Study of Hospital Funding and Payment Methodologies for Florida Medicaid

Prepared for:

Florida Agency for Health Care Administration

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Table of Contents

1 Executive Summary

1.1 Background

Since the approval of its Medicaid Reform 1115 Waiver in 2005, the State of Florida has significantly expanded its Medicaid managed care program, representing a major transition from traditional Medicaid fee-for-service payment. During 2014, this Medicaid managed care transition was accelerated and included rollout of mandatory managed care enrollment for nearly all Medicaid recipients throughout the state. In contrast to state fiscal year (SFY) 2005/06, when managed care payments comprised approximately 13 percent of Medicaid payments, the Florida Agency for Health Care Administration (AHCA) estimates that by SFY 2015/16, 85 percent of all Florida Medicaid recipients will be enrolled in managed care plans and 65 percent of Medicaid payments will be made for services provided to recipients enrolled in Medicaid managed care.

Prior to the Medicaid Reform waiver, Florida Medicaid distributed payments annually (approximately $660 million in SFY 2005/06) to hospitals in the form of supplemental payments. These payments were made through the Upper Payment Limit (UPL) program which allows supplemental payments to be made to a Medicaid provider based on the difference between the amount paid in standard payment rates and a maximum amount referred to as the "Upper Payment Limit." However, federal regulations specify that standard UPL payments are allowed only for services provided through a traditional Medicaid fee-for-service program, and not through managed care. As such, the transition from fee-for-service to managed care had the potential to significantly reduce the amount of funds Florida Medicaid could pay to providers through supplemental payments because of standard (non-waiver) federal regulations related to Medicaid supplemental payments. In other words, the transition from fee-for-service to managed care made it necessary for Florida Medicaid to find another way to continue making these supplemental payments.

To enable continued supplemental payments with the transition to Medicaid managed care, a new program was defined within the 2005 1115 demonstration waiver called the Low Income Pool (LIP) program. The LIP program was "established to ensure continued government support for the provision of health care services to Medicaid, underinsured and uninsured populations."[1] As originally defined, the LIP program was limited to $1 billion in total payments each year. In addition to replacing the UPL supplemental payment program, the LIP program increased total annually dispersed funds by approximately $300 million and increased the list of providers available to receive supplemental payments. Under the former UPL program, supplemental payments were only made to acute care hospitals. In contrast under the LIP program, supplemental payments could be made to a variety of provider types and in practice have been made to acute care hospitals, Federally Qualified Health Centers (FQHCs) and Community Health Departments (CHDs).

[1] Centers for Medicare and Medicaid Services, *Special Terms and Conditions for Florida Medicaid Reform Section 1115 Demonstration*, Document number 11-W-00206/4, (2005).

The LIP program has been an approved component of the State's 1115 demonstration waiver through June 30, 2014. In 2014, when the mandatory Medicaid managed care portion of the waiver was renewed for an additional three years, the LIP program was only renewed for one more year. Included in this one-year renewal was a shift of self-funded inter-governmental transfer (IGT) rate enhancements (totaling $963 million annually) and the teaching physician supplement payment program (totaling $204 million annually) into the LIP program. These funds transitioning into the LIP program were in addition to the traditional $1 billion cap previously available through LIP. Thus in this renewal year, SFY 2014/15, a total of nearly $2.2 billion will be distributed as supplemental payments through LIP.

Also included in CMS's Special Terms and Conditions (STCs) for the 2014 waiver renewal was a requirement for AHCA to contract with an independent consultant to conduct a review of the state's funding and payment mechanisms. The intent of this study is to suggest "sustainable, transparent, equitable, appropriate, accountable, and actuarially sound Medicaid payment systems and funding mechanisms that will ensure quality health care services to Florida's Medicaid beneficiaries throughout the state ***without the need for Low Income Pool (LIP) funding***."[2] (emphasis added by Navigant) To do this, the STC's outlined several key requirements. The report must:

- Include detailed information on the historical methods of funding hospital payments, the interaction between state funded payments and provider funded payments, and describe the composition of payments, including base and supplemental payments.

- Analyze the adequacy of current payment levels for Medicaid providers, and the adequacy, equity, accountability and sustainability of the state's funding mechanisms for these payments. The report must primarily focus on the types of providers supported by IGT or LIP funds.

- Include an analysis of how future changes in Medicaid, including possible Medicaid expansion would affect Medicaid payment amounts and structure, including fee-for-service payments, managed care, and LIP.

- Recommend reforms to the Florida Medicaid financing system that can allow the state, beginning in state fiscal year 2015-2016, to move toward Medicaid fee-for-service and managed care payments to providers that ensure access and quality of care for Medicaid beneficiaries without the need for LIP funds. These payments should be based on a rationalized, non-facility specific payment mechanism, which can be applicable to future changes in Medicaid including Medicaid expansion. This type of rationalized payment

[2] Centers for Medicare and Medicaid Services, *Special Terms and Conditions for Florida Medicaid Reform Section 1115 Demonstration*, Document number 11-W-00206/4, (2014).

mechanism would not include payment based on facility specific costs or local tax revenue and would discontinue incentive payments through the LIP.

In addition, the 2014 Legislature included proviso language in the 2014/15 General Appropriations Act stating additional requirements of the report including:

- Identify federal regulations on the following: IGTs, including their sources, uses, and allowable repayment arrangements; supplemental hospital payments, including allowable types, purposes, and payees; and direct provider payments that are allowed within Medicaid programs that are based primarily on risk-bearing managed care plans.

- Identify other states' uses of IGTs and supplemental hospital payments, including: arrangements for incenting or requiring IGTs; methods of payment, particularly in states with high managed care penetration; and specific federal waiver terms and conditions that apply to IGTs and supplemental hospital payments.

AHCA engaged Navigant Consulting, Inc. (Navigant) to perform this study. A draft of the resulting report is due to CMS no later than January 15, 2015 with the final report due March 1, 2015.

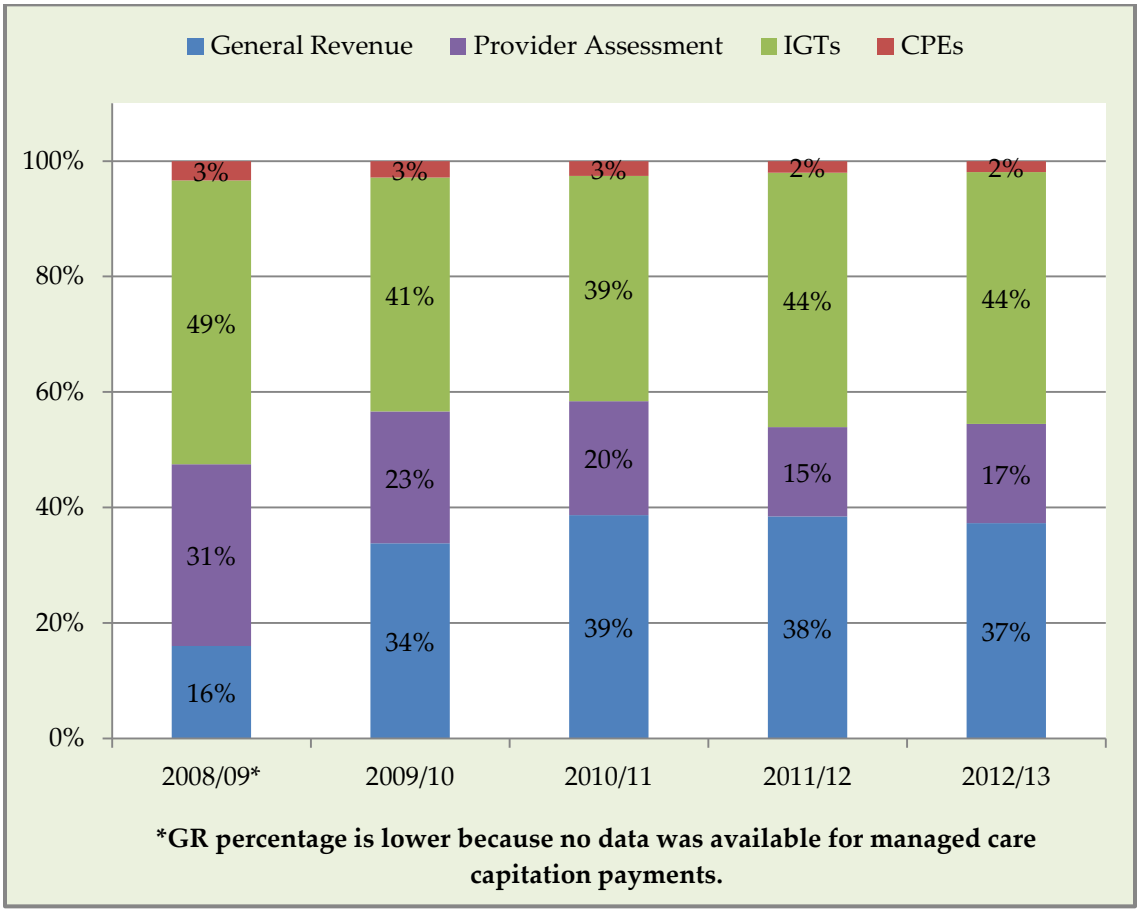
This study deals primarily with funding and payment made through the LIP program. The vast majority of funds for the LIP program come from inter-governmental transfers (IGTs) made in the names of specific hospitals. In addition, the vast majority of payments made through the LIP program are made to acute care hospitals. As a result, the study has a very strong focus on Florida Medicaid hospital reimbursements and the funds gathered to enable those reimbursements. In addition, the study considers hospital costs for care of uninsured and under-insured as well as Medicaid reimbursements for these patients which come from Disproportionate Share Hospital (DSH) payments and from a portion of payments made through the LIP program.

1.2 Hospital Funding

At a high level, funds that pass through a Medicaid program for payment for health care services for Medicaid recipients, the uninsured, and the underinsured, can be categorized as either "state share" or "federal share." For every dollar spent, a certain percentage of that dollar comes from the state share and the rest from the federal share. For the State of Florida, the blended state share percentage has been in the low forties or high thirties over the last few years. The federal share has been in the high fifties or low sixties over that same time period. In state fiscal year 2014/15, for example, the state share percentage is 40.44 percent and the federal share percentage is 59.56 percent. This means for every dollar spent by the Medicaid Agency in SFY 2014/15, 40.44 cents come from state resources and 59.56 cents come from federal resources. Another way to think of this is that $1.00 in state funds in SFY 2014/15 yields $2.47 in total funds for the Medicaid program (1 / 0.4044 = $2.47).

Prior to 1986, the entire state share of funds used for payments to hospitals under the Medicaid program came from state general revenue. Starting in 1986 and continuing in subsequent years, a variety of legislation has been passed which has slowly reduced the percentage of the state share of hospital funding coming from general revenue and replaced that money with funds from other sources. Those other sources are generated through a provider assessment and IGTs. To a small degree, Florida Medicaid also utilizes certified public expenditures (CPEs). For a recent five year period, the percentages of funding for Florida Medicaid hospital reimbursement from each of the various sources are shown in Figure 1 below.

Figure 1. Distribution of funding sources for state share of Medicaid hospital payments over the previous five years.



Notes for Figure 1:

1) The figure above includes funding for hospital fee-for-service rates, hospital managed care capitation rates, LIP supplemental payments and DSH supplemental payments. Medicare crossover claims, in which Medicare is the primary payer, are excluded.
2) During these timeframes, the state portion of all funding for managed care capitation came from state general revenue.

3) Expenditures in SFY 2008/09 are understated because hospital managed care expenditures were not available for this year.

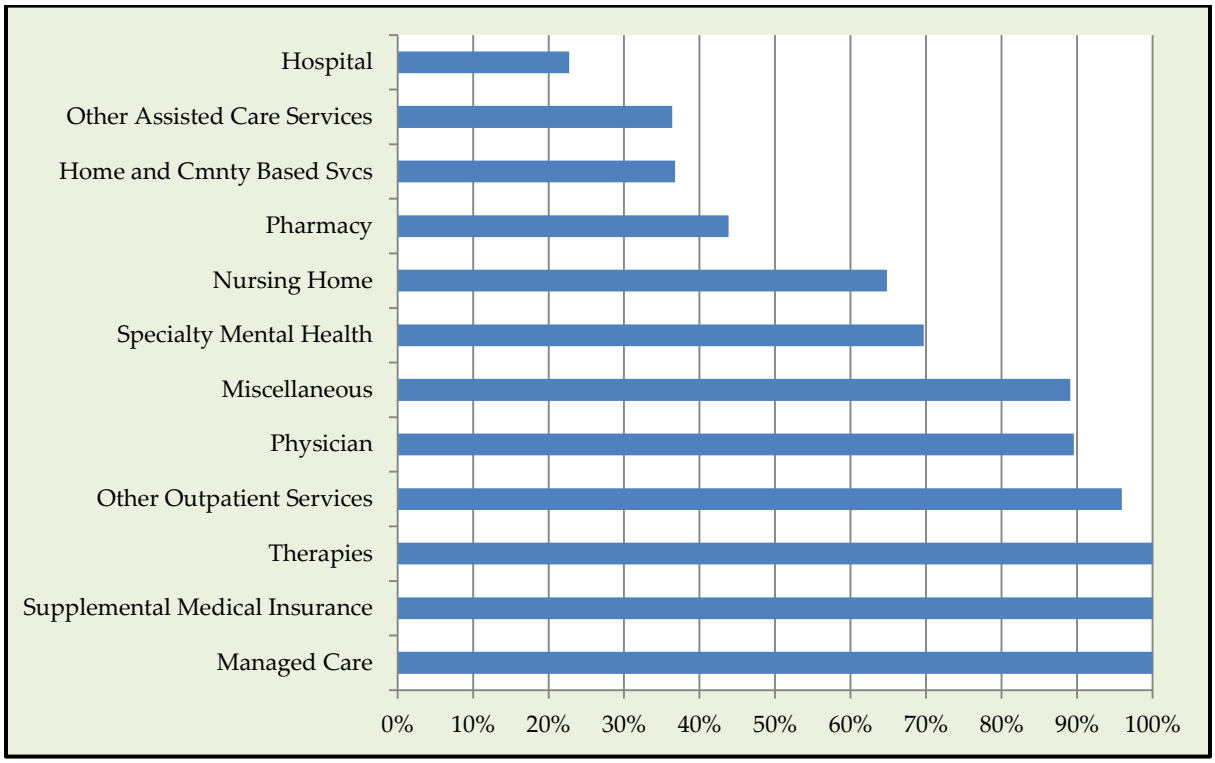
1.2.1 General Revenue

Funds coming from state general revenue offer Medicaid agencies significant flexibility in how provider reimbursements can be designed. In addition, federal regulations require at least 40 percent of funding for Medicaid programs come from state general revenue. In the State of Florida, general revenue constitutes 61 percent, more than half, of the total state share when looking at the overall Medicaid program, including payment for all health care services, such as hospital, nursing home, physician, pharmacy, school programs, etc. However specifically for hospital reimbursement, funds from general revenue constitute 37 percent, less than half, of the total state share. In SFY 2012/13, general revenue contributed just over $1 billion towards funding Medicaid hospital reimbursements and $4.9 billion towards funding the entire Medicaid program, overall.[3]

The state general revenue used to fund the Medicaid program is not spread evenly across the various types of providers and types of services offered to Medicaid recipients. General revenue as a percentage of total state share varies by type of service anywhere from 100 percent of the funding at the high end of the range down to 23 percent at the low end of the range. General revenue funding for hospital services is at the low end of the range. This can be seen in Figure 2 below.

[3] Numbers generated from Florida Social Services Estimating Conference, August 2014, "*Long-Term Medicaid Services and Expenditures Forecast,*" plus AHCA reports of payments for hospital services provided to Medicaid recipients in managed care plans.

Figure 2. Percentage of state share from general revenue by type of service in SFY 2012/13.



Specifically for hospital reimbursements, state general revenue is used primarily to fund inpatient and outpatient rates, distributed through fee-for-service claim payments, and to fund managed care capitation payments. General revenue also funds very small portions of supplemental payments made within the LIP and DSH programs.

1.2.2 Provider Assessment

The provider assessment in Florida is referred to as the Public Medical Assistance Trust Fund (PMATF), and includes a 1.0 percent assessment of hospital outpatient net operating revenue and a 1.5 percent assessment of hospital inpatient net operating revenue. This is a mandatory program, as defined in Florida statute. In SFY 2012/13, nearly $470 million was collected through the PMATF program, which drew down over $641 million in federal matching funds, resulting in a total of $1.1 billion in funds available for Medicaid reimbursements. These funds are combined with general revenue funds and used to reimburse hospitals through fee-for-service claim rates and managed care capitation rates.

In a majority of cases, the cost of the assessment is paid back to providers through an increase in the Medicaid reimbursement rate, but consistent with the federal redistributive and hold harmless provisions of health care-related tax programs, not all hospitals get back all that they were assessed. Hospitals with very low Medicaid volume may not receive as much in increased rates as they paid out through the assessment.

1.2.3 Inter-Governmental Transfers

Inter-governmental transfers (IGTs) are transfers of funds from a non-Medicaid governmental entity (e.g., counties, hospital taxing districts, providers operated by state or local government) to the Medicaid agency. As long as the funds collected through IGTs are used in ways that comply with federal regulations, they may be used to draw down federal matching funds. "Federal policy regarding both the permissible sources of non-federal Medicaid expenditures and federal contributions toward those expenditures dates to Medicaid's 1965 enactment. Prior to 1965, health care services for low-income individuals were provided primarily through a patchwork of programs sponsored by state and local governments, charities, and community hospitals. … While the administration of each state's Medicaid program was required to be centralized at the state level, federal provisions allowed the pre-existing patchwork of programs to maintain primary responsibility for service delivery and non-federal financing of services that now qualified for federal payments."[4]

In Florida, IGTs are used to help fund hospital rate payments (inpatient and outpatient), the LIP program, the DSH program, and the physician supplemental payment program. In SFY 2014/15, for example, AHCA anticipates receiving a little over $1.3 billion[5] in IGTs resulting in nearly $3.3 billion in reimbursements when combined with federal matching funds. 43 non-Medicaid governmental entities are expected to contribute IGTs, and the State plans to spread these funds (along with related federal matching funds) across approximately 140 hospitals, 7 medical schools, and 60 non-hospital facilities (primarily FQHCs and CHDs).

Despite the significant sums of money and numbers of health care facilities benefiting from IGT funds, IGTs are optional contributions. Generally, governmental agencies cannot be legally obligated to contribute IGTs towards the state Medicaid program. To ensure continued contribution of IGT funds, payment methods are devised in ways that ensure a return on investment for funds contributed. IGT contributors, most of which are county governments and hospital taxing districts, contribute money in the names of hospitals within their jurisdiction. Medicaid payment methods ensure payments to these named hospitals offer more value than would be afforded through keeping the funds within their local districts. This is possible because of the fact that the IGT funds draw down federal matching funds resulting in enough total dollars to offer a return on investment to the named hospitals and still have additional funds available to distribute amongst other hospitals and some non-hospital providers.

In previous years and in the current year (SFY 2014/15), IGTs fund nearly the entire state share of the traditional $1 billion LIP program and over 60 percent of the state share of the DSH program. Prior to SFY 2014/15, IGTs also funded approximately 40 percent of fee-for-service claim payments and did not fund any managed care capitation payments. Beginning in SFY

[4] Medicaid and CHIP Payment and Access Commission (MACPAC), "*Report to the Congress on Medicaid and CHIP*," (March 2012).

[5] The Florida Legislature, *"Medicaid Hospital Funding Programs Fiscal Year 2014-2015 – Final Conference Report for House Bill 5001*," (April 29, 2014).

2014/15, these percentages changed. Self-funded IGTs were moved from claim payments into the LIP program. In addition, funds collected through IGTs for automatic rate enhancements now fund both fee-for-service rates and managed care capitation rates. As a result of these changes, in SFY 2014/15 IGTs fund approximately 27 percent of hospital fee-for-service rates, and approximately 27 percent of the hospital portion of managed care capitation rates. In addition, IGTs fund 100 percent of the state share of LIP-6, which was formerly known as self-funded IGTs. Also, beginning on January 1, 2014, IGTs fund the state share for the teaching physician supplemental payment program.

The payment methods designed to incent contribution of IGTs have evolved over time to be relatively complicated within the State of Florida. The payment methods are discussed in section 1.3 – Hospital Payments of the Executive Summary and discussed in greater detail in section 4.4 – Claim and Supplemental Payments. It should be noted that, although the distribution of IGT funds benefits many health care facilities whose local governments do not contribute any IGTs, by far, greater financial benefit is provided to hospitals located in regions in which local government agencies are contributing IGTs.

Not all IGTs are contributed by hospitals. Many are contributed by local governmental agencies. However, the IGTs contributed for the LIP program, automatic rate enhancements, and self-funded rate enhancements are all donated in the names of specific hospitals. In this study, those IGTs are treated as donations from the named hospitals under the assumption that the local governments would find ways to contribute those funds directly to the named hospitals if they were not contributed as IGTs to the Medicaid agency.

1.2.4 Certified Public Expenditures

Certified public expenditures (CPEs) are expenditures made by a governmental entity, including a provider operated by state or local government, under the state's approved Medicaid state plan, for health care services provided to Medicaid recipients. The public provider of service certifies the uncompensated cost of services rendered to eligible individuals. The Medicaid agency records the certified expenditures and draws the Federal share of the expenditure from CMS.

Florida Medicaid utilizes CPEs to help fund Medicaid payments for school-based services, hospital disproportionate share payments, and historically for physician supplemental payments. In SFY 2012/13, CPEs comprised 100 percent of the state share of funding for school-based Medicaid services, 34 percent of the state share for DSH payments and 100 percent of the state share for physician supplemental payments. In terms of hospital reimbursements overall, CPEs comprised two percent of total state funding. Beginning January 1, 2014, this percentage has dropped slightly as funding for the physician supplemental payment program has shifted from CPEs to IGTs.

1.3 Hospital Payments

Payments to hospitals are generally made by the Florida Medicaid Agency in four forms, 1) claim payments for health care services provided to Medicaid fee-for-service recipients; 2) capitation payments to Medicaid managed care organizations, which in turn, pay hospitals for services provided to Medicaid managed care recipients; 3) quarterly supplemental payments determined through the LIP program; and 4) quarterly DSH payments determined through the DSH program. Fee-for-service claim payments and Medicaid managed care capitation payments are both intended to compensate providers for services offered to recipients eligible for Medicaid health benefits. In contrast, DSH payments are intended to compensate providers for costs associated with caring for a high proportion of uninsured recipients (often referred to as "uncompensated care") and Medicaid shortfall. Similarly, payments made through the LIP program are intended to compensate providers for both services offered to uninsured and underinsured recipients as well as help cover shortfalls between Medicaid payments and provider costs incurred from caring for Medicaid eligible recipients.

Fee-for-service hospital claim payments and managed care capitation rates are funded through a combination of general revenue, provider assessment revenue, and automatic rate enhancement IGTs. Payments made through the LIP program are funded almost entirely through IGTs. Funding for the DSH program is a combination of IGTs and CPEs.

As mentioned previously, Florida Medicaid has developed payment methods which ensure return on investment for contributors of IGTs. This is done primarily in two ways. First, most IGT funds collected for the traditional $1 billion LIP program and for automatic rate enhancements are summed together. Hospitals in whose names these funds are contributed receive supplemental payments through the traditional $1 billion LIP program that equal 108.5 percent of the contribution amounts (8.5 percent return on investment). This return on investment is documented within the LIP program as the "LIP Allocation Distribution," and comprises a majority of the funds distributed through the traditional $1 billion LIP program. For example in SFY 2014/15, approximately $745 million will be contributed through IGTs to help fund the LIP program and automatic rate enhancements. Of this amount, $689 million was considered "above the line" and eligible for the 108.5% LIP Allocation Factor. This results in $748 million expected to be allocated through the LIP Allocation Distribution, which means only $252 million is available through the waiver program to fund safety net hospitals, uncompensated care, and various initiatives intended to improve the delivery of health care to Florida Medicaid recipients. Thus, despite being a $1 billion program, only 25 percent of that money has been made available for discretionary distribution.

The second guaranteed return on investment occurs for LIP-6 funds, which were referred to as self-funded IGTs prior to SFY 2014/15. IGT contributors have the option to designate their

funds to be applied to traditional LIP and automatic IGT rate enhancements or to LIP-6[6]. Funds designated to LIP-6 provide contributors approximately 147 percent return on investment as the hospitals named for these contributions receive back the IGT contribution (the state share) plus all of the associated federal matching funds.

The total amount of money Florida Medicaid may spend within each of these programs is finite. Each is controlled through federal regulation or state regulation, or both. The state share, total funds payable (total computable), distribution determination, and funding limitation for each program are depicted in Figure 3 below.

Figure 3. Distribution of IGT funds by Florida Medicaid.

Traditional[7] $1 Billion LIP Program		**Rate Enhancements**	
IGTs available for LAD:	$350 million	State Share from IGTs:	
IGTs not available for LAD[8]:	$56 million	IGTs for "auto" rate enh.:	$312 million
State share from general rev:	$9 million	IGTs for "Statewide issues":	$23 million
Total state share for LIP:	$415 million	IGTs for Liver global fee:	$4 million
Total computable:	$1 billion	Total IGTs for rate enh.:	$339 million
Funding Limitation(s):	1115 demonstration waiver	State GR for rate enh.:	$10 million
		Total state share for rt enh:	$349 million
The $1 billion is distributed as follows:		Total Computable:	$863 million
LIP Allocation Distr. (LAD):	$748 million	Distribution Determination:	LIP Council and Florida Legislature
Distribution Determination:	108.5 percent of IGT contributions for rate enhancements and a portion of LIP ($689 million)[9]	Funding Limitation(s):	UPL regulations and Florida Legislative authority
Discretionary Distribution:	$252 million		
Distribution Determination:	LIP Council and Florida Legislature		

[6] IGT contributors also have the option to designate their funds be applied to the DSH program, the teaching physician supplemental payment program, or two other smaller sub-programs within the traditional $1 billion LIP program.

[7] In this document, the "traditional $1 billion LIP program," refers to the LIP program originally defined in the 2005 1115 demonstration waiver.

[8] IGTs which contribute to Alternative LIP programs are considered "below the line" and are not eligible for the LIP Allocation Distribution.

[9] IGTs contributed for rate enhancements plus IGTs contributed for all portions of LIP except Alternative LIP are consider "above the line" and are eligible for the LIP Allocation Distribution.

LIP-6 (Formerly Self-Funded IGTs)		DSH Program	
IGTs:	$390 million	State share:	$146 million
Total computable:	$963 million	Total computable:	$362 million
Distribution Determination:	All IGT and federal matching funds paid to named hospital	Distribution Determination:	Formula defined in State Plan
Funding Limitation(s):	1115 demonstration waiver and Florida Legislative authority	Funding Limitation(s):	Federal Medicaid DSH cap for State of Florida and individual hospital DSH limits
Teaching Physician Supplemental Program		**Legend:**	
IGTs:	$82 million	- state share affecting LIP Allocation Distribution	
Total Funds in SFY 2014/15:	$204 million	- funds distributed through the 1115 waiver	
Distribution Determination:	Based on historical number of Medicaid encounters		
Funding Limitation(s):	1115 demonstration waiver		

In addition to the guaranteed returns mentioned above, some hospitals and, to a smaller extent, FQHCs and CHDs receive additional benefit from funds contributed to the traditional $1 billion LIP program and to automatic rate enhancements. Funds that are not paid out through the LIP Allocation Distribution are distributed to these health care facilities a through complex set of policies and regulations designed to provide benefit for facilities considered to be most critical to the Medicaid program. In recent years, just under $900 million has been available annually for more discretionary distribution designed to promote Medicaid program goals.

In SFY 2014/15, fee-for-service and managed care claim payments, which are utilization based, constitute roughly two-thirds of the Medicaid payments made to hospitals. The other third of hospital reimbursements come from supplemental payments, primarily through the LIP program (a total of nearly $2.2 billion in SFY 2014/15). In addition, the distribution of funds originating from IGTs is designed in such a way that those hospitals with access to an IGT contributor are clearly reimbursed at higher levels than those who do not have access to IGTs.

1.4 Evaluation of Florida Medicaid Hospital Funding and Payment

1.4.1 Introduction

One of the most fundamental and commonly quoted regulations within the Social Security Act is section 1902(a)(30)(A) which says,

> "A state plan for medical assistance must provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan … as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."[10]

This regulation indicates Medicaid agencies must define policies and payment levels in a way that balances competing goals of access to care along with efficiency and economy with safeguards against unnecessary utilization.

One seemingly reasonable measure of adequate payment would be a comparison of payments to the cost to render care to a Medicaid recipient. In order to remain in operation, hospitals, like any other businesses, must receive enough income to cover all expenses including items such as labor, facilities, and equipment. In addition, it is critical for all hospitals to be able to generate some margin over the cost of operations – for-profit hospitals need to satisfy investors and stock holders, and both for-profit and not-for-profit hospitals need to fund the replenishment of operating infrastructure and capital. Thus, paying hospitals an amount equal to their costs or at least equal to reasonable market value for services provided, if such a number can be defined, would be one way to measure payments. In fact, in Medicaid Upper Payment Limit analyses, for example, hospital cost is accepted as a proxy for Medicare payment and can be used as the Upper Payment Limit or maximum allowable reimbursement amount. Note however, that CMS does not consider operating margin to be a reasonable and necessary cost of providing services. In addition, payment levels simply based on cost offer no incentive for hospitals to control costs. Thus, purely cost-based payments do not promote efficiency and economy.

In truth, defining adequate payment levels is not a precise science. Medicaid agencies commonly pay less than full hospital cost and, yet, hospitals remain open and continue to accept Medicaid patients. Traditionally, the assumption has been that hospitals are able to achieve or maintain sufficient operating margin by balancing relatively low revenues received from Medicaid with higher revenues received from commercial insurance companies. This phenomenon is referred to as "cost-shifting," and is more of a theoretical exercise than an actual function performed by hospital accountants. Cost shifting is relatively easy to do for hospitals with a small amount of their business coming from Medicaid and uninsured patients. On the opposite side, cost shifting is more difficult for hospitals with a relatively high percentage of their business coming from Medicaid and uninsured patients. Note also that while it is CMS' intent that the Medicare program pay for the reasonable and necessary costs of providing services to the Medicare population, critics of the Medicare program argue that such is not the case. As such, the Medicare program also contributes to the need for hospitals to "cost-shift."

[10] The Social Security Act, section 1902(a)(30)(A).

1.4.2 Florida Medicaid Aggregate Hospital Pay-to-Cost

Overall pay-to-cost ratios for hospital services provided to Medicaid and uninsured recipients in Florida in SFY 2012/13 are shown in Table 1 below. As shown in this table, we compare payments to costs in two ways for the Medicaid program by itself, and in two ways for a combination of the Medicaid program combined with care for uninsured and underinsured patients (referred to in the table as "uncompensated care"). For the Medicaid program alone, aggregate pay-to-cost ratios were calculated with and without inclusion of LIP payments. For the combination of Medicaid recipients and the uninsured, pay-to-cost ratios were calculated with and without inclusion of provider assessment fees and IGTs subtracted for hospital payments to estimate net hospital revenue. Under guidelines defining upper payment limit and DSH limit calculations, provider assessment fees and IGT contributions are not considered to be valid hospital costs. At the same time, provider assessment fees and IGTs coming from hospitals are included in Medicaid payments back to hospitals. Thus, true net revenue to hospitals should take these hospital outlays into consideration.

Table 1. Pay-to-cost values for Medicaid program overall – SFY 2012/13.

Description	Payment	Estimated Hospital Cost	Pay-to-Cost Ratio
Pay-to-cost - Medicaid recipients - w/o LIP	$4,544	$5,770	79%
Pay-to-cost - Medicaid recipients - w LIP payments	$5,459	$5,770	95%
Pay-to-cost - Overall including claim, LIP, and DSH payments as well as claim (Medicaid) and uncompensated care costs	$5,699	$8,587	66%
Pay-to-cost - Overall including claim, LIP, and DSH payments minus PMATF and IGT hospital contributions as well as claim (Medicaid) and uncompensated care costs	$4,186	$8,587	49%
Note(s): 1) Dollar amounts are in millions. 2) Payments include hospital inpatient and outpatient claim data from both FFS and managed care encounter claims. 3) Data is from SFY 2012/13.			

The table above shows that aggregate pay-to-cost for hospitals when excluding supplemental payments was 79 percent in SFY 2012/13. In that year, self-funded IGTs were included in claim payments, not in LIP. In SFY 2014/15, self-funded IGTs, which total $963 million, have been moved out of claim payments and into the LIP program. Thus, the aggregate pay-to-cost ratio for hospitals excluding supplemental payments in SFY 2014/15 will be approximately 62 percent. Further, if the LIP program expired without any type of replacement, the IGTs used to fund automatic rate enhancements would also be at risk. If automatic rate enhancements were not available, average hospital cost coverage for services to Medicaid recipients excluding LIP and automatic rate enhancements would be 48 percent.

The table above also shows the aggregate hospital pay-to-cost ratio is relatively high for a Medicaid program at 95 percent when including LIP payments. However, this ratio does not take into consideration that LIP is intended to help offset both the cost of uncompensated care and the gap between Medicaid payments and hospital cost to care for Medicaid recipients. The next pay-to-cost ratio shown in the table includes LIP and DSH payments as well as the cost of uncompensated care. When all these values are included, the aggregate hospital pay-to-cost ratio drops to 66 percent.

1.4.3 Florida Medicaid Hospital Pay-to-Cost Based on IGT Status

Because IGTs play a significant role in funding and payment, we also compared pay-to-cost ratios across three categories of hospitals, 1) hospitals that contribute and receive IGTs; 2) hospitals that do not contribute IGTs, but do receive payments from IGT funds; and 3) hospitals that neither contribute nor receive IGT funds. In truth, not all IGTs are contributed by hospitals; many are contributed by local governmental agencies. However, the IGTs contributed for the

LIP program, automatic rate enhancements, and self-funded rate enhancements (now part of the LIP program) are all donated in the names of specific hospitals. We treat those IGTs as donated by the named hospitals under the assumption that the local governments would find ways to contribute those funds directly to the named hospitals if they were not contributed as IGTs to the Medicaid agency.

Pay-to-cost ratios are shown in Figure 4 for the four different methods we used to calculate the ratios. With each method, hospitals that contribute IGTs and receive payments from IGT funds are paid the highest relative to cost. Hospitals that neither contribute IGTs nor receive payments from IGT funds are paid lowest relative to cost.

Figure 4. Hospital pay-to-cost ratios based on IGT status.

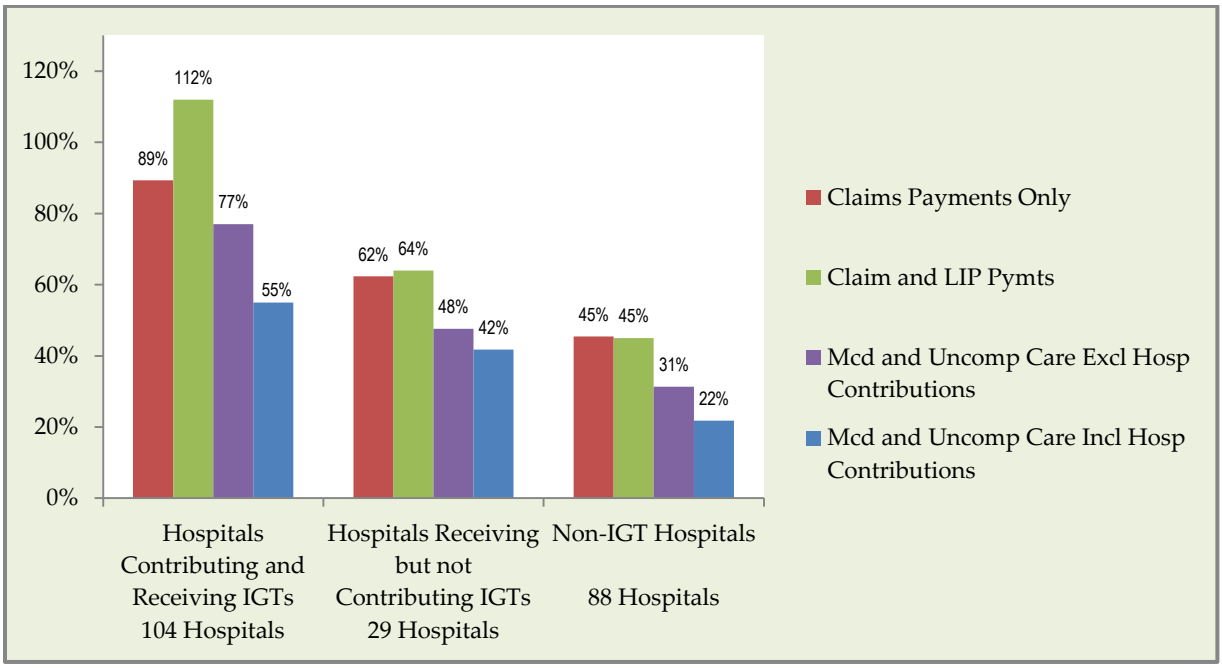
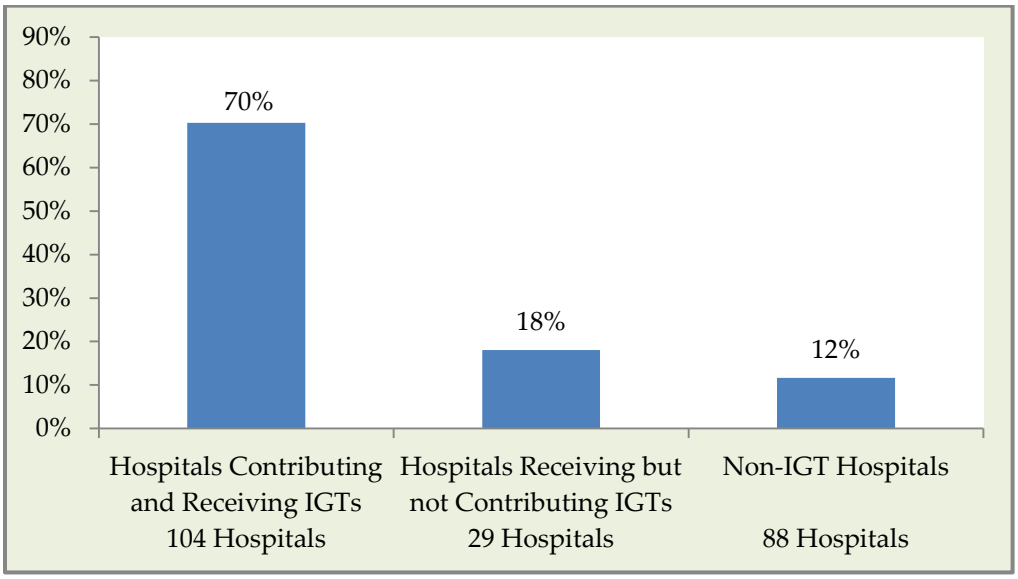


Figure 4 above shows that payments within the Florida Medicaid program are not the same relative to cost when compared across hospitals. However the hospitals that receive relatively higher payments are those that treat the majority of Medicaid patients. This is shown in Figure 5 below and is consistent with the state's goal stated in the SFY 2005 1115 demonstration waiver, "The state will continue to foster and protect its safety net providers."[11]

[11] Florida Agency for Health Care Administration, *Application for 1115 Research and Demonstration Waiver*, (August 2005).

Figure 5. Percentage of Medicaid business based on IGT status.



Notes for Figure 5 :

1) Data is based on claim payments and cost from SFY 2012/13. Both fee-for-service and managed care program claims for hospital inpatient and outpatient services are included. In addition, LIP payments, DSH payments, and the cost of uncompensated care are included.
2) Data is limited to in-state hospitals with at least one submitted claim in SFY 2012/13.

1.5 Options for Future Hospital Funding and Payment

1.5.1 Interaction between Funding and Payment

In general, we categorized the funding options available to Florida Medicaid as either broad-based or qualified. The broad-based funding options include increasing the provider assessment (PMATF), creating a managed care assessment, and increasing general revenue for the Medicaid program. The more qualified funding options include continued use of IGTs and, potentially, expansion of CPEs. These categorizations have as much to do with how the funds are allocated across hospitals in Florida as they are related to who is contributing the funding. With the broad-based funding methods, Florida Medicaid would have significantly more flexibility with how the funds are ultimately distributed to providers. IGTs tend to restrict how payers distribute the federal funds they are used to generate – generally obligating payers to return more than the IGT contribution, in amounts that provide enough financial return for the entity to make the contribution in the first place. Without the dependence on providers to make IGT contributions to replace the State's share of funding, there could be less of an obligation to tie payments to the funding sources. Payment allocations could be focused on achieving Florida Medicaid's overall policy priorities, such as rewarding those providers who make a

commitment to serving Medicaid and uninsured patients, or improving the health of Medicaid patients.

In contrast, we made the assumption that any payment allocation for IGTs must ensure a return on investment for those public hospitals and local governments contributing the State's share of funding. Thus, payment methods that rely on this type of funding must be designed in a way that takes into consideration who contributed money to fund the Medicaid program, as is the case today in Florida. In addition, CPEs are limited to public institutions and the federal matching funds generated through CPEs generally must be paid to the entity that incurred the health care costs. This tie between funding mechanism and payment flexibility is summarized in the following table:

Table 2. Tie between funding source and payment flexibility.

		Funding Sources				
		Health Care-related Tax (New or Expand Existing	Managed Care Assessment	IGTs	CPEs	General Revenue Funds
Payment Distribution Models	Delivery System Reform Incentive Payment (DSRIP) Program	XX	XX	X	X	XX
	Broad Based Rate Increases (FFS and PMPM)	XX	XX			XX
	UPL/Targeted Supplemental	XX	XX	X	X	XX
	GME Payments (limited to qualified providers)	X	X	X	X	X
	DSH Payments (limited to qualified providers)	XX	XX	X	X	XX
	Uncompensated Care Pool Distributions	XX	XX	X	X	XX
	Physician Supplemental Payment Program	XX	XX	X	X	XX
Legend: XX = generally would work for all provider types. X = would generally work only for hospitals that actually fund the state dollars.						

1.5.2 Combination Funding and Payment Options Offered in this Study

In this study, we define three very broad options that combine type of funding and payment distribution approaches. These options all assume the LIP program, in its current form, has been discontinued, as that is a supposition defined in the requirements of this study. The options are:

1) Fully replace the funds currently used for the LIP program with a broad-based funding source and an increase in fee-for-service and capitation rates;
2) Continue current level of IGTs, design, and implement a large Delivery System Reform Incentive Payment (DSRIP) program;
3) Expand the Florida Medicaid program through the ACA combined with either a broad-based funding source or IGTs for funding for the existing Medicaid population.

For illustrative purposes, these non-LIP options describe all-encompassing funding methods for the funds currently used within the LIP program. One option replaces all of the LIP funds, which are almost entirely IGTs, with a broad-based funding method. Another option continues to use IGTs as the source for all of the funds. In reality, there are a multitude of variations that could be applied related to these combinations of funding and payment. Of course, if both types of funding are implemented the benefits and limitations of each method will apply. For example, a hybrid option that moves a portion of LIP-6 into fee-for-service and capitation rates might need to reserve some amount, such as 110 or 120 percent of IGT contributions, for supplemental payments back to the hospitals named by the IGT contributors. The supplemental payments would be needed to guarantee some return on investment for the IGT contributors.

1.5.3 Modifying the Low Income Pool Program

In addition to the options above which replace LIP, we believe continuation of a modified version of LIP should be a consideration. Like the DSH program, the LIP program, to a degree, helps offset Florida's relatively low federal DSH allotment by providing other funding that helps offset hospital costs for care to the uninsured. However, the LIP program does not go through the same level of program oversight as the DSH program. Both the LIP and DSH programs have a requirement that total reimbursement to hospitals should not exceed hospital cost to treat Medicaid and uninsured recipients. Under the DSH program, states are required to prepare annual DSH reports comparing total payments to costs, and annual independent audits of those reports are performed to ensure this requirement is met. Audits are not performed for the LIP program. Instead, costs self-reported by hospitals are used to ensure total reimbursement is within applicable hospital costs. If more program oversight and control is added to the LIP program, and greater transparency is provided related to the levels of funding and payment occurring through the LIP program and IGT-funded rate enhancements, perhaps continuation of the LIP program would be considered a viable option by CMS.

In addition program oversight and transparency could be increased by developing reports which document a combination of claim payments and supplemental payments. Separately,

AHCA monitors claim payments and supplemental payments in detail. However, few, if any standard reports show the combination of both at the individual hospital level. Creating such reports would be relatively easy for AHCA as they already monitor both types of payments. Combining more comprehensive payment reports with data on the source of funding at the hospital level, would significantly increase transparency within the program.

Any change in funding and/or payment method will likely result in shifting Medicaid reimbursement levels between providers – particularly with a change as large as a replacement for the LIP program. If a modified version of the LIP program would be acceptable to CMS, then this would likely generate the least amount of changes to the Florida Medicaid program. In addition, given the lead time required to design and implement many of the other options described in this report, being able to preserve much of what already is in place with the current LIP program makes it an attractive option.

1.5.4 Delivery System Reform Incentive Payment Program

A Delivery System Reform Incentive Payment (DSRIP) program is offered as an option for Florida Medicaid because DSRIP projects could, in theory, be developed in ways that allow contributors of IGTs to experience a return on investment. DSRIP programs allow states to make incentive payments that are linked to performance-based incentive initiatives, or "projects," aimed at improving health care processes, clinical outcomes, and otherwise positively transform health service delivery. Generally, progress on these projects is tracked and payments are adjusted based on providers' successes in meeting agreed-upon milestones. DSRIP programs are designed to advance CMS's "Triple Aim" of improving the health of the population, enhancing the experience and outcomes of the patient and reducing the per capita cost of care. The overarching goal is transformation of the Medicaid payment and delivery system in an effort to achieve measureable improvements in quality of care and overall population health.

If a DSRIP program was implemented in place of LIP, payments would not be guaranteed as they are under LIP. Hospitals would be required to document successes against predetermined measurable objectives specifically related to improving quality of care and overall population health. Those that meet the objectives would receive incentive payments. In addition, recently approved DSRIP programs have included initiatives that include multiple types of providers in addition to hospitals. Thus, it is safe to assume reimbursements to individual hospitals would be different from those currently provided under the LIP program.

In addition, it should be noted that the DSRIP landscape is rapidly changing. Program design and related terms and conditions developed for states with currently approved DSRIP programs should not necessarily be indicative of CMS' willingness to approve similar terms and conditions in other states considering DSRIP. Consistent with the intent of 1115 Demonstration Waivers, CMS is looking for innovative models intended to transform health care delivery. Simply replicating another state's model may not be consistent with CMS' overall objectives in this regard.

1.5.5 Medicaid Expansion

To a degree, the LIP program helps compensate hospitals for cost of care to the uninsured and under-insured (often referred to as uncompensated care). This is particularly important in Florida because the State was not a heavy user of DSH funds at the time DSH funding became capped based on historical usage. As a result, Florida's program-wide Medicaid DSH limit is relatively low in comparison to the size of its uninsured population. Expiration of the LIP program without any type of replacement would be detrimental to Florida hospitals for many reasons, one of which would be loss of compensation helping to cover the costs of uncompensated care.

The decision whether or not to expand Medicaid is of particular concern to hospitals because the ACA can affect both payment increases and reductions for hospitals. The ACA offers increases in hospital revenue through expanded Medicaid eligibility and new subsidies to help low and moderate income households buy coverage through health insurance exchanges. Accompanying this are planned reductions in Medicaid and Medicare DSH funding as well as a reduction on Medicare hospital fee-for-service payments through reductions or removals of planned future increases.[12]

States that do not expand Medicaid receive their regular FMAP (around 59 percent for Florida) for new enrollment of recipients eligible for Medicaid. In addition, federal subsidies are offered to families with incomes between 100 percent and 400 percent of the federal poverty level (FPL) to help them purchase commercial insurance coverage through a Health Information Exchange (which is now referred to as the "Marketplace"). In contrast, for states that do expand their Medicaid program, federal subsidies are offered to families with incomes between 138 percent and 400 percent of the FPL to help them purchase commercial insurance coverage through the Marketplace. Also in expanding states, Medicaid coverage is offered to all families up to 138 percent of the FPL. For recipients receiving Medicaid coverage under the expanded eligibility rules, states will receive 100 percent federal matching for costs in 2014 through 2016. Between 2017 and 2020, the federal matching percentage gradually decreases down to 90 percent and continues at 90 percent thereafter.[13] There are two exceptions where states who had waiver programs covering childless adults for FPL percentages up to or over 100 percent prior to enactment of the ACA may receive the new, higher FMAP for these recipients. However, we do not believe these exceptions apply to any existing programs within Florida Medicaid.

Expansion would increase the number of Florida residents with medical insurance, bring a significant amount of federal funds into the state, and help offset planned reductions in DSH payments and Medicare fee-for-service payments to hospitals. Of course, all of these benefits would only be achieved with some additional cost to the State. After 2016, Florida would need to find a way to increase its state share of funding for the Medicaid program.

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[12] Urban Institute, *The Financial Benefit to Hospitals from State Expansion of Medicaid.* (March, 2013)

[13] Kaiser Family Foundation, *A Guide to the Supreme Court's Decision on the ACA's Medicaid Expansion,* (August, 2012).

Estimating the impact of Medicaid expansion in any state is not an exact science; a variety of assumptions must be made. With that said, estimates adopted by the Florida Social Services Estimating Conference (SSEC) in March 2013 indicate Medicaid expansion would have a steady-state cost of just under $1 billion per year in additional non-federal funds when the FMAP drops to 90 percent. For that additional cost, Florida would receive approximately $7.8 billion in additional federal funds annually.[14] Of course, if the federal government drops the FMAP percentage below 90 percent, the costs of Medicaid expansion to the state of Florida would increase above this estimate.

If Medicaid expansion is to be implemented, there may be options as to how it can be implemented. A standard implementation enrolls the uninsured below 138 percent of the FPL into Medicaid. In addition, CMS has approved a few other implementations, some of which include offering premium assistance to help low income individuals and families buy commercial insurance through Marketplace Qualified Health Plans (QHPs). These premium assistance programs may include other stipulations such as healthy behavior incentives, flexible spending accounts, and other tools designed to increase recipient impact in the costs of health care.

There are four states with approved 1115 waivers related to Medicaid expansion – Arkansas, Iowa, Michigan and Pennsylvania. In addition, CMS is currently reviewing Indiana's waiver, while Utah and Tennessee are working toward alternative proposals. CMS approved Arkansas and Iowa utilizing premium assistance programs. Following Arkansas' and Iowa's approval, other states began developing similar approaches. Common themes among the alternatives include:

- Reliance on the private insurance market
- Exemptions from current Medicaid rules on cost-sharing, benefits, time limits and work requirements
- An emphasis on healthy behaviors and personal responsibility — in all states mandating premiums, the premiums will be eliminated or reduced for compliance with health behaviors[15]
- Limits or contingencies on the expansion, including ending the expansion program if the federal government reduces its enhanced matching rate[16]

We do not believe that a decision to expand Medicaid in Florida would be sufficient as a full replacement of the LIP program. The LIP program funds some of the gap between Medicaid payments and the Medicare Upper Payment Limit (UPL). This has been true throughout the

[14] Retrieved from a presentation from the Florida Agency for Healthcare Administration (AHCA), available at http://edr.state.fl.us/Content/conferences/medicaid/FederalAffordableHealthCareActEstimates.pdf, (March, 2013).
[15] Kaiser Commission on Medicaid and the Uninsured, *The ACA and Recent Section 1115 Medicaid Demonstration Waivers*, November, 2014.
[16] Center for Health Care Strategies, Inc., *Alternative Medicaid Expansion Models: Exploring State Options,* February, 2014.

life of the LIP program, and is particularly true in SFY 2014/15 in which self-funded IGTs have been moved into LIP. In addition in SFY 2014/15 the LIP program contains supplemental payments to teaching physicians that would not get replaced by expanding Medicaid. In the SFY 2014/15 LIP program, self-funded IGTs were estimated to equal $963 million (total computable) and supplemental payments to teaching physicians were estimated to equal $204 million (total computable). Also, increasing the number of recipients enrolled in Medicaid will increase the volume of patients for which hospitals receive payments below cost. Thus, even with Medicaid expansion, we believe continuation of the LIP program, or some form of replacement for the LIP program will still be needed.

1.5.6 Constraints for the Various Options

In the discussion of various options, we consider current federal and state regulations as well as precedent related to what CMS has approved recently in 1115 demonstration waivers. We also consider the ability of each option to maintain current program-wide payment levels to hospitals and teaching physicians. In addition, we consider the potential to maintain payment levels for individual hospitals and teaching physicians similar to what is provided today. (For teaching physicians, discussion in this study relates only to the supplemental payments made through the LIP program. There is no consideration of physician fee-for-service rates.) With the exception of uncompensated care pools, all payment methods have constraints that will likely result in placing limits on how funds are distributed at the individual hospital level. Even so, there are ways in which each option could be implemented to help mitigate changes in reimbursement for individual facilities.

All options discussed could, in theory, maintain an overall Medicaid funding level at or above what exists today. However, to do so, a federal waiver will be needed for distribution of some of the funds. The current level of payments exceeds the Medicare upper payment limit and is helping reimburse costs not only for care of Medicaid recipients, but also for care of uninsured patients. Maintaining a payment level above the UPL and/or reimbursing some costs for the uninsured outside of DSH would require a federal waiver. Although the UPL only applies to the fee-for-service program, we assume payments reaching the upper payment limit are also the maximum that would be considered actuarially sound within the Medicaid managed care program.

1.6 Conclusion

As defined in CMS's STCs for the 2014 renewal of Florida's 1115 demonstration waiver, the intent of this study is to suggest "sustainable, transparent, equitable, appropriate, accountable, and actuarially sound Medicaid payment systems and funding mechanisms that will ensure quality health care services to Florida's Medicaid beneficiaries throughout the state ***without the need for Low Income Pool (LIP) funding***."[17] (emphasis added by Navigant)

[17] Centers for Medicare and Medicaid Services, *Special Terms and Conditions for Florida Medicaid Reform Section 1115 Demonstration*, Document number 11-W-00206/4, STC number 69, (2014).

In SFY 2014/15, the LIP program will distribute just under $2.2 billion, approximately $1.3 billion[18] of which is federal funds. Thus, expiration of the LIP program without any sort of replacement would take $1.3 billion out of Medicaid payments to Florida hospitals, which is over 15 percent of their total Medicaid reimbursement. This would be enough to create financial hardship for hospitals, particularly those with a high utilization from Medicaid and uninsured patients.

We believe that funding and payment options do exist that can preserve the aggregate funding levels that have historically been achieved through the LIP program. However, in the absence of a federal waiver, the UPL limitations in payments simply restrict how much funding can be federally matched. This appears to be one of the unintended, but common consequences associated with a transition to a capitated managed care model. Shifting the financial risk from the State to the Medicaid managed care plans also means that the State is passing substantial control of how payments are made over to the plans. None of the options included in this study will likely afford the State the same flexibility to maintain the payment levels currently made to individual hospital providers.

This study provides context in which decisions can be made about the future of hospital funding and payment within the Florida Medicaid program. In this study, we provide background on the Florida Medicaid program, description of applicable federal and state regulations, and description of trade-offs for various individual funding and payment options. The study also describes combinations of funding and payment that will likely work well together. Unfortunately, given the size, complexity, and variety of stakeholders involved with the Florida Medicaid program, no single option or combination thereof is void of drawbacks. Thus, there are no clear and obvious answers. Ultimately, final decisions will come down to matching available options with the priorities of the Florida Medicaid program and of CMS.

For example, implementation of Medicaid expansion would significantly reduce the amount of uncompensated care in the state. However, the State may not want to absorb the additional costs of Medicaid expansion, including the risk that the FMAP gets reduced below 90 percent at some point in the future. Similarly, the State may prefer an option that continues current levels of IGT funding. However, if current IGT funding is maintained, payment methods will need to be developed that meet CMS requirements while still allowing sufficient incentives for IGT contributors. CMS would likely prefer a shift to more broad-based funding, however, this may not be the preference of the State of Florida or the entities that contribute a portion of the State's share of funding. In addition, an option including IGT funding for a DSRIP program will need to balance meeting CMS's goals for health care delivery transformation with the need to provide return on investment to IGT contributors.

[18] The $1.3 billion estimate is based on the federal share of the total estimated LIP-based payments of approximately $2.168 billion. The assumed FMAP for this calculation is 59.56 percent.

Whatever the course of action selected by the State of Florida, we strongly recommend that Florida maintain an open dialogue with CMS in determining how to best move forward, and use CMS as a partner in determining the best solutions.

2 Introduction

In fiscal year 2012, the Medicaid and the State Children's Health Insurance Program (CHIP) were sources of health coverage for 80 million people, just over one quarter of the population of the United States. Those served by these programs included one-third of all children, many low-wage workers and their families, persons who have physical and mental disabilities, and seniors with Medicare. Together, the Medicaid and CHIP programs accounted for 15 percent, approximately $434 billion, of total U.S. health care spending. In Florida, Medicaid consumed nearly 22 percent of state general revenue, approximately $8.3 billion in state fiscal year (SFY) 2012. With federal matching funds, this resulted in a little over $19 billion spent by the Florida Medicaid program.[19]

Governance and financing for Medicaid programs is a shared responsibility of the federal government and the states. States that operate their Medicaid programs within federal guidelines are entitled to federal reimbursement for a share of their total program costs. States incur these costs by making payments to health care providers and managed care plans and by performing administrative tasks such as making eligibility determinations, enrolling and monitoring providers, and paying claims. They then submit quarterly expense reports in order to receive federal matching dollars.

Part of the challenge in setting policies for Medicaid and CHIP is balancing federal and state interests. Both the federal and state governments have a financial stake in the programs and reconciling their sometimes different and conflicting priorities can be difficult, particularly under stressful fiscal circumstances such as during a national and/or state recession. States are incented to maximize flow of federal funds into the state, but must do so while maintaining a balanced state budget. Medicaid and CHIP provide an important source of revenue for the health care industry that affects economic activity throughout each state. They are major sources of federal financing for costs that might otherwise be borne by state and local governments, and by individuals and providers. However, being a jointly financed program, states must increase their own contributions in order to increase federal contributions.

From a federal perspective, Medicaid and CHIP represent a growing portion of the federal budget, having increased from 1.4 percent of federal outlays in fiscal year (FY) 1970 to 8.1 percent in FY 2010. In comparison, Medicare increased from 3.0 percent of federal outlays to 12.3 percent over the same period. However, unlike Medicare, an exclusively federal program for which a substantial portion of spending is financed by dedicated revenue sources that include payroll taxes and enrollee premiums, federal spending for Medicaid and CHIP is financed by general revenues.[20] The federal government has a fiscal responsibility to control costs of the Medicaid program, much the same as the states' fiscal responsibility.

[19] MACPAC. *Report to the Congress on Medicaid and CHIP, (*March 2014)
[20] MACPAC. *Report to the Congress on Medicaid and CHIP, (*March 2011).

To control costs and ensure access to quality care, the Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for coordinating Medicaid, monitors each state Medicaid program. CMS oversees the approval of state plan amendments, waivers, and demonstrations and provides guidance to states through State Medicaid Director (SMD) and State Health Official (SHO) letters. As a condition of receiving federal Medicaid funds, Section 1902 of the Social Security Act requires states to have an approved state plan on file with CMS that demonstrates an understanding of all federal Medicaid requirements. States are required to submit state plan amendments (SPAs) to CMS for review and approval prior to making program modifications.

In addition to SPAs, CMS works with state Medicaid agencies to review and approve waivers. The Social Security Act (the Act) contains multiple waiver authorities that provide states flexibility in certain areas to operate their programs outside of standard federal requirements that would otherwise apply. In particular, Section 1115 of the Act gives broad authority to the Secretary to authorize "any experimental, pilot or demonstration project likely to assist in promoting the objectives of the programs" specified in that section of the Act. Under Section 1115 research and demonstration authority, states may waive certain provisions of the Medicaid and CHIP statutes related to state program design. Provisions that may be waived under Section 1115 include Medicaid eligibility criteria, covered services, and service delivery and payment methods used by the state to administer the program. Section 1115 demonstrations include a research or evaluation component and usually are approved for a five-year period, with a possible three-year renewal period after the first five years. The ability to waive certain aspects of the Medicaid statute gives states flexibility to experiment with different approaches to program operation, service delivery, and financing in terms of both program expansion and contraction. Approval of states' waiver applications is at the discretion of the Secretary of federal Health and Human Services (HHS).[21]

All states operate one or more Medicaid waivers. In Florida, an 1115 demonstration waiver was negotiated between the Florida Agency for Health Care Administration (AHCA) and CMS which allowed for a transition from a fee-for-service (FFS) to Medicaid managed care model. The waiver program began in SFY 2006/07 and was renewed in 2011 and again in 2014. In addition to conversion from FFS to Medicaid managed care models, the waiver included development of a new program called the Low Income Pool (LIP). The goal of the LIP program is to provide government support for safety net hospitals that furnish health care to the Medicaid, underinsured and uninsured populations. The LIP program is also designed to establish new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations. In addition, the LIP program allowed for supplemental payments to hospitals to continue even with the transition to Medicaid managed care.

[21] MACPAC. *Report to the Congress on Medicaid and CHIP, (*March 2011).

CMS' renewal of Florida's 1115 demonstration waiver in 2014 included a three-year extension on Medicaid managed care (known as the Managed Medical Assistance (MMA) program in Florida), but only included a one year extension of the LIP program. Also included in the 2014 Special Terms and Conditions (STCs) accompanying approval of the 1115 waiver was a mandate requiring AHCA to contract with an independent consultant to conduct a review of the state's funding and payment mechanisms. The intent of this study is to suggest "sustainable, transparent, equitable, appropriate, accountable, and actuarially sound Medicaid payment systems and funding mechanisms that will ensure quality health care services to Florida's Medicaid beneficiaries throughout the state ***without the need for Low Income Pool (LIP) funding***."[22] (emphasis added by Navigant) To do this the STC's outlined several key requirements. The report must:

- Include detailed information on the historical methods of funding hospital payments, the interaction between state funded payments and provider funded payments, and describe the composition of payments, including base and supplemental payments.

- Analyze the adequacy of current payment levels for Medicaid providers, and the adequacy, equity, accountability and sustainability of the state's funding mechanisms for these payments. The report must primarily focus on the types of providers supported by IGT or LIP funds.

- Include an analysis of how future changes in Medicaid, including possible Medicaid expansion would affect Medicaid payment amounts and structure, including fee-for-service payments, managed care, and LIP.

- Recommend reforms to the Florida Medicaid financing system that can allow the state, beginning in state fiscal year 2015-2016, to move toward Medicaid fee-for-service and managed care payments to providers that ensure access and quality of care for Medicaid beneficiaries without the need for LIP funds. These payments should be based on a rationalized, non-facility specific payment mechanism, which can be applicable to future changes in Medicaid including Medicaid expansion. This type of rationalized payment mechanism would not include payment based on facility specific costs or local tax revenue and would discontinue incentive payments through the LIP.

In addition, the 2014 Legislature included proviso language in the 2014/15 General Appropriations Act stating additional requirements of the report including:

- Identify federal regulations on the following: inter-governmental transfers (IGTs), including their sources, uses, and allowable repayment arrangements; supplemental hospital payments, including allowable types, purposes, and payees; and direct provider

[22] Centers for Medicare and Medicaid Services, *Special Terms and Conditions for Florida Medicaid Reform Section 1115 Demonstration*, Document number 11-W-00206/4, STC number 69, (2014).

payments that are allowed within Medicaid programs that are based primarily on risk-bearing managed care plans.

- Identify other states' uses of IGTs and supplemental hospital payments, including: arrangements for incenting or requiring IGTs; methods of payment, particularly in states with high managed care penetration; and specific federal waiver terms and conditions that apply to IGTs and supplemental hospital payments.

AHCA engaged Navigant Consulting, Inc. (Navigant) to perform this study. A draft of the resulting report is due to CMS no later than January 15, 2015 with the final report due March 1, 2015.

In the first eight years of the LIP, a combination of state and federal funding resulted in $1 billion distributed to health care providers in Florida, with the majority of the funds going to hospitals. In the ninth year of the LIP program, the one-year renewal for state fiscal year (SFY) 2014/15, additional funding and payment mechanisms were added into the LIP program – self-funded IGTs and physician supplemental payments. In SFY 2014/15, the LIP program will distribute almost $2.2 billion with the following broad distribution:

$1.9 billion to hospitals
$200 million to medical school teaching physicians
$42 million to Federally Qualified Health Centers (FQHCs) and County Health Departments (CHDs)

Overall, the LIP program will distribute almost 10 percent of total Florida Medicaid spending in SFY 2014/15 and approximately one-third of Medicaid hospital reimbursements. In addition to distributing a very significant amount of funds, the LIP program has been a primary vehicle used by Florida Medicaid in recent years to incent donations of inter-governmental transfers (IGTs) from local governments, taxing districts, and public hospitals. If the LIP program is terminated in the future, other options will need to be developed to help fund and distribute Medicaid reimbursements, otherwise Florida hospitals, particularly those treating large percentages of Medicaid recipients, risk financial hardship.

This study offers a set of options available to Florida Medicaid to maintain current funding and payment levels without use of the LIP program. The discussion focuses primarily on hospital funding and payment as hospitals are the provider type most affected by the LIP program.

Before offering options for the future, the study begins by describing applicable federal and state regulations related to funding and payment of Medicaid programs. On the funding side, this includes a discussion of inter-governmental transfers (IGTs), general revenue, certified public expenditures and health care provider assessments. On the payment side, fee-for-service claim payments, managed care capitation payments, non-Disproportionate Share Hospital (non-DSH) supplemental payments and DSH supplemental payments are discussed. Note that for

purposes of this report, we use the term "supplemental payment" to mean any payment made outside of the traditional claims-based payment process, and made directly from the state to the provider. Such "supplemental payments" include DSH supplemental payments, UPL-based supplemental payments, graduate medical education supplemental payments, and incentive payments (such as those designed to create incentives under Delivery System Reform Incentive Payment, or DSRIP programs).

To further define context, the study goes on to describe the LIP program and the current Florida Medicaid funding mechanisms and payment methods, particularly related to hospitals. This is followed with an analysis of the current funding and payment methods with a focus on topics mentioned in the STCs – adequacy, sustainability, accountability, and equity. Navigant used Medicaid payments as compared to hospital costs as a measure of payment adequacy. To assess sustainability, Navigant determined the likelihood that funding will continue at current levels and that payment will be sufficient to incent hospitals to accept Medicaid and uninsured patients. Navigant then reviewed the level of transparency and simplicity within the current system to evaluate accountability. The final analysis looked at equity and to do this Navigant concentrated on funding and payment levels across providers in the state of Florida and across Medicaid programs in the United States.

The study then provides background on two significant and complex potential options for Florida Medicaid – Medicaid expansion and a Delivery System Reform Incentive Payment (DSRIP) program. This is followed by a description of funding and payment mechanisms utilized by other Medicaid agencies, all with similar challenges as those faced by Florida Medicaid, including finding ways to control costs, maintain access, and improve quality of health care for Medicaid recipients. Navigant conducted research on several states that have similar characteristics to Florida, and states that have unique funding and payment approaches.

This study then goes on to identify and describe individual options for Florida Medicaid for both funding for and payment to hospitals. Each option offers some benefits and contains some limitations, both of which are discussed. We then discuss a small number of combinations of individual options that have potential to offer the best set of benefits with the least drawbacks.

To help develop these options, Navigant conducted numerous interviews with key stakeholders across the State gathering opinions on how Florida should reform its current system. Navigant had conversations with representatives from the following organizations: Florida Hospital Association, Safety Net Hospital Alliance of Florida, Florida Association of Health Plans, Hospital Corporation of America, Florida children's hospitals, The Council of Florida Medical School Deans, AHCA, and CMS. Navigant also spoke with staff representing the state legislature and the Executive Office of the Governor.

Following discussion of the options, the study includes an evaluation of selected option combinations based on a predetermined set of evaluation criteria. Our goal was to provide an

objective evaluation of what might best maintain access and ensure quality health care for Florida Medicaid recipients if the LIP program is no longer acceptable to CMS.

Note that as we present a set of options that should be considered by Florida Medicaid, we have attempted to put forth solutions that have been successfully implemented in other states with the approval of CMS. However, as with any such program design, the devil is always in the details. The details of the program design must be consistent not only with current CMS regulations, but in the case of waiver programs, consistent with CMS goals and objectives related to such waiver programs. In other words, the fact that a waiver or other type of program has been established and successful in another state is no guarantee that CMS will approve a similar program in Florida.

3 Applicable Federal and State Regulations

3.1 Regulatory Summary

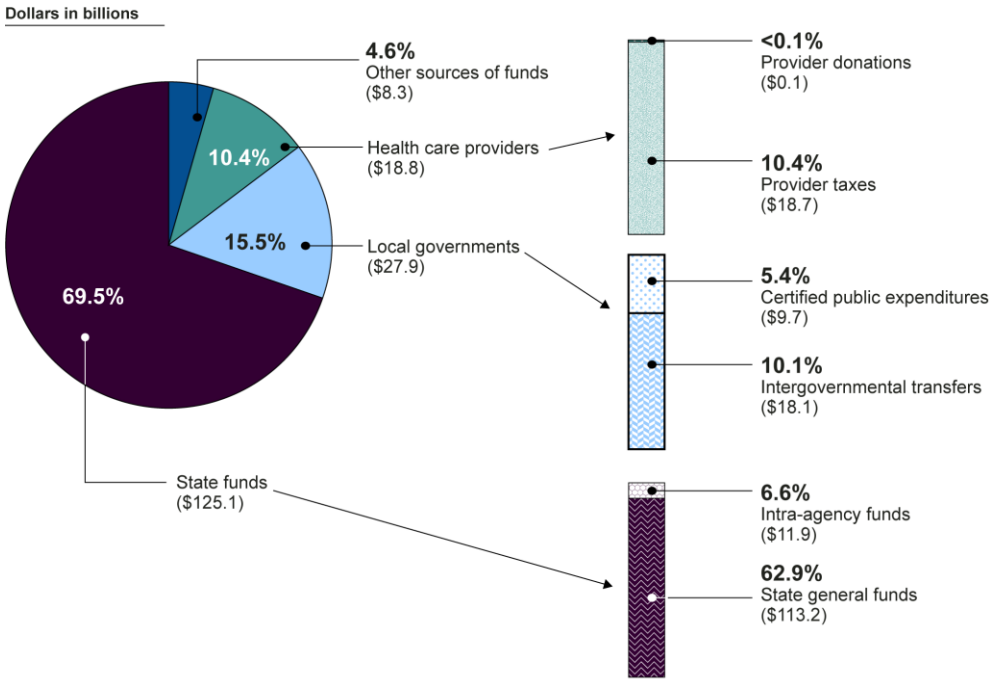
A variety of federal and state regulations establish the requirements and provide guidelines regarding how Florida Medicaid may collect and distribute funds in operation of the Florida Medicaid program. As long as a Medicaid Agency operates its program in a way that is compliant with these regulations, it is eligible to receive federal matching funds toward allowable Medicaid expenditures. Any funding or payment practices that are not compliant with these regulations may result in denial of federal financial participation for the portion of funding that is not compliant. Because of this, all options for changes in the Florida Medicaid program suggested in this paper were developed with these guidelines in mind.

