Medicaid Reimbursement Rates and Supplemental Payment Programs

Health Care Appropriations Subcommittee

February 14, 2023

FLORIDA MEDICAID REIMBURSEMENT

How does Medicaid pay providers?

Fee-For-Service (FFS) payments made by the Florida Medicaid program directly to individual providers.

Capitated payments to health plans who in turn make payments for services rendered to providers in the plan network.

FEE-FOR-SERVICE RATE SETTING

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- Prospective Payment Systems
- Cost Based/All Inclusive Reimbursement Rates
- Market Based Fee Schedules with Resource Based Relative Value System (RBRVS)

HOSPITAL INPATIENT RATE SETTING

Hospital Inpatient FFS Rate Setting	
Type of Rate	Prospective Payment System; Diagnosis Related Groups
Data Used	FFS Claims data/Managed Care data
Rate Period	Annual - rates set once a year effective July 1 of each year
Standard Base Rate	$3,562.10

HOSPITAL OUTPATIENT RATE SETTING

Hospital Outpatient Rate Setting	
Type of Rate	Prospective Payment System; Enhanced Ambulatory Patient Groups (EAPG)
Data Sources	FFS Claims/ Managed Care Encounters
Rate Period	Annual - rates set once a year effective July 1 of each year
Standardized Base Rate	$385.91
Ambulatory Surgical Center Base Rate	$246.68

NURSING HOME PPS FACT SHEET

Nursing Home Rate Setting	
Type of Rate	Prospective Payment System with 17 carved out exempt providers
Facility Specific Rate	Rates are facility-specific, all inclusive, per diems that reimburse for all necessary care and services
Data Used	Cost reports, CMS quality data, FRV data, NFQA
Rate Period	Annual - rates set once a year effective October 1 each year
Current Weighted Average	$253.54
Rate Adjustments Allowed?	No

Nursing Home Rate Setting	
Add-ons	• Ventilator • Direct Care Staffing • Minimum Wage Increase
Transitional Period	• Providers received the greater of their September 2016 rate or the prospective payment rate for 3 years (10/18 - 10/20). • For the next 2 years, providers received the greater of 95% of their September 2016 rate or their prospective payment rate (10/21 - 10/22).
Patient Care Component	• Patient care component is 80% of total reimbursement. • Consists of direct, indirect, and operating costs.
Peer Groups	• South: Palm Beach, Okeechobee, Broward, Miami-Dade, and Monroe Counties • North: All other counties

HOSPICE RATE SETTING

- Hospice rates include two components:
  - Room and Board
  - Level of Care

- Annual - rates set once a year effective October 1.

COST BASED/ALL INCLUSIVE REIMBURSEMENT RATES

- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)
  - Annual - rates set once a year effective July 1 of each year
- Federally Qualified Health Centers/Rural Health Clinics
  - Annual - rates set once a year effective October 1 each year
- County Health Departments
  - Annual - rates set once a year effective July 1 of each year

PRACTITIONER SERVICES RATE SETTING

- Based on the current market by utilizing the Resource Based Relative Value Scale (RBRVS).
- The RBRVS assigns procedures a relative value, which is adjusted based on geographic region.
- Other components that the RBRVS takes into account are:
  - Physician Work
  - Practice Expense
  - Malpractice Expense
- Annual - rates set once a year effective January 1 each year

CAPITATION RATE SETTING

CAPITATION RATE SETTING

- A capitation rate is the per-member, per-month (PMPM) amount, including any adjustments, that is paid by the Agency to a Managed Care Plan for each Medicaid recipient enrolled under a contract for the provision of Medicaid services during the payment period.
- The capitation rates reflect historical utilization and spending for covered services projected forward.
- The capitation rate is paid regardless of the level of claims of the recipient.
- Rates paid to the plans must be certified by an actuary and be actuarially sound.
  - Required by 42 CFR 438.4(b).
  - Florida Medicaid contracts with an actuarial firm for rate setting.
- Any changes to rates must be accompanied by documentation from the actuary.
- Rates must be approved by the Federal Centers for Medicare and Medicaid Services (CMS).
  - A detailed CMS checklist is completed by the actuary and submitted to CMS along with the full rate report.

PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

- Provides a comprehensive array of home and community-based services at a cost less than nursing home care for individuals who would otherwise qualify for Medicaid nursing home placement.
- Calendar Year Rates are set by PACE organization, not by region.
- The Agency revised the PACE capitation rate setting methodology in January 2021 to reflect a discount of the Upper Payment Limits, or UPLs.
  - The UPL is the amount that would otherwise have been paid under the Medicaid program if the participants were not enrolled in PACE.
- Once the UPL is developed, a discount factor is applied to the UPL of each individual PACE organization to develop the capitation rates.

MEDICAID SUPPLEMENTAL PAYMENT PROGRAMS

MEDICAID SUPPLEMENTAL PAYMENT OVERVIEW

- ❑Low Income Pool (LIP)
- ❑Disproportionate Share Hospital (DSH)
- ❑Graduate Medical Education (GME)
- ❑Physician Supplemental Payment (PSP)
- ❑Multi-Visceral Transplant Program
- ❑Florida Cancer Hospital Program (FCHP)
- ❑Public Emergency Medical Transportation (PEMT)
- ❑Indirect Medical Education (IME)
- ❑Directed Payment Program (DPP)

WHAT ARE SUPPLEMENTAL PAYMENTS?

- Payments made to Medicaid providers in addition to the Medicaid reimbursement they received for services provided.
- The state share is generally funded through non-General Revenue funds.
- Authorized by the Legislature either through statute or the General Appropriations Act and approved by the federal Centers for Medicare and Medicaid Services.
- Florida currently has 9 supplemental payment programs.

INTERGOVERNMENTAL TRANSFERS OVERVIEW

- The Agency collects Intergovernmental Transfers (IGTs) to pay the state match for Medicaid supplemental payments.
- IGTs are the transfer of funds from a governmental entity (other than Medicaid) such as:
  - Counties
  - Local health care taxing districts
  - Providers operated by state or local government.
- Entities planning on providing IGTs sign a Letter of Agreement (LOA) with the Agency each state fiscal year stating the amount of funds they plan on contributing.
- The Agency uses IGTs to draw down federal funds based on the Federal Medical Assistance Percentage (FMAP).

HISTORY OF IGTs

- Local government funds have supported the Medicaid program since 1992 beginning with Disproportionate Share Hospital (DSH).
- The growth of the DSH program and the implementation of the Low Income Pool (LIP) program increased the need for local government funds in order to sustain both programs.
- In state fiscal year 1992-93, **three** local governments helped fund the Medicaid DSH program.

LOW INCOME POOL (LIP): HISTORY

- Began in 2006 as part of Medicaid Reform pilot
- Original purpose:
  - Provide supplemental funding to hospitals, clinics, and other entities to improve access to health care services in rural communities.
  - Ensure continued government support for the provision of health care services to the uninsured and underinsured.
- Current purpose:
  - Provide government support for the costs of uncompensated care for low income individuals who are uninsured.

LIP: HOW IT WORKS

- Local government entities put money into the pool through Intergovernmental Transfers (IGTs).
  - The Agency draws matching funds from the federal government based on the Federal Medical Assistance Percentage (FMAP).
- The Agency distributes the combined local and federal funds to qualified providers based on a legislatively approved distribution funding model.

HISTORY OF LIP AUTHORIZATION

State Fiscal Year (SFY)	Total LIP Allotment
SFY 2006-2007 through SFY 2013-2014	$ 1 billion
SFY 2014-2015	$ 2.17 billion
SFY 2015-2016	$ 1 billion
SFY 2016-2017	$ 608 million
SFY 2017-2018 through SFY 2021-2022	$ 1.5 billion
SFY 2022-2023	$2.17 billion

LOW INCOME POOL PROVISIONS FOR SFYs 2018-2023

- Approximately $2.17 billion through SFY 2022-23.
- Provides support to safety net providers for the costs of uncompensated charity care for low-income individuals who are uninsured.
- It does not include uncompensated care for individuals with insurance, bad debt, or Medicaid or CHIP “shortfall.”
  - “Shortfall” is the difference between what Medicaid or CHIP pays and the providers’ cost.

