FLORIDA LEGAL SERVICES, INC.

MEDICAID SAFETY-NET FUNDING ISSUES:

IMPLICATIONS FOR COUNTIES AND LOW-INCOME UNINSURED FLORIDIANS

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JANUARY 2016

EXECUTIVE SUMMARY

Governor Scott and House leadership have indicated that they will not consider accepting federal funding under the Affordable Care Act for coverage of approximately one million low-income adults ("expansion funding"). This refusal shifts the issue of paying for the care of uninsured Floridians from Tallahassee to counties. Because low-income, uninsured Floridians depend on local safety-net providers for needed medical care, county leaders need to understand how and why safety-net funding is changing. This brief explains the background, status, and changes to the safety-net's funding streams: the Low-Income Pool, Rate Enhancements, and the Disproportionate Share Hospital Program; as well as the role of Inter-Governmental Transfers.

The brief also analyzes both the negative economic impact from scheduled funding reductions and the positive financial impact if federal dollars are accepted to purchase coverage for uninsured adults. Finally, the brief highlights key issues county leaders should consider in light of imminent funding changes. Along with this brief addressing a state-wide analysis, the authors are releasing a brief focusing on Miami-Dade County, the county with the highest number of uninsured adults eligible for expansion coverage and the safety-net providers most impacted by LIP cuts.

Why the Low Income Pool (LIP) is being significantly reduced and restructured?
The LIP, which began in 2006 as part of a "waiver" agreement between Florida and the federal agency administering Medicaid (CMS), has been the major source of safety-net funding in Florida. The overarching purpose of Florida's "waiver" was to shift beneficiaries into managed care organizations, and the LIP's purpose was to provide support for local safety-nets through "supplemental payments" during the transition.

It was logical and expected that LIP would end. After the move to managed care was completed in 2014, Florida and CMS agreed that the 9 year old LIP program would end on June 30, 2015. Moreover, given that states can now use federal funds to cover low-income adults under the ACA, CMS established uniform principles for reviewing any state waiver requests. Those principles include the fact that *coverage is a much better use of public funds than uncompensated care pools such as the LIP*.

Although "waivers" are negotiated between a state and CMS, all of the discretion rests with CMS. Nonetheless, Florida sought to maintain its $2.167 billion LIP program, and in April 2015, Florida officials sued CMS for alleged "coercion" during negotiations over the LIP. After the lawsuit was dismissed, the parties agreed to reduce LIP by over half for FY 2015-16, and by 75% for 2016-17.

How is the new LIP program different?

In October 2015, CMS announced new waiver terms establishing a complex structure for disbursing future LIP funds based on the hospitals' ratio of uncompensated care to compensated care. While it is not yet clear how the disbursement will operate in terms of the amount of LIP dollars individual hospitals will receive, two major changes are clear:

1) the size of the LIP program can *only* include the cost of reimbursing providers for treating patients who are currently uninsured *and would not be covered even if the state accepted expansion coverage*, e.g. state residents ineligible for Medicaid due to immigration status; and 2) LIP funds can only be used for verifiable charity care, meaning LIP funds can no longer be used to make up alleged or actual shortfall in the Medicaid reimbursement rate. Additionally, LIP recipients must have a charity program that conforms to federal standards.

Economic impact of the LIP reduction "will be felt." In April 2015, Florida's state economist described the LIP program as federal dollars that are "helicopter dropped" into the state. The 75% reduction of LIP funds in 2016-17 represents a $4.85 billion loss over 5 years. This loss of federal dollars translates into an $8 billion reduction in state GDP, 15,000 lost jobs, and an $8.25 billion loss in personal income.

Disproportionate Share Program: The Medicaid Disproportionate Share Hospital Program (DSH) provides additional financial support to hospitals that serve a "disproportionate share" of the poor. Florida's current annual DSH funding is almost $240 million. Under the ACA, the DSH program was significantly reduced because Congress intended that the ACA's provisions for Medicaid expansion would considerably reduce the number of uninsured individuals. Florida's safety-net providers face the potential loss of DSH revenue, commencing in 2017.

Rate enhancements (RE) are *not* guaranteed payments like LIP and DSH
Under a managed care system, rate enhancements are a projection–not an appropriation or supplemental payment like LIP or DSH. Rate enhancements depend on 2 major variables: 1) the extent to which managed care plan 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 plans' enrollees actually receive "enhanced rate" services at that hospital. Thus, individual hospital rate enhancements should not be reported in the "net payment" column in the *hospital funding tables*. This is significant if a county is counting on rate enhancement "dollars" as part of the budget for indigent care at the county's safety-net.

