The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 526
INTRODUCER:	Senator Grimsley
SUBJECT:	Reimbursement of Medicaid Providers
DATE:	January 13, 2016
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Pre-meeting**
2.			AHS	
3.			AP	

I. Summary:

SB 526 amends s. 409.901, F.S., to add a definition of "usual and customary charge" specific to the Medicaid program. The term excludes free or discounted charges or goods based on a person's uninsured, indigent, or other financial hardship status.

The changes made by SB 526 are intended to clarify existing law and are remedial in nature.

The bill is effective July 1, 2016.

II. Present Situation:

Florida Medicaid Program

The Florida Medicaid program is a partnership between the federal and state governments. Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare and Medicaid Services (CMS). The state plan outlines Medicaid eligibility standards, policies, and reimbursement methodologies.

Florida Medicaid is administered by the Agency for Health Care Administration (AHCA) and financed with federal and state funds. Over 3.7 million Floridians are currently enrolled in Medicaid, and the program's estimated expenditures for the 2015-2016 fiscal year are over $23.4 billion.[1]

The Medicaid program has a variety of reimbursement arrangements with providers and suppliers; however, regardless of those payment arrangements the AHCA is required to make

[1] Office of Economic and Demographic Research, *Social Services Estimating Conference of August 4, 2015*, available at: http://edr.state.fl.us/Content/conferences/medicaid/medltexp.pdf *(*last visited Dec. 11, 2015).

timely payment arrangements upon receipt of a properly completed claim form. Section 409.907(5)(a), F.S., specifically states:

> (5) The agency:
>
> (a) Is required to make timely payment at the established rate for services or goods furnished to a recipient by the provider upon receipt of a properly completed claim form. The claim form shall require certification that the services or goods have been completely furnished to the recipient and that, with the exception of those services or goods specified by the agency, the amount billed does not exceed the provider's usual and customary charge for the same services or goods.

Florida law further allows, with some exceptions, for Medicaid services to be reimbursed on a fee-for-service basis, in accordance with Medicaid rules, policy manuals, handbooks, and state and federal law, subject to any policy limitations in the General Appropriations Act. The statute specifies the amount billed by the provider as the provider's usual and customary charge, or the maximum allowable fee established by the agency, whichever amount is less, with the exception of those services or goods that the agency reimburses based on capitation rates, average costs, or negotiated fees.[2]

The Florida Medicaid Provider General Handbook, promulgated as Rule 59G-5.020 of the Florida Administrative Code, also requires that Medicaid services be reimbursed at the lesser of the Medicaid fee or the provider's usual and customary charge, except for cost-based or capitation reimbursed providers. For prescribed drug services, a similar rule applies. Providers must ensure that the average charge does not exceed the charge to all other customers in any quarter for the same drug, quantity, and strength.[3,4]

Medicaid managed care plans must reimburse non-contracted providers for emergency services for their enrollees at either the lesser of the provider's charges, usual and customary charges for similar services, the charge mutually agreed upon by the parties within 60 days of claim submission, or the Medicaid rate. [5]

All of these Medicaid statutes or administrative rule references use the term "usual and customary charges"; however, the term is not currently defined in either state law or administrative rule.

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[2] Section 409.908(3), F.S. *See also* s. 409.908(11), F.S., addressing reimbursement for independent laboratory services, s. 409.908(14), F.S., pertaining to reimbursement for prescribed drugs, and s. 409.908(20), F.S., relating to renal dialysis facilities.
[3] Rule 59G-4.250, F.A.C.
[4] Agency for Health Care Administration, *Florida Medicaid Prescribed Drug Services, Coverage, Limitations and Reimbursement Handbook* (July 2014), pp. 16, 88, https://www.flrules.org/Gateway/reference.asp?No=Ref-04163 (last visited Dec. 29, 2015).
[5] *See* s. 409.9128(5), F.S. and s. 409.967, F.S.

Definition of Usual and Customary

In the context of health care claims, the term "usual and customary charge" has been accepted as a term of art and its definition generally agreed upon by the parties transacting business, in this case the health care provider and the insurer or claims payor.

