Covering Florida

Expanding Access to Healthcare for the Low-Income Uninsured

DEVELOPING STATEWIDE STRATEGIES

Opportunities for Collaboration and Change in Health Care Access for Florida's Uninsured

Addendum

Medicaid, DSH and UPL

Among the most significant areas of interest for those seeking to understanding health care finance are the areas of Medicaid funding, Disproportionate Share (DSH) funding and Upper Payment Limits (UPL). These also are among the most complex and nuanced funding arenas.

With that in mind, the Florida Hospital Association offers some additional perspectives on these topics.

With respect to Medicaid financing, states earn federal funds as state funds are spent. DSH and UPL expenditures are not tied to individual claims for specific beneficiaries.

Enhanced payments under DSH and UPL are mechanisms for states to compensate providers when the claim-by-claim payments have been inadequate for a variety of reasons. In the case of DSH, the intent of the program is to "take into account the situation of providers serving a disproportionate number of low income patients with special needs." Note that this objective exceeds that of paying for Medicaid patients and encompasses the larger mission of delivering uncompensated care to charity patients.

Such enhancements are particularly important in this state because Florida's basic Medicaid program and payments are inadequate in a number of ways:

- Florida's eligibility standard is low -- 34th among 50 states for children and 37th for adults.
- Per capita Medicaid expenditures in Florida are lower than the national average.
- On average, Medicaid payments to Florida hospitals are equal to 83% of the cost of the services, while other states average 94%.
- Specific payment restrictions include a $1,500 cap on outpatient visits and a 45-day limit on inpatient stays.

Clearly, some enhancements are necessary to even approach reasonable payment levels to providers.

The state match in Florida for both DSH and UPL is supported with a combination of state and local funds. The earned federal match does not supplant the state's share of this Medicaid spending. Recently, the Centers for Medicare and Medicaid Services (CMS) has initiated stricter controls and more active oversight for DSH and UPL programs. These changes are affecting the way several states implement DSH and UPL. However, Florida's plan has not been the subject of any direct or specific criticism.

Understanding the amount of DSH funding in the state is complicated by the fact that there are several ways to calculate the numbers depending on the specific program and variations in the state or federal fiscal year.

Florida established the PMATF (a 1.5% assessment on hospital revenues) in 1988 and used it initially to fund the establishment of DSH programs. In 1992, the fund was directed to general support of the Medicaid program and local taxes from four counties were transferred to the state to pay for DSH. This method continued until last fiscal year when the local tax base providing DSH match was broadened further. The PMATF is clearly a broad provider tax and these funds are general revenue to the state.

Hospital taxing districts in Florida are, in many instances, units of county government. Through counties and districts, local taxes are raised to pay for many of the same or similar services as covered by Medicaid. These sources often supplement Medicaid payments that do not cover costs. Intergovernmental Transfers (IGTs) provide a reasonable mechanism for allowing these local taxes -- dedicated to similar purposes -- to be matched by federal funds. The resulting enhanced payments allow Medicaid to come closer to covering costs.

Additionally, there are controls on payments to individual hospitals that go beyond the aggregate upper payment limit. These are the "charge limit" and the "general limit." Under the general limit, the state cannot pay any individual hospital more than the cost of treating Medicaid and charity care patients. According to the charge limit, the state cannot pay more than the amount of hospital charges for Medicaid patients alone.

For several years, there were two tiers of UPLs: one for all nursing facilities and private hospitals; another for county or other public hospitals. However, guideline revisions that became effective in May 2002 ended this two-tiered approach.

The plan amendment for physician UPL submitted by AHCA this year seeks to allow payments for physician services provided through all teaching hospitals in the state. The FY 03-04 budget anticipates expansion of the program in order to provide sufficient funding to increase all physician fees.