

# Medicaid Provider Rate Setting Study

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## Table of Contents

Summary.....	1
Background .....	4
Florida’s Medicaid Program: An Overview .....	4
Expenditure and Enrollment Growth.....	5
Reform and Provider Rate Setting.....	6
Methodology.....	8
Findings.....	10
Finding I: Federal Medicaid Reimbursement Policy Provides Considerable Flexibility To States For Setting Provider Rates.....	10
Summary of Finding I .....	12
Finding II: 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.....	13
Prospective Cost-Based Reimbursement.....	13
Cost-Based Reimbursement Methodologies in Other States .....	15
Fee Schedule Reimbursement.....	19
Fee Schedule Reimbursement Methodologies in Other States .....	20
Capitated Reimbursement .....	22
Capitated Reimbursement Methodologies in Other States .....	24
Prescription Drug Reimbursement .....	26
Pharmacy Reimbursement.....	26
Pharmaceutical Manufacturer Rebates .....	28
Prescription Drug Reimbursement Methodologies in Other States .....	29
Medicare Prescription Drug Benefit (Part D) and Medicaid .....	31
Summary of Finding II .....	31
Finding III: 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.....	32
Nationally, Rates For Every Component of the Medicaid Program Have Been Challenged.....	32
Providers Face Two Public Policy Issues with Rate Challenges in Florida.....	32
Federal Requirements for Rate Setting for Facilities Were More Stringent Before the 1997 Repeal of the Boren Amendment.....	34
Federal Requirements After 1997 Concerning Rate Setting and Rate Changes are Simplified and Less Stringent.....	35
Florida’s Medicaid Marketplace Affects the Balance Between Buyers and Sellers .....	36
Summary of Finding III.....	37
Finding IV: Current Provider Rate Setting Methodologies Do Not Provide Incentives for Providers to Improve Their Quality of Care.....	37
Current Methodologies May Create Disincentives for Improving the Quality of Care.....	38
Pay for Performance Methodologies .....	39
Summary of Finding IV.....	44
Recommendations .....	45
Recommendation: Current Florida Statutes that Trade State Control of Medicaid Expenditures for Provider Input and Allow Rate Setting by Administrative Rule May be Reviewed and Amended to Align with Federal Law.....	45
Recommendation: Pay-for-Performance Strategies Should be Tested as a Method for Improving Health Outcomes While Lowering Medicaid Expenditures .....	48

## Summary

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. The Florida Medicaid Program provides health care coverage and services to over 2.2 million Floridians at a cost of over \$15 billion in fiscal year 2005-06.

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. Because some providers, such as "safety-net" hospitals, clinics, and nursing homes are heavily dependent on Medicaid funding, payment levels can have broad effects on the delivery system and community access to care.

Because Medicaid expenditures are a major component of state and federal spending, decisions about reimbursement policies can have significant budgetary effects. For both hospitals and nursing homes, Medicaid payment rates in most states are below the actual costs facilities incur in providing care to Medicaid patients. Payment rates for other kinds of providers, such as physicians or dentists, cannot be directly compared to costs; however, Medicaid often pays less for comparable services than Medicare or private insurers.

Medicaid payment shortfalls can have a variety of possible consequences. Providers may engage in "cost-shifting," raising charges to private payers to make up their losses. In addition, the need to subsidize Medicaid patients may reduce providers' ability to fund care for people with no coverage at all. Some providers may adopt cost-cutting measures that potentially affect quality. Others may refuse to accept Medicaid patients or limit the number they will treat, since Medicaid law has no requirement prohibiting providers from doing so.<sup>1</sup>

In Florida, Medicaid provider reimbursement rates are developed based on legislative appropriations and put into rule by the Agency for Health Care Administration (AHCA). Once rates are adopted, they are included in provider contracts or handbooks. Under current law, providers have the ability to challenge rate changes through Chapter 120, Florida Statutes. 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.

In 2005, Medicaid Reform legislation (CS/CS/SB 838) included several studies of Medicaid policy issues, one of which was a study of Medicaid provider rate setting methodologies. Specifically, 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.

This report examines the core questions outlined in law and presents recommendations for consideration by the Legislature. This report contains the following major sections:

- An overview of the state's Medicaid program;
- A description of the basic federal requirements applicable to payments for Medicaid services to determine the level of flexibility available to states to modify their rate setting methodologies;
- A description of the major categories of rate setting methodologies used in Florida's Medicaid Program and a comparison of these methodologies with those used in other states to identify strengths and opportunities for improvement;
- A review of the role of previous and current litigation on the state's ability to set or adjust Medicaid provider rates and how Florida's Medicaid provider agreements and administrative rulemaking affect the state's ability to set or adjust rates;
- A description of various pay-for-performance systems in both the public and private sectors and how they are being used to improve clinical outcomes and reduce inappropriate utilization to save costs.

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. The primary federal limitations on reimbursement policy require: 1) Medicaid payments are consistent with efficiency, economy, and quality of care; 2) 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 3) 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. Actual rate setting methodologies, however, are still left largely to the discretion of the states.

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 the 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. 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.

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

The Senate Select Committee on Medicaid Reform's recommendations can be found on pages 45-48, and are directly related to each of the findings. These recommendations include the following:

1. Current Florida Statutes that trade state control of Medicaid expenditures for provider input and allow rate setting by administrative rule may be reviewed and amended to align with federal law; and
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 for Health Care Administration is the single state agency responsible for administering the Florida Medicaid Program. The statutory provisions for the Medicaid program appear in Sections 409.901 through 409.9205, Florida Statutes.

Some services are mandatory services that must be covered in any state that participates in the Medicaid program. Other services are optional. A state may choose to include optional services in its state Medicaid plan, but such optional services must be offered to all individuals statewide who meet Medicaid eligibility criteria. Payments for services to individuals in the optional categories are subject to the availability of monies and any limitations established by the General Appropriations Act or Chapter 216, Florida Statutes.

Florida's Medicaid Program provides health care coverage and services to over 2.2 million Floridians at a cost of over \$15 billion in fiscal year 2005-06.<sup>2</sup> The Medicaid program is an important source of health care financing in the state. Currently in Florida, the Medicaid program provides financing for:

- Health care services for 27 percent of all children in the state;
- Obstetrical services for 44 percent of pregnant women and 43 percent of all births in the state;
- Sixty-six percent of all nursing home days; and
- Health care services for 885,000 adults (mostly parents of low income children, the aged, and disabled).

The most significant share of Medicaid costs is borne by the federal government under the Federal Medical Assistance Percentage (FMAP) program. For federal fiscal year 2005-06, Florida's FMAP is 58.89 percent, which means that for every dollar the state spends on Medicaid services, it is reimbursed approximately 59 cents by the federal government.

## **Expenditure and Enrollment Growth**

In recent years, health care costs have been rising nationally for both public and private health care coverage. This increase in health care costs is due to a number of factors, most prominently increases in prescription drug and hospital costs. However, analysts are projecting that the country is entering a period of decelerating cost trends following the steep acceleration during the 1996-2001 time period. Nevertheless, these health care cost trends remain high by historical standards and continue to outpace U.S. economic growth by a sizable margin.

### ***Expenditure Growth***

Within Florida's Medicaid Program, expenditures and enrollment growth are slowing down. In November 2005, the Social Services Estimating Conference adjusted its Medicaid expenditure forecast for the current fiscal year (2005-06), bringing it in at \$4.5 million lower than originally appropriated, for a total cost of \$15.059 billion. This represents a 7.8 percent increase in total Medicaid expenditures from the prior year. The new forecast anticipates a surplus in General Revenue funding of \$39.1 million for the current fiscal year (2005-06).<sup>3</sup>

Higher than expected costs are contributing to an expenditures deficit in prescribed medicine services, but it is expected that this will be offset by increased rebates that were required in the FY 2005-06 General Appropriations Act. Small surpluses are projected in institutional services such as hospital inpatient, nursing home, and hospice care.

This projection may have to be adjusted again as the November projection for FY 2005-06 anticipated full and immediate implementation of the new Medicare prescription drug coverage plan (Part D) beginning January 1, 2006; however, the Medicare Part D program was not fully operational and the state chose to continue paying some prescription drug costs for dual eligibles through at least February 2006. The federal government will fully reimburse these costs at a future date.

For the upcoming fiscal year (2006-07), Medicaid expenditures are expected to rise to \$15.99 billion, an increase of 6.2 percent from the current year recurring appropriation base. The General Revenue share of the increase is projected at \$596.3 million (+13.5 percent) above the recurring FY 2005-06 base appropriations.

### ***Enrollment Growth***

Florida's Medicaid Program covers approximately 2.2 million individuals. This means that approximately 11.6 percent of the Florida population is entitled to receive full Medicaid services, with another 0.9 percent receiving a subset of Medicaid services.

The Social Services Estimating Conference, in October 2005, adopted a caseload projection for the current fiscal year (2005-06) that is slightly lower than the projection upon which the appropriation was based. The new caseload for FY 2006-07 is estimated at 2.37 million individuals. Caseload groups representing the elderly and disabled were reduced by less than 1 percent, while the groups comprising women and children were unchanged. For the upcoming fiscal year (2006-07), enrollment in the elderly and disabled groups is expected to decline by 2.7 percent from this fiscal year, while enrollment in the women and children group is projected to rise by 4 percent.<sup>4</sup>

## **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. The Select Committees also held five joint public hearings in cities around the state, including Tampa, Ft. Lauderdale, Orlando, Panama City, and Jacksonville.

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 Select Committees considered the ideas and suggestions from the various stakeholders and provided reform recommendations to their respective substantive committees that were included in bills in each chamber. The Legislature eventually passed a Medicaid Reform law in CS/CS/SB 838 (ch. 2005-133, L.O.F.). The provisions of the final bill offered opportunities to improve the current Medicaid program, while continuing a deliberative review of more comprehensive reform initiatives.

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:

1. Are there ways that the current rate setting methodologies and system can be improved while reform is being implemented?
2. How will risk-adjusted capitation rates be established within the reform pilot sites and how will plans set rates for providers in their networks?
3. How can the state maintain or strengthen its ability to adjust provider rates as budgetary pressures require?
4. 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.

# Methodolog

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 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 the AHCA, the Office of the Attorney General, the Agency for Persons with Disabilities, and the Department of Elderly Affairs.

## Findings

### **Findings I: 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: 1) Medicaid payments are consistent with efficiency, economy, and quality of care; 2) 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 3) 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.

There is an additional set of basic rules for payment of institutional services, including hospitals, nursing facilities, and intermediate care facilities for the mentally retarded (or in Florida, intermediate care facilities for developmentally disabled). These particular rates must be established through a public process which requires states to publish proposed and final rates, including justifications and underlying methodologies. Providers, beneficiaries, and the public must be given an opportunity to comment on these rates.

Beyond these general rules, actual payment requirements or methodologies are prescribed by law for only a few types of providers, such as disproportionate share hospitals (those serving a high proportion of low income patients), federally qualified health centers, and hospices. There are also specific rules relating to payment for prescription drugs. All other provider rate setting methodologies; however, are still left largely to the discretion of the states.<sup>5</sup>

#### ***Efficiency, Economy, and Quality of Care***

Title XIX, Section 1902(a), of the Social Security Act<sup>6</sup> requires that a state Medicaid plan for medical assistance must:

“Provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and

services and to assure that payments are consistent with efficiency, economy, and quality of care . . .”

The Centers for Medicare and Medicaid Services relies on this provision as a general authority to regulate state reimbursement methodologies. In particular, this provision is the basis for the upper payment limit (UPL) regulations, which require that Medicaid payments for a class of institutional providers not exceed, in the aggregate, the amount that would have been paid for comparable services under Medicare principles.

***Rates Must be Sufficient to Ensure Availability of Medicaid Services***

Title XIX, Section 1902(a), of the Social Security Act also requires that a state Medicaid plan for medical assistance must:

“provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . 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 . . .”

This provision explicitly connects the level of Medicaid payment rates with the willingness of providers to serve Medicaid beneficiaries. While payment levels are not the only factor affecting provider participation, there has been a tension between cost containment and access to care in Florida and across the nation. This is one of the main provisions under which Medicaid providers have sued states over their reimbursement levels (legal challenges under this provision and their implications for provider rate setting in the Florida Medicaid Program are addressed in more detail later in this report).

***Medicaid Providers Must Accept Medicaid Reimbursement as Payment in Full***

Enrollment in a state Medicaid program as a provider of health services and acceptance of Medicaid recipients as patients requires the provider to accept payment by the state Medicaid agency as payment in full. The federal regulation (42 CFR 447.15) states:

“A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amount paid by the agency plus any deductible. Coinsurance or co-payment required by the plan to be paid by the individual. However, the provider may not deny services to any eligible individual on account of the individual’s inability to pay the cost-sharing amount imposed by the plan in accordance with 42 CFR 431.55 (g) or 42 CFR 447.53. The previous

sentence does not apply to an individual who is able to pay. An individual's inability to pay does not eliminate his or her liability for the cost sharing charge."

Generally, health care providers are not required to accept Medicaid patients. However, if they accept Medicaid patients, they must accept Medicaid payments in full, except for certain specific services for which a co-payment may be charged. This means that a provider cannot bill a beneficiary when Medicaid's allowed payment is less than the provider's charge for a service. In contrast, Medicare allows limited balance billing by physicians and some other providers. Private insurance rules vary; plans with networks commonly restrict balance billing by network providers and permit it for out-of-network services.

At times, these rules have been another area of tension with some medical service providers as the rates for any particular Medicaid service may not be near the actual cost of delivering the service. Providers, as a result, turned to the Medicaid patient for payment to offset the difference between Medicaid reimbursement and cost. Several years ago, CMS (the Health Care Financing Administration at the time) informed state Medicaid programs of providers inappropriately requiring Medicaid patients to make cash payments for Medicaid covered services. There were reports from states of incidents where an anesthesiologist would not provide an epidural to a Medicaid patient in childbirth unless she paid in advance, with her own funds, for the procedure. In one instance, the obstetrician ordered the epidural in advance but when the woman was in active labor, she was refused the service for lack of pre-payment.

A health care provider enrolled as a Medicaid provider cannot, under the federal Medicaid law, demand these additional payments. However, when a provider agrees to treat a Medicaid recipient as a private patient and the Medicaid beneficiary accepts the arrangement as a condition of treatment, the arrangement is not governed by Medicaid program requirements.