WHO CAN RECEIVE LIP FUNDS

- Provider groups that can participate:
  - Hospitals
  - Federally Qualified Health Centers and Rural Health Clinics (FQHCs/RHCs)
  - Medical School Faculty Physician Practices
  - Community Behavioral Health providers
- Each group may be divided in up to five tiered subgroups, any of which may be based on:
  - Ownership
    - Publicly Owned, Privately Owned, statutory teaching, freestanding children's hospital status, and Regional Perinatal Intensive Care Center (RPICC) hospital status
  - Uncompensated Charity Care ratio
  - Section 330 Public Health Service Act grant type and FQHC Look-Alike status (for FQHCs/RHCs only)

PARTICIPATION REQUIREMENTS

- All providers must be enrolled in Medicaid
- Hospitals must:
  - Contract with:
    - At least 50% of the standard Medicaid health plans in their region.
    - At least one Medicaid specialty plan for each target population that is served by a specialty plan in their region.
  - Participate in the Encounter Notification System
  - Have at least 1% Medicaid utilization

PARTICIPATION REQUIREMENTS, CONTINUED

- Medical School Physician Practices:
  - Must participate in the Florida Medical Schools Quality Network.
  - Must have at least 1% Medicaid utilization.
- Federally Qualified Health Centers/Rural Health Clinics:
  - Must contract with at least 50% of the Medicaid health plans in their region.
- Community Behavioral Health Providers
  - Must be a designated Central Receiving System

LIP SFY 2022-23 MODEL: HOSPITALS

Tier	Hospital Qualifications	Percent of Charity Care Paid by LIP
1	Private Hospitals with a Uncompensated Care (UC) ratio greater than or equal to 17% and less than 51.5%	8.5%
2	All Public Hospitals, All Children's Hospitals, RPICC Hospitals, Statutory Teaching Hospitals with UC ratio greater than or equal to 6.5%, and Private Hospitals with UC ratio greater than or equal to 51.5%	100.0%
3	High UC Statutory Teaching Hospitals with UC greater than 6.5% and not in a tier above.	100.0%
4	Low UC Statutory Teaching Hospitals with UC ratio less than 6.5%	8.5%
5	All remaining Hospitals with a minimum of 1% Medicaid Utilization.	1.0%

LIP SFY 2022-23 MODEL: OTHER PROVIDER TYPES

Provider Type	Percent of Charity Care Paid by LIP
Medical School Physician Practice	100.0%
Federally Qualified Health Center/ Rural Health Clinic	26.9%
Community Behavioral Health Central Receiving System	100.0%

LIP SFY 2022-23 FUNDING

Programs	Category	Total Funds
Low Income Pool	Low Income Pool - Group 1	$1,161,892,161
Program	Low Income Pool - Group 2	$97,828,079
	Low Income Pool - Group 3	$74,999,998
	Low Income Pool - Group 4	$24,098,020
	Total Low Income Payments	**$1,358,818,258**

DISPROPORTIONATE SHARE HOSPITAL (DSH)

- DSH was created under federal law to compensate hospitals that have provided a disproportionate share of Medicaid or charity care services.
- Federal law establishes an annual DSH allotment for each state that limits Federal Financial Participation for payments made to hospitals.
- Florida began receiving IGTs to fund the state share of DSH programs in SFY 1992-93.
- Currently there are 84 Florida hospitals participating in 8 DSH categories:
  - Public DSH
  - Provider Service Network DSH
  - Graduate Medical Education DSH
  - Family Practice DSH
  - Specialty DSH
  - Mental Health DSH
  - Rural DSH
  - Specialty Hospitals for Children DSH