The American Medical Association (AMA) defines "usual, customary and reasonable" or "UCR" as:

> 1. Our AMA adopts as policy the following definitions:
>
> (a) "usual; fee means that fee usually charged, for a given service, by an individual physician to his private patient (i.e., his own usual fee);
> (b) a fee is 'customary' when it is within the range of usual fees currently charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area; and
> (c) a fee is 'reasonable' when it meets the above two criteria and is justifiable, considering the special circumstances of the particular case in question, without regard to payments that have been discounted under governmental or private plans.[6]

Medicare and Medicaid Programs

The federal CMS provides a definition of UCR on its website as: "the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar service. The UCR amount is sometimes used to determine the allowed amount."[7]

Additionally, federal regulations further define "customary charges":

> **(a)** ***Customary charge defined.*** The term "customary charges" will refer to the uniform amount which the individual physician or other person charges in the majority of cases for a specific medical procedure or service. In determining such uniform amount, token charges for charity patients and substandard charges for welfare and other low income patients are to be excluded. The reasonable charge cannot, except as provided in § 405.506, be higher than the individual physician's or other person's customary charge. The customary charge for different physicians or other persons may, of course, vary. Payment for covered services would be based on the actual charge for the service when, in a given instance, that charge is less than the amount which the carrier would otherwise have found to be within the limits of acceptable charges for the particular service. Moreover, the income of the individual beneficiary is not to be

[6] American Medical Association, H-385-923, *Definition of Usual, Customary and Reasonable" (UCR),* https://www.ama-assn.org/ssl3/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/resources/html/PolicyFinder/policyfiles/HnE/H-385.923.HTM *(*last visited Jan. 6, 2016).
[7] Centers for Medicare and Medicaid Services, *Glossary - Usual, Customary and Reasonable (UCR),* https://www.healthcare.gov/glossary/UCR-usual-customary-and-reasonable/ (last visited: Jan. 6, 2016).

> taken into account by the carrier in determining the amount which is considered to be a reasonable charge for a service rendered to him. There is no provision in the law for a carrier to evaluate the reasonableness of charges in light of an individual beneficiary's economic status.[8]

The regulations permit a physician to vary his or her charges for the same service, and under the Medicare program, the carrier would then develop a median or midpoint of his or her charges as the customary charge. The customary charge is not expected to remain the same and may be amended as long as the new customary charge is not above the top range of the prevailing charges.[9]

A proposed regulation for Medicare laboratory services was released in October 2015 which would change reimbursement beginning January 1, 2017 to reflect market rates for most lab tests.[10]

Medicaid federal regulations also define customary charges specific to inpatient and outpatient facility services as "customary charges of the provider that must not be more than the prevailing charges in the locality for comparable services under comparable circumstances."[11]

For the Florida Medicaid program, subsection 409.908(3), F.S., establishes payment directions for reimbursement on a fee-for-service basis. Such payments are to be: "the amounts billed by the provider, the provider's usual and customary charge, or the maximum allowable fee established by the agency." Subsection (11) of that same section addresses independent laboratory services, requiring reimbursement to be "the least of the amount billed by the provider, the provider's usual and customary charge, or the maximum allowable fee established by the agency." The statute does not define usual and customary charge.

The Florida Medicaid Handbook, as promulgated in Rule 59G-5.020, F.A.C., does describe the UCR reimbursement methodology more precisely for pharmacy claims, specifically Rule 59G-4.250, F.A.C. The policy handbook defines UCR and re-states it as the provider's charges must not exceed the average charge to all other customers in any quarter for the same drug, quantity, and strength.[12]

Medicaid managed care plans must act in accordance with a different state statute when enrollees receive emergency services from non-contracted providers and reimburse these providers the lesser of:

- The provider's charges;
- The usual and customary provider's charges for similar services in the community where provided;

[8] *See* 42 CFR 405.503 (2015).
[9] Id.
[10] *See* Medicare Program; Medicare Clinical Diagnostic Laboratory Tests Payment System; Proposed Rule; Vol. 80 Fed. Reg. 59386 (Oct. 1, 2015)(to be codified at 42 CFR Part 414).
[11] 42 CFR 447.325 (2015).
[12] Agency for Health Care Administration, *Florida Medicaid Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook* (July 2014), p. 1-2.