Funding for safety-net programs through Intergovernmental Transfers (IGTs) has fundamentally changed. Funding for safety-nets through LIP, DSH, and RE is, like all Medicaid services in Florida, based on a federal/state match, with the federal government providing roughly 60% of the cost and the state the other 40%. (Notably, funding for the expansion population has a much higher federal match rate, starting at 100% and gradually reducing to no less than 90% over 10 years). However, unlike other Medicaid services and programs, the state match portion of safety-net funding comes from local communities—rather than general revenue. These local funds, which are generated in various ways, must be submitted to Tallahassee from a governmental agency in the name of a specific hospital. In FY 2014-15 counties contributed over $1 billion in IGTs.

Prior to the 2015 session, and the new federal agreement governing LIP, 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 a significant dollar increase, ranging between 8.5% and 147%, as well.

However, as of FY 20216-17, there is no longer a guaranteed rate of return in the LIP program—much less such a lucrative rate. Further, during the 2015 session it became clear that IGT funded rate enhancements were not a sound investment for counties in the new managed care environment. Thus, the amount that counties will submit to Tallahassee, and which the state had been using to draw down the 60% federal match, has been tremendously reduced. In sum, the ability of IGTs to leverage substantial amounts of enhanced funding for the state and counties is over.

Gain to county health care providers with federal expansion funding:
The 5-year economic gain *just* to health care providers—not counting multiplier effects in the economy or other savings to budget, e.g. reduction in medically needy program or revenue from newly created jobs—is over $22 billion. Those dollars, which would be paid to health care providers for services to the newly insured, would be virtually all federal dollars.

Impact on county low-income county residents without insurance:
Even if rate enhancement numbers could be counted on as actual income (which they cannot), and even if DSH is not cut, the cuts to LIP are so deep that it will be impossible for even well funded local safety-nets, such as Jackson, to maintain even limited charity care programs without significant additional funds**.**

Questions for County Leaders and Stakeholders:

- Whether services for uninsured county residents under local charity care program(s) will remain the same or be reduced; and if the decision is made to maintain the program(s) at current level, what will be the necessary increased local revenue source?
- What should be done with local funds previously submitted to Tallahassee on behalf of specific local providers as IGTs?
- Given that future LIP dollars can only be used for verifiable "charity care," what consumer protections should be provided to uninsured county residents who are eligible for charity care programs at local LIP recipient hospitals?
- Can local dollars be used to leverage additional funds for delivery system reforms related to improving outcomes and lowering costs?

Conclusion: Changes to the amount and the structure of Medicaid safety-net funding in FY 2016-17 will have a significant adverse impact on local economies and providers serving low-income insured and uninsured county residents. This brief will assist county leaders and local stakeholders in addressing how to fund and deliver health care for uninsured county residents.

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I. Introduction

Low-income, uninsured Floridians depend on safety-net providers for needed medical care. The 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. The anticipated end of the LIP, along with the opportunity to cover almost 1 million low-income uninsured Floridians with mostly federal dollars, prompted the 2015 Florida Legislature to consider a coverage plan developed by the state Senate.[1] In an unprecedented special session, the Legislature ultimately rejected the plan (the Sen. voted 33 to 3 in favor; the House voted 72 to 41 against).

While LIP was not eliminated entirely, the program's structure was changed, the amount greatly reduced, and coverage of the uninsured was left unresolved. Unless the Governor and House leadership reconsider their position and accept federal funding under the Affordable Care Act (ACA) for coverage of low-income adults[2] (also referred

to as "expansion funding"),[3] the issue of paying for the care of low-income uninsured Floridians will shift from Tallahassee to counties—at least in the short term.

Funding for safety-net providers is critical–both in terms of ensuring some level of health care access for uninsured state residents, as well as the impact of that funding on the local economies. This brief explains the background, current status, and future changes to the safety-net's funding streams: the Low-Income Pool, Rate Enhancements, and the Disproportionate Share Hospital Program, as well as the role of Inter-Governmental Transfers. The brief will also discuss the negative impact on the economy as a result of scheduled LIP reductions over the next five years and the positive financial impact on the Florida's health care providers if federal expansion dollars are accepted to purchase coverage for the state's uninsured adults. Finally, the brief highlights key issues local leaders should consider in light of imminent changes to safety-net funding.

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[4] (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").[5] 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 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 to ease the transition to managed care.[6]

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 in both federal and state funds to support safety-net providers throughout Florida.

