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July 8, 2016

Jackie Glaze
Associate Administrator
Medicaid and Children's Health Operations
Atlanta Federal Center
61 Forsyth Street, Room 5B95
Atlanta, GA 30303-8909

Re: CMS letter dated May 20, 2016

Dear Ms. Glaze:

As requested by the Safety Net Hospital Alliance of Florida, the Agency for Health Care Administration is forwarding their analysis of the referenced letter regarding the Standard Terms and Conditions (STCs) agreed upon by CMS and the Agency.

In October of 2015, after extended negotiations, the Agency and CMS agreed to the STCs. This was the culmination of a multi-year effort to extend the LIP funding to which CMS has expressly agreed for DY 11. As you will note, the Alliance has raised several points regarding the language of your letter.

The Agency plans to implement the Medicaid Hospital Funding Programs Final Conference Report as laid out in Florida House Bill 5001, the General Appropriations Act for State Fiscal Year 2016-2017. In implementing this Act, the Agency intends to comply with paragraph 71.b.ii. of the STCs to ensure that all providers that meet the LIP provider participation requirements and that furnished uncompensated charity care will receive some amount of payment. The Agency equally intends to comply with paragraph 92.e. by accepting any and all voluntary local contributions of intergovernmental transfers in a manner that does not make such contributions contingent on pre-arranged agreements directly between health care providers and the state government to return and/or redirect any portion of Medicaid payments. It remains unclear why CMS believes the Agency would not comply with the above mentioned STC paragraphs in implementing the Medicaid Hospital Funding Programs Final Conference Report as laid out in our state's General Appropriations Act. If, at any point, you believe the Agency has failed to comply with these specific paragraphs, we look forward to hearing your concerns.

The Agency did not seek a waiver of section 1902(a)(2) of the Social Security Act. However, STC 67 for Demonstration Year (DY) 11clarifies that Medicaid Recipients are not included in the Low Income Pool (LIP), thus the language of section 1902(a)(2) of the Social Security Act does not apply to LIP program funds contributed from local sources. No State Plan services are provided to Florida Medicaid recipients through LIP funding and, consequently, a lack of adequate funding from local sources does not result in lowering the amount, duration, scope or quality of services available under the State Plan. As noted by Florida in its response to CMS' draft STCs relating to this issue: (1) the Agency does not have the constitutional authority to commit state funds if the locally sourced IGTs are not voluntarily provided to the State; (2) no

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language relating to 1902(a)(2) was included in CMS' agreement in principle letter dated June 23, 2015; and (3) Florida's LIP program is entirely voluntary and not tied to the State Plan and, now the LIP program is entirely based on charity care in DY 11. The STCs do not contain this inapplicable language because the Agency and CMS mutually agreed to excise it from the original draft submitted by you during the summer of 2015.

We recognize and value our ongoing partnership in funding medical services for Medicaid recipients and for those not on Medicaid who receive uncompensated care. We also understand that the STCs we agreed to are mutually binding.

Should you have any questions, please contact Tom Wallace on my staff by phone at (850) 412-4117 or by email at Thomas.Wallace@ahca.myflorida.com.

Sincerely,

Elizabeth Dudek
Secretary

ED/mgt
Enclosure

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MEMORANDUM

To: Safety Net Hospital Alliance of Florida

From: Eyman Associates, PC
Jan Gorrie, Ballard Partners

Date: June 20, 2016

Re: Legal Analysis of CMS' May 20, 2016 Letter to the Agency for Health Care Administration

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You have asked us to provide a legal assessment of the concerns outlined by the Centers for Medicare & Medicaid Services (CMS) in a letter dated May 20, 2016 to the Agency for Health Care Administration (AHCA). In that letter, CMS cautioned that implementation of Florida's Low Income Pool (LIP) and Medicaid rate adjustments could potentially violate certain provisions of federal Medicaid law and portions of the Special Terms and Conditions (STCs) governing the state's section 1115 waiver. As detailed further below, we believe the concerns outlined in CMS' May 20 letter are premature and unfounded.

