Low Income Pool (LIP) vs. Upper Payment Limit (UPL): A Comparison

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Presented to the Senate Health and Human Services Appropriations Committee

February 9, 2010

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History

- UPL Payment Methodology was in place in Florida from July 1, 2000 until June 30, 2006.
  - Payments were made to qualifying **hospitals** only.
  - The methodology provided a mechanism to supplement fee-for-service inpatient payments.
  - Expenditures of $631 Million for SFY 2005-06.
  - Federal Centers for Medicare and Medicaid issued a final rule on May 2007 that change the calculation.

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History

- Low-Income Pool was implemented effective July 1, 2006, under the 1115 Waiver.
  - Payments are made to qualifying Provider Access Systems.
  - Provides government support for the provision of health care services to Medicaid, underinsured and uninsured populations.
  - Expenditures cannot exceed $5 Billion over 5 yr period (71/2006 – 6/30/2011).

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What Is UPL?

- The Upper Payment Limit (UPL) payment methodology is allowable under federal regulations 447.272 to help offset the Medicaid shortfall for Medicaid participating hospitals.
- The limit for UPL is based on a specific calculation (performed annually) using historical fee-for-service hospital costs and Medicaid expenditures.
- The UPL is broken into two categories: Public and Private. Private includes For Profit and Not For Profit entities.
- Each category has a separate limit for inpatient hospital services and outpatient hospital services.

UPL Maximums

- A limit or maximum is established for each category that cannot be exceeded.
- UPL for private facilities cannot exceed Medicare limit.
- UPL for state government and non- state government facilities is individual provider's Medicaid cost.
- Maximums are calculated at the provider level and aggregated statewide for each category.
- The formula used to calculate the maximum or UPL must be submitted to and approved by Federal CMS.

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Authority Required For UPL

- Specific Authority within the General Appropriations Act and Florida Statute.
- The UPL does not require waiver authority of any type. However, phase out provisions of the 1115 Waiver must be completed prior to implementation of the UPL.
- The Medicaid State Plan would need to be amended to again include the UPL.

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What Is LIP?

- The Low Income Pool (LIP) was established July 1, 2006, to ensure continued government support for the provision of health care services to Medicaid, underinsured and uninsured populations.
- In accordance with Special Term and Condition (STC) #91 of the 1115 Wavier, the LIP limit is determined by the waiver with supporting documentation. The Low-Income Pool consists of a capped annual allotment of $1 billion total computable for each year of the 5-year demonstration period.

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Why LIP was Needed?

- 409.91211, F.S., Medicaid managed care pilot program, in an effort to create a statewide initiative to provide for a more efficient and effective service delivery system that enhances quality of care and client outcomes in the Florida Medicaid program.
- Managed care expansion can reduce the UPL maximum available since the number of fee-for-service days will reduce.

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Authority Required For LIP

- Operation of the Low Income Pool is authorized in the 1115 Medicaid Reform Demonstration Waiver.
- Federal funds are provided via the waiver under the technical terminology **Costs Not Otherwise Matchable (CNOM).**
- Specific Authority within the General Appropriations Act and Florida Statutes.
- Authority requires renewal of the waiver for the program to continue for SFY 2011-12.
- Renewal request must be submitted by June 30, 2010, to the federal Centers for Medicare and Medicaid Services (CMS).

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Side By Side

UPL	LIP
State Plan Amendment	1115 Waiver
Only Hospitals are eligible	Provider Access Systems, Including:
	• Hospitals
	• Federally Qualified Health Centers
	• County Health Departments
	• Premium Assistance
Estimated $700.9 Formula Driven $ Limit	$ 1 Billion per year

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UPL Changes

- The UPL methodology used in Florida prior to the implementation of LIP included the use of (Florida Hospital Uniform Reporting System (FHURS) data as a data source for variables used to calculate the UPL Cap.
- Since the implementation of LIP, federal CMS has changed the policy regarding data sources that can be used to calculate the UPL cap. “Federal Regulation CMS-2258”.
- Data used to calculate the UPL cap must be supported using the cost reports. In addition, CMS requires that the data be a national standard and auditable data source which FHURS is not. Therefore, the use of the FHURS data is no longer acceptable in the methodology to determine the UPL cap.
- This change results in a more restrictive and lower calculation of the UPL cap.

