The Florida Senate

Interim Project Summary 2006-134 *March 2006*

Committee on Health Care Senator Durell Peaden, Jr., Chair

MEDICAID PROVIDER RATE SETTING STUDY

SUMMARY

Medicaid reimbursement policies play a central role in determining whether beneficiaries have access to services of adequate quality, as well as the nature of the services they receive.

In Florida, Medicaid provider reimbursement rates are developed based on legislative appropriations and put into rule by the Agency for Health Care Administration (AHCA or agency). Once rates are adopted, they are included in provider contracts or handbooks. Under current law, providers have the ability to challenge rate changes through ch. 120, F.S. This process has created a situation that limits the state's ability to adjust provider rates, even resulting in litigation by providers against the state to prevent rate reductions.

Chapter 2005-133, Laws of Florida, requires that the Senate Select Committee on Medicaid Reform shall study how provider rates are established and modified, how provider agreements and administrative rulemaking affect those rates, the discretion allowed by federal law for the setting of rates by the state, and the impact of litigation on provider rates. The committee shall issue a report containing recommendations by March 1, 2006, to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

This report contains four major findings. First, under federal Medicaid laws and regulations, states have considerable freedom to develop their own methods and standards for reimbursement of Medicaid services.

Second, the Florida Medicaid Program's provider rate setting methodologies are generally consistent with those used in other states. Although there are aspects of each methodology for which improvements may exist, no specific methodology used in another state is seen as vastly superior to those currently used by AHCA.

Third, previous litigation and rule challenges demonstrate that no statute currently exists that brings state Medicaid rate setting procedures into line with today's federal requirements.

Finally, current Medicaid provider rate setting methodologies are not structured to ensure that the state receives maximum value for its expenditures.

Based on these findings, the Senate Select Committee on Medicaid Reform recommends the following:

1) Current Florida Statutes that trade state control of Medicaid expenditures for provider input and allow rate setting by administrative rule should be reviewed and amended to align with federal law.

2) Pay-for-performance strategies should be tested as a method for improving health outcomes while lowering Medicaid expenditures in the Florida Medicaid Program.

BACKGROUND

Florida's Medicaid Program: An Overview

The Florida Medicaid Program is jointly funded by the federal, state, and county governments to provide medical care to eligible individuals. Medicaid is the largest program providing medical and health related services to the nation's poorest citizens. Within broad national guidelines, which the federal government establishes, each of the states:

- Establishes its own eligibility standards;
- Determines the type, amount, duration, and scope of services on a statewide basis;
- Sets the rate of payment for services; and
- Administers its own program.

The agency is the single state agency responsible for administering the Florida Medicaid Program. The statutory provisions for the Medicaid program appear in ss. 409.901 through 409.9205, F.S.

Reform and Provider Rate Setting

In 2003, Governor Bush raised the issue of Medicaid reform as a priority for the state. The Governor stressed the need for predictability in Medicaid budgeting and the principle of empowering Medicaid recipients to manage their personal health care. This process would fundamentally restructure the financing of Medicaid in Florida, including the way most provider rates are established. Over the next year, the Governor's office developed the Medicaid reform proposal that was released in January 2005.

In response to the release of the Governor's Medicaid reform proposal, the President of the Senate and the Speaker of the House of Representatives created Select Committees on Medicaid Reform in their respective chambers. The respective Select Committees met separately several times prior to and during the 2005 Regular Session.

During these meetings, the Select Committees heard testimony from hundreds of individuals including Medicaid recipients, health care providers, health maintenance organizations (HMOs), advocacy groups, and other interested parties on ways to improve the Medicaid program. Committee members also met with stakeholders in one-on-one meetings during the Regular Session.

The issue of provider rate setting in Florida's Medicaid program was one of the recurring issues raised during the meetings with stakeholders on Medicaid reform. From these discussions, several issues related to provider rate setting were raised, including:

- Are there ways that the current rate setting methodologies and system can be improved while reform is being implemented?
- How will risk-adjusted capitation rates be established within the reform pilot sites and how will plans set rates for providers in their networks?
- How can the state maintain or strengthen its ability to adjust provider rates as budgetary pressures require?
- Is there a way to provide incentives through the rate setting process for providers to improve the quality of care they deliver?

The Senate Select Committee on Medicaid Reform concluded that these issues should be examined in greater depth and any recommendations to address these issues should be provided to the Legislature and Governor by March 2006. The requirement for this Medicaid Provider Rate Setting study was included in the Medicaid reform bill that eventually passed in the 2005 Regular Session.

