NAVIGANT

FLORIDA MEDICAID SPECIALTY CHILDREN'S HOSPITAL REIMBURSEMENT REVIEW

October 31, 2019

Prepared for:

Florida Agency for Health Care Administration

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Executive Summary

In the 2019 session, the Florida Legislature directed the Florida Agency for Health Care Administration (AHCA) to commission a study of Medicaid reimbursement to stand-alone specialty children's hospitals. The exact language included in the General Appropriations Act (GAA) for this reimbursement review is shown below:

> "... the Agency for Health Care Administration shall review the current reimbursement methodologies for stand-alone specialty children's hospitals to evaluate the manner in which rates are calculated for each provider and identify any variances in reimbursements by facility. The report shall include an evaluation of factors included in each reimbursement rate, a comparison of acuity levels for each facility type, a comparison of procedure types, comparisons of reimbursement methodologies with other similar sized Medicaid programs for similar hospital sizes, and opportunities to incentivize efficiencies through alternative reimbursement strategies. The report shall also include potential state and federal costs or savings associated with implementing alternative methodologies."[1]

The legislation directs that this review be completed and submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than October 31, 2019.

AHCA hired Navigant Consulting to perform this study. Navigant used claim data with dates of service in calendar year 2017 repriced using State Fiscal Year (SFY) 2018/19 payment parameters and SFY 2018/19 supplemental payment amounts to perform the data analysis provided in this report.[2]

The four hospitals in Florida that are licensed as stand-alone specialty children's hospitals are:

Johns Hopkins All Children's Hospital based in Saint Petersburg
Nemours Children's Hospital based in Orlando
Nicklaus Children's Hospital based in Miami
Wolfson Children's Hospital based in Jacksonville

Wolfson Children's Hospital was licensed as part of Baptist Medical Center of Jacksonville for many years. In March of 2018, Wolfson became officially licensed as a stand-alone specialty children's hospitals. Because the separate license took affect after the timeframe of the data used for this report, the numbers included for Wolfson Children's Hospital are based on assumptions made to identify which services were performed at Wolfson Children's Hospital versus Baptist Medical Center of Jacksonville. Some inaccuracies may exist based on these assumptions. In addition, Shriners Hospital for Children in Tampa has recently shifted to an outpatient-only facility and was excluded from this study.

[1] SFY 2019/20 Florida General Appropriations Act (GAA), Specific Appropriation 203.
[2] For purposes of this report, the repricing of hospital outpatient claims for Wolfson Children's Hospital included the High Medicaid Utilization policy adjustor even though Wolfson Children's Hospital did not actually qualify for this adjustor until SFY 2019/20.

Florida Medicaid's hospital inpatient and outpatient reimbursement methods for medical claims are acuity-based, and are very similar to those used by other similarly-sized Medicaid agencies. In the Florida Medicaid inpatient payment method, patient acuity is measured using All Patient Refined Diagnosis Related Groups (APR-DRGs), and in the outpatient payment method, patient acuity is measured using Enhanced Ambulatory Patient Groups (EAPGs). Both of these tools, APR-DRGs and EAPGs, categorize patients and the care provided to those patients based on the amount of resources expended by a hospital in providing care. These tools map categories to relative weights (numerical values), where a higher relative weight indicates higher patient acuity and higher resource expenditure required by a hospital in care of the patient. The relative weights allow for higher payment to be provided for more complex care and lower payment for less complex care.

Particularly for inpatient services, the stand-alone specialty children's hospitals care for more medically complex patients on average than many other hospitals in the state. This higher acuity is captured by the APR-DRG classification system and results in higher average Medicaid payment per admission to the children's hospitals than to many other hospitals in Florida. In addition to the acuity-based payment adjustment built into the standard APR-DRG payment, Florida Medicaid has implemented payment policies specifically for the stand-alone specialty children's hospitals that raise reimbursement above what is determined using the standard claim payment calculations. These policies include an inpatient policy adjustor which increases base APR-DRG payment, an outpatient policy adjustor which increases base EAPG payment, a provider grouping (known as a tier) which reimburses 100 percent of charity care through the Low Income Pool (LIP) program, and a different allocation calculation in the Disproportionate Share Hospital (DSH) program. These policies and their associated higher Medicaid reimbursement exist because stand-alone specialty children's hospitals have very high Medicaid utilization, over 60 percent on average, versus less than 20 percent average Medicaid utilization for all other hospitals in the state. As a result, the stand-alone specialty children's hospitals are heavily dependent on Medicaid reimbursement and are less able to cost share using higher reimbursement levels from commercial payers.

All except one of Florida Medicaid's payment policies which benefit the stand-alone specialty children's hospitals use the same criteria and calculation methods for all four facilities. The one exception is Automatic Rate Enhancements (AREs), which are distributed as an add-on to standard APR-DRG and EAPG payments. Within DRG and EAPG reimbursement the allocation of AREs to individual hospitals is based on a method developed for State Fiscal Year (SFY) 2013/14 that was heavily tied to the sources of inter-governmental transfers (IGTs) used to fund ARE disbursements. Since SFY 2013/14, the source of funding of AREs has been shifted from IGTs to state general revenue. The allocation of AREs to individual hospitals, however, has not been updated to be based on the volume and type of care provided to Medicaid recipients instead of the source of local funding.

Figure 1 below shows average ARE payment per inpatient admission and outpatient visit with and without case mix adjustment. As shown in the figure the amounts are not particularly similar across hospitals and are noticeably lower for Wolfson Children's Hospital and Nemours Children's Hospital. It is estimated that an additional $14.3 million, the state share of which would be $5.6 million[3], would be needed to set the inpatient and outpatient ARE payment amounts to equal values (with or without case mix adjustment) across the four facilities. This estimated additional spend was determined by setting the new average ARE payment for all

[3] Florida Medicaid's blended FMAP value for SFY 2018/19 equal to 0.6110 was used to determine the state share.

four hospitals equal to the current average ARE payment for the two facilities with the highest AREs, Johns Hopkins All Children's Hospital and Nicklaus Children's Hospital.

Figure 1 – Average ARE payment per unit for the four stand-alone specialty children's hospitals

Hospital[1]	Inpatient Admits	Inpatient Case Mix	Medicaid ARE Payment Per Admit	Case Mix Adjusted ARE Pymt Per Admit	Outpatient Visits	Outpatient Case Mix	Medicaid ARE Payment Per Visit	Case Mix Adjusted ARE Pymt Per Visit
Johns Hopkins All Children's Hospital	4,307	2.38	$4,854	$2,040	146,530	0.62	$38	$62
Nemours Children's Hospital	2,168	1.66	$2,959	$1,782	51,892	0.71	$20	$28
Nicklaus Children's Hospital	5,968	1.61	$4,297	$2,669	259,943	0.52	$33	$64
Wolfson Children's Hospital[2]	2,170	1.89	$0	$0	8,733	2.25	$0	$0
Total / Average	**14,613**	**1.89**	**$3,625**	**$1,922**	**467,098**	**0.61**	**$33**	**$54**

Note(s):
1) Numbers in this table include Medicaid fee-for-service and Medicaid managed care claims for dates of service in calendar year 2017 that have been repriced under SFY 2018/19 rates and rules.
2) Values for Wolfson Children's Hospital are our estimate of the portion of these amounts for Baptist Medical Center Jacksonville that apply to Wolfson.

Despite the inequities in AREs, case mix adjusted average Medicaid payment per inpatient admission and outpatient visit are relatively similar across the four stand-alone children's hospitals. The only exception is lower inpatient payment to Wolfson Children's Hospital, which can be explained by the fact that Wolfson Children's Hospital does not currently qualify for the Inpatient High Medicaid Utilization and High Medicaid Outlier policy adjustor. Average payment per inpatient admission and outpatient visit is summarized in Figure 2 below.

Figure 2 – Average Medicaid payment per unit for the four stand-alone specialty children's hospitals

Hospital[1]	Inpatient Admits	Inpatient Case Mix	Case Mix Adjusted Pymt Per Admit	Case Mix Adjusted Cost Per Admit[3]	Outpatient Visits	Outpatient Case Mix	Case Mix Adjusted Pymt Per Visit	Case Mix Adjusted Cost Per Visit[3]
Johns Hopkins All Children's Hospital	4,307	2.38	$13,852	$15,501	146,530	0.62	$713	$933
Nemours Children's Hospital	2,168	1.66	$13,575	$20,140	51,892	0.71	$680	$1,497
Nicklaus Children's Hospital	5,968	1.61	$14,091	$16,664	259,943	0.52	$715	$771
Wolfson Children's Hospital[2]	2,170	1.89	$7,481	$11,234	8,733	2.25	$652	$715
Total / Average	**14,613**	**1.89**	**$12,951**	**$15,877**	**467,098**	**0.61**	**$706**	**$906**

Note(s):
1) Numbers in this table include Medicaid fee-for-service and Medicaid managed care claims for dates of service in calendar year 2017 that have been repriced under SFY 2018/19 rates and rules.
2) Values for Wolfson Children's Hospital are our estimate of the portion of these amounts for Baptist Medical Center Jacksonville that apply to Wolfson.
3) Numbers in the "cost" columns are estimates of hospital cost to provide health care to Medicaid recipients.

Medicaid payment as a percentage of hospital cost to provide care is less homogeneous than the case mix adjusted average payment per unit shown in the figure above because the cost structures differ between the four facilities. That is, some hospitals have higher cost per unit than other hospitals. In recent years, the Florida Legislature has deliberately moved away from payment methods based on individual hospital cost and towards payment methods which consider average cost for categories of like facilities, referred to as hospital peer groups. In fact, separate inpatient and outpatient peer groups were created during the implementation of APR-DRG and EAPG pricing to which only stand-alone specialty children's hospitals qualify. The

applicable inpatient peer group, referred to as the Inpatient High Medicaid Utilization and High Outlier group was given a policy adjustor in SFY 2013/14 (the first year of DRG pricing) which resulted in Medicaid inpatient claim payments equaling 100 percent of hospital cost. Similarly, the outpatient peer group, referred to as the Outpatient High Medicaid Utilization group was given a policy adjustor in SFY 2017/18 (the first year of EAPG pricing) which resulted in budget neutral Medicaid claim payments for the qualifying hospitals, and these payments equaled 93 percent of hospital cost. Over time, hospital costs have increased, Medicaid reimbursement has decreased, and the list of stand-alone specialty children's hospitals has changed such that cost coverage using SFY 2018/19 rates is estimated to be lower – 82 percent for inpatient care and 77 percent for outpatient care of Medicaid recipients at the four stand-alone specialty children's hospitals.

In summary, Florida Medicaid payment policies and methods, including policies providing additional reimbursement for stand-alone specialty children's hospitals, are consistent with those used by other, similarly-sized Medicaid agencies. Reimbursement amounts are relatively consistent across the four Florida stand-alone specialty children's hospitals, with the exception of inpatient reimbursement for Wolfson Children's Hospital. In addition, the payment policies and methods are consistently applied to all stand-alone specialty children's hospitals, with the exception of allocation of AREs. Also, the current thresholds set for the Inpatient High Medicaid Utilization and High Outlier policy adjustor are applied consistently for all facilities, but are so high that one stand-alone specialty children's hospital, Wolfson Children's Hospital, does not qualify. The Florida Legislature might consider a change for one or both of these so that all Florida stand-alone specialty children's hospital are treated equally. Of course, to do so in a budget neutral manner would require reducing Medicaid reimbursement to other hospitals. Any adjustment made in a non-budget neutral manner would require finding a source for additional funding.

1 Introduction

The State of Florida's fiscal year 2019/20 General Appropriations Act (GAA) included a provision directing the Florida Agency for Health Care Administration (AHCA) to review Medicaid reimbursement to stand-alone specialty children's hospitals. According to the legislation documented in the GAA, the review should consider levels of reimbursement, method for determining reimbursement rates and types of services offered at the stand-alone specialty children's hospitals in Florida. In addition, this reimbursement review should include a comparison of reimbursement methodologies employed by Florida Medicaid and by other state Medicaid agencies to reimburse services provided at stand-alone specialty children's hospitals. Lastly, the review should include a discussion of potential alternative reimbursement strategies that could incentivize efficient delivery of care to Medicaid beneficiaries within stand-alone specialty children's hospitals. The exact language included in the GAA for this reimbursement review is shown below:

> "... the Agency for Health Care Administration shall review the current reimbursement methodologies for stand-alone specialty children's hospitals to evaluate the manner in which rates are calculated for each provider and identify any variances in reimbursements by facility. The report shall include an evaluation of factors included in each reimbursement rate, a comparison of acuity levels for each facility type, a comparison of procedure types, comparisons of reimbursement methodologies with other similar sized Medicaid programs for similar hospital sizes, and opportunities to incentivize efficiencies through alternative reimbursement strategies. The report shall also include potential state and federal costs or savings associated with implementing alternative methodologies."[4]

The legislation directs that the review be completed and submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than October 31, 2019.

Florida AHCA has contracted with Navigant Consulting to complete this review and the contents of this document are intended to fulfill this Legislative requirement.

The review begins with an overview of the four stand-alone specialty children's hospitals in Florida and a discussion of their dependence on Medicaid reimbursement resulting from very high Medicaid utilization. Next, this review analyzes funding and reimbursement pathways used by Florida Medicaid. In particular, the discussion of funding reviews reimbursement goals in recent years for claim payments, Automatic Rate Enhancements (AREs), and the Low Income Pool (LIP). The discussion of reimbursement describes policies and payment adjustors that have been put in place by Florida Medicaid specifically for the stand-alone specialty children's hospitals. Several reimbursement-related policies currently exist that increase reimbursement for these specialty hospitals beyond that calculated using standard hospital inpatient and outpatient payment methods. In addition, this review highlights where the payment calculations are consistent across all four Florida stand-alone specialty children's hospitals, and the few scenarios in which the payment calculations currently differ between these four hospitals.

[4] SFY 2019/20 Florida General Appropriations Act (GAA), Specific Appropriation 203.

Comparison of reimbursement levels and cost coverage across the four Florida stand-alone specialty children's hospitals is also provided. The comparisons are performed using average Medicaid payment and hospital cost per unit with and without case mix adjustment. Comparisons of average per unit instead of comparison of aggregate values is necessary because the volume of Medicaid recipients seen by the four hospitals varies significantly. For these comparisons, a unit is defined as a hospital admission for inpatient care and a hospital visit for outpatient care. In addition, the report provides comparisons of case mix adjusted average Medicaid payment and hospital cost per unit. Case mix adjustment offers a more fair comparison across hospitals because it adjusts for patient acuity under the assumption that hospitals who treat higher acuity patients on average will incur greater costs and will receive greater payment from Medicaid.

Next, the review provides a brief survey of reimbursement strategies utilized by other state Medicaid agencies for payment to specialty children's hospitals. In general, the payment methods implemented by Florida Medicaid for reimbursement of care provided at stand-alone specialty children's hospitals is consistent with methods used by other Medicaid agencies. Nearly all Medicaid agencies, including Florida Medicaid, reimburse inpatient care using Diagnosis Related Groups (DRGs) and most, including Florida Medicaid, specifically use All Patient Refined Diagnosis Related Groups (APR-DRGs), which were created and are maintained by 3M Health Information Systems. Methods used by Medicaid agencies to reimburse hospital outpatient care are more varied, but several Medicaid agencies use the same method as Florida Medicaid, which is based on Enhanced Ambulatory Patient Groups (EAPGs), also created and maintained by 3M Health Information Systems. In addition, like Florida Medicaid, most other Medicaid agencies employ methods which reimburse stand-alone children's hospitals at higher levels than some, if not all, other hospitals.

This report concludes with a discussion of key factors and challenges to consider in creating alternative payment methods for pediatric care.

2 Background

2.1 Stand-alone Specialty Children's Hospitals in Florida

There are four (4) stand-alone specialty children's hospitals in the State of Florida. They are,

Johns Hopkins All Children's Hospital based in Saint Petersburg
Nemours Children's Hospital based in Orlando
Nicklaus Children's Hospital based in Miami
Wolfson Children's Hospital based in Jacksonville[5]

Each of these facilities is specifically licensed as a specialty children's hospital. There are other relatively large children's units within acute care hospitals in Florida, such as the Arnold Palmer Hospital for Children in Orlando and the Joe DiMaggio Children's Hospital in Hollywood. In contrast, these children's units are licensed in Florida as part of larger acute care hospitals (Arnold Palmer Children's is part of Orlando Health and Joe DiMaggio Children's is part of Memorial Regional Hospital), and are not considered stand-alone children's facilities. Children's units licensed as part of a larger acute care hospital are considered out of scope for this study. Additionally, Shriners Hospital for Children based in Tampa is now operating as a health care clinic and clinical laboratory and is no longer licensed as a stand-alone specialty children's hospital. For this reason, Shriners Hospital for Children is not included in this report.

