DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

May 21, 2015

Justin Senior
Deputy Secretary for Medicaid
State of Florida
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 8
Tallahassee, FL 32308

Dear Mr. Senior:

This is a follow up to recent conversations between the Centers for Medicare & Medicaid Services (CMS) and the state about a proposed funding level and approach to Florida's Low-Income Pool (LIP). On April 20th, Florida posted a "Low Income Pool Amendment Request" for public comment. CMS has conducted a preliminary review of the proposal, for which the state public comment period will soon close. We plan to review the state's official proposal and the public comments that the state has received before reaching a final determination on the LIP. However, in recognition of the state's request for timely feedback as well as the Florida legislature's calendar and time frames for resolving a fiscal year 2015-2016 budget, we are prepared at this point to provide preliminary feedback on this proposal.

Overview

CMS believes that a level of ongoing LIP support consistent with the principles articulated in our April 14, 2015, letter will be best implemented through a phased-in approach. Subject to review of the state's official proposal and public comments, and further conversations with you and your colleagues, we have preliminarily concluded that 2015-16 funding should be at approximately $1 billion, consistent with the funding level for the LIP prior to 2014, to maintain stability while the system transitions. Funding in subsequent years at a more sustainable and appropriate level to cover the state's remaining uncompensated care costs would be approximately $600 million. We note that this level of funding for the LIP, coupled with the options the state may elect at its discretion described in this letter, would enable Florida to retain Medicaid investment in the state at or above the current $2.16 billion level of LIP funding. In addition, the option to expand Medicaid to low-income adults remains available to the state, and as described later in this letter, could provide an estimated revenue increase of $2 billion annually to the Florida hospitals over and above funding through sources such as the LIP.

Background

When CMS agreed to a temporary one-year extension of the LIP in 2014, CMS made clear that it expected Florida would use the year to develop reformed Medicaid payment systems and funding mechanisms that would ensure quality health care services to Florida's Medicaid beneficiaries throughout the state so that starting in state fiscal year 2015 Florida would move

toward Medicaid payments directly to providers rather than payments through the LIP. Since then, CMS has reaffirmed that the LIP program would not continue after June 30, 2015, in its current form.

From its inception in 2006 until 2013, LIP funding was capped at $1 billion each year. In 2014, as you know, in our one-year extension of the LIP, CMS increased the amount of the LIP by $1.16 billion at the state's request because the state was moving to statewide managed care. Prior to this, the state had the authority to make additional payments based on fee-for-service payments under its state plan. CMS allowed the state to temporarily make provider payments through the LIP while the state determined how to appropriately transition provider payment to rates through a new managed care system. This transition was completed late in 2014; as discussed below, however, the state has not proposed significant changes to the structure of the LIP to recognize this change.

CMS' April 14, 2015, letter laid out the three principles by which CMS intends to review proposals relating to the extension of the LIP. CMS intends to apply these principles to uncompensated care pools in all states. Specifically, we noted that coverage is the best way to secure affordable access to health care for low-income individuals and uncompensated care pool funding should not pay for costs that would be paid for in a Medicaid expansion; that Medicaid payments should support services provided to Medicaid beneficiaries and low-income uninsured individuals; and that provider payment rates must be sufficient to promote provider participation and access, and should support plans in managing and coordinating care. These principles are consistent with the concerns that we have expressed over time regarding Florida's approach to provider payment and the need for reforms.

Preliminary Review of LIP Proposal Florida Posted for Public Comment

As noted above, CMS conducted an initial review of the LIP proposal that the state posted for public comment on April 20, 2015, and conducted two conference calls with the state to better understand this proposal. While we appreciate that this proposal makes modifications to the current LIP, and plan to review public comments and the official proposal before we reach a final determination, it is our preliminary conclusion that this proposal makes only limited progress toward realizing the principles we articulated in April.