Since the Medicaid program's inception in 1965, flexibility in financing the non-federal share has allowed states to use local sources of health care financing while making these local funds eligible for federal match. Section 1902(a)(2) of the Act, included in the original statute, has a provision requiring at least forty (40) percent of the "state share" to come from the state while allowing up to sixty (60) percent to come from local sources.[23] The most common sources of local funding are inter-governmental transfers (IGTs), certified public expenditures (CPEs), and health care related taxes, often referred to as provider assessments. IGTs and CPEs must originate from a governmental agency such as a non-Medicaid state agency or local government such as a county or municipality. Medicaid providers such as county hospitals or school districts also qualify as units of local government. Provider assessments are defined by federal statute as taxes in which at least 85 percent of the tax burden falls on health care providers.[24]

A recent report from the Government Accountability Office entitled "Medicaid Financing States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection" detailed the sources of non-federal share of Medicaid expenditures for state fiscal year 2012. As shown in Figure 6, about 70 percent of non-federal share of Medicaid funding (also known as "the state share") comes from state general revenue. Other sources including local governments and health care providers (through provider assessments) also contribute significant funds towards the state share of Medicaid programs.

[23] The Social Security Act, Section 1902(a)(2).
[24] The Social Security Act, Section 1903(w)(3)(A).

Figure 6. Sources of funds for the state share of Medicaid across all Medicaid programs in the United States.



Source: GAO. | GAO-14-627

25

A recent report from the Medicaid and CHIP Payment and Access Commission (MACPAC) related to this issue stated:

> "At various points, particularly beginning in the early 1990s, this multi-source approach to financing has been the subject of federal scrutiny, sometimes because of evidence of state excesses (GAO 2004b, GAO 1994), and sometimes in an effort to control federal spending by limiting states' ability to make expenditures that qualify for federal contributions."[26]

As recently as May of 2014, CMS issued a Medicaid Directors' letter intending to provide guidance to states concerning Federal statute and regulations related to the allowable and unallowable use of contributions to the state share of Medicaid funds. The letter reminded state Medicaid agencies of regulations requiring non-state donations contributing to the state share of Medicaid funding to originate from governmental agencies:

> "This letter only discusses situations where governmental entities and private entities enter into agreements or relationships that constitute non-bona fide provider-related

[25] GAO "*Medicaid Financing States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection*" (GAO-14-627), Figure 1. (July 2014)
[26] MACPAC. *Report to the Congress on Medicaid and CHIP.* (March 2012)

> donations, in which private entities provide a governmental entity with funds or other consideration and receive in return additional Medicaid payments typically in the form of a supplemental payment. … Government entities are free to enter into agreements with private entities; however such agreements may affect the allowability of Medicaid funding if there is a hold harmless provision or practice. A hold harmless practice exists if there is a positive correlation between the agreement and the Medicaid payments, Medicaid payments are conditioned upon the receipt of a donation from a private entity, or if there is a guarantee that the private entity will see a return of some, or all, of that donation through a Medicaid payment."[27]

Within traditional fee-for-service Medicaid, payments are generally made in three forms, 1) on a claim-by-claim basis for services rendered to Medicaid recipients; 2) through non-DSH[28] supplemental payments[29]; and, 3) through DSH supplemental payments. Non-DSH supplemental payments may be distributed for a variety of reasons, most common of which are Graduate Medical Education (GME) payments, Upper Payment Limit (UPL) payments, and incentive payments. GME payments, made to teaching hospitals, help offset hospitals' costs for operating Graduate Medical Education programs. UPL payments offset some or all of the difference between total traditional claims-based Medicaid payments for services and the maximum payment level allowed under the Medicare Upper Payment Limit regulations for those services. Incentive payments, which we also describe generally as supplemental payments, are made to hospitals for achieving certain incentive goals related to patient quality or access, and can be made directly by states to providers related to services provided to patients who are served through the FFS program or are enrolled with a Medicaid managed care plan.

The UPL regulations establish the maximum amounts of payments for Medicaid services that are eligible for federal matching funds. The maximum total payment is generally calculated as an approximation of what Medicare would pay for these same services, or as an approximation of hospital costs to provide these services following Medicare allowable cost rules.

UPL regulations establish limits on the federal portion of Medicaid outlays for recipients paid under Medicaid FFS programs. In contrast, federal matching funds for Medicaid managed care programs are limited by a different set of regulations which require capitation rates paid by Medicaid to managed care organizations to be actuarially sound. In addition, federal regulations dictate that services covered by Medicaid managed care plans must be considered "paid in full" through the rate paid to the plan.[30] Based on this regulation, non-DSH supplemental payments for services provided to Medicaid recipients are generally prohibited

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[27] Centers for Medicare and Medicaid Services (CMS). *SMDL#14-004 RE: Accountability #2: Financing and Donations.* (May 9, 2014)

[28] DSH stands for Disproportionate Share Hospital

[29] As mentioned previously, the term "supplemental payments" is used broadly in this report, and includes incentive payments made directly from a state to a provider as part of a DSRIP or other waiver program.

[30] Code of Federal Regulations, Title 42, Section 438.60 (October 2014)

from being paid directly by Medicaid agencies to hospitals, unless they are explicitly approved through a waiver program, such as incentive payments made through an approved DSRIP program. Further, Medicaid agencies are generally not allowed to dictate how Medicaid managed care plans pay for services with contracted hospitals, which also means that Medicaid agencies cannot direct the plans to pass through or otherwise distribute supplemental payments. A recent MACPAC report stated "CMS considers strategies that require MCOs to 'pass through' supplemental payments to contracted providers to be inconsistent with the statute that requires capitation rates to be actuarially sound."[31] Thus, traditional UPL supplemental payments are not an acceptable payment mechanism under a Medicaid managed care model.

One exception to this rule is that states are allowed to make GME supplemental payments to hospitals in a Medicaid managed care model because they are tied to costs of maintaining Graduate Medical Education programs, not to the cost of care for Medicaid recipients. Similarly, DSH payments are allowed under both fee-for-service and Medicaid managed care programs. Federal Fund Participation (FFP) for Medicaid DSH payments is controlled by two limitations. For FFP, one limit requires the total Medicaid payment to an individual hospital to be no greater than the cost of care for Medicaid recipients, uninsured, and underinsured. The other limit caps total FFP to each state for DSH at values pre-set within federal regulation. These values were based on historical DSH payments increased annually by an inflation factor. The total federal DSH allotment for Florida Medicaid is relatively low when compared to those of other large states.

In recent years, states have explored alternative ways to maintain supplemental payments to hospitals when converting to capitated Medicaid managed care models. The LIP program in Florida, as an example, was created in 2006 as part of Florida's managed care waiver and was created specifically to allow supplemental payments to continue while transitioning much of the Medicaid population from traditional FFS to a Medicaid managed care model. If the LIP program is terminated, as CMS is suggesting would be their preference, Florida Medicaid will be left in a difficult position trying to find ways to maintain current funding levels. In addition, any replacement for the LIP program will require some form of waiver in order to maintain current payment levels as those levels (when including the LIP program) are above the UPL limits. In addition, current funding for the Medicaid program is heavily dependent on IGTs, which have been forthcoming in the past because the LIP program ensured all IGT contributors would receive back more than if they kept their IGT funds within their local jurisdiction.

3.2 State Plans and Waivers

Each state operates its Medicaid program in accordance with a state plan submitted to and approved by CMS that describes the nature and scope of the program (e.g., administrative structure and operations, eligibility, covered benefits, payment methods). Section 1902 of the Social Security Act requires states to have a state plan on file with CMS as a condition of

[31] MACPAC. *Report to the Congress on Medicaid and CHIP. (*March 2014)

receiving federal Medicaid funds. The state plan demonstrates states' understanding of all federal Medicaid requirements. When states make changes to the Medicaid program in areas documented in the state plan, states are required to submit state plan amendments (SPAs) to CMS for review and approval prior to making the program modifications. Included in state plans is a description of how payments are made in traditional Medicaid fee-for-service programs.

The Social Security Act also contains multiple waiver authorities that provide states flexibility in certain areas by allowing them to operate their programs without regard to federal requirements that would otherwise apply. For example, the Act provides the authority to waive certain provisions of the Medicaid and CHIP statutes such as eligibility and benefits in order to explore new approaches to the delivery of and payment for health care and long-term services and supports. This flexibility has enabled states to make fundamental changes to their programs. All states operate one or more Medicaid waivers, which are generally referred to by the section of the Act granting the waiver authority. Those waivers are categorized as program waivers or research and demonstration projects. Regardless of the type of waiver, estimated federal spending over the period for which the waiver is in effect cannot be greater than it would have been without the waiver. Approval of states' waiver applications is at the discretion of the Secretary of HHS.[32]

Section 1915(b) waivers permit states to implement service delivery models (e.g., those involving primary care case management programs or managed care plans) that restrict beneficiaries' choice of providers other than in emergency circumstances. Section 1915(c) of the Medicaid statute authorizes states to provide home and community-based services as an alternative to institutional care in nursing homes, intermediate care facilities for individuals with mental retardation (ICF-MRs), and hospitals. Section 1115 of the Social Security Act gives broad authority to the Secretary to authorize "any experimental, pilot or demonstration project likely to assist in promoting the objectives of the programs" specified in that section of the Act. Under Section 1115 research and demonstration authority, states may waive certain provisions of the Medicaid and CHIP statutes related to state program design. Provisions that may be waived under Section 1115 include Medicaid eligibility criteria, covered services, and service delivery and payment methods used by the state to administer the program. Section 1115 demonstrations include a research or evaluation component and usually are approved for a five-year period, with possible three-year renewal periods after the first five years. The ability to waive certain aspects of the Medicaid statute gives states flexibility to experiment with different approaches to program operation, service delivery, and financing in terms of both program expansion and contraction. Section 1115 authority has been used in a variety of ways and for an array of purposes.[33] In Florida, an 1115 demonstration waiver has been created to enable the use of Medicaid managed care and the LIP program.

3.3 Regulations Related to Medicaid Funding

[32] MACPAC. *Report to the Congress on Medicaid and CHIP. (*March 2011).
[33] Ibid.

Medicaid programs are jointly funded by the federal government and the state government. The Social Security Act Section 1902(a)(2) and 42 CFR §433.53(b) require that a state must use at least 40 percent of state funds as the non-federal share of total Medicaid expenditures. The minimum 40 percent is typically generated from general tax revenue. Florida primarily receives its general tax revenue from property taxes and sales and gross receipt taxes and currently funds approximately 60 percent of the Medicaid program through general funds – well above the minimum requirement.

Because the program is jointly funded by federal and state governments, the federal government contributes funds to each state Medicaid program using a percentage referred to as the Federal Medical Assistance Percentage (FMAP). FMAP values vary by state and are computed using a formula that takes into account the average per capita income for each state relative to the national average. Also, each state receives multiple FMAP values. For the cost of health care services, one FMAP is assigned for the traditional Medicaid program and another is assigned for the State Children's Health Insurance Program (CHIP). For states that expand Medicaid, there is a separate FMAP for the expansion population and there are additional FMAPs assigned for the cost of administrating the Medicaid program and for making upgrades to the program. The non-expansion health care services Medicaid average state FMAP is 57%, but FMAPs range from 50% in wealthier states up to 75% in states with lower per capita incomes. Florida's blended Medicaid and CHIP FMAP for SFY 2014/15 is 40.44 percent and the federal share percentage is 59.56 percent. This means for every dollar spent by the Medicaid Agency in SFY 2014/15, 40.44 cents come from state resources and 59.56 cents come from federal resources. Another way to think of this is that $1.00 in state funds in SFY 2014/15 yields $2.47 in total funds for the Medicaid program (1 / 0.4044 = $2.47).

In addition to general revenue, there are three common forms of revenue used to fund the state share of a Medicaid program. These are inter-governmental transfers, certified public expenditures, and provider taxes/assessments. The statutes and regulations related to each are discussed in the following sections.

3.3.1 Inter-governmental Transfers

3.3.1.1 Federal Regulations

States have used inter-governmental transfers (IGTs) for decades as a tool to fund the non-federal share of allowable Medicaid expenditures. A recent study by the Government Accountability Office reports that 10.1 percent of the non-federal share of Medicaid expenditures was funded with inter-governmental transfers.[34] The Department of Health and Human Services (HHS), Office of Inspector General (OIG), CMS, and the Government Accounting Office (GAO) have been suspect of this funding tool through the years. In 2002, the GAO stated that "IGTs are a legitimate state budget tool and not problematic in themselves … [b]ut when they are used to carry out questionable financial transactions that inappropriately

[34] Government Accountability Office. "*States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrant Improved CMS Data Collection*" (GAO-14-627), (July 2014)

shift state Medicaid costs to the federal government, they become problematic."[35] The Office of Inspector General has been critical of the IGT funding mechanism as well. On one occasion, the OIG stated the "use of the IGT as part of the supplemental payment program is a financing mechanism designed solely to maximize Federal Medicaid reimbursements without providing either additional funds to the participating county nursing facilities or additional medical services to their Medicaid residents."[36]

Despite the concerns of CMS, OIG, and GAO, the use of IGTs is allowable for the purposes of funding the non-federal share based on Social Security Act Section 1903(w)(6) and 42 CFR §433.51 – "Public Funds" as the State share of financial participation.

42 CFR §433.51 – "Public Funds as the State Share of Financial Participation" states the following:

(a) Public Funds may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (b) and (c) of this section.

(b) The public funds are appropriated directly to the State or local Medicaid agency, or are transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section.

(c) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

However as stated previously, CMS requires IGTs to originate from public entities in order to be eligible for FFP. As stated in the CMS state Medicaid directors letter entitled "SMD 14-004 – "Accountability #2: Financing and Donations" and released on May 9, 2014, funds that do not originate from a public entity are deemed "non-bona fide" and are not subject to federal matching:

> "This letter only discusses situations where governmental entities and private entities enter into agreements or relationships that constitute non-bona fide provider-related donations, in which private entities provide a governmental entity with funds or other consideration and receive in return additional Medicaid payments typically in the form of a supplemental payment."

[35] GAO report entitled *Intergovernmental Transfers Have Facilitated State Financing Schemes*, (May 2004).
[36] OIG report entitled "Review of Commonwealth of Pennsylvania's Use of Intergovernmental Transfers to Finance Medicaid Supplemental Payments to County Nursing Facilities." (A-03-00-00203), (February 9, 2001).

3.3.1.2 State Regulations

The State of Florida also has several statutes dictating collection and use of IGTs for the non-federal share Medicaid funds. The allowance for additional funds from local governmental entities for hospital services is detailed in Florida Statute 409.908 – "Reimbursement of Medicaid Providers." This statute states the following:

> "The agency may receive funds from state entities, including, but not limited to, the Department of Health, local governments, and other local political subdivisions, for the purpose of making special exception payments, including federal matching funds, through the Medicaid inpatient reimbursement methodologies."
>
> "The agency is authorized to receive funds from state entities, including, but not limited to, the Department of Health, the Board of Governors of the State University System, local governments, and other local political subdivisions, for the purpose of making payments, including federal matching funds, through the Medicaid outpatient reimbursement methodologies."

Further, Florida Statute 409.017(2) indicates that IGTs are voluntary and may be used to replace state funds for the Medicaid program (Title XIX):

(c) It is the intent of the Legislature that participation in revenue maximization is to be voluntary for local political subdivisions.

(d) Except for funds expended pursuant to Title XIX of the Social Security Act, it is the intent of the Legislature that certified local funding for federal matching programs not supplant or replace state funds. Beginning July 1, 2004, any state funds supplanted or replaced with local tax revenues for Title XIX funds shall be expressly approved in the General Appropriations Act or by the Legislative Budget Commission pursuant to chapter 216.

3.3.2 Certified Public Expenditures

3.3.2.1 Federal Regulations

As with IGTs, CPEs are governed by Social Security Act Section 1903(w)(6) and 42 CFR §433.51 – "Public Funds." A recent study by the Government Accountability Office reported that 5.4 percent of non-federal share of Medicaid expenditures for Federal fiscal year 2012 was in the form of certified public expenditures.[37]

The major difference between IGTs and CPEs is that IGTs are considered a funding source while CPEs are actual expenditures resulting from providing care to patients eligible under the

[37] Government Accountability Office. "*States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrant Improved CMS Data Collection*" (GAO-14-627), (July 2014).

Medicaid program. The public provider of service certifies the uncompensated cost of services rendered to eligible individuals. The Medicaid agency records the certified expenditures and draws the Federal share of the expenditure from its grant award authorized by CMS.

3.3.2.2 State Regulations

From a broad perspective, authority to collect federal matching funds through the use of CPEs is covered under Florida State statute 409.017(2)(a) which states that it "is the intent of the Legislature to authorize the use of certified local funding for federal matching programs to the fullest extent possible to maximize federal funding of local preventive services and local child development programs in this state." In practice, CPEs are used in Florida primarily to fund school based services and a portion of the DSH program. Specifically, statute 409.9071 – "Medicaid Provider Agreements for School Districts Certifying State Match" contains the following text:

> Subject to any limitations provided for in the General Appropriations Act, the agency, in compliance with appropriate federal authorization, shall develop policies and procedures and shall allow for certification of state and local education funds which have been provided for school-based services as specified in s. 1011.70 and authorized by a physician's order where required by federal Medicaid law.

3.3.3 Health Care-Related Taxes

3.3.3.1 Federal Regulations

The third category of alternative funding sources for non-federal share of Medicaid expenditures is the use of health care-related taxes or assessments. A recent study by the GAO reported that 10.4 percent of non-federal share of Medicaid expenditures for Federal fiscal year 2012 was paid for using these taxes or assessments.[38] The Federal statute governing this source of funding is the Social Security Act, Section 1903(w)(3).

42 CFR §433.55 – "Health Care-Related Taxes Defined" establishes the regulations for health care-related taxes under the Act. This regulation allows for the use of a tax/assessment levied on health care providers as a source of funding for non-federal share of expenditures. The main conditions for which a tax imposed by government can be considered a health care-related tax are addressed 42 CFR §433.55 (a) through (c) as follows:

(a) A health care-related tax is a licensing fee, assessment, or other mandatory payment that is related to —

(1) Health care items or services;

[38] Government Accountability Office. "*States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrant Improved CMS Data Collection*" (GAO-14-627), (July 2014)

(2) The provision of, or the authority to provide, the health care items or services; or

(3) The payment for the health care items or services.

(b) A tax will be considered to be related to health care items or services under paragraph (a)(1) of this section if at least 85 percent of the burden of the tax revenue falls on health care providers.

(c) A tax is considered to be health care related if the tax is not limited to health care items or services, but the treatment of individuals or entities providing or paying for those health care items or services is different than the tax treatment provided to other individuals or entities.

A key item in the above conditions is the 85% burden in paragraph (b). A tax imposed on all businesses is not considered a health care-related tax and no limitations exist on use of the funds. For example, sales tax paid by a hospital is not considered a health care-related tax.

Only certain health care providers may be taxed under a health care-related tax and have the tax be permissible as a source of non-federal share of Medicaid expenditures. These classes of health care items or services are outlined in 42 CFR §433.56 – "Classes of Health Care Services and Providers Defined" as follows:

a. For purposes of this subpart, each of the following will be considered as a separate class of health care items or services:

(1) Inpatient hospital services;

(2) Outpatient hospital services;

(3) Nursing facility services (other than services of intermediate care facilities for individuals with intellectual disabilities);

(4) Intermediate care facility services for individuals with intellectual disabilities, and similar services furnished by community-based residences for individuals with intellectual disabilities, under a waiver under section 1915(c) of the Act, in a State in which, as of December 24, 1992, at least 85 percent of such facilities were classified as ICF/IIDs prior to the grant of the waiver;

(5) Physician services;

(6) Home health care services;

(7) Outpatient prescription drugs;

(8) Services of managed care organizations (including health maintenance organizations, preferred provider organizations);

(9) Ambulatory surgical center services, as described for purposes of the Medicare program in section 1832(a)(2)(F)(i) of the Social Security Act. These services are defined to include facility services only and do not include surgical procedures;

(10) Dental services;

(11) Podiatric services;

(12) Chiropractic services;

(13) Optometric/optician services;

(14) Psychological services;

(15) Therapist services, defined to include physical therapy, speech therapy, occupational therapy, respiratory therapy, audiological services, and rehabilitative specialist services;

(16) Nursing services, defined to include all nursing services, including services of nurse midwives, nurse practitioners, and private duty nurses;

(17) Laboratory and x-ray services, defined as services provided in a licensed, free-standing laboratory or x-ray facility. This definition does not include laboratory or x-ray services provided in a physician's office, hospital inpatient department, or hospital outpatient department;

(18) Emergency ambulance services; and

(19) Other health care items or services not listed above on which the State has enacted a licensing or certification fee, subject to the following:

(i) The fee must be broad based and uniform or the State must receive a waiver of these requirements;

(ii) The payer of the fee cannot be held harmless; and

(iii) The aggregate amount of the fee cannot exceed the State's estimated cost of operating the licensing or certification program.

b. Taxes that pertain to each class must apply to all items and services within the class, regardless of whether the items and services are furnished by or through a Medicaid-certified or licensed provider.

Further requirements related to a permissible health care-related tax are outlined in 42 CFR §433.68 – "Permissible health care-related taxes." Paragraph (b) of this regulation states the following:

> Subject to the limitations specified in §433.70, a State may receive, without a reduction in FFP, health care-related taxes if all of the following are met:
>
> (1) The taxes are broad based, as specified in paragraph (c) of this section;
>
> (2) The taxes are uniformly imposed throughout a jurisdiction, as specified in paragraph (d) of this section; and
>
> (3) The tax program does not violate the hold harmless provisions specified in paragraph (f) of this section.

Paragraph (c)(1) of the regulation defines broad based as meaning "the tax is imposed on at least all health care items or services in the class or providers of such items or services furnished by all non-federal , non-public providers in the State, and is imposed uniformly, as specified in paragraph (d) of this section."[39] The uniformity provision requires that the unit of government that imposes the tax applies the tax to "all items or services or providers (or all providers in a class) in the area" that the unit of government has jurisdiction.[40] 42 CFR §433.68(c)(3) does allow for waivers to the broad based and uniformity requirements. Further explanation of the waiver process is included as Appendix F.

One of the reasons for identifying a tax as a health care-related tax is that the taxpayer cannot be held harmless for the tax. 42 CFR §433.68(f) outlines how a taxpayer might be held harmless:

> A taxpayer will be considered to be held harmless under a tax program if any of the following conditions applies:
>
> (1) The State (or other unit of government) imposing the tax provides for a direct or indirect non-Medicaid payment to those providers or others paying the tax and the payment amount is positively correlated to either the tax amount or to the difference between the Medicaid payment and the tax amount. A positive correlation includes any positive relationship between these variables, even if not consistent over time.

[39] Code of Federal Regulations, Title 42, Section §433.68(c)(1)
[40] Code of Federal Regulations, Title 42, Section §433.68(c)(2)

(2) All or any portion of the Medicaid payment to the taxpayer varies based only on the tax amount, including where Medicaid payment is conditional on receipt of the tax amount.

(3) The State (or other unit of government) imposing the tax provides for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount.

(i)(A) An indirect guarantee will be determined to exist under a two prong "guarantee" test. If the health care-related tax or taxes on each health care class are applied at a rate that produces revenues less than or equal to 6 percent of the revenues received by the taxpayer, the tax or taxes are permissible under this test. The phrase "revenues received by the taxpayer" refers to the net patient revenue attributable to the assessed permissible class of health care items or services. However, for the period of January 1, 2008 through September 30, 2011, the applicable percentage of net patient service revenue is 5.5 percent. Compliance in State fiscal year 2008 will be evaluated from January 1, 2008 through the last day of State fiscal year 2008. Beginning with State fiscal year 2009 the 5.5 percent tax collection will be measured on an annual State fiscal year basis.

(B) When the tax or taxes produce revenues in excess of the applicable percentage of the revenue received by the taxpayer, CMS will consider an indirect hold harmless provision to exist if 75 percent or more of the taxpayers in the class receive 75 percent or more of their total tax costs back in enhanced Medicaid payments or other State payments. The second prong of the indirect hold harmless test is applied in the aggregate to all health care taxes applied to each class. If this standard is violated, the amount of tax revenue to be offset from medical assistance expenditures is the total amount of the taxpayers' revenues received by the State.

The exception to the hold harmless provision is that "the indirect guarantee test does not apply if the tax rate falls within a "safe harbor" established under regulation" which is the 6 percent of net patient revenue described above.[41]

3.3.3.2 *State Regulations*

State authority to impose a health-care related tax on hospitals is included in statute 395.701(2) which states:

[41] MACPAC. "*Health Care Related Taxes in Medicaid*." (August 2012)

(a) There is imposed upon each hospital an assessment in an amount equal to 1.5 percent of the annual net operating revenue for inpatient services for each hospital, such revenue to be determined by the agency, based on the actual experience of the hospital as reported to the agency.

(b) There is imposed upon each hospital an assessment in an amount equal to 1 percent of the annual net operating revenue for outpatient services for each hospital, such revenue to be determined by the agency, based on the actual experience of the hospital as reported to the agency.

3.4 Regulations Related to Medicaid Payment

One of the most fundamental and commonly quoted regulations within the Social Security Act dictates that provider payment be adequate to ensure access to care for the Medicaid population.[42] More detailed regulations exist separately for the Medicaid fee-for-service program, which has to be documented in the State Plan, and Medicaid managed care programs, which is documented through a demonstration waiver. In addition, some payments, are allowable in both fee-for-service and managed care. These are Disproportionate Share Hospital (DSH) payments and Graduate Medical Education (GME) payments. DSH payments help cover Medicaid shortfall and help cover hospital costs for care to the uninsured, who are by definition, not enrolled in the Medicaid program. GME payments help cover the costs of operating medical schools and training medical residents.

3.4.1 Fee for Service Regulatory Environment

3.4.1.1 Federal Regulations

The traditional delivery methodology for payments under a Medicaid system was a FFS model. Inpatient and outpatient hospital services under FFS typically receive payments in the following forms:

1. Claim payments for services rendered
2. Supplemental payments received under Upper Payment Limit (UPL) regulations
3. Disproportionate Share Hospital (DSH) payments
4. Graduate Medical Education (GME) payments (less common and also governed by UPL regulations)

Claim payments made through the Medicaid Management Information System (MMIS) typically are based on a specified payment methodology that is applied to claims for all hospitals. States typically fund the non-federal share of claim payments from general revenue. Florida uses a combination of general revenue funds, IGTs, and a provider assessment to fund the state share of claim payments.

[42] The Social Security Act, section 1902(a)(30)(A)

UPL supplemental payments are most often funded by IGTs and are designed to offset some or all of the difference between total base Medicaid FFS payments for services and the maximum payment level allowed under the regulatory UPL for those services. At the federal level, the upper payment limit for inpatient hospital services is governed by 42 CFR 447.272 – "Inpatient Services: Application of Upper Payment Limits," and outpatient hospital services fall under 42 CFR 447.321 – "Outpatient Hospital and Clinic Services: Application of Upper Payment Limits." These regulations allow states to maximize Medicaid fee-for-service payments to hospitals. In addition to the claims paid through the MMIS system, supplemental payments can be made to hospitals to allow a maximum payment that is generally calculated as an approximation of Medicare payment for these same services, or as an approximation of hospital costs to provide these services.

The UPL limit is aggregated over each provider type (hospitals, nursing homes, clinics, etc…) and class (state-owned, non-state government owned, and private). State payments to any individual hospital may exceed that hospital's upper payment limit as long as the aggregated payments to hospitals in that provider class are within the overall Medicare UPL. Also, UPL limits are calculated separately for hospital inpatient and outpatient care. The result is six UPL limits for hospital reimbursement, made up of three provider classes for two different categories of service.

UPL limits apply only to payments made within the parameters and authority established by each state's State Plan. This includes FFS payments (both claim-based and supplemental payments), but in many cases does not include Medicaid managed care payments. Medicaid managed care programs are generally established and defined under a waiver and thus are considered to be separate from the scope established in the state plan. This is the case in Florida, although it is not always the case. Some states have implemented Medicaid managed care programs that are defined within their state plans.

In addition, UPL calculations apply only to Medicaid recipients. Uncompensated care payments made through approved DSH programs are not limited by UPL regulations.[43] Based on recent regulation changes from CMS, Medicaid agencies are required to submit UPL analyses for hospital reimbursement (as well as other provider types) at the beginning of each fiscal year predicting whether or not Medicaid FFS payments, including claim and supplemental payments, will be within upper payment limits.

As Florida Medicaid continues to move more Medicaid recipients into a managed care model, the volume of Medicaid FFS business declines and the amount available to fund and pay out through the UPL becomes smaller and smaller. As a simplified example, if total gap between Medicaid FFS payments and Medicare payments for the same services is $100 million prior to the migration to Medicaid managed care and 60 percent of the FFS business is moved to

[43] In contrast, DSH limits are calculated individually for each hospital and include payments and costs for care of Medicaid recipients (both FFS and managed care) plus uncompensated care.

Medicaid managed care, then the remaining fee-for-service gap available for UPL supplemental payments reduces to $40 million ($100 million times (100 percent – 60 percent)).

In Florida, CMS has approved a one-year renewal of the LIP program for SFY 2014/15 that allows supplemental payments from the traditional $1 billion LIP program, LIP 6 (formerly self-funded IGTs), and physician supplemental payments. The LIP program is established through an 1115 waiver and limits on payments distributed through the LIP program are subject to the hospital-specific limits established under federal DSH regulations (discussed in a later section), but not governed by UPL limits. If these funds were subject to UPL limits, the amount of funds paid to hospitals that would be allowable for FMAP purposes would be a small fraction of what is paid today. Even before considering the reduction in the UPL gap created by Florida Medicaid's migration to Medicaid managed care, the LIP program paid out more money to some hospital classes than was available under the UPL. With the continued migration of the program to Medicaid managed care in 2014, the amount that payments would exceed the UPL has only increased. Current LIP payments are well above what would be allowable if the standard UPL regulations were to be applied.

DSH and GME payments are acceptable with both FFS and Medicaid managed care programs, and are discussed in a later section.

3.4.1.2 State Regulations

State regulations for setting of hospital inpatient FFS rates are summarized below:

> 409.905(5) – "Hospital Inpatient Services"
> The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act. Effective August 1, 2012, the agency shall limit payment for hospital emergency department visits for a nonpregnant Medicaid recipient 21 years of age or older to six visits per fiscal year.

> 409.905(5)(c) – "Hospital Inpatient Services"
> The agency shall implement a prospective payment methodology for establishing reimbursement rates for inpatient hospital services. Rates shall be calculated annually and take effect July 1 of each year. The methodology shall categorize each inpatient admission into a diagnosis-related group and assign a relative payment weight to the base rate according to the average relative amount of hospital resources used to treat a patient in a specific diagnosis-related group category. … The agency shall establish a single, uniform base rate for all hospitals unless specifically exempt pursuant to s. 409.908(1).

409.908(1)(a) – "Reimbursement of Medicaid providers":

1. If authorized by the General Appropriations Act, the agency may modify reimbursement for specific types of services or diagnoses, recipient ages, and hospital provider types.

2. The agency may establish an alternative methodology to the DRG-based prospective payment system to set reimbursement rates for:
    a. State-owned psychiatric hospitals.
    b. Newborn hearing screening services.
    c. Transplant services for which the agency has established a global fee.
    d. Recipients who have tuberculosis that is resistant to therapy who are in need of long-term, hospital-based treatment pursuant to s. 392.62.

State regulations for setting of hospital outpatient fee-for-service rates are summarized below:

409.905(6) – "Hospital Outpatient Services"

(a) The agency shall pay for preventive, diagnostic, therapeutic, or palliative care and other services provided to a recipient in the outpatient portion of a hospital licensed under part I of chapter 395, and provided under the direction of a licensed physician or licensed dentist, except that payment for such care and services is limited to $1,500 per state fiscal year per recipient, unless an exception has been made by the agency, and with the exception of a Medicaid recipient under age 21, in which case the only limitation is medical necessity.

(b) The agency shall implement a methodology for establishing base reimbursement rates for outpatient services for each hospital based on allowable costs, as defined by the agency. Rates shall be calculated annually and take effect July 1 of each year based on the most recent complete and accurate cost report submitted by each hospital.

The Upper Payment Limit program within Florida Medicaid was discontinued at the end of SFY 2005/06 in favor of the LIP program which was included as part of the Medicaid managed care demonstration waiver. State regulations related to the LIP program are mentioned in the following section.

3.4.2 Managed Care Regulatory Environment

3.4.2.1 Federal Regulations

Upper Payment Limit regulations control federal Medicaid outlays for recipients paid within Medicaid FFS programs. In contrast, federal matching funds for Medicaid managed care programs are limited by a different set of regulations regarding capitation rates paid by Medicaid to Medicaid managed care organizations. Federal regulation 42 CFR §438.6(c)(2)(i) dictates that "all payments under risk contracts and all risk-sharing mechanisms in contracts

must be actuarially sound." In addition, regulation 42 CFR §438.60 dictates that services covered by Medicaid managed care plans must be considered "paid in full" through the rate paid to the plan. Based on this regulation, UPL supplemental payments made directly from a state to providers for services provided to Medicaid recipients enrolled in Medicaid managed care plans are generally not allowed. "CMS considers strategies that require MCOs to 'pass through' supplemental payments to contracted providers to be inconsistent with the statute that requires capitation rates to be actuarially sound."[44]

In recent years, states have explored alternative ways to maintain supplemental payments to hospitals when converting to risk-sharing capitated programs. Social Security Act Section 1115 and 42 CFR §431.400 – "Basis and Purpose" allow states to establish a demonstration project for CMS approval. Conversion from a FFS environment to a managed care environment is an example project that has been approved through 1115 waivers in several states. In many cases, these waiver projects have included transitional payments that allow providers time to adjust to changes in Medicaid reimbursement, although there is no specific stipulation requiring transitional payments in either 42 CFR §431.400 or Section 1115 of the Act. Another option to make additional payments to hospitals is discussed in a recent issue brief by the Kaiser Commission on Medicaid and the Uninsured. In the Kaiser brief, the use of Delivery System Reform Incentive Payment (DSRIP) programs are discussed as follows:

> DSRIP initiatives are part of broader Section 1115 Waiver programs and provide states with significant funding that can be used to support hospitals and other providers in changing how they provide care to Medicaid beneficiaries. Originally, DSRIP initiatives were more narrowly focused on funding for safety net hospitals and often grew out of negotiations between states and HHS over the appropriate way to finance hospital care. Now, however, they increasingly are being used to promote a far more sweeping set of payment and delivery system reforms.[45]

DSRIP programs have justification under the Social Security Act Sections 1115, and are discussed in much more detail later in this report.

3.4.2.2 State Regulations

AHCA makes capitation payments to managed care plans which then make claim payments to hospitals based on Medicaid utilization. Claim payments between the managed care organizations and hospitals are governed by Florida Statute 409.968(1) – "Managed care plan payments" which says,

> Prepaid plans shall receive per-member, per-month payments negotiated pursuant to the procurements described in s. 409.966. Payments shall be risk-adjusted rates based on

[44] MACPAC. *Report to the Congress on Medicaid and CHIP. (*March 2014)

[45] Kaiser Commission on Medicaid and Uninsured, "*An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers*." (October 2014)

> historical utilization and spending data, projected forward, and adjusted to reflect the eligibility category, geographic area, and clinical risk profile of the recipients. In negotiating rates with the plans, the agency shall consider any adjustments necessary to encourage plans to use the most cost-effective modalities for treatment of chronic disease such as peritoneal dialysis.

Payments between managed care organizations and providers are governed by Florida Statute 409.975(6) – "Provider Payment" which sets minimum and maximum rates based on agency fee for service rates.

> Managed care plans and hospitals shall negotiate mutually acceptable rates, methods, and terms of payment. For rates, methods, and terms of payment negotiated after the contract between the agency and the plan is executed, plans shall pay hospitals, at a minimum, the rate the agency would have paid on the first day of the contract between the provider and the plan. Such payments to hospitals may not exceed 120 percent of the rate the agency would have paid on the first day of the contract between the provider and the plan, unless specifically approved by the agency. Payment rates may be updated periodically.

This statute along with experience of Medicaid managed care plans in other states suggest that rates negotiated between managed care organizations and providers will align relatively closely with Medicaid fee-for-service rates.

When Florida Medicaid began migration to managed care in 2006, the LIP program was created specifically to allow supplemental payments to continue while transitioning much of the Medicaid population from traditional FFS to Medicaid managed care programs. Authorization for the low income pool is described in the Special Terms and Conditions (STCs) document associated with approval of the 1115 demonstration waiver in 2006. Specifically, STC 91 says:

> **Low Income Pool Definition.** A Low Income Pool (LIP) will be established to ensure continued government support for the provision of health care services to Medicaid, underinsured and uninsured populations. The low-income pool consists of a capped annual allotment of $1 billion total computable for each year of the 5-year demonstration period.

In addition, section 409.91211(1)(c) of the Florida Statutes, states that the LIP program goals are:

- Assure a broad and fair distribution of available funds based on the access provided by Medicaid participating hospitals, regardless of their ownership status, through their delivery of inpatient or outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;
- Assure accessible emergency inpatient and outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;

- Enhance primary, preventive, and other ambulatory care coverages for uninsured individuals;
- Promote teaching and specialty hospital programs;
- Promote the stability and viability of statutorily defined rural hospitals and hospitals that serve as sole community hospitals;
- Recognize the extent of hospital uncompensated care costs;
- Maintain and enhance essential community hospital care;
- Maintain incentives for local governmental entities to contribute to the cost of uncompensated care;
- Promote measures to avoid preventable hospitalizations;
- Account for hospital efficiency; and
- Contribute to a community's overall health system.

If the LIP program is terminated as CMS is suggesting would be their preference, Florida Medicaid will be left in a difficult position trying to find ways to maintain current funding levels, which are heavily based on IGTs, and current payment levels, which include significant non-DSH supplemental payments and succeed in reimbursing hospitals for IGTs contributed in their name.

3.4.3 Disproportionate Share Hospital Payments

3.4.3.1 Federal Regulations

DSH payments are intended to make Medicaid payment adjustments for hospitals that serve a disproportionate share of low income patients with special needs. As such, DSH funds help to cover hospital costs for Medicaid shortfall and for care of the uninsured. Medicaid shortfall is the difference between non-DSH Medicaid payments and hospital cost to provide care to Medicaid recipients. The cost of care for uninsured is defined as hospital costs to care for recipients who have no health insurance or other source of third party coverage or whose health insurance does not cover any of the services related to an entire episode of care (such as a hospital admission). DSH supplemental payments may be made directly from the Medicaid agency to hospitals completely independent of capitation payments made to managed care organizations. Total Medicaid payments to a hospital, including FFS, managed care, and DSH payments, may not exceed the hospital's cost for care of Medicaid recipients and the uninsured. To enforce this limitation, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 defined a requirement for annual auditing and standard reporting of state DSH payments in comparison to hospital costs.

Section 1902(a)(13)(A)(iv) of the Social Security Act states that,

> A State plan for medical assistance must provide for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which in the case of hospitals, such rates take into account (in a manner consistent with section 1923) the

> situation of hospitals which serve a disproportionate number of low-income patients with special needs.

Sections 1923(b) and (d) of the Social Security Act specify the requirements to qualify as a DSH hospital. Section 1923(c) – "Payment Adjustment" provides a variety of ways to calculate the allowable amount of DSH payment per hospital. Most importantly, sections 1923(f)(2) and (3) freeze federal Medicaid DSH allotments per state based on historical levels. Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) capped federal funding for Medicaid DSH payments as of 1993. The original state DSH allotments provided in FFY 1993 were based on each state's FFY 1992 DSH payments. In FFY 1992, some states provided relatively more DSH payments to hospitals, and, as a result, these states locked in relatively higher Medicaid DSH allotments. Other states made relatively fewer DSH payments, and these states locked in relatively lower DSH allotments.

Efforts have been made over time to reduce the disparity in DSH allotments by providing larger annual increases to DSH allotments for states that initially made fewer DSH payments and limiting the growth of DSH allotments for states that initially provided relatively more DSH payments.

In FY 1992, Florida was not a heavy user of the DSH program, so its federal DSH allotment was capped at a relatively low level. Even with adjustments that have occurred since the early 1990's the disparity remains, and Florida is considered "a low DSH state" in relation to other states with similarly large uninsured populations. Florida's federal DSH allotment for FFY 2014 is $213 million resulting in a total computable disbursement of $362 million.[46]

3.4.3.2 State Regulations

Florida's primary regulation governing the DSH program is 409.911 – "Disproportionate Share Program" which states,

> Subject to specific allocations established within the General Appropriations Act and any limitations established pursuant to chapter 216, the agency shall distribute, pursuant to this section, moneys to hospitals providing a disproportionate share of Medicaid or charity care services by making quarterly Medicaid payments as required. Notwithstanding the provisions of s. 409.915 counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

Subsections 409.911(6) and (7) further defines DSH payments and funding as follows:

[46] Kaiser Family Foundation, *Federal Medicaid Disproportionate Share Hospital (DSH) Allotment*, downloaded from http://kff.org/medicaid/state-indicator/federal-dsh-allotments/ in December, 2014.

(6) In no case shall total payments to a hospital under this section, with the exception of public non-state facilities or state facilities, exceed the total amount of uncompensated charity care of the hospital, as determined by the agency according to the most recent calendar year audited data available at the beginning of each state fiscal year.

(7) The agency is authorized to receive funds from local governments and other local political subdivisions for the purpose of making payments, including federal matching funds, through the Medicaid disproportionate share program. Funds received from local governments for this purpose shall be separately accounted for and shall not be commingled with other state or local funds in any manner.

3.4.4 Graduate Medical Education Payments

3.4.4.1 Federal Regulations

Federal regulations 413.75 through 413.83, establish a methodology for determining Medicare payments to hospitals for the costs of approved graduate medical education (GME) programs. There are no federal regulations that dictate if or how Medicaid agencies must compensate hospitals for the costs of GME programs.

3.4.4.2 State Regulations

The Florida Medicaid Agency makes supplemental payments to help hospitals cover the costs of training new physicians through a program called the Statewide Medicaid Residency Program. This program is defined in Florida Statute 409.909 and specifics of the payment calculation are defined in subsections (3) and (4) as follows:

(3) The agency shall use the following formula to calculate a participating hospital's allocation fraction:

HAF = [0.9 x (HFTE/TFTE)] + [0.1 x (HMP/TMP)]
Where:
HAF = A hospital's allocation fraction.
HFTE = A hospital's total number of FTE residents.
TFTE = The total FTE residents for all participating hospitals.
HMP = A hospital's Medicaid payments.
TMP = The total Medicaid payments for all participating hospitals.

(4) A hospital's annual allocation shall be calculated by multiplying the funds appropriated for the Statewide Medicaid Residency Program in the General Appropriations Act by that hospital's allocation fraction. If the calculation results in an annual allocation that exceeds $50,000 per FTE resident, the hospital's annual allocation shall be reduced to a sum equaling no more than $50,000 per FTE resident.

The funds calculated for that hospital in excess of $50,000 per FTE resident shall be redistributed to participating hospitals whose annual allocation does not exceed $50,000 per FTE resident, using the same methodology and payment schedule specified in this section.

4 Description of Current Funding and Payment Methods

4.1 Introduction

The Florida Medicaid program, like most Medicaid programs in the United States is funded and disburses payments for medical care in a variety of ways. This chapter of the report documents current funding and payment mechanisms and offers a history of how these have changed in recent years. In particular, our discussion concentrates on funding and payment mechanisms used by Florida Medicaid for hospital services, including both inpatient and outpatient services. In addition, we examine the funding and payment mechanisms related to LIP waiver currently in effect and DSH disbursements. DSH payments are made exclusively to hospitals. LIP payments, in contrast, are made primarily to hospitals, but are also distributed to other health care institutions such as County Health Departments (CHDs) and Federally Qualified Health Centers (FQHCs). Generally however, this report focuses on payments made to hospitals.

Funding for payment of hospital services provided to Medicaid recipients, including those made through the FFS and Medicaid managed care programs, the LIP program, and the DSH program generally come from five sources: 1) Florida state general revenue funds; 2) IGTs from local governmental agencies such as counties and taxing districts; 3) CPEs; 4) a hospital provider assessment; and 5) federal matching funds provided through CMS.

Payments are made by the state Medicaid Agency in four forms, 1) claim payments for health care services provided to Medicaid fee-for-service recipients; 2) capitation payments to Medicaid managed care organizations, which in turn, pay hospitals for services provided to Medicaid managed care recipients; 3) quarterly supplemental payments determined through the LIP program; and 4) quarterly DSH payments determined through the DSH program. Fee-for-service claim payments and Medicaid managed care capitation payments are both intended to compensate providers for services offered to recipients eligible for Medicaid health benefits. DSH payments are intended to compensate providers for costs associated with caring for a high proportion of low-income individuals including Medicaid, uninsured and underinsured recipients. Similarly, payments made through the LIP program are intended to compensate providers for both services offered to uninsured and underinsured recipients as well as help cover shortfalls between Medicaid payments and provider costs incurred from caring for Medicaid eligible recipients.

4.2 Low Income Pool Program

4.2.1 Overview

The LIP program is authorized as part of Florida's Medicaid Reform section 1115 Demonstration Waiver, and is a significant funding source for Medicaid participating hospitals and several non-hospital safety net health care providers. The goal of the LIP program is to provide government support for safety net hospitals that furnish health care to the Medicaid, underinsured and uninsured populations. The LIP program is also designed to establish new,

or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations.

As originally defined in House Bill 3B in the December 2005 special session of the Florida Legislature and carried over to Section 409.91211(1)(c) of the Florida Statutes, the LIP program goals are:

- "Assure a broad and fair distribution of available funds based on the access provided by Medicaid participating hospitals, regardless of their ownership status, through their delivery of inpatient or outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;
- Assure accessible emergency inpatient and outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;
- Enhance primary, preventive, and other ambulatory care coverages for uninsured individuals;
- Promote teaching and specialty hospital programs;
- Promote the stability and viability of statutorily defined rural hospitals and hospitals that serve as sole community hospitals;
- Recognize the extent of hospital uncompensated care costs;
- Maintain and enhance essential community hospital care;
- Maintain incentives for local governmental entities to contribute to the cost of uncompensated care;
- Promote measures to avoid preventable hospitalizations;
- Account for hospital efficiency; and
- Contribute to a community's overall health system."[47]

The LIP program authorizes supplemental Medicaid payments to hospitals serving Medicaid recipients receiving benefits through both the FFS and the Medicaid managed care programs. The LIP program was implemented in conjunction with a pilot migration of Florida Medicaid FFS to Medicaid managed care. The LIP program allowed for the expansion of managed care in Florida without reducing Federal matching funds to providers.[48] Some of these funds were previously made available through CMS's UPL policy which allows states to claim supplemental UPL Federal matching funds to cover the difference between Medicaid payments and what Medicare payments would have been for the same services.

Within the 1115 waiver's Special Terms and Conditions (STCs), controls were put in place to limit the types of expenditures reimbursable through the LIP program. Below is the definition of permissible expenditures reimbursable through LIP funds as defined in the 2014 STCs, which is relatively unchanged from the definition included in the original 2005 STCs:

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[47] Florida general laws, Section 409.91211(1)(c), Retrieved August 19, 2014 from http://www.leg.state.fl.us/statutes/, Chapter 409.

[48] The Lewin Group, *Medicaid Upper Payment Limit Policies: Overcoming a Barrier to Managed Care Expansion*, November 13, 2006. Downloaded from the web on August 19, 2014.

> "Funds from the LIP may be used for health care costs (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act. These health care costs may be incurred by the state, by hospitals, clinics, or by other provider types to furnish medical care for the uninsured and underinsured for which compensation is not available from other payers, including other federal or state programs. Such costs may include premium payments, payments for provider access systems (PAS) and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the state and CMS. These health care costs may also include costs for Medicaid services that exceed Medicaid payments (after all other Title XIX payments are made, including disproportionate share hospital payments)."[49]

This definition of allowable expenses expanded upon the standard UPL program it replaced in that it included costs to furnish medical care for uninsured and underinsured recipients. In addition, the LIP program allowed for reimbursements to provider types other than hospitals, which is typically outside the scope of a standard UPL program.

The total computable dollar limit for LIP expenditures in waiver demonstration year (DY) 9 (7/1/14-6/30/15) is $2,167,718,341. This is a total from three separate elements:

1. $1 billion (for DY 1 - DY 8, LIP funding had a capped allotment of $1 billion disbursed in quarterly payments to providers. In DY 9, the two following supplemental payments were made a part of LIP funds);

2. $963,184,508 (historical spending amount for self-funded hospital rate exemptions and buybacks, conditional on the state's assurance that no such rate exemptions or buybacks will be executed apart from LIP in DY 9);

3. $204,533,833 (historical supplemental payment amount for physician groups with medical school affiliation, conditional on the state's assurance that no such supplemental payments will be made apart from LIP in DY 9).

Distribution of the "traditional" LIP funds, i.e. $1 billion, to Florida health care providers is determined by the Florida Legislature based on recommendations from the LIP Council, which was established with the implementation of the LIP program. The LIP Council existed for the purpose of making recommendations on the financing and distribution of funds for the LIP and DSH programs. In addition, the Council was charged with advising the Florida Medicaid on the inpatient rates, rebased rates, or other exemptions for hospitals from reimbursement limits as financed by automatic IGTs. (Please see a section later in this document for a detailed

[49] Centers for Medicare and Medicaid Services, *Special Terms and Conditions for Florida Medicaid Reform Section 1115 Demonstration*, Document number 11-W-00206/4, STC number 51. (June 2014)

description of IGTs.) For LIP demonstration years one through eight, the 24-member Council submitted a report of findings and recommendations to the Governor and the Legislature no later than February 1st of each year. For DY 9, State Fiscal Year (SFY) 2014/15, the LIP Council was disbanded. The distributions being made in SFY 2014/15 are reflective of the SFY 2013/14 core distribution of $1 billion, and incorporate Physician Supplemental funding and LIP 6 (formerly self-funded IGTs).

4.2.2 History

The LIP program was initially approved on October 19, 2005, as a part of Florida's Medicaid Reform 1115 Research and Demonstration Waiver for a five-year demonstration period. The LIP program has been renewed twice since; once in 2011 and recently awarded a one-year extension in 2014 for SFY 2014/15.

Florida's Medicaid Reform 1115 Research and Demonstration Waiver is primarily intended to shift much of Florida Medicaid service delivery from a FFS model to a capitated managed care model. The final decision and authority to pursue this waiver came from Senate Bill 838 passed during the normal legislative session in the spring of 2005. Once the 1115 waiver was approved by CMS, House Bill 3B was created and passed in a special session in December 2005 to further define AHCA's direction for reforming Medicaid primarily through migration to managed care. Managed care implementation was planned to be done in phases, the first being implementation in two counties in SFY 2006/07, Broward and Duval; the second being roll-out to three additional counties in SFY 2007/08, Baker, Clay and Nassau. State wide Implementation of managed care was originally planned to occur in state fiscal years 2008/09 and 2009/10 as stated in STC number 27 from CMS's 2005 Special Terms and Conditions for the 1115 waiver:

> "Implementation of Phase III will occur over the course of the following 2 State fiscal years, with near or full geographic implementation of Medicaid Reform expected by June 2010. Phase III geographic expansion is targeted to culminate in Medicaid Reform plans being operational statewide. This will be accomplished in stages, again with mandatory and voluntary populations enrolled on a staggered basis."[50]

In reality, implementation of Medicaid managed care to the entire state was not approved until 2013 and was implemented in the summer of 2014. Implementation began on May 1, 2014 and was completed by August 1, 2014.

Although Medicaid managed care was not implemented statewide until eight years after the initial pilot counties were converted, policy makers were considering full state wide implementation when developing Senate Bill 838 and negotiating the Demonstration Waiver approval back in 2005. With this in mind, there was considerable concern over ensuring

[50] Centers for Medicare and Medicaid Services, *Special Terms and Conditions for Florida Medicaid Reform Section 1115 Demonstration*, Document number 11-W-00206/4, STC number 51. (2005)

hospitals receive reimbursements at a level similar to what they received under the fee-for-service program. Language from Senate Bill 838, which became part of Florida Statute Section 409.91211(1)(a), states approval to seek a Medicaid managed care Demonstration Waiver pursuant to section 1115 of the Social Security Act is, "… contingent upon federal approval to preserve the upper-payment-limit funding mechanism for hospitals, including a guarantee of a reasonable growth factor … provisions to preserve the state's ability to use inter-governmental transfers, and provisions to protect the disproportionate share program …"[51] Reasons for concern over the DSH program are unclear as this program is independent of the design of the Medicaid program. However, concerns over the UPL program were certainly valid as these payments have traditionally only applied to hospitals' Medicaid FFS business.

During the negotiation of the 1115 Demonstration Waiver between the State of Florida and CMS, protection of hospital reimbursement levels became a key fiscal issue. "As noted above, SB 838 required that these programs [UPL and DSH] be protected and preserved in any demonstration program approved by waiver. On the other hand, Section 1115 waivers must be 'budget neutral' from a federal perspective, meaning that approval could not put the federal government at risk for higher contributions to a state's Medicaid program than those which would be expected to occur in the absence of the waiver. Protecting Florida's UPL/DSH financing for safety-net hospitals while implementing the other proposed changes to Medicaid in a manner acceptable to CMS became difficult. The establishment and allocation of funding ($1.0 billion) to a Low-Income Pool (LIP) became the solution."[52]

The resulting LIP program is defined in STC 91 for the Demonstration Waiver from 2005 as, "A Low Income Pool (LIP) … established to ensure continued government support for the provision of health care services to Medicaid, underinsured and uninsured populations. The low-income pool consists of a capped annual allotment of $1 billion total computable for each year of the five-year demonstration period." Text within STC 100 for the Demonstration Waiver from 2005 goes on to say, "The state agrees not to establish any new inpatient or outpatient UPL programs for the duration of the demonstration."

Although originally conceived as a replacement for the UPL funding mechanism, the definition of the program included payment for services to the uninsured and underinsured which are considered outside the scope of a traditional UPL program. In addition, the LIP program was considered a step above a standard UPL program because it allowed for distribution of funds to providers other than hospitals. Given this broad definition, the LIP program has evolved considerably since its inception.

In DY 1, LIP was strictly a $1 billion annual disbursement to providers that helped fund health care services for the Medicaid, underinsured and uninsured populations, with the amounts

[51] Florida general laws, Section 409.91211(1)(b), Retrieved August 19, 2014 from http://www.leg.state.fl.us/statutes/ Chapter 409.

[52] Department of Health Services Research, Management and Policy – University of Florida, *Evaluating Medicaid Reform in Florida – Summary Report on Section 1115 Waiver Process*. (July 2006)

decided by a newly formed LIP Council. Included in the Demonstration Waiver renewal in 2011 were additional provisions regarding the definition of the LIP program. The additional provisions specified:

> "The LIP is also designed to establish new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations. Initiatives must broadly drive from the three overarching goals of CMS' Three-Part Aim as described in paragraph 61(a)."[53]

In addition, terms and conditions were added defining new requirements for the State and providers to access portions of LIP funding through the establishment of programs that enhance the quality of care and health of low income populations and fulfill the goals of CMS's Three-Part Aim:

1. Better care for individuals including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity;
2. Better health for populations by addressing areas such as poor nutrition, physical inactivity, and substance abuse; and,
3. Reducing per-capita costs.

These requirements are defined as "Tier – One Milestones" and "Tier – Two Milestones." These milestones tie portions of reimbursement through the LIP to measurable improvements in the delivery of health care, very much like DSRIP programs which have been developed in recent years. Under STC 61 in the 2011 STCs (Tier – One Milestones), CMS mandated that the state allocate "$50 million in total LIP funding in Demonstration Years 7 and 8 to establish new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations. These initiatives must broadly drive from the three overarching goals of CMS' Three- Part Aim."[54] Of the $50 million available in Tier – One Milestones funding, $35 million is designated to support primary care initiatives ($20 million dedicated to the start-up of new primary care initiatives and the remaining $15 million designated to enhance existing primary care programs). The projects selected for these funds are based on the program's capability to achieve the following goals:

- Reduce potentially avoidable emergency room visits by developing initiatives to identify persons inappropriately using hospital emergency rooms or other emergency care services and provide care coordination and referral to primary care providers.
- Reduce potentially avoidable hospitalizations for ambulatory care sensitive conditions, which involve admissions that evidence suggests could have been avoided.
- Expansion of primary care infrastructure to treat patients.

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[53] Centers for Medicare and Medicaid Services, *Special Terms and Conditions for Florida Medicaid Reform Section 1115 Demonstration*, Document number 11-W-00206/4, STC number 51. (December 2011)

[54] Centers for Medicare and Medicaid Services, *Special Terms and Conditions for Florida Medicaid Reform Section 1115 Demonstration*, Document number 11-W-00206/4, STC number 61. (December 2011)

- Expansion of primary care through expanded service hours (e.g., evening or weekend hours).
- Provide the services most needed by the local community, such as the following:
    - Additional physicians
    - Dental care
    - Nurse practitioners
    - Pharmaceutical services

The remaining $15 million in Tier – One Milestones falls under the Special LIP Provider Access System category. This $15 million is distributed to hospitals based on the hospitals meeting Quality Measures collected by AHCA and Core Measures collected by CMS.

As defined in STC 62 of the 2011 renewal (Tier – Two Milestones), AHCA required each of the top 15 hospitals (based on the largest allocation of LIP funds) to propose three initiatives that follow the guidelines of the Three-Part Aim. These hospitals had to implement new, or enhance existing health care initiatives, investments, or activities with the goal of meaningfully improving the quality of care and the health of populations served. The three initiatives focused on: infrastructure development; innovation and redesign; and population-focused improvement. The 2011 STCs did not allocate additional money for Tier – Two Milestones. The STCs stated that 3.5 percent of the LIP funds allocated to each of these hospitals are at risk pending evidence of progress or completion of each pre-defined milestone.

In DY 6 (SFY 2011/12), AHCA received the required proposals and worked with CMS to grant approval for 44 of the 45 initiatives. CMS granted an exemption for the 45th, which was the third initiative for Indian River Memorial Hospital in Vero Beach, Florida. Included with each proposal, also referred to as a "milestone plan," was a description of the specific health care initiative, investment, and activities, and the applicable standards, measures, and evaluation measures and protocols that will allow for implementation and monitoring. In DY 6, approval by CMS of each milestone plan was required for the participating hospitals to receive associated LIP funds. In DY 7 and DY 8, participating hospitals submitted to AHCA quarterly reports describing and measuring progress on the initiatives.

During DY 7 and DY 8, monitoring of the milestone reports has been relatively light. Hospitals have been given credit for submitting a report. Very little review has been performed by AHCA to ensure hospitals have reached outcome targets defined in their milestone plans. To date, no hospital has been refused payment of LIP funds for failure to reach targeted milestones. Also, LIP Tier – Two Milestone projects were designed to operate in DYs 7 – 8, and to reach their target goals by the end of Demonstration Year 8, June 30, 2014. The LIP Tier – Two Milestone projects were not extended in the one-year extension of the LIP.

In the 2014 renewal of Florida's 1115 demonstration waiver, the LIP program was given a one year extension with the intent of providing stability for providers for a limited time during

Florida's transition to statewide Medicaid managed care and a significantly reformed Medicaid payment system. The LIP may be funded only through existing state and local funding arrangements. The total amount of LIP funding may not exceed $2,167,718,341 (total computable).

4.3 Hospital Claim and Supplemental Payment Funding

4.3.1 Background

At a high level, funds that pass through a Medicaid program for payment for health care services for Medicaid recipients, the uninsured, and the underinsured, are categorized as either "state share" or "federal share." For every dollar spent, a certain percentage of that dollar comes from the state share and the rest from the federal share. For the state of Florida, the blended state share percentage has been in the low forties or high thirties over the last few years. The federal share has been in the high fifties or low sixties over that same time period. In state fiscal year 2014/15, for example, the state share percentage is 40.44 percent and the federal share percentage is 59.56 percent. This means for every dollar spent by the Medicaid Agency in SFY 2014/15, 40.44 cents come from state resources and 59.56 cents come from federal resources. Another way to think of this is that $1.00 in state funds in SFY 2014/15 yields $2.47 in total funds for the Medicaid program (1 / 0.4044 = $2.47).

Unfortunately, all Medicaid agencies struggle with a fundamental contradiction. The stronger the economy, the more money available in state general revenue which can be used to fund the Medicaid program and the fewer recipients in need of Medicaid support for health care services. In contrast, when the economy is weaker, as it has been in recent years, state general revenue decreases yet the number of recipients in need of Medicaid support for health care services increases. In addition, as in other states, Medicaid costs are rising at a rate that may not be sustainable. State governments and the federal government must find ways to control the costs of Medicaid.

To help cover the cost of the Medicaid program, Florida, like many states, funds the state share of Medicaid through a combination of general tax revenue, a hospital provider assessment, IGTs, and CPEs. Each of these is discussed in more detail in the following sections.

4.3.2 Historical Mix of Funds

4.3.2.1 Introduction

Prior to 1986, the entire state share of funds used for payments to hospitals under the Medicaid program came from state general revenue. Starting in 1986 and continuing in subsequent years, a variety of legislation has been passed which has slowly reduced the percentage of the state share of hospital funding coming from general revenue and replaced that money with funds from other sources. Those other sources are generated through a provider assessment and IGTs.

4.3.2.2 Hospital Rate Reductions

The first such legislation was a provider assessment, referred to in Florida as the Public Medical Assistance Trust Fund (PMATF), which began in 1986. The provider assessment applies to all hospitals in Florida and is a gross receipts tax. Initially, it was implemented as a 1.5 percent assessment on all inpatient and outpatient revenue. The PMATF has since been reduced to 1.0 percent for outpatient revenue and continues to be 1.5 percent for inpatient revenue.

Starting in July 1990, the state legislature began applying reimbursement ceilings in order to slow the steady increase in hospital inpatient and outpatient per diem rates which were based on hospital cost. For SFY 1990/91, the ceiling was set at 3.3 percent, meaning a hospital's per diem was allowed to increase by no more than 3.3 percent of the previous year's rate, regardless of the increase called for by the cost-based methodology. In subsequent years, the ceiling has been set each year based on a formula using inflation factors.[55]

From the onset of rate ceilings, select hospitals have been designated as exempt. Initially, rural hospitals, teaching hospitals, and certain specialized hospitals were designated as exempt from the rate ceilings. Over the years, other hospitals have been made exempt from rate ceilings as described below:

- In 1991, hospitals whose charity and Medicaid days exceeded 15 percent of their overall days were exempted. (That percentage has been lowered over the years and now stands at 11 percent, which allows more hospitals to qualify for the exemption.)
- In 2000, teaching hospitals, Community Hospital Education Program (CHEP) hospitals, children's hospitals and certain specialized hospitals were made exempt.
- In 2001, trauma centers whose percentage of Medicaid days exceeded 9.6 percent were made exempt. (This percentage has also been reduced to 7.3 percent, which allows more hospitals to qualify for the exemption.)
- In 2004 and 2005, certain hospitals with neonatal intensive care units were made exempt.
- In 2008, more hospitals were made exempt, including hospitals experiencing an increase in Medicaid caseload by more than 25 percent in any year and hospitals whose Medicaid per diem rate is at least 25 percent below the Medicaid per patient cost for the year.[56]

Exemptions for rural hospitals are funded with state general revenue. However, the other exemptions described above are funded through county and local tax dollars that are transferred to the state through IGTs and used to draw federal match. The IGTs are voluntary and are contributed by some, but not all, of the counties and taxing districts in the state. These IGTs, along with federal match, allow the state to continue to pay exempt hospitals higher Medicaid rates without expending state general revenue. The IGTs used for these exemptions became what is known today as automatic IGTs.

[55] The Florida State Senate, Bill Analysis and Fiscal Impact Statement for SB 1988 (SPB 7094), (February 15, 2012).
[56] Ibid.

Over time, the annual ceiling on rate increases widened the gap between Medicaid rates and hospital cost to treat Medicaid recipients. The automatic IGTs became insufficient to cover this gap. In response, Florida Medicaid started a UPL supplemental payment program in the year 2000 that allows IGTs to be contributed, federally matched, and paid to hospitals to fund the gap between Medicaid fee-for-service payment and hospital cost. This option was only available to hospitals with access to a local government or taxing district willing to contribute IGT funds. In general, this provided a worthwhile benefit to public and safety net hospitals, but was of little help to private hospitals.

Beginning in 2005, one year prior to approval of the Medicaid managed care demonstration waiver, the Florida Legislature began reducing rates for many Medicaid providers, including hospitals, to help balance the overall state budget. New cuts have been applied nearly every year between 2005 and 2012 resulting in an average of 4 percent each year with the greatest reduction equaling approximately 12.5 percent. According to AHCA, these cuts have collectively amounted to over 25 percent in reductions to hospital rates. In its rate-setting methodology, AHCA refers to these cuts as "Medicaid Trend Adjustments."[57]

The historical rate cuts, exemptions, and buy-backs described above applied to both hospital inpatient and outpatient per diem rates. Since July 1, 2013, Florida Medicaid has converted to DRG reimbursement for hospital inpatient services. The rate cuts do not directly apply to DRG reimbursement. However, the DRG payment method was implemented in a budget neutral fashion. As a result, the effects of the rate cuts were carried over into the current inpatient claim payment methodology. In addition, during the conversion to DRG pricing, automatic and self-funded IGT calculations and disbursement were held consistent with the rules followed under the per diem payment methodology.

4.3.2.3 Introduction of the LIP Program

Beginning in SFY 2006/07, the UPL program was terminated in favor of the new LIP program. The new LIP program was included as part of Florida's 1115 Demonstration Waiver. The Waiver involved shifting some of the Medicaid recipients into managed care with a plan of eventually moving most Medicaid recipients into managed care. Without the LIP program, this would have resulted in limitations on the UPL program, which by definition, could only take advantage of the UPL gap associated with the remaining Medicaid fee-for-service business. By that time, the UPL program was distributing about $630 million each year. From the state's point of view, the LIP program offered a way for hospitals to continue to receive supplemental payments from IGT funds even when the amount of Medicaid fee-for-service business declined. From CMS's point of view, the LIP program continued the level of funding for the safety net hospitals and offered additional funds for the creation and continuous improvement of provider access and quality.

[57] The Florida State Senate, Bill Analysis and Fiscal Impact Statement for SB 1520, (April 3, 2013).

4.3.2.4 Self-Funded Inter-Governmental Transfers

Beginning in 2008, the Legislature began including language in the General Appropriations Act (GAA) allowing certain hospitals to use additional IGTs (above and beyond the IGTs used to fund exemptions) to "buy-back" all or a portion of the rate cuts imposed by the GAA in the 2008/09 fiscal year and in prior years. In this way, certain hospitals would not be paid less due to the Legislative rate cuts if local IGTs could be secured to offset the effect of the rate cuts. In the first year that "buy-backs" were implemented (2008/09), they were applied to the following hospitals:

- Hospitals that were part of a system that operates a provider service network (PSN), including Jackson Memorial, hospitals in Broward Health, hospitals in Memorial Healthcare System, Shands Jacksonville, and Shands Gainesville;
- Children's specialty hospitals whose Medicaid and charity days equaled or exceeded 30 percent;
- Rural hospitals; and
- Public hospitals, teaching hospitals that had 70 or more resident physicians, and hospitals whose Medicaid and charity days exceeded 25 percent.[58]

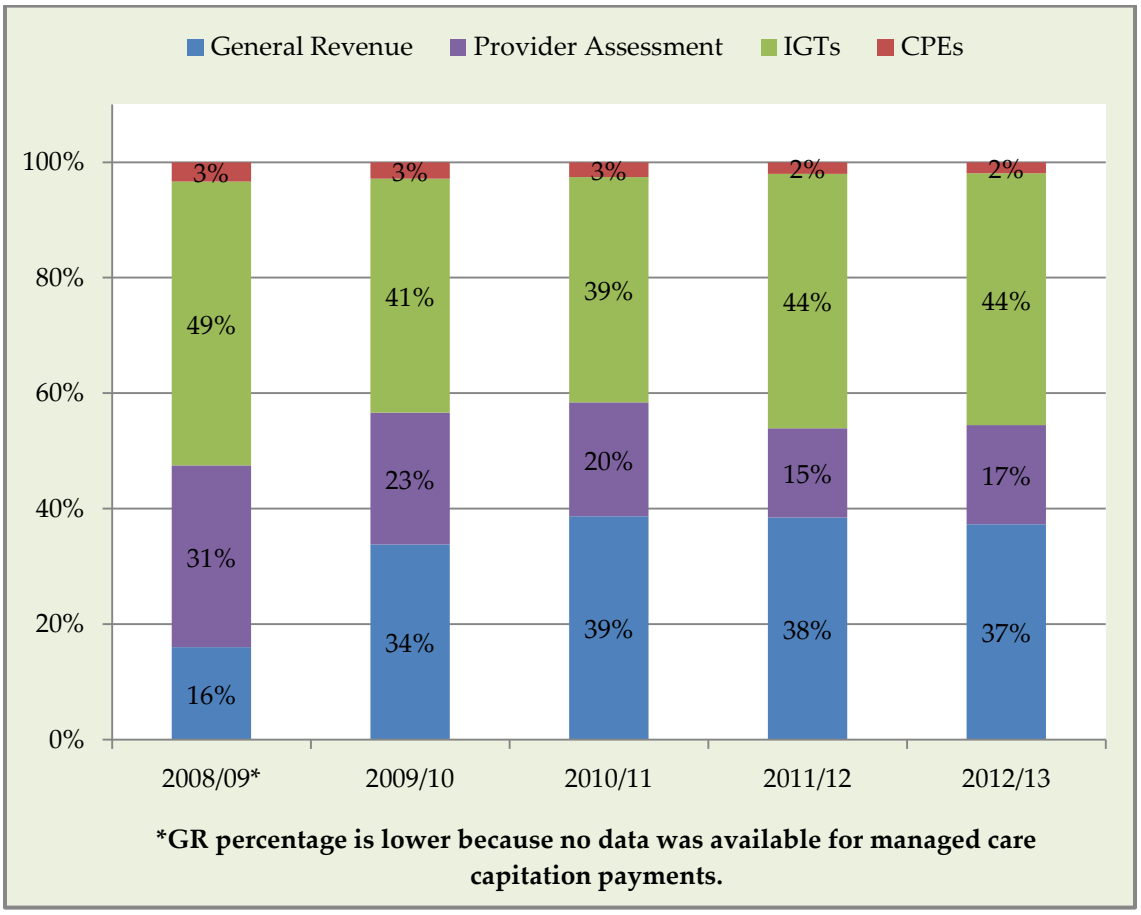
In SFY 2009/10, designated trauma hospitals were added to the list of hospitals allowed to use IGTs to buy-back their rate cuts. In SFY 2010/11, hospitals with graduate medical education positions that did not otherwise qualify were added to the list. Finally for SFY 2011/12, proviso was included to allow all other hospitals to get involved in the self-funded IGT program, as long as they could secure IGTs for this purpose. Each year the proviso has included a limit on the amount of self-funded IGTs. In SFY 2011/12, this limit was $187 million. In subsequent years, as the state learned there were donors willing to contribute, the Legislature has continuously increased the self-funded IGT limit. In SFY 2014/15, this limit is just under $390 million in state share which translates to approximately $960 million total computable (total when adding federal matching funds).

