Tuesday, April 21, 2015

WORKSHOP ON SENATE PLAN FOR MEDICAID SUSTAINABILITY

THE FLORIDA SENATE

SENATOR ANDY GARDINER
President

TO: All Senators
FROM: Andy Gardiner, President
SUBJECT: Workshop on Senate Plan for Medicaid Sustainability
DATE: April 17, 2015

As you are aware, the Senate proposed and passed a new LIP model based on the coverage expansion outlined in the FHIX program. Earlier this week in her testimony before our Committee on Ethics and Elections, AHCA Secretary Liz Dudek indicated our Senate plan would be the model the agency submits to CMS on behalf of the State of Florida.

Unfortunately, at this juncture, we do not know when the plan will be formally submitted as a waiver application. Additionally, CMS is under no obligation to respond to Florida's application by any particular deadline.

Considering this uncertainty surrounding critical health care issues, I have asked Chair Lee to utilize the first portion of the final meeting of our Committee on Appropriations, scheduled for Tuesday, April 21, at 10:00 a.m. to host a workshop during which all Senators will have the opportunity to hear from our Senate professional staff about potential funding scenarios and implications for their constituents.

The workshop will also include a brief history and summary of the issues surrounding the discussion on LIP and Medicaid, as well as background on the Senate's comprehensive plan for Medicaid Sustainability. We will include time for public testimony to enable Senators to hear from the people who will be impacted by our decisions on these issues.

I encourage all Senators to make this workshop a priority and look forward to seeing you there.

Agenda

1. Opening Remarks, *President Andy Gardiner*

2. Panel Presentation

    - Low Income Pool Methods of Payment and History
      Carol Gormley, Senior Policy Advisor, Office of the President

    - Current Payment Levels
      Malcolm Ferguson, Navigant

    - Senate LIP Model
      Allen Brown, Chief Analyst, Senate Committee on Appropriations

    - Economic Impacts
      Amy Baker, EDR

3. Senator Questions

4. Public Testimony

5. Closing Remarks: *Senator Tom Lee, Chair, Senate Committee on Appropriations*

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Problem and Solution Matrix

	Funding	Coverage
LIP[1]	➢ $2.1 billion total funding ➢ $1.5 billion in net payments to hospitals ➢ Targeted support for critical facilities and services ➢ Statewide benefit from local partnerships	➢ Supports access for Medicaid enrollees by compensating for reimbursement shortfalls ➢ Supports specialized services such at trauma care, rural hospitals, hospital-based primary care systems ➢ Supports services provided to uninsured patients, i.e. uncompensated care
Expansion[2]	➢ 100% federal funding through CY 2016 ➢ Estimated $3 billion federal funding in FY 2015-16 ➢ Savings available from phase out of Medically Needy (estimated $400 m)	➢ 951,826 estimated eligible ➢ 834,674 estimated enrollees

[1] Navigant, *Study of Hospital Funding and Payment Methodologies for Florida Medicaid* (January 2015)., p.26: "We do not believe that a decision to expand Medicaid in Florida would be sufficient as a full replacement of the LIP program."
[2] *Ibid., p. 201:* "However, expansion would not replace the portion of the LIP program funding the difference between Medicaid payments and hospitals' costs to treat Medicaid recipients."

History of LIP and IGT Funding

- Initiated in 2006 as part of the Medicaid reform pilot launched by Governor Jeb Bush;
    - LIP modified and expanded a previous supplemental hospital payment system known as UPL (upper payment limit); UPL accounted for approximately $631 m in annual hospital payments prior to Medicaid reform.
    - UPL refers to the maximum amount Medicaid can pay a provider, which is the Medicare payment level; since Medicaid pays less than Medicare, the federal government allows *supplemental payments* to providers up to the UPL.
    - Supplemental payments are only allowed in fee-for-service systems;
    - Florida's expansion of managed care means that special permission (waiver) is needed to continue supplemental payments.
- CMS initially authorized up to **$1 B in annual supplemental payments** to providers:
    - Supplemental payments are made in quarterly lump sum distributions to qualified providers;
    - LIP supplemental payments are not linked to specific services or specific patients like claims-based reimbursement; providers qualify for LIP based on special criteria or policies.
    - Florida's LIP program uses several policy criteria used to allocate payments in various silos;
- IGT funding is used not only for LIP, but also to increase hospital rates for 130 of the state's 225 hospitals
    - IGTs are repaid through LIP, but some are used to fund automatic (or policy-based) rate enhancements
    - Between 2008-2014, Florida allowed self-funded rate enhancements
        - During this period, these payments grew from about $30 m in payments for less than a dozen hospitals to almost $1b for 80 hospitals
        - Self-funded 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.
- In 2014-15, CMS gave Florida 1 year for an increase in LIP to give transitional support to hospitals
    - The 1-year authority allowed LIP to increase from $1 billion to $2.1 billion;
    - Approximately $967 m of this increase replaced previously "self-funded" rate increases.
    - Funding for physicians affiliated with medical schools ($204 M) constituted the remaining amount of the one-year increase
- Though primarily used as a way to fund hospitals, LIP payments are also made to other providers
    - LIP funds FQHCs and health departments, primary care initiatives, premium assistance programs in two counties, emergency room diversion, and poison control centers;
    - LIP payments to non-hospital providers totaled $321 m in FY 2014-15

LIP and IGT Basics

Low Income Pool (LIP) *Payment Method*	**Intergovernmental Transfers (IGTs)** *Financing Method*
Waiver required: • To make provider payments outside of capitation; • Waivers are not subject to specific federal rules; • Federal policies have been inconsistent over time and for different states; • No time limits on negotiations.	Federal requirements: • Must come from public sources; • Payments can't exceed costs; • No hold harmless provisions or practices.
Florida LIP structure: • Used primarily to repay IGT donors; • Policy silos: o Special LIP (six categories including rural, trauma, primary care, etc) o LIP 4 = financing silo (8.5% ROI) o LIP 6 = replacement for self-funded rates ($964 m) o LIP 7 = new silo in 2015 Senate plan o Provider Access Systems (PAS) = funding for health departments, FQHCs, etc. ($117 m) o Physician UPL = supplemental payments for medical schools ($204 m) • Because LIP repays IGTs, these sources are also available to fund Disproportionate Share Hospital (DSH) and enhanced rates: o DSH funding = $239 m in hospital payments; o IGT funded rate enhancements = $797 m	Local requirements: • Sources must be local taxes or other public revenue. • Fiduciary responsibilities to local taxpayers prohibit donations that do not yield a net benefit.
Without LIP supplemental payments • Net benefits cannot be guaranteed to donors and without these guarantees, donations may not continue. • Payments can only be made through rates; o Base rate increases benefit all hospitals; o Facility adjusters can be used to benefit selected hospitals. • Differential rates drive patients to lower cost hospitals in a managed care environment.	Without IGTs • Hospital payments are reduced by $1.3 b or 15% below current levels; hospital payments currently average 49% of costs. • Federal approval of hospital rates may be withheld if the rates are not "adequate". • Lower hospital rates reduce managed care capitation rates. • Below-market funding of hospital rates may cause capitation rates to fall below actuarially sound levels. • Continuation of statewide managed care depends on actuarially sound rates.
Spending Alternatives • Allow hospital payments to be reduced. • Maintain current levels with other funds. • Mitigate reductions with other funds.	Funding Alternatives • GR, through allocations and reprioritizations • Provider assessments

Parameters for LIP and IGTs

Problem Statement

Without federal approval for LIP payments, Medicaid payments to Florida hospitals will be reduced by $1.3 b or 15% of current levels.

- Hospital payments
  - Federal regulations require provider payment rates to be "adequate".
  - State capitation rates must be "actuarially sound" enabling the managed care organization to pay providers at market-based rates.
  - Based on the Navigant study, Florida Medicaid payments to hospitals currently constitute, on average, just 49% of the costs for Medicaid and uncompensated care.
  - The pay to cost ratios range from a high of 55% (for 104 hospitals that contribute IGTs and receive related payments) to 22% of costs for 88 non-IGT hospitals.
  - The 104 IGT-hospitals account for 70% of Medicaid hospital claims.
- Net payments
  - 139 hospitals receive $1.6 B in net benefit from LIP/IGT related payments.
  - Nets range from $115,634 (Sacred Heart, Gulf Coast) to $270 M for Jackson Memorial
  - $679 m in state funds are needed to sustain these nets without IGTs.
  - If only 60% of the net benefits are preserved, $407 M in state funds are required.
  - 23 hospitals receive more than $15 M in net benefits; $497 M in state funds are required to sustain nets for these 23 hospitals.
- Payment methods
  - Claims-based payments are made either directly as fees for services (FFS) or through managed care organizations
  - Supplemental payments require a waiver; supplemental payments are the only way to ensure net benefits remain proportionate to prior payments.
  - Payments to providers made as part of an approved rate structure do not require a waiver.
  - States have considerable flexibility in setting provider rates; rates can be enhanced for all hospitals when the base is increased or for certain hospitals when facility adjusters are used.
  - Facility adjusters that increase the difference in payment levels for some hospitals can negatively affect use of that hospital in a managed care environment.
- Funding sources
  - Since 1986, a variety of policies have replaced state GR in hospital payments with funds from other sources; currently, state GR constitutes only 37% of the state share of Medicaid payments to hospitals.
  - IGTs are voluntary donations and their availability depends on incentives to the donors.
  - GR is only available depending on other state spending priorities.
  - Provider assessments (PMATF): could be used to replace IGTs or as a transition to more GR.
- Beneficiaries
  - Old LIP/IGT primarily benefits public hospitals
  - Senate LIP plan extends benefits (through increases in base DRG rates) to almost all hospitals
  - Amount of GR required to replace IGTs is lowered marginally by limiting number of beneficiaries or limiting degree of benefit

Florida Health Insurance Affordability Exchange (FHIX) Program

Florida Medicaid Background	o The Medicaid program is a partnership between the federal and state governments to provide medical care to low income children and disabled persons. o Florida Medicaid is administered by the Agency for Health Care Administration (AHCA) and is financed with federal and state funds. The Department of Children and Families (DCF) determines eligibility for the Medicaid program and transmits that information to the AHCA. The AHCA is designated as the single state Medicaid agency and has the lead responsibility for the overall program. o Over 3.7 million Floridians are currently enrolled in Medicaid and the program's estimated expenditures for the 2014-2015 fiscal year are $23.4 billion. The federal government currently pays 59.56% of the costs of Medicaid services with the state paying 40.44%. Florida has the fourth largest Medicaid program in the country. o Medicaid currently covers: ▪ 20% of Florida's population; ▪ 27% of Florida's children; ▪ 62.2% of Florida's births; ▪ 69% of Florida's nursing homes days.
FHIX Program Principals	The FHIX program is a consumer-driven approach to providing high-quality, affordable health care coverage while promoting personal responsibility. FHIX participants will have access to a state-operated marketplace to shop and select coverage, services and products. The FHIX Program is based on the following principals: • Fair Value; • Consumer Choice; • Simplicity; • Portability; • Promotes Employment; • Consumer Empowerment; and • Risk adjustment.
Coverage Population & Eligibility Requirements	o The FHIX program will extend coverage to an estimated 800,000 low-income Floridians. o Applicant must be a Florida resident between ages of 19-64. o The expanded population will include individuals whose income is at or below 133% of the Federal Poverty Level (FPL). ▪ Individuals who earn an annual income up to $16,000; or ▪ Parents who earn up to an annual income of $33,000 for a family of four.
Products & Services	o All Florida Health Choices Program products and services; o All Medicaid Managed Care plans; o All products offered by Florida Healthy Kids Corporation; and o Employer sponsored plans.
Responsibilities of Participants	o Cost-Sharing Principles: ▪ Participants must make mandatory monthly premium payments ranging from $3-$25 based on their income to maintain health benefits coverage on the FHIX marketplace. ▪ Participants may be charged for inappropriate use of emergency room visits up to $25. o Employment Requirements: ▪ Participants are required to complete an initial application for coverage which includes proof of employment, on-the-job training or placement activities, or pursuit of educational opportunities and will submit a renewal annually.

Florida Health Insurance Affordability Exchange (FHIX) Program

Application for Benefits

- To enroll in the FHIX program, applicants will apply using the same process used today for Medicaid eligibility through the Department of Children and Families (DCF). The DCF is responsible for processing applications, determining eligibility and transmitting information to the AHCA or the corporation, depending on the phase on each applicant's eligibility status. An application is only deemed complete when it has met all of the requirements under participant responsibilities.

Implementation

Implementation Activities

Phase	Start Date	Activities
Readiness	Effective Date - Ongoing Based on Phase/Region	• Implementation Activities. • AHCA will conduct a readiness review in consultation with the FHIX Workgroup.
One	July 1, 2015	• Enroll newly eligible, low-income, uninsured into Medicaid managed care plans. • Corporation readies for implementation of FHIX marketplace for Phase Two. • Healthy Kids prepares for customer service, financial support and choice counseling in Phase Two and Three.
Two	January 1, 2016*	• Enroll newly eligible, low income, uninsured into FHIX. • Transition Phase One enrollees from MMA plans to FHIX by April 1, 2016. • Renew existing enrollees at annual enrollment date. • Healthy Kids prepares to transition enrollees to FHIX under Phase Three.
Three	July 1, 2016*	• Enroll newly eligible, low income, uninsured into FHIX. • Renew existing enrollees at annual enrollment date. • Healthy Kids transitions enrollees to FHIX under Phase Three .

*Phase Two implementation is contingent upon federal approval

Estimated Fiscal

- The expansion is fully funded by the federal government for calendar years 2015 and 2016.
- States must begin covering a portion of the adult expansion costs in 2017.
- States are required to contribute 10% of the adult expansion costs beginning in 2020.

- Estimated FHIX program costs:
  - Year 1: $2.8 billion from the federal government to cover 100% of costs for coverage of expanded adult population; $9.6 million from state
  - Year 2: $3.7 billion from the federal government to cover 95% of costs for coverage of expanded adult population; $118.5 million from state

Federal Requirements for 1115 Waiver Application	
Public Document Notice	• AHCA must publish a Public Document Notice and include a comprehensive description of the 1115 Waiver • Application to notify and solicit public input must be available for a 30-day period before submission.
Notify Indian Tribes	• AHCA must notify the Seminole Indian Tribe and the Miccosukee Tribe through written correspondence to request input on the amendment request.
Public Meetings	• AHCA must publish public notices for at least two public meetings in the Florida Administrative Register (FAR). • AHCA must post the public meeting schedule including dates, times and locations as well as the public notice document for the 1115 Waiver Application on the agency's home webpage.
Submission of 1115 Waiver Application	• After 30 days of public input, AHCA may formally submit the 1115 Waiver Application to CMS for consideration. • **There are no requirements or deadlines for CMS to respond to Florida's 1115 Waiver Application once it is submitted.**

History of Medicaid Reform Waivers

Florida Action	Key Dates	CMS Action and Date
Medicaid Reform waiver	1. Discussions/meetings: **November, 2004** 2. Concept paper: **January, 2005** 3. Formal application: **August 30, 2005**	Approval: **October 19, 2005**
First Renewal for Medicaid Reform Pilot	1. SB 1484 directs AHCA to seek extension: **April 30, 2010** 2. Formal application: **June 30, 2010** 3. Respond to questions **January 11, 2011** 4. Gov. Scott letter requesting approval **January 31, 2011** 5. Letters requesting temporary extension **June 20, 2011** **July 29, 2011** **August 12, 2011** **August 31, 2011** **September 13, 2011** **September 29, 2011** **October 12, 2011** **October 26, 2011** **November 10, 2011** **November 22, 2011**	Letter advising state of change in review authority: **August 17, 2010** Written questions: **December 16, 2010** Letters approving temporary extensions: **June 28, 2011** **July 29, 2011** **August 31, 2011** **September 15, 2011** **September 30, 2011** **October 14, 2011** **October 31, 2011** **November 14, 2011** **November 29, 2011** Approval: **December 15, 2011**
Amendment to allow statewide expansion	1. Letter advising of intent to expand: **March 29, 2011** 2. Formal application: **August 1, 2011** 3. Written responses to questions **April 13, 2012** 4. Quality improvement strategies and implementation plan submitted: **September/October, 2012**	Letter requesting more information: **April 28, 2011** Informal questions: **January 3, 2012** Letter of agreement in principle: **February 20, 2013** Approval: **June 14, 2013**
Application for second 3-Year Extension	1. Formal application: **November 27, 2013**	Letter memorializing agreements: **April, 2014** Approval: **August 1, 2014**
Request for LIP authority	1. Navigant report submitted: **January 15, 2015** 2. In-person meetings and phone calls: **January 20, 2015** 3. Gov. Scott letter saying no state funds for backfill: **March 4, 2015** 4. Senate plan informally presented by AHCA: **March 26, 2015** 5. Email indicating Senate plan is formal proposal: **April 13, 2015** 6. Formal application: **April 20, 2015 (subject to 30 day public notice)**	Letter with guidance for LIP proposal **April 14, 2015**

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

FOR IMMEDIATE RELEASE
April 20, 2015

Contact: AHCA Communications Office
AHCACommunications@ahca.myflorida.com
(850) 412-3623

AHCA Submits Senate's LIP Model to Amend 1115 Medicaid Waiver

- Amendment would request $2.167 billion for a redesigned Low Income Pool program -

Tallahassee, FL – Today the Agency for Health Care Administration (Agency) sent the Senate Low Income Pool (LIP) proposal as an amendment to the 1115 Managed Medical Assistance Waiver which would extend the LIP program through June 30, 2017. Additional information from the public comment period will be submitted upon the conclusion of the public meetings scheduled for April 29th in Orlando, April 30th in Miami and May 1st in Tallahassee.

Secretary Liz Dudek said, "We are submitting the Florida Senate's LIP model to CMS today in hopes that they will quickly grant us approval or give us any feedback to continue supporting uncompensated care for low income Floridians. We are expediting our submission of this LIP model in order to help CMS speed up their decision. CMS knows that our budget depends on their rapid response to this model. After the federally required public comment period has concluded, the agency will compile the public comments, along with any needed adjustments and send them to CMS."

The LIP proposal shares some characteristics with the existing program but has been redesigned in key areas to support federal and state goals. The redesigned program built off of the Florida Senate's LIP model:

- Has a total funding level of $2.167 billion (including state, local and federal funds)
- Includes restructured hospital distributions to more broadly distribute funding and encourage access for vulnerable populations
- Maintains funding for Florida medical schools
- Maintains funding to Florida's County Health Departments (CHD) and Federally Qualified Health Centers (FQHCs) to encourage primary care
- Includes enhanced reporting of LIP activities and fund flows to improve transparency

Below is the process to submit a formal request for 1115 waiver amendment to the Centers for Medicare and Medicaid Services (CMS):

Notify Tribes: The Agency has sent correspondence to the Seminole Tribe and the Miccosukee Tribe on April 20, 2015 requesting input on the amendment request.

Public Meetings: The Agency published public notices for three public meetings in the Florida Administrative Register (FAR).

- April 29, 2015 in Orlando,
  - As required, during the April 29, 2015 meeting in Orlando, the Agency will be asking for input on this amendment request from the members of the Medical Care Advisory Committee, and the public at large
- April 30, 2015 in Miami, and
- May 1, 2015 in Tallahassee

Public Comment Period:

- Posted the Public Notice Document Amendment Request, today, April 20, 2015, on the Agency's website (LINK)
- The Public comment period will run for thirty days, beginning on April 21, 2015 through May 22, 2015.

The Agency for Health Care Administration is committed to better health care for all Floridians. The Agency administers Florida's Medicaid program, licenses and regulates more than 45,000 health care facilities and 34 health maintenance organizations, and publishes health care data and statistics at FloridaHealthFinder.gov. For more information about the health information exchange, please visit http://www.fhin.net/ or https://www.florida-hie.net.

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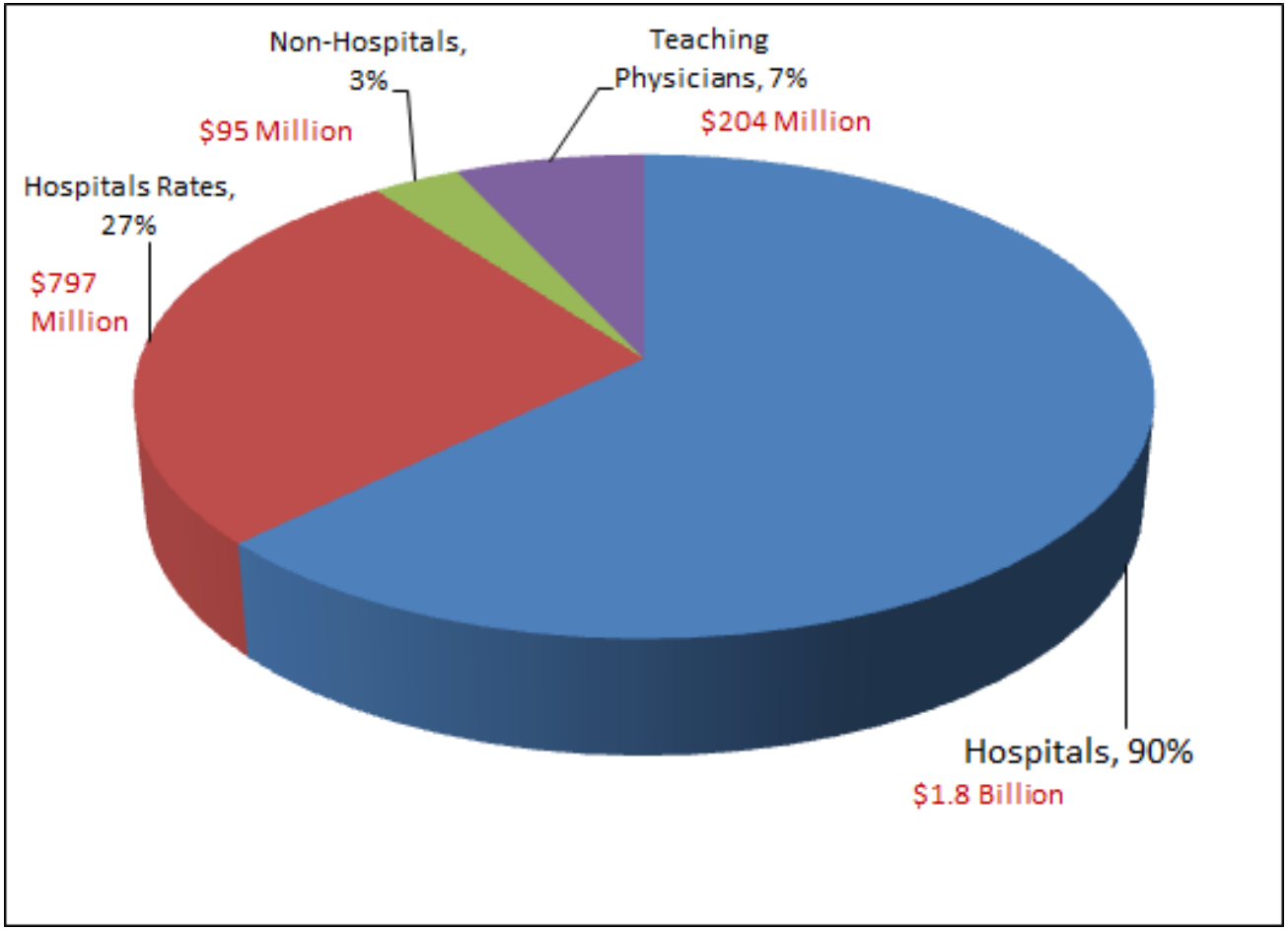
Hospital Reimbursement Levels from Florida Medicaid

April 21, 2015

Presenter

Malcolm Ferguson
Associate Director
Navigant Consulting

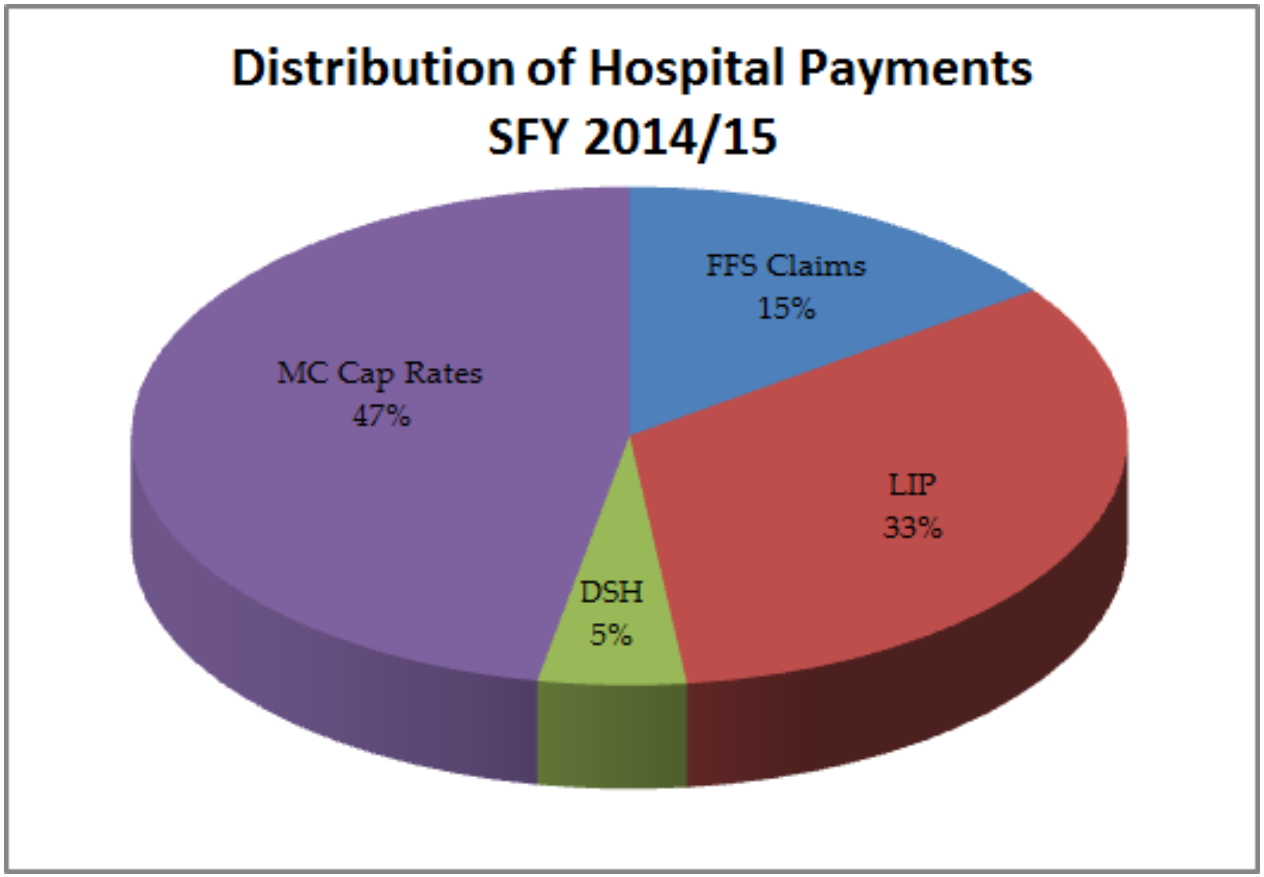
Distribution of LIP Payments – 2014/15



Hospital rates are outside of the LIP program, but the LIP program provides a 108.5% guaranteed return on IGTs contributed to fund rate enhancements.