## **Summary of Finding I**

Under federal Medicaid law, states have considerable freedom to develop their own methods and standards for reimbursement of Medicaid services. The primary federal limitations on reimbursement policy require that: 1) Medicaid payments are consistent with efficiency, economy, and quality of care; 2) payments must be 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 3) 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.

## **Finding II: 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 policies are consistent with those used in other states.

For purposes of this study, Florida Medicaid reimbursement methodologies were 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.

### **Prospective Cost-Based Reimbursement**

Prospective cost-based reimbursement methodologies are fundamentally designed to reimburse providers based on their cost of delivering services. Florida Medicaid utilizes this type of reimbursement methodology to reimburse providers that deliver "institutional" types of services, such as, hospitals, nursing homes and intermediate care facilities for the developmentally disabled (ICF-DDs). The services delivered through these types of providers constitute a large portion of current Medicaid expenditures; therefore, it was imperative that their reimbursement methodologies be included in this study.

For purposes of the study, Senate staff reviewed the current reimbursement methodologies, and interviewed AHCA staff and key stakeholders of Medicaid hospital, intermediate care facilities, and nursing home providers. Although the services delivered through these entities may differ, they are all reimbursed based on amounts derived from a cost-based reimbursement methodology. The methodologies used for reimbursing these providers are largely similar, as each methodology results in a unique, provider-specific, daily per diem reimbursement rate that is subject to certain limitations, which AHCA ultimately uses to reimburse each provider.

### ***Development of an Average Daily Cost***

The fundamental design of the cost-based methodology is the calculation of the provider's average daily cost. To calculate this rate, AHCA requires each provider to submit an annual report of its prior year Medicaid costs, a "cost report." Utilizing this information, AHCA then calculates the provider's average daily cost of services provided to Medicaid recipients for the reported year.

Recognizing that this average daily cost of services is based on historical data, the methodology requires AHCA to adjust the calculated rate to develop a prospective rate that is reflective of the provider's current cost of providing services to recipients, subject to certain limitations that will be discussed below. The agency utilizes nationally published medical inflation trend tables to adjust the provider's historical average daily cost into an amount that can be used to reimburse the provider for the upcoming period, producing a prospective daily per diem rate that is unique for each provider. This per diem rate is used to reimburse the provider for services delivered to Medicaid recipients for the next six months. The agency repeats this process every six months utilizing the most recent cost report information submitted by the provider and the most recent inflation trends in order to provide the most accurate estimate of the provider's current average daily cost of providing services to Medicaid recipients.

### ***Rate Limiters: Ceilings and Targets***

Each cost-based reimbursement methodology reviewed in this study contains limitations on the amount the final reimbursement rate may increase. These limitations are identified in the reimbursement methodologies as rate ceilings and rate targets.

Although the methodologies used to calculate rate ceilings are different between each type of provider being reimbursed, the ceilings accomplish the same goal of limiting the increase in the growth of the rate each year. Each ceiling methodology generally relies on a comparison of the facility whose rate is being set and the rates of peer providers of similar size and within the same geographical region. For example, the hospital ceiling is derived by comparing the rates for all hospitals across the state in conjunction with the specific inflation trends within the county in which the hospital is located. Similarly, the nursing home ceiling methodology relies on a comparison of rates between nursing homes of similar size within the same geographic region. Fundamentally, the ceilings accomplish the same goal of limiting the increase in each provider's rate.

Target rates were introduced into the cost-based reimbursement methodologies as an additional method of containing the annual increase in provider rates. The target rate methodology was added to ICF-DDs in 1984, nursing homes in 1988, and hospitals in 1991. The methodologies used to calculate the target rates are

very similar between the three provider types. The target rates are unique to each provider, whereas during the initial implementation of the methodology, the provider's actual cost was used as a basis for establishing the target rate, and is subsequently increased annually utilizing published inflation factors.

## **Cost-Based Reimbursement Methodologies in Other States**

Cost-based reimbursement methodologies are widely used in state Medicaid programs. As in Florida, these methodologies are mainly used with institutional services and providers, such as inpatient hospitalization and nursing facilities. These methodologies do vary among provider groups, although the main concepts outlined above are common components of methodologies in other states. Within this study, the Select Committee found no specific aspect of the methodologies used by other states that should be considered for improving AHCA's rate setting policies.

Most of the comparison information from other states used in this section of the report was derived from the publication, *Medicaid Reimbursement Policy*, by the Congressional Research Service, October 2004.<sup>7</sup>

### ***Hospital Inpatient***

All states now use some form of prospective payment system as their basic method for setting inpatient hospital payments. That is, payment amounts per day or per case are fixed at the start of a year and are generally not subject to retrospective adjustment on the basis of actual costs incurred. States may establish a different rate for each participating hospital, may use one rate for all hospitals in a defined peer group, or may have one statewide rate. Two-thirds of the states have adopted some form of case mix adjustment, under which reimbursement varies according to the intensity of services required or the expected resources used by each individual patient. These adjustments can be applied regardless of the state's method for setting basic rates.

In 24 states, fixed per diem or per case payment rates are established for each hospital, using historic data on that hospital's Medicaid costs and some form of fixed update factor for inflation. A hospital whose costs rise faster than the update will therefore lose money. Some states use an objective inflation index, such as CMS-released estimates of price changes for a "market basket" of goods and services commonly purchased by hospitals. Often, however, annual updates are set by legislation and regulation and may be higher or lower than actual inflation.

Of the states using hospital-specific rates, five use peer group ceilings; the hospital's rate is based on the lesser of its own costs or some percentile of costs for similar hospitals. Hospital characteristics used to establish peer groups include

size, location, presence of a teaching program, specialized services (for example, pediatric hospitals), and volume of Medicaid services.

Six states use a statewide ceiling for all general hospitals, based on a percentile of all hospitals' costs. One effect of systems using ceilings is that, while a hospital with costs above the ceiling will lose money, a hospital with costs below the ceiling will receive a rate derived from its base-year costs. It can earn a profit only if it can reduce its costs still further; it is not rewarded for being more efficient than its competitors.

In 21 other states, a fixed rate is set for an entire class of hospitals or for all hospitals in the state. In most of these states, part or all of the fixed rate is adjusted (as in Medicare's inpatient prospective payment system or PPS) for higher or lower labor costs in the hospital's market area. In fixed rate systems, unlike ceiling systems, a hospital with costs below the rate can realize a profit.

Nearly two-thirds of the states have adopted some form of case mix adjustment, under which reimbursement varies according to some measure of the intensity of services required or the resources used by each individual patient. Most of these use the diagnosis-related groups (DRGs) developed for Medicare hospital reimbursement.<sup>8</sup>

Because Medicaid patients may be different from Medicare patients, the weighting factors established for DRGs under Medicare may not be appropriate for Medicaid reimbursement. Most states using DRGs have developed their own weights on the basis of Medicaid-specific data. Some states use alternative DRG classification systems, such as the DRGs developed for the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) or New York's All Patient DRGs.

Under Medicare, small rural hospitals may enter into "swing bed" agreements with CMS, under which beds may be used either for inpatient hospital care or for care equivalent in intensity to that furnished by a nursing facility. Costs are allocated and reimbursement adjusted to reflect the level of care furnished to each patient. A Medicaid program may also allow for swing beds, but only in hospitals that have entered into a Medicare swing bed arrangement. The state may develop a specific payment methodology for swing bed days of care at the nursing facility level or may pay at a rate based on average payments for comparable services in freestanding nursing facilities. The swing bed program assists hospitals that are underused and also helps to meet local shortages of nursing facility beds.

Sometimes a hospital which is not a swing bed facility will provide care to a patient at the nursing facility level of intensity because a place cannot be found for the patient in an appropriate facility and the patient cannot be discharged. The days of inpatient care received by patients in this situation are known as

“administrative days.” Prior to 1997, Medicaid payment for an administrative day was limited to the statewide average Medicaid payment rate for a day of care in a skilled nursing facility. Most states have continued this practice despite the repeal of the provision in the Balanced Budget Act of 1997.

### *Nursing Facilities*

Since the 1980 Boren Amendment allowed states to move away from Medicare’s retrospective cost-based reimbursement rules, states have evolved very complex nursing facility payment systems (more detail on the Boren Amendment and its effect on provider rate setting are found later in this report). These systems commonly distinguish among direct patient care costs; costs for various operating, support, and administrative functions; and capital costs, such as interest, rent, and depreciation.

A state may treat each component differently. For example, payment to a particular facility might be the sum of a case-mix adjusted fixed amount for direct care, a facility-specific cost-based payment subject to a peer group ceiling for other operating costs, and a “fair rental value” payment for capital costs. The following discussion focuses chiefly on how states pay for the direct care component, the actual delivery of services to individual residents by nursing staff.

Over two-thirds of the states pay the lesser of the facility’s actual costs for Medicaid residents or a fixed ceiling based on the cost experience of comparable nursing facilities. States may set statewide ceilings or define peer groups on a number of dimensions, including size, location, ownership, and whether a facility is hospital-based or freestanding. Of the states paying the lesser of cost or fixed ceilings for direct care, 11 have incentive arrangements, under which facilities whose costs are below the ceiling share in the savings. Many more states use these arrangements for other cost components, such as administration, where rewards for cost-cutting may arguably be less likely to affect patient care.

Eleven states pay fixed per diem amounts for direct care. In some states the per diem rates are based, as in states using cost ceilings, on the experience of comparable facilities. In other states, the per diem rates are fixed by law or regulation. (While the rates may be derived through some form of cost analysis, a specific formula is not described in the state plan.)

More than half the states now use some form of case mix adjustment in paying nursing facilities. Of these, 14 use the resource utilization groups (RUGs) developed by CMS for Medicare skilled nursing facility payments. The Medicare system assigns each resident to one of 44 groups based on a resident assessment that measures physical function, rehabilitation needs, cognitive impairment, and other factors. Medicaid programs commonly use a set of 34 RUGs; these have fewer distinct categories of rehabilitative care, because fewer Medicaid residents

are receiving such care. The remaining states have developed their own classification systems, usually grouping residents into a much smaller number of care categories.

Case mix adjustment is intended both to treat nursing facilities fairly and to reduce incentives to refuse heavy care patients. At least some observers contend that the adjustments may create perverse incentives of their own. For example, a nursing facility might be penalized for promoting resident independence, because payment is greater for residents requiring more assistance.<sup>9</sup> (The issue of provider rate setting and its ability to affect quality of care will be addressed later in this study.)

As in the case of hospital payments, Medicaid payments to nursing facilities are usually based on historical cost data with periodic updates. Annual increases in rates or ceilings may or may not keep pace with inflation, and some states may go for long intervals without “rebasings” –updating cost data to reflect changes in facility case mix, occupancy levels, or other factors that may affect costs. As a result, even facilities whose costs were at one time fully covered by Medicaid reimbursement may gradually see shortfalls. Even in states whose payments keep pace with inflation and other changes affecting costs, some facilities may still lose money. Nearly all state systems pay the lesser of actual costs or a fixed ceiling, in order to create pressure for greater efficiency in the most costly providers. If a state pays nearly all facilities their full costs and underpays a small number of facilities, the average payment to cost ratio will inevitably be less than 100 percent.

In some states, peer group or statewide ceilings, or flat rates based on group experience, may be at least as important as limited annual increases in explaining current payment shortfalls. Whether these ceilings are set at appropriate levels is a difficult policy question, the answer to which depends in part on how sensitive the state’s system is to differences in facility and resident characteristics. If a state uses a single statewide ceiling with no case mix adjustment, then a very efficient facility might be penalized because it is in a high-cost urban area or has residents with complex needs.

Some observers have suggested that the states use of complex ceiling systems for nursing facility cost containment, in preference to simple rate cuts or freezes, was driven in part by concerns about litigation during the period when the Boren Amendment was still in effect. It was easier for states to show that their payments were adequate to meet the costs of “efficiently and economically operated” facilities if only a minority of nursing facilities were affected by payment constraints.<sup>10</sup> With the repeal of the Boren requirements, across-the-board limitations may have greater appeal for states. In fact, many states limited general 1999-2000 rate increases to levels below average cost growth; more may do so in response to future budgetary problems.

### ***Intermediate Care Facilities for the Mentally Retarded/Developmentally Disabled***

Until the 1980s, most Medicaid services for people with mental retardation or developmental disabilities were provided in large state-operated Intermediate Care Facilities for the Mentally Retarded/Developmentally Disabled (ICFs-MR/DDs). As a result of the availability of the home and community-based services waivers, court decisions requiring treatment in less restrictive settings, and other factors, over three-fourths of people receiving Medicaid-funded MR/DD services were in the community in 2002.<sup>11</sup> However, the absolute number of ICF-MR/DD residents actually grew slightly between 1977 and 2002, and ICF-MR/DD spending still accounts for nearly 5 percent of Medicaid spending.

Most states have both state-operated and non-state ICF-MR/DDs, which, in turn, results in different payment rules for the two classes of facilities. States generally pay state-operated ICF-MR/DDs their full operating costs, because paying less would mean forgoing federal matching funds without reducing state expenditures. While some states also reimburse the full costs of non-state facilities, many have developed alternate rate setting systems.

When examining the payment methods used by the 44 states that make payments to non-state facilities, whether public or private, 11 of the states pay non-state ICFs-MR/DDs their full costs; a few of these require that operating budgets be approved in advance. Another 19 use cost ceilings, comparable to those used in nursing facility payment, for the direct care component of costs or for the entire per diem rate. Some of these use peer groups, based on beds per facility or other characteristics. Others group all facilities together (partly because some states have few or no residents in larger facilities). Of the remaining states, three use different methods for smaller and larger facilities. Most of the rest use some form of fixed rate, often based on peer group means.

## **Fee Schedule Reimbursement**

Reimbursement through fee schedules is widely used throughout many state Medicaid programs. Services delivered by physicians, home health agencies, and durable medical equipment providers are just a few examples of the type of services that are subject to fee schedule reimbursement. This study focuses on Florida's methodology used to develop the fee schedule for physician reimbursement. For this study, Senate staff interviewed AHCA staff, representatives of the Florida Medical Association, and practicing physicians who serve Medicaid recipients.

Physicians are largely responsible for the direct care of Medicaid recipients, and their services constitute the majority of the expenditures for providers reimbursed

through a fee schedule. The Florida Medicaid Program reimburses physicians an amount that is the lesser of their actual charge to the state or an amount developed by the state as listed in its fee schedule for each visit or procedure. The Florida Medicaid Program's methodology is based on the Medicare fee schedule, the resource-based relative value scale (RBRVS). Under RBRVS, each procedure is assigned a weight, reflecting relative physician work, practice expenses and malpractice costs associated with different procedures.

Each year, Florida Medicaid utilizes Medicare's published RBRVS data as a basis to develop its physician reimbursement fee schedule. Utilizing the amount appropriated each year for physician services, AHCA considers estimated utilization patterns, and allocates the amounts across the fee schedule based upon the weighting methodology in the RBRVS data, thereby creating a specific reimbursement amount for each procedure while utilizing 100 percent of the appropriation. This process is repeated at the beginning of each fiscal year and the fee schedule is published on AHCA's web site. Once the fee schedule is set, the Florida Medicaid Program will then reimburse physicians based on the lesser of the physician's charge to the state or the amount listed in the fee schedule for each service.

## **Fee Schedule Reimbursement Methodologies in Other States**

States have commonly paid independent practitioners using fixed fee schedules, often at rates below those paid by Medicare or private insurers. Medicaid payment levels for physician and dental care, and their effects on provider participation and beneficiary access, have been issues since the earliest years of the program. Many physicians refused to accept Medicaid patients or limited their Medicaid caseloads, leaving beneficiaries to rely on more costly hospital outpatient departments and emergency rooms as a primary source of care.

Medicaid payments to physicians and other providers are subject to the general requirement that payments be sufficient to attract enough providers to ensure that covered services will be as available to Medicaid beneficiaries as they are to the general population (this issue was discussed earlier in this report). The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) codified this requirement (previously established only by regulation) and established specific reporting requirements with respect to payment rates for obstetric and pediatric services, to allow the U.S. Secretary of Health and Human Services to determine the adequacy of state payments for these services. These special reporting requirements were repealed by the Balanced Budget Act of 1997, but the requirement that payments be sufficient to assure access remains in the statute. It has been the basis for numerous lawsuits by groups of physicians, dentists and other providers (discussions of the lawsuits and the effect in Florida will be discussed later in this report).<sup>12</sup>

Most of the comparison information from other states used in this section was derived from the publication, *Medicaid Reimbursement Policy*, by the Congressional Research Service, October 2004.<sup>13</sup> This report indicates that fee schedule reimbursement methodologies are used in every state, with slight variations among specific provider groups. Within this study, the Select Committee found no specific aspect of fee schedule reimbursement methodologies used by other states that should be considered for improving AHCA's rate setting policies.

### ***Physician Services***

States set their Medicaid physician fee schedules in various ways. Every state except Hawaii now pays physicians the lesser of actual charges or a fixed fee schedule amount for each visit or procedure, whether performed in offices, hospitals, or other settings. Some fee schedules were originally based on physicians' actual charges for services, while others are set arbitrarily by the state or negotiated with provider groups. Other states, including Florida, use systems comparable to Medicare's, under which each procedure is assigned a weight on a RBRVS; the weightings reflect relative physician work, practice expenses, and malpractice costs associated with different procedures.<sup>14</sup> Some states have adopted Medicare's scales, while others use different weighting systems. The effect is the same as under a fee schedule, except that the Medicaid agency has an external reference for its pricing decisions. However, the physician fee schedule is established, basic rates and/or inflation increases are fixed by the state and may bear no relation to what physicians ordinarily charge or what they are paid by Medicare or private insurers.<sup>15</sup>

Based on survey data, states' physician payment rates vary enormously. One of these surveys is an annual survey conducted by the American Academy of Pediatrics. In this survey, Medicaid rates are reported by state Medicaid directors on a large number of different procedures. Based on this survey, physician rates for an initial pediatric preventive office visit range from \$20 in Pennsylvania to \$114.87 in New Mexico, almost six times as much.<sup>16</sup> Payment for a complex procedure can be even greater. A cardiac catheterization ranges from \$80 in New York to \$1,688 in Arizona, a twenty-fold difference.<sup>17</sup>

Although states generally pay less than Medicare for the listed services, the gap varies considerably by procedure. In states that have systems similar to Medicare's RBRVS, but use a different dollar multiplier to establish Medicaid rates, the ratio of Medicaid to Medicare rates will be roughly constant. In other states that have assigned their own values to different procedures, rates may be far below Medicare's for some services and higher for others. The payment gap tends to be larger for preventive office visits and for cardiac catheterization than for the other listed services.

The gap between Medicaid physician payment rates and rates paid by private insurers is likely to be even greater. Studies done for the Medicare Payment Advisory Commission (MedPAC) estimate that Medicare physician rates were about 83 percent of average private rates in 2001.<sup>18</sup> When coupled with other studies comparing Medicare and Medicaid rates, Medicaid physician reimbursement rates are estimated at 54 percent of private payer rates.<sup>19</sup>

### ***Dental Services***

Adequacy of payment for dental care, as for physician care, has been a constant issue in Medicaid programs. States have always used fixed fee schedules for dental services, and payments are commonly below dentists' usual fees. One of the few national studies to look at the issue found that dental fees across states are only comparable on three service codes, and for only 45 states. This study indicated that the 10 largest states, including Florida, rank in the lowest quartile of reimbursement rates.<sup>20</sup>

As with physician payment, there is wide variation among states in payments for dental services. However, there appears to be somewhat more consistency across different procedures within a single state--that is, some of the states are low payers and others high payers across the board. It should be emphasized that the comparison here is not between what Medicaid pays and what some insurer or third-party payer pays for the same service, but between Medicaid rates and providers' charges. Private dental insurance plans also commonly use fixed fee schedules, and these, too, may often be well below providers' charges. The difference is that, while patients with private insurance may have to pay the balance, dentists who treat Medicaid patients must accept the Medicaid rate as payment in full.

## **Capitated Reimbursement**

Under capitation, contracting organizations or health plans agree to provide or accept financial liability for a broad range of Medicaid covered services in return for a fixed monthly payment for each individual enrolled in the contracting organization's plan. The Florida Medicaid Program has been using capitated reimbursement systems since the early 1990s. Under the Governor's 2005 Medicaid reform proposal, capitated reimbursement will become the primary, if not sole, reimbursement methodology used within Medicaid reform demonstration sites.

In Florida's Medicaid Program, capitation payments are used to reimburse many different provider types such as Health Maintenance Organizations (HMOs), Prepaid Behavioral Health programs, and Nursing Home Diversion programs. HMO plans are by far the largest of these provider types and receive the majority of reimbursements within the Medicaid managed care program. For purposes of

this study, Senate staff reviewed the Medicaid managed care capitation payment calculation methodology for HMO providers participating in the Florida Medicaid managed care program.

Medicaid HMOs in Florida are reimbursed based on capitation payments calculated for the applicable contract year. Currently, AHCA as the administrating agency is responsible for calculating the capitation payment rates for reimbursement to the HMO managed care plans. The agency's methodology is established through the administrative rule process (59G-8.100; F.A.C) and is available to the public. The methodology is very complex, but can be summarized as follows:

- The capitation payment is the fixed amount paid monthly by AHCA to an HMO for each enrolled HMO member to provide covered services needed by each member during the month as specified in each contract.
- The Agency for Health Care Administration uses two years of certain historical expenditure data (excluding some fees and payments as described in the rule) from the Medicaid fee-for-service program for the same service the HMO is responsible for delivering.
- These data are then categorized into "rate cells" by age, gender, eligibility group, geographic region and are forecasted to the applicable year using inflation factors adopted by the Legislature in the Social Services Estimating Conference. Once forecasted to the applicable year, these expenditure data are adjusted to reflect policy changes adopted by the Legislature. Any policy changes that will be implemented in the coming year that may affect fee-for-service expenditures are accounted for in the capitation rates (i.e., reductions in the fee-for-service hospital inpatient reimbursement rates).<sup>21</sup>
- After the adjustment for policy issues, the agency applies a discount factor and a trend adjustment to each rate cell to remain within appropriations. The discount factor ranges from 0 to 8 percent and varies by rate cell depending on the geographic region and eligibility category.
- Upon completion, the rates are reviewed and certified by an independent actuarial firm. Upon actuarial certification, and confirmation by CMS, the agency will begin reimbursing HMOs the monthly capitation payment for each recipient enrolled in the plan.

The division of individuals into rate cells is based on age, sex, eligibility category, or location and can capture differences in average spending for entire population groups. However, rate cells cannot predict the level of risk represented by individual enrollees. This has two consequences. First, in states in which managed

care enrollment is voluntary, individuals choosing to enroll may have better or worse health status than individuals choosing to remain in the fee-for-service system. If capitation rates are based on fee-for-service experience, overall payments to managed care organizations (MCOs) might not reflect the level of risk they are actually assuming. Second, when multiple MCOs are competing, any one entity may be over-paid or under-paid, depending on the health status of the beneficiaries it enrolled. This creates incentives for MCOs to market to healthier beneficiaries and/or to promote disenrollment by sicker individuals, often called “cherry picking.”<sup>22</sup>

One way to reduce or eliminate this incentive is to pay MCOs more if they have a higher risk pool, and less if they have a healthier risk pool. Under the Medicaid Reform demonstration program established in 2005, AHCA will begin developing capitation rates utilizing a risk-adjusted capitation methodology. The main difference between the risk adjustment model and the current methodology is the addition of additional criteria utilizing the health status of the recipient. There are currently 18 states that use some type of health status indicator in their capitation rate methodology.

Quality utilization data is critical in order to implement a risk-adjusted capitated rate methodology. This type of data is generally acquired through the use of an encounter data system. However, AHCA does not currently collect enough patient-specific information (specifically regarding diagnoses) through its current fee-for-service claims system to establish an extensive risk adjustment methodology. Recognizing this, the Legislature included provisions in the Medicaid Reform law<sup>23</sup> requiring AHCA to establish an encounter data system.

The encounter data system will be implemented in July 2007. It is unlikely that sufficient encounter data for risk adjustment will be available for at least a year after implementation. As a result, the Legislature included a provision in law<sup>24</sup> passed during the 2005 Special Session that requires a phase-in of the risk adjustment methodology over three years. During this phase-in period, AHCA will use historical prescription drug claims as a proxy for diagnostic codes as a way to implement the risk adjustment in reform demonstration sites.

## **Capitated Reimbursement Methodologies in Other States**

Most of the comparison information from other states used in this section was derived from the publication, *Medicaid Reimbursement Policy*, by the Congressional Research Service, October 2004,<sup>25</sup> and the *2004 Medicaid Managed Care Enrollment Report*, Centers for Medicare and Medicaid Services.<sup>26</sup> Within these studies, the Select Committee found no specific aspect of capitation reimbursement methodologies used by other states that should be considered for improving AHCA’s rate setting policies, other than the use of

encounter data information which is already scheduled to begin in Florida in 2007.

Capitation is widely used among state Medicaid programs as the primary reimbursement methodology for MCOs. Nationally, over 26.9 million beneficiaries, or approximately 61 percent of the Medicaid population, were enrolled in MCOs or other full-risk capitated arrangements as of June 2004.<sup>27</sup> Most of these individuals were enrolled in either commercial or Medicaid-only HMOs.

The Federal Medicaid law simply requires that “prepaid payments to the entity [be] made on an actuarially sound basis.” Until recently, federal regulations provided that state payments for enrollees in MCOs could not exceed the “fee-for-service equivalent” –the estimated amount the state would have spent for a comparable population not enrolled in the MCO and continuing to receive services on a fee-for-service basis. The use of the fee-for-service equivalent as an upper limit was dropped in 2001, partly because some states had enrolled so many beneficiaries in MCOs that they no longer had reliable data on fee-for-service experience. Instead the regulations now provide detailed specifications of what constitutes “actuarially sound” payment rates.

Under the concept of actuarially sound rates, federal rules give states broad discretion over methodologies they can use to set their capitation rates. There are basically three overarching rules that govern the methodology a state may use. The federal rules require that: 1) a qualified actuary must certify that the state’s capitation rates have been developed in accordance with generally accepted actuarial principles and practices; 2) rates must be based only on services covered under the states Medicaid plan; and 3) the state must provide CMS with documentation of the basis used for the rates, along with an explanation of any incentive arrangements.

Reports indicate that capitation rates can be established in three basic ways: the state can simply set them administratively, it can negotiate with plans, or it can use a process of competitive bidding. Based on the Congressional Research Service study, of those states that use capitated rates for HMOs, 19 states set their capitation rates administratively (Florida is one of those), 7 states set rates through negotiations, and 10 states set rates through a competitive bid process.

One of the major changes in capitation rate setting in Medicaid is the concept of risk adjustment. Risk adjustment is a corrective tool designed to reorient the incentives for health plans and enrollees, reducing the negative consequences of enrolling high-risk users by compensating plans according to the health risk of plans’ enrollees. The use of risk adjustment methodologies has been growing slowly across state Medicaid programs with only nine states using the method to

set statewide rates (Florida will begin using a risk adjustment methodology in the Medicaid reform demonstration pilot areas in 2006).

There are two major types of risk adjustment models being used by state Medicaid programs: diagnosis-based systems [e.g., Chronic Illness and Disability Payment System; Adjusted Clinical Groups; and Hierarchical Co-Existing Condition System]; and prescription drug-based systems (e.g., MedicaidRx and RxGroups). All of these systems have certain advantages or disadvantages, but each has shown that it increases the state's ability to adjust capitation rates for risk when coupled with traditional demographic data. An additional benefit of using these risk-adjusted systems is that they can be used to identify high-risk individuals for specific clinical interventions like disease management programs.

## **Prescription Drug Reimbursement**

Prescription drug reimbursement methodologies are treated separately in this report because of the unique nature of pricing and reimbursement and the overall amount that is spent on this Medicaid service. In FY 2004-05, the Florida Medicaid Program's gross expenditures on prescription drugs were \$2.5 billion, or 18.2 percent of the expenditures for all Medicaid services.<sup>28</sup> However, the introduction of the Medicare prescription drug benefit (Medicare Part D) in January 2006 should significantly reduce actual prescription drug expenditures over the coming years.

Prescription drug reimbursement has two major components. First, the Medicaid program reimburses pharmacies for the ingredient cost of each drug filled for a recipient plus a dispensing fee. Second, pharmaceutical manufacturers must provide federal and state supplemental rebates to have their medications included on the Medicaid preferred drug list (PDL). Each of these components will be examined in more detail below.

## **Pharmacy Reimbursement**

The Florida Medicaid Program's current methodology for reimbursement to pharmacies for a prescription drug furnished to a recipient contains two components: 1) an amount to cover the pharmacy's cost to fill the prescription (the dispensing fee); and 2) an amount to cover the cost of the ingredients in the drug (ingredient cost).

Every prescription billed to the Florida Medicaid Program is subject to the four ingredient cost pricing methods discussed in more detail below. As each prescription drug claim is processed, each of the four pricing algorithms is calculated for the specific prescription (98 percent of Florida's Medicaid prescription claims are billed electronically). This generates four separate

reimbursement rates for that claim. The pharmacy is reimbursed the lowest of these four amounts plus a dispensing fee.

### ***Dispensing Fee Calculation***

The Florida Medicaid Program pays a fixed dispensing fee of \$4.23 per prescription to the pharmacy. All state Medicaid programs, with the exception of Arizona, pay pharmacies some type of fixed dispensing fee, ranging from \$3 to \$6 per prescription. Some states pay different dispensing fees for brand name and generic drugs, or for drugs compounded by the pharmacist. Florida, however, does not.

### ***Ingredient Cost Calculation***

As with other states, the Florida Medicaid Program's reimbursement methodology for the ingredient cost of a prescription is more complex than the simple fixed dispensing fee. Florida's methodology for the reimbursement of ingredient cost is based on the lower of four costs: 1) what the state estimates pharmacies pay for drugs (referred to as Estimated Acquisition Cost); 2) the pharmacy's usual and customary price for the drug; 3) the Federal Upper Limit (FUL); or 4) the State Maximum Allowable Cost (SMAC).

#### **Estimated Acquisition Cost (EAC)**

States use the Estimated Acquisition Cost (EAC) methodology to estimate the price the pharmacy actually paid for the drug's ingredients. Since actual sale transactions between pharmaceutical manufactures, wholesalers, and pharmacies are confidential under federal rules, states using the EAC methodology must utilize nationally published pricing of Average Wholesale Prices (AWP), or Wholesale Acquisition Costs (WAC) as a basis to estimate a pharmacy's acquisition cost.

The AWP resembles a list price, or sticker price, and does not reflect what pharmacies are actually paying the wholesalers for the drug after volume discounts or rebates. Therefore, Florida, as do other states, tries to arrive at the pharmacy's EAC by applying a fixed discount percentage to the published AWP's (currently AWP minus 15.4 percent).

To further provide the most accurate estimate of the pharmacy's acquisition cost, Florida, as do many other states, utilizes published WAC pricing plus a fixed percentage to reflect the wholesaler's mark-up to the pharmacy (currently WAC plus 5.75 percent).

### Usual and Customary

A pharmacy's usual and customary charge can be simply defined as the amount the pharmacy actually bills the state Medicaid program for the drug. Generally, the amount that is billed to the program is the same as what the pharmacy would bill a customer without insurance coverage. The usual and customary charge is generally higher than any of the other pricing mechanisms used in the methodology, and is seldom used as the final reimbursed amount.

### Federal Upper Limit (FUL) and State Maximum Allowable Cost (SMAC)

Federal and state governments also set maximum pricing amounts for certain drugs. The federal government maintains a FUL price for certain drugs based on aggregate national spending. The FUL is set by the CMS for certain generic drugs that are available from at least three manufacturers. States are also allowed to set SMAC for certain generics as long as they are not above the FUL. States must update these prices on a routine basis as generic pricing fluctuates frequently.

## **Pharmaceutical Manufacturer Rebates**

Since 1991, federal law has required pharmaceutical manufacturers to give rebates to states for drugs paid for by Medicaid. The rebate formulas are designed to assure that states pay the lowest price offered by the manufacturer to any other high-volume purchaser. In return, the state must generally cover all the drugs marketed by the manufacturer. Rebates are calculated using a pre-negotiated rate that is applied to the gross expenditures for a particular drug over a particular quarter of the year.

The 2001 Florida Legislature significantly expanded its efforts to control pharmaceutical costs in the state's Medicaid program by enacting a program called the preferred drug list (PDL). Under this law,<sup>29</sup> Medicaid prescribing practitioners are required to prescribe the medications on the PDL, or must obtain prior authorization from the AHCA to prescribe a medication not on the PDL, in order for the prescription to be paid for by Medicaid.

In order for a pharmaceutical manufacturer to have its medications considered for inclusion on the PDL, it must agree to provide the state both federally-mandated rebates and state-mandated supplemental rebates.<sup>30</sup> The required rebates are different for generic and brand-name medications.

Under state law, AHCA may enter into arrangements that require manufacturers of generic drugs prescribed to Medicaid recipients to provide rebates of at least 15.1 percent of the average manufacturer price for the manufacturer's generic products. These arrangements require that if a generic-drug manufacturer pays federal rebates for Medicaid-reimbursed drugs at a level below 15.1 percent, the

manufacturer must provide a supplemental rebate to the state in an amount necessary to achieve a 15.1 percent rebate level.

For brand-name medications, AHCA is authorized to negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the Social Security Act and at no less than 14 percent of the Average Manufacturer Price (AMP) on the last day of a quarter unless the federal or supplemental rebate, or both, equals or exceeds 29 percent. There is no upper limit on the supplemental rebates the agency may negotiate.

Negotiated rebates, in addition to other pharmaceutical cost containment strategies, have been successful in slowing the rate of growth in prescription drug expenditures in Florida Medicaid. Medicaid gross prescription drug expenditures had an average annual growth rate of 15.1 percent for the five-year period between FY 2000-01 and FY 2004-05. This was significantly less than the average annual growth rate of 21.2 percent over the previous five fiscal years. Net drug expenditures grew at an even lower rate over the same time period. Net expenditures had an average annual growth rate of 1.7 percent between FY 2000-01 and FY 2004-05, compared to 14.3 percent in the previous five years.<sup>31</sup>

## **Prescription Drug Reimbursement Methodologies in Other States**

Most of the comparison information from other states used in this section was derived from the publication, *Medicaid Reimbursement Policy*, by the Congressional Research Service, October 2004.<sup>32</sup> From this study, the Select Committee found no specific aspect of prescription drug reimbursement methodologies used by other states that should be considered for improving AHCA's reimbursement policies for this service.

Generally, all states use the same factors as Florida for establishing reimbursements for prescription drugs to Medicaid recipients on an outpatient basis: 1) the acquisition or ingredient cost and a dispensing fee; and 2) state supplemental rebates from manufacturers. Federal Medicaid regulations establish upper limits on payment for acquisition costs, but do not limit dispensing fees; these must merely be "reasonable." Two separate limits on acquisition costs are used, one for certain multiple source drugs—those for which therapeutic equivalents or "generic" versions are available from three or more suppliers—and one for all other drugs. The limits are designed to encourage the substitution of lower cost generic equivalents for more costly brand name drugs.

### ***Acquisition and Dispensing Fees***

Most states base their Estimated Acquisition Cost (EAC) for a particular drug on the average wholesale price (AWP). Because it is an arbitrary number that does

not reflect what pharmacies actually pay wholesalers, all states that use AWP take a fixed percentage reduction. But there have been allegations that some manufacturers report highly inflated AWPs. As a result, even though the state pays less than the full AWP, it may pay the pharmacy much more than the pharmacy actually paid for the drug.

To address this issue, Congress recently passed a provision as part of the Deficit Reduction Act of 2006 that allows states to access and use an estimate of pharmacy drug costs called the AMP. This price takes into account available discounts and rebates, and most experts believe it is a more accurate estimate of market price than AWP. Prior to this legislation, only Texas required manufacturers to submit AMP as a condition for providing drugs through the state's Medicaid program.<sup>33</sup>

Most states pay fixed dispensing fees ranging from about \$3 to \$6 per prescription. Some states pay different fees for brand-name and generic drugs; for drugs dispensed in nursing facilities (or for drugs provided in the unit dose systems often used in nursing facilities), or for drugs compounded by the pharmacist from multiple ingredients. A few states pay different fees to different pharmacies, depending on geographic area, the pharmacy's historic costs, or volume of Medicaid or other state-paid prescriptions.

### ***Manufacturer Rebates***

The federal Omnibus Budget Reduction Act of 1990 (OBRA 90) required drug manufacturers, as a condition of Medicaid coverage of their prescription drug products, to enter into agreements with the Secretary of Health and Human Services, under which they pay state Medicaid programs rebates for Medicaid-reimbursed drugs. In return, states are required to cover under Medicaid all of the drugs marketed by that manufacturer, with certain exceptions. States may require prior authorization to dispense certain drugs or can establish a formulary, a listing of preferred drugs, and require authorization for all drugs not on the list. There are also certain categories of drugs which can be excluded from coverage entirely.

In setting the amount of required rebates, the federal law distinguishes between two classes of drugs. The first includes single source drugs (generally, those still under patent) and "innovator" multiple source drugs (drugs originally marketed under a patent but for which generic competition now exists). The second class includes all other, "non-innovator" multiple source drugs (generics).

Some states have negotiated supplemental rebates from manufacturers, in return for which the state might agree to include all the manufacturer's products on its formulary or waive prior authorization. As of 2004, 12 states had implemented supplemental rebate provisions and another 10 had passed supplemental rebate legislation that had not been implemented.

## **Medicare Prescription Drug Benefit (Part D) and Medicaid**

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 added a new outpatient prescription drug benefit known as “Part D” to the Medicare program. The drug benefit was implemented on January 1, 2006. The benefit is provided by private entities, both stand-alone prescription drug plans and comprehensive managed care plans known as Medicare Advantage (MA) plans (formerly Medicare+Choice). These entities will assume part of the financial risk associated with offering the new Part D benefit. The MMA also contains safeguards for ensuring the availability of plans and sufficient choice in all geographic areas.

For state Medicaid programs, the introduction of the Part D benefit will have a significant effect on prescription drug expenditures. First, all persons that were eligible for Medicare and Medicaid (the dual eligibles) prior to January 2006, were required to be auto-enrolled by each state into Medicare Part D plans for prescription drugs. These individuals previously received their prescription medications solely through Medicaid. In Florida, 329,000 Medicaid beneficiaries were automatically enrolled in a Medicare drug plan. Since many of these beneficiaries utilized relatively high levels of prescription drug services, the implementation of the Part D benefit is expected to significantly lower gross pharmaceutical expenditures in Medicaid. It will also change the drugs which are prescribed most often under Medicaid. Together, lower utilization and a different mix of drugs may result in different rebate negotiations. As a result, the prescription drug savings achieved through rebates in the past may not continue at the same levels.

### **Summary of Finding II**

The Florida Medicaid Program’s 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 found no specific aspect of methodologies used by other states that should be considered for improving AHCA’s current rate setting methodologies in general.

During focus group and one-on-one meetings with major stakeholder groups, there were aspects of each group’s reimbursement methodologies for which they 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. However, 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.

### **Finding III: 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**

#### **Nationally, Rates for Every Component of the Medicaid Program Have Been Challenged**

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, including psychiatric hospital rates,<sup>34</sup> community care facility rates,<sup>35</sup> nursing home rates,<sup>36</sup> municipal hospital rates,<sup>37</sup> pediatric physician rates,<sup>38</sup> medical laboratory overpayments,<sup>39</sup> pharmacy rates for prescription drugs,<sup>40</sup> pharmaceutical manufacturers,<sup>41</sup> mental health provider rates,<sup>42</sup> developmental disabilities provider rates,<sup>43</sup> home health agency rates,<sup>44</sup> physician rates,<sup>45</sup> and rates for Medicaid providers generally.<sup>46</sup>

In Florida, court challenges to Medicaid rates<sup>47</sup> have often occurred in the area of persons with disabilities, services provided through the Agency for Persons with Disabilities<sup>48</sup> 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.<sup>49</sup> These cases have been generally excluded from this report.

#### **Providers Face Two Public Policy Issues with Rate Challenges in Florida**

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.<sup>50</sup> 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.<sup>51</sup>

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.<sup>52</sup> 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.<sup>53</sup>

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. For the purposes of this report, those grounds have been identified as including:

- having multiple state agencies involved in rate setting somehow violates the federal requirement for a single state Medicaid agency,
- alleged arbitrary and capricious agency action,
- appropriations act proviso that is allegedly in conflict with statute or is too vague,
- alleged conflicting legislative intent of related laws,
- allegations that the federal rights of Medicaid recipients can be used by providers to challenge rates,
- improper display of budget detail in the General Appropriations Act allegedly in conflict with constitutional requirements,
- requirements of fee schedules allegedly contained in provider agreements,
- allegations that contractual notice, though not explicit in the contract, is required for rate change,
- alleged breach of contract and impairment of contract,
- procedural and substantive due process allegations, and
- alleged invalid delegation of legislative authority and improper separation of powers.

[Note that all of these allegations can be found in a single case currently in litigation.<sup>54</sup>]

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

setting. Such grounds include increased costs attributable to patient care costs, lease payments and liability insurance costs. A number of Florida cases involving Medicaid rate increases have been considered first by administrative hearing officers who recommend orders to the Medicaid agency. In a number of these cases, the agency had not followed the hearing officers' findings of fact,<sup>55</sup> or of law,<sup>56</sup> and issued final orders adverse to the providers. In reviewing these orders, the appellate courts have reversed the agency in some cases where the agency did not state with specificity its reasons for rejecting the hearing officer's findings of fact, or of law, when those findings were supported by substantial evidence.<sup>57</sup>

### **Federal Requirements for Rate Setting for Facilities Were More Stringent Before the 1997 Repeal of the Boren Amendment**

Until 1980, the Medicaid Act (42 U.S.C. §§ 1396 et seq., enacted in 1965) required all participating states to formulate plans that would reimburse providers for the "reasonable cost" of services actually provided to Medicaid patients.<sup>58</sup> This process of paying bills that are rendered—called a "retrospective" standard in social services argot—proved over time to be "inherently inflationary," containing "no incentives for efficient performance. S.Rep. No. 139, 97th Cong., 1st Sess. 478 (1981). 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. Pub.L. No. 96-499, § 962(a), 94 Stat. 2650 (1980). The Boren Amendment, which was applicable initially to nursing and intermediate care facilities only, was made applicable to hospitals in 1981. Pub.L. No. 97-35, § 2173, 95 Stat. 808 (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.<sup>59</sup> The states were left considerable latitude in how to determine what the costs are that had to be incurred by efficiently and economically operated facilities. The Health Care Financing Administration specifically rejected the suggestion that states should be required to define efficiently and economically operated facilities, because the state's methods and standards implicitly act as the state's definition of an efficiently and economically operated facility.