4.3.2.5 Mix of Funding in Recent Years

Over the most recent five years for which complete data are available, the sources of funding for the state share of Medicaid hospital reimbursement have been fairly consistent. In addition, the relative contribution from each source has been consistent. For hospital reimbursements, the bulk of state funding comes from state general revenue and IGTs, with a sizeable amount also coming from the PMATF provider assessment, and a very small portion of the funds coming from CPEs. This is shown in Figure 7 below:

[58] The Florida State Senate, Bill Analysis and Fiscal Impact Statement for SB 1988 (SPB 7094), (February 15, 2012).

Figure 7. Distribution of funding sources for state share of Medicaid hospital payments over the previous five years.

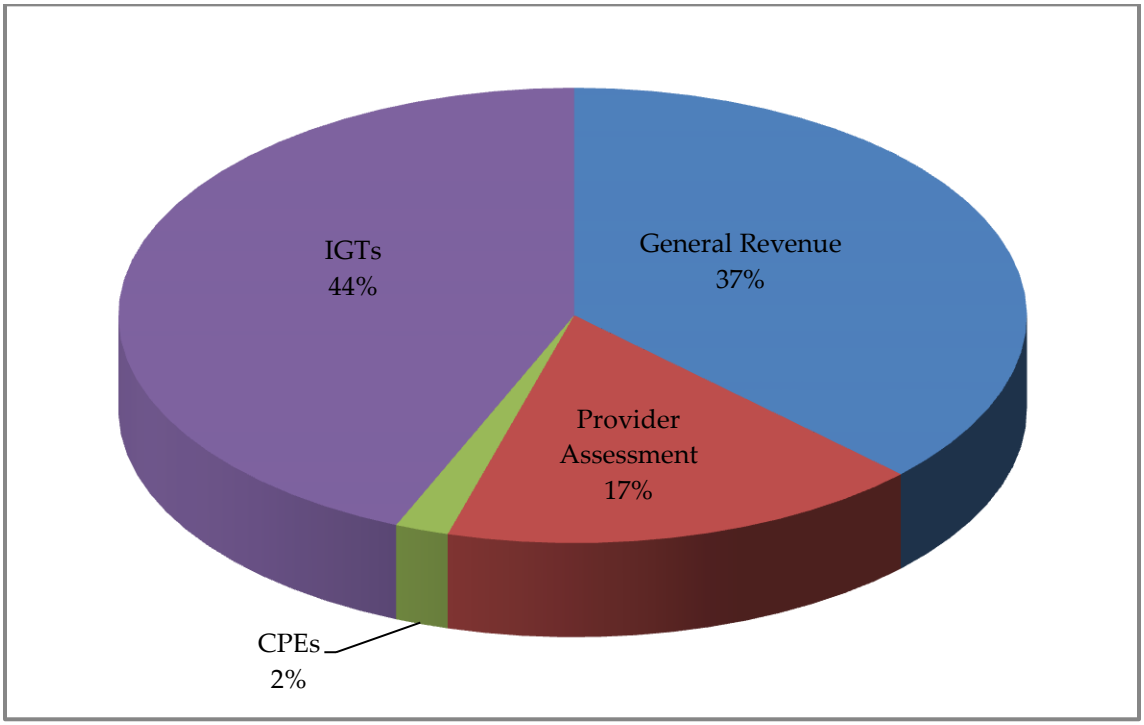


Notes for Figure 7:

1) The figure above includes funding for hospital fee-for-service rates, hospital managed care capitation rates, LIP supplemental payments and DSH supplemental payments. Medicare crossover claims, in which Medicare is the primary payer, are excluded.
2) During these timeframes, the state portion of all funding for managed care capitation came from state general revenue.
3) Expenditures in SFY 2008/09 are understated because hospital managed care expenditures were not available for this year.

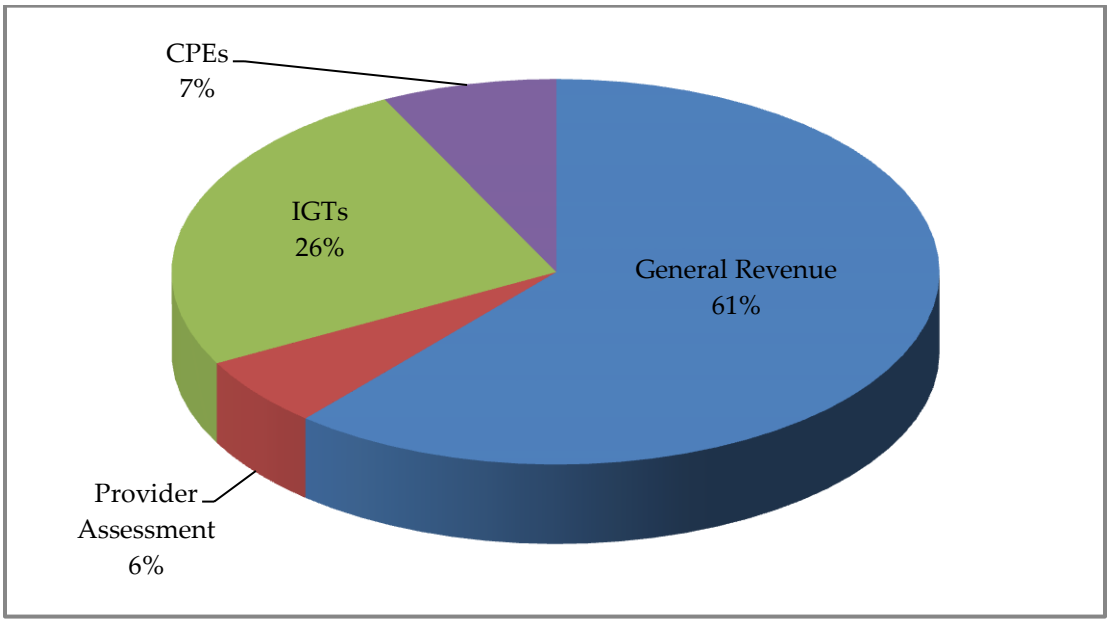
The sources of funds for SFY 2012/13 are shown in the following figure:

Figure 8. Sources of state share of Medicaid funding for hospitals in SFY 2012/13.



Specifically for hospital reimbursement, funds from general revenue constitute less than half of the total state share. However, general revenue constitutes more than half of the total state share when looking at the overall Medicaid program, including payment for all health care services, such as hospital, nursing home, physician, pharmacy, school programs, etc. Using values from SFY 2012/13, this is depicted in Figure 9 below. Comparing the previous and following figures, general revenue funds 37 percent of the non-federal share of Medicaid hospital reimbursements and 61 percent of the non-federal portion of Medicaid reimbursements overall.

Figure 9. Sources of state share of Medicaid funding for all health care services in SFY 2012/13.



4.3.3 General Revenue

In SFY 2012/13, Florida raised over $23.7 billion through its General Fund, the predominant fund for financing a state's operations, with revenue received from broad-based state taxes.[59] Florida primarily receives its general revenue through property taxes and sales and gross receipt taxes, accounting for 43 and 47 percent of state tax revenue respectively (FY 2010 data).[60] These funds help finance various state programs such as elementary and secondary education, higher education, public assistance, corrections, transportation, and Medicaid.

In most states, Medicaid is the largest or second largest line item in the state budget. This is true in Florida as well. When looking at state share only in Florida, Medicaid was the second largest budget line item behind education (when including elementary, secondary, and higher education) in SFY 2011/12. However, Medicaid receives significantly more federal funds than education. When looking at total expenditures, including state and federal share, Medicaid was the largest expenditure item in Florida in SFY 2011/12.[61] In addition, total Medicaid expenses are continually increasing as a percentage of total state outlays. For example, in Florida in SFY

[59] NASBO, *State Expenditure Report 2012,* http://www.nasbo.org/sites/default/files/State%20Expenditure%20Report%20%28Fiscal%202011-2013%20Data%29.pdf

[60] Tax Foundation. *The Sources of State and Local Tax Revenue.* (January 29, 2013) http://taxfoundation.org/sites/taxfoundation.org/files/docs/ff354.pdf

[61] NASBO, *State Expenditure Report 2012.*

2011/12, Medicaid accounted for almost 31 percent of state expenditures, up over seven percent from SFY 2007/08.[62] The trend over this last five year stretch is shown in Table 3 below.

Table 3. Medicaid expenditures as compared to total State of Florida expenditures over a recent five year period.[63]

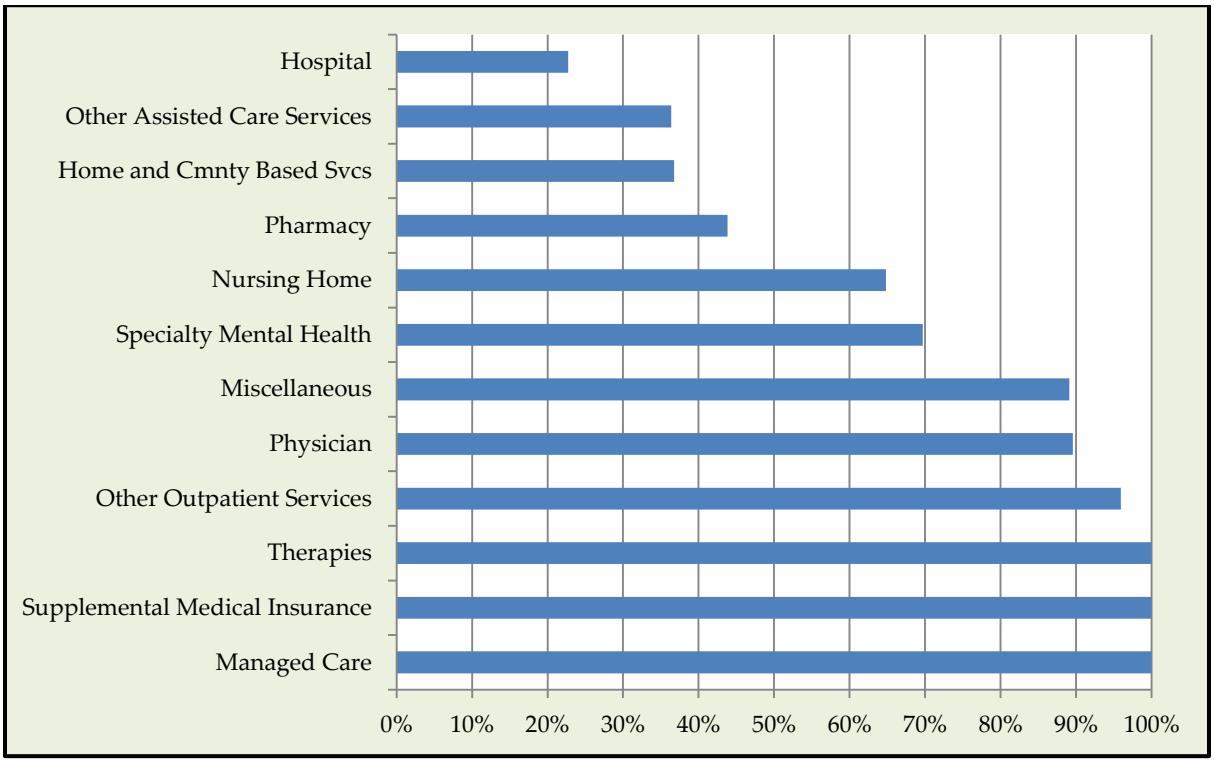
	2007/08	2008/09	2009/10	2010/11	2011/12
Medicaid Expenditures as a percentage of Total Expenditures	23%	26%	29%	29%	31%
State Expenditures on Medicaid (in billions)	$14.9	$16.6	$18.6	$19.1	$19.3
Total Expenditures (in billions)	$64.4	$60.7	$62.0	$65.5	$63.0
Note(s): Amounts and percentages displayed in this table include expenditures from both state revenue and federal matching funds from programs that provide federal matching.					

During this relatively short timeframe, Medicaid expenditures have grown by 23 percent.

The state general revenue used to fund the Medicaid program is not spread evenly across the various types of providers and types of services offered to Medicaid recipients. General revenue as a percentage of total state share varies by type of service anywhere from 100 percent of the funding at the high end of the range down to 23 percent at the low end of the range. General revenue funding for hospital services is at the low end of the range. This can be seen in Figure 10.

[62] NASBO, *State Expenditure Report 2012.*
[63] NASBO, "*State Expenditure Reports*," (multiple years).

Figure 10. Percentage of state share from general revenue by type of service in SFY 2012/13.



Notes for Figure 10:

1) Managed care is listed in Figure 10 as fully funded by general revenue because the data in this chart applies to SFY 2012/13. In SFY 2014/15, at which time most Medicaid recipients have been moved into Medicaid managed care plans, managed care capitation rates are funded by a combination of general revenue, PMATF, and automatic IGTs.
2) The following AHCA budget line items are included in each of the categories on the vertical access in Figure 10.

Table 4. AHCA budget line items included in summarized categories in Figure 10.

Category in Figure 10	Included AHCA Budget Line Items
Hospital	Hospital inpatient services Hospital outpatient services Grants and aids – Shands Teaching Hospital Graduate medical education Mental health DSH Rural DSH Tuberculosis hospital DSH "Regular" DSH LIP
Other Assisted Care Services	Case management services Adult congregate living facility

Category in Figure 10	Included AHCA Budget Line Items
	Assistive care services waiver Healthy start waiver Capitated nursing home diversion Program care for the elderly (PACE) Personal care services
Home and Community Based Services	Home and Community Based Services (HCBS) Private duty nursing services Home health services
Pharmacy	Prescribed medicine Medicare Part D
Nursing Home	Nursing Home
Specialty Mental Health	State mental health hospitals ICF-MR Sunland ICF-MR community Community mental health services
Miscellaneous	Patient transportation Hospice School based services Developmental evaluation and intervention Medipass – program expired with the full migration to Managed Medical Assistance in the summer of 2014
Physician	Physician services Physician assistant services Adult dental Adult vision and hearing EPSDT
Other Outpatient Services	Other lab and x-ray Family planning services Clinic services Dialysis center Rural health clinics Birthing center services Nurse practitioner services
Therapies	Physical therapy services Occupational therapy services Speech therapy services Respiratory therapy services Therapy for children
Supplemental Medical Insurance	Supplemental Medical Insurance
Managed Care	Prepaid health plan

4.3.4 Inter-governmental Transfers

4.3.4.1 Introduction – IGTs

The primary way hospitals contribute money to fund the Medicaid program is through Inter-governmental Transfers (IGTs). The IGT program in Florida is an optional program for which government-owned hospitals, counties, and taxing districts may choose to participate. For

those that do participate, the IGT contributors have an option of five types of programs to which they may contribute:

1) LIP and automatic IGTs (automatic IGTs are rate buy-backs which enhance the inpatient and outpatient claim payments for hospitals that qualify)
2) Alternative LIP - various small programs which are included within the $1 billion LIP waiver and are listed below (a short description of each of these programs is given in Appendix B):
    a. $4.5 million County Health Department Initiatives
    b. $7.2 million for FQHCs and CHDs
    c. $2 million for primary care within CHDs
    d. $11 million for FQHCs
    e. $3.2 million for poison control programs
    f. $34 million for primary care awards
    g. Premium assistance for Palm Beach and Miami-Dade counties
    h. $3 million for hospital-based primary care initiatives – $750,000 for each hospital
    i. $35 million for quality initiatives described in STC 61a – split into $20 million for new initiatives and $15 million to expand existing initiatives
    j. Manatee ER Diversion program
3) Disproportionate Share Hospital (DSH)
4) Self-funded rate enhancements (referred to as "LIP 6" in SFY 2014/15 and moved under the LIP program)

Local governments may specify how their IGT dollars should be applied to the above programs. Because of this, AHCA cannot definitively predict the budgets for each program until annual commitment letters are submitted by the IGT contributors. The annual commitment letters are referred to as "letters of agreement (LOAs)" and are received by AHCA during the first quarter of each state fiscal year – between July and September. In recent years, enough IGTs have been received to fund over 99 percent of the LIP and Alternative LIP programs.

The programs comprise a significant portion of hospital Medicaid and uninsured funding each year. In SFY 2012/13, for example, these programs made up 46 percent of payments to hospitals. Some of these are paid out as supplemental payments (LIP and DSH) while others have traditionally been distributed through claim payments as rate enhancements (automatic and self-funded rate enhancements). In SFY 2014/15, automatic rate enhancements continue, and also affect the managed care capitation rates. Self-funded rate enhancements, in contrast, have been moved to supplemental payments in the form of LIP 6 and are paid directly from AHCA to the participating hospitals.

4.3.4.2 LIP, Alternative LIP and Automatic IGTs

For SFY 2012/13, budgeted contributions towards LIP and rate buy-backs total $750 million in IGTs, which comprise the state share and $1.025 billion in federal matching for a total of $1.775 billion available for distribution. Of this, $996 million was paid out through the LIP Waiver

program and the remainder, $779 million, was paid out via enhanced rates for inpatient and outpatient services for select hospitals in the form of automatic rate enhancements.

Hospitals with access to IGTs and who choose to contribute to the LIP and automatic rate enhancement programs are given a guarantee of receiving back their IGT money plus an 8.5 percent usage fee at a minimum through a category of LIP disbursements referred to as "LIP Allocation Distribution." In addition, IGT funds are used to draw down federal matching funds which contribute to LIP, alternative LIP, and automatic rate enhancements. Using the federal matching funds, hospitals that contribute to LIP and automatic rate enhancements may, and generally do, receive back more than the 8.5 percent usage fee through the allocation of LIP and automatic rate enhancements whose distribution is determined by the Florida Legislature (with recommendations from the LIP Council). In addition, some of the federal matching funds are made available through LIP and alternative LIP to hospitals which do not contribute IGTs and to some health care providers that are not hospitals at all. Thus with these two programs, some health care providers who have not contributed IGTs are able to receive financial benefit.

The LIP Allocation Distribution, which refunds hospitals their IGT contributions plus an 8.5 percent usage fee, is refunding money used to fund more than just the $1 billion LIP Waiver program. This money is also used to fund rate enhancements through automatic IGTs. Thus, the more rate enhancements are funded through this program, the more money gets paid out through the LIP Allocation Distribution, leaving less money for discretionary distribution under the $1 billion LIP Waiver program. In SFY 2012/13, for example, $711 million was contributed through IGTs to help fund the LIP program and automatic rate enhancements. This resulted in $772 million was allocated through the LIP Allocation Distribution, which meant only $228 million was available through the Waiver to fund safety net hospitals, uncompensated care, and various initiatives intended to improve the delivery of health care to Florida Medicaid recipients through the Alternative LIP program. Thus, despite being a $1 billion program, only 23 percent of that money is made available for discretionary distribution. The discretionary distribution funds all of the sub-programs listed previously as being part of Alternative LIP.

There are numerous local governmental programs that contribute IGTs to fund LIP and automatic IGT rate enhancements. In SFY 2012/13, for example, there were 43 local government contributors. However, a striking majority of the IGTs come from three specific agencies, Miami-Dade County, North Broward Hospital District, and South Broward Hospital District. 82 percent of the funds collected in SFY 2012/13 came from these three local governments.

4.3.4.3 Disproportionate Share Hospital Funding

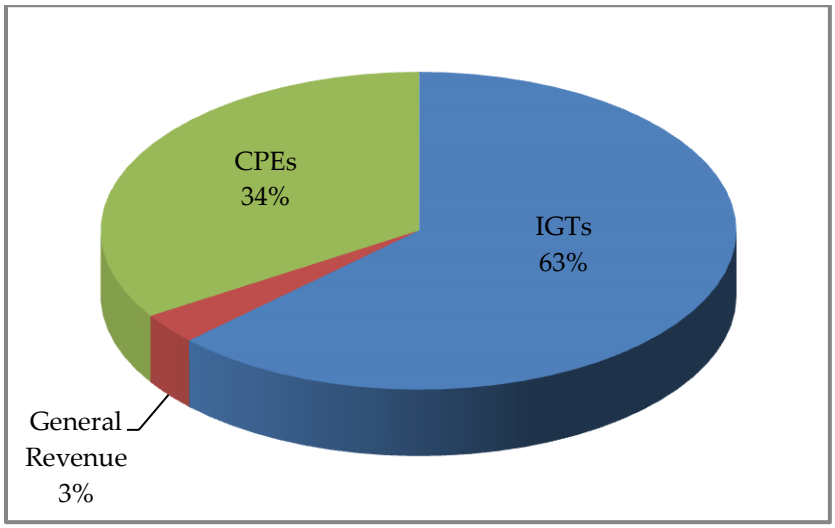
Florida pays out relatively little in DSH payments as compared to other state Medicaid agencies. Despite being the fifth[64] (5th) largest Medicaid program in FFY 2012, Florida Medicaid

[64] The Kaiser Family Foundation, *State Health Facts, Federal Medicaid Disproportionate Share Hospital (DSH) Allotments*. Available at http://kff.org/medicaid/state-indicator/total-medicaid-spending.

was the eighteenth[65] (18th) largest distributor of DSH payments in FFY 2012 and is expected to be the seventeenth[66] (17th) largest distributor of DSH payments in SFY in FFY 2014. In SFY 2012/13, Florida Medicaid paid $360 million in DSH funds[67].

The state portion of disproportionate share funds comes primarily from IGTs and CPEs as shown in Figure 11 below.

Figure 11. Distribution of sources of state share of DSH funding for SFY 2012/13.



4.3.4.4 *Self-Funded Inter-Governmental Transfers*

Self-funded IGTs are similar to standard upper payment limit funds. These are funds used as buy-backs of state rate reductions and to cover the gap between Medicaid payments and hospital upper payment limits for Medicaid fee-for-service business. As is indicated by its name, the self-funded IGT program is funded fully from voluntary inter-governmental transfers. The funds are contributed in the name of a specific hospital (in contrast to automatic IGTs) so that each designated hospital receives back its IGT funds and the federal match for those funds through claim payments. The amount each hospital may contribute is capped at the projected gap between each hospital's cost (a proxy for the UPL) and reimbursements for Medicaid services provided under the FFS program.

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[65] The Kaiser Family Foundation, *State Health Facts, Federal Medicaid Disproportionate Share Hospital (DSH) Allotments*. Available at http://kff.org/medicaid/state-indicator/federal-dsh-allotments.

[66] The Kaiser Family Foundation, *State Health Facts, Federal Medicaid Disproportionate Share Hospital (DSH) Allotments*. Available at http://kff.org/medicaid/state-indicator/federal-dsh-allotments.

[67] Florida Agency for Health Care Administration, *Local Funding Revenue Maximization and Local Funding for Hospital Inpatient Reimbursement, SFY 2012/13*. (December 2013)

Prior to SFY 2014/15, self-funded IGTs were distributed as rate enhancements. Because of this, hospitals are at risk of losing money if their Medicaid utilization is unexpectedly low. However, given a federal matching percentage over 59 percent this risk is not significant. As long as a hospital's Medicaid utilization in the rate year is at least 41 percent of its anticipated volume, the hospital receives back all of its self-funded IGT contributions. In addition, not all hospitals have access to contribute IGT funds. IGTs must come from a governmental agency and cannot be sent directly from a private hospital to the Medicaid Agency. Hospitals without access to IGTs have no other option than to rely on the automatic IGTs distributed by the LIP Council and Florida Legislature to help cover the gap between Medicaid payment and hospital cost. As stated earlier, only about 23 percent of the $1 billion in total computable LIP dollars is available for discretionary distribution, which includes hospitals without access to IGTs.

In SFY 2014/15, self-funded IGTs were abolished in their previous form, and were incorporated into the LIP program. They became what are referred to as the "LIP-6" program.

4.3.5 Certified Public Expenditures

Florida Medicaid utilizes Certified Public Expenditures (CPEs) to help fund Medicaid payments for school-based services, hospital disproportionate share payments, and physician supplemental payments. In SFY 2012/13, CPEs comprised 100 percent of the state share of funding for school-based Medicaid services, 34 percent of the state share for DSH payments and 100 percent of the state share for physician supplemental payments. In terms of hospital reimbursements overall, CPEs comprised two percent of total state funding.

No CPEs are used to help fund Medicaid payments to the four state-owned psychiatric specialty hospitals.

A total of $96 million in CPEs were identified in SFY 2012/13 for school based services. Another $52 million was identified for the DSH program and was spread across three DSH categories, mental health DSH, "regular" DSH, and specialty hospital DSH. $79 million in CPEs were identified for the physician supplemental payment program, which provides for "supplemental payments for services provided by doctors of medicine and osteopathy as well as other licensed health care practitioners employed by or under contract with either (1) and medical school that is part of the public university system (Florida State University, The University of Florida, and The University of South Florida; (2) a private medical school that places over 50 percent of their residents with a public hospital (The University of Miami); (3) Nova Southeastern University."[68] In SFY 2014/15, the physician supplemental program moved under the LIP program. In addition, the funding for the physician supplemental program changed from CPEs to IGTs.

4.3.6 Hospital Assessment

Florida Medicaid has had a hospital assessment, otherwise known as a provider tax, in place for over 20 years. As mentioned previously, the hospital assessment is referred to as the "Public

[68] Florida State Plan, Attachment 4.19-B, effective for SFY 2013/14.

Medical Assistance Trust Fund." The assessment collects from each hospital an amount equal to 1.5 percent of the annual net operating revenue for inpatient services and one percent of the annual net operating revenue for outpatient services. Net operating revenue is defined as gross operating revenue minus revenue not collected. In this formula, gross operating revenue is defined as "the sum of daily hospital service charges, ambulatory service charges, ancillary service charges, and other operating revenue."[69] In addition, revenue not collected is defined as "bad debts; contractual adjustments; uncompensated care; administrative, courtesy, and policy discounts and adjustments; and other such revenue deductions, but also includes the offset of restricted donations and grants for indigent care."[70] Lastly, a hospital is defined in section 395.002 (12) of the Florida Statues as any facility in Florida meeting the following criteria:

(a) "Offers services more intensive than those required for room, board, personal services, and general nursing care, and offers facilities and beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care for illness, injury, deformity, infirmity, abnormality, disease, or pregnancy; and

(b) Regularly makes available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment of similar extent, except that a critical access hospital, as defined in s. 408.07, shall not be required to make available treatment facilities for surgery, obstetrical care, or similar services as long as it maintains its critical access hospital designation and shall be required to make such facilities available only if it ceases to be designated as a critical access hospital."[71]

As shown previously in Figure 7, funds collected through the provider assessment each state fiscal year have been relatively constant despite the fact that no hospital assessment funds were paid out in SFY 2010/11 and two years of hospital assessment funds were distributed in SFY 2011/12. Money from the hospital assessment, both state and federal share, contributes to hospital inpatient and outpatient rates and is distributed through claim payments. In SFY 2012/13, nearly $470 million was collected, which drew down over $641 million in federal matching funds, resulting in a total of $1.1 billion in funds contributing to hospital rates. In a majority of cases, the cost of the assessment is paid back to providers through an increase in the Medicaid reimbursement rate, but consistent with the federal redistributive and hold harmless provisions of health care-related tax programs, not all hospitals get back all that they were

[69] Florida Statutes, Section 395.701 (1)(b), Retrieved August 25, 2014 from http://www.leg.state.fl.us/statutes/index.cfm?mode=View%20Statutes&SubMenu=1&App_mode=Display_Statute&Search_String=395.701&URL=0300-0399/0395/Sections/0395.701.html.

[70] Florida Statutes, Section 395.701 (1)(e), Retrieved August 25, 2014 from http://www.leg.state.fl.us/statutes/index.cfm?mode=View%20Statutes&SubMenu=1&App_mode=Display_Statute&Search_String=395.701&URL=0300-0399/0395/Sections/0395.701.html.

[71] Florida Statutes, Section 395.002 (12), Retrieved August 25, 2014 from http://www.leg.state.fl.us/statutes/index.cfm?mode=View%20Statutes&SubMenu=1&App_mode=Display_Statute&Search_String=395.701&URL=0300-0399/0395/Sections/0395.701.html.

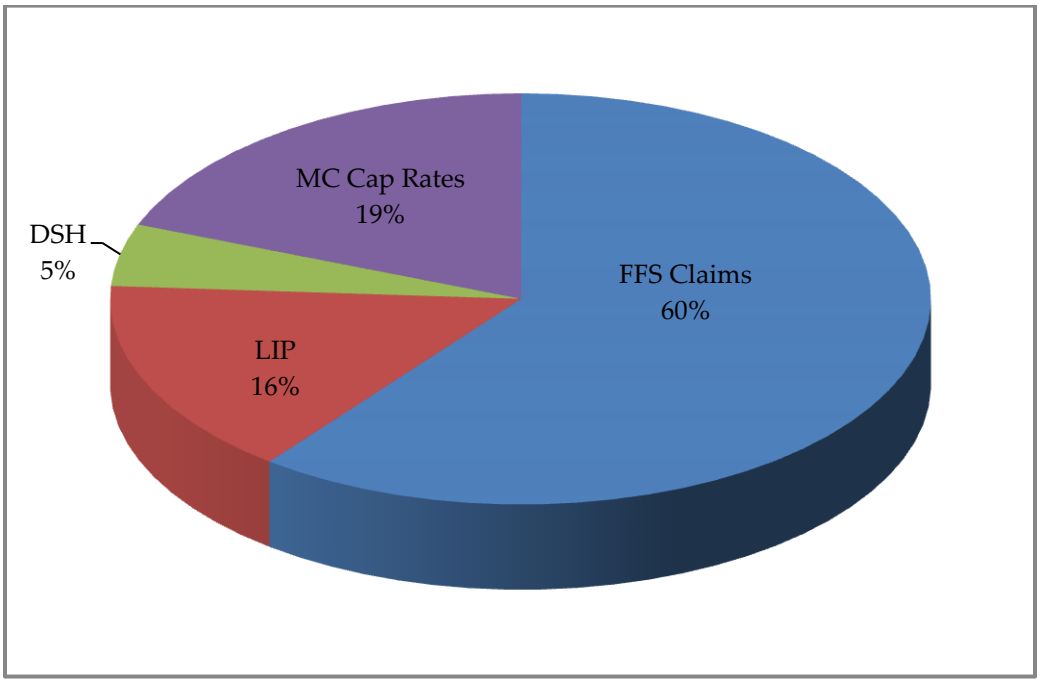
assessed. Hospitals with very low Medicaid volume may not receive as much in increased rates as they paid out through the assessment.

4.4 Claim and Supplemental Payments

AHCA reimburses hospitals in two general forms – claim payments, which are directly tied to Medicaid utilization, and supplemental payments distributed on a periodic basis. For services provided under the FFS program, claim payments are made directly to hospitals from AHCA. For services provided under the Medicaid managed care waiver, AHCA makes capitation payments to managed care plans that in turn, make claim payments to hospitals based on Medicaid utilization. LIP and DSH payments are considered separate from FFS claims based payments and managed care capitation payments, and are paid by AHCA to hospitals on a quarterly basis.

In SFY 2012/13, the distribution between claim payments (including those made through capitation arrangements) and supplemental payments – LIP and DSH payments, was as shown in Figure 12 below.

Figure 12. Source of Medicaid payments to hospitals in SFY 2012/13.



Historically, Florida Medicaid has paid for hospital services primarily through a fee-for-service program. However, a major shift to Medicaid managed care occurred in calendar year 2014 at which time approximately 75 percent of the Medicaid program moved to managed care. Because of this migration, self-funded IGTs and physician supplemental payments were moved into the LIP program for SFY 2014/15.

4.4.1 Claim Payments

Historically, Florida Medicaid has paid for hospital inpatient and outpatient services in the FFS program through cost-based rates. Each hospital was assigned its own unique inpatient per diem and outpatient procedure rate. The rates were based on available unaudited Medicare cost report data, which includes historical hospital allowable cost information and lags behind present day. Over time, often two or three years after a rate year, hospital cost reports are audited or otherwise finalized, and the cost-based rates are adjusted based on the audited or finalized cost data. If a hospital's rates change as a result of a cost report audit, then the historical claims get adjusted so that they pay out at the new rate.

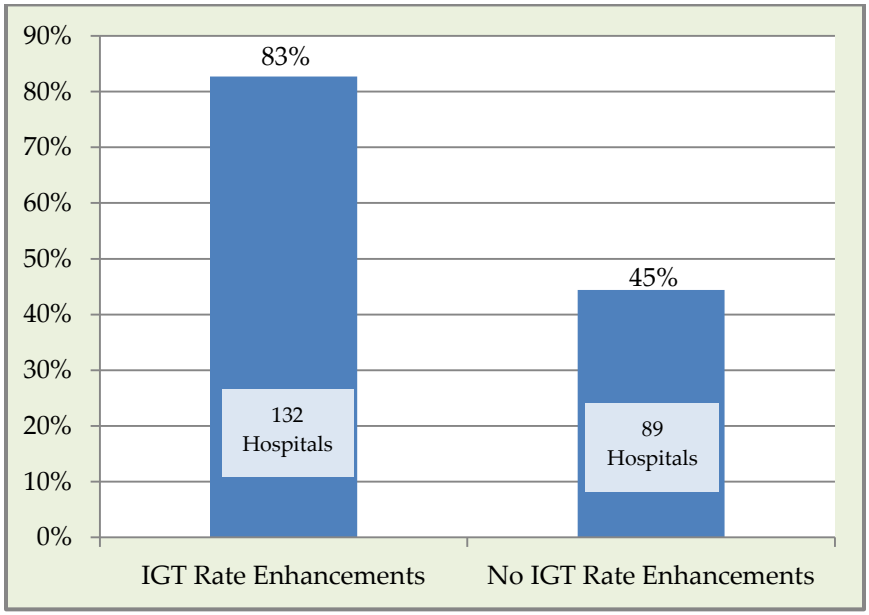
As of SFY 2014/15, cost-based rates continue to be used by Florida Medicaid to reimburse hospital outpatient services. In contrast, the method for paying for FFS hospital inpatient services has been modified, and payments were established using a DRG-based prospective payment method starting July 1, 2013. The DRG-based payment method has only five hospital-based rates, instead of separate hospital-specific rates as were present under the legacy per diem payment method. The five categories of hospitals with their own DRG base rate are rural hospitals, long term acute care hospitals, free-standing rehabilitation hospitals, hospitals with very high Medicaid utilization and very high outlier payments, and all other hospitals. These categories were selected because of general differences in cost structures across the categories and to help minimize losses at hospitals with a significant percentage of their business coming from Medicaid recipients. The DRG payment method is a prospective payment method that is much less tied to costs at individual hospitals. Because of this, rates are not adjusted and claims are not reprocessed after cost reports are audited or finalized.

In all of the hospital payment methods, inpatient per diem, inpatient DRG payment, outpatient average procedure rate and capitation, money from general revenue, the provider assessment and IGTs are used to fund the non-federal share of reimbursements. Historically the rules for how much each hospital received from the various funding sources varied based on an evolving set of rate cuts, rate ceilings, and exemptions to the cuts and the ceilings. The cuts, ceilings, and exemptions were defined through a series of rules set by the Florida Legislature over the last 20 years. This resulted in a relatively complicated process for setting rates in which different rules applied to various categories of hospitals. With the move DRG payment, and the move to Medicaid managed care, the rate setting process has been simplified.

However, the funding sources have remained the same, with funds from IGTs making up a significant portion of the overall budget. Prior to SFY 2014/15, the IGT funds were categorized as either automatic IGTs or self-funded IGTs. Automatic IGTs were distributed across hospitals by the Florida Legislature with recommendations made by the Low Income Pool Council which used an extensive set of criteria to allocate the money. The LIP Council allocated automatic IGTs to many hospitals due to their specialty designation, even some in counties which did not contribute any funds through IGTs. In SFY 2012/13, for example, 99 hospitals received rate enhancements from automatic IGT funds. That left 122 hospitals without the benefit of rate enhancement from automatic IGT funds.

Historically, rate enhancements were also available through self-funded IGTs. Self-funded IGTs are contributed in the name of a specific hospital (in contrast to automatic IGTs) so that hospitals receive back their IGT funds and the federal matching on those funds through claim payments. However, not all hospitals have the capacity to contribute IGT funds. IGTs must come from a governmental agency and cannot be sent directly from a private hospital to the Medicaid Agency. In SFY 2012/13, 80 hospitals received rate enhancements from self-funded IGTs. Combining automatic and self-funded rate enhancements, a total of 132 hospitals received rate enhancements from IGT funds. The remaining 89 Florida hospitals who saw Medicaid patients during that fiscal year did not receive rate enhancements from IGT funds. The result is a rather strong disparity in the average pay-to-cost values for hospitals receiving IGTs versus those that do not when looking at claim payments alone. This disparity is shown in Figure 13 when looking at the Medicaid FFS program (not considering uncompensated care).

Figure 13. Claim payment pay-to-cost ratios for hospitals who receive IGT funds versus hospitals that do not.



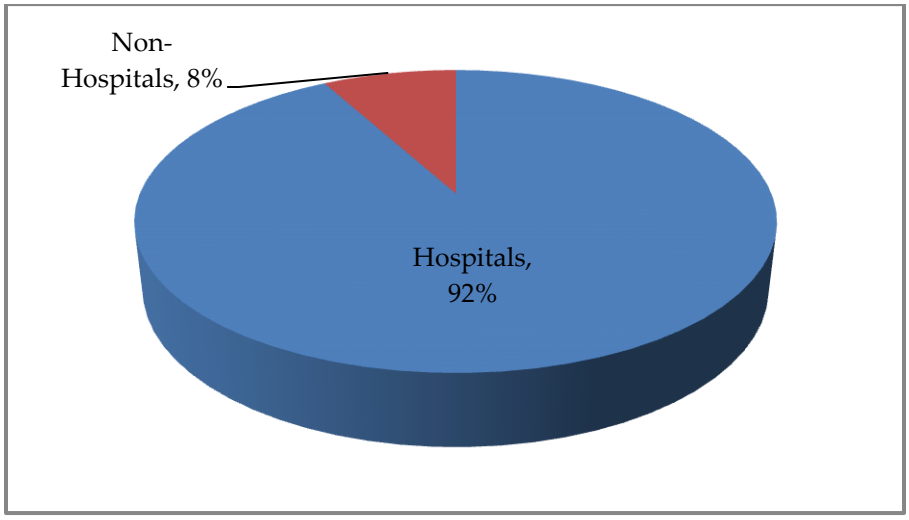
The fact that the LIP Council determined distribution of funds for both the LIP program and for automatic IGTs had the benefit of allowing both sets of funds to be distributed across more than just hospitals in counties which contributed IGT funds. However, to date, automatic IGTs have been used solely for hospital rate enhancements and have not been tied to any quality measures or programs designed to improve health care delivery in Florida.

4.4.2 Supplemental Payments

Distribution of funds for both the $1 billion LIP program and the DSH program are made through supplemental payments outside of claim-based or capitation payments. The payments are made quarterly.

In SFY 2012/13, there were 44 governmental agencies (including state general revenue and the Department of Health) contributing to the LIP program. Payments were made to 178 health care entities, 107 of which were hospitals and 71 were non-hospitals – primarily County Health Departments (CHDs) and Federally Qualified Health Centers (FQHCs). Although 40 percent of the health care agencies receiving LIP payments were not hospitals, the vast majority of funds went to hospitals, as shown in Figure 14.

Figure 14. Distribution of LIP payments in SFY 2012/13 by type of facility.



During the same year, there were 11 governmental agencies contributing to the DSH program, including general revenue from the state government, and 74 recipients of DSH payments, 73 of which were hospitals and one was the Department of Health. A total of $360 million was distributed through DSH payments in SFY 2012/13.

Also in SFY 2012/13, a total of $187 million was distributed to four teaching hospitals through the physician supplemental payment program. $79 million of this were certified public expenditures and the other $108 million were federal matching funds for the CPEs. In SFY 2014/15, the physician supplemental payment program has been moved into the LIP program.

4.4.3 State Perspective on Waiver Payments

Florida Medicaid, the LIP Council and the Florida Legislature put a priority on funding care within the hospital setting when distributing money from the LIP program with an assumption that this provides the greatest benefit to Medicaid and uninsured recipients. As stated in the Reimbursement and Funding Methodology document:

> "An evaluation of services typically covered within a coverage model generally results in a broad array of services that vary in cost per unit and the financial risk for the insured related to the use of such services. An individual may be able to afford a dental visit or a single pharmaceutical, but would incur significant financial risk if a lengthy or acute hospital stay was required. Therefore, consistent with the prioritization of covered services in Medicare Part A and the general insurance market, the State recognizes a priority of services subject to coverage from the LIP. Just as Medicare and commercial coverage attempt to cover hospital services first, the LIP recognizes that the uninsured must have their hospital risk addressed first. Subsequent to addressing the hospital risk, the LIP can then address subsequent services such as physician services, clinic services, drugs or limited benefit packages as they present lower risks than critical hospital services."[72]

The distribution of LIP funds also takes into consideration the originators of the state share of the funds, many of which name specific hospitals in their jurisdictions for which the local governments wish their funds to be applied. Florida Medicaid feels this is necessary to ensure continued local government support in funding the Medicaid program.

> "Although the State is not promoting a predetermined benefit for the local governments providing funding, the State does recognize that it is inappropriate to require a local government to assist with the funding of a benefit for providers outside that local government's area without consideration of the benefits received by providers within its political subdivision. The State believes it is sound public policy to provide each local government the assurance that its providers will not receive less from LIP than if the local government provided direct financial assistance to its providers."[73]

At the same time, controls exist to ensure LIP funding does not exceed the costs of services provided to uninsured, underinsured, and Medicaid recipients. The LIP Council and Florida Legislature use the following set of priorities when distributing funds within the LIP Waiver:

1. Hospital services are prioritized in the distribution methodology;
2. Providers within a local area will not receive less than they would have received if they were to obtain funding directly from their local governments for services related to Medicaid, the uninsured, and the underinsured; and
3. Payments to providers will not exceed the cost of services for the uninsured, underinsured, and Medicaid shortfalls.

[72] Florida Agency for Health Care Administration, *Reimbursement and Funding Methodology – Florida Medicaid Reform Section 1115 Waiver – Low Income Pool*. (February 2014)
[73] Ibid.

4.4.4 Review of CMS-64 Reports

CMS-64 reports, entitled "Quarterly Medicaid Statement of Expenditures" are completed quarterly by each state Medicaid agency and are submitted to CMS. These reports are used to document and communicate state expenditures made through the Medicaid program and to define the amount of funds due to states from CMS for the federal share of Medicaid costs. Thus CMS-64 reports, while routine and produced as part of standard operating practice, are very important as they affect transfer of extremely large sums of money from the federal government to state governments. Because of the importance of these reports, the specifications for this study included a request for a review to be performed of the data included in recent CMS-64 reports versus Medicaid payments documented via other sources.

We performed the review of Medicaid payments made during state fiscal year 2012/13 as this was the most recent complete state fiscal year for which data was available at the time of this study. Florida SFY 2012/13 runs from July 1, 2012 through June 30, 2013. Because CMS-64 reports are produced quarterly, this included CMS-64 reports for quarters ending September 30, 2012, December 31, 2012, March 31, 2013, and June 30, 2013. In addition, the scope of this study focuses on providers receiving payments through the LIP program, which are primarily acute care hospitals, so our payment comparisons focused on those related to acute care hospitals.

Overall payments reported through CMS-64 reports aligned relatively closely with Medicaid payments reported through other sources. This comparison is shown in Table 5 below. For hospital inpatient and outpatient claim data, we used claim extracts from the Florida MMIS to validate against payments reported on the CMS-64 reports. The total of $3.635 billion shown in Table 5 matches the sum of total inpatient and outpatient fee-for-service payments displayed in Appendix D – Hospital Payments.[74] For disbursements within the LIP and DSH programs, we used data reported in AHCA's annual "Local Funding Revenue Maximization and Local Funding for Hospital Inpatient Reimbursement" report which is submitted to both the Florida Legislature and CMS each year.

[74] Managed care capitation payments are not included in this section because they are typically reported as a single line item, not broken out by type of provider.

Table 5. Medicaid payments reported for SFY 2012/13.

	CMS-64	Other Reporting	Percentage Difference	Source of Other Reporting
FFS Hospital Claims	$3,718	$3,635	-2.2%	Claim data from FL MMIS
LIP	$1,019	$996	-2.3%	AHCA Revenue Maximization Report
DSH – Inpatient Hospitals	$244	$241	-1.2%	AHCA Revenue Maximization Report
DSH – Mental Health Facilities	$86	$74	-14.0%	AHCA Revenue Maximization Report
DSH Total	$330	$315	-4.5%	AHCA Revenue Maximization Report
Overall Total	**$5,067**	**$4,946**	**-2.4%**	

Notes:
1) Data from SFY 2012/13.
2) Dollar amounts are in millions.
3) Claim payments in CMS-64 reports were retrieved from reporting categories 1A and 6A.
4) LIP payments in CMS-64 reports were retrieved from reporting category 1C.
5) DSH payments in CMS-64 reports were retrieved from reporting categories 1B and 2B.

Differences between payment amounts reported in the CMS-64 reports versus other sources can be attributed to the fact that the timeframes for payments selected in each reporting method differ slightly. CMS-64 reports include payments based on actual date of payment. In contrast, our MMIS claim data was selected based on date of service because this is the way claim data is typically selected for rate setting. Because there is some lag between first date of service and the date in which an individual claim is submitted by the provider and paid by Medicaid, claims included in the CMS-64 reports will not exactly match claims selected based on first date of service. Also, our claim data included only billings from in-state hospitals, not out of state hospitals. The CMS-64 includes payments to out-of-state hospitals. In addition for claim data, differences between payment amounts in the CMS-64 versus claim data retrieved from the MMIS may be caused by claim adjustments performed after the end of the fiscal year. Claim adjustments are recorded in CMS-64 reports as "prior period adjustments" and are reported in the report applying to the time frame in which the adjustment was performed. In our analysis, if the adjustment occurred outside of SFY 2012/13, it would be included in a future CMS-64 report, not in any of the four reports used in this analysis. However, the claim extract retrieved for this analysis was generated well after the end of SFY 2012/13 and does reflect any claim adjustments performed up through the data extract date for claims with date of service in SFY 2012/13.

When considering supplemental payments, data included in the Revenue Maximization report documents payments applicable to a state fiscal year. This is true because the report is intended to demonstrate that AHCA's payments utilizing IGT funds stay within the limits defined within the Legislature's annual General Appropriations Act. However, operationally, payments

applicable to a state fiscal year may not always occur within that fiscal year. This will generate differences between numbers included in the Revenue Maximization report versus numbers in the CMS-64 reports. For example, payments made just after the end of the state fiscal year and applicable to the appropriation for that fiscal year would not be included in the CMS-64 reports, but would be included in the Revenue Maximization report. The Revenue Maximization reports are completed six months after the end of a state fiscal year, in contrast to CMS-64 reports, which are generated immediately after the end of each quarter. These differences in payment reporting criteria could explain two or three percent difference in amounts reported.

The DSH payments to Mental Health Facilities differed by more than three percent. We believe this larger difference is due to the fact that expenditures certified by non-Medicaid governmental agencies (CPEs) are included in the CMS-64 reports, but are not included in the Revenue Maximization report. CPEs are included in CMS-64 reports because they affect the determination of federal matching funds due to the state. CPEs are not included in the Revenue Maximization report because they are not expenditures incurred by AHCA.

A more detailed review of payments in the CMS-64 reports could be performed to align timing of data selection more thoroughly within all data sources. This should allow for the payment reconciliations to tie within a much tighter tolerance. However, such an effort would be very time consuming and is outside the scope of this study.

5 Analysis of Hospital Funding and Payment Methods

5.1 Introduction

The previous chapter of this report described current policies and processes related to funding and payment of hospital services by Florida Medicaid. This chapter of the report analyzes and evaluates current funding and payment based on four fundamental criteria – adequacy, sustainability, accountability, and equity. Payment adequacy is measured primarily in comparison to hospital cost. Program-wide pay-to-cost ratios are the focus of this section. The sustainability section considers the likelihood that funding will continue at current levels and that payment will be sufficient to incent hospitals to accept Medicaid and uninsured patients. The section on accountability discusses the level of transparency and simplicity within current funding and payment mechanisms. Finally, the equity section concentrates on funding and payment levels across providers in the state of Florida and across Medicaid programs in the United States.

5.2 Methodology

In Section 5.3, regarding Adequacy, and Section 5.6, regarding Equity, we present a variety of numbers and figures, many related to pay-to-cost ratios. This section describes the general methodology used to calculate these numbers.

- Unless otherwise noted, all payment and cost values are derived from SFY 2012/13 data, which spans the period from July 1, 2012 through June 30, 2013, and represents the most recent complete state fiscal year of data available at the time of this study. In addition, unless otherwise noted, claim payment and cost include those for services provided through both the fee-for-service and managed care programs, and include hospital inpatient and outpatient services.

- We calculated the cost of hospital services provided to Medicaid recipients by determining two cost-to-charge ratios (CCRs) for each hospital, one for inpatient services and one for outpatient services. We then multiplied the applicable cost-to-charge ratio times the charges on each claim. We determined the cost-to-charge ratios using information provided by AHCA which they extracted from hospital Medicare cost reports for the purpose of determining inpatient cost per diems (no longer used)[75] and outpatient cost per-service average payment rates. Separately for inpatient and outpatient services for each hospital, CCRs were calculated by dividing Medicaid costs by Medicaid charges. The only exception to this calculation is for hospitals with less than 200 Medicaid days included on their cost reports. For these hospitals, we calculated the inpatient CCR by dividing total hospital inpatient cost by total hospital inpatient charges. For the outpatient CCR, no such minimum

[75] AHCA converted its inpatient payment methodology from cost-based per diems reimbursement to APR-DRG reimbursement effective July 1, 2013.

volume rule was applied. This logic is consistent with the way AHCA has historically calculated cost-based per diems.

- For all hospitals reimbursed by Medicare through the Inpatient Prospective Payment System (IPPS), we extracted hospital cost for uncompensated care from Schedule S-10 of the Medicare cost report. For each hospital, we selected the most recent cost report available with hospital fiscal year end less than or equal to 2013. The time periods represented in these cost reports do not perfectly overlap with state fiscal year 2012/13 in all cases, but will overlap with at least some portion of the state fiscal year. For hospitals that are not reimbursed through the Medicare IPPS, and thus, do not submit a Schedule S-10, but do receive funds through the LIP program, we retrieved uncompensated care costs from SFY 2011/12 LIP Cost Limit reports provided by AHCA and which we inflated to SFY 2012/13. Uncompensated care costs were not available for hospitals that are not reimbursed by the Medicare IPPS and do not receive supplemental payments through LIP funds. The hospitals in this category tended to be low-volume Medicaid hospitals, mostly private, and mostly free-standing rehabilitation and free-standing long term acute care facilities.

- When comparing Medicaid payments to cost, we included LIP payments only when comparing to costs that also include the costs associated with uncompensated care. LIP is defined as a program to help ensure access to care for the uninsured as well as cover or partially cover shortfalls between Medicaid payments and hospital cost for providing health care to Medicaid enrollees. In the disbursement of LIP funds, there are no distinctions made between reimbursements for uncompensated care versus reimbursements for Medicaid recipients. Thus, there is no way to identify the proportion of LIP payments between uncompensated care and Medicaid shortfalls. As a result, we do not compare payments to costs using all or part of the LIP payments unless we also included each hospital's uncompensated care costs.

- In the section 5.6.3.3.3, in which provider assessment fees and IGT contributions are subtracted from hospital payments to determine net hospital revenue, only inpatient IGT contributions are included. This is because only inpatient IGTs are contributed in the name of specific hospitals. IGTs contributed to outpatient rate enhancements, referred to by AHCA as "statewide issues" and IGTs contributed to fund the DSH program are not submitted in the name of individual hospitals. As a result, they could not be divided into the provider categories defined in this report.

- In the figures showing the percentage of Medicaid business for each IGT category, the percentage is calculated based on hospital costs instead of days or admissions because it includes inpatient and outpatient claim data, for which admissions and days are not necessarily comparable. In addition, some charts presented in this document include uncompensated care, for which counts of admissions and days are not available. Using cost as the unit of measure here allows all similar charts to use the same unit of measure.

5.3 Adequacy

In this report, we express the relationship between payment and cost in the form of a calculated pay-to-cost ratio which is one of the metrics that can be used to understand the adequacy of hospital payments. In order to remain in operation, hospitals, like any other businesses, must receive enough income to cover all expenses including items such as labor, facilities, and equipment. In addition, it is critical for all hospitals to be able to generate some margin over the cost of operations – for-profit hospitals need to satisfy investors and stock holders, and not-for-profits need to fund the replenishment of operating infrastructure and capital. Thus, paying hospitals an amount equal to their costs or at least equal to reasonable market value for services provided, if such a number can be defined, would seem to be a reasonable definition of adequate reimbursement. In fact, in Medicaid Upper Payment Limit analyses, for example, hospital cost is accepted as a proxy for Medicare payment and can be used as the Upper Payment Limit or maximum allowable reimbursement amount. Note however, that CMS does not consider operating margin to be a reasonable and necessary cost of providing services.

It is important to note, however, that defining adequate payment levels is not a precise science as Medicaid agencies commonly pay less than full hospital cost and, yet, hospitals remain open and continue to accept Medicaid patients. Traditionally, the assumption has been that hospitals are able to achieve or maintain sufficient operating margin by balancing relatively low revenues received from Medicaid with higher revenues received from commercial insurance companies. This phenomenon is referred to as "cost-shifting," and is more of a theoretical exercise than an actual function performed by hospital accountants. Cost shifting is relatively easy to do for hospitals with a small amount of their business coming from Medicaid and uninsured patients. On the opposite side, cost shifting is more difficult for hospitals with a relatively high percentage of their business coming from Medicaid and uninsured patients. Note also that while it is CMS' intent that the Medicare program pay for the reasonable and necessary costs of providing services to the Medicare population, critics of the Medicare program argue that such is not the case. As such, the Medicare program also contributes to the need for hospitals to "cost-shift."

Overall pay-to-cost ratios for hospital services provided to Medicaid and uninsured recipients in Florida in SFY 2012/13 are shown in Table 6 below. As shown in this table, we calculated payment versus cost for the Medicaid program by itself, and then display the ratios for a combination of the Medicaid program combined with payments and costs associated with uninsured and underinsured patients (referred to in the table as "uncompensated care"). We also display the combined Medicaid and uncompensated care results two ways – one in which hospital provider assessment fees and contributions to IGTs used to fund the Medicaid program are not considered, and the other with assessment fees and IGTs subtracted from hospital payments to estimate net hospital revenue. Under guidelines defining upper payment limit and DSH limit calculations, provider assessment fees and IGT contributions are not considered to be valid hospital costs. At the same time, provider assessment fees and IGTs coming from hospitals are included in Medicaid payments back to hospitals. Thus, true net revenue to hospitals should take these hospital outlays into consideration.

In truth, not all IGTs are contributed by hospitals. Many are contributed by local governmental agencies. However, the IGTs contributed for the LIP program, automatic rate enhancements, and LIP-6 (previously self-funded rate enhancements) are all donated in the names of specific hospitals. In this section, those IGTs are treated as donations from the named hospitals under the assumption that the local governments would find ways to contribute those funds directly to the named hospitals if they were not contributed as IGTs to the Medicaid agency.

Table 6. Pay-to-cost values for Medicaid program overall.

Description	Payment	Estimated Hospital Cost	Pay-to-Cost Ratio
Pay-to-cost - Medicaid recipients - w/o LIP	$4,544	$5,770	79%
Pay-to-cost - Overall including claim, LIP, and DSH payments as well as claim (Medicaid) and uncompensated care costs	$5,699	$8,587	66%
Pay-to-cost - Overall including claim, LIP, and DSH payments minus PMATF and IGT hospital contributions as well as claim (Medicaid) and uncompensated care costs	$4,186	$8,587	49%

Note(s):

1) Dollar amounts are in millions.
2) PMATF stands for Public Medical Assistance Trust Fund which is Florida Medicaid's provider assessment program.
3) Payments include hospital inpatient and outpatient claim data from both FFS and managed care encounter claims.

When looking at claim payments for care of Medicaid recipients alone, the pay-to-cost ratio is 79 percent. When including uncompensated care, the pay-to-cost ratio is lower – at 66 percent. This is an indication that the LIP and DSH programs pay out less than total uncompensated care costs for each of these categories of hospitals. When including Medicaid and uncompensated care, and including provider assessment fees and IGT contributions as a reduction in hospital revenue, the state-wide average pay-to-cost ratio is 49 percent.

In addition to looking at the pay-to-cost ratios overall, we also compared pay-to-cost ratios for fee-for-service versus managed care and for inpatient versus hospital outpatient services. The results, in Table 7 below, indicate Florida Medicaid pays slightly better for hospital inpatient services than it does for outpatient services. In addition, payment is relatively consistent when comparing Medicaid fee-for-service versus Medicaid managed care. The data presented is from state fiscal year 2012/13 at which time approximately 85 percent of Medicaid hospital reimbursements were made through the fee-for-service program. Starting in state fiscal year 2014/15 and going forward, the proportions are somewhat reversed and approximately 65 percent of Medicaid hospital reimbursements will be made through the Medicaid managed care

program and only 35 percent will be made through the fee-for-service program. However, the expectation is that overall pay-to-cost ratios will remain unchanged with the movement of business to Medicaid managed care. To ensure payments do remain at current levels in future years, decisions will need to be made regarding how best to distribute traditional LIP funds ($1 billion), plus traditional self-funded IGTs and physician supplemental payments, both of which have been incorporated into the LIP program for SFY 2014/15.

Table 7. Pay-to-cost comparison of fee-for-service and managed care claim data for hospital inpatient and outpatient services.

Description	Payment	Estimated Hospital Cost	Pay-to-Cost Ratio
Pay-to-cost - FFS	$3,635	$4,635	78%
Pay-to-cost - MC	$909	$1,135	80%
Pay-to-cost - FFS - Inpatient Only	$2,738	$3,385	81%
Pay-to-cost - FFS - Outpatient Only	$896	$1,250	72%
Pay-to-cost - MC - Inpatient Only	$477	$615	78%
Pay-to-cost - MC - Outpatient Only	$433	$520	83%

Note(s):
1) Numbers are in millions.
2) All numbers exclude LIP payments.

In this section, numbers are presented in the aggregate for all hospitals in the state of Florida. Values for individual hospitals vary. Some receive payments relative to cost that are higher than the state-wide average and others are paid below the state-wide average. In general, those who have access to IGT funds are paid better in relation to their costs and those who do not have access to IGTs are reimbursed lower relative to cost. This is discussed in more detail later in this document in section 5.6 - Equity.

5.4 Sustainability

The sustainability of funding for Medicaid programs is a concern of all state Medicaid agencies as health care costs continue to rise more quickly than state revenues. In particular in Florida, Medicaid costs have grown by 23 percent in the five year period from July 1, 2007 through June 30, 2012. The State of Florida has worked to reduce the effect of Medicaid increases on the overall state budget through the migration to Medicaid managed care, payment reform, and cost sharing.

Medicaid managed care spreads the financial risk associated with the Medicaid program across more entities. Instead of the state incurring all risk, which is the case with traditional fee-for-service programs, Medicaid managed care spreads the risk across the State and the various managed care organizations (MCOs). In addition, managed care plans are responsible for coordinating and managing the health care of Medicaid recipients with a goal of improving health outcomes and reducing inappropriate utilization. Florida Medicaid made a significant

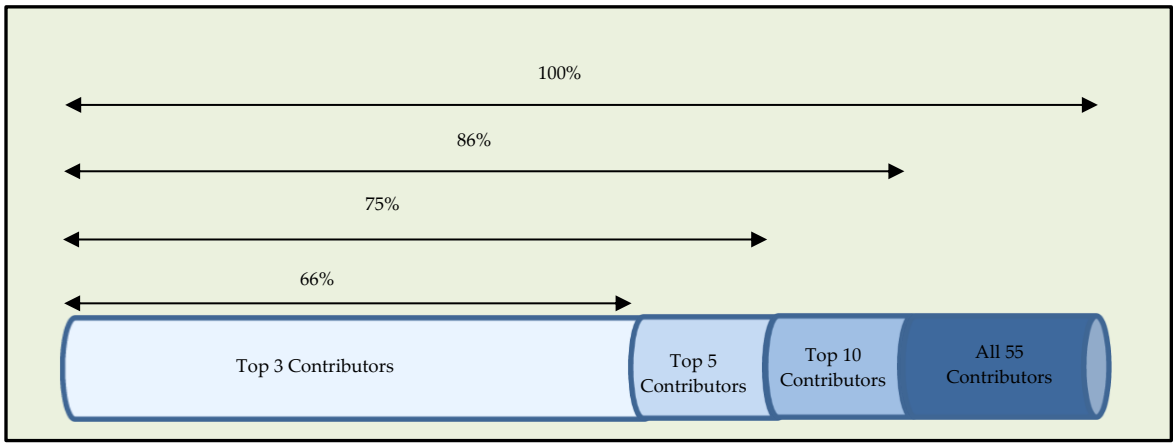
move to Medicaid managed care in SFY 2006/07. At that time, a pilot program began in which most recipients in two counties, Broward and Duval, were transitioned to managed care. A year later, three smaller counties, Baker, Clay, and Nassau, were also transitioned to managed care. Then in the summer of 2014, the rest of the state was transitioned to managed care as part of a program AHCA refers to as Managed Medical Assistance (MMA). Currently, AHCA has moved just under three million Medicaid beneficiaries from fee-for-service to capitated or premium-based managed care programs, thus adding another level of stability in service delivery, which should contribute to increases in the overall cost effectiveness of the program.

Provider payment reform is one method used by state Medicaid agencies to enhance cost effectiveness and program fiscal stability. States have moved providers from cost-based reimbursement systems, where providers are incented to increase utilization, to acuity-based and quality of care systems of reimbursement. Florida's implementation in July 2013 of a Diagnosis Related Group (DRG) payment methodology, which replaced a cost-based per diem methodology for inpatient hospital payments, generated greater incentives for hospitals to control costs. In addition, it is good first step towards future value-based strategies that pay incentives for improved processes and outcomes.

The bulk of the cost sharing implemented by the state has been in the form of county billing, a provider assessment, and collection of inter-governmental transfers. These cost sharing measures have been concentrated on expenditures to hospital and nursing home providers which combine for approximately 45 percent of the total state share of Medicaid funding in SFY 2012/13. County billing and the provider assessment are mandatory programs and are relatively reliable. IGTs are optional and as such are a less dependable funding source.

Medicaid IGTs in Florida are voluntary, yet comprise a significant portion of overall funding. Specifically in the area of hospital funding, IGTs comprised 44 percent of the state share in SFY 2012/13. The IGTs help fund inpatient and outpatient rates, the LIP program, and the DSH program. In total for hospital reimbursements, there were 55 contributors in SFY 2012/13 including 54 local governmental agencies and the Florida State Department of Health. Of these, a small number contribute a vast majority of the funds. The top three contributors donate 66 percent of the funds; the top five donate 75 percent of the funds and the top ten donate 86 percent of the funds. These funds are substantial, totaling over $1.1 billion dollars in SFY 2012/13. The unevenness of the IGT contributions is depicted in Figure 15.

Figure 15. Distribution of IGT contributions across donors.



To date, reimbursement methodologies have been defined to ensure contributors of IGTs receive back at least as much as they donate. In practice, thanks to the addition of federal matching funds, the contributors ultimately receive significantly more than they donate. However, any change in reimbursement methodology that offers a more broad-based distribution of funds will offer less benefit to those contributing IGTs. This will decrease the incentive for local governments to provide IGTs and risks lowering overall funding of the Medicaid program. Certainly, if the reimbursement methodology reached a point in which local governments felt they could obtain greater benefit from keeping their funds internal to their geographic area versus donating them to AHCA for federal matching, IGT contributions to the state Medicaid program would suffer significantly.

5.5 Accountability

Accountability consists of equal measures of compliance and transparency. Compliance means the establishment of state programs meeting the full requirements of the federal regulations. Transparency means thorough documentation that is both accessible to the general public and capable of withstanding scrutiny.

Accountability is the joint responsibility of state and federal governments for the Medicaid program. They share the mutual obligations for operating the Medicaid program in each respective state consistent with the Title XIX of the Social Security Act and various regulations. CMS provides the regulations, financing, technical assistance, and other tools while states fund their share of financing, operate the program within areas of enrolling beneficiaries, registering providers, paying for medical services rendered to Medicaid recipients, and reporting. The partnership is central to the success of the Medicaid program.

An area in which CMS provides regulations and technical assistance is funding sources and payment methods. A specific area of regulations and guidance is supplemental payment

programs, i.e. UPL payments, DSH payments, and specialized programs, such as the LIP program. The Florida LIP program is funded primarily through IGTs matched with federal funds and payments to hospitals.

The state operates the Medicaid program with all of the complexities of federal and state regulations. Operationally, states are required to report funding sources and payments. Quarterly and annual reports to state leaders and CMS are one method the partnership is held accountable. Various reports required by either the Florida Legislature and/or CMS contain detailed information, particularly related to inter-governmental transfers used to help fund the program. In particular, the *Local Funding Revenue Maximization and Local Funding for Hospital Inpatient Reimbursement* document generated annually by AHCA contains very detailed information on the collection and distribution of IGT funds. In addition, the *Reimbursement and Funding Methodology - Florida Medicaid Reform Section 1115 Waiver - Low Income Pool* document, also generated annually, provides detailed descriptions of allowable costs under the LIP program. Associated with this document are spreadsheets hospitals submit annually to communicate their total costs of care to Medicaid, uninsured, and underinsured recipients. These spreadsheets are used to confirm that total reimbursement paid by the Medicaid agency does not exceed total hospital cost.

During interviews with various stakeholders while researching this report, we learned there is a concern about lack of transparency available within the current Florida Medicaid hospital funding and payment mechanisms. Our conclusion, in contrast, is that documentation on the program is readily available and plentiful. However, the program is complicated and this complexity likely contributes to stakeholder impression that it is not transparent. Any modifications to the program that provide simplification will likely increase stakeholder comfort level. In addition, modifications could be made to AHCA's end of year financial reporting to help improve transparency of funding and payment. For example, the documents mentioned above give excellent detail of funding and payment of inter-governmental transfers. But little or no documentation exists that combines that information with claim payments or hospital cost in order to show a full picture of reimbursement for the program.

5.6 Equity

5.6.1 Introduction

Equity within a Medicaid program can be defined in a variety of ways. One measure is the consistency of payment for services independent of where the services are performed. A second measure is the level of payment relative to cost across hospitals. Equity across Medicaid programs may also be reviewed in terms of the level of federal funding provided relative to the size of Medicaid programs. Each of these measures of equity is discussed in further detail in the sections that follow.

5.6.2 Equity in Payments by Service

One definition of equity in Medicaid hospital reimbursements can be considered in the context of whether or not there is consistency of payment for the same service independent of where the service is performed. However, there are some scenarios in which payment rates may be varied while still maintaining a sense of equity. Medicaid agencies may vary from identical pay across hospitals to account for legitimately varying costs structures within categories of hospitals. For example, payments to teaching hospitals may be set higher to help cover the costs of graduate medical education programs. Or, a Medicaid agency may keep payments for medical services the same and offer supplemental payments to teaching hospitals as a way to maintain equity of utilization-based payments. Medicaid agencies may also choose to set higher payment rates for specific services for which Medicaid is a major player in the market. For example, some Medicaid agencies choose to set a higher pay-to-cost ratio for obstetrical services and newborn care, because Medicaid generally pays for about half of the births in each state. With that kind of volume, Medicaid rates have a significant impact on financial viability of those services within hospitals, thus higher rates can increase or maintain the likelihood that sufficient capacity exists to care for Medicaid recipients.

Specifically within Florida Medicaid hospital reimbursement, outpatient services are reimbursed through a cost-based methodology that pays an average rate per revenue code based on each hospital's individual cost structure and anticipated volume of outpatient services provided to Medicaid recipients. This method clearly does not pay the same amount for the same service independent of where the service is provided. In addition, the variation in rates is not based on category of provider or otherwise related to the impact the Medicaid rate may have on access to these services across the state. Instead, a unique rate is assigned to each hospital based on the individual hospital's costs of care. Critics of this type of payment model believe that it can provide inappropriate incentives for hospitals in managing their costs. However, these potential incentives are somewhat mitigated by a relatively small proportion of Medicaid outpatient services when compared to all other services provided in a hospital setting.

AHCA, the Florida Governor's Office, and the Florida Legislature have considered making a change to the outpatient payment methodology to get away from connection with individual hospital costs. The Florida Governor's original proposed budget for state fiscal year 2014/15 included a proposal to move away from cost-based reimbursement of hospital outpatient services. However, with conversion to Medicaid managed care ongoing and conversion to DRG reimbursement for hospital inpatient services still in its infancy, this change was not approved for SFY 2014/15. It may be considered in future years.

