FLORIDA HOSPITAL ASSOCIATION

POLICY DOCUMENT

HOSPITAL DIRECTED PAYMENT PROGRAM (DPP)

ISSUE BRIEF

MARCH 2023

Background

Florida hospitals historically have been reimbursed less than their actual costs for caring for Medicaid enrollees. On average, payment is 60% of total costs. This leaves an underpayment of 40%.

Hospitals have also not seen Medicaid rate increases for many years. Supplemental Medicaid payments help offset some of the unfunded costs of caring for Florida's more than five million Medicaid enrollees.

The Directed Payment Program provides funding for hospitals that provide inpatient and outpatient services to Medicaid managed care enrollees. As a Medicaid payment, this funding includes a combination of both Intergovernmental Transfers (IGTs) and federal dollars.

Florida first received approval by CMS for the hospital DPPs in 2021.[1] In state fiscal year 2021-2022, hospitals received $1.8 billion with a net DPP payment (after IGT) of $1.2 billion.[2]

As part of its comprehensive update to Medicaid managed care regulations in 2016, CMS required states to phase out the use of pass-through payments. In their place, the agency created a new option for states to direct payments to providers under certain circumstances. CMS required that directed payments be tied to utilization and delivery of services under the managed care contract, be distributed equally to specified providers under the managed care contract, advance at least one goal in the state's managed care quality strategy, and not be conditioned on provider participation in intergovernmental transfer (IGT) agreements. In addition, CMS requires annual approval of DPP arrangements.

Hospitals participating in the program must operate in one of Florida's Statewide Medicaid Managed Care (SMMC) regions, providing inpatient and outpatient hospital services to SMMC enrollees that fall into one of the following three mutually exclusive hospital classes: Private Hospital Class, Public Hospitals, and Cancer Hospitals.

The eligible hospitals within each region will receive payments under the arrangement upon the conclusion of certain time intervals during the rating period, as the state sets. After an interval period concludes, the state will solicit and collect a report from the health plans in a standard format that details utilization and associated base payment data for the interval period for each eligible hospital contracted with the plan.

[1] Senate HHS Appropriations DPP Presentation, 2021
[2] https://ahca.myflorida.com/Medicaid/Finance/finance/LIP-DSH/dpp/pdf/Year_1_Hospital_DPP_payment.pdf

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The Agency for Health Care Administration (AHCA or the agency) will use these reports as the primary source to determine the payments the health plan will be directed to pay to eligible hospitals. Due to the payment amounts being calculated on a retrospective, periodic basis, the health plans will effectively make additional payments on claims for which initial payments at base contracts have previously been made.

The estimated Medicaid shortfall amount is determined by taking the Medicaid cost and deducting the reimbursement received to inform the analysis. The uniform rate increase percentages are initially set in a manner intended to result in eligible hospitals, in the aggregate, receiving an amount equal to the estimated Medicaid shortfall amount, assuming utilization and negotiated base rates will not materially deviate from historic utilization during the previous managed care contract rating period.

AHCA annually reviews and evaluates the data from the program. The collected data includes performance data on the measures throughout the subsequent years of the program and assess the direction of change in relation to the baseline data to determine if the projected thresholds have been met from the previous fiscal year. For each of these areas of focus in which the region's average score meets the regional target, the state makes the withholding portion of the payment. The withhold payment will not be made if the regional targets are not met.

It is important to have the correct metrics in place to measure these outcomes. For example, the quality metric regarding follow-up visits for mental illness may not appropriately reflect a hospital's quality of care. It is also important to assess individual hospital performance, instead of regionally.

DPP is not a substitute for, nor is it an opportunity to supplant general revenue. Proactive action needs to be taken each year by hospitals, local governments, AHCA, and CMS to obtain approval to continue the program. There are multiple stakeholders in each Medicaid Region, and there is the possibility that some regions will participate in the program each year while others will not. Because of the fluctuations that can occur in this program, permanent fund decisions should not be based on these temporary funding streams.