DISPROPORTIONATE SHARE HOSPITAL CONTINUED

- Although DSH is a federal program, state matching funds are required every year for the Agency to distribute payments.
- The state match for DSH is funded through the receipt of IGTs except for the following DSH categories:
  - Rural DSH: Funded through Grants and Donations (Other Fraud Recoveries) and Medical Care Trust Fund.
  - Mental Health DSH: Funded through Certified Public Expenditures (CPEs) and Medical Care Trust Fund.
  - Specialty DSH: Funded through CPEs and Medical Care Trust Fund.
  - Specialty Hospitals for Children DSH: Funded through General Revenue and Medical Care Trust Fund.

DSH SFY 2022-23 FUNDING

Programs	Category	Total Funds
Disproportionate Share Hospital Program	Children's Hospital Disproportionate Share	$21,175,953
	Mental Health Disproportionate Share	$79,546,579
	Regular Disproportionate Share	$242,909,099
	Rural Disproportionate Share	$10,260,193
	Specialty Hospital Disproportionate Share	$1,443,885
	Total DSH Programs	**$355,335,709**

GRADUATE MEDICAL EDUCATION STATUTORY PROGRAMS

- Graduate Medical Education (GME) currently consists of eight programs:
- The **Statewide Medicaid Residency Program** is established to improve the quality of care and access to care for Medicaid recipients, expand graduate medical education on an equitable basis, and increase the supply of highly trained physicians statewide.
  - Funded by General Revenue and the Medical Care Trust Fund.
  - Began in SFY 2012-13.
- The **Startup Bonus Program** provides funding to hospitals with newly accredited physician residency positions or programs in the statewide supply-and-demand deficit specialties or subspecialties.
  - Funded by IGTs and the Medical Care Trust Fund.
  - Began in SFY 2013-14.

GRADUATE MEDICAL EDUCATION PROVISO PROGRAMS – BEGINNING SFY 2018-19

- These programs began in SFY 2018-19 and are funded by IGTs and the Medical Care Trust Fund:
- The **High Tertiary Program** distributes funding to teaching hospitals which provide highly specialized tertiary services, have greater than $15 million in charity care costs and provide highly specialized tertiary care including: comprehensive stroke and Level 2 adult cardiovascular services; NICU II and III; and adult open heart.
- The **Severe Deficit Program** aims to address the declining Graduate Medical Education in severe deficit physician specialties. The program funds up to $100,000 per-FTE to residency positions in urology, thoracic surgery, nephrology, and ophthalmology.
- The **Primary Care Program** funds up to $150,000 per full time resident in primary care and training in Medicaid regions with primary care demand greater than supply by 25% or more.

GRADUATE MEDICAL EDUCATION PROVISO PROGRAMS – BEGINNING IN SFY 2020-21

- These programs began in SFY 2020-21 and are funded by IGTs and the Medical Care Trust Fund:
- The **Mental/Behavioral Health Program** distributes funding for residents, fellows or interns who rotate through mental health and behavioral health facilities to address the severe deficit of physicians trained in these areas.
- The **Primary Care in Regions 1 and 8** distributes funding for each full-time employee in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, osteopathic general practice, obstetrics and gynecology, emergency medicine, general surgery, and psychiatry.
  - This payment will not be made as the intergovernmental transfers were not provided.
- The **Tallahassee Memorial Healthcare** payment distributes funding for each internal medicine residency slot at this hospital.
  - This payment will not be made as no IGTs were provided.

GME SFY 2022-23 FUNDING

Programs	Category	Total Funds
Graduate Medical Education	Graduate Medical Education Startup Bonus	$100,000,000
Program	Statewide Medicaid Residency Program	$97,300,000
	Mental and Behavior	$4,400,000
	Psychiatry Health	$1,344,447
	High Tertiary	$66,000,000
	Primary Care Region 1	$8,000,000
	Primary Care Region 8	$14,600,000
	Total GME Program Funded with IGTs	**$291,644,447**

PHYSICIAN SUPPLEMENTAL PAYMENT

- Physician Supplemental Payment (PSP) provides supplemental payments based on the calculation of the difference between the base Medicaid payment and supplemental payment for allowable procedure codes.
- Payments are made to medical school faculty physician practice plans at eligible universities.
- Payments made through both fee-for-service and a directed payment, which is paid through the Medicaid health plans.
- The state share is funded through IGTs.
- Program began in SFY 2016-17.

