The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 322
INTRODUCER:	Senator Stargel
SUBJECT:	Medicaid Reimbursement for Hospital Providers
DATE:	February 2, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Favorable**
2.			FP	

I. Summary:

SB 322 clarifies reimbursement provisions, provider notification requirements, and the administrative challenge process for Medicaid inpatient and outpatient hospital rates. The bill specifies that the written notice of the hospital reimbursement rates provided by the Agency for Health Care Administration (AHCA or agency) constitutes final agency action for purposes of administrative challenges to the rate. Challenges to the rate are barred if the hospital fails to timely file a petition and include all documentation supporting the challenge in the petition.

The bill also establishes time limitations for rate corrections or adjustments to within the first rate period after either an administrative order or civil judgment is final, but it must occur within five years after the date on which the provider received AHCA's written notice of the reimbursement rate. An administrative body or court may not compel the agency to pay a monetary judgment relating to the hospital reimbursement rates beyond the 5-year timeframe.

These clarifications are deemed remedial in nature and apply retroactively to all proceedings pending or commenced on or after the effective date of this act.

The fiscal impact of the bill is indeterminate; however, should the state not prevail in pending or potential administrative challenges, the state's liability could reach $30 million.

The bill is effective upon becoming a law.

II. Present Situation:

Florida Medicaid

Medicaid is a joint federal and state funded program that provides health care for low income Floridians. The program is administered by the AHCA and financed with federal and state funds.

Over 3.7 million Floridians are currently enrolled in Medicaid[1] and its enrollees make up 20 percent of Florida's population.[2] The state statutory authority for the Medicaid program is contained in ch. 409, F.S.

Medicaid's estimated expenditures for Fiscal Year 2014-2015 are over $23.3 billion.[3] The total budget for the current state fiscal year is over $24.5 billion with $14.6 billion of those funds coming from federal sources.[4]

Nationally, Medicare and Medicaid account for 58 percent of all care provided by hospitals.[5] The Florida Hospital Association reports providing more than $1.4 billion in community benefit to Florida Medicaid and other government programs in 2012.[6]

While hospital participation in Medicaid is voluntary, in order for a hospital receive a federal tax exemption for providing health care to the community, not for profit hospitals are required to care for Medicare and Medicaid beneficiaries.[7]

Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare and Medicaid Services (CMS). The plan outlines current Medicaid eligibility standards, policies, and reimbursement methodologies, including inpatient and outpatient hospital rate charges. Florida's Medicaid state plan and its attachments provide the methodology for the reimbursement of both inpatient and outpatient services.

Hospital Reimbursements for Medicaid

Prior to July 1, 2013, rates for hospital inpatient and outpatient services under the Florida Medicaid program were set on a facility-specific basis based on each facility's reported costs.[8, 9] Outpatient services continue to be facility-specific based on each facility's reported costs. Hospital rates based on reported costs for services provided by the hospital to Medicaid recipients on a fee-for-service basis are an all-inclusive "per diem" rate.

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[1] Agency for Health Care Administration, *Number of Medicaid Eligibles by Age, by Assistance Category as of 12/31/2014 Plus Medikids A, Medikids B, & Medikids C,* http://ahca.myflorida.com/medicaid/about/pdf/age_assistance_category_2014-12-31.pdf (Last visited Jan. 29, 2015).
[2] Agency for Health Care Administration, *Agency for Health Care Administration - An Overview - Presentation to Senate Health and Human Services Appropriations Subcommittee* (January 22, 2015), slide 2, *available at* http://edr.state.fl.us/Content/conferences/medicaid/medsummary.pdf (Last visited Jan. 29, 2015).
[3] Social Services Estimating Conference, *Medicaid Caseloads and Expenditures, June 27, July 22, and August 4, 2014 Executive Summary,* http://edr.state.fl.us/Content/conferences/medicaid/medsummary.pdf (Last visited Jan. 29, 2015).
[4] Agency for Health Care Administration, *see supra* note 2, at slide 3.
[5] American Hospital Association, *Underpayment by Medicare and Medicaid Fact Sheet-2015,* http://www.aha.org/content/15/medicaremedicaidunderpmt.pdf (last visited Jan. 28, 2015).
[6] Florida Hospital Association, *2014 Florida Hospitals' Community Benefit Report,* p. 4, *available at* http://www.fha.org/ (Last visited Jan. 28, 2015).
[7] American Hospital Association, *see supra* note 5.
[8] Agency for Health Care Administration, *Senate Bill 322 Analysis* (January 28, 2015) (on file with Senate Health Policy Committee).
[9] Beginning July 1, 2013, the agency began paying Medicaid inpatient hospital fee-for-service claims under the Diagnosis Related Groups (DRG) method. Under Statewide Medicaid Managed Care, hospitals providing services to Medicaid managed care enrollees are paid by managed care plans typically in accordance with negotiated rates.