I. Background

As you know, the Florida Legislature recently enacted legislation appropriating funds to the LIP for the 2016-2017 fiscal year. As has been the state's practice for many years, the legislature incorporated by reference the calculations in a document titled "Medicaid Hospital Funding Programs" "for the purpose of displaying the calculations used by the Legislature" in determining the amount of LIP funding to authorize.[1] The funding document describes the methodology for distributing LIP funding for the 2016-2017 fiscal year. More specifically, it specifies that hospitals receiving LIP funds will be placed into four tiers based on their ratios of charity care cost to commercial charges, and hospitals in each tier will be paid up to a different percentage of charity care costs. The state's share of LIP payments will be financed through intergovernmental transfers (IGTs) from local governmental entities. The General Appropriations Act (GAA) also clearly authorizes AHCA to make modifications to the LIP "in the event the

[1] H.B. 5001, 2016 Leg., Reg. Sess. (Fla. 2016); H.B. 5003, 2016 Leg., Reg. Sess. (Fla. 2016).

amount of approved nonfederal share of matching funds is not provided" provided those changes are "consistent with the model, methodology, and framework utilized by the Legislature."[2]

Outside the LIP, the state has for many years provided for rate adjustments for certain categories of hospitals that serve a unique role in caring for Medicaid patients. The Florida legislature also appropriated funding for rate adjustments for 2016-2017 in its recent legislation, incorporating by reference calculations of projected payments from the Medicaid Hospital Funding Programs document. The state's share of rate adjustments will be financed with general revenues. The rate adjustment methodology for the 2016-2017 rate period will be incorporated into a state plan amendment (SPA) to be approved by CMS.

CMS appears to have concerns with two provisions in the Medicaid Hospital Funding Programs document that is referenced in recent appropriations language. First, the document's discussion of the LIP includes a "cascading provision," which indicates that if local funds are not available as anticipated to fully fund all four tiers of the LIP, LIP payments will be applied to hospital tiers in order of priority, with Tier 1 receiving full funding before funds are applied to Tier 2 and so on. Second the document authorizes that AHCA may re-assign rate adjustments among hospitals if:

> "(1) the hospital forfeiting the add-on agrees to the change; (2) the hospital receiving the increase is supporting the LIP program with contributions of local governmental funds via intergovernmental transfer (IGT), and (3) the commitment to contribute the IGTs is communicated to the Agency prior to the Agency finalizing hospital rates."[3]

The purpose of re-assigning rate adjustments is to "secure the non-federal share of LIP . . . payments from as many local sources as possible."[4] We analyze CMS' concerns with these two provisions and the state's compliance with applicable legal requirements below.

II. <u>Analysis</u>

As described below, the concerns outlined in CMS' May 20 letter are premature and unfounded. AHCA can implement LIP payments and rate adjustments for fiscal year 2016-2017 in a manner that is both consistent with its legislative authority and fully compliant with applicable federal and waiver requirements.

- If local funds are insufficient to fully support payments to hospitals in all four LIP tiers, AHCA can and must ensure that some amount of funding, even if small, is available for qualifying hospitals in all tiers, consistent with the legislature's intent and the requirements of STC 71(b)(1).

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[2] H.B. 5001, Line 208.

[3] Medicaid Hospital Funding Programs Fiscal Year 2016-2017, Final Conference Report for House Bill 5001, at 35 (Mar. 8, 2016), http://flsenate.gov/PublishedContent/Session/2016/Appropriations/Documents/2016_Medcaid_Hospital_Funding_Conference_Report.pdf [hereinafter the "Medicaid Hospital Funding Programs Document"].

[4] *Id.* at 37.

- AHCA may properly re-assign projected rate adjustments among hospitals to encourage broad participation in local financing arrangements to support LIP payments. CMS' provider donation regulations and related STC provisions simply are not implicated because providers have no legal entitlement to the projected adjustment amounts.
- Providers will retain all payments to which they are legally entitled in compliance with STC 92(e).
- Section 1902(a)(2) of the Social Security Act is not implicated because a reduction in local funding will not result in any reduction in the amount, duration, scope, or quality of care and services available to Medicaid beneficiaries.

A. Cascading Provision

Florida's STCs explicitly contemplate tiering of the sort described in the Medicaid Hospital Funding Programs document, but require that each qualifying provider "receive some amount of payment."[5] CMS' concern appears to be that the cascading provision in the appropriations legislation could in theory be interpreted in such a way that certain qualifying providers (e.g., those in Tier 4) would receive no LIP payment, if there are insufficient IGTs to support the LIP in its entirety. First, it is not at all certain that there will be insufficient local funds to fully finance LIP payments to all eligible hospitals in all tiers. Yet even if that were to occur, AHCA would be required to implement a final LIP methodology for the 2016-2017 fiscal year that complies with both the requirements of STC 71(b)(1) and the legislature's intent. It can do so by ensuring that some amount of payment, even if small, will be paid to hospitals in each tier. For example, AHCA could fully fund Tiers 1-3 and provide a de minimis amount of funding to hospitals in Tier 4. And certainly the Florida Legislature expects that AHCA will determine how to implement the LIP "consistent with the requirements of…federal law" so that the LIP is "redesigned to meet new federal CMS requirements."[6] Thus, CMS' concern is premature and is one that must be and would be resolved by AHCA as authorized in the GAA in the event that the IGTs are insufficient to support full LIP funding.