Principle: *Coverage rather than uncompensated care pools is the best way to secure affordable access to health care for low-income individuals, and uncompensated care pool funding should not pay for costs that would be covered in a Medicaid expansion.*

The state has recently said that it is "willing to size LIP so that it would not duplicate or serve as a substitute for Medicaid expansion."[1] The proposal, however, makes no reduction in the overall

[1] *Scott v. HHS*, No. 15-00193 (N.D. Fla. May 7, 2015)(Pls' Mem. Supp. Prelim. Inj.); *see also* http://www.flgov.com/wp-content/uploads/2015/05/050715.pdf. See also Amendment Request for Florida's 1115 Managed Medical Assistance Waiver (Powerpoint presented by Justin Senior at the April 29, 2015 Medical Care Advisory Committee and Public Meeting Orlando, Florida). Available at: http://ahca.myflorida.com/medicaid/statewide_mc/pdf/mma/Presentation_Orlando_Public_Meeting_2015-04-29.pdf.

size of the pool to account for the potential effects of expanded coverage through Medicaid or to account for the increase in coverage for those who became insured through the Marketplace.

Principle: *Medicaid payments should support services provided to Medicaid beneficiaries and low-income uninsured individuals*.

The proposal takes an incremental step towards tying payments to services delivered by making a modest change in the way LIP dollars are distributed for about 10 percent of the proposed LIP. This is a positive step, but we think more fundamental changes to the distribution approach are needed so that payments support services provided to beneficiaries and low-income individuals.

Principle: *Provider payment rates must be sufficient to promote provider participation and access, and should support plans in managing and coordinating care.*

The proposal shifts some funds to rate increases while adding new funds to the prior LIP methodology. Together, these changes mean that the LIP distributes funds in a way that does not align with providers' role in serving the Medicaid population and financing low-income uncompensated care. Additionally, no net LIP dollars would be shifted to rates. As we noted in our April letter, we are concerned that provider payment rates be sufficient to promote provider participation and access, and support plans in managing and coordinating care. These concerns are buttressed by the finding in the independent report that the state commissioned that during the time LIP has been in existence, provider payment rates have been cut by 25 percent, continuing a trend that started before LIP was created. We also note the December 2014 U.S. district court findings that identified Florida's Medicaid reimbursement rates as insufficient to ensure access for services provided to children in Florida. While the district court later determined that a private right of action to challenge Medicaid payment rates was not available in light of the Supreme Court's decision in Armstrong v. Exceptional Child, 135 S. Ct 1278 (2015), the findings raise questions as to whether or not Florida reimbursement rates comply with the requirements of section 1902(a)(30)(A) of the Social Security Act. CMS is concerned about these findings and would like to work with the state to better understand and address them as the state continues to strengthen its managed care delivery system.

Transitional LIP Funding in 2015-2016

This letter outlines an approach to the LIP over the next two years to help Florida maintain the stability of its providers while the state makes changes to its payment structures. Our preliminary view is that 2015-2016 should serve as a transition year, and that funding for the LIP during this fiscal year should revert to $1 billion, the LIP funding level in 2013-2014, before completion of the state's transition to managed care. This effectively returns the LIP to its annual level from 2006-2013 and helps to create stability for providers, while the state creates alternative financing arrangements. During this transition year, the state may request changes to the distribution methodology for LIP funds to support our shared goal of maintaining stability of providers during this transition. This could include retaining current LIP distribution methodologies or distributing funds to LIP providers in proportion to the amounts those providers receive in the 2014-2015 LIP.

Additional Funding for Financing Health Care to Enhance Medicaid Revenues

In addition to having the federal funding for the LIP, Florida has a number of options under Medicaid state plan authority to increase payment rates and draw down associated federal matching dollar revenues in a manner that supports beneficiary access to care and pays Medicaid providers in ways that are consistent with the principles articulated in our April 14, 2015, letter. One option is for the state to broadly increase Medicaid rates, which would better support providers in delivering care to Medicaid beneficiaries by addressing any shortfall in payment rates. The state could elect to increase rates paid to managed care organizations and used to support hospitals, which would improve coordination of care, as noted in our April 14 letter.

The state could fund its share of the increased provider rates through continued use of intergovernmental transfers. Using existing state and local contributions (which are currently providing match inside of the LIP) over and above the funds that would be necessary for the state share of a $1 billion 2015-2016 LIP, the state could use those same dollars to fund provider rate increases. With federal match, we believe this would generate approximately $1.8 billion in funds for providers who serve Medicaid beneficiaries. Alternatively, or additionally, Florida could use state general revenue as the non-federal share to fund an increase in provider rates. We note that the Florida House of Representatives on April 24, 2015, proposed the use of state general funds to pay providers. With the federal match, the amount proposed by the House would total about $1.5 billion in additional funds for providers.