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<sup>60</sup>), the state’s 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.<sup>61</sup> Rather than resulting in efficiency and reduced costs, the Boren Amendment, in application, had the opposite result.<sup>62</sup> Ultimately, Congress repealed the Boren Amendment in 1997.

The legislative history indicates that Congress repealed the Boren Amendment to shield states from having to litigate over Medicaid rates. The House of Representatives, in a conference committee report, described the pre-repeal situation in this way:

Under so-called Boren Amendments, states are required to pay hospitals, nursing facilities, and intermediate care facilities for the mentally retarded (ICFs/MR) rates that are “reasonable and adequate” to cover the costs which must be incurred by “efficiently and economically operated facilities.” A number of courts found that state systems failed to meet the test of “reasonableness” and some states have had to increase payments to these providers.<sup>63</sup>

An earlier House committee report, HR 105-149, was even more explicit about Congress’ intention to curb Boren Amendment litigation:

Repeal of the Boren Amendment . . . Many states have argued that suits or threats of suits under the Boren Amendment have been an important cause of rapid increases in provider reimbursement rates. CBO estimates that the repeal of the Boren Amendment would reduce spending by about \$1.2 billion over the 1998-2002 period. This estimate assumes that reimbursement rates for institutional providers would increase more slowly than if providers could continue to use the threat of Boren suits as leverage against the states.<sup>64</sup>

## **Federal Requirements after 1997 Concerning Rate Setting and Rate Changes are Simplified and Less Stringent**

Repeal of the federal Boren Amendment and the similar Florida law<sup>65</sup> in the late 1990’s was intended to eliminate a basis for legal challenges to Medicaid rates for facilities.<sup>66</sup> The effect of the repeal of the Boren Amendment and the Congressional intent has been recognized by the courts. In *re NYAHS* Litigation, 318 F. Supp. 2d 30, 39-40 (N.D.N.Y. 2004), provides that current 42 U.S.C. § 1396a(a)(13), the successor to the Boren Amendment,

provides that “[a] State plan for medical assistance must...provide for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which . . . providers, . . . are given a

reasonable opportunity for review and comment on the proposed rates . . .” Through the repeal of the Boren Amendment and the enactment of this section, “according to the legislative history, Congress intended to free the states from federal regulation and to eliminate a basis for causes of action by providers to challenge reimbursement rates.” *Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908, 919 n.12 (5th Cir. 2000) (citing H.R. Rep. No. 105-149, at 1230) (“It is the Committee’s intention that, following the enactment of [the Balanced Budget Act of 1997], neither this nor any other provision of [§ 1396a] will be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they receive”). Thus, “by replacing the Boren Amendment with a requirement that a state establish a public process by which its rates would be determined, Congress has removed a party’s ability to enforce any substantive right.” See *Children’s Seashore House v. Waldman*, 197 F.3d 654, 659 (3d Cir. 1999). {Footnotes omitted.}

The successor federal statute, 42 U.S.C. § 1396a(a)(13)(A),<sup>67</sup> 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.<sup>68</sup> 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.<sup>69</sup> 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” through Section 1983.<sup>70</sup> The fundamental disagreement in these cases is whether the successor to the Boren Amendment contains “rights-creating language” according to the Supreme Court’s decision in *Gonzaga University v. Doe*<sup>71</sup>—a matter of Section 1983 jurisprudence.

## **Florida’s Medicaid Marketplace Affects the Balance between Buyers and Sellers**

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.<sup>72</sup> 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.

### **Summary of Finding III**

The Select Committee’s review of litigation and its effect on Medicaid provider rate setting 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, Medicaid providers may challenge the adequacy of Medicaid rates, but such challenges may pit them against three opposing forces including: 1) Florida’s Constitution requires a balanced budget, with all expenditures from the state treasury being made pursuant to an appropriation; 2) legislative decisions to increase provider rates may have to be balanced against reductions in services or eligibility of recipients in order to control total expenditures; and 3) current Florida laws only allow Medicaid providers to challenge rates based on the technical and other requirements.

The setting of rates in Florida is, in effect, a price negotiation in the marketplace between AHCA (the purchaser) and the Medicaid providers (the sellers). 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.

### **Finding IV: 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.<sup>73</sup>

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.

### **Current Methodologies May Create Disincentives for Improving the Quality of Care**

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.<sup>74</sup>

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. Diagnosis Related Groups 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 Methodologies**

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. The Bridges to Excellence program typifies the first approach. Physicians, who achieve certain process and outcomes measures, as determined by National Committee for Quality Assurance, are paid a threshold bonus (e.g., \$100 per diabetic) for every patient with the diagnosis in their practice. The Bridges to Excellence program is concentrating initially on diabetic and cardiac care. There is an additional component for maintenance of infrastructure (e.g., information technology) that makes these initiatives easier.

Tiering bonuses are typified by the Integrated Healthcare Association in California and the Central Florida HealthCare Coalition. Under these programs, the universe of providers who seek to be paid on this basis is aggregated, and their performance is arrayed normatively. Providers in the top tier get additional payments or administrative burden reduction. Second-tier providers get somewhat lower payments, and third-tier providers likely get nothing. Under these tiering mechanisms, whether or not providers will ever receive any money is speculative because they have no idea what the other players will do, nor can they control the behavior of others in the risk pool.

The third type of pay-for-performance program is seen in the CMS demonstration programs, both at the hospital level and in the physician group practice demonstration. In these mechanisms, providers are tiered but their behavior also is evaluated against a benchmark of cost savings. If providers do not achieve cost savings above the comparison pool, no bonuses will be available. Uncertainty about return for the effort exists in these programs, too, because of the tiering phenomenon.

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 Pay-For-Performance Initiatives***

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. The following is a list of Medicare's pay-for-performance and disease management initiatives as of 2005.<sup>75</sup>

#### **Hospital Quality Initiative (MMA of 2003, Section 501(b))**

This is part of the U.S. Health and Human Service's broader National Quality Initiative<sup>76</sup> that focuses on an initial set of 10 quality measures by linking reporting of those measures to the payments the hospitals receive for each discharge. Hospitals that submit the required data receive the full payment update to their Medicare DRG payments. Nearly all (98.3 percent) of the hospitals eligible to participate in this program are complying with the requirements of the provision as of 2005.

#### **Premier Hospital Quality Incentive Demonstration**

The purpose of the demonstration is to improve the quality of inpatient care for Medicare beneficiaries by giving financial incentives to almost 300 hospitals for high quality. Under this demonstration, CMS is collecting data on 34 quality measures relating to five clinical conditions. Hospital specific performance will be publicly reported on CMS's web site. Hospitals scoring in the top 10 percent for a given set of quality measures will receive a 2 percent bonus payment on top of the standard DRG payment for the relevant discharges. Those scoring in the next highest 10 percent will receive a 1 percent bonus. In the third year of the demonstration, those hospitals that do not meet a predetermined threshold score on quality measures will be subject to reductions in payment.

During the life of the three-year demonstration project, which began in October 2003, Medicare will reward high performers with bonuses totaling \$7 million per year for a total of \$21 million. Poorly performing hospitals may face financial penalties in the third year.

A preliminary analysis of the first year of the program showed improvement in all five clinical areas being tracked in the three-year demonstration.<sup>77</sup> The analysis was done by Premier Inc., whose member hospitals are participants in the demonstration. The preliminary analysis of first-year performance found median quality scores for hospitals improved:

- From 90 percent to 93 percent for patients with acute myocardial infarction (heart attack).
- From 86 percent to 90 percent for patients with coronary artery bypass graft.
- From 64 percent to 76 percent for patients with heart failure.
- From 85 percent to 91 percent for patients with hip and knee replacement.
- From 70 percent to 80 percent for patients with pneumonia.

Overall, these conditions account for a substantial portion of Medicare costs. By achieving improvements in aspects of care that are proven to help patients avoid complications, CMS hopes patients are less likely to require more costly follow-up care for such conditions, and are more likely to have a better quality of life. Hospitals participating in the project cared for more than 400,000 patients in the five conditions during the first year.

### **Physician Group Practice Demonstration [Benefits Improvement and Protection Act (BIPA) of 2000]**

Mandated by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), this demonstration is the first pay-for-performance initiative for physicians under the Medicare program. The demonstration rewards physicians for improving the quality and efficiency of health care services delivered to Medicare fee-for-service beneficiaries. The demonstration seeks to encourage coordination of Part A and Part B services, promote efficiency through investment in administrative structure and process, and reward physicians for improving health outcomes.

Ten large (200 or more physicians) group practices across the country are participating in this demonstration, which was operational April 2005. The physician group practices will be able to earn performance-based payments after achieving savings in comparison to a control group. The performance payment is largely based on various quality results.<sup>78</sup>

**Medicare Care Management Performance Demonstration (MMA of 2003, Section 649)**

Modeled on the “Bridges to Excellence” program, this is a three-year, pay-for-performance demonstration with physicians to promote the adoption and use of health information technology to improve the quality of patient care for chronically ill Medicare patients. Doctors who meet or exceed performance standards established by CMS in clinical delivery systems and patient outcomes will receive bonus payments for managing the care of eligible Medicare beneficiaries. In contrast to the Physician Group Practice Demonstration, this demonstration, which is currently under development, is focused on small and medium-sized physician practices. It will be implemented in four states: Arkansas, California, Massachusetts, and Utah, with the support of the Quality Improvement Organizations in those states.

**Medicare Health Care Quality Demonstration (MMA of 2003, Section 646)**

This demonstration will be a five-year demonstration program under which projects enhance quality by improving patient safety; reducing variations in utilization by appropriate use of evidence-based care and best practice guidelines; encouraging shared decision making; and using culturally and ethnically appropriate care. Eligible entities include physician groups, integrated health systems, or regional coalitions of the same.

**Chronic Care Improvement Program (MMA of 2003, Section 721)**

This pilot program will test a population based model of disease management, whereby the participating organizations are paid a monthly per beneficiary fee for managing a population of chronically ill beneficiaries with advanced congestive heart failure and/or complex diabetes. These organizations, which include disease management vendors and larger organizations such as insurance companies, must guarantee CMS a savings of at least 5 percent plus the cost of the monthly fees compared to a similar population of beneficiaries. Payment of fees is also contingent upon performance on quality measures and satisfaction of both beneficiaries and providers. Nine sites have been selected for the pilot phase: Humana in South and Central Florida; XLHealth in Tennessee; Aetna in Illinois; LifeMasters in Oklahoma; McKesson in Mississippi; CIGNA in Georgia; Health Dialog in Pennsylvania; American Healthways in Washington, D.C. and Maryland; and Visiting Nurse Service of New York and United Healthcare in Queens and Brooklyn, New York. After two years, pending successful interim results, this pilot may be expanded more broadly, possibly nationally.

**End-Stage Renal Disease (ESRD) Disease Management Demonstration (MMA of 2003, Section 623)**

This three-year demonstration will test a fully case-mix adjusted payment system for an expanded bundle of end stage renal disease (ESRD) services. A portion of the payment will be linked to ESRD-related quality measures. An advisory board for the demonstration is required by the legislation and held its first public meeting in February 2005. The demonstration is projected to be operational in 2006.

#### **Disease Management Demonstration for Severely Chronically Ill Medicare Beneficiaries (BIPA 2000)**

This demonstration, which began enrollment in February 2004, is designed to test whether applying disease management and prescription drug coverage in a fee-for-service environment for beneficiaries with illnesses such as congestive heart failure, diabetes, or coronary artery disease can improve health outcomes and reduce costs. Three disease management organizations: XLHealth in Texas, CorSolutions in Louisiana, and HeartPartners in California and Arizona, are participating. They receive a monthly payment for every beneficiary they enroll to provide disease management services and a comprehensive drug benefit, and must guarantee a net reduction in Medicare expenditures as a result of their services. Submission of data on a number of relevant clinical measures is required to permit evaluation of the demonstration's impact on quality.

#### **Disease Management Demonstration for Chronically Ill Dual Eligible Beneficiaries**

Under this demonstration, disease management services are being provided to dually (Medicare & Medicaid) eligible beneficiaries in Florida who suffer from advanced-stage congestive heart failure, diabetes, or coronary heart disease. The demonstration provides the opportunity to combine the resources of the state's Medicaid pharmacy benefit with a disease management activity funded by Medicare to coordinate the services of both programs and achieve improved quality with lower total program costs. LifeMasters, the demonstration organization, is being paid a fixed monthly amount per beneficiary and is at risk for 100 percent of its fees if performance targets are not met. Savings above the targeted amount will be shared equally between CMS and LifeMasters. Submission of data on a variety of relevant clinical measures is required to permit evaluation of the demonstration's impact on quality.

#### **Care Management for High Cost Beneficiaries**

This demonstration will test models of care management in a Medicare fee-for-service population. The demonstration will target beneficiaries who are both high-cost and high-risk. The announcement for this demonstration was published in the Federal Register on October 6, 2004 and applications were due in

January 2005. The payment methodology will be similar to that implemented in the Chronic Care Improvement Program, with participating providers required to meet relevant clinical quality standards as well as guarantee savings to the Medicare program.

## **Summary of Finding IV**

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 fee-for-service 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 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. Medicare is currently testing a number of pay-for-performance strategies across provider types that may be models for the Florida Medicaid Program.

These 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.