Stand-alone specialty children's hospitals are considered Class II hospitals under Florida Administrative Rule 59A-3.252 because they provide medical services similar to those offered by general hospitals, "but restricted to a defined age or gender group of the population."[6] To maintain licensure, Class II hospitals must "provide the treatment services, equipment, supplies and staff appropriate to the particular category of patients treated at the facility,"[7] in addition to all other requirements of acute care hospitals. Also, Class II hospitals must "have a valid Certificate of Need from the Certificate of Need and Commercial Managed Care Unit."[8]

2.2 Medicaid Utilization at Stand-Alone Specialty Children's Hospitals

Because Medicaid is a large payor for services to children, stand-alone specialty children's hospitals rely heavily on Medicaid reimbursement to remain in business. According to data collected by the Florida Center for Health Information and Transparency, at least 56 percent of the inpatient services each of these four facilities provide is to Medicaid recipients, with three of the four children's hospitals having Medicaid inpatient utilization over 60 percent. In contrast, the statewide average Medicaid inpatient utilization for all acute care hospitals in Florida is 12 percent.[9] Medicaid utilization in the outpatient setting is also very high for the stand-alone specialty children's hospitals. All four facilities have Medicaid outpatient utilization percentages equal to or greater than 54 percent, and three of the four children's hospitals have Medicaid

[5] Wolfson Children's Hospital was licensed as part of Baptist Medical Center of Jacksonville for many years. In March of 2018, Wolfson became officially licensed as a stand-alone specialty children's hospitals.
[6] Florida Administrative Rule 59A-3.252 (3)(B) – Classification of Hospitals.
[7] Florida Administrative Rule 59A-3.252 (4) – Classification of Hospitals.
[8] https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Hospital_Outpatient/Hospitals/LicensureRequirements.shtml
[9] Psychiatric specialty hospitals were excluded from the determination of statewide average Medicaid inpatient utilization.

outpatient utilization above 60 percent. For comparison, the statewide average Medicaid outpatient utilization for all acute care hospitals in Florida is 17 percent.[10] Utilization values for each stand-alone specialty children's hospital in Florida are shown in Figure 3 below:

Figure 3 – Medicaid utilization at stand-alone specialty children's hospitals in Florida

Hospital	Medicaid Inpatient Utilization	Medicaid Outpatient Utilization
Johns Hopkins All Children's Hospital	68%	61%
Nemours Children's Hospital	72%	66%
Nicklaus Children's Hospital	64%	71%
Wolfson Children's Hospital	56%	54%
Statewide average	**12%**	**17%**

Note(s):
1) Percentages in this table were calculated using hospital charges for services provided self-reported by hospitals to the Florida Center for Health Information and Transparency.

With such high percentages of healthcare services at these stand-alone specialty children's hospitals being provided to Medicaid beneficiaries, Medicaid reimbursement is a key component of the hospitals' overall revenue. In Florida and across the country, Medicaid traditionally reimburses providers less than the cost the providers incur to treat Medicaid patients. When considering claim payments only, Florida Medicaid reimbursed hospital inpatient care in SFY 2018/19 at 62% of cost on average for all hospitals in Florida and at 82% of cost for the four stand-alone specialty children's hospitals. For outpatient hospital services, Florida Medicaid reimbursement in SFY 2018/19 equaled 53% of hospital cost on average for all hospitals in Florida and 77% of hospital cost for the four stand-alone specialty children's hospitals.[11] Hospitals must make up these losses through other reimbursement streams, most commonly including reimbursement for care provided to patients with commercial insurance. This practice, in which some payers make up for losses generated by other payers, is referred to as "cost shifting." Stand-alone specialty children's hospitals are less able to cost shift because so much of their business involves caring for Medicaid beneficiaries.

2.3 Data Included in Report

2.3.1 Timeframe of the Data

When reviewing claims payment amounts to stand-alone specialty children's hospitals in Florida, we selected State Fiscal Year (SFY) 2018/19 as our timeframe. This encompasses dates of service from July 1, 2018 through June 30, 2019. To allow sufficient time for claim

[10] Medicaid utilization percentages included in this paragraph are based on data provided by the Florida Center for Health Information and Transparency in January of 2019. The Medicaid utilization values are based on services provided in calendar year 2017 for all but Wolfson Children's Hospital. For Wolfson Children's Hospital, the Medicaid utilization values are based on services provided in the first and second quarter of calendar year 2018.
[11] There are supplemental payments distributed by Florida Medicaid outside of claim payments that increase the cost coverage. A more detailed description of cost coverage including these supplemental payments is included later in the report.

billing and processing, we selected claims in Calendar Year (CY) 2017 and repriced these claims using SFY 2018/19 fee-for-service payment rates. Also, our estimates of hospital cost were determined by applying hospital cost-to-charge ratios applicable in CY 2017 to the claim data and then inflating hospital cost to the midpoint of SFY 2018/19. In addition, the supplemental payments from Medicaid to hospitals and provider assessment payments from hospitals to the state are from SFY 2018/19.

2.3.2 Type of Claim Data

The claim data used in calculation of hospital cost and Medicaid claim payments are paid claims for services provided to Medicaid recipients in both the traditional fee-for-service and the Medicaid managed care programs. Medicaid fee-for-service claims were retrieved from a data warehouse maintained by AHCA and populated by the Florida Medicaid Management Information System (FMMIS). Medicaid managed care claims were retrieved from the February 2019 managed care "special feed" encounter files which are submitted by the managed care plans to AHCA and are currently used in the annual fee-for-service and capitation rate setting processes.

Claims that were denied are not included in the analyses in this report, even if there are appeals of the denials still being negotiated between hospitals and the managed care plans.

2.3.3 Assumptions Made for Wolfson Children's Hospital

The data available for Wolfson Children's Hospital is incomplete because the hospital did not become a separately licensed entity until March of 2018. For claim data, which had dates of service in CY 2017, we applied logic to estimate which claims assigned the Medicaid ID for Baptist Medical Center Jacksonville were for services performed at Wolfson Children's Hospital. For inpatient claims, our logic assumed the services were performed at Wolfson Children's Hospital if the claim was assigned the Wolfson or Baptist Medical Center Jacksonville Medicaid provider ID, the Medicaid recipient was less than 18 years old, the services performed were not related to delivery or birth of a healthy baby, and the patient account number was not one used exclusively by Baptist Medical Center Jacksonville. For outpatient claims, we did not deem recipient age and service performed to be sufficient to distinguish services performed at Wolfson Children's versus Baptist Medical Center Jacksonville. Instead, we used claim volume. Medicaid outpatient claim volume at Wolfson Children's Hospital has averaged a little under 750 outpatient claims per month, with some seasonal variability, in those months that Wolfson has been a separately licensed facility. In the CY 2017 claims used for this report, we reassigned enough claims from Baptist Medical Center Jacksonville to Wolfson as needed to result in 775 Medicaid claims at Wolfson in each of the months of January and February 2017 and 725 claims per month for the other ten months in CY 2017. CY 2017 Medicaid outpatient claims originally assigned the Baptist Medical Center Jacksonville provider ID were sorted by month and descending by submitted charges, and the claims with the highest submitted charges were shifted from Baptist Medical Center Jacksonville to Wolfson.

Information regarding provider assessment contributions and supplemental payments, which include payments through the Disproportionate Share Hospital (DSH) program and the Low Income Pool (LIP), were only available for Baptist Medical Center Jacksonville. For these dollar

amounts, we estimated that 27 percent could be applied to Wolfson Children's Hospital. Our estimate of Wolfson Children's Hospital making up 27 percent of Baptist Medical Center Jacksonville during the time the two facilities operated under one license came from review of hospital inpatient and outpatient billed charges submitted by Baptist Medical Center Jacksonville to the Florida Center for Health Information and Transparency. We compared billed amounts from Baptist Medical Center Jacksonville for half of calendar year 2017, inflated by 2 percent, to billed amounts from Wolfson Children's Hospital for the first two quarters of calendar year 2018.

3 Florida Medicaid Funding and Reimbursement Pathways

3.1 Funding Pathways

Under federal regulations, a variety of sources can be used to fund the state share of Medicaid reimbursements. The most common source of the state share for Medicaid agencies is state general revenue collected through various state taxes. In addition, funding may come from "local sources" through Inter-Governmental Transfers (IGTs), Certified Public Expenditures (CPEs), and healthcare provider assessments.

IGTs must originate from a governmental entity. Since each of the stand-alone specialty children's hospitals in Florida is privately owned, these facilities cannot contribute IGTs to AHCA, but their county governments could contribute IGTs on the hospitals' behalf. In State Fiscal Year (SFY) 2018/19, there were no IGTs contributed to Medicaid on behalf of any of the Florida stand-alone specialty children's hospitals.

CPEs are based on the hospital cost of healthcare services provided to Medicaid beneficiaries, or, in some cases, the uninsured. Also, the healthcare services must be provided in a government-owned facility. CPEs are not an avenue available to the four stand-alone specialty children's hospitals in Florida because they are all privately owned.

In contrast, healthcare provider assessments can be applied to hospitals independent of the hospitals' ownership. Florida Medicaid does utilize healthcare provider assessments. The healthcare assessment in Florida, which is referred to as the Public Medical Assistance Trust Fund (PMATF), is calculated as 1.5 percent of hospital inpatient net operating revenue and 1.0 percent of hospital outpatient net operating revenue.[12] The four stand-alone specialty children's hospitals in Florida do contribute funds for the Medicaid program through the healthcare provider assessment. The provider assessment contributions from each hospital in SFY 2018/19 are shown in Figure 4 below.

Figure 4 – Provider assessment contributions based on hospital fiscal year end 2018 cost reports

Hospital	Provider Assessment Contributions
Johns Hopkins All Children's Hospital	$5,619,078
Nemours Children's Hospital	$2,411,725
Nicklaus Children's Hospital	$7,312,490
Wolfson Children's Hospital	$3,648,587[1]

Note(s):
1) The amount listed for Wolfson Children's Hospital is our estimate of the portion of the assessment paid by Baptist Medical Center Jacksonville that can be attributed to Wolfson.

[12] Florida Statutes, Section 395.701 (2)(a) and (b), Retrieved July 27, 2019 from http://www.leg.state.fl.us/statutes/index.cfm?mode=View%20Statutes&SubMenu=1&App_mode=Display_Statute&Search_String=hospital+assessment&URL=0300-0399/0395/Sections/0395.701.html

3.2 Reimbursement Pathways

In SFY 2018/19, and in the last few years prior to SFY 2018/19, there have been five pathways in which Florida Medicaid reimburses stand-alone children's hospitals. These are:

1) Claim payments for Medicaid recipients enrolled in traditional Medicaid fee-for-service
2) Claim payments for Medicaid recipients enrolled in Medicaid managed care
3) Supplemental payments distributed through the Disproportionate Share Hospital (DSH) program
4) Supplemental payments distributed through the Low Income Pool (LIP)
5) Supplemental payments distributed through the Graduate Medical Education (GME) program

3.2.1 Claim Payments in Medicaid Fee-for-Service

3.2.1.1 Hospital Inpatient Claim Payment Formula

Florida Medicaid payments for individual hospital inpatient admissions are calculated using the All Patient Refined Diagnosis Related Groups (APR-DRG)[13] classification system. In the Florida Medicaid implementation of APR-DRG pricing, the most common calculation of payment for a hospital admission is,

[Hospital Base Rate] * [DRG Relative Weight] * [Maximum Applicable Policy Adjustor]
Plus
Outlier Payment
Plus
Trauma Add-On
Plus
Automatic Rate Enhancement

The Hospital Base Rate is the same for all hospitals including the stand-alone specialty children's hospitals. Similarly, the APR-DRG classification logic and associated assignment of DRG Relative Weight is the same for all hospitals. The DRG relative weights are based on the relative costs of services provided in a hospital inpatient setting as calculated using a very large dataset including inpatient claims from across the United States. The relative weights adjust payment upward for more complex and costly care and adjust payment downward for less complex and less costly care. Thus, base DRG pricing without any adjustors will result in higher payment per admission to hospitals that care for more medically complex patients. Whether or not this payment is sufficient to cover hospital costs depends on the hospital's cost structure and on the DRG base rate assigned by the payer.

In order to improve cost coverage for specific categories of hospitals and specific services, Florida Medicaid employs Policy Adjustors which are numerical multipliers that increase

[13] APR-DRGs are a product of 3M™ Health Information Systems. All copyrights in and to the APR-DRG classification system are owned by 3M. All rights reserved.

payment.[14] Different types of Policy Adjustors are employed by Florida Medicaid, one of which, referred to as the "High Medicaid Utilization and High Outlier" adjustor is applied to all inpatient payments for services provided at Johns Hopkins All Children's Hospital, Nemours Children's Hospital, and Nicklaus Children's Hospital. In SFY 2018/19, the value for "High Medicaid Utilization and High Outlier" adjustor was 2.370.[15] Thus, all "standard" DRG payments are more than doubled through this adjustor. Wolfson Children's Hospital did not meet the qualifications for this adjustor. However, there is another policy adjustor referred to as a "Pediatric Adjustor" that has multiple values and is applied to admissions for recipients whose age at admission is less than 21. The Pediatric Adjustor values are based on the patient's "Severity of Illness" (SOI) as defined through the APR-DRG classification system. Within this classification system, there are four severity of illness values and their associated "Pediatric Adjustor" values for SFY 2018/19 are shown below:

Severity of Illness	Pediatric Adjustor
1	1.00
2	1.52
3	1.80
4	2.00

Thus, payment for many of the admissions at Wolfson Children's Hospital are also receiving a payment increase through a policy adjustor. Figure 5 below documents the percentage of claims for this hospital in our CY 2017 dataset that receive a policy adjustor.

Figure 5 – Percentage of Wolfson Children's Hospital inpatient claims receiving a DRG policy adjustor

Severity of Illness	Policy Adjustor Applied	Percentage of Inpatient Claims for Wolfson Children's Hospital[1]
1	1.00	39%
2	1.52	35%
3	1.80	19%
4	2.00	7%

Note(s):

1) An estimate was made to identify claims at Wolfson Children's Hospital because Wolfson was still part of Baptist Medical Center Jacksonville in calendar year 2017.

The Florida Medicaid DRG outlier payment policy is the same for all hospitals including the stand-alone specialty children's hospitals. This policy pays a percentage of hospital cost on unusually expensive inpatient stays. The outlier calculation formula used by AHCA is:

[14] Florida Medicaid currently only uses policy adjustors greater than 1.0, which increase payment. In theory, policy adjustors could be set less than one, resulting in a decrease in payment.

[15] For SFY 2019/20, the High Medicaid Utilization and High Outlier policy adjustor reduced to 2.020 because of increases in the relative weights particular to neonate DRGs in APR-DRG version 36.

DRG Outlier Payment = the greater of, $0 and
[(Hospital Cost) – (Fixed Loss Threshold) – (DRG Base Payment)]
* (Marginal Cost Factor)

Estimated hospital cost for an inpatient stay must be at least $60,000 (referred to as "Fixed Loss Threshold" in the formula above) greater than the standard DRG payment (referred to as "DRG Base Payment" in the formula above) for an outlier payment to be applied. If this threshold is met on an individual admission, then the outlier payment is calculated as 60% of hospital cost above the threshold for DRG SOI values of 1 and 2 and 80% of hospital cost above the threshold[16] for more medically complex cases in which the DRG SOI value is 3 or 4. The 60% and 80% values are the "Marginal Cost Factors" in the formula above.

An outlier policy is beneficial because the cost of care for individual admissions varies even within APR-DRG categories. As a result, standard DRG payment may not be sufficient for extremely expensive cases. An outlier policy allows for the payer (in this case Florida Medicaid) to share in some of the cost incurred by the hospital for those extreme cases. However, because outlier payments are cost based, they create an incentive for hospitals to report very high costs, and this is an incentive most healthcare payers in the United States are trying to avoid. The fixed loss threshold of $60,000 and the marginal cost percentage of 60% and 80% mentioned in the previous paragraph help keep the percentage of total inpatient claim payments coming through outliers relatively low. The values for these parameters are selected to reach a balance between the fairness of the payer sharing in the cost of extreme cases, which will help ensure access to care, and the desire to avoid cost-based reimbursement for high cost cases.

An outlier policy is particularly important to hospitals that treat patients with complex medical conditions because unusually high cost of care occurs most often with these patients. Teaching hospitals, tertiary care hospitals and specialty children's hospitals are facilities that tend to treat higher percentages of patients with complex medical conditions and, as a result, receive a significant portion of their Medicaid claim payment through outliers. The percentage of Medicaid inpatient payment made through outliers for the four Florida stand-alone specialty children's hospitals is shown in the table below. Even with the policy adjustors mentioned above, all four facilities receive approximately one-fifth of their claim payments through the outlier policy. Across all hospitals in Florida, many of which do not receive a policy adjustor, the average percentage of claim payments paid through the outlier policy is 12%.

Figure 6 – Percentage of inpatient claim payment made through the outlier policy

Hospital	Percentage of Payment from Outliers Excluding Automatic Rate Enhancements and Trauma[1]	Percentage of Payment from Outliers Versus Total Claim Payment[2]
Johns Hopkins All Children's Hospital	31%	25%
Nemours Children's Hospital	31%	27%
Nicklaus Children's Hospital	29%	23%
Wolfson Children's Hospital	25%	25%

[16] No outlier is paid on the initial $60,000 in loss.

Hospital	Percentage of Payment from Outliers Excluding Automatic Rate Enhancements and Trauma[1]	Percentage of Payment from Outliers Versus Total Claim Payment[2]
Stand-Alone Specialty Children's Hosp Avg	**30%**	**24%**
Statewide Average	**14%**	**12%**

Note(s):

2) These percentages are calculated by dividing outlier payment by the sum of [(DRG Base Payment) plus (Outlier Payment)]. Automatic rate enhancements and trauma add-on payments are excluded because they do not affect outlier calculations. This is the calculation method used in annual rate setting documentation.