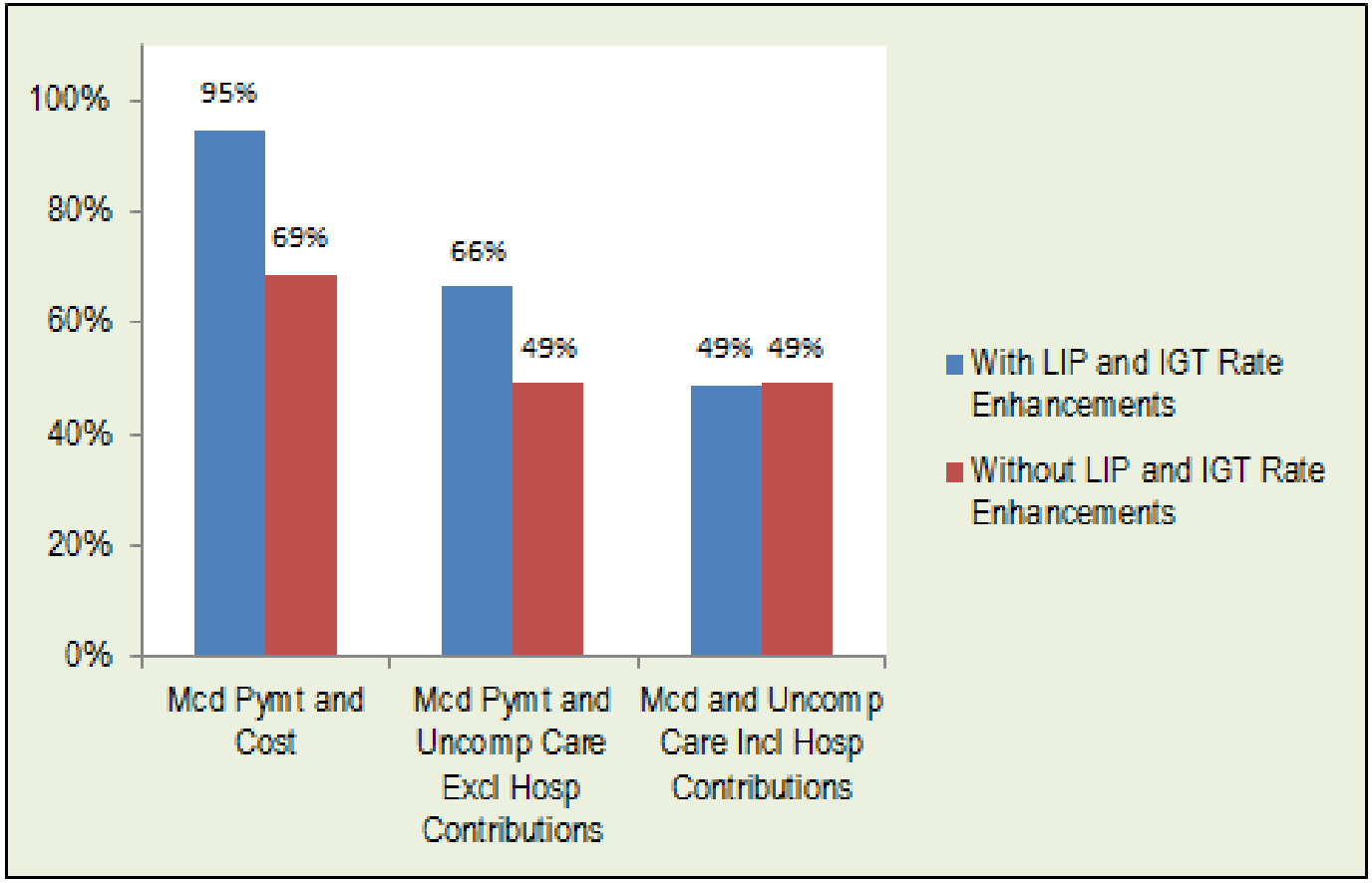
NAVIGANT HEALTHCARE

Distribution of Florida Medicaid Hospital Payments – 2014/15



For hospitals, payments through the LIP program constitute a significant portion of overall reimbursement.

Pay-to-Cost Ratios with and without LIP – 2012/13



The "Without LIP and Rate Enhancement" values assume IGT funds previously contributed to Medicaid would be paid to the hospitals by the county governments.

Pay-to-Cost Ratios with and without LIP – 2012/13

	Payment	Cost	Pay-to-Cost Ratio
With LIP and IGT Rate Enhancements			
Mcd Pymt and Cost	$5.5	$5.8	95%
Mcd Pymt and Uncomp Care Excl Hosp Contributions	$5.7	$8.6	66%
Mcd and Uncomp Care Incl Hosp Contributions	$4.2	$8.6	49%
Without LIP and IGT Rate Enhancements			
Mcd Pymt and Cost	$4.0	$5.8	69%
Mcd Pymt and Uncomp Care Excl Hosp Contributions	$4.2	$8.6	49%
Mcd and Uncomp Care Incl Hosp Contributions	$4.2	$8.6	49%

The "Without LIP and Rate Enhancement" values assume IGT funds previously contributed to Medicaid would be paid to the hospitals by the county governments.

Questions

Questions?

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Study of Hospital Funding and Payment Methodologies for Florida Medicaid

Prepared for:

Florida Agency for Health Care Administration

January 15, 2015

navigant.com/healthcare

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1 Executive Summary

1.1 Background

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

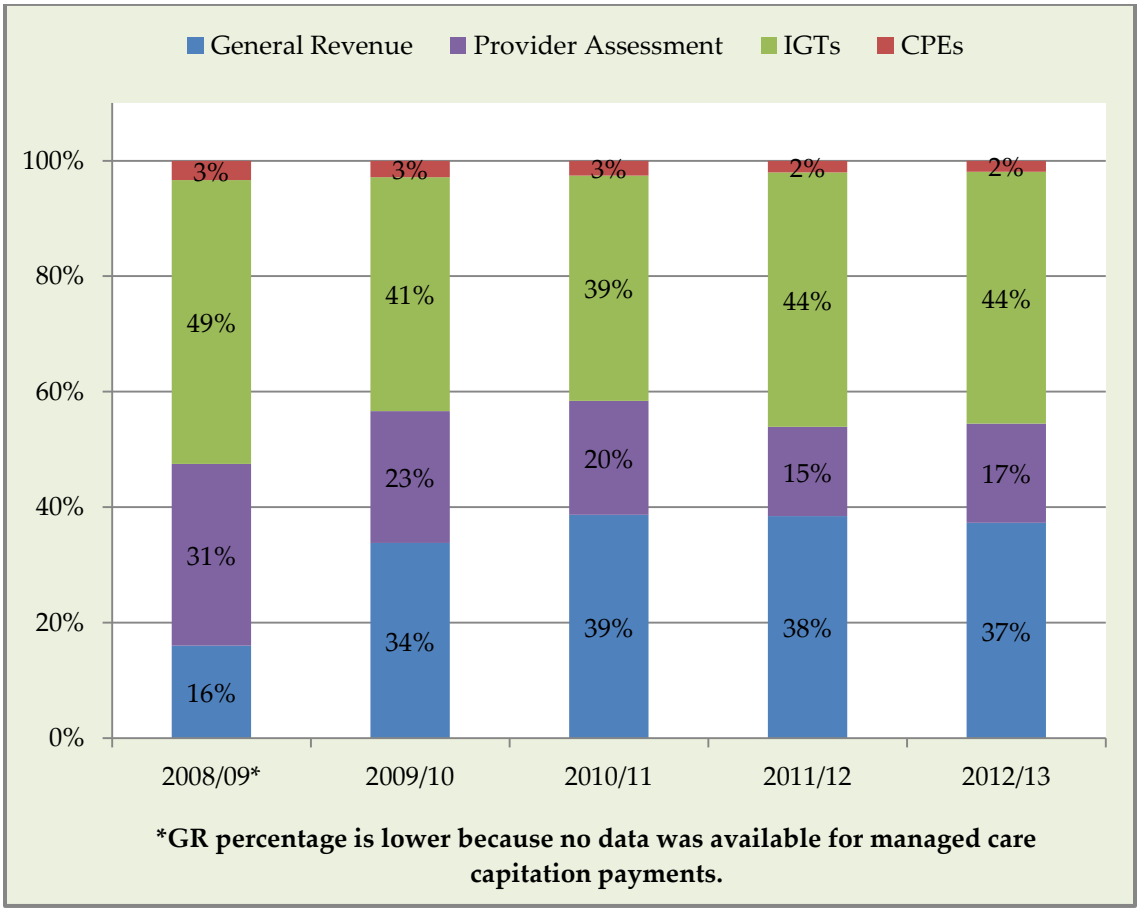
This study deals primarily with funding and payment made through the LIP program. The vast majority of funds for the LIP program come from inter-governmental transfers (IGTs) made in the names of specific hospitals. In addition, the vast majority of payments made through the LIP program are made to acute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

1.2 Hospital Funding

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

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

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



***GR percentage is lower because no data was available for managed care capitation payments.**

Notes for Figure 1:

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

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

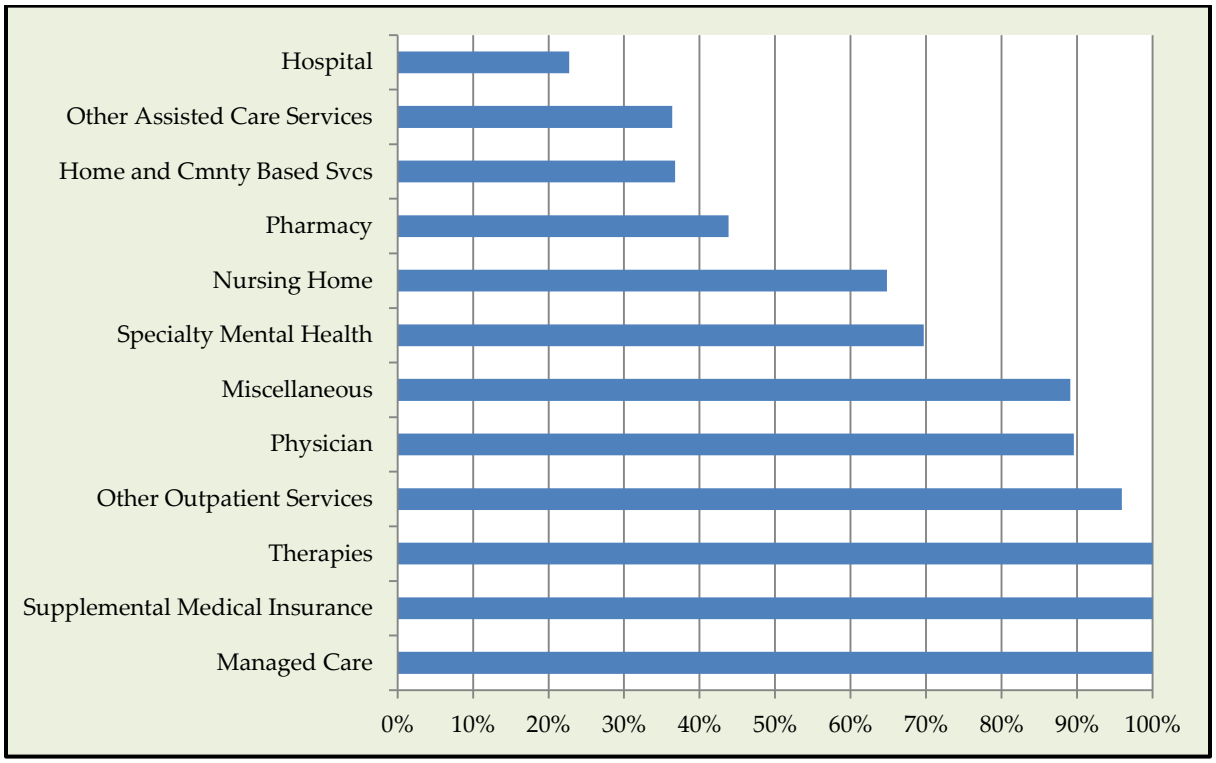
1.2.1 General Revenue

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

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

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

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



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

1.2.2 Provider Assessment

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

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

1.2.3 Inter-Governmental Transfers

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

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

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

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

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

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

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

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

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

1.2.4 Certified Public Expenditures

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

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

1.3 Hospital Payments

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

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

As mentioned previously, Florida Medicaid has developed payment methods which ensure return on investment for contributors of IGTs. This is done primarily in two ways. First, all IGT funds collected for the traditional $1 billion LIP program and for automatic rate enhancements are summed together. Hospitals in whose names these funds are contributed receive supplemental payments through the traditional $1 billion LIP program that equal 108.5 percent of the contribution amounts (8.5 percent return on investment). This return on investment is documented within the LIP program as the "LIP Allocation Distribution," and comprises a majority of the funds distributed through the traditional $1 billion LIP program. For example in SFY 2012/13, $772 million was paid through the LIP Allocation Distribution, which meant only $228 million was available through the waiver program to fund safety net hospitals, uncompensated care, and various initiatives intended to improve the delivery of health care to Florida Medicaid recipients. Thus, despite being a $1 billion program, only 23 percent of that money was made available for discretionary distribution.

The second guaranteed return on investment occurs for LIP-6 funds, which were referred to as self-funded IGTs prior to SFY 2014/15. IGT contributors have the option to designate their funds to be applied to traditional LIP and automatic IGT rate enhancements or to LIP-6[6]. Funds designated to LIP-6 provide contributors approximately 147 percent return on investment as the

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

hospitals named for these contributions receive back the IGT contribution (the state share) plus all of the associated federal matching funds.

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

Figure 3. Distribution of IGT funds by Florida Medicaid.

<table>
<tr>
<td>Traditional $1 Billion LIP Program

Total Funds in SFY 2014/15: $1 billion
Funding Limitation(s): 1115 demonstration waiver

The $1 billion is distributed as follows:
LIP Allocation Distribution: $772 million
Distribution Determination: 108.5 percent of IGT contributions

Discretionary Distribution: $228 million
Distribution Determination: LIP Council and Florida Legislature</td>
<td>Automatic IGT Rate Enhancements

Total Funds in SFY 2014/15: $666 million
Distribution Determination: LIP Council and Florida Legislature
Funding Limitation(s): UPL regulations and Florida Legislative authority</td>
</tr>
<tr>
<td>LIP-6 (Formerly Self-Funded IGTs)

Total Funds in SFY 2014/15: $963 million
Distribution Determination: All IGT and federal matching funds paid to named hospital
Funding Limitation(s): 1115 demonstration waiver and Florida Legislative authority</td>
<td>DSH Program

Total Funds in SFY 2014/15: $315 million
Distribution Determination: Formula defined in State Plan
Funding Limitation(s): Federal Medicaid DSH cap for State of Florida and individual hospital DSH limits</td>
</tr>
<tr>
<td>Teaching Physician Supplemental Program

Total Funds in SFY 2014/15: $204 million
Distribution Determination: Based on historical number of Medicaid encounters
Funding Limitation(s): 1115 demonstration waiver</td>
<td><u>Legend:</u>

- state share affecting LIP Allocation Distribution

- funds distributed through the 1115 waiver</td>
</tr>
</table>

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

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

1.4 Evaluation of Florida Medicaid Hospital Funding and Payment

1.4.1 Introduction

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

> "A state plan for medical assistance must provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan … as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."[7]

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

One seemingly reasonable measure of adequate payment would be a comparison of payments to the cost to render care to a Medicaid recipient. In order to remain in operation, hospitals, like any other businesses, must receive enough income to cover all expenses including items such as labor, facilities, and equipment. In addition, it is critical for all hospitals to be able to generate some margin over the cost of operations – for-profit hospitals need to satisfy investors and stock holders, and both for-profit and not-for-profit hospitals need to fund the replenishment of operating infrastructure and capital. Thus, paying hospitals an amount equal to their costs or at least equal to reasonable market value for services provided, if such a number can be defined,

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

would be one way to measure payments. In fact, in Medicaid Upper Payment Limit analyses, for example, hospital cost is accepted as a proxy for Medicare payment and can be used as the Upper Payment Limit or maximum allowable reimbursement amount. Note however, that CMS does not consider operating margin to be a reasonable and necessary cost of providing services. In addition, payment levels simply based on cost offer no incentive for hospitals to control costs. Thus, purely cost-based payments do not promote efficiency and economy.

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

1.4.2 Florida Medicaid Aggregate Hospital Pay-to-Cost

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

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

Description	Payment	Estimated Hospital Cost	Pay-to-Cost Ratio
Pay-to-cost - Medicaid recipients - w/o LIP	$4,544	$5,770	79%
Pay-to-cost - Medicaid recipients - w LIP payments	$5,459	$5,770	95%
Pay-to-cost - Overall including claim, LIP, and DSH payments as well as claim (Medicaid) and uncompensated care costs	$5,699	$8,587	66%
Pay-to-cost - Overall including claim, LIP, and DSH payments minus PMATF and IGT hospital contributions as well as claim (Medicaid) and uncompensated care costs	$4,186	$8,587	49%

Note(s):

1) Dollar amounts are in millions.
2) Payments include hospital inpatient and outpatient claim data from both FFS and managed care encounter claims.
3) Data is from SFY 2012/13.

The table above shows that aggregate pay-to-cost for hospitals when excluding supplemental payments was 79 percent in SFY 2012/13. In that year, self-funded IGTs were included in claim payments, not in LIP. In SFY 2014/15, self-funded IGTs, which total $963 million, have been moved out of claim payments and into the LIP program. Thus, the aggregate pay-to-cost ratio for hospitals excluding supplemental payments in SFY 2014/15 will be approximately 62 percent.

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

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

Because IGTs play a significant role in funding and payment, we also compared pay-to-cost ratios across three categories of hospitals, 1) hospitals that contribute and receive IGTs; 2) hospitals that do not contribute IGTs, but do receive payments from IGT funds; and 3) hospitals that neither contribute nor receive IGT funds. In truth, not all IGTs are contributed by hospitals; many are contributed by local governmental agencies. However, the IGTs contributed for the LIP program, automatic rate enhancements, and self-funded rate enhancements (now part of the LIP program) are all donated in the names of specific hospitals. We treat those IGTs as donated by the named hospitals under the assumption that the local governments would find

ways to contribute those funds directly to the named hospitals if they were not contributed as IGTs to the Medicaid agency.

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

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

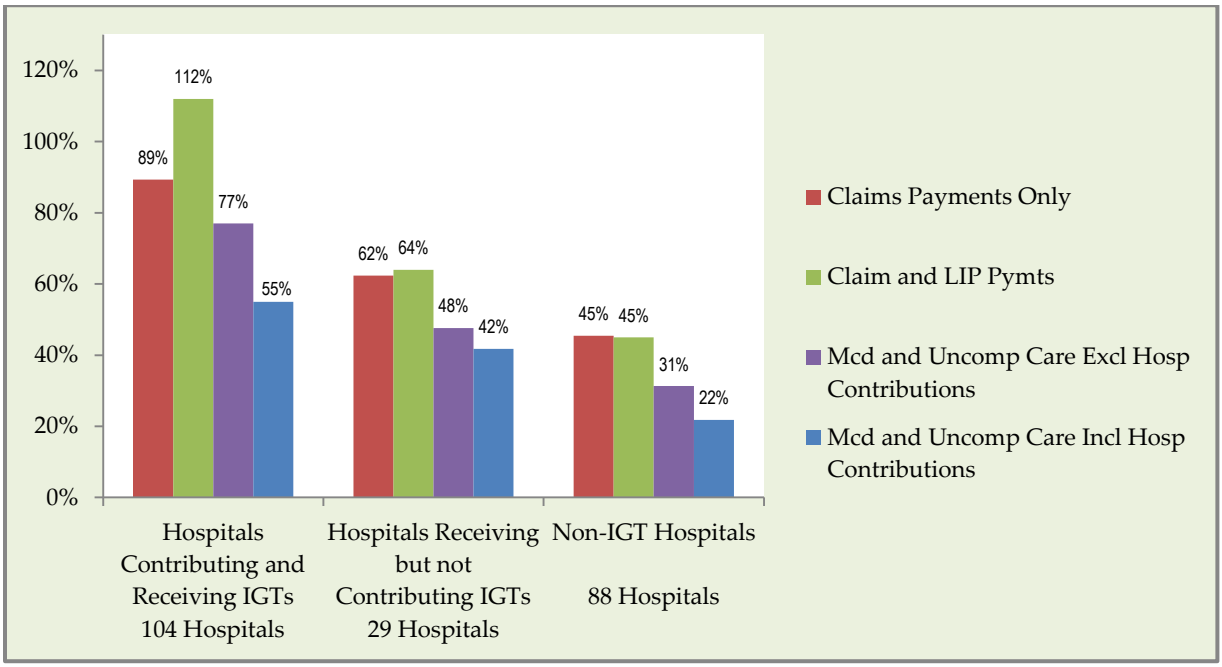
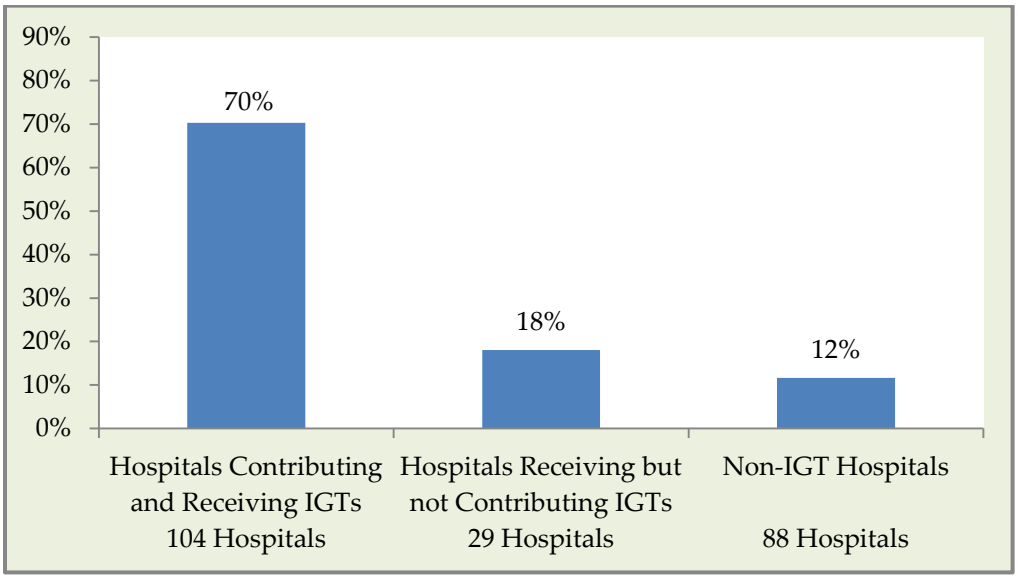


Figure 4 above shows that payments within the Florida Medicaid program are not the same relative to cost when compared across hospitals. However the hospitals that receive relatively higher payments are those that treat the majority of Medicaid patients. This is shown in Figure 5 below and is consistent with the state's goal stated in the SFY 2005 1115 demonstration waiver, "The state will continue to foster and protect its safety net providers."[8]

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

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



Notes for Figure 5 :

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

1.5 Options for Future Hospital Funding and Payment

1.5.1 Interaction between Funding and Payment

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

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

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

Table 2. Tie between funding source and payment flexibility.

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

1.5.2 Combination Funding and Payment Options Offered in this Study

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

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

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

1.5.3 Modifying the Low Income Pool Program

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

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

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

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

1.5.4 Delivery System Reform Incentive Payment Program

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

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

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

1.5.5 Medicaid Expansion

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

The decision whether or not to expand Medicaid is of particular concern to hospitals because the ACA can affect both payment increases and reductions for hospitals. The ACA offers increases in hospital revenue through expanded Medicaid eligibility and new subsidies to help low and moderate income households buy coverage through health insurance exchanges. Accompanying this are planned reductions in Medicaid and Medicare DSH funding as well as a reduction on Medicare hospital fee-for-service payments through reductions or removals of planned future increases.[9]

States that do not expand Medicaid receive their regular FMAP (around 59 percent for Florida) for new enrollment of recipients eligible for Medicaid. In addition, federal subsidies are offered to families with incomes between 100 percent and 400 percent of the federal poverty level (FPL) to help them purchase commercial insurance coverage through a Health Information Exchange (which is now referred to as the "Marketplace"). In contrast, for states that do expand their Medicaid program, federal subsidies are offered to families with incomes between 138 percent and 400 percent of the FPL to help them purchase commercial insurance coverage through the Marketplace. Also in expanding states, Medicaid coverage is offered to all families up to 138 percent of the FPL. For recipients receiving Medicaid coverage under the expanded eligibility rules, states will receive 100 percent federal matching for costs in 2014 through 2016. Between 2017 and 2020, the federal matching percentage gradually decreases down to 90 percent and continues at 90 percent thereafter.[10] There are two exceptions where states who had waiver programs covering childless adults for FPL percentages up to or over 100 percent prior to enactment of the ACA may receive the new, higher FMAP for these recipients. However, we do not believe these exceptions apply to any existing programs within Florida Medicaid.