Inpatient services, in contrast, were recently converted from an individual hospital cost based per-diem payment methodology to a Diagnosis Related Grouping (DRG) payment methodology. This payment model generally pays a fixed amount for each discharge based on the assigned DRG (which is determined using a preset algorithm that considers primarily the patient's diagnoses, surgical procedures performed, gender, age, and for newborn cases, birthweight). In the Florida Medicaid DRG payment methodology, AHCA and the Florida

Legislature chose to increase payments for specific services for which Medicaid is a significant payer. Payment increases are made to services provided to sick newborns and to children with complex medical conditions. This is done by applying a payment multiplier, referred to as a "policy adjustor" to claims for applicable recipients in which the severity of illness of the DRG is high.

In addition to service adjustors, AHCA and the Florida Legislature chose to adjust payment for specific categories of providers. Five different provider categories have been defined within the DRG payment method and are listed below:

a) Rural hospitals
b) Hospitals with a very high percentage of Medicaid utilization and a very high percentage of claims reaching outlier payment status
c) Free-standing long-term acute care hospitals
d) Free-standing rehabilitation hospitals
e) All other hospitals.

The first four categories of hospitals listed above receive a policy adjustor which increases their payment on each admission. The fifth category, all other hospitals, is not given a payment multiplier. Rural hospitals and hospitals with significant Medicaid business and numerous claims reaching outlier status were separated out to help ensure continued viability of these hospitals and thus access to care for Medicaid recipients. Rural hospitals have lower patient volume across which to spread their fixed costs. High Medicaid utilization and high outlier hospitals have less commercial business available for cost shifting and are seeing Medicaid recipients with very significant medical needs (which is indicated by the number of admissions reaching outlier payment status). Free-standing rehabilitation and long term acute care (LTAC) hospitals were separated out because of the existing discrepancy between hospitals with access to IGTs and those without access. Nearly all rehabilitation and LTAC hospitals are without access to IGTs and were paid considerably lower rates under the per diem payment method used through the end of SFY 2012/13. With the conversion to DRG reimbursement, AHCA and the Florida Legislature decided to offer assistance to these hospitals to compensate for the lack of IGT revenue. Free-standing rehabilitation and LTAC hospitals have relatively low volume in the Florida Medicaid program, so this was done without shifting significant amounts of money away from other hospitals.

As mentioned above, within each provider category in the inpatient DRG payment methodology, payment is the same for the same service, independent of the hospital in which the service is performed. The elements which determine payment for a particular service, hospital base rate, hospital policy adjustor, and DRG relative weight are the same for each hospital within a provider category. Thus, all hospitals within a provider category receive the same DRG payment for admissions assigned the same DRG code – that is, admissions for the same type of patient, requiring the same types of health care services.

However, "pure" DRG payment, which is the sum of DRG base payment and outlier payment, only constituted about 55 percent of total inpatient reimbursements for Florida Medicaid recipients in SFY 2013/14[76]. The other 45 percent comes from supplemental payments made using funds received through IGTs. And these funds are distributed primarily to hospitals that have access to contribute IGTs. As a result, full inpatient payment for specific services is not consistent across different providers even within the same provider category. In general, hospitals with access to IGTs are paid more per admission because of the supplemental payments they receive. This is discussed in more detail in section 5.6.3 – Equity in Payments Across Hospitals.

5.6.3 Equity in Payments Across Hospitals

5.6.3.1 Introduction

In addition to measuring equity within a Medicaid program by comparing payments for similar services across hospitals, equity can also be measured by comparing overall payment levels across hospitals. A variety of definitions exist as to what is defined as a payment and what is defined as an allowable cost. Because of this, we chose to compare hospital Medicaid pay-to-cost ratios in a variety of ways, including:

a) Services rendered to Medicaid recipients as identified through paid claims – payment and cost include fee-for-service and managed care claims (both inpatient and outpatient) and exclude the provider assessment and IGTs contributed to fund the Medicaid program as a reduction in hospital net revenue.

b) Services rendered to Medicaid, uninsured, and underinsured recipients – payments include claim payments for both fee-for-service and managed care claims (both inpatient and outpatient) as well as LIP and DSH supplemental payments. Costs include claim costs for both fee-for-service and managed care claims (both inpatient and outpatient), and cost of uncompensated care. Hospital contributions to the provider assessment and IGTs contributed to fund the Medicaid program are not considered.

c) Services rendered to Medicaid, uninsured, and underinsured recipients with PMATF and IGTs subtracted from hospital payments – payments include claim payments for both fee-for-service and managed care claims (both inpatient and outpatient) as well as LIP and DSH supplemental payments. Costs include claim costs for both fee-for-service and managed care claims (both inpatient and outpatient), and cost of uncompensated care. Hospital contributions to the provider assessment and IGTs contributed to fund the Medicaid program are subtracted from hospital payments to determine net hospital revenue.

[76] SFY 2013/14 is the first year of DRG payment, and includes both automatic and self-funded IGTs in inpatient rate enhancements distributed with claim payments. In SFY 2014/15, only automatic IGTs are used as a rate enhancement. Self-funded IGTs are included in the LIP program and distributed as quarterly supplemental payments.

Claim payments and costs referenced above may also be referred to as service payments or utilization payments as they are specifically tied to services provided to Medicaid, uninsured and underinsured recipients. We did not include a fourth option of calculating pay-to-cost ratios for claim payments when the provider assessment and IGT contributions are subtracted from payment. This is because there is no clear way to determine how much of a hospital's IGTs contributed to automatic IGT rate enhancements, which are included in claim payments, versus LIP payments, which are supplemental to claim payments.

Because IGTs play a significant role in funding and payment, we decided to compare pay-to-cost ratios across three categories of hospitals, 1) hospitals that contribute and receive IGTs; 2) hospitals that do not contribute IGTs, but do receive payments from IGT funds; and 3) hospitals that neither contribute nor receive IGT funds. In truth, not all IGTs are contributed by hospitals; many are contributed by local governmental agencies. However, the IGTs contributed for the LIP program, automatic rate enhancements, and self-funded rate enhancements (which were moved into the LIP program in SFY 2014/15) are all donated in the names of specific hospitals. In this section, those IGTs are treated as donated by the named hospitals under the assumption that the local governments would find ways to contribute those funds directly to the named hospitals if they were not contributed as IGTs to the Medicaid agency.

In addition to the three hospital categories mentioned above, pay-to-cost ratios are also compared for public versus private hospitals. This is done because public hospitals generally have access to IGTs while private hospitals generally do not. We wanted to identify any inequities in reimbursement for public versus private hospitals.

In fact, the pay-to-cost ratios we calculated do indicate that hospitals with access to IGTs receive significantly higher levels of reimbursement than hospitals without access to IGTs. This is because individual hospital overall reimbursement in the Florida Medicaid program is heavily tied to the hospital's access to contribute inter-governmental transfer funds into the Medicaid program.

5.6.3.2 Equitable Pay-to-cost Ratios

Medicaid does not necessarily need a goal of making the pay-to-cost ratios for each hospital equal. Ideally, the reimbursement methodology contains incentives for hospitals to control costs and provide high quality care. In terms of hospital cost, this is often done by basing payments on the average costs for a category of hospitals so that the hospitals are incented to control costs. Those most successful in controlling costs will receive better margins from Medicaid reimbursements, and, thus, will have higher pay-to-cost ratios.

As described in the previous section, Medicaid agencies may choose to define certain categories of hospitals and review payment levels within these categories. This is because certain hospitals are determined to have unique cost structures or because certain hospitals are determined to be critical to the Medicaid program. Critical access hospitals and rural hospitals

are common examples in which payment rates are sometimes increased to ensure viability of these hospitals, thus ensuring local access to care for Medicaid recipients living in rural areas.

5.6.3.3 Pay-to-Cost Ratios by Category of Provider

As mentioned above, we chose to calculate average pay-to-cost ratios for three categories of providers because reimbursements, particularly in the n LIP program, are heavily tied to IGT contributions. The three categories of hospitals we created are: 1) hospitals that contribute and receive IGTs; 2) hospitals that do not contribute IGTs, but do receive payments from IGT funds; and 3) hospitals that neither contribute nor receive IGT funds.

In addition, we chose to calculate the pay-to-cost ratios three different ways, consistent with the way overall program pay-to-cost ratios were calculated in section 5.2 – Methodology. The three methods used vary in terms of what is included in the payments and what is included in the hospital costs. These methods are listed in the following table:

Table 8. Methods used to calculate pay-to-cost ratios when analyzing reimbursement equity across hospitals.

Method Number	Description	Included in Payments	Included in Cost
1	Medicaid program – hospital services rendered to Medicaid recipients	• Fee-for-service claim payments – both inpatient and outpatient • Medicaid managed care claim payments – both inpatient and outpatient	• Costs calculated from charges on fee-for-service claim payments – both inpatient and outpatient • Costs calculated from charges Medicaid managed care claim payments – both inpatient and outpatient
2	Medicaid program and uncompensated care – provider assessment and IGTs excluded from hospital cost	• Fee-for-service claim payments – both inpatient and outpatient • Medicaid managed care claim payments – both inpatient and outpatient • LIP supplemental payments • DSH supplemental payments	• Costs calculated from charges on fee-for-service claim payments – both inpatient and outpatient • Costs calculated from charges Medicaid managed care claim payments – both inpatient and outpatient • Costs of uncompensated care
3	Medicaid program and uncompensated care – provider assessment and IGTs included in hospital cost	• Fee-for-service claim payments – both inpatient and outpatient • Medicaid managed care claim payments – both inpatient and outpatient • LIP supplemental payments • DSH supplemental payments • Net payment calculate by subtracting funds	• Costs calculated from charges on fee-for-service claim payments – both inpatient and outpatient • Costs calculated from charges Medicaid managed care claim payments – both inpatient and outpatient • Costs of uncompensated care

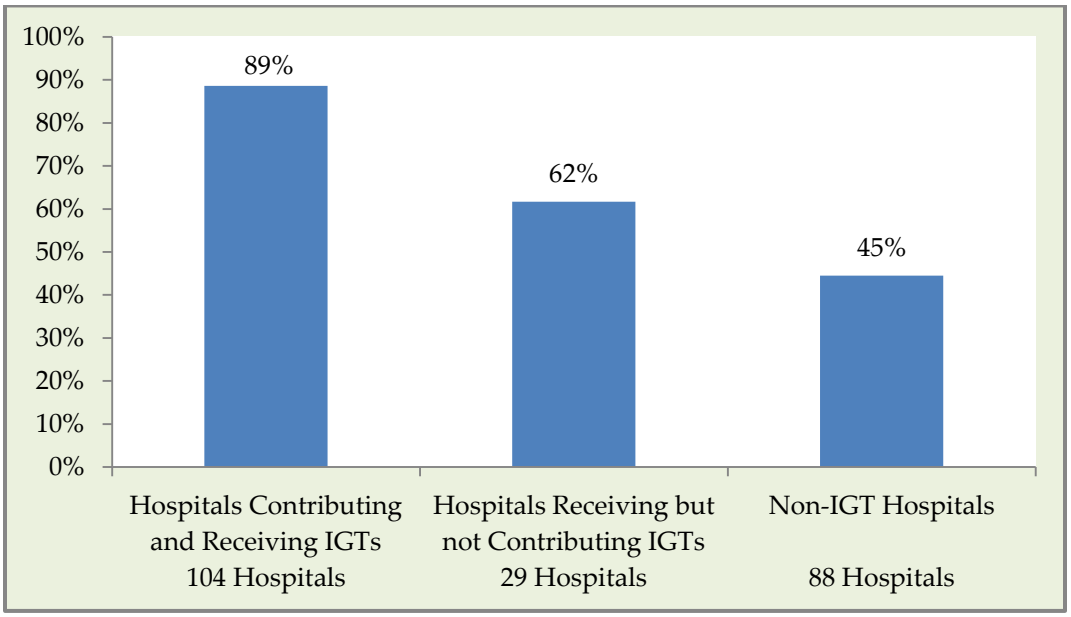
Method Number	Description	Included in Payments	Included in Cost
		contributed to the Medicaid program through provider assessment fees and IGTs from total payments	

The results of the pay-to-cost calculations using the three methods and the various provider categories described above are discussed in detail in the following report sections.

5.6.3.3.1 Pay-to-Cost Ratios – Claim Payments and Costs Only

As shown in Figure 16, pay-to-cost ratios are significantly higher for hospitals that contribute IGTs, less for hospitals that receive but do not contribute IGTs and lowest for hospitals that neither contribute nor receive IGTs. In Figure 16, claim payments and estimated costs are reflective of services provided for both fee-for-service and managed care programs. The overall average pay-to-cost ratio for hospitals in all categories combined is 79 percent.

Figure 16. Comparing average pay-to-cost ratios for hospitals based on IGT category – claim data only – IGTs and provider assessment payments and contributions excluded.



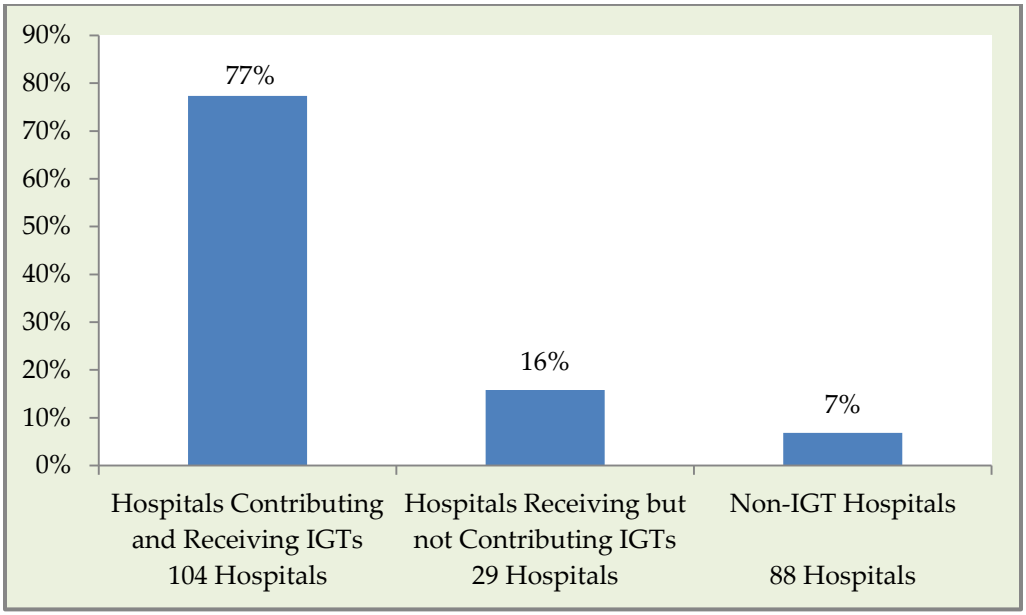
Notes for Figure 16:

1) Data is based on claim payments and cost from SFY 2012/13. Both fee-for-service and managed care program claims for hospital inpatient and outpatient services are included. LIP payments, DSH payments, and the cost of uncompensated care are not included.

2) Data is limited to in-state hospitals with at least one submitted claim in SFY 2012/13.

Although the 104 hospitals that contributed IGTs and received IGT payments in SFY 2012/13 comprise only 47 percent of the in-state hospitals, they account for 77 percent of the Medicaid business[77] in SFY 2012/13. Thus, payments are better for providers who do a significant amount of Medicaid business. This is consistent with the state's goal stated in the SFY 2005 1115 demonstration waiver, "The state will continue to foster and protect its safety net providers."[78] The percentage of total Medicaid business by these three hospital categories is shown in Figure 17.

Figure 17. Percentage of Medicaid business based on IGT category – claim data only – IGT and provider assessment payments and contributions excluded.



Notes for Figure 17:

1) Data is based on claim payments and cost from SFY 2012/13. Both fee-for-service and managed care claims for both hospital inpatient and outpatient services are included. LIP payments, DSH payments, and the cost of uncompensated care are not included.
2) Data is limited to in-state hospitals with at least one submitted claim in SFY 2012/13.

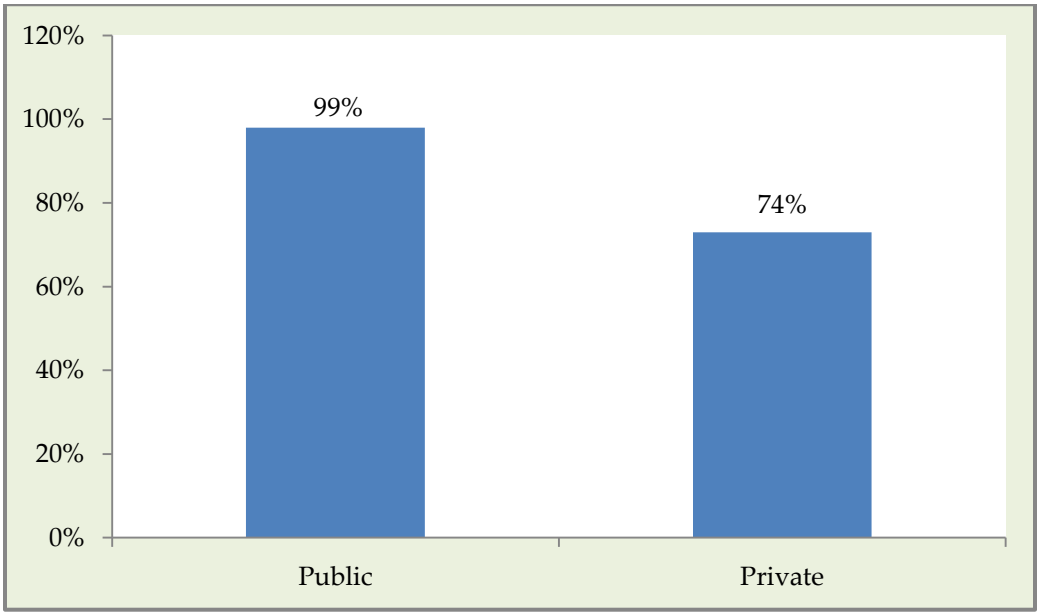
[77] Percentage of Medicaid business is determined using hospital cost.

[78] Florida Agency for Health Care Administration, *Application for 1115 Research and Demonstration Waiver*. (August 2005)

The 88 hospitals that do not contribute IGTs nor receive IGT funds account for only seven percent of the Medicaid business and are paid 45 percent of cost on average (see Figure 16 above). As long as the percentage of Medicaid patients at these hospitals is very low, they presumably can offset their losses from Medicaid reimbursement with payments for non-Medicaid patients. In contrast, hospitals with higher Medicaid utilization, either currently or in a scenario in which Medicaid expansion is implemented, would have difficulty maintaining margin with such a differential between cost and reimbursement.

When comparing public hospitals to private hospitals, the pay-to-cost ratio for the public hospitals is noticeably higher. This is shown in Figure 18 below. This calculation of pay-to-cost is similar to the upper payment limit analyses[79], except that managed care business is included in this version. Public hospitals in particular are paid reasonably well when considering only payments for services rendered to Medicaid recipients and when ignoring the contributions hospitals provide to fund the Medicaid program.

Figure 18. Comparing average pay-to-cost ratios for hospitals based on ownership status – claim data only – IGT and provider assessment payments and contributions excluded.



[79] Upper payment limit (UPL) analyses are performed annually by Medicaid agencies to ensure federal matching funds are not used to pay hospitals any more than they would be paid by Medicare for the same set of services. This analysis is performed broadly for three categories of hospitals, state-owned, non-state government owned, and privately owned hospitals. In addition, it is only performed for the Medicaid fee-for-service program, not the Medicaid managed care program.

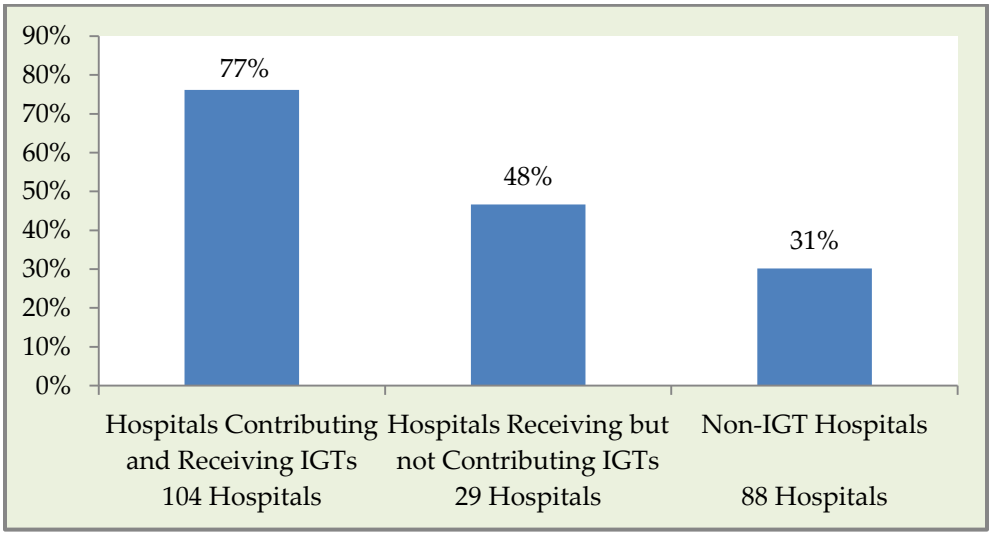
5.6.3.3.2 Pay-to-cost Ratios – All Payments – Assessment and IGTs Excluded from Net Revenue

The next two figures include consideration of not only Medicaid recipients, but also uncompensated care for the uninsured and underinsured. In these measurements of average pay-to-cost ratios, claim payments and supplemental payments from the LIP program and the DSH program are included. In addition, each hospital's cost of uncompensated care is included. This version is similar to the way DSH payment limit and Florida LIP payment limit calculations are performed, and provides a picture that includes both the Medicaid program and uncompensated care. However, hospitals would argue it is still not a complete picture as it does not account for hospital funds contributing to the state share through the provider assessment and through contribution of IGTs.

The resulting average pay-to-cost ratios are shown in Figure 19. For each category of hospitals, the ratio has decreased from the values shown in Figure 16. This is an indication that the LIP and DSH programs pay out less than total uncompensated care costs for each of these categories of hospitals. This finding is expected, as the LIP and DSH programs were never intended to cover all uncompensated care costs. In addition, DSH audits ensure federal Medicaid matching funds are not used to pay any individual hospital more than the cost of care for its Medicaid and uninsured patients.

Under this analysis, the overall average pay-to-cost for hospitals in all three categories combined is 66 percent.

Figure 19. Comparing average pay-to-cost ratios for hospitals based on IGT category – all payments and cost, including LIP, DSH and uncompensated care – IGT and provider assessment contributions excluded.

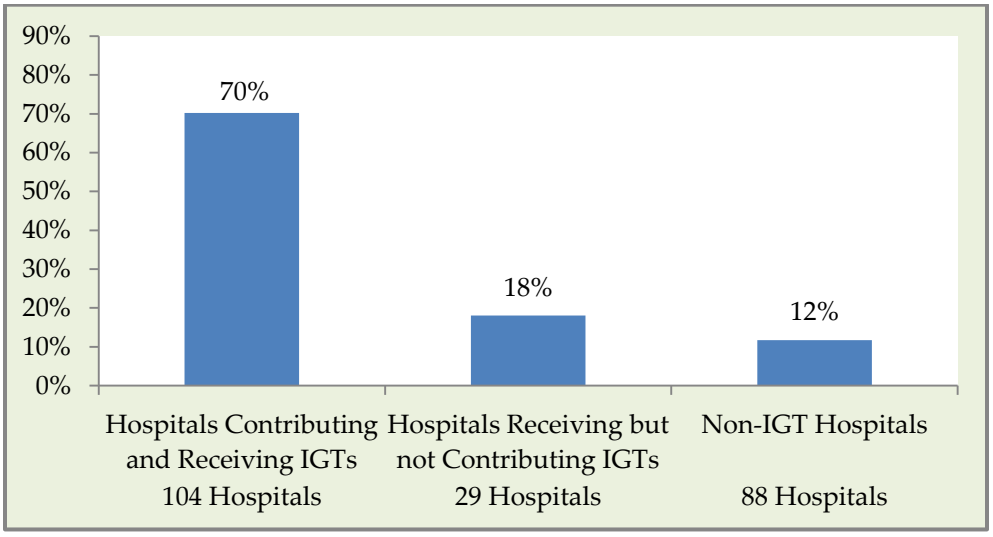


Notes for Figure 19:

1) Data is based on claim payments and cost from SFY 2012/13. Both fee-for-service and managed care program claims for hospital inpatient and outpatient services are included. In addition, LIP payments, DSH payments, and the cost of uncompensated care are included.
2) Data is limited to in-state hospitals with at least one submitted claim in SFY 2012/13.

When uncompensated care costs are included in the cost-based calculation of percentage of Medicaid and uncompensated care business across our three categories of hospitals, the numbers change slightly, but not significantly. Still a great majority of the Medicaid and uncompensated care business occurs at the hospitals that both contribute and receive IGTs, which is depicted in Figure 20 below.

Figure 20. Percentage of Medicaid business based on IGT category – all payments and cost, including LIP, DSH and uncompensated care – IGT and provider assessment contributions excluded.



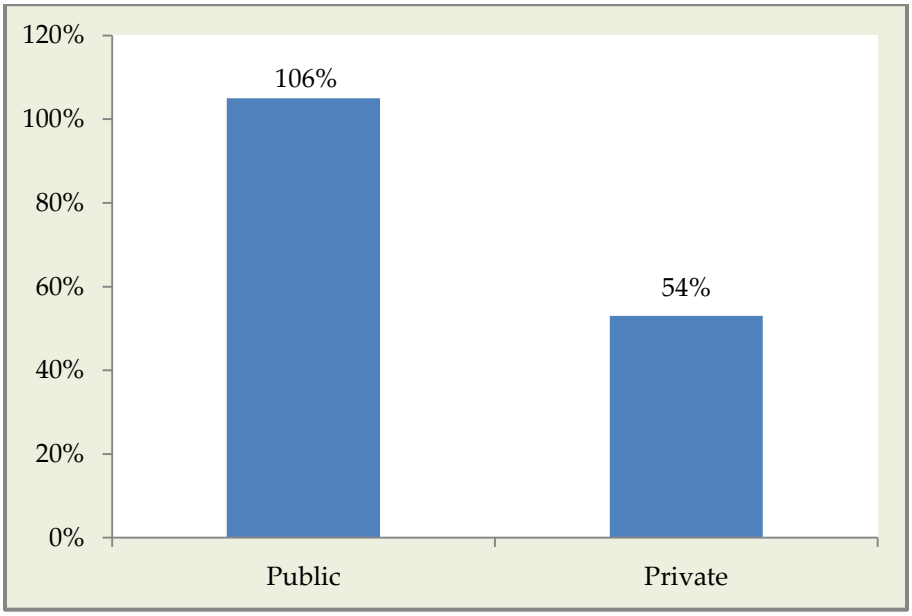
Notes for Figure 20:

3) Data is based on claim payments and cost from SFY 2012/13. Both fee-for-service and managed care program claims for hospital inpatient and outpatient services are included. In addition, LIP payments, DSH payments, and the cost of uncompensated care are included.
4) Data is limited to in-state hospitals with at least one submitted claim in SFY 2012/13.

When comparing public hospitals to private hospitals, the pay-to-cost ratio for the public hospitals is significantly higher. This is shown in Figure 21 below. Note that the pay-to-cost ratio for the public hospitals is over 100 percent. This suggests that some hospitals may have been paid above their DSH cost limit in SFY 2012/13. By our calculations, seven hospitals were

paid above their DSH cost limit by a total of approximately $115 million. However, our uncompensated care cost calculations use data reported on Medicare cost reports, not data reported in AHCA DSH cost limit reports. AHCA's calculations may vary from those presented in this document. Note also that our estimates of cost are made using aggregated CCRs. Had we applied a more detailed approach to estimating costs (for example, one that replicated the more detailed cost apportionment methodology used in filing a Medicare cost report), our results may have been different.

Figure 21. Comparing average pay-to-cost ratios for hospitals based on ownership status – all payments and cost, including LIP, DSH and uncompensated care – IGT and provider assessment contributions excluded.



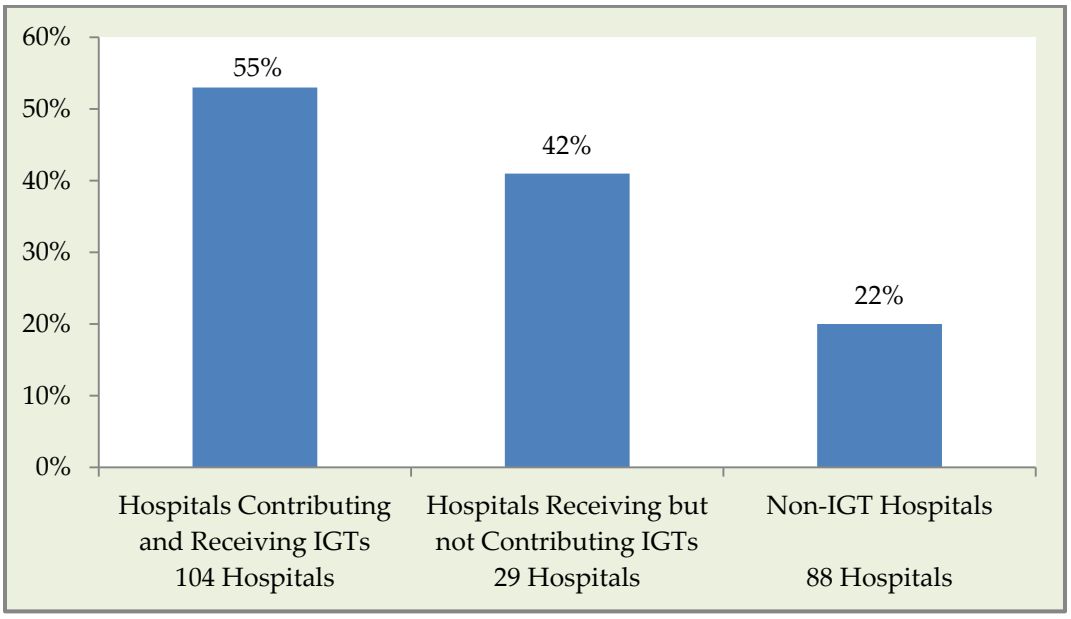
5.6.3.3.3 Pay-to-cost Ratios – All Payments – Including Assessment and IGTs

Our third review of pay-to-cost ratios includes net Medicaid payments, which are claim, LIP, and DSH payments reduced by contributions to help fund the state share of the Medicaid program borne by providers and other governmental agencies. In addition, similar to the second analysis, this third analysis includes all hospital costs including costs of care for Medicaid, uninsured, and underinsured recipients. Funding of the Medicaid program by providers and other governmental agencies is done through the provider assessment, which is referred to in Florida as the Public Medical Assistance Trust Fund (PMATF), and through IGTs. The PMATF is a mandated program and affects all providers in the state, while the contribution of IGTs is a voluntary process only available to publicly owned facilities and facilities able to make agreements with local governmental agencies.

The pay-to-cost ratios in this section demonstrate a more complete look at hospital payment and cost for Medicaid and uncompensated care in Florida. As stated in the MACPAC report to Congress dated March 2014, "… provider contributed financing, such as health care related taxes, has significant effects on the net amount of Medicaid payments that providers receive."[80] This report also concludes "without data on both health care related taxes and supplemental payments, it is not possible to meaningfully compare Medicaid payments across providers and states."[81]

Under this analysis, the overall average pay-to-cost for hospitals in all three categories combined is 49 percent.

Figure 22. Comparing average pay-to-cost ratios for hospitals based on IGT category – all payments and cost, including LIP, DSH and uncompensated care – IGT and provider assessment contributions subtracted from payments.



Notes for Figure 22:

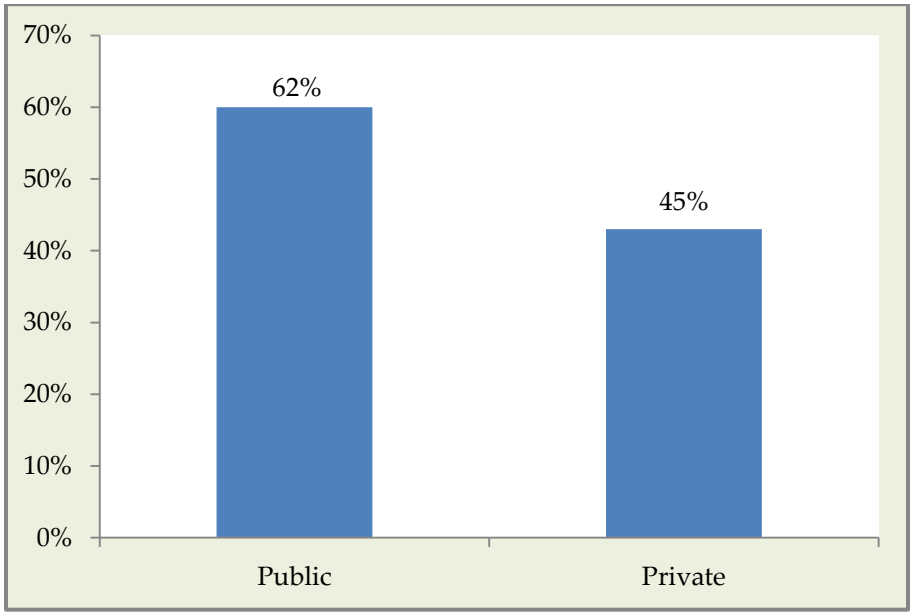
1) Data is based on claim payments and cost from SFY 2012/13. Both fee-for-service and managed care claims for both hospital inpatient and outpatient services are included. In addition, LIP payments, DSH payments, and the cost of uncompensated care are included.
2) Data is limited to in-state hospitals with at least one submitted claim in SFY 2012/13.

[80] Medicaid and CHIP Payment Access Commission (MACPAC), *Report to the Congress on Medicaid and CHIP*. (March 2014)

[81] Ibid.

[82]When comparing public hospitals to private hospitals, the pay-to-cost ratio for the public hospitals is still noticeably higher, which is shown in Figure 23 below. These numbers indicate public hospitals are compensated relatively higher than private hospitals even though the public hospitals bear the burden of contributing IGTs. Also in these results, pay-to-cost ratios are below 100 percent for both categories of hospitals. When including the provider assessment and IGT contributions as a reduction in net hospital reimbursement, payments are less than cost for nearly every hospital.

Figure 23. Comparing average pay-to-cost ratios for hospitals based on ownership status – all payments and cost, including LIP, DSH and uncompensated care – IGT and provider assessment contributions subtracted from payments.



5.6.4 Equity in Funding Across Medicaid Programs

Another way to measure equity in Medicaid funding is to look at the funding of other states' Medicaid programs, while comparing it to the extent Florida Medicaid is funded. As a system jointly funded by state and federal governments, Medicaid payments are largely dependent on the amount of funding the federal government contributes. For example, Florida spent $17.9 billion on Medicaid, with the federal government contributing over $10 billion or 56 percent of the total Medicaid spending amount, during Federal Fiscal Year (FFY) 2012.[83] This amount of

[82] In this section, a chart showing the percentage of Medicaid and uncompensated care by hospital category is not given because the only difference between this section and the previous one is inclusion of PMATF and IGT contributions as a reduction to hospital reimbursement. Neither PMATF nor IGT contributions are an indication of the volume of Medicaid and uncompensated care provided by a hospital.

[83] The Kaiser Family Foundation, *State Health Facts, Total Medicaid Spending.* Available at http://kff.org/medicaid/state-indicator/total-medicaid-spending/

funding is relatively low compared to other states considering the high number of Medicaid and uninsured beneficiaries in Florida. A major reason for Florida's lower funding for its Medicaid program is the small amount of federal funds allotted for its supplemental programs. Supplemental funding is an avenue many states use to draw down considerable federal funds to help reduce the Medicaid shortfall and cover the cost of uncompensated care. Florida Medicaid receives and distributes supplemental funds for uncompensated care through its DSH and LIP programs. When looking at other similarly-sized Medicaid programs, Florida's supplemental funding is rather low.

When examining the volume of uninsured individuals, Florida ranks 3rd among all states with 25 percent of its non-elderly population without health insurance, equating to approximately 3.8 million people.[84] While it may not necessarily be the State's obligation to fund health care services for the uninsured population, this high percentage should not be ignored. Uninsured patients present to hospitals, and in many instances, hospitals are legally obligated to provide care. This presents a financial burden on the hospitals that can affect the overall financial viability of the hospitals, which are critical to maintaining access to care for the Medicaid population. Health services provided to the combined Medicaid and uninsured populations in the State of Florida comprise 45 percent of those provided to all of the State's non-elderly residents. As one of the largest Medicaid programs in the country, responsible for paying for a large percentage of its population's health care, Florida requires a significant amount of funding to adequately pay providers for the care administered to Medicaid and uninsured patients.

With so many Florida residents dependent on the Medicaid system, adequate funding from the federal government is critical for providers to continue to have the ability to provide necessary care. Florida ranks 33rd among all states in regards to the percentage of federal funding it receives compared to the total amount spent on Medicaid.[85] The amount contributed by the federal government is largely dependent on the amount of the non-federal share the state is able to contribute to the program and on the state's individual Federal Medical Assistance Percentage (FMAP). The FMAP determines the federal government's share of the cost of covered services in state Medicaid programs and is calculated annually by assessing a state's average personal income relative to the national average. States with a lower average personal income have higher FMAPs. For FFY 2012, Florida's FMAP was 56 percent, which is lower than average for the 50 states. Section 1905(b) of the Social Security Act specifies the formula for calculating FMAPs as follows:

> "'Federal medical assistance percentage' for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and

[84] The Kaiser Family Foundation, *State Health Facts, Nonelderly Uninsured.* Available at http://kff.org/uninsured/state-indicator/rate-by-gender/

[85] The Kaiser Family Foundation, *State Health Facts, Total Medicaid Spending.* Available at http://kff.org/medicaid/state-indicator/total-medicaid-spending/

Hawaii; except that the federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum."

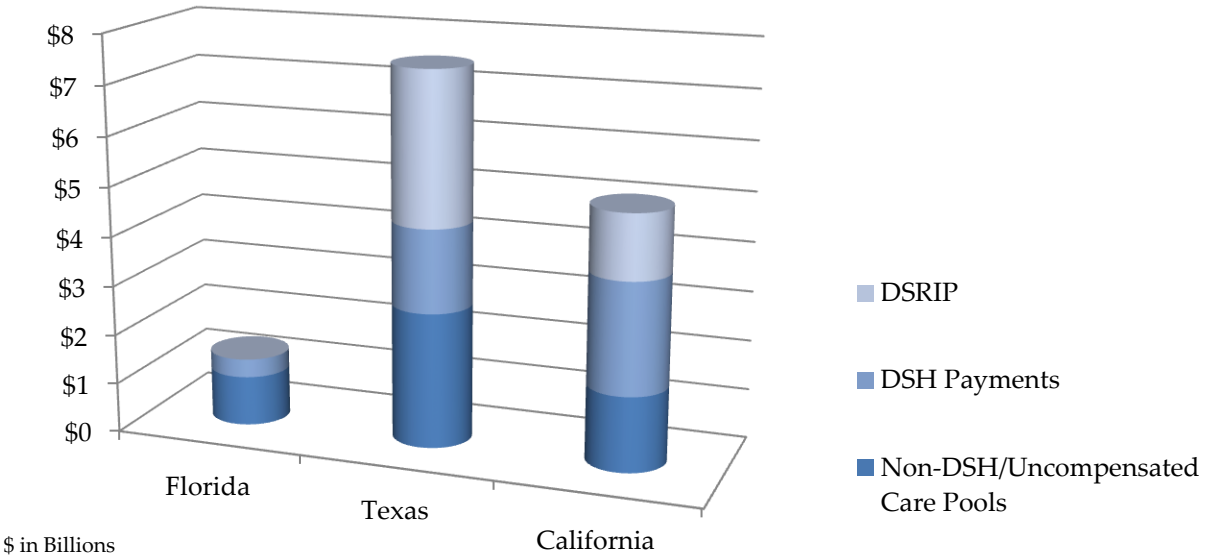
In addition to having a relatively low FMAP percentage, another reason for the comparatively low amount of federal funds contributed to Florida Medicaid is the discrepancy in funding for supplemental programs when comparing Florida with other similar states such as California and Texas. Florida receives funds for both DSH and non-DSH supplemental programs. DSH payments are a common way for states to provide supplemental funds to hospitals. States receive an annual DSH allotment to cover the costs of DSH hospitals that provide care to low-income patients that are not paid by other payers, such as Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or other health insurance. In FFY 2013, Florida was allotted a little over $200 million in federal dollars for its DSH program. This amount fails to compensate for the substantial size of Florida's uninsured population. Even with the addition of Florida's $1 billion LIP program, the funds available to reimburse hospitals for uncompensated care are less than the hospitals' costs.

In order to put this amount of supplemental funding into context, Florida can be compared to Medicaid programs of similar size, such as California and Texas. Each of these three states submitted a Medicaid Reform Section 1115 demonstration waiver that addressed supplemental funding during the post-ACA era. Each waiver affected hundreds of thousands of Medicaid beneficiaries, involved billions of federal dollars and was meant to provide better care, improve population health and reduce costs. However, there is a large disparity in the state and federal dollars that were allocated to achieve these goals. The average annual waiver pools and DSH funding for Florida, California, and Texas were $1.37 billion, $5.06 billion, and $7.48 billion, respectively.

A contributing factor to California and Texas receiving significantly more supplemental funding than Florida is their access to funds through their Delivery System Reform Incentive Payment (DSRIP) Programs. DSRIP is used to reward hospital systems for improving access to care and the health of the Medicaid and uninsured patients they serve.[86] California and Texas were both granted approval of DSRIP programs resulting in additional funding of $1.3 billion and $3.1 billion, respectively, amounting to a large portion of both states supplemental funds. In addition, Florida lags significantly behind in the amount of DSH funding it receives. The $200 million Florida receives in federal funds for DSH payments fail to compare to the $1.2 billion California receives and the $1.0 billion Texas receives. These numbers are depicted in Figure 24 below.

[86] Sellers Dorsey, *Review of Medicaid Reform 1115 Demonstration Waiver: Comparing California, Texas and Florida at the request of The Safety Net Hospital Alliance of Florida, (*February 12, 2012.)

Figure 24. Comparison of average annual DSH and waiver program funding for Florida, Texas, and California.

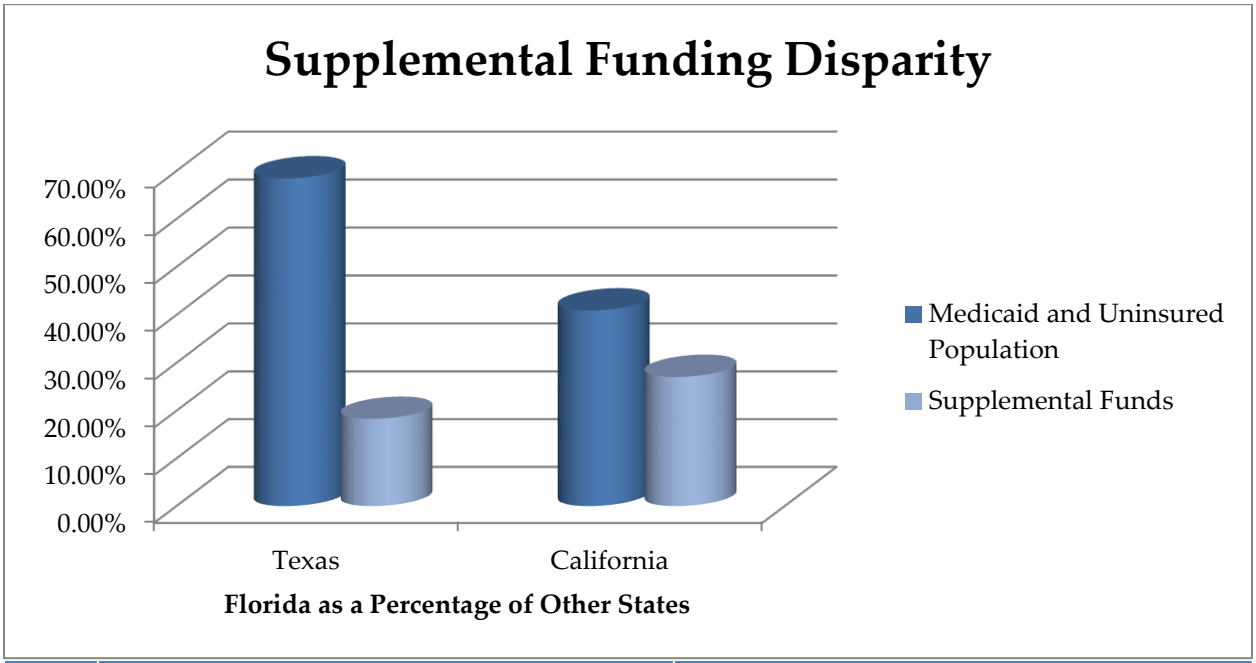


	Florida	Texas	California
DSRIP	$-	$3.08	$1.30
DSH Payments	$0.37	$1.68	$2.24
Non-DSH/Uncompensated Care Pools	$1.00	$2.72	$1.51

The numbers in Figure 24 reflect average annual supplemental funding outlined in each state's 1115 demonstration waiver[87]. While California and Texas have larger Medicaid programs, the amount of funding they receive for their supplemental programs is disproportionately higher than what Florida receives. When examining the size of the Medicaid and uninsured population, Florida's population is 69 percent the size of the equivalent population in Texas. However, the amount of supplemental funding Florida receives is only 18 percent of what Texas receives. The same disparity arises when comparing with California. Florida's Medicaid and uninsured population is 41 percent the size of California's, but Florida only receives 27 percent of the funding California receives. When considering the total population that Medicaid funding will cover, California and Texas are both receiving substantially more supplemental funding than Florida.

[87]Sellers Dorsey, *Review of Medicaid Reform 1115 Demonstration Waiver: Comparing California, Texas and Florida at the request of The Safety Net Hospital Alliance of Florida,* (February 12, 2012).

Figure 25. DSH and Waiver program funding disparity when comparing Florida to Texas and California.



State	Medicaid and Uninsured Population		Average Annual Supplemental Funds	
	Total	Florida as a % of Other State	Total	Florida as a % of Other State
Florida	7,537,088	-	$ 1,370,000,000	-
Texas	11,010,937	68.45%	$ 7,480,000,000	18.32%
California	18,421,211	40.92%	$ 5,060,000,000	27.08%

The combination of low federal assistance and high Medicaid and uncompensated care costs puts a strain on Florida to produce sufficient payments to hospitals to care for this population. This has resulted in lower payments to hospitals, as illustrated both by the pay-to-cost ratios documented in Sections 5.3 and 5.6 of this chapter and by Florida's low Medicaid-to-Medicare Fee Index. The Medicaid-to-Medicare fee index measures each state's physician fees relative to Medicare fees in each state. In 2012, Florida ranked 45th with a fee index of 0.57 with the national average at 0.66.[88] In addition, the lack of funding contributes to low Medicaid payments per enrollee. Florida spends on average $4,660[89] on each enrollee per year, over $1,000 less than the national average, ranking Florida 46th among Medicaid programs. Low Medicaid funding is directly related to this lack in provider payment adequacy.

[88] The Kaiser Family Foundation, *State Health Facts, Medicaid & Chip*, Available at http://kff.org/state-category/medicaid-chip/.

[89] The Kaiser Family Foundation, *Medicaid Spending Per Enrollee*, Available at http://kff.org/medicaid/state-indicator/medicaid-spending-per-enrollee/#, downloaded in January 2015 – Data is from FFY 2011, includes both state and federal funds, and does not include DSH payments.

When addressing equity in funding between Medicaid programs, the amount of federal funding allocated to each state is a major factor. Even though Florida is ranked 3rd in the amount of uninsured individuals and has an additional 20 percent of its population covered by Medicaid, it receives a federal assistance percentage that is less than the national average. This results in lower payments to providers and potentially less access to care for Medicaid recipients. In addition, Florida is receiving substantially less in supplemental funding than states of similar size, as other states have taken advantage of additional opportunities to pull down federal funds. Florida's Medicaid program is not funded to the level that programs of similar size across the nation are, resulting in below average payments to providers throughout the state.

5.7 Conclusion

Given the size of the Medicaid program and the amount of uninsured in the State of Florida, there is room to provide greater compensation to hospitals while staying within CMS's standard limit of paying no more than hospital cost. Increasing funding for the program to enable greater compensation will require agreement from AHCA, the Florida Legislature, the Florida hospital community, and CMS. AHCA, the Florida Legislature, and the Florida hospital community would need to develop methods for increasing the state share of funds contributing to the Medicaid program. CMS would need to agree that the spending of federal matching funds remains within federal guidelines. Finding options all parties can agree to will be no easy task.

Even maintaining current funding levels within the program will require effort. The current method has inherit inequities based on hospitals' access to IGTs. The method also relies on a significant amount of supplemental payments, which are traditionally considered unacceptable by CMS for services delivered under Medicaid managed care models, and Florida Medicaid recently shifted most of the beneficiaries into Medicaid managed care. In addition, the method relies, to a relatively small degree, on DSH payments which the federal government is planning to decrease as part of the Patient Protection and Affordable Care Act (PPACA).

6 Medicaid Expansion

6.1 Introduction

CMS's specifications for this study of hospital funding and payment made two specific references to Medicaid expansion. These references are shown below:

> "The report must also include an analysis of how future changes in Medicaid, including possible Medicaid expansion would affect Medicaid payment amounts and structure, including fee-for-service payments, managed care, and LIP.
>
> Finally, the report must recommend reforms to the Florida Medicaid financing system that can allow the state, beginning in state fiscal year 2015-2016, to move toward Medicaid fee-for-service and managed care payments to providers that ensure access and quality of care for Medicaid beneficiaries without the need for LIP funds. These payments should be based on a rationalized, non-facility specific payment mechanism, which can be applicable to future changes in Medicaid including Medicaid expansion."[90]

Because of these specifications, we have included in this study a discussion of the potential for Medicaid expansion. For a variety of reasons, we do believe Medicaid expansion is an option worthy of consideration by the State of Florida. Expansion would increase the number of Florida residents with medical insurance, bring a significant amount of federal funds into the state, and help offset planned reductions in DSH payments and Medicare fee-for-service payments to hospitals. Of course, all of these benefits would only be achieved with some additional cost to the State. After 2016, Florida would need to find a way to increase its state share of funding for the Medicaid program.

We do not, however, believe that a decision to expand Medicaid in Florida would be sufficient as a full replacement of the LIP program. The LIP program funds some of the gap between Medicaid payments and the Medicare Upper Payment Limit (UPL). This has been true throughout the life of the LIP program, and is particularly true in SFY 2014/15 in which self-funded IGTs have been moved into LIP. In addition in SFY 2014/15 the LIP program contains supplemental payments to teaching physicians that would not get replaced by expanding Medicaid. In the SFY 2014/15 LIP program, self-funded IGTs were estimated to equal $963 million (total computable) and supplemental payments to teaching physicians were estimated to equal $204 million (total computable).

In terms of the traditional $1 billion LIP program (total computable), there is no distinction made in terms of what portion is used to fund the gap between Medicaid payments and the UPL versus the portion intended to help fund the costs of services provided to uninsured patients. From its inception in SFY 2006/07 through SFY 2010/11, the $1 billion LIP program

[90] Centers for Medicare and Medicaid Services, *Special Terms and Conditions for Florida Medicaid Reform Section 1115 Demonstration*, Document number 11-W-00206/4, STC number 69. (June 2014)

primarily funded the gap between Medicaid reimbursements and the UPL. (This statement assumes payments from the LIP program are applied first to the UPL gap and secondly to uncompensated care.) In SFY 2011/12, the Florida Legislature authorized the use of self-funded IGTs to all hospitals who could contribute IGTs, and the amount of money distributed by the State from self-funded IGTs increased by 370 percent in two years.[91] Thus, in more recent years, the gap between Medicaid payment and the UPL has been relatively well covered by self-funded IGTs for those hospitals who are able to contribute self-funded IGTs. For example, when looking at the UPL calculations for SFY 2013/14, which was the last year Florida Medicaid was primarily a fee-for-service program, the Non-State, Government Owned hospital category had a UPL gap of only $18 million, whereas the Privately Owned hospital category had a UPL gap of $480 million. Although no formal distinction is made, one might imply from these numbers that payments from the traditional $1 billion LIP program to Non-State, Government Owned hospitals primarily contribute to those hospitals' costs of caring for the uninsured. Payments from the traditional $1 billion LIP program to Privately Owned hospitals primarily contribute to the gap between Medicaid reimbursement and the UPL. (Again, this statement assumes payments from the LIP program are applied first to the UPL gap and secondly to uncompensated care.)

6.2 Background on Medicaid Expansion

One of Congress' goals in enacting the Patient Protection and Affordable Care Act ("ACA") was to reduce the number of uninsured Americans by expanding access to affordable health insurance coverage. Congress sought to achieve this goal through a variety of means, including expansion of eligibility for Medicaid benefits. The ACA's Medicaid expansion originally required that, beginning in 2014, states cover nearly all people under age 65, who are not entitled to Medicare, not described in an existing mandatory Medicaid coverage group, and who have incomes at or below 138[92] percent of the Federal poverty level (FPL).

In June 2012, the U.S. Supreme Court ruled as unconstitutional, the provisions of the ACA denying federal matching funds to states that refuse to extend Medicaid eligibility to 138 percent of the FPL. The challenge to the ACA's Medicaid expansion raised questions about the proper balance of power between the federal government and the states. The court ruled that Medicaid expansion is unconstitutionally coercive of states because states lacked adequate notice to voluntarily consent and the secretary could withhold all existing Medicaid funds. Chief Justice Roberts along with Justices Breyer and Kagan emphasized that states, as independent sovereigns, must have a "genuine choice" about whether to accept offers of federal funds that have conditions attached.[93] As a result, Florida and other states now have the opportunity to compare the costs and benefits of expanding Medicaid eligibility.

[91] $247 million was distributed in SFY 2010/11 and $912 million was distributed in SFY 2012/13.

[92] 138 percent of FPL represents the maximum gross income level for Medicaid eligibility as defined in the PPACA. However, in determining "net income" 5 FPL percentage points are subtracted from household income. Accordingly, the net or nominal income threshold for expanded Medicaid is 133 percent of the FPL.

[93] National Center for Policy Analysis, *An Economic and Policy Analysis of Florida Medicaid Expansion*, (March, 2013).

States that do not expand Medicaid receive their regular FMAP (around 59 percent for Florida) for new enrollment of recipients eligible for Medicaid. In addition, federal subsidies are offered to families with incomes between 100 percent and 400 percent of the FPL to help them purchase commercial insurance coverage through a Health Insurance Exchange (which is now referred to as the "Marketplace"). In contrast, for states that do expand their Medicaid program, federal subsidies are offered to families with incomes between 138 percent and 400 percent of the FPL to help them purchase commercial insurance coverage through the Marketplace. Also in expanding states, Medicaid coverage is offered to all families up to 138 percent of the FPL. For recipients receiving Medicaid coverage under the expanded eligibility rules, states will receive 100 percent federal matching for costs in 2014 through 2016. Between 2017 and 2020, the federal matching percentage gradually decreases down to 90 percent and continues at 90 percent thereafter.[94] There are two exceptions where states who had waiver programs covering childless adults for FPL percentages up to or over 100 percent prior to enactment of the ACA may receive the new, higher FMAP for these recipients. However, we do not believe these exceptions apply to any existing programs within Florida Medicaid.

The decision whether or not to expand Medicaid is of particular concern to hospitals because the ACA can affect both payment increases and reductions for hospitals. The ACA offers increases in hospital revenue through expanded Medicaid eligibility and new subsidies to help low and moderate income households buy coverage through health insurance exchanges. Accompanying this are planned reductions in Medicaid and Medicare DSH funding as well as a reduction on Medicare hospital fee-for-service payments through reductions or removals of planned future increases.[95]

6.3 Florida's Current Stance on Medicaid Expansion

As of December 1, 2014, 28 states and the District of Columbia have opted to expand Medicaid in their state, allowing more than 10.5 million low-income Americans to now have access to health coverage. The remaining 22 states, including Florida, have refrained from expanding Medicaid. In 2012, Gov. Rick Scott spoke publicly against the idea of Medicaid expansion in the State of Florida. Since then his stance on the topic has evolved and more recent comments have been guardedly in favor of some form of Medicaid expansion for Florida. In February of 2014 in a public statement, Scott indicated he is in favor of Medicaid expansion in Florida:

> "To be clear - our options are either having Floridians pay to fund this program in other states while denying health care to our citizens – or – using federal funding to help some of the poorest in our state with the Medicaid program as we explore other health care reforms... We will support a three-year expansion of our Medicaid program under the

[94] Kaiser Family Foundation, *A Guide to the Supreme Court's Decision on the ACA's Medicaid Expansion,* (August, 2012).

[95] Urban Institute, *The Financial Benefit to Hospitals from State Expansion of Medicaid,* (March, 2013).

new health care law, as long as the federal government meets their commitment to pay 100 percent of the cost during this time."[96]

However, Gov. Scott does not have unilateral authority to implement Medicaid expansion in Florida. A decision to expand Medicaid and the method in which expansion would be implemented must be approved by the Florida State Legislature. This topic was discussed by the Florida State Legislature in both the 2013 and 2014 sessions, and in both sessions, the Legislature voted against expanding Medicaid.

6.4 Proposed Medicaid Expansion Outcomes

There are many different views on Medicaid expansion and its effects on each state from both a financial and health outcomes perspective. Outlined below are important issues at the heart of the decision to implement Medicaid expansion.

In a July 2014 report from the White House, The Council of Economic Advisers (CEA) summarized the negative consequences of states deciding to forego Medicaid expansion. Prior to the CEA report, the National Center for Policy Analysis (NCPA) published a report in March of 2013 that expressed the negative repercussions for the state of Florida *if* they were to expand Medicaid. An examination of these differing viewpoints allows for a more thorough understanding of the issues at hand for this important policy decision.

6.4.1 Access to and Use of Medical Care

Improving access to care for low income populations was one of the pillars of the ACA. According to the CEA, Medicaid expansion would provide a great opportunity to accomplish this. The CEA used the Oregon Health Insurance Experiment (OHIE) as a comparison to what is expected to happen under Medicaid expansion. The OHIE arose from Oregon's decision in 2008 to reopen enrollment under an earlier Medicaid expansion that had extended coverage to uninsured adults under 100 percent of the FPL. However, the state could not accommodate all interested applicants and decided to allocate the opportunity to enroll in Medicaid by lottery. By comparing those who were awarded coverage under Medicaid to those who lost the lottery, it is possible to isolate the causal effect of having or not having Medicaid coverage. Citing the OHIE results, the CEA expects access to care will dramatically improve for Medicaid patients under proposed Medicaid expansion. During the OHIE, Medicaid coverage increased the probability that individuals reported receiving all needed medical care over the prior 12 months by 11.4 percentage points. Forecasting this increase in access to care to Florida's population, the CEA believes if Medicaid is fully expanded as originally proposed in the ACA, there will be an additional 201,000 Floridians with a usual source of clinic care (ex. primary care physician). In addition, the CEA projects there will be an additional 2,290,000 physician visits per year. The CEA cites an additional observation from the OHIE, an increase in preventative care. The CEA projects that if Florida expands Medicaid, the amount of cholesterol-level screenings,

[96] Rick Scott, "*We Must Protect the Uninsured and Florida Taxpayers with Limited Medicaid Expansion*," PolitiFact Florida (February 25, 2014).

mammograms, and papanicolaou tests per year will increase by 123,600; 35,300; 52,200 respectively.[97] The CEA considers Medicaid expansion for Florida a huge step in the right direction towards improving access and use of care.

The NCPA, on the other hand, believes that the increase in the access to coverage for newly insured Medicaid patients is overstated. Nationally, according to the NCPA, slightly less than one-third of physicians will not accept new Medicaid patients. Physicians are four times more likely to turn away new Medicaid patients than those with no insurance (31 percent versus 8 percent). This practice is especially true of doctors in larger cities or in small practices. More than one-third of primary care physicians do not accept new Medicaid patients.[98]

The NCPA presents similar percentages of physicians unwilling to accept Medicaid patients in the State of Florida. However, their surveys and calculations were performed prior to Florida Medicaid's state-wide rollout of mandatory managed care in 2014 that includes much stricter requirements on the managed care plans to develop provider networks. In addition, the NCPA's percentages were based on a survey where Medicaid had not been expanded. These percentages might be different if a much larger proportion of the population were Medicaid eligible.

NCPA also suggests the increase in Medicaid patients will have a substantial impact on ER use. The National Center for Health Statistics (NCHS) found Emergency Room use is closely associated with Medicaid enrollment. For instance, the agency found that nearly one-third of Medicaid enrollees used the ER at least once during a 12-month period. Individuals with private health coverage were only about half as likely as Medicaid enrollees to visit an ER. Furthermore, Medicaid enrollees are three times as likely (15 percent vs. 5 percent) as the privately insured, and twice as likely as the uninsured (15 percent vs. 7 percent), to have visited an ER twice in the previous year.[99] While the expansion of Medicaid in Florida would improve likelihood of gaining access to primary/preventative care for new enrollees, it must be realized that doctors still have to decide to accept or deny new patients and there could be unintended consequences, such as increased ER use.

6.4.2 Health Outcomes

As one of the components of CMS' triple aim, better health for the population is an area that the CEA believes Medicaid expansion can address. The CEA states the OHIE provides clear evidence that individuals receiving Medicaid coverage perceived themselves to be in better health. In results through approximately two years of follow-up, Medicaid coverage increased

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[97] The Council of Economic Advisers, *Missed Opportunities: The Consequences of State Decisions Not to Expand Medicaid.* (July, 2014)

[98] National Center for Policy Analysis, *An Economic and Policy Analysis of Florida Medicaid Expansion*. (March, 2013). Available at: http://www.ncpa.org/pub/st347

[99] Tamyra Carroll Garcia, Amy B. Bernstein, and Mary Ann Bush, National Center for Health Statistics, "*Emergency Department Visitors and Visits: Who Used the Emergency Room in 2007?*", NCHS Data Brief No. 38, (May 2010). Available at http://www.cdc.gov/nchs/data/databriefs/db38.pdf.

the share of individuals reporting that their health had remained the same or improved over the prior year by 7.8 percentage points. In earlier results through slightly more than one year of follow-up, Medicaid also increased the probability that an individual reported that his or her health was good, very good, or excellent by 13.3 percentage points. The CEA believes Medicaid expansion will create an additional 113,000 Floridians that will report having "Good, Very Good, or Excellent Health" and reduce the number of patients reporting having depression by 68,000.

The NCPA is more skeptical about the added health benefit that being enrolled in Medicaid has, as they indicate that various academic papers have found that Medicaid enrollees sometimes fare worse than patients with private insurance and often worse than patients with no insurance. For example:

- Post-surgical patients enrolled in Medicaid are almost twice as likely to die as privately-insured individuals and about 12 percent more likely to die than the uninsured, according to a University of Virginia study.[100]

- Florida Medicaid enrollees were nearly one-third (31 percent) more likely to be diagnosed with late-stage breast cancer and 81 percent more likely to be diagnosed with melanoma at a late stage. Medicaid patients did outperform the uninsured on late-stage colon cancer.[101]

- Patients in children's hospitals that rely heavily on Medicaid payments have more adverse events than those in hospitals caring for predominately privately insured patients.[102]

Again, it should be noted that these results are in the absence of a Medicaid expansion in Florida, and the results might be different if the uninsured were in fact transitioned to Medicaid. In any case, these results should not imply that being Medicaid eligible would somehow "cause" poorer health care outcomes, so long as appropriate standards of care are applied. In other words, we do not believe it is reasonable to conclude that an uninsured patient's health outcomes would somehow be compromised by providing them with some form of insurance.

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[100] Damien J. LaPar et al., "*Primary Payer Status Affects Mortality for Major Surgical Operations*," presentation to the 130th Annual Meeting of the American Surgical Association, 130th Annual Meeting Abstracts, (April 2010). Available at http://www.americansurgical.info/abstracts/2010/18.cgi.

[101] Richard G. Roetzheim et al., Journal of the National Cancer Institute, "*Effects of Health Insurance and Race on Early Detection of Cancer*," (August 18, 1999) Available at http://jnci.oxfordjournals.org/cgi/content/full/91/16/1409?ijkey=3894238ad956b166ab570c56f9648d625979f6d.

[102] Richard B. Smith et al., Health Services Research, "*Medicaid, Hospital Financial Stress, and the Incidence of Adverse Medical Events for Children*," Vol. 47, No 4, (August 2012) Available at http://www.hsr.org/hsr/abstract.jsp?aid=47903270811.

6.4.3 Impact on Providers

Uncompensated care creates a large financial strain on many providers, especially those identified as safety-net hospitals. Researchers at the Urban Institute have estimated that, if all States expanded Medicaid, reductions in uncompensated care currently financed by State governments would more than offset any additional Medicaid costs, generating $10 billion in savings over ten years for all States, while also producing savings for providers at the same time.[103] Our high-level analysis of the Florida Medicaid program suggests some savings would be available, but without further detailed study it is unclear if the savings would be enough to offset all of the additional costs to the state when the FMAP for the expansion population reaches 90 percent.

Also, the increase in Medicaid patients may not always translate into an increase in benefits provided. The NCPA points out that Florida's physician supply is relatively inelastic and cannot increase quickly to accommodate rising demand for medical services. More than 85 percent of Florida physicians have already reached middle age, and many will retire in the coming years. Florida physicians have little if any excess capacity to treat additional Medicaid patients. Half of Florida's doctors already see more than 75 patients per week; nearly one-third (30.1 percent) see more than 100 patients each week. Florida physicians have little if any capacity to expand the number of patients they treat and it is an already bad situation for Florida doctors struggling to keep their office doors open to Medicaid patients. While decreasing the amount of uncompensated care costs, the increase in Medicaid patients may create additional problems for Florida to consider.[104]

6.4.4 Financial/Economic Implications

One of the biggest proposed benefits of Medicaid expansion is the financial stability it gives to newly insured Floridians. The CEA describes that in the OHIE, Medicaid coverage nearly eliminated the risk of facing catastrophic out-of-pocket medical costs. Specifically, being enrolled in Medicaid reduced the probability of experiencing such an outcome by 4.5 percentage points, relative to a baseline risk of 5.5 percent in the uninsured group (catastrophic costs were defined as out-of-pocket spending in excess of 30 percent of household income).

"By expanding Medicaid, states can pull billions in additional Federal funding into their economies every year, with no state contribution until FFY 2017 and only a relatively modest one thereafter for coverage for newly eligible people. If the 24 States that have not yet expanded Medicaid had done so as of January 1, 2014, those states and their citizens would

[103] Kaiser Commission on Medicaid and the Uninsured, Holahan, John, Matthew Buettgens, Stan Dorn, "*The Cost of Not Expanding Medicaid*," (2013).

[104] National Center for Policy Analysis, *An Economic and Policy Analysis of Florida Medicaid Expansion*, (March, 2013). Available at: http://www.ncpa.org/pub/st347

have received an additional $88 billion in Federal support through calendar year 2016."[105] Florida would take over $15 billion of that share.

By pumping more Federal dollars into their economies, states' decisions to expand Medicaid creates jobs. The CEA projects there could be 63,800 additional jobs in Florida by 2017, due to the expansion.

However, the NCPA is worried the federal government won't be able to sustain the amount of funding they are promising to states. Federal and state governments spent $389 billion on Medicaid in 2010. Medicaid is the largest expense in most state budgets — and it is growing at unsustainable rates. For instance:

- State Medicaid spending was only $84 billion in 2000.
- State Medicaid spending is projected to quadruple to $357 billion by 2020 — less than a decade from now.
- Federal spending on Medicaid was about $250 billion in 2009.
- Federal spending is projected to more than double by 2020 to $574 billion.

Currently, the federal government pays 59.56 percent of Florida's Medicaid costs. Medicaid costs in Florida are likely to rise whether or not Florida expands Medicaid eligibility. Additional costs for the Medicaid expansion population could be higher than anticipated for many reasons. Over the past two decades, as Florida's population grew approximately 50 percent, the Medicaid caseload tripled and expenditures increased approximately 450 percent.

6.5 Enrollment and Cost Estimates for Medicaid Expansion in Florida

Estimating the effect of Medicaid expansion in a state in terms of enrollment and state cost is a difficult task. It requires applying a large number of assumptions, some of which may prove true while others may not. In our research, we have found two detailed estimates of the effect of Medicaid expansion on the State of Florida. One set of estimates was adopted by the Florida Social Services Estimating Conference (SSEC) and another was produced by the Urban Institute and documented in a number of articles distributed both by the Urban Institute and by the Kaiser Commission on Medicaid and the Uninsured. These estimates are summarized in Table 9 below:

[105] The Council of Economic Advisers, *Missed Opportunities: The Consequences of State Decisions Not to Expand Medicaid*, (July, 2014).

Table 9. Estimates of enrollment and cost increases from expansion of Medicaid in Florida.

Measure	Source	2016	2013 - 2022
New Medicaid Enrollees	Florida SSEC	870,480[3]	1,090,018[3]
	Urban Institute/KCMU[1,2]	1,080,000[4]	1,276,000[5]
Additional State Cost	Florida SSEC	$154.5 million[3]	$5.2 billion[3]
	Urban Institute/KCMU[1,2]	$87 million[6]	$5.4 billion[6]
Federal Matching Funds	Florida SSEC	$5.3 billion[3]	$60.7 billion[3]
	Urban Institute/KCMU[1,2]	$6.7 billion[7]	$66.1 billion[7]

Notes:

1) KCMU is an acronym for Kaiser Commission on Medicaid and the Uninsured.
2) Authors of the articles on this topic released by the Kaiser Commission on Medicaid and the Uninsured (KCMU) are researchers for the Urban Institute. We are assuming KCMU and the Urban Institute are sharing analyses.
3) Retrieved from a presentation from the Florida Social Services Estimating Conference (SSEC), available at http://edr.state.fl.us/Content/conferences/medicaid/FederalAffordableHealthCareActEstimates.pdf, March, 2013.
4) Retrieved from Kaiser Commission on Medicaid and the Uninsured, *The Cost of not Expanding Medicaid*, March, 2013, Table 1.
5) Retrieved from Kaiser Commission on Medicaid and the Uninsured, *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*, November, 2012, Table 9.
6) Retrieved from Kaiser Commission on Medicaid and the Uninsured, *The Cost of not Expanding Medicaid*, July, 2013, Table 4.
7) Retrieved from Kaiser Commission on Medicaid and the Uninsured, *The Cost of not Expanding Medicaid*, July, 2013, Table 3. Can also be found in Urban Institute, *What is the Result of States Not Expanding Medicaid*, August, 2014, pg. 1.