3) These percentages are calculated by dividing outlier payment by *total claim payment* which equals [(DRG Base Payment) plus (Outlier Payment) plus (Automatic Rate Enhancements) plus (Trauma Add-On Payment)].

The Trauma Add-On is calculated as [(DRG Base Payment) times (Trauma Add-On Percentage)]. The Trauma Add-On Percentage applied to stand-alone specialty children's hospitals equals four (4) percent and is applied to hospitals that qualify as Pediatric Trauma facilities under the definition documented in sections 395.4001 and 395.4025 (14) of the Florida Statutes. In SFY 2018/19 (as well as SFY 2019/20), Johns Hopkins All Children's Hospital and Nicklaus Children's Hospital qualified for the Pediatric Trauma Add-On payment. In SFY 2019/20, Wolfson Children's Hospital also qualified for the Pediatric Trauma Add-On payment. Nemours is not designated as a pediatric trauma facility.

Automatic Rate Enhancements (AREs) were for several years funded through Inter-Governmental Transfers (IGTs) and distribution was heavily tied to hospitals relative to the governmental entity that contributed the IGTs. However, since SFY 2015/16, AREs have been funded through state general revenue. Also, in recent years, the legislature has reduced funding and, thus, payment of AREs has decreased. A significant reduction was applied in SFY 2017/18, a smaller reduction in SFY 2018/19, and a shift of three (3) percent of AREs into funds available for the DRG base and EARG rates and policy adjustors was made in SFY 2019/20. Total hospital AREs in recent years are summarized below in Figure 7.

Figure 7 – Total computable hospital automatic rate enhancement amounts by year

SFY	Inpatient	Outpatient	Total
13/14	$666,805,513	$130,249,425	$800,803,211
14/15	$666,508,483	$130,546,454	$800,803,211
15/16	$683,678,370	$133,997,698	$817,676,068
16/17	$683,678,369	$133,997,698	$817,693,422
17/18	$338,482,743	$66,605,381	$405,088,124
18/19	$265,765,413	$53,452,835	$319,218,248
19/20	$257,792,451	$51,849,250	$309,641,701

Note(s):

1) Numbers in this table do not include self-funded IGTs which were distributed with claim payments in SFY 2013/14, distributed through LIP in SFY 2014/15, and no longer used from SFY 2015/16 through current day.

Even though the source of the state share of AREs shifted to state general revenue starting in SFY 2015/16, allocation of AREs to individual hospitals remained the same for two years – through SFY 2016/17. With the relatively large ARE reduction in SFY 2017/18, allocation of AREs to individual hospitals was adjusted as follows:

- Tier 1 Paid at 70.27% of SFY 2016/17 value. Qualifications for Tier 1 were:
  - Medicaid utilization between 50%-90%, OR
  - Hospitals with greater than 105,000 Medicaid days and a Public hospital

- Tier 2 Paid at 58.77% of SFY 2016/17 value. Qualifications for Tier 2 were:
  - Medicaid Utilization between 32% and 49% OR
  - Medicaid Utilization between 25% and 49% AND Statutory Teaching and/or Public hospital

- Tier 3 Paid at 9.0% of SFY 2016/17 value. Qualifications for Tier 3 were:
  - Medicaid utilization between 25% and 32%, AND
  - Not in Tier 1 or Tier 2

- Tier 4 Paid at 0% of SFY 2016/17 value. Qualifications for Tier 4 were:
  - Not in Tier 1, 2, or 3

Figure 8 below documents how ARE payments have changed for the four stand-alone specialty children's hospitals from the year with the highest ARE budget to the report year, SFY 2018/19.

Figure 8 – Automatic Rate Enhancement allocation in highest year versus report year

Hospital	SFY 2016/17 ARE Allotment[1]	SFY 2018/19 ARE Allotment[1]	SFY 2018/19 ARE Tier
Johns Hopkins All Children's Hospital	$37,729,932	$26,515,195	1
Nemours Children's Hospital	$9,128,686	$7,458,025	1
Nicklaus Children's Hospital	$48,734,868	$34,246,790	1
Wolfson Children's Hospital[2]	$0	$0	N/A
Total for Stand Alone Children's Hospitals	**$95,597,997**	**$68,220,010**	
Total for All Hospitals	**$817,693,422**	**$319,218,248**	

Note(s):
1) Numbers in this table are the sum of inpatient and outpatient Automatic Rate Enhancements
2) Wolfson Children's Hospital was licensed as part of Baptist Medical Center Jacksonville until March of 2018 and neither Wolfson nor Baptist Medical Center Jacksonville received any AREs in SFY 2018/19.

A discussion of the inequities in current ARE disbursement between the four stand-alone specialty children's hospitals is included in sections 4.3 and 4.5.1.

3.2.1.2 Hospital Outpatient Claim Payment Formula

Florida Medicaid calculation of claim payment for hospital outpatient services changed recently. Through June 30, 2017, payments were determined using hospital-specific cost-based rates. Starting July 1, 2017, payments have been calculated using the Enhanced Ambulatory Patient Grouping (EAPG)[17] classification system. With the Florida Medicaid implementation of EAPG pricing, the calculation of payment for an individual service line on an outpatient claim is,

> [Hospital EAPG Base Rate] * [EAPG Relative Weight] * [EAPG Discounting/Bundling Factor] * [Provider Policy Adjustor]
> Plus
> Automatic Rate Enhancement

The Hospital EAPG Base Rate is the same for all hospitals including the stand-alone specialty children's hospitals. Similarly, the EAPG classification logic and associated assignment of EAPG Relative Weight and EAPG Discounting/Bundling Factor is the same for all hospitals. A Provider Policy Adjustor is applied for two categories of hospitals, High Medicaid Utilization Hospitals and Rural Hospitals. Since the inception of EAPG pricing, all stand-alone specialty children's hospitals have qualified for the EAPG High Medicaid Utilization hospital policy adjustor. In SFY 2018/19, this value was 1.9343, which means all outpatient payments to the stand-alone specialty children's hospitals were nearly doubled compared to hospitals that did not qualify for a policy adjustor.

Outpatient AREs are paid to Johns Hopkins All Children's Hospital, Nemours Children's Hospital, and Nicklaus Children's Hospital and have reduced in amount in recent years as described in the Inpatient Claim Payment section above. A discussion of the inequities in current ARE disbursement between the four stand-alone specialty children's hospitals is included in sections 4.3 and 4.5.1.

3.2.2 Claim Payments in Medicaid Managed Care

AHCA does not mandate how Medicaid managed care plans pay for hospital services, and the plans negotiate proprietary rates with individually contracted hospitals. As a result, we cannot provide the same level of detail about individual claim payments made by managed care plans. However, most managed care plans pay hospitals based on a percentage of Medicaid fee-for-service reimbursement.

3.2.3 Supplemental Payments Distributed through the DSH Program

The funds available in individual state Medicaid Disproportionate Share Hospital (DSH) programs have been capped by the federal government for many years based on DSH expenditure levels in 1992. Florida's Medicaid DSH allotment is unusually small on a per capita basis in comparison to many other state Medicaid programs. Figure 9 below shows a comparison of federal DSH allotments for several states with Medicaid programs of similar size to Florida and of states geographically near Florida.

[17] EAPGs are a product of 3M™ Health Information Systems. All copyrights in and to the EAPG classification system are owned by 3M. All rights reserved.

Figure 9 – Comparison of federal Medicaid DSH allotment for select states

State	Population[1] July, 2018	Medicaid Enrollment[2, 3] July, 2019	Federal Total DSH Allotment[4, 5, 6]	DSH Allotment per Capita	DSH Allotment per Medicaid Beneficiary
Florida	21,299,325	4,168,312	$230,193,053	$10.81	$55.20
Illinois	12,741,080	2,799,188	$247,457,531	$19.42	$89.14
California	39,557,045	11,625,691	$1,261,745,666	$31.90	$107.59
Georgia	10,519,475	1,808,764	$309,321,914	$29.40	$172.04
Pennsylvania	12,807,060	2,936,664	$645,979,253	$50.44	$218.99
Texas	28,701,845	4,178,332	$1,100,610,532	$38.35	$262.04
New York	19,542,209	6,502,376	$1,848,737,951	$94.60	$283.99
Alabama	4,887,871	918,024	$353,921,819	$72.41	$390.80

Note(s):

1) Source: https://www.census.gov/quickfacts/fact/map/US/PST045218
2) Source: https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html, downloaded October 23, 2019.
3) Medicaid enrollment includes both Medicaid and CHIP populations
4) Source: https://www.govinfo.gov/content/pkg/FR-2019-02-11/pdf/2019-01928.pdf
5) Values include only the federal share, not the state share
6) Federal DSH allotments are labelled as "preliminary 2019" values in this version of the Federal Register

As shown in Figure 9 above, the preliminary federal Medicaid DSH allotment for Florida for federal fiscal year 2019 was just over $230 million.[18] Including the state share, the total computable size of the Florida Medicaid DSH program was just under $378 million in SFY 2018/19.[19]

Many state Medicaid agencies define various hospital types and target DSH payments based on hospital type. Florida targets DSH payments and applies separate DSH calculation formulas for the following categories of hospitals:

- Non-state government owned
- Teaching hospitals
- Provider Service Network (PSN) Hospitals
- Rural hospitals
- Mental health services (applies to multiple hospital categories)
- Non-children's specialty hospitals
- Children's specialty hospitals[20]

[18] Federal Register, February 11, 2019 (Vol. 84 No. 28), pp. 3177
[19] $124 million of these funds came from Certified Public Expenditures.
[20] Florida Medicaid State Plan Attachment 4.19-A Section VI - Disproportionate Share Hospital (DSH) Reimbursement Methods; effective July 1, 2018.

To qualify for the specialty children's hospital DSH allocation, a hospital must be licensed as a specialty hospital for children, have a federal CMS certification number in the 3300-3399 range, have Medicaid days that exceed 55% of total days, and Medicare days that are less than 5% of total days.[21] Florida uses the following formula to calculate DSH payments to children's hospitals: [22]

$$DSH\ Pymt = Total\ Amount\ Earned + Total\ Additional\ Payment$$

Unlike Florida DSH payments for non-children's hospitals, DSH payments for specialty children's hospitals are not solely based on a comparison of hospital Medicaid days to total state Medicaid days. Instead, Florida uses the Base Medicaid Per Diem rate, Medicaid days, and "Disproportionate Share Rate" to calculate a value referred to as the Total Amount Earned (TAE). The TAE is calculated as:

$$TAE = Disproportionate\ Share\ Rate\ x\ Base\ Medicaid\ Per\ Diem\ x\ Medicaid\ Days$$

Disproportionate Share Rate (DSR) is calculated using the following formula:[23]

$$DSR = \left(\left(\frac{Charity\ Care\ Days}{Adjusted\ Patient\ Days}\right) x\ 4.5\right) + \frac{Medicaid\ Days}{Adjusted\ Patient\ Days}$$

"Adjusted Patient Days" means the sum of acute care patient days and intensive care patient days as reported to AHCA, divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues.[24]

Under state law, children's hospitals in Florida receive DSH payments in addition to Total Amount Earned. Additional payments are calculated using the following formula:[25]

$$Total\ Additional\ Payment = \frac{(Total\ Amount\ Earned\ \ x\ Total\ Appropriation)}{Sum\ of\ Total\ Amount\ Earned}$$

Where:

- "Total Appropriation" is equal to the total appropriation for the specialty hospital for children DSH program, and
- "Sum of Total Amount Earned" is equal to the sum of total amount earned by each hospital that participates in the specialty hospital for children DSH program.

[21] http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0409/Sections/0409.9119.html

[22] Florida Medicaid State Plan Attachment 4.19-A Section VI - Disproportionate Share Hospital (DSH) Reimbursement Methods; effective July 1, 2018.

[23] http://www.leg.state.fl.us/statutes/index.cfm?App_Mode=Display_Statute&Search_String=&URL=Ch0409/Sec911.htm&StatuteYear=2002

[24] Ibid.

[25] Florida Medicaid State Plan Attachment 4.19-A Section VI - Disproportionate Share Hospital (DSH) Reimbursement Methods; effective July 1, 2018.

The DSH payments to the individual stand-alone specialty children's hospitals in Florida in SFY 2018/19 are shown in Figure 10 below.[26]

Figure 10 – Annual DSH allocation in SFY 2018/19 for the stand-alone specialty children's hospitals

Hospital	SFY 2018/19 DSH Allocation
Johns Hopkins All Children's Hospital	$10,639,444
Nemours Children's Hospital	$1,647,379
Nicklaus Children's Hospital	$4,475,512
Wolfson Children's Hospital[1]	$0

Note(s):
1) Neither Wolfson Children's Hospital, whose license became effective in March of 2018, nor Baptist Medical Center Jacksonville, under whose license Wolfson Children's Hospital operated prior to March of 2018 received any DSH funds in SFY 2018/19.

3.2.4 Supplemental Payments Distributed through the Low Income Pool

The Low Income Pool (LIP) is a supplemental payment program authorized through an 1115 Demonstration Waiver. The LIP provides government support for safety net providers for the costs of uncompensated charity care for low-income individuals who are uninsured. Uncompensated care (UC) includes charity care for the uninsured but does not include UC for insured individuals, "bad debt," or Medicaid and CHIP shortfall.[27] After being steady for many years, the total size of the LIP has gone up and down in recent years as shown in Figure 11 below.

Figure 11 – Size of LIP Over the Life of the Program

Demonstration Year(s)	Total Computable Size of LIP
1 – 8 (SFY 06/07 – SFY 13/14)	$1 billion
9 (SFY 14/15)	$2.2 billion
10 (SFY 15/16)	$1 billion
11 (SFY 16/17)	$608 million
12 – 16 (SFY 17/18 – SFY 21/22)	$1.5 billion

Although the maximum size of the LIP program increased to $1.5 billion in SFY 2017/18 and for the following four years that encompass the current 1115 Waiver period, funding of the state

[26] Nemours was given an exception by the Florida Legislature to receive funds through the DSH program in SFY 2017/18 and by SFY 2018/19, Nemours had enough historical data (a minimum of 3 years required) to be included in the normal calculations with all other DSH hospitals.
[27] Florida Medicaid 1115 Demonstration Waiver Special Terms and Conditions, approved June 8, 2018; CMS Document number 11-W-00206/4; page 4 of 69.

share of the program was not sufficient in SFY 2018/19 to utilize the entire program. Funding of the state share of LIP comes from IGTs and $336 million was collected in IGTs in SFY 2018/19 resulting in the total size of the LIP program being $858 million.

In addition, the allocation method for LIP payments as defined in the waiver Special Terms and Conditions (STCs) changed significantly in SFY 2017/18. Under the new STCs, the maximum an individual hospital can be paid through LIP is set at the hospital's total annual cost of charity care for the uninsured that is furnished through a charity care program and that adheres to the principles of the Healthcare Financial Management Association (HFMA) operated by the provider.[28] Applicable charity care is care provided to the uninsured, and does not include uncompensated care for insured individuals, "bad debt", or Medicaid and CHIP shortfall. In addition, for purposes of allocating LIP funds, acute care hospitals are categorized into one of five tiers based on ownership type and their Uncompensated Care (UC) Ratio. For this categorization, the UC Ratio is calculated as a provider's uncompensated, uninsured charity care costs divided by the provider's privately insured patient care costs. The five LIP hospital tiers defined in SFY 2018/19 are shown in Figure 12 below.

Figure 12 – Hospital tiers and charity care coverage through LIP in SFY 2018/19

Hospital Tier Number	Tier Criteria	Percentage of Charity Care Cost Reimbursed Through LIP
1	Private Hospitals with a UC Ratio greater than or equal to 17%	9.33%
2	All Public Hospitals, All Children's Hospitals, and Statutory Teaching Hospitals with a UC Ratio greater than or equal to 17%	100%
3	Statutory Teaching Hospitals with UC Ratio less than 17%	63.64%
4	Regional Perinatal Intensive Care Centers (non-Public and non-Statutory Teaching)	100%
5	Private Hospitals with a UC Ratio less than 17%	1.00%

The stand-alone specialty children's hospitals are categorized in Tier 2 and their SFY 2018/19 LIP allocations are shown Figure 13 below.

Figure 13 – SFY 2018/19 allocation of LIP funds to stand-alone specialty children's hospitals

Hospital	SFY 2018/19 LIP Allocation
Johns Hopkins All Children's Hospital	$2,558,326
Nemours Children's Hospital	$505,481
Nicklaus Children's Hospital	$123,846
Wolfson Children's Hospital[1]	$140,593
Note(s): 1) In SFY 2018/19, no LIP allocation was made separately for Wolfson Children's Hospital. The number shown above is our estimate of the portion	

[28] Florida Medicaid 1115 Demonstration Waiver Special Terms and Conditions, approved June 8, 2018; CMS Document number 11-W-00206/4; page 30 of 69.

Hospital	SFY 2018/19 LIP Allocation
of the LIP payment to Baptist Medical Center Jacksonville that applies to Wolfson. Note, Baptist Medical Center Jacksonville was categorized as Tier 5, so they were reimbursed 1.00% of their charity care cost.	

