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World of medical reimbursements becoming more complex

By Catherine Lackner

The complicated world of medical reimbursement will get a little more difficult if Gov. Rick Scott makes good on his threat of criminal prosecution of executives at hospitals that try to shore up their balance sheets by charging Medicaid HMOs more than single Medicaid members.

Rick Scott

"There are a lot of moving parts to reimbursement," said Keith Arnold, a senior principal and lobbyist within the Fort Myers office of the Buchanan Ingersoll & Rooney law firm who represents "safety-net" facilities, mainly nonprofits and public hospitals.

Because Medicaid – a federal insurance program for low-income individuals that is administered by the states – offers one of the lowest reimbursement rates for care, many hospitals and other providers, including physicians, refuse to accept patients on the program because they cannot cover their expenses, Mr. Arnold said. Florida also has turned down millions in Medicaid dollars because Mr. Scott opposes the federal Affordable Care Act, he added, making the situation worse for those who must rely on Medicaid.

To get care for these patients, Medicaid HMOs have sprung up and have signed contracts with whatever institutions accept the program, mostly safety-net facilities that are charged with accepting all patients, regardless of ability to pay.

Mr. Scott created the Commission on Healthcare and Hospital Spending and directed it to examine the rate of return on tax dollars used for Medicaid, Politico Florida reported in November. The governor contended then that the contracts could exceed a legal limit on Medicaid payment rates.

But, Mr. Arnold said, those payment rates are not formally established. While the state has guidelines for Medicaid reimbursement, the details are often worked out between the HMO and the provider.

The reality of the situation is that Medicaid HMOs – which get a set payment per member per month – try to keep patients out of the hospital by stressing preventive care and wellness or by diverting patients to facilities that charge less, like urgent care centers.

"The HMO as gatekeeper really tries to steer Medicaid patients to the most cost-effective delivery system possible," Mr. Arnold said.

But, if a patient does have to go to the hospital, hospitals have negotiated rates that are slightly higher than what an individual on Medicaid would be charged. If the HMO successfully keeps its patients out of the hospital most of the time, the slightly higher payment (especially considering that hospital stays have become shorter) can be absorbed without major losses. And the slightly higher rate gives hospitals an incentive to continue working with the Medicaid HMOs, observers say.

"The governor's task force is looking at a variety of ways to shift the burden away from Medicaid HMOs, which they want to be fiscally viable, to the safety-net hospitals," Mr. Arnold said. "This drains institutions that already have limited resources."

Mr. Scott, himself a former hospital-company CEO, last summer ordered Liz Dudek, secretary of the state Agency for Health Care Administration, to have hospitals and insurers certify that they do not exceed 120% of the informal Medicaid fee schedule. In a follow-up letter, he directed Ms. Dudek to conduct audits of contracts that had not been certified as complying with state law.

"Any hospital or insurance plan that did not submit their compliance information necessitates immediate further action to ensure taxpayers are not being overcharged due to contracts above and beyond the legal Medicaid rate limit," Mr. Scott's letter said. The audit later showed that 38% of the agreements were in violation of a 2011 law that said a private company cannot be reimbursed more than 120% of the Medicaid schedule.

Historically, healthcare providers and payers have had an adversarial relationship, Mr. Arnold said. "The stronger providers are more adept at the negotiating process. The objective of the state is to make managed more financially viable. What the state is saying is, 'We know providers don't cover their expenses through Medicaid reimbursements, but we need to keep the HMOs viable so they can continue to reduce the burden on the state and shift that burden to the hospitals.' "

In many areas with tax-supported public hospitals, this means "the burden is shifted to the local community," in the form of higher property taxes or other means of funding the hospitals, Mr. Arnold said.