The Florida SSEC and Urban Institute estimates of expansion in Florida are somewhat similar, particularly considering they included significantly different assumptions. However, one assumption in common in these numbers is that they both include increases resulting from the "welcome mat" or "woodwork" effects, which are increases in Medicaid enrollment from recipients who were eligible for Medicaid prior to the ACA, but had not yet enrolled. There is an expectation that many of these people will enroll in Medicaid now that the ACA is in effect because of the ACA's health coverage mandate, availability of subsidies under the Marketplace, automatic routing of subsidy applications from exchanges to Medicaid programs, and streamlined enrollment procedures. The Urban Institute makes the argument that "most of the 'welcome mat' or 'woodwork' effect is likely to result from the ACA's other provisions, even without expansion."[106] Conceptually, this idea makes sense, although would be difficult to accurately quantify. The Florida SSEC's estimates include slightly fewer than 80,000 new recipients and an additional $385 million in state costs over the next ten years that are

[106] Urban Institute, *Medicaid Expansion Under the ACA: How States Analyze the Fiscal and Economic Trade-Offs*, (June 2013).

attributable to new enrollees who were previously eligible for Medicaid but had not enrolled. Thus, the estimates of additional state cost from Medicaid expansion shown in Table 9 above are likely to be slightly overstated.

6.6 Potential Savings and Offsetting Revenue Increases from Expansion

Some states are actually seeing a reduction in net cost to the state when they implemented Medicaid expansion. Most of these states had expanded their Medicaid programs prior to the enactment of the ACA through waivers or use of state funds. For these states, Medicaid expansion allowed them to increase the federal matching rate and in some cases, replace state-only programs with heavily federal-funded ACA expansion for recipients between 100 and 138 percent of the FPL.

Florida Medicaid does not have many programs in this category and is not likely going to see a net decrease in the state share of Medicaid costs through expansion. Even so, there are areas where Florida Medicaid's costs will be reduced through expansion as well as expectations that Medicaid expansion will increase state tax revenue. These financial benefits from Medicaid expansion were not included in the Florida SSEC's estimates of the cost of expansion. Thus, the estimated cost of expansion predicted by the Florida SSEC in March of 2013 is likely overstated. In this study, we did not attempt to re-estimate the cost of Medicaid expansion to the State of Florida based on our assumptions of benefits from expansion, which are detailed below.

6.6.1 Potential Reductions in State Cost from Expansion

There are two eligibility categories in which we believe Medicaid expansion would generate savings to the State as long as the expansion FMAP percentage remains higher than the standard Medicaid percentage. These two eligibility categories are medically needy (also known as spend-down) and disabled adults. Under expansion, medically needy adults with incomes at or below 138 percent of the FPL will qualify as newly eligible adults, without incurring any health care costs. Because they will not meet pre-ACA spend-down requirements, they will not fall within this pre-ACA eligibility category and so can receive FMAP reserved for newly eligible adults. Medicaid will pay all of covered medical costs for these recipients, rather than only the costs incurred after spend-down requirements are met. However, the savings to the State from the increased federal matching percentage is expected to more than compensate for costs of additional services being covered.[107]

Also for disabled adults there is potential for the state to benefit from the higher expansion FMAP for new recipients with incomes at or below 138 percent of the FPL. If expansion is implemented, low-income adults who would otherwise qualify for eligibility based on disability might select qualification based on income to avoid the lengthy process of disability

[107] Urban Institute, *Medicaid Expansion Under the ACA: How States Analyze the Fiscal and Economic Trade-Offs*, (June 2013).

determination. If eligibility is based on income instead of disability, the Medicaid agency may claim the higher expansion FMAP.[108]

In addition, an article from the Kaiser Commission on Medicaid and the Uninsured identifies several other potential scenarios in which a Medicaid agency might experience reductions in cost from implementation of expansion. We believe these other scenarios are less likely to apply within the Florida Medicaid program, but there is potential for these to apply:

> *Limited benefit Medicaid programs:* Beneficiaries who received less than full-scope Medicaid before the ACA can qualify for enhanced FMAP as newly eligible adults.
>
> *Pre-ACA coverage of poor adults:* States that, before the ACA, extended Medicaid to all poor adults, including childless adults, can receive special enhanced FMAP for the latter.
>
> *Breast and cervical cancer treatment:* Almost all state Medicaid programs cover women whom CDC-affiliated clinics have diagnosed to have breast or cervical cancer. If a state adopts the Medicaid expansion, these women could qualify as newly eligible adults, at higher FMAP levels.[109] (This scenario would be applicable to Florida if it can be categorized as a limited benefit program.)

6.6.2 Potential Increases in Revenue from Expansion

In addition to a few possible reductions in state cost based on expansion, there are also several areas of anticipated increases in state revenue. The Florida SSEC's estimates show increases in federal funds into the State reaching a sustained level of over $7 billion annually by SFY 2022/23. This significant increase in funds into the state economy will generate increases in state general revenue through sales taxes. In addition, the increased reimbursements to hospitals will result in greater revenue collected by the state through the hospital provider assessment.

Without more detailed analysis it is unknown whether or not the reductions in existing state share of Medicaid cost and increases in revenue through Medicaid expansion will fully offset the increases in the state share resulting from expanding the number of recipients covered by Medicaid. But these factors will certainly help defray new costs resulting from expansion.

6.7 Alternatives to Medicaid Expansion

While most states expanding Medicaid (24 of 28) chose to do so by implementing a State Plan Amendment (SPA), several states pursued alternative models to expansion through 1115 waivers[110]. The states that have chosen to expand and their method of expansion are shown in Figure 26.

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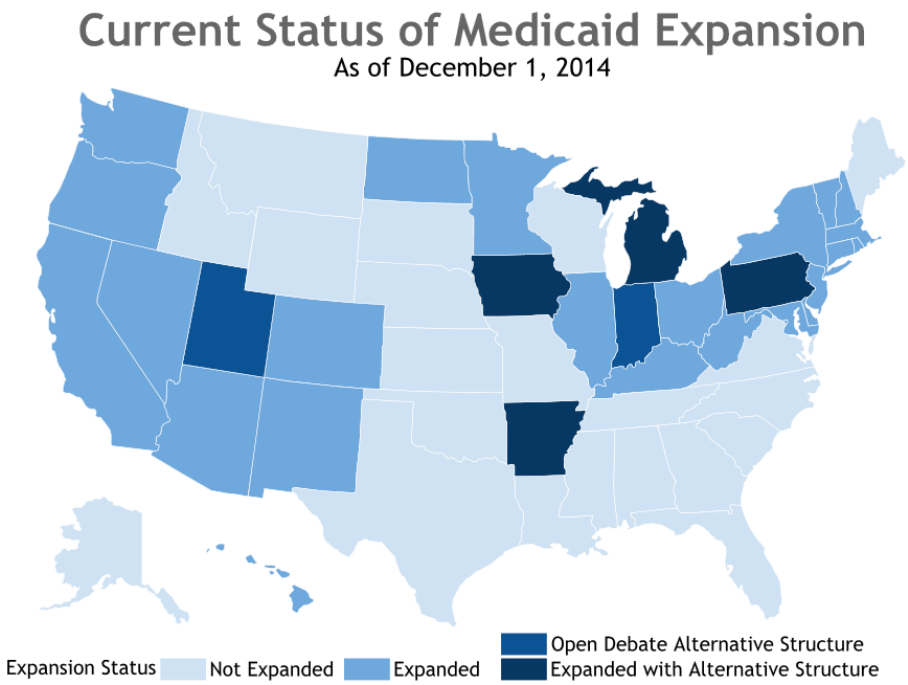
[108] Kaiser Commission on Medicaid and the Uninsured, *The Cost of not Expanding Medicaid*, (July, 2013).
[109] Kaiser Commission on Medicaid and the Uninsured, *The Cost of not Expanding Medicaid*, (July, 2013).
[110] Kaiser Commission on Medicaid and the Uninsured, *The ACA and Recent Section 1115 Medicaid Demonstration Waivers*, (November, 2014).

Figure 26. Map of states that have expanded Medicaid as of December 1, 2014.[111]



The four states with approved 1115 waivers are Arkansas, Iowa, Michigan and Pennsylvania. In addition, CMS is currently reviewing Indiana's waiver, while Utah and Tennessee are working toward alternative proposals. CMS approved Arkansas and Iowa utilizing premium assistance programs. These programs use Medicaid funds to purchase coverage in Marketplace Qualified Health Plans (QHPs) for all or some of the newly eligible beneficiaries (up to 138 percent FPL). Following Arkansas' and Iowa's approval, other states began developing similar approaches. Common themes among the alternatives include:

- Reliance on the private insurance market
- Exemptions from current Medicaid rules on cost-sharing, benefits, time limits and work requirements
- An emphasis on healthy behaviors and personal responsibility — in all states mandating premiums, the premiums will be eliminated or reduced for compliance with health behaviors[112]
- Limits or contingencies on the expansion, including ending the expansion program if the federal government reduces its enhanced matching rate[113]

[111] Source for State Map: http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/medicaid-expansion-state-map.pdf; downloaded 11/25/2014.
[112] Kaiser Commission on Medicaid and the Uninsured, *The ACA and Recent Section 1115 Medicaid Demonstration Waivers*, November, 2014.

"Under the premium assistance approach, states use Medicaid funds to purchase coverage for some or all newly eligible beneficiaries in Marketplace Qualified Health Plans (QHPs). States can implement premium assistance programs without a waiver, subject to certain rules. Arkansas and Iowa received waivers to allow them to mandatorily enroll beneficiaries in premium assistance. In Arkansas all newly eligible adults, including childless adults between 0-138% FPL and parents between 17-138% FPL, are enrolled in premium assistance. In Iowa, only newly eligible adults with incomes above 100% up to 138% FPL are enrolled in premium assistance."[114]

When using an 1115 waiver to expand Medicaid, additional options can be chosen as long as the options are deemed acceptable by CMS. CMS will want to ensure that waivers are used to "promote the objectives" of the Medicaid program and are budget neutral for the federal government. In the waivers, these states indicate they are using premium assistance to test how private coverage works for Medicaid beneficiaries and whether enrolling beneficiaries in Marketplace coverage will increase provider access and reduce churning between Medicaid and Marketplace coverage due to income fluctuations. How premium assistance affects continuity of care, the impact on access to benefits, how well wrap-around coverage will work, how states will exempt people who are medically frail from their demonstrations, what the impact of premiums and cost sharing will be, and whether the demonstrations will be cost effective are key issues to monitor and are included in the evaluation requirements of these waivers. The various options selected by the four states with currently approved waivers are shown in Table 10.

Table 10. Alternative breaks out provisions from these alternative models.

State	Premium Assistance Model	Member Premiums (101%-138% FPL)	Non-Emergency Medical Transportation (NEMT)	Voluntary work search program for Eligibility
Arkansas	Yes	No	In all years	No
Iowa	Yes	Yes ($10/month)	Cut in Year 1	No
Michigan	No	Yes (2% of Income)	In all Years	Yes
Pennsylvania	No	Yes (2% of Income)	Cut in Year 1	No

In the three states charging premiums to recipients, Iowa, Michigan, and Pennsylvania, "premiums will not be imposed immediately. Iowa waives premiums in the first year of its demonstration. Under Michigan's waiver, premiums were not to be imposed for at least six months after implementation of its expansion, and Pennsylvania's waiver calls for premiums beginning in year 2. All three states would also allow individuals to have premiums waived or

[113] Center for Health Care Strategies, Inc., *Alternative Medicaid Expansion Models: Exploring State Options,* (February, 2014).

[114] Kaiser Commission on Medicaid and the Uninsured, *The ACA and Recent Section 1115 Medicaid Demonstration Waivers*, (November, 2014).

reduced based on compliance with healthy behavior incentives. In Iowa, healthy behavior incentives in year 1 include completing a health risk assessment and obtaining a wellness examination. In addition, beneficiaries in Iowa have a 90 day grace period to pay past-due premiums in full before termination of Medicaid coverage, and the state must waive premiums for beneficiaries who self-attest to financial hardship in paying the premiums. The Michigan waiver terms and conditions specify that individuals may not lose coverage for failure to pay premiums (or other copayments). In Pennsylvania, there is a 90-day grace period before disenrollment for failure to pay premiums, and beneficiaries may re-enroll without a waiting period."[115], [116]

The post-ACA health care landscape makes the establishment of large-scale premium assistance programs a more affordable and realistic option for states for several reasons. First, state Medicaid programs have access to a significant influx of new funding: the federal government will pay 100 percent of the cost of expanding Medicaid between 2014 and 2016, and slowly reducing down to 90 percent thereafter. Second, the newly operational health insurance Marketplaces provide the infrastructure necessary to cover large numbers of beneficiaries in non-employer-based plans. The creation of Marketplaces are especially significant for states like Arkansas that lack a strong Medicaid managed care presence, as these states previously had no public or private plans available to cover Medicaid beneficiaries in a cohesive, organized fashion. Finally, Marketplace plans may cost less than many pre-ACA private options thanks to greater consumer purchasing power, more plan competition, and narrower networks.[117]

Each state must take into account all considerations, before deciding to pursue a premium assistance program approval from CMS. The anticipated benefits and downsides of expansion through premium assistance include:

- *Reduced Churn* – Research suggests that of the estimated 96 million Americans eligible to receive Medicaid or Marketplace subsidies during a given year, up to 29 million are likely to "churn" between coverage options, and seven million are likely to experience coverage shifts between Medicaid and Marketplace policies. Theoretically, if Medicaid-eligible individuals are enrolled in Marketplace QHPs instead of traditional Medicaid and their incomes rise above the Medicaid eligibility ceiling, they can stay in private coverage rather switch insurance plans and/or providers, resulting in better continuity of care. The states expanding through QHPs stated they will monitor this issue through their waiver.

[115] Kaiser Commission on Medicaid and the Uninsured, *The ACA and Recent Section 1115 Medicaid Demonstration Waivers*, (November, 2014).
[116] The Pennsylvania expansion is currently scheduled to go into effect on January 1, 2015, but the newly elected governor may opt to implement a straight-forward expansion via a state plan change instead of the waiver.
[117] Kaiser Commission on Medicaid and the Uninsured, *The ACA and Recent Section 1115 Medicaid Demonstration Waivers*, (November, 2014).

- *Better Access to Providers* – Individuals enrolled in private commercial plans may have better access to health care than traditional Medicaid beneficiaries, as more providers accept commercial insurance than Medicaid.

- *Higher Overall Cost* – Medicaid is almost always cheaper than private plans, so any proposal to cover individuals via private coverage instead of Medicaid should have a higher immediate price tag. In 2012, the Congressional Budget Office estimated that by 2022, the average person who enrolled in a marketplace plan instead of Medicaid would cost the federal government about $3,000 more ($9,000 vs. $6,000). Milliman estimated premium assistance programs to cost 20 percent to 40 percent more than traditional Medicaid programs, though the amount depends on a state's provider reimbursement rates.[118]

Premium assistance is not the only model states are pursuing to expand Medicaid. Michigan, for example, will enroll its expansion population in public plans, but plans to require beneficiaries to deposit money into health accounts to actively participate in paying for their care, similar to a model used by Indiana. It is also working to create incentives for healthier behaviors among beneficiaries.

6.8 Medicaid Expansion Conclusion

Because of the 2012 U.S. Supreme Court ruling, Florida is now in the position to make the best decision for the citizens of their own state, without any financial consequences from the Federal government. The State must carefully examine the possible advantages and repercussions from this important policy decision and determine the right course of action. Estimating the impact of Medicaid expansion in any state is not an exact science; a variety of assumptions must be made. With that said, by the Florida SSEC's estimates, Medicaid expansion would have a steady-state cost of just under $1 billion per year in additional non-federal funds when the FMAP drops to 90 percent. For that additional cost, Florida would receive approximately $7.8 billion in additional federal funds annually.[119] Of course, if the federal government drops the FMAP percentage below 90 percent, the costs of Medicaid expansion to the state of Florida would increase above this estimate.

Medicaid expansion would likely benefit hospitals in Florida, many of which are required to treat uninsured patients. In fact, some hospitals treat a significant number of uninsured patients, particularly in emergency departments. The ACA offers increases in hospital revenue through expanded Medicaid eligibility and new subsidies to help low and moderate income households buy coverage through health insurance exchanges. Accompanying this are planned

[118] Center for Health Care Strategies, Inc., *Alternative Medicaid Expansion Models: Exploring State Options,* (February, 2014).
[119] Retrieved from a presentation from the Florida Agency for Healthcare Administration (AHCA), available at http://edr.state.fl.us/Content/conferences/medicaid/FederalAffordableHealthCareActEstimates.pdf, (March, 2013).

reductions in Medicaid and Medicare DSH funding as well as a reduction on Medicare hospital fee-for-service payments through reductions or removals of planned future increases.[120]

Finally, if Medicaid expansion is to be implemented there may be options as to how it can be implemented. A standard implementation enrolls the uninsured below 138 percent of the FPL into Medicaid. In addition, CMS has approved a few other implementations, some of which include offering premium assistance to help low income individuals and families buy commercial insurance through the Marketplace. These premium assistance programs may include other stipulations such as healthy behavior incentives, flexible spending accounts, and other tools designed to increase recipient impact in the costs of health care.

The decision whether to pull down billions of dollars from the Federal government to extend coverage to potentially over a million people or to continue searching for alternative approaches to extend affordable coverage to the uninsured rather than expand Medicaid, the answer is not simple, and Florida must take into account the various advantages and disadvantages of all options.

[120] Urban Institute, *The Financial Benefit to Hospitals from State Expansion of Medicaid*. (March, 2013)

7 Delivery System Reform Incentive Payment Programs

7.1 Introduction

As stated previously, states that migrate from fee-for-service to managed care models have limited options for continuing to offer supplemental payments to providers. Although it should not be considered as a substitute for the LIP program, one option that has been approved in recent years is a Delivery System Reform Incentive Payment (DSRIP) program. DSRIP programs are available to states through an 1115 demonstration waiver to incentivize health delivery system transformation. DSRIP programs allow states to make incentive payments that are linked to performance-based incentive initiatives, or "projects," aimed at improving health care processes and clinical outcomes, or otherwise transforming health service delivery. Generally, progress on these projects is tracked and payments are adjusted based on providers' successes in meeting agreed-upon milestones. The overarching goal of state DSRIP initiatives is transformation of the Medicaid payment and delivery system in an effort to achieve measureable improvements in quality of care and overall population health.

DSRIP programs are not intended to be mechanisms to distribute funds to cover services provided to low income populations, as is the case with the current Florida LIP and DSH programs. At the same time, it may be an option for replacing the aggregate funding that is at risk in the event that LIP is discontinued. The key difference would be that incentive payments paid to providers under a DSRIP program would be dependent upon measured successes against predetermined measurable objectives specifically related to improving quality of care and overall population health, in support of the overall objectives of a Medicaid program. Establishing incentive payments around treating higher volumes of uninsured patients would not meet that criteria, nor would a provider's ability to fund the non-federal share of payments. Further, where Florida's LIP program focuses primarily on payments to hospitals, DSRIP programs are required to focus on health delivery system transformation, of which hospitals play only a part. The focus of a DSRIP program is much broader than that of a LIP or DSH program.

To date, all DSRIP programs have been approved as a component of a larger Medicaid 1115 demonstration waiver. CMS has approved several DSRIP programs that fall within a common framework, however allows flexibility for states to construct their own individual programs by accepting various unique design elements. As of September 2014, six states have approved DSRIP programs and several more states are in the process of applying for approval. The first DSRIP initiatives were approved and implemented in California and Texas in 2010 and 2011, followed by New Jersey, Kansas, and Massachusetts in 2012 and 2013 and most recently New York which was approved in 2014 and will be implemented in 2015.[121] Alabama, Illinois, and New Hampshire all are in various stages of developing DSRIP waivers. In addition, New

[121] Kaiser Commission on Medicaid and Uninsured, "*An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers,*" (October 2014).

Mexico, Oregon, and Florida (the LIP waiver) operate initiatives that share key elements of DSRIP waivers.

The amount of Medicaid funding available to support DSRIP initiatives varies considerably across states, and can be substantial. For example, California, New York and Texas each expect to make several billion dollars in payments (over $6 billion in California and New York and more than $11 billion in Texas) for their DSRIP initiatives over a five-year period (though the time period varies across states). Kansas, Massachusetts, and New Jersey have smaller DSRIP initiatives with less spending.

7.2 Background on 1115 Demonstration Waivers

Section 1115 Medicaid demonstration waivers provide states with an avenue to test new approaches in Medicaid that differ from federal program rules. These waivers are intended to allow for "experimental, pilot, or demonstration projects" that, in the view of the HHS Secretary, "promote the objectives" of the Medicaid program. Section 1115 demonstration waivers have historically been used for a variety of purposes, including expanding coverage to populations who were not otherwise eligible, changing benefits packages, and instituting delivery system reforms. There is long-standing policy that requires 1115 Waivers to be budget neutral for federal spending meaning the federal government will not spend more with the waiver than if the waiver were not in place. Setting waiver policies and budget neutrality typically involve significant negotiations between the states and the federal government.[122]

7.3 Key Components of DSRIP Programs

In general, DSRIP programs are designed to advance CMS's "Triple Aim" of improving the health of the population, enhancing the experience and outcomes of the patient and reducing the per capita cost of care. There is no official federal guidance regarding what qualifies as a DSRIP program; instead states review the most recently approved DSRIP programs to understand current CMS thinking and requirements. The health care environment varies from state to state and DSRIP is designed to transform the health care environment. As a result, implementation of several key design elements varies between states to best address health care needs in the specific state. Key design elements discussed in the following sections include, eligible providers, projects and organizations, and financing.

7.3.1 Eligible Providers

The number of providers receiving DSRIP funding varies across states. For example, all acute care hospitals in New Jersey are eligible, resulting in 63 providers participating and eligible to receive funds. In California, 21 designated public hospitals in 17 hospital systems are eligible, while 7 hospitals in Massachusetts and only 2 hospitals in Kansas can participate in DSRIP programs. DSRIP waivers in Texas and New York require that funds be used for a broader set

[122] The Kaiser Commission on Medicaid and the Uninsured, *An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers*, (October 2014).

of providers, and these states are using their DSRIP waivers to promote collaborative provider networks that consist of an anchor hospital, associated clinics, and other providers or entities. The Texas and New York DSRIP programs require providers to form partnerships and apply for DSRIP projects together. The two states differ slightly in this approach in that Texas takes a prescriptive approach by establishing 20 Regional Health Partnerships (RHPs) that interested providers may join. Each RHP is led by a public hospital or local governmental entity – such as a county or district hospital – that is responsible for funding the state match in partnership with regional health care providers. The larger provider network, however, can include community health centers, county health departments, and other non-hospital providers. New York allows the providers to establish their own partnerships based around a lead hospital, which is usually a public hospital that contributes the State's share of funding through an IGT. With both approaches, hospitals and other providers are challenged to connect beyond their walls to foster improved patient outcomes.

Specifically for hospitals, eligibility to participate in a DSRIP program generally requires meeting standards for serving a certain proportion of Medicaid and uninsured populations. In many states, hospitals with larger Medicaid/uninsured populations are eligible to receive higher funding allocations so that transformation is targeted to these populations. This is consistent with CMS' objective that DSRIP programs will help to transform health care for the entire population, and as such, targeting providers that serve a high number of Medicaid beneficiaries will serve to better measure the potential benefits of selected DSRIP projects. In addition, a state may require a hospital to contribute IGTs as a condition of receiving DSRIP funds, as is the case in California.

7.3.2 Projects and Organization

Each state's pre-approved projects are meant to drive overall health system transformation consistent with the CMS triple aim. In addition, states designing DSRIP programs are required by CMS to perform data analysis to identify areas of greatest need and develop projects to meet those needs. DSRIP projects primarily fall into four categories (although the terminology differs across states): process redesign, system redesign, clinical outcome improvements, and population health focused improvements. In general, DSRIP programs are set up to focus on achieving metrics and milestones in infrastructure and system redesign (more process oriented changes) in the earlier years of the waiver and then focus shifts toward reaching clinical and population health focused metrics and milestones (more outcome based measures) in the later years of the waiver. Innovative care models that are piloted, tested, and proved successful can be replicated across the state and potentially to other states.

7.3.2.1 Process and System Redesign Projects

Process improvement projects lay the foundation for delivery system transformation through investments in tools and human resources that will strengthen the ability of providers to serve populations and continuously improve services. System redesign projects focus on fostering new and innovative models of care delivery that expand access and improve quality.

For example, process improvement projects can focus on any of the following:

- Developing training for the primary care workforce
- Introducing telemedicine
- Implementing disease management or chronic care management registries/systems
- Enhancing interpretation services and culturally competent care (including the collection of accurate Race, Ethnicity and Language (REAL) data)[123]

Example system redesign projects include the following:

- Redesigning primary care models and expanding medical homes
- Establishing patient navigation programs
- Expanding chronic care management models and medication management programs
- Integrating physical and behavioral health care
- Creating integrated delivery systems[124]

The New York DSRIP Planning Protocol is the most recent protocol that was approved, so the program offers a window into CMS's current DSRIP strategy. Examples of New York's systems transformation projects include:

- Create a medical village using existing hospital infrastructure
- Develop co-located primary care services in the emergency department
- Create care transitions intervention for skilled nursing facility residents
- Develop community-based health navigation services

7.3.2.2 Clinical Care and Population Health Improvement Projects

Clinical care improvements and population health focused improvements are tied to measurable outcomes and metrics to address patient care and safety, and improvements in overall health. Some states specify areas for clinical and population health improvement, while others allow providers flexibility to determine the key areas for improvement. Generally, over the course of a state's DSRIP initiative, funding allocations for meeting milestones related to clinical care and population health receive higher levels of funding than process related improvements.

Example clinical care improvement metrics tracked under the California DSRIP program include the following:

- Rate of sepsis detection
- Effectiveness of stroke management techniques

[123] The Kaiser Commission on Medicaid and the Uninsured, *An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers*, (October 2014).
[124] Ibid.

- Prevention of Central Line-Associated Bloodstream Infection (CLABSI).

In addition to these standardized requirements, each participating hospital in California must also select and report on their progress in improving outcomes for high burden conditions such as HIV/AIDS and asthma.[125] Note, however, that California had the first approved DSRIP program. They are in the process of negotiating a waiver renewal that may include a redesign of their DSRIP program.

As another example, each DSRIP project in New Jersey has defined outcome measures that are similar across projects, such as:

- Reduced admissions
- Reduced emergency department visits
- Improvements in care processes
- Increases in patient satisfaction

Each project will have specific objectives which are primarily measured using nationally standardized metrics[126]. For example, specific metrics for the project to improve cardiac care by reducing 30-day readmissions requires reporting and progress on several NCQA measures, such as controlling high blood pressure and compliance with post-discharge appointments.[127]

In the New York DSRIP program, the clinical care and population health improvement projects include:

- Clinical Improvement Projects
  - Integrate primary care and behavioral health services
  - Develop evidence-based strategies for disease management in high risk populations
  - Expand asthma home-based self-management program
  - Increase support programs for maternal and child health (including high-risk pregnancies)

- Population-wide Projects: New York's Prevention Agenda
  - Prevent Substance Abuse and other Mental Emotional Behavioral Disorders
  - Increase access to high quality chronic disease preventive care and management
  - Increase early access to, and retention in, HIV care
  - Reduce premature births

[125] The Kaiser Commission on Medicaid and the Uninsured, *An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers*, (October 2014).
[126] Such metrics may be those established by entities such as the National Committee for Quality Assurance (NCQA), the American Medical Association (AMA) Primary Care Incentive Program (PCIP), the Joint Commission, the Agency for Healthcare Research and Quality (AHRQ), CMS, or the Health Resources and Services Administration (HRSA).
[127] The Kaiser Commission on Medicaid and the Uninsured, *An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers*, (October 2014).

7.3.2.3 Statewide DSRIP Metrics

CMS has not released specific guidance for states regarding requirements for DSRIP programs. However, more recent waiver approvals point to certain trends such as the need for more accountability and involvement of a broader set of providers. To that point, New York has a design feature that ties total DSRIP funding for the entire state to statewide performance. In addition to the metrics and milestones applicable to each Performing Provider System (PPS) project, New York must meet statewide performance goals and targets to obtain full DSRIP funding. Failure to achieve these goals and targets will result in the withholding of some DSRIP funds beginning in year three of the demonstration. We anticipate that CMS would require some form of statewide accountability in future DSRIP programs.

7.3.3 Financing

States remain obligated to pay for their share of the cost of DSRIP initiatives under Medicaid financing requirements. As such, they must identify a source of state dollars that can be used to "match" federal funding. The majority of states with DSRIP programs use IGTs to fund the state share. A few states use general revenue to draw down federal dollars or use a combination of IGTs and general revenue. To satisfy budget neutrality requirements, some states are redirecting federal Medicaid funds that they would have spent on supplemental payments to hospitals toward new delivery system reform payments. These supplemental payments can include DSH payments or UPL payments. In the case of Florida, funds currently going into the LIP program could be made available to fund a DSRIP program if the LIP program were discontinued. However, in order to ensure IGT funding contributions are continued by the contributing entities, the DSRIP projects would likely need to be defined in ways that primarily gave access to DSRIP projects to those hospitals for which IGTs were contributed. It should be noted, however, that all financing arrangements must be approved by CMS, and a financing arrangement that directs DSRIP dollars primarily to hospitals does not appear to be in line with CMS' desire to involve a broader range of providers in delivery system transformation. Further, approval of a financing arrangement for an existing DSRIP program in another state is no guarantee that CMS will approve similar financing approach for a new DSRIP program.

As discussed previously, one of the requirements of an 1115 demonstration waiver is budget neutrality. Specifically in the context of DSRIP waivers, it can be challenging to demonstrate budget neutrality. The cost of making payments to hospitals and other providers for broad-based delivery system reform is not an expense that the federal government would match in the absence of the waiver. As a result, states must demonstrate that their waiver will generate "savings" (i.e., a return on investment, reducing the federal cost of operating Medicaid relative to the "without waiver" cost). They can then "tap" the expected savings and repurpose them for new investments in delivery system reform.

7.4 Challenges with DSRIP Programs

DSRIP programs offer some significant opportunities to state Medicaid agencies, but they also generate some challenges. On the positive side, DSRIP programs offer a way to maintain IGT-funded payments (which would be in the form of incentive payments) to flow to hospitals even after making significant transitions from FFS to managed care models. In addition, DSRIPs hold the promise of improving the health of the population, enhancing the experience and outcome of the patient, and reducing the per capita cost of care for Medicaid and uninsured patients and potentially offer the same benefits to patients with any other type of insurance. However, these benefits come at a cost. DSRIP programs can be large and complex, and often require substantial ongoing operational support. They also take a considerable amount of time to define and implement. In addition, "it is important to note that the future of this program remains uncertain as CMS has not provided guidance on DSRIPs, nor have they indicated how many Section 1115 waiver demonstrations they will permit to include a DSRIP."[128] The potential for these programs to be short-lived makes the decision to implement a DSRIP program extremely unclear, particularly when considering the fact that these programs are taking multiple years to define and implement, and require significant effort to monitor.

In the sections that follow, we examine three primary challenges, complexity involved in defining program requirements, implementation time, and administrative complexity. In these sections, we offer anecdotal notes that we observed from the discussions during two conference calls held by the National Association of Medicaid Directors (NAMD) on July 10, 2014 and September 16, 2014. The primary topic of these calls was DSRIP programs.

7.4.1 Dynamic DSRIP Requirements

CMS has not established formal DSRIP guidance, so the requirements may change in each state. State officials should be prepared for new or shifting requirements that build upon the experience of other DSRIP programs and increase the accountability for both the state and its providers.

The following anecdotal comments were mentioned in recent NAMD conference calls related to shifting requirements. Also included are anecdotes offered by Medi-Cal administrators during an interview with Navigant Healthcare consultants working on defining a DSRIP program in Alabama:

- Medi-Cal personnel indicated that it takes significant infrastructure in the ramp-up phase. Medi-Cal had to increase its in-house, and academic / private sector capacity. DSRIP is not easy to understand and needs a particularly skilled team especially during the evaluation phase. They also reported that CMS required a rigorous midyear assessment in the first year approval, which took a "grueling" 18 months.

[128] National Association of Medicaid Directors (NAMD*), Issue Brief – Medicaid Innovation: Delivery System Reform Incentive Pools*, (June 2014).

- New Jersey reported needing two years overall to obtain approval for their DSRIP program, including eight months just to define DSRIP protocols. It should be noted that those protocols have already required revision. New Jersey Medicaid held over 100 calls with CMS during the definition of the protocols.

7.4.2 Lengthy Implementation Time

"States should anticipate a long runway from conceptualization to implementation. This can be a multi-year process and will encompass numerous negotiations since federal officials must approve nearly all facets of the program, including every provider's projects."[129] The time from conceptualization to implementation is commonly between 18 months and 2 years. For Florida, this means a DSRIP program is not likely to be an option for SFY 2015/16 and quite possibly not an option for SFY 2016/17. Florida's current 1115 waiver expires at the end of SFY 2016/17. So a DSRIP program, if chosen as a good option for Florida, might, realistically, be implemented with the next renewal of the 1115 waiver.

The following anecdotal comments were mentioned in recent NAMD member update conference calls[130] related to implementation time and effort:

- New York required two years to negotiate DSRIP program definition with CMS. There was a lot of time spent discussing funding which ended up being a mix of Designated State Health Programs (DSHP) and IGT. There were many false starts. New York Medicaid had to redeploy resources to keep the DSRIP design process moving.

- Texas reported it generally took six months to approve projects. They also reported that determination and calculation of pay for performance outcomes is difficult given their inclusion of a broad spectrum of providers. Similarly, valuation of projects has been challenging given the mix of providers. Getting to a menu of outcomes took until the middle of demonstration year 3 and still did not offer a clean tie between project goals and metrics.

- New Jersey reported that the application process often took more than three months. Some hospitals required up to 15 revisions to their application. No application was approved without at least one revision. This is despite New Jersey Medicaid holding face-to-face meetings with all 55 hospitals who submitted applications. New Jersey reported the cost of implementing DSRIP turned out to be three times greater than initial estimates.

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[129] Navigant Consulting, Center for Healthcare Research and Policy Analysis, John Colleran and Paul Keckley. "*Pulse Alert: The Delivery System Reform Incentive Payment (DSRIP) Program*.". (November 6, 2014). Available at: http://www.naviganthrp.com/wp-content/uploads/2014/11/FINAL-HC_DSRIPPulseAlert_NSL_1014.pdf

[130] The NAMD member update conference calls referenced here occurred on July 10, 2014 and September 16, 2014.

7.4.3 Administrative Complexity

"DSRIP programs have stringent reporting and evaluation requirements that necessitate diligent oversight by state officials. Complicating matters is the middleman role that states play, being the conduit for information and financial exchanges between the federal government and providers. Due to this complexity, states must identify staff resources to aid in design, implementation and ongoing administration of DSRIP programs."[131]

The following anecdotal comments were mentioned in recent NAMD conference calls related to administrative complexity:

- California reported having between 10 and 12 state staff along with three or four consultants monitoring the program.
- Texas has over 300 providers and 1,500 projects to monitor. Texas has 20 state staff working on DSRIP and is gradually increasing staff. In addition, Texas uses five external firms to help monitor the program.
- New Jersey has three state staff and 14 consultants involved in monitoring the program.
- New York reported having three state staff currently monitoring the program with a plan to get up to 15 state staff. In addition, they rely on between 80 and 90 external consultants.

7.5 Comparison of LIP and DSRIP

7.5.1 LIP Demonstration Years 1 Through 5

The goal of the LIP program is to provide government support for safety net hospitals that furnish health care to the Medicaid, underinsured and uninsured populations. Like DSRIP programs, the LIP program allows for IGT-funded payments to be made to providers even with Florida Medicaid's migration from FFS to managed care models, although the intent of such payments are significantly different, the values of such payments would vary significantly, and the DSRIP incentive payments are more strictly conditioned on the achievement of specific, measurable milestones and outcomes tied to overall Medicaid transformation objectives. Also like many DSRIP programs, the LIP program allows for funding to hospitals and non-hospital provider types. In particular, the LIP program allows for payments to Provider Access Systems (PASs), which may include hospital and non-hospital providers such as County Health Departments (CHDs) and Federally Qualified Health Centers (FQHCs). In its first year of

[131] Navigant Consulting, Center for Healthcare Research and Policy Analysis, John Colleran and Paul Keckley. "*Pulse Alert: The Delivery System Reform Incentive Payment (DSRIP) Program*," (November 6, 2014). Available at: http://www.naviganthrp.com/wp-content/uploads/2014/11/FINAL-HC_DSRIPPulseAlert_NSL_1014.pdf

implementation, SFY 2006/07, the LIP program expanded the list of providers receiving supplemental funding as compared to the prior year's UPL program (SFY 2005/06).[132]

- There were 206 PASs that received payments through the LIP program as opposed to 87 hospital providers that received payments through the UPL payments for the previous year.

- The LIP program allowed for 43 non-hospital providers to participate that were not eligible for payments under the UPL.

In demonstration years 1-3, also similar to DSRIP programs, PASs were required to complete milestones that required the reporting of specific metrics in order to receive the $1 billion in allotted funds. The reports were intended to give AHCA an ability to determine the cost-effectiveness of PASs. These metrics included:[133]

- Unduplicated count of individuals served (separated by Inpatient, Outpatient, and Total)
- Hospital discharges
- Case mix index
- Hospital inpatient days
- Hospital emergency department encounters
- Other related measures

7.5.2 LIP Demonstration Years 6 Through 8

In demonstration years 6-8, which were included in the first waiver renewal, the LIP program evolved to be even more like a DSRIP program. CMS's Special Terms and Conditions in the 2011 renewal implemented two tiers of milestones that had to be met for the State and providers to have access to 100 percent of the annual LIP funding. The STCs stated,

> "The LIP is also designed to establish new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations. Initiatives must broadly drive from the three overarching goals of CMS' Three-Part Aim as described in paragraph 61(a)."[134]

As described in STC 61, Tier – One Milestone allocated $50 million, of which $35 million was designated to support primary care initiatives ($20 million dedicated to the start-up of new primary care initiatives and the remaining $15 million designated to enhance existing primary

[132] University of Florida Department of Health Services Research Management and Policy, *Summary Report on Section 1115 Waiver Process*, (July 2006).
[133] Florida Agency for Health Care Administration, *Florida 1115 Research and Demonstration Waiver Extension Request*, (2010).
[134] Centers for Medicare and Medicaid Services, *Special Terms and Conditions for Florida Medicaid Reform Section 1115 Demonstration*, Document number 11-W-00206/4, STC number 51, (December 2011).

care programs). The remaining $15 million in Tier – One Milestone funding fell under the Special LIP Provider Access System category. This $15 million was distributed to hospitals based on the hospitals meeting Quality Measures collected by AHCA and Core Measures collected by CMS. As described in STC 62, Tier – Two Milestone mandated that the top 15 hospitals in terms of largest allocation of LIP funds each propose three initiatives that follow the guidelines of the Three-Part Aim. These hospitals had to implement new, or enhance existing, health care initiatives, investments, or activities with the goal of meaningfully improving the quality of care and the health of populations served. The three initiatives focused on: infrastructure development; innovation and redesign; and population-focused improvement. The 2011 STCs did not allocate a specific amount of money for Tier – Two Milestones. Instead, the STCs stated that 3.5 percent of the LIP funds allocated to each of these hospitals are at risk pending evidence of progress or completion of each pre-defined milestone.

Again, similar to DSRIP programs, approval by CMS of each milestone plan was required for the participating hospitals to receive associated LIP funds in Demonstration Year (DY) 6. In DY 7 and DY 8, participating hospitals submitted to AHCA quarterly reports describing and measuring progress on the initiatives.

Where the LIP program may have fallen short of DSRIP programs was in the monitoring of the milestone reports during DY 7 and DY 8. The monitoring was relatively light; hospitals were given credit for reaching a milestone simply by submitting a report. Very little review was performed to ensure hospitals reached outcome targets defined in their milestone plans. In contrast, DSRIP programs are designed to only distribute incentives to providers when they meet specific, measurable milestones and outcome targets that are aligned with a State's Medicaid transformation objectives. To date, no hospital has been refused payment of LIP funds for failure to reach target milestones. AHCA maintains the LIP program primarily with two full time resources. That low level of manpower is insufficient to enable detailed review of hospital performance against milestones.

7.5.3 AHCA Proposal for LIP Demonstration Years 9 Through 11

In November 2013, AHCA submitted a proposal to CMS to redesign its LIP program into a "System Access and Transformation Incentive Fund (Incentive Fund)" funded at $4.5 billion annually for three years. The proposed Incentive Fund, financed by voluntary IGTs, would be used to support various safety net providers and have two primary components: a Quality Enhancement Pool and System Transformation Awards. Starting in DY 9, the Quality Enhancement Pool would constitute 85 percent of the funding, and then decrease to 70 and 60 percent over the next two demonstration years, with the System Transformation Awards accounting for the remaining funds each year. This proposal was subsequently denied by CMS. The basic design elements of the program are as follows:

- The Quality Enhancement Pool was to be targeted toward providers that have consistently participated heavily in serving Medicaid and low-income populations. In order to receive funds from this pool, providers would have to participate in certain

activities that would further federal and state health delivery system goals, such as successful contracting with Medicaid managed care organizations and participation in Event Notification Service activities[135]. Funding methodologies would have considered the challenges faced by providers that serve predominantly low-income populations and the linkage with local funding sources. This would have reflected the principle that providers in a local area should not receive less than if they were to receive the funding directly from their local governments.

- System Transformation Awards would have been designed to support and reward collaborative projects that address particular aspects of service delivery that affect Medicaid recipients and other low-income Floridians. This funding would be balanced between up front funding and outcome-based incentives. These projects would be focused around areas such as improving timeliness and appropriate setting for care, preventing potentially preventable events, or improving birth outcomes.

- In addition, a portion of the Incentive Fund would have been allocated to funding an annual evaluation. The evaluation would have included process measures for looking at the activities/improvements/interventions that are being put into place and the outcome measures to see if the process/infrastructure changes resulted in improved outcomes. This would have allowed the State to identify which projects were resulting in real improvement.

In the end, CMS rejected this plan and approved a waiver renewal that includes three years for the managed care portion, but only one year for the LIP program, from July 1, 2014 through June 30, 2015. "During the one-year extension for the LIP, expenditures are authorized to provide stability for providers, for a limited time during Florida's transition to statewide Medicaid managed care and a significantly reformed Medicaid payment system."[136] Collection of the quarterly reports will continue in DY 9 for Tier – One Milestones, but not for Tier – Two Milestones. The Tier - Two Milestones are no longer tied to disbursement of LIP funds as they were not included in the 2014 STCs.

7.6 DSRIP Conclusion

DSRIP has developed into a way for states to incentivize the transformation from "volume to value" in their health systems. DSRIPs have also proven, at least temporarily, to be an acceptable mechanism to provide incentive payments to hospitals and other types of providers outside of the limitations of the FFS UPL, even after a significant transition to a Medicaid managed care model. As traditional supplemental funding amounts are increasingly

[135] The Event Notification Service (ENS) provides health plans with timely notifications about their members' hospital encounters. Information about a member's visit (including demographic information, information on the source facility, and primary complaint) securely sent the plans preferred method and schedule. This service offers the opportunity for health plans to better engage in care coordination and ensure proper follow-up care is received.
[136] Centers for Medicare and Medicaid Services, *Special Terms and Conditions for Florida Medicaid Reform Section 1115 Demonstration*, Document number 11-W-00206/4. (July 2014)

scrutinized, DSRIP allows states to use those funds as incentives for providers to embrace CMS's triple aim of pursuing better care for individuals, better health for the population, and lower health care related costs through improvements in service delivery. While each state's DSRIP program may vary, generally providers are rewarded for meeting designated milestones and achieving improved clinical outcomes that ultimately improve population health. Only those participating providers that achieve measureable process and outcome milestones receive the financial incentive. CMS is looking to see return on investment for the federal funds provided to state Medicaid agencies, particularly for programs like DSRIP, that are approved as part of an 1115 demonstration waiver.

Conceptually, there are tremendous potential benefits to DSRIP programs. DSRIP programs have potential to improve coordination of care across various provider types, fund development of new and innovative ways to treat chronic health conditions, spur other innovations that improve overall population health, and reduce per capita health care costs. However, from a practical point of view, these programs tend to be extremely complex and require a tremendous amount of operational support from providers, the Medicaid agency, and CMS. However, even with this uncertainty, and the time and cost required to ramp up a DSRIP program, such a program may represent a significant opportunity to not only support the providers of Florida to achieve system transformation through incentives, but to improve the overall health and wellbeing of all Floridians.

8 Survey of Other Medicaid Programs

8.1 Introduction

In this section of the report, we discuss Navigant's surveys of other states' payment methods and funding sources. Our objective for these survey efforts was to identify and analyze other States' Medicaid programs that have a proven history of effectively managing the Medicaid program through innovative funding practices, and gain better understanding of options based on their experiences.

8.1.1 Purpose of Survey

The purpose of these surveys was to gain a better understanding of how other State Medicaid programs are funding and paying hospital providers for inpatient and outpatient hospital services, whether through fee-for-service (FFS) programs, Medicaid managed care (or capitated) programs, and through other funding streams that are outside of traditional FFS or capitation payments, such as supplemental or UPL payments and DSH payments, including those that are performance based. We also endeavored to understand the funding sources for all payments – specifically how the states generated the funds necessary to fulfill the states' shares of the funding obligations under the FFP funding regulations. In particular, we reviewed use of state general revenue, IGTs, CPEs, and provider assessments. Finally, it was our objective to better understand if and how each of these payment and funding streams have been operationalized and maintained in states that have made a commitment to transitioning a significant portion of their Medicaid-eligible populations to capitated Medicaid managed care models.

Ultimately, the goal of this survey process was to identify options for consideration in Florida, as potential replacements for the current Florida LIP program.

8.1.2 State characteristics reviewed (specifically reviewing and why relevant)

In our survey of other state Medicaid programs, Navigant established goals based on the Proviso passed by the Florida State Legislature and Terms and Conditions set by CMS during the waiver application. The goals are listed below:

- States that have a significantly large number of Medicaid eligibles
- States that have not chosen to expand under ACA
- States that have chosen to expand under ACA
- States that have converted a large portion or virtually all of their eligible population to a managed care environment or are in the process doing so
- States that have found ways to distribute payments successfully outside of the traditional managed care capitation fees or traditional FFS
- States that have implemented a premium assistance program for the expansion eligible categories under the ACA
- States that have implemented a DSRIP program
- States where we could readily obtain the necessary comparison information

With goals set, Navigant chose nine states to survey.

8.1.3 States selected for Survey

Based on the criteria described above, we selected the following nine states for our survey process:

- *Alabama* has not chosen to expand Medicaid eligibility under the ACA. The hospitals self-fund Medicaid hospital reimbursements through IGTs and CPEs. Also, the state is in the process of implementing Medicaid managed care through Regional Care Organizations (RCOs), and has submitted a waiver application to CMS to implement a DSRIP program.

- *Arizona* has chosen to expand Medicaid eligibility with a separate assessment to help defray the state's cost associated with meeting the minimum federal standards to participate in the expansion. Arizona is a managed care state for the majority of its Medicaid population, and has a safety net hospital pool fund.

- *California,* like Florida, has a very large Medicaid program. The state has expanded the categories of eligibility under ACA, does have a managed care program, has implemented a DSRIP program, and has a provider assessment.

- *Illinois* is another state transitioning to managed care with the intent to maintain supplemental payments funded through a provider assessment, uses CPEs, and has expanded Medicaid categories of eligibility.

- *New Jersey* was surveyed for its recently approved DSRIP waiver with CMS.

- *New York* was studied for its robust Medicaid program. The state has expanded the Medicaid eligible population under ACA. It has also transitioned to managed care, and is implementing a DSRIP waiver.

- *Pennsylvania* was studied for its managed care environment and the state has expanded Medicaid eligibility under ACA using a premium assistance plan.

- *Texas* is similar to Florida in that it has not expanded eligibility under ACA and has a large uncompensated care population. Texas has implemented a DSRIP program which is up for renewal in 2016.

- *Washington* has transitioned quickly into a managed care environment in the past two years. Recently, CMS approved a physician supplemental payment program funded by IGTs. The state has also expanded Medicaid eligibility under ACA.

Table 11. Summary of hospital funding and payment for states surveyed.

Criteria	States								
	Alabama	Arizona	California	Illinois	New Jersey	New York	Pennsylvania	Texas	Washington
Significant Managed Care		x	x	x		x	x	x	x
Large Number of Eligibles			x			x		x	
Provider Assessment	x	x	x	x			x		x
DSH	x	x	x	x	x	x	x	x	x
UPL	x	x	x	x					
CPE			x	x					x
ACA Expansion		x	x	x		x	x		x
1115 Demonstration Waiver		x	x		x	x		x	
DSRIP Program			x		x	x		x	
Hospital Payments (self-funded)	x								

8.1.4 Survey Method

Our survey approach focused on internet research, internal discussions and research with Navigant personnel that have worked in the various surveyed states, and interviews with the states' Medicaid agencies. For our internet research, we went to each state's websites, the CMS website, the National Association of Medicaid Directors website, the Kaiser Family Foundation website, GAO public reports, and other sites.

Navigant is a consultant to many of the states included in this survey approach. As such, we interviewed Navigant project leaders that have worked in the specific states chosen for survey. The project leader interviews provided current status of what the states are pursuing relative to similar funding solutions, key issues encountered by the states, and insights as to any new challenges.

Navigant also prepared and completed a standard survey questionnaire for each state. The questionnaire focused on payment methods and funding sources currently in use or in the implementation process.

8.2 Summary of states and findings

Table 12. Description of hospital funding and payment utilized by Alabama Medicaid.

Payment Methods	Description
Fee-for-service and/or Managed Care	FFS but planning implementation of Medicaid managed care through Regional Care Organizations (RCOs)
Supplemental Payments-Upper Payments Limit(UPL)/Low Income Pool(LIP)	Yes, Alabama Medicaid Agency pays "access" payments to public and private hospitals.
Disproportionate Share Payments	Yes, $327M annual allotment
DSRIP	Pending, has applied with CMS
Funding Sources	**Description**
General Fund Revenue	Yes, but not for hospital reimbursements. IGTs from public hospitals and a provider assessment applied to private hospitals fund all Medicaid hospital reimbursements including claim payments, supplemental payments, and DSH payments.
IGTs	Yes, used for hospital rates.
CPEs	Yes, used for supplemental and DSH payments but the states is considering moving to IGTs in the future.
Provider Assessment	Yes, private hospitals, nursing homes and pharmacies. The provider assessment funds approximately 1/3 of the state share for hospital payments
DSRIP Funding	Pending CMS approval
Uncompensated Care/Expansion	**Description**
Expansion under ACA	No

Table 13. Description of hospital funding and payment utilized by Arizona Medicaid.

Payment Methods	Description
Fee-for-service and/or Managed Care	99% of population is in a managed care environment.
Supplemental Payments-Upper Payments Limit(UPL)/Low Income Pool(LIP)	Supplemental payments are made to Critical Access Hospitals, hospitals with Graduate Medical Education programs, providers developing ability to create and share Electronic Health Records (EHR Incentive Payments), and Safety Net hospitals.
Disproportionate Share Payments	Yes, there are 5 funding pools.
DSRIP	Has not implemented this payment method.
Funding Sources	**Description**
General Fund Revenue	Yes
IGTs	Yes, used for DSH funding pool 5.
CPEs	Yes, used for DSH payments to public hospitals in funding pools 1, 1A, 2, 2A, and 4.
Provider Assessment	Yes, there is a hospital assessment based on hospital discharges. Assessment proceeds are used to cover the state share for expansion eligible categories, and allow Arizona to cover the follow expansion under ACA. Assessments do not fund rate increases or supplemental payments at this time.
DSRIP Funding	Not applicable.
Uncompensated Care/Expansion	**Description**
Expansion under ACA	Yes

Table 14. Description of hospital funding and payment utilized by California Medicaid (Medi-Cal).

Payment Methods	Description
Fee-for-service and/or Managed Care	Both FFS and Managed Care but primarily managed care waiver
Supplemental Payments-Upper Payments Limit(UPL)/Low Income Pool(LIP)	Yes, Medi-Cal utilizes supplemental payments. Enough business remains in fee-for-service that remaining supplemental payments stay within CMS upper payment limits.
Disproportionate Share Payments	Yes, approximately $1.1 billion dollars annually. Primarily funded through IGTs. In addition, Medi-Cal's current 1115 waiver allows for an uncompensated care pool which will pay out approximately $8 billion over five years.
DSRIP	Yes. The DSRIP program is only available to the 21 designated public hospitals. Total allowable expenditures under DSRIP are $6.7 billion over five years.
Funding Sources	**Description**
General Fund Revenue	Total general revenue funding for hospitals is about $4.1 billion: • The State pays about $1.9 billion in general revenue to hospitals annually for FFS. State share of Medicaid funds FFS for public hospitals are provided through CPEs and are not included in that $1.9 billion number. • The State pays about $1.7 billion in general revenue to hospitals annually for managed care capitation rates. State share of Medicaid funds for capitation payments for public hospitals are provided through CPEs and are not included in that $1.7 billion number. • The State contributes about $440 million in general revenue annually towards hospital supplemental payments.
IGTs	Yes; IGTs from non-designated public hospitals fund supplemental, DSH, and a portion of rate payments.
CPEs	Yes, fund FFS and capitation rates for designated public hospitals
Provider Assessment	Yes, Medi-Cal recently implemented a provider assessment for private hospitals. Private hospitals do not have access to the DSRIP program, but they receive nearly all the benefit from federal funds drawn down as a result of the provider assessment.
DSRIP Funding	Funded by IGTs from the 21 designated public hospitals. The DSRIP program is only available to the designated public hospitals.
Uncompensated Care/Expansion	**Description**
Expansion under ACA	Yes. Previous to ACA expansion, Medi-Cal had several programs in which county governments were required to provide health care to the uninsured, partially funded through state revenue. With ACA expansion, the state funds that were previously sent to counties for care of uninsured is staying at the state level to fund added costs resulting from expansion.

Table 15. Description of hospital funding and payment utilized by Illinois Medicaid.

Payment Methods	Description
Fee-for-service and/or Managed Care	FFS but moving to coordinated care; goal is 50% by end of 2015.
Supplemental Payments-Upper Payments Limit(UPL)/Low Income Pool(LIP)	Currently have $350M in hospital supplements payments paid for by the State General Fund (with Federal match), $290M of which is transitional to mitigate the impacts of the new inpatient and outpatient payment systems. Illinois in 2014 transitioned a significant portion of supplemental payments into its claim payment system.
Disproportionate Share Payments	Yes, majority of funds are paid to Cook County, Chicago
DSRIP	Has not implemented this payment method.
Funding Sources	**Description**
General Fund Revenue	Yes
IGTs	Cook County and University of Illinois fund the state share of their cost-based rates with IGTs.
CPEs	Cook County and University of Illinois are CPE hospitals.
Provider Assessment	Yes, a large portion of total hospital reimbursement ($2 billion) is made through assessment payments. Approximately $500M of assessment payments are passed through the MCO plans.
DSRIP Funding	Not applicable.
Uncompensated Care/Expansion	**Description**
Expansion under ACA	Yes

Table 16. Description of hospital funding and payment utilized by New Jersey Medicaid.

Payment Methods	Description
Fee-for-service and/or Managed Care	78% Managed care
Supplemental Payments-Upper Payments Limit(UPL)/Low Income Pool(LIP)	Graduate Medical Education payments are made to eligible hospitals on a monthly basis.
Disproportionate Share Payments	Disproportionate Share Hospital payment program consists of the following programs: Health Care Subsidy Fund – Charity Care Subsidy, Payments to University of Medicine and Dentistry of New Jersey Hospitals, Hospital Relief Subsidy Fund, and Hospital Relief Subsidy Fund for the Mentally Ill and Developmentally Disabled. The Federal allotment for Federal Fiscal Year 2014 was $685,540,358.
DSRIP	Yes, implemented in October, 2012
Funding Sources	**Description**
General Fund Revenue	Budget estimate of $3.105 billion of general funds from $8.287 billion total Medicaid cost budget.[137]
IGTs	No evidence of this funding source
CPEs	No evidence of this funding source
Provider Assessment	$12.3 million for 2014-2015 budget estimate is generated from hospital assessments in the Hospital Health Care Subsidy Fund.[138]
DSRIP Funding	Funding: The non-federal share of pool payments to providers may be funded by state general revenue funds and transfers from units of local government Transition Funds: 2013 Hospital Relief Subsidy Funds Transition Payments may be paid to hospitals in proportion to the supplemental payments that each hospital received from the Hospital Relief Subsidy Fund in SFY 2012. The total amount of 2013 HRSF Transition Payments for all hospitals combined may not exceed the following amount: $166,600,000, less any payments that hospitals received in Hospital Relief Subsidy Fund payments under the State plan in SFY 2013. 2013 GME Transition Payments may be paid to hospitals in proportion to the supplemental payments that each hospital received for GME in SFY 2012. The total amount of 2013 GME Transition Payments for all hospitals combined may not exceed the following amount: $90,000,000 less any payments that hospitals received in Graduate Medical Education payments under the State plan in SFY 2013.

[137] State of New Jersey Office of Management and Budget, *The Governor's FY 2015 Budget Detailed Budget*, Page D-175, (February 25, 2014).
[138] Ibid.

	Eligible providers: All acute care hospitals
Uncompensated Care/Expansion	**Description**
Expansion under ACA	Yes, traditional

Table 17. Description of hospital funding and payment utilized by New York Medicaid.

Payment Methods	Description
Fee-for-service and/or Managed Care	4.45 million of the 5.89 Medicaid beneficiaries are enrolled in managed care at the end of August 2014.[139]
Supplemental Payments-Upper Payments Limit(UPL)/Low Income Pool(LIP)	Hospitals receive payments for supplemental indigent care payments which must not exceed the upper payment level for inpatient hospital services. Graduate medical education payments are made for services related to inpatient services for individuals enrolled in Medicaid managed care or Family Health Plus plans.
Disproportionate Share Payments	The 2014 Federal allotment was $1,713,018,172. The Payments made under the Disproportionate share hospital program are include a base payment to all eligible hospitals and additional payments to various governmental providers based on location and affiliation with the state or state universities.
DSRIP	CMS approved $6.42 billion DSRIP program for the State of New York on April 14, 2014. This amount includes funds for DSRIP Planning Grants, DSRIP Provider Incentive Payments and DSRIP Administrative costs. Based on Attachment J – New DSRIP Strategies Menu and Metrics, each "DSRIP project plan must include a minimum of five projects (at least two system transformation projects, two clinical improvement projects, and one population-wide project)."
Funding Sources	**Description**
General Fund Revenue	$11.599 billion of general funds to Department of Health for Medicaid services in enacted FY 2014-2015 budget. Accounts for 52.60% of state share ($22.052 billion) for FY 2014-2015.[140]
IGTs	See DSRIP Funding below
CPEs	Certified public expenditures are used as part of reimbursement for school based health services.
Provider Assessment	The state of New York has a Health Facility Cash Assessment Program (HFCAP) that "requires New York State designated providers to pay an assessment on cash operating receipts on monthly basis." The amount various based on provider type. Provider types that are subject to the assessment include hospitals, residential health care facilities, certified home health agencies, long term home health care program, and personal care providers.
DSRIP Funding	Intergovernmental transfers are employed by an "IGT Entity" to supply the non-Federal share for "incentive payments related to milestone achievement."
Uncompensated Care/Expansion	**Description**
Expansion under ACA	Yes

[139] New York Department of Health. "*Medicaid Global Spending Cap Report Redesigning the Medicaid Program,*" (August 2014).
[140] New York State Division of the Budget, "*FY 2015 Enacted Budget Financial Plan,*" Page 90, (May 2014).

Table 18. Description of hospital funding and payment utilized by Pennsylvania Medicaid.

Payment Methods	Description
Fee-for-service and/or Managed Care	Managed care capitation payments make up 78.09% of forecasted expenditures in the Department of Public Welfare's Medical Assistance budget for 2014-2015. Total payments made for inpatient and outpatient hospital services in SFY 2011, under both the managed care program and FFS program (excluding DSH) totals approximately $5.11 billion.
Supplemental Payments-Upper Payments Limit(UPL)/Low Income Pool(LIP)	Supplemental payments made to hospitals with at least 80% of inpatient care (fee for service and managed care). Supplemental payments are also made related to direct graduate medical education, medical assistance dependency payments, and medical assistance stability payments. Supplemental payments made for inpatient and outpatient hospital services in SFY 2011, excluding DSH payments, totaled approximately $1.02 billion, and remain at approximately 20 percent of non-DSH funding for hospitals.
Disproportionate Share Payments	The allotment for the State of Pennsylvania for 2014 is $598,556,544. Several different reimbursement programs exist as part of the Disproportionate Share Hospital Program. These include the following: Trauma Disproportionate Share Hospital Payments, hospitals in economically distressed areas, hospitals with qualified burn centers, small and sole community hospitals, critical access hospitals, qualified rural hospitals, and enhanced high volume hospitals.
DSRIP	Has not implemented DSRIP.
Funding Sources	**Description**
General Fund Revenue	Pennsylvania 2014-2015 Budget for Medical Assistance is $16.9 billion. $5.3 billion of the budget is forecasted from general funds.
IGTs	None – no publicly owned or operated hospitals in Pennsylvania
CPEs	None – no publicly owned or operated hospitals in Pennsylvania
Provider Assessment	Pennsylvania has a Statewide Hospital Quality Care Assessment that has "all inpatient acute care general and freestanding rehabilitation hospitals located within the Commonwealth of Pennsylvania."[141] This assessment is used to enhance the inpatient acute care hospital reimbursement system and allow for enhanced capitation payments for inpatient hospital services within the managed care environment.[142] The city of Philadelphia has implemented a Philadelphia Hospital Assessment of $157 million is budgeted to assist in payment of outpatient hospital services.[143]
DSRIP Funding	None

[141] PA Department of Public Welfare. "*PA DPW Statewide Hospital Quality Care Assessment Frequently Asked Questions*," (Revised September 23, 2013).
[142] PA Department of Public Welfare. "*Governor's 2014-2015 Executive Budget*," Page 125, (February 2014).
[143] PA Department of Public Welfare. "*Governor's 2014-2015 Executive Budget*," Page 113, (February 2014).

Uncompensated Care/Expansion	Description
Expansion under ACA	Yes – through a premium assistance program

Table 19. Description of hospital funding and payment utilized by Texas Medicaid.

Payment Methods	Description
Fee-for-service and/or Managed Care	Based on preliminary June 2014 enrollment information, 67.64% of Medicaid beneficiaries are serviced by a Medicaid managed care plan,
Supplemental Payments-Upper Payments Limit(UPL)/Low Income Pool(LIP)	No upper payment limit payments defined in Medicaid State Plan.
Disproportionate Share Payments	The DSH allotment for the State of Texas for FY 2014 is $1,019,812,376. DSH funds are first distributed to state-owned teaching hospitals, state-owned IMDs and state-owned chest hospitals with any remaining funds being distributed to other qualifying hospitals.[144]
DSRIP	The Texas Transformation and Quality Improvement Program has a DSRIP program and an uncompensated care pool. The DSRIP program "embodies the principles of CMS overreaching triple aim: improving the experience of care, improving the health of populations, and containing cost."[145] Regional Healthcare Partnerships (RHPs) are established by public hospitals and local governments to administer the DSRIP. According to the Special Terms and Conditions (STCs), "[i]ndividual hospital's DSRIP proposals must flow from the RHP plans, and be consistent with the hospital's shared mission and quality goals within the RHP."[146] The DSRIP proposals have four focus areas: infrastructure development, program innovation and redesign, quality improvements, and population focused improvements.
Funding Sources	**Description**
General Fund Revenue	Budget information not available for Medicaid only. Texas Health and Human Services Commission administers Medicaid, Children Health Insurance Program (CHIP), Texas Women's Health Program, Temporary Assistance for Needy Families (TANF), SNAP Food Benefits and Nutritional Programs, Family Violence Services, Refugee Services and Disaster Assistance.
IGTs	See DSRIP funding
CPEs	
Provider Assessment	
DSRIP Funding	According to the Special Terms and Conditions for the Texas Healthcare Transformation and Quality Improvement Program, the DSRIP funding will be "financially supported by a public hospital or a local governmental entity with the authority to make intergovernmental transfers (IGTs)."[147]

[144] Texas Medicaid State Plan Attachment 4.19-A Page 19.

[145] Texas Health and Human Services Commission. "*Texas Healthcare Transformation and Quality Improvement Program Medicaid 1115 Waiver Proposal,*" Page 12, (July 13, 2011).

[146] CMS Special Terms and Conditions (STCs) for Texas Healthcare Transformation and Quality Improvement Program (11-W-00278/6), Page 54, Amendment 7 Approved March 6, 2014.

[147] CMS Special Terms and Conditions (STCs) for Texas Healthcare Transformation and Quality Improvement Program (11-W-00278/6), Page 54, Amendment 7 Approved March 6, 2014.

Uncompensated Care/Expansion	Description
Expansion under ACA	No

Table 20. Description of hospital funding and payment utilized by Washington Medicaid.

Payment Methods	Description
Fee-for-service and/or Managed Care	Approximately 80% of the Medicaid population is in managed care.
Supplemental Payments-Upper Payments Limit(UPL)/Low Income Pool(LIP)	Yes, supplemental payments occur in FFS and managed care. Recently, CMS approved supplemental payments through the managed care plans. A total of $300 million has been legislated for manage care health plans to increase in their PMPM capitated payment rates. The supplemental payments are treated as a 100% pass through to providers (no admin. fee) by the managed care plans. After the state makes the capitation payments, the health plans make the provider payments. The hospital association has a 100% participation rate and is very strong in Washington. It has a strong working relationship with the health plans.
Disproportionate Share Payments	Approximate total is $197 million for SFY 2014. Payments are capped in legislation and subject to Federal DSH limit. DSH payments are categorized as follows: • Low Income DSH (LIDSH) adjustment-appropriated amounts • Medical Care Services DSH (MCSDSH) per claim payment • Small Rural DSH (SRDSH) paid quarterly • Small Rural Indigent DSH (SRDSH) • Non rural indigent assistance DSH (NRIADSH) • Public Hospital DSH (PHDSH) • Children's Health Program (CHPDSH) per claim data • Sole Community DSH (SCDSH) (new)
DSRIP	Has not implemented this payment method.
Funding Sources	**Description**
General Fund Revenue	It is the primary source of the state share in the Medicaid program.
IGTs	This funding source funds the Physician UPL program. It is a current program through the University, which has a large physician's network.
CPEs	Qualifying hospitals use this funding source to drawdown federal funds for interim (50%) hospital payments. Interim settlement occurs usually within six months of state year. During this settlement, the payment is difference in the DRG rate minus the interim payment made at time of service. This payment is all state funds.
Provider Assessment	Yes, safety net hospital assessment restores rate cuts and raises rates but is set to expire in 2019. The assessment is for all hospitals except non-governmental hospitals (CPE hospitals). Used to fund state share of IP/OP services, rate increases, UPL for FFS and managed care, grants to CPE hospitals, CAH hospitals,

	small rural DSH funds.
DSRIP Funding	Not applicable.
Uncompensated Care/Expansion	**Description**
Expansion under ACA	Yes, Washington executed the option to expand under ACA within the traditional Medicaid program. As of date, Washington has not implemented new funding sources to pay for the expansion of Medicaid eligible.

9 Options for Florida Medicaid to Consider

9.1 Introduction of Options

This section describes options that could be considered by Florida Medicaid as potential alternatives to the current LIP program. We describe separately potential alternatives for the distribution of funds that are currently paid out as part of the LIP program, and alternative ways for generating the state and federal shares of the funds needed for such distributions.

The federal waiver that allowed the LIP program to operate has historically provided Florida Medicaid with significant flexibility in generating the state share of funding, and in distributing those funds plus associated federal matching funds. However, as described previously in Chapter 3 – Applicable Federal and State Regulations, without such a waiver program, there are significant limitations on what the State can do from a funding and payment perspective.

The federal UPL regulations described in Chapter 3, place limits on the amounts that can be paid to hospitals for services provided to individuals in Florida Medicaid's FFS program. Because of these limits, as Florida Medicaid transitions from a FFS model to a capitated Medicaid managed care model, the amounts that can be distributed through the FFS program will get smaller. At the same time, the flexibility afforded through the FFS program, which allows states to hold hospitals harmless for their IGT contributions, will continue to diminish.

With a larger proportion of Medicaid funding being channeled through capitated PMPM rates paid to Medicaid managed care plans, the State has shifted substantial financial risk to the plans. As a trade-off however, Florida Medicaid has given up some control over how hospitals are paid. Specifically, the funding and payment options that have been traditionally available to Florida Medicaid for optimizing the generation of federal matching funds, and Florida Medicaid's flexibility in determining how to distribute those funds to hospitals is much more limited. Florida Medicaid may set the capitated PMPM rates, but does not have authority to dictate the rates that are negotiated between managed care plans and individual hospitals.

In the context of these limitations, this chapter explores the current options available to Florida Medicaid on both sides – the payment distribution side and the funding generation side. We also discuss some of the key advantages and disadvantages of each.

9.2 Current Upper Payment Limit Gap

We make the assumption that the guaranteed return on investment provided through the LIP program offered sufficient incentive for local governments and taxing districts to execute inter-governmental transfers contributing funds to the state Medicaid program. As shown in Table 21, just over one billion dollars is planned for collection through IGTs in SFY 2014/15 to fund hospital payments made through the LIP program (including LIP 6) and automatic IGT rate

enhancements.[148] In return, designated hospitals in the local areas contributing this money receive back a minimum a 108.5 percent of the amounts they contributed towards automatic IGTs and the "traditional" $1 billion LIP program. Many of these hospitals receive additional funds in the form of "traditional" LIP supplemental payments and automatic IGT rate enhancements. In addition for the LIP 6 funds (previously known as self-funded IGTs), hospitals receive back 100 percent of the IGT investment plus all of the federal matching funds drawn down because of that investment.