The hospital cost report[10] details costs for the entire year and includes any appropriate adjustments as required by the state's adopted *Medicaid Hospital Outpatient or Inpatient Reimbursement Plans* for allowable costs.[11, 12] Both inpatient and outpatient hospital rate reimbursement plans are promulgated as rules under the Florida Administrative Procedures Act and are made available for public comment and inspection.[13]

Hospitals participating in the Medicaid program submitted cost reports to the agency for both inpatient and outpatient services twice a year (July and January) and then just once a year beginning in 2011. These reports are now due no later than five calendar months after the close of the hospital's cost-reporting year.[14,15,16] The AHCA must retain all cost reports for at least 5 years following the date of submission pursuant to the record keeping requirements of 45 CFR 205.60.

Hospitals were notified of their "per diem" rates via letters sent from the AHCA. As amended or updated cost reports were submitted by hospitals, rates were adjusted to reflect the updated reported cost, if applicable. However, hospital rates, once set, are only adjusted under limited circumstances. Those circumstances are:[17]

- The fiscal intermediary[18] or AHCA made an error in the calculation.
- A hospital submits an amended cost report within three years of the initial rate's effective date and the change is material.
- Desk or field audits of the cost reports disclose material changes in the reports. [19,20]
    - For cost reports received on or after October 1, 2003, all desk or onsite audits of these cost reports are final and may not be reopened past three years of the date that the audit adjustments are noticed through a revised per diem rate completed by the agency.
    - Effective October 1, 2013, for cost reports received prior to October 1, 2003, all desk or onsite audits of these cost reports are final and not subject to reopening.

      These limitations do not apply when Medicare audit re-openings result in the issuance of revised Medicaid cost report schedules. Also, a cost report may be reopened for inspection, correction, or referral to a law enforcement agency at any time by the agency

[10] The cost report forms are established by the federal CMS. *See* 42 U.S.C.s. 1396a(6) (2012).
[11] Fla. Admin. Code R. 59G-6.030, *infra,* Note 14, Section I, Paragraph C.
[12] Fla. Admin. Code R. 59G-6.020, *infra* note 15, Section I, Paragraph N.
[13]Fla. Admin. Code R. 59G-6.020, *infra* note 15, Section V, Paragraph B(7).
[14] Fla. Admin. Code R. 59G-6.030, *Florida Title XIX Outpatient Hospital Reimbursement Plan, Version XL,* (Effective July 1, 2013) Section I, Paragraph A (Attachment 4.19-B, Part I) http://ahca.myflorida.com/Medicaid/cost_reim/pdf/Florida_Title_XIX_Hospital_Outpatient_Plan_Version_v24.pdf (Last visited Jan. 30, 2015).
[15] Fla. Admin. Code R. 59G-6.020, *Florida Title XIX Inpatient Hospital Reimbursement Plan, Version XXIV* (Effective July 1, 2013) https://www.flrules.org/gateway/reference.asp?No=Ref-04814 Section I, Paragraph A (Attachment 4.19-A, Part I) (Last visited Jan. 30, 2015).
[16] A hospital filing a certified cost report audited by independent auditors may receive a 30-day extension.
[17] Fla. Admin. Code R. 59G-6.030, *supra* note 14, Section IV, Paragraph G.
[18] The Agency has entered into written agreements with Medicare intermediaries to conduct common hospital cost report audits. These audits are conducted on hospitals located in Florida, Georgia, and Alabama which participate in various federal programs.
[19] Fla. Admin. Code R. 59G-6.020, *supra* note 15, Section I, Paragraph J.
[20] Fla. Admin. Code R. 59G-6.030, *supra* note 14, Section I, Paragraph K.

or its contractor if program payments appear to have been obtained by fraud, similar fault, or abuse.

- The charge structure of a hospital changes.

The *Medicaid Hospital Outpatient Plan* and the *Inpatient Reimbursement Plan* each include a provision for challenging any rate adjustment or denial of a rate adjustment by the AHCA under Rule 28-106 of the Florida Administrative Code and s. 120.57, F.S.

Beginning July 1, 2013, the agency implemented a new prospective payment methodology that uses Diagnosis Related Groups (DRG) for Medicaid inpatient hospital fee-for-service claims. Under this reimbursement methodology, hospital inpatient per diem reimbursement rates are not noticed, except for the state mental health hospitals which will continue to be paid based on a per diem methodology.[21] DRG payments are based on the classification of inpatient stays and then a determination of price based on a combination of the classification and the hospital where the services were performed.[22] Classification of the hospital stay is based on the diagnoses describing the patient's condition, the surgical procedures performed, if any, patient age, and discharge status.[23] These payments are generally fixed based on the DRG assignment, rather than a unique rate per hospital.

