FLORIDA LEGAL SERVICES, INC.

Medicaid Safety-Net Funding Issues:

Implications for Hillsborough County

By: Miriam Harmatz and Charlotte Cassel

July 2016

Table of Contents

Executive Summary

Governor Scott and House leadership have indicated that they will not accept federal funding available under the Affordable Care Act for coverage of low-income adults ("expansion funding"). This refusal has left approximately one million Floridians without health insurance and shifted the issue of paying for their care from Tallahassee to counties. Because uninsured Floridians depend on local "safety-net" providers for needed medical care, county leaders should understand how and why safety-net funding is changing.

This brief explains the background and status of the safety-net providers' funding streams: the Low-Income Pool (LIP), Rate Enhancements (RE), and the Disproportionate Share Hospital (DSH) Program; as well as the significantly changed role of Intergovernmental Transfers (IGTs).

The brief also details how the funding changes have impacted individual Hillsborough County providers and compares the scheduled safety-net funding reductions with potential new revenue for local health care providers if the Legislature decides to accept federal expansion dollars.

Finally, the brief highlights key issues Hillsborough County stakeholders and leaders should consider in light of funding changes, including:

- How will the long term reduction in supplemental payments to local hospitals impact the Hillsborough County Health Care Plan (HCHCP)?
- Given that there is no longer a guaranteed rate of return for IGTs, what criteria should the County use in determining IGT submissions?
- What can the County do to maximize federal LIP dollars for local providers?
- How would the County be able to improve the HCHCP, as well as population health overall, if the Legislature accepts federal expansion dollars?

I. Introduction

Low-Income, uninsured Floridians depend on local safety-net providers for needed medical care. Florida's Low-Income Pool (LIP), which has provided the major Medicaid funding stream for this care in Florida since 2006, was scheduled to end June 30, 2015. While the LIP was not eliminated, the program's structure was fundamentally changed, the amount was greatly reduced, and coverage of the uninsured was left unresolved. Until the Governor and House leadership reconsider their position and accept federal funding under the Affordable Care Act (ACA) for coverage of low-income adults[1] (also referred to as "expansion funding"),[2] the issue of paying for the care of low-income uninsured Floridians will largely fall to counties.

This issue is particularly critical in Hillsborough County, which has a significant number of low-income uninsured Floridians,[3] including more than 70,000 individuals eligible for expansion funding,[4] and more than 43,000 people who fall into the "coverage gap."[5] Further, Hillsborough has a county-funded health plan, the Hillsborough County Health Care Plan ("HCHCP" or "the Plan") which provides indigent county residents with primary, preventive, and hospital care. The Plan's participating hospitals rely on funding from the LIP program, and as discussed below, LIP funding has been significantly reduced since 2014.[6]

II. Safety-Net Funding

A. The Low-Income Pool (LIP)

1. Background Prior to 2015

In 2006, the Secretary of the Department of Health and Human Services (HHS) granted Florida permission to establish the Low-Income Pool as part of Florida's Medicaid Section 1115 Demonstration Waiver[7] (initially referred to during the multi-year pilot as "Medicaid Reform" and now called the "Managed Medical Assistance Program") (hereafter referred to as "the Waiver").[8] Section 1115 waivers allow states to ignore certain otherwise mandatory provisions of the Medicaid Act for time-limited "experiments" that the Secretary determines will further the purpose of the Medicaid Act. The overarching purpose of Florida's 1115 Waiver was to allow the State to shift Medicaid enrollees from fee-for-service into a managed care delivery system.

While the mandatory enrollment in managed care was initially limited to a five-county pilot, the LIP program applied statewide.[9] The Secretary's approval of the LIP allowed Florida to establish a pool of federal and local funds to finance supplemental payments—lump sum payments that were disconnected from any individual patient—to certain types of Florida health care providers. The LIP, which was approved in 2006 for a five-year period, distributed approximately $1 billion annually to support safety-net providers throughout Florida. As with all of Florida's Medicaid programs and services, funding for the LIP was comprised of state and federal dollars, with Florida receiving a federal match, or FMAP, of approximately 60%.[10] In other words, approximately $600 million of LIP dollars were from the federal government. However, unlike other state Medicaid programs, the $400 million "state match" was comprised of local county funds, submitted to Tallahassee in the form of Intergovernmental Transfers (IGTs).[11]

Years of negotiations ensued over the state's request to make the pilot a Statewide managed care program, including a request to extend and expand LIP. In July 2014, the Centers for Medicare and Medicaid Services (CMS) announced it would grant a three-year extension of the Florida Waiver, except that the LIP would only be extended for one year. "This extension is approved for three years . . . except for the Low-Income Pool (LIP) supplemental payment authority which will be extended through June 20, 2015."[12]

It was not unexpected that the LIP was scheduled to end in 2015. First, the Secretary had granted Florida permission to establish the LIP program in order to support safety-net funding during the transition into managed care that began with the 2006 Medicaid reform pilot waiver – a transition that was completed in 2014. And, as noted in the CMS July 2014 letter, Florida was given an explicit and agreed upon one-year extension of LIP. "CMS and Florida agree that this one-year extension of the LIP will provide stability for providers as Florida transitions to Statewide Medicaid managed care, while allowing the state to move toward a significantly reformed Medicaid payment system."[13]

Further, as early as 2008, the Secretary of HHS was informed that the LIP program was "problematic" and lacked "fiscal integrity."[14] Those concerns were reiterated in a 2015 independent report.[15] Moreover, the LIP began before the Affordable Care Act (ACA), established an opportunity for states to expand coverage to nearly all Low-Income adults.[16] While there would still be some individuals who would remain uninsured even with an expanded Medicaid program, e.g. undocumented immigrants, the need to continue federal funding of large uncompensated care pools (such as the LIP) in order to reimburse hospitals for the cost of treating uninsured patients was largely eliminated by the ACA.

Finally, it must be underscored that LIP dollars were never sufficient–even at the 2014 height of the program–to reimburse safety-net providers for the cost of treating all of the State's low income uninsured residents. For example, of Hillsborough County's 70,000 Low-Income residents eligible for expansion coverage, membership in the Hillsborough County Health Care Plan (HCHCP) in 2016 is about 12,500, or approximately 18% of those who would be eligible for coverage if the State accepted federal expansion funding.[17]

2. 2015 LIP Negotiations and Litigations

In spite of CMS' July 2014 letter, state officials informally urged CMS to continue funding LIP at the current level both before and during the 2015 Legislative Session. The State did not submit a written waiver request for additional funds, and there were no public documents exchanged between state officials and CMS until the Session was over half over. Lack of certainty over the LIP created confusion over the state's budget and was the topic of significant press.[18] Approximately a month before the end of the regularly scheduled 2015 Session, CMS sent a letter to Florida's Deputy Secretary for Medicaid, reiterating that LIP was a "time-limited demonstration," and reminding the State

The LIP began before the Affordable Care Act (ACA) established an opportunity for states to expand coverage to nearly all low-income adults.

that "last year CMS made clear that LIP would not continue in its current form." The letter stated CMS' longstanding concerns regarding the program's "lack [of] transparency" and "the distribution of funds based on providers' access to local revenue instead of service to Medicaid patients."[19] The letter also articulated principles CMS would apply in reviewing the State's request for a LIP:

1. *Coverage rather than uncompensated care pools is the best way to secure access to health care for Low-Income individuals* and uncompensated care pool funding should not pay for costs that would be covered in a Medicaid expansion;

2. Provider payment rates must be sufficient to promote provider participation and access; and

3. Medicaid payments should support services provided to Medicaid beneficiaries and Low-Income uninsured individuals. [20]