### **Recommendation: Current Florida Statutes that Trade State Control of Medicaid Expenditures for Provider Input and Allow Rate Setting by Administrative Rule May 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 where APD providers are 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.<sup>79</sup>

An alternative to requiring Medicaid rates to be set by administrative rule is to require that the rate-setting agency (AHCA) give prior notice to the Medicaid providers who will be affected by any rate reductions. Such a notification requirement could simply track federal law in 42 USC 1396a(a)(13) and 42 CFR 447.205. These notification requirements only ask the State Medicaid agency to tell providers of proposed and final rate setting methodologies and open a brief window for comment (at least for rates for intermediate care facilities). The final decision is up to the agency and providers are deliberately given no mechanism in federal law to challenge the adequacy of rates.

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 rulemaking 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.

The Legislature may wish to consider changes that relate to all Medicaid rate setting or may consider targeting proposed legislation to components of the Medicaid program. While such targeted rate setting limitations may raise equal protection concerns, they may pass constitutional muster if constructed on a rational basis.<sup>80</sup> For example, rate setting for Medicaid waiver programs might be addressed separately from rate setting for all Medicaid programs because recipient

participation in waiver programs is limited to funds available and waiting lists are known to exist, thus increased rates necessarily mean fewer services.<sup>81</sup> In addition, no statute currently exists that brings state Medicaid rate setting procedures into line with federal requirements. Any new provisions would, presumably, be modeled on 42 U.S.C. s. 1396a(a)(13)(A) and on 42 C.F.R. s. 447.205.<sup>82</sup> Congress enacted the current version of 42 U.S.C. s. 1396a(a)(13) (which replaced the Boren Amendment) to give states maximum flexibility in rate setting and to limit judicial challenges to rate-setting decisions. The following sections of Florida Statutes could be reviewed and considered for amendment:

***Section 409.907(2), Florida Statutes***

Section 409.907(2), Florida Statutes, describes agreements between Medicaid providers and AHCA.<sup>83</sup> This section could be amended to increase state flexibility in rate setting. In the past, some provider agreements have explicitly incorporated fee or rate schedules in their terms. Some providers have argued that when fees or rates are part of the contract or other Medicaid agreement they cannot be changed, even when the projected fiscal demands on the program may exceed appropriations. This threatens the state's ability to implement the rate reform legislation enacted in 2003 and 2004 and thus to contain rising Medicaid costs.

***Section 409.908, Florida Statutes***

Section 409.908, Florida Statutes, describes the process for reimbursement of Medicaid providers and specifically calls for methodologies set out, or adopted by reference, in administrative rules.<sup>84</sup> This section could be amended to remove Medicaid rate setting from the administrative rulemaking requirements of Chapter 120, Florida Statutes, the Administrative Procedures Act. Requiring rate setting to be conducted through Chapter 120, Florida Statutes, limits state flexibility in meeting the challenges posed by unexpected and often rapid growth in program expenditures. Any change to this section should take into consideration the existing requirements of Section 393.0661(4), Florida Statutes, which requires rate adjustments for the APD home and community-based services waiver to stay within appropriations.<sup>85</sup>

***Section 393.0661(3), Florida Statutes***

Section 393.0661(3), Florida Statutes, provides for adoption of rate methodologies through emergency rules for the APD home and community-based services waiver.<sup>86</sup> The Legislature may wish to consider clarifying the rulemaking requirements of this section. Without regard to the intent of the Legislature, Medicaid providers have argued that this section requires rulemaking for all phases of rate setting for the developmental disabilities home and community-based services waiver, including efforts to reduce rates in the face of budget shortfalls.<sup>87</sup>

### ***Chapter 409, Florida Statutes***

Chapter 409, Florida Statutes, does not specify the venue for lawsuits involving Medicaid rates. The Legislature may wish to consider legislation that would specify the venue for such cases as being in Leon County as, for example, is specified for Medicaid program integrity overpayment cases,<sup>88</sup> election lawsuits involving the Secretary of State,<sup>89</sup> lawsuits against the Department of the Lottery,<sup>90</sup> and workers' compensation self-insurer delinquency proceedings.<sup>91</sup>

### ***Alignment with Federal Law***

This study revealed that most of the current Medicaid laws in Florida that form a basis for providers to challenge Medicaid rate setting were, in fact, passed by the Legislature before the repeal of the federal Boren Amendment.<sup>92</sup> The requirements of these laws, or at least the requirements alleged by providers in current lawsuits, go beyond the requirements of current federal law.<sup>93</sup> It appears that the Legislature could consider amendments to current Florida law and still be well within the current federal requirements.

1. The Legislature may wish to increase state flexibility in rate setting: In the past, some provider agreements have incorporated fee or rate schedules. Some providers have argued that when fees or rates are part of the contract or other Medicaid agreement they cannot be changed, even when fiscal demands on the program may exceed appropriations. This has seriously threatened the state's ability to implement the rate reform legislation enacted in 2003 and 2004 and thus to contain rising Medicaid costs.
2. The Legislature may wish to remove Medicaid rate setting from Chapter 120, F.S.: Requiring rate setting to be conducted through Chapter 120, F.S., limits state flexibility in meeting the challenges posed by unexpected and often rapid growth in program expenditures.
3. The Legislature may wish to give Florida the Medicaid rate setting flexibility allowed by federal law and rules--42 U.S.C. s. 1396a(a)(13)(A) (federal law) and 42 C.F.R. s. 447.205 (federal regulations).
4. The Legislature may wish (in conjunction with 1. through 3. above) to ensure that any proposed legislation does not prohibit access to the courts for a provider who believes the rate-setting process has been unfair. Proposed legislation could limit the ability of a provider to challenge "the substance of Medicaid rates," meaning they can't challenge the dollar amount of the rates. Providers could still go to court over the process of rate setting, the fairness of rate-setting, etc., but not the rates themselves

unless the dollar amount of the rates violates the state constitution or federal law. This would be consistent with the state constitution requirement that “No money shall not be drawn from the treasury except in pursuance of appropriation made by law.” (Section 1(c) of Article VII of the Florida Constitution).

**Recommendation: 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.

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Endnotes:

<sup>1</sup> *Medicaid Reimbursement Policy*. Congressional Research Service, The Library of Congress. Report Code RL32644. October 25, 2004. <http://www.cq.com/flatfiles/editorialFiles/temporaryItems/20041101Medicaid.pdf>

<sup>2</sup> *Executive Summary*. Social Services Estimating Conference. November 2005.

<sup>3</sup> Ibid.

<sup>4</sup> *Basic Medicaid Caseloads, Historical and Forecasted Average Monthly Caseloads by Fiscal Year, FY 1998-99 to FY 2008-09*. Results of the Social Services Estimating Conference, October 11, 2005.

<sup>5</sup> *Medicaid Reimbursement Policy*. Congressional Research Service, The Library of Congress. Report Code RL32644. October 25, 2004. <http://www.cq.com/flatfiles/editorialFiles/temporaryItems/20041101Medicaid.pdf>.

<sup>6</sup> 42 U.S.C. 1396a

<sup>7</sup> *Medicaid Reimbursement Policy*. Congressional Research Service, The Library of Congress. Report Code RL32644. October 25, 2004. <http://www.cq.com/flatfiles/editorialFiles/temporaryItems/20041101Medicaid.pdf>

<sup>8</sup> Patients are assigned to one of 540 DRGs on the basis of admitting diagnosis, procedures performed, presence of complications, or other characteristics. Each DRG has an assigned weight--for example, 0.8889 for an uncomplicated appendectomy or 9.7823 for a liver transplant--which is then multiplied by the fixed rate established for the hospital. So, if a hospital's standard rate were \$5,000, it would be paid \$4,445 for the appendectomy and \$48,912 for the liver transplant.

<sup>9</sup> C. Harrington, et al., *1998 State Data Book on Long Term Care Program and Market Characteristics*, Centers for Medicare and Medicaid Services.

<sup>10</sup> *CMS Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes* (known as the "Phase I" report) ch. 2, Centers for Medicare and Medicaid Services.

<sup>11</sup> Of 489,138 service recipients, 378,566 were served under HCBS waivers as of June 2002. Research and Training Center on Community Living, *Residential Services for Persons with Developmental Disabilities, Status and Trends Through 2002*, University of Minnesota, Minneapolis, 2003.

<sup>12</sup> For reviews of recent litigation, see National Health Law Program, *Docket of Medicaid Cases to Improve Provider Participation*, February 23, 2003, at <http://www.nls.org/conf2003/provider-docket.htm> and summaries by the American Dental Association.

<sup>13</sup> *Medicaid Reimbursement Policy*. Congressional Research Service, The Library of Congress. Report Code RL32644. October 25, 2004. <http://www.cq.com/flatfiles/editorialFiles/temporaryItems/20041101Medicaid.pdf>

<sup>14</sup> Under the RBRVS system, a brief physician office visit might have a value of three, an appendectomy a value of 150. The state then multiplies the different values by a single standard dollar amount. If a unit is valued at \$5, the state will pay \$15 for the brief office visit and \$450 for the appendectomy.

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<sup>15</sup> There have been some studies looking at Medicaid physician and dentist reimbursement rates compared to Medicare. In a 2001 study by the Lewin Group, Florida's average Medicaid physician fee was 65.1 percent of Medicare-allowed charges. *Comparing Physician and Dentist Fees Among Medicaid Programs*, The Lewin Group, June 2001.

<sup>16</sup> Alaska is not included in this comparison because its high cost of living makes it a statistical outlier.

<sup>17</sup> This rate applies to individuals not enrolled in the Arizona Health Care Cost Containment System (AHCCCS), the managed care program that serves most Medicaid beneficiaries in Arizona.

<sup>18</sup> The difference is much smaller than in 1994, when Medicare paid 66 percent of average private rates. MedPAC attributes the change to shifts from indemnity plans to lower-paying HMOs and PPS. MedPAC, *Report to the Congress: Medicare Payment Policy*, 2003.

<sup>19</sup> This calculation was based on the MedPAC study that found Medicare reimbursements are about 83% of rates paid by private insurers and the previously cited Lewin Group study which indicated Florida's physician rates are estimated at 65.1 percent of Medicare. The calculation used the following assumptions: if a private payer reimburses a Level 4 office visit at \$250, the Medicare rate would be approximately \$208 ( $\$250 \times 83\% = \$207.50$ ). Based on the Lewin Group study, the Medicare rate would then be discounted by 35 percent to obtain the Medicaid rate of \$135 for the comparable service ( $\$207.50 \times 65.1\% = \$135.08$ ). The Medicaid rate of \$135 would be 54 percent of the private payer rate of \$250.

<sup>20</sup> This study ranked Florida 38<sup>th</sup> (1<sup>st</sup> indicating the highest Medicaid reimbursement rate) among the 45 states in the study in terms of dental service reimbursement in Medicaid. *Comparing Physician and Dentist Fees Among Medicaid Programs*, The Lewin Group, June 2001.

<sup>21</sup> For example, hospital inpatient expenditures are a major component of HMO capitation rates and whether or not certain factors in these expenditures were included in FY 2005-06 managed care capitation rates became a contentious issue.

<sup>22</sup> *Medicaid Reimbursement Policy*. Congressional Research Service, The Library of Congress. Report Code RL32644. October 25, 2004. <http://www.cq.com/flatfiles/editorialFiles/temporaryItems/20041101Medicaid.pdf>

<sup>23</sup> Chapter 2005-133, L.O.F.

<sup>24</sup> Chapter 2005-358, L.O.F.

<sup>25</sup> *Medicaid Reimbursement Policy*. Congressional Research Service, The Library of Congress. Report Code RL32644. October 25, 2004. <http://www.cq.com/flatfiles/editorialFiles/temporaryItems/20041101Medicaid.pdf>

<sup>26</sup> *2004 Medicaid Managed Care Enrollment Report*, Centers for Medicare and Medicaid Services. Found at <http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer04.pdf> as of February 2006.

<sup>27</sup> The unduplicated managed care enrollment figures include enrollees receiving comprehensive benefits and limited benefits. This table also provides unduplicated national figures for the total Medicaid population and other populations. The statistics also include individuals enrolled in state health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards.

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<sup>28</sup> *Inflated Pricing and Confidential Information Prevent Medicaid from Ensuring Lowest Prescription Drug Prices*. Office of Program Policy Analysis and Government Accountability, The Florida Legislature, Report Number 06-07, January 2006.

<sup>29</sup> Chapter 2001-104, L.O.F.

<sup>30</sup> Section 409.912(39)(a), F.S.

<sup>31</sup> *Inflated Pricing and Confidential Information Prevent Medicaid from Ensuring Lowest Prescription Drug Prices*. Office of Program Policy Analysis and Government Accountability, The Florida Legislature, Report Number 06-07, January 2006.

<sup>32</sup> *Medicaid Reimbursement Policy*. Congressional Research Service, The Library of Congress. Report Code RL32644. October 25, 2004.  
<http://www.cq.com/flatfiles/editorialFiles/temporaryItems/20041101Medicaid.pdf>

<sup>33</sup> *Inflated Pricing and Confidential Information Prevent Medicaid from Ensuring Lowest Prescription Drug Prices*. Office of Program Policy Analysis and Government Accountability, The Florida Legislature, Report Number 06-07, January 2006.

<sup>34</sup> See, e.g., Rye Psychiatric Hospital Center, Inc. v. Surles, 777 F. Supp. 1142 (S.D.N.Y.1991) partial summary judgment finding that the state defendants were providing inadequate reimbursement to the plaintiff Medicaid provider and that “the portion of plaintiff’s action relating to inadequate reimbursement payments and improper rate methodologies occurring since [the ruling] represents injuries arising after the court issued its decision. Relief for these injuries is clearly prospective in nature.” Id. at 1147.

<sup>35</sup> See e.g., McGee Guest Home, Inc. v. Department of Social and Health Services, 142 Wn.2d 316, 12 P.3d 144 (Wash. 2000), where the court found that the state health services department was not required to promulgate rules before setting payment rates for services to mentally ill people. The court noted that the Washington Legislature amended state administrative procedures law to exempt from rulemaking requirements “reimbursement unit values, fee schedules, arithmetic conversion factors, and similar arithmetic factors used to determine payment rates that apply to goods and services purchased under contract for clients” receiving state medical assistance.