The decision about whether or not to expand Medicaid is a state option, as we have noted previously. Regardless of whether a state expands, uncompensated care pool funding should not pay for costs that would be covered in a Medicaid expansion. Therefore, the state's expansion decision does not affect the size of the LIP itself. We believe that Medicaid expansion as evidenced by experience in other states would bring significant benefits to low income Floridians and the Florida health care system. Should the state elect this option, it would serve as an additional means for the state to support providers in delivering care to the low-income population. The Urban Institute has projected that coverage expansion would increase revenues for Florida hospitals by over $2 billion.[2] This revenue, if added to LIP funding, either alone or in combination with the above options, could significantly increase provider revenues in the state. As we noted in our April 14 letter, the impact of Medicaid expansion on broadening coverage, reducing uncompensated care, and increasing economic activity would be substantial.

LIP Funding Starting in 2016-2017 for Ongoing Uncompensated Care in Florida

CMS has also made a preliminary estimate of a funding level for the LIP after the transitional year that would be consistent with the principles articulated in our April 14 letter. The LIP is authorized under a section 1115 demonstration, which is approved at CMS's discretion. In

[2] Stan Dorn, Matthew Buettgens, John Holahan and Caitlin Carroll (March 2013) "The Financial Benefit to Hospitals from State Expansion of Medicaid: Timely Analysis of Immediate Health Policy Issues." Urban Institute. Available at http://research.urban.org/uploadedpdf/412770-The-Financial-Benefit-to-Hospitals-from-State-Expansion-of-Medicaid.pdf.

CMS' view, authorizing funds through the LIP to support providers by covering the costs of uncompensated and charity care for low-income individuals who are uninsured and cannot be

covered through Medicaid or other insurance programs supports the objectives of the Medicaid program. However, we do not consider paying through an uncompensated care pool for costs that could be covered through Medicaid expansion or other coverage to promote the objectives of the Medicaid program. Consistent with these principles, our preliminary analysis indicates that the amount of hospital uncompensated care that would not be covered through Medicaid expansion or other coverage is approximately 25-28 percent of the current LIP, or about $600 million per year. CMS has preliminarily concluded that it would be willing to provide demonstration authority to the state for an uncompensated care pool at this level for the remainder of Florida's current demonstration period which ends June 2017. The data and assumptions that we used to develop this estimate are identified in the attachment to this letter. We note that in 2016-2017, the state may also receive federal matching funds over and above the LIP amount by exercising the same options to increase provider funding through rates or expand coverage that we described above.

In addition, over the next year, CMS plans to work with the state to develop a distribution methodology for the LIP that distributes funds in a way that more closely aligns with providers' role in serving the Medicaid population and financing low-income uncompensated care. We also intend to work with the state to establish annual reporting to improve the transparency of the LIP program.

Thank you for your continued work with CMS to develop provider payments that best promote our shared goals of ensuring access and the quality of care to Florida Medicaid beneficiaries and support a strong safety net in Florida. If you have questions about this letter, please contact Eliot Fishman, Director, Children and Adults Health Programs Group, at 410-786-9535.

Sincerely,

/s/

Vikki Wachino
Director

Attachment

The estimated funding level for the LIP beyond state fiscal year 2015-2016 figure is based on charity care costs reported in the 2013 Healthcare Cost Report Information System (HCRIS) data, the most recent available federal hospital cost report data. This data source was used extensively in the independent report, "Hospital Funding and Payment Methodologies for Florida Medicaid" commissioned by the Florida Agency for Health Care Administration, and was suggested by the state as a data source for uncompensated care costs in Florida earlier this year. This estimate also reflects the exclusion of costs associated with the estimated difference between Medicaid payment and the cost to providers of providing these services. The estimate also excluded costs associated with pending receivables and costs associated with other payment issues for patients with insurance. The estimate also includes adjustments to 2013 charity care levels to reflect projections of reduced levels of uninsured from implementation of the Marketplace and Medicaid expansion, estimated at slightly over 50% by the Kaiser Family Foundation[3]

.

[3] John Holahan, Matthew Buettgens, Caitlin Carroll, Stan Dorn, "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis" (November 2012). Available at https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8384.pdf