B. Rate Adjustment Provision

CMS has expressed concern that the "[r]e-assignment of add-on rate adjustment amounts between hospitals in consideration for provision of IGT funds" could violate several legal requirements, in particular 42 C.F.R. § 433.67(b), requiring states to deduct non bona fide provider-related donations from their quarterly medical assistance expenditures, and STC 92(e), requiring that providers retain 100% of the reimbursement amounts under the waiver.

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[5] STC 71(b).

[6] Medicaid Hospital Funding Programs Document (see cover letter and SFY 2016-17 LIP/Rate Report Model Summary); *see also* FL. STAT. § 409.908(1)(c) ("The agency shall seek and maintain a low-income pool *in a manner authorized by federal waiver* and implemented under spending authority granted in the General Appropriations Act.") (emphasis added).

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1. There would be no provider-related donations.

With respect to the cited provider donation regulation, no donation of funds from a private provider to the state or a local government will occur. A provider-related donation is defined as "a donation or other voluntary payment (in cash or in kind) made directly or indirectly to a State or unit of local government by or on behalf of a health care provider" or related entities.[7] Here, no direct payments will flow from providers to the state or local governments.

Nor will there be any indirect donations. Presumably CMS is concerned that the potential for AHCA to reassign rate adjustments among hospitals with their consent constitutes an indirect donation. Yet a donation can only be derived from funds to which a provider has a legal entitlement. Here, the passage of the appropriations legislation does not constitute a perfected legal entitlement to a rate adjustment. The provider has nothing to donate. All that providers will consent to forego is an opportunity for a potential adjustment in their rates. AHCA will be re-assigning *projected* rate adjustments among the hospitals for the policy goal of securing broad participation in local financing arrangements to support LIP payments.

The appropriations legislation referencing the Medicaid Hospital Funding Programs document does not guarantee specified payment amounts for individual hospitals. Table 1 of the document, for example, simply lists the "Effect of ***Projected*** Payments for Low Income Pool, DSH and Rate Enhancements."[8] Actual payments received by providers ultimately may be higher or lower than those projected in the document.

The legislation instead appropriates aggregate funding to AHCA (not directly to providers) for specified purposes (e.g., hospital inpatient services, LIP payments, disproportionate share hospital payments).[9] In many cases, amounts appropriated are contingent upon the availability of sufficient state and local funding. And the Medicaid Hospital Funding Programs document gives AHCA express authority to make adjustments to or re-assign rate adjustments among hospitals.[10] In other words, the appropriations bill is not self-implementing, but gives AHCA the authority to make rate changes.

Many intervening steps must occur before rate adjustments become final and owed to providers. Of the total funds projected for the rate adjustment in the Medicaid Funding Document, approximately **eighty-percent** will be incorporated into Medicaid Managed Care Organization (MCO) rates and not paid directly by the state to the provider. AHCA does not direct the expenditure of those funds or require the MCOs to pay the rate adjustments as projected in the funding document. Rather, the amount that the

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[7] 42 C.F.R. § 433.52; *see also* 42 U.S.C. § 1396b(w)(2)(A).
[8] Medicaid Hospital Funding Programs Document at 2 (emphasis added). The document explicitly states that IGT amounts—and by necessity the LIP payments funded with those IGTs—"are presented for demonstration purposes only and are not binding." *Id.* at 37.
[9] H.B. 5001 ("The moneys contained herein are appropriated from the named funds for Fiscal Year 2016-2017 *to the state agency indicated*, as the amounts to be used to pay the salaries, other operational expenditures, and fixed capital outlay of the named agencies . . ." and "for other specified purposes of the various agencies of state government") (emphasis added).
[10] Medicaid Hospital Funding Programs Document at 35.

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provider ultimately receives from the MCO, including the amount of any rate adjustment, depends solely upon the contractual rates that the provider negotiates at arm's length with each MCO and finalizes in an executed provider agreement. A hospital provider therefore has no legal entitlement to the portion of the rate adjustments listed in the funding document associated with managed care.

