RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

June 2, 2015

Representative Richard Corcoran
418 The Capitol
402 South Monroe Street
Tallahassee, FL
32399-1300

Dear Chair Corcoran:

On May 22, the Agency for Health Care Administration (Agency) sent exhibits to the Centers for Medicare and Medicaid Services (CMS) that presented a new LIP and hospital reimbursement proposal for fiscal year 2015-16. That proposal was designed to respond to and be consistent with the federal reduction in LIP funding to $1 billion for the upcoming fiscal year as well as federal principles articulated over the course of the LIP negotiations. The Agency's goals with the proposal were to design something that retained the largest possible amount of current dollars within the system, was federally approvable, and that provided a transition in funding to hospitals most likely to be affected by the changes.

In its May 21 letter to the Agency, CMS stipulated that the LIP must be no larger than $1 billion for fiscal year 2015-16. Working within that constraint, the Agency's new LIP and hospital reimbursement proposal demonstrates that $909 million in local funding could draw down federal funds of just under $1.4 billion, to produce a total funding level of $2.3 billion. While this level of local funding is lower than the amount contributed in fiscal year 2014-15, it produces total funding of $1.3 billion over and above the CMS-authorized $1 billion for LIP. As long as this $1.3 billion can be maintained in the Medicaid hospital funding system, the impact of the changed LIP amount would be less dramatic.

CMS laid out principles which must be included in any LIP and hospital reimbursement proposal. The Agency believes it has met these principles without the need for further general revenue to offset any estimated loss. These principles include:

- More money should follow the patient and the service, rather than act as a supplemental payment to a source of local funding.
- Increased transparency in the system.
- Provider payment rates must be sufficient to promote provider participation and access.

In order to meet these principles, CMS is requiring the state to "de-link" Medicaid payments from its funding source. In other words, it isn't fair to pay some hospitals more money than others just because they have a local donor able to make a donation on their behalf. The proposal takes a substantial component of the current year LIP that was more directly related to the

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source of local dollars and more equitably distributes it through an industry-wide enhancement to Medicaid rates; assuring that money follows the patient.

The $1 billion distributed through LIP will remain associated with local donations, to ensure that the local donors do see a direct benefit to making the contribution with hospitals associated with local donors receiving 110 percent of the value of the local donation through LIP, *in addition to* higher payment rates when they provide services to Medicaid recipients. This figure of 110 percent mirrors the same rate of return that was in the original LIP model proposed by the Florida Senate. All additional funds generated beyond this $1 billion for LIP will flow through Medicaid managed care and DRG hospital inpatient rates, providing for a transparent process by which monies flow to those hospitals who provide services to the patients. The addition of any increase in funds that either fall outside of or attempt to manipulate these structural elements would conflict with the stated principles from CMS.

We must also caution against the extensive use of additional policy adjusters that would convolute the DRG system, as they undermine the equity and accountability built into the system. While well meaning, they often have the opposite effect. 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. Hospitals should have equal incentives to control costs and should compete for patients on an even footing with a minimum of government imposed distortions to the market.

To provide additional insight into how individual facilities might be affected by these changes, the Agency commissioned its DRG consultant, Navigant, to prepare simulations of payments with the higher inpatient payment rates. 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.

Not surprisingly, when a system changes its distribution of $1.3 billion to service-based payment, certain hospitals are modeled to receive lower overall funding. To mitigate that impact and provide "bridge funding" to those facilities, the Agency has shown one-year "transition payments" to affected hospitals, similar to those used when Medicaid moved to an inpatient DRG payment system in fiscal year 2013-14. Those transition payments are shown in the simulation results provided to CMS.

While the Agency continues to discuss this proposal with CMS, we believe that it balances the key federal considerations for approval with the goals to leverage local funding opportunities

and retain as much current funding in the system as possible, without showing a need for additional general revenue. The Agency would like to work with you on constructing a proposal for Medicaid financing to ensure we use taxpayer money in the most efficient manner possible. Please contact me at your earliest convenience.

Sincerely,

Elizabeth Dudek
Secretary