

Florida Medicaid: Hospital Rate Setting Methodology

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Budget Process: Hospitals

- Use most recent 12 months of complete claims data to determine number of admissions, inpatient days and outpatient claims, by eligibility group.
- Analyze that data to determine utilization trends.
 - Utilization rate for all admissions and claims is applied to projected caseload to project Medicaid days
 - Inpatient admissions per eligible x days per admission x projected eligibles = projected total inpatient days.
 - Outpatient claims per eligible x projected eligibles = projected total outpatient claims

Budget Process: Hospitals

- Calculate estimate based on prior year data trended forward to incorporate utilization trends and anticipated changes in inpatient and outpatient reimbursement rates (if any from the GAA).
 - Estimate will use current final average per diem for July 1, 2011, rate setting period.
 - Total projected inpatient days x final average inpatient per diem = projected inpatient expenditures
 - Total projected outpatient claims x final average outpatient per diem = projected outpatient expenditures
- Hospital expenditure estimates are included as part of the Social Services Estimating Conference; the principals reach consensus on estimates.

Authority – Hospital Reimbursement

- ▶ Section 409.905 (5) & (6), and Section 409.908(1), Florida Statutes
- ▶ Rule 59G-4.150 & 59G-4.160, Florida Administrative Code
- ▶ Florida Title XIX Inpatient (I/P) and Outpatient (O/P) Hospital Reimbursement Plans

Rate Setting Statistics

(Information Based on 7/11 Rates)

➤ Total number of Medicaid participating hospitals	242
➤ Type of Control	
▪ Proprietary	116
▪ Non-Profit Faith-Based	23
▪ Non-profit Other	65
▪ Government	38
➤ Average I/P hospital per diem	\$1,095.48
➤ Average O/P rate	\$83.63
➤ Patient days/claims summary per cost reports	
▪ Total Medicaid Inpatient	1,610,793
▪ Total Medicaid Outpatient	5,525,946
➤ Patient days/claims per budget	
▪ Total Budget Inpatient days	2,167,957
▪ Total Budget Outpatient claims	7,628,501

Major Characteristics of the Reimbursement Rates

- Historically, hospital rates established twice a year.
 - January 1st & July 1st.
- Effective July 1, 2011 (pursuant to 2011 HB 7109)
 - Rates shall be established annually- July 1st each year.
 - Adjustments may not be made to the rates after September 30 of the state fiscal year in which the rate takes effect.
- Rates are established based on allowable Medicaid costs as reported in each hospital's cost report.
- Each hospital participating in the Florida Medicaid Hospital Program shall submit a cost report postmarked no later than 5 calendar months after the close of the hospital's cost reporting year.

Major Characteristics of the Reimbursement Rates (continued)

- The cost report shall be prepared in accordance with the method of reimbursement and cost finding of Title XVIII (Medicare) Principles of reimbursement described in 42 CFR 413.5-413.35 and further interpreted by the provider reimbursement manual CMS PUB. 15-1, as incorporated by reference in rule 59G-6.020 and 59G-6.030, F.A.C., except as modified by the Florida Title XIX hospital reimbursement plans.

Major Characteristics of the Reimbursement Rates (continued)

- Reimbursement rates are facility specific based on each facility's cost report.
- Reimbursement rates are prospective and are subjected to audit.
- Prospective rates are based on historical cost adjusted for inflation.

Major Characteristics of the Reimbursement Rates (continued)

- Property reimbursement of 80% applies to all hospitals except rural and specialized psychiatric hospitals.
- Medicaid reimbursement payment is payment in full for covered services.
- Inpatient services are reimbursed on a per diem basis. Adults age 21 and older are limited to 45 days per state fiscal year.
- Outpatient services are reimbursed on an occasion-of-services basis. Adults age 21 and older are limited to \$1,500 per recipient, per state fiscal year.

Hospital Reimbursement Rate Limitations

- Reimbursement Rate Components:
 - Facility specific variable cost rate.
 - Facility specific target rate.
 - County ceiling rate.
 - County ceiling target rate.
 - Property rate (N/A for outpatient).
- All rural, specialized, and statutory teaching hospitals are exempt from the county ceiling rate & county ceiling target rate.
- All rural and specialized psychiatric hospitals are exempt from the facility specific target rate.