Shortly thereafter, Governor Scott sued the federal government for allegedly "coercing" the state into expanding Medicaid, in violation of the Supreme Court's decision in *NFIB v. Sebelius*.[21] The lawsuit asked the federal court to order CMS to continue funding Florida's LIP program. The editorial boards of major newspapers across the State criticized the lawsuit, reiterating their opinion that the state should accept federal expansion funding.[22]

At the same time, the State finally filed a formal amendment to the Section 1115 waiver seeking to renew LIP for two years at the current funding level.[23] In response, CMS proposed a one-year reduction of LIP by approximately $1 billion (a 55% reduction), with a further reduction to $608 million for FY 2016-17 (a 75% reduction from FY 2014-15).[24] The lawsuit was then dismissed, and the 2015 Legislature concluded the Special Session with a reconfigured allocation of funding related to each of the state's hospitals.[25]

3. Current Status – Terms and Conditions and 2016 Legislation

a.) CMS: Special Terms and Conditions

On October 5, 2015, CMS announced new Special Terms and Conditions (STC), which specified major changes for the 2016-17 LIP program. First, LIP funds can no longer be used to cover Medicaid "shortfall,"[26] or insufficient rates, as in the past.[27] Instead, LIP funds can now only be distributed for verifiable costs of care provided to uninsured individuals with incomes up to 200% of the federal poverty level.[28]

Second, the size of the LIP program cannot be expanded to include the cost of treating uninsured county residents who would have been eligible for coverage if the State accepted Medicaid expansion funding.[29] Third, the State cannot develop a model for distributing LIP funds based on a guaranteed return.[30] This represents a fundamental change in Medicaid funding for Florida's safety-net providers. *See infra* at 7-10 for further discussion of IGTs.[31]

Finally, the STC allowed the state

Coverage rather than uncompensated care pools is the best way to secure access to health care for low-income individuals

flexibility to establish a "tiering" system whereby the state could divide hospitals into up to four tiers, and allocate LIP funds (and tier assignment) based on the hospital's ratio of charity care to compensated care.[32]

b) Florida 2016 Legislation, CMS Response and Reimbursement and Funding Methodology for Demonstration Year 11 (RFMD)

The "Medicaid Hospital Funding Program Fiscal Year 2016-17" (hereafter "Hospital Funding Tables" or "HB 5001") contained the Legislature's calculations for each of the hospital's "projected payments" for LIP, DSH and Rate Enhancements and displayed each hospital's tier assignment.[33] The Hospital Funding Tables also included projected Intergovernmental transfers ("IGTs").[34]

Pursuant to HB 5001, the Legislature divided LIP distributions into four tiers and hospitals were assigned to a tier based on the ratio of the hospital's charity care costs to its commercial charges. Of their eligible charity care costs, Tier 1 hospitals will be paid up to 100% of their maximum LIP allotment; Tier 2 hospitals up to 67%; Tier 3 up to 14%: and Tier 4 will be paid up to 1.87% of their charity care costs. For example, in Miami-Dade County, Jackson has a LIP allotment of $107,395,764.[35] Assuming that the LIP is fully funded and that Jackson incurs eligible charity care costs of at least $107,395,764, it will receive that entire amount in LIP funds.

Tampa General is in Tier 2 and has a LIP allotment of $52 million.[36] Assuming the LIP is fully funded, and Tampa General incurs eligible charity care costs of approximately $77.6 million, it will receive its full LIP allotment of $52 million (67% of $77.6 million).

In addition to establishing the hospital funding tables, the 2016 legislation also described the process by which LIP funds would be distributed if insufficient local funds were collected for the state match portion of a fully funded LIP. A fully funded LIP requires a state match of approximately $240 million,[37] or approximately 40% of $608 million.

Two provisions of HB 5001 were subsequently called into question by CMS. First, the legislation provided that if the counties did not come forward with the $240 million required for the full state match, funds would first be distributed to hospitals based on their respective tier, starting with Tier 1 hospitals. After Tier 1 is fully funded, any additional funds would be allocated to Tier 2 and so on.[38] However, if for example only $120 million in IGTs are collected, there would not even be sufficient LIP funds for all of the hospitals in Tier 1 to get their full allotment and hospitals in Tier 2-4 hospitals would get nothing.[39]

On May 20, 2016, CMS sent Florida's Medicaid Director a letter stating that two provisions violated the Special Terms and Conditions (STC).[40] First, CMS advised that if there are insufficient IGTs for a fully funded LIP program, the distribution cannot be just to Tier 1 hospitals. Instead, CMS told the State that the program's STC require that all eligible LIP providers must receive at least "some amount of payment."[41]

CMS' second issue with HB 5001 was the legislation's provision that AHCA could reassign the add-on rate adjustment amounts (also called "rate enhancements", *see infra* at 6-7) under certain circumstances.[42] In the same May 20 letter, CMS advised the State that "reassignment of add-on rate adjustments between hospitals in consideration of IGTs" would also violate the STC. In other words, a hospital which qualifies for a LIP allotment, but which has no authority over local funds that could be used as IGTs, cannot "exchange" its rate add-on dollars for IGTs. *See infra* at 6-7 for discussion of rate add-ons or rate enhancements.[43]

The May 20, 2016 letter attached the approved RFMD which states that "all providers who qualify for a LIP distribution will be reimbursed a percentage of the charity care costs."[44] The document also provides a flowchart illustrating the

flow of IGTs for the LIP program. First, the State and local governments will execute a Letter of Agreement (LOA). Next, the Agency will receive both the IGTs from the counties and the federal match for the LIP distributions. Then, the designated LIP recipient providers will receive their LIP distribution.[45] As of the date of this report, the LOAs have not been finalized.[46]

B. Disproportionate Share Hospital (DSH) Program

Congress established the Medicaid Disproportionate Share Hospital Program (DSH) in the early 1980s[47] to provide additional financial support to hospitals that serve a "disproportionate share" of the poor.[48] Florida's current annual DSH funding is almost $240 million; with approximately $15 million going to Hillsborough County hospitals.[49]

Under the ACA, DSH was significantly reduced because Congress intended that the ACA's provisions for Medicaid expansion would considerably reduce the number of uninsured individuals.[50] The Supreme Court's decision that states were not required to expand Medicaid[51] effectively undermined this *quid pro quo* in states that have not expanded their Medicaid program. Because the scheduled DSH reduction is not being offset with expansion funding as contemplated by the ACA,[52] Florida's safety-net providers face the additional loss of DSH revenue, commencing in 2017 with the loss increasing over the next seven years.[53]

C. Rate Enhancements

In addition to LIP and DSH, the "*Hospital Funding Tables*" also lists specific dollar amounts as "Distributions" to individual hospitals for what are referred to as "Rate Enhancements." (*See* excerpts from Table 5 below; reconfigured to include only Hillsborough County hospitals).

TABLE 1: Net Payments for LIP, DSH, and Rate Enhancements for Hillsborough County Hospitals in FY 2016-17

		Distributions					
	Provider Name	Total All LIP Payments	DSH Payments	Rate Enhancements: Inpatient DRGs and Outpatient Exemptions	Rate Enhancements: Outpatient Buy-backs	Total All Payments	Net Payments
TIER ONE	SHRINER'S HOSPITAL FOR CHILDREN	1,382,765			527,351	1,910,117	1,910,117
	SOUTH FLORIDA BAPTIST HOSPITAL	7,965,214		2,327,215		10,292,429	10,292,429
TIER TWO	TAMPA GENERAL HOSPITAL	52,622,670	5,604,597	38,719,354		96,946,621	65,584,577
TIER THREE	ST. JOSEPH'S HOSPITAL	5,847,398		20,451,356	2,012,536	28,311,289	28,311,289

	H. LEE MOFFIT CANCER CENTER	295,799	9,335,623	7,950,004		17,581,427	13,861,733
	KINDRED HOSPITAL - CENTRAL TAMPA	5,953				5,953	5,953
TIER FOUR	KINDRED HOSPITAL BAY AREA - TAMPA	2,630				2,630	2,630
	MEMORIAL HOSPITAL OF TAMPA	13,272				13,272	13,272
	SOUTH BAY HOSPITAL	30,541				30,541	30,541
	TOWN & COUNTRY HOSPITAL	19,909				19,909	19,909
	UNIVERSITY COMMUNITY HOSP. - CARROLLWOOD	89,320				89,320	89,320
	UNIVERSITY COMMUNITY HOSPITAL - TAMPA	295,146				295,146	295,146
	TOTALS:	68,758,822	14,940,220	73,319,975	2,539,887	159,558,904	124,477,166

For example, in FY 2016, Tampa General could potentially receive $52,622,670 in LIP (See infra page 11) and $5.6 million in DSH. However, despite being listed alongside LIP and DSH, the hospital's specified "rate enhancement" amount of $38,719,354 is fundamentally different. Unlike LIP and DSH, the rate enhancement dollar amounts are embedded in individual fee-for-service and Managed Care Organization (MCO) rates, and do not represent actual payments to the hospital.[54]

Rather, a hospital's rate enhancements represent a projection, or "simulation."[55] This projection is based on the individualized rates for various services that the State has agreed to pay to each hospital as reimbursement for patients in the fee-for-service system.[56] Under a managed care system, a hospital's projected rate enhancement distribution is contingent upon two major variables: 1) the extent to which managed care company contracts with that individual hospital mirror the hospital's "enhanced rate" agreed to by the State; *plus*, 2) the extent to which a given number of the MCO enrollees actually receive "enhanced rate" services at that hospital. As the Secretary for the Agency for Healthcare Administration explained, "the inpatient payments shown in these materials are merely simulations based on historical Medicaid utilization, not proposed appropriations. *Actual hospital results will vary based on their contracts with Medicaid managed care plans and the services they provide*…."[57]

Thus, it is misleading for Table 5's column labeled "Net Payments" to include rate enhancements as a "payment" to the hospital, along with LIP and DSH.[58] Again, as of the date of this report, the LIP allotments for each hospital are not yet final and the potential allotment currently indicated in the Tables may be reduced. The relevant distinction is that each hospital's LIP payment, unlike the hospital's "rate enhancements," will be a specified dollar amount, provided to the hospital from AHCA as a supplemental payment. And again, the only way to guarantee supplemental payments to specified hospitals in a managed care system is either through a waiver, *e.g.* LIP, or through the DSH program.[59]

D. Intergovernmental Transfers "IGTs": *Past, Present, and Future*

1. IGTs are still used for LIP and DSH

As noted above, the state match portion of the LIP and DSH programs is funded through local funds sent to Tallahassee as Intergovernmental Transfers

(IGTs).[60] These local funds, which are generated in various ways, including local taxing districts and local indigent care surtaxes[61] must be submitted to Tallahassee from a governmental agency in the name of a specific hospital.[62]

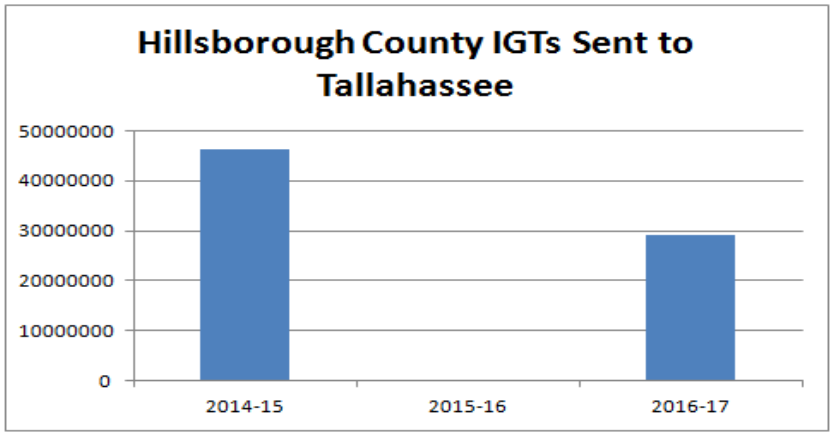
TABLE 2: IGT Payments for Hillsborough County Hospitals in FY 2014-15, 2015-16, and 2016-17

		IGTs[63]		
	Provider Name	2014-15	2015-16	2016-17
TIER ONE	SHRINER'S HOSPITAL FOR CHILDREN	0	0	0
	SOUTH FLORIDA BAPTIST HOSPITAL	841,406	0	0
TIER TWO	TAMPA GENERAL HOSPITAL	19,401,607	0	29,128,943
TIER THREE	ST. JOSEPH'S HOSPITAL	11,915,090	0	0
	BRANDON REGIONAL HOSPITAL	1,572,219	0	0
	H. LEE MOFFIT CANCER CENTER	12,690,190	0	0
	KINDRED HOSPITAL - CENTRAL TAMPA	0	0	0
TIER FOUR	KINDRED HOSPITAL BAY AREA - TAMPA	0	0	0

	MEMORIAL HOSPITAL OF TAMPA	0	0	0
	SOUTH BAY HOSPITAL	309,806	0	0
	TOWN & COUNTRY HOSPITAL	370,174	0	0
	UNIVERSITY COMMUNITY HOSP. - CARROLLWOOD	391,947	0	0
	UNIVERSITY COMMUNITY HOSPITAL - TAMPA	1,382,539	0	0
	TOTALS:	46,420,512	0	29,128,943

Pursuant to the State statute[64] allowing counties to implement a local indigent care surtax, Hillsborough County did so in 1991.[65] The language of the County's ordinance specifies that local tax dollars are collected pursuant to a half cent sales tax dedicated to support indigent health care. These local funds go into a Health Care Trust Fund, and can be used as IGTs.[66]

Prior to the 2015 Session and the new STC governing Florida's LIP program, there was tremendous local incentive to contribute to the IGT program. Counties and local taxing sources were not only assured that their local safety-net providers would receive the amount submitted on the provider's behalf, but also a significant dollar increase.[67] In fiscal year 2014-15, of the approximate $1 billion in total IGTs collected, approximately $46 million (or approximately 4.6%) came from Hillsborough.[68] Following the approximate 50% reduction in the state's LIP for FY 2015-16, the total state IGTs for LIP were correspondingly reduced to approximately $465 million. Interestingly, the Legislature did not request an IGT from Hillsborough County, and the county did not experience a similar reduction in their LIP allotment.[69] Instead, Hillsborough hospitals received approximately $52 million in LIP for 2015-16 (about 5% of the total 2015 $1 billion



*2016-17 amounts are still a projection as of the release of this report.

LIP, a similar percentage as in past years).

For 2016-17, CMS agreed to a LIP of just over $600 million. Accordingly, the state match will be approximately $240 million, which represents approximately 40% of the total LIP funds. The Hospital Funding Tables reflect approximately $35 million in IGTs from Hillsborough County.