<sup>36</sup> See, e.g., Oklahoma Nursing Home Association v. Demps, 816 F. Supp. 688 (W.D. Okla. 1992), where nursing homes argued that a worker’s compensation premium increase warranted a Medicaid reimbursement rate increase. The court found that the state Medicaid agency must “make findings which identify and determine: (1) efficiently and economically operated hospitals; (2) the costs which must be incurred by such hospitals; and (3) payment rates which are reasonable and adequate to meet the reasonable costs of such hospitals. In other words, the state must make findings which establish a nexus between the costs of operating efficient and economic nursing facilities and the state’s reimbursement rate. Consistency between the facilities’ expenditures and the amount appropriated by the state legislature does not establish this nexus.” {Citations omitted.}

<sup>37</sup> See, e.g., New York City Health & Hosps. Corp. v. Perales, 50 F.3d 129 (2d Cir. 1995). Plaintiff health care providers obtained a judgment against defendant state Medicaid program, voiding regulations that permitted the state to pay less than the full deductible and coinsurance liability incurred prospectively under the social security act.

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<sup>38</sup> See, e.g., Okla. Chptr. of the Am. Acad. of Pediatrics v. Fogarty, 366 F. Supp. 2d 1050 (N.D. Okla. 2005) The court found, inter alia, that the Oklahoma Medicaid agency failed to set physician reimbursement rates high enough to attract enough providers for services to be as available to Medicaid children as to insured children, that the level of Medicaid physician reimbursement was insufficient as a matter of law, and that lack of pediatricians for children with complex needs demonstrated failure to assure that payments to providers were consistent with quality of care.

<sup>39</sup> See, e.g., Yorktown Medical Lab., Inc. v. Perales, 948 F.2d 84 (2d Cir. 1991). Lab, a Medicaid provider, claimed, inter alia, that the statistical sampling techniques used by the state Medicaid agency to calculate overcharges by the lab violated due process. The court found that plaintiff's argument failed because it sought to craft a distinction between monetary damages and money in which it had a property interest.

<sup>40</sup> See, e.g., Walgreen Co. v. Hood, 275 F.3d 475 (5th Cir. 2001), Walgreen Co. v. Hood, 536 U.S. 951 (2002). The Medicaid provider pharmacy claimed that reimbursement rates used by the Louisiana Medicaid agency to calculate payments to pharmacies for prescription drugs provided to recipients violated 42 U.S.C.S. § 30(A), which "requires that states' Medicaid plans provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and 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." The court rules that Medicaid providers do not have a right to bring suit under 42 U.S.C.S. § 1983, which provides a cause of action against a state official for the deprivation of any rights, privileges, or immunities secured by the U.S. Constitution and laws, to remedy violations of 42 U.S.C.S. § 30(A). See also, Pennsylvania Pharmacists Ass'n. v. Houstoun, 283 F.3d 531, (3rd Cir. 2002).

<sup>41</sup> See, e.g., Pharm. Research & Mfrs. of Am. v. Medows, 184 F. Supp. 2d 1186 (N.D. Fla. 2001), where pharmaceutical companies challenged two revisions to Florida Statutes as creating a state Medicaid formulary in violation of the federal Medicaid law. The court upheld the magistrate's ruling that the statutes allowed the establishment of a preferred drug list and a prior authorization program which are permitted by the federal Medicaid law.

<sup>42</sup> See, e.g., Burlington United Methodist Family Services. v. Atkins, 227 F. Supp. 2d 593 (S.D.W.V. 2002), where Medicaid mental health providers challenged the West Virginia Medicaid agency's method of calculating reimbursement rates. The court found there was no private right of action for providers, rather that the state plan must provide procedures to assure that payments to providers produce efficiency and economy for the state program, not for providers. Providers' procedural due process argument failed since they had no right to any particular type of rate methodology, and their substantive due process argument failed because the agency's rate-determination system was neither "conscience shocking" nor "fatally arbitrary." Provider's equal protection claim, if it could be clarified, was allowed to be considered.

<sup>43</sup> See, e.g., Sanchez v. Johnson, 416 F.3d 1051 (9th Cir. 2005), as amended August 12, 2005, where the court, considering 42 U.S.C.S. § 1396a(a)(30)(A), reasoned that "[f]ar from focusing on the rights of a specific class of beneficiaries, § 30(A) is concerned with a number of competing interests. It requires a State to "provide such methods and procedures relating to . . . care and services . . . as may be necessary to . . . assure that payments are consistent with efficiency, economy, and quality of care." The most efficient and economical system of providing care may be one that benefits taxpayers to the detriment of medical providers and recipients; likewise, the provision of "quality" care--whatever standard may be implied by such a nebulous term -is likely to conflict with the goals of efficiency and economy. The tension between these statutory objectives supports the conclusion that § 30(A) is

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concerned with overall methodology rather than conferring individually enforceable rights on individual Medicaid recipients.”

<sup>44</sup> See, e.g., Procure, Inc. v. White, 1995 Tenn. App. LEXIS 406 (Tenn. Ct. App. June 21, 1995). The Tennessee Medicaid agency contended that each home health agency’s per visit reimbursement was, by rule, frozen at the level shown on the provider’s cost reports on a certain date. The court found that, as no Medicaid payment limit was in effect on the date in the rule, the agency’s interpretation of its own rule was invalid.

<sup>45</sup> See, e.g., Pennsylvania Medical Society v. Snider, 29 F.3d 886 (3d Cir. 1994). The medical society challenged Pennsylvania’s plan to have Medicare-eligible people whose income was below the federal poverty line but who were not eligible for Medicaid become “qualified Medicare beneficiaries” (QMB’s) so that the state would pay Medicare Part B premiums, coinsurance, and deductibles. The state limited its coinsurance and deductible payments such that total reimbursement would exceed the amount that a provider received under Medicaid. Stating that Congress intended that the providers receive 100 percent of the reasonable charges for Part B Medicare patients even if they were Medicaid-eligible and meant for the state to relieve the QMB’s plight of having to pay out of pocket expenses, the court held that the state had to pay the full amount of Part B cost-sharing on behalf of QMB’s.

<sup>46</sup> See, e.g., Evergreen Presbyterian Ministries, Inc. v. Hood, 235 F.3d 908 (5th Cir. 2000), where a broad coalition of Medicaid providers claimed provisions of the Social Security Act were violated when the Louisiana Medicaid agency implemented reductions of Medicaid reimbursement rates and cuts in the Medicaid program. The court concluded that plaintiffs’ factual evidence focused on the impact of reduced reimbursement rates on health care providers, rather than on impairment of recipient access. Thus, the court found the evidence was inadequate to conclude that the providers had a substantial likelihood of success in proving a violation of recipients’ right to equal access to medical care.

<sup>47</sup> Note that many cases not covered by this research address the provision of services to Medicaid recipients. Even though these cases may be brought by providers, who gain financial benefit from providing more services, these have not been considered rate cases. See, e.g., Doe v. Chiles, 136 F.3d 709, 715-19 (11th Cir. 1998), where a class of mentally retarded or developmentally disabled adults, who were eligible to receive Medicaid services under a numerosity cap in the state waiver program, were currently on a waiting list for such services. The court granted the plaintiffs’ summary judgment motion as defendants had not fulfilled their 42 U.S.C.S. § 1396a(a)(8) obligation to provide mandated Medicaid residential habilitation services with reasonable promptness. The court further ordered the state to provide the services within 90 days.

<sup>48</sup> See, e.g., Sunrise Opportunities v. DCF, Case No. 04-22152 CIV-Martinez, U.S. District Court for the Southern District (Miami), brought by five of the larger APD providers of Medicaid waiver services who allege breach of contract (due to rate change and computer review of provider billings), violation of due process (computer review of billings), impairment of contracts under state and federal constitutions (rate change), and violation of the Medicaid Act (computer review of billings). See also, American Habilitation v. DCF, AHCA, Case No. 2004-CA-000326, Leon County Circuit Court, where 57 providers seek a declaration of their rights under contracts between DCF and AHCA regarding waiver rates allegedly set in those contracts and damages for alleged breach of contract for paying less than contract rates.

Providers allege breach of agreements relating to rates and allege unconstitutionality of proviso language directing DCF to adjust rates to stay within appropriation for implementation of rate schedules. As of January 2006, 46 of the providers have made offers of judgment. See also, Florida Association of Rehabilitation Facilities v. AHCA, 1st DCA Case No. 1D05-2155, where DOAH (Case No. 05-0087-RP) found in favor of the providers challenge of

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ICF/DD rate reductions based on a procedural error in the rulemaking process. The decision is in abeyance pending the outcome of the state's appeal. As of January 2006, AHCA has begun the rulemaking process anew.

<sup>49</sup> See, e.g., Agency for Health Care Administration v. Mied, Inc., 869 So. 2d 13, 18 (Fla. 1st DCA 2004) Mied purchased a nursing home and attempted to have a Medicaid rate step-up approved, requiring AHCA to deem Mied an unrelated purchaser. Before making that determination, AHCA's petition for receivership was granted. Additionally, Mied's lender declared Mied in default. AHCA then determined that Mied was a related party purchaser and was not entitled to a rate step-up. The parties entered into a settlement, which in part required Mied to dismiss its petition for formal administrative hearing on the rate step-up issue. The court reversed the jury award and held that: 1) Mied's breach of contract claim was insufficient as a matter of law due to the settlement agreement and Mied's failure to exhaust administrative remedies, 2) the receivership could not be considered by the jury because the corporation failed to appeal the receivership order; 3) AHCA's reimbursements were timely made.

<sup>50</sup> Article VII, Section (1), Florida Constitution, provides in part:

SECTION 1. Taxation; appropriations; state expenses; state revenue limitation.—

(c) No money shall be drawn from the treasury except in pursuance of appropriation made by law.

(d) Provision shall be made by law for raising sufficient revenue to defray the expenses of the state for each fiscal period.

<sup>51</sup> *Id.* American Habilitation, *supra* note 48. The prior judge in this case appeared to agree with the providers that the language in the introductory paragraph of s. 409.908, F.S., does not exempt the agency from rulemaking when reducing rates to comply with the availability of appropriations. The statutory language reads:

Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

<sup>52</sup> For an example of a Medicaid rate lawsuit in a non-waiver program, see Agency for Health Care Administration v. Baker Community Medical Services, 832 So. 2d 841 (Fla. 1st DCA 2002). Baker was a hospital that had a Medicaid provider agreement with AHCA, entitling it to full Medicaid payment for services to Medicaid-eligible persons. Some of Baker's emergency outpatient services were provided to Medicaid-eligible enrollees of health maintenance organizations (HMOs) which were under separate contract with AHCA to provide Medicaid services. The HMOs reimbursed Baker for emergency outpatient services at a different, lower rate. The appellate court found that: "When Medicaid services are provided through a contract with an HMO, federal law requires emergency care coverage. States; however, are given the option of paying for such services or requiring the HMO to cover them. Florida has opted to require the HMO to provide emergency services. When a state requires an HMO to provide emergency care as a covered service, federal law prohibits the state from paying another provider for services that are supposed to be provided by a Medicaid HMO." {Citations omitted.}

<sup>53</sup> We appear to be seeing some of this dilemma in the APD Medicaid waiver program when providers request administrative hearings attempting to have more services authorized for Medicaid recipients. That program has a lengthy waiting list, so increasing services to current recipients uses resources that might be used to reduce waiting lists. Where recipients or their family or friends request increased services, one assumes that the services are desired by the recipient. Where the provider requests increased services, one may wonder whether the recipient requires the service or the provider wants to sell more services. Specifically, s. 393.125, F.S., authorizes anyone representing the Medicaid recipient—including providers—to request an administrative hearing. The pertinent provision is:

393.125 Hearing rights.—

(1) REVIEW OF AGENCY DECISIONS.—

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(a) Any developmental services applicant or client, or his or her parent, guardian, guardian advocate, or authorized representative, who has any substantial interest determined by the agency, has the right to request an administrative hearing pursuant to ss. 120.569 and 120.57, F.S.

<sup>54</sup> See, e.g., American Habilitation, supra note 48.

<sup>55</sup> See, e.g., Sunrise Community v. Agency for Health Care Administration, 704 So. 2d 1135 (Fla. 1st DCA 1998). The provider (Sunrise) challenged ACHA's denial of an interim rate increase; disputing AHCA's rejection of an administrative hearing officer's finding that AHCA should approve the request because it had previously approved similar requests. The court reversed AHCA's order, finding that an agency may not reject or modify findings of fact in a hearing officer's recommended order unless the agency first states that those findings are not supported by competent, substantial evidence.

Also see, Golfcrest Nursing Home v. State, Agency for Health Care Administration, 662 So. 2d 1330 (Fla. 1st DCA 1995), where the nursing home's requested interim Medicaid reimbursement increase for patient care and operating costs was denied by the state Medicaid agency based on its interpretation the state's Medicaid plan and its finding that the nursing home had not met its burden of proof as to the increase. The court found that the nursing home had carried the burden of proof and established a prima facie case that its claimed costs were allowable.

<sup>56</sup> See, e.g., Golden Isles Convalescent Center, Inc. v. HRS, 500 So. 2d 651 (Fla. 1 DCA 1986). The nursing home's requested Medicaid interim rate increase due to increased lease costs was denied by the state Medicaid agency, even though a hearing officer found that a lease payment is a cost related to patient care and that the nursing home's renegotiation of its lease with a higher payment was reasonable and prudent. The court found that the issue was one of fact and the agency had specifically adopted the hearing officer's findings of fact, yet rejected the hearing officer's conclusions of law.

<sup>57</sup> See, e.g., Brookwood-Walton County Convalescent Center and Brookwood-Washington County Convalescent Center v. Agency for Health Care Administration, 845 So. 2d 223 (Fla. 1st DCA 2003). The court found that AHCA approved rate increases for some nursing homes due to increases in liability premiums while denying similar increases in this case. Such inconsistent policies were found to be contrary to established administrative principles and sound public policy. The court also found that the federal Medicare manual stated that payment for losses would not be considered allowable if the provider did not carry liability insurance, so a prudent nursing home would carry insurance. The court ruled that AHCA erred in rejecting hearing officer findings that were supported by substantial evidence.

<sup>58</sup> See Wilder v. Virginia Hospital Association, 496 U.S. 498, 505-506 (1990).

<sup>59</sup> Folden v. Washington State Department of Social and Health Services, 981 F.2d 1054 (9th Cir. 1992).

<sup>60</sup> See, e.g., Connecticut Hosp. Ass'n v. Weicker, 46 F.3d 211 (2nd Cir. 1995).

<sup>61</sup> See, e.g., Tallahassee Memorial Regional Medical Center v. Cook, 109 F.3d 693 (11th Cir. 1997). This was a garden variety Medicaid rate case. Its holding turned on the application of the former Boren Amendment--a now-repealed federal law (see s. 4711(a), P.L. 105-33, effective October 1997) setting substantive requirements for Medicaid rates. The plaintiffs in Cook alleged that they were being underpaid for providing in-patient psychiatric services to teenagers in violation of the then-Boren Amendment's requirement (the Boren Amendment was formerly codified at 42 U.S.C. s. 1396a(a)(13)(A)) that they be paid reasonable and adequate rates. Id. at 698. To be specific, the hospitals alleged that their rates had been "diluted" in violation of the Boren Amendment. Id. The plaintiff

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hospitals were compensated by the Medicaid program for providing in-patient services to teenagers when those services were “medically necessary.” However, the patients improved to the point where they could be discharged and treated as outpatients in community settings, but since often there were no placements available, the patients remained in the hospital for what were known as “grace days.” Florida refused to pay for those grace days, saying they were not medically necessary. *Id.* at 698. The trial court held that failing to pay for the grace days “at any rate under this scenario . . . is directly contrary to the express mandate of the Boren Amendment . . . The wholesale failure to reimburse any moneys to two in-patient providers of psychiatric care for adolescents, when such care is only medically necessary on an outpatient basis, does not comport with the strictures of the Boren Amendment.” *Id.* at 703. In the absence of the Boren Amendment--which is now repealed--the outcome of the case could very well have been different.

<sup>62</sup> See, e.g., Toal v. Dekalb Medical Center, 542 S.E.2d 184 (Ga. App. 2000).

<sup>63</sup> H.Conf.R. 105-217, 105th Cong. 1st Session, 1997 U.S. Code Congr. & Admin. News 176, 488, emphasis added; record excerpt exhibit 9.

<sup>64</sup> HR Rep. No. 149 pp. 1175-1176, 105th Cong. 1st Session, 1997, 1997 WL 353017.

<sup>65</sup> Section 6 of Chapter 96-417, L.O.F., repealed language in section 409.908(2)(b), F.S.

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, [1] or number of services, or [2] making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(2)(b) Subject to any limitations or directions provided for in the General Appropriations Act, the agency shall establish and implement a Florida Title XIX Long Term Care Reimbursement Plan (Medicaid) for nursing home care ~~which uses a rate setting mechanism whereby the rates are reasonable and adequate to cover a nursing home's cost which must be incurred by an efficiently and economically operated facility~~ in order to provide care and services in conformance with the applicable state and federal laws, rules, regulations, and quality and safety standards and to ensure that individuals eligible for medical assistance have reasonable geographic access to such care. The agency shall base the establishment of any maximum rate of payment, whether overall or component, on the available moneys as provided for in the General Appropriations Act. The agency may base the maximum rate of payment on the results of scientifically valid analysis and conclusions derived from objective statistical data pertinent to the particular maximum rate of payment.

<sup>66</sup> See, e.g., Florida Association of Rehabilitation Facilities, Inc. v. State of Fla., Department of Health and Rehabilitative Services, 225 F.3d 1208 (11th Cir. 2000), the state Medicaid agency appealed a district court judgment that the agency had violated the Boren Amendment and had to correct its Medicaid reimbursement plan prospectively as well as retrospectively. Congress had repealed the Boren Amendment while the case was pending before the district court. The circuit court concluded that Amendment XI to the U.S. Constitution barred retrospective relief because it affected the state treasury. Further, the court remanded the issue of whether the

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provider's claim for prospective relief had become moot, but did not rule whether prospective relief, like retroactive relief, was barred by the U.S. Constitution.

<sup>67</sup>42 U.S.C. s. 1396a(a)(13) provides:

TITLE 42. THE PUBLIC HEALTH AND WELFARE  
CHAPTER 7. SOCIAL SECURITY ACT  
TITLE XIX. GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

§ 1396a. State plans for medical assistance

(a) Contents. A State plan for medical assistance must--

(13) provide--

(A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which--

(i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,

(ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,

(iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and

(iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1923 [42 USCS § 1396r-4]) the situation of hospitals which serve a disproportionate number of low income patients with special needs; and

(B) for payment for hospice care in amounts no lower than the amounts, using the same methodology, used under part A of title XVIII [42 USCS §§ 1395c et seq.] and for payment of amounts under section 1905(o)(3) [42 USCS § 1396d(o)(3)]; except that in the case of hospice care which is furnished to an individual who is a resident of a nursing facility or intermediate care facility for the mentally retarded, and who would be eligible under the plan for nursing facility services or services in an intermediate care facility for the mentally retarded if he had not elected to receive hospice care, there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual;

<sup>68</sup> The current 42 U.S.C. s. 1396a(a)(13)—which replaced the Boren Amendment—states that “[a] State plan for medical assistance must . . . provide for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which . . . providers, . . . are given a reasonable opportunity for review and comment of the proposed rates . . . ”

<sup>69</sup> See e.g. In Re NYAHS A Litigation, 318 F. Supp. 2d 30 (N.D.N.Y. 2004); Children’s Seashore House v. Waldman, 197 F.3d 654 (3d Cir. 1999). With respect to legislative history, it has been argued that “Congress intended to free the states from federal regulation and to eliminate a basis for causes of action by providers to challenge reimbursement rates.” Evergreen Presbyterian Ministries, Inc. v. Hood, 235 F.3d 908, 919 n.12 (5<sup>th</sup> Cir. 2000) (citing H.R. Rep. No. 105-149, at 1230) (“It is the Committee’s intention that, following the enactment of [the Balanced Budget Act of 1997], neither this nor any other provision of [s. 1396a] will be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of rates they receive”).

<sup>70</sup> See e.g. American Society of Consultant Pharmacists v. Concannon, 214 F. Supp. 2d 23 (D. Me. 2002).

<sup>71</sup> 536 U.S. 273 (2002).

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<sup>72</sup> See, e.g., Department of Social Services v. Villa Capri Homes, 684 S.W.2d 327 (Mo. 1985), where the court noted:

Nursing homes participating in programs such as the Medicaid program operate at a risk. Their ability to obtain funds depends upon the federal government's willingness to continue the program. The amount of funds they obtain is also dependent upon changing federal guidelines, such as the switch to a "reasonable cost related basis." Cf. Edgewater Nursing Center, Inc. v. Miller, 678 F.2d 716, 717-18 (7th Cir. 1982). On the state level, the nursing homes rely upon the State's continuing participation in the program.

<sup>73</sup> These states include: California, Iowa, Maine, Maryland, Massachusetts, Michigan, New Mexico, New York, North Carolina, Pennsylvania, Rhode Island, Texas, and Vermont. *Paying for Performance in Medicaid: States are Demanding Accountability*. In Depth: State Health Notes. Volume 27, Issue 459. January 23, 2006.

<sup>74</sup> *Reducing Hospital-acquired Infections: The Business Case*. Pennsylvania Health Care Cost Containment Council. Issue 8. November 2005.

<sup>75</sup> Centers for Medicare and Medicaid Services. <http://new.cms.hhs.gov/apps/media/press/release.asp?Counter=1343>

<sup>76</sup> The HHS Quality Initiative was launched nationally in November 2002 for nursing homes, and was expanded in 2003 to the nation's home health care agencies and hospitals. In 2004, the Quality Initiative was further expanded to officially include kidney dialysis facilities that provide services for patients with end-stage renal disease. See at: <http://www.cms.hhs.gov/HospitalQualityInits/downloads/HospitalOverview200512.pdf>.

<sup>77</sup> Centers for Medicare and Medicaid Services. <http://new.cms.hhs.gov/apps/media/press/release.asp?Counter=1441>

<sup>78</sup> A more in-depth description of the Physician Group Practice (PGP) Demonstration program can be found at <http://www.premierinc.com/advocacy/issues/medicare/05/physician-group-practice-fact-sheet-0105.pdf>.

<sup>79</sup> Id. American Habilitation, *supra* note 48.

<sup>80</sup> See, e.g., Association of Residential Resources v. Gomez, 51 F.3d 137 (8th Cir. 1995). Minnesota scaled back funding for intermediate care facilities for the mentally retarded and private facilities became under funded due to the lag time for their reimbursement. Public facilities experienced no lag time. The private facilities claimed that this violated the Equal Protection Clause. The court found no violation since public and private facilities were not similarly situated. The court noted that state facilities employed a unionized workforce, had different management structures, served different clients, could not select what type of clients they would serve, and faced greater challenges in resident care than private facilities. The court also found that unequal treatment was justified by the legitimate state purpose of preserving the fiscal integrity of the state's welfare programs.

See also, Minnesota Association of Health Care Facilities v. Minnesota Department of Public Welfare, 742 F.2d 442 (8th Cir. 1984). Nursing homes were not allowed to charge non-Medicaid residents higher rates than Medicaid residents. They contended that the statute violated due process and equal protection because it applied only to nursing homes. The court held that the statute's rate limits were reasonably related to a state purpose and that the limits would survive scrutiny under due process and equal protection.

<sup>81</sup> Rate setting for entities with cost-based rates also might be considered separately.

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<sup>82</sup> 42 C.F.R. s. 447.205 provides:

TITLE 42 -- PUBLIC HEALTH  
CHAPTER IV -- CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH  
AND HUMAN SERVICES  
SUBCHAPTER C -- MEDICAL ASSISTANCE PROGRAMS  
PART 447 -- PAYMENTS FOR SERVICES  
SUBPART B--PAYMENT METHODS: GENERAL PROVISIONS

§ 447.205 Public notice of changes in statewide methods and standards for setting payment rates.

(a) When notice is required. Except as specified in paragraph (b) of this section, the agency must provide public notice of any significant proposed change in its methods and standards for setting payment rates for services.

(b) When notice is not required. Notice is not required if--

- (1) The change is being made to conform to Medicare methods or levels of reimbursement;
- (2) The change is required by court order; or
- (3) The change is based on changes in wholesalers' or manufacturers' prices of drugs or materials, if the agency's reimbursement system is based on material cost plus a professional fee.

(c) Content of notice. The notice must--

- (1) Describe the proposed change in methods and standards;
- (2) Give an estimate of any expected increase or decrease in annual aggregate expenditures;
- (3) Explain why the agency is changing its methods and standards;
- (4) Identify a local agency in each county (such as the social services agency or health department) where copies of the proposed changes are available for public review;
- (5) Give an address where written comments may be sent and reviewed by the public; and
- (6) If there are public hearings, give the location, date and time for hearings or tell how this information may be obtained.

(d) Publication of notice. The notice must--

- (1) Be published before the proposed effective date of the change; and
- (2) Appear as a public announcement in one of the following publications:
  - (i) A State register similar to the Federal Register.
  - (ii) The newspaper of widest circulation in each city with a population of 50,000 or more.
  - (iii) The newspaper of widest circulation in the State, if there is no city with a population of 50,000 or more.

<sup>83</sup> Subsection (2) of section 409-907, F.S., provides:

409.907 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, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other

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reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

(2) Each provider agreement shall be a voluntary contract between the agency and the provider, in which the provider agrees to comply with all laws and rules pertaining to the Medicaid program when furnishing a service or goods to a Medicaid recipient and the agency agrees to pay a sum, determined by fee schedule, payment methodology, or other manner, for the service or goods provided to the Medicaid recipient. Each provider agreement shall be effective for a stipulated period of time, shall be terminable by either party after reasonable notice, and shall be renewable by mutual agreement.

<sup>84</sup> The introductory paragraph to section 409.908, F.S., provides:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

<sup>85</sup> Subsection (4) of section 393.0661, F.S., provides:

393.0661 Home and community-based services delivery system; comprehensive redesign.—The Legislature finds that the home and community-based services delivery system for persons with developmental disabilities and the availability of appropriated funds are two of the critical elements in making services available. Therefore, it is the intent of the Legislature that the Agency for Persons with Disabilities shall develop and implement a comprehensive redesign of the system.

(4) Nothing in this section or in any administrative rule shall be construed to prevent or limit the Agency for Health Care Administration, in consultation with the Agency for Persons with Disabilities, from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or from limiting enrollment, or making any other adjustment necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act. If at any time, based upon an analysis by the Agency for Health Care Administration in consultation with the Agency for Persons with Disabilities, the cost of home and community-based waiver services are expected to exceed the appropriated amount, the Agency for Health Care Administration may implement any adjustment, including provider rate reductions, within 30 days in order to remain within the appropriation.

<sup>86</sup> Subsection (3) of section 393.0661, F.S., provides:

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393.0661 Home and community-based services delivery system; comprehensive redesign.—The Legislature finds that the home and community-based services delivery system for persons with developmental disabilities and the availability of appropriated funds are two of the critical elements in making services available. Therefore, it is the intent of the Legislature that the Agency for Persons with Disabilities shall develop and implement a comprehensive redesign of the system.

(3) Pending the adoption of rate methodologies pursuant to nonemergency rulemaking under s. 120.54, the Agency for Health Care Administration may, at any time, adopt emergency rules under s. 120.54(4) in order to comply with subsection (4). In adopting such emergency rules, the agency need not make the findings required by s. 120.54(4)(a), and such rules shall be exempt from time limitations provided in s. 120.54(4)(c) and shall remain in effect until replaced by another emergency rule or the nonemergency adoption of the rate methodology.

<sup>87</sup> *Id.* American Habilitation, *supra* note 48.

<sup>88</sup> Section 409.913, F.S.

<sup>89</sup> Section 97.012, F.S.

<sup>90</sup> Section 24.110, F.S.

<sup>91</sup> Section 440.386, F.S.

<sup>92</sup> Florida's core Medicaid laws are found at ss. 409.901 through 409.920, F.S. The original version of the state's Medicaid laws was passed by the Legislature in 1991.

<sup>93</sup> Note the split of authority among the federal courts, discussed in the last paragraph of the section titled: "Federal Requirements After 1997 Concerning Rate Setting and Rate Changes are Simplified and Less Stringent."