3.2.5 Supplemental Payments Distributed through the Graduate Medical Education Program

As directed under section 409.909 of the Florida Statutes, AHCA provides supplemental payments to hospitals and "Federally Qualified Health Centers holding an Accreditation Council for Graduate Medical Education institutional accreditation" that provide training to interns and residents. The total size of the Florida Medicaid GME pool is $242 million, however $145 million of that is dependent on the state receiving funding for the non-federal share through IGTs.

The GME payment amounts for SFY 2018/19 for the Florida stand-alone specialty children's hospitals are shown in Figure 14 below.

Figure 14 – SFY 2018/19 Graduate Medical Education supplemental payments

Hospital	SFY 2018/19 GME Allocation
Johns Hopkins All Children's Hospital	$1,639,774
Nemours Children's Hospital	$0
Nicklaus Children's Hospital	$3,154,295
Wolfson Children's Hospital[1]	$390,553

Note(s):

1) In SFY 2018/19, no GME allocation was made separately for Wolfson Children's Hospital. The number shown above is our estimate of the portion of the GME payment to Baptist Medical Center Jacksonville that applies to Wolfson.

3.3 Conclusion

The Florida Legislature has historically put a priority on reimbursing stand-alone specialty children's hospitals as evidenced by the DRG and EAPG policy adjustors for which only stand-alone specialty children's hospitals have qualified. In addition, a separate calculation method is used to allocate DSH funds to stand-alone specialty children's hospitals. With the addition of new stand-alone specialty children's hospitals, specifically Nemours and Wolfson, AHCA and the Florida Legislature must determine whether or not it is the intent of Medicaid policy to make reimbursement methods the same for all hospitals in this category. If the answer to this question is yes, then future year allocations need to increase disbursements to Nemours and Wolfson for AREs and possibly the inpatient policy adjustor. Funds to support these increased

payments could come from “new money” made available to the Medicaid program.[29] In theory, the state share for additional Medicaid dollars (i.e. “new money”) could come from increased inter-governmental transfers. However, this is an unlikely option given the fact that the stand-alone children’s hospitals are not publicly owned. Instead, “new money” options are limited to reallocation of limited State funds or an increase in the hospital provider assessment, which would impact all hospitals in Florida. If, on the other hand, additional reimbursement is provided to stand-alone specialty children’s hospitals without additional Medicaid funding, then payments to the other stand-alone children’s hospitals and/or payments to all non-children’s hospitals would need to be reduced.

In addition, LIP and DSH allocations to Wolfson Children’s Hospital will likely increase in the future when more data separately reported for Wolfson Children’s Hospital and Baptist Medical Center Jacksonville is provided to AHCA. Specifically for the LIP program, Florida Hospital Uniform Reporting System (FHURS) data will need to be reported for Wolfson Children’s Hospital separate of Baptist Medical Center Jacksonville before Wolfson Children’s Hospital will be treated as a Tier 2 facility in the LIP program. Similarly, for the DSH program, Disproportionate Share Review (DSR) data will need to be reported for Wolfson Children’s Hospital separate of Baptist Medical Center Jacksonville for the most recent 3 years before Wolfson will receive DSH payments like other Florida stand-alone specialty children’s hospitals. DSH is a fixed amount for Florida, so additional money attributed to Wolfson would result in a reduction of DSH to other hospitals.

[29] Shriners Hospital for Children in Tampa received $359,452 in Automatic Rate Enhancements in SFY 2019/20 that could be made available to other stand-alone specialty children’s hospitals now that Shriners is no longer licensed as an acute care facility.

4 Medicaid Reimbursement Comparisons for Specialty Children's Hospitals in Florida

4.1 Medicaid Budget Targets

4.1.1 Hospital Inpatient Budget Target

The process of determining the DRG Base Rate and the inpatient High Medicaid Utilization and High Outlier Policy Adjustor for a state fiscal year involves assigning a budget target to a set of historical hospital inpatient claims and then solving for numerical values for the Base Rate and Policy Adjustor that distribute the budgeted amount of money across the historical claims. Separate budget targets are identified for different categories of hospitals. These separate budget targets maintain relative historical funding levels regardless of different levels of cost increases between the groups.

A budget target for the "All Other" hospital category, which includes all hospitals that do not receive a provider policy adjustor, is used to determine the DRG Base Rate. Using this Base Rate and the budget goal for the hospitals in the High Medicaid Utilization and High Outlier category, the High Medicaid Utilization and High Outlier policy adjustor is calculated. To qualify for the High Medicaid Utilization and High Outlier policy adjustor, a hospital must have at least 50% inpatient utilization from Medicaid recipients and at least 30% of DRG payment through outliers before the policy adjustor is applied.[30] Since implementing DRG pricing in SFY 2013/14, only Johns Hopkins All Children's Hospital, Nemours Children's Hospital, and Nicklaus Children's Hospital have met this criteria. Thus, a separate budget target is set for these three hospitals and the High Medicaid Utilization and High Outlier policy adjustor is calculated annually to meet that target.

When DRG pricing was first implemented in SFY 2013/14, the Florida Legislature requested that the budget target for the hospitals qualifying for the High Medicaid Utilization and High Outlier policy adjustor be 100% of hospital cost.[31] In most subsequent years, the budget goal has been set to be budget neutral for these three hospitals in terms of DRG payments. The exceptions were SFY 2017/18, in which $24.5 million was added to the budget for DRG payment for these facilities, and in SFY 2018/19, in which $6.7 million was reduced from the budget. In both years, the budget adjustment was applied through the High Medicaid Utilization and High Outlier policy adjustor. The DRG payment increase in SFY 2017/18 for hospitals qualifying for the High Medicaid Utilization and High Outlier policy adjustor coincided with a relatively significant decrease in funding for Automatic Rate Enhancements. A historical view of the budget target for hospitals qualifying for the High Medicaid Utilization and High Outlier policy adjustor is shown in Figure 15 below.

[30] Application of a policy adjustor reduces the amount of money paid through outliers.
[31] When calculating DRG rates for SFY 2013/14 and 2014/15, there were no historical claims available from Nemours Children's Hospital, so the budget target and High Medicaid Utilization and High Outlier policy adjustor, were based on claims from only Johns Hopkins All Children's Hospital and Nicklaus Children's Hospital.

Figure 15 – Historical budget goals for inpatient payments to hospitals qualifying for the High Medicaid Utilization and High Outlier policy adjustor

Rate Setting SFY	Inpatient Admits	Budget Goal for DRG Payment	Automatic Rate Enh.	Self-Funded IGT Rate Enh.	Total Budget Goal Total	Budget Goal Per Admit	Budget Change from Previous Year
2013/14	9,229	$141,109,669	$64,385,789	$18,261,269	$223,756,727	$24,245	Goal was 100% of cost
2014/15	9,210	$166,614,989	$73,514,475	$0	$240,129,464	$26,073	2% inflationary increase
2015/16	11,402	$202,966,990	$75,372,903	$0	$278,339,893	$24,411	2% inflationary increase Trauma add-on payment created
2016/17	12,425	$218,561,234	$75,372,903	$0	$293,934,137	$23,657	2% inflationary increase
2017/18	12,424	$285,075,506	$56,866,861	$0	$341,942,367	$27,523	$24,548,530 increase for DRG pymts ARE decrease
2018/19	10,942	$247,916,488	$52,967,708	$0	$300,884,196	$27,498	$6,710,995 decrease for DRG pymts ARE decrease
2019/20	12,443	$289,288,733	$51,378,677	$0	$340,667,410	$27,378	3% of ARE moved to DRG pymts

Note(s):

1) Numbers in this table are from rate setting analyses performed using historical data prior to the start of each state fiscal year. Thus, these numbers are projections, not depictions of actual results.
2) In SFY 2013/14, Automatic and self-funded IGTs were not finalized until after DRG rates had been set. The final SFY 2013/14 IGT values were higher than anticipated and resulted in total estimated payment being higher than 100% of hospital cost.
3) Automatic Rate Enhancements for Nemours were added in SFY 2014/15.
4) Inpatient services provided by Wolfson Children's Hospital are not included in this table because Wolfson does not qualify for the inpatient High Medicaid Utilization and High Outlier policy adjustor.

As mentioned previously, the budget goal for SFY 2013/14 was 100% of hospital cost. In subsequent years, hospital cost has increased faster than increases in the budget resulting in a decrease in estimated cost coverage for hospitals that qualify for the High Medicaid Utilization and High Outlier policy adjustor. A comparison of the annual budget goal to estimated hospital cost is provided in Figure 16 below.

Figure 16 – Estimated cost coverage over time for inpatient payments to hospitals qualifying for the High Medicaid Utilization and High Outlier policy adjustor

Rate Setting SFY	Inpatient Admits	Total Budget Goal Total	Estimated Hospital Cost	Cost Per Admit	Estimated Cost Coverage
2013/14	9,229	$223,756,727	$190,763,390	$20,670	117%
2014/15	9,210	$240,129,464	$238,871,061	$25,936	101%
2015/16	11,402	$278,339,893	$277,024,511	$24,296	100%
2016/17	12,425	$293,934,137	$302,760,157	$24,367	97%
2017/18	12,424	$341,942,367	$403,494,027	$32,477	85%
2018/19	10,942	$300,884,196	$349,241,478	$31,918	86%
2019/20	12,443	$340,667,410	$403,001,758	$32,388	85%

Note(s):

1) Numbers in this table are from rate setting analyses performed using historical data prior to the start of each state fiscal year. Thus, these numbers are projections, not depictions of actual results.

Rate Setting SFY	Inpatient Admits	Total Budget Goal Total	Estimated Hospital Cost	Cost Per Admit	Estimated Cost Coverage
2) In SFY 2013/14, Automatic and self-funded IGTs were not finalized until after DRG rates had been set. The final SFY 2013/14 IGT values were higher than anticipated and resulted in total estimated payment being higher than 100% of hospital cost.					

Although cost coverage for the stand-alone specialty children's hospitals has decreased to approximately 86% in SFY 2018/19, this value is still well above the state-wide average cost coverage from Medicaid inpatient claim payments in the same year, which is estimated to be 62%.

4.1.2 Hospital Outpatient Budget Target

Since EAPG pricing was implemented for Medicaid fee-for-service claims on July 1, 2017, the process for calculating the EAPG Base Rate and High Medicaid Utilization provider policy adjustor has been very similar to the process used for inpatient DRG rate setting. That is, a budget target is determined for a set of historical hospital outpatient claims and then an algorithm is run to solve for numerical values for the EAPG Base Rate and Policy Adjustor that distribute the budgeted amount of money across the historical claims.

First, a budget target for the "All Other" hospital category, which includes all hospitals that do not receive a provider policy adjustor, is used to determine the EAPG Base Rate. Using this Base Rate and the budget goal for the hospitals in the outpatient High Medicaid Utilization category, the High Medicaid Utilization policy adjustor is calculated. To qualify for the High Medicaid Utilization outpatient policy adjustor, a hospital must have at least 55% of their outpatient utilization from Medicaid beneficiaries. All four stand-alone specialty children's hospitals in Florida qualify for the outpatient High Medicaid Utilization adjustor.[32] Thus, a budget target is set for these four hospitals and the High Medicaid Utilization policy adjustor is calculated annually to meet that target.

In the first year of EAPG pricing, hospital-specific base rates were calculated with an intent of limiting changes in payment for individual hospitals to be within 5% from the conversion from hospital-specific cost-based rates to reimbursement based on EAPG categories. The 5% cap on gains and losses applied only for SFY 2017/18. In year two of EAPG pricing, SFY 2018/19, the budget target for hospitals qualifying for the outpatient High Medicaid Utilization adjustor was budget neutrality. That is, the budget target was set to the amount of money the historical claims, in aggregate for the qualifying hospitals, would have been paid by Medicaid fee-for-service under the pre-EAPG payment method. This same budget target methodology was used for EAPG rates and policy adjustors calculated for SFY 2019/20.

To determine what would have been paid by fee-for-service pre-EAPG, historical claims were priced under SFY 2016/17 rates, which was the last year before EAPG pricing was implemented, and then an average payment per outpatient visit was calculated for each

[32] The first year this adjustor has applied to Wolfson Children's Hospital is SFY 2019/20.

hospital. The average Medicaid payment per outpatient visit by hospital using SFY 2016/17 rates is shown in Figure 17 below.

Figure 17 – Average SFY 2016/17 payment per outpatient visit for hospitals qualifying for the outpatient EAPG High Medicaid Utilization adjustor

Hospital	Avg Pymt Per OP Visit from SFY 2016/17 Rates Excluding AREs
Johns Hopkins All Children's Hospital	$405.20
Nemours Children's Hospital	$634.17
Nicklaus Children's Hospital	$342.81
Shriners Hospital for Children	$615.60

Note(s):

1) At the time of SFY 2018/19 rate setting, Wolfson Children's Hospital was not recognized as a stand-alone specialty children's hospital so no claims from Wolfson Children's Hospital were included in the calculation of average payment per outpatient visit for SFY 2018/19 rate setting.
2) Also at the time of SFY 2018/19 rate setting, Shriners Hospital for Children qualified for the adjustor.

After removing a small amount of money that was shifted from claim payments to supplemental Graduate Medical Education payments with the move to EAPG pricing, the weighted average historical payment per outpatient visit was determined to be $405.59. Thus, with a goal of budget neutrality for implementation of EAPGs, the outpatient High Medicaid Utilization policy adjustor was calculated for SFY 2018/19 and SFY 2019/20 to meet a budget target of $405.59 per outpatient visit.

Cost coverage in SFY 2018/19 based on these rates is estimated to be 69% in aggregate for these four hospitals from EAPG payments. When adding in SFY 2018/19 Automatic Rate Enhancements, cost coverage in aggregate is estimated to be 77%. For comparison, statewide average Medicaid hospital outpatient cost coverage, including AREs, is estimated to be 53%.

4.2 Comparison of Hospital Cost at Florida Stand-Alone Specialty Children's Hospitals

In this section, we compare the cost of care for Medicaid beneficiaries at the four different stand-alone specialty children's hospitals in Florida. We anticipate these facilities having higher than average cost due to the facts that they treat many patients with complex medical conditions, they often provide care performed by specialists, and, in some cases, the care is performed using equipment specially designed for physically small patients. The assumption of higher than average hospital cost of care at stand-alone specialty children's hospitals proves true when reviewing hospital cost figures. The average cost per inpatient admission in SFY 2018/19 across the four Florida stand-alone specialty children's hospitals is $29,764 and the average cost per inpatient admission for all acute care hospitals in Florida is $9,270. The average cost per outpatient visit in SFY 2018/19 across the four Florida stand-alone specialty

children's hospitals is $539.16 and the average cost per outpatient visit for all acute care hospitals in Florida is $444.06.

In general, we assume medical care will be more costly for patients with more complex medical conditions. In addition, some hospitals see on average patients with more complex medical conditions than other hospitals. As a result, doing a direct compare of cost across hospitals is not necessarily a fair comparison. One way to make cost comparisons across hospitals more fair is to apply a case mix adjustment to the cost values. We do this by dividing each hospital's cost per admission by their case mix, where a higher case mix value indicates care for higher acuity patients.[33] For hospitals with case mix higher than 1.0, this calculation lowers their cost per admission and for hospitals with case mix lower than 1.0, this calculation increases their cost per admission. Comparing these case mix adjusted costs offers a more fair comparison across hospitals that provide different types of care. The combined case mix for the four Florida stand-alone specialty children's hospitals is 1.89, and the case mix adjusted average cost per inpatient admission is $15,844. For comparison, the case mix for all acute care hospitals in Florida is 1.04 and the case mix adjusted average cost per inpatient admission is $8,913. For outpatient visits, the case mix for the stand-alone specialty children's hospitals is 0.61, and the statewide average is 0.60. Case mix adjusted average cost per outpatient visit for the four Florida stand-alone specialty children's hospitals is $912.36 and for all acute care hospitals in Florida the average cost is $740.81.

A comparison of hospital inpatient cost of care for Medicaid beneficiaries at the four Florida stand-alone specialty children's hospitals is shown in Figure 18 below. When reviewing case mix adjusted average cost per admission, Nemours has the highest costs and Wolfson the lowest costs.

Figure 18 – Comparison of hospital inpatient cost for care of Medicaid beneficiaries at the Florida stand-alone specialty children's hospitals

Hospital	IP Claim Count	Inpatient Case Mix	Hospital Cost	Average Hospital Cost Per Admission	Case Mix Adjusted Avg Cost Per Admission
Johns Hopkins All Children's Hospital	4,307	2.38	$158,892,367	$36,892	$15,471
Nemours Children's Hospital	2,168	1.66	$72,482,264	$33,433	$20,111
Nicklaus Children's Hospital	5,968	1.61	$160,112,897	$26,829	$16,640
Wolfson Children's Hospital	2,191	1.88	$46,073,259	$21,028	$11,181
Total / Average for Stand-Alone Children's Hospitals	**14,634**	**1.89**	**$437,560,787**	**$29,900**	**$15,844**
Total / Average All Florida Hospitals	**514,759**	**1.04**	**$4,771,688,565**	**$9,270**	**$8,913**

[33] For inpatient services, case mix is calculated as average APR-DRG relative weight for all admissions at the hospital when using Florida re-centered APR-DRG relative weights. For outpatient services, case mix is measured by first calculating total case mix weight for each outpatient visit as the sum of [(EAPG relative weight) times (EAPG payment adjustment factor)] on all claim service lines and then calculating the average of these values across all outpatient visits at the hospital.