- The charge mutually agreed to by the entity and the provider within 60 days after submittal of the claim; or
- The Medicaid rate.[13]

The AHCA initiated rulemaking in September 2014 to update its existing definitions and adopt a definition for "usual and customary charge." The proposed definition under that notice meant that the usual and customary charge phrase related only to Medicaid-enrolled independent laboratory service providers and meant the most frequent price or fee accepted as full payment by the provider from the provider's non-Medicaid Florida customers.[14]

Administrative petitions against the rule were filed by several laboratory providers for Medicaid with the State of Florida Division of Administrative Hearings (DOAH) that sought to invalidate the proposed rule as an "invalid exercise of delegated legislative authority."[15] Under a Settlement Agreement, the litigating parties agreed that the AHCA would not rely upon the proposed definition of usual and customary charge as stated in the proposed rule for any agency action, unless it is adopted as a rule and the AHCA would withdraw the definition from the Notice of Proposed Rule.[16] The AHCA withdrew the entire Proposed Rule in the January 13, 2015 publication of the Florida Administrative Registrar.[17]

Reimbursement for Laboratory Services - Qui Tam Action Against Certain Providers[18]

In a *qui tam* action, a private party, known as a relator, brings an action against a person or a corporation on behalf of the government. Such actions are also known as whistle blower lawsuits. The private citizen plaintiff is authorized to prosecute the lawsuit; however, the government may intervene in the action. If the suit is successful, the relator receives a share of the award.

In an action under the Federal False Claims Act (FCA), the *qui tam* action is against a party who has defrauded the federal government.[19] A relator in a successful False Claims Action may receive up to 30 percent of the government's award. Florida also has its own Florida False Claims Act under ss. 68.081 -092, F.S., which allows the Department of Legal Affairs or a person to bring a *qui tam* action. A person who brings an action under Florida's statute receives at least 15 percent, but not more than 25 percent of the proceeds of any successful action or settlement of the claim.

In 2007, Hunter Labs and Chris Riedel filed a *qui tam* action under the Florida False Claims Act in the circuit court in Leon County, alleging that LabCorp and Quest Diagnostics (LabCorp/Quest) had defrauded the Medicaid program by overcharging for laboratory services.

[13] *See* ss. 409.9128(5) and 409.967, F.S.
[14] Vol. 40. Fla. Admin. Register, p. 4145 (Sept. 25, 2014).
[15] Laboratory Corp. of America v. Agency for Health Care Admin., Case No. 14-5381RP and Quest Diagnostic v. Agency for Health Care Admin. v. Agency for Health Care Admin., Case No. 14-5507RP (Fla. DOAH 2014) *Cases Consolidated.*
[16] Id at 3.
[17] *See* Vol. 4, Florida Administrative Register, p. 178 (Jan. 13, 2015).
[18] *See State of Florida ex rel. Hunter Laboratories, LLC and Chris Riedel v. Quest Diagnostics, Inc., et al, in the Circuit Court for the Second Judicial Circuit in and for Leon County, case number 2007-CA-003549.*
[19] *See* 31 U.S.C. §3279.

In 2013, the state Attorney General (AG) intervened in the lawsuit alleging that LabCorp/Quest defrauded the state by failing to charge the Medicaid program its lowest charge to any other third party payer for laboratory services.

Following the 2014 DOAH Consent Order on the AHCA's "invalid exercise of delegated authority," the AG modified its legal theory against LabCorp/Quest in the *qui tam* action. The AG alleges that LabCorp/Quest defrauded the Medicaid program by charging more than their usual and customary charge and defined usual and customary charge as any amount accepted by LabCorp/Quest as payment from any other third-party payer.[20]

Although litigation of the petitions with DOAH over the administrative rule have been resolved, the *qui tam action* is currently ongoing.

