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Report

Florida Will Not See the Full $1.5 Billion in Federal Low Income Pool (LIP) Funding

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While the federal government has authorized total funding of $1.5 billion for Florida's uncompensated care pool, the state is unable to generate the required match to draw down all available federal funds. The Low Income Pool is an ongoing victim of politics at the federal, state and local levels. It is highly inefficient, unpredictable. and no substitute for expanding Medicaid to meet the needs of uninsured Floridians.

Introduction

Florida's Low Income Pool (LIP) is an uncompensated care fund. It was initially created in 2005 as a temporary measure to continue supplemental Medicaid payments to charity care providers, as Medicaid beneficiaries were transitioned to a new Medicaid managed care delivery system. After the passage of the Affordable Care Act (ACA) in 2010, however, health insurance coverage, rather than an uncompensated care pool, became the key vehicle for ensuring access to health care. This included Medicaid expansion for people in poverty, providing a guarantee of access to preventive and other medical care, and a stable source of funding for these services.

Given this paradigm shift, LIP has faced a rocky and uncertain future. Its existence and funding levels are the subject of ongoing political scrutiny and shifting political leadership at both the state and federal levels. Further, reliance on local funding to meet Medicaid state matching requirements has also made LIP a victim of local politics.

LIP History/Purpose Under the Bush Administrations

The LIP fund was originally created in 2005 as part of a five-county Medicaid waiver pilot project (under Section 1115 of the Social Security Act) to transition beneficiaries into a new Medicaid managed care program. The transition from fee-for-service provider reimbursement to capped monthly payments (capitated payments) to health maintenance organizations (HMOs) required that the state adopt a new model for making supplemental payments to

hospitals.[1] These payments were necessary to make up for insufficient Medicaid reimbursement, particularly for safety net providers serving primarily low-income communities.

The fund was envisioned as a "stopgap measure" to provide *temporary* financial assistance to charity providers until Medicaid managed care evolved into a statewide delivery system with new provider reimbursement methodologies.[2]

As part of a 1115 Medicaid pilot project, the LIP program required approval by the federal Centers for Medicare and Medicaid Services (CMS) with special terms and conditions (STCs) negotiated between the state and federal governments. Under this process, all discretion on waiver approval resides with the federal government.[3] Governor Jeb Bush put his full backing behind the proposal and it was approved by CMS in record time (eight business days) under the administration of his brother, George W. Bush.[4]

The original purpose of the LIP program, as specified in the STCs, is to:

"provide supplemental funding to hospitals, clinics and other entities to improve access to health care services in rural communities; and ensure continued government support of the provision of health care services to the uninsured and underinsured."[5]

The original waiver terms covered a five-year period, from 2006 to 2011, with total LIP funding at $1 billion per year.[6] However, consistent with the overall Medicaid program funding model, the state was required to contribute nearly 40 percent of this amount to draw down all available federal dollars.

Since LIP's inception, the state share has been raised through intergovernmental transfers (IGTs), or funds from counties, hospital taxing districts, municipalities and providers operated by state or local governments.[7] These transfers are "optional contributions," so Medicaid payment methods were originally devised to guarantee a return on investment for local funds contributed.[8] Specifically, IGT participants donated on behalf of particular hospitals within their jurisdictions, and Medicaid payment methods ensured that payments to these named hospitals offered more value than keeping the funds within their local districts. The resulting draw down of federal matching funds generated enough dollars to offer a return on investment to the named hospitals and still have additional funds available to distribute among other hospitals and some non-hospitals.[9] But the greatest benefit was provided to hospitals in regions in which local IGT funds were contributed.[10]

LIP Under the Scott and Obama Administrations: Uncompensated Care Pools vs. Coverage

Under the Obama Administration, CMS's actions on LIP were largely driven by the passage of the ACA. Under the ACA, states were required to expand their Medicaid programs to cover

families and individuals at or below 138 percent of the federal poverty level. In 2017, the limit represents $16,643 annually for an individual and $33,948 annually for a family of four. The expansion was effective January 1, 2014. However, in 2012, the expansion requirement was struck down by the U.S. Supreme Court, which held this provision to be unconstitutionally "coercive" for states. After the decision, Medicaid expansion became a state option.[11]

To date, Florida has rejected Medicaid expansion, leaving more than 500,000 low income Floridians in the coverage gap. These individuals earn too much to meet Florida's very restrictive Medicaid income limits, but not enough income to get government subsidies to purchase private health insurance.

When Florida's waiver program came up for renewal in 2011, LIP was approved for three years at the same funding level of $1 billion annually, but with some modified waiver terms. While its purpose continued to be providing "government support for safety net providers that furnish uncompensated care to the Medicaid, underinsured and uninsured populations…" for the first time, access to these funds was tied to providers meeting certain quality milestones.[12] CMS also required the state to set aside $50 million in total LIP funding to include support of primary care start-up initiatives and to enhance existing primary care programs.[13]

During the next round of the 1115 waiver renewal in 2014, the future of LIP funding became highly uncertain. It became ground zero for playing out the political differences between federal and state leadership on how to best serve Florida's low-income uninsured population. While CMS provided a three-year approval of the Medicaid managed care portion of the 1115 waiver, LIP was only approved for one year through June 30, 2015.[14] During this time, the state was required to conduct an independent review of its provider payment system and funding methods with the goal of developing a sustainable, transparent and actuarially sound payment system providing quality health care to Medicaid beneficiaries *without LIP.* In the interim, just for state fiscal year (SFY) 2014 to 2015, total LIP funding increased from $1 billion to $2.17 billion because additional funds for hospital rate enhancements and supplemental payments for physicians' groups affiliated with medical schools were shifted into LIP. [15]

In April 2015, shortly before the scheduled expiration of LIP, CMS reiterated in a letter to the state Agency for Health Care Administration (AHCA) that LIP was a time limited demonstration which would not continue in its current form, and that new principles would be used to review the state's proposal to continue the program. This included the benchmarks that:

- coverage rather than an uncompensated care pool is the best way to secure access to health care for low income individuals;
- LIP funding should not pay for costs that would be covered in a Medicaid expansion; and
- provider payment rates must be sufficient to promote provider participation.[16]

In response, the state filed a lawsuit against the federal government claiming that the state was being coerced into expanding the Medicaid program in violation of the Supreme Court's

decision.[17] A settlement was reached under the following terms: a) for SFY 2015-16, a reduction of LIP from $2.17 billion to $1 billion; and b) for SFY 2016-17 a further reduction from $1 billion to $608 million.[18] Notably, for SFY 2016-17, the Legislature agreed to spend $400 million in state general revenue dollars for hospital rate enhancements to help make up for the lost LIP dollars.[19]

The stage was then set for another showdown between the state and federal government when the overall 1115 waiver program, including LIP, was due to expire July 2017.

LIP Under the Scott and Trump Administrations: Uncompensated Care Trumps Coverage

In December 2016, after President Trump was elected, the state submitted another five-year 1115 waiver renewal proposal, which included a request to continue LIP. When Florida's Legislative Session began on March 1, 2017, CMS had not acted on this request and LIP funding was expiring on June 20, 2017. On top of this uncertainty, Florida hospitals were facing millions of dollars in proposed Medicaid cuts. [20]

Shortly before the end of session, Governor Scott announced that he had reached a deal with the federal government to continue the LIP program for five years at an increased funding level of $1.5 billion annually. Governor Scott took that opportunity to take another jab at the previous Administration's prioritizing of coverage over uncompensated care pools: "Florida was on the front line of fighting against federal overreach under President Obama…it is refreshing to now have a federal government that treats us fairly and does not attempt to coerce us into expanding Medicaid."[21]

However, the details of Governor Scott's deal on LIP funding were not shared with legislators. This uncertainty, during a time when legislative session was ending, is reflected in Senate Bill 2514 (Chapter 2017-129, Laws of Florida) which provided statewide policies to implement the healthcare provisions contained in the state budget. While the bill authorized AHCA to spend $1.5 billion in LIP funds for FY 2017-18, these funds must be held in reserve pending adoption of a budget amendment by the Legislative Budget Commission to release the funds. The proposed amendment must include the reimbursement and funding methodology, including a proposed distribution model and listing of entities contributing IGTs to support the state match. If the Chair and Vice Chair of the Legislative Budget Commission object, or if the Senate President and House speaker object in writing to the proposed amendment within four days after notification, the governor "shall void the action." In addition, if the IGT funds are not available, "the State of Florida is not obligated to make payments" under LIP. [22]

On August 3, 2017, CMS announced its formal approval of Florida's overall waiver renewal request. The only terms that changed pertained to the LIP program. The new terms reverse the previous Administration's decision to not provide LIP dollars for uncompensated care costs attributable to the state's failure to expand Medicaid under the ACA. Instead, the state is authorized to use these funds "for costs associated with uncompensated care furnished through a charity care program for individuals with incomes up to 200 percent of the FPL…." LIP

can only be used for uninsured individuals, but not for the underinsured who, for example, are unable to afford deductibles and coinsurance. The new terms also permit the state to set aside $50 million in LIP funds for federally qualified health centers and rural health centers (FQHCs/RHCs).[23]

However, some of the current terms carry over Obama-era policies. LIP cannot be used to cover bad debt or shortfalls in Medicaid reimbursement rates. Also, LIP funds must be distributed to providers based on their level of uncompensated care rather than simply an ability to finance the non-federal share through IGTs. [24] Thus, there is no guarantee that the money local entities provide through IGTs will be returned in a dollar-for-dollar match to their communities.

The terms also specify that LIP providers are categorized into one of three groups: hospitals, medical school physician practices and FQHCs/RHCs. Hospitals may be divided into up to five tiers based on a combination of ownership status, statutory teaching hospital designation, children's hospital designation and uncompensated care (UC) ratio (amount of a provider's uncompensated uninsured charity care costs expressed as a percentage of its privately insured patient care costs.) Providers in tiers with a lower range of UC ratios cannot be paid a greater share of their charity care cost than providers in tiers with higher UC ratios.[25]

All providers must comply with certain participation requirements. Hospitals must contract with at least 50 percent of standard Medicaid health plans in their region, including at least one specialty plan, they must be enrolled as Medicaid providers and they must have a minimum of at least 1 percent Medicaid utilization.[26]

The FQHCs/RHCs are required to contract with all health plans in their region. They must also agree that the supplemental wrap-around payments, previously paid to them by the state, will now be included in plan capitation rates and paid to the FQHC/RHC by the plans.[27] These payments cover the difference between what managed care plans pay health clinics and the rate the federal government says the clinics should be paid to meet their "reasonable costs" for providing services.[28] This new reimbursement model has been controversial with the centers, as discussed in greater detail below.

Current Status of LIP: $1.5 billion is not really $1.5 billion

The new LIP dollars were pitched as a way to offset the $521 million in Medicaid hospital cuts ultimately passed by the Legislature in 2017.[29] However, to access the full amount of the $1.5 billion LIP allotment, local entities must raise $559 million in matching funds. That is not going to happen.

Instead, AHCA's proposed funding model is based on historical IGT contributions, far less than what is required to draw down all the federal funds. Thus, for FY 2017-18, total LIP funding is projected at $790 million, including $487 million of federal funds and $303 million in IGT funds. Under the distribution model $654 million is directed to 204 hospitals, $85 million to eight

medical faculty teaching practices and another $50 million to a yet undetermined number of FQHCs/RHCs.[30]

The IGT funding shortfall means that just over half of the LIP funding is actually available for Florida uncompensated care. As Senator Anitere Flores, Chair of the Senate Health and Human Services Appropriations Committee, has recently stated, "$1.5 billion is not $1.5 billion." [31]

Another controversy impacting whether the state will draw down all the federal funds relates to the $50 million set aside for FQHCs/RHCs. To tap into this funding these providers must agree to access other supplemental "wrap around" funding through the health plans instead of the state, as they have been paid in the past. The centers have expressed great concern over this change because of historical difficulties in getting timely payments from plans. Some centers have indicated that they may walk away entirely from these funds since their costs to access the funds will exceed the pay off.[32]

Recognizing this year's delay in finalizing the special terms and conditions for LIP, the governor and AHCA have extended key deadlines. Local entities were required to submit letters of intent committing to IGTs by November 15 instead of the usual October 1 deadline. Instead of October 31, locals had until December 15 to actually pay IGT funds to AHCA. [33] So well into the current state fiscal year, the exact amount of available IGT for LIP funding remained uncertain.

Conclusion

Florida's health care system faces the ongoing pressures of more than $2.4 billion annually for uncompensated care,[34] as well as the costs of 2.6 million uninsured residents.[35] LIP is not a health coverage program: it doesn't expand coverage to the uninsured or bring more participating providers into the Medicaid program. It simply reimburses providers for uncompensated care.[36]

Federal LIP funding is substantially less than the billions of federal Medicaid dollars that Florida could be drawing down to provide real coverage through Medicaid expansion. And for this fiscal year, LIP is even smaller than originally touted because the state is unable to raise through IGTs the full required match. Since the new federal waiver terms continue to ban a guaranteed return to local providers on local investment, it is highly questionable whether more IGTs can be raised in the future.

LIP funding still largely depends on difficult decisions at all levels. This is a highly unpredictable and inefficient way to fund the health care needs of millions of uninsured Floridians.

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