If the LIP program is discontinued, and is not replaced with some other kind of waiver, then guaranteed return on investment can only be offered for amounts that are compliant with the FFS UPL. Estimates of those amounts at a program-wide level are shown in Table 21 for SFY 2013/14 and SFY 2014/15. It should be noted that the FFS UPL is significantly lower in SFY 2014/15 than in SFY 2013/14. The UPL demonstration in SFY 2013/14 is indicative of a program in the pilot stage of the managed care transition, with approximately 32 percent of Medicaid expenditures being made to managed care plans. The SFY 2014/15 UPL demonstration was adjusted to take into consideration the transition to state-wide Medicaid managed care.

Table 21 estimates the amount of IGT funds available to pay through a FFS UPL if the LIP program did not exist. That is, how much IGT funding could Florida Medicaid payout through FFS UPL if no money was paid out through the LIP program and no automatic IGT rate enhancements were applied. This amount of money is labeled "UPL Gap" in Table 21 and equals the difference between FFS claim payments (without IGT-funded rate enhancements) and the cost-based upper payment limit. The cost-based upper payment limits used in determination of UPL gap are those that were submitted to CMS in the UPL demonstrations for SFY 2013/14 and 2014/15. In addition, Table 21 compares the UPL gap to the amount of funds generated through federally-matched IGTs.

The data shows that even in SFY 2013/14, Florida Medicaid would have been over the UPL by approximately $560 million if all the IGT funds (including both state and federal dollars) were counted as payments that are limited to the UPL. However, the one billion dollars distributed as part of the LIP program in SFY 2013/14 were considered payments under the current 1115 waiver and were not considered as a payment in the demonstration UPL calculations. Due to the transition of Medicaid recipients into managed care in SFY 2014/15, the UPL gap shrinks to approximately $411 million and Florida Medicaid would be spending almost $2.2 billion over the UPL if these funds were no longer paid out as part of the 1115 waiver program. In other words, Florida Medicaid would need to cut back spending to hospitals and teaching physicians by approximately of $2.2 billion if the LIP program was discontinued and no other changes were made to funding or payment mechanisms.

[148] The $1.032 billion value excludes funds contributing to LIP payments for non-hospitals (i.e. FQHCs and CHDs) because those payments would not affect hospital UPL calculations.

Table 21. Estimate of UPL gap in SFY 2013/14 and 2014/15 if IGT funds were excluded from claim and LIP payments.

IGT Contribution[2]	Total Computable[2, 3]	SFY 2013/14 UPL Gap[4, 5, 6, 7]	SFY 2013/14 IGT Payment Over Gap	SFY 2014/15 UPL Gap[4, 5, 6, 7, 8, 9]	SFY 2014/15 IGT Payment Over Gap[9]
$1,032	$2,605	$2,051	$554	$412	$2,193

Notes:

1) Numbers presented are in millions.
2) IGT contributions and total computable are assumed to be the same from SFY 2013/14 and SFY 2014/15.
3) Total computable equals IGT contribution (the state share) plus the associated federal matching funds.
4) UPL gap includes sum of values for hospital inpatient and outpatient services.
5) UPL gap is calculated as the difference between estimated hospital cost for Medicaid fee-for-service business and claim payments ***excluding*** IGT rate enhancements.
6) For inpatient services, claim payment excluding IGTs is calculated as the sum of DRG base payment and outlier payment from databases used for SFY 2013/14 and 2014/15 UPL submissions to CMS. These datasets use historical claims from SFY 2010/11 and 2011/12, respectively, which are then re-priced under DRG pricing rules.
7) For outpatient services, claim payment excluding IGT rate enhancements is calculated as total outpatient expenditure estimated from databases used for SFY 2013/14 and 2014/15 UPL submissions to CMS minus outpatient per diem exemptions and buybacks listed in Tables 3 and 4 of the LIP distributions in SFY 2013/14 and 2014/15 GAA.
8) Broad assumptions were made to estimate the volume of Medicaid business remaining in fee-for-service.
9) UPL Gap in SFY 2014/15 decreases significantly because of migration of recipients into Medicaid managed care.

Table 21 shows an estimate of UPL gap across all hospitals. However, UPL demonstrations are actually required to be determined separately for each of three hospital classes. The three classes of hospitals are state-owned or operated, non-state, government owned or operated (a.k.a. public), and privately owned or operated hospitals. In addition, current LIP and automatic rate enhancement distributions are focused more heavily on some providers than others. In particular, non-state, government owned hospitals receive a higher than average percentage of the reimbursements for a variety of reasons, which include their ability to contribute IGTs, and their criticality to the Medicaid program. Thus, some hospitals are more at risk than others if the LIP program is discontinued. This is depicted in Table 22 below, which estimates current levels of reimbursements that are over the SFY 2014/15 FFS UPL gap by UPL hospital class.

Table 22. Estimated UPL gap by UPL category for SFY 2014/15 if IGT funds were excluded from claim and LIP payments.

UPL Category	Number of Hospitals	UPL	Pymts w/o IGTs	UPL Gap	Current IGT Pymt	Payment Over Gap
State-owned	4	$2.2	$1.5	$0.7	$0	-($0.7)
Non-state, government owned	23	$198	$122	$76	$1,299	$1,223
All Other	190	$793	$458	$336	$1,305	$969
Total	**217**	**$993**	**$582**	**$413**	**$2,604**	**$2,191**

Notes:

1) Numbers presented are in millions.
2) Count of hospitals includes those that submitted Medicaid inpatient claims in 2012 and 2013.
3) Numerical values in this table include the sum of values for hospital inpatient and outpatient services.
4) "Payments without IGTs" are claim payments excluding IGT rate enhancements. LIP payments, which are supplemental payments, not claim payments, are also excluded.
5) Differences from equivalent numbers in Table 21 are due to rounding differences.
6) Broad assumptions were made to estimate the volume of Medicaid business remaining in fee-for-service.

It is clear from these numbers that maintaining current Medicaid payment levels to hospitals in Florida will require some form of waiver or will require a change in funding sources. Furthermore, Medicaid expansion, which is discussed as one of the options in this chapter, would not by itself alleviate the need for a waiver or a change in funding sources.

9.3 Options for Funding Sources

9.3.1 Increase Current Assessment

One quite broad option available to Florida Medicaid for generating the state share of funding to support payment for health care-related services is expansion of or modification to the current provider assessment program. The current provider assessment program, referred to as the Public Medical Assistance Trust Fund (PMATF), qualifies as a health care-related tax under current federal regulations. Proceeds generated through the current PMATF program already contribute to payments intended to cover the costs associated with hospital care to Medicaid recipients. PMATF funds are combined with other state general revenue funds to support the State's share of Medicaid hospital payments for both the Medicaid FFS and managed care populations.

The provider assessment model could be modified or otherwise expanded to maximize funding so long as the assessment meets all of the broad federal requirements, including a hold harmless provision (a prohibition against ensuring that providers are paid back at least what they contribute in taxes), requirements that tax programs be generally broad-based, uniform in nature, and redistributive. In addition, federal regulations impose a cap on the size of health

care-related assessment programs. Currently the limit is six percent – a state may not collect more than six percent of the aggregated net patient service revenue of the hospitals that are assessed under the program. Further, any payments generated through the provider tax program must be made in ways that comply with Medicare UPL regulations and facility-specific DSH payment limitations. However, CMS has recently changed the requirements for calculation of UPLs and now allows the Medicaid portion of a hospital assessment to be included as a hospital cost. Under a cost-based UPL demonstration, this allows a hospital's UPL to be calculated a little higher than it would have been without inclusion of the assessment as a cost.

The current provider assessment program in the State of Florida assesses hospitals, nursing facilities, and intermediate care facilities for the intellectually disabled. Specifically from hospitals, the assessment collects an amount equal to 1.5 percent of the annual net operating revenue for inpatient services and one percent of the annual net operating revenue for outpatient services. In SFY 2012/13, the provider assessment generated $497 million in funds for the Medicaid program which generated $679 million in federal matching funds resulting in a total of $1.176 billion in funds for Medicaid reimbursements. Table 23 below estimates how these numbers change using hospital SFY 2012/13 revenue, the SFY 2015/16 FMAP value, and various provider assessment percentages.

Table 23. Estimated increases in Medicaid funds based on increases in provider assessment rates.

Inpatient Assessment Percentage	Outpatient Assessment Percentage	Assessment Revenue	Associated Federal Matching Funds	Funds Available to Medicaid Program	Increase in Funds Above Current Level
1.5%	1.0%	$497	$761	$1,258	n/a
2.5%	2.0%	$873	$1,338	$2,211	$1,036
3.5%	3.0%	$1,249	$1,915	$3,164	$1,988
3.75%	3.5%	$1,344	$2,059	$3,402	$2,227

Notes:
1) Numbers presented are in millions
2) SFY 2015/16 FMAP percentage of 60.51 percent is used in these calculations. This is the FMAP used in the December 2014 SSEC.

Table 23 estimates that a provider assessment set at 3.75 percent of hospital inpatient revenue and 3.25 percent of hospital outpatient revenue would bring in enough funds for the state to completely replace the funding created by the current LIP program. (Total computable on the SFY 2015/16 LIP program is $2.168 billion.) In addition, if the Medicaid program was expanded, hospital revenues would likely increase and PMATF revenues would correspondingly increase.

It should be noted, however, that without some form of Medicaid waiver, a provider assessment could not be designed to fund the Medicaid program at the same level as the current

LIP program. This is because the current LIP program distributes more funds than is allowable under UPL regulations, as discussed in section 9.2 Current Upper Payment Limit Gap. Without a waiver the provider assessment would at most be able to fund approximately $1.5 billion beyond what the assessment already funds today.

Provider assessment programs generally afford states flexibility in the methods used to distribute the funds generated by the program, notwithstanding the political obstacles associated with the redistributive requirements of how the funds are collected. Assessment programs have the advantage of being mandated within law, thus are not optional as are IGT donations. Assessments also have the advantage of being applied equally to all hospitals, unlike IGTs which can only be received from public institutions, local governments, and taxing districts. The actual distribution of funds can be determined by the state, and do not need to be established in a way that incents contribution of funds to the Medicaid program. Payments can be applied across providers through rate increases, or can be targeted to specific types of providers or services. As is done today, the funds generated from the provider assessment could be used to increase fee-for-service and managed care capitation rates for all hospitals, while reducing the role of supplemental payments within the overall hospital reimbursement scheme employed by Florida Medicaid. This would tie payments more closely to Medicaid utilization and patient acuity and resource requirements, and remove the link of hospital reimbursements to the donator of funds. This option will also give managed care organizations more leverage to incent cost effectiveness and quality improvements because the managed care organizations will have control of more of the hospitals' total Medicaid reimbursement.

As a negative, provider assessments cannot be explicit in holding hospitals harmless for all (or a portion) of the tax, or otherwise guarantee that hospitals will get all of the tax paid into the program back in payments. For many hospitals, this will not likely be an issue. However, it is likely that hospitals that see a relatively low volume of Medicaid patients will be required to pay more into a provider tax than they receive in Medicaid revenue.

Replacement of IGT funding and the LIP program with an increase in the provider assessment would also require modification to the current inpatient payment method. This is because the LIP program and automatic IGT rate enhancements have been distributed in ways that protect hospitals deemed critical to the Medicaid program, including safety net hospitals, rural hospitals, and free-standing children's hospitals. With this new funding, Florida Medicaid would need to determine how funds would be distributed to the providers, and whether or not portions of the funds should be directed to specific provider types or services. The current payment already pays more to specific categories of hospitals, but those differences would need to be reconsidered if current supplemental payments were replaced with higher claim payment rates. If such distributions result in significant payment differences among hospitals, and if such differences are carried forward through the contracting process between the hospitals and the Medicaid managed care plans, there is a risk that rate variations between hospitals may incent the managed care organizations to steer Medicaid recipients towards hospitals with lower rates.

In addition, an increase in the provider assessment is likely to be politically problematic. Tax increases are never popular. Also, replacement of IGTs with a larger provider assessment will redistribute funds, to the benefit of some hospitals and the detriment of others. In particular, hospitals with very low Medicaid utilization may be assessed more than they receive in payment for services rendered to Medicaid recipients. However in this case, replacement of the LIP program with an increased provider assessment could tend to even out the burden of funding the Medicaid program across all hospitals. Funding would not be reliant on the limited number of public hospitals, local governments, and taxing districts that are currently contributing non-federal portions of funds to the Medicaid program. In addition, it might increase access to care by incenting low Medicaid volume hospitals to accept more Medicaid patients in order to cover their cost of the provider assessment.

9.3.2 Increase General Fund Revenue

Continuing with the theme of politically problematic is the option of increasing general revenue funds appropriated for the Medicaid program. Many providers of Medicaid services would argue that funding the program is an obligation of the State. In addition, the State of Florida has had budget surpluses over the last couple of years. In theory, a portion of that surplus could be used towards increasing general revenue funding of the Medicaid program.

At the same time, Medicaid costs have been rising at rates that offer substantial risk of crippling state budgets, thus making full funding of the state share of Medicaid programs through state general revenue and untenable solution. In SFY 2013, the State of Florida contributed 22 percent of its general revenue funds to Medicaid, the fourth highest percentage of any state in the country. Across the country, the average percentage of state general revenue used to fund the Medicaid program is 14 percent.[149] However, Florida's state tax revenue per capita ranked 47th out of the 50 states in 2012 when looking only at state tax revenue. In 2012, Florida's per capita state tax revenue was $1,719 and the average across all states was $2,557.[150] When looking at total state and local tax revenue per capita, Florida ranked 31st out of the 50 states in 2011. In 2011, Florida's per capita state and local tax revenue was $3,699 and the average across all states was $4,217.[151]

It would be outside of the scope of this study to make to recommendations regarding how the State of Florida allocates its tax revenue to best benefit of the citizens of Florida. We can only offer that increases in general revenue used for the Medicaid program offer the greatest flexibility in terms of payment distribution. General revenue funds can be used for fee-for-service claim payments, managed care capitation payments, supplemental UPL payments, DSH

[149] Percentages were derived from data in The National Association of State Budget Officers State Expenditure Report Examining Fiscal 2012 – 2014 State Spending, (2014).
[150] The Tax Foundation, "*Facts and Figures 2014*," Table 4, retrieved from http://taxfoundation.org/sites/taxfoundation.org/files/docs/Facts%20and%20Figures%202014.pdf in December, 2014.
[151] The Tax Foundation, "*Facts and Figures 2014*," Table 2, retrieved from http://taxfoundation.org/sites/taxfoundation.org/files/docs/Facts%20and%20Figures%202014.pdf in December, 2014.

payments, and supplemental payments defined through an 1115 waiver, such as a DSRIP program or an uncompensated care pool.

9.3.3 Managed Care Assessment

The Department of Health and Human Services' Office of Inspector General issued a report entitled "Pennsylvania's Gross Receipts Tax on Medicaid Managed Care Organizations Appear to be an Impermissible Health-Care-Related Tax" (A-03-13-00201) on May 28, 2014. The report made the following recommendations:

- CMS should determine whether the tax on Medicaid MCOs is an impermissible health-care-related tax.
- CMS should clarify its policy concerning permissible health-care-related taxes with all States.

In response to the OIG report, CMS issued State Health Official Letter SHO #14-001 on July 25, 2014, talking on the issue of health care related taxes ("provider assessment"). The letter discussed briefly the history of health care related taxes in relation to managed care organizations. A few key points made in that history include:

- The Balance Budget Act of 1997 replaced the language referencing the term "health care organizations" with the term "Medicaid managed care organizations." This language allowed states to develop an assessment for managed care organizations who dealt with Medicaid beneficiaries only.
- The Deficit Reduction Act of 2005 removed the word "Medicaid" from the description of managed care organizations, leaving the class of providers as simply "managed care organizations (MCOs)." This change required states that have managed care assessment programs to assess both Medicaid MCOs and non-Medicaid MCOs.

Despite the SHO #14-001 restrictions on managed care organization taxes, the following states are currently using some form of a tax or assessment on managed care companies/health insurers that benefits the Medicaid agency:

Table 24. Description of managed care assessments utilized by other state Medicaid agencies specifically on plans caring for Medicaid recipients.

State	Description
California	A tax on Medi-Cal managed care plans under Article 5 of the state's sales tax law. Article 5 Section 6174 through 6189 created a sales tax on Medi-Cal managed care plans. With this tax, Medi-Cal managed care plans "for the privilege of selling Medi-Cal health care services at retail, a tax is hereby extended to all sellers of Medi-Cal managed care plans at the rate of 3.9375

State	Description
	percent of the gross receipts of any seller from the sale of all Medi-Cal managed care plans sold at retail in this state."[152] All monies that are collected from the Medi-Cal managed care plans were deposited into Children's Health and Human Services Special Fund where it will be "appropriated to the State Department of Health Care Services solely for purposes of funding managed care rates for health care services for children, seniors, persons with disabilities, and dual eligibles in the Medi-Cal program that reflect the cost of services and acuity of the population served."[153] The tax included a requirement that the California Department of Health Care Services "provider actuarially sound, monthly capitation payments" to the Medi-Cal managed care organizations and these payments have to be "certified as actuarially sound by State Department of health Care Services' actuaries or contracted actuaries."[154] Because of the uncertainty of taxes levied on Medicaid managed care companies only, the sales tax in California shall "shall be implemented only if and to the extent that federal financial participation under Title XIX of the federal Social Security Act (42 U.S.C. 1395 et seq.) is available and any necessary federal approvals have been obtained" and the sales tax law "is automatically repealed if it is delayed based upon a challenge under federal law." [155] Furthermore, this sales tax shall have "no force or effect if there" is any of the following:[156] 1. A final judicial determination made by any state or federal court that is not appealed, in any action by any party. 2. A final determination by the administrator of the federal Centers for Medicare and Medicaid Services, that disallows, defers, or alters the implementation of this article. If there is no legal or CMS objection to the tax this tax would "become inoperative on July 1, 2016" and repealed on January 1, 2017.[157] Despite the issues raised by the OIG and responded to by CMS, California is anticipating use of this managed care tax to save general fund monies for SFY 2014-2015. The initial Governor's Budget stated the following: The Budget projects net General Fund savings for the CCI of $159.4 million in 2014-15. General Fund savings from the sales tax on managed care organizations is included in the net savings figure.

[152] California Revenue & Tax Code §6175
[153] California Revenue & Tax Code §6184
[154] California Revenue & Tax Code §6186
[155] California Revenue & Tax Code §6187
[156] California Revenue & Tax Code §6188
[157] California Revenue & Tax Code §6189

State	Description
	Without the tax revenue, the CCI would have a General Fund cost of $172.9 million in 2014-15.[158]
Michigan	The State of Michigan reintroduced its tax on Medicaid managed care organizations with the passage of P.A. 162 of 2014 which was signed by Governor Rick Snyder on June 11, 2014. The use tax was effective beginning April 1, 2014 and reinstated the 6 percent rate on "medical services provided by Medicaid Health Maintenance Organizations (HMOs) and Prepaid Inpatient Health Plans (PIHPs)."[159] The Michigan Senate Fiscal Agency estimated the impact of the use tax at a net of $101 million for SFY 2014 and $236 million for SFY 2015. The net amount is after payment for increase in the managed care capitation payments and an amount re-directed to the school aid fund.[160]
Missouri	Missouri employs a Medicaid managed care reimbursement allowance. The reimbursement allowance is for "the privilege of engaging in the business of providing health benefit services in the state."[161] This reimbursement allowance "shall be based on a formula set forth in rules, including emergency rules if necessary, promulgated by the department of social services."[162] The statute expires on September 30, 2015. As with the California sales tax, the reimbursement allowance under section 208.431 "be collected by the department of social services if the federal Center for Medicare and Medicaid Services determines that such reimbursement allowance is not authorized under Title XIX of the Social Security Act" In addition, the statute allows for repayment of "any Medicaid managed care organization reimbursement allowance collected prior to such determination shall be immediately returned to the Medicaid managed care organizations which have paid such allowance."[163]
Ohio	Chapter 5739.01(11)(a) of the Ohio Revised Code requires a sales tax on "all transactions by which health care services are paid for, reimbursed, provided, delivered, arranged for, or otherwise made available by a Medicaid health insuring corporation's contract with the state."[164] Chapter 5739.01(11)(b) does have a caveat on the as follows:

[158] State of California, "*Welcome to California's Governor's Budget 2014-2015 Proposed Budget Summary*," Page 50, (January 10, 2014).
[159] Michigan Department of Treasury HMO Use Tax Information. Downloaded from http://www.michigan.gov/taxes/0,4676,7-238-43519-334456--,00.html
[160] Michigan Senate Fiscal Agency. "*Health Insurance Claim Adjustment and Use Tax S.B. 893 (S-3) & 912 (S-2) Bill Analysis,*" (May 9, 2014).
[161] Missouri Revised Statutes §208.431
[162] Ibid.
[163] Ibid.
[164] Ohio Revised Code Title 57 Chapter 5739.01(11)(a)

State	Description
	If the centers for Medicare and Medicaid services of the United States department of health and human services determines that the taxation of transactions described in division (B)(11)(a) of this section constitutes an impermissible health care-related tax under the "Social Security Act," section 1903(w), 42 U.S.C. 1396b(w), and regulations adopted thereunder, the Medicaid director shall notify the tax commissioner of that determination. Beginning with the first day of the month following that notification, the transactions described in division (B)(11)(a) of this section are not sales for the purposes of this chapter or Chapter 5741. of the Revised Code. The tax commissioner shall order that the collection of taxes under sections 5739.02, 5739.021, 5739.023, 5739.026, 5741.02, 5741.021, 5741.022, and 5741.023 of the Revised Code shall cease for transactions occurring on or after that date.[165] Current sales tax rate is 5.5 percent and is collected from the Buckeye Health Plan, CareSource, Molina Healthcare, Inc., Paramount Advantage and UnitedHealth.[166] Based on the sales tax only applying to Medicaid managed care organizations and the July 25, 2014 State Health Official Letter SHO# 14-001, the Ohio Department of Medicaid is currently reviewing if changes need to be made to the State's collection of tax on managed care organizations.[167]

Most states, however, moved away from a tax on Medicaid managed care organizations and adopted a tax on all health insurers that a portion or all of the tax was used to benefit the Medicaid program. Examples of these states are as follows:

Table 25. Description of managed care assessments utilized by other state Medicaid agencies and applied to all health insurers in the state.

State	Description
Arizona	Arizona Revised Statutes 20-224(B) requires the payment of a "tax of 2.0 per cent of such net premiums."
Louisiana	The State of Louisiana has a tax on life, accident, health, or service insurance providers. The minimum tax paid is $140 on annual gross premiums of $7,000 or less and then an additional $225 for each additional $10,000 of annual gross revenue.[168]

[165] Ohio Revised Code Title 57 Chapter 5739.01(11)(b).
[166] Carries Ghose. "*Feds scrutinizing state taxes like Ohio's singling out Medicaid managed care*," Columbus Business First, (September 14, 2014).
[167] Ibid.
[168] Louisiana Revised State Chapter 22 §842A.

State	Description
	Louisiana Revised Statute Chapter 22 §842B requires "[t]axes collected under the provision of this Section from health care premium assessments paid by Medicaid-enrolled managed care organizations, after first having been credited to the Bond Security and Redemption Fund as required by Article VII, Section 9(B) of the Constitution of Louisiana, shall be deposited into the Louisiana Medical Assistance Trust Fund." During state fiscal year ended June 30, 2013, the Louisiana Department of Insurance collected $17,921,585 from the Medicaid-Enrollment Managed Care Organizations – Bayou Health Plans[169]
Michigan	The Health Insurance Claims Assessment Act of 2011 (P.A. 142 of 2011) created Michigan Compiled Laws Section 550.1731 through 550.1741. The initial purpose of the act was to collect "an assessment of 1% on that carrier's or third party administrator's paid claims" for dates of services beginning on January 1, 2012 and ending on June 30, 2014 with some exceptions detailed in the law.[170] The funds collected from this tax have to be used to "finance the expenditures of Medicaid managed care organizations that include Medicaid contracted health plans and specialty prepaid health plans"[171] or "[t]hrough June 30, 2014, if the assessment under this section collects revenue in an amount greater than $400,000,000.00, adjusted annually by the medical inflation rate since 2011, each carrier and third party administrator that paid the assessment shall receive a proportional credit against the carrier's or third party administrator's assessment in the immediately succeeding year."[172] The 1 percent tax under the Health Insurance Claims Assessment was reduced to 0.75 percent beginning July 1, 2014 with the passage of P.A. 162 of 2014 which created the use tax on Medicaid managed care organizations.[173] In addition to the decrease in the tax rate for the Health Insurance Claims Assessment, the maximum amount of receipts before carry forwards into the next year begin was raised from $400 million to $450 million with the use tax and HICA being combined.[174] The Health Insurance Claims Assessment generated $268.45 million in State Fiscal Year ended June 30, 2013.[175] The implementation of the use tax for Medicaid managed care services discussed previously would

[169] Louisiana Department of Insurance. "2012-2013 Annual Report," Page 187.
[170] Michigan Compiled Laws Section 550.173(1)
[171] Michigan Compiled Laws Section 550.1737(5)(a)
[172] Michigan Compiled Laws Section 550.1733(6)
[173] Michigan Department of Treasury Update on Health Insurance Claims Assessment (HICA) Act. http://www.michigan.gov/taxes/0,4676,7-238-43519-264498--,00.html
[174] Michigan Compiled Laws Section 550.1733(6)
[175] Michigan Department of Treasury. "*Annual Report of the Michigan State Treasurer 2012-2013*," Page 19.

State	Description
	reduce the Health Insurance Claim Assessment by $77.55 million in rate year.[176]
Texas	The Texas Insurance Code includes two taxes that Medicaid managed care organizations are required to pay. The first tax is a premium tax based on gross premiums or gross revenue which include "premiums, membership fees, assessments, dues, revenues, and other considerations received by the insurer or health maintenance organization in a calendar year."[177] These gross revenues and gross premiums are taxed at 0.0875% on the first $450,000 of gross premiums and 1.75% on gross premiums above the first $450,000.[178] The second tax required to be paid by Medicaid managed care organizations in the state of Texas is a maintenance tax. The Medicaid managed care organizations are considered health maintenance organizations and therefore are governed by the maintenance tax prescribed under the Texas Insurance Code §258. Under this tax, a per capita maintenance tax at a "rate of assessment set by the commissioner" that "may not exceed $2 per enrollee" on an annual basis.[179] The administrative potion of rates set for STAR+PLUS managed care entities include an allowance for these taxes. Premium rates for STAR+PLUS managed care entities include a premium tax (1.75%) and a maintenance tax ($0.1025 for each PMPM).[180] For State Fiscal Year 2014, the insurance premium tax collected $1.811 billion and the insurance maintenance tax collected $83.188 million which were deposited into the general fund. A portion of these taxes are diverted to the Texas Health and Human Service Commission to reduce the agency's impact on the traditional sources of funding in the General Fund. During the managed care expansion as part of the 2012-2013 biennial, HHSC estimated that $238 million in increased revenue would be generated to relieve commitments from pre-existing general fund sources.[181]

CMS has detailed a methodology for including any health insurance related tax that is paid by Medicaid managed care organizations that would allow these Medicaid MCOs to be paid for

[176] Michigan Senate Fiscal Agency. "*Health Insurance Claim Adjustment and Use Tax S.B. 893 (S-3) & 912 (S-2) Bill Analysis*," (May 9, 2014).
[177] Texas Insurance Code §222.002
[178] Texas Insurance Code §222.003
[179] Texas Insurance Code §258.003
[180] Even L. Dial. "*State of Texas Medicaid Managed Care STAR+PLUS Program Rate Setting State Fiscal Year 2014*," Prepared for Texas Health and Human Services Commission, (July 11, 2013).
[181] Texas Health and Human Services Commission, "*Health and Human Services System Consolidated Budget for Fiscal Year 2012-2013*," Table IV.3.

the tax. In October 2014, CMS issued a frequently asked questions memo related to the Section 9010 of the Affordable Care Act's health insurance provider fees and the impact on Medicaid managed care organizations. CMS stated that "this fee, like other similar fees, should be considered a business cost to health plans." The same logic would exist in a state generated tax causing the managed care organizations to potentially be held harmless if the tax is under 6 percent of net revenues, and broad based, and assessed in a uniform manner.

9.3.4 Continue Inter-Governmental Transfers

IGTs currently generate a significant portion of funding for the Florida Medicaid program. In SFY 2012/13, $1.2 billion in IGT dollars were contributed to the Florida Medicaid program, which funded 44 percent of the state share of hospital reimbursements and 26 percent of the state share of the Medicaid program overall.[182] These percentages are relatively unchanged in SFY 2013/14 and 2014/15.

IGTs fund a portion of the state share for claim payments and fund nearly the entire state share of the LIP program. In SFY 2014/15, approximately $270 million will be contributed through automatic IGTs to help fund the state share of claim payments in the FFS and managed care programs. IGTs also fund approximately 98 percent of the "traditional" $1 billion in the LIP program and fund all of state share of "LIP 6" (formerly "self-funded IGTs")[183]. IGTs for the physician supplemental payment program and a small amount of general revenue comprise the rest of the state share for the SFY 2014/15 LIP program.

These very sizeable IGT contributions have evolved because the payment distribution methods have ensured local governments and public hospitals receive measureable benefit from their contributions. At a minimum, the LIP program ensures IGT contributors receive back their money plus an 8.5 percent usage fee for all money contributed toward funding the state's share of the traditional $1 billion LIP program and automatic rate enhancements applied to claim payments. In addition to the usage fee, many, but not all hospitals, receive benefit from increased rates through automatic rate enhancements and supplemental payments through various sub-programs defined within the LIP program. Lastly, contributors to LIP 6 receive back their contribution plus the entire federal share related to that contribution.

As long as such clear benefits are available to contributors of IGTs, it is safe to assume the contributors will continue to make these funds available. If the LIP program continues in the future, it can continue to distribute funds generated through IGT contributions. If on the other hand, the LIP program is discontinued, other payment methods will need to be devised to ensure continued Medicaid funding through IGT contributions.

[182] Includes funding for hospital fee-for-service rates, managed care capitation rates, LIP supplemental payments and DSH supplemental payments.

[183] Note that Florida began referring to the "self-funded IGT" program as the "LIP 6" program starting in SFY 2014/2015.

Without a waiver for the LIP program, the transition to managed care in Florida will continue to "shrink" the available gap between FFS claim payments and the Medicare UPL, which in turn will limit the amount of federal matching funds that can be generated through IGTs. It simply will not be possible to sustain the same funding levels using IGTs without the waiver. At the same time, some states have preserved the use of IGTs through the creation of DSRIP programs, although as described in Chapter 7 of this report, even with DSRIP waivers, states need to be able to demonstrate budget neutrality, so there are some financial constraints.

This is an option several other states, such as California, Texas, and New York, have chosen to enable supplemental payments (or DSRIP incentive payments) to continue while most of the recipients are enrolled in Medicaid managed care programs. DSRIP programs tie distribution of funds to quality measures, so hospitals would not be guaranteed payment in the same way they are today within the Florida LIP program. Hospitals would need to reach pre-determined milestones in order to receive full payment. In addition, California and Texas have uncompensated care pools. Uncompensated care pools could provide another avenue for distribution of IGT funds, if approved by CMS.

The benefits to public hospitals, local governments, and taxing districts who contribute IGTs would not necessarily need to be as great as they are today to create sufficient incentive for IGTs to continue. IGTs increase the state share and enable significant federal funds to flow into the state. So there is clear benefit for IGTs to continue. However, payment methods will need to be defined in ways that offer direct, identifiable benefit to IGT contributors. Without that, administrators of public hospitals, local governments, and taxing districts will be unable to justify to their constituents donation of local tax revenue to the state Medicaid program.

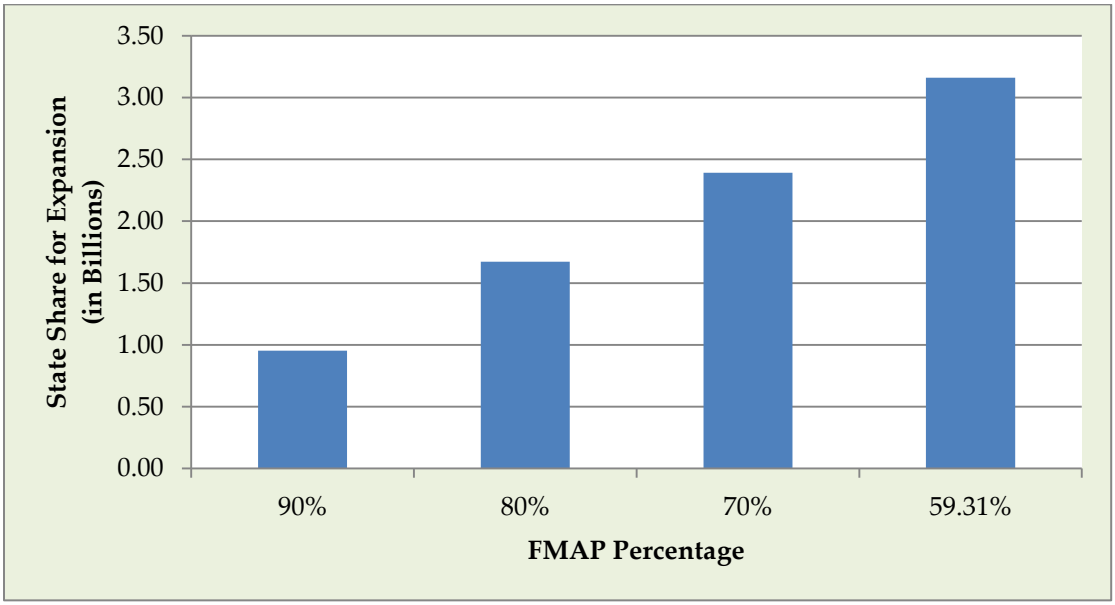
9.3.5 Medicaid Expansion – Funding

Coming up with the state share of funding for Medicaid expansion is a critical concern for states deciding whether or not to implement. While the Federal government promises to supply all of the funding for the first three years of expansion, the states are required to contribute a steadily increasing percentage which reaches 10 percent by FFY 2020 and continues at 10 percent through the rest of the initially designated period (with the federal government paying the other 90 percent). An obvious concern for state governments is the question of how long the FMAP for the expansion population will remain at 90 percent. With a 90 percent FMAP, there is certainly temptation to find ways to fund the 10 percent state share in order to bring a very significant amount of additional federal funds into the state. However, if the FMAP percentage reduces over time, the costs to the state can increase significantly.

By SFY 2022/23, the Florida SSEC estimates the additional state costs from Medicaid expansion to be $953 million and continuing annually around that level, with adjustments for inflation and Medicaid utilization. This estimate assumes a 90 percent FMAP for the expansion population. Figure 27 below shows how the amount of state share for the expansion population changes if the FMAP gets reduced below 90 percent. These numbers use estimates of expansion costs to

the state for SFY 2022/23, but the concept they depict would apply if the expansion FMAP percentage is reduced in any future year.

Figure 27. Increase in state share of Medicaid expansion costs if FMAP decreases.



Given the increase in state share from expansion, at 90 percent FMAP and the risk of lower future FMAPs, it will be necessary for Florida Medicaid to develop a strategy defining how to provide funding if a Medicaid expansion is implemented.

9.3.6 Certified Public Expenditures

As mentioned earlier, certified public expenditures represented 5.4 percent or $9.7 billion of the non-Federal share of Medicaid expenditures for State Fiscal Year 2012.[184] This significant dependence on the use of this financing tool has caused the use of certified public expenditures as well as the other financing tools described in this report to come under scrutiny from CMS, HHS OIG and the GAO in recent years. The United States Government Accountability Office discussed in a recent report certified public expenditures in the following manner:

> A state may obtain funds from local governments (e.g., counties or cities), or from hospitals or other providers that are owned or operated by local governments, via certifications of spending—known as certified public expenditures (CPE)—that can be used to document state Medicaid spending in order to obtain federal matching funds. CPEs do not involve the transfer of money to be used to finance the nonfederal share; rather, the local government provider or entity certifies to the state an amount that it has

[184] U.S. Government Accountability Office. "*Medicaid Financing States' Increased Reliance of Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection*," Figure 1, (July 2014).

expended for Medicaid covered services provided to Medicaid beneficiaries. A CPE represents the total costs (both the federal and the nonfederal share) incurred for the Medicaid services. The state has the flexibility to send the federal matching funds it receives to the local government or local government provider that certified the expenditure or may retain some or all of those funds.[185]

Certified public expenditures have several advantages over the other financing tools discussed in this report. Some of these advantages are as follows:

1. Inter-governmental transfers require the public provider or local government transferring on behalf of the health care provider to send funds to the Medicaid agency for the Medicaid agency to pull the corresponding Federal dollars for the allowable expenditure. The entire computable expenditure must be paid to the health care provider under intergovernmental transfers. As stated above, the certified public expenditure represents both the Federal and non-Federal share of the total computable expenditure. The Medicaid agency receives the Federal share from the grant award and CMS considers the expenditure paid. The Medicaid agency has complete discretion on how to spend the Federal portion on the expenditure although the manner of its use is usually defined in a contract between the health care provider and the Medicaid agency.

2. Health care-related taxes may be applied to only permissible classes listed in 42 CFR §433.56. Certified Public Expenditures are governed by 42 CFR §433.51 which requires that "the actual expenditures incurred by the contributing unit of government in providing services to eligible individuals receiving medical assistance or in the administration of the State Plan."

3. Health care-related taxes have a hold harmless provision where certified public expenditures have no such hold harmless provision.

Several states have adopted certified public expenditures as a financing tool within the Medicaid program. A summary of several states using certified public expenditures is shown in Table 26.

[185] US GAO, "*Medicaid Financing – States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection (GAO-14-627),*" Page 7-8, (July 2014).

Table 26. Summary of state utilization of certified public expenditures.

State	I/P Hospital	O/P Hospital	DSH	School Based Services	Other[186]
Alabama			X	X	
Arizona			X		
California			X		X
Georgia				X	
New York				X	
North Carolina			X	X	X
Washington	X	X	X		X

Colorado allows for the use of certified public expenditures in the payment of capitated rates. Colorado's statutes regarding the use of CPE are as follows:

- Government-owned Prepaid Inpatient Health Plan (PIHP) Agreements shall be allowed to use "certified public expenditures or other federally recognized financing mechanisms to provide the state share for the federal match to enhance capitation payments up to or above the one hundred percent limit.[187]
- Government-owned Managed Care Entitites (MCE) shall be allowed to use "certified public expenditures or other federally recognized financing mechanisms to provide the state share for the federal match to enhance capitation payments up to or above the one hundred percent limit.[188]

Tennessee uses certified public expenditures within its 1115 waiver through the creation of the "Unreimbursed Public Hospitals Costs Pool." This pool uses certified public expenditures in the following manner:

> Actual costs incurred by government operated hospitals for the provision of inpatient and outpatient TennCare services for TennCare enrollees and uninsured patients are eligible as CPE. The state must be able to document that the applicable hospitals had actual unreimbursed costs for providing those TennCare covered hospital inpatient and outpatient services, which exceeded the amounts paid to the hospital from the following sources: the MCOs; the TennCare enrollees and the uninsured; TennCare supplemental pool payments; the amount of GME funds received that exceeded the hospital's Medicaid

[186] Services include targeted case management, physician and non-physician professional services, and nursing facility supplemental payments.
[187] Colorado Revised Statutes 25.-5-407.5(4)
[188] Colorado Revised Statutes 25.-5-408(12)

GME expenditures; any DSH payments received; and other sources (except for local government indigent care funds).[189]

States have learned to use the flexibility of certified public expenditures to help meet the needs of both health care providers and the Medicaid agency. Health care providers are able to receive reimbursement above normal claims payments without the Medicaid agencies needing to use general funds for the allowable expenditures. In addition, some Medicaid agencies keep portions of the CPE federal matching funds for use in paying for health care services beyond those certified by the public facility.

9.3.7 Designated State Health Program

Designated State Health Programs (DSHPs) have become a common source of funding for States under 1115 waivers. These programs are "health programs funded entirely by the state, many of which provide safety-net health care services for low-income or uninsured individuals such as adult day care, outpatient substance abuse treatment, or care for the mentally ill who are not eligible for Medicaid."[190] The key component of DSHP is that a state uses existing programs that traditionally were not available for Federal match and receives Federal dollars. The State continues to pay for the programs as they have in the past, and the state can pull down federal matching funds that can be used for reforms defined under an 1115 waiver.

The following are examples of how DSHP is implemented in various states:

California Bridge to Reform Demonstration (11-W-00193/0) – effective November 1, 2010

The California Health and Human Services Agency uses DSHP expenditures to assist in the funding of the Safety Net Care Pool program by using expenditures for medical care from the following programs: Breast and Cervical Treatment Program (BCCTP); Medically Indigent Adults/Long-Term Care (MIA/LTC) Program; California Children's Services (CCS) Program; Genetically Handicapped Persons Program (GHPP); Expanded Access to Primary Care (EAPC); AIDS Drug Assistance Program (ADAP); Department of Development Services (DSS); and County Mental Health Services. In addition to the above expenditures, California is allowed to use expenditures for workforce development programs related to medically disadvantaged service areas in the following programs: Song Brown HealthCare Workforce Training; Health Professions Education Foundation Loan Repayment; Mental Health Loan Assumption; and training programs for medical professionals at California community colleges, California State Universities and the University of California.[191]

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[189] CMS Approval Letter for amendment to TennCare II (Project No. 11-W-00151/4) 1115 demonstration letter, Page 71, (September 5, 2014).

[190] Alexandra Gates, Robin Rudowitz, and Jocelyn Guyer (Kaiser Family Foundation), "*An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers,*" (September 29, 2014).

[191] CMS Expenditure Authority Letter, California Bridge to Reform Demonstration (11-W-00193/9), Page 4-5.

The FFP annual limit on DSHP expenditures for Medi-Cal is $400 million for demonstration years covering SFY 2010 through SFY 2015.

New York Federal-State Health Reform Partnership (F-SHRP) 1115 – effective October 1, 2006

The State of New York's F-SHRP 1115 waiver used programs from certain Health Care Reform Act (HCRA) programs and certain programs "administered by other State agencies such as the offices of Mental Health, Mental Retardation and Developmental Disabilities, Aging, Alcohol and Substance Abuse Services and Children and Family Services" that are not Medicaid services and do not qualify for standard Medicaid Federal matching. The State of New York was entitled to draw $300 million of Federal funds each year of the demonstration to use as the State share for other expenditures under the 1115 waiver.[192]

Oregon Health Plan (21-W00031/10 and 11-W00160/10) – effective July 5, 2012

Oregon Health Authority is allowed to use expenditures from the following programs as DSHP funds available to draw down Federal funds under the waiver: Alcohol and Drug; Adults and People with Disabilities; Addictions & Mental Health; Children, Adults and Families; Client Process Monitoring System; Division of Medical Assistance Programs; Express Payment and Reporting System; Oregon State Public Health Lab; Oregon Medical Insurance Pool; Public Health Division; Statewide Financial Management System; and Seniors and People with Disabilities.[193]

The maximum limit on the Federal Fund Participation for DSHP in Oregon is as follows: Demonstration Year 1 & 2: $230 million annually, Year 3: $108 million, and Year 4 & 5: $68 million annually.[194]

9.4 Options for Payment Methods

9.4.1 Continue the LIP Program

As mentioned in previous sections, Florida Medicaid receives a relatively small amount of federal funds for the DSH program as compared to other states. To a degree, the LIP program helps offset Florida's low DSH funding by providing other funding that helps offset hospital costs for care to the uninsured. However, the LIP program does not go through the same level of oversight as the DSH program. Both the LIP and DSH programs have a requirement that total reimbursement to hospitals should not exceed hospital cost to treat Medicaid and

[192] New York Department of Health, "*Federal-State Health Reform Partnership (F-SHRP) Overview,*" (June 2007).
[193] CMS Amended Waiver List and Expenditure Authority, Oregon Health Plan (OHP) (21-W-00013/10 and 11-W-00160/10), Attachment G.
[194] CMS Amended Waiver List and Expenditure Authority, Oregon Health Plan (OHP) (21-W-00013/10 and 11-W-00160/10), Table 4.

uninsured recipients. Under the DSH program, annual audits of hospital cost are performed to ensure this requirement is met. Audits are not performed for the LIP program. Instead, costs self-reported by hospitals are used to ensure total reimbursement is within applicable hospital costs. If more program oversight and control is added to the LIP program, and greater transparency is provided related to the levels of funding and payment occurring through the LIP program and IGT-funded rate enhancements, perhaps continuation of the LIP program would be considered a viable option by CMS.

Improved transparency of funds flow would be helpful because of the complexity of the current program. The overlap between distribution of LIP funds and IGT-funded automatic rate enhancements creates some complexity that makes tracking of funds flow more difficult. The LIP program is part of an 1115 waiver and is managed separately from claim payments. However, the LIP Council, which determined distribution of LIP funds also determined distribution of automatic rate enhancements, which are distributed with claim payments. In addition, the hold-harmless provision that guarantees hospitals receive back their contributions plus 8.5 percent is handled through supplemental payments in the LIP program, even though some of their IGT contributions are used as state share in funding automatic rate enhancements. Inclusion of separately negotiated self-funded IGTs further compounds the complexity of Florida Medicaid hospital funding and payment mechanisms.

To fully monitor the flow of Medicaid reimbursements to hospitals, a combination of claim payments and supplemental payments needs to be reported. Separately, AHCA monitors claim payments and supplemental payments in detail. However, few, if any standard reports show the combination of both at the individual hospital level. Creating such reports would be relatively easy for AHCA as they already monitor both types of payments. Combining more comprehensive payment reports with data on the source of funding at the hospital level, would significantly increase transparency within the program. Combining this with better reporting and auditing standards for hospital costs (similar to the reporting and auditing standards established for the DSH program), instead of reliance on hospital self-reporting, and assuring that payments will not exceed allowable costs, could potentially be sufficient for CMS to reconsider the appropriateness of continuing the LIP program. And, given the lead time required to design and implement many of the other options described in this report, being able to preserve much of what already is in place with the current LIP program makes it an attractive option.

9.4.2 Increase Medicaid Fee-for-Service Program Rates and Medicaid Managed Care Capitation Rates

One of the more administratively straight forward options for distributing funds that have previously been distributed through the LIP program is to increase Medicaid FFS rates for inpatient and outpatient hospital services. Such rate increases would ultimately translate into increases to the Medicaid managed care capitation rates for both inpatient and outpatient hospital services. Such increases could be made in a way that maintains budget neutrality of overall Medicaid spending across inpatient and outpatient hospital services, by simply shifting

the current levels of supplemental payments distributed through the LIP program into claim-based or capitation-based payments. For services provided under the FFS program, the claim payment increases would be made directly from AHCA to the hospitals. For inpatient and outpatient hospital services provided through the Medicaid managed care plans, the increased rates could be translated into larger capitation rates from Medicaid to the managed care plans, which would generally be passed on from the managed care plans to hospitals.[195]

Increases to FFS rates for Medicaid inpatient and outpatient hospital services are limited by federal UPL regulations, which generally specify that Medicaid programs cannot pay more than what Medicare would pay for the same services. This same limitation also indirectly affects how much can be added to the managed care capitation rates. Medicaid managed care capitation rates must meet a standard of actuarial soundness, which is determined by the State's designated actuary. Generally, actuarial soundness means that the capitation rates must be appropriate for the populations covered by the plans and the services to be furnished. While capitation rates may not be directly related to FFS payment levels, we assume that the State's actuary does consider what would be paid for services provided to the Medicaid managed care populations when establishing capitation rates.

We believe there is an opportunity to increase both the FFS rates and the capitation rates, which can both be used to distribute some of the funding currently distributed though the LIP program. However, the traditional $1 billion LIP program amounts are intended to compensate hospitals for both the unfunded gap between Medicaid and Medicare payments as well as to partially offset the hospital costs associated with providing services for uncompensated care populations. As discussed previously, adding the entire $1 billion LIP program amount into the FFS and capitation rates would exceed allowable reimbursement levels under the FFS UPL rules and potentially the principles associated with capitation rate actuarial soundness. As a result, if this option was selected, some funds from the LIP program may need to be held out of the FFS rates (and indirectly the capitation rates) and potentially distributed through other means.

Making some increases to FFS rates can provide some flexibility to the State as far as directing Medicaid funds to certain providers. Similar to what is done today with inpatient fee-for-service payments, the rates can be set by category of hospital to account for justifiable variations in cost structures and different levels of Medicaid utilization. Today, separate fee-for-service inpatient payment rates exist for rural hospitals, free-standing long-term acute care hospitals, free-standing rehabilitation hospitals, and hospitals with very high Medicaid utilization and very high outlier payments. In addition, GME and DSH payments can continue to be made separately.

This option has the distinct advantage of being rationally based, and would be consistent with the U.S.C. § 1396 (a)(30)(A) standards related to efficiency and economy, and adequate access to

[195] We are assuming most negotiated rates between managed care plans and hospitals are based on the Agency's fee-for-service rates.

quality care, a requirement for CMS. We assume that CMS would also consider this option attractive because it more closely aligns payments with Medicaid patient utilization than does the current LIP funding distribution method. The bulk of the hospitals' reimbursement would be tied to patient utilization, as was the case in SFY 2013/14 when 84 percent of total hospital reimbursement was utilization based. In SFY 2014/15, this amount dropped to 70 percent[196] because self-funded IGTs shifted from claim payments to supplemental LIP payments.

In addition, this option has the advantage of enabling the managed care plans the flexibility to offer stronger quality-based financial incentives as the plans generally will have more control over all payments related to the managed care population. This option allows for greater payments made to hospitals from the plans and less made through supplemental payments directly from AHCA to hospitals. This would give the plans greater purchasing power and a greater ability to implement value-based purchasing strategies that could help reduce unnecessary utilization and lower overall cost to the Medicaid program.

As clear as the advantages are to this option, there are equally clear disadvantages. The primary concern with this option relates to the source of the funding. This option could be designed with much more fair and even distribution of funds across all hospitals based on services provided to Medicaid recipients, for example, through an across-the-board proportional increase to the FFS rates (which would presumably translate to higher capitation rates as well). However, under current funding mechanisms, this approach will result in the IGT contributors (counties, hospital districts, etc.) contributing funds that would be spread across the entire state, with little or no control over what funding comes back to the specific jurisdictions who provided the funds. This easily could result in local governments choosing to keep their funds within their local area instead of offering the funds to the Medicaid program through IGTs, even at the risk of giving up the federal matching funds that have been generated through these programs. At the same time, it should be noted that although state Medicaid agencies generally may not dictate how the Medicaid managed care plans distribute funds to participating providers, we do know that hospital providers in some states have successfully established arrangements that allow supplemental funding streams to be redistributed between hospitals after payments are received from the managed care plans. It should also be noted that these types of "back door" redistribution arrangements have typically been established without any state involvement.

Another way to implement this option is to set different rates for different hospitals based on the amount of IGT funds contributed on the hospitals' behalf. This rate setting method would be very similar to what was done in SFY 2013/14 when most Medicaid payments were made through the FFS program. However, this option might give managed care organizations incentives to direct Medicaid patients towards hospitals with lower rates thus reducing utilization and reimbursement levels at hospitals in the jurisdictions that contribute IGTs.

[196] The percentages of payments based on Medicaid utilization assume all fee-for-service and managed care capitation payments are based on Medicaid utilization and all LIP payments are not based on utilization. Also, these estimates exclude GME payments, DSH payments, and physician supplemental payments.

Again, the result could be local governments choosing to keep their funds within their local area instead of offering the funds to the Medicaid program through IGTs.

The option of increasing claim payment rates for both fee-for-service and Medicaid managed care creates a risk of reduced IGT contributions, which could result in reductions in the overall state share of funding available for Medicaid hospital reimbursement. As a result, this option is likely only viable if coupled with a shift in funding to a broad-based increase in the provider assessment (which would replace the need to rely on voluntary contributions from other governmental entities) or an increase in State general revenue funds applied to the Medicaid program.

9.4.3 Delivery System Reform Incentive Payment Program

In most, if not all, DSRIP programs, funds are distributed through incentive payments outside of claim payments and outside of managed care capitation payments. Payments are made directly from Medicaid agencies to providers.

Similar to Florida's current LIP program, if a DSRIP program is funded primarily with IGTs, one would expect the projects selected and the distribution of funds would be primarily to those who contributed the IGTs. Given the influx of federal matching dollars for the IGTs, some funds could be set aside specifically for projects operated by non-public hospitals. This is done in New York, for example. Alternatively, projects could be required to be defined in such a way that project teams include both public and private institutions. Hospitals in similar geographic locations that offer similar service lines may consider each other as competitors and have a difficult time forming partnerships for DSRIP programs. However, hospitals that are geographically separate, or offer different service lines may find these arrangements easier to develop. The free-standing children's hospitals, for example, may be able to develop partnerships because they offer care for severely ill or injured children that other hospitals do not necessarily offer. Similarly, an arrangement for placement of residents may provide an opportunity for a public teaching hospital, which does have access to IGTs, and a private hospital, which does not have access to IGTs, to form a partnership.

While defining a DSRIP program, payments are generally held at current levels and using current distribution methods to allow time for providers to transition into the new fund distribution mechanisms. In addition, most DSRIP programs set milestones in the first two or three years of the program to be based primarily on meeting predetermined program requirements and achieving milestones related to process improvement and system redesign. Starting in year three and continuing in subsequent years, the payments shift to being tied more to outcome measures related to improvement in quality of care and/or reduction in health care costs.

Calculation of specific payment amounts can be determined using a variety of factors. Certainly, in later years of the DSRIP program, levels of completion of milestones should be considered, likely with tiers defined allowing for higher levels of payment for higher levels of

success in pre-defined milestones. In addition, some DSRIP programs set aside money to reward projects that succeed beyond expectations. For example, New Jersey funds a program called Universal Performance Pool (UPP) which is available to hospitals that successfully maintain or improve on a subset of DSRIP performance indicators. Similarly, New York plans to set aside some DSRIP funds for a performance pool available to providers that exceed the stated quality improvement goals.

Like all programs that include incentive or other types of supplemental payments, a balance has to be struck between fairness and administrative simplicity. The payment methods need to be robust enough to fairly reward those who meet or exceed program goals. At the same time, administrative simplicity and transparency of the payment calculations increases understanding of how incentive payments are determined, a critical component of facilitating buy-in from all of the many critical stakeholders affected by the projects, including CMS.

9.4.4 Medicaid Expansion – Payments

In theory, payments for the expansion population could be defined differently than payments for the non-expansion population. However, we don't see any particular value in defining separate payment methods. On the contrary, we would expect folding an expansion population into existing Medicaid payment methods offers the greater simplicity and administrative ease. In addition, in the case of Florida, where most recipients are enrolled in managed care plans, enrolling the expansion population in Medicaid managed care would give the managed care organizations greater purchasing power and more ability to manage cost through value-based purchasing strategies.

We do not expect that Medicaid expansion would do away with uncompensated care entirely, so we would hope the DSH program could continue even if Florida decided to undergo expansion. Florida's DSH allotment is currently unusually small given the size of the state's uninsured population. Expansion would succeed in making the current DSH allotment in Florida more reasonable for the population it serves.

The LIP program on the other hand, could justifiably be reduced if the number of uninsured reduced significantly through expansion. Recent Upper Payment Limit calculations show that the LIP program is contributing towards care of the uninsured, particularly in the public hospitals which receive the bulk of the LIP funding. For example, when looking at the UPL calculations for SFY 2013/14, the last year Florida Medicaid was primarily a fee-for-service program, the Non-State, Government Owned hospital category had a UPL gap of only $18 million, whereas the Privately Owned hospital category had a UPL gap of $480 million. Although no formal distinction is made, one might imply from these numbers that payments from the traditional $1 billion LIP program to Non-State, Government Owned hospitals primarily contribute to those hospitals' costs of caring for the uninsured. Payments from the traditional $1 billion LIP program to Privately Owned hospitals primarily contribute to the gap between Medicaid reimbursement and the Upper Payment Limit. (This assertion assumes

payments from the LIP program are applied first to the UPL gap and secondly to uncompensated care.)

9.4.5 Upper Payment Limit Program for Fee-for-Service Eligibles

Upper Payment Limit programs are generally supplemental payment programs where payments are made outside of the claims-based payment process, generally made in the form of lump sum amounts (e.g., quarterly payments for trauma service providers). These UPL payments are commonly made to as a way for a state to direct funding to specific types of providers outside of the claims-based payment methodology, and are typically targeted to providers that are critical for maintaining adequate access to services for the Medicaid population (e.g., safety net hospitals). Such payments are eligible for federal match as long as, when combined with all other payment sources, payments do not exceed the Medicare UPL (which is the maximum amount that a Medicaid program can pay).

Generally, UPL payment programs are difficult to maintain when states transition to fully capitated managed care models. This is because states are not allowed to make payments directly to hospitals for services provided to Medicaid-eligible individuals that are enrolled in Medicaid managed care programs. In other words, with few exceptions, all payments to hospitals for services provided as part of Medicaid managed care programs must be made by the managed care plans. States make PMPM capitation rate payments to the Medicaid plans – and the plans are responsible for negotiating contracts with participating hospitals and making payments in accordance with those contracts.

Further, as states transition to capitated managed care models, the Medicare Upper Payment Limit "gap", or the difference between what Medicare would pay for services and what is actually paid for by Medicaid, gets smaller. This is because the Medicare Upper Payment Limit "gap" can be determined based on the service payments associated with the FFS population only.

As such, Florida's opportunity for UPL payments is growing smaller.

With the transition to a Medicaid managed care model, Florida's Statewide Managed Care (SMMC) Managed Medical Assistance (MMA) program now only has the following individuals who are not required to participate and who are not eligible to participate, and whose payments will continue through the FFS program:[197]

[197] AHCA. "*A Snapshot of the Florida Medicaid Managed Care*"

Table 27. Eligibility categories currently carved out of Florida's Managed Medical Assistance program.

Category	Not Required to Participate	Not Eligible to Participate
Medicaid recipients who have other creditable health care coverage, excluding Medicare	X	
Persons eligible for refugee assistance	X	
Medicaid recipients who are residents of a developmental disability center	X	
Medicaid recipients enrolled in the developmental disabilities home and community based services waiver or Medicaid recipients waiting for waiver services	X	
Children receiving services in a prescribed pediatric extended care center	X	
Women who are eligible only for family planning services		X
Women who are eligible through the breast and cervical cancer services program		X
Persons who are eligible for emergency Medicaid for aliens		X

Again, these individuals would continue to receive FFS payments for Medicaid eligible services.

Florida has not submitted a State Plan Amendment to establish a UPL program for inpatient and outpatient hospital services paid through the FFS program. As part of creating UPL program pools for hospital inpatient and outpatient services, the state will have to comply with State Medicaid Director Letter 13-003 "Federal and State Oversight of Medicaid Expenditures" which requires "that states submit UPL demonstrations for inpatient hospital services, outpatient hospital services, and nursing facilities." These submissions will dictate on a yearly basis the magnitude of funds that can be paid to hospitals through UPL protocols.

9.4.6 Graduate Medical Education

As described above, UPL programs are generally supplemental payment programs that are limited to services provided to the FFS population only.

One exception to this rule is funding for Graduate Medical Education programs. Graduate Medical Education is one area in which CMS has allowed states to carve out a supplemental payment made directly to teaching hospitals from the state Medicaid agency – even when services are provided as part of a Medicaid managed care program.

Based on the Association of American Medical College's "Medicaid Graduate Medical Education Payments: A 50-State Survey" published in March 2013, the following Medicaid

agencies had graduate medical education payments carved out of their managed care programs during 2012:

Table 28. States with managed care and supplemental payments for Graduate Medical Education.[198]

State	Rationale for Making Medicaid GME Payments Directly (Carve-Out) to Teaching Programs
Arizona	Desire to use funds to advance state policy goals.
Colorado	Follow Medicare to make explicit GME payments to teaching hospitals for Medicaid funds to advance state policy goals; Desire to help train the next generation of physicians who will serve Medicaid beneficiaries.
District of Columbia	Follow Medicare's decision to make explicit GME payments to teaching hospitals for managed care enrollees.
Georgia	GME seen as public good; Desire to use Medicaid funds to advance state policy goals; Desire to help train the next generation of physicians who will serve Medicaid beneficiaries.
Indiana	Follow Medicare to make explicit GME payments to teaching hospitals for Medicaid managed care enrollees.
Kansas	GME seen as a public good; Follow Medicare to make explicit GME payments to teaching hospitals for Medicaid managed care enrollees; Concern from teaching hospitals about losing GME payments; Desire to use Medicaid funds to advance state policy goals; Desire to help train the next generation of physicians who will serve Medicaid beneficiaries.
Maryland	Desire to help train the next generation of physicians who will serve Medicaid beneficiaries; Desire to use Medicaid funds to advance state policy goals; Promote training of primary care physician.
Minnesota	GME seen as a public good; Follow Medicare to make explicit GME payments to teaching hospitals for Medicaid managed care enrollees; Concern from teaching hospitals about losing GME payments; Desire to use Medicaid funds to advance state policy goals; Desire to help train the next generation of physicians who will serve Medicaid beneficiaries.
Nebraska	GME seen as a public good.
New York	Concern from teaching hospitals about losing GME payments; GME seen as a public good; Desire to use Medicaid funds to advance state policy goals; Desire to help train the next generation of physicians who will serve Medicaid beneficiaries; Follow Medicare to make explicit GME payments to teaching hospitals for Medicaid managed care enrollees.
Oklahoma	Desire to use Medicaid funds to advance state policy goals; Desire to help train the next generation of physicians who will serve Medicaid beneficiaries.
South Carolina	To pay for cost of medical education.
Tennessee	GME seen as a public good; Desire to help train the next generation of physicians who will serve Medicaid beneficiaries; Desire to use Medicaid funds to advance state policy goals; Concern from teaching hospitals about losing GME payments.
Vermont	GME seen as a public good; Desire to help train the next generation of

[198] Source: AAMC's, *Medicaid Graduate Medical Education Payments: 50 State Survey*, Table 4, Page 15, (March 2013)

State	Rationale for Making Medicaid GME Payments Directly (Carve-Out) to Teaching Programs
	physicians who will serve Medicaid beneficiaries; Desire to use Medicaid funds to advance state policy goals.
Virginia	Do not want managed care to disadvantage teaching hospitals

The State of Florida already has a graduate medical education supplemental payment program documented under State Plan Attachment 4.19-A Section VII – Statewide Medicaid Residency Program. The goal of the program is "to improve the quality of care and access to care for Medicaid recipients, expand graduate medical education on an equitable basis, and increase the supply of highly trained physicians statewide."

Each hospital's reimbursement under the Statewide Medicaid Residency Program contains a ceiling of $50,000 per resident. If a hospital's calculated amount per resident exceeds $50,000 then that hospital will not receive additional reimbursement. The reimbursement that hospital would have received will be allocated between the hospitals whose allocated amount per resident was below the $50,000 per resident threshold.

The 2013 cost reports for Florida hospitals participating in this program indicate per resident costs noticeably higher than the current Florida Medicaid $50,000 per resident threshold. The following is a listing of a portion of the Florida hospitals qualifying for GME supplemental payments:

Table 29. Cost per resident at seven sample Florida teaching hospitals based on cost reports files with fiscal year ending in 2013.

Hospital	Allowable Direct GME[199]	Allowable Indirect GME[200]	Total Cost	Total Resident FTEs[201]	Cost Per Resident
University of Miami Hospital & Clinics		$3,477,134	$3,477,134	41.46	$83,867
University of Miami Hospital		$10,042,216	$10,042,216	97.01	$103,517
Orlando Health	$30,442,121	$6,358,285	$36,800,406	247.00	$148,990
Tampa General Hospital	$24,156,004	$14,418,760	$38,574,764	268.17	$143,844
St. Petersburg General	$2,730,060	$1,101,270	$3,831,330	39.07	$98,063
Florida Hospital	$13,803,028	$15,650,976	$29,454,004	137.13	$214,789
Broward Health Medical Center	$5,676,531	$501,510	$6,178,041	97.16	$63,586

[199] CMS Form 2552-10 Worksheet B Part I Line 118 Column 21
[200] CMS Form 2552-10 Worksheet B Part I Line 118 Column 22
[201] CMS Form 2552-10 Worksheet S-3 Part I Line 14 Column 9

As shown above, hospitals incur costs related to teaching interns and residents that are substantially above the Statewide Medicaid Residency Program cap. In addition, using Medicare policies as a model, there is room to increase GME payments to teaching hospitals, since the amount paid by Florida to hospitals on a per intern and resident basis is significantly lower than the amount allowed under the Medicare program. The state could increase its per resident cost cap amount and shift current inter-governmental transfer payments made to teaching hospitals under the LIP program to the Statewide Medicaid Residency Program. Funding for this change could come from inter-governmental transfers that are currently being used to support other payments within the LIP program for the teaching hospitals.

The advantage of this option is that CMS has already approved a graduate medical education supplemental payment program for Florida and allows other states the same option – even in a Medicaid managed care model. In addition, this option complies with the State of Florida's desire to ensure that doctors are properly trained and available to become contracted providers with the Medicaid program to ensure proper access to care for Medicaid beneficiaries.

A constraint with graduate medical education programs is the inclusion of the payments as a Medicaid payment within the calculation of the hospital specific disproportionate share hospital limit for each hospital. As payment increases are made and the use of inter-governmental transfers for the non-Federal share of the payment increase, these additional payments increase the chances of a hospital exceeding its hospital specific DSH limit because the payment must be treated as the Federal funds plus the inter-governmental transfer used as the state share. Therefore, a hospital could exceed its hospital specific DSH limit based on monies that were originally the hospitals or another local governmental entity that paid on behalf of the hospital.

Creating a component of a DSRIP for graduate medical education could eliminate this constraint by structuring the payment program in a way that would waive the DSH limit, and allow for federal matching funds related to the payment for this purpose outside of the requirements of the DSH audit.

9.4.7 Disproportionate Share Hospital Payments

The Disproportionate Share Hospital (DSH) payment program was created with the Omnibus Budget Reconciliation Act of 1981 allowing for the additional payment to hospitals which "serve a disproportionate number of low income patients with special needs." In practice, the DSH program has become a tool in which Medicare and Medicaid can compensate hospitals that treat a large volume of uninsured patients. Hospitals receive DSH payments separately from Medicare and Medicaid.

We certainly recommend continuing the DSH program within Florida Medicaid as long as possible. The DSH program is funded primarily by a combination of IGTs and CPEs, so the program is not consuming a significant amount of state general revenue. Unfortunately, we do not see increasing the DSH program as a viable option. Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) capped federal funding for Medicaid

DSH payments as of 1993. The original state DSH allotments provided in FFY 1993 were based on each state's FFY 1992 DSH payments. In FFY 1992, some states provided relatively more DSH payments to hospitals, and, as a result, these states locked in relatively higher Medicaid DSH allotments. Other states made relatively fewer DSH payments, and these states locked in relatively lower DSH allotments.

This disparity still remains to some extent in current DSH allotments because DSH allotments are not distributed according to a formula based on the number of DSH hospitals in a state or the amount of hospital services these hospitals provide to low-income patients. Efforts have been made over time to reduce the disparity in DSH allotments by providing larger annual increases to DSH allotments for states that initially made fewer DSH payments and limiting the growth of DSH allotments for states that initially provided relatively more DSH payments.

In FY 1992, Florida was not a heavy user of the DSH program, so its federal DSH allotment was capped at a relatively low level. Even with adjustments that have occurred since the early 1990's the disparity remains.

In addition to being capped in 1993, the more recently passed ACA includes stipulations to reduce DSH payments further in the near future. Originally, the DSH reductions were set to begin in FFY 2014, but have been delayed until the start of FFY 2016.

9.4.8 Uncompensated Care Pool

The State of Florida is tied for the 17th largest DSH allotment for FY 2014 at $213 million while being the 5th largest Medicaid agency based on the most recent expenditures reported by CMS. Two other states that rank high on the list of DSH allotments and total Medicaid spending, California and Texas, have created uncompensated care pools as part of their managed care programs.

The State of California's current Safety Net Care Pool program consists of an uncompensated care pool that pays out approximately $8 billion over 5 years to reimburse uncompensated care cost at designated public hospitals. For 2013 and 2014, the program was amended to allow for payments to certain Indian Health Service providers. In addition to the designated public hospitals, approved designated state health programs can participate in the pool.[202] This program is in addition to the Disproportionate Share Hospital program where the State of California has a federal allotment of $1.169 billion for Federal Year 2014.

The State of Texas received approval in December 2011 for an 1115 waiver entitled "Texas Healthcare Transformation and Quality Improvement Program" that also included the establishment of an uncompensated care pool. The purpose of this pool is to "defray the actual

[202] California Department of Health Care Services, *California Bridge to Reform Section 1115 Demonstration Fact Sheet*, downloaded from http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ca/ca-bridge-to-health-reform-fs.pdf in November 2014.

uncompensated cost of medical services that meet the definition of 'medical assistance' contained in 1905(a) of the Act, that are provided to Medicaid eligible or uninsured individuals incurred by hospitals, clinics, or other provider types…"[203] As long as payments under the uncompensated care pool and through Disproportionate Share Hospital payments do not exceed the total hospital specific DSH limit when combined with interim payments through fee for service and managed care payments, a hospital may receive payments from both programs.

The State of Tennessee also recently obtained approval from CMS for elimination of its DSH program and shift of its DSH allotment into an existing program known as the Essential Access Hospital Pool.

The State of Florida could potentially follow the Tennessee model and request to combine LIP and DSH into a single uncompensated care pool. Or Florida could potentially following the California and Texas models and request an uncompensated care pool along with a DSRIP program in an 1115 waiver. To gain approval in today's environment, the uncompensated care pool would likely need to be more tied to utilization of services by the uninsured than is currently done with the LIP program.

9.4.9 Physician Supplemental Program

The State of Florida had a supplemental program that ended on June 30, 2014. Starting on July 1, 2014, SFY 2014/15, this program has been moved within the LIP program so that the supplemental payments could continue even though the volume of FFS recipients, and thus, the size of the UPL gap, has decreased. The program supports teaching physicians affiliated with a public university system medical school or a private medical school that had 50 percent of residents placed in a public hospital. As stated previously, supplemental payment programs governed by the rules of upper payment limits cannot exist in a managed care environment. Therefore finding options to continue the $204 million (total computable) program is essential to maintain current reimbursement levels to these providers.

Many other states struggle with this funding issue as they continue their transitions from traditional FFS delivery models to fully capitated Medicaid managed care models. The states of Texas and Washington are two where solutions are being sought to preserve, or even expand, this important funding stream. For example, Texas has an 1115 waiver designed to address this issue through an uncompensated care pool. The objective of the uncompensated care pool with the Texas 1115 waiver is to allow physicians to be reimbursed for the uncompensated care for Medicaid eligible beneficiaries and uninsured individuals. With regard to the changes to supplemental physicians' payments in Texas, the Texas Health and Human Services Commission issued the following question and answers, which offer specifics about the program:[204]

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[203] Texas Health and Human Services Commission, *Waiver No. 11-W-00278/6 entitled "Texas Healthcare Transformation and Quality Improvement Program*," Page 34.

[204] Texas Health Care Transformation and Quality Improvement Program – FAQ (http://www.hhsc.state.tx.us/1115-faq.shtml)

Will HHSC still pay supplemental payments for services provided by physician practice groups under the 1115 waiver?

Uncompensated care payments under the waiver may cover the unmet cost of providing physician services to Medicaid patients and uninsured patients. HHSC will seek clarification from CMS as to whether payments out of the pool may be made to qualifying physician practice groups where appropriate.

Will the payments still be calculated based on 145 percent of the Medicare rate?

Uncompensated care payments under the waiver will be limited to the cost of providing services, and therefore the current physician supplemental funding methodology using 145 percent of the Medicare rate will no longer be used. However, HHSC will compute transition payment caps for the first year based on historical Physician UPL payments.

The State of Florida could incorporate the existing $204 million program into the calculation of an uncompensated care pool as long as that option is deemed acceptable to CMS. Uncompensated care pools approved recently by CMS have been coupled with implementation of a DSRIP program. Similarly, CMS might require a DSRIP program to be implemented if it allows for an uncompensated care pool.

Given that the current Florida physician supplemental payment program is funded through the use of IGTs, the new program could still use IGTs for establishing the payments for physicians affiliated with a public university system medical school or a private medical school that has 50 percent of residents placed in a public hospital.

As another example, Washington Medicaid has established a professional supplemental payment program for University of Washington (UW) Medicine, which comprises two hospitals that are large state-owned and operated hospitals (University of Washington Medical Center and Harborview Medical Center) and a large physician practice group (University of Washington Physicians). Physicians who are a part of University of Washington Physicians are considered employees of UW Medicine, and therefore of the State, which enables the use of an IGT model for the physician supplemental payment program.

When this program was first implemented, funding was initially limited to the physician UPL gap associated with only services provided as part of the FFS program. Recently, Washington expanded the program to also take advantage of the "imputed" gap associated with the capitated managed care population - a program that was recently approved by CMS. This new expansion was also funded through the use of IGTs, whereby UW Medicine funds the state's portion of an increase in the actuarially sound capitation rates paid to the Medicaid managed care plans that contract with UW Medicine. Although the State cannot direct how those plans contract with or otherwise pay UW Medicine for their enrollees, it is our understanding that,

with the cooperation and brokering efforts of the Washington State Hospital Association on behalf of UW Medicine, funds are being distributed by the plans to the hospitals in a way that is satisfactory to all parties involved.

Another option for maintaining supplemental payments to teaching physicians if the LIP program goes away would be to move these payments into the GME program. There is precedent for CMS allowing GME supplemental payments to continue as these payments are associated with the cost of teaching medical students, and not associated with the care of Medicaid recipients. Similarly, the teaching physician supplemental payment program helps offset costs of physicians instructing medical students.

9.4.10 Transition Period

Regardless of funding and payment methods chosen, any major change in reimbursement should be accompanied by a transition period. Medicare applies transition periods on payment formula changes, often by blending payment amounts from the older and newer payment methods for a period of three or four years. Similarly, many Medicaid agencies have implemented a transition period when shifting from an older inpatient payment method, such as per diem, to a newer inpatient payment method, such as Diagnosis Related Groups (DRGs). Often this is done by controlling the hospital base rates in order to buffer changes in individual hospital reimbursement levels for some period of time. We believe a replacement of the LIP program would also warrant a transition period if the replacement results in significant changes in Medicaid reimbursement to individual hospitals.

Specifically for Florida, continuation of the LIP program or creation of some other form of IGT-funded supplemental payments is appropriate to allow hospitals time to adjust to whatever is installed in the longer term as a replacement of the current LIP program.

9.5 Combination of Various Options

9.5.1 Introduction

In general, we can categorize the funding options described previously as either broad-based or qualified. The broad-based funding options include increasing the provider assessment (PMATF), creating a managed care assessment, and increasing general revenue for the Medicaid program. The more qualified funding options include continued use of IGTs and, potentially, expansion of CPEs. These categorizations have as much to do with how the funds are allocated across hospitals in Florida as they are related to who is contributing the funding. With the broad-based funding methods, Florida Medicaid would have significantly more flexibility with how the funds that are generated are ultimately distributed to providers. Without the dependence on providers eligible for contributing the State's share of funding, there could be less of a tie between payment allocation and source of funding. Payment allocation could be focused on achieving Florida Medicaid's overall policy priorities, such as rewarding those providers who make a commitment to serving Medicaid and uninsured patients.

In contrast, we make the assumption that any payment allocation for IGTs must ensure a return on investment for those public hospitals and local governments contributing the State's share of funding. Thus, payment methods that rely on this type of funding must be designed in a way that takes into consideration who contributed money to fund the Medicaid program, as is the case today in Florida. In addition, CPEs are limited to public institutions and the federal matching funds generated through CPEs generally must be paid to the entity that incurred the health care costs. This tie between funding mechanism and payment flexibility is summarized in the following table:

Table 30. Tie between funding source and payment flexibility.

		Funding Sources				
		Health Care-related Tax (New or Expand Existing	Managed Care Assessment	IGTs	CPEs	General Revenue Funds
Payment Distribution Models	DSRIP	XX	XX	X	X	XX
	Broad Based Rate Increases (FFS and PMPM)	XX	XX			XX
	UPL/Targeted Supplemental	XX	XX	X	X	XX
	GME Payments (limited to qualified providers)	X	X	X	X	X
	DSH Payments (limited to qualified providers)	XX	XX	X	X	XX
	Uncompensated Care Pool Distributions	XX	XX	X	X	XX
	Physician Supplemental Payment Program	XX	XX	X	X	XX
Legend: XX = generally would work for all provider types. X = would generally work only for hospitals that actually fund the state dollars.						

The following sections highlight three quite broad options that combine type of funding and payment distribution approaches. These options all assume the LIP program, in its current form, has been discontinued, as that is a supposition defined in the requirements of this study. The options are:

1) Fully replace the funds currently used for the LIP program with a broad-based funding source and an increase in fee-for-service and capitation rates;
2) Continue current level of IGTs, design, and implement a large DSRIP program;
3) Expand the Florida Medicaid program through the ACA combined with either a broad-based funding source or IGTs for funding for the existing Medicaid population.

For illustrative purposes, these options describe all-encompassing funding methods for the funds currently used within the LIP program. One option replaces all of the LIP funds, which are almost entirely IGTs, with a broad-based funding method. Another option continues to use IGTs as the source for all of the funds. In reality, there are a multitude of variations that could be applied related to these combinations of funding and payment. Of course, if both types of funding are implemented the benefits and limitations of each method will apply.

In the discussion of these options, we consider current federal and state regulations as well as precedent related to what CMS has approved recently in 1115 demonstration waivers. We also consider the ability of each option to maintain current program-wide payment levels to hospitals and teaching physicians. In addition, we consider the potential to maintain payment levels for individual hospitals and teaching physicians similar to what is provided today. (For teaching physicians, discussion in this study relates only to the supplemental payments made through the LIP program. There is no consideration of physician fee-for-service rates.) With the exception of uncompensated care pools, all payment methods have constraints that will likely result in limited redistribution of funds at the individual hospital level. Even so, there are ways in which each option could be implemented to help mitigate changes in reimbursement for individual facilities.

All options discussed could, in theory, maintain an overall Medicaid funding level at or above what exists today. However, to do so, a federal waiver will be needed for distribution of some of the funds. As mentioned earlier in this chapter, the current level of payments exceeds the Medicare upper payment limit and is helping reimburse costs not only for care of Medicaid recipients, but also for care of uninsured patients. Maintaining a payment level above the UPL would require a federal waiver. Although the UPL only applies to the fee-for-service program, we assume payments reaching the upper payment limit are also the maximum that would be considered actuarially sound within the Medicaid managed care program.

Note that several of these options include some type of DSRIP design and implementation as a component part. While CMS is increasingly using DSRIP programs to provide funding for health reform and transformation to states using 1115 Demonstration Waivers as the vehicle for this funding, the DSRIP landscape is rapidly evolving. Our firm is having ongoing discussions with CMS and the National Governors Association about DRSIP funding as a part of our work in other states, and the flow of information is rapid and changing. In particular, it should be noted that program design and related terms and conditions for states that have received DSRIP funding in prior years should not necessarily be indicative of CMS' willingness to approve similar terms and conditions in other states considering DSRIP programs. Consistent with the

intent of 1115 Demonstration Waivers, CMS is looking for innovative models intended to transform health care delivery. Simply replicating another state's model may not be consistent with CMS' overall objectives in this regard.

9.5.2 Increase in Broad-Based Funding and Increased Rates

As described previously, broad-based funding sources include a provider assessment, a managed care organization assessment, and state general revenue. Use of any one, or a combination of these three funding sources to replace the $1.03 billion (state share only) from IGTs funding the LIP program and automatic rate enhancements in SFY 2014/15 could be used to maintain program-wide hospital reimbursement levels while increasing Florida Medicaid's flexibility on how those funds are distributed.

If a broad-based funding mechanism is used, AHCA and the Florida Legislature would be able to distribute these funds in a manner consistent with the overall policy objectives of the program. There would generally be less of a need to directly link the payments to the contributions. Thus, the funds could be distributed in a way that ties to services provided to Medicaid recipients and that ties to promotion of access to quality care. One way to do this would be through an increase in fee-for-service and capitation rates. We make the assumption that these increases would also translate into increases in rates paid by Medicaid managed care plans to hospitals based on Florida Statute 409.975(6) – "Provider Payment" which sets minimum and maximum Medicaid managed care rates based on agency fee for service rates:

> "Managed care plans and hospitals shall negotiate mutually acceptable rates, methods, and terms of payment. For rates, methods, and terms of payment negotiated after the contract between the agency and the plan is executed, plans shall pay hospitals, at a minimum, the rate the agency would have paid on the first day of the contract between the provider and the plan. Such payments to hospitals may not exceed 120 percent of the rate the agency would have paid on the first day of the contract between the provider and the plan, unless specifically approved by the agency. Payment rates may be updated periodically."[205]

With this option that increases broad-based funding, the current inpatient DRG payment method would likely need to be adjusted to direct more money to categories of hospitals deemed critical to the Medicaid program including statutory teaching, rural, safety net, trauma, and large children's hospitals. Some logic of this type is already built into the current DRG payment method, but not enough to mimic the benefits these hospitals currently receive through the LIP program. The LIP program has several small sub-programs in a grouping referred to as "Special LIP" that target money to these specific categories of hospitals. In addition, the allocation of automatic IGT funds also targets these specific categories of hospitals. Also the current LIP program provides greater benefit to those with access to IGTs, which in

[205] Florida general laws, Section 409.975(6), Retrieved August 19, 2014 from http://www.leg.state.fl.us/statutes/, Chapter 409.

many cases are public and safety net hospitals. To highlight this point, the benefit certain categories of hospitals are predicted receive through the LIP program in SFY 2014/15 is shown in Table 31.

Table 31. Net gain from IGT contributions and the LIP program in SFY 2014/15.

Provider Category	Net Gain from IGT Contributions	Number of Hospitals in Category	Average Gain Per Hospital
Statutory Teaching	$682,327,258	11	$62,029,751
Trauma	$1,015,445,509	23	$44,149,805
Safety Net	$905,234,085	22	$41,147,004
Children	$116,658,481	4	$29,164,620
Public	$310,981,163	28	$11,106,470
For Profit	$314,292,767	116	$2,709,420
General Acute	$227,641,506	101	$2,253,876
Rural	$21,487,504	29	$740,948
Long Term Acute Care	$0	19	$0
State-Owned Psychiatric	$0	4	$0
Free-Standing Rehabilitation	$0	13	$0

Notes:
1) Hospitals may be included in more than one category in this table.
2) Net gain equals payment through the LIP program (including LIP 6) minus IGTs contributed to fund the LIP program.

Adjustments to the current inpatient DRG payment method, and potentially to the outpatient payment method, could help maintain benefits to individual categories of hospitals currently afforded through the LIP program. Particularly for the inpatient DRG payment method, this could be obtained reasonably easily by resetting policy adjustors. However, adjustments in payment rates by category of hospital should be done sparingly as differing rates between hospitals may create incentives for managed care organizations to direct Medicaid recipients towards facilities with the lower rates. Thus, the new payment method would not likely distribute funds exactly the way they are distributed today.

In terms of program-wide funding, this option will allow for payments up to the Medicare upper payment limit. Although the UPL only applies to payments made under the FFS program, we assume payments reaching the FFS upper payment limit would also be representative of payment levels expected to be achieved under Medicaid managed care, and which would ultimately translate into actuarially sound capitation rates. However, current payment levels are over the upper payment limit at a program-wide level when including payments made under the 1115 waiver through the LIP program. Thus, with this option, additional funds would have to be distributed outside of fee-for-service rates and capitation payments to maintain reimbursement equal to current-day levels. But an advantage of this option is that the amount of funds needed to be paid through other mechanisms would be

relatively small in comparison to overall hospital reimbursements made by the Medicaid program.

These other payment mechanisms could include reinstitution of supplemental payments under the UPL program, an increase in GME payments, and a DSRIP program. UPL supplemental payments could be made to individual hospitals so long as such payments do not exceed the UPL limit for the hospital's UPL class when aggregated with all other fee-for-service payments made to hospitals in that same UPL class. Payments would not necessarily need to be directed to hospitals in whose name IGTs were contributed because the funding is not coming from voluntary IGTs. In addition, using Medicare per resident amounts as a model, there is room to increase GME payments to teaching hospitals, since the amount paid by Florida to hospitals on a per intern and resident basis is significantly lower than the amount allowed under the Medicare program.

Unfortunately, we do not expect the UPL program and increased GME payments will cover the entire difference between amounts that could be made available through new rate payments and current reimbursement levels. The LIP program helped fund cost of care to the uninsured which cannot be covered through UPL and GME payments. As a result, payments defined through an 1115 demonstration waiver will likely still be needed, and potentially could be established using a DSRIP program and possibly an uncompensated care pool. If that proves true, it might be most administratively prudent to pursue a relatively simple and targeted DSRIP program. Under this option, the amount of funds being distributed through the DSRIP program might be relatively small, and might not warrant a large, complex program. Alternatively, instead of a DSRIP program, these funds potentially could be set aside for a program-wide quality incentive program, similar to what is done in the State of Maryland. Comparisons of quality measures across hospitals, such as readmissions, complications, avoidable emergency department visits, etc… could be performed with the funds distributed to those hospitals that exceed predetermined benchmarks for the selected quality measures. Another less complex option would be an uncompensated care pool which pays out these funds based on a percentage of uncompensated care provided at each hospital in the State, similar to programs established in other states that have high federal DSH allotments.

This option, an increase in broad-based funding and an increase and FFS and capitation rates would not necessarily replace teaching physician supplemental payments that currently exist within the LIP program. Under this option, replacement of the teaching physician supplemental payments if the LIP program is discontinued potentially could be accomplished through a DSRIP program or through an increase in GME payments, if acceptable to CMS.

9.5.3 Continued Use of IGTs and a DSRIP Program

Understandably, increases in broad-based funding may not be a preferred option for the State as this approach may involve increases in uses of tax or assessment revenue. An option on the other side of the spectrum is continuation of funding a significant portion of Medicaid reimbursements to hospitals with IGTs. With this option, we assume payment methods will

need to be designed in ways that ensure contributors of IGTs receive more benefit from their contributions than they would receive from keeping their local tax dollars within their geographic region.

Ensuring such incentives is not likely to be possible using only claim-based payment rates. If an attempt was made to accomplish these incentives with claim-based payment rates, many hospitals in the state would need to be assigned their own payment rate. And the disparity in rates across hospitals for the same service would be significant in many cases. This would create strong and unwanted incentives for managed care organizations to direct recipients towards lower cost (lower rate) hospitals whenever possible, and is an option for which it may be difficult to obtain CMS SPA approval.

Potentially a better payment solution with this funding option might be constructing a DSRIP program, possibly accompanied with an uncompensated care pool. To ensure IGT funding, the quality and health care delivery initiatives defined under the DSRIP program would likely need to focus on hospitals for which the IGTs were contributed. The initiatives could still involve multiple hospitals and non-hospitals, but each initiative would likely have a primary provider and that provider might need to be a hospital for which IGTs were contributed. It is expected that these would generally be public hospitals, but could also be private hospitals in counties or local taxing districts that have agreed to contribute IGTs in the name of the private hospital. As with the LIP program, not all funds would go to these hospitals. DSRIP programs reach beyond hospitals to other entities that can affect health care transformation, and it is likely that DSRIP incentive payments would likely be earmarked for non-hospital entities as well. In addition, payments would not be guaranteed as they are today under the LIP program. Providers within a DSRIP project, both hospital and non-hospital, would need to meet the projects' objectives to receive all the DSRIP funding.

New York Medicaid's DSRIP model initiatives, for example, include a primary provider and other affiliated providers. New York's program does not allow stand-alone providers to apply for DSRIP funds independently. To be eligible, providers must form "Performing Provider System" (PPS) coalitions comprised of a lead provider and component providers, which must participate in programs across three domains that focus on broad system transformation and collaboration. [206]

As described in Chapter 7 – Delivery System Reform Incentive Payment Programs, DSRIP programs do not guarantee annual payment distributions to individual hospitals. They define a maximum annual payment distribution and milestones for which providers can receive payments up to that maximum if they achieve the project milestones and outcomes. For this reason, hospitals would not necessarily receive the same funding they receive today through the LIP program, within which only a small fraction conditionally relies on milestones or benchmarks. In addition, the provider networks created within proposals for DSRIP initiatives

[206] NY Medicaid, *Program Funding and Mechanics Protocol,* (April 2014).

would not necessarily include the exact same set of providers as the set that currently receives payments through the LIP program. CMS will likely require distribution of the DSRIP dollars be based on the achievement of measurable milestones and outcomes that are linked to demonstrating improvements in health in the State. CMS will also want to see a positive return for its federal investment in the DSRIP program. Even so, the DSRIP initiatives may be definable in a way that not necessarily ensures, but creates an achievable opportunity for a positive return on investment for those contributing IGTs, so long as conditional milestones are achieved.

An uncompensated care pool potentially could be included with a DSRIP program. Rather significant uncompensated care pools were approved for both Medi-Cal and Texas Medicaid. Uncompensated care pools are much like most sub-programs within LIP in that they offer payments to hospitals without restrictions based on meeting quality measures or implementing new health care delivery initiatives. As indicated by their name, generally, uncompensated care pools make funds available for providers that treat a significant number of uninsured patients.

DSRIP programs have proven to be complex and require long lead times to develop. Needing up to two years to design and implement a DSRIP program and to receive final approval from CMS is not uncommon. As a result, if DSRIP is selected, interim funding and payment mechanisms would need to be defined and implemented for the time in which the DSRIP program is being developed. It would simply not be realistic to expect the hospitals to absorb payment reductions that would have to occur if the LIP program were discontinued on June 30, 2015, while the State works with CMS for the next two years to get a DSRIP program designed and implemented.

A logical interim solution would be to work with CMS to temporarily continue the LIP program. Since parts of Florida's existing 1115 demonstration waiver have been renewed through state fiscal year 2016/17 (through June 30, 2017), a renewal of the LIP program for the remainder of the current 1115 waiver might coincide well with the time needed to develop a DSRIP program.

There are no guarantees that CMS would temporarily approve this type of interim "bridge" solution. However, it the State were to make modifications to the LIP program to increase the transparency of the program funding and payment distributions, enhance program integrity protocols, and make the revised temporary program contingent on a robust effort to have a DSRIP program up and running by the end of SFY 2017, it may very well be worth consideration by CMS.

As an example of how a temporary LIP program might work, the State could incorporate the following changes to the current program:

- Apply the same limitations on payments under the program as are applied for DSH payment purposes. This would include incorporating the same data collection, cost

determination, reporting and audit protocols that are now required under the DSH program, and would require limiting federal matching funds to the costs of the Medicaid and uninsured populations at the hospital-specific level.

- Modify the distributions of funding to be more closely tied to utilization of services. For example, currently under the LIP-6 portion (formerly self-funded rate enhancements) of the LIP program, the State returns to contributing providers all of their contribution plus 100 percent of the federal matching funds related to their contribution. In the future, some of these federal matching funds could instead be redistributed to other providers, particularly those that do not have the capacity to make IGT contributions but serve large proportions of Medicaid and/or people without insurance – that is, based on utilization of services.
- Similarly, federal funds could be distributed based on other quality improvement-related goals, which would be determined by the State, consistent with an overall value-based purchasing strategy. For example, distributions could be tied to measured reductions in preventable hospital readmissions or complications.
- Since redistributing funds in the manner described above could represent a significant reduction in payments to the hospitals that currently contribute IGTs through LIP-6, it might be appropriate to phase in the reductions over the span of the two-year "bridge" period. For example, returns on IGTs could be set to limit the total payment to be 80 percent of what they had received under legacy program for the first year, and 40 percent in the second year.
- In any event, the pay-back related to the IGT contribution would need to represent a significant enough return to the hospitals to preserve the incentive for the IGT contributions to continue to be made.

Implementation of a DSRIP program has the distinct advantage of being able to maintain incentives for IGT contributions. Thus, the program has the potential to avoid the need for increases in use of general revenue or increases in health care assessments. In addition, DSRIP programs have the potential to promote creation of new, innovative health care service delivery models which may result in improved population health and/or decreased costs of health care in the State. Also, a DSRIP program would likely involve teaching institutions and teaching physicians, thus providing a potential replacement for the physician supplemental payment program within LIP. However, these benefits need to be weighed against the drawbacks associated with implementing a complex program that requires considerable effort to administer. In addition, the lack of regulations regarding DSRIP programs makes the future of DSRIP programs unclear. Going forward, CMS will likely want to understand how states will use DSRIP programs to transform their delivery system so that states will not require the same amount of additional federal investment in the future. States implementing DSRIPs that are not successful at achieving real system transformation will likely spend considerable effort on these programs only to find themselves searching for new solutions when their DSRIP programs fall out of favor with CMS.

9.5.4 Medicaid Expansion with Either a Broad-Based Funding Increase or IGTs

As a third option, the State of Florida could expand the Florida Medicaid program. Expansion would significantly mitigate the problems associated with limited compensation for most of the population currently uninsured or underinsured. Thus, expansion could, in theory, replace the portion of the LIP program currently helping to fund uncompensated care. This is true with any type of implementation of expansion selected by the Florida Government. As discussed in Chapter 6 – Medicaid Expansion, this could be a traditional expansion as defined in the ACA, or an alternative expansion, such as a premium assistance program. However, expansion would not replace the portion of the LIP program funding the difference between Medicaid payments and hospitals' costs to treat Medicaid recipients. To replace this "UPL portion" of the LIP program will require a solution like the options described in the previous two sections.

If current LIP funding is replaced with a broad-based funding mechanism, then potential increases in claim-based payments through rates could help to close the gap between current payment levels and the allowable costs incurred by providers of health care services. A DSRIP program would not necessarily be needed. With the option of replacing LIP funding with a broad-based funding mechanism, a DSRIP program was included only for reimbursement of funds currently paid out through the LIP program for care of the uninsured and underinsured. However, Medicaid expansion would cover care for this population, thus generally offsetting the need for DSRIP. Medicaid expansion would also increase volume in both Medicaid FFS and managed care. In particular, the increase in FFS volume might be enough to enable the teaching physicians to receive standard UPL supplemental payments up to the levels they currently receive through the LIP program.

If on the other hand, Florida's replacement for the LIP program is a DSRIP program, then DSRIP would still be needed, even with Medicaid expansion, although with Medicaid expansion, the size of the DSRIP program could be smaller. Current program-wide reimbursement levels could be obtained with DSRIP replacing only the portion of the LIP program used to close the gap between Medicaid claim payments and hospitals' cost of care plus the portion of LIP defined for teaching physician supplemental payments. The DSRIP program would not need to replace the portion of LIP that reimburses hospitals for uncompensated care. Medicaid expansion would significantly reduce the number of uninsured Floridians, and would significantly reduce uncompensated costs associated with this population.

Starting in FFY 2017, the FMAP for Medicaid expansion will drop below 100 percent. As a result, expansion will likely increase costs to the Medicaid program in the long term. Future options for funding the state share of costs for the expansion population when it becomes a state obligation are the same as those discussed for funding a replacement for the LIP program. Broad-based funding methods provide the most flexibility for payment methods, while IGTs offer less flexibility but allow the program to be funded without increases in taxes or assessments.

9.5.5 Partial Implementation of Funding Options

For ease of explanation, sections 9.5.2 and 9.5.3 describe "all-or-nothing" options. The option described under section 9.5.2 shifts all current LIP funding, which is almost entirely IGTs, to a broad-based funding method including increased use of general revenue and/or an increase in health care related assessments – either through increases in the provider assessment or creation of a new managed care assessment. In contrast, the option described under section 9.5.3 continues use of IGTs at the same levels as currently exist for funding the LIP program. In reality, some form of combination of these two funding methods could be used. In the future, the funds currently used for the LIP program could come from a combination of an increase in broad-based funding and a smaller collection of IGTs. Of course, if both types of funding are implemented the benefits and limitations of each method will apply. Broad-based funding methods generate money that can be used for claim payments, capitation payments, and supplemental payments, to the extent that these distributions remain within the regulations set forth by CMS. IGTs generate money that must be distributed first to compensate those who have contributed and then any remaining funds have flexibility to be distributed in the way that best suits the Florida Medicaid program – again, to the extent that these distributions remain within the regulations set forth by CMS.

10 Evaluation of Options for Consideration for Florida Medicaid

In a program as large and complex as Florida Medicaid, there are many competing priorities. In addition, any change in funding and/or payment method will likely result in shifting Medicaid reimbursement levels between providers – particularly with a change as large as a replacement for the LIP program. If a modified version of the LIP program would be acceptable to CMS, then this would likely generate the least amount of changes to the Florida Medicaid program. In case that proves an unacceptable option, we developed a set of objective evaluation criteria to help evaluate the options defined in Section "9.5 – Combination of Various Options." Each of the three combination options are rated using this criteria with the third option evaluated twice; once with Medicaid expansion and an increase in broad-based funding, and a second time with Medicaid expansion and an increase in IGTs.

The evaluation criteria are based on the goals of all stakeholders including CMS, the Florida Legislature, AHCA, providers, and Medicaid and uninsured beneficiaries. The criteria include items such as access to care, funding level, program simplicity, equity, and cost effectiveness. In addition, we felt some criteria were more important than others, so the evaluation matrix includes a weighting for each criteria. Weighting the criteria is subjective and would likely differ based on each stakeholder's point of view. We chose a relatively simple weighting, one – least important, two – medium importance, and three – greatest importance, and aimed to define the weights and individual ratings using a program-wide perspective. The results are shown in Table 32.

Table 32. Numerically weighted comparison of the combined options.

Nbr	Measure	Weight	Increase Broad Based Funding without Expansion[1]	IGT Funding with DSRIP, without Expansion[1]	Increase Broad Based Funding with Expansion[1]	IGT Funding with DSRIP, with Expansion[1]
	Payment					
1	Improves equity of payment, while considering the resource requirements that may be unique to certain types of providers (safety net, children's, psychiatric, etc.) consistent with Section (a)(30)(A) requirements.	2	4	2	4	2
2	Enhances the state's ability to ensure access to care, consistent with Section (a)(30)(A) requirements.	3	3	3	4	4
3	Recognizes the additional resource requirements associated with caring for higher proportions of uninsured or under insured patients.	3	2	3	4	4
4	Contributes to a transition from volume-based purchasing to value-based purchasing.	3	1	4	1	4
5	Creates payment incentives that contribute to improvement of quality of care consistent with Section (a)(30)(A) requirements.	3	2	4	2	4
6	Provides for aggregate payment levels greater than or equal to current levels.	3	3	3	4	4
7	Offers transparent, predictable and simplistic payments for providers and the State.	2	4	3	4	3
8	Provides for administrative ease for implementation and ongoing operation and monitoring.	1	4	1	2	1
	Funding					
9	Improves equity of provider funding obligation across all categories of hospitals (public, private, non-profit etc…)	2	3	2	4	2
10	Improves long term sustainability and stability of funding.	2	2	1	4	3

Nbr	Measure	Weight	Increase Broad Based Funding without Expansion[1]	IGT Funding with DSRIP, without Expansion[1]	Increase Broad Based Funding with Expansion[1]	IGT Funding with DSRIP, with Expansion[1]
11	Improves transparency of funding streams (State, county, provider, etc.)	1	4	2	4	2
	State/Federal					
12	Mitigates increasing the fiscal burden placed on State/local taxpayers.	3	2	2	3	3
13	Offers consistency with current federal and state guidelines and regulations.	**3**	3	3	2	2
	Total Weighted Score (sum of individual rating times weight)		**82**	**85**	**98**	**98**

Notes:

1) Rating Scale: 1=Strongly Disagree, 2=Disagree, 3=Agree, 4=Strongly Agree
2) Maximum possible total weighted score is 124.

In general, the expansion options rate higher because they increase access to care for those currently uninsured, and they increase federal funds coming into the state, thus resulting in greater payments to hospitals (assuming current funding levels can be maintained for the current Medicaid population). However, the expansion options rate lower on one particular category, consistency with federal and state guidelines, because Medicaid expansion is not known to be a preference of the Florida Legislature. In addition, expansion, if implemented, will require more state-share funds in the near future as the 100 percent FMAP only continues through September 30th, 2016.

The options that include continued use of IGTs and a DSRIP program rate higher on criteria relating to improvement of quality of health care delivery and to implementation of value-based purchasing. At the same time, they rate lower in relation to equity, transparency, and simplicity. As defined, the option including an increase in broad-based funding does not include implementation of a DSRIP or any other kind of new health care quality incentives, and thus did not score as high on those categories. However, there is nothing in this option that precludes implementation of new value-based initiatives.

11 Conclusion

The State of Florida has placed significant reliance on the LIP program to enable funding a portion of the state share and to draw down federal matching funds. As such, without renewal of the provision within the current 1115 demonstration waiver that authorizes the LIP program, the State is at risk of losing approximately $1.3 billion[207] in federal matching funds that are currently used supplemental LIP payments. The State may also be at risk of losing some or all of the $397 in federal matching funds currently used for automatic rate enhancements. Specifically for the $1.3 billion federal funds at risk for the LIP program, approximately $728 million will be paid to the State's 23 public hospitals and $577 million to the State's 190 privately-owned hospitals in SFY 2014/15. These federal funds are generated almost entirely through application of IGT contributions received from public hospitals, county governments, and other local sources. As such, there is almost no cost to the State associated with generating these federal matching funds.

These funds are critical for maintaining access to essential hospital services for the State's large Medicaid and uninsured population. Not having these funds available for payment to Florida's hospitals may exacerbate an already tenuous situation. Based on our analyses, if LIP payments are not counted, we estimate that Medicaid payments covered an average of 79 percent of the costs incurred by hospitals for providing services to Medicaid recipients in SFY 2012/13. During that year, self-funded IGTs were paid out as rate enhancements. However, in SFY 2014/15, self-funded IGTs have been moved into the LIP program, as LIP-6. Thus in SFY 2014/15, the average hospital cost coverage for services to Medicaid recipients when LIP payments are not counted will be approximately 62 percent. Further, if the LIP program expired without any type of replacement, the IGTs used to fund automatic rate enhancements would also be at risk. If automatic rate enhancements were not available, average hospital cost coverage for services to Medicaid recipients excluding LIP and automatic rate enhancements would be 48 percent.

In addition, pay-to-cost coverage differs significantly for hospitals that have capacity to contribute IGTs versus those that do not. For example in SFY 2012/13, hospitals that received IGT rate enhancements (including self-funded IGTs) were paid on average 83 percent of their cost for treating Medicaid recipients. Hospitals that did not receive IGT rate enhancements were paid on average 45 percent of their costs. Payment below cost generally requires hospitals to cover a portion of Medicaid costs with payments from other payers, a situation commonly referred to as "cost shifting". Further, many hospitals in the State provide some services to the uninsured, and in fact are required by law to do so in emergency-related situations. Although it is not necessarily a legal obligation for the State to provide health benefits to the uninsured population, most states, including Florida make some effort to compensate hospitals caring for the uninsured. When you consider the costs associated with providing services to the

[207] The $1.3 billion estimate is based on the federal share of the total estimated LIP-based payments of approximately $2.2 billion for SFY 2014/15. The assumed FMAP for this calculation is 59.56 percent.

uninsured, Medicaid payments without LIP obviously would cover a much smaller percentage of hospital cost.

It is possible that an IGT-funded UPL supplemental payment program could be used to replace a portion of LIP-related funds, but such a program would be limited to the available fee-for-service program UPL gap, which is approximately $412 million, total computable, of which approximately $245[208] million is the federal share. Thus if the federal share of the LIP program and automatic rate enhancements were not available, approximately $1.7 billion in federal funds would be removed from the program, for which re-institution of a standard UPL program would replace only about $245 million.

There is no perfect solution to this problem. In the absence of a federal waiver, the UPL limitations in payments simply restrict how much funding can be federally matched. This appears to be one of the unintended, but common consequences associated with a transition to a capitated managed care model. Shifting the financial risk from the State to the Medicaid managed care plans also means that the State is passing substantial control of how payments are made over to the plans.

In Chapters 9 and 10 of this report, we identify and evaluate four broad options for consideration, two of which include an expansion of Medicaid eligibility provided under the ACA. While we have evaluated and attempted to "score" these options using a standard set of evaluation criteria, we fully understand that there are numerous other factors that must be considered outside of these criteria that make it difficult to recommend one option over another. We believe that all four of these options represent opportunities to preserve the aggregated funding levels that have historically been achieved through the LIP program. None of these funding models, however, afford the State the flexibility to maintain exactly the same payment levels currently made to individual hospital providers.

As these four options are considered, there are three key questions that must be answered. The answers to these questions can provide a guide for determining which of the four options should be pursued and/or what combination of options will work best for Florida Medicaid.

1) Are the citizens of Florida ready to move forward with a Medicaid expansion? Medicaid expansion in Florida as afforded by the ACA could significantly help offset the costs incurred by the State's hospitals in caring for uninsured and under-insured patients, but would come with additional cost to the State. Starting in FFY 2017, the FMAP for the expansion population will start to be reduced, and the balance, which will increase to as much as 10 percent over the years, will transfer to the State.

2) Should the State consider linking hospital reimbursements more closely to a hospital's commitment to serve higher proportions of Medicaid and uninsured patients, and less

[208] The assumed FMAP for this calculation is 59.56 percent.

on their ability to make IGT contributions? Today, hospitals with access to IGT contributions receive significantly higher reimbursements in relation to their cost. And while hospitals with higher reimbursements generated by IGT contributions oftentimes are those that tend to care for high percentages of Medicaid and uninsured patients, the differences in per unit payment between those with access to IGT contributions and those that do not may be too disparate.

3) Should the State evolve the program further by transitioning to more of a value-based purchasing model instead of a utilization-based model? Today, payments are for the most part volume-based. In other words, the more patients a hospital can admit and discharge, the more payments that hospital will receive. Payment amounts are not necessarily predicated on achieving quality outcomes. The current payment models tend to incent more hospital-based volume instead of incenting preventable care and less hospital-based volume. Payment models could be established to incentivize reductions in unnecessary utilization of services (unnecessary admissions, readmissions, complications, emergency room visits, etc.), or otherwise provide incentives for hospitals to become more cost effective. A more value-based model could be achieved through implementation of carefully considered quality-based incentive payments, or through a DSRIP program, for which quality-based incentive payments are a foundational element.

The answers to these questions can effectively narrow the four broader options down to one option or a mixture of options that best suits the circumstances of Florida.

We also believe that there may be a fifth option to consider. This study generally assumes that the LIP program will be discontinued. Consistent with the 2014 Special Terms and Conditions of Florida's 1115 demonstration waiver, this study is intended to identify "sustainable, transparent, equitable, appropriate, accountable and actuarially sound Medicaid payment systems and funding mechanisms that will ensure quality health care services to Florida's Medicaid beneficiaries throughout the state without the need for LIP funding."[209] However, given the potential risk to individual providers and the State related to discontinuation of the LIP program, we believe that it would be prudent to determine if some form of LIP program can be maintained.

We believe that the complexity and lack of transparency related to the LIP program may have contributed to CMS' decision to not renew the LIP component of the 1115 demonstration waiver beyond 2015. The goal of the LIP program appears to be very similar to that of the DSH program. If Florida Medicaid could modify the LIP program in a way that creates more transparency in funding and payment distribution, and applies the same fiscal oversight standards that are now required as a part of operating a DSH program, much of what is good about the LIP program might be retained. Such fiscal oversight would likely have to include

[209] Centers for Medicare and Medicaid Services, *Special Terms and Conditions for Florida Medicaid Reform Section 1115 Demonstration*, Document number 11-W-00206/4, (2014).

reporting and auditing standards that are now integral to the DSH program, and potentially reconsideration of the equity of how funds are distributed.

In any event, we strongly recommend that Florida maintain an open dialogue with CMS in determining how to best address this problem, and use CMS as a partner in determining the best solutions.

12 Appendices

12.1 Appendix A – Definitions and Acronyms

ACA	Affordable Care Act – a shortened version of the full acronym – PPACA
AHCA	Agency for Health Care Administration – the agency within the Florida state government that oversees the Florida Medicaid program
CFR	Code of Federal Regulations
CHD	County Health Department
CHEP	Community Hospital Education Program – hospitals participating in this program are referred to as "CHEP hospitals."
CMS	Centers for Medicare and Medicaid Services – the federal governmental agency overseeing state Medicaid programs
CPE	Certified Public Expenditure – an expenditure made by a governmental entity, including a provider operated by state or local government, under the state's approved Medicaid state plan, making the expenditure eligible for federal match
DRG	Diagnosis Related Grouping – a categorization scheme used in determining payment and measuring acuity of inpatient admissions
DSH	Disproportionate Share Hospital – a hospital receiving a disproportionate share of Medicaid, under insured and uninsured patients.
DSHP	Designated State Health Programs
DSRIP	Delivery System Reform Incentive Payment
DY	Demonstration Year – the demonstration years for the Florida's current 1115 Demonstration Waiver are: • DY 1 – July 1, 2006 – June 30, 2007 • DY 2 – July 1, 2007 – June 30, 2008 • DY 3 – July 1, 2008 – June 30, 2009 • DY 4 – July 1, 2009 – June 30, 2010 • DY 5 – July 1, 2010 – June 30, 2011 • DY 6 – July 1, 2011 – June 30, 2012 • DY 7 – July 1, 2012 – June 30, 2013

- DY 8 – July 1, 2013 – June 30, 2014
- DY 9 – July 1, 2014 – June 30, 2015
- DY 10 – July 1, 2015 – June 30, 2016
- DY 11 – July 1, 2016 – June 30, 2017

EPSDT	Early Periodic Screening, Diagnosis, and Treatment
FFP	Federal Financial Participation
FFY	Federal Fiscal Year – runs from October 1st through September 30th of the following calendar year.
FMAP	Federal Medical Assistance Percentage
FQHC	Federally Qualified Health Center
FPL	Federal Poverty Level
GAA	General Appropriations Act
GME	Graduate Medical Education
GR	General Revenue – state funds collected through state taxes, licensing fees, and various other avenues
ICF-MR	Intermediate Care Facilities for individuals with Mental Retardation
IGT	Inter-governmental transfer – a method in which local (non-state) governments and public hospitals can transfer money to AHCA to help fund the Medicaid program.
LIP	Low Income Pool – part of Florida's 1115 Demonstration Waiver
MACPAC	Medicaid and CHIP Payment and Access Commission
MMA	Managed Medical Assistance – name for Florida's Medicaid managed care program
PMATF	Public Medical Assistance Trust Fund – Florida's hospital provider assessment program which helps fund the Medicaid program.
PMPM	Per member per month

PPACA Patient Protection and Affordable Care Act

SFY State Fiscal Year – Florida's state fiscal year runs from July 1 of one year through June 30th of the following year. AHCA generally includes both years when defining a state fiscal year, such as "SFY 2011/12" and "SFY 2012/13". This convention has been followed in this report.

SMMC Statewide Medicaid Managed Care

SPA State Plan Amendment

SSEC Social Services Estimating Conference

STC Special Term and Condition – these are parameters and conditions which help define waivers granted to a Medicaid program under a section 1115 demonstration.

Supplemental Payment

Within this report, we define a "supplemental payment" as any lump-sum payment a Medicaid Agency makes to a provider that is made in addition to standard payment rates for services provided to Medicaid beneficiaries. This includes UPL payments, DSH payments, LIP payments, and, potentially in the future, DSRIP payments.

Total Computable

Sum of state share and federal share of funds used by a state Medicaid agency for Medicaid reimbursements.

UPL Upper Payment Limit – a program that allows states to claim supplemental UPL Federal matching funds to cover the difference between Medicaid payments and what Medicare would have paid for the same services.

12.2 Appendix B – Description of Alternative LIP Programs

a. $4.5 million County Health Department Initiatives

Funds are provided for county health initiatives emphasizing the expansion of primary care services and rural health networks. The DOH will develop the funding criteria processes, which include assessing statewide benefits, sustainability, access to primary care improvements, ER diversion potential, and health care innovations that are replicable and with a three-year limit on low-income pool funding.

b. $7.2 million for FQHCs and CHDs

Funds are provided to make Medicaid low-income pool payments to Federally Qualified Health Centers. These payments may be used to provide funding for Federally Qualified Health Centers supporting primary care services in medically underserved areas.

c. $2 million for primary care within CHDs

Funds are provided for county health department clinics to enhance primary care health services, targeting low-income, uninsured, and under-insured individuals, in the following counties:

Bay.....$518,987
Okaloosa.....$555,412
Walton.....$172,760
Holmes.....$150,000
Washington.....$150,000
Jackson.....$152,476
Gadsden.....$150,365
Gulf.....$150,000

d. $11 million for FQHCs

Funds are provided to make Medicaid low-income pool payments to Federally Qualified Health Centers. These payments may be used to provide funding for Federally Qualified Health Centers supporting primary care services in medically underserved areas.

e. $3.2 million for poison control programs

Funds are provided to make Medicaid low-income pool payments to hospitals. These payments shall be used, in collaboration with the Department of Health, to provide funding for hospitals providing poison control programs.

f. $34 million for primary care awards

Funds are provided to continue the primary care grants.

g. Premium assistance for Palm Beach and Miami-Dade counties

Funds are provided to make health insurance premium payments for low-income residents enrolled in the Miami-Dade Premium Assistance Program.

Funds are provided to make Medicaid low-income pool payments for premium assistance programs operated by Palm Beach County Health Care District.

h. $3 million for hospital-based primary care initiatives – $750,000 for each hospital

Funds are provided to make Medicaid low-income pool payments to hospitals. These payments shall be used, in collaboration with the DOH, to provide funding for hospitals with hospital based primary care initiatives.

i. $35 million for quality initiatives described in STC 61a – split into $20 million for new initiatives and $15 million to expand existing initiatives

Tier-one Milestone Distributions (STC 61) are included as a portion of the total of the $50 million in new funds required by updated STCs from CMS. The distribution of the $35 million in this section will be determined by the agency based upon the requirements herein. A total of $20 million will be used for the start-up of new primary care programs and a total of $15 million will be used to meaningfully enhance existing primary care programs. There is a cap of $4 million per grant proposal. The CMS Tier-one Milestones are for the establishment of new, or enhancement of existing, innovative primary care programs that meaningfully enhance the quality of care and the health of low income populations. The new or enhanced primary care programs must broadly drive from the three overarching goals of CMS's Three-Part Aim.

1. Better care for individuals, including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity.
2. Better health for populations by addressing areas such as poor nutrition, physical activity, and substance abuse; and
3. Reducing per capita-costs.

Within these broad goals, the agency will establish further requirements for new or enhanced primary care programs to provide the services most needed by the local community, such as needed physician, dental, nurse practitioner, or pharmaceutical services; expand local capacity to treat patients; and provide for extended service hours. Additionally, reduction of unnecessary emergency room visits and preventable hospitalizations will be components of new or enhanced primary care programs.

j. Manatee ER Diversion program

Funds are provided to continue the primary care and emergency room diversion program in Manatee, Sarasota and DeSoto counties.

12.3 Appendix C – Summary of Tier – Two Milestones Defined in 2011 Waiver STCs

1. 100421 JACKSON MEMORIAL HOSPITAL (JHS) DADE

i. *Reductions of Surgical Site Infections (SSIs) and Other Surgical Complications* – Reductions in preventable surgical site infections, other preventable surgical complications, and significant improvement in employee safety culture throughout the organization. To mitigate this challenge, JHS has purchased an information technology (IT) software (Vigilanz) that once active, will be able to provide a round-the-clock automated data surveillance. Educate staff on safety.

ii. *Population-Focused Improvement: Reductions of Readmissions* – Schedule follow-up appointments on a patient preferred day, distribute meds for at least 30 days, and send prescription to patients preferred pharmacy and have follow-up calls with goal of reducing readmissions to 10%.

iii. *Improve Primary Care Capacity* – Adjust the Teaching Residency Model. Increase number of patients seen by 30% (the current no-show rate) by increasing scheduled appointments. Move some of the OB/GYN to work in Primary Care. Increase Primary Care services at the County Employee Clinics.

2. 100129 BROWARD HEALTH - BROWARD GENERAL MEDICAL CENTER BROWARD

i. *Primary Care Residency Program Expansion* – Increase the amount of residents being trained for Primary Care. Start new Pediatric program and rotating internship.

ii. *Sickle Cell Day Treatment Program* – Start an outpatient Sickle Cell Treatment program. Plan to reduce admissions by 10%.

iii. *Post-Discharge Support Services* – Consists of follow-up calls and appointments for patients with Congestive Heart Failure as they transition from inpatient to home. Plan to reduce readmission to 21%.

3. 102521 MEMORIAL HOSPITAL WEST BROWARD

i. *Readmission Reduction Program (RRP)* – Use Transition Coaches who will assist individuals discharged into the community through in-home visits and follow-up calls with the goal of lower ED visits and readmissions.

ii. *Specialty Care Coordination Program (SCCP) (Acute Care at Home Program)* – Treat patients with certain conditions at home rather than in the hospital setting.

iii. *Emergency Department Diversion (EDD)* – Upon discharge Patient Negotiators will educate ER patients who meet certain criteria on the importance of having follow-up appointments and a Medical Home. Surrounding clinic will extend hours, Community Health Center in Hollywood.

4. 100676 SHANDS AT JACKSONVILLE DUVAL

i. *Post Discharge Primary Care Visit* – Schedule a follow-up visit at discharge and develop program based on amount of patients that attend the follow-up visit; could include after-hour clinic hours, transportation, and patient education.

ii. *City Contract Primary Care Redesign* – Plan on having all types of health care in one or two locations with the goals of improving access, delivering services in an appropriate setting, changing health seeking behaviors and reducing cost.

iii. *No-show Physician Appointments* – Hire employees to call and remind patients of upcoming appointments and identify the patients' transportation barriers and develop a webpage "Catch a Caravan to Improved Health." Reduce no-shows by 10-15% and decrease unnecessary ER visits.

5. 100200 MEMORIAL REGIONAL HOSPITAL BROWARD

i. *Specialty Care Clinic Program (Acute Care at Home Program) at Memorial Regional Hospital* – Treat patients with certain conditions at home rather than in the hospital setting.

ii. *Enhancement of Patient Centered Medical Home (PCMH) at 4 Community Health Centers Operated by Memorial Regional Hospital* – Expand staff to improve availability and educate the patients. Will also purchase a web-based business intelligence tool (database of patients medical data that multiple physicians have access to) to improve care coordination and reduce cost.

iii. *Readmission Reduction Program at Memorial Regional Hospital* – Use Transition Coaches who will assist individuals discharged into the community through in-home visits and follow-up calls with the goal of lower ED visits and readmissions.

6. 108219 BROWARD HEALTH - IMPERIAL POINT HOSPITAL BROWARD

i. *Readmission Pneumonia Reduction* – Create group of individuals to evaluate the hospital's processes impacting the readmissions and form a plan to lower readmissions to 18%.

ii. *Improve Emergency Department Turn Around Time* – A team will work on reducing the average Turn-Around-Time (from the moment the patient is seen to discharge) of 390 minutes by 10%.

iii. *Inpatient Fall Reduction* – National Patient Safety Goal Performance Improvement Team to evaluate current fall prevention processes and lower the fall rate by 3%.

7. 101842 HALIFAX HEALTH VOLUSIA

i. *Center For Women & Infant Health* – Make certain every woman in the Labor & Delivery department sees a physician (24/7 OB), will the goal of lowering non-medically required caesareans and inductions, along with reducing lengths of stay for infants in the neonatal unit.

ii. *Congestive Heart Failure Observation Services* – Develop a specialized observation protocol for patients with Congestive Heart Failure with the goal of reducing readmission rates and lengths of stay, thus reducing per-capita cost and increasing effectiveness of care.

iii. *Expanded ED Diversion Program* – Build a second location for ED medical Triage and extend the hours at existing locations with the goal of diverting patients from the ED.

8. 100994 TAMPA GENERAL HOSPITAL (TGH) HILLSBOROUGH

i. *Practice Connect – Investment in Technology* – Provide surrounding physician practices with access to the Electronic Health Record (EHR) system for a small fee that is subsidized by the hospital with the goal of increasing the effectiveness of care

ii. *Population Focused Initiative to Reduce CLABSI in NICU* – Join an eight state collaborative committed to reducing the Central-Line-Blood Stream Infections (CLABSI) in neonatal intensive care units (NICUs); the goal is to reduce the rate by following evidence-based practices and engaging in continuous quality improvement.

iii. *Primary Care Clinics Extended Hours* – Will extend hours in TGH's Primary Care Clinics to afternoons, weekends and even offer same-day appointments and walk-ins.

9. 102229 MEMORIAL HOSPITAL PEMBROKE BROWARD

i. *Specialty Care Clinic Program (Acute Care at Home Program) at Memorial Hospital Pembroke* – Treat patients with certain conditions at home rather than in the hospital setting.

ii. *Readmission Reduction Program at Memorial Hospital Pembroke* – Use Transition Coaches who will assist individuals discharged into the community through in-home visits and follow-up calls with the goal of lower ED visits and readmissions.

iii. *Enhancement of the Patient Centered Medical Home (PCMH) at 1 Community Health Center Operated by Memorial Hospital Pembroke* – Expand staff to improve availability and educate the patients. Purchase a web-based business intelligence tool (database of patients medical data that multiple physicians have access to) to improve care coordination and reduce cost.

10. 101761 SARASOTA MEMORIAL HOSPITAL SARASOTA

i. *mHealth (Mobile Health) Trial Use of Mobile Phone Technology to Improve Monitoring of Heart Failure Patients* – Familiarize the target group with their mobile devices. Cell phones will be used several times a day to send updates of patients' blood pressure cuff and external scale to nurse practitioners, nurse practitioner will respond to patients outside of pre-prescribed ranges.

ii. *Decrease Average Length-of-Stay (ALOS) for Neonatal Abstinence Syndrome (NAS) Patients* – Infants born to mothers that used illicit or prescription meds while in utero and have developed a dependency. The goal is to more effectively care for these infants by identifying and administering the most appropriate pharmaceutical intervention

iii. *Improve Quality, Safety and Experience of Care Through Patient Centered Rounding* –Staff will make specially educated and trained to make hourly rounds to check on patients. Sarasota intends for patient-centered rounding to reduce patient reliance on call lights by 10% and to provide proactive care rather than reactive care in the inpatient setting, thus reducing falls and hospital induced ulcers.

11. 101109 LEE MEMORIAL HOSPITAL LEE

i. *Improve Health Status of Low Income Patients with COPD* – Improve the health status for low income patients with chronic obstructive pulmonary disease (COPD) with an evidenced based plan of care developed and monitored by the assignment of patient to a patient centered primary care home physician that provides the evaluation, education, care coordination and support system to best equip patients to manage their disease and improve their quality of life.

ii. *Improve Health of Obese Low Income Population* – Improve the health status for low income patients that are obese (BMI greater than or equal to 30) by initiating a motivational medical program based on proven methods to improve diet and exercise habits

iii. *Improve Health of Dual Diagnosis Low Income Behavioral Health Patients* – Improve the health status through appropriate screening for and treating behavioral health issues for low-income patients with dual diagnosis of behavioral health disorder such as depression with comorbid medical conditions.

12. 100218 BROWARD HEALTH - NORTH BROWARD MEDICAL CENTER BROWARD

i. *Decrease Catheter Associated Urinary Tract Infections (CAUTI)* - Increased education on appropriate Foley care and handling for all staff. Daily assessment of Foley catheter need for appropriate discontinuation. Reduce CAUTIs to 2.0/catheter day X 1,000.

ii. *Decrease Readmissions in Chronic Obstructive Pulmonary Disease (COPD) Patient Population* – Reduce readmissions through improved patient education about their disease process and lifestyle changes required to reduce acute exacerbations; improve patient compliance with appropriate medication usage; primary care follow-up.

iii. *Admitted Patient Flow* – Develop a team that analyzes and cuts down on delays associated with the time between the doctor giving the order to admit the patient to when the patient is transported to nurse station for inpatient care. Goal is to reduce time from 152 minutes to 137 minutes.

13. 103454 MEMORIAL HOSPITAL MIRAMAR BROWARD

i. *Readmission Reduction Program at Memorial Hospital Miramar* – Use Transition Coaches who will assist individuals discharged into the community through in-home visits and follow-up calls with the goal of lower ED visits and readmissions.

ii. *Specialty Care Clinic Program (Acute Care at Home Program) at Memorial Hospital Miramar* – Treat patients with certain conditions at home rather than in the hospital setting.

iii. *Emergency Department Diversion Program at Memorial Hospital Miramar* – Upon discharge Patient Negotiators will educate ER patients who meet certain criteria on the importance of having follow-up appointments and a Medical Home. Surrounding clinic will extend hours, Community Health Center in Hollywood.

14. 120405 BROWARD HEALTH - CORAL SPRINGS MEDICAL CENTER BROWARD

i. *Mislabeled Specimens* – Reduce number of specimens mislabeled, currently is over 1.0/1000 patient days goal is to reduce to .3/1000 patient days by DY8

ii. *Patient Care Flow* – Improve patient flow by optimizing discharge timing. By expediting the discharge procedure they hope to reduce the pressure on the ED while the new ED is being constructed.

iii. *Reducing 30-day CHF Readmissions* – Reduce readmissions by 2 percentage points for patients with Congestive Heart Failure, as well as prepare the family and patient for discharge.

15. 101044 INDIAN RIVER MEDICAL CENTER INDIAN RIVER

i. *Outpatient Heart Failure Clinic* – Clinic designed to provide patients with information to modify their lifestyles in order to reduce their symptoms and prevent progression of their disease. The Program consists of a team of health providers. The Clinic health providers are available to patients 24 hours a day by telephone.

ii. *Health Information Exchange* – Create an electronic record system that can be accessed by at least 40% of the 200 community physician; utilize Health Information Exchange in order to improve patient care, patient flow, and reduce health care costs.

iii. *Exemption Approved by CMS* – They are requesting the exemption because Initiative #2 is a significant financial investment that requires the Hospital to maintain well beyond the term of the Section 1115 Demonstration Project. In addition, they are the 15th hospital of the Top 15 and receive the lowest funding in the group.

12.4 Appendix D – Hospital Payments

Row Nbr	Provider Medicaid ID	Provider Name	Payments							Contributions to State Share			Net Provider Revenue from Medicaid
			Fee-for-Service Inpatient	Fee-for-Service Outpatient	Managed Care Inpatient	Managed Care Outpatient	LIP	DSH	Total Payments Unadjusted	Provider Assessment	LIP and Auto IGT Contribution	Self-Funded IGT Contribution	
1	010151600	All Children's Hospital	$103,348,491	$31,784,771	$15,421,037	$18,790,405	$5,246,162	$396,811	$174,987,677	$3,152,926	$0	$1,006,312	$170,828,440
2	011648300	Anne Bates Leach Eye Hospital	$93,198	$7,185,075	$0	$1,673,873	$0	$0	$8,952,147	$992,088	$0	$9,876	$7,950,183
3	012037500	Aventura Hospital & Medical Center	$4,079,933	$632,496	$1,914,485	$471,908	$0	$0	$7,098,822	$3,602,823	$0	$0	$3,495,999
4	010074900	Baptist Hospital (Pensacola)	$10,853,728	$5,704,823	$3,421,231	$2,121,281	$546,886	$0	$22,647,950	$4,161,936	$0	$1,328,576	$17,157,437
5	010232600	Baptist Hospital of Beaches	$1,653,833	$1,136,505	$267,722	$439,399	$0	$0	$3,497,459	$1,243,385	$0	$0	$2,254,074
6	010064100	Baptist Medical Center	$31,000,099	$18,825,745	$6,644,513	$8,455,125	$514,648	$0	$65,440,130	$9,233,730	$0	$0	$56,206,400
7	010123100	Baptist Medical Center - Nassau	$3,683,000	$2,027,047	$302,177	$375,720	$229,816	$197,300	$6,815,061	$616,644	$116,833	$0	$6,081,584
8	010035800	Baptist of Miami	$35,176,939	$11,611,522	$6,668,516	$4,765,908	$1,220,091	$0	$59,442,976	$11,397,312	$0	$0	$48,045,665
9	012041300	Bartow Memorial Hospital	$1,864,043	$1,481,200	$917,526	$2,231,829	$0	$0	$6,494,598	$738,119	$0	$678,950	$5,077,529
10	010006400	Bay Medical Center	$11,613,395	$5,887,645	$1,109,324	$1,492,406	$90,745	$3,970,299	$24,163,813	$2,238,102	$0	$2,659,724	$19,265,987
11	010372100	BayCare Alliant Hospital	$664,800	$0	$222,565	$0	$0	$0	$887,365	$256,636	$0	$167,370	$463,359
12	010156700	Bayfront Medical Center	$23,027,837	$2,709,692	$6,145,287	$2,002,067	$352,378	$1,088,480	$35,325,741	$3,318,325	$0	$4,430,309	$27,577,107
13	011988100	Bayonet Point/Hudson	$3,474,339	$921,680	$1,397,030	$1,030,069	$206,266	$0	$7,029,384	$2,291,380	$0	$0	$4,738,004
14	010183400	Bert Fish Memorial Hospital	$2,215,710	$2,922,119	$590,670	$1,746,702	$0	$0	$7,475,201	$318,621	$0	$731,091	$6,425,488
15	010140100	Bethesda Mem. Hosp.	$27,827,765	$5,530,642	$2,945,077	$1,694,537	$134,104	$0	$38,132,125	$3,264,890	$0	$3,635,257	$31,231,978
16	010141900	Boca Raton Community Hospital	$2,488,786	$882,036	$356,246	$436,257	$0	$0	$4,163,324	$3,708,782	$0	$327,475	$127,067
17	011807900	Brandon Regional Medical Center	$16,841,846	$4,045,096	$6,678,527	$3,744,741	$211,138	$0	$31,521,348	$3,856,045	$0	$2,011,121	$25,654,183
18	010087100	Brooksville Regional Hospital	$10,644,529	$3,709,113	$1,317,214	$2,702,809	$1,163,827	$0	$19,537,492	$1,946,513	$894,559	$1,960,431	$14,735,988
19	010012900	Broward General Hospital	$88,495,213	$18,820,144	$302,147	$7,509,647	$100,000,897	$22,957,145	$238,085,194	$4,975,129	$91,131,966	$12,829,661	$129,148,437
20	010026900	Calhoun Liberty Hospital	$203,953	$606,105	$22,483	$244,310	$215,492	$355,286	$1,647,629	$107,458	$18,853	$0	$1,521,318
21	010194000	Campbellton-Graceville Hospital	$10,527	$226,851	$0	$5,263	$0	$476,266	$718,907	$81,731	$0	$0	$637,176

Row Nbr	Provider Medicaid ID	Provider Name	Payments							Contributions to State Share			Net Provider Revenue from Medicaid
			Fee-for-Service Inpatient	Fee-for-Service Outpatient	Managed Care Inpatient	Managed Care Outpatient	LIP	DSH	Total Payments Unadjusted	Provider Assessment	LIP and Auto IGT Contribution	Self-Funded IGT Contribution	
22	010009900	Cape Canaveral Hospital	$2,315,717	$1,252,156	$313,739	$691,209	$0	$0	$4,572,822	$1,179,616	$0	$0	$3,393,206
23	011971700	Cape Coral Hospital	$13,382,168	$4,248,094	$2,108,809	$1,776,114	$0	$1,640,204	$23,155,389	$2,423,077	$0	$3,318,400	$17,413,911
24	011980600	Capital Regional Medical Center	$4,959,701	$2,917,713	$2,622,443	$3,378,977	$0	$0	$13,878,834	$1,879,218	$0	$379,593	$11,620,022
25	010036600	Cedars Medical Center, Inc.	$24,536,682	$5,579,010	$7,188,753	$1,386,086	$19,635	$0	$38,710,166	$4,295,680	$0	$1,298,177	$33,116,309
26	010178800	Central Florida Regional Hospital	$2,944,171	$1,809,630	$1,823,771	$2,123,761	$0	$0	$8,701,333	$1,762,286	$0	$0	$6,939,047
27	010027700	Charlotte Regional Medical Center	$1,076,658	$642,058	$248,651	$238,223	$0	$0	$2,205,590	$1,434,879	$0	$0	$770,711
28	010219900	Citrus Memorial Hospital	$7,283,214	$3,139,939	$1,255,529	$1,247,124	$7,829,231	$703,346	$21,458,384	$1,797,195	$7,215,881	$1,955,644	$10,489,663
29	010314400	Cleveland Clinic FL Hospital - Naples	$6,074,020	$3,341,106	$1,087,182	$1,830,980	$0	$0	$12,333,288	$2,163,314	$0	$1,722,448	$8,447,525
30	010220200	Cleveland Clinic Hospital	$466,469	$193,700	$273,695	$297,588	$0	$0	$1,231,453	$2,466,218	$0	$0	-$1,234,765
31	010253900	Columbia Englewood Community Hosp	$293,804	$221,992	$65,700	$95,454	$0	$0	$676,949	$450,945	$0	$0	$226,004
32	012030800	Columbia Hospital	$5,497,249	$829,271	$3,480,501	$652,226	$79,786	$0	$10,539,034	$997,729	$0	$1,037,158	$8,504,147
33	010146000	Columbia JFK Medical Center	$22,303,196	$4,164,950	$6,011,954	$2,091,568	$2,147,115	$0	$36,718,782	$5,036,335	$0	$4,237,212	$27,445,234
34	012013800	Columbia Kendall Medical Center	$19,441,179	$4,908,192	$4,540,174	$1,742,058	$451,017	$0	$31,082,620	$3,349,602	$0	$0	$27,733,018
35	010138900	Columbia Medical Center-Osceola	$11,325,582	$4,435,642	$5,672,449	$5,222,023	$180,741	$0	$26,836,437	$3,189,856	$0	$0	$23,646,581
36	010552000	Columbia New Port Richey Hospital	$6,818,976	$762,132	$2,282,932	$640,117	$0	$0	$10,504,158	$1,753,524	$0	$0	$8,750,633
37	012026000	Columbia Palms West Hospital	$15,438,083	$3,890,113	$3,732,356	$1,882,988	$232,180	$0	$25,175,720	$1,821,279	$0	$2,890,717	$20,463,723
38	012000600	Columbia Plantation General Hosp	$25,117,400	$5,241,969	$3,035,622	$2,662,830	$1,158,364	$11,874	$37,228,059	$3,793,979	$0	$0	$33,434,080
39	010125700	Columbia Twin Cities Hospital	$342,307	$665,674	$41,392	$115,313	$0	$0	$1,164,686	$501,598	$0	$0	$663,088
40	010960600	Coral Gables Hospital	$3,098,646	$1,511,557	$598,702	$704,839	$41,320	$0	$5,955,064	$1,009,063	$0	$0	$4,946,001
41	012040500	Coral Springs Medical Center	$17,201,884	$6,552,956	$3,726,774	$2,749,094	$15,039,128	$2,229,442	$47,499,277	$1,710,262	$13,821,547	$2,503,847	$29,463,622
42	012009000	Delray Comm. Hospital	$4,971,851	$910,540	$1,010,002	$573,229	$438,491	$0	$7,904,113	$3,586,302	$0	$1,323,752	$2,994,059
43	010192300	Desoto Memorial Hospital	$3,346,217	$2,710,582	$125,390	$186,631	$267,943	$178,036	$6,814,799	$333,291	$113,196	$0	$6,368,312

Row Nbr	Provider Medicaid ID	Provider Name	Payments							Contributions to State Share			Net Provider Revenue from Medicaid
			Fee-for-Service Inpatient	Fee-for-Service Outpatient	Managed Care Inpatient	Managed Care Outpatient	LIP	DSH	Total Payments Unadjusted	Provider Assessment	LIP and Auto IGT Contribution	Self-Funded IGT Contribution	
44	010180000	Doctor's Memorial Hospital	$902,135	$2,010,344	$46,217	$116,789	$215,147	$163,834	$3,454,465	$198,283	$67,518	$0	$3,188,664
45	010354300	Doctors Hospital	$1,481,130	$733,694	$562,787	$220,871	$0	$0	$2,998,483	$2,388,239	$0	$0	$610,244
46	011995400	Doctors Hospital of Sarasota	$519,451	$285,387	$175,237	$234,651	$0	$0	$1,214,726	$1,355,044	$0	$0	-$140,317
47	010103600	Doctors Memorial Hospital	$981,576	$1,590,460	$11,884	$35,144	$176,247	$255,560	$3,050,870	$127,218	$51,582	$0	$2,872,070
48	010277600	Douglas Gardens Hospital	$0	$0	$0	$48	$0	$0	$48	$103,905	$0	$0	-$103,857
49	010004800	Ed Fraser Memorial Hospital	$21,398	$1,010,914	$0	$221,275	$1,850,957	$3,748,863	$6,853,407	$155,475	$29,898	$0	$6,668,035
50	010259800	Edward White Hospital	$537,137	$290,351	$321,903	$234,352	$0	$0	$1,383,743	$663,150	$0	$0	$720,593
51	011746300	Fawcett Memorial Hospital	$1,208,149	$594,135	$341,258	$246,515	$0	$0	$2,390,057	$1,826,707	$0	$0	$563,350
52	010120600	Fishermen's Hospital	$256,351	$508,484	$17,886	$51,475	$226,884	$384,972	$1,446,051	$66,680	$14,921	$0	$1,364,450
53	010171100	Flagler Hospital	$5,795,032	$3,333,347	$1,119,473	$864,924	$0	$0	$11,112,777	$2,517,820	$0	$845,975	$7,748,982
54	010129000	Florida Hospital	$125,350,702	$32,741,663	$66,043	$34,389,031	$261,699	$1,715,181	$194,524,319	$28,763,353	$0	$5,416,922	$160,344,044
55	010189300	Florida Hospital - Flagler	$3,100,884	$2,496,086	$776,020	$797,515	$345,896	$369,337	$7,885,737	$1,352,837	$129,865	$0	$6,403,035
56	010090100	Florida Hospital Heartland Med Cntr	$3,029,866	$2,609,092	$469,921	$959,379	$0	$0	$7,068,258	$1,798,019	$0	$0	$5,270,239
57	010109500	Florida Hospital Waterman	$9,802,642	$2,893,233	$2,173,973	$2,257,862	$203,570	$0	$17,331,279	$2,282,967	$187,622	$3,378,841	$11,481,849
58	010260100	Florida Hospital Wauchula	$118,685	$1,887,309	$42,727	$285,906	$229,467	$353,419	$2,917,514	$225,545	$37,007	$0	$2,654,961
59	005456800	Florida Hospital Wesley Chapel	$702,950	$716,749	$188,623	$625,720	$0	$0	$2,234,043	$0	$0	$0	$2,234,043
60	010149400	Florida Hospital Zephyrhills	$2,105,184	$1,227,298	$733,612	$1,293,623	$0	$0	$5,359,716	$1,740,891	$0	$0	$3,618,825
61	011132500	Ft. Walton Beach Medical Center	$4,485,028	$1,768,355	$582,637	$251,985	$0	$0	$7,088,005	$2,428,852	$0	$0	$4,659,153
62	010271700	Genesis Rehabilitation Hospital	$1,412,673	$1,730,651	$147,246	$633,577	$0	$0	$3,924,148	$969,668	$0	$0	$2,954,480
63	010080300	George E. Weems Memorial Hosp	$204,196	$552,514	$0	$28,824	$165,528	$306,364	$1,257,426	$62,323	$28,359	$0	$1,166,744
64	010144300	Glades General Hospital	$5,956,535	$2,630,009	$1,438,744	$1,251,586	$6,802,125	$1,528,119	$19,607,118	$360,894	$3,631,439	$18,668	$15,596,117
65	010152400	Good Samaritan Hospital	$7,250,446	$3,281,097	$2,233,648	$2,923,646	$0	$0	$15,688,837	$1,868,156	$0	$1,689,237	$12,131,444
66	011761700	Gulf Coast Community Hospital	$8,652,777	$4,559,589	$853,751	$1,434,232	$165,191	$0	$15,665,540	$2,072,209	$0	$0	$13,593,330