Hospital Exemptions/ “Exempt Rates”:

- Rates for hospitals participating in the Medicaid program are set using methodology outlined in the Title XIX Reimbursement Plans.
- These plans include limitations to reimbursement known as “targets” or “ceilings” which are intended to limit the rates to a predetermined rate of growth.
- In order to maximize funding for certain hospitals, budget authority has been provided to allow these providers to be “exempt” from these limits, provided that the state share of the additional rate resulting from that exemption is provided through contribution from local governments (county and special taxing authorities).
- The rates paid to these facilities is referred to as the “exempt rate”.
- The funds used as state share for the additional rate paid to these “exempt” facilities are collectively known as Intergovernmental Transfers, or “IGTs”

Authority to “Buy-Back” Rate Reductions:

- Over the past several years, the GAA has included a series of reductions to the hospital inpatient and hospital outpatient categories.
- When a reduction is made in General Revenue there is a corresponding federal funding, or “federal match” reduction as well.
- In order to maximize funding for the hospitals participating in the Medicaid program, budget authority has been provided allowing the hospitals to “buy-back” the federal match by ensuring contributions of county, local government, or hospital funds to serve as the state share to draw down federal funds in the amount of the reduction made through the GAA.
- The funds used to “buy-back” these reductions are collectively known as Intergovernmental Transfers, or “IGTs”.

Intergovernmental Transfers (IGTs) Process

- Buyback and Exemption IGTs are calculated after hospital rate setting is complete.
- Cost of Buybacks and Exemptions is calculated by multiplying the rate difference by days or claims.
- Letters of Agreement (LOAs) are then sent to qualified IGT providers such as counties, taxing districts and public hospitals.
- After execution of the LOA, the hospital inpatient and outpatient reimbursement rate is adjusted.

Medicaid Hospital Expenditure History

	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011*	2011-2012*
Total Expenditures	\$2,629,862,711	\$2,699,608,145	\$3,215,938,400	\$3,616,987,543	\$4,453,550,405	\$4,378,219,755
IGT	\$228,274,020	\$350,407,952	\$350,383,235	\$346,515,202	\$621,081,301	\$691,278,057
GR	\$393,654,011	\$321,200,537	\$79,406,213	\$331,725,128	\$920,848,625	\$157,219,638
Other State Funds	\$478,673,668	\$549,886,780	\$694,223,583	\$488,361,975	\$20,921,720	\$1,075,145,302
Total State Share	\$1,100,601,699	\$1,221,495,269	\$1,124,013,031	\$1,166,602,305	\$1,562,851,646	\$1,923,642,997
Total Federal Share	\$1,529,261,012	\$1,478,112,876	\$2,091,925,369	\$2,450,385,238	\$2,890,698,759	\$2,454,576,758

Source: Medicaid Services' Budget Forecasting System Reports.
 *FY 2010-11 February 2011 Social Services Estimating Conference.
 *FY 2011-12 July 2011 Social Services Estimating Conference.

Rate Setting Process – July 2011

- **STEP – 1** Establish Rate with no Reductions/Buybacks
- **STEP – 2** Apply Recurring Rate Reductions (prior year – Medicaid Trend Adjustment aka MTA)
- **STEP - 3** Compare Unit Cost (SFY 2011-2012)
- **STEP – 4** Compare Unit Cost – Rate Freeze Provision
- **STEP – 5** Application of Exemptions (tiered or partial)
- **STEP – 6** Application of Buy Backs (tiered or partial)
- **STEP – 7** Additional Specific Buy-Back of MTA (public/teaching hospitals)
- **STEP – 8** Additional Specific Buy-Back of MTA (all hospitals)
- **STEP – 9** Additional Specific Buy-Back of Exemption

STEP 2 – Recurring Rate Reductions

Recurring Rate Reductions (Medicaid Trend Adjustment aka MTA)

- There are five historically recurring rate reductions
- Rates are adjusted for each of the recurring rate reductions based on certain limitations for each reduction
- Cost report days are utilized in calculating all recurring rate reductions

	<u>Inpatient</u>		<u>Outpatient</u>	
First Cut (SFY 05/06)	4.127263%	\$100,537,618	2.239302%	\$16,796,807
Second Cut (SFY 07/08)	2.413944%	\$ 68,641,064	2.145548%	\$17,211,796
Third Cut (SFY 08/09)	5.513843%	\$154,333,435	4.613485%	\$36,403,451
Fourth Cut (SFY 08/09)	3.091489%	\$ 76,712,855	2.817804%	\$19,384,437
Fifth Cut (SFY 09/10)	.375210%	\$ 9,635,295	0%	\$0
Sixth Cut (SFY 10/11)	0%	\$0	0%	\$0

STEP 3– Compare Unit Cost (SFY 2011-2012)

1. 7th MTA reduction

- In establishing rates, prior to including this year’s reduction, if the Unit Cost is equal to or less than the Unit Cost used in establishing the budget, then no additional reduction is necessary.
- If the Unit Cost is greater than the Unit Cost used in establishing the budget, then rate shall be reduced by an amount required to achieve the savings.
- Specialty Children’s and Rural hospitals are exempt from this reduction.
- The 7th MTA was required and the necessary reduction was applied. Budgeted days utilized in the determination of the 7th MTA.

	<u>Inpatient</u>		<u>Outpatient</u>	
Seventh Cut	12.5288169%	\$394,928,848	12.51944075%	\$99,864,555

STEP 3– Compare Unit Cost (continued)

2. 7th MTA reduction for Specialty Children's and Rural hospital
 - The methodology is the same as listed above. This reduction was not necessary; the Budget Unit Cost was greater than the Rate Setting Unit Cost. Inpatient Appropriation was \$12,608,937 and Outpatient was \$3,886,602.
 - The total cumulative reduction for the July 2011 rate setting is inpatient 25.347% and outpatient 22.423% and the reduction amounts are \$804,789,115 and \$189,661,046, respectively.

STEP 4– Compare Unit Cost Rate Freeze Provision

- The legislature directed the Agency to establish rates at a level that ensures no increase in statewide expenditures resulting from any change in unit costs effective July 1, 2011
- This reduction was not necessary; the Budget Unit Cost was greater than the Rates Unit Cost base on the prior year rates as of June 30, 2011.

STEP 5– Application of Exemptions (tiered or partial)

- There are means by which hospitals qualify for exemptions through the LIP program. The exemptions are all inclusive. Providers are those who are exempt from the ceiling and target limitations. These providers are allowed to receive a specific percentage of the exemption based on the provider's classification.

- Hospital Classification and Allowable Percent of Exemption- FY 2011-12

A) Specialty Children's Hospital	89.00%
B) Statutory Teaching Hospital	72.00%
C) Designated Trauma (greater than 7.3 XIX utilization)	67.00%
D) Specialty Hospital (Eye, TB, Teaching)	67.00%
E) Specific Legislative	67.00%
F) Medicaid and Charity Utilization (greater than 15%)	67.00%

STEP 6– Application of Buy Backs (tiered or partial)

- The qualifying hospitals for the MTA buy-back through the LIP program are provided in the Medicaid Supplemental Hospital Funding Program- Fiscal Year 2011-2012, Table 4. The funds were distributed as specified in the Medicaid funding directive.

Inpatient Buy-Back

1.	PSN:	\$54,966,655
2.	Specialty Children:	\$18,048,848
3.	Rural Hospitals:	\$5,710,750
4.	Trauma / Teaching	\$25,243,793

STEP 6– Application of Buy Backs (continued)

➤ Outpatient Buy-Back

1.	PSN:	\$8,510,191
2.	Specialty Children:	\$5,379,352
3.	Rural Hospitals:	\$4,191,469
4.	Trauma / Teaching	\$2,991,278

The total Tier Buy-Back amount is \$125,042,336.

STEP 7– Additional Specific Buy-Back of MTA

- Continued SFY 2011-2012
 - A) For public, teaching hospitals with 70 or more residents and leased public with sovereign immunity only.
 - B) I/P - \$543,389,836 O/P - \$115,394,825

STEP 8– Additional Specific Buy-Back of MTA

➤ Continued SFY 2011-2012

A) For all hospitals

B) I/P - \$286,624,908 O/P - \$80,007,502

STEP 9– Additional Specific Buy-Back of Exemption

- Continued SFY 2011-2012
 - A) For all hospitals- exemption from targets and ceilings
 - B) I/P - \$424,872,347 O/P - \$68,528,485

Overview of Medicaid Hospital Reimbursement

- In summary, the total rate Medicaid pays is the sum of the following components:
 - Variable cost rate - The lower of the variable cost rate, the facility specific target rate, county ceiling, or the county ceiling target rate.
 - Property - plus the property fixed cost rate.
 - Medicaid Trend Adjustments (MTA).
 - Buy Back of Medicaid Trend Adjustments (MTA).
 - Exemptions to ceilings by Low Income Pool program (LIP).

HB 7107 and HB 7109

- 2011 House Bill 7107 and House Bill 7109 contained provisions relating to Hospital Reimbursement rates.
- In addition to the annual rate setting provisions discussed earlier, HB 7107 requires that:
 - The Agency establish a tiered hospital rate distribution methodology, through which the Agency will set a base rate that will be adjusted based on certain categories and allocated across several tiers based on specific formulas set out in statute.
- HB 7109 requires that:
 - The Agency develop a plan to convert inpatient hospital rates to a prospective payment systems utilizing diagnosis related groups (DRG), with a due date of January 1, 2013.

Questions?