PSP SFY 2022-23 FUNDING

Programs	Category	Total Funds
Physician Supplemental Payments Program	Fee-For-Service Payments	$59,661,495
	Uniform Increase Payments (MCO)	$329,207,561
	Total Physician Supplemental Payments	**$388,869,056**

MULTI-VISCERAL TRANSPLANT

- A per Medicaid recipient global fee is paid to approved intestine and multi-visceral transplant facilities.
- The global fee is an all-inclusive payment that includes 365 days of transplant related care.
- The state share is funded through IGTs for the physician and hospital inpatient reimbursements.
- There is currently 1 provider participating.
- Program began in SFY 2009-10.

MULTI-VISCERAL SFY 2022-23 FUNDING

Programs	Category	Total Funds
Multi-Visceral Transplant Program	Global Reimbursement for Intestinal and Multi-Visceral Transplants	$7,342,387
	Total Multi-Visceral Transplant Program	**$7,342,387**

FLORIDA CANCER HOSPITAL PROGRAM (FCHP)

- Provides supplemental payments to Florida cancer hospitals that meet the criteria in 42 USC s. 1395ww(d)(1)(B)(v).
- Providers are reimbursed up to their respective upper payment limit gap for inpatient and outpatient services.
- Payments made through both fee-for-service and a directed payment, which is paid through the Medicaid health plans.
- The state share is funded through IGTs.
- There are currently 2 providers participating.
- Program began in October 2017.

FCHP SFY 2022-23 FUNDING

Programs	Category	Total Funds
Florida Cancer Hospital	Fee-For-Service and Uniform Increase Payments	$156,288,947
Program		
	Total FCHP Program	**$156,288,947**

PUBLIC EMERGENCY MEDICAL TRANSPORTATION

- Provides supplemental payments for eligible Public Emergency Transportation (PEMT) providers for allowable costs that are in excess of other Medicaid revenue that the entities receive for services to Medicaid recipients.
- Payments made through both fee-for-service and a directed payment, which is paid through the Medicaid health plans.
- The state share is funded through Certified Public Expenditures for the fee-for-service portion and IGTs for the directed payment portion.
- This program began in October 2015.
- There are currently 88 providers participating.

PEMT SFY 2022-23 FUNDING

Programs	Category	Total Funds
Public Emergency Medical Transportation Program	Fee-For-Service Payments	$42,000,000
	Uniform Increase Payments (MCO)	$83,539,043
	Total PEMT Program	**$125,539,043**

INDIRECT MEDICAL EDUCATION (IME)

- The Indirect Medical Education (IME) program was authorized in the state fiscal year (SFY) 2021-22 General Appropriations Act.
- The Indirect Medical Education (IME) program supports hospitals with residents in Graduate Medical Education (GME) who are in training to become physicians. The intent of the IME program is to provide additional funding to hospitals to support these residents.
- IME covers costs associated with residency programs that may result in higher patient care costs in teaching hospitals relative to non-teaching hospitals. For example, resident-provided care may be more expensive due to additional testing that residents may order as part of their training.
- Providers will be reimbursed based on the hospital's IME costs for services provided and may be paid on a quarterly basis.