Row Nbr	Provider Medicaid ID	Provider Name	Payments							Contributions to State Share			Net Provider Revenue from Medicaid
			Fee-for-Service Inpatient	Fee-for-Service Outpatient	Managed Care Inpatient	Managed Care Outpatient	LIP	DSH	Total Payments Unadjusted	Provider Assessment	LIP and Auto IGT Contribution	Self-Funded IGT Contribution	
67	012032400	H L Moffitt Cancer Center	$16,323,785	$16,988,375	$17,962	$4,120,349	$6,296,532	$0	$43,747,004	$5,899,331	$5,803,255	$2,318,526	$29,725,892
68	011975000	H.H. Raulerson	$2,838,623	$2,219,140	$715,873	$685,768	$108,302	$0	$6,567,707	$794,054	$99,818	$0	$5,673,836
69	010184200	Halifax Medical Center	$28,320,354	$7,585,889	$9,116,256	$5,060,609	$20,646,506	$7,403,123	$78,132,738	$4,771,824	$18,109,172	$4,217,886	$51,033,856
70	010135400	Health Central	$8,064,973	$3,720,509	$5,675,513	$3,122,410	$19,734	$2,341,071	$22,944,210	$2,798,735	$0	$1,818,545	$18,326,930
71	010270900	HealthSouth Rehab Hosp - Miami	$209,856	$0	$61,450	$0	$0	$0	$271,306	$286,947	$0	$0	-$15,641
72	012038300	HealthSouth Rehab Hosp Sarasota	$48,299	$0	$25,962	$0	$0	$0	$74,261	$463,845	$0	$0	-$389,584
73	010175300	HealthSouth Rehab Hosp-Largo	$101,122	$0	$27,387	$0	$0	$0	$128,509	$303,368	$0	$0	-$174,859
74	012042100	HealthSouth Rehab Hosp-Sea Pines	$37,452	$482	$48,888	$0	$0	$0	$86,822	$302,808	$0	$0	-$215,987
75	012027800	HealthSouth Rehab Hosp-Sunrise	$4,303	$8,502	$67,992	$0	$0	$0	$80,797	$629,635	$0	$0	-$548,838
76	012033200	HealthSouth Rehab Hosp-Tallahassee	$38,932	$22,811	$77,033	$4,682	$0	$0	$143,459	$273,404	$0	$0	-$129,944
77	012034100	HealthSouth Rehab Hosp-Treasure Coast	$171,111	$15,826	$0	$0	$0	$0	$186,938	$330,679	$0	$0	-$143,741
78	010188500	Healthmark Regional Medical Center	$421,431	$830,258	$3,665	$22,467	$207,680	$315,768	$1,801,269	$112,819	$41,531	$0	$1,646,919
79	010275000	Healthsouth Emerald Coast Hospital	$130,386	$13,910	$2,378	$1,132	$0	$0	$147,806	$308,930	$0	$0	-$161,124
80	010355100	Healthsouth Hospital of Spring Hill	$21,486	$4,825	$0	$92	$0	$0	$26,402	$377,737	$0	$0	-$351,334
81	012005700	Healthsouth Larkin Hospital-Miami	$2,538,072	$693,748	$868,821	$297,183	$3,672	$1,088,480	$5,489,975	$722,557	$0	$0	$4,767,419
82	008369200	Healthsouth Rehab of Ocala	$19,443	$0	$0	$0	$0	$0	$19,443	$0	$0	$0	$19,443
83	010356000	Healthsouth Ridgelake Hospital	$157,686	$0	$46,535	$0	$0	$0	$204,221	$121,259	$0	$0	$82,963
84	010228800	Heart of Florida Hospital	$7,254,241	$2,033,836	$4,198,936	$2,555,777	$125,120	$0	$16,167,910	$1,859,157	$0	$1,513,907	$12,794,846
85	010161300	Helen Ellis Memorial Hospital	$918,006	$811,143	$355,407	$933,019	$0	$0	$3,017,575	$785,235	$0	$0	$2,232,340
86	010086200	Hendry Regional Medical Center	$882,424	$1,613,975	$59,439	$438,499	$256,263	$381,256	$3,631,856	$155,036	$76,842	$0	$3,399,977
87	010041200	Hialeah Hospital	$13,062,005	$3,336,373	$1,882,633	$1,180,077	$251,529	$8,134	$19,720,751	$1,499,110	$0	$0	$18,221,641
88	010089700	Highlands Regional	$3,135,051	$1,471,566	$715,581	$846,335	$843,800	$0	$7,012,333	$670,976	$777,696	$1,085,585	$4,478,077

Row Nbr	Provider Medicaid ID	Provider Name	Payments							Contributions to State Share			Net Provider Revenue from Medicaid
			Fee-for-Service Inpatient	Fee-for-Service Outpatient	Managed Care Inpatient	Managed Care Outpatient	LIP	DSH	Total Payments Unadjusted	Provider Assessment	LIP and Auto IGT Contribution	Self-Funded IGT Contribution	
		Medical Center											
89	010008100	Holmes Regional Medical Center	$16,516,545	$3,569,177	$4,487,436	$2,503,231	$305,830	$0	$27,382,218	$5,537,304	$0	$0	$21,844,914
90	010018800	Holy Cross Hospital, Inc.	$3,437,558	$1,228,251	$594,168	$793,411	$0	$0	$6,053,388	$3,756,061	$0	$0	$2,297,327
91	010226100	Homestead Hospital	$15,977,725	$9,588,409	$5,557,448	$6,562,777	$417,436	$5,381	$38,109,177	$2,059,449	$0	$0	$36,049,728
92	010821900	Imperial Point Hospital	$5,678,292	$1,532,086	$1,730,293	$1,056,126	$34,378,555	$2,683,479	$47,058,831	$1,158,853	$31,557,004	$1,180,739	$13,162,236
93	010104400	Indian River Memorial Hospital	$10,167,293	$4,330,910	$1,446,540	$1,048,784	$9,673,051	$0	$26,666,579	$2,090,632	$8,915,254	$3,026,398	$12,634,295
94	010106100	Jackson Hospital	$4,695,413	$2,913,517	$65,633	$162,799	$289,774	$258,275	$8,385,411	$490,788	$157,935	$0	$7,736,688
95	010042100	Jackson Memorial Hospital	$313,560,886	$63,320,623	$22,651,168	$18,368,417	$365,499,429	$75,963,625	$859,364,148	$12,063,078	$328,264,793	$56,477,630	$462,558,647
96	010173700	Jay Hospital	$130,440	$398,038	$40,199	$104,678	$177,355	$285,075	$1,135,785	$138,204	$45,714	$0	$951,867
97	012029400	Jupiter Hospital	$2,468,942	$882,046	$448,555	$479,168	$0	$0	$4,278,712	$1,935,156	$0	$435,403	$1,908,152
98	010234200	Kindred Hospital (Tampa)	$55,742	$0	$46,019	$0	$0	$0	$101,761	$319,832	$0	$0	-$218,070
99	011993800	Kindred Hospital - Coral Gables	$0	$0	$26,344	$0	$0	$0	$26,344	$375,404	$0	$0	-$349,061
100	010019600	Kindred Hospital - Ft.Lauderdale	$11,622	$0	$61,904	$0	$0	$0	$73,527	$446,774	$0	$0	-$373,247
101	010267900	Kindred Hospital - North Florida	$15,039	$0	$0	$0	$0	$0	$15,039	$427,237	$0	$0	-$412,198
102	000417000	Kindred Hospital - Palm Beaches	$12,198	$0	$2,562	$0	$0	$0	$14,760	$332,075	$0	$0	-$317,316
103	010353500	Kindred Hospital Ocala	$92,853	$0	$12,857	$0	$0	$0	$105,709	$148,954	$0	$0	-$43,245
104	010191500	Kindred Hospital-Hollywood	$10,666	$0	$66,957	$0	$0	$0	$77,623	$572,953	$0	$0	-$495,331
105	001681500	Kindred Hospital-Melbourne	$99,538	$0	$29,272	$0	$0	$0	$128,811	$263,004	$0	$0	-$134,193
106	010276800	Kindred Hospital-St. Petersburg	$50,241	$0	$16,328	$0	$0	$0	$66,569	$416,309	$0	$0	-$349,740
107	011021300	L.W. Blake Memorial Hospital	$3,882,936	$1,439,381	$1,704,088	$1,105,529	$206,266	$0	$8,338,199	$2,274,229	$0	$726,751	$5,337,219
108	010822700	Lake Butler Hospital	$19,752	$778,483	$0	$15,952	$455,768	$478,786	$1,748,741	$93,312	$40,015	$0	$1,615,415
109	011976800	Lake City Medical Center	$584,419	$1,383,185	$38,699	$61,920	$0	$0	$2,068,223	$736,753	$0	$0	$1,331,470
110	010166400	Lake Wales Hospital Association	$1,930,962	$1,231,361	$1,544,823	$1,362,746	$0	$0	$6,069,893	$738,327	$0	$283,664	$5,047,902
111	010164800	Lakeland Regional	$33,967,374	$13,088,958	$17,348,578	$18,007,721	$4,380,361	$0	$86,792,992	$6,548,212	$0	$5,303,622	$74,941,158

Row Nbr	Provider Medicaid ID	Provider Name	Payments							Contributions to State Share			Net Provider Revenue from Medicaid
			Fee-for-Service Inpatient	Fee-for-Service Outpatient	Managed Care Inpatient	Managed Care Outpatient	LIP	DSH	Total Payments Unadjusted	Provider Assessment	LIP and Auto IGT Contribution	Self-Funded IGT Contribution	
		Medical Center											
112	010342000	Lakewood Ranch Medical Center	$598,719	$553,056	$330,274	$641,959	$0	$0	$2,124,008	$655,201	$0	$0	$1,468,808
113	011974100	Largo Medical Center	$4,465,281	$1,085,867	$1,784,244	$887,077	$535,676	$1,523,262	$10,281,407	$3,070,127	$0	$0	$7,211,280
114	011969500	Lawnwood Regional Medical Center	$15,471,785	$3,459,489	$4,418,923	$1,934,503	$461,249	$0	$25,745,949	$3,333,836	$0	$0	$22,412,113
115	010110900	Lee Memorial Hospital	$69,536,640	$17,583,191	$8,369,008	$5,469,943	$20,396,422	$8,425,535	$129,780,739	$7,591,288	$16,377,741	$10,101,413	$95,710,298
116	010107900	Leesburg Regional Medical Center	$9,331,710	$2,877,625	$2,567,691	$1,407,232	$1,530,203	$0	$17,714,461	$2,913,705	$1,410,325	$2,907,100	$10,483,330
117	010111700	Lehigh Regional Medical Center	$1,057,415	$1,860,209	$266,332	$527,136	$0	$0	$3,711,092	$517,879	$0	$0	$3,193,213
118	010119200	Lower Florida Keys Hospital	$2,764,513	$1,057,472	$64,581	$100,526	$73,506	$0	$4,060,598	$0	$0	$0	$4,060,598
119	010115000	Madison County Memorial Hospital	$82,485	$311,732	$60,850	$374,912	$208,250	$359,928	$1,398,157	$74,515	$39,675	$0	$1,283,968
120	010116800	Manatee Memorial Hospital	$20,582,754	$3,424,034	$5,298,745	$3,158,014	$3,985,352	$0	$36,448,898	$2,597,673	$3,586,236	$4,191,776	$26,073,213
121	010121400	Mariners Hospital	$353,170	$1,310,060	$0	$138,333	$181,941	$178,409	$2,161,913	$500,424	$53,129	$0	$1,608,360
122	010118400	Martin Memorial Hospital	$6,252,477	$5,811,346	$1,177,222	$3,282,851	$0	$0	$16,523,896	$3,419,568	$0	$942,380	$12,161,947
123	010072200	Mayo Clinic Florida	$1,583,231	$335,447	$405,079	$142,444	$6,197	$1,715,181	$4,187,579	$4,944,567	$0	$0	-$756,989
124	010154100	Mease Hospital Clinic	$1,662,801	$693,191	$1,295,839	$781,179	$0	$0	$4,433,011	$4,350,126	$0	$847,968	-$765,083
125	012008100	Mease Hospital Countryside	$8,724,162	$2,428,639	$2,069,119	$1,854,042	$0	$0	$15,075,962	$0	$0	$0	$15,075,962
126	010176100	Memorial Hospital	$24,821,141	$6,440,443	$4,752,628	$3,806,501	$20,867,702	$2,446,438	$63,134,853	$5,511,508	$19,232,905	$7,800,688	$30,589,752
127	010020000	Memorial Hospital	$91,115,732	$37,059,964	$10,878,019	$15,304,428	$75,386,641	$18,056,087	$247,800,870	$8,917,503	$63,228,972	$10,141,636	$165,512,759
128	010252100	Memorial Hospital - West	$23,758,572	$13,409,655	$2,878,076	$4,969,205	$29,867,096	$3,513,325	$78,395,928	$4,799,984	$27,081,474	$4,698,336	$41,816,135
129	010187700	Memorial Hospital - West Volusia	$7,743,654	$3,057,862	$1,892,737	$1,735,874	$0	$0	$14,430,126	$1,337,079	$0	$2,212,116	$10,880,931
130	010345400	Memorial Hospital Miramar	$10,577,728	$7,566,116	$1,220,258	$2,250,780	$17,611,246	$138,450	$39,364,579	$1,950,762	$15,990,963	$1,926,185	$19,496,669
131	011279800	Memorial Hospital of Tampa	$936,030	$271,489	$302,359	$243,421	$0	$0	$1,753,298	$787,621	$0	$0	$965,677
132	010193100	Memorial Medical Center	$9,026,666	$3,543,416	$2,399,093	$1,910,556	$0	$0	$16,879,732	$3,851,051	$0	$0	$13,028,681
133	010054400	Metropolitan Hospital Miami	$1,978,168	$1,077,751	$406,472	$338,306	$0	$0	$3,800,696	$0	$0	$0	$3,800,696
134	010060900	Miami Childrens Hospital	$88,087,834	$44,185,047	$14,232,466	$15,300,218	$4,429,069	$400,441	$166,635,076	$5,031,350	$0	$0	$161,603,726

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135	010158300	Morton F. Plant Hospital	$18,669,195	$4,042,879	$5,813,168	$3,313,955	$281,521	$1,088,480	$33,209,198	$5,305,481	$0	$3,553,692	$24,350,025
136	010046300	Mt. Sinai Medical Center	$21,528,548	$7,504,964	$4,568,289	$2,387,597	$6,171,932	$3,818,455	$45,979,785	$5,189,963	$0	$2,899,223	$37,890,599
137	010117600	Munroe Regional Medical Center	$20,154,790	$7,487,553	$3,566,523	$3,421,804	$2,190,748	$2,267,911	$39,089,330	$3,586,554	$2,019,123	$6,160,661	$27,322,992
138	010031500	Naples Community Hospital	$19,239,574	$3,858,182	$3,286,074	$1,642,416	$309,182	$0	$28,335,429	$5,333,246	$0	$2,105,201	$20,896,981
139	004087600	Nemours Children's Hospital	$4,440,099	$1,876,894	$2,537,463	$1,676,748	$0	$0	$10,531,203	$0	$0	$0	$10,531,203
140	010150800	North Bay Medical Center	$3,652,673	$1,147,319	$2,637,594	$1,110,506	$0	$0	$8,548,093	$1,126,264	$0	$0	$7,421,829
141	010021800	North Broward Medical Center	$15,700,148	$5,306,728	$3,430,585	$2,651,073	$24,734,088	$9,055,179	$60,877,801	$2,228,996	$20,996,228	$2,440,886	$35,211,691
142	010862600	North Florida Regional Hospital	$6,314,508	$3,658,001	$420,037	$162,176	$0	$0	$10,554,723	$4,494,796	$0	$0	$6,059,927
143	010126500	North Okaloosa Medical Center	$1,947,077	$2,441,988	$184,960	$291,889	$0	$0	$4,865,915	$1,020,431	$0	$0	$3,845,484
144	010049800	Northshore Medical Center	$22,038,818	$4,675,211	$5,107,046	$3,899,025	$89,269	$12,251	$35,821,619	$3,656,161	$0	$0	$32,165,458
145	011519300	Northside Hospital	$3,149,054	$770,137	$1,784,743	$696,491	$103,184	$0	$6,503,609	$1,682,968	$0	$0	$4,820,641
146	010190700	Northwest Community Hospital	$514,080	$1,788,995	$10,710	$38,541	$237,773	$304,549	$2,894,648	$233,354	$41,668	$0	$2,619,626
147	010459100	Northwest Regional Hospital	$4,222,032	$1,392,204	$1,180,391	$831,847	$0	$0	$7,626,474	$2,151,504	$0	$0	$5,474,970
148	012007300	Oak Hill Community Hospital	$1,228,303	$759,154	$859,724	$686,388	$0	$0	$3,533,569	$2,171,233	$0	$0	$1,362,336
149	010988600	Ocala Regional Medical Center	$4,936,327	$3,655,334	$1,207,736	$1,761,359	$71,639	$0	$11,632,395	$2,846,789	$66,027	$602,354	$8,117,225
150	011174100	Orange Park Medical Center	$6,843,742	$3,085,082	$2,010,574	$1,861,675	$206,266	$0	$14,007,339	$2,649,638	$0	$0	$11,357,701
151	010133800	Orlando Regional Medical Center	$128,604,056	$25,897,784	$31,007,225	$21,086,821	$4,718,173	$4,417,440	$215,731,499	$19,070,292	$0	$6,332,808	$190,328,400
152	010186900	Ormond Beach Memorial Hospital	$5,281,643	$2,094,438	$772,715	$991,376	$0	$0	$9,140,173	$2,600,474	$0	$0	$6,539,699
153	003297500	Palm Bay Hospital	$1,897,362	$1,501,701	$887,604	$1,387,110	$0	$0	$5,673,776	$529,144	$0	$0	$5,144,632
154	010210500	Palm Beach Gardens Medical Center	$3,875,730	$1,120,815	$1,691,875	$912,250	$0	$0	$7,600,669	$2,306,231	$0	$1,113,251	$4,181,187
155	010053600	Palm Springs General Hospital	$1,155,373	$511,549	$244,967	$134,652	$0	$0	$2,046,540	$795,716	$0	$0	$1,250,825
156	010460400	Palmetto General Hospital	$17,408,766	$6,729,979	$2,336,875	$1,330,857	$296,451	$1,088,480	$29,191,407	$3,278,249	$0	$0	$25,913,157

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157	012011100	Palms of Pasadena Hospital	$430,451	$205,300	$221,930	$165,259	$0	$0	$1,022,940	$957,224	$0	$0	$65,716
158	006344700	Park Royal Hospital	$39,374	$0	$0	$0	$0	$0	$39,374	$0	$0	$0	$39,374
159	010010200	Parrish Medical Center	$5,033,434	$4,636,061	$1,482,525	$3,137,967	$1,145,682	$1,063,987	$16,499,656	$1,711,111	$1,055,928	$1,683,330	$12,049,287
160	010959200	Pasco Community Hospital	$824,161	$1,127,607	$450,960	$1,388,402	$0	$0	$3,791,130	$628,619	$0	$0	$3,162,511
161	010028500	Peace River Regional Medical Center	$4,091,955	$1,691,959	$518,772	$563,182	$0	$0	$6,865,867	$1,132,986	$0	$0	$5,732,881
162	010222900	Pembroke Pines Hospital	$5,706,722	$5,178,141	$1,010,512	$2,562,383	$23,388,504	$2,869,746	$40,716,007	$1,294,989	$20,765,069	$1,030,227	$17,625,722
163	011351400	Putnam Community Hospital	$3,418,929	$2,867,824	$1,133,750	$1,218,839	$211,609	$0	$8,850,952	$702,679	$195,031	$0	$7,953,241
164	010323300	Sacred Heart Hosp - Emerald Coast	$4,541,782	$2,220,786	$193,878	$185,480	$114,197	$0	$7,256,123	$979,746	$105,251	$0	$6,171,127
165	002012700	Sacred Heart Hosp. - Gulf	$562,978	$1,577,804	$34,982	$69,997	$453,100	$0	$2,698,860	$89,824	$417,604	$0	$2,191,433
166	010076500	Sacred Heart Hospital	$36,507,810	$11,451,855	$5,329,289	$4,604,181	$4,405,782	$16,871	$62,315,788	$5,128,626	$0	$2,016,588	$55,170,573
167	010174500	Santa Rosa Hospital	$3,558,855	$2,945,659	$836,515	$1,344,721	$132,894	$0	$8,818,645	$666,399	$122,483	$866,551	$7,163,212
168	012001400	Sebastian Hospital	$575,523	$672,900	$193,185	$237,672	$0	$0	$1,679,279	$895,379	$0	$0	$783,900
169	010339000	Select Specialty Hospital - Orlando	$243,446	$0	$10,913	$0	$0	$0	$254,359	$515,537	$0	$0	-$261,178
170	010337300	Select Specialty Hospital Miami	$0	$0	$86,598	$0	$0	$0	$86,598	$352,181	$0	$0	-$265,584
171	010343800	Select Specialty Hospital Panama City	$120,918	$0	$19,684	$0	$0	$0	$140,602	$197,041	$0	$0	-$56,439
172	011998900	Seven Rivers Community Hospital	$1,494,936	$1,146,901	$368,818	$700,803	$0	$0	$3,711,458	$1,019,356	$0	$0	$2,692,102
173	010033100	Shands At Lake Shore	$8,897,874	$5,299,203	$996,133	$726,779	$3,549,903	$211,791	$19,681,683	$403,606	$2,968,218	$111,568	$16,198,291
174	010067600	Shands Jacksonville Med Cntr	$85,570,569	$35,274,547	$7,353,003	$4,622,671	$38,654,443	$14,017,104	$185,492,338	$5,393,995	$4,171,073	$11,889,965	$164,037,305
175	010003000	Shands Teaching Hospital	$166,226,596	$41,926,030	$15,280,508	$3,131,908	$8,336,553	$14,031,063	$248,932,658	$12,873,148	$0	$18,641,540	$217,417,970
176	010179600	Shands at Live Oak	$674,344	$3,186,313	$49,096	$415,940	$764,440	$203,592	$5,293,725	$215,837	$306,413	$1,229	$4,770,245
177	010007200	Shands at Starke	$942,367	$3,184,344	$151,051	$711,696	$390,869	$191,797	$5,572,124	$230,723	$89,366	$0	$5,252,034
178	002576600	Shriners Hospital for Children	$1,948,482	$629,832	$185,200	$402,828	$0	$0	$3,166,343	$26,398	$0	$0	$3,139,945
179	010328400	Sister Emmanuel	$16,314	$0	$50,900	$162	$0	$0	$67,375	$132,677	$0	$0	-$65,302

Row Nbr	Provider Medicaid ID	Provider Name	Payments							Contributions to State Share			Net Provider Revenue from Medicaid
			Fee-for-Service Inpatient	Fee-for-Service Outpatient	Managed Care Inpatient	Managed Care Outpatient	LIP	DSH	Total Payments Unadjusted	Provider Assessment	LIP and Auto IGT Contribution	Self-Funded IGT Contribution	
		Hospital											
180	011994600	South Bay Hospital	$1,058,951	$585,369	$700,719	$672,009	$0	$0	$3,017,048	$968,621	$0	$236,853	$1,811,574
181	010098600	South Florida Baptist	$5,664,951	$2,991,238	$2,354,998	$2,639,731	$17,064	$0	$13,667,982	$1,029,083	$0	$1,383,495	$11,255,404
182	010108700	South Lake Memorial Hospital	$5,341,881	$2,985,574	$2,486,109	$2,330,458	$0	$0	$13,144,022	$1,583,685	$0	$1,629,196	$9,931,141
183	010058700	South Miami Hospital	$14,004,206	$3,033,174	$1,159,618	$610,291	$0	$0	$18,807,289	$5,593,240	$0	$0	$13,214,049
184	011134100	Southwest Florida Regional Medical	$17,386,310	$4,675,930	$4,535,321	$2,410,754	$0	$799,353	$29,807,669	$3,748,530	$0	$6,165,920	$19,893,218
185	010377200	Specialty Hospital - Gainesville	$155,176	$0	$0	$0	$0	$0	$155,176	$224,461	$0	$0	-$69,285
186	010376400	Specialty Hospital - Palm Beach	$81,835	$0	$39,966	$0	$0	$0	$121,801	$320,173	$0	$0	-$198,372
187	010368300	Specialty Hospital - Pensacola	$360,378	$0	$40,914	$0	$0	$0	$401,292	$377,005	$0	$0	$24,286
188	010374800	Specialty Hospital - Tallahassee	$222,560	$0	$10,462	$0	$0	$0	$233,022	$216,757	$0	$0	$16,265
189	012022700	St Anthonys Hospital	$7,452,531	$2,196,957	$3,478,013	$1,805,717	$16,338	$0	$14,949,555	$2,169,177	$0	$0	$12,780,378
190	010346200	St. Cloud Regional Center	$838,467	$982,652	$563,631	$1,163,092	$0	$0	$3,547,842	$605,182	$0	$0	$2,942,660
191	010240700	St. John's Rehabilitation Hospital	$261,260	$0	$222,758	$0	$0	$0	$484,018	$146,793	$0	$0	$337,224
192	010097800	St. Joseph's Hospital	$78,787,275	$17,584,182	$0	$15,720,415	$938,998	$29,384	$113,060,253	$9,792,404	$0	$14,745,376	$88,522,473
193	010373000	St. Lukes- St. Vincent's Healthcare	$3,568,721	$1,046,210	$532,161	$453,200	$0	$0	$5,600,291	$1,770,351	$0	$0	$3,829,940
194	010148600	St. Mary's Hospital	$57,154,158	$7,356,544	$9,439,087	$4,477,081	$1,090,304	$20,317	$79,537,491	$3,360,947	$0	$7,069,928	$69,106,615
195	012010300	St. Petersburg General Hospital	$4,066,860	$1,429,729	$1,638,460	$1,119,038	$582,350	$1,088,480	$9,924,917	$1,286,138	$0	$0	$8,638,779
196	010073100	St. Vincent's Hospital	$10,740,438	$2,526,366	$2,793,611	$1,117,429	$1,670,918	$1,088,480	$19,937,242	$4,931,686	$0	$0	$15,005,556
197	012002200	St.Catherine's Rehab Hosp	$505,185	$0	$296,840	$14	$0	$0	$802,039	$376,932	$0	$0	$425,107
198	011997100	St.Lucie Medical Center	$5,261,694	$1,464,353	$1,504,842	$862,997	$104,347	$1,088,480	$10,286,713	$2,171,609	$0	$0	$8,115,104
199	010113300	Tallahassee Memorial Rgnl Med Cntr	$19,840,010	$4,912,227	$5,463,544	$3,306,661	$1,651,845	$1,088,480	$36,262,766	$5,140,181	$0	$0	$31,122,586
200	010099400	Tampa General Hospital	$122,846,651	$14,599,975	$28,898,713	$10,162,807	$17,702,984	$9,507,190	$203,718,320	$12,278,638	$0	$21,606,920	$169,832,762
201	010317900	The Villages Regional Hospital	$1,457,561	$936,256	$360,270	$446,967	$0	$0	$3,201,053	$1,783,143	$0	$0	$1,417,911
202	011984900	Town and Country	$1,541,229	$827,355	$752,379	$786,317	$0	$0	$3,907,280	$683,836	$0	$337,202	$2,886,242

Row Nbr	Provider Medicaid ID	Provider Name	Payments							Contributions to State Share			Net Provider Revenue from Medicaid
			Fee-for-Service Inpatient	Fee-for-Service Outpatient	Managed Care Inpatient	Managed Care Outpatient	LIP	DSH	Total Payments Unadjusted	Provider Assessment	LIP and Auto IGT Contribution	Self-Funded IGT Contribution	
		Hospital											
203	010114100	Tri-County Hospital Williston	$440,880	$240,445	$5,202	$17,487	$141,113	$156,896	$1,002,024	$52,822	$26,221	$0	$922,981
204	000949600	UCHLTACH at Connerton	$228,428	$0	$819	$1,638	$0	$0	$230,885	$333,210	$0	$0	-$102,325
205	010094300	Univ Community Hosp Carrollwood	$1,548,592	$1,240,547	$856,158	$1,302,508	$0	$0	$4,947,805	$1,187,694	$0	$758,866	$3,001,245
206	010102800	Univ Community Hosp-Tampa	$8,637,144	$2,164,622	$3,853,767	$2,846,079	$0	$0	$17,501,612	$4,123,553	$0	$1,406,140	$11,971,919
207	011280100	University Hospital & Medical Center	$1,549,050	$708,809	$414,551	$398,062	$0	$0	$3,070,472	$1,315,839	$0	$0	$1,754,633
208	010047100	University of Miami Hospital	$4,684,177	$21,930,071	$371,143	$2,861,198	$0	$0	$29,846,589	$2,641,524	$0	$0	$27,205,064
209	011973300	Venice Hospital	$858,682	$355,381	$202,085	$241,757	$0	$0	$1,657,906	$2,006,290	$0	$0	-$348,385
210	003158800	Viera Hospital	$887,853	$589,236	$195,286	$364,382	$0	$0	$2,036,757	$361,054	$0	$0	$1,675,704
211	010182600	Volusia Medical Center	$4,364,136	$2,822,141	$2,517,196	$2,677,811	$0	$0	$12,381,284	$1,525,972	$0	$1,717,903	$9,137,409
212	010213000	Wellington Regional Medical Center	$10,746,689	$2,473,196	$1,246,339	$1,244,512	$21,108	$0	$15,731,845	$1,535,221	$0	$1,853,769	$12,342,854
213	012024300	West Boca Medical Center	$6,468,585	$1,950,797	$1,373,362	$1,580,855	$0	$0	$11,373,600	$1,744,057	$0	$0	$9,629,543
214	011321200	West Florida Regional Med Cntr	$3,613,751	$1,423,503	$1,580,038	$640,284	$0	$0	$7,257,576	$2,535,488	$0	$0	$4,722,088
215	010170200	West Gables Rehabilitation	$229,445	$0	$131,746	$0	$0	$0	$361,191	$300,157	$0	$0	$61,034
216	003226500	West Kendall	$3,602,796	$3,587,399	$547,654	$1,644,463	$0	$0	$9,382,312	$689,232	$0	$0	$8,693,079
217	010062500	Westchester General Hospital	$3,108,657	$602,495	$3,252,794	$285,829	$0	$0	$7,249,775	$785,068	$0	$0	$6,464,706
218	011230500	Westside Regional Medical Center	$2,008,372	$462,734	$628,559	$326,896	$0	$0	$3,426,560	$2,221,317	$0	$0	$1,205,243
219	010169900	Winter Haven Hospital	$16,068,909	$3,620,900	$8,764,858	$3,421,325	$1,104,422	$0	$32,980,413	$2,607,402	$0	$2,363,288	$28,009,723
220	010320900	Wuesthoff Medical Center Melbourne	$1,688,016	$986,496	$1,070,599	$1,260,586	$0	$0	$5,005,697	$887,089	$0	$0	$4,118,608
221	010011100	Wuesthoff Memorial Hospital	$4,926,664	$1,863,288	$1,825,298	$1,917,107	$0	$0	$10,532,356	$1,720,574	$0	$0	$8,811,781
	Total		**$2,738,439,044**	**$896,174,845**	**$476,766,429**	**$432,627,901**	**$914,743,618**	**$240,525,403**	**$5,699,277,240**	**$491,249,874**	**$711,727,197**	**$310,674,932**	**$4,185,625,237**

12.5 Appendix E – Hospital Cost

Row Nbr	Provider Medicaid ID	Provider Name	Hospital Cost					
			Fee-for-Service Inpatient	Fee-for-Service Outpatient	Managed Care Inpatient	Managed Care Outpatient	Uncompensated Care [1]	Total Hospital Cost
1	010151600	All Children's Hospital	$118,389,287	$41,865,809	$16,007,081	$25,212,651	$1,183,380	$202,658,209
2	011648300	Anne Bates Leach Eye Hospital	$201,154	$8,801,208	$0	$1,594,503	$3,527,051	$14,123,915
3	012037500	Aventura Hospital & Medical Center	$14,081,669	$2,245,680	$6,410,892	$1,664,530	$8,593,152	$32,995,922
4	010074900	Baptist Hospital (Pensacola)	$18,627,257	$8,320,891	$2,671,536	$1,918,000	$14,845,943	$46,383,627
5	010232600	Baptist Hospital of Beaches	$4,552,048	$2,390,141	$595,212	$621,806	$7,234,360	$15,393,567
6	010064100	Baptist Medical Center	$53,473,371	$27,263,608	$10,462,575	$9,989,732	$43,484,388	$144,673,674
7	010123100	Baptist Medical Center - Nassau	$3,217,724	$2,324,133	$264,603	$362,783	$3,134,558	$9,303,802
8	010035800	Baptist of Miami	$68,853,222	$18,042,358	$11,668,746	$6,241,271	$58,673,939	$163,479,536
9	012041300	Bartow Memorial Hospital	$1,939,401	$1,760,499	$1,003,689	$2,532,766	$3,023,372	$10,259,726
10	010006400	Bay Medical Center	$24,120,401	$5,659,680	$2,088,294	$1,030,412	-$5,030,463	$27,868,325
11	010372100	BayCare Alliant Hospital	$876,895	$0	$601,220	$0	$0	$1,478,115
12	010156700	Bayfront Medical Center	$24,253,290	$4,842,577	$7,297,817	$2,997,565	$6,143,912	$45,535,160
13	011988100	Bayonet Point/Hudson	$9,101,216	$1,760,328	$3,223,321	$1,664,549	$9,339,063	$25,088,477
14	010183400	Bert Fish Memorial Hospital	$1,867,520	$1,967,737	$457,015	$963,896	$5,632,901	$10,889,069
15	010140100	Bethesda Mem. Hosp.	$31,732,709	$7,683,365	$3,426,879	$2,098,763	$17,423,404	$62,365,121
16	010141900	Boca Raton Community Hospital	$4,603,662	$1,550,757	$612,513	$582,737	$6,503,105	$13,852,774
17	011807900	Brandon Regional Medical Center	$21,121,359	$7,708,259	$9,996,820	$6,297,191	$15,088,539	$60,212,169
18	010087100	Brooksville Regional Hospital	$11,259,626	$4,230,114	$1,766,040	$2,870,167	$10,910,407	$31,036,354
19	010012900	Broward General Hospital	$90,415,913	$23,982,500	$324,009	$8,150,177	$88,846,340	$211,718,939
20	010026900	Calhoun Liberty Hospital	$126,370	$704,291	$17,246	$198,994	$1,201,849	$2,248,751
21	010194000	Campbellton-Graceville Hospital	$7,365	$220,844	$0	$5,272	$359,762	$593,243
22	010009900	Cape Canaveral Hospital	$6,455,873	$1,867,683	$933,040	$930,684	$6,192,975	$16,380,255
23	011971700	Cape Coral Hospital	$12,592,389	$4,681,920	$2,411,600	$1,732,167	$12,142,313	$33,560,389
24	011980600	Capital Regional Medical Center	$9,835,277	$4,977,502	$5,040,990	$5,028,367	$5,025,526	$29,907,662

Row Nbr	Provider Medicaid ID	Provider Name	Hospital Cost					
			Fee-for-Service Inpatient	Fee-for-Service Outpatient	Managed Care Inpatient	Managed Care Outpatient	Uncompensated Care [1]	Total Hospital Cost
25	010036600	Cedars Medical Center, Inc.	$26,352,824	$6,815,624	$5,500,576	$1,481,567	$10,982,578	$51,133,170
26	010178800	Central Florida Regional Hospital	$8,242,246	$2,852,519	$5,259,922	$2,992,956	$4,532,835	$23,880,478
27	010027700	Charlotte Regional Medical Center	$2,343,402	$1,334,072	$631,074	$386,524	$4,584,996	$9,280,069
28	010219900	Citrus Memorial Hospital	$6,001,626	$3,570,342	$1,108,057	$1,193,841	$6,969,633	$18,843,499
29	010314400	Cleveland Clinic FL Hospital - Naples	$3,782,141	$3,995,974	$672,034	$1,663,052	$10,689,605	$20,802,805
30	010220200	Cleveland Clinic Hospital	$1,708,159	$328,031	$952,446	$567,823	$5,370,553	$8,927,012
31	010253900	Columbia Englewood Community Hosp	$997,487	$876,915	$205,101	$352,834	$1,182,433	$3,614,770
32	012030800	Columbia Hospital	$5,708,813	$1,254,409	$3,052,536	$1,003,768	$5,065,371	$16,084,897
33	010146000	Columbia JFK Medical Center	$23,629,720	$5,662,612	$5,387,668	$2,455,268	$20,877,462	$58,012,729
34	012013800	Columbia Kendall Medical Center	$37,517,968	$8,045,797	$7,724,526	$2,876,774	$14,068,715	$70,233,780
35	010138900	Columbia Medical Center-Osceola	$18,649,249	$7,698,425	$10,580,714	$7,052,618	$8,310,396	$52,291,402
36	010552000	Columbia New Port Richey Hospital	$10,527,480	$3,450,139	$4,187,703	$2,714,837	$6,798,713	$27,678,872
37	012026000	Columbia Palms West Hospital	$15,874,602	$5,437,889	$3,933,266	$2,585,159	$4,759,530	$32,590,445
38	012000600	Columbia Plantation General Hosp	$40,257,366	$11,304,470	$4,324,450	$4,977,945	$15,743,435	$76,607,666
39	010125700	Columbia Twin Cities Hospital	$856,712	$1,512,941	$82,826	$224,585	$1,028,313	$3,705,377
40	010960600	Coral Gables Hospital	$4,762,986	$2,661,313	$1,015,163	$1,226,143	$1,281,546	$10,947,150
41	012040500	Coral Springs Medical Center	$17,651,323	$8,169,253	$3,726,407	$3,268,203	$26,465,607	$59,280,792
42	012009000	Delray Comm. Hospital	$7,204,349	$1,189,489	$1,332,720	$661,919	$8,177,677	$18,566,153
43	010192300	Desoto Memorial Hospital	$3,985,527	$2,820,049	$128,475	$177,772	$3,334,510	$10,446,333
44	010180000	Doctor's Memorial Hospital	$1,000,033	$2,108,425	$33,046	$98,252	$3,619,770	$6,859,526
45	010354300	Doctors Hospital	$4,939,902	$1,497,200	$1,858,924	$379,516	$6,580,389	$15,255,931
46	011995400	Doctors Hospital of Sarasota	$1,334,771	$587,887	$321,631	$396,442	$1,646,095	$4,286,825
47	010103600	Doctors Memorial Hospital	$1,061,812	$1,802,629	$9,672	$30,295	$993,537	$3,897,944
48	010277600	Douglas Gardens Hospital	$0	$0	$5,808	$3,588	-$494,825	-$485,429
49	010004800	Ed Fraser Memorial Hospital	$22,074	$1,310,349	$0	$256,850	-$40,807	$1,548,466
50	010259800	Edward White Hospital	$1,520,556	$531,296	$965,253	$400,462	$714,397	$4,131,965

Row Nbr	Provider Medicaid ID	Provider Name	Hospital Cost					
			Fee-for-Service Inpatient	Fee-for-Service Outpatient	Managed Care Inpatient	Managed Care Outpatient	Uncompensated Care [1]	Total Hospital Cost
51	011746300	Fawcett Memorial Hospital	$3,670,107	$1,495,339	$887,946	$581,641	$3,388,307	$10,023,340
52	010120600	Fishermen's Hospital	$343,333	$671,119	$12,706	$59,399	$1,625,959	$2,712,516
53	010171100	Flagler Hospital	$9,426,306	$5,162,512	$1,760,037	$1,130,043	$13,054,080	$30,532,978
54	010129000	Florida Hospital	$175,539,015	$45,696,873	$66,834	$33,027,979	$101,313,699	$355,644,401
55	010189300	Florida Hospital - Flagler	$2,779,956	$2,897,427	$641,891	$789,190	$6,805,571	$13,914,036
56	010090100	Florida Hospital Heartland Med Cntr	$7,483,663	$4,579,952	$1,168,542	$1,391,803	$6,919,877	$21,543,837
57	010109500	Florida Hospital Waterman	$11,004,948	$5,034,292	$2,632,506	$2,904,773	$13,246,763	$34,823,283
58	010260100	Florida Hospital Wauchula	$51,152	$2,341,890	$16,491	$294,309	$1,473,608	$4,177,449
59	005456800	Florida Hospital Wesley Chapel	$2,581,178	$1,633,021	$779,821	$1,141,062	$2,405,114	$8,540,196
60	010149400	Florida Hospital Zephyrhills	$5,918,804	$2,649,281	$2,414,878	$2,496,473	$7,279,361	$20,758,796
61	011132500	Ft. Walton Beach Medical Center	$11,235,839	$6,085,368	$1,036,326	$682,921	$4,337,901	$23,378,355
62	010271700	Genesis Rehabilitation Hospital	$2,324,101	$2,063,577	$207,638	$763,258	-$14,673	$5,343,901
63	010080300	George E. Weems Memorial Hosp	$237,424	$633,283	$0	$25,770	-$412,243	$484,234
64	010144300	Glades General Hospital	$7,776,757	$2,767,850	$1,677,299	$994,071	$5,806,696	$19,022,674
65	010152400	Good Samaritan Hospital	$7,467,119	$3,905,601	$2,176,671	$2,878,006	-$703,727	$15,723,670
66	011761700	Gulf Coast Community Hospital	$14,261,541	$6,141,388	$1,468,977	$1,568,696	$3,546,834	$26,987,436
67	012032400	H L Moffitt Cancer Center	$15,773,312	$22,879,591	$22,207	$3,226,315	$15,947,928	$57,849,353
68	011975000	H.H. Raulerson	$3,100,173	$3,049,960	$752,329	$921,072	$2,801,045	$10,624,579
69	010184200	Halifax Medical Center	$34,440,176	$12,066,724	$9,487,031	$5,870,295	$35,388,346	$97,252,572
70	010135400	Health Central	$9,558,132	$6,057,147	$7,172,458	$5,334,582	$17,838,465	$45,960,784
71	010270900	HealthSouth Rehab Hosp - Miami	$581,594	$0	$187,816	$0	-$17,239	$752,171
72	012038300	HealthSouth Rehab Hosp Sarasota	$120,319	$0	$53,757	$0	-$18,519	$155,557
73	010175300	HealthSouth Rehab Hosp-Largo	$246,223	$0	$64,304	$0	-$25,428	$285,100
74	012042100	HealthSouth Rehab Hosp-Sea Pines	$79,454	$770	$71,113	$0	-$9,151	$142,185
75	012027800	HealthSouth Rehab Hosp-Sunrise	$9,074	$15,274	$133,822	$0	-$21,785	$136,385
76	012033200	HealthSouth Rehab Hosp-Tallahassee	$85,999	$41,042	$173,721	$9,638	-$19,225	$291,174

Row Nbr	Provider Medicaid ID	Provider Name	Hospital Cost					
			Fee-for-Service Inpatient	Fee-for-Service Outpatient	Managed Care Inpatient	Managed Care Outpatient	Uncompensated Care [1]	Total Hospital Cost
77	012034100	HealthSouth Rehab Hosp-Treasure Coast	$445,900	$41,769	$0	$0	-$11,068	$476,602
78	010188500	Healthmark Regional Medical Center	$412,936	$909,697	$3,626	$18,468	$1,324,024	$2,668,751
79	010275000	Healthsouth Emerald Coast Hospital	$270,133	$32,056	$4,866	$7,091	-$24,284	$289,863
80	010355100	Healthsouth Hospital of Spring Hill	$37,413	$5,302	$0	$127	-$9,309	$33,534
81	012005700	Healthsouth Larkin Hospital-Miami	$5,124,100	$1,408,048	$1,618,321	$566,051	$2,541,421	$11,257,941
82	008369200	Healthsouth Rehab of Ocala	$26,687	$0	$0	$0	$0	$26,687
83	010356000	Healthsouth Ridgelake Hospital	$349,682	$0	$91,649	$0	$0	$441,331
84	010228800	Heart of Florida Hospital	$7,280,060	$3,657,931	$4,027,687	$3,981,013	$7,394,244	$26,340,936
85	010161300	Helen Ellis Memorial Hospital	$3,665,531	$1,610,640	$1,118,768	$1,578,676	$3,960,792	$11,934,407
86	010086200	Hendry Regional Medical Center	$932,983	$2,314,147	$61,549	$463,532	$4,389,288	$8,161,499
87	010041200	Hialeah Hospital	$21,283,138	$5,704,604	$2,729,916	$1,550,497	$6,370,574	$37,638,729
88	010089700	Highlands Regional Medical Center	$4,058,178	$2,112,789	$942,726	$982,022	$4,049,850	$12,145,565
89	010008100	Holmes Regional Medical Center	$26,167,694	$5,360,660	$7,145,072	$3,430,022	$22,816,398	$64,919,846
90	010018800	Holy Cross Hospital, Inc.	$9,108,947	$3,105,641	$1,398,251	$1,389,139	$6,554,665	$21,556,642
91	010226100	Homestead Hospital	$33,047,535	$15,919,722	$10,920,465	$8,162,864	$36,531,460	$104,582,047
92	010821900	Imperial Point Hospital	$4,916,593	$1,752,175	$1,402,718	$1,153,410	$17,294,235	$26,519,131
93	010104400	Indian River Memorial Hospital	$10,247,303	$5,131,854	$895,968	$838,718	$5,451,986	$22,565,829
94	010106100	Jackson Hospital	$2,610,501	$3,467,399	$38,679	$145,253	$3,262,217	$9,524,048
95	010042100	Jackson Memorial Hospital	$257,999,570	$83,312,062	$16,865,035	$17,961,941	$253,095,723	$629,234,331
96	010173700	Jay Hospital	$250,276	$577,339	$69,279	$102,901	$1,268,179	$2,267,974
97	012029400	Jupiter Hospital	$3,298,240	$1,330,822	$514,636	$591,456	$6,499,133	$12,234,286
98	010234200	Kindred Hospital (Tampa)	$139,564	$0	$136,387	$0	$0	$275,951
99	011993800	Kindred Hospital - Coral Gables	$0	$0	$47,306	$0	$0	$47,306
100	010019600	Kindred Hospital - Ft.Lauderdale	$34,458	$0	$146,401	$0	$0	$180,858
101	010267900	Kindred Hospital - North Florida	$35,957	$0	$0	$0	$0	$35,957
102	000417000	Kindred Hospital - Palm Beaches	$20,251	$0	$3,684	$0	$0	$23,935

Row Nbr	Provider Medicaid ID	Provider Name	Hospital Cost					
			Fee-for-Service Inpatient	Fee-for-Service Outpatient	Managed Care Inpatient	Managed Care Outpatient	Uncompensated Care [1]	Total Hospital Cost
103	010353500	Kindred Hospital Ocala	$134,267	$0	$22,639	$0	$0	$156,906
104	010191500	Kindred Hospital-Hollywood	$23,015	$0	$191,005	$0	$0	$214,020
105	001681500	Kindred Hospital-Melbourne	$135,467	$0	$24,874	$0	$0	$160,341
106	010276800	Kindred Hospital-St. Petersburg	$147,592	$0	$45,694	$0	$0	$193,286
107	011021300	L.W. Blake Memorial Hospital	$4,737,231	$2,063,069	$1,759,352	$1,911,364	$4,977,005	$15,448,021
108	010822700	Lake Butler Hospital	$16,198	$1,171,230	$0	$26,834	$1,617,686	$2,831,948
109	011976800	Lake City Medical Center	$1,703,831	$2,386,434	$100,551	$94,234	$1,541,748	$5,826,798
110	010166400	Lake Wales Hospital Association	$2,171,130	$1,610,558	$1,412,990	$1,721,770	$2,402,525	$9,318,974
111	010164800	Lakeland Regional Medical Center	$34,762,356	$20,002,566	$16,960,112	$22,051,515	$53,470,586	$147,247,135
112	010342000	Lakewood Ranch Medical Center	$1,716,768	$1,049,679	$1,097,457	$940,766	$3,164,190	$7,968,860
113	011974100	Largo Medical Center	$6,128,005	$1,879,789	$2,764,623	$1,400,900	$7,030,899	$19,204,216
114	011969500	Lawnwood Regional Medical Center	$25,057,520	$5,824,141	$6,943,659	$2,587,692	$14,109,277	$54,522,289
115	010110900	Lee Memorial Hospital	$62,627,057	$16,297,584	$8,082,671	$4,498,313	$34,651,457	$126,157,082
116	010107900	Leesburg Regional Medical Center	$12,131,643	$4,350,959	$3,089,221	$1,829,181	$12,270,533	$33,671,536
117	010111700	Lehigh Regional Medical Center	$2,452,031	$4,560,092	$509,363	$1,353,638	$6,104,568	$14,979,692
118	010119200	Lower Florida Keys Hospital	$5,762,172	$1,950,662	$74,566	$108,500	$12,328,643	$20,224,544
119	010115000	Madison County Memorial Hospital	$42,247	$349,247	$32,246	$299,739	$5,597,610	$6,321,089
120	010116800	Manatee Memorial Hospital	$22,892,936	$4,572,829	$6,105,475	$3,493,710	$17,203,008	$54,267,957
121	010121400	Mariners Hospital	$557,657	$1,617,830	$0	$127,103	$6,525,294	$8,827,883
122	010118400	Martin Memorial Hospital	$11,720,004	$6,806,016	$2,072,746	$3,295,965	$14,469,137	$38,363,867
123	010072200	Mayo Clinic Florida	$2,353,577	$528,772	$377,224	$172,129	$8,775,979	$12,207,680
124	010154100	Mease Hospital Clinic	$1,700,835	$1,030,792	$1,212,315	$934,487	$6,117,380	$10,995,808
125	012008100	Mease Hospital Countryside	$12,791,338	$3,565,650	$2,946,714	$2,431,061	$11,752,761	$33,487,524
126	010176100	Memorial Hospital	$24,663,614	$7,839,772	$4,415,627	$4,139,714	$47,242,023	$88,300,750
127	010020000	Memorial Hospital	$92,074,355	$44,386,998	$10,225,996	$11,681,172	$91,470,434	$249,838,955
128	010252100	Memorial Hospital - West	$24,756,181	$15,099,330	$3,484,374	$4,250,239	$32,770,250	$80,360,374

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			Fee-for-Service Inpatient	Fee-for-Service Outpatient	Managed Care Inpatient	Managed Care Outpatient	Uncompensated Care [1]	Total Hospital Cost
129	010187700	Memorial Hospital - West Volusia	$7,445,007	$4,222,439	$1,742,835	$2,078,919	$11,145,522	$26,634,723
130	010345400	Memorial Hospital Miramar	$14,035,118	$8,167,974	$1,734,001	$2,344,157	$15,206,716	$41,487,966
131	011279800	Memorial Hospital of Tampa	$1,394,481	$447,556	$524,853	$302,533	$1,555,418	$4,224,841
132	010193100	Memorial Medical Center	$20,582,856	$7,899,163	$6,145,569	$4,058,036	$11,070,321	$49,755,946
133	010054400	Metropolitan Hospital Miami	$2,885,024	$1,800,910	$574,221	$474,010	$5,089,084	$10,823,249
134	010060900	Miami Childrens Hospital	$105,138,188	$69,296,801	$13,094,217	$20,931,003	$5,493,379	$213,953,588
135	010158300	Morton F. Plant Hospital	$18,896,834	$6,500,910	$5,385,360	$4,090,704	$26,017,026	$60,890,834
136	010046300	Mt. Sinai Medical Center	$25,031,228	$8,576,913	$4,592,669	$2,011,083	$21,095,867	$61,307,760
137	010117600	Munroe Regional Medical Center	$23,431,559	$9,453,784	$3,885,987	$3,571,378	$25,265,303	$65,608,011
138	010031500	Naples Community Hospital	$23,017,977	$6,482,593	$4,094,836	$2,267,534	$27,937,864	$63,800,804
139	004087600	Nemours Children's Hospital	$11,545,080	$3,622,006	$5,799,951	$3,293,948	$0 [2]	$24,260,986
140	010150800	North Bay Medical Center	$4,524,108	$2,080,401	$2,343,749	$1,662,962	$11,888,997	$22,500,218
141	010021800	North Broward Medical Center	$16,874,702	$6,466,461	$3,572,066	$2,754,649	$40,661,251	$70,329,129
142	010862600	North Florida Regional Hospital	$14,949,445	$6,398,185	$1,076,272	$264,191	$7,584,162	$30,272,254
143	010126500	North Okaloosa Medical Center	$4,503,945	$4,687,219	$377,420	$423,181	$3,006,820	$12,998,585
144	010049800	Northshore Medical Center	$34,856,585	$9,115,248	$7,463,786	$6,200,169	$10,860,938	$68,496,725
145	011519300	Northside Hospital	$6,234,900	$1,435,206	$3,499,236	$1,245,180	$8,164,346	$20,578,868
146	010190700	Northwest Community Hospital	$482,200	$2,039,940	$6,712	$33,684	$1,873,826	$4,436,361
147	010459100	Northwest Regional Hospital	$10,449,631	$2,907,755	$3,000,768	$1,554,978	$7,134,109	$25,047,241
148	012007300	Oak Hill Community Hospital	$3,465,543	$1,517,981	$2,057,540	$1,166,325	$3,618,702	$11,826,090
149	010988600	Ocala Regional Medical Center	$9,808,568	$5,165,870	$2,245,541	$2,194,614	$8,733,852	$28,148,444
150	011174100	Orange Park Medical Center	$16,266,037	$6,639,551	$4,982,715	$3,325,514	$9,702,383	$40,916,200
151	010133800	Orlando Regional Medical Center	$184,276,572	$36,809,441	$47,326,110	$18,509,378	$93,527,039	$380,448,539
152	010186900	Ormond Beach Memorial Hospital	$11,066,486	$3,749,992	$1,737,602	$1,577,246	$12,664,517	$30,795,843
153	003297500	Palm Bay Hospital	$3,693,183	$2,379,387	$1,659,684	$1,846,829	$7,621,011	$17,200,094
154	010210500	Palm Beach Gardens Medical Center	$3,590,407	$1,285,006	$1,449,878	$887,266	$5,045,368	$12,257,925

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155	010053600	Palm Springs General Hospital	$2,405,310	$1,608,813	$547,687	$422,008	$6,480,003	$11,463,821
156	010460400	Palmetto General Hospital	$33,517,745	$9,424,008	$3,100,462	$1,342,450	$6,327,259	$53,711,923
157	012011100	Palms of Pasadena Hospital	$1,022,027	$312,126	$534,600	$181,855	$1,728,165	$3,778,772
158	006344700	Park Royal Hospital	$123,003	$0	$0	$0	$0	$123,003
159	010010200	Parrish Medical Center	$6,372,096	$4,666,154	$1,917,333	$2,795,108	$10,052,217	$25,802,908
160	010959200	Pasco Community Hospital	$2,643,556	$1,474,945	$1,506,132	$1,588,126	$4,497,887	$11,710,646
161	010028500	Peace River Regional Medical Center	$7,275,519	$4,199,581	$1,002,076	$963,986	$2,636,137	$16,077,299
162	010222900	Pembroke Pines Hospital	$6,150,684	$5,764,481	$826,205	$2,570,866	$26,051,436	$41,363,671
163	011351400	Putnam Community Hospital	$3,901,303	$3,226,532	$1,130,531	$1,239,256	$5,030,642	$14,528,265
164	010323300	Sacred Heart Hosp - Emerald Coast	$4,931,872	$2,388,925	$228,990	$169,554	$4,636,976	$12,356,317
165	002012700	Sacred Heart Hosp. - Gulf	$800,711	$1,445,453	$33,985	$54,015	$2,624,996	$4,959,160
166	010076500	Sacred Heart Hospital	$45,731,462	$16,575,779	$7,146,725	$5,336,158	$22,079,472	$96,869,596
167	010174500	Santa Rosa Hospital	$4,284,954	$3,607,058	$954,534	$1,215,776	$4,373,827	$14,436,148
168	012001400	Sebastian Hospital	$1,701,482	$1,218,625	$523,614	$338,875	$3,430,812	$7,213,409
169	010339000	Select Specialty Hospital - Orlando	$478,888	$0	$13,456	$0	-$117,590	$374,753
170	010337300	Select Specialty Hospital Miami	$0	$0	$205,553	$0	-$319,966	-$114,413
171	010343800	Select Specialty Hospital Panama City	$133,190	$0	$20,724	$0	-$17,627	$136,287
172	011998900	Seven Rivers Community Hospital	$4,472,397	$1,499,569	$1,233,807	$889,598	$2,748,545	$10,843,916
173	010033100	Shands At Lake Shore	$8,804,810	$4,749,890	$961,694	$480,205	$4,111,332	$19,107,932
174	010067600	Shands Jacksonville Med Cntr	$83,272,762	$36,414,689	$9,006,247	$5,467,948	$84,165,739	$218,327,384
175	010003000	Shands Teaching Hospital	$169,865,760	$49,740,405	$12,139,450	$3,530,942	$254,815,148	$490,091,705
176	010179600	Shands at Live Oak	$653,740	$2,737,318	$49,696	$264,554	$2,675,184	$6,380,492
177	010007200	Shands at Starke	$791,184	$2,962,255	$143,907	$461,228	$2,944,980	$7,303,554
178	002576600	Shriners Hospital for Children	$1,565,920	$687,404	$1,109,563	$442,032	$0	$3,804,920
179	010328400	Sister Emmanuel Hospital	$13,182	$0	$107,332	$11,034	$0	$131,548
180	011994600	South Bay Hospital	$1,304,355	$830,444	$760,841	$830,112	$2,118,332	$5,844,084

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181	010098600	South Florida Baptist	$5,290,790	$3,325,308	$2,600,511	$2,530,103	$8,826,784	$22,573,496
182	010108700	South Lake Memorial Hospital	$6,665,998	$3,069,907	$3,138,702	$1,802,081	$5,501,175	$20,177,863
183	010058700	South Miami Hospital	$45,978,196	$11,377,942	$3,723,152	$2,222,556	$28,588,320	$91,890,167
184	011134100	Southwest Florida Regional Medical	$20,256,533	$3,981,179	$5,154,511	$1,812,937	$6,729,352	$37,934,512
185	010377200	Specialty Hospital - Gainesville	$281,640	$0	$0	$0	$0	$281,640
186	010376400	Specialty Hospital - Palm Beach	$250,229	$0	$102,809	$0	-$117,346	$235,692
187	010368300	Specialty Hospital - Pensacola	$486,035	$0	$37,835	$0	-$46,762	$477,108
188	010374800	Specialty Hospital - Tallahassee	$468,288	$0	$12,336	$0	-$38,841	$441,784
189	012022700	St Anthonys Hospital	$12,273,594	$3,718,428	$4,814,100	$2,754,802	$16,267,973	$39,828,897
190	010346200	St. Cloud Regional Center	$1,874,691	$1,932,089	$1,044,801	$1,570,665	$6,302,140	$12,724,385
191	010240700	St. John's Rehabilitation Hospital	$1,050,859	$0	$443,818	$3,701	$0	$1,498,377
192	010097800	St. Joseph's Hospital	$84,894,037	$22,940,420	$0	$16,636,576	$56,544,838	$181,015,871
193	010373000	St. Lukes- St. Vincent's Healthcare	$9,531,278	$2,289,189	$1,913,073	$976,334	$9,101,127	$23,811,002
194	010148600	St. Mary's Hospital	$55,666,110	$10,379,217	$8,272,658	$4,942,281	$15,252,835	$94,513,101
195	012010300	St. Petersburg General Hospital	$7,777,771	$2,653,312	$3,339,620	$2,157,404	$4,397,700	$20,325,808
196	010073100	St. Vincent's Hospital	$17,899,237	$6,572,992	$4,975,872	$2,552,373	$20,621,195	$52,621,669
197	012002200	St.Catherine's Rehab Hosp	$2,498,549	$0	$1,109,894	$178	$0	$3,608,621
198	011997100	St.Lucie Medical Center	$9,020,206	$2,940,032	$2,507,941	$1,324,158	$5,775,194	$21,567,532
199	010113300	Tallahassee Memorial Rgnl Med Cntr	$32,315,345	$8,374,006	$8,780,254	$5,047,872	$51,046,490	$105,563,966
200	010099400	Tampa General Hospital	$112,906,411	$24,267,051	$32,289,734	$13,822,901	$87,826,622	$271,112,719
201	010317900	The Villages Regional Hospital	$2,525,200	$1,444,911	$639,547	$542,708	$5,614,068	$10,766,434
202	011984900	Town and Country Hospital	$1,664,940	$998,063	$864,256	$737,789	$2,546,574	$6,811,622
203	010114100	Tri-County Hospital Williston	$451,618	$451,049	$6,006	$33,229	$983,005	$1,924,907
204	000949600	UCHLTACH at Connerton	$347,551	$0	$9,839	$45,850	-$93,326	$309,914
205	010094300	Univ Community Hosp Carrollwood	$2,433,685	$2,981,596	$1,007,206	$2,580,339	$5,076,806	$14,079,632
206	010102800	Univ Community Hosp-Tampa	$16,173,449	$5,073,860	$7,396,573	$5,953,035	$15,911,369	$50,508,287

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207	011280100	University Hospital & Medical Center	$3,886,270	$1,658,354	$1,027,205	$838,493	$5,196,858	$12,607,181
208	010047100	University of Miami Hospital	$5,940,711	$21,376,860	$471,717	$1,912,046	$173,183	$29,874,517
209	011973300	Venice Hospital	$2,724,712	$898,701	$509,091	$417,131	$6,338,189	$10,887,824
210	003158800	Viera Hospital	$1,731,001	$1,160,937	$422,481	$673,494	$2,994,651	$6,982,564
211	010182600	Volusia Medical Center	$4,526,803	$4,076,142	$2,475,601	$3,458,513	$9,943,679	$24,480,738
212	010213000	Wellington Regional Medical Center	$14,191,512	$3,816,277	$2,281,558	$1,602,023	$9,927,856	$31,819,226
213	012024300	West Boca Medical Center	$13,360,503	$3,635,944	$2,552,727	$2,727,999	$4,168,732	$26,445,905
214	011321200	West Florida Regional Med Cntr	$10,090,937	$2,812,940	$2,896,193	$1,078,005	$4,962,609	$21,840,684
215	010170200	West Gables Rehabilitation	$541,119	$0	$346,156	$0	-$6,921	$880,354
216	003226500	West Kendall	$16,022,165	$8,115,963	$2,872,667	$2,932,973	$21,195,109	$51,138,877
217	010062500	Westchester General Hospital	$5,228,435	$1,072,758	$3,342,507	$504,502	$3,769,613	$13,917,814
218	011230500	Westside Regional Medical Center	$5,731,413	$1,167,549	$1,452,446	$796,032	$4,789,233	$13,936,673
219	010169900	Winter Haven Hospital	$13,953,703	$5,520,255	$7,359,925	$5,976,595	$17,767,764	$50,578,242
220	010320900	Wuesthoff Medical Center Melbourne	$4,577,157	$1,950,066	$3,279,518	$2,087,731	$6,088,707	$17,983,178
221	010011100	Wuesthoff Memorial Hospital	$11,751,147	$3,339,263	$4,459,044	$3,044,184	$14,780,258	$37,373,896
	Total		**$3,384,659,884**	**$1,250,293,578**	**$614,995,340**	**$520,247,231**	**$2,816,756,864**	**$8,586,952,897**

Notes:

[1] Uncompensated care costs were not available for hospitals that are not paid via the Medicare IPPS (thus, do not submit a schedule S-10 in their Medicare cost report) and have not submitted LIP cost limit reports to AHCA because they do not receive payments through the LIP program. This primarily affected free-standing rehabilitation hospitals and long term acute care hospitals, both of which have relatively low Medicaid volume.

[2] Uncompensated care costs for Nemours Children's Hospital were not available at the time data tables were built for this report. Nemours has since indicated to AHCA that their uncompensated care cost was $2.25 million for the period from November 30, 2012 through December 31, 2013.

12.6 Appendix F – Waiver for Health Care-Related Taxes

12.6.1 Overview of Waivers

A state may request a waiver from CMS for the broad based and uniformity requirements for health care-related taxes[210]. If a tax is imposed on more than one class of health care services, a separate waiver must be obtained for each class subject to the tax. For CMS to approve a waiver, the state must demonstrate that its tax program meets all of the following requirements:

- The net impact of the tax and any payments made to the providers by the state under the Medicaid program is generally redistributive[211].
- The amount of the tax is not directly correlated[212] to Medicaid payments; and
- The tax program does not fall within the hold harmless provisions

If the state desires a waiver of only the broad-based tax requirement, it must demonstrate compliance with a redistributive test that measures, in aggregate, the proportion of the tax burden to Medicaid providers. If the state desires a waiver of the uniform tax requirement, whether or not the tax is broad-based, it must demonstrate compliance with a different redistributive test that measures, for each provider, the relationship between the tax burden and each provider's "Medicaid Statistic". The following sections describe in more detail the calculations required in applying for waivers of the broad based and uniformity requirements.

If a state wishes to present an application to CMS for a waiver of the broad based and/or uniform requirements, there is a formal submittal process. States generally submit a cover letter that describes the tax, a copy of the legislation, and the results of the appropriate test(s) showing that the tax is "generally redistributive", as well as the data to support the calculations. CMS will re-run the data to verify the results of the test.[213]

Assuming the waiver is approved by CMS, the waiver will be effective on the first day in the quarter in which the waiver is received by CMS.

12.6.2 Waiver Of Broad-Based Requirement Only ("P" Values)

A state may request a waiver of the broad-based requirement if it can demonstrate that the tax is generally redistributive. This test is applied on a per class basis to a tax that is imposed on all

[210] Waivers will automatically be granted in cases of variations in licensing/certification fees if the fees are not more than $1,000 annually per provider and if all the fees are used by the state to administer the licensing/cert. program.
[211] Per the Interim Final Regulations 57 FR 5518, Nov. 24, 1992, redistributive is interpreted "…to mean the tendency of a state's tax and payment program to derive revenues from taxes imposed on non-Medicaid services…and to use these revenues as the state's share of Medicaid payments. To the extent that a tax is imposed more heavily on providers with low Medicaid utilization than high Medicaid providers, the tax would be considered redistributive."
[212] Per the Final Rule 58 FR 43156, Aug. 13, 1993, "…states may not make… payments…that result in taxpayers automatically being repaid dollar (or part of a dollar)-for-dollar for their tax costs. This is a direct correlation…"
[213] The submittal process description is based on discussions with CMS.

revenues but excludes certain providers. For example, a tax that is imposed on all revenues but excludes teaching hospitals would have to meet this test.

A state must demonstrate that a non-broad-based provider tax is generally redistributive by completing the following calculations:

1. **Calculate the P_1 value:** The P_1 value is the proportion of the tax revenue applicable to Medicaid[214] if the tax were broad based and applied to all providers within the class[215]
2. **Calculate the P_2 value:** The P_2 value is the proportion of the tax revenue applicable to Medicaid under the state's proposed tax program.
3. **Calculate the P_1/P_2 value:** Divide the P_1 value by the P_2 value.

If the P_1/P_2 value is one or greater (in other words, the P_1 value is larger than the P_2 value), CMS will automatically approve the waiver request. This would occur when the proportion of the tax revenue applicable to Medicaid under the state's proposed tax (that tax that would exclude certain providers) is less than the proportion of the tax revenue applicable to Medicaid if the tax were broad-based.

If the P_1/P_2 value is at least 0.95, CMS will review and approve the request if the tax excludes or provides credits or deductions only to one or more of the following providers within the class[216]:

- Providers that furnish no services within the class in the state
- Providers that do not charge for services within the class
- Rural hospitals
- Sole community hospitals
- Physicians practicing primarily in a medically underserved area
- Financially distressed hospitals (defined by state law). No more than ten percent of nonpublic hospitals are exempt from the tax.
- Psychiatric hospitals
- Hospitals owned and operated by HMOs

This test cannot be used when a state excludes any or all Medicaid revenue from its tax in addition to the exclusion of providers, since the test compares the proportion of Medicaid revenue being taxed under the proposed tax with the proportion of Medicaid revenue being taxed under a broad-based tax.

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[214] Per the Final Rule 58 FR 43156, Aug. 13, 1993, "The proportion of the tax revenue applicable to Medicaid means how much of the tax burden shifts to Medicaid."

[215] Based on discussions with CMS, all facilities that provide the service being assessed, including government facilities, should be included in the P_1 portion of the test.

[216] For taxes enacted and in effect prior to August 13, 1993, waivers with a P_1/P_2 value of at least 0.90 would be reviewed by CMS.

12.6.3 Waiver Of Uniform Tax Requirement ("B" Values)

A state may request a waiver of the uniform application requirement if it can demonstrate that the tax is generally redistributive. This test is applied on a per class basis to all taxes that are not uniform - including taxes that are *neither* broad based nor uniform. For example, a tax for inpatient hospital services that has a different tax rate for teaching hospitals in the same class would have to meet this test.

A state must demonstrate that a non-uniform provider tax is generally redistributive by completing the following calculations:

1. **Calculate the slope of two linear regressions:** Determine the B value by using ordinary least squares to calculate the slope of two linear regressions using the following dependent and independent variables:
   a. *Dependent Variable* – Each provider's percentage share of the total tax paid by all taxpayers during a 12-month period
   b. *Independent Variable* – Each provider's "Medicaid Statistic". The Medicaid Statistic is defined as the number of the provider's taxable units applicable to the Medicaid program during a 12-month period. For example, if the provider pays a tax based on inpatient days, the provider's Medicaid Statistic would be the number of Medicaid days during a 12-month period.
2. **Calculate the B_1 value:** The B_1 value is the slope of the linear regression for the state's tax program, were it broad-based and uniform[217].
3. **Calculate the B_2 value:** The B_2 value is the slope of the linear regression for the state's tax program as proposed[218].
4. **Calculate the B_1/B_2 value:** Divide the B_1 value by the B_2 value

If the B_1/B_2 value is one or greater (in other words, the B_1 value is larger than the B_2 value), CMS will automatically approve the state's waiver request. This would occur when the increase in each provider's portion of the tax increases more slowly with an increase in the Medicaid Statistic under the proposed tax system (non-uniform/broad-based) than under the uniform/broad-based system.

If the B_1/B_2 value is at least 0.95, CMS will review and approve the request if the tax excludes or provides credits or deductions only to one or more of the following providers within the class:

- Providers that furnish no services within the class in the state
- Providers that do not charge for services within the class
- Rural hospitals

[217] Based on discussions with CMS, all facilities that provide the service being assessed, including government facilities, should be included in the B_1 portion of the test.

[218] Based on discussions with CMS, all facilities that provide the service being assessed, including government facilities, should be included in the B_2 portion of the test. For non-taxed facilities under the proposed system, the B_2 Tax Percentage would be 0% and the B_2 Medicaid Statistic would be equal to the B_1 Medicaid Statistic.

- Sole community hospitals
- Physicians practicing primarily in a medically underserved area
- Financially distressed hospitals (defined by state law). No more than ten percent of nonpublic hospitals are exempt from the tax.
- Psychiatric hospitals
- Providers/payors with tax rates that vary based exclusively on regions[219], but only if the regional variations are coterminous with preexisting political (and not special purpose) boundaries. Taxes within each regional boundary must meet the broad-based and uniformity requirements.

For purposes of this redistributive test, it is not relevant that a tax program exempts Medicaid from the tax.

[219] A B_1/B_2 value of 0.70 will be applied to taxes enacted and in effect prior to November 24, 1992.