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

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

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

Estimating the impact of Medicaid expansion in any state is not an exact science; a variety of assumptions must be made. With that said, estimates adopted by the Florida Social Services Estimating Conference (SSEC) in March 2013 indicate Medicaid expansion would have a steady-state cost of just under $1 billion per year in additional non-federal funds when the FMAP drops to 90 percent. For that additional cost, Florida would receive approximately $7.8 billion in additional federal funds annually.[11] Of course, if the federal government drops the FMAP percentage below 90 percent, the costs of Medicaid expansion to the state of Florida would increase above this estimate.

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

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

- Reliance on the private insurance market
- Exemptions from current Medicaid rules on cost-sharing, benefits, time limits and work requirements
- An emphasis on healthy behaviors and personal responsibility — in all states mandating premiums, the premiums will be eliminated or reduced for compliance with health behaviors[12]
- Limits or contingencies on the expansion, including ending the expansion program if the federal government reduces its enhanced matching rate[13]

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

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

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

1.5.6 Constraints for the Various Options

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

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

1.6 Conclusion

As defined in CMS's STCs for the 2014 renewal of Florida's 1115 demonstration waiver, the intent of this study is to suggest "sustainable, transparent, equitable, appropriate, accountable, and actuarially sound Medicaid payment systems and funding mechanisms that will ensure quality health care services to Florida's Medicaid beneficiaries throughout the state ***without the need for Low Income Pool (LIP) funding***."[14] (emphasis added by Navigant)

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

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

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

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

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

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

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

Senate 2015-16 Low-Income Pool Proposal

Compared to 2014-15 LIP

Including LIP and Hospital Rate Enhancements

Comparison of 2014-15 Hospital Funding Programs to 2015-16 Senate Proposal

		2014-2015 (Current LIP)			2015-2016 (Senate Proposal)			
		Total Dollars	IGT Portion	Federal Match drawn by IGTs	Total Dollars	IGT Portion	Federal Match drawn by IGTs	
1	LIP-4	$764,004,489	$308,963,415	$455,041,074	$1,249,597,303	$494,465,653	$755,131,650	1
2	Other Hospital Components	$118,911,922	$47,387,981	$69,792,981	$118,411,922	$46,155,598	$70,487,308	2
3	Critical-Needs Hospital Component				$233,719,378	$92,482,758	$141,236,620	3
4	LIP-6 / Residual LIP-6	$963,184,508	$389,511,815	$573,672,693	$244,372,316	$96,698,125	$147,674,191	4
5	Other Provider Access Sytems	$117,333,588	$39,029,977	$57,483,319	$117,333,588	$38,009,174	$58,046,359	5
6	Medical Schools	$204,533,833	$82,713,482	$121,820,351	$204,533,833	$80,934,038	$123,599,795	6
7	**Total LIP**	**$2,167,968,340**	**$867,606,670**	**$1,277,810,417**	**$2,167,968,340**	**$848,745,346**	**$1,296,175,922**	7
8	**Hospital IP and OP Rate Enhancements**	$797,054,938	$312,273,017	$459,915,452	$1,000,000,000	$385,644,000	$588,942,808	8
9	**Total for Hospitals (rows 1, 2, 3, 4, 8)**	$2,643,155,856	$1,058,136,228	$1,558,422,200	$2,846,100,919	$1,115,446,133	$1,703,472,576	9

IGT: Intergovernmental Transfer of funds to state government from a public hospital or local governmental authority.

Dollar figures for 2014-15 reflect spending authority appropriated in the 2014-15 General Appropriations Act.

LIP contains $9.1 million GR. Rate enhancements contain $10 million GR. The GR and federal match it draws are not included in these figures.

Redesigned LIP-6 Component

Senate LIP Proposal for 2015-16

	Current LIP	Senate's 2015-2016 LIP Proposal: Distribution of Former LIP-6 Dollars				
	LIP-6 Dollars (2014-15 FMAP)	**Additional Rate Enhancements**	**Additional LIP-4 Dollars**	**Critical-Needs Hospital Component**	**Residual LIP-6**	**Totals (2015-16 FMAP)**
IGTs	$389,511,815	$80,305,361	$111,645,863	$92,482,758	$96,698,125	$381,132,107
Federal match	$573,672,693	$122,639,702	$170,501,882	$141,236,620	$147,674,191	$582,052,395
Total	**$963,184,502**	$202,945,063	$282,147,745	$233,719,378	$244,372,316	**$963,184,502**
Distributed by		Inpatient rates for hospitals via SMMC or FFS	Current LIP-4 methodology	Separate methodology for Critical-Needs Component	Current LIP-6 methodology, prorated	

Critical-Needs Hospital Component

Distribution based on Medicaid utilization and on how many of the following critical-needs designations are met:

Essential Community Providers:
Hospitals that meet a number of federal criteria for serving predominantly low-income, medically underserved individuals

Regional Perinatal Intensive Care Centers (RPICC):
Hospitals specially designed and equipped to provide obstetrical services to women who have a high-risk pregnancy and to care for newborns with special health needs, such as critical illness or low birth-weight

Statutory Teaching Hospitals:
Hospitals meeting the definition of "teaching hospital" under s. 408.07(45), Fla. Stat.

Trauma Centers:
Hospitals meeting the criteria for trauma centers under s. 395.4025, Fla. Stat.

FMAP: Federal Medical Assistance Percentage. This is the percentage of Medicaid costs paid by the federal government. For SFY 2014-15, the federal government pays 59.56%. For SFY 2015-16, that percentage will move to 60.43% for the purposes of LIP.

Exhibit 1

Senate LIP Proposal for 2015-16

Net Dollars Compared to 2014-15, by Hospital

The 2014-15 figures in this document reflect letters of agreement with IGT donors and the corresponding allocations made effective after publication of spending authority appropriated in the 2014-15 GAA.

Senate LIP Proposal for 2015-16

Net Dollars Compared to 2014-15, by Hospital

		Net LIP Dollars, Including LIP and Rate Enhancements (does not include DSH)		
Row	**Hospital**	**2014-15 Net**	**2015-16 Net (projected)**	**Gain (Loss)**
1	ALL CHILDREN'S HOSPITAL	$55,562,140	$56,659,380	$1,097,240
2	ANN BATES LEACH EYE HOSPITAL	$3,009,237	$1,886,937	($1,122,300)
3	AVENTURA HOSPITAL & MEDICAL CENTER	$0	$1,304,094	$1,304,094
4	BAPTIST HOSPITAL OF MIAMI	$18,723,363	$23,487,634	$4,764,271
5	BAPTIST HOSPITAL OF PENSACOLA	$7,662,147	$10,792,281	$3,130,134
6	BAPTIST MEDICAL CENTER	$12,166,017	$17,997,589	$5,831,572
7	BAPTIST MEDICAL CENTER - BEACHES	$0	$298,537	$298,537
8	BAPTIST MEDICAL CENTER - NASSAU	$718,410	$825,283	$106,874
9	BARTOW REGIONAL MEDICAL CENTER	$1,325,137	$1,184,880	($140,257)
10	BAY MEDICAL CENTER	$8,269,880	$7,183,479	($1,086,401)
11	BAYCARE ALLIANT HOSPITAL	$0	$239,479	$239,479
12	BAYFRONT MEDICAL CENTER	$12,214,884	$13,257,310	$1,042,427
13	BERT FISH MEDICAL CENTER	$2,062,037	$1,334,790	($727,247)
14	BETHESDA HEALTHCARE SYSTEM	$7,195,872	$8,599,595	$1,403,723
15	BLAKE MEDICAL CENTER	$1,233,603	$1,121,896	($111,707)
16	BOCA RATON COMMUNITY HOSPITAL	$935,935	$840,928	($95,008)
17	BRANDON REGIONAL HOSPITAL	$6,398,746	$7,408,775	$1,010,029
18	BROOKS HEALTH SYSTEM	$0	$244,603	$244,603
19	BROOKSVILLE REGIONAL HOSPITAL	$4,429,110	$4,304,061	($125,049)
20	BROWARD HEALTH - BROWARD GEN MED CENTER	$62,749,667	$77,792,917	$15,043,249
21	BROWARD HEALTH - CORAL SPRINGS MED CENTER	$9,890,446	$8,910,375	($980,070)
22	BROWARD HEALTH - IMPERIAL POINT HOSPITAL	$7,070,245	$7,651,199	$580,954
23	BROWARD HEALTH - NORTH BROWARD MED CENT	$13,104,621	$12,930,301	($174,319)
24	CALHOUN LIBERTY HOSPITAL	$240,645	$254,392	$13,747
25	CAMPBELLTON-GRACEVILLE HOSPITAL	$574,589	$364,060	($210,529)
26	CAPE CANAVERAL HOSPITAL	$0	$335,160	$335,160
27	CAPE CORAL HOSPITAL	$5,101,179	$3,200,361	($1,900,818)
28	CAPITAL REGIONAL MEDICAL CENTER	$662,899	$1,302,467	$639,569
29	CENTRAL FLORIDA REGIONAL HOSPITAL	$0	$658,148	$658,148
30	CHARLOTTE REGIONAL MEDICAL CENTER	$0	$317,623	$317,623
31	CITRUS MEMORIAL HEALTH SYSTEM	$1,982,444	$1,545,272	($437,173)
32	CLEVELAND CLINIC FLORIDA WESTON	$0	$123,694	$123,694
33	COLUMBIA HOSPITAL	$2,398,655	$2,637,785	$239,131
34	COMMUNITY HOSPITAL	$0	$772,191	$772,191
35	CORAL GABLES HOSPITAL	$836,673	$1,275,302	$438,630
36	DELRAY MEDICAL CENTER	$2,716,209	$2,274,943	($441,266)
37	DESOTO MEMORIAL HOSPITAL	$1,282,755	$1,447,739	$164,984
38	DOCTORS' HOSPITAL - CORAL GABLES	$0	$245,555	$245,555
39	DOCTORS HOSPITAL OF SARASOTA	$0	$138,448	$138,448
40	DOCTORS MEMORIAL HOSPITAL - HOLMES CO	$2,419,515	$1,521,095	($898,420)
41	DOCTORS MEMORIAL HOSPITAL - TAYLOR CO	$725,400	$802,818	$77,418
42	ED FRASER MEMORIAL HOSPITAL	$1,897,515	$1,145,903	($751,612)
43	EDWARD WHITE HOSPITAL	$0	$140,899	$140,899
44	ENGLEWOOD COMMUNITY HOSPITAL	$0	$55,891	$55,891
45	FAWCETT MEMORIAL HOSPITAL	$0	$366,211	$366,211
46	FISHERMEN'S HOSPITAL	$270,179	$260,133	($10,047)
47	FLAGLER HOSPITAL	$1,072,290	$1,177,244	$104,954
48	FLORIDA HOSPITAL	$59,077,862	$77,536,435	$18,458,573
49	FLORIDA HOSPITAL - WAUCHULA	$374,250	$419,744	$45,494
50	FLORIDA HOSPITAL FISH MEMORIAL	$2,147,620	$1,576,343	($571,276)
51	FLORIDA HOSPITAL FLAGLER	$968,562	$1,132,130	$163,568
52	FLORIDA HOSPITAL HEARTLAND MED. CTR.	$980,433	$1,210,803	$230,370
53	FLORIDA HOSPITAL ORMOND MEMORIAL	$0	$970,915	$970,915

Senate LIP Proposal for 2015-16

Net Dollars Compared to 2014-15, by Hospital

		Net LIP Dollars, Including LIP and Rate Enhancements (does not include DSH)		
Row	**Hospital**	**2014-15 Net**	**2015-16 Net (projected)**	**Gain (Loss)**
54	FLORIDA HOSPITAL WATERMAN	$4,729,283	$3,317,257	($1,412,026)
55	FLORIDA HOSPITAL WESLEY CHAPEL	$0	$0	$0
56	FLORIDA HOSPITAL ZEPHYRHILLS	$361,367	$988,645	$627,278
57	FLORIDA STATE HOSPITAL	$0	$0	$0
58	FLORIDA STATE HOSPITAL - MED SURG.	$0	$0	$0
59	FORT WALTON BEACH MEDICAL CENTER	$0	$1,283,310	$1,283,310
60	G. PIERCE WOOD HOSPITAL	$0	$0	$0
61	GEORGE E. WEEMS MEMORIAL HOSPITAL	$224,986	$285,897	$60,911
62	GLADES GENERAL HOSPITAL	$2,865,919	$2,674,200	($191,719)
63	GOOD SAMARITAN MEDICAL CENTER	$2,771,612	$2,053,312	($718,300)
64	GULF COAST MEDICAL CENTER	$4,002,040	$5,518,734	$1,516,694
65	H. LEE MOFFIT CANCER CENTER	$18,939,572	$14,893,875	($4,045,697)
66	H.H. RAULERSON	$1,079,450	$1,333,872	$254,422
67	HALIFAX HEALTH	$19,605,072	$19,320,687	($284,385)
68	HEALTH CENTRAL	$5,481,933	$4,315,495	($1,166,438)
69	HEALTHMARK REGIONAL MEDICAL CENTER	$330,841	$362,120	$31,279
70	HEALTHSOUTH EMERALD COAST REHAB HOSPITAL	$0	$41,187	$41,187
71	HEALTHSOUTH REHAB HOSPITAL - TALLAHASSEE	$0	$22,743	$22,743
72	HEALTHSOUTH REHAB HOSPITAL OF MIAMI	$0	$58,521	$58,521
73	HEALTHSOUTH REHAB OF SPRING HILL	$0	$6,867	$6,867
74	HEALTHSOUTH REHAB. HOSPITAL - LARGO	$0	$40,582	$40,582
75	HEALTHSOUTH REHAB. HOSPITAL TREAS COAST	$0	$35,494	$35,494
76	HEALTHSOUTH REHAB. INSTITUTE - SARASOTA	$0	$19,647	$19,647
77	HEALTHSOUTH RIDGELAKE HOSPITAL	$0	$36,259	$36,259
78	HEALTHSOUTH SEA PINES REHAB HOSPITAL	$0	$19,428	$19,428
79	HEALTHSOUTH SUNRISE REHAB. HOSPITAL	$0	$5,982	$5,982
80	HEART OF FLORIDA REGIONAL MEDICAL CENTER	$3,890,630	$4,129,366	$238,736
81	HELEN ELLIS MEMORIAL HOSPITAL	$0	$274,824	$274,824
82	HENDRY REGIONAL MEDICAL CENTER	$385,547	$488,734	$103,186
83	HIALEAH HOSPITAL	$6,329,444	$7,906,131	$1,576,687
84	HIGHLANDS REGIONAL MEDICAL CENTER	$1,903,054	$1,276,805	($626,249)
85	HOLMES REGIONAL MEDICAL CENTER	$6,860,857	$8,865,544	$2,004,687
86	HOLY CROSS HOSPITAL	$0	$588,097	$588,097
87	HOMESTEAD HOSPITAL	$8,387,138	$9,793,763	$1,406,625
88	INDIAN RIVER MEDICAL CENTER	$4,948,163	$4,010,690	($937,472)
89	JACKSON HOSPITAL	$2,139,078	$2,215,561	$76,483
90	JACKSON MEMORIAL HOSPITAL	$237,240,249	$239,756,529	$2,516,280
91	JAY HOSPITAL	$306,896	$378,150	$71,254
92	JFK MEDICAL CENTER	$11,189,738	$10,962,738	($226,999)
93	JUPITER MEDICAL CENTER	$761,578	$703,410	($58,168)
94	KENDALL REGIONAL MEDICAL CENTER	$4,689,618	$9,344,998	$4,655,380
95	KINDRED HOSPITAL - CENTRAL TAMPA	$0	$3,131	$3,131
96	KINDRED HOSPITAL - NORTH FLORIDA	$0	$11,420	$11,420
97	KINDRED HOSPITAL - OCALA	$0	$19,490	$19,490
98	KINDRED HOSPITAL - PALM BEACHES	$0	$13,798	$13,798
99	KINDRED HOSPITAL - S FLORIDA - HOLLYWOOD	$0	$9,035	$9,035
100	KINDRED HOSPITAL - S. FLA - CORAL GABLES	$0	$1,372	$1,372
101	KINDRED HOSPITAL - SOUTH FLORIDA	$0	$32,946	$32,946
102	KINDRED HOSPITAL BAY AREA - ST. PETE	$0	$7,353	$7,353
103	KINDRED HOSPITAL BAY AREA - TAMPA	$0	$11,520	$11,520
104	KINDRED HOSPITAL - MELBOURNE	$0	$15,957	$15,957
105	LAKE BUTLER HOSPITAL	$621,489	$660,607	$39,119
106	LAKE CITY MEDICAL CENTER	$0	$166,878	$166,878

Senate LIP Proposal for 2015-16

Net Dollars Compared to 2014-15, by Hospital

Row	Hospital	Net LIP Dollars, Including LIP and Rate Enhancements (does not include DSH)		
		2014-15 Net	2015-16 Net (projected)	Gain (Loss)
107	LAKE WALES MEDICAL CENTERS	$1,170,151	$817,680	($352,471)
108	LAKELAND REGIONAL MEDICAL CENTER	$17,927,839	$19,099,511	$1,171,672
109	LAKEWOOD RANCH MEDICAL CENTER	$0	$126,293	$126,293
110	LARGO MEDICAL CENTER	$1,532,203	$2,269,751	$737,547
111	LARKIN COMMUNITY HOSPITAL	$1,585,372	$2,487,108	$901,736
112	LAWNWOOD REGIONAL MEDICAL CENTER	$6,414,568	$10,835,821	$4,421,252
113	LEE MEMORIAL HOSPITAL	$35,469,558	$46,218,972	$10,749,414
114	LEESBURG REGIONAL MEDICAL CENTER	$4,913,465	$3,490,888	($1,422,577)
115	LEHIGH REGIONAL MEDICAL CENTER	$0	$252,153	$252,153
116	LOWER KEYS MEDICAL CENTER	$1,748,422	$1,950,881	$202,459
117	MADISON COUNTY MEMORIAL HOSPITAL	$255,261	$186,389	($68,872)
118	MANATEE MEMORIAL HOSPITAL	$10,866,302	$9,970,752	($895,550)
119	MARINERS HOSPITAL	$457,458	$337,593	($119,865)
120	MARTIN MEMORIAL HOSPITAL	$2,375,411	$1,983,073	($392,337)
121	MEASE HOSPITAL - COUNTRYSIDE	$4,792,394	$3,541,481	($1,250,913)
122	MEASE HOSPITAL - DUNEDIN	$433,331	$411,819	($21,512)
123	MEMORIAL HOSPITAL - WEST VOLUSIA	$3,654,213	$2,523,056	($1,131,157)
124	MEMORIAL HOSPITAL JACKSONVILLE	$0	$1,893,374	$1,893,374
125	MEMORIAL HOSPITAL MIRAMAR	$11,639,410	$8,641,310	($2,998,100)
126	MEMORIAL HOSPITAL OF TAMPA	$0	$213,688	$213,688
127	MEMORIAL HOSPITAL PEMBROKE	$6,962,179	$5,887,573	($1,074,606)
128	MEMORIAL HOSPITAL WEST	$16,370,729	$10,975,169	($5,395,560)
129	MEMORIAL REGIONAL HOSPITAL	$62,643,795	$75,742,281	$13,098,486
130	MERCY HOSPITAL	$0	$0	$0
131	MIAMI CHILDRENS HOSPITAL	$51,464,568	$56,122,356	$4,657,787
132	MIAMI JEWISH HOME & HOSPITAL	$0	$0	$0
133	MORTON F. PLANT HOSPITAL	$11,090,648	$11,009,626	($81,022)
134	MORTON PLANT NORTH BAY HOSPITAL	$0	$856,613	$856,613
135	MT. SINAI MEDICAL CENTER	$16,413,531	$17,339,795	$926,264
136	MUNROE REGIONAL MEDICAL CENTER	$3,353,359	$3,505,763	$152,404
137	N.E. FLORIDA STATE HOSPITAL	$0	$0	$0
138	NATURE COAST REGIONAL HEALTH NETWORK	$232,000	$264,014	$32,014
139	NCH DOWNTOWN NAPLES HOSPITAL	$10,818,207	$9,620,333	($1,197,874)
140	NEMOURS HOSPITAL	$9,128,686	$9,315,227	$186,541
141	NORTH FLORIDA REGIONAL MEDICAL CENTER	$0	$1,707,113	$1,707,113
142	NORTH OKALOOSA MEDICAL CENTER	$0	$447,179	$447,179
143	NORTH SHORE MEDICAL CENTER	$8,491,078	$11,865,137	$3,374,059
144	NORTHSIDE HOSPITAL & HEART INST.	$1,999,577	$2,697,410	$697,833
145	NORTHWEST FLORIDA COMMUNITY HOSPITAL	$425,932	$485,237	$59,305
146	NORTHWEST MEDICAL CENTER	$0	$938,503	$938,503
147	OAK HILL HOSPITAL	$0	$414,833	$414,833
148	OCALA REGIONAL MEDICAL CENTER	$1,859,981	$1,948,592	$88,611
149	ORANGE PARK MEDICAL CENTER	$0	$1,541,977	$1,541,977
150	ORLANDO HEALTH	$54,845,355	$69,788,616	$14,943,261
151	OSCEOLA REGIONAL MEDICAL CENTER	$4,498,963	$6,198,460	$1,699,497
152	PALM BAY HOSPITAL	$0	$315,144	$315,144
153	PALM BEACH GARDENS MEDICAL CENTER	$1,331,024	$969,659	($361,365)
154	PALM SPRINGS GENERAL HOSPITAL	$0	$289,950	$289,950
155	PALMETTO GENERAL HOSPITAL	$7,081,793	$9,981,793	$2,900,000
156	PALMS OF PASADENA HOSPITAL	$0	$132,751	$132,751
157	PALMS WEST HOSPITAL	$7,600,976	$7,314,820	($286,156)
158	PAN AMERICAN HOSPITAL	$0	$251,256	$251,256
159	PARK ROYAL HOSPITAL	$0	$0	$0

Senate LIP Proposal for 2015-16

Net Dollars Compared to 2014-15, by Hospital

		Net LIP Dollars, Including LIP and Rate Enhancements (does not include DSH)		
Row	**Hospital**	**2014-15 Net**	**2015-16 Net (projected)**	**Gain (Loss)**
160	PARRISH MEDICAL CENTER	$4,679,924	$2,845,544	($1,834,379)
161	PASCO REGIONAL MEDICAL CENTER	$0	$230,265	$230,265
162	PEACE RIVER REGIONAL MEDICAL CENTER	$0	$896,682	$896,682
163	PHYSICAN'S REGIONAL MEDICAL CENTER	$2,007,118	$1,609,142	($397,976)
164	PLANTATION GENERAL HOSPITAL	$4,941,295	$8,604,611	$3,663,316
165	PUTNAM COMMUNITY MEDICAL CENTER	$1,281,636	$1,494,699	$213,063
166	REGIONAL MEDICAL CENTER AT BAYONET POINT	$206,266	$1,015,457	$809,191
167	SACRED HEART HOSPITAL	$19,177,152	$28,497,981	$9,320,829
168	SACRED HEART HOSPITAL ON THE GULF	$120,678	$91,663	($29,014)
169	SACRED HEART OF THE EMERALD COAST	$905,576	$1,057,252	$151,676
170	SAINT ANTHONY'S HOSPITAL	$5,446,083	$5,414,298	($31,785)
171	SAINT LUKE'S HOSPITAL	$254,093	$434,910	$180,818
172	SAINT PETERSBURG GENERAL HOSPITAL	$2,380,221	$2,984,241	$604,020
173	SAINT VINCENT'S MEDICAL CENTER	$2,988,193	$4,706,284	$1,718,092
174	SANTA ROSA MEDICAL CENTER	$2,064,819	$1,405,467	($659,352)
175	SARASOTA MEMORIAL HOSPITAL	$12,279,466	$9,806,750	($2,472,716)
176	SEBASTIAN RIVER MEDICAL CENTER	$0	$162,473	$162,473
177	SELECT SPECIALTY HOSP - ORLANDO	$0	$43,828	$43,828
178	SELECT SPECIALTY HOSP - MEMORIAL HEALTH JAX	$0	$0	$0
179	SELECT SPECIALTY HOSPITAL MIAMI	$0	$5,968	$5,968
180	SELECT SPECIALTY HOSPITAL PANAMA CITY	$0	$87,681	$87,681
181	SEVEN RIVERS COMMUNITY HOSPITAL	$0	$478,764	$478,764
182	SHANDS AT JACKSONVILLE	$94,922,651	$98,210,778	$3,288,127
183	SHANDS AT LAKE SHORE	$5,503,568	$4,186,934	($1,316,635)
184	SHANDS AT LIVE OAK	$617,661	$825,154	$207,493
185	SHANDS AT STARKE	$637,134	$751,904	$114,769
186	SHANDS TEACHING HOSPITAL & CLINIC	$106,672,132	$114,917,338	$8,245,206
187	SHRINER'S HOSPITAL FOR CHILDREN	$527,351	$571,189	$43,838
188	SISTER EMMANUEL HOSPITAL	$0	$5,770	$5,770
189	SOUTH BAY HOSPITAL	$456,282	$383,297	($72,985)
190	SOUTH FLORIDA BAPTIST HOSPITAL	$3,583,502	$3,434,128	($149,374)
191	SOUTH FLORIDA STATE HOSPITAL	$0	$0	$0
192	SOUTH LAKE HOSPITAL	$3,001,579	$1,912,622	($1,088,958)
193	SOUTH MIAMI HOSPITAL	$0	$4,430,139	$4,430,139
194	SOUTHWEST FLORIDA REGIONAL MEDICAL CENTER	$7,846,518	$5,698,632	($2,147,886)
195	SPECIALTY HOSPITAL - GAINESVILLE	$0	$68,473	$68,473
196	SPECIALTY HOSPITAL - PALM BEACH	$0	$57,097	$57,097
197	SPECIALTY HOSPITAL - PENSACOLA	$0	$107,757	$107,757
198	SPECIALTY HOSPITAL - TALLAHASSEE	$0	$46,578	$46,578
199	ST CLOUD REGIONAL MEDICAL CENTER	$0	$226,838	$226,838
200	ST. CATHERINE'S REHABILITATION HOSPITAL	$0	$127,343	$127,343
201	ST. JOHN'S REHABILITATION HOSPITAL	$0	$59,490	$59,490
202	ST. JOSEPH'S HOSPITAL	$41,381,614	$45,970,397	$4,588,783
203	ST. LUCIE MEDICAL CENTER	$2,296,803	$3,031,955	$735,152
204	ST. LUKE'S - ST. VINCENT'S HEALTHCARE	$0	$569,734	$569,734
205	ST. MARY'S HOSPITAL	$25,247,154	$31,260,319	$6,013,165
206	TALLAHASSEE MEMORIAL HOSPITAL	$8,018,297	$13,701,069	$5,682,772
207	TAMPA GENERAL HOSPITAL	$86,586,975	$95,471,385	$8,884,410
208	THE VILLAGES REGIONAL HOSPITAL	$0	$285,507	$285,507
209	TOWN & COUNTRY HOSPITAL	$545,193	$533,709	($11,484)
210	TWIN CITIES HOSPITAL	$0	$71,040	$71,040
211	UCHLTACH at Connerton	$0	$78,448	$78,448
212	UNIVERSITY COMMUNITY HOSP. - CARROLLWOOD	$577,259	$488,765	($88,494)

Senate LIP Proposal for 2015-16

Net Dollars Compared to 2014-15, by Hospital

		Net LIP Dollars, Including LIP and Rate Enhancements (does not include DSH)		
Row	**Hospital**	**2014-15 Net**	**2015-16 Net (projected)**	**Gain (Loss)**
213	UNIVERSITY COMMUNITY HOSPITAL - TAMPA	$2,036,203	$2,436,292	$400,089
214	UNIVERSITY HOSPITAL & MEDICAL C	$0	$488,711	$488,711
215	UNIVERSITY OF MIAMI HOSPITAL	$16,550,645	$15,616,550	($934,095)
216	UNIVERSITY OF MIAMI HOSPITAL & CLINICS	$10,079,550	$6,855,090	($3,224,460)
217	VENICE REGIONAL MEDICAL CENTER	$0	$241,716	$241,716
218	VIERA HOSPITAL	$0	$76,273	$76,273
219	W. FLORIDA COMMUNITY CARE	$0	$0	$0
220	WELLINGTON REGIONAL MEDICAL CENTER	$3,780,463	$3,873,493	$93,030
221	WEST BOCA MEDICAL CENTER	$2,543,264	$2,597,304	$54,040
222	WEST FLORIDA HOSPITAL	$0	$1,033,606	$1,033,606
223	WEST GABLES REHABILITATION HOSPITAL	$0	$51,630	$51,630
224	WEST KENDALL BAPTIST HOSPITAL	$0	$400,861	$400,861
225	WESTCHESTER GENERAL HOSPITAL	$1,415,531	$2,339,695	$924,164
226	WESTSIDE REGIONAL MEDICAL CENTE	$0	$511,320	$511,320
227	WINTER HAVEN HOSPITAL	$8,457,963	$7,824,132	($633,831)
228	WUESTHOFF MEDICAL CENTER - MELBOURNE	$0	$327,556	$327,556
229	WUESTHOFF MEDICAL CENTER - ROCKLEDGE	$0	$934,190	$934,190
		$1,544,362,275	**$1,709,893,933**	$165,531,658

Hospitals Getting No Benefit from	93	11	(82)
LIP or Rate Enhancements	40.6%	4.8%	

Exhibit 2

IGTs and Federal Dollars within 2014-15 LIP and Hospital Rate Enhancements

The 2014-15 figures in this document reflect letters of agreement with IGT donors and the corresponding allocations made effective after publication of spending authority appropriated in the 2014-15 GAA.

IGTs and Federal Dollars within LIP and Rate Enhancements in 2014-15

		IGTs and Federal Match for LIP and Rate Enhancements (does not include DSH)			
Row	Hospital	2014-15 IGTs Donated for LIP and Rate Enhancements	LIP and Rate Enhancement Dollars Received in 2014-15	Federal Dollars Lost if 2014-15 LIP Had Not Existed	IGTs Potentially Available in 2014-15 without LIP
1	ALL CHILDREN'S HOSPITAL	$8,444,120	$64,006,259	($55,562,140)	$8,444,120
2	ANN BATES LEACH EYE HOSPITAL	$1,517,727	$4,526,964	($3,009,237)	$1,517,727
3	AVENTURA HOSPITAL & MEDICAL CENTER	$0	$0	$0	$0
4	BAPTIST HOSPITAL OF MIAMI	$0	$18,723,363	($18,723,363)	$0
5	BAPTIST HOSPITAL OF PENSACOLA	$0	$7,662,147	($7,662,147)	$0
6	BAPTIST MEDICAL CENTER	$0	$12,166,017	($12,166,017)	$0
7	BAPTIST MEDICAL CENTER - BEACHES	$0	$0	$0	$0
8	BAPTIST MEDICAL CENTER - NASSAU	$0	$718,410	($718,410)	$0
9	BARTOW REGIONAL MEDICAL CENTER	$552,988	$1,878,125	($1,325,137)	$552,988
10	BAY MEDICAL CENTER	$3,615,997	$11,885,877	($8,269,880)	$3,615,997
11	BAYCARE ALLIANT HOSPITAL	$0	$0	$0	$0
12	BAYFRONT MEDICAL CENTER	$4,090,877	$16,305,761	($12,214,884)	$4,090,877
13	BERT FISH MEDICAL CENTER	$2,585,673	$4,647,710	($2,062,037)	$2,585,673
14	BETHESDA HEALTHCARE SYSTEM	$2,068,501	$9,264,373	($7,195,872)	$2,068,501
15	BLAKE MEDICAL CENTER	$697,540	$1,931,143	($1,233,603)	$697,540
16	BOCA RATON COMMUNITY HOSPITAL	$635,481	$1,571,416	($935,935)	$635,481
17	BRANDON REGIONAL HOSPITAL	$1,572,219	$7,970,965	($6,398,746)	$1,572,219
18	BROOKS HEALTH SYSTEM	$0	$0	$0	$0
19	BROOKSVILLE REGIONAL HOSPITAL	$1,713,676	$6,142,786	($4,429,110)	$1,713,676
20	BROWARD HEALTH - BROWARD GEN MED CEN	$103,695,419	$166,445,086	($62,749,667)	$103,695,419
21	BROWARD HEALTH - CORAL SPRINGS MED CE	$17,085,447	$26,975,893	($9,890,446)	$17,085,447
22	BROWARD HEALTH - IMPERIAL POINT HOSPIT	$32,529,319	$39,599,565	($7,070,245)	$32,529,319
23	BROWARD HEALTH - NORTH BROWARD MED C	$25,859,981	$38,964,602	($13,104,621)	$25,859,981
24	CALHOUN LIBERTY HOSPITAL	$0	$240,645	($240,645)	$0
25	CAMPBELLTON-GRACEVILLE HOSPITAL	$220,000	$794,589	($574,589)	$220,000
26	CAPE CANAVERAL HOSPITAL	$0	$0	$0	$0
27	CAPE CORAL HOSPITAL	$4,792,668	$9,893,847	($5,101,179)	$4,792,668
28	CAPITAL REGIONAL MEDICAL CENTER	$450,094	$1,112,993	($662,899)	$450,094
29	CENTRAL FLORIDA REGIONAL HOSPITAL	$0	$0	$0	$0
30	CHARLOTTE REGIONAL MEDICAL CENTER	$0	$0	$0	$0
31	CITRUS MEMORIAL HEALTH SYSTEM	$1,346,039	$3,328,483	($1,982,444)	$1,346,039
32	CLEVELAND CLINIC FLORIDA WESTON	$0	$0	$0	$0
33	COLUMBIA HOSPITAL	$742,232	$3,140,886	($2,398,655)	$742,232
34	COMMUNITY HOSPITAL	$0	$0	$0	$0
35	CORAL GABLES HOSPITAL	$0	$836,673	($836,673)	$0
36	DELRAY MEDICAL CENTER	$1,470,924	$4,187,133	($2,716,209)	$1,470,924
37	DESOTO MEMORIAL HOSPITAL	$0	$1,282,755	($1,282,755)	$0
38	DOCTORS' HOSPITAL - CORAL GABLES	$0	$0	$0	$0
39	DOCTORS HOSPITAL OF SARASOTA	$0	$0	$0	$0
40	DOCTORS MEMORIAL HOSPITAL - HOLMES CO	$1,300,000	$3,719,515	($2,419,515)	$1,300,000
41	DOCTORS MEMORIAL HOSPITAL - TAYLOR CO	$0	$725,400	($725,400)	$0
42	ED FRASER MEMORIAL HOSPITAL	$0	$1,897,515	($1,897,515)	$0
43	EDWARD WHITE HOSPITAL	$0	$0	$0	$0
44	ENGLEWOOD COMMUNITY HOSPITAL	$0	$0	$0	$0
45	FAWCETT MEMORIAL HOSPITAL	$0	$0	$0	$0
46	FISHERMEN'S HOSPITAL	$0	$270,179	($270,179)	$0
47	FLAGLER HOSPITAL	$728,063	$1,800,353	($1,072,290)	$728,063
48	FLORIDA HOSPITAL	$7,638,732	$66,716,594	($59,077,862)	$7,638,732
49	FLORIDA HOSPITAL - WAUCHULA	$0	$374,250	($374,250)	$0
50	FLORIDA HOSPITAL FISH MEMORIAL	$1,458,189	$3,605,809	($2,147,620)	$1,458,189
51	FLORIDA HOSPITAL FLAGLER	$0	$968,562	($968,562)	$0
52	FLORIDA HOSPITAL HEARTLAND MED. CTR.	$665,693	$1,646,126	($980,433)	$665,693
53	FLORIDA HOSPITAL ORMOND MEMORIAL	$0	$0	$0	$0

IGTs and Federal Dollars within LIP and Rate Enhancements in 2014-15

		IGTs and Federal Match for LIP and Rate Enhancements (does not include DSH)			
Row	Hospital	2014-15 IGTs Donated for LIP and Rate Enhancements	LIP and Rate Enhancement Dollars Received in 2014-15	Federal Dollars Lost if 2014-15 LIP Had Not Existed	IGTs Potentially Available in 2014-15 without LIP
54	FLORIDA HOSPITAL WATERMAN	$3,672,565	$8,401,848	($4,729,283)	$3,672,565
55	FLORIDA HOSPITAL WESLEY CHAPEL	$0	$0	$0	$0
56	FLORIDA HOSPITAL ZEPHYRHILLS	$0	$361,367	($361,367)	$0
57	FLORIDA STATE HOSPITAL	$0	$0	$0	$0
58	FLORIDA STATE HOSPITAL - MED SURG.	$0	$0	$0	$0
59	FORT WALTON BEACH MEDICAL CENTER	$0	$0	$0	$0
60	G. PIERCE WOOD HOSPITAL	$0	$0	$0	$0
61	GEORGE E. WEEMS MEMORIAL HOSPITAL	$0	$224,986	($224,986)	$0
62	GLADES GENERAL HOSPITAL	$4,303,723	$7,169,641	($2,865,919)	$4,303,723
63	GOOD SAMARITAN MEDICAL CENTER	$1,881,867	$4,653,479	($2,771,612)	$1,881,867
64	GULF COAST MEDICAL CENTER	$0	$4,002,040	($4,002,040)	$0
65	H. LEE MOFFIT CANCER CENTER	$13,549,572	$32,489,144	($18,939,572)	$13,549,572
66	H.H. RAULERSON	$115,000	$1,194,450	($1,079,450)	$115,000
67	HALIFAX HEALTH	$25,204,070	$44,809,142	($19,605,072)	$25,204,070
68	HEALTH CENTRAL	$2,831,525	$8,313,458	($5,481,933)	$2,831,525
69	HEALTHMARK REGIONAL MEDICAL CENTER	$0	$330,841	($330,841)	$0
70	HEALTHSOUTH EMERALD COAST REHAB HOS	$0	$0	$0	$0
71	HEALTHSOUTH REHAB HOSPITAL - TALLAHAS	$0	$0	$0	$0
72	HEALTHSOUTH REHAB HOSPITAL OF MIAMI	$0	$0	$0	$0
73	HEALTHSOUTH REHAB OF SPRING HILL	$0	$0	$0	$0
74	HEALTHSOUTH REHAB. HOSPITAL - LARGO	$0	$0	$0	$0
75	HEALTHSOUTH REHAB. HOSPITAL TREAS COA	$0	$0	$0	$0
76	HEALTHSOUTH REHAB. INSTITUTE - SARASOT	$0	$0	$0	$0
77	HEALTHSOUTH RIDGELAKE HOSPITAL	$0	$0	$0	$0
78	HEALTHSOUTH SEA PINES REHAB HOSPITAL	$0	$0	$0	$0
79	HEALTHSOUTH SUNRISE REHAB. HOSPITAL	$0	$0	$0	$0
80	HEART OF FLORIDA REGIONAL MEDICAL CENT	$740,302	$4,630,932	($3,890,630)	$740,302
81	HELEN ELLIS MEMORIAL HOSPITAL	$0	$0	$0	$0
82	HENDRY REGIONAL MEDICAL CENTER	$0	$385,547	($385,547)	$0
83	HIALEAH HOSPITAL	$0	$6,329,444	($6,329,444)	$0
84	HIGHLANDS REGIONAL MEDICAL CENTER	$1,292,134	$3,195,188	($1,903,054)	$1,292,134
85	HOLMES REGIONAL MEDICAL CENTER	$0	$6,860,857	($6,860,857)	$0
86	HOLY CROSS HOSPITAL	$0	$0	$0	$0
87	HOMESTEAD HOSPITAL	$0	$8,387,138	($8,387,138)	$0
88	INDIAN RIVER MEDICAL CENTER	$11,760,236	$16,708,399	($4,948,163)	$11,760,236
89	JACKSON HOSPITAL	$3,518,866	$5,657,944	($2,139,078)	$3,518,866
90	JACKSON MEMORIAL HOSPITAL	$373,276,901	$610,517,150	($237,240,249)	$373,276,901
91	JAY HOSPITAL	$0	$306,896	($306,896)	$0
92	JFK MEDICAL CENTER	$3,527,851	$14,717,589	($11,189,738)	$3,527,851
93	JUPITER MEDICAL CENTER	$517,095	$1,278,673	($761,578)	$517,095
94	KENDALL REGIONAL MEDICAL CENTER	$0	$4,689,618	($4,689,618)	$0
95	KINDRED HOSPITAL - CENTRAL TAMPA	$0	$0	$0	$0
96	KINDRED HOSPITAL - NORTH FLORIDA	$0	$0	$0	$0
97	KINDRED HOSPITAL - OCALA	$0	$0	$0	$0
98	KINDRED HOSPITAL - PALM BEACHES	$0	$0	$0	$0
99	KINDRED HOSPITAL - S FLORIDA - HOLLYWOO	$0	$0	$0	$0
100	KINDRED HOSPITAL - S. FLA - CORAL GABLES	$0	$0	$0	$0
101	KINDRED HOSPITAL - SOUTH FLORIDA	$0	$0	$0	$0
102	KINDRED HOSPITAL BAY AREA - ST. PETE	$0	$0	$0	$0
103	KINDRED HOSPITAL BAY AREA - TAMPA	$0	$0	$0	$0
104	KINDRED HOSPITAL - MELBOURNE	$0	$0	$0	$0
105	LAKE BUTLER HOSPITAL	$0	$621,489	($621,489)	$0
106	LAKE CITY MEDICAL CENTER	$0	$0	$0	$0

IGTs and Federal Dollars within LIP and Rate Enhancements in 2014-15

		IGTs and Federal Match for LIP and Rate Enhancements (does not include DSH)			
Row	Hospital	2014-15 IGTs Donated for LIP and Rate Enhancements	LIP and Rate Enhancement Dollars Received in 2014-15	Federal Dollars Lost if 2014-15 LIP Had Not Existed	IGTs Potentially Available in 2014-15 without LIP
107	LAKE WALES MEDICAL CENTERS	$794,508	$1,964,659	($1,170,151)	$794,508
108	LAKELAND REGIONAL MEDICAL CENTER	$6,461,167	$24,389,006	($17,927,839)	$6,461,167
109	LAKEWOOD RANCH MEDICAL CENTER	$0	$0	$0	$0
110	LARGO MEDICAL CENTER	$0	$1,532,203	($1,532,203)	$0
111	LARKIN COMMUNITY HOSPITAL	$0	$1,585,372	($1,585,372)	$0
112	LAWNWOOD REGIONAL MEDICAL CENTER	$0	$6,414,568	($6,414,568)	$0
113	LEE MEMORIAL HOSPITAL	$27,329,255	$62,798,813	($35,469,558)	$27,329,255
114	LEESBURG REGIONAL MEDICAL CENTER	$3,737,821	$8,651,286	($4,913,465)	$3,737,821
115	LEHIGH REGIONAL MEDICAL CENTER	$0	$0	$0	$0
116	LOWER KEYS MEDICAL CENTER	$0	$1,748,422	($1,748,422)	$0
117	MADISON COUNTY MEMORIAL HOSPITAL	$0	$255,261	($255,261)	$0
118	MANATEE MEMORIAL HOSPITAL	$6,067,187	$16,933,489	($10,866,302)	$6,067,187
119	MARINERS HOSPITAL	$0	$457,458	($457,458)	$0
120	MARTIN MEMORIAL HOSPITAL	$1,612,854	$3,988,265	($2,375,411)	$1,612,854
121	MEASE HOSPITAL - COUNTRYSIDE	$3,253,936	$8,046,330	($4,792,394)	$3,253,936
122	MEASE HOSPITAL - DUNEDIN	$294,223	$727,554	($433,331)	$294,223
123	MEMORIAL HOSPITAL - WEST VOLUSIA	$2,481,134	$6,135,347	($3,654,213)	$2,481,134
124	MEMORIAL HOSPITAL JACKSONVILLE	$0	$0	$0	$0
125	MEMORIAL HOSPITAL MIRAMAR	$10,146,635	$21,786,045	($11,639,410)	$10,146,635
126	MEMORIAL HOSPITAL OF TAMPA	$0	$0	$0	$0
127	MEMORIAL HOSPITAL PEMBROKE	$5,986,221	$12,948,400	($6,962,179)	$5,986,221
128	MEMORIAL HOSPITAL WEST	$18,833,131	$35,203,861	($16,370,729)	$18,833,131
129	MEMORIAL REGIONAL HOSPITAL	$100,544,422	$163,188,217	($62,643,795)	$100,544,422
130	MERCY HOSPITAL	$0	$0	$0	$0
131	MIAMI CHILDRENS HOSPITAL	$0	$51,464,568	($51,464,568)	$0
132	MIAMI JEWISH HOME & HOSPITAL	$0	$0	$0	$0
133	MORTON F. PLANT HOSPITAL	$2,459,746	$13,550,394	($11,090,648)	$2,459,746
134	MORTON PLANT NORTH BAY HOSPITAL	$0	$0	$0	$0
135	MT. SINAI MEDICAL CENTER	$3,388,382	$19,801,913	($16,413,531)	$3,388,382
136	MUNROE REGIONAL MEDICAL CENTER	$2,541,961	$5,895,320	($3,353,359)	$2,541,961
137	N.E. FLORIDA STATE HOSPITAL	$0	$0	$0	$0
138	NATURE COAST REGIONAL HEALTH NETWORK	$0	$232,000	($232,000)	$0
139	NCH DOWNTOWN NAPLES HOSPITAL	$4,365,204	$15,183,411	($10,818,207)	$4,365,204
140	NEMOURS HOSPITAL	$0	$9,128,686	($9,128,686)	$0
141	NORTH FLORIDA REGIONAL MEDICAL CENTER	$0	$0	$0	$0
142	NORTH OKALOOSA MEDICAL CENTER	$0	$0	$0	$0
143	NORTH SHORE MEDICAL CENTER	$0	$8,491,078	($8,491,078)	$0
144	NORTHSIDE HOSPITAL & HEART INST.	$0	$1,999,577	($1,999,577)	$0
145	NORTHWEST FLORIDA COMMUNITY HOSPITAL	$0	$425,932	($425,932)	$0
146	NORTHWEST MEDICAL CENTER	$0	$0	$0	$0
147	OAK HILL HOSPITAL	$0	$0	$0	$0
148	OCALA REGIONAL MEDICAL CENTER	$1,183,400	$3,043,381	($1,859,981)	$1,183,400
149	ORANGE PARK MEDICAL CENTER	$0	$0	$0	$0
150	ORLANDO HEALTH	$9,316,518	$64,161,873	($54,845,355)	$9,316,518
151	OSCEOLA REGIONAL MEDICAL CENTER	$0	$4,498,963	($4,498,963)	$0
152	PALM BAY HOSPITAL	$0	$0	$0	$0
153	PALM BEACH GARDENS MEDICAL CENTER	$903,738	$2,234,762	($1,331,024)	$903,738
154	PALM SPRINGS GENERAL HOSPITAL	$0	$0	$0	$0
155	PALMETTO GENERAL HOSPITAL	$0	$7,081,793	($7,081,793)	$0
156	PALMS OF PASADENA HOSPITAL	$0	$0	$0	$0
157	PALMS WEST HOSPITAL	$2,736,223	$10,337,199	($7,600,976)	$2,736,223
158	PAN AMERICAN HOSPITAL	$0	$0	$0	$0
159	PARK ROYAL HOSPITAL	$0	$0	$0	$0

IGTs and Federal Dollars within LIP and Rate Enhancements in 2014-15

		IGTs and Federal Match for LIP and Rate Enhancements (does not include DSH)			
Row	Hospital	2014-15 IGTs Donated for LIP and Rate Enhancements	LIP and Rate Enhancement Dollars Received in 2014-15	Federal Dollars Lost if 2014-15 LIP Had Not Existed	IGTs Potentially Available in 2014-15 without LIP
160	PARRISH MEDICAL CENTER	$4,172,558	$8,852,482	($4,679,924)	$4,172,558
161	PASCO REGIONAL MEDICAL CENTER	$0	$0	$0	$0
162	PEACE RIVER REGIONAL MEDICAL CENTER	$0	$0	$0	$0
163	PHYSICAN'S REGIONAL MEDICAL CENTER	$1,362,791	$3,369,909	($2,007,118)	$1,362,791
164	PLANTATION GENERAL HOSPITAL	$0	$4,941,295	($4,941,295)	$0
165	PUTNAM COMMUNITY MEDICAL CENTER	$0	$1,281,636	($1,281,636)	$0
166	REGIONAL MEDICAL CENTER AT BAYONET PO	$0	$206,266	($206,266)	$0
167	SACRED HEART HOSPITAL	$792,557	$19,969,709	($19,177,152)	$792,557
168	SACRED HEART HOSPITAL ON THE GULF	$0	$120,678	($120,678)	$0
169	SACRED HEART OF THE EMERALD COAST	$0	$905,576	($905,576)	$0
170	SAINT ANTHONY'S HOSPITAL	$1,541,504	$6,987,587	($5,446,083)	$1,541,504
171	SAINT LUKE'S HOSPITAL	$0	$254,093	($254,093)	$0
172	SAINT PETERSBURG GENERAL HOSPITAL	$0	$2,380,221	($2,380,221)	$0
173	SAINT VINCENT'S MEDICAL CENTER	$0	$2,988,193	($2,988,193)	$0
174	SANTA ROSA MEDICAL CENTER	$1,517,383	$3,582,202	($2,064,819)	$1,517,383
175	SARASOTA MEMORIAL HOSPITAL	$26,460,414	$38,739,880	($12,279,466)	$26,460,414
176	SEBASTIAN RIVER MEDICAL CENTER	$0	$0	$0	$0
177	SELECT SPECIALTY HOSP - ORLANDO	$0	$0	$0	$0
178	SELECT SPECIALTY HOSP - MEMORIAL HEALT	$0	$0	$0	$0
179	SELECT SPECIALTY HOSPITAL MIAMI	$0	$0	$0	$0
180	SELECT SPECIALTY HOSPITAL PANAMA CITY	$0	$0	$0	$0
181	SEVEN RIVERS COMMUNITY HOSPITAL	$0	$0	$0	$0
182	SHANDS AT JACKSONVILLE	$26,414,528	$121,337,179	($94,922,651)	$26,414,528
183	SHANDS AT LAKE SHORE	$2,400,000	$7,903,568	($5,503,568)	$2,400,000
184	SHANDS AT LIVE OAK	$233,644	$851,305	($617,661)	$233,644
185	SHANDS AT STARKE	$35,000	$672,134	($637,134)	$35,000
186	SHANDS TEACHING HOSPITAL & CLINIC	$28,724,709	$135,396,841	($106,672,132)	$28,724,709
187	SHRINER'S HOSPITAL FOR CHILDREN	$0	$527,351	($527,351)	$0
188	SISTER EMMANUEL HOSPITAL	$0	$0	$0	$0
189	SOUTH BAY HOSPITAL	$309,806	$766,088	($456,282)	$309,806
190	SOUTH FLORIDA BAPTIST HOSPITAL	$841,406	$4,424,908	($3,583,502)	$841,406
191	SOUTH FLORIDA STATE HOSPITAL	$0	$0	$0	$0
192	SOUTH LAKE HOSPITAL	$2,038,010	$5,039,589	($3,001,579)	$2,038,010
193	SOUTH MIAMI HOSPITAL	$0	$0	$0	$0
194	SOUTHWEST FLORIDA REGIONAL MEDICAL CE	$10,048,089	$17,894,607	($7,846,518)	$10,048,089
195	SPECIALTY HOSPITAL - GAINESVILLE	$0	$0	$0	$0
196	SPECIALTY HOSPITAL - PALM BEACH	$0	$0	$0	$0
197	SPECIALTY HOSPITAL - PENSACOLA	$0	$0	$0	$0
198	SPECIALTY HOSPITAL - TALLAHASSEE	$0	$0	$0	$0
199	ST CLOUD REGIONAL MEDICAL CENTER	$0	$0	$0	$0
200	ST. CATHERINE'S REHABILITATION HOSPITAL	$0	$0	$0	$0
201	ST. JOHN'S REHABILITATION HOSPITAL	$0	$0	$0	$0
202	ST. JOSEPH'S HOSPITAL	$17,915,090	$59,296,704	($41,381,614)	$17,915,090
203	ST. LUCIE MEDICAL CENTER	$0	$2,296,803	($2,296,803)	$0
204	ST. LUKE'S - ST. VINCENT'S HEALTHCARE	$0	$0	$0	$0
205	ST. MARY'S HOSPITAL	$8,172,713	$33,419,866	($25,247,154)	$8,172,713
206	TALLAHASSEE MEMORIAL HOSPITAL	$0	$8,018,297	($8,018,297)	$0
207	TAMPA GENERAL HOSPITAL	$36,023,991	$122,610,966	($86,586,975)	$36,023,991
208	THE VILLAGES REGIONAL HOSPITAL	$0	$0	$0	$0
209	TOWN & COUNTRY HOSPITAL	$370,174	$915,367	($545,193)	$370,174
210	TWIN CITIES HOSPITAL	$0	$0	$0	$0
211	UCHLTACH at Connerton	$0	$0	$0	$0
212	UNIVERSITY COMMUNITY HOSP. - CARROLLW	$391,947	$969,206	($577,259)	$391,947

IGTs and Federal Dollars within LIP and Rate Enhancements in 2014-15

		IGTs and Federal Match for LIP and Rate Enhancements (does not include DSH)			
Row	**Hospital**	2014-15 IGTs Donated for LIP and Rate Enhancements	LIP and Rate Enhancement Dollars Received in 2014-15	Federal Dollars Lost if 2014-15 LIP Had Not Existed	IGTs Potentially Available in 2014-15 without LIP
213	UNIVERSITY COMMUNITY HOSPITAL - TAMPA	$1,382,539	$3,418,742	($2,036,203)	$1,382,539
214	UNIVERSITY HOSPITAL & MEDICAL C	$0	$0	$0	$0
215	UNIVERSITY OF MIAMI HOSPITAL	$7,009,694	$23,560,339	($16,550,645)	$7,009,694
216	UNIVERSITY OF MIAMI HOSPITAL & CLINICS	$4,599,751	$14,679,301	($10,079,550)	$4,599,751
217	VENICE REGIONAL MEDICAL CENTER	$0	$0	$0	$0
218	VIERA HOSPITAL	$0	$0	$0	$0
219	W. FLORIDA COMMUNITY CARE	$0	$0	$0	$0
220	WELLINGTON REGIONAL MEDICAL CENTER	$1,483,446	$5,263,910	($3,780,463)	$1,483,446
221	WEST BOCA MEDICAL CENTER	$1,726,823	$4,270,087	($2,543,264)	$1,726,823
222	WEST FLORIDA HOSPITAL	$0	$0	$0	$0
223	WEST GABLES REHABILITATION HOSPITAL	$0	$0	$0	$0
224	WEST KENDALL BAPTIST HOSPITAL	$0	$0	$0	$0
225	WESTCHESTER GENERAL HOSPITAL	$0	$1,415,531	($1,415,531)	$0
226	WESTSIDE REGIONAL MEDICAL CENTE	$0	$0	$0	$0
227	WINTER HAVEN HOSPITAL	$2,418,153	$10,876,116	($8,457,963)	$2,418,153
228	WUESTHOFF MEDICAL CENTER - MELBOURNE	$0	$0	$0	$0
229	WUESTHOFF MEDICAL CENTER - ROCKLEDGE	$0	$0	$0	$0
		$1,076,493,695	$2,620,855,969	($1,544,362,275)	$1,076,493,695

Low Income Program

#	Scenarios	Net Loss (in millions)	Comments
A	**Program Not Renewed**	**(1,544.4)**	**Option 1: No General Revenue appropriated** ($1.5b) net hospital losses. **Option 2: Estimated General Revenue Impact: $604.8m** Offsets ($1.5b) net hospital losses. **Option 3: Estimated General Revenue Impact: $309.2m** Preserves current hospital rates for services; ($747.3m) net loss of LIP payments to hospitals.
B	**$600m Program Authorized**	**(716.3)**	**Estimated General Revenue Impact: $283.4m** Preserves current hospital rates for services. ($716.3m) net loss of LIP payments to hospitals.
C	**$1.2b Program Authorized**	**(421.3)**	**Estimated General Revenue Impact: $166.7m** Preserves current hospital rates for services. ($421.3m) net loss of LIP payments to hospitals.