METHODOLOGY

Chapter 2005-133, Laws of Florida, provides:

> Section 21. The Senate Select Committee on Medicaid Reform shall study how provider rates are established and modified, how provider agreements and administrative rulemaking affect those rates, the discretion allowed by federal law for the setting of rates by the state, and the impact of litigation on provider rates. The committee shall issue a report containing recommendations by March 1, 2006, to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

To meet these objectives, staff from the Senate Health Care Committee, Senate Ways and Means Committee, and Senate Health and Human Services Appropriations Committee developed a study design that was reviewed and approved by the Chair of the Senate Select Committee on Medicaid Reform. The study design required Senate staff to:

- Review and summarize the basic federal requirements applicable to establishing Medicaid provider rates. This included reviewing federal policies and publications to determine the state's flexibility in establishing its reimbursement policies.
- Review and summarize how Florida's Medicaid program currently establishes and modifies provider rates for four general service categories: 1) acute care (including hospital inpatient and outpatient services, services for physicians and dentists, and services provided through certain health centers and clinics); 2) long term care (including care in nursing homes, assisted living facilities, intermediate care facilities for the developmentally disabled, and home and community-based care waivers); 3) managed care (including any reimbursement arrangement based on an entity accepting financial risk for covered Medicaid services in return for a fixed, monthly

payment per Medicaid enrollee); and 4) prescription drugs. This included a review of federal regulations and guidelines, a review of the Florida Medicaid Program's current rate setting methodologies and policies, and interviews and educational briefings with AHCA personnel.
- Review and contrast the reimbursement methodologies used by other states to determine if they could provide opportunities to promote better quality of care, increased efficiencies, or more budgetary predictability in the Florida Medicaid Program.
- Interview appropriate provider groups and other stakeholders to identify and assess the positive aspects of Florida's current reimbursement methodologies and areas for improvement.
- Review and summarize case law (including administrative hearing decisions) and pending litigation to identify critical barriers to establishing or modifying Medicaid provider rates in Florida. Included in this review were interviews with individuals in the Office of the Attorney General, AHCA, the Agency for Persons with Disabilities, and the Department of Elderly Affairs regarding litigation on this issue.
- Review and assess alternative provider reimbursement methodologies that could be used in the Florida Medicaid program to promote better quality of care, increased efficiencies, or more budgetary predictability.

Senate staff on the part of the Select Committee conducted the study with the full cooperation and participation of major provider groups in both one-on-one and focus group settings. Staff also received full cooperation and assistance from staff in AHCA, the Office of the Attorney General, the Agency for Persons with Disabilities, and the Department of Elderly Affairs.

FINDINGS

Federal Medicaid Reimbursement Policy Provides Considerable Flexibility to States for Setting Provider Rates

Under Federal Medicaid law, states have considerable freedom to develop their own methods and standards for reimbursement of Medicaid services. Congress has periodically intervened to modify the broad guidelines within which states operate, and the Centers for Medicare and Medicaid Services (CMS) has used its regulatory authority to restrict certain state practices.

The primary federal limitations on reimbursement policy require that:

- Medicaid payments are consistent with efficiency, economy, and quality of care;
- Payments are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area; and
- Providers must accept Medicaid reimbursement as payment in full, except for any beneficiary cost-sharing amounts provided for by the state plan or any amount due from a medically needy beneficiary with a spend-down liability.

Beyond these general rules, actual payment requirements or methodologies are prescribed by law for only a few types of providers. All other specific provider rate setting methodologies are left largely to the discretion of the states.

Florida Medicaid Provider Rate Setting Policies Can Be Grouped Into A Few Major Categories of Methodologies and These Methodologies Are Consistent With Those Used In Other States

The Select Committee was charged with reviewing current reimbursement methodologies to determine whether there are comprehensive changes that would fundamentally improve the current rate setting methodologies in Florida's Medicaid Program. The intent was not to focus on a single provider group or particular methodology, but rather examine rate setting policies in general to determine if current polices are consistent with those used in other states.

For purposes of this study, Florida Medicaid reimbursement methodologies where grouped into four general categories: 1) prospective cost-based reimbursement; 2) fee-schedule reimbursement; 3) capitated reimbursement; and 4) prescription drug reimbursement. All the provider rate setting methodologies used in the state can be placed under one of these major headings, although it is recognized that there are unique aspects of each methodology.