Likewise, there are many intervening steps on the fee-for-service side before the hospital is entitled to any particular funding amounts. AHCA must, exercising the authority delegated to it by the legislature, finalize fee-for-service rates for the applicable fiscal year—including the amounts of not only rate adjustments, but base rates, policy adjustors and other components of hospital inpatient rates. The legislature has delegated explicit authority to AHCA to determine the precise methodologies for reimbursing Medicaid providers and to adjust reimbursement rates as necessary to comply with the availability of funds and any other limitations or directions, "provided the adjustment is consistent with legislative intent."[11] The agency is also empowered to adopt methodologies that "the agency considers efficient and effective for purchasing services or goods on behalf of recipients."[12] Actual rate payment amounts, therefore, are not finally determined until AHCA completes its rate-setting process.

AHCA must then submit a SPA to CMS for approval. Based on the number of factors described above, that SPA could include final rate adjustments applicable to each hospital that are different than the amounts projected by the legislature. Only once CMS has approved the SPA are rates officially "established," thereby triggering AHCA's legal obligation under its contracts with providers to pay "the established rate" for services furnished to Medicaid recipients.[13] Indeed, AHCA's provider contracts are explicitly "contingent upon the availability of funds," such that even if CMS has approved certain rates in Florida's state plan, providers' entitlement to those rates is severed if funding to support those rates is not available as anticipated.[14]

Moreover, even after provider rates, including rate adjustments, are finalized (in negotiated contracts for managed care and in an approved SPA for fee-for-service), providers *still* do not have a legal entitlement to the funds. They must first provide services to Medicaid patients during the rate year in order to be entitled to the payments, and then they must submit clean and timely claims for payment. Only then will providers have a perfected legal entitlement to the rate adjustments.

Again, without a legal entitlement to the rate adjustment funding, AHCA's decision to re-assign funding for projected rate adjustments among hospitals cannot possibly constitute a provider donation. The provider has nothing to donate. Because no provider donations are implicated, AHCA may appropriately direct general revenue-funded rate increases to providers whose local governments help fund the

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[11] FL. STAT. § 409.908 ("Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth *in the rules of the agency and in policy manuals and handbooks incorporated by reference therein*.")
[12] *Id.*
[13] AHCA, Institutional Medicaid Provider Agreement, https://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/Public%20Misc%20Files/MPA_Inst.pdf; *see also* FL. STAT. § 409.907 ("[AHCA i]s required to make timely payment at the established rate for services or goods furnished to a recipient by the provider upon receipt of a properly completed claim form.").
[14] *Id.*

Medicaid program in order to fulfill the legislature's intent to secure the non-federal share of LIP payments from as many local sources as possible. IGTs from local governmental entities are a legitimate and statutorily protected source of non-federal share financing for LIP payments so long as they are not derived from provider donations—and here, as described above, they would not be.[15]

2. The hospitals would retain 100% of the relevant funds.

A similar analysis applies to STC 92(e), which provides that "health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures." STC 92(e) also prohibits providers from entering "pre-arranged agreements (contractual or otherwise) to return and/or redirect any portion of the Medicaid payments." Here, the "reimbursement amounts claimed by the state as demonstration expenditures" that providers must retain are the amounts actually paid to reimburse providers' claims pursuant to the approved state plan (after any adjustments made by AHCA). Providers would retain 100% of those amounts and would have no agreement of any sort to redirect those payments to the state or a local government. Although AHCA would be re-assigning projected rate adjustments, providers have no legal entitlement to the projected adjustments and cannot be viewed as redirecting something to which they are not entitled.

C. Section 1902(a)(2) of the Social Security Act

At the end of its letter, CMS cites a portion of section 1902(a)(2) of the Social Security Act, which provides as follows:

> A State plan for medical assistance must . . . provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1396b of this title are authorized by this subchapter; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.[16]

CMS does not explain the relevance of this provision or why it believes AHCA might violate its requirements. The rate adjustments are funded with state general revenue funds, not local funding, so the provision is inapplicable. With respect to the use of local sources to fund the LIP, the statutory provision is not relevant because the LIP is not a payment for Medicaid services. Rather, as stated in Florida's STCs, in fiscal year 2016-2017, the LIP "provides government support for safety net providers for the costs of uncompensated charity care for low-income individuals that are uninsured."[17] A reduction in IGTs would result in a reduction in LIP payments

[15] *See* 42 U.S.C. § 1396b(w)(6); 42 C.F.R. § 433.51.
[16] 42 U.S.C. §1396a(a)(2) (emphasis added).
[17] STC 67.

under the 1115 waiver, not a reduction in the "amount, duration, scope, or quality of care and services available under the [state] plan." CMS should have no concerns that this provision will be violated.

III. Conclusion

In sum, we believe that AHCA can implement LIP payments and rate adjustments for fiscal year 2016-2017 in a manner that is both consistent with its legislative authority and fully compliant with applicable federal and waiver requirements.

Please feel free to contact us with any questions.

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