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 the LIP. In July 2014, the Centers for Medicare and Medicaid Services (CMS) announced it would grant a three-year extension of the 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 supplemental payment authority which will be extended through June 20, 2015."[7]

It was not unexpected that the LIP program was scheduled to end. First, the program is entirely discretionary, and all of the discretion rests with the Secretary of HHS.[8] 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. As noted in the CMS July 2014 letter referenced above, 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."[9]

Also, as early as 2008, the Secretary of HHS was informed that the LIP program was "problematic" and lacked "fiscal integrity."[10] Those concerns were reiterated in a 2015 independent report.[11] Moreover, the LIP began before the Affordable Care Act (ACA) established an opportunity for states to expand coverage to nearly all low-income adults.[12] 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 is worth noting that there were never sufficient LIP dollars–even at the 2014 height of the program–to reimburse safety-net providers for the cost of treating the uninsured. For example, in response to a 2014 complaint from low-income Miami-Dade residents who were eligible for charity care at Jackson Memorial, the publicly funded hospital, officials explained that funding for covering the cost of uncompensated care is inadequate.[13] Jackson officials reported that 29,176 county residents were served under the hospital's charity care program at a cost of $365 million.[14] That number included 6,000 who would be ineligible for federal expansion funding due to immigration status.[15] The remaining 23,000 county residents enrolled in the hospital's charity care program represent only approximately 25% of county residents who are in the "coverage gap"[16] and less than 15% of those who would be eligible for coverage if the state were to accept federal expansion funding.[17]

2. 2015 Negotiations and Litigation

On April 14, 2015, CMS sent a letter to Florida's Deputy Secretary for Medicaid, reiterating that LIP was a "time-limited demonstration," and reminding the state that "last year CMS made clear that LIP would not continue in its current form." The letter also 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."[18] The letter also articulated principles CMS would apply in reviewing Florida's LIP proposal:

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;[19]
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.

On April 15, 2015, the state Medicaid Director sent a response letter to CMS expressing concern that the federal government was "coercing" the state into expanding Medicaid in violation of the Supreme Court's decision in *NFIB v. Sebelius*.[20] Shortly thereafter, Governor Scott filed a lawsuit against the federal government for alleged coercion.[21] The lawsuit asked the federal court to order CMS to continue funding Florida's LIP program. The editorial boards of the state's major newspapers criticized the lawsuit, reiterating their opinion that the state should accept federal expansion funding.[22]

On April 20, 2015, the state filed a formal amendment to the Waiver seeking to renew LIP for two years at the current funding level.[23]

On May 21, 2015, the day before the Department of Justice brief defending the federal government was due, CMS sent a letter reiterating the new CMS principles in response to the state's April 20th LIP extension request.[24] The letter proposed a one-year reduction of LIP by approximately $1 billion (a 55% reduction), with a further reduction to $608 million the following year (a 75% reduction from FY 2014-15). The letter also reiterated the concern that Florida's Medicaid rates are too low.[25] While underscoring the new principles that provider rates must be sufficient and noting that LIP dollars could no longer be shifted to rates,[26] CMS also reminded the state that it could obtain additional federal revenue through increasing payment rates. The rate increases would allow the state to draw down additional federal matching dollars—separate and apart from LIP—which would generate additional funds for providers serving Medicaid beneficiaries. The letter stated that rate increases, which would affect both fee-for-service and managed care payments to hospitals, "would better support providers in delivering care to Medicaid beneficiaries by addressing any shortfall in payment rates."[27]

On June 23, 2015, CMS sent a final letter memorializing discussions on the amount of the LIP and the methodology for distribution during the next two fiscal years.[28] The lawsuit was dismissed, and the 2015 Legislature concluded the special session with a reconfigured allocation of funding related to each of the state's hospitals.[29]

3. Current and Future Status

Overall, state LIP program funding in FY 2015-16 was reduced by over half. Moving forward, and consistent with CMS' principles, the LIP will 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.[30] In FY 2016 LIP is scheduled to be further reduced to $608 million, approximately a 75% decrease from its peak of over $2.167 billion FY 2014-15. Put another way: Florida tax payers and providers will be absorbing the cost of treating (most likely through hospital emergency rooms) uninsured Florida residents whose coverage could have been purchased almost entirely with federal funds, *and* they will be doing so with far less funding than has been available since LIP began in 2006.

On October 5, 2015, CMS announced its new Special Terms and Conditions (STC), which include a complex structure and procedure for dispersing the reduced FY 2016-17 LIP funds. The STC allows the state flexibility to establish a "tiering" system whereby the state could divide hospitals into up to four tiers and allocate LIP funds based on the hospital's ratio of charity care to compensated care.[31] It is not yet clear how the new LIP disbursement structure will be established and function.

However, it is clear that there will be major changes in the 2016-17 LIP program. First, 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. The care must be provided through a charity care program administered by the hospital in compliance with specific federal principles.[32] Providers that receive LIP funds can no longer use those funds to cover Medicaid "shortfall"[33] or insufficient rates, as in the past.[34] This is a logical and expected change—especially in light of 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.[35] 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). Thus, the rates paid by the state to plans must be sufficient such that the plans can ensure "provider participation and [consumer] access"[36] and hospitals can no longer use LIP funds to make up for any alleged or actual "shortfall" in their rates.[37]

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 had accepted Medicaid expansion funding.[38] And finally, the state can only make LIP distributions based on the ratio of charity care to commercial pay; LIP distributions are no longer be based on a guaranteed return.[39] Again, it is not yet known what the individual hospital distributions will be for 2016-17 based on the scheduled LIP reduction to $608,000,000.