2. IGTs are no longer used for Rate Enhancements

Prior to 2015, IGTs were also used to support what are called "rate add-ons" or "rate enhancements" (RE).[70] As with LIP, there were tremendous local incentives to maximize IGTs in order to increase payment rates to local hospitals.[71] However, as discussed, the dollar amounts for rate enhancements listed in the *Hospital Funding Tables* are merely projections. In a managed care environment, counties cannot be assured that their IGTs submitted for rate enhancements will be returned to the designated provider. "Rate enhancements are not compatible with managed care because the donor cannot be certain of earning back the donation and the price differential discourages use of hospitals with higher rates."[72] Counties responded to this lack of guarantee by not submitting IGTs for 2015-16 rate enhancements.[73] Instead, in 2015-16, the State Legislature (for the first time) provided general revenue for rate enhancements.[74] The 2016 Legislature again allocated funding for the state share of rate enhancements.[75]

III. Potential Impact of Funding Changes on Hillsborough County

A. The Hillsborough County Health Care Plan

While many Florida counties use tax dollars to support their local safety-net providers, Hillsborough County uses local tax dollars to provide actual health care coverage for low-income county residents. In 1991, the County adopted a half cent sales tax, and used the funding to create the Hillsborough County Health Care Plan ("HCHCP" or "the Plan").[76] The HCHCP enrolls eligible indigent county residents into a managed care plan which provides qualified indigent county residents with primary, preventive, pharmacy and hospital care.[77] In 2016, the County Commission approved integration of mental health treatment and expanded eligibility to those earning up to 110% Federal Poverty Level (from 100%).[78] By contrast, Miami Dade County, the only other large Florida County to adopt a sales surtax related to indigent care directed that the tax revenue simply "be deposited in a fund only for the operation of the county public general hospital." There is no requirement that the tax dollars be used to fund indigent care—either services or coverage.[79]

The Plan, initially covered approximately about 30,000 individuals and received tremendous national recognition and awards, including from the Harvard University School of Government,[80] and an "Innovations in American Government" award from the Ford Foundation.[81] It has also been noted as a model program in providing coordinated care to low-income populations by the Robert Wood Johnson Foundation.[82] In describing the political genesis and ongoing struggles of the Plan, Lawrence Brown, a Columbia University Professor of Health Policy and Management, praised the HCHCP creators as "unwilling simply to channel more money to safety-net providers, its creators fearlessly uttered the "t[ax]" word, launched a redistributive exercise on behalf of a unorganized and largely apolitical constituency; and designed a distinct, dedicated and supposedly secure funding mechanism . . .to sustain the new coverage they invented."[83]

The Plan has been funded by the County's half-

cent sales surtax. A portion of those funds were transmitted to Tallahassee as an Intergovernmental Transfer. This local funding provided the state share of Hillsborough County's LIP distributions. It was returned with an enhanced federal match.[84] Three hospitals have typically received most of the county's LIP. Those hospitals, which include H. Lee Moffit Cancer Center, St. Joseph's Hospital, and Tampa General Hospital, received approximately $116 million of the county's total $128 million in LIP funding in 2014. Based on the Hospital Funding Tables, Hillsborough County Hospitals have received the following LIP allotments in 2014-15 and 2015-16 and are potentially eligible for LIP distributions as follows in 2016-17.

All Amounts in USD	LIP 2014-15	LIP 2015-16	LIP 2016-17
Provider Name			
TIER ONE			
SHRINER'S CHILDREN'S HOSPITAL	**0**	**0**	**1,382,765**
SOUTH FLORIDA BAPTIST HOSPITAL	**2,097,694**	**222,723**	**7,965,214**
TIER TWO			
TAMPA GENERAL HOSPITAL	**62,439,175**	**32,077,129**	**52,622,670**
TIER THREE			
ST. JOSEPH'S HOSPITAL	**30,402,461**	**10,656,861**	**5,847,398**
TIER FOUR			
BRANDON REGIONAL HOSPITAL	**4,098,919**	**595,423**	**188,205**
H. LEE MOFFIT CANCER CENTER	**23,326,539**	**7,847,914**	**295,799**
KINDRED HOSPITAL - CENTRAL TAMPA	**0**	**0**	**5,953**
KINDRED HOSPITAL BAY AREA - TAMPA	**0**	**0**	**2,630**
MEMORIAL HOSPITAL OF TAMPA	**0**	**0**	**13,272**
SOUTH BAY HOSPITAL	**766,088**	**75,723**	**30,541**
TOWN & COUNTRY HOSPITAL	**915,367**	**90,479**	**19,909**
UNIVERSITY COMMUNITY HOSP. - CARROLLWOOD	**969,206**	**95,801**	**89,320**
UNIVERSITY COMMUNITY HOSPITAL - TAMPA	**3,418,742**	**337,923**	**295,146**
Totals for Hillsborough County	**128,434,191**	**51,999,976**	**68,758,822**

*2016-17 amounts are still a projection as of the release of this report.

Notably, for FY 2016 neither of Hillsborough County's two major safety-net hospitals, Tampa General nor St. Joseph's, were assigned to Tier 1. The only County hospitals to receive a Tier 1 designation are South Florida Baptist Hospital and Shriner's Childrens Hospital.

The tier assignments could be significant *if* the counties fail to contribute the entire state match portion for a fully funded LIP program. The May 20, 2016 CMS letter advised that the State could not make LIP distributions only to hospitals in Tier 1 in the event that local funds are insufficient to fully fund the state share as set forth in HB 5001.[85] Instead, "all providers….that meet LIP provider participation requirements and that furnished uncompensated charity care must receive *some* amount of payment."[86] (Emphasis added). However, there is no requirement in the CMS letter or the STC regarding the amount or percentage of LIP that must be distributed to hospitals in Tier 2 and below, and "some" could be de minimis.

B. Federal Funding for Coverage of the Uninsured Will Offset Losses

The scheduled reduction of Florida LIP and DSH funding will be more than offset if the Florida Legislature accepts federal funding to expand coverage for uninsured low-income adults. According to Florida's Office of Economic and Demographic Research, nearly 1 million (951,826) people are eligible for expansion,[87] and nearly 850,000 (834,674) would enroll under expanded coverage. This number includes almost 570,000 low-income Floridians who have no opportunity to obtain affordable health insurance because they fall into the coverage gap.[88]

The Social Services Estimating Conference (SSEC) previously predicted that coverage of the expansion population over ten years would result in a net influx of approximately $50 billion in federal funding, over those ten years to cover the cost of health care for the newly enrolled.[89] This estimate was derived by estimating the per member per month (PMPM) cost of health care coverage for a childless adult times the number of newly eligible adults in the Medicaid expansion population expected to enroll.[90]

The same methodology can be applied to estimate the potential annual net gain in revenue to Hillsborough County health care providers if the Legislature accepts funding to expand coverage to uninsured low-income adults in the gap. Specifically, multiplying the estimated number of county residents eligible for expansion coverage (70,000)[91] times the annual cost of paying for their coverage ($543[92] x 12) equals $456,120,000. An estimate of the revenue that would be generated for their care (taking into account the Medical Loss Ratio (MLR), which requires that 85% of the payment to the managed care company must be spent on health care services and treatments for enrollees)[93] is almost $2 billion over 5 years. This new revenue, which is almost entirely comprised of federal tax dollars,[94] far exceeds the County's 5 year cumulative loss of $388 million LIP dollars.

Again, this estimate only represents new dollars that the County's health care providers will receive if federal funding for expansion coverage is accepted. It does not include economic data related to the improved health and productivity of county residents by virtue of having insurance. Nor does it include the positive multiplier effects to the local economy from the new revenue local health care providers can expect. Studies demonstrating the substantial gains throughout state and local economies as a result of expansion funding have been published and are cited in the endnotes, along with studies documenting savings to the state budget if federal expansion dollars were to be drawn down.[95]

IV. Conclusion: Issues for Hillsborough County to Consider

Hillsborough County, like all Florida counties, has been adversely impacted by the State's refusal to accept federal expansion dollars. While the Legislature has not increased coverage of the uninsured, the funding for safety-net providers has been significantly reduced. Specifically, the County's LIP funding was reduced from $128 million in 2014 to $52 million in 2015 and the future of federal dollars for safety-net funding is uncertain.

Stakeholders should understand that the ability to leverage local IGT dollars for federally-matched and enhanced funding has been fundamentally altered. IGTs are no longer used to fund hospital rate enhancements and can no longer guarantee any return-rate for the LIP program.

Critical questions for this fiscal year for Hillsborough (and other counties for whom Letters of Agreement are requested) include if/when to submit IGTs and how much to submit. For example, under the 2016-17 LIP Program, if Tampa General Hospital submits its fully requested IGT allotment, but the rest of the IGT pool is not sufficient to meet the State match, the hospital could receive significantly less than its LIP allocation.[96] Conversely, if Hillsborough declines to send IGTs for Tampa General, and if other county contributions are sufficient to fully fund the LIP program, the hospital will nonetheless be eligible for its full allotment, assuming it incurs a sufficient amount of uncompensated care costs.[97]

Beyond this fiscal year, county leaders should remember that the LIP is part of the current 1115 Waiver, and the Waiver expires in 2017. Even if the LIP is renewed, the greatly reduced funding will be felt acutely by the local health care system and the County's economy. Given the currently scheduled reduction of the LIP, an estimated $388 million of federal Medicaid dollars will no longer be "helicopter dropped" into Hillsborough County over the next five years.[98]

County leaders should consider that because approximately 70,000 uninsured residents are eligible for expansion coverage, local health care providers would gain almost $2 billion in new revenue over five years if those individuals received coverage. Finally, local leaders and stakeholders should understand how that increased revenue would impact the local economy.

In sum, it is clear that future Medicaid safety-net funding is extremely uncertain. Both the amount and the structure of this funding will change in FY 2016-17, and this change will have a significant adverse impact on Hillsborough County's economy, health care providers and low income residents. Thus, it is critical that Hillsborough County stakeholders, including the County's Legislative delegation, continue to discuss how to fund and deliver health care for uninsured local residents.

For more information, please contact:

Miriam Harmatz
Senior Health Law Attorney
Florida Legal Services, Inc.
miriam@floridalegal.org
(786) 853-9385

Charlotte Joseph Cassel
Equal Justice Works Fellow
Sponsored by the Florida Bar Foundation & Greenberg Traurig
Florida Legal Services, Inc.
charlotte@floridalegal.org
(305) 542-2077

The authors would like to thank Dena Gross Leavengood and Talal Rashid for their invaluable assistance in preparing this report.

1. Lloyd Dunkelberger, *Scott rules out Medicaid Expansion*, HERALD-TRIBUNE, May 5, 2015, http://politics.heraldtribune.com/2015/05/05/scott-rules-out-medicaid-expansion/; Steve Crisafulli, *Why the Florida House opposes Medicaid Expansion*, TAMPA BAY TIMES, Apr. 28, 2015, http://www.tampabay.com/opinion/columns/crisafulli-why-the-florida-house-opposes-medicaid-expansion/2227220.
2. The ACA expanded Medicaid to include coverage for previously ineligible low income adults between age 19 and 64. 42 U.S.C. 1396a(a)(10)(ii)(XX). As with all Medicaid coverage groups, costs are shared between the federal and state governments. The federal government covers approximately 60% of all Medicaid costs in Florida. This percentage is referred to as the federal matching rate or "FMAP." Significantly, in contrast to the approximately 60% FMAP for the current Medicaid population (including a 60/40 Federal/State match for LIP), the ACA required the federal government to cover 100% of costs associated with the newly eligible population until 2016. The FMAP for the newly eligible population gradually tapers down to no less than 90% in 2020 and thereafter. 42 U.S.C. § 1396d(y)(1).
3. Alan W. Hodges & Mohammad Rahmani, FLORIDA HOSPITAL ASSOCIATION, ECONOMIC IMPACTS OF EXTENDING HEALTH CARE COVERAGE IN FLORIDA, SPONSORED PROJECT REPORT TO THE FLORIDA HOSPITAL ASSOCIATION, at 12 (Mar. 28, 2013) [hereinafter *FHA Economic Impact Report*], *available at* https://www.Statereforum.org/system/files/economicimpactsofextendinghealthcarecoverageinflorida-march2013-final_copy.pdf.
4. According to EDR data, there are 951,826 Floridians eligible for Medicaid expansion. THE FLORIDA LEGISLATURE OFFICE OF ECONOMIC AND DEMOGRAPHIC RESEARCH, IMPACT ANALYSIS LIP, IGTS AND SB 2512 (Apr. 21, 2015) [hereinafter EDR Presentation April 21, 2015], available at http://edr.State.fl.us/Content/presentations/affordable-careact/Expansion2015PresentationtoSenate.pdf. According to the Florida Agency for Health Care Administration (AHCA), Medicaid recipients in Hillsborough account for 7.4% of Medicaid recipients in the State of Florida. FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, CURRENT COMPREHENSIVE MEDICAID MANAGED CARE ENROLLMENT REPORTS: December 2015, at table 5 [hereinafter AHCA Medicaid Enrollment by County], available at http://www.fdhc.State.fl.us/medicaid/Finance/data_analytics/enrollment_report/docs/ENR_201606.xls.

   Assuming that the percent of people eligible for Medicaid expansion, per county, is roughly equivalent to the percent currently on Medicaid, per county, the number of people eligible in Hillsborough County is derived by multiplying the number eligible Statewide, 951,826, by 7.4%, totaling 70,435.

   The state data is consistent with a July 2016 report from the Robert Wood Johnson Foundation and Urban Institute finding over 2.3 million Floridians potentially gaining Medicaid eligibility under expansion. This includes 877,000 who are uninsured and 475,000 enrolled in the Marketplace. Matthew Buettgens & Genevieve M. Kenney, ROBERT WOOD JOHNSON FOUNDATION AND URBAN INSTITUTE, WHAT IF MORE STATES EXPANDED MEDICAID IN 2017? CHANGES IN ELIGIBILITY, ENROLLMENT, AND THE UNINSURED (July 2016) *available at* http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000866-What-if-More-States-Expanded-Medicaid-in-2017-Changes-in-Eligibility-Enrollment-and-the-Uninsured.pdf. Notably, those individuals between 100%-138% FPL who are currently enrolled in a marketplace plan would receive more affordable coverage in an expanded Medicaid program.
5. According to the Florida Agency for Health Care Administration (AHCA), Medicaid recipients between 18 and 64 years old in Hillsborough account for 7.6% of Medicaid recipients in the State of Florida. FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, MEDICAID ELIGIBLES REPORT: MAY 2016, at table "Age by County,' available at http://www.fdhc.State.fl.us/medicaid/Finance/data_analytics/eligibles_report/docs/age_cnty_2016-05-31.pdf. Assuming that the percent of people in the coverage gap, per county, is roughly equivalent to the percent currently on Medicaid, per county, the number of people in the coverage gap in Hillsborough County is derived by multiplying the number in the gap Statewide, 567,000, by 7.6%, totaling approximately 43,000.

6. FL. S. & FL. H.R., MEDICAID HOSPITAL FUNDING PROGRAMS, FISCAL YEAR 2014-15, FINAL CONFERENCE REPORT FOR HOUSE BILL 5001, at 21-24 (Apr. 29, 2014), http://www.fdhc.State.fl.us/medicaid/Finance/finance/LIP-DSH/LIP/docs/Medicaid_Supp_Hospital_Funding_Programs_SFY_2014-2015_Final_Conference_Report_HB_5001.pdf [hereinafter *Hospital Funding Tables 2014-15*]; FL. S. & FL. H.R., MEDICAID HOSPITAL FUNDING PROGRAMS, FISCAL YEAR 2015-16, CONFERENCE REPORT ON SB 2500-A, at 24-32 (June 16, 2015), https://www.flsenate.gov/PublishedContent/Session/2015A/Appropriations/Documents/Medicaid_Conference_Report.pdf [hereinafter *Hospital Funding Tables 2015-16*] & FL. S. & FL. H.R., MEDICAID HOSPITAL FUNDING PROGRAMS, FISCAL YEAR 2016-17, FINAL CONFERENCE REPORT FOR HB 5001, at 2-7 (Mar. 8, 2016), https://www.flsenate.gov/PublishedContent/Session/2016/Appropriations/Documents/2016_Medcaid_Hospital_Funding_Conference_Report.pdf [hereinafter *Hospital Funding Tables 2016-17*]. Notably, the LIP and IGT "allotments" reflected in the 2016-17 Tables are not final.
7. Section 1115 of the Social Security Act allows the Secretary of HHS to waive compliance with most (but not all) of the Medicaid statutory requirements "to the extent and for the period he finds necessary" to enable a state or states to carry out an "experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of" the Medicaid Act. 42 U.S.C § 1315(a); *see* 42 C.F.R. § 431.404
8. *See* Fla. Stat. § 409.91211(1)(c).
9. Ctrs. for Medicare & Medicaid Servs., *Medicaid Reform Section 1115 Demonstration – Special Terms and Conditions*, 7-8, 24 (2006) ("2006 Waiver Terms and Conditions"), *available at* https://www.nachc.com/client/documents/issues-advocacy/State-issues/1115-waivers/FlSTC.pdf.
10. See THE HENRY J. KAISER FAMILY FOUNDATION, FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) FOR MEDICAID AND MULTIPLIER, available at http://kff.org/medicaid/State-indicator/federal-matching-rate-and-multiplier/. For FY 2016 the FMAP is 60.67%.
11. *See infra* note 60.
12. Letter from Cindy Mann, Director, Centers for Medicare & Medicaid Servs., to Justin Senior, Deputy Sec'y for Medicaid, Florida Agency for Health Care Admin, at 103 (July 31, 2014), *available at* http://www.faast.org/sites/default/files/Supporting%20042415.pdf [hereinafter *CMS July 2014 Letter*].
13. *Id*.
14. U.S. Government Accountability Office, Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns 28 (Jan. 2008) (GAO-08-87) (finding federal spending under the Florida LIP "problematic" and that HHS had not ensured the "fiscal integrity" of the Medicaid program); *see also* GAO, Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lacks Transparency 14-17 (June 2013) (GAO-13-384) (raising similar concerns with similar pooling arrangements in Texas).
15. Navigant Healthcare, *Study of Hospital Funding and Payment Methodologies for Florida Medicaid*, Prepared for: Florida Agency for Health Care Administration, at 24-25, 142, 181 (Feb. 27, 2015) (noting the lack of monitoring) [hereinafter the *Navigant Report], available at* http://ahca.myflorida.com/medicaid/Finance/finance/LIP-DSH/LIP/docs/FL_Medicaid_Funding_and_Payment_Study_2015-02-27.pdf.
16. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII)
17. Hillsborough County Health Care Plan, *Financial Statements, Fiscal Year 2016* (on file with authors).
18. *E.g*. Gray Rohrer, *Gov. Scott: Take up budget without LIP, Medicaid Expansion*, ORLANDO SENTINEL, Apr. 30, 2015, http://www.orlandosentinel.com/news/politics/political-pulse/os-gov-scott-weighs-in-budget-impasse-post.html.

19. Letter from Vikki Wachino, Acting Director, Centers for Medicare and Medicaid Servs., to Justin Senior, Deputy Sec'y for Medicaid, Florida Agency for Health Care Admin (Apr. 14, 2015), *available at* http://ccf.georgetown.edu/wp-content/uploads/2015/04/CMS-FL-Letter-April-2015.pdf [hereinafter *Vikki Wachino April 14, 2015 letter*].

20. *Id*.

21. *Scott et al v. United States Department of Health and Human Services et al*, No. 3:15-cv-00193RS-CJK, (N.D. Fla. 2015).

22. *See, e.g.*, TALLAHASSEE DEMOCRAT, OUR OPINION: FLORIDA NEEDS MEDICAID EXPANSION (Apr. 17, 2015), *available at* http://www.tallahassee.com/story/opinion/editorials/2015/04/17/opinion-florida-needs-medicaid-expansion/25958373/; MIAMI HERALD, LITIGATION IS NOT SAFETY-NET LEADERSHIP (Apr. 18, 2015), *available at* http://www.miamiherald.com/opinion/editorials/article18911385.html; FLORIDA TODAY, EDITORIAL: STOP GOUGING US, HOUSE; COVER THE POOR (Apr. 19, 2015), *available at* http://www.floridatoday.com/story/opinion/2015/04/17/editorial-stop-gouging-us-house-cover-poor/25948631/.

23. FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, LOW-INCOME POOL AMENDMENT REQUEST (Apr. 20, 2015), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/Managed-Medical-Assistance-MMA/fl-medicaid-reform-pa-low-inc-pool-amend-05262015.pdf.

24. The FY 2016-17 reduction is consistent with CMS' principle that the LIP be "sized" to reimburse safety-net providers for the cost of treating those who are not eligible for other forms of coverage, including those Floridians who would have been eligible for coverage under Medicaid expansion. Ctrs. for Medicare & Medicaid Servs., *Florida Managed Medical Assistance Program – Special Terms and Conditions*, # 67 (2015) [hereinafter *2015 STC*]. CMS also expressed concern that Florida's Medicaid rates are too low. While underscoring the new principle that provider rates must be sufficient and noting that LIP dollars could no longer be shifted to rates, CMS reminded the state that it could obtain additional federal revenue by increasing payment rates. The rate increases would allow the state to draw down additional federal matching dollars—separate and apart from LIP. This would generate additional funds for providers serving Medicaid beneficiaries and "better support providers in delivering care to Medicaid beneficiaries by addressing any shortfall in payment rates."

25. *Hospital Funding Tables 2015-16, supra* note 6.

26. "Medicaid shortfall" refers to the difference between Medicaid payments and the hospital's cost in providing the care. *Navigant Report, supra* note 15, at 56.

27. *2015 STC, supra* note 24, at # 71(a). This is a logical and expected change with Florida's move to managed care. For at least two years, CMS has made clear that the State was expected to reform its Medicaid payment and funding systems by moving away from LIP and supplemental payments and toward a system that would ensure beneficiaries' access to providers Statewide. *CMS July 2014 Letter, supra* note 12 & Letter from Vikki Wachino, Acting Director, Centers for Medicare and Medicaid Servs., to Justin Senior, Deputy Sec'y for Medicaid, Florida Agency for Health Care Admin (May 21, 2015), *available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/Managed-Medical-Assistance-MMA/fl-medicaid-reform-lip-ltr-05212015.pdf [hereinafter Vikki Wachino May 21, 2015 letter]*. Florida's Medicaid payments are now almost exclusively in the form of per member per month payments to managed care plans–rather than payments to hospitals or other providers based upon individual reimbursements (or fee-for-service). However, while hospitals can no longer use LIP funds to make up for any alleged or actual "shortfall," it is important to ensure that the rates paid by the state to plans are sufficient such that the plans can ensure "provider participation and [consumer] access. *2015 STC, supra* note 24, at # 68(b).

28. The care must be provided through a charity care program administered by the hospital in compliance with specific federal principles. *2015 STC, supra* note 24, at # 68(b).

29. *2015 STC, supra* note 24, at # 67.

30. Tom Wallace, AGENCY FOR HEALTH CARE ADMINISTRATION, LOW INCOME POOL, AT 8 (NOV. 3, 2015) [hereinafter *Wallace Presentation*], *available at* http://ahca.myflorida.com/medicaid/recent_presentations/LIP_House_HC_Approp_2015-11-03.pdf.

31. There is clearly no longer any guarantee of the previously generous return rates. *Id*. It is not clear that there will even be a guarantee that the hospital will receive the full amount of the IGT submitted on its behalf. *See* E-mail from Charlotte Cassel, Fl. Legal Svcs. to Thomas J. Wallace, Bureau Chief, Medicaid Program Finance, Fl. Agency for Health Care Admin. (July 8, 2016, 03:04 PM EST) (on file with authors). The RFMD, however, did include a discussion of the "State's Perspective on Waiver Payments" noting that "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 area without consideration of the benefits received by providers within its political subdivisions. 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." *See RFMD, infra* note 44, at 3-4. In light of this acknowledgment, the Letters of Agreement (LOA) (not available at the time of this Brief release, July 25, 2016) may be drafted in a manner aimed at protecting counties against the possibility that they could contribute more in IGTs than they receive back in LIP.
32. *2015 STC, supra* note 24, at # 71(b)(i).
33. *Hospital Funding Tables 2016-17, supra* note 6.
34. *Id*. at Table 3, pp. 23-28.
35. *Id*. at Table I, p. 4.
36. *Id*. at 7.
37. The actual amount is $236,541,143. *Id*. at Table 3, p. 28.
38. *Id*. at 32.
39. *Id*. at 7. Thus, if half of that state match, or $120 million, is collected from the counties, that amount would "draw down" federal matching funds of approximately $184 million, creating a total LIP of $304 million. Because the Tier 1 hospital allocations alone total $467,519,112, under the legislation, this would leave nothing for hospitals in the the remaining Tiers.
40. Letter from Angela D. Garner, Director, Division of System Reform Demonstrations, Centers for Medicare and Medicaid Servs., to Justin Senior, Deputy Sec'y for Medicaid, Florida Agency for Health Care Admin (May 20, 2016), available at http://www.miamiherald.com/latest-news/article82363412.ece/binary/2016%20May%20CMS%20Guidance%20Letter.pdf [hereinafter CMS May 20 Letter].
41. *Id*.
42. *Hospital Funding Tables 2016-17, supra* note 6, at 35.
43. For example, Homestead Hospital in Miami Dade qualifies for a LIP allotment of almost $25 million because it serves a large number of uninsured county residents. However in Miami-Dade, the local IGTs are controlled by Jackson Memorial Hospital. Jackson and Homestead cannot negotiate an "exchange" of Homestead's rate add on dollars for Jackson's IGTs dollars.
44. FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, REIMBURSEMENT AND FUNDING METHODOLOGY FOR DEMONSTRATION YEAR 11, FLORIDA'S 1115 MANAGED MEDICAL ASSISTANCE WAIVER, LOW INCOME POOL, AT 7 (Nov. 30, 2015), *available at* http://www.fdhc.State.fl.us/medicaid/Finance/finance/LIP-DSH/LIP/pdfs/FINAL_FL_MMA_RFMD_DY10_05-20-2016.pdf [hereinafter RFMD].
45. *RFMD, supra* note 44, at 8.
46. Ten hospitals have a designated IGT associated with LIP allocation and Letters of Agreement will be sought from eligible contributors on behalf of those hospitals. Hospital Funding Tables 2016-17 at 23-28 & E-mail from Thomas J. Wallace, Bureau Chief, Medicaid Program Finance, Fl. Agency for Healthcare Admin. (June 29, 2016, 08:08 PM EST) (on file with authors).

47. Corey Davis, NATIONAL HEALTH LAW PROGRAM, Q&A DISPROPORTIONATE SHARE HOSPITAL PAYMENTS AND THE MEDICAID EXPANSION 2 (July 2012) [hereinafter *NHeLP DSH*], *available at* http://www.healthlaw.org/component/jsfsubmit/showAttachment?tmpl=raw&id=00Pd0000006EJLlEAO.

48. FL. S. COMM. HEALTH REGULATIONS, INTERIM REPORT 2010-120 SUPPLEMENTAL MEDICAID PAYMENTS, at 2 (2010) [hereinafter *Senate Report*].

49. *Hospital Funding Tables 2016-17, supra* note 6, at 36.

50. Robin Rudowitz, THE HENRY J. KAISER FAMILY FOUNDATION, HOW DO MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS CHANGE UNDER THE ACA? (Nov. 2013) [hereinafter *Kaiser DSH Issue Brief*], *available at* http://kff.org/medicaid/issue-brief/how-do-medicaid-disproportionate-share-hospital-dsh-payments-change-under-the-aca/.

51. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012).

52. Protecting Access to Medicare Act, H.R. 4302, 113th Cong. § 221 (2014) (extending the implementation of DSH reductions from 2014 to 2017); s*ee also, Kaiser DSH Issue Brief, supra* note 54, at 2-3. The federal government delayed implementation of the DSH reductions until 2017 and will follow the DSH Health Reform Methodology specified in the final rule. This methodology takes 5 factors into account in determining DSH cuts across states: (1) Is the state a Low-DSH or a Non-Low DSH State?; (2) How will the reductions be allocated for the Low-DSH and Non-Low DSH states?; (3) How will the pool amounts be allocated across the states?; (4) What is a state's total reduction?; and (5) What other factors are considered?

53. Although the details are not yet clear, under the ACA, the Secretary of Health and Human Services is required to cut DSH funding by $14.1 billion from 2014-2019. *NHeLP DSH, supra* note 51, at 4.

54. Letter from Elizabeth Dudek, Secretary, Florida Agency for Health Care Admin., to Richard Corcoran, Chair, Florida House of Representatives (June 2, 2015), *available at* http://ahca.myflorida.com/docs/ChairCorcoran.pdf [hereinafter *Dudek Letter*] & E-mail from Thomas J. Wallace, Bureau Chief, Medicaid Program Finance, Fl. Agency for Healthcare Admin. (Dec. 30, 2015, 04:27 PM EST) (on file with authors).

55. *Dudek Letter, supra* note 54.

56. *Id*. "Raising one hospital's price compared to another may seem like a helpful measure on its face, but it will undermine that hospital's ability to attract patients in a managed care environment. Health plans will simply steer patients to less expensive hospitals nearby, undermining the impact of the increase…It is important to note that the inpatient payments shown in these materials are merely simulations based on historical Medicaid utilization, not proposed appropriations. Actual hospital results will vary based on their contracts with Medicaid managed care plans and the services they provide during fiscal year 2015-16."

57. *Dudek Letter, supra* note 54; Further underscoring the uncertain nature of rate enhancements is the fact that "self-funded [IGT] rate enhancements are not compatible with managed care because the donor cannot be certain of earning back the donation and the price differential discourages use of hospitals with higher rates." FL. SENATE, WORKSHOP ON SENATE PLAN FOR MEDICAID SUSTAINABILITY, at 6 (Apr. 21, 2015) [hereinafter *April 21, 2015 Senate Meeting Materials], available at* http://www.faast.org/sites/default/files/Supporting%20042415.pdf. *See also* as the Deputy Secretary for Medicaid explained "these types of facility specific add-ons were not expected to continue to work well in managed care." Justin Senior, AGENCY FOR HEALTH CARE ADMINISTRATION, UPDATE ON STATEWIDE MEDICAID MANAGED CARE AND LOW INCOME POOL PROGRAM, AT 20 (JAN. 7, 2015) [hereinafter *Justin Senior January 7, 2015 Presentation*] *available at* https://ahca.myflorida.com/medicaid/recent_presentations/SMMC_LIP_Update_Senate_HHS_Approps_2015-01-07.pdf.

58. *See supra* Table 1, last column.

59. 42 CFR 438.60

60. *Navigant Report, supra* note 15, at 13-14. ("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 in IGTs resulting in nearly $3.3 billion in reimbursements when combined with federal matching funds…. 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…. In addition, IGTs fund 100 percent of the State share of LIP-6, which was formerly known as self-funded IGTs."). 42 U.S.C. 1396b(w)(6)(A) & Fla. Stat. 409.908(1)(c).

61. *See* Fla. Stat. §212.055(4) & (5)
62. *Navigant Report*, *supra* note 15, at 14-15.
63. *Hospital Funding Tables*, *supra* note 6.
64. Fla. Stat. §212.055
65. Hillsborough County Health Care Ordinance, Secs. 46-382 & 46-384.
66. Hillsborough County Health Care Ordinance, Secs. 46-385.
67. *Navigant Report*, *supra* note 15, at 15.
68. *Hospital Funding Tables 2014-15*, *supra* note 6.
69. *Hospital Funding Tables 2015-16*, *supra* note 6.
70. *Justin Senior January 7, 2015 Presentation*, *supra* note 57, at 20. "[S]elf-funded (IGT) hospital rate enhancements have been used by Florida for several years to allow hospitals with local funding sources to 'buy back' rate cuts."
71. *Navigant Report*, *supra* note 15, at 29, 183.
72. *April 21, 2015 Senate Meeting Materials*, *supra* note 57, at 6.
73. Counties submitted a total of $459,108,788 for IGTs in 2015-16, which was applied to the State match portion of LIP. The State match portion for rate enhancements was provided through $400 million in GR. *Hospital Funding Tables 2015-16*, *supra* note 6, at 53
74. *Hospital Funding Tables 2015-16*, *supra* note 6, at 53. Under the column for "Total IGTs" there is a line item for GR (i.e. General Revenue) totaling $411,256,000. *See also*, Mary Ellen Klas, *House and Senate agree to $400 million to backfill LIP*, TAMPA BAY TIMES, June 6, 2015, http://www.tampabay.com/blogs/the-buzz-florida-politics/house-and-senate-agree-to-400-million-to-backfill-lip/2232615.
75. *Hospital Funding Tables 2016-17*, *supra* note 6, at 28.
76. Hillsborough County Health Care Ordinance, Secs. 46-382 & 46-385.
77. Hillsborough County Health Care Plan, *About the Program*, *available at* http://www.hillsboroughcounty.org/index.aspx?NID=1966.
78. Mitch Perry, *Hillsborough County to expand eligibility for its health care program*, SAINT PETERS BLOG, Mar. 23, 2016, http://saintpetersblog.com/hillsborough-county-expand-pool-people-get/.
79. 212.055(5) & Miami-Dade County Ordinance, Article XII, Sec. 29-99.
80. HARVARD KENNEDY SCHOOL, ASH CENTER FOR DEMOCRATIC GOVERNANCE AND INNOCATION, HILLSBOROUGH COUNTY HEALTH CARE PLAN, *available at* http://www.innovations.harvard.edu/hillsborough-county-health-care-plan.
81. ROBERT WOOD JOHNSON FOUNDATION, COMMUNITIES IN CHARGE: FINANCING AND DELIVERING HEALTH CARE TO THE UNINSURED, AN RWJF NATIONAL PROGRAM, at 2 (Apr. 4, 2007) [hereinafter *RWJF HCHCP Report*], *available at* http://www.rwjf.org/content/dam/farm/reports/program_results_reports/2007/rwjf69549.
82. Id.
83. Lawrence D. Brown, *Impermanent Politics: The Hillsborough County Health Care Plan And Community Innovation For The Uninsured*, Health Affairs 25 (Apr. 11, 2006), *available at* http://content.healthaffairs.org/content/25/3/w162.full.pdf+html

84. Hillsborough County, Department of Family and Aging Services, Division of Health Care SErvices, FY12/FY13, Hillsborough County Health Care Plan (HCHCP) and the Patient Protection and Affordable Care Act, at 23 (on file with authors).

85. CMS May 20 letter, *supra* note 40.

86. *Id*.

87. *EDR Presentation April 21, 2015*, *supra* note 4.

88. Rachel Garfield & Anthony Damico, THE HENRY J. KAISER FAMILY FOUNDATION, THE COVERAGE GAP: UNINSURED POOR ADULTS IN STATES THAT DO NOT EXPAND MEDICAID – AN UPDATE, at 7 (Oct. 2015) *available at* http://files.kff.org/attachment/issue-brief-the-coverage-gap-uninsured-poor-adults-in-States-that-do-not-expand-medicaid-an-update.

89. The authors recognize that at this point in time, this estimate is outdated, and an updated estimate, accounting for the years without expansion, is not yet available. *See also*, THE HENRY J. KAISER FAMILY FOUNDATION, THE FLORIDA HEALTHCARE LANDSCAPE (Nov. 2013), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/11/8511-the-florida-health-care-landscape1.pdf.

90. SOCIAL SERVICES ESTIMATING CONFERENCE, ESTIMATES RELATING TO FEDERAL AFFORDABLE CARE ACT: TITLE XIX (MEDICAID) & TITLE XXI (CHIP) PROGRAMS, at 15 (Mar. 7, 2013), *available at* http://edr.State.fl.us/Content/conferences/medicaid/FederalAffordableHealthCareActEstimates.pdf [hereinafter *SSEC*], at 14 -16. Note that the PMPM of $543 was based on SFY 2013. For the purpose of this report, it has not been adjusted for inflation.

91. *See Supra* note 4.

92. *SSEC*, *supra* note 89, at 14 -16. Note that the PMPM of $543 was based on SFY 2013. For the purpose of this report, it has not been adjusted for inflation nor does it reflect the regional PMPM provided to Miami Dade County as compared to the State average rate.

93. CENTERS FOR MEDICARE AND MEDICAID SERVICES, MEDICAL LOSS RATIO, *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio.html (Pursuant to the ACA insurance companies must comply with a medical loss ratio (MLR) standard. This standard, which requires insurance companies to spend 80-85% of premium dollars on the provision of medical care as opposed to administrative costs, underlies the assumption that 80-85% of funding allocated to MCOs will be paid to local health care providers).

94. 42 C.F.R. 433.10(c)(6)(i)

95. Deborah Bachrach, Patricia Boozang & Dori Glanz, MANATT HEALTH SOLUTIONS AND ROBERT WOOD JOHNSON FOUNDATION, STATES EXPANDING MEDICAID SEE SIGNIFICANT BUDGET SAVINGS AND REVENUE GAINS (Apr. 2015) *available at* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf419097; Leighton Ku, et. al., CENTER FOR HEALTH POLICY RESEARCH THE GEORGE WASHINGTON UNIVERSITY, CONE HEALTH FOUNDATION & KATE B. REYNOLDS CHARITABLE TRUST, THE ECONOMIC AND EMPLOYMENT COSTS OF NOT EXPANDING MEDICAID IN NORTH CAROLINA: A COUNTY-LEVEL ANALYSIS (Dec. 2014) *available at* http://www.wral.com/asset/news/State/nccapitol/2014/12/17/14288878/158632-Expanding_Medicaid_in_North_Carolina_12-15-14_EMB_r.pdf; Joan Alker et. al., FLORIDA'S MEDICAID CHOICE: UNDERSTANDING IMPLICATIONS OF SUPREME COURT RULING ON AFFORDABLE HEALTH CARE ACT, Health Policy Institute at Georgetown University (Nov. 2012), *available at* http://ccf.georgetown.edu/wp-content/uploads/2012/11/florida-medicaid-choice-nov-2012.pdf.

96. CMS May 20 letter, *supra* note 40 & *2015 STC*, *supra* note 24, at # 71(b)(ii) requiring but not defining "some."

97. CMS May 20 letter, *supra* note 40 & *2015 STC*, *supra* note 24, at # 71(b) distribution is based on eligible costs times percentage relevant to tier 2.

98. In 2014-15, Hillsborough received 6% of total Statewide LIP Funding; in 2015-16 5%; and in 2016-17 11%. For purposes of this report, we have used 8% as an average for extrapolation.

If Hillsborough has historically received an average of 8% of the total State LIP funding, we can extrapolate that Hillsborough will experience approximately 8% of the loss felt Statewide. It is estimated that the cumulative loss of LIP funding Statewide over 5 years is approximately $4.85 billion. 8% of $4.85 billion is approximately $388 million.