Caveats:

1 Net Losses will vary by hospital. Analysis assumes local IGT dollars will remain at the local level. The donation of IGT dollars are not uniform by county.

2 $321m in other programs funded through the LIP Program are also at risk. These programs include:
- $204.5m: Payments to Medical Schools for faculty physicians
- $117m: Payments to certain programs such as County Health Departments, Federally Qualified Health Centers and Enhanced Primary Care initiatives.

Exhibit 3

Simulation of 2014-15 LIP Funded at $1.2 Billion

1 *The 2014-15 figures in this document reflect letters of agreement with IGT donors and the corresponding allocations made effective after publication of spending authority appropriated in the 2014-15 GAA.*

2 *Simulation based on 2014-15 LIP funded at $1.2 billion instead of $2.167 billion.*

3 *Net losses will vary by hospital. Dollars may flow differently if total dollars are reduced. Simulation assumes IGT dollars will remain at the local level. Donations of IGT dollars are not uniform by county.*

4 *$321 million in non-hospital programs funded through LIP are also at risk if LIP funding is reduced. These programs include:*

Medical school faculty portion of LIP ($204.5 million), and

LIP payments to other provider access systems, such as county health departments, federally qualified health centers, and enhanced primary care initiatives ($117 million).

2014-15 LIP Compared to a $1.2 Billion LIP

Comparison of Net Dollars, by Hospital

		Net LIP Dollars, Including LIP and Rate Enhancements (does not include DSH)		
Row	**Hospital**	**2014-15 Nets: $2.167 Billion LIP**	**Projected Nets: $1.2 Billion LIP**	**Gain (Loss)**
1	ALL CHILDREN'S HOSPITAL	$55,562,140	$46,514,149	($9,047,991)
2	ANN BATES LEACH EYE HOSPITAL	$3,009,237	$1,382,971	($1,626,265)
3	AVENTURA HOSPITAL & MEDICAL CENTER	$0	$0	$0
4	BAPTIST HOSPITAL OF MIAMI	$18,723,363	$18,723,363	$0
5	BAPTIST HOSPITAL OF PENSACOLA	$7,662,147	$7,662,147	$0
6	BAPTIST MEDICAL CENTER	$12,166,017	$12,166,017	$0
7	BAPTIST MEDICAL CENTER - BEACHES	$0	$0	$0
8	BAPTIST MEDICAL CENTER - NASSAU	$718,410	$718,410	$0
9	BARTOW REGIONAL MEDICAL CENTER	$1,325,137	$732,603	($592,533)
10	BAY MEDICAL CENTER	$8,269,880	$4,395,290	($3,874,590)
11	BAYCARE ALLIANT HOSPITAL	$0	$0	$0
12	BAYFRONT MEDICAL CENTER	$12,214,884	$7,831,455	($4,383,429)
13	BERT FISH MEDICAL CENTER	$2,062,037	$639,641	($1,422,396)
14	BETHESDA HEALTHCARE SYSTEM	$7,195,872	$4,979,445	($2,216,427)
15	BLAKE MEDICAL CENTER	$1,233,603	$486,179	($747,424)
16	BOCA RATON COMMUNITY HOSPITAL	$935,935	$255,009	($680,926)
17	BRANDON REGIONAL HOSPITAL	$6,398,746	$4,714,093	($1,684,653)
18	BROOKS HEALTH SYSTEM	$0	$0	$0
19	BROOKSVILLE REGIONAL HOSPITAL	$4,429,110	$2,592,884	($1,836,226)
20	BROWARD HEALTH - BROWARD GEN MED CENTER	$62,749,667	$47,144,731	($15,604,936)
21	BROWARD HEALTH - CORAL SPRINGS MED CENTER	$9,890,446	$6,393,133	($3,497,313)
22	BROWARD HEALTH - IMPERIAL POINT HOSPITAL	$7,070,245	$6,028,396	($1,041,850)
23	BROWARD HEALTH - NORTH BROWARD MED CENT	$13,104,621	$10,036,072	($3,068,549)
24	CALHOUN LIBERTY HOSPITAL	$240,645	$240,645	$0
25	CAMPBELLTON-GRACEVILLE HOSPITAL	$574,589	$338,855	($235,734)
26	CAPE CANAVERAL HOSPITAL	$0	$0	$0
27	CAPE CORAL HOSPITAL	$5,101,179	$1,477,116	($3,624,063)
28	CAPITAL REGIONAL MEDICAL CENTER	$662,899	$180,617	($482,282)
29	CENTRAL FLORIDA REGIONAL HOSPITAL	$0	$0	$0
30	CHARLOTTE REGIONAL MEDICAL CENTER	$0	$0	$0
31	CITRUS MEMORIAL HEALTH SYSTEM	$1,982,444	$540,147	($1,442,298)
32	CLEVELAND CLINIC FLORIDA WESTON	$0	$0	$0
33	COLUMBIA HOSPITAL	$2,398,655	$1,603,344	($795,310)
34	COMMUNITY HOSPITAL	$0	$0	$0
35	CORAL GABLES HOSPITAL	$836,673	$836,673	$0
36	DELRAY MEDICAL CENTER	$2,716,209	$1,140,094	($1,576,115)
37	DESOTO MEMORIAL HOSPITAL	$1,282,755	$1,282,755	$0
38	DOCTORS' HOSPITAL - CORAL GABLES	$0	$0	$0
39	DOCTORS HOSPITAL OF SARASOTA	$0	$0	$0
40	DOCTORS MEMORIAL HOSPITAL - HOLMES CO	$2,419,515	$1,026,546	($1,392,969)
41	DOCTORS MEMORIAL HOSPITAL - TAYLOR CO	$725,400	$725,400	$0
42	ED FRASER MEMORIAL HOSPITAL	$1,897,515	$1,897,514	($1)
43	EDWARD WHITE HOSPITAL	$0	$0	$0
44	ENGLEWOOD COMMUNITY HOSPITAL	$0	$0	$0
45	FAWCETT MEMORIAL HOSPITAL	$0	$0	$0
46	FISHERMEN'S HOSPITAL	$270,179	$270,179	$0
47	FLAGLER HOSPITAL	$1,072,290	$437,476	($634,814)
48	FLORIDA HOSPITAL	$59,077,862	$52,579,391	($6,498,471)
49	FLORIDA HOSPITAL - WAUCHULA	$374,250	$374,250	$0
50	FLORIDA HOSPITAL FISH MEMORIAL	$2,147,620	$585,151	($1,562,469)
51	FLORIDA HOSPITAL FLAGLER	$968,562	$968,561	($1)
52	FLORIDA HOSPITAL HEARTLAND MED. CTR.	$980,433	$267,134	($713,299)
53	FLORIDA HOSPITAL ORMOND MEMORIAL	$0	$0	$0

2014-15 LIP Compared to a $1.2 Billion LIP

Comparison of Net Dollars, by Hospital

		Net LIP Dollars, Including LIP and Rate Enhancements (does not include DSH)		
Row	**Hospital**	**2014-15 Nets: $2.167 Billion LIP**	**Projected Nets: $1.2 Billion LIP**	**Gain (Loss)**
54	FLORIDA HOSPITAL WATERMAN	$4,729,283	$1,318,848	($3,410,435)
55	FLORIDA HOSPITAL WESLEY CHAPEL	$0	$0	$0
56	FLORIDA HOSPITAL ZEPHYRHILLS	$361,367	$361,367	$0
57	FLORIDA STATE HOSPITAL	$0	$0	$0
58	FLORIDA STATE HOSPITAL - MED SURG.	$0	$0	$0
59	FORT WALTON BEACH MEDICAL CENTER	$0	$0	$0
60	G. PIERCE WOOD HOSPITAL	$0	$0	$0
61	GEORGE E. WEEMS MEMORIAL HOSPITAL	$224,986	$224,989	$3
62	GLADES GENERAL HOSPITAL	$2,865,919	$2,004,719	($861,200)
63	GOOD SAMARITAN MEDICAL CENTER	$2,771,612	$755,167	($2,016,445)
64	GULF COAST MEDICAL CENTER	$4,002,040	$4,002,040	$0
65	H. LEE MOFFIT CANCER CENTER	$18,939,572	$11,343,810	($7,595,762)
66	H.H. RAULERSON	$1,079,450	$956,226	($123,224)
67	HALIFAX HEALTH	$19,605,072	$12,002,794	($7,602,278)
68	HEALTH CENTRAL	$5,481,933	$2,447,916	($3,034,017)
69	HEALTHMARK REGIONAL MEDICAL CENTER	$330,841	$330,841	$0
70	HEALTHSOUTH EMERALD COAST REHAB HOSPITAL	$0	$0	$0
71	HEALTHSOUTH REHAB HOSPITAL - TALLAHASSEE	$0	$0	$0
72	HEALTHSOUTH REHAB HOSPITAL OF MIAMI	$0	$0	$0
73	HEALTHSOUTH REHAB OF SPRING HILL	$0	$0	$0
74	HEALTHSOUTH REHAB. HOSPITAL - LARGO	$0	$0	$0
75	HEALTHSOUTH REHAB. HOSPITAL TREAS COAST	$0	$0	$0
76	HEALTHSOUTH REHAB. INSTITUTE - SARASOTA	$0	$0	$0
77	HEALTHSOUTH RIDGELAKE HOSPITAL	$0	$0	$0
78	HEALTHSOUTH SEA PINES REHAB HOSPITAL	$0	$0	$0
79	HEALTHSOUTH SUNRISE REHAB. HOSPITAL	$0	$0	$0
80	HEART OF FLORIDA REGIONAL MEDICAL CENTER	$3,890,630	$3,097,386	($793,244)
81	HELEN ELLIS MEMORIAL HOSPITAL	$0	$0	$0
82	HENDRY REGIONAL MEDICAL CENTER	$385,547	$385,547	$0
83	HIALEAH HOSPITAL	$6,329,444	$6,329,444	$0
84	HIGHLANDS REGIONAL MEDICAL CENTER	$1,903,054	$518,514	($1,384,540)
85	HOLMES REGIONAL MEDICAL CENTER	$6,860,857	$6,860,857	$0
86	HOLY CROSS HOSPITAL	$0	$0	$0
87	HOMESTEAD HOSPITAL	$8,387,138	$8,387,138	$0
88	INDIAN RIVER MEDICAL CENTER	$4,948,163	$1,899,528	($3,048,634)
89	JACKSON HOSPITAL	$2,139,078	$1,904,559	($234,519)
90	JACKSON MEMORIAL HOSPITAL	$237,240,249	$160,562,795	($76,677,454)
91	JAY HOSPITAL	$306,896	$306,896	$0
92	JFK MEDICAL CENTER	$11,189,738	$7,409,597	($3,780,141)
93	JUPITER MEDICAL CENTER	$761,578	$207,502	($554,075)
94	KENDALL REGIONAL MEDICAL CENTER	$4,689,618	$4,689,618	$0
95	KINDRED HOSPITAL - CENTRAL TAMPA	$0	$0	$0
96	KINDRED HOSPITAL - NORTH FLORIDA	$0	$0	$0
97	KINDRED HOSPITAL - OCALA	$0	$0	$0
98	KINDRED HOSPITAL - PALM BEACHES	$0	$0	$0
99	KINDRED HOSPITAL - S FLORIDA - HOLLYWOOD	$0	$0	$0
100	KINDRED HOSPITAL - S. FLA - CORAL GABLES	$0	$0	$0
101	KINDRED HOSPITAL - SOUTH FLORIDA	$0	$0	$0
102	KINDRED HOSPITAL BAY AREA - ST. PETE	$0	$0	$0
103	KINDRED HOSPITAL BAY AREA - TAMPA	$0	$0	$0
104	KINDRED HOSPITAL - MELBOURNE	$0	$0	$0
105	LAKE BUTLER HOSPITAL	$621,489	$621,489	$0
106	LAKE CITY MEDICAL CENTER	$0	$0	$0

2014-15 LIP Compared to a $1.2 Billion LIP

Comparison of Net Dollars, by Hospital

Row	Hospital	Net LIP Dollars, Including LIP and Rate Enhancements (does not include DSH)		
		2014-15 Nets: $2.167 Billion LIP	Projected Nets: $1.2 Billion LIP	Gain (Loss)
107	LAKE WALES MEDICAL CENTERS	$1,170,151	$318,825	($851,326)
108	LAKELAND REGIONAL MEDICAL CENTER	$17,927,839	$11,004,613	($6,923,227)
109	LAKEWOOD RANCH MEDICAL CENTER	$0	$0	$0
110	LARGO MEDICAL CENTER	$1,532,203	$1,532,203	$0
111	LARKIN COMMUNITY HOSPITAL	$1,585,372	$1,585,372	$0
112	LAWNWOOD REGIONAL MEDICAL CENTER	$6,414,568	$6,414,568	$0
113	LEE MEMORIAL HOSPITAL	$35,469,558	$26,438,569	($9,030,989)
114	LEESBURG REGIONAL MEDICAL CENTER	$4,913,465	$1,365,108	($3,548,357)
115	LEHIGH REGIONAL MEDICAL CENTER	$0	$0	$0
116	LOWER KEYS MEDICAL CENTER	$1,748,422	$1,748,422	$0
117	MADISON COUNTY MEMORIAL HOSPITAL	$255,261	$255,261	$0
118	MANATEE MEMORIAL HOSPITAL	$10,866,302	$6,742,822	($4,123,479)
119	MARINERS HOSPITAL	$457,458	$457,458	$0
120	MARTIN MEMORIAL HOSPITAL	$2,375,411	$647,215	($1,728,196)
121	MEASE HOSPITAL - COUNTRYSIDE	$4,792,394	$1,305,758	($3,486,636)
122	MEASE HOSPITAL - DUNEDIN	$433,331	$118,067	($315,264)
123	MEMORIAL HOSPITAL - WEST VOLUSIA	$3,654,213	$995,644	($2,658,568)
124	MEMORIAL HOSPITAL JACKSONVILLE	$0	$0	$0
125	MEMORIAL HOSPITAL MIRAMAR	$11,639,410	$6,093,827	($5,545,584)
126	MEMORIAL HOSPITAL OF TAMPA	$0	$0	$0
127	MEMORIAL HOSPITAL PEMBROKE	$6,962,179	$4,764,873	($2,197,306)
128	MEMORIAL HOSPITAL WEST	$16,370,729	$6,206,709	($10,164,020)
129	MEMORIAL REGIONAL HOSPITAL	$62,643,795	$48,539,746	($14,104,049)
130	MERCY HOSPITAL	$0	$0	$0
131	MIAMI CHILDRENS HOSPITAL	$51,464,568	$51,464,571	$2
132	MIAMI JEWISH HOME & HOSPITAL	$0	$0	$0
133	MORTON F. PLANT HOSPITAL	$11,090,648	$8,454,998	($2,635,650)
134	MORTON PLANT NORTH BAY HOSPITAL	$0	$0	$0
135	MT. SINAI MEDICAL CENTER	$16,413,531	$12,782,835	($3,630,696)
136	MUNROE REGIONAL MEDICAL CENTER	$3,353,359	$931,071	($2,422,288)
137	N.E. FLORIDA STATE HOSPITAL	$0	$0	$0
138	NATURE COAST REGIONAL HEALTH NETWORK	$232,000	$232,000	$0
139	NCH DOWNTOWN NAPLES HOSPITAL	$10,818,207	$6,140,832	($4,677,375)
140	NEMOURS HOSPITAL	$9,128,686	$9,128,686	$0
141	NORTH FLORIDA REGIONAL MEDICAL CENTER	$0	$0	$0
142	NORTH OKALOOSA MEDICAL CENTER	$0	$0	$0
143	NORTH SHORE MEDICAL CENTER	$8,491,078	$8,491,078	$0
144	NORTHSIDE HOSPITAL & HEART INST.	$1,999,577	$1,999,577	$0
145	NORTHWEST FLORIDA COMMUNITY HOSPITAL	$425,932	$425,932	$0
146	NORTHWEST MEDICAL CENTER	$0	$0	$0
147	OAK HILL HOSPITAL	$0	$0	$0
148	OCALA REGIONAL MEDICAL CENTER	$1,859,981	$660,820	($1,199,161)
149	ORANGE PARK MEDICAL CENTER	$0	$0	$0
150	ORLANDO HEALTH	$54,845,355	$46,026,514	($8,818,841)
151	OSCEOLA REGIONAL MEDICAL CENTER	$4,498,963	$4,498,963	$0
152	PALM BAY HOSPITAL	$0	$0	$0
153	PALM BEACH GARDENS MEDICAL CENTER	$1,331,024	$362,656	($968,368)
154	PALM SPRINGS GENERAL HOSPITAL	$0	$0	$0
155	PALMETTO GENERAL HOSPITAL	$7,081,793	$7,081,793	$0
156	PALMS OF PASADENA HOSPITAL	$0	$0	$0
157	PALMS WEST HOSPITAL	$7,600,976	$4,669,076	($2,931,900)
158	PAN AMERICAN HOSPITAL	$0	$0	$0
159	PARK ROYAL HOSPITAL	$0	$0	$0

2014-15 LIP Compared to a $1.2 Billion LIP

Comparison of Net Dollars, by Hospital

		Net LIP Dollars, Including LIP and Rate Enhancements (does not include DSH)		
Row	**Hospital**	**2014-15 Nets: $2.167 Billion LIP**	**Projected Nets: $1.2 Billion LIP**	**Gain (Loss)**
160	PARRISH MEDICAL CENTER	$4,679,924	$1,340,414	($3,339,510)
161	PASCO REGIONAL MEDICAL CENTER	$0	$0	$0
162	PEACE RIVER REGIONAL MEDICAL CENTER	$0	$0	$0
163	PHYSICAN'S REGIONAL MEDICAL CENTER	$2,007,118	$546,869	($1,460,248)
164	PLANTATION GENERAL HOSPITAL	$4,941,295	$4,941,295	$0
165	PUTNAM COMMUNITY MEDICAL CENTER	$1,281,636	$1,281,636	$0
166	REGIONAL MEDICAL CENTER AT BAYONET POINT	$206,266	$206,266	$0
167	SACRED HEART HOSPITAL	$19,177,152	$18,327,916	($849,236)
168	SACRED HEART HOSPITAL ON THE GULF	$120,678	$120,678	$0
169	SACRED HEART OF THE EMERALD COAST	$905,576	$905,576	$0
170	SAINT ANTHONY'S HOSPITAL	$5,446,083	$3,794,340	($1,651,742)
171	SAINT LUKE'S HOSPITAL	$254,093	$254,093	$0
172	SAINT PETERSBURG GENERAL HOSPITAL	$2,380,221	$2,380,221	$0
173	SAINT VINCENT'S MEDICAL CENTER	$2,988,193	$2,988,193	$0
174	SANTA ROSA MEDICAL CENTER	$2,064,819	$570,165	($1,494,654)
175	SARASOTA MEMORIAL HOSPITAL	$12,279,466	$4,535,093	($7,744,373)
176	SEBASTIAN RIVER MEDICAL CENTER	$0	$0	$0
177	SELECT SPECIALTY HOSP - ORLANDO	$0	$0	$0
178	SELECT SPECIALTY HOSP - MEMORIAL HEALTH JAX	$0	$0	$0
179	SELECT SPECIALTY HOSPITAL MIAMI	$0	$0	$0
180	SELECT SPECIALTY HOSPITAL PANAMA CITY	$0	$0	$0
181	SEVEN RIVERS COMMUNITY HOSPITAL	$0	$0	$0
182	SHANDS AT JACKSONVILLE	$94,922,651	$72,058,693	($22,863,959)
183	SHANDS AT LAKE SHORE	$5,503,568	$2,931,937	($2,571,631)
184	SHANDS AT LIVE OAK	$617,661	$577,308	($40,353)
185	SHANDS AT STARKE	$637,134	$599,632	($37,503)
186	SHANDS TEACHING HOSPITAL & CLINIC	$106,672,132	$75,893,222	($30,778,910)
187	SHRINER'S HOSPITAL FOR CHILDREN	$527,351	$527,351	$0
188	SISTER EMMANUEL HOSPITAL	$0	$0	$0
189	SOUTH BAY HOSPITAL	$456,282	$124,321	($331,962)
190	SOUTH FLORIDA BAPTIST HOSPITAL	$3,583,502	$2,681,924	($901,578)
191	SOUTH FLORIDA STATE HOSPITAL	$0	$0	$0
192	SOUTH LAKE HOSPITAL	$3,001,579	$817,824	($2,183,755)
193	SOUTH MIAMI HOSPITAL	$0	$0	$0
194	SOUTHWEST FLORIDA REGIONAL MEDICAL CENTER	$7,846,518	$2,447,694	($5,398,824)
195	SPECIALTY HOSPITAL - GAINESVILLE	$0	$0	$0
196	SPECIALTY HOSPITAL - PALM BEACH	$0	$0	$0
197	SPECIALTY HOSPITAL - PENSACOLA	$0	$0	$0
198	SPECIALTY HOSPITAL - TALLAHASSEE	$0	$0	$0
199	ST CLOUD REGIONAL MEDICAL CENTER	$0	$0	$0
200	ST. CATHERINE'S REHABILITATION HOSPITAL	$0	$0	$0
201	ST. JOHN'S REHABILITATION HOSPITAL	$0	$0	$0
202	ST. JOSEPH'S HOSPITAL	$41,381,614	$28,614,436	($12,767,177)
203	ST. LUCIE MEDICAL CENTER	$2,296,803	$2,296,803	$0
204	ST. LUKE'S - ST. VINCENT'S HEALTHCARE	$0	$0	$0
205	ST. MARY'S HOSPITAL	$25,247,154	$16,489,984	($8,757,170)
206	TALLAHASSEE MEMORIAL HOSPITAL	$8,018,297	$8,018,298	$0
207	TAMPA GENERAL HOSPITAL	$86,586,975	$65,797,894	($20,789,081)
208	THE VILLAGES REGIONAL HOSPITAL	$0	$0	$0
209	TOWN & COUNTRY HOSPITAL	$545,193	$148,546	($396,647)
210	TWIN CITIES HOSPITAL	$0	$0	$0
211	UCHLTACH at Connerton	$0	$0	$0
212	UNIVERSITY COMMUNITY HOSP. - CARROLLWOOD	$577,259	$157,283	($419,976)

2014-15 LIP Compared to a $1.2 Billion LIP

Comparison of Net Dollars, by Hospital

		Net LIP Dollars, Including LIP and Rate Enhancements (does not include DSH)		
Row	**Hospital**	**2014-15 Nets: $2.167 Billion LIP**	**Projected Nets: $1.2 Billion LIP**	**Gain (Loss)**
213	UNIVERSITY COMMUNITY HOSPITAL - TAMPA	$2,036,203	$554,794	($1,481,409)
214	UNIVERSITY HOSPITAL & MEDICAL C	$0	$0	$0
215	UNIVERSITY OF MIAMI HOSPITAL	$16,550,645	$9,039,664	($7,510,981)
216	UNIVERSITY OF MIAMI HOSPITAL & CLINICS	$10,079,550	$5,150,855	($4,928,695)
217	VENICE REGIONAL MEDICAL CENTER	$0	$0	$0
218	VIERA HOSPITAL	$0	$0	$0
219	W. FLORIDA COMMUNITY CARE	$0	$0	$0
220	WELLINGTON REGIONAL MEDICAL CENTER	$3,780,463	$2,190,932	($1,589,532)
221	WEST BOCA MEDICAL CENTER	$2,543,264	$692,949	($1,850,315)
222	WEST FLORIDA HOSPITAL	$0	$0	$0
223	WEST GABLES REHABILITATION HOSPITAL	$0	$0	$0
224	WEST KENDALL BAPTIST HOSPITAL	$0	$0	$0
225	WESTCHESTER GENERAL HOSPITAL	$1,415,531	$1,415,531	$0
226	WESTSIDE REGIONAL MEDICAL CENTE	$0	$0	$0
227	WINTER HAVEN HOSPITAL	$8,457,963	$2,651,978	($5,805,985)
228	WUESTHOFF MEDICAL CENTER - MELBOURNE	$0	$0	$0
229	WUESTHOFF MEDICAL CENTER - ROCKLEDGE	$0	$0	$0
		$1,544,362,275	**$1,123,056,492**	($421,305,783)

Exhibit 4

Simulation of 2014-15 LIP Funded at $600 Million

1 *The 2014-15 figures in this document reflect letters of agreement with IGT donors and the corresponding allocations made effective after publication of spending authority appropriated in the 2014-15 GAA.*

2 *Simulation based on 2014-15 LIP funded at $1.2 billion instead of $2.167 billion.*

3 *Net losses will vary by hospital. Dollars may flow differently if total dollars are reduced. Simulation assumes IGT dollars will remain at the local level. Donations of IGT dollars are not uniform by county.*

4 *$321 million in non-hospital programs funded through LIP are also at risk if LIP funding is reduced. These programs include:*

Medical school faculty portion of LIP ($204.5 million), and

LIP payments to other provider access systems, such as county health departments, federally qualified health centers, and enhanced primary care initiatives ($117 million).

2014-15 LIP Compared to a $600 Million LIP

Comparison of Net Dollars, by Hospital

		Net LIP Dollars, Including LIP and Rate Enhancements (does not include DSH)		
Row	**Hospital**	**2014-15 Nets: $2.167 Billion LIP**	**Projected Nets: $600 Million LIP**	**Gain (Loss)**
1	ALL CHILDREN'S HOSPITAL	$55,562,140	$38,189,883	($17,372,256)
2	ANN BATES LEACH EYE HOSPITAL	$3,009,237	$856,601	($2,152,636)
3	AVENTURA HOSPITAL & MEDICAL CENTER	$0	$0	$0
4	BAPTIST HOSPITAL OF MIAMI	$18,723,363	$17,503,272	($1,220,091)
5	BAPTIST HOSPITAL OF PENSACOLA	$7,662,147	$7,118,545	($543,603)
6	BAPTIST MEDICAL CENTER	$12,166,017	$11,651,369	($514,648)
7	BAPTIST MEDICAL CENTER - BEACHES	$0	$0	$0
8	BAPTIST MEDICAL CENTER - NASSAU	$718,410	$462,721	($255,689)
9	BARTOW REGIONAL MEDICAL CENTER	$1,325,137	$540,818	($784,319)
10	BAY MEDICAL CENTER	$8,269,880	$2,844,194	($5,425,686)
11	BAYCARE ALLIANT HOSPITAL	$0	$0	$0
12	BAYFRONT MEDICAL CENTER	$12,214,884	$6,061,781	($6,153,103)
13	BERT FISH MEDICAL CENTER	$2,062,037	$140,842	($1,921,195)
14	BETHESDA HEALTHCARE SYSTEM	$7,195,872	$4,127,952	($3,067,920)
15	BLAKE MEDICAL CENTER	$1,233,603	$37,995	($1,195,608)
16	BOCA RATON COMMUNITY HOSPITAL	$935,935	$34,614	($901,321)
17	BRANDON REGIONAL HOSPITAL	$6,398,746	$3,957,684	($2,441,062)
18	BROOKS HEALTH SYSTEM	$0	$0	$0
19	BROOKSVILLE REGIONAL HOSPITAL	$4,429,110	$1,805,323	($2,623,787)
20	BROWARD HEALTH - BROWARD GEN MED CENTER	$62,749,667	$32,724,006	($30,025,661)
21	BROWARD HEALTH - CORAL SPRINGS MED CENTER	$9,890,446	$4,191,607	($5,698,839)
22	BROWARD HEALTH - IMPERIAL POINT HOSPITAL	$7,070,245	$2,757,604	($4,312,642)
23	BROWARD HEALTH - NORTH BROWARD MED CENT	$13,104,621	$6,909,154	($6,195,467)
24	CALHOUN LIBERTY HOSPITAL	$240,645	$69,967	($170,678)
25	CAMPBELLTON-GRACEVILLE HOSPITAL	$574,589	$56,638	($517,951)
26	CAPE CANAVERAL HOSPITAL	$0	$0	$0
27	CAPE CORAL HOSPITAL	$5,101,179	$199,334	($4,901,845)
28	CAPITAL REGIONAL MEDICAL CENTER	$662,899	$24,517	($638,382)
29	CENTRAL FLORIDA REGIONAL HOSPITAL	$0	$0	$0
30	CHARLOTTE REGIONAL MEDICAL CENTER	$0	$0	$0
31	CITRUS MEMORIAL HEALTH SYSTEM	$1,982,444	$73,318	($1,909,126)
32	CLEVELAND CLINIC FLORIDA WESTON	$0	$0	$0
33	COLUMBIA HOSPITAL	$2,398,655	$1,266,140	($1,132,515)
34	COMMUNITY HOSPITAL	$0	$0	$0
35	CORAL GABLES HOSPITAL	$836,673	$795,352	($41,320)
36	DELRAY MEDICAL CENTER	$2,716,209	$191,463	($2,524,746)
37	DESOTO MEMORIAL HOSPITAL	$1,282,755	$955,724	($327,031)
38	DOCTORS' HOSPITAL - CORAL GABLES	$0	$0	$0
39	DOCTORS HOSPITAL OF SARASOTA	$0	$0	$0
40	DOCTORS MEMORIAL HOSPITAL - HOLMES CO	$2,419,515	$352,521	($2,066,994)
41	DOCTORS MEMORIAL HOSPITAL - TAYLOR CO	$725,400	$421,804	($303,596)
42	ED FRASER MEMORIAL HOSPITAL	$1,897,515	$26,684	($1,870,831)
43	EDWARD WHITE HOSPITAL	$0	$0	$0
44	ENGLEWOOD COMMUNITY HOSPITAL	$0	$0	$0
45	FAWCETT MEMORIAL HOSPITAL	$0	$0	$0
46	FISHERMEN'S HOSPITAL	$270,179	$89,691	($180,488)
47	FLAGLER HOSPITAL	$1,072,290	$132,779	($939,511)
48	FLORIDA HOSPITAL	$59,077,862	$50,261,796	($8,816,066)
49	FLORIDA HOSPITAL - WAUCHULA	$374,250	$208,413	($165,837)
50	FLORIDA HOSPITAL FISH MEMORIAL	$2,147,620	$79,428	($2,068,192)
51	FLORIDA HOSPITAL FLAGLER	$968,562	$674,480	($294,082)
52	FLORIDA HOSPITAL HEARTLAND MED. CTR.	$980,433	$36,261	($944,172)
53	FLORIDA HOSPITAL ORMOND MEMORIAL	$0	$0	$0

2014-15 LIP Compared to a $600 Million LIP

Comparison of Net Dollars, by Hospital

Row	Hospital	Net LIP Dollars, Including LIP and Rate Enhancements (does not include DSH)		
		2014-15 Nets: $2.167 Billion LIP	Projected Nets: $600 Million LIP	Gain (Loss)
54	FLORIDA HOSPITAL WATERMAN	$4,729,283	$200,045	($4,529,238)
55	FLORIDA HOSPITAL WESLEY CHAPEL	$0	$0	$0
56	FLORIDA HOSPITAL ZEPHYRHILLS	$361,367	$361,367	$0
57	FLORIDA STATE HOSPITAL	$0	$0	$0
58	FLORIDA STATE HOSPITAL - MED SURG.	$0	$0	$0
59	FORT WALTON BEACH MEDICAL CENTER	$0	$0	$0
60	G. PIERCE WOOD HOSPITAL	$0	$0	$0
61	GEORGE E. WEEMS MEMORIAL HOSPITAL	$224,986	$79,005	($145,981)
62	GLADES GENERAL HOSPITAL	$2,865,919	$1,256,530	($1,609,389)
63	GOOD SAMARITAN MEDICAL CENTER	$2,771,612	$102,505	($2,669,107)
64	GULF COAST MEDICAL CENTER	$4,002,040	$3,836,849	($165,191)
65	H. LEE MOFFIT CANCER CENTER	$18,939,572	$8,688,049	($10,251,523)
66	H.H. RAULERSON	$1,079,450	$813,024	($266,426)
67	HALIFAX HEALTH	$19,605,072	$7,924,845	($11,680,227)
68	HEALTH CENTRAL	$5,481,933	$1,446,164	($4,035,769)
69	HEALTHMARK REGIONAL MEDICAL CENTER	$330,841	$165,906	($164,935)
70	HEALTHSOUTH EMERALD COAST REHAB HOSPITAL	$0	$0	$0
71	HEALTHSOUTH REHAB HOSPITAL - TALLAHASSEE	$0	$0	$0
72	HEALTHSOUTH REHAB HOSPITAL OF MIAMI	$0	$0	$0
73	HEALTHSOUTH REHAB OF SPRING HILL	$0	$0	$0
74	HEALTHSOUTH REHAB. HOSPITAL - LARGO	$0	$0	$0
75	HEALTHSOUTH REHAB. HOSPITAL TREAS COAST	$0	$0	$0
76	HEALTHSOUTH REHAB. INSTITUTE - SARASOTA	$0	$0	$0
77	HEALTHSOUTH RIDGELAKE HOSPITAL	$0	$0	$0
78	HEALTHSOUTH SEA PINES REHAB HOSPITAL	$0	$0	$0
79	HEALTHSOUTH SUNRISE REHAB. HOSPITAL	$0	$0	$0
80	HEART OF FLORIDA REGIONAL MEDICAL CENTER	$3,890,630	$2,715,519	($1,175,111)
81	HELEN ELLIS MEMORIAL HOSPITAL	$0	$0	$0
82	HENDRY REGIONAL MEDICAL CENTER	$385,547	$242,340	($143,207)
83	HIALEAH HOSPITAL	$6,329,444	$6,077,915	($251,529)
84	HIGHLANDS REGIONAL MEDICAL CENTER	$1,903,054	$70,382	($1,832,672)
85	HOLMES REGIONAL MEDICAL CENTER	$6,860,857	$6,555,027	($305,830)
86	HOLY CROSS HOSPITAL	$0	$0	$0
87	HOMESTEAD HOSPITAL	$8,387,138	$7,969,702	($417,436)
88	INDIAN RIVER MEDICAL CENTER	$4,948,163	$640,591	($4,307,572)
89	JACKSON HOSPITAL	$2,139,078	$1,378,318	($760,760)
90	JACKSON MEMORIAL HOSPITAL	$237,240,249	$112,256,115	($124,984,134)
91	JAY HOSPITAL	$306,896	$168,672	($138,224)
92	JFK MEDICAL CENTER	$11,189,738	$5,038,968	($6,150,770)
93	JUPITER MEDICAL CENTER	$761,578	$28,167	($733,411)
94	KENDALL REGIONAL MEDICAL CENTER	$4,689,618	$4,238,601	($451,017)
95	KINDRED HOSPITAL - CENTRAL TAMPA	$0	$0	$0
96	KINDRED HOSPITAL - NORTH FLORIDA	$0	$0	$0
97	KINDRED HOSPITAL - OCALA	$0	$0	$0
98	KINDRED HOSPITAL - PALM BEACHES	$0	$0	$0
99	KINDRED HOSPITAL - S FLORIDA - HOLLYWOOD	$0	$0	$0
100	KINDRED HOSPITAL - S. FLA - CORAL GABLES	$0	$0	$0
101	KINDRED HOSPITAL - SOUTH FLORIDA	$0	$0	$0
102	KINDRED HOSPITAL BAY AREA - ST. PETE	$0	$0	$0
103	KINDRED HOSPITAL BAY AREA - TAMPA	$0	$0	$0
104	KINDRED HOSPITAL - MELBOURNE	$0	$0	$0
105	LAKE BUTLER HOSPITAL	$621,489	$97,193	($524,296)
106	LAKE CITY MEDICAL CENTER	$0	$0	$0

2014-15 LIP Compared to a $600 Million LIP

Comparison of Net Dollars, by Hospital

Row	Hospital	Net LIP Dollars, Including LIP and Rate Enhancements (does not include DSH)		
		2014-15 Nets: $2.167 Billion LIP	Projected Nets: $600 Million LIP	Gain (Loss)
107	LAKE WALES MEDICAL CENTERS	$1,170,151	$43,277	($1,126,874)
108	LAKELAND REGIONAL MEDICAL CENTER	$17,927,839	$8,383,416	($9,544,423)
109	LAKEWOOD RANCH MEDICAL CENTER	$0	$0	$0
110	LARGO MEDICAL CENTER	$1,532,203	$996,527	($535,676)
111	LARKIN COMMUNITY HOSPITAL	$1,585,372	$1,581,700	($3,672)
112	LAWNWOOD REGIONAL MEDICAL CENTER	$6,414,568	$5,953,319	($461,249)
113	LEE MEMORIAL HOSPITAL	$35,469,558	$20,993,834	($14,475,724)
114	LEESBURG REGIONAL MEDICAL CENTER	$4,913,465	$203,599	($4,709,866)
115	LEHIGH REGIONAL MEDICAL CENTER	$0	$0	$0
116	LOWER KEYS MEDICAL CENTER	$1,748,422	$1,674,916	($73,506)
117	MADISON COUNTY MEMORIAL HOSPITAL	$255,261	$40,875	($214,386)
118	MANATEE MEMORIAL HOSPITAL	$10,866,302	$5,246,150	($5,620,152)
119	MARINERS HOSPITAL	$457,458	$111,924	($345,534)
120	MARTIN MEMORIAL HOSPITAL	$2,375,411	$87,853	($2,287,558)
121	MEASE HOSPITAL - COUNTRYSIDE	$4,792,394	$177,242	($4,615,152)
122	MEASE HOSPITAL - DUNEDIN	$433,331	$16,026	($417,305)
123	MEMORIAL HOSPITAL - WEST VOLUSIA	$3,654,213	$135,148	($3,519,065)
124	MEMORIAL HOSPITAL JACKSONVILLE	$0	$0	$0
125	MEMORIAL HOSPITAL MIRAMAR	$11,639,410	$3,929,583	($7,709,828)
126	MEMORIAL HOSPITAL OF TAMPA	$0	$0	$0
127	MEMORIAL HOSPITAL PEMBROKE	$6,962,179	$3,175,490	($3,786,690)
128	MEMORIAL HOSPITAL WEST	$16,370,729	$2,222,505	($14,148,225)
129	MEMORIAL REGIONAL HOSPITAL	$62,643,795	$33,925,416	($28,718,379)
130	MERCY HOSPITAL	$0	$0	$0
131	MIAMI CHILDRENS HOSPITAL	$51,464,568	$46,876,440	($4,588,128)
132	MIAMI JEWISH HOME & HOSPITAL	$0	$0	$0
133	MORTON F. PLANT HOSPITAL	$11,090,648	$7,320,397	($3,770,251)
134	MORTON PLANT NORTH BAY HOSPITAL	$0	$0	$0
135	MT. SINAI MEDICAL CENTER	$16,413,531	$5,505,478	($10,908,053)
136	MUNROE REGIONAL MEDICAL CENTER	$3,353,359	$138,461	($3,214,898)
137	N.E. FLORIDA STATE HOSPITAL	$0	$0	$0
138	NATURE COAST REGIONAL HEALTH NETWORK	$232,000	$93,194	($138,806)
139	NCH DOWNTOWN NAPLES HOSPITAL	$10,818,207	$4,319,650	($6,498,557)
140	NEMOURS HOSPITAL	$9,128,686	$9,128,686	$0
141	NORTH FLORIDA REGIONAL MEDICAL CENTER	$0	$0	$0
142	NORTH OKALOOSA MEDICAL CENTER	$0	$0	$0
143	NORTH SHORE MEDICAL CENTER	$8,491,078	$8,401,808	($89,269)
144	NORTHSIDE HOSPITAL & HEART INST.	$1,999,577	$1,896,393	($103,184)
145	NORTHWEST FLORIDA COMMUNITY HOSPITAL	$425,932	$207,390	($218,542)
146	NORTHWEST MEDICAL CENTER	$0	$0	$0
147	OAK HILL HOSPITAL	$0	$0	$0
148	OCALA REGIONAL MEDICAL CENTER	$1,859,981	$64,460	($1,795,521)
149	ORANGE PARK MEDICAL CENTER	$0	$0	$0
150	ORLANDO HEALTH	$54,845,355	$38,463,225	($16,382,130)
151	OSCEOLA REGIONAL MEDICAL CENTER	$4,498,963	$4,318,222	($180,741)
152	PALM BAY HOSPITAL	$0	$0	$0
153	PALM BEACH GARDENS MEDICAL CENTER	$1,331,024	$49,226	($1,281,798)
154	PALM SPRINGS GENERAL HOSPITAL	$0	$0	$0
155	PALMETTO GENERAL HOSPITAL	$7,081,793	$6,785,342	($296,451)
156	PALMS OF PASADENA HOSPITAL	$0	$0	$0
157	PALMS WEST HOSPITAL	$7,600,976	$3,487,931	($4,113,045)
158	PAN AMERICAN HOSPITAL	$0	$0	$0
159	PARK ROYAL HOSPITAL	$0	$0	$0

2014-15 LIP Compared to a $600 Million LIP

Comparison of Net Dollars, by Hospital

		Net LIP Dollars, Including LIP and Rate Enhancements (does not include DSH)		
Row	**Hospital**	**2014-15 Nets: $2.167 Billion LIP**	**Projected Nets: $600 Million LIP**	**Gain (Loss)**
160	PARRISH MEDICAL CENTER	$4,679,924	$181,071	($4,498,852)
161	PASCO REGIONAL MEDICAL CENTER	$0	$0	$0
162	PEACE RIVER REGIONAL MEDICAL CENTER	$0	$0	$0
163	PHYSICAN'S REGIONAL MEDICAL CENTER	$2,007,118	$74,231	($1,932,887)
164	PLANTATION GENERAL HOSPITAL	$4,941,295	$3,807,918	($1,133,377)
165	PUTNAM COMMUNITY MEDICAL CENTER	$1,281,636	$1,041,856	($239,780)
166	REGIONAL MEDICAL CENTER AT BAYONET POINT	$206,266	$0	($206,266)
167	SACRED HEART HOSPITAL	$19,177,152	$14,744,662	($4,432,490)
168	SACRED HEART HOSPITAL ON THE GULF	$120,678	$80,138	($40,540)
169	SACRED HEART OF THE EMERALD COAST	$905,576	$758,246	($147,330)
170	SAINT ANTHONY'S HOSPITAL	$5,446,083	$3,243,385	($2,202,698)
171	SAINT LUKE'S HOSPITAL	$254,093	$247,895	($6,197)
172	SAINT PETERSBURG GENERAL HOSPITAL	$2,380,221	$1,797,871	($582,350)
173	SAINT VINCENT'S MEDICAL CENTER	$2,988,193	$2,817,274	($170,918)
174	SANTA ROSA MEDICAL CENTER	$2,064,819	$75,980	($1,988,839)
175	SARASOTA MEMORIAL HOSPITAL	$12,279,466	$599,665	($11,679,802)
176	SEBASTIAN RIVER MEDICAL CENTER	$0	$0	$0
177	SELECT SPECIALTY HOSP - ORLANDO	$0	$0	$0
178	SELECT SPECIALTY HOSP - MEMORIAL HEALTH JAX	$0	$0	$0
179	SELECT SPECIALTY HOSPITAL MIAMI	$0	$0	$0
180	SELECT SPECIALTY HOSPITAL PANAMA CITY	$0	$0	$0
181	SEVEN RIVERS COMMUNITY HOSPITAL	$0	$0	$0
182	SHANDS AT JACKSONVILLE	$94,922,651	$31,445,643	($63,477,008)
183	SHANDS AT LAKE SHORE	$5,503,568	$1,520,002	($3,983,566)
184	SHANDS AT LIVE OAK	$617,661	$265,307	($352,354)
185	SHANDS AT STARKE	$637,134	$281,408	($355,727)
186	SHANDS TEACHING HOSPITAL & CLINIC	$106,672,132	$58,393,418	($48,278,714)
187	SHRINER'S HOSPITAL FOR CHILDREN	$527,351	$527,351	$0
188	SISTER EMMANUEL HOSPITAL	$0	$0	$0
189	SOUTH BAY HOSPITAL	$456,282	$16,875	($439,407)
190	SOUTH FLORIDA BAPTIST HOSPITAL	$3,583,502	$2,373,046	($1,210,455)
191	SOUTH FLORIDA STATE HOSPITAL	$0	$0	$0
192	SOUTH LAKE HOSPITAL	$3,001,579	$111,010	($2,890,569)
193	SOUTH MIAMI HOSPITAL	$0	$0	$0
194	SOUTHWEST FLORIDA REGIONAL MEDICAL CENTER	$7,846,518	$328,099	($7,518,419)
195	SPECIALTY HOSPITAL - GAINESVILLE	$0	$0	$0
196	SPECIALTY HOSPITAL - PALM BEACH	$0	$0	$0
197	SPECIALTY HOSPITAL - PENSACOLA	$0	$0	$0
198	SPECIALTY HOSPITAL - TALLAHASSEE	$0	$0	$0
199	ST CLOUD REGIONAL MEDICAL CENTER	$0	$0	$0
200	ST. CATHERINE'S REHABILITATION HOSPITAL	$0	$0	$0
201	ST. JOHN'S REHABILITATION HOSPITAL	$0	$0	$0
202	ST. JOSEPH'S HOSPITAL	$41,381,614	$23,360,079	($18,021,535)
203	ST. LUCIE MEDICAL CENTER	$2,296,803	$2,192,456	($104,347)
204	ST. LUKE'S - ST. VINCENT'S HEALTHCARE	$0	$0	$0
205	ST. MARY'S HOSPITAL	$25,247,154	$12,567,250	($12,679,904)
206	TALLAHASSEE MEMORIAL HOSPITAL	$8,018,297	$7,620,425	($397,873)
207	TAMPA GENERAL HOSPITAL	$86,586,975	$44,098,731	($42,488,245)
208	THE VILLAGES REGIONAL HOSPITAL	$0	$0	$0
209	TOWN & COUNTRY HOSPITAL	$545,193	$20,164	($525,029)
210	TWIN CITIES HOSPITAL	$0	$0	$0
211	UCHLTACH at Connerton	$0	$0	$0
212	UNIVERSITY COMMUNITY HOSP. - CARROLLWOOD	$577,259	$21,349	($555,910)

2014-15 LIP Compared to a $600 Million LIP

Comparison of Net Dollars, by Hospital

Row	Hospital	Net LIP Dollars, Including LIP and Rate Enhancements (does not include DSH)		
		2014-15 Nets: $2.167 Billion LIP	Projected Nets: $600 Million LIP	Gain (Loss)
213	UNIVERSITY COMMUNITY HOSPITAL - TAMPA	$2,036,203	$75,307	($1,960,896)
214	UNIVERSITY HOSPITAL & MEDICAL C	$0	$0	$0
215	UNIVERSITY OF MIAMI HOSPITAL	$16,550,645	$6,588,956	($9,961,689)
216	UNIVERSITY OF MIAMI HOSPITAL & CLINICS	$10,079,550	$3,555,589	($6,523,961)
217	VENICE REGIONAL MEDICAL CENTER	$0	$0	$0
218	VIERA HOSPITAL	$0	$0	$0
219	W. FLORIDA COMMUNITY CARE	$0	$0	$0
220	WELLINGTON REGIONAL MEDICAL CENTER	$3,780,463	$1,655,341	($2,125,123)
221	WEST BOCA MEDICAL CENTER	$2,543,264	$94,060	($2,449,204)
222	WEST FLORIDA HOSPITAL	$0	$0	$0
223	WEST GABLES REHABILITATION HOSPITAL	$0	$0	$0
224	WEST KENDALL BAPTIST HOSPITAL	$0	$0	$0
225	WESTCHESTER GENERAL HOSPITAL	$1,415,531	$1,415,531	$0
226	WESTSIDE REGIONAL MEDICAL CENTE	$0	$0	$0
227	WINTER HAVEN HOSPITAL	$8,457,963	$3,912,164	($4,545,799)
228	WUESTHOFF MEDICAL CENTER - MELBOURNE	$0	$0	$0
229	WUESTHOFF MEDICAL CENTER - ROCKLEDGE	$0	$0	$0
		$1,544,362,275	**$828,048,925**	($716,313,349)

Impact Analysis
LIP, IGTs and SB 2512

Phase 1: Simple Expansion (July 2015)
Phase 2: FHIX (January 2016)
Phase 3: Healthy Kids Transition (July 2016)

April 21, 2015

Presented by:

The Florida Legislature
Office of Economic and Demographic Research
850.487.1402
http://edr.state.fl.us

LIP—SSEC and Economic Assumptions...

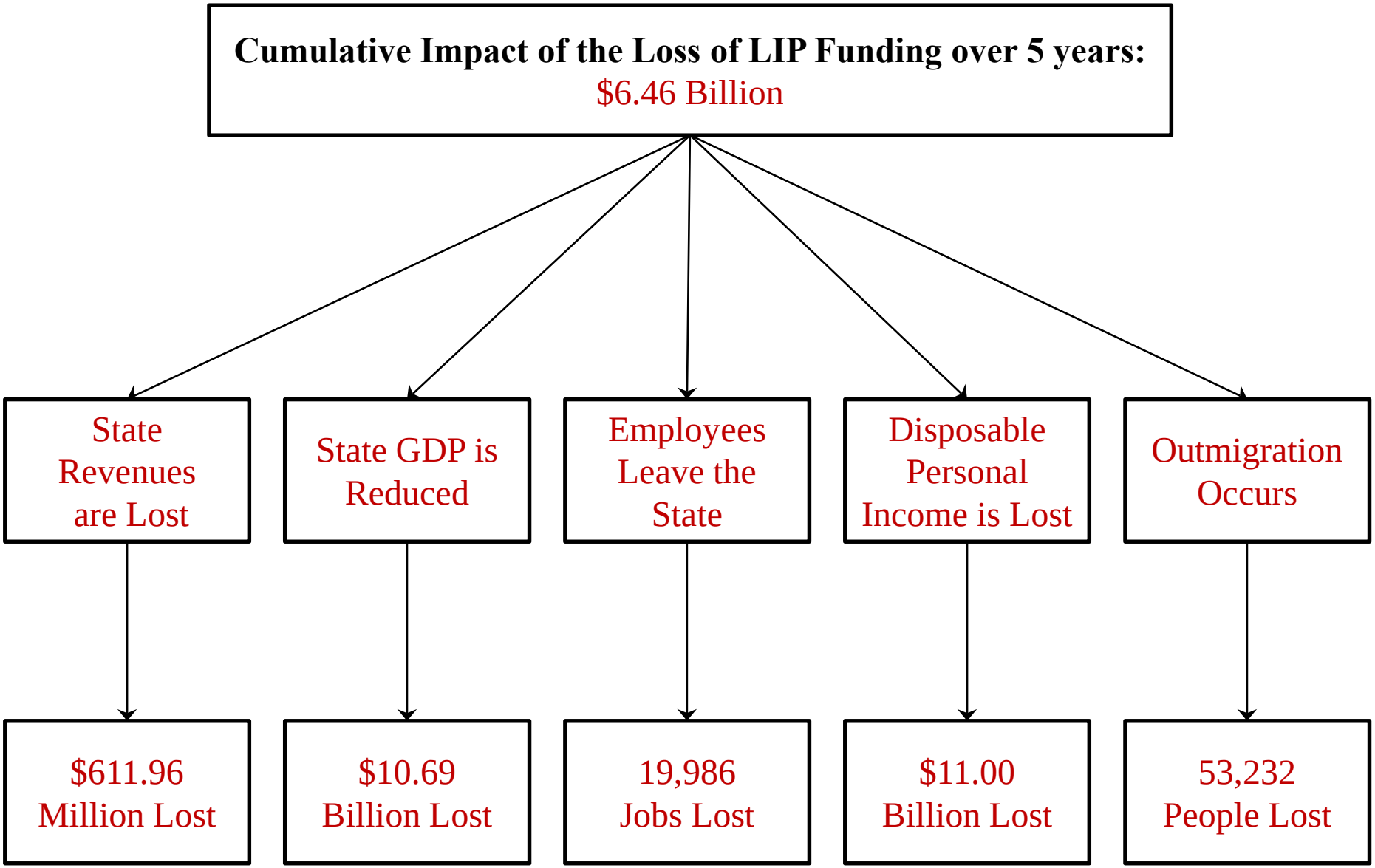
Social Services Estimating Conference zeroed out LIP Funding in 2015-16

Issue APPROPRIATIONS	County Transfers	General Revenue	Medical Care TF	Total Funds
Low Income Pool - Primary Care Hospitals	$4,854,712	$0	$7,150,016	$12,004,728
Low Income Pool - Provisional Trauma Centers	$3,569,512	$0	$5,257,175	$8,826,687
Low Income Pool - Rural Hospitals	$2,273,635	$0	$3,348,607	$5,622,242
Low Income Pool - Safety Net Hospitals	$28,873,580	$700,000	$43,555,946	$73,129,526
Low Income Pool - Independent Report	$202,200	$0	$297,800	$500,000
Low Income Pool - Poison Control Hospitals	$0	$1,283,082	$1,889,723	$3,172,805
Low Income Pool - Specialty Pediatric Hospitals	$569,867	$0	$839,299	$1,409,166
Low Income Pool - Hospitals Providers Access System	$309,941,891	$0	$456,482,171	$766,424,062
Low Income Pool - Quality Add On	$6,066,000	$0	$8,934,000	$15,000,000
Low Income Pool - LIP 6	$389,511,815	$0	$573,672,693	$963,184,508
Low Income Pool - Federally Qualified Health Centers	$5,919,659	$1,471,259	$10,885,338	$18,276,256
Low Income Pool - Primary Care and ER Diversion, Manatee, Sarasota, and Desoto	$0	$485,280	$714,720	$1,200,000
Low Income Pool - Premium Assistance Program - Miami Dade	$101,100	$0	$148,900	$250,000
Low Income Pool - Premium Assistance Program - HCDPB	$6,416,620	$0	$9,450,394	$15,867,014
Low Income Pool - County Health Initiatives	$1,833,844	$0	$2,700,883	$4,534,727
Low Income Pool - Primary Care Health Departments	$808,800	$0	$1,191,200	$2,000,000
Low Income Pool - Hospital Primary Care with DOH	$1,213,200	$0	$1,786,800	$3,000,000
Low Income Pool - Teaching Physicians	$82,713,482	$0	$121,820,351	$204,533,833
Low Income Pool - STC 61_Tier One Milestone Distribution	$14,154,000	$0	$20,846,000	$35,000,000
Low Income Pool - Primary Care	$8,582,754	$5,180,105	$20,269,927	$34,032,786
Total Low Income Pool Provider Access System Payments	$867,606,670	$9,119,726	$1,291,241,942	$2,167,968,340

The Legislative Office of Economic and Demographic Research modeled the full effects (direct, indirect and induced) of losing the federal dollars on Florida's economy over five years. Key assumptions are:

- The inter-governmental transfers (IGTs) associated with LIP are retained locally.
- The federal LIP funding ($1.29 billion) has been used in the past to support the daily operations of the Hospital and Nursing industry through a "helicopter drop". These dollars are removed each year from the economy.

Economic Analysis Using Statewide Model



Loss of Federal LIP Dollars...

Major State Revenue Impact Areas

- Sales Tax: -$361.4 Million
- Documentary Stamps: -$78.9 Million
- Corporate Income Tax: -$30.8 Million
- Motor Fuel Tax: -$22.04 Million

Significant Employment Change by Industry

- Hospital and Nursing: -4.17%
- Real Estate: -0.26%
- Retail: -0.14%
- Construction: -0.07%

Related Risk Areas

- The Social Services Estimating Conference assumed non-LIP related IGTs of $359.5 million for FY 2015-16 would continue. Of this amount, $99.7 million are in Hospital Outpatient and $259.8 million are in Hospital Inpatient. Overall, the SSEC placed 80.4% in prepaid, and 19.6% in fee for service. Any future transfers are at risk if LIP is discontinued since the local dollars are voluntary, and local governments will reassess their return from the statewide distribution of these dollars.

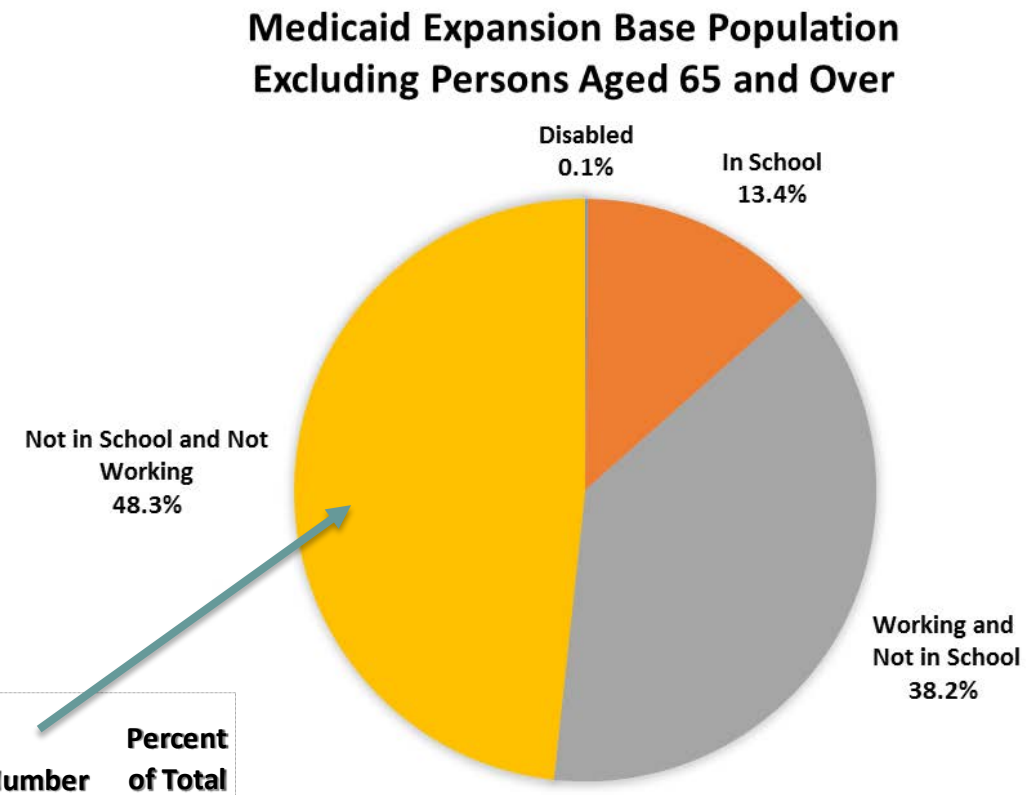
Replacing Federal LIP Dollars...

- Federal funds come into Florida from outside the state ("helicopter drop").

- A preliminary analysis shows that redirecting state funds from other areas of the budget to offset the elimination of federal dollars would only partially mitigate the lost economic activity. While the state is not made whole, mitigation spreads the shock from being concentrated in a limited number of industries to a greater number of industries—diffusing some of the economic consequences.

SB 2512 ~ Characteristics of the Expansion Base Population from the American Community Survey (ACS) 2011-2013, Public Use Microdata (PUMS)...

Population of 829,802



	Number	Percent of Total
Not in School and Not Working	400,612	48.28%
Parents	59,186	7.13%
Non-Parents	341,426	41.15%

Population Adjustments to Base...

CROWD OUT

- The crowd out population is individuals who are paying for private health insurance today and who would qualify for Medicaid coverage under Simple Expansion-Phase 1.

- Using the 2011-13 ACS PUMS data, there were 122,704 individuals who would be classified as crowd out population.

Revised Population of 951,826

LIKELY PRESENTERS

- A take-up rate of 85.8% is applied to the Medicaid Expansion population to match the health insurance participation rate of today's Medicaid eligible population. The crowd out population is assumed to present fully.

- The total number of likely presenters is 834,674. This number is subsequently adjusted for population growth, reaching 908,127 in 2019-20.

Likely Presenting Population is 834,674

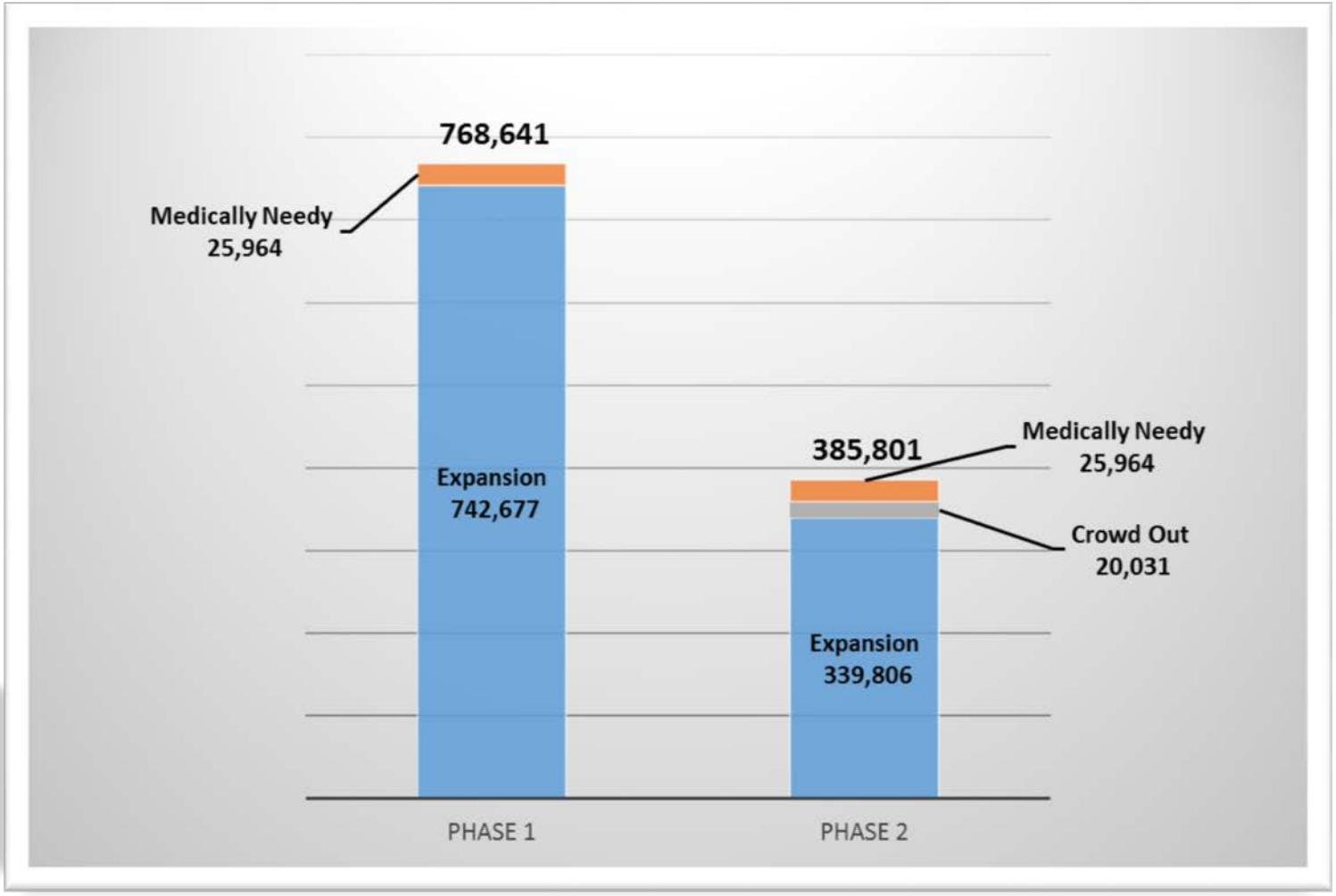
Medically Needy...

- Non-pregnant adults aged 19-64 under 133% FPL (25,964) would automatically transition from the Medically Needy Program to Medicaid Simple Expansion-Phase 1.
  - Transition of these individuals would result in state savings due to the different federal participation matching rates.

- Persons aged 19-64 who are above 133% FPL and Seniors at all income levels (5,114) are disenrolled from the Medically Needy Program on October 1, 2015.
  - The disenrollment of these individuals produces savings from the state match that will no longer be required.

- Children under the age of 19 and Pregnant Women who do not otherwise qualify for Medicaid (936) are enrolled until October 1, 2019.
  - The disenrollment of these individuals produces savings from the state match that will no longer be required.

Year 1 ~ Simple Expansion and Transition to FHIX…



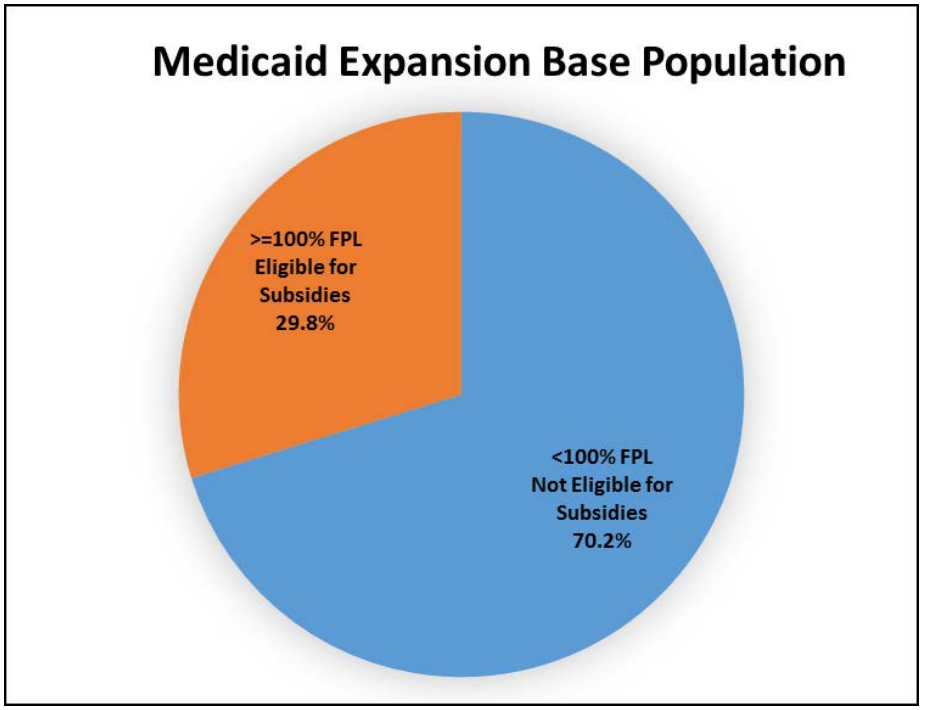
The various components of the population are grown to the start of the program in FY 2015-16, and then through the subsequent years. Adjustments are also made to reflect SB 2512.

Assumptions for Transition to FHIX-Phase 2…

- Expansion enrollees from Phase 1 (742,677) are:
  - Reduced for Constraints (64.4% remain).
    - School
    - Employment by hours for parents and others
    - Job Seekers
    - Disabled
  - Increased for Caregivers (estimated to be 7,153 in the base population) who otherwise would have been removed by the Constraints.
  - Further reduced for attrition between Phase 1 and Phase 2 (30% removed).
  - Ultimately, 339,806 enroll.
- Medically Needy enrollees from Phase 1 (25,964) are assumed to transition fully.
- Since the Crowd Out population (122,704) already has insurance, they wait for the FHIX options to become known at the beginning of Phase 2 to make a decision and do not participate in Phase 1.
  - The Eligible Universe was screened to determine those most likely to stay with private insurance (approximately 67% based on school status, youth, and probability of constraint failure).
  - The remaining population was reduced again by 50% to reflect those making a case by case decision based on specific FHIX offerings.
  - Ultimately, 20,031 enroll in FHIX.

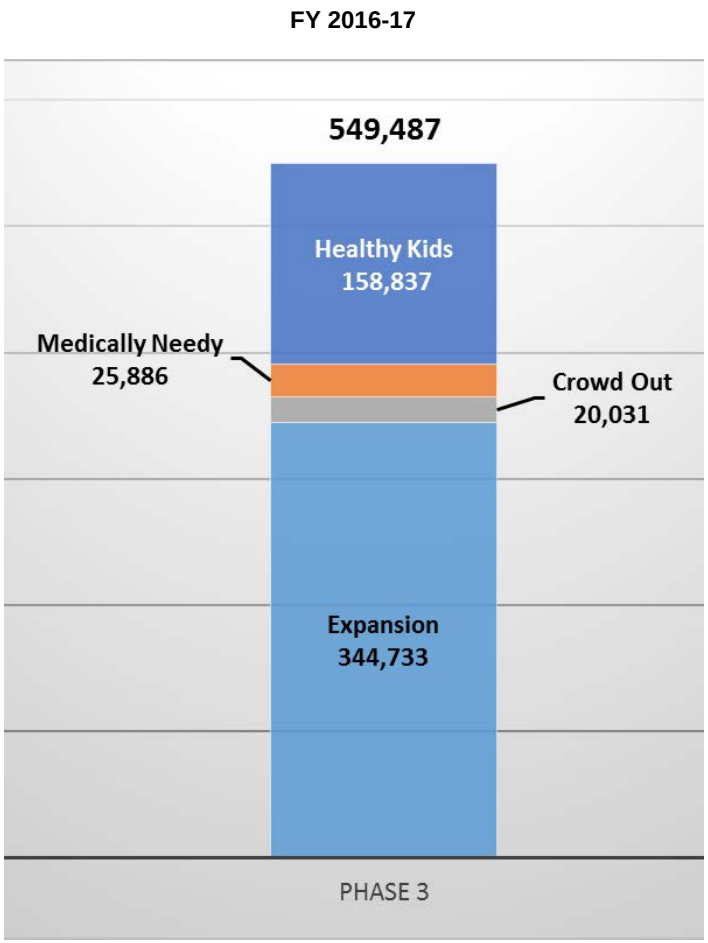
Disenrollees and the Exchange…

- Subsidies (health insurance premium tax credits) are only available to persons between 100% to 400% FPL selecting insurance coverage through the Exchange.
- Florida's Medicaid Expansion base population has 70.2% who are not eligible for subsidies today, and the remaining 29.8% are eligible for subsidies.
- EDR assumes that the disenrolled population would mirror Florida's Medicaid Expansion base population and therefore at least 70.2% would continue to be ineligible for subsidies on the Exchange and may no longer have access to unsubsidized options.
- It is unknown how the remaining 29.8% who are between 100% and 133% FPL could be allowed to access or receive subsidies for private insurance coverage purchased on the Exchange. If access and future subsidies are denied, this population would be worse off.



Healthy Kids in FHIX-Phase 3…

- Current Healthy Kids Title XXI (133% - 200% FPL):
  - Current enrollees (158,837) will transition to FHIX-Phase 3.
  - The monthly premium amount for these children will be the maximum $25 because all have family incomes above 100% FPL (the current average monthly premium is $12.48; the shift to FHIX will reduce costs to the state due to the increase in premiums).
- Current Healthy Kids Full Pay (above 200% FPL):
  - This analysis assumes Healthy Kids Full Pay enrollees (37,607) will not be eligible for the FHIX marketplace (today, these families pay 100% of their insurance costs).
  - Instead of moving to FHIX, Full Pay enrollees will shift to private insurance coverage on July 1, 2016.



Savings from Changes to Existing Programs…

- Savings from Transition to Expansion/FHIX:
  - 25,964 Medically Needy individuals - state savings due to both the higher federal participation matching rates and newly required premium payments.
  - 158,837 Healthy Kids individuals - state savings due to the increased average monthly premium paid by families.

- Savings from Disenrollment:
  - 5,114 Medically Needy individuals (October 1, 2015) – state savings because state match is no longer required.
  - 936 Medically Needy pregnant women and children (October 1, 2019) – state savings because state match is no longer required.

State Savings (in Millions)	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	Total
Transition to Expansion/FHIX						
Medically Needy Non Pregnant adults 19-64 Under 133%	$237.4	$219.0	$200.5	$193.9	$180.8	**$1,031.6**
Healthy Kids Title XXI	N/A	$0.9	$1.0	$1.0	$5.3	**$8.2**
Disenrollment from Medically Needy						
Non Pregnant adults 19-64 Above 133% (in October 2015)	$22.0	$28.9	$28.9	$28.8	$28.7	**$137.4**
Adults 65+ (in October 2015)	$11.6	$15.2	$15.2	$15.2	$15.1	**$72.3**
Children and Pregnant Women (in October 2019)	$0.0	$0.0	$0.0	$0.0	$3.3	**$3.3**
Total	**$271.1**	**$264.1**	**$245.6**	**$238.8**	**$233.1**	**$1,252.7**

Note: Dollars in Millions; Positive Total = Savings; Negative Total = Expenditures; Numbers may not sum due to rounding

Insurance Premium Tax...

A. The current revenue forecast assumes 1.44 million individuals are induced by the Affordable Care Act to obtain private insurance that is subject to the Insurance Premium Tax in the 2015 calendar year.

B. This analysis assumes that 234,284 of the 1.44 million individuals would qualify for and move to Medicaid under Simple Expansion-Phase 1, in lieu of seeking private insurance. This number grows and is included within the uninsured presenters.

C. This analysis also assumes that 20,031 individuals who currently pay for their own private insurance will seek and obtain coverage through FHIX (Crowd Out population).

D. The premiums and tax collections from the underlying Insurance Premium Tax forecast associated with all of these individuals [from above: (B + C)] are removed throughout the entire forecast.

E. Some of the Phase 1 participants would be disenrolled during the transition to Phase 2; however, their remaining insurance options are unclear and the disenrollee feedback to the Insurance Premium Tax forecast is indeterminate.

State Insurance Premium Tax

	Insurance Premium Tax				
	FY 2015-16	FY 2016-17	FY2017-18	FY 2018-19	FY 2019-20
Phase 1 - Impact of Simple Expansion	($7,226,394)	($6,187,003)	($6,570,490)	($6,807,356)	($7,108,618)
Phase 2 - Impact of Crowd Out Leaving Private Insurance	$0	($403,304)	($311,722)	($307,841)	($317,198)
Phase 2 - Impact of FHIX Plan Selection	$0	Indeterminate	Indeterminate	Indeterminate	Indeterminate
Impact of Disenrolled	$0	Indeterminate	Indeterminate	Indeterminate	Indeterminate
Phase 3 - Impact of Healthy Kids Full Pay Purchasing Insurance	$0	$362,106	$629,801	$525,205	$548,440
Total Cash Impact of Insurance Premium Tax	($7,226,394)	($6,228,201)	($6,252,411)	($6,589,992)	($6,877,376)

- The ultimate mix of insurance offerings on FHIX are currently unknown.
- Among other options, FHIX can offer "...a managed care plan contracted with the Agency for Health Care Administration under the managed medical assistance program under part IV of Chapter 409." Today, these plans (Medicaid MMA) are not subject to the Insurance Premium Tax. The Insurance Premium Tax status of the FHIX options is unclear.
- For these reasons, the impact of FHIX selections on Insurance Premium Tax collections is indeterminate.

Overall Coverage Status after Full Implementation...