B. Disproportionate Share Hospital (DSH) Program

Congress established the Medicaid Disproportionate Share Hospital Program (DSH) in the early 1980s[40] to provide additional financial support to hospitals that serve a "disproportionate share" of the poor.[41] Florida's current annual DSH funding is almost $240 million. 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.[42] The Supreme Court's decision that states were not required to expand Medicaid[43] 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,[44] Florida's safety-net providers face the additional loss of DSH revenue, commencing in 2017 with the loss increasing over the next seven years.[45] Further underscoring the risk to uninsured residents who rely on the safety net is that the Governor's budget proposes a new DSH distribution which would adversely impact DSH funding for statutory teaching hospitals such as Jackson and Mount Sinai.[46]

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 the state's major safety-net hospitals).

	IGTs			Distributions							
Provider Name	DSH IGTs	Total LIP, SWI, Rate Enhancements	Total All IGTs	Total All LIP Payments	DSH Payments	Rate Enhancements: Inpatient DRGs and Outpatient Exemptions	Rate Enhancements: Outpatient Buy-backs	Increase in DRG Rates	GME Add	Total All Payments	Net Payments
BROWARD HEALTH - BROWARD GENERAL MEDICAL CENTER	12,144,796	36,230,408	48,375,204	60,159,933	24,761,508	24,100,891	11,175,249	9,226,101	705,324	130,129,006	81,753,802
JACKSON MEMORIAL HOSPITAL	32,804,082	184,586,579	217,390,661	250,052,007	66,367,766	84,249,293	21,006,892	24,388,868	34,910,250	480,975,076	263,584,415
LEE MEMORIAL HOSPITAL	4,005,336	17,979,174	21,984,510	36,522,512	8,579,513	18,692,564	1,639,755	5,536,259	303,474	71,274,077	49,289,568
MEMORIAL REGIONAL HOSPITAL	11,159,571	35,244,335	46,403,907	60,882,660	22,577,551	24,225,007	10,264,735	12,142,915	429,262	130,522,129	84,118,222
TAMPA GENERAL HOSPITAL	3,322,203	-	3,322,203	32,077,129	9,033,361	38,719,354	-	12,476,868	2,795,752	95,102,465	91,780,262
UF HEALTH JACKSONVILLE	4,711,475	-	4,711,475	49,456,602	13,520,613	21,363,900	11,642,944	8,954,120	3,170,451	108,108,630	103,397,155
UF HEALTH SHANDS	-	15,000,000	15,000,000	28,211,678	13,524,503	43,385,941	8,294,766	15,369,509	23,162,002	131,948,399	116,948,399
TOTAL	68,147,463	289,040,496	357,187,960	517,362,521	158,364,815	254,736,950	64,024,341	88,094,640	65,476,515	1,148,059,782	790,871,823

For example, in FYI 2016, Jackson will receive $250,052,007 in LIP and $66,367,766 in DSH. However, while listed alongside LIP and DSH, the hospital's specified "rate enhancement" amounts of $84,249,293 (inpatient), $21,006,892 (outpatient), and $24,388,668 (DRG rates) are fundamentally different. Unlike LIP and

DSH, the rate enhancement dollar amounts are embedded in individual fee-for-service and MCO rates, and do not represent guaranteed payments to the hospital.[47]

Rather, hospital rate enhancements represent a projection, or "simulation."[48] 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.[49] 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 Managed Care Organization's (MCO) enrollees actually receive "enhanced rate" services at that hospital. As the Secretary for the Agency for Health Care 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...*").[50]

Thus, it is somewhat misleading for the column labeled "Net Payments" to include rate enhancements as a "payment" to the hospital, along with LIP and DSH.[51] 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.[52]

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

1. LIP

As noted above, the state match portion of the LIP program has largely been funded through local funds sent to Tallahassee as Intergovernmental Transfers (IGT).[53] These local funds, which are generated in various ways, including local taxing districts

and local indigent care surtaxes[54] must be submitted to Tallahassee from a governmental agency in the name of a specific hospital.[55]

Prior to the 2015 session and the new agreement governing LIP, 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 a significant dollar increase, ranging between 8.5% and 147%, as well.[56] Not surprisingly, counties with greater resources and access to local indigent care funding, contributed most of the IGTs and received most of the LIP dollars.[57] For example, in 2014-15, Miami-Dade and Broward Counties contributed over 75% of the total amount of IGTs and received over 50% of the total amount of LIP payments.

In 2016-17, the LIP is scheduled to decline to approximately $600 million. Accordingly, the state match for the LIP will be reduced to approximately $240 million, which represents the state's share of the total LIP program funding.