The Florida Medicaid Program's reimbursement methodologies were reviewed and compared to those used in other states to determine whether there were any opportunities to improve Medicaid rate setting policies in Florida.

During focus group and one-on-one meetings with major stakeholder groups, there were aspects of each group's reimbursement methodologies for which the stakeholders advocated some modifications (e.g., eliminating target limits; including regular, automatic inflationary adjustments; using encounter data information to establish risk adjusted capitation rates; etc.); however, the Select Committee was examining whether there are comprehensive changes that would fundamentally improve the current rate setting methodologies.

After reviewing current methodologies and those used in other states, the Select Committee found that no general reimbursement methodology was deemed significantly superior to current payment policies and the Select Committee determined this study should not include recommendations for changes to current methodologies that would only benefit a select group of providers. The Select Committee determined that specific rate setting issues should continue to be considered through the substantive and appropriations committee process.

The Effect of Litigation on Medicaid Provider Rate Setting Has Skewed the Market toward Providers As No Statute Currently Exists That Brings State Medicaid Rate Setting Procedures into Line with Federal Requirements

The Select Committee's review of litigation involving Medicaid rates indicates that across the nation, providers have gone to court to challenge Medicaid rates in virtually every major component of the states' Medicaid programs.

In Florida, court challenges to Medicaid rates have often occurred in the area of persons with disabilities, services provided through the Agency for Persons with Disabilities and funded through the Medicaid program in the AHCA, particularly related to the federal Medicaid waiver which has been operational in that program for over a decade. Any review of Medicaid rate cases is necessarily complicated by the number of cases that are resolved on other grounds, but that involve some issue related to rates.

Medicaid providers may challenge the adequacy of Medicaid rates, but such challenges may pit them against three opposing forces. First, Florida's Constitution requires a balanced budget, with all expenditures from the state treasury being made pursuant to an appropriation. Historically, Medicaid expenditures in some Medicaid programs have exceeded initial legislative appropriations and subsequent appropriations and budget amendments have been necessary to bring spending authority up to the level of expenditures. Medicaid waiver program expenditures are limited to available appropriations, though the impact of at least one current provider lawsuit would have the effect of making appropriations limitations nonbinding.

Second, decisions to increase provider rates may have to be balanced against reductions in services or eligibility of recipients in order to control total expenditures. Certainly in Medicaid waiver programs, in which services are capped by available appropriations, a mid-year increase in provider rates may mean that the appropriation for that year is inadequate to fund the originally anticipated service levels.

Current Florida laws allow Medicaid providers to challenge rates based on the technical and other requirements. Federal law does not require the state to have these statutory provisions in place. Without directly challenging the adequacy of Florida's Medicaid rates, providers have various opportunities to challenge rate-setting on a number of technical and other grounds that, at least based on appearance, avoid the two issues in the preceding paragraphs.

Notwithstanding the types of allegations above, Medicaid providers do regularly challenge their rates on substantive grounds directly related to rates and rate setting.

Until 1980, the Medicaid Act (42 U.S.C. §§ 1396) required all participating states to formulate plans that would reimburse providers for the "reasonable cost" of services actually provided to Medicaid patients. This process of paying bills that are rendered—called a "retrospective" standard in social services jargon—proved over time to be "inherently inflationary," containing "no incentives for efficient performance." In order to give states more flexibility to rein in costs through alternative reimbursement strategies not permitted under the existing Act, Congress enacted the Boren Amendment in 1980. The Boren Amendment, which was applicable initially to nursing and intermediate care facilities only, was made applicable to hospitals in 1981.

The Boren Amendment changed reimbursement to certain health care providers from reimbursement of all reasonable costs to only those costs that had to be incurred by efficiently and economically operated

facilities to provide the care that is required under federal and state quality standards. This was intended to permit states to alter their Medicaid plans for the purpose of encouraging providers to contain the costs of health care services and allow states to accommodate the reductions in the amount of funds that the federal government would pay to the states under the Medicaid program. The states were left considerable latitude in how to determine what level of costs had to be incurred by efficiently and economically operated facilities.

Although the Boren Amendment was intended to increase state flexibility (indeed, some Medicaid plans approved prior to the Boren Amendment were found as a matter of law to meet the "lesser" Boren requirements), the states quickly found themselves to be major opponents of the Boren Amendment as Medicaid providers were able to obtain judgments from state and federal courts that drove up Medicaid costs. Rather than resulting in efficiency and reduced costs, the Boren Amendment, in application, had the opposite result. Ultimately, Congress repealed the Boren Amendment in 1997.