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OLD UPL vs. NEW UPL

- SFY 2005-06 Funding
  - $631 Million in In-patient UPL payments were budgeted in SFY 2005-06.
  - Outpatient UPL was not a component of the previous UPL methodology.
  - Methodology is based on FHURS data as well as submitted cost reports.

- Projected UPL using January 2010 Hospital Rates
  - $637.1 Million Inpatient
    - $12.8 Million Public
    - $624.3 Million Private
  - $63.8 Million Outpatient
    - $0.5 Million Public
    - $63.7 Million Private
  - Total IP and OP
    - $700.9 Million
  - Methodology is based on submitted cost reports.

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Public vs. Private

- **Public**
  - 32 Public Hospitals
  - $1,564,148,168 claims payment for SFY 2008-09
  - 28 Public Hospitals Participate in LIP
  - $560,147,191 paid under LIP for 08/09
  - Anticipated Maximum payments under the new UPL could not exceed $12,771,255

- **Private**
  - 210 Private Hospitals
  - $2,489,443,593 claims payment for SFY 2008-09
  - 134 Private Hospitals Participate in LIP
  - $294,659,199 paid under LIP for 2008-09
  - Anticipated Maximum payments under the new UPL could not exceed $628,087,250

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Driving Factors of Variance

UPL Calculation and Allowable Data Sources

- The previous formula used to establish the UPL maximum included data from FHURS which is no longer an allowable UPL data source for Federal CMS.
- The proposed formula uses only the provider 2552 Standard Medicaid/Medicare Cost report as recommended by Federal CMS which reflects a true cost basis for the calculation.

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Driving Factors of Variance

Exemptions

- Exemption Status: Qualifying hospitals are eligible for Medicaid reimbursement that is exempt from specific ceilings and targets which are limits on the reimbursement of Medicaid Allowable Costs (MAC).
  - 76 Hospitals are Exempt: 85.66% of MAC
  - 166 Hospitals are Non-Exempt: 56.74% of MAC
- Growth in the number of providers that qualify for exemptions has reduced the amount of potential reimbursement eligible between the Medicaid payment and the UPL maximum.

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Driving Factors of Variance

Buy Back Authority

- Authority was granted in the 2008 Legislative Session to allow qualifying hospitals to “Buy Back” required rate reductions. This results in increased reimbursement paid by Medicaid.
- The Authority was modified and expanded in the 2009 Session.
- Growth in the number of providers that qualify for buy backs has further reduced the amount of potential reimbursement eligible between the Medicaid payment and the UPL maximum.

Driving Factors of Variance

- Managed Care Expansion
  - The UPL calculation is limited to Medicaid days paid via Fee For Service. Medicaid payments made by participating managed care plans for Medicaid recipients is considered payment in full and no UPL “supplement” is available.
  - As the Enrollment in Managed Care increases the allowable days and costs are reduced therefore reducing the UPL maximum available under the payment methodology.

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Key Points

- The UPL or LIP programs are not single payment programs. The success of Exemptions and Buy Backs are directly tied to the existence of a payment methodology.
- IGTs received by the Agency through the LIP program are used to support the Exemptions and Buybacks.
- Without this link between local revenue and a return to a linked facility, many qualifying facilities might not have the source to fund exemptions or buybacks and would receive less funding from the State.
- UPL provides supplemental payment for fee-for-service days.
- LIP provides payment for uncompensated care to under and uninsured people.

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Implementation of UPL

- The LIP would need to be phased out in accordance with the 1115 waiver.
- The Agency would develop and submit the UPL proposal to Federal CMS for approval which would include the UPL formula and payment method as well as a State Plan amendment.
- Federal CMS approval of the formula and payment methodology is required prior to implementation.
- State authority is required.

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Impact of UPL

- The implementation of UPL would result in an anticipated total loss of $363 million in available funding to hospital and non-hospital providers.
- Due to the category limits, the public hospitals would suffer nearly 100% loss in available supplemental funding.
- Due to the process and use of IGTs, many entities such as rural hospitals would lose the ability to receive exempt and buyback rates.
- In addition, current non-hospital based providers would loss 100% of available funding.

Continuation of LIP

- The continuation of LIP would allow the providers and the Agency to keep the current level of funding.
- The $1 Billion is subject to Federal CMS review and renewal.
- If LIP was not continued, the non-hospital based providers would not be eligible for payments.
- If LIP is not continued, the public providers would NOT be able to obtain funding for underinsured and uncompensated care expenditures, regardless of the availability of IGTs.

Questions?