A similar comparison of hospital outpatient cost of care for Medicaid beneficiaries at the four Florida stand-alone specialty children's hospitals is shown in Figure 19 below. When reviewing case mix adjusted average cost per outpatient visit, Nemours Children's has the highest costs.

Figure 19 – Comparison of hospital outpatient cost for care of Medicaid beneficiaries at the Florida stand-alone specialty children's hospitals

Hospital	OP Visit Count	Outpatient Case Mix	Hospital Cost	Average Hospital Cost Per Visit	Case Mix Adjusted Avg Cost Per Visit
Johns Hopkins All Children's Hospital	146,530	0.62	$84,784,390	$579	$929
Nemours Children's Hospital	51,892	0.71	$55,171,489	$1,063	$1,501
Nicklaus Children's Hospital	259,943	0.52	$104,190,936	$401	$770
Wolfson Children's Hospital	8,733	2.25	$14,050,829	$1,609	$715
Total / Average for Stand-Alone Children's Hospitals	**467,098**	**0.61**	**$258,197,644**	**$553**	**$912**
Total / Average All Florida Hospitals	**4,827,419**	**0.60**	**$2,143,685,548**	**$444**	**$740**

4.3 Comparison of Medicaid Claim Payments to the Florida Stand-Alone Specialty Children's Hospitals

Hospital inpatient and outpatient Medicaid claim payments are shown in Figures 20 and 22, respectively, in this section.

4.3.1 Medicaid Inpatient Claim Payments

For inpatient payments, three hospitals, John's Hopkins All Children's, Nemours Children's and Nicklaus Children's, receive significantly higher average payment per admission than Wolfson Children's Hospital. This discrepancy is due to the fact that these three hospitals receive more in Automatic Rate Enhancements and they receive the DRG High Medicaid Utilization and High Outlier policy adjustor, for which Wolfson does not qualify.

Figure 20 – Comparison of Medicaid hospital inpatient claim payments to the Florida stand-alone specialty children's hospitals

Hospital[1]	Inpatient Admissions	Inpatient Case Mix	DRG Base Payment	DRG Outlier Payment	Inpatient Automatic Rate Enhancement	Total Claim Payment	Medicaid Claim Payment Per Admission	Case Mix Adjusted Pymt Per Admission
Johns Hopkins All Children's Hospital	4,307	2.38	$83,250,224	$37,832,718	$20,906,870	$141,989,812	$32,967	$13,825
Nemours Children's Hospital	2,168	1.66	$29,167,294	$13,271,207	$6,414,728	$48,853,228	$22,534	$13,555
Nicklaus Children's Hospital	5,968	1.61	$78,325,201	$31,425,323	$25,646,111	$135,396,636	$22,687	$14,071
Wolfson Children's Hospital[2]	2,170	1.89	$22,958,443	$7,724,649	$0	$30,683,092	$14,140	$7,500
Total / Average	**14,613**	**1.89**	**$213,701,162**	**$90,253,898**	**$52,967,709**	**$356,922,769**	**$24,425**	**$12,938**
Notes:								

Hospital[1]	Inpatient Admissions	Inpatient Case Mix	DRG Base Payment	DRG Outlier Payment	Inpatient Automatic Rate Enhancement	Total Claim Payment	Medicaid Claim Payment Per Admission	Case Mix Adjusted Pymt Per Admission

1) Numbers in this table include Medicaid fee-for-service and Medicaid managed care claims for dates of service in calendar year 2017 that have been repriced under SFY 2018/19 rates and rules.
2) Values for Wolfson Children's Hospital are our estimate of the portion of these amounts for Baptist Medical Center Jacksonville that apply to Wolfson.

Figure 21 below compares one component of inpatient claim payment in more detail, Automatic Rate Enhancements (AREs). Whether comparing unadjusted average ARE per admission or case mix adjusted average ARE per admission, the payments to Nemours Children's Hospital are noticeably lower than the payments to All Children's and Nicklaus Children's. In addition, Wolfson Children's does not receive any AREs. ARE distribution has been relatively fixed for several years, dating back prior to the inception of Nemours Children's Hospital and the licensing of Wolfson Children's Hospital as a stand-alone entity. As described in a prior section of the report, the only changes in ARE distribution recently have been uniform percentage decreases in annual allocations. Currently, the ARE distributions are determined by the Florida Legislature.

Section 4.5.1 later in this report offers suggestions of how the distribution of AREs to stand-alone children's hospitals could be updated to be more equitable either in a budget neutral manner or through new funding.

Figure 21 – Review of average ARE payment per admission

Hospital[1]	Inpatient Admissions	Inpatient Case Mix	Inpatient Automatic Rate Enhancement	Avg ARE Pymt Per Admission	Case Mix Adjusted Avg ARE Pymt Per Admission
Johns Hopkins All Children's Hospital	4,307	2.38	$20,906,870	$4,854	$2,040
Nemours Children's Hospital	2,168	1.66	$6,414,728	$2,959	$1,782
Nicklaus Children's Hospital	5,968	1.61	$25,646,111	$4,297	$2,669
Wolfson Children's Hospital[2]	2,170	1.89	$0	$0	$0
Total / Average	**14,613**	**1.89**	**$52,967,709**	**$3,625**	**$1,920**

Notes:
1) Numbers in this table include Medicaid fee-for-service and Medicaid managed care claims for dates of service in calendar year 2017 that have been repriced under SFY 2018/19 rates and rules.
2) Values for Wolfson Children's Hospital are our estimate of the portion of these amounts for Baptist Medical Center Jacksonville that apply to Wolfson.

4.3.2 Medicaid Outpatient Claim Payments

Medicaid hospital outpatient claim payments for the four Florida stand-alone specialty children's hospitals are shown in Figure 22 below. When considering case mix adjusted payment, Wolfson is receiving the lowest amount of the four hospitals.

Figure 22 – Comparison of Medicaid hospital outpatient claim payments to the Florida stand-alone specialty children's hospitals

Hospital[1]	Outpatient Visits	Outpatient Case Mix	Outpatient EAPG Payment	Outpatient Automatic Rate Enhancement	Total Claim Payment	Medicaid Claim Payment Per Visit	Case Mix Adjusted Pymt Per Visit
Johns Hopkins All Children's Hospital	146,530	0.62	$59,487,569	$5,608,325	$65,095,894	$444	$713
Nemours Children's Hospital	51,892	0.71	$23,955,615	$1,043,297	$24,998,912	$482	$680
Nicklaus Children's Hospital	259,943	0.52	$88,197,478	$8,600,679	$96,798,157	$372	$715
Wolfson Children's Hospital[2]	8,733	2.25	$12,827,602	$0	$12,827,602	$1,469	$652
Total / Average for Stand-Alone Children's Hospitals	**467,098**	**0.61**	**$184,468,264**	**$15,252,301**	**$199,720,565**	**$428**	**$706**
Total / Average All Florida Hospitals	**4,827,419**	**0.60**	**$1,084,007,543**	**$53,452,835**	**$1,136,373,684**	**$235**	**$392**

Notes:

1) Numbers in this table include Medicaid fee-for-service and Medicaid managed care claims for dates of service in calendar year 2017 that have been repriced under SFY 2018/19 rates and rules.
2) Values for Wolfson Children's Hospital are our estimate of the portion of these amounts for Baptist Medical Center Jacksonville that apply to Wolfson.

Figure 23 below compares one particular component of outpatient claim payment in more detail. The data shows that average ARE payment per outpatient visit is noticeably lower for Nemours. In addition, Wolfson, being newly licensed, is not yet receiving any ARE payments. Section 4.5.1 later in this report offers suggestions of how the distribution of AREs to stand-alone children's hospitals could be updated to be more equitable either in a budget neutral manner or through new funding.

Figure 23 – Review of average ARE payment per outpatient visit

Hospital[1]	Outpatient Visits	Outpatient Case Mix	Outpatient Automatic Rate Enhancement	Avg ARE Pymt Per Visit	Case Mix Adjusted Avg ARE Pymt Per Visit
Johns Hopkins All Children's Hospital	146,530	0.62	$5,608,325	$38.27	$61.73
Nemours Children's Hospital	51,892	0.71	$1,043,297	$20.11	$28.32
Nicklaus Children's Hospital	259,943	0.52	$8,600,679	$33.09	$63.63
Wolfson Children's Hospital[2]	8,733	0.72	$0	$0.00	$0.00
Total / Average	**467,098**	**0.58**	**$15,252,301**	**$32.54**	**$56.11**

Notes:

1) Numbers in this table include Medicaid fee-for-service and Medicaid managed care claims for dates of service in calendar year 2017 that have been repriced under SFY 2018/19 rates and rules.
2) Values for Wolfson Children's Hospital are our estimate of the portion of these amounts for Baptist Medical Center Jacksonville that apply to Wolfson.

4.4 Comparison of Medicaid Cost Coverage at Florida Stand-Alone Specialty Children's Hospitals

In this section, we pull together payment and cost values described in previous sections to compare overall Medicaid and charity care cost coverage for the four Florida stand-alone children's hospitals. In this comparison, we include all claim and supplemental payments on the payment side, including DSH, LIP and GME. On the cost side, we include all "local funding" from IGTs, CPEs, and provider assessments that are paid to Medicaid to help fund the state share of Medicaid reimbursements. In addition, we include the cost of charity care, which is a key factor in calculating LIP reimbursement amounts.

Because this comparison includes so many data elements, it is displayed below in three different figures. Figure 24 shows Medicaid payments; Figure 25 shows hospital cost; and Figure 26 shows pay-to-cost ratios, which are a measure of cost coverage.

Figure 24 –Medicaid payments to the Florida stand-alone specialty children's hospitals

Hospital[1]	Inpatient Claim Payment	Outpatient Claim Payments	Non-DSH Supplemental Payments		DSH Payments	Total Medicaid Payments
			LIP	GME		
Johns Hopkins All Children's Hospital	$141,989,812	$65,095,894	$2,558,326	$1,639,774	$10,639,444	$221,923,250
Nemours Children's Hospital	$48,853,228	$24,998,912	$505,481	$0	$1,647,379	$76,005,000
Nicklaus Children's Hospital	$135,396,636	$96,798,157	$123,846	$3,154,295	$4,475,512	$239,948,446
Wolfson Children's Hospital[2]	$30,683,092	$12,827,602	$140,593	$390,553	$0	$44,041,840
Total / Average	**$356,922,768**	**$199,720,565**	**$3,328,246**	**$5,184,622**	**$16,762,335**	**$581,918,536**

Notes:
1) Numbers in this table include Medicaid fee-for-service and Medicaid managed care claims for dates of service in calendar year 2017 that have been repriced under SFY 2018/19 fee-for-service rates and rules.
2) Values for Wolfson Children's Hospital are our estimate of the portion of these amounts for Baptist Medical Center Jacksonville that apply to Wolfson.

Figure 25 –Hospital cost of charity care and care of Medicaid beneficiaries at the Florida stand-alone specialty children's hospitals

Hospital[1]	Estimated Hospital Cost to Treat Medicaid Recipients		IGTs	CPEs	Provider Assessment[3]	Total Medicaid Cost	Charity Care Cost	Total Medicaid and Charity Care Cost
	Inpatient[2]	Outpatient[2]						
Johns Hopkins All Children's Hospital	$158,892,367	$84,784,390	$0	$0	$5,619,078	$249,295,835	$2,558,326	$251,854,161
Nemours Children's Hospital	$72,482,264	$55,171,489	$0	$0	$2,411,725	$130,065,478	$505,481	$130,570,959
Nicklaus Children's Hospital	$160,112,897	$104,190,936	$0	$0	$7,312,490	$271,616,323	$123,846	$271,740,169
Wolfson Children's Hospital[5]	$46,073,259	$14,050,829	$0	$0	$3,648,587	$63,772,675	$6,769,313	$70,541,988
Total / Average	**$437,560,787**	**$258,197,644**	**$0**	**$0**	**$18,991,880**	**$714,750,311**	**$9,956,966**	**$724,707,277**

Notes:
1) Numbers in this table include Medicaid fee-for-service and Medicaid managed care claims for dates of service in calendar year 2017.
2) Calculated as [(hospital cost-to-charge ratio) times (submitted charges)] then inflated from Calendar Year 2017 to State Fiscal Year 2018/19.
3) Includes the full assessment amount, not a calculation of the "Medicaid portion" used for cost-based Upper Payment Limit Demonstrations.

Hospital[1]	Estimated Hospital Cost to Treat Medicaid Recipients		IGTs	CPEs	Provider Assessment[3]	Total Medicaid Cost	Charity Care Cost	Total Medicaid and Charity Care Cost
	Inpatient[2]	Outpatient[2]						

4) The provider assessment and charity care cost values in this table are our estimate of the portion of these amounts document for Baptist Medical Center Jacksonville that apply to Wolfson.

Figure 26 – Medicaid cost coverage for the Florida stand-alone specialty children's hospitals

Hospital[1]	Inpatient Admits	Outpatient Visits	Total Medicaid Payments	Total Medicaid Cost	Charity Care Cost	Total Medicaid and Charity Care Cost	Medicaid Pay-to-Cost Ratio	Medicaid and Charity Pay-to-Cost Ratio
Johns Hopkins All Children's Hospital	4,307	146,530	$221,923,250	$249,295,835	$2,558,326	$251,854,161	89%	88%
Nemours Children's Hospital	2,168	51,892	$76,005,000	$130,065,478	$505,481	$130,570,959	58%	58%
Nicklaus Children's Hospital	5,968	259,943	$239,948,446	$271,616,323	$123,846	$271,740,169	88%	88%
Wolfson Children's Hospital[2]	2,170	8,733	$44,041,840	$63,772,675	$6,769,313	$70,541,988	69%	62%
Total / Average	**14,613**	**467,098**	**$581,918,536**	**$714,750,311**	**$9,956,966**	**$724,707,277**	**81%**	**80%**

Notes:

1) Numbers in this table include Medicaid fee-for-service and Medicaid managed care claims for dates of service in calendar year 2017 that have been repriced under SFY 2018/19 rates and rules.

2) Numbers for Wolfson Children's Hospital included in this table are our estimate of the portion of these amounts for Baptist Medical Center Jacksonville that apply to Wolfson.

The numbers in Figure 26 above indicate that Medicaid cost coverage is significantly lower for Nemours and Wolfson children's hospitals in comparison to the other stand-alone specialty children's hospitals. For Wolfson, this is likely due to the fact that it receives relatively little money through LIP, receives no money through Automatic Rate Enhancements, and does not receive the hospital inpatient High Medicaid Utilization and High Outlier policy adjustor. For Nemours, this is likely due to the fact that it receives significantly less outpatient ARE payment per visit, receives no GME, does not qualify for the inpatient trauma add-on, and has a noticeably higher cost structure.

4.5 Potential Adjustments in Reimbursement

Most of the reimbursement pathways are calculated using the same methods and parameters for all of the stand-alone specialty children's hospitals in Florida. However, there are a couple of funding pools that do not appear to be distributed equally across these four hospitals. In this section, we highlight the funding pools with disproportionate allocations, review what a more proportional budget neutral distribution method might look like, and review the added cost to Florida Medicaid for a more proportional distribution with additional funds so that reductions in Medicaid reimbursement would not be needed for other hospitals. Lastly in this section, we estimate potential additional cost to Florida Medicaid to return Medicaid claim payment cost coverage to the level originally set as the goal in the first year of DRG pricing and the level in place during the year prior to the implementation of EAPG pricing.

4.5.1 Automatic Rate Enhancements

As described in previous sections, the distribution of Automatic Rate Enhancements does not appear equal across the four stand-alone specialty children's hospitals. In fact, a letter was sent on April 4, 2019 from AHCA Secretary Mayhew to the Chair of the Florida Senate Appropriations Subcommittee on Health and Human Services acknowledging inequities in ARE allocations particularly for Nemours Children's Hospital. A copy of that letter is included in Appendix A of this report. For Wolfson Children's Hospital, the topic of ARE payments may be getting discussed for the first time in this report.

In this report, we define equal, or proportionate, distribution of AREs as the same payment per inpatient admission and the same payment per outpatient visit. These per-unit payments can be calculated with or without case mix adjustment. If the level of services provided at the different stand-alone specialty children's hospitals differ significantly, then a case mix adjustment would be appropriate. However, the case mix adjustment applies additional complexity to the distribution method. If the Legislature and/or the industry consider the level of services provided in these facilities to be reasonably similar, then the added complexity of case mix adjustment is not warranted.

Figures 27 and 28 below calculate a more proportional distribution of Automatic Rate Enhancements for inpatient and outpatient services, respectively using the same payment amount per inpatient admission and per outpatient visit. Calculations were made using Medicaid volume alone and then using Medicaid volume adjusted by case mix. In this version, we increased the funds distributed through AREs to the stand-alone children's hospitals. In our calculations, we did not leave the ARE allocations at SFY 2018/19 levels or higher for every hospital. To do so would have left some inequities in the per-unit payment amounts. Instead, we calculated the average per-unit reimbursement for the two facilities with the highest AREs, Johns Hopkins All Children's Hospital and Nicklaus Children's Hospital, and applied these average payment amounts to all four stand-alone specialty children's hospitals.