The successor federal statute, 42 U.S.C. § 1396a(a)(13)(A), to the Boren Amendment requires that a state plan for medical assistance must provide a public process for determination of rates that basically requires a state to: publish its proposed rates, methodologies, and justifications; provide an opportunity for public review and comment; publish its final rates, methodologies, and justifications; and take into account certain hospital populations.

Courts disagree on whether the successor to the Boren Amendment affords providers substantive rights to sue states in federal courts. Looking at legislative history and the current statutory language requiring rates to be set by a "public process," some courts have found that providers no longer have an enforceable right to challenge these rate plans in federal court. Other courts have allowed a limited right of action by providers and beneficiaries of "hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded." The fundamental disagreement in these cases is whether the successor to the Boren Amendment contains "rights-creating language."
Medicaid is structured in Florida on a market model of buying medical goods and services. In effect, the state is a purchaser of medical goods and services from private providers. As such a purchaser, the state, (or more accurately AHCA) is a participant in the marketplace.

The setting of rates is, in effect, a price negotiation in the marketplace between AHCA (the purchaser) and the Medicaid providers (the sellers). Placing standards or limitations on AHCA's ability to conduct this negotiation—such as by imposing rate adequacy standards that can be litigated or requiring rate setting by rule—interferes with the normal operation of the marketplace.

Normally, buyers have a great deal of flexibility in negotiating price. Standards and limitations imposed by statute disrupt such negotiations and seriously impede AHCA's ability to obtain the best goods and services for the lowest cost. The marketplace skews in favor of the sellers, the providers, resulting in higher prices for goods and services. Amendments to the statutes could be drafted to remove those market imperfections, and to ensure the medical market works more efficiently. The extent that this puts the Legislature clearly in control of authorizing the Medicaid budget, and AHCA clearly in control of managing it, Medicaid providers can be expected to be very wary initially.

Current Provider Rate Setting Methodologies Do Not Provide Incentives for Providers to Improve Their Quality of Care

With the exception of certain risk-based payment systems (capitation), current Medicaid provider rate setting methodologies in Florida are not structured to include incentives for providers to improve their quality of care or overall health outcomes of their patients. In fact, the nature of some reimbursement methodologies can actually create disincentives for improving outcomes. This problem is not unique to the Florida Medicaid Program.

There is a general trend among both private and public payers to change reimbursement methodologies to encourage better health outcomes, often called pay-for-performance strategies, or P4P. Currently, 13 states and the District of Columbia have adopted pay-for-performance strategies in their Medicaid programs either through legislation or by executive order.

Pay-for-performance strategies are based on the simple principle that reimbursing medical providers for improved outcomes results in better patient care and less long-term medical costs. While a simple concept, the reimbursement strategy is controversial among some providers who feel there are problems with how the measurement of quality occurs, and these payment systems may unfairly lower their reimbursements due to factors beyond their control.

The idea of using financial incentives to encourage better performance is a direct challenge to traditional provider rate setting methodologies. One of the main arguments for pay-for-performance strategies is that current payment systems may actually provide disincentives for improving health outcomes. Recently, the Pennsylvania Health Care Cost Containment Council released a study of the financial cost of hospital-acquired infection rates which illustrates the problem of disincentives for quality in current payment methodologies.

Under both Medicare and Medicaid, inpatient hospitalizations are reimbursed based on the medical condition of the beneficiary and procedure required. For example, a hospital treating a patient that is admitted for surgery on a herniated disk will be reimbursed by Medicare based on a specific Diagnosis Related Group (DRG) reimbursement code. DRGs are a classification system that is used as the basis to reimburse hospitals for inpatient services. Under DRGs, a hospital is paid at a predetermined, lump sum amount, regardless of the costs involved, for each Medicare discharge. The prospective payment price, also referred to as the DRG payment, covers all hospital costs for treating the patient during a specific inpatient stay, including the costs of all devices that are used (separate payment is made to physicians for the care they provide to patients during these inpatient admissions).