III. Effect of Proposed Changes:

Section 1 - The bill adds a definition for "usual and customary charge" to s. 409.901, F.S., as applicable to the Medicaid program. The "usual and customary charge" is defined as the amount routinely billed by a provider or supplier to an uninsured consumer for services or goods before any discount, rebate, or supplemental plan is applied. Free or discounted charges for services or goods based on a person's economic hardship status are not included in the definition.

Section 2 - The bill provides that the changes made to s. 409.901, F.S., clarify existing law and are remedial in nature.

Section 3 - The effective date of the bill is July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

[20] Defendant Laboratory Corp. of America and Laboratory Corp. of America Holdings' Memorandum in Support of their Motion to Dismiss the State's Amended Intervention Complaint, at 5-6, State of Florida ex rel Hunter Laboratories, LLC and Chris Riedel v. Quest Diagnostics, Inc., No. 2007-CA-003549 (2nd Cir. Apr. 28, 2014).

D. Other Constitutional Issues:

SB 526 provides that it is intended to clarify existing law and is remedial in nature. Retroactive application of a statute is generally unconstitutional if the statute impairs vested rights, creates new obligations, or imposes new penalties.[21]

To determine whether a statute should be retroactively applied, courts apply two interrelated inquiries. First, courts determine whether there is clear evidence of legislative intent to apply the statute retrospectively. If so, then courts determine whether retroactive application is constitutionally permissible.[22]

The second prong looks to see if a vested right is impaired. To be vested, a right must be more than a mere expectation based on an anticipation of the continuance of an existing law. It must be an immediate, fixed right of present or future enjoyment.[23] This bill contains a finding that it is remedial. "Remedial statutes or statutes relating to remedies or modes of procedure, which do not create new or take away vested rights, but only operate in furtherance of the remedy or confirmation of rights already existing, do not come within the legal conception of a retrospective law, or the general rule against retrospective operation of statutes."[24]

To the extent this law confirms a definition of "usual and customary charge" already in existence, this law may be constitutionally permissible.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

For purposes of Medicaid billing, a Medicaid provider or supplier may be required to modify its billing system to accommodate how it calculates charges for Medicaid enrollees if its definition of usual and customary is different than the definition proposed under SB 526.

Additionally, to the extent that a payor aligns its payment practices to those of the Medicaid program, the addition of a statutory definition for usual and customary may impact that payor's own reimbursement guidelines.

[21] *See State Farm Mutual Automobile Insurance Company v. Laforet*, 658 So.2d 55, 61 (Fla. 1995).
[22] *See Florida Ins. Guar. Ass'n, Inc., v. Devon Neighborhood Ass'n, Inc.*, 67 So.3d 187, 194 (Fla. 2011); *See, also Metropolitan Dade County v. Chase Federal Housing Corp.*, 737 So.2d 494, 499 (Fla. 1999).
[23] *See R.A.M. of South Florida, Inc. v. WCI Communities, Inc.*, 869 So.2d 1210, 1218 (Fla. 2d DCA 2004).
[24] *City of Lakeland v. Catinella*, 129 So.2d 133, 136 (Fla. 1961).

C. Government Sector Impact:

The AHCA reports the bill's clarification of the term "usual and customary charge" will have no operational or fiscal impact on the Medicaid program.[25] Adding the definition to s. 409.901, F.S., will clarify a term that is used in multiple sections of the statutes relating to Medicaid, but is not currently defined in either statute or administrative rule.

VI. Technical Deficiencies:

The definition for "usual and customary" references both providers and suppliers of goods and services. The Medicaid definitions section, s. 409.901, F.S., defines only "Medicaid provider" or "provider" and does not include the term "supplier." It may not be clear for which Medicaid vendors the definition is applicable.

It determining the usual and customary charges by a provider or supplier, the definition does not clarify if the services or goods provided to an uninsured consumer must be medically or necessary or not to be included in the calculation.

VII. Related Issues:

Litigation over how to define, calculate, and what information sources should be used in the calculation for UCRs have been an issue in many states. The AMA and several state medical societies have filed several lawsuits against large insurers which used the same database as their benchmark on which to determine out-of-network payments. For example, when an insured member used an out-of-network provider, the insurer may have covered 80 percent of the UCR of that visit and the insured member would then be responsible for the remaining 20 percent. The AMA alleged that the insurers systematically used unreliable or inaccurate data to calculate the UCR to set those reimbursement amounts.