Legislation Limiting Hospital Reimbursement Rate Adjustments

In 2011, the Legislature amended s. 409.905(5), F.S., relating to hospital inpatient services with, among other provisions, the following new language:

> Errors in cost reporting or calculation of rates discovered after September 30 must be reconciled in a subsequent rate period. The agency may not make any adjustment to a hospital's reimbursement rate more than 5 years after a hospital is notified of an audited rate established by the agency. The requirement that the agency may not make any adjustment to a hospital's reimbursement rate more than 5 years after a hospital is notified of an audited rate established by the agency is remedial and shall apply to actions by providers involving Medicaid claims for hospital services.[24]

In 2012, the Legislature again amended s. 409.905(5), F.S., and republished the above language changing the September 30 date to October 31 along with a technical, grammatical modification.[25]

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[21] Agency for Health Care Administration, *Hospital Rates*, http://ahca.myflorida.com/Medicaid/cost_reim/hospital_rates.shtml (Last visited Jan. 29, 2015).
[22] Navigant, *DRG Conversion Implementation Plan - Final* (December 21, 2012) http://ahca.myflorida.com/medicaid/cost_reim/pdf/DRG_Payment-Conversion_Implementation_Plan-FL_AHCA-Final.pdf (Last visited Jan. 29, 2015).
[23] Id.
[24] Ch. 2011-135, s. 9, Laws of Fla.
[25] Ch. 2012-33, s. 5, Laws of Fla.

Then in 2013, the Legislature amended s. 409.905(5), F.S., again modifying the provision somewhat and amended subsection (6) relating to hospital outpatient services, with identical new language. Those two subsections now provide:

> Errors in source data or calculations discovered after October 31 must be reconciled in a subsequent rate period. However, the agency may not make any adjustment to a hospital's reimbursement more than 5 years after a hospital is notified of an audited rate established by the agency. The prohibition against adjustments more than 5 years after notification is remedial and applies to actions by providers involving Medicaid claims for hospital services.[26]

Administrative Challenges

Under current law, hospital providers are bringing administrative challenges to fee-for-service, per diem hospital rates regardless of the time passed since the initial rate setting period. Currently, the AHCA is involved in several challenges to hospital rates set under the old, per diem methodology. Some of these challenges involve rates initially set as far back as the 1990's, and even the 1980's.[27] In addition to the costs of litigation, given the passage of time for some of these challenges and the expedited timeframe for administrative hearings, the AHCA may not have all the documentation readily available that is necessary to support and defend the rates challenged.

III. Effect of Proposed Changes:

SB 322 amends s. 409.908, F.S., to clarify provider notification requirements and the administrative challenge process for Medicaid inpatient and outpatient fee-for-service hospital rates by placing clear limits on the time within which hospital reimbursement rates may be challenged, procedural steps for challenging those rates, and time frames for final disposition.

Although the agency has historically provided written notice of the reimbursement rates, the bill requires such notice and specifies the notice is final agency action in order to set the point of entry for an administrative challenge under the Florida Administrative Procedures Act. As a result, the agency may re-notice historical rates in accordance with this bill to start the 21-day clock in order to put an end to the perceived open-ended period for challenging rates.

The bill further provides:

- Any administrative challenge must be filed within 21 days after receipt of the written notice along with all documentation upon which the provider intends to rely, otherwise the hospital reimbursement rate is deemed conclusively accepted by the provider.
- Any correction or adjustment of a hospital reimbursement rate resulting from the challenge must be reconciled in the first rate period after the order or judgment becomes final but within 5 years after the provider received the written notice of the rate.

[26] Ch. 2013-48, s. 3, Laws of Fla.
[27] Agency for Health Care Administration, *see supra* note 8.

- Neither an administrative body nor court may compel the agency to pay a monetary judgment relating to hospital reimbursement rates more than 5 years after the date on which the provider received written notice.
- The periods of time set out in this bill are not tolled by the pendency of any administrative or civil proceeding.
- These clarifications are deemed remedial in nature and apply retroactively to all proceedings pending or commenced upon the act becoming law.

Other sections of related Medicaid and Kidcare statutes, ss. 383.18, 409.8132(4), 409.905(5)(c), and (6)(b), and 409.91211(3)(y), F.S., are reenacted for the purpose of incorporating the amendment made by SB 322.

The bill takes effect upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Specific timelines for filing challenges and addressing corrections or adjustments will establish finality in hospital reimbursements. The bill could affect the ability of privately owned hospitals to seek increased retroactive rate enhancements. Several administrative challenges are currently pending. The results of those petitions is unknown. Private hospitals will have 21 days from re-notice under this bill to file petitions. The fiscal impact of any subsequent challenges is indeterminate at this time according to the AHCA's analysis.[28]

[28] Agency for Health Care Administration, *see supra* note 8.

C. Government Sector Impact:

As with the private sector impact, specific timelines for filing challenges and addressing corrections or adjustments will establish finality in hospital reimbursements. The bill could affect the ability of public hospitals to seek increased retroactive rate enhancements. Several administrative challenges are currently pending. The results of those petitions is unknown. Should the state not prevail in the pending challenges, the state's liability could reach $30 million.[29] Public hospitals will have 21 days from re-notice under this bill to file petitions. The fiscal impact of any subsequent challenges is indeterminate at this time.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends sections 409.908, 383.18, 409.8132, 409.905, and 409.91211 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

[29] Agency for Health Care Administration, *see supra* note 8.