But, as the Council's study found, if a patient acquires an infection while in the hospital, the hospital may bill for another DRG to cover the cost of care. In Pennsylvania, the Medicare and Medicaid programs were billed for 76 percent of the reported hospital-acquired infections in 2004. Medicare and Medicaid were billed, respectively, for 7,870 and 1,028 hospital-acquired infections, respectively. As a result, Pennsylvania and federal taxpayers paid $1.4 billion more in hospital charges in 2004 than the programs would have paid had infections been prevented. Commercial insurers also incurred substantial costs—an extra $604 million in hospital charges.

These disincentives (e.g., poor outcomes result in additional payments) are a risk in many of the current Medicaid reimbursement policies and pay-for-performance strategies are seen as a possible solution.

Pay-for-performance programs typically reflect three principal approaches: 1) threshold bonuses; 2) tiering bonuses; and 3) tiering plus sharing a pool generated by cost savings against a benchmark, usually related to specific health outcomes or preventive services.

Pay-for-performance payments to physicians usually entail a per-patient payment, capitation enhancement, or some administrative burden reduction (e.g., no need to remain on formulary, no need for prior authorization). Hospital pay-for-performance payments are somewhat different, reflecting stipend awards, a shared bonus pool, or administrative burden reduction.

Medicare has been a leader in various initiatives to encourage improved quality of care in all health care settings where Medicare beneficiaries receive their health care services, including physicians' offices and ambulatory care facilities, hospitals, nursing homes, home health care agencies and dialysis facilities.

Through collaborative efforts with health quality improvement organizations, CMS is developing and implementing a set of pay-for-performance initiatives to support quality improvement in the care of Medicare beneficiaries. In addition to the initiatives for hospitals, physicians, and physician groups described below, CMS is also exploring opportunities in nursing home care—building on the progress of the Nursing Home Quality Initiative—and is considering approaches for home health and dialysis providers as well. Finally, recognizing that many of the best opportunities for quality improvement are patient-focused and cut across settings of care, CMS is pursuing pay-for-performance initiatives to support better care coordination for patients with chronic illnesses.

Pay-for-performance strategies can be controversial and should be developed in such a way that performance is measured against only those factors for which the provider can reasonably be held accountable. This includes the concept that maintenance of health status, rather than only improvement in certain conditions or outcomes, may be the appropriate measure of good performance.

RECOMMENDATIONS

Based on the information collected through this study, the Senate Select Committee on Medicaid Reform provides the following recommendations and policy options for provider rate setting in the Florida Medicaid Program.

Current Florida Statutes that Trade State Control of Medicaid Expenditures for Provider Input and Allow Rate Setting by Administrative Rule Should be Reviewed and Amended to Align with Federal Law

Taking Medicaid rate setting out of administrative rule would ensure that Medicaid providers cannot impede or manipulate rate setting in the courts, as they now attempt to do. A specific example is when APD providers were attempting to prevent implementation of a November 2003 rate reduction, which the Legislature required if reasonable projections were made that spending would exceed the amount fixed in proviso and appropriations in general.

Ultimately, the Legislature may want to consider statutory changes that put the state on the same footing as any purchaser of medical goods and services, which purchasers do not have to engage in rule making in such circumstances; and to prevent providers from bringing court challenges to rate reductions that are necessary to control Medicaid expenditures. Florida law could be amended to allow market forces, rather than administrative law judges, to govern the rates Florida pays for Medicaid services.

Previous litigation and rule challenges demonstrate that no statute currently exists that brings state Medicaid rate setting procedures into line with today's federal requirements as most of the rate setting statutes were adopted prior to repeal of the Boren Amendment. To the extent that post-Boren federal law allows greater flexibility to states, the Legislature may choose to create a new statute to codify the flexibility in state statute. Any new provision would, presumably, be modeled on federal rules that give states maximum flexibility in rate setting and the ability to limit judicial challenges to rate-setting decisions.

Pay-for-Performance Strategies should be Tested as a Method for Improving Health Outcomes While Lowering Medicaid Expenditures

There are many pay-for-performance methodologies being used in both the public and private sector. These methodologies tie reimbursement levels to health outcomes in a way that promotes better care at a lower aggregate cost.

The Legislature could require AHCA to evaluate which pay-for-performance methodologies, especially of those being tested in the Medicare program, could be adopted and implemented in the Florida Medicaid Program.

As the Florida Medicaid Program continues to move forward with implementation of Medicaid Reform, the Select Committee recognizes that AHCA will need to consider the opportunity to implement these methodologies in the remaining fee-for-service and MediPass programs, as well as in the capitated managed care arrangements in the reform demonstration sites.