2. DSH

IGTs are also used to fund the state match for the DSH program. In FY 2014-15, more than $97 million in IGTs, were submitted to Tallahassee to fund the DSH program.[58] The state-wide total contribution was reduced to approximately $90 million in 2015-16.[59] This will decrease further if the DSH reductions commence as scheduled in 2017.

3. Rate Enhancements

Prior to 2015, IGTs were also used to support "rate enhancements."[60] Also, as with the LIP, there were tremendous local incentives to maximize IGTs in order to

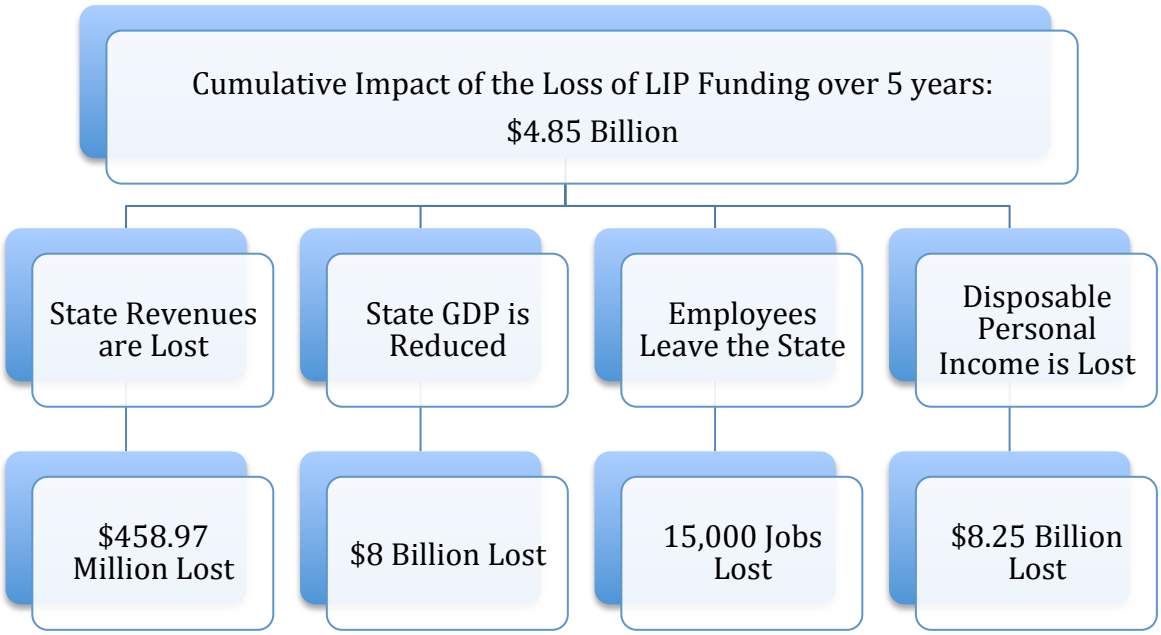
increase payment rates to local hospitals.[61] However, as discussed, the dollar amounts for rate enhancements listed in the *Hospital Funding Tables* are merely projections. In a managed care environment, counties cannot be assured that their IGTs submitted for rate enhancements will be returned to the designated provider. As noted during the the April 2015 Senate workshop on Medicaid sustainability, "self-funded (i.e. 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."[62] Counties responded to this lack of guarantee by not submitting IGTs for 2015-16 rate enhancements.[63] Instead, in 2015-16, the state legislature (for the first time) provided significant general revenue ($400 million) for rate enhancements.[64] It is also unclear if $400 million in general revenue will again be allocated by the 2016 Legislature.

III. Economic Impact of LIP Reduction

On April 21, 2015, the Legislature's Office of Economic and Demographic Research (EDR) released an Impact Analysis regarding LIP, IGTs, and the state Senate's plan to draw down federal funds available under the ACA to provide health care coverage to low-income uninsured Floridians.[65] Dr. Amy Baker, Chief Economist for EDR, explained how the federal funds for Florida's LIP program function like a "*helicopter drop*" of federal dollars into the state and detailed how the reduction in LIP funds would lead to loss of jobs and revenue, as well as program closures.

Over the course of five (5) years, approximately $6.5 billion in federal dollars will be lost if the LIP were eliminated.[66] In adjusting this data to reflect a 75% reduction, the

cumulative loss of LIP funding over five (5) years is approximately $4.85 billion. Dr. Baker's testimony concluded that the LIP loss "is a big enough change to the economy that we can see it. We will feel it. We will know it."[67] Her slides included a chart illustrating losses based on the then scheduled elimination of LIP, and the chart below is adjusted to reflect a 75% reduction in LIP dollars.



In sum, this reduction in the amount of federal dollars being "*helicopter dropped*" into the state translates into the following losses for Florida's economy:

- $459 million in state revenue;
- $8 billion in GDP;
- $8.25 billion in personal income,
- 15,000 jobs.

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

The scheduled reduction of LIP and DSH funding would be more than offset if the Florida Legislature accepts federal funding to expand coverage for uninsured low-income adults. According to the EDR's April 2015 data, nearly 1 million (951,826) people would be eligible for expansion coverage, [68] 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 are in the coverage gap.[69]

The Social Services Estimating Conference previously predicted that coverage of the expansion population over ten years would result in a net influx of over $50 billion in federal funding over ten years to cover the cost of health care for the newly enrolled.[70] This data was derived by estimating the per member per month cost of health care coverage for a childless adult multiplied by the number of newly eligible adults in the Medicaid expansion population expected to enroll.[71]

The same methodology can be applied to estimate the potential annual net revenue gain to Florida health care providers if the Legislature accepts funding to expand coverage to uninsured low-income adults in the coverage gap. 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)[72] is more than $ 23 billion.[73] This new revenue, which is almost entirely comprised of federal tax dollars,[74] far exceeds the five (5) year cumulative loss of Florida's federal LIP dollars.

Again, this data only represents the increased revenue that 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 state residents by virtue of having insurance–as opposed to relying on hospital emergency rooms and underfunded charity care programs.[75] Nor does it include any of the positive multiplier effects to the state economy from the new revenue local health care providers can expect. Recent 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 are drawn down.[76]

V. Conclusion: Issues for Florida Counties to Consider

Paying for the care of low-income uninsured Floridians will shift from Tallahassee to local counties—at least in the short term if Florida continues to refuse to accept federal Medicaid dollars. Given the currently scheduled reduction of the LIP, $4.85 billion of federal Medicaid dollars will no longer be "helicopter dropped" into Florida over the next five years. [77]

Stakeholders should understand that the ability to use local IGT dollars to leverage federally matched and enhanced funding for county health care providers has been fundamentally altered, and that IGTs are no longer used to fund hospital rate enhancements. They should also understand the budget implications to the counties with large safety net providers. For example, the $105,256,185 of RE dollars for Jackson listed as "distributions" and "net payments" by the Legislature represent simulations that are

subject to major variables rather than "net payments" to the County's publicly funded safety-net.

County leaders should understand how many of their uninsured residents are eligible for expansion coverage and how much new revenue health care providers would gain over five (5) years if those individuals received coverage. Finally, local leaders and stakeholders should understand the positive multiplier effect of how that increased revenue would impact the local economy.

Important questions for local leaders and stakeholders include:

- Whether services for local indigent health care under current local charity care programs will remain the same or be reduced; and if the decision is made to maintain the local charity care programs at least at their current level, what will be the necessary increased local revenue source?

- Can the county retain all previously collected local tax revenue used for IGTs and direct these dollars to designated providers and programs rather than submit the tax dollars to Tallahassee? Under the state law establishing this taxing authority, it is not clear that all counties that were supporting local LIP programs, e.g. Hillsborough, through local sales surtax, can retain those funds. The Florida statute authorizing counties to impose a discretionary sales surtax for indigent care and trauma centers states that "[m]oneys collected pursuant to this paragraph remain the property of the state."[78]

- Assuming the county continues its local funding and is able to retain those funds, how should local dollars previously submitted to Tallahassee on behalf of providers eligible for LIP and/or DSH payments be allocated in terms of specific providers and program?
- Given that future LIP dollars can only be used for verifiable "charity care," what consumer protections should be provided to uninsured county residents who are eligible for charity care programs at local LIP recipient hospitals in order to ensure that the consumer is not subject to any collection action related to the event reported as "charity care"?

- Can local dollars be used to leverage additional funds for delivery system reform, including programs related to addressing the social determinants of health, [79] and/or aimed at improving outcomes and lowering costs?

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 local economies and providers serving low income insured and uninsured county residents. Thus, it is critical that stakeholders both individually understand, and publicly discuss, how to fund and deliver health care for uninsured local residents.

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January 20, 2016

[1] FL. SB 7044, *available at* http://www.flsenate.gov/Session/Bill/2015/7044.

[2] 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,
[2] 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.

[3] Under Medicaid, costs are shared between the federal and state governments. The federal government covers approximately 58% of all Medicaid costs in Florida. This percentage is referred to as the federal matching rate or "FMAP." In contrast to 58% FMAP for the current Medicaid population (including a 58/42 federal/state match for LIP), the ACA requires 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. Florida Legal Services, *Medicaid Funding Losses to County Safety-Net Providers: Federal Funding Extending Coverage Would Offset* (Apr. 27, 2015) [hereinafter the *2015 South Florida Report], available at* https://flshealthblog.files.wordpress.com/2015/03/miami-dade-lip-report-april-27-2015_update_final1.pdf.

[4] 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.

[5] *See* Fla. Stat. § 409.91211(1)(c).

[6]Ctrs. for Medicare & Medicaid Servs., *Medicaid Reform Section 1115 Demonstration – Special Terms and Conditions*, 7-8, 24 (2006) ("2006 Waiver Terms and Conditions").

[7] 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*].

[8] *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994) (citation omitted); *see also, e.g., Aquayo v. Richardson*, 352 F. Supp. 462, 470 (S.D.N.Y. 1972), aff'd, 473 F.2d 1090 (2d Cir. 1973).

[9] *CMS July 2014 Letter, supra* note 7, at 103.

[10] 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).

[11] 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.

[12] 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

[13] Daniel Chang, *Advocates for poor say Jackson Health System bars needy from charity care*, MIAMI HERALD, Aug. 28, 2014, http://www.miamiherald.com/2014/08/27/4312867/advocates-for-poor-say-jackson.html.

[14] *Id.*

[15] E-mail from Ashwin Kumar, Jackson Health System (Apr. 8, 2015, 08:54 AM EST) (on file with authors).

[16] "Nationally, more than three million poor uninsured adults fall into the "coverage gap" that results from state decisions not to expand Medicaid, meaning their income is above current Medicaid eligibility but below the lower limit for Marketplace premium tax credits. These individuals would have been newly-eligible for Medicaid had their state chosen to expand coverage." The Kaiser Commission on Medicaid and the Uninsured, KFF Issue Brief (October 23, 2015), *available at* http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/.

[17] 23,000 of the 89,778 county residents in the gap is approximately 25%. 23,000 of the 167,521 county residents eligible for expansion is approximately 13%.

[18] 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*].

[19] *Id.*

[20] Letter from Justin Senior, Deputy Secretary for Medicaid, Fl. Agency for Health Care Administration to Vikki Wachino, Acting Director, Centers for Medicare and Medicaid Servs., (Apr. 15, 2015), *available at* http://ahca.myflorida.com/Executive/Communications/Press_Releases/archive/docs/2014_2015/apr/signedletter.pdf.

[21] Press Release, Governor's Press Office, Governor Rick Scott to Take Legal Action Against Obama for Stopping Federal Funds to Force State Further Into Obamacare (Apr. 16, 2015), *available at* http://www.flgov.com/2015/04/16/governor-rick-scott-to-take-legal-action-against-obama-for-stopping-federal-funds-to-force-state-further-into-obamacare/.

[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] 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*].

[25] Id at 3.

[26] Id.

[27] Id at 4.

[28] 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 (June 23, 2015), *available at* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/Managed-Medical-Assistance-MMA/fl-medicaid-reform-lip-ltr-06232015.pdf.

[29] The Legislature produced a document entitled *Medicaid Hospital Funding Programs*, composed of multiple spreadsheets, which "display calculations made by the Florida Legislature in making appropriations for the Medicaid hospital funding programs." The document's spreadsheets include columns for the amount of each hospital's different LIP programs, rate enhancements and DSH, as well as the amount of funding ("intergovernmental transfers" or "IGT") contributed by local entities on behalf of each individual hospital. 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), [hereinafter *Hospital Funding Tables 2014-15*], *available at* http://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?FileName=Medicaid%20Hospital%2 0Funding%20Programs%20-%204-29-2014.pdf&DocumentType=Conf&BillNumber=5001&Session=2014 & 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), [hereinafter *Hospital Funding Tables 2015-16*], *available at* https://www.flsenate.gov/PublishedContent/Session/2015A/Appropriations/Documents/Medicaid_Conference_Report.pdf.

[30] Ctrs. for Medicare & Medicaid Servs., *Florida Managed Medical Assistance Program – Special Terms and Conditions*, #67 (2015) [hereinafter *2015 STC*].

[31] *2015 STC, supra* note 30, at #71(b)(i). The hospitals in each tier will then be compensated a percent of their uncompensated care. For example, hospitals in Tier 1 may be compensated for 100% of their charity care costs, hospitals in Tier 2 - 75%, Tier 3 – 50%, and Tier 4 – 25%. The state is currently developing a model, which will then need to be approved by CMS.

[32] *2015 STC, supra* note 30, at #68(b).

[33] "Medicaid shortfall is the difference between non-DSH Medicaid payments and hospital cost to provide care to Medicaid recipients." *Navigant Report, supra* note 11, at 56.

[34] *2015 STC, supra* note 30, at #71(a).

[35] *CMS July 2014 Letter, supra* note 7 & *Vikki Wachino May 21, 2015*, *supra* note 24.

[36] *Vikki Wachino May 21, 2015*, *supra* note 24, at 3.

[37] *2015 STC, supra* note 30, at #68(b).

[38] *2015 STC, supra* note 30, at #67.

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

[40] FL. S. COMM. HEALTH REGULATION, INTERIM REPORT 2010-120 SUPPLEMENTAL MEDICAID PAYMENTS, at 2 (2010) [hereinafter *Senate Report*], *available at* http://archive.flsenate.gov/data/Publications/2010/Senate/reports/interim_reports/pdf/2010-120hr.pdf.

[41] 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.

[42]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/.

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

[44] 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 42, 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?

[45] Although the details are not yet clear, under the ACA, the Secretary of HHS is required to cut DSH funding by $14.1 billion from 2014-2019. *NHeLP DSH, supra* note 40, at 4. For details on Medicaid DSH reductions, *see* 42 U.S.C. § 1396r-4(f)(7).

[46] The Governor's 2016-17 proposed budget includes various line items for DSH. For example, in one budget, DSH receives $0 (http://www.floridafirstbudget.com/web%20forms/Budget/BudgetIssueDetail.aspx?p=disproportionate%20share&si=68501400&icd=3004500&title=MEDICAID%20SERVICES) whereas in another budget, DSH receives $228,720,825 (http://www.floridafirstbudget.com/web%20forms/Budget/BudgetIssueDetail.aspx?p=disproportionate%20share&si=68501400&icd=1001000&title=ESTIMATED%20EXPENDITURES%20-%20OPERATIONS).

[47] 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 Health Care Admin. (Dec. 30, 2015, 04:27 PM EST) (on file with authors).

[48] *Dudek Letter, supra* note 47.

[49] *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."

[50] *Dudek Letter, supra* note 47. 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.

[51] *See* Table, *supra* page 13, last column.

[52] *See* 42 CFR 438.60

[53] *Navigant Report, supra* note 11, 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.")

[54] *See* Fla. Stat. §212.055(5).

[55] *Navigant Report, supra* note 11, at 14-15.

[56] *Navigant Report, supra* note 11, at 15-16.

[57] Over 80% of the State's IGTs come from Miami-Dade and Broward counties. *Hospital Funding Tables 2014-15, supra* note 29.

[58] *Id.*

[59] *Hospital Funding Tables 2015-16, supra* note 29.

[60] *Justin Senior January 7, 2015 Presentation, supra* note 50, 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."

[61] *Navigant Report, supra* note 11, at 29, 183.

[62] *April 21, 2015 Senate Meeting Materials, supra* note 50, at 6.

[63] 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 29, at 53.

[64] *Hospital Funding Tables 2015-16, supra* note 29, 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.

[65] 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-care-act/Expansion2015PresentationtoSenate.pdf.

[66] *Id* at 2. The state's April 2015 model estimated that elimination of LIP would result in the following losses: $611.96 million of state revenue, $10.69 billion in GD, and $11 billion in personal income, along with nearly 20,000 jobs.

[67] Rick Stone, *State Economist Warns 'We Will Feel It' If Medicaid-Related Hospital Funds Are Lost*, WLRN, Apr. 21, 2015, http://wlrn.org/post/state-economist-warns-we-will-feel-it-if-medicaid-related-hospital-funds-are-lost.

[68] *EDR Presentation April 21, 2015*, *supra* note 65, at 5.

[69]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.

[70] The authors recognize that at this point in time, this estimate is marginally 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.

[71] 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 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.

[72] *2015 STC, supra* note 30, at 2.

[73] 834,674 Floridians who would enroll in Medicaid under expansion * $543 (PMPM) * 12 months * 5 years * 85% MLR = $23 billion

[74] Ctrs. for Medicare & Medicaid Servs., *Increased Federal Medical Assistance Percentage Through the Affordable Care Act of 2010* (2013), *available at* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2013-Fact-sheets-items/2013-03-29.html.

[75] In addition, Jackson has significant encounter fees that are much larger than Medicaid's and which are a proven barrier for people below 100% FPL. Jackson Health System Fees, *available at* http://www.jacksonhealth.org/library/forms/carecard-fees.pdf.

[76] 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.

[77] If Miami-Dade has historically received approximately 25% of the total state LIP funding, we can extrapolate that Miami-Dade will experience approximately 25% of the loss felt statewide. As explained in Section III, it is estimated that the cumulative loss of LIP funding statewide over 5 years is approximately $4.85 billion. 25% of $4.85 billion is approximately $1.2 billion.

[78] *See* Fla Stat 212.055(5)

[79] Harry J. Heiman & Samantha Artiga, THE HENRY J. KAISER FAMILY FOUNDATION, BEYOND HEALTH CARE: THE ROLE OF SOCIAL DETERMINANTS IN PROMOTING HEALTH AND HEALTH EQUITY (Nov. 2015) *available at* http://files.kff.org/attachment/issue-brief-beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity.