial in nature.
Section 3: Provides an effective date of July 1, 2016.

[16] See Metropolitan Dade County v. Chase Federal Housing Corp., 737 So.2d 494 (Fla. 1999).
[17] Id.
[18] Id.
[19] For example, a law which retroactively criminalizes a vested legal right, such as the right to marriage, would be considered unconstitutional. Similarly, a zoning law which retroactively prohibits the use of real property is unconstitutional if the right to that particular use had previously vested in the owner.
[20] See City of Lakeland v. Cantinella, 129 So.2d 133 (Fla. 1961); see also Smiley v. State, 966 So.2d 330 (Fla. 2007); City of Orlando v. Desjardins, 493 So.2d 1027 (Fla. 1986).
[21] Id.
[22] See Lowry v. Parole and Probation Commission, 473 So.2d 1248 (Fla. 1985).

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:

If a provider has a system in place to calculate the usual and customary charge for Medicaid billing which applies a definition of "usual and customary" which is different from the definition in the bill, then the provider may need to change the way they calculate billing rates.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill contains an unnumbered section of law which states, "The changes made by this act to s. 409.901, Florida Statutes, are intended to clarify existing law and are remedial in nature." It is unclear whether a statement of remedial intent in an unnumbered section of law in pending legislation has the same impact as a statement of remedial intent contained within a statute. Existing statutes that expressly intend for remedial application of the law include such statements within the statute itself.[23] Thus, it is recommended that the statement of remedial intent contained within the bill be placed within s. 409.901, F.S.

[23] For example, the remedial statement is contained within the statute itself in ss. 553.73 (14), 655.851 and 222.21(2)(c), F.S.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES