

# Medicaid and Health Plan Information

## Overview of Low Income Pool Distributions and Intergovernmental Transfers

Justin M. Senior

Deputy Secretary for Medicaid

Agency for Health Care Administration

Presented to the Commission on Healthcare and  
Hospital Funding

**May 20, 2015**

**Tallahassee, Florida**



# Managed Medical Assistance (MMA) Rates



# Managed Care Plan Rate Setting

- Plans are paid a capitation rate for each recipient enrolled in their plan.
- Rates paid to the health plans must be actuarially sound.



# Managed Care Plan Rate Setting

- Capitation rate is the per-member-per-month amount (PMPM), including any adjustments, that is paid by the Agency to a health plan for each Medicaid recipient enrolled under a contract for the provision of Medicaid services during the payment period.
- The capitation rates reflect historical utilization and spending for covered services projected forward and are adjusted to reflect the level of care profile (risk) for enrollees in each health Plan.



# Managed Care Rate Setting

- Rates must be approved by CMS.
- “Actuarial Soundness” required by 42 CFR 438.6(c).
- Rates must be certified; changes to rates must be accompanied by documentation from the actuary.
- Florida contracts with an actuarial firm for rate setting: Milliman.



# Managed Care Plan Rate Setting

- Actuarial Soundness:
- Developed by a qualified actuary and provide for all reasonable, appropriate, and attainable costs of providing the required care and administering the contract.
  - Benefit costs
  - Administrative expenses
  - Fees and taxes
  - Cost of capital



# MMA Capitation Rates

- Competitive procurement (2014-2015)
  - “Best value” to the state included negotiated capitation rates for the period May 1, 2014 – Aug 31, 2015
  - Detailed Data Book & sample methodology in ITN
  - Bidders submitted cost proposals, methodology, and actuarial certification
  - Negotiations resulting in a rate schedule of common rates for all awarded standard plans in each region
- State Established (remaining contract years)



# MMA Rates – Year 2

- Will be effective from September 2015 – August 2016
- Established by the Agency's contracted actuarial firm, Milliman, with significant input and feedback from the plans
- Target distribution of draft rates for plan review: June 5





# Low-Income Pool Program Overview



# Low-Income Pool Program

- The Low Income Pool (LIP) program was initially established as part of the Florida Medicaid Reform Demonstration Waiver which began operation in 2006.
- The Low Income Pool is a way to provide more funding to providers, mainly hospitals, for providing care to Florida's vulnerable population.
- The current LIP program will end on June 30, 2015.



# Low-Income Pool Program

- Local government entities, such as taxing districts, put money into the Pool using a mechanism called an Intergovernmental Transfer, or IGT.
- The Agency then draws federal Medicaid funding from the federal government in the amount of the Federal Medical Assistance Percentage, or FMAP.
- The current FMAP is 59.56 (for SFY 2014-2015). Therefore, if a local entity puts up \$40.44, they will get back \$100.00 (which includes \$59.56 in federal funds)



# Low-Income Pool Program

- The current LIP program total computable dollar limit for expenditures in DY9 (SFY 2014-2015) is \$2,167,968,341. This total includes the following elements:
  - \$1 billion (for DY1 - DY8, LIP funding had a capped allotment of \$1 billion disbursed in quarterly payments to providers);
  - \$963,184,508 (historical spending amount for self-funded hospital rate exemptions and buybacks, conditional on the state's assurance that no such rate exemptions or buybacks will be executed apart from LIP in DY9);
  - \$204,533,833 (historical supplemental payment amount for physician groups with medical school affiliation, conditional on the state's assurance that no such supplemental payments will be made apart from LIP in DY9).



# Low-Income Pool Program Participation Requirements for Hospitals

- Must contract with at least fifty percent of the Standard Plan Managed Care Organizations (MCOs) in their corresponding region;
- Must contract with at least one Specialty Plan serving each specialty population in their corresponding region; and,
- Participate in the Florida Event Notification program.



# Where do LIP dollars come from? (in millions)

State General Revenue	\$9.1
Local Taxes & Other Agencies	\$867.6
<u>Federal Funds</u>	<u>\$1,291.2</u>
<b>Total</b>	<b>\$2,167.9 billion</b>



# LIP Distribution (in millions)

LIP 4	\$764.0
LIP 5	\$2.4
LIP 6	\$963.2
Special LIP	\$116.5
Other Provider Programs	\$321.8
<b>Total</b>	<b>\$2,167.9</b>



# LIP Allocated and Proportional Distribution

Funding of \$1,729.6 million

- Allocation factor is 8.5%
- Increased \$963.2 million due to the addition of the LIP 6 distribution.





# LIP 4 and LIP 5

Total Funding \$766.4 million

- Funds in LIP 4 (\$764.0 million) are first allocated to hospitals where local government funds are transferred to the State of Florida for use in the LIP program and former exemption programs.
- The designated hospital will receive a LIP 4 distribution equal to the IGT plus an 8.5% allocation factor.
- Funds in the LIP 5 category (\$2.4 million) are provided to statutorily defined rural hospitals that ensure access to medical care for those individuals in the rural parts of Florida.
- Quarterly LIP payment contingent on the non-federal share of matching funds provided by local governmental entities based upon a Letter of Agreement (LOA) between the Agency and the local government.



# LIP 6

Total Funding \$963.2 million

- Existing funding but new to the LIP.
- Based on the SFY 2013-14 spending amount for self-funded Inpatient hospital DRG Add-on and Outpatient hospital rate exemptions and buybacks.
- Quarterly LIP payment contingent on the non-federal share of matching funds provided by local governmental entities based upon a Letter of Agreement (LOA) between the Agency and the local government.



# Special Hospital LIP

Funding \$116.5 million for the following initiatives:

– Rural	\$ 5.6 m
– Primary Care	\$ 12.0 m
– Specialty Pediatric	\$ 1.4 m
– Trauma	\$ 8.8 m
– Tier One Quality Measures	\$ 15.0 m
– Safety Net	\$ 73.1 m
– <u>Independent Report</u>	<u>\$ 0.5 m</u>

**Total Special LIP**

**\$ 116.5 m**



# Questions?