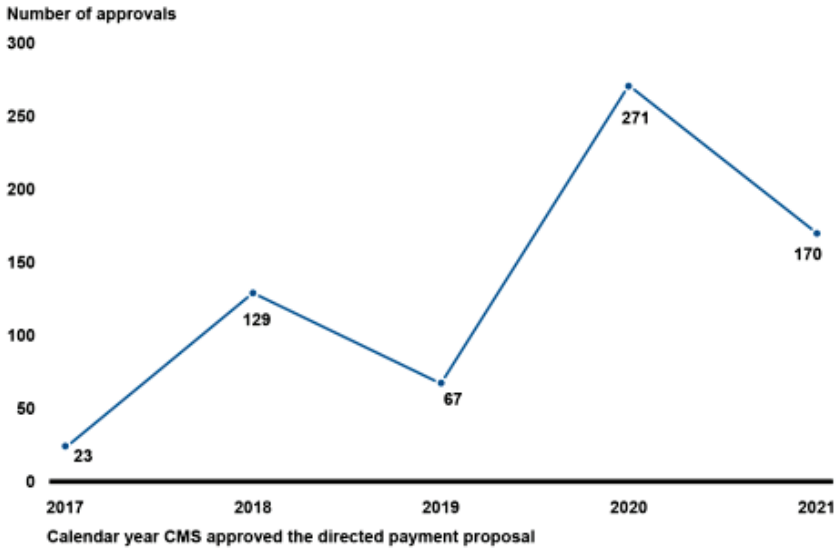
Federal Authorization

In 2016, the Centers for Medicare & Medicaid Services (CMS) updated Medicaid Managed Care (MCC) regulations to create a new option for states. This option allowed states to direct managed care organizations (MCOs) to pay providers according to specific rates or methods. This permitted the use of state directed payment arrangements. CMS review of state directed payment arrangements took effect beginning with contract rating periods on or after July 1, 2017.

CMS requires the state to seek approval each year for the program's pre-print model and receive authorization by the Florida Legislature. CMS has approved 660 state directed payment proposals since it began approving them in 2017.[3] As shown in the below figure, CMS approved the most state directed payment proposals in 2020, the same year guidance was issued on how states could use directed payments to require managed care plans to temporarily enhance provider payments in response to the COVID-19 pandemic.

[3] US GAO Report, June 28, 2022

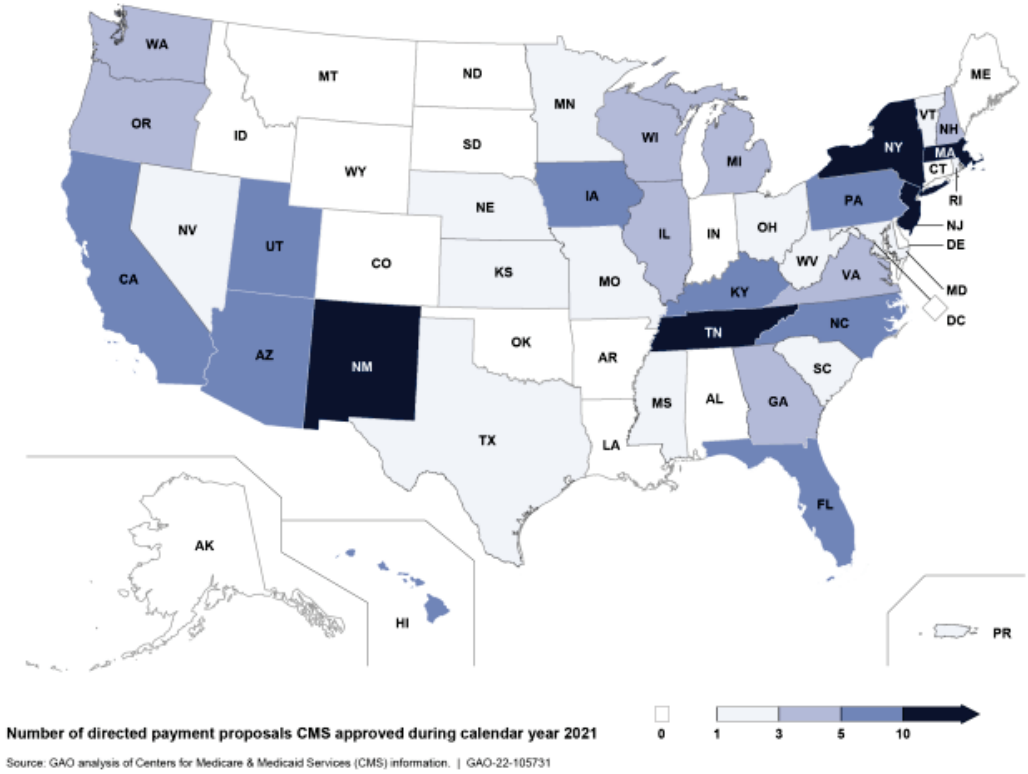
Figure 2: State Directed Payments CMS Approved in 2017-2021



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information. | GAO-22-105731.

In 2021, 36 states had CMS approval for one or more directed payments, the most recent year for which complete information on the number of approvals was available, up from 10 in 2017.

Figure 3: State Directed Payments Approved in 2021



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information. | GAO-22-105731

State Authorization

Florida's Hospital Directed Payment Program (DPP) was authorized through the General Appropriations Act, SB 2500, in the 2021 Legislative Session.

The program collects Intergovernmental Transfers (IGTs) as the non-federal/state match to draw down federal Medicaid matching dollars—not requiring additional General Revenue from the state's budget. A directed payment program is a mechanism authorized by CMS that allows states with Medicaid Managed Care waivers to seek approval from CMS to direct managed care plans to make certain payments.

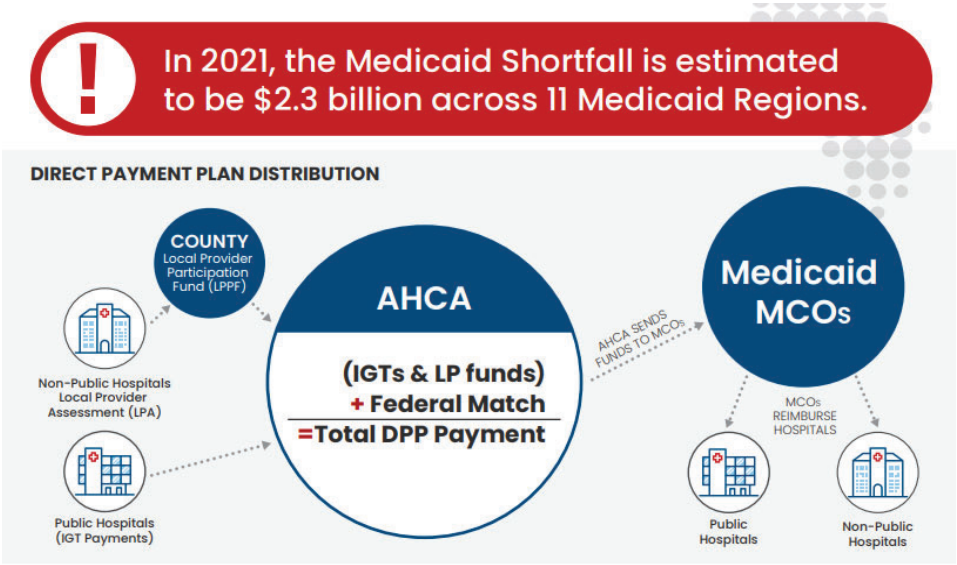
The program was allocated $1.8 billion total funds to disburse payments through the Medicaid Managed Care contracts for the 2021-2022 (Year 1) state fiscal year. The Hospital DPP Program is a non-recurring appropriation and must be renewed by the Joint Legislative Budget Commission (LBC) each year and must be approved annually by CMS.

Collection of State Intergovernmental Transfers (IGTs) and Local Provider Participation Fund (LPPF)

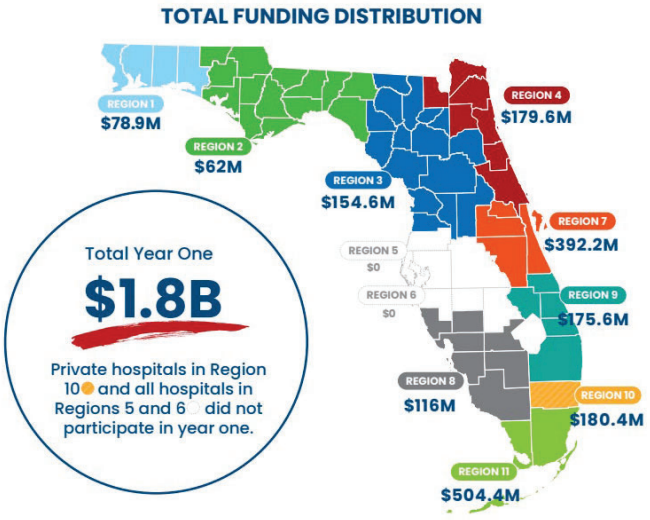
Similar to other Medicaid supplemental payment programs, public hospitals contribute Intergovernmental Transfers (IGTs) directly to the Agency. For private hospitals, county governments established Local Provider Participation Funds (LPPFs) to assess, collect and contribute to Local Provider Assessments (LPAs) to also be used to draw federal matching funds. Provider assessments, levied to collect IGTs for directed payment programs going to a similar type of provider, must not exceed six percent of net patient revenue.

