Parameters for LIP and IGTs

Problem Statement
Without federal approval for LIP payments, Medicaid payments to Florida hospitals will be reduced by $1.3 b or 15% of current levels.

- Hospital payments
  - Federal regulations require provider payment rates to be "adequate".
  - State capitation rates must be "actuarially sound" enabling the managed care organization to pay providers at market-based rates.
  - Based on the Navigant study, Florida Medicaid payments to hospitals currently constitute, on average, just 49% of the costs for Medicaid and uncompensated care.
  - The pay to cost ratios range from a high of 55% (for 104 hospitals that contribute IGTs and receive related payments) to 22% of costs for 88 non-IGT hospitals.
  - The 104 IGT-hospitals account for 70% of Medicaid hospital claims.
- Net payments
  - 139 hospitals receive $1.6 B in net benefit from LIP/IGT related payments.
  - Nets range from $115,634 (Sacred Heart, Gulf Coast) to $270 M for Jackson Memorial
  - $679 m in state funds are needed to sustain these nets without IGTs.
  - If only 60% of the net benefits are preserved, $407 M in state funds are required.
  - 23 hospitals receive more than $15 M in net benefits; $497 M in state funds are required to sustain nets for these 23 hospitals.
- Payment methods
  - Claims-based payments are made either directly as fees for services (FFS) or through managed care organizations
  - Supplemental payments require a waiver; supplemental payments are the only way to ensure net benefits remain proportionate to prior payments.
  - Payments to providers made as part of an approved rate structure do not require a waiver.
  - States have considerable flexibility in setting provider rates; rates can be enhanced for all hospitals when the base is increased or for certain hospitals when facility adjusters are used.
  - Facility adjusters that increase the difference in payment levels for some hospitals can negatively affect use of that hospital in a managed care environment.
- Funding sources
  - Since 1986, a variety of policies have replaced state GR in hospital payments with funds from other sources; currently, state GR constitutes only 37% of the state share of Medicaid payments to hospitals.
  - IGTs are voluntary donations and their availability depends on incentives to the donors.
  - GR is only available depending on other state spending priorities.
  - Provider assessments (PMATF): could be used to replace IGTs or as a transition to more GR.
- Beneficiaries
  - Old LIP/IGT primarily benefits public hospitals
  - Senate LIP plan extends benefits (through increases in base DRG rates) to almost all hospitals
  - Amount of GR required to replace IGTs is lowered marginally by limiting number of beneficiaries or limiting degree of benefit