The New York Attorney General's Office began an investigation in 2008 to determine if insurers had defrauded consumers through manipulation of reimbursement rates. As a result, the investigation found that one such database was defective and that most major insurers used it to set rates for out-of-network reimbursement. New York's Department of Insurance issued a new regulation in 2009 requiring "usual and customary rates" to reflect market rates and prohibited the use of third party sources with a pecuniary interest in the development or use of the UCR. The plans involved signed a Settlement Agreement which required their financial contribution towards the creation of the FAIR Health systems as a replacement database which collects millions of health care bills; however, the Settlement Agreement did not require the plans to use this system as the new benchmark.[26]

In 2009, the United State Senate Commerce Committee (Committee) conducted an investigation into how the insurance industry reimburses consumers for services who buy "out-of-network" health insurance coverage. The Committee found that in every region of the United States, large health insurance companies had been using the same two faulty databases to under-pay insurance

[25] Agency for Health Care Administration, *Senate Bill* 526 *Agency Analysis*, p. 2, (Oct. 15, 2015).
[26] Physicians for a National Health Program, *Insurers Dodge Intent of Ingenix Settlement, (New York Times, April 23, 2012),* Nina Bernstein, http://www.pnhp.org/news/2012/april/insurers-dodge-intent-of-ingenix-settlement (last visited: Jan. 6, 2016).

claims. While many of the companies responding to the Committee's correspondence noted that the information was used only on a small percentage of their claims, the report highlighted that "even a small percentage of the tens of millions of claims these insurance companies pay every year is a substantial number."[27]

In 2010, Florida's First District Court of Appeal reviewed a case involving the calculation of reimbursement charges and reimbursement rates for emergency medical services between a hospital and an insurance plan where no contractual relationship existed for health maintenance organization enrollees. Part of the appeal involved the variety of ways that prices are set for emergency services, including defining "usual and customary provider charges."

The court noted that "when a statute does not define a term, we rely on the dictionary to determine the definition."[28] Using Black's Law Dictionary:

- "Charge" is defined as "price, cost, or expense."[29]
- "Usual" is defined as "ordinary, customary, and expected based on previous experience."[30]
- "Customary" is defined as "a record of all of the established legal and quasi-legal practices in a community."[31]

Taking the three terms together, the *Baker* court concluded that "usual and customary charges" in the context of the statute meant fair market value and fair market value is "the price that a willing buyer will pay and a willing seller will accept in an arm's length transaction.[32] The court made one exception to this willing buyer and willing seller scenario: reimbursement rates for Medicaid and Medicare are set by government agencies and, therefore, it would not be appropriate to consider the amount accepted by providers for patients covered by these programs.[33]

VIII. Statutes Affected:

This bill substantially amends section 409.901 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

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[27] U.S. Senate Committee on Commerce, Science and Transportation, Office of Oversight and Investigations, *Underpayments to Consumers by the Health Insurance Industry (Staff Report for Chairman Rockefeller, June 24, 2009)*, https://www.commerce.senate.gov/public/index.cfm/reports?ID=1C8A4657-86C1-4461-9927-3727CB502EBF (last visited Jan. 6, 2016).

[28] *See* Baker County Medical Services, Inc. v. Aetna Health Mgmt., 31 So.3d 842, 845(Fla. 2010), quoting Green v. State, 604 So.2d 471, 473 (Fla. 1992).

[29] Id. *See also* Black's Law Dictionary 248 (8th ed. 2004).

[30] Id. *See also* quoting also Black's Law Dictionary at 1579.

[31] Id. *See also* Black's Law Dictionary at 413.

[32] Baker County Medical Services, Inc. v. Aetna Health Mgmt., 31 So3d 842, 845 (Fla. 2010). *See also* United States v. Cartwright, 411 U.S. 546, 551, 93 S.Ct. 1713, 36 L.Ed.2d 528 (1973).

[33] Id at 845-846.

B. Amendments:

None.