Year 1: Fiscal Year 2021 - 2022

The payment arrangement directed payments within each Statewide Medicaid Managed Care (SMMC) region equally to all hospitals in each class for hospital services provided by hospitals and paid by Medicaid health plans. Of the $1.8 billion that was distributed in year one, roughly $622 million came from directed payment Intergovernmental Transfers, and $1.2 billion came from matching federal Medicaid funds.



In Year 1 of the program, all public hospitals in the designated regions participated in the program, except hospitals in regions 5, 6, and the private hospitals in region 10.



Year 2: Fiscal Year 2022 - 2023

On September 29, 2022, CMS approved Florida's application for the second year of the DPP program for the rating period ending September 30, 2022.[4] Included are preprint are details on how the program will be administered and quality measures that will require hospitals to meet certain metrics to qualify for payments. More details are listed below. The next step is for AHCA to obtain budget authority from the state Joint Legislative Budget Commission (LBC).

Included with CMS' approval of Florida's 2022-2023 DPP program is a companion letter indicating that CMS will conduct a focused review of the state's LPPF program during FY2023 and the state's financing of the non-federal share of the DPP program. The audit will investigate the extent to which the state's current LPPF arrangements constitute "hold harmless arrangements" in violation of the Social Security Act. CMS draws a comparison to other state DPP programs that have apparent hold harmless arrangements but note that a state need not directly participate for the hold harmless arrangement to violate federal law. AHCA has denied awareness of any hold harmless arrangements in previous communications with CMS on the matter.

New Quality Metrics: Measure Year 1 (Program Year 2)

The state deployed a Hospital Quality Improvement and Measures Monitoring Program to improve health outcomes for Medicaid recipients enrolled in managed care. The 2019 calendar year acted as a baseline year to calculate the performance metrics by Medicaid region to determine the improvement targets for each region. The performance metrics established by the Agency were used to determine improvement targets for each region are primary cesarean sections (c-sections), potentially preventable hospital readmissions, and follow-ups after hospitalization for mental illness. These metrics were run for each region for the Rate Year 2021-2022 period at least nine months after the end of the second program year.

[4] CMS approval of Florida's DPP Application, September 29, 2022

Each regional rate was compared to the improvement targets to see if the performance metrics were met.

In the first year of the program, the state collected baseline data on the proposed measures for Year 2. The state reviewed and evaluated the data metrics annually to determine if hospitals are reaching the improvement targets for each region. For each of these areas of focus in which the region's average score meets the regional target, the state will make the withholding portion of the payment. The withhold payment will not be made if the regional targets are not met.

- If a region meets the improvement targets for the three metrics, the hospitals in that region will receive the six percent withhold.
- If a region meets the improvement targets for two metrics, the hospitals in that region will receive four percent (two-thirds of the withhold).
- If only one of the metrics meets the improvement target, the regional hospitals will receive two percent (one-third of the withhold).

AHCA will calculate the outcome of the measurement for each fiscal year of the payment program to determine how much will be allocated to each region.

FHA is seeking further clarification from AHCA on follow-up visits after a hospitalization for mental illness. We recognize the importance of this nationally recognized quality metric; however, post-hospitalization follow-up visits are not always under the control of the hospital. A variety of other factors, including the availability of community-based behavioral health providers, also influence whether a patient is seen after a hospital visit.

Key Takeaways

FHA supports all approaches to help hospitals receive funding to care for Florida's most vulnerable patients. FHA also supports quality improvement goals. Timely access to accurate data is important to measure quality outcomes. It is also important to have the correct metrics in place to measure these outcomes. For example, the quality metric regarding follow-up visits for mental illness may not appropriately reflect a hospital's quality of care. It is also important to assess individual hospital performance, instead of regionally. FHA looks forward to continuing working with Agency to enhance the quality of care in Florida through the DPP program.

Resources

CMS Approval Of Florida's DPP Application, September 29, 2022
CMS Letter To AHCA, Review Of The State's LPPF Program
AHCA Emergency Order 22-002
Year One DPP Payment Model
CMS Letter to AHCA, April 2021
AHCA Legislative Budget Commission Meeting Number: B2022-0114 September 2021
Senate HHS Appropriations Subcommittee, DPP, November 2021
CMS Guidance on State Directed Payments in Medicaid Managed Care, January 2021
Medicaid State Directed Payments Guidance
SB 2500, 2021 GAA
HB 5001, 2022 GAA