Figure 27 – Equal distribution of inpatient AREs – with additional funds

Hospital	Inpatient Automatic Rate Enhancement SFY 2018/19	Inpatient Admissions	Inpatient ARE Even Distribution w/o Case Mix Adjustment	Change in Reimbursement w/o Case Mix Adjustment	Inpatient Case Mix	Inpatient ARE Even Distribution w Case Mix Adjustment	Change in Reimbursement with Case Mix Adjustment
Johns Hopkins All Children's Hospital	$20,906,870	4,307	$19,513,741	-$1,393,129	2.38	$24,625,689	$3,718,819
Nemours Children's Hospital	$6,414,728	2,168	$9,822,566	$3,407,838	1.66	$8,645,775	$2,231,047
Nicklaus Children's Hospital	$25,646,111	5,968	$27,039,240	$1,393,129	1.61	$23,082,946	-$2,563,165
Wolfson Children's Hospital	$0	2,170	$9,831,627	$9,831,627	1.89	$9,852,764	$9,852,764
Total / Average	**$52,967,709**	**14,613**	**$66,207,174**	**$13,239,465**	**1.89**	**$66,207,174**	**$13,239,465**

Note(s):
1) ARE even distributions based on ARE per admission for Johns Hopkins All Children's and Nicklaus Children's which is $4,530.70.
2) Numbers for Wolfson Children's Hospital included in this table are our estimate of the portion of these amounts for Baptist Medical Center Jacksonville that apply to Wolfson.

Figure 28 – Equal distribution of outpatient AREs – with additional funds

Hospital	Outpatient Automatic Rate Enhancement SFY 2018/19	Outpatient Visits	Outpatient ARE Even Distribution w/o Case Mix Adjustment	Change in Reimbursement w/o Case Mix Adjustment	Outpatient Case Mix	Outpatient ARE Even Distribution w Case Mix Adjustment	Change in Reimbursement with Case Mix Adjustment
Johns Hopkins All Children's Hospital	$5,608,325	146,530	$5,122,223	-$486,102	0.62	$5,266,231	-$342,094
Nemours Children's Hospital	$1,043,297	51,892	$1,813,979	$770,682	0.71	$2,120,368	$1,077,071
Nicklaus Children's Hospital	$8,600,679	259,943	$9,086,781	$486,102	0.52	$7,807,955	-$792,724
Wolfson Children's Hospital	$0	8,733	$305,278	$305,278	2.25	$1,133,707	$1,133,707
Total / Average	**$15,252,301**	**467,098**	**$16,328,261**	**$1,075,960**	**0.61**	**$16,328,261**	**$1,075,960**

Note(s):
1) ARE even distributions based on ARE per visit for Johns Hopkins All Children's and Nicklaus Children's, which is $34.96.
2) Numbers for Wolfson Children's Hospital included in this table are our estimate of the portion of these amounts for Baptist Medical Center Jacksonville that apply to Wolfson.

Figure 29 below shows the combined impact of a more equitable distribution of AREs based on an equal average per unit and on a case-mix adjusted average per unit. The total computable additional funds equal approximately $14.3 million and the state share of this would be $5,568,700.[34] [35]

Figure 29 – Combined inpatient and outpatient results of equal distribution of AREs – with additional funds

Hospital	Total ARE SFY 2018/19	ARE Even Distribution w/o Case Mix Adjustment	Change in ARE w/o Case Mix Adjustment	ARE Even Distribution w Case Mix Adjustment	Change in Reimbursement with Case Mix Adjustment
Johns Hopkins All Children's Hospital	$26,515,195	$24,635,964	-$1,879,231	$29,891,919	$3,376,724
Nemours Children's Hospital	$7,458,025	$11,636,545	$4,178,520	$10,766,143	$3,308,118
Nicklaus Children's Hospital	$34,246,790	$36,126,021	$1,879,231	$30,890,901	-$3,355,889
Wolfson Children's Hospital	$0	$10,136,905	$10,136,905	$10,986,472	$10,986,472
Total	**$68,220,010**	**$82,535,435**	**$14,315,425**	**$82,535,435**	**$14,315,425**

Note(s):
1) ARE even distributions based on ARE per admission (or visit) for Johns Hopkins All Children's and Nicklaus Children's.
2) Numbers for Wolfson Children's Hospital included in this table are our estimate of the portion of these amounts for Baptist Medical Center Jacksonville that apply to Wolfson.

4.5.2 Low Income Pool

The LIP allocation method is the same for all stand-alone specialty children's hospitals. The allocation is set equal to 100% of hospital charity care. However, Wolfson Children's Hospital, being newly licensed as a stand-alone specialty children's hospital, did not receive 100% of charity care costs in SFY 2018/19 and is not allocated to receive this amount in SFY 2019/20.

[34] Florida Medicaid's blended FMAP value for SFY 2018/19 equal to 0.6110 was used to determine the state share.
[35] The state share of Shriners' AREs is $139,827.

Based on our rough estimate that Wolfson Children's Hospital made up 27% of Baptist Medical Center Jacksonville when the two entities were licensed together, Wolfson's charity care costs are $14,059,342. In SFY 2018/19, Baptist Medical Center Jacksonville received a LIP payment equal to $520,716. Removing the Wolfson portion of Baptist Medical Center Jacksonville's charity care would reduce the LIP payment to Baptist Medical Center Jacksonville down to $380,123. Thus, if in future years Wolfson's LIP reimbursement is calculated the same way as other stand-alone children's hospitals, the new combined LIP payment for both Wolfson and Baptist Medical Center Jacksonville would be approximately ($14,059,342 + $380,123) or $14,439,465.[36] This would be an increase of $13,918,749 over the LIP allocation for these facilities in SFY 2018/19.

4.5.3 Policy Adjustors

Although the inpatient and outpatient High Medicaid Utilization policy adjustors were generally intended for the stand-alone children's hospitals, they were intentionally named and designed with generic thresholds so that any hospital that met the thresholds would receive the adjustor(s). We feel this is good payment policy, as any hospital that reached these thresholds will likely struggle financially with un-adjusted Medicaid reimbursement levels, and, thus, deserves the policy adjustor(s).

With that said, if it is Florida Medicaid's intention to ensure that all free-standing children's hospitals receive the inpatient and outpatient High Medicaid Utilization policy adjustors, then the threshold for the inpatient High Medicaid Utilization and High Outlier policy adjustor will need to be changed. This is because the newest stand-alone children's hospital, Wolfson Children's, does not have enough payments coming from outliers to meet the outlier portion of this DRG provider policy adjustor. The thresholds for the DRG (inpatient) High Medicaid Utilization and High Outlier policy adjustor are 50% or greater Medicaid inpatient utilization and 30% or greater payment from outliers prior to application of the provider policy adjustor. The applicable values for the four stand-alone specialty children's hospitals are shown in the figure below.

Figure 30 – Stand-alone children's hospital values used for qualification for High Medicaid Utilization and High Outlier inpatient policy adjustor

Hospital	Inpatient Medicaid Utilization	Inpatient Percent of Payments from Outliers without the High Medicaid Utilization and High Outlier Policy Adjustor
Johns Hopkins All Children's Hospital	68%	35%
Nemours Children's Hospital	72%	37%
Nicklaus Children's Hospital	64%	32%
Wolfson Children's Hospital	56%	25%

The hospital with the next highest Medicaid inpatient utilization is 41 percent. In terms of percentage of payments through outliers, there are approximately 12 hospitals with a percentage equal to 25 percent (the value for Wolfson) or higher. Most of these are long term acute care hospitals and none have Medicaid utilization above 50%. Thus, the threshold for

[36] This number is based on a cursory estimate of the amount of charity care at Wolfson Children's Hospital

DRG payments from outliers could be lowered or removed to allow Wolfson Children's Hospital to qualify for this inpatient policy adjustor without any additional hospitals qualifying.

4.5.4 Medicaid Claim Payment Cost Coverage

When DRG pricing was first implemented in SFY 2013/14, the Florida Legislature directed AHCA to create a provider policy adjustor for facilities that meet the high Medicaid utilization and high outlier thresholds (for which only the stand-alone specialty children's hospitals qualified) such that their pay-to-cost ratio for care of Medicaid recipients would be 100%. As mentioned in a previous section, since SFY 2013/14, cost coverage for the stand-alone specialty children's hospitals has dropped below 100% due to increases in hospital costs and decreases in inpatient Automatic Rate Enhancements.

Similarly, when EAPG pricing was implemented in SFY 2017/18, the Florida Legislature set the budget target in aggregate for facilities meeting the outpatient high Medicaid utilization threshold to be budget neutrality. In the previous SFY, which is the year used to determine budget neutrality, these hospitals were paid in aggregate 85% of their costs for outpatient services provided to Medicaid beneficiaries.

Cost coverage based on claim payments in SFY 2018/19 is provided in Figure 31 below.

Figure 31 – Cost coverage from Medicaid hospital inpatient and outpatient claim payments

Hospital[1]	Medicaid Inpatient Claim Payments	Hospital Cost for Inpatient Care of Medicaid Recipients	Inpatient Cost Coverage	Medicaid Outpatient Claim Payments	Hospital Cost for Outpatient Care of Medicaid Recipients	Outpatient Cost Coverage	Combined Claim Payment Cost Coverage
Johns Hopkins All Children's Hospital	$141,989,812	$158,892,367	89%	$65,095,894	$84,784,390	77%	85%
Nemours Children's Hospital	$48,853,228	$72,482,264	67%	$24,998,912	$55,171,489	45%	58%
Nicklaus Children's Hospital	$135,396,636	$160,112,897	85%	$96,798,157	$104,190,936	93%	88%
Wolfson Children's Hospital[2]	$30,683,092	$46,073,259	67%	$12,827,602	$14,050,829	91%	72%
Total / Average	**$356,922,768**	**$437,560,787**	**82%**	**$199,720,565**	**$258,197,644**	**77%**	**80%**

Note(s):
1) Numbers in this table include Medicaid fee-for-service and Medicaid managed care claims for dates of service in calendar year 2017 that have been repriced under SFY 2018/19 rates and rules.
2) Numbers for Wolfson Children's Hospital included in this table are our estimate of the portion of these amounts for Baptist Medical Center Jacksonville that apply to Wolfson.

The estimated increase in reimbursement needed to bring those hospitals that qualify for the inpatient High Medicaid Utilization and High Outlier policy adjustor back up to 100% of cost using the SFY 2018/19 rates would be $65.2 million, of which, the state share would be $25.4 million. The estimated increase in reimbursement needed to bring all four stand-alone specialty children's hospitals back up to 100% of cost using the SFY 2018/19 rate setting dataset would be $80.5 million, of which, the state share would be $31.3 million. Similarly, the increase in reimbursement needed to bring those hospitals that qualify for the outpatient EAPG High

Medicaid Utilization policy adjustor (all four free-standing children's hospitals) back up to 85% of cost using the SFY 2018/19 rate setting dataset would be $26.4 million, of which, the state share would be $10.3 million.

Thus, if the Florida Legislature decided it was their goal to maintain these cost coverage values for the hospitals that qualify for the High Medicaid Utilization policy adjustors, then the total additional reimbursement under SFY 2018/19 dollars for both inpatient and outpatient hospital services would be $91.6 million, of which the state share would be $35.7[37] million. Also, if Wolfson Children's Hospital qualified for the inpatient policy adjustor, then the increase in reimbursement would be $106.9 million and the state share would be $41.6[38] million. Of course, hospital cost increases over time, so the amount needed to maintain this cost coverage would increase annually.

4.6 Conclusion

Because the volume of Medicaid patients differs at each hospital, accurate comparisons of reimbursement cannot be made by reviewing total payment amounts. Instead, we find it helpful to review average payment per unit when comparing reimbursement at different hospitals. For hospital services, a unit is an admission for inpatient services and a hospital visit for outpatient services. In addition, applying a case mix adjustment to these averages is also helpful to make the comparisons as fair as possible. This is because we consider higher payment acceptable for facilities who treat more medically complex patients, which have higher case mix, and lower payment acceptable for facilities who treat less medically complex patients.

The DRG and EAPG payment methods apply higher payment for higher patient acuity and lower payment for lower patient acuity. Thus, these payment methods already adjust for patient acuity. The provider policy adjustor generates payment beyond what is calculated in the basic DRG and EAPG payment calculations, and is used to maintain access to care to facilities who might struggle financially or might turn away Medicaid recipients if not for higher than average reimbursement from Medicaid. The ARE allocations, in contrast, are based on historical rate buy-backs from a time period where rates were cost-based and calculated separately for each hospital. These allocations have less tie to acuity and were not designed to provide similar reimbursement for similar services performed at different hospitals. In addition, the ARE distribution has not been updated as the hospital landscape has changed in Florida, such as the addition of Nemours and Wolfson children's hospitals.

If the Florida Legislature would prefer the ARE funds be distributed based fully on patient acuity, then these funds should be added to the High Medicaid Utilization inpatient and outpatient policy adjustors, thus doing away with the ARE add-on payments. If, on the other hand, the Legislature prefers to maintain ARE add-on payments, a distribution could be calculated as described in a previous section with average payment per unit or case mix adjusted average payment per unit to provide a more equitable distribution of funds. Also, due particularly to the licensing of Wolfson Children's Hospital as a stand-alone specialty children's hospital, equitable distribution of AREs to all four stand-alone specialty children's hospital will require additional

[37] Florida Medicaid's blended FMAP value for SFY 2018/19 equal to 0.6110 was used to determine the state share.
[38] Florida Medicaid's blended FMAP value for SFY 2018/19 equal to 0.6110 was used to determine the state share.

Medicaid funding, or a shift in funds away from other hospitals and towards the stand-alone children's facilities.

5 Survey of Other State Medicaid Reimbursement for Specialty Children's Hospitals

State Medicaid agencies can use different payment policies to ensure access to high quality inpatient and outpatient services for beneficiaries. States also often apply extra payment factors for children's hospitals to enhance reimbursement. This is done both because Medicaid is a significant payer of care for children in each state and because Medicaid utilization is particularly high at stand-alone children's hospitals making Medicaid reimbursement critical to these facilities. This section reviews inpatient and outpatient policies and outlines specific policies for children's hospitals implemented by other large Medicaid programs in the United States.

5.1 Inpatient Payment Policies

Inpatient services refer to services delivered to a patient during a hospital stay. There are three common methods that State Medicaid agencies utilize to reimburse facilities for inpatient services[39]:

1. Diagnosis Related Group (DRG): Launched by Medicare in 1983, DRGs are assigned weights that are applied to fixed payments based on the typical cost of the reason for admission.
2. Per Diem: Payments are made by multiplying the number of days a patient stays in the hospital by standard base rates for procedures.
3. Cost-based: Payments are made as a percentage of the hospital's reported costs.

Most state Medicaid agencies (approximately 80%) reimburse hospitals for inpatient services using a DRG pricing methodology. By far, the two most common types of DRGs used are:

1. Medicare Severity DRG (MS-DRG): Considers reason for admission, the costliest secondary diagnosis, and any particular costly procedures associated with admission to adjust base payments. Designed for the Medicare population.
2. All Patient Refined DRG (APR-DRG): Considers severity of illness (SOI) and risk of mortality (ROM) in addition to considering the reason for admission to adjust base payments. Designed for a full population.[40]

APR-DRGs were launched in the early 1990s to adapt DRGs for the non-Medicare population. Since MS-DRGs were designed for Medicare beneficiaries, the method did not include adjustments for most pediatric and pregnancy-related risks.[41] Considering that nearly 40% of all patients aged 0-18 are covered by Medicaid, APR-DRGs were created to account for these key population differences.[42]

[39] Medicaid Inpatient Hospital Services Fee-For-Service Payment Policy. MACPAC.gov. https://www.macpac.gov/wp-content/uploads/2016/03/Medicaid-Inpatient-Hospital-Services-Fee-for-Service-Payment-Policy.pdf
[40] APR-DRGs: An Overview. https://www.bcbst.com/providers/webinar/APRDRG.pdf
[41] 3M All Patient Refined Diagnosis Related Group. https://www.forwardhealth.wi.gov/kw/pdf/handouts/3M_APR_DRG_Presentation.pdf
[42] Health Insurance Coverage of Children 0-18. Kaiser Family Foundation. https://www.kff.org/other/state-indicator/children-0-18/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Given the stronger applicability of APR-DRGs to a Medicaid population, more Medicaid inpatient DRG payment methods use APR-DRGs than any other type of DRG. Our current estimate is that 26 Medicaid agencies (including the District of Columbia) use APR-DRGs, including the eight largest Medicaid programs (CA, NY, TX, FL, PA, IL, OH, MI). 10 state Medicaid programs utilize MS-DRG systems for inpatient reimbursement, 3 other states use other versions of DRGs and the remaining states employ either per-diem or cost-based reimbursement.

States may choose to establish payments in addition to base rates to foster access to high quality health services for vulnerable patient populations. Currently, all 50 states and the District of Columbia utilize policy adjustors to adjust reimbursement based on hospital type, geography, or outlier cases that are exceptionally costly. Additionally**,** supplemental payments including Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL) payments are offered to hospitals that care for higher volumes of Medicaid patients.[43]

5.1.1 Children's Hospital Inpatient Reimbursement Policies in Select States

As documented in previous sections of this report, Florida Medicaid provides additional inpatient reimbursement for stand-alone specialty children's hospitals through provider policy adjustors and Automatic Rate Enhancements. In this section, we document similar policies applied by other Medicaid programs of similar size to Florida Medicaid including California, Illinois, New York, Pennsylvania, and Texas. The information below does not offer a comparison of DRG base rates because those dollar amounts are only a part of a DRG payment method. To accurately compare DRG reimbursement levels, information about outlier policy, and DRG relative weights would be needed.[44] In addition, fair comparison of overall inpatient reimbursement levels across Medicaid agencies would need to consider non-claim supplemental payments made through the DSH program and other state-specific programs which are not always publicly available.

California

The State of California's Medicaid program (Medi-Cal) utilizes the APR-DRG system to reimburse inpatient services. In addition, in SFY 2018/19, Medi-Cal included three separate policy adjustors applicable to specialty children's hospitals and to care for children at any hospital:[45]

- Policy adjustor for non-newborn pediatric patients except for obstetric and mental health services.
    - Value is 1.25 (25% increase) for APR-DRG severity of illness values 1, 2, and 3
    - Value is 1.75 (75% increase) for APR-DRG severity of illness value 4
- Policy adjustor for newborns including those in a Neonatal Intensive Care Unit (NICU)

[43] Medicaid Inpatient Hospital Services Fee-For-Service Payment Policy. MACPAC.gov. https://www.macpac.gov/wp-content/uploads/2016/03/Medicaid-Inpatient-Hospital-Services-Fee-for-Service-Payment-Policy.pdf

[44] DRG relative weights may differ between Medicaid agencies, even when all are using APR-DRGs. For example, Medi-Cal uses unaltered national relative weights, Florida Medicaid uses relative weights re-centered to 1.0, Illinois Medicaid uses relative weights re-centered to approximately 1.3, and Texas Medicaid uses state-specific weights.

[45] SFY 2018/19 DRG Calculator downloaded from https://www.dhcs.ca.gov/provgovpart/Pages/DRG-Pricing-SFY2018-19.aspx on September 6, 2019.

- Value is 1.25 (25% increase) for APR-DRG severity of illness values 1, 2, and 3 at hospitals that do not have a "designated NICU"[46]
- Value is 1.75 (75% increase) for APR-DRG severity of illness value 4 at hospitals that do not have a "designated NICU"
- Value is 1.75 (75% increase) for APR-DRG severity of illness values 1, 2, and 3 at hospitals that do have a "designated NICU"
- Value is 2.45 (245% increase) for APR-DRG severity of illness value 4 at hospitals that do have a "designated NICU"

Illinois

Illinois Medicaid uses APR-DRG payment to reimburse all inpatient services at stand-alone children's hospitals except for mental health and rehabilitation services. Mental health and rehabilitation services are paid via a per diem method.

The State of Illinois also includes additional payments and adjustments to provide access to children's hospitals. Effective 7/1/2018, these include:[47]

- Policy adjustor perinatal services (obstetrics and newborn, including NICU) for facilities recognized by the Department of Public Health as a Level II, Level II+ or Level III perinatal center. Values in SFY 2018/19 were:
  - 1.35 for APR-DRG severity of illness 1
  - 1.43 for APR-DRG severity of illness 2
  - 1.41 for APR-DRG severity of illness 3
  - 1.54 for APR-DRG severity of illness 4
- Safety Net Policy adjustment equal to $57.50 per general acute care day that applies to the primary free-standing children's hospital in Illinois (along with other non-children's safety net hospitals)
- Medicaid High Volume Adjustment (MHVA) paid as a per diem for primary free-standing children's hospital in Illinois. For SFY 2018/19, the value was $259.46.

New York

The State of New York uses both APR-DRG and per diem methods for inpatient reimbursement. Children's hospitals in New York are exempt from APR-DRG reimbursement and are paid per diem.[48] Per diem rates are established using the facility's reported operating costs from 2007 as submitted to the state.

New York also applies a policy adjustor to the per diem for inpatient psychiatric services administered to patients under age 18. Reimbursement for these services is subject to a 1.3597 adjustor (35.97% increase).[49]

[46] "Designated NICU" facilities are recognized by the California Children's Services (CCS) as being able to perform neonatal surgery.

[47] https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IL/IL-18-0005.pdf

[48] https://www.hcrapools.org/medicaid_state_plan/DOH_PDF_PROD/nys_medicaid_state_plan.pdf - Page 1299

[49] https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NY/NY-18-0059.pdf - Page 3

Pennsylvania

The Commonwealth of Pennsylvania uses APR-DRG method for inpatient reimbursement for facilities including children's hospitals.[50] Individual cost-based rates are determined for each hospital in Pennsylvania,[51] which removes the need to incorporate additional payment parameters for the unique cost structure and utilization in stand-alone specialty children's hospitals.

Texas

The State of Texas uses the APR-DRG method for inpatient reimbursement of facilities including children's hospitals. APR-DRG reimbursement for children's hospitals is based on a unique Standard Dollar Amount (SDA) rate (a DRG base rate) that is calculated based on cost of care and services provided only at children's hospitals. That is, a separate provider peer group is used for children's hospitals, similar to the process used by Florida Medicaid to determine the High Medicaid Utilization and High Outlier policy adjustor. This SDA reflects the unique cost structure of children's hospitals. In addition, children's hospitals in Texas, like other hospitals in Texas may receive payment add-ons for Graduate Medical Education programs and safety net hospital designation.[52]

Lastly, children's hospitals in Texas are exempt from a recently implemented 10% reduction to DRG outlier payments.[53]

5.2 Outpatient Payment Policies

Outpatient (or ambulatory) services refer to preventive, diagnostic, therapeutic, rehabilitative, or palliative care that does not require an overnight hospital stay.[21] There are four common methods that State Medicaid agencies use to reimburse facilities for outpatient services:

1. Fee schedules: A price identified per unit based on procedure code;
2. Cost-based: Allowed amount is calculated as a percentage of hospital cost;
3. Ambulatory Patient Classification (APC) system: Payment method used by Medicare that covers some, but not all services provided in a hospital outpatient setting, is like a fee schedule payment method, but is based on APC codes which are less granular than procedure codes, and does include some bundling of services;
4. Enhanced Ambulatory Patient Groups (EAPG) system: Based on a proprietary classification system built by 3M Health Information Systems that applies to all services provided in a hospital outpatient setting and includes significantly more bundling and discounting logic than APCs, thus offering less financial incentive for providers to maximize the number of services performed.

[50] https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/PA/PA-15-0028.pdf
[51] Section § 1163.126. Computation of hospital specific base payment rates of the Pennsylvania Administrative Code viewed online at https://www.pacode.com/secure/data/055/chapter1163/chap1163toc.html#1163.51 on September 7, 2019.
[52] https://apps.hhs.texas.gov/documents/medicaid-chip-state-plan-attachments.pdf - Pages 997-999
[53] http://www.tmhp.com/Manuals_PDF/TMPPM/TMPPM_Living_Manual_Current/2_Inpatient_Outpatient_Hosp_Srvs.pdf - Pages 34

Compared to inpatient reimbursement methods, there is more variation across states in determining outpatient reimbursement. Sixteen (16) states utilize cost-based reimbursement, including Texas. Thirteen (13) states, including larger programs in California and Pennsylvania, utilize fee schedules. Twelve (12) states use APC groups to reimburse outpatient Medicaid services, and seven (7) states utilize the EAPG system, including Florida.[54]

As with inpatient reimbursement, states can amend current plans to include supplemental payments and adjustments for certain hospitals and services, including children's hospitals.[55]

5.2.1 Children's Hospital Outpatient Reimbursement Policies in Select States

As documented in previous sections of this report, Florida Medicaid provides additional outpatient reimbursement for stand-alone specialty children's hospitals through provider policy adjustors and Automatic Rate Enhancements. In this section, we document similar policies applied by other Medicaid programs of similar size to Florida Medicaid including California, Illinois, New York, Pennsylvania, and Texas. As with inpatient reimbursement, states may also provide supplemental payments for outpatient services that are often less clearly described in public documentation than claim payment policies.

California

California Medicaid uses a fee schedule to determine reimbursement for outpatient services covered by Medi-Cal. Children's hospitals in California may be eligible for fee upgrades for certain outpatient services. A 9% fee upgrade is applied to reimbursement for 85 selected primary care and preventive services when delivered to patients under 17 years of age.[56]

Illinois

Illinois Medicaid uses an EAPG-based reimbursement method for payment of hospital outpatient services. Illinois Medicaid's outpatient claim payment methodology does not provide any additional payment specifically for stand-alone specialty children's hospitals.

New York

Medicaid outpatient reimbursement in New York is based on the EAPG-based prospective payment system. The state provides for 5 separate "peer specific" base rates for categories of services:

1. Outpatient services provided by general hospitals
2. Emergency department services provided by general hospitals
3. Ambulatory surgical services provided by general hospitals
4. Ambulatory services provided by diagnostic and treatment centers
5. Ambulatory surgical services provided by free-standing ambulatory surgical centers

[54] State Medicaid Payment Policies for Outpatient Hospital Services. MACPAC.gov. https://www.macpac.gov/publication/state-medicaid-payment-policies-for-outpatient-hospital-services/

[55] Medicaid Outpatient Payment Policy. MACPAC.gov. https://www.macpac.gov/wp-content/uploads/2016/07/Medicaid-Outpatient-Payment-Policies-Overview.pdf

[56] http://files.medi-cal.ca.gov/pubsdoco/Rates/rates_download.asp

Base rates are adjusted for location in either upstate or downstate New York to account for regional cost factors.[57] According to section 1(b)(i)(1)(a) of attachment 4.19-B of the New York Medicaid state plan, it appears specialty children's hospitals are carved out of the EAPG payment method and, instead, are paid via a cost-based per-visit rate.

Pennsylvania

The Commonwealth of Pennsylvania reimburses providers for outpatient services based on an outpatient fee schedule. Pennsylvania also has a separate fee schedule for infant/toddler early intervention educational services, which may apply to children's hospitals. Otherwise, there does not appear to be any specific payment provisions for stand-alone children's hospitals in the Pennsylvania Medicaid hospital outpatient payment method.[58]

Texas

Texas utilizes a cost-based method to reimburse outpatient services covered by Medicaid. The state reviews each hospital's most recent Medicaid cost report settlement and pays a percentage of reasonable costs incurred by the hospital.

The state uses different allowable reimbursement rates for different hospital classifications (rural hospital, children's hospital, state-owned teaching hospital), as well as higher rates for high-volume hospitals, defined as facilities receiving at least $200,000 in Medicaid reimbursement in 2004.[59]

Children's hospitals in Texas are eligible for enhanced cost-based reimbursement rates under outpatient payment policy. For non-high volume children's hospitals, Texas reimburses at 72.27% of allowable charges, or 3.38% higher than the rate for typical non-high volume hospitals. If a children's hospital meets the criteria for high-volume status, it is reimbursed at 76.03% of allowable charges, or 4.03% higher than the rate for most high-volume hospitals. All cost-based reimbursement rates (including enhanced rates for children's hospitals) are summarized in the tables below:[60]

Figure 32 – Texas Medicaid hospital outpatient rate structure

Non-high-volume Provider	Current Allowable Rate
Children's hospitals	72.27 percent of the allowable charges
Rural hospitals	100 percent of the allowable charges
State-owned teaching hospitals	72.27 percent of the allowable charges
Other hospitals	68.44 percent of the allowable charges

[57] https://www.health.ny.gov/health_care/medicaid/rates/apg/docs/apg_regulations.pdf - Pages 37-38
[58] http://www.dhs.pa.gov/publications/forproviders/schedules/mafeeschedules/index.htm
[59] http://www.tmhp.com/Manuals_PDF/TMPPM/TMPPM_Living_Manual_Current/2_Inpatient_Outpatient_Hosp_Srvs.pdf - Page 68
[60] Ibid.

High-volume Provider	Current Allowable Rate
Children's hospitals	76.03 percent of the allowable charges
Rural hospitals	100 percent of the allowable charges
State-owned teaching hospitals	76.03 percent of the allowable charges
Other hospitals	72 percent of the allowable charges
ASCs/HASCs that qualify as high-volume providers	Additional 5.2 percent increase in payment rates

The State of Texas also includes a conversion factor adjustment for certain outpatient anesthesia services delivered by children's hospitals. The base conversion factor for anesthesia services administered to patients 21 years of age and older is $24.32. However, reimbursement for services delivered to patients under 21 receive an enhanced conversion factor of $25.50. If the services were administered using a care team model and the facility meets Medicaid utilization and NICU/trauma statuses, the conversion factor is increased to $34.00.[61]

5.3 Conclusion

States select from a variety of payment methods to ensure access to high quality inpatient and outpatient services for Medicaid beneficiaries. As a provider of services for a critical population and because of heavy reliance on Medicaid reimbursement, children's hospitals are often subject to special provisions within payment methods to enhance reimbursement. Most states utilize the APR-DRG method to reimburse hospitals (including children's hospitals) for inpatient care. Outpatient reimbursement for providers (including children's hospitals) is more varied, with numerous states utilizing fee schedules, cost-based reimbursement, APC groups, and EAPG reimbursement. Within these payment methods, particularly the inpatient payment methods, many Medicaid agencies, including Florida, include provisions which provide higher than standard reimbursement levels to stand-alone specialty children's hospitals.

[61] https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/TX/TX-19-0007.pdf - Page 5

6 Discussion of Alternative Payment Models for Specialty Children's Hospitals

6.1 Introduction

Requirements for this report, as defined by the Florida Legislature, include a discussion of "opportunities to incentivize efficiencies through alternative reimbursement strategies. The report shall also include potential state and federal costs or savings associated with implementing alternative methodologies."[62] This chapter discusses alternative reimbursement strategies with particular focus on child populations, but provides only a very cursory estimate of potential additional cost or savings for the state and the federal government. Alternative Payment Methods (APMs) are still in their infancy, the payment methods are varied, and procedures for accurately predicting savings do not exist. According to Kelly Church of the Children's Hospital Association:

> *"Industry-accepted pediatric-specific quality measures have yet to be formally developed. Many measurements used in adult care need to be adjusted for the needs of pediatric populations."* [63]

Thus, we concentrated our discussion of APMs on options that AHCA, the Florida Medicaid managed care plans, and the Florida stand-alone children's hospitals should analyze when considering APMs for the Medicaid population.

Some initiatives experimenting with alternative reimbursement strategies have been implemented across the U.S. healthcare system in recent years with mixed results in terms of reducing healthcare costs.[64] Most of the models developed to date have focused on the adult population, with many being developed by Medicare, such as Medicare bundled payments for select episodes of care including knee and hip replacements and Medicare's Merit-based Incentive Payment System (MIPS). In addition, a few alternative reimbursement initiatives have even been undertaken specifically by hospitals specializing in care for children. One example program focusing on children is the Coordinating All Resources Effectively (CARE) Award given to the national Children's Hospital Association (CHA) which concluded in June of 2018.[65] The CARE award was a three-year, $23 million Health Care Innovation Award from the Center for Medicare and Medicaid Innovation (CMMI) intended to develop and test ideas for healthcare delivery to children with medically complex conditions. The program was designed to identify policies and procedures that will:

- Decrease the impact of chronic illness on families
- Enhance patient experience of care and care coordination
- Provide care closer to home and at lower cost
- Create payment models that support high-quality care and rewards savings
- Decrease utilization of health services

[62] SFY 2019/20 Florida General Appropriations Act (GAA), Specific Appropriation 203.
[63] Article called "The State of Value-Based Care in Pediatrics" written by Kelly Church on July 29, 2019 for the Children's Hospital Association's quarterly magazine, "Children's Hospitals Today."
[64] Navigant presentation to Wyoming Medicaid on Value-Based Payment trends, July 2018.
[65] Two Florida hospitals, Wolfson Children's Hospital in Jacksonville and St. Joseph's Children's Hospital in Tampa participated in the CARE program.

Successful Alternative Payment Methods must provide benefit to both the payer and the providers of healthcare. In addition, development of APMs generally require infrastructure development including robust data analytics and advanced medical management and care model capabilities. In order to reduce total cost of care, hospitals engaging in APMs must develop clinically, and possibly financially, integrated networks so that care is coordinated across all provider types. Also, APMs for children may require reimbursement for items not traditionally paid for by Medicaid, such as care coordinators. The challenges in developing APMs are significant and may require redesign of the structure of healthcare delivery and healthcare reimbursement. Even so, this effort is necessary to control Medicaid expenditures which have grown in the last two decades at rates which are putting severe strain on state budgets and are not maintainable in the long term.

6.2 Basics of Alternative Reimbursement Methods

APMs, which are often referred to as Value-Based Purchasing (VBP) methods, generally link healthcare reimbursement to reductions in cost and improvements in quality of care provided. These payment methods reward high performance and shifts in delivery of care to the most appropriate healthcare settings. As total health expenditures have increased in the United States at unsustainable rates,[66] APMs are designed to financially incentivize healthcare providers to offer more "valuable" care, or better care at a lower cost. This idea can be seen in Institute for Healthcare Improvement's (IHI's) Quadruple Aim, which is an expansion of CMS's Triple Aim and includes the following goals:

- Improve the health of populations
- Improve the patient experience of care
- Reduce the cost of care
- Improve the work-life of health care providers

To meet these goals, both government and commercial payers have looked to transition away from traditional fee-for-service (FFS) payment arrangements, which simply pay more for more services provided. While numerous APM models exist, the basic principles include rewarding providers with quality bonuses and opportunities for shared savings (upside risk) and potentially requiring providers to lose reimbursement for incurring excessive costs or providing lower quality care (downside risk). The CMS Learning Action Network (LAN) Framework categorizes APM models into three groups based on these principles:

- Category 2: FFS - Link to Quality and Cost
- Category 3: Alternative Payment Models Built On FFS Architecture
- Category 4: Population-Based Models

Category 1 of the CMS LAN Framework includes traditional FFS arrangements without link to quality and cost, which are not considered APMs. The most common APM models are **Pay-for-Performance (P4P)** (Category 2), **Patient-Centered Medical Homes (PCMHs)** (Category 2 or 3), **Accountable Care Organizations (ACOs)** (Category 3), and **Bundled Payments**

[66] https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/

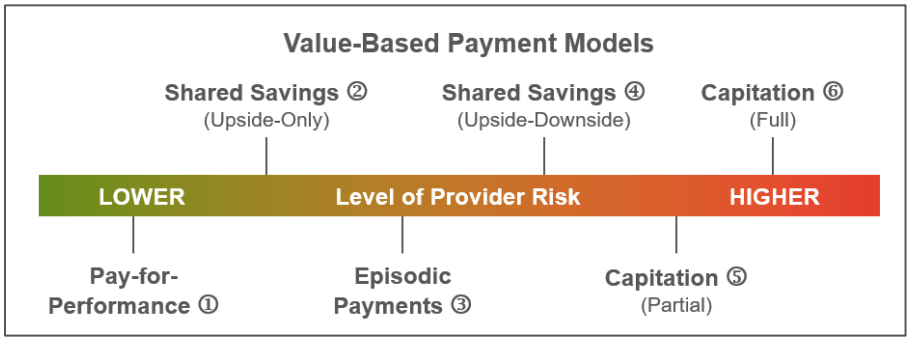
(Category 3). P4P models are defined as Category 2 models; PCMH models can be considered Category 2 or 3 depending on how they are designed; and ACOs and Bundled Payments are considered Category 3 models. Category 4 models include the most provider-side risk and include payment structures such as capitated payments.

Each APM falls on a spectrum of financial risk level incurred by providers. P4P arrangements simply offer additional payments and bonuses to providers for quality performance and are considered low-risk models. Upside-only PCMH and ACO models are also considered low-risk, as they allow providers to share savings if costs are below previously established reimbursement benchmarks with no penalty if savings are not generated. While these models typically require providers to meet a quality threshold in order to share savings, they include no downside risk for excessive costs.

Conversely, higher risk models require providers to bear downside risk. Upside-downside PCMH and ACO models incorporate risk of shared losses as well as opportunities for shared savings, while bundled (or episodic) payments reimburse a fixed fee for an episode of care and hold providers accountable for any costs beyond the allotted payment. Partial and full capitation arrangements pose the largest amount of risk with per-member per-month (PMPM) global payments for patient populations and are less common than other APMs.

The APM (a.k.a. VBP model) risk spectrum is summarized in Figure 33 below:

Figure 33 – Spectrum of provider risk under various value-based payment models



According to a 2018 study by Open Minds, many Medicaid agencies are using their managed care contracts to push APMs. As of 2017, 38 states have Medicaid managed care contracts, 22 states require managed care organizations (MCOs) to use (APMs) with providers, and 2 more states have added alternative payment model requirements to future MCO contracts.[67]

[67] OPEN MINDS, State-By-State Analysis of Medicaid MCO Requirements For Provider Alternative Payment Models: The 2017 Update, published in 2018.

6.3 Current AHCA Initiatives Involving Alternative Payment Methods

AHCA has a variety of cost reduction programs already in place that are based on healthcare quality and delivery measures. The majority of these cost reduction programs are implemented only in the Medicaid managed care program, which for hospital services comprises most (approximately 80%) of AHCA's Medicaid hospital expenditures. These programs provide cost savings to the State of Florida through reduction in managed care capitation rates. Medicaid managed care plans, who are receiving the lower capitation rates, are expected to manage care in ways that improve healthcare quality and reduce overall cost of care.

The specific healthcare delivery measures AHCA put in place with the most recent round of Medicaid managed care contracts relate to Potentially Preventable Events (PPEs), as defined by 3M Health Information Systems, and birth outcomes. In particular, three PPE measures are included, Potentially Preventable Admissions (PPAs), Potentially Preventable Readmissions (PPRs), and Potentially Preventable Emergency Department Visits (PPVs). For improvement of birth outcomes and reductions of cost, the measures AHCA is using are rates of primary cesarean section deliveries, rates of pre-term deliveries, and rates of babies born with neonatal abstinence syndrome (NAS), also known as neonatal opioid withdrawal. For NAS, AHCA is also considering using length of stay as a healthcare quality measure.

These programs were implemented by AHCA in a prospective manner by asking Medicaid managed care plans to project the cost savings the plans could generate related to PPE reductions and birth outcome improvements during the most recent contract negotiation period. The cost savings projected by the managed care plans have been taken out of the capitation rates, thus putting the risk of successful cost reductions on the plans. This program led to a $90 million reduction in capitation payments for SFY 2018-19, and a $106 million reduction for SFY 2019-20. The MCOs' projected percentage reductions in cost were greatest in the first year and smaller in subsequent years under the assumption that the opportunities for improvement become smaller over time.

To support these initiatives, AHCA calculated benchmark rates for each of the three PPE measures and each of the three birth cost/outcome measures for all 11 managed care regions in the state. Each of the managed care plans committed to reducing the regional average values by certain percentages, and AHCA translated those projected percentage decreases into reductions in the capitation rates. The original PPE and birth outcome rates were measured using historical claim data with dates of service in SFY 2015-16. As the program progresses, AHCA continues to monitor these healthcare delivery measures to determine whether or not the managed care plans are meeting their commitments. If not met, provisions in the contracts between AHCA and the managed care plans allow for liquidated damages to be assessed by AHCA. The contracts also allow for a re-evaluation of the regional benchmarks in contract year three, beginning October 1, 2020.

6.4 Considerations for Alternative Payment Methods

6.4.1 Applicable Population

One of the first steps in developing an APM would be identification of the applicable population. The population will likely include high users of healthcare, as those are the ones most likely to have a potential for savings. Our own analysis looking at one year of hospital inpatient data indicates that 85% of Medicaid claim payments to the four stand-alone children's were for services provided to 10% of the Medicaid recipients seen at these facilities. Medicaid claim payments for the recipients in the highest 10% of costs totaled just under $486 million. Also, there may be particular services or health conditions for which savings may be possible, such as asthma, drug addiction and mental health issues. Such services may also be considered for APMs.

The size of the population will help determine the amount of potential savings. For example, initiatives defined through the CARE program through the grant provided to the national Children's Hospital Association resulted in 2.6% reduction in healthcare costs. Applying this percentage to the 10% of high-cost Medicaid recipients at stand-alone specialty children's hospitals would result in a savings of approximately $12.6 million. Applicable Medicaid stakeholders would need to determine if these savings are enough to cover program set up and maintenance costs.

The size of the population will also help determine whether managed care plans or hospitals will be willing to accept downside risk. The actuarial firm Milliman estimates that a population between 5,000 to 20,000 is necessary to achieve actuarial soundness.[68] That is, healthcare cost on a population smaller than this could be volatile enough to make population-based reimbursement, such as per member, per month (PMPM) rates too risky. The number of Medicaid recipients receiving either inpatient or outpatient care in a year is higher than 5,000 at each of the four stand-alone children's hospitals. However, many of these recipients only receive outpatient services. If considering only inpatient services, which on average incur much higher cost and reimbursement, then the annual Medicaid population is less than 5,000 at most, if not all of the stand-alone children's hospitals in Florida.

6.4.2 Potential Alternative Payment Methods

A variety of potential payment methods exist with varying degrees of risk taken on by the hospitals. Example payment methods include,

- Care management PMPM fee for integration of care across providers
- Supplemental payments for care management team infrastructure development
- Bundled payment for specific episodes of care
- DRG and/or EAPG rate add-ons based on historical measures of quality of care, such as potentially preventable events
- Upside shared savings model aligning incentives across the system-owned hospital and physician network

[68] Milliman White Paper (2018), "What is the minimum number of members required to take downside risk in a payment model for children with complex medical conditions?".

- Capitated payment from a Medicaid managed care plan to a stand-alone children's hospital for care of a specific population of Medicaid enrollees

As a first step, hospitals are more likely to accept models which include no downside risk and provide reimbursement for investment in the infrastructure to manage care across the continuum. As models progress and mature, migration to upside shared savings models is more likely and an eventual goal could be full upside/downside risk models in which healthcare providers receive capitated payments and manage all care for a population.

6.4.3 A Potential Opportunity Through the ACE Kids Act

The federal Medicaid Services Investment and Accountability Act of 2019 includes a section referred to as the Advancing Care for Exceptional Kids Act (ACE Kids Act) which will give states the option to provide coordinated care to children with medically complex conditions through health homes. Beginning on October 1, 2022, states may pass a state plan amendment to establish health homes specifically designed for eligible children in return for a 15% increase to the state's federal matching rate (FMAP). Children under 21 years of age with at least one chronic condition affecting three or more organ systems, severely reducing cognitive and physical functioning, and requiring durable medical equipment, therapy, surgery, or other treatments are eligible for the program. Other children who have "one life-limiting or rare pediatric condition" are also eligible under the Act. Providers (including children's hospitals) may qualify as a health home if they coordinate prompt care for eligible children, develop individualized pediatric family-centered care plans, coordinate access to subspecialty pediatric services, and provide palliative services if covered under their state's Medicaid plan. Health homes must also arrange access to services from out-of-state providers when medically necessary. States participating in this program will share relevant pediatric patient data with CMS and specify methodologies for determining payment to health homes within state plan amendments, including payments on a per-member, per month (PMPM) basis and alternative payment models (APMs). In addition, under this act, the federal Health and Human Services Secretary will award planning grants of up to $5 million for states to develop home health programs and document them in their state plan amendments.

7 Conclusion

A variety of funding sources and payment pools exist for reimbursement of care provided at hospitals to Medicaid beneficiaries and the uninsured. Funding sources that are and/or could be used to fund reimbursement to the stand-alone specialty children's hospitals in Florida include state general revenue, inter-governmental transfers, and the healthcare provider assessment. Current reimbursement pools include DRG payments for hospital inpatient services, EAPG payments for hospital outpatient services, per-claim add-on payments referred to as Automatic Rate Enhancements (AREs), Graduate Medical Education (GME) payments, Disproportionate Share Hospital (DSH) payments, and Low Income Pool (LIP) payments.

Several of these payment pools include rates and/or allocations that are higher for stand-alone specialty children's hospitals. These include:

- Inpatient and outpatient claim payments, both of which have policy adjustors applied to stand-alone children's hospitals,
- The DSH program, which has a separate allocation calculation for stand-alone children's hospitals, and
- LIP, which has reimbursed 100% of charity care at stand-alone children's hospitals in prior years

These higher payment amounts are justified by the fact that Medicaid utilization is extremely high at the stand-alone children's hospitals. As a result, stand-alone children's hospitals are heavily dependent on Medicaid reimbursement and less able to cover costs through higher reimbursement from other payers.

Specifically for claim payments, the Florida Legislature has in recent years moved Medicaid reimbursement to acuity-based methods, consistent with methods used by most Medicaid agencies across the country. This payment method modernization moved Florida Medicaid away from cost-based, hospital-specific rates and into rates which are consistent for all hospitals within certain categories. These provider categories are developed to provide equity across hospitals with similar characters and cost structures. Even so, cost coverage will not be consistent for each hospital within a category because the cost structures are not exactly the same for every hospital in a category.

One hold-over from the older cost-based payment methods, Automatic Rate Enhancements (AREs), is still in existence and distributes funds in a way that is not equitable to hospitals within categories. In addition, the thresholds currently defined for the Inpatient High Medicaid Utilization and High Outlier provider policy adjustor are applied consistently, but are high enough to exclude Wolfson Children's Hospital, one of the stand-alone children's hospitals. If the Florida Legislature wishes to change the ARE inequity and/or adjust the thresholds so that Wolfson Children's Hospital qualifies for the same DRG provider policy adjustor as the other stand-alone children's hospitals, the result will be higher total reimbursement to the stand-alone children's hospitals. If either of these changes is made without an increase in Medicaid funding, then a necessary consequence will be a decrease in Medicaid reimbursement to other Florida hospitals.

Two other payment pools, the LIP program and the DSH program, have not yet been updated to include Wolfson Children's Hospital as a stand-alone specialty children's facility. Inclusion of Wolfson in the LIP program will occur once FUHRs data has been reported for Wolfson separate from Baptist Medical Center Jacksonville. Once such data is obtained, the amount of inter-governmental transfers submitted for LIP Tier 2 will determine if all hospitals in the tier will continue to receive reimbursement for 100% of their charity care. Inclusion of Wolfson in the DSH program requires Disproportionate Share Review (DSR) data to be reported separately for Wolfson for the most recent three years.

Lastly, in addition to existing payment methods, Alternative Payment Methods (APMs) for the stand-alone specialty children's hospitals may be considered by Florida Medicaid. APMs are relatively new in the U.S. healthcare system, particular when designed specifically for a child population. A small number of pilot programs designed specifically for a child population have shown modest reductions in healthcare costs. To achieve these reductions, significant improvements in coordination of care, integration of hospital and community-based care, and involvement of family members were required.

Appendix A – Letter from AHCA Documenting Inequity in ARE Disbursements

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

April 4, 2019

Honorable Senator Aaron Bean
405 Senate Office Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Chair Bean:

I recently had the pleasure of meeting with leaders from Nemours Children's Hospital on a range of health care issues. During our discussion, a funding inequity with regard to the hospital's Medicaid reimbursement was brought to my attention. As the Florida Senate begins budget conference, I wish to highlight this issue.

As part of the approval of the Nemours Children's Hospital Certificate of Need (CON) in 2005, the hospital's Medicaid reimbursement was limited, for the first five years of operation, to the Medicaid reimbursement of the average of the then two existing specialty children's hospitals. This condition meant that the hospital received substantially less reimbursement than it would otherwise have been entitled to had it been calculated in the same manner as the other specialty children's hospitals exempt from the cost limits and ceilings. Opening in October of 2012, by 2017 the hospital had satisfied that CON condition; however, the method for calculation of their reimbursement of automatic rate enhancements has not changed. Nemours continues to have a reimbursement for automatic rate enhancements that is not calculated in the same manner as that utilized in the original calculation for the other two specialty children's hospitals.

The Agency believes that it requires legislative budget authority to address the funding inequity in reimbursement to Nemours Children's Hospital to assure their reimbursement for the automatic rate enhancement in the Diagnosis-Related Groups (DRG) and Enhanced Ambulatory Patient Grouping (EAPG) payment methodology is calculated in the same manner as that utilized in the calculation of the other specialty children's hospitals.

Sincerely,

Mary C. Mayhew
Secretary

MCM/ww
cc: Honorable Senator Bob Bradley

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Appendix B – Acronyms

ACO	Accountable Care Organization
AHCA	Florida Agency for Health Care Administration
APC	Ambulatory Patient Classification System
APM	Alternative Payment Model
APR-DRG	All Patient Refined Diagnosis Related Group
ARE	Automatic Rate Enhancement
CARE	Coordinating All Resources Effectively
CHA	Children's Hospital Association
CHIP	Children's Health Insurance Program
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
CPE	Certified Public Expenditure
CY	Calendar Year
DRG	Diagnosis Related Group
DSH	Disproportionate Share Hospital
DSR	Disproportionate Share Rate
DSR	Disproportionate Share Review data
EAPG	Enhanced Ambulatory Patient Grouping
FFS	Fee-For-Service
FHURS	Florida Hospital Uniform Reporting System
FMAP	Federal Medical Assistance Percentages
FMMIS	Florida Medicaid Management Information System
GAA	General Appropriations Act
GME	Graduate Medical Education
HFMA	Healthcare Financial Management Association
IGT	Inter-Governmental Transfer
IHI	Institute for Healthcare Improvement
LAN	Learning Action Network
LIP	Low Income Pool
MCO	Managed Care Organization
MHVA	Medicaid High Volume Adjustment
MIPS	Merit-Based Incentive Payment System
MS-DRG	Medicare Severity Diagnosis Related Group

NAS	Neonatal Abstinence Syndrome
NICU	Neonatal Intensive Care Unit
P4P	Pay-For-Performance
PCMH	Patient-Centered Medical Home
PMATF	Public Medical Assistance Trust Fund
PMPM	Per Member Per Month
PPA	Potentially Preventable Admission
PPE	Potentially Preventable Event
PPR	Potentially Preventable Readmission
PPV	Potentially Preventable Emergency Department Visit
PSN	Provider Service Network
ROM	Risk of Mortality
SDA	Standard Dollar Amount
SFY	State Fiscal Year
SOI	Severity of Illness
STC	Special Terms and Conditions
TAE	Total Amount Earned
UC	Uncompensated Care
UPL	Upper Payment Limit
VBP	Value-Based Purchasing