IME FUNDING

Programs	Total Funds for SFY 22-23
Statutory Teaching Hospitals	$ 12,394,226
Public Teaching Hospitals	$ 67,917,739
Children's & RPICC Teaching Holspitals	$ 20,627,177
Academic Medical Centers Group 2 (AMC 2)	$ 59,021,309
Academic Medical Centers Group 1 (AMC 1)	$ 462,025,445
Grand Total	$ 621,985,896

HOSPITAL DIRECTED PAYMENT PROGRAM: HISTORY

- The Hospital Directed Payment Program (DPP) was authorized in the state fiscal year (SFY) 2021-22 General Appropriations Act.
- Purpose: To provide directed payment to hospitals in an amount up to the Medicaid shortfall, or the difference between the cost of providing care to Medicaid-eligible patients and the payments received for those services.
- The payment arrangement will direct payments, within each Medicaid region, equally to all hospitals in each class for hospital services provided by hospitals and paid by Medicaid health plans.
- The total anticipated program funds distribution for Year 2 is $2,210,456,823.

HOSPITAL DIRECTED PAYMENT PROGRAM

- The DPP operates regionally. Each region's DPP operates independent of other regions once certain conditions are met.

- Participating hospitals must meet the following three criteria:
  1. Fall into one of the following three mutually exclusive provider classes:
     - private hospitals
     - public hospitals; and
     - cancer hospitals
  2. Operate in one of Florida's 11 SMMC regions; and
  3. Provide inpatient and outpatient hospital services to Florida Medicaid managed care enrollees.

HOSPITAL DIRECTED PAYMENT PROGRAM: HOW IT WORKS

- In addition, for a region to participate in the DPP, all hospitals in at least one of the classes (private, public, cancer hospitals), must agree to participate and be subject to an assessment to fund the state share of the DPP.

- The DPP funding is contingent on Local Provider Participation Funds (LPPFs) & Intergovernmental Transfers (IGTs). Private hospitals in the State of Florida must be partnered with a governmental entity in order to participate in this DPP. The hospital DPP is a local option that allows local governments to establish a non-ad valorem (non-property tax) special assessment that is charged solely to hospitals.

    - Currently, 10 out of 11 regions are participating with at least one provider class.

HOSPITAL DIRECTED PAYMENT PROGRAM

- The State had to identify how the payment arrangement will advance at least one of the goals and objectives in its comprehensive quality strategy.

- The payment arrangement aligns with the Agency's quality goals to reduce:

  - Cesarean Sections (C-sections),
  - Potentially Preventable Hospital Readmissions, and
  - Follow-up after Hospitalization for Mental Illness.

FUNDING DISTRIBUTION FOR PROGRAM

Managed Care Regions	Provider Class	Amount	Region Total
1	Private	$ 78,857,416	$ 78,857,416
2	Public	$ 1,154,433	
2	Private	$ 60,882,029	$ 62,036,462
3	Private	$ 154,602,779	$ 154,602,779
4	Public	$ 26,095,040	
4	Private	$ 153,540,549	$ 179,635,589
6	Private	$ 310,870,670	$ 310,870,670
7	Public	$ 6,134,796	
7	Private	$ 386,029,050	$ 392,163,847
8	Public	$ 80,230,329	
8	Private	$ 35,736,281	$ 115,966,610
9	Public	$ 4,810,567	
9	Private	$ 170,739,748	$ 175,550,315
10	Public	$ 180,420,385	
10	Private	$ 55,987,221	$ 236,407,606
11	Public	$ 208,907,288	
11	Private	$ 295,458,240	$ 504,365,528
Totals			$ 2,210,456,823

FLORIDA MEDICAID SUPPLEMENTAL FUNDING PROGRAMS

SFY 2022-23	
Programs	**Total Funds**
Directed Payment Program	$ 2,210,456,823
Low Income Pool Program	$ 1,358,818,258
Indirect Medical Education Program	$ 621,985,896
Physician Supplemental Program	$ 388,869,056
Disproportionate Share Hospital Program	$ 355,335,709
Graduate Medical Education Program	$ 291,644,447
Florida Cancer Hospital Program	$ 156,288,947
Public Emergency Medical Transportation Progra	$ 125,539,043
Physician Hospital Payments Program	$ 92,984,629
Multi-Visceral Transplant Program	$ 7,342,387
Total SFY 2022-23	$ 5,609,265,195