Current Coverage Status	Coverage Status under SB 2512 (after Phase 3 full implementation)	Description	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Uninsured	FHIX	This group is currently uninsured and would qualify for the FHIX marketplace (school/work requirements and premium payment requirements).	344,733	349,639	354,520	359,364
Private Insurance	FHIX	This group currently has private insurance and would transition to the FHIX marketplace; they will meet all FHIX requirements and will opt for a FHIX plan over their current private insurance plan.	20,031	20,031	20,031	20,031
Medicaid Medically Needy	FHIX	This group is currently in Medicaid Medically Needy and would be transitioned to FHIX because they would meet all the requirements. This group, which has not paid premiums in Medicaid, would be subject to premium payments starting in Phase 2.	25,886	25,808	25,731	25,653
Healthy Kids Title XXI	FHIX	This group comprises the current Healthy Kids Title XXI population. They would be transitioned to FHIX in Phase 3; premiums would increase from the current average of $12.48 per month to $25.00 per month (all are above 100% FPL).	158,837	162,305	164,740	167,211
		FHIX Enrollment Subtotal	549,486	557,783	565,021	572,259
Medicaid Medically Needy	Medicaid Medically Needy	This group is children or pregnant women currently in Medicaid Medically Needy. They would remain in Medicaid until the Medically Needy program is terminated on October 1, 2019.	934	931	928	- 925
Medicaid Medically Needy	No longer with a state-sponsored program	This group includes the elderly at all income levels and the individuals with incomes above 133% FPL who are currently in Medicaid Medically Needy. This group would not meet income and/or age requirements for FHIX. They would be disenrolled from Medicaid on October 1, 2015.	- 5,099	- 5,084	- 5,069	- 5,053
Healthy Kids Full Pay	No longer with a state-sponsored program	This group comprises the Healthy Kids Full Pay population (all have incomes above 200% FPL). It is assumed that they would not have a path to insurance through the FHIX marketplace.	- 37,607	- 37,607	- 37,607	- 37,607
Uninsured	Not with a state-sponsored program	This group is currently uninsured and would not qualify for the FHIX marketplace (school/work requirements and/or premium payment requirements).	~ 408,713	~ 414,528	~ 420,315	~ 426,059
		Number of individuals no longer benefitting after full implementation	451,419	457,219	462,991	469,644

A negative sign (-) indicates individuals who are currently enrolled in a state-sponsored program but would be disenrolled under SB 2512.
A tilde (~) indicates Expansion individuals who are currently uninsured and would not become eligible for a state-sponsored program through SB 2512.

Overall Fiscal Impacts...

Expansion Program	Impact on State $$$					
	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	Total
Uninsured Presenters (new)	-	(75.1)	(172.3)	(212.3)	(289.3)	**(749.0)**
Crowd-Out (new)	-	(12.2)	(27.6)	(33.5)	(45.0)	**(118.3)**
Medically Needy Shift (net)	237.4	218.9	200.2	193.5	180.4	**1,030.4**
Medicaid Subtotal	237.4	131.6	0.3	(52.3)	(153.9)	**163.1**
Insurance Premium Revenue Adj.	(8.9)	(8.0)	(8.4)	(8.7)	(9.1)	**(43.1)**
Total	228.5	123.6	(8.1)	(61.0)	(163.0)	**120.0**

Impact on Federal $$$ Coming to FL					
FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	Total
2,872.4	2,929.3	2,960.6	3,053.7	3,114.5	**14,930.4**
472.6	475.0	473.4	481.6	484.5	**2,387.1**
237.4	218.9	200.2	193.5	180.4	**1,030.4**
3,582.4	3,623.2	3,634.2	3,728.8	3,779.4	**18,347.9**
N/A	N/A	N/A	N/A	N/A	**N/A**
3,582.4	3,623.2	3,634.2	3,728.8	3,779.4	**18,347.9**

SB 2512 Phases 1 and 2	Impact on State $$$					
	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	Total
Uninsured Presenters (new)	-	(32.5)	(75.0)	(92.1)	(125.7)	**(325.3)**
Crowd-Out (new)	-	(1.9)	(4.3)	(5.2)	(7.0)	**(18.4)**
Medically Needy Shift (net)	237.4	219.0	200.5	193.9	180.8	**1,031.6**
Medically Needy Sunset	33.6	44.2	44.1	44.0	47.1	**213.0**
Phase 1 and 2 Subtotal	271.0	228.8	165.3	140.6	95.2	**900.9**
Insurance Premium Revenue Adj.	(7.2)	(6.6)	(6.9)	(7.1)	(7.4)	**(35.2)**
Total	263.8	222.2	158.4	133.5	87.8	**865.7**
Compared to Expansion Program	**+35.3**	**+98.6**	**+166.5**	**+194.5**	**+250.8**	**+745.7**

Impact on Federal $$$ Coming to FL					
FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	Total
1,946.8	1,266.8	1,282.2	1,324.4	1,352.6	**7,172.8**
30.6	74.0	73.9	75.2	75.8	**329.6**
235.3	213.8	195.3	188.7	175.6	**1,008.7**
(51.5)	(69.6)	(69.9)	(70.3)	(75.9)	**(337.3)**
2,161.1	1,485.0	1,481.5	1,518.1	1,528.1	**8,173.9**
N/A	N/A	N/A	N/A	N/A	**N/A**
2,161.1	1,485.0	1,481.5	1,518.1	1,528.1	**8,173.9**
-1,421.2	**-2,138.1**	**-2,152.7**	**-2,210.7**	**-2,251.2**	**-10,174.0**

SB 2512 Phases 1, 2, and 3	Impact on State $$$					
	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	Total
Uninsured Presenters (new)	-	(32.5)	(75.0)	(92.1)	(125.7)	**(325.3)**
Crowd-Out (new)	-	(1.9)	(4.3)	(5.2)	(7.0)	**(18.4)**
Medically Needy Shift (net)	237.4	219.0	200.5	193.9	180.8	**1,031.6**
Medically Needy Sunset	33.6	44.2	44.1	44.0	47.1	**213.0**
Healthy Kids Title XXI	N/A	0.9	1.0	1.0	5.3	**8.2**
Phase 1, 2, and 3 Subtotal	271.0	229.7	166.3	141.6	100.5	**909.1**
Insurance Premium Revenue Adj.	(7.2)	(6.2)	(6.3)	(6.6)	(6.9)	**(33.2)**
Total	263.8	223.5	160.0	135.0	93.6	**875.9**
Compared to Expansion Program	**+35.3**	**+99.9**	**+168.1**	**+196.0**	**+256.6**	**+755.9**
Compared to SB 2512 Phases 1 and 2	**0.0**	**+1.3**	**+1.6**	**+1.5**	**+5.8**	**+10.2**

Impact on Federal $$$ Coming to FL					
FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	Total
1,946.8	1,266.8	1,282.2	1,324.4	1,352.6	**7,172.8**
30.6	74.0	73.9	75.2	75.8	**329.6**
235.3	213.8	195.3	188.7	175.6	**1,008.7**
(51.5)	(69.6)	(69.9)	(70.3)	(75.9)	**(337.3)**
N/A	(21.0)	(23.4)	(23.8)	(19.8)	**(88.0)**
2,161.1	1,464.0	1,458.1	1,494.4	1,508.3	**8,085.9**
N/A	N/A	N/A	N/A	N/A	**N/A**
2,161.1	1,464.0	1,458.1	1,494.4	1,508.3	**8,085.9**
-1,421.2	**-2,159.1**	**-2,176.1**	**-2,234.5**	**-2,271.0**	**-10,262.0**
0.0	**-21.0**	**-23.4**	**-23.8**	**-19.8**	**-88.0**

Note: Dollars in Millions; Positive Total = Surplus; Negative Total = Shortfall

THE FLORIDA SENATE

SENATOR ANDY GARDINER
President

TO: All Senators
FROM: Andy Gardiner, President
SUBJECT: Florida Health Insurance Affordability Exchange Program
DATE: March 5, 2015

Florida is at an important crossroads in the Medicaid program. Nearly $2 billion of Low Income Pool (LIP) funding is in jeopardy. LIP funding is a critical source of support for hospitals that provide essential services to Medicaid patients as well as the uninsured. Some of our safety net hospitals struggle to remain solvent even with the supplemental payments provided through LIP. Our communities depend on the services supported by LIP payments and loss of these funds poses a significant threat.

At the same time, more than 800,000 uninsured Floridians can qualify for Medicaid if we decide to expand coverage. Extra federal funds will enable more of our friends and neighbors to obtain health coverage. Not surprisingly, the federal money comes with strings attached. Some say Florida should not expand the existing Medicaid program and I agree. But we have the obligation to make coverage affordable and the opportunity to develop a consumer-driven approach—one that provides access to high-quality, affordable health care coverage while promoting personal responsibility. We should develop options that uniquely suit the needs of Floridians. We should examine the opportunity for expansion and determine the best way to put in place conservative, free market guardrails that will control the cost and growth of the Medicaid program for Florida's taxpayers.

This week, the Health Policy Committee conducted a workshop and panel discussion on health care coverage options. The committee received a presentation on the Healthy Indiana Plan 2.0 (HIP 2.0), Indiana's recently expanded health insurance program. HIP 2.0 is an alternative to traditional Medicaid expansion. Indiana's waiver is different than other Medicaid expansion waivers approved by the federal government to date in that it allows new flexibility to the state. Additionally, senators heard from the AHCA regarding the capacity of the agency to add the new group of eligible enrollees under the existing Medicaid managed care program.

During the workshop, members discussed ideas with experts and listened to constituents from across the state. As a result, the Health Policy Committee, under the leadership of Chair Bean, has developed Proposed Committee Bill 7044. PCB 7044 creates a state-operated marketplace for

low-income Floridians to access health care coverage, services and products. Under the proposed legislation, enrollment will begin July 1, 2015 and will utilize a phased transition to ensure continuity of care. A summary of the proposed legislation is attached. I encourage you to review this information and become familiar with the challenges facing Florida's Medicaid program. I look forward to working with all of you to find the best way to meet the healthcare needs of our state.

PCB 7044 relating to Access to Health Coverage

Establishment of the Florida Health Insurance Affordability Exchange (FHIX) Program:
The FHIX program is a consumer-driven approach to providing access to high-quality, affordable health care coverage while promoting personal responsibility. FHIX participants will have access to a state-operated marketplace to shop and select coverage, services and products. The FHIX program will have a start date of July 1, 2015 and offer existing Medicaid Managed Care Plans immediately.

Coverage Population & Eligibility Requirements:
- The FHIX program will extend coverage to an estimated 800,000 low-income Floridians.
- The expanded population will include individuals earning less than 138% of the Federal Poverty Level (FPL), who are not currently eligible under section 409.902, Florida Statutes. Individuals who earn an annual income of up to approximately $16,000 or parents who earn up to approximately $33,000 for a family of 4 will now be eligible.
- Must be a Florida resident.

Products and Services:
- All Florida Health Choices Program products and services.
- All Medicaid Managed Care plans.
- All products offered by Florida Healthy Kids Corporation.
- Employer sponsored plans.

Cost-Sharing Principles:
- Participants may be charged for inappropriate use of emergency room visits, $8 for the first visit and up to $25 for subsequent visits.
- Participants will be assessed mandatory monthly premiums based on their modified adjusted gross income as follows:
    - Less than 22% of the FPL: $3
    - Between 22.01%-50% of the FPL: $8
    - Between 50.01%-75% of the FPL: $15
    - Between 75.01%-100% of the FPL: $20
    - Between 100.01%-138% of the FPL: $25
- If a full premium payment is not received after a 30-day grace period, the premium assistance will be suspended and the participant may not re-activate coverage for a minimum of 6 months.

Employment Requirements:
- Participants are required to complete an initial application for coverage which includes proof of employment, on-the-job training or placement activities, or pursuit of educational opportunities at a minimum hourly level as follows:
    - Parents with children under the age of 18: Minimum requirement of 20 hours per week.

  - Childless adults (disabled adults or caregivers of disabled children or adults may submit exceptions): Minimum requirement of 30 hours per week.
- Participants must maintain the above work or educational requirements and will submit a renewal annually.

Implementation:

There will be a 3-phased approach to eligibility and enrollment that uses existing resources:

- Phase One - Extend eligibility to the newly eligible with the Medicaid Managed Care Plans while seeking approval for Phase 2;
- Phase Two - Transition participants to the Florida Health Choices marketplace to select plans, services and products using premium credits based on a risk adjusted rate beginning January 1, 2016; and
- Phase Three - Fold Florida Healthy Kids enrollees into the marketplace starting July 1, 2016.
- A Transition Workgroup will oversee the process and make recommendations to the Agency for Health Care Administration (AHCA).
- The AHCA, as the single state agency for Medicaid, will make the ultimate decision on whether or not a region or phase is ready to "go live".

Administration:

- The Department of Children and Families will continue to determine eligibility.
- The Agency for Health Care Administration will administer Phase One, is the recipient and distributor of federal funds, chairs the FHIX Workgroup and has overall responsibility for the program.
- The Florida Healthy Kids Corporation will provide customer support, financial services and retain its other responsibilities until Phase Three.
- Florida Health Choices, Inc., will implement and operate the FHIX marketplace.

Participant Responsibilities:

- Apply for coverage.
- Execute participant contract to acknowledge program limitations, including possible non-funding, participant responsibilities for payments and work or education, and disenrollment consequences.
- Make monthly premium payments based on income and work or educational requirements that begin in Phase Two.
- Assume cost sharing for services based on products selected in the marketplace.
- Renew eligibility annually.

Participant Rights:

- Access the FHIX marketplace to shop and select coverage, services and products.
- Avoid disruption of coverage through portability and continuity of coverage when eligibility changes.

- Retain premium credits earned despite changes in circumstances in a health reimbursement or health savings account.
- Select more than one plan or product on the FHIX marketplace.
- Choose from at least two plans on the FHIX marketplace that are compliant with the Patient Protection and Affordable Care Act.

THE FLORIDA SENATE

SENATOR ANDY GARDINER
President

TO: All Senators
FROM: Andy Gardiner, President
SUBJECT: Senate Plan for Medicaid Sustainability
DATE: March 19, 2015

As we work together to develop the Fiscal Year 2015-16 General Appropriations Act, the single greatest unknown factor influencing our decision-making is the future of Low-Income Pool (LIP) funding. As you are aware, funds contributed by local hospital authorities and county governments, combined with the federal match, generate more than $2 billion in funding that enables many hospitals to continue serving Floridians in need.

The LIP has helped Florida fund its Medicaid program since 2006. Last session, to account for delays in federal reauthorization of the LIP, the Senate passed its initial budget without a LIP model. The current-year model and associated federal funding were included during the budget conference after eleventh hour approval from the federal government. At that time, and several times subsequently, the Centers for Medicare & Medicaid Services (CMS) have clearly stated that the federal government will not approve an extension of the current LIP model for another year.

Understanding this history, the Senate budget aims to avoid brinksmanship negotiations with the federal government. Instead the Senate proactively proposes an alternative plan for Medicaid sustainability in Florida.

Today Chair Garcia will publish a proposal for the Health and Human Services portion of the Fiscal Year 2015-16 General Appropriations Act. Chair Garcia's proposal includes a new LIP model which we believe offers a better chance for swift approval by the federal government.

The Senate's Plan for Medicaid Sustainability seeks to preserve but restructure the LIP by changing the portions of the LIP that have received the most criticism from CMS. Our plan directs more funds to increase base hospital rates and more broadly distributes LIP dollars.

Under the Senate plan, the redeployed LIP will maintain an aggregate level of funding identical to the current LIP or $2.16 billion.

SUITE 409, THE CAPITOL, 404 SOUTH MONROE STREET ▪ TALLAHASSEE, FLORIDA 32399-1100 ▪ TELEPHONE (850) 487-5229
Senate's Website: *www.flsenate.gov*

The Senate plan also maintains two crucial components of the current LIP:

- Support for rural hospitals, trauma centers, primary care services, specialty pediatric hospitals, and safety-net hospitals, along with a special aspect of incenting quality (known as Special LIP; $116 million); and
- Funding for primary care and other non-hospital providers, such as federally qualified health centers, emergency room diversion, county health departments, poison control programs, and medical schools ($322 million).

The Senate plan continues to provide a return on investment to local governments and hospital authorities that voluntarily donate their funds (local tax dollars), known as intergovernmental transfers (IGTs), but alters the methodology for the return on that investment, in ways which are consistent with how the federal government has told Florida the system must be changed. These changes include:

- Funds previously targeted for specific hospitals will instead be distributed in a broad-based system so that *all* hospitals can benefit.
- More than $200 million will be directed into the base funding for hospital Medicaid reimbursement.
- An additional $234 million will be distributed among hospitals based on their Medicaid utilization and criteria regarding the provision of critical-needs services.
- The donors' return on investment will be limited and it will be the same for all IGTs.

The overall effect of the Senate plan is a new LIP that distributes funds more broadly, so more hospitals benefit, and does so in a manner our federal partners are much more likely to accept on an ongoing basis.

The Senate plan also asks our federal partners to amend certain Medicaid calculations so that our local partners are not penalized as a result of donating IGTs. Medicaid does not allow providers to be compensated beyond certain limits when providing Medicaid services. Under the current CMS method for calculating those limits, some IGT donors are being penalized for the IGTs they donate to the system. We are asking our federal partners to work with us to begin using a more realistic and fair method for calculating provider cost limits.

The Senate's Medicaid Sustainability Plan couples the revamped LIP with the Health Policy Committee's Florida Health Insurance Affordability Exchange (FHIX) program to provide private health coverage for persons under 133 percent of the federal poverty level who are not already covered by Medicaid. These two proposals, a new LIP and the FHIX, go hand-in-hand.

Gaining federal approval of the new Senate LIP model, as well as federal authority to fully implement the FHIX, are ambitious goals. I am confident, however, that our federal partners will

recognize how the Senate plan benefits everyone involved. The Senate's Medicaid Sustainability Plan is innovative, forward-thinking, and budget conscious. The plan is designed not only to provide market-based health insurance for Floridians currently in a coverage gap, but also ensure that the backbone of our health care system – community hospitals and safety-net hospitals – can continue relying on the Medicaid funding that has provided critical support since 2006.

Unlike last year when we had good reason to expect a last-minute federal extension of the current LIP, Washington has been abundantly clear: the LIP in its current form will not continue. If our Senate model does not gain approval from CMS and the federal government walks away from a LIP of some form, we simply cannot count on our local partners to continue contributing hundreds of millions of dollars. Such contributions are available only if the donors realize a benefit for their local taxpayers, and federal approval of a LIP is the only way to provide that guarantee.

Without federal approval of a new LIP model, state funds may be needed to help maintain hospital rates at their current levels. This state funding would be eligible for a federal drawdown that would more than double any funding we contribute. We must keep this risk in mind as we evaluate other spending priorities.

We can no longer wait for Washington. We must advocate for our own pro-active, market-based, Florida-driven solution for the enormous health care challenges facing our state. I look forward to your continued input and assistance with this important issue.

THE FLORIDA SENATE

SENATOR ANDY GARDINER
President

TO: All Senators
FROM: Andy Gardiner, President
SUBJECT: Information on Senate Plan for Medicaid Sustainability
DATE: April 14, 2015

With the first two-thirds of session complete, I would like to provide some additional information related to the Senate Plan for Medicaid Sustainability, including today's developments.

Today AHCA received a letter from CMS (attached for your reference) stating the following:

- **"…the future of the LIP, sufficient provider rates, and Medicaid expansion are linked…"**
- **"Transition periods can ease the process of reducing the LIP as the state makes the transition to broader Medicaid coverage for its residents…"**

I have included some additional information below, which I hope you will find useful in answering questions as to how we arrived at this point.

Many opposed to expansion point to examples of California and Texas to make the case that expansion and LIP are separate issues. It is true California expanded Medicaid and receives LIP funding, while Texas did not expand, but also receives LIP funding. However, comparing Texas to Florida is misleading. The Texas waiver authorizing LIP payments was approved prior to the Supreme Court decision that made expansion voluntary instead of mandatory. Next year, the Texas waiver will need to be renewed and that request is likely to face similar scrutiny. Federal decisions about Florida will serve as precedent for Texas, not vice versa.

In Fiscal Year 2014-15, Florida fully implemented its Managed Medical Assistance demonstration program (managed care) as authorized by CMS. As part of the managed care demonstration program, Florida was permitted to receive federal matching funds for LIP payments up to $2.16 billion. Specifically, in April 2014, CMS provisionally granted Florida a one year extension of LIP funding and specifically required Florida to review "Medicaid provider payments and funding mechanisms, with the goal of developing sustainable, transparent, equitable, appropriate, accountable, and actuarially sound Medicaid payment

systems and funding mechanisms that will ensure quality health care services to Florida's Medicaid beneficiaries throughout the state **without the need for LIP funding**."

In July 2014, when CMS officially granted the one year LIP extension, another requirement directed Florida to obtain an independent study (The Navigant Report) by March 1, 2015. The report was required to "recommend reforms to Florida's Medicaid financing system that can…move toward Medicaid managed care and fee-for-service payments…rather than through over reliance on supplemental payments" such as LIP.

Since the report was submitted, AHCA has been in discussions with CMS regarding Florida's LIP funding for FY 2015-16. The following is a summary of the discussions between AHCA and CMS:

- All discussions with CMS have revolved around estimating Florida's cost for uncompensated care **absent those Floridians who could be covered through an expansion of Medicaid.** (This factor contributed to the Senate decision to include both LIP and expansion in our budget.)
- Though AHCA has presented credible information that uncompensated care after expansion of Medicaid would still exceed $2.16 billion, CMS has questioned this data and indicated an interest in seeking an assessment of uncompensated care from an independent source.
- **CMS has also pointed to an additional source for the analysis of uncompensated care costs that pegs Florida's uncompensated costs at less than half the amount advanced by AHCA.**
- Public statements from federal officials further indicate the federal government will not "cover the same people twice," meaning CMS will not continue to authorize supplemental payments to hospitals to pay for services for those who can be covered by expansion.

Today's letter from CMS also states the following:

"**We will approach a review of a LIP proposal from Florida based on several key principles. First, coverage rather than uncompensated care pools is the best way to secure affordable access to health care for low-income individuals, and uncompensated care pool funding should not pay for costs that would be covered in Medicaid expansion. Second, Medicaid payments should support services provided to Medicaid beneficiaries and low-income uninsured individuals. Finally, provider payment rates must be sufficient to promote provider participation and access, and should support plans in managing and coordinating care. We also note that transition periods can ease the process of reducing LIP as the state makes the transition to broader Medicaid coverage for its residents at**

sustainable rates, and that disproportionate share hospital payments will remain available to support uncompensated care."

This and all prior indications from the federal government since April 2014 outlined above indicate the LIP program will be phased out.

Absent expansion or additional state funding, what does the phasing out of LIP mean for Florida's hospitals and the people they serve?

On average, Medicaid payments to Florida hospitals at current levels equate to only 49 percent of costs. The Navigant report states elimination of LIP payments results in a loss of $1.3 billion in hospital revenues or an average 15 percent reduction statewide. Many hospitals will be unable to sustain a cut this large. If LIP funding is eliminated or substantially reduced, we should expect layoffs and less services. The programs most at risk are those with high costs and low margins. Cancer centers, dialysis units, transplant services, graduate medical education capacity, and other special services will be limited or may even close their doors as hospitals struggle to cover the high emergency room costs of uninsured Floridians who could qualify for expanded coverage.

The impact is not limited to hospitals alone. State payments to managed care organizations will also drop. During implementation of statewide managed care, contracts were negotiated and signed based on expected revenues. Sudden cuts in managed care funding that would result from the loss of LIP also jeopardize the arrangements between managed care and all providers and raise questions about whether Florida can continue to meet federal requirements for actuarial sound rates and adequate payment levels.

The bottom line is: more than ever, today's correspondence from CMS highlights the link between LIP and expansion and the need to consider a comprehensive Florida solution. Time is of the essence. The Senate remains open to meeting at any time to discuss our free-market approach to expansion or any alternative the House or Governor would like to propose.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

April 11, 2014

Justin Senior
State of Florida, Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 8
Tallahassee, FL 32308

Dear Justin:

I am writing to memorialize the work we have accomplished together to date on Florida's request to renew its section 1115 demonstration, titled, Managed Medical Assistance, demonstration number 11-W-00206/4. We have made significant progress toward the goal of finalizing the terms of the demonstration renewal. We are eager to continue working together to grant the renewal based on the following agreements described below:

- A three-year extension of the demonstration through June 30, 2017, except for the Low Income Pool (LIP), which will be extended only for one year from July 1, 2014 through June 30, 2015.
- During the one-year extension for the LIP, expenditures would be authorized to provide stability for providers for a limited time during Florida's transition to statewide Medicaid managed care and a significantly reformed Medicaid payment system. The LIP would be funded only through existing state and local funding arrangements. Federal LIP funding for the year is still under review, but would not exceed $2.16 billion (total computable), or the level of previous LIP funding (in the prior year) increased by the amount of federal funding previously provided for certain supplemental payments, to the extent that those payments are discontinued by the state. Final LIP funding amounts and provider participation requirements will be specified in the terms and conditions of the demonstration approval documents.
- During this one year extension of the LIP, Florida will review Medicaid provider payments and funding mechanisms, with the goal of developing sustainable, transparent, equitable, appropriate, accountable, and actuarially sound Medicaid payment systems and funding mechanisms that will ensure quality health care services to Florida's Medicaid beneficiaries throughout the state without the need for LIP funding.
- Expenditures authorized under the LIP would be limited to uncompensated care costs of providers, the independent report discussed below, and other categories of expenditure as specified in the demonstration's current special terms and conditions. Uncompensated care costs will be verified through provider cost reports. Allowable LIP expenditures will be offset by the amount of payments that were made to providers in prior demonstration years in excess of allowable costs identified on provider cost reports.

- During the one-year LIP extension, the state will use a portion of the LIP funds to commission a report from an independent entity on Medicaid provider payment in the state that reviews the adequacy of payment levels, and the adequacy, equity, accountability and sustainability of the State's funding mechanisms for these payments. The report must recommend reforms to the Florida Medicaid financing system that can allow the state, beginning in state fiscal year 2015, to move toward Medicaid fee-for-service and managed care payments that ensure access for Medicaid beneficiaries to providers without payments through the LIP. A final report will be due no later than March 1, 2015.

We look forward to working with you further on these topics as part of our effort to reach a final agreement on the demonstration. Please feel free to call me if you have concerns or questions as we continue our discussions.

Sincerely,

/s/

Cindy Mann
Director

cc: Jackie Glaze, Associate Regional Administrator, Region IV

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

JUL 3 1 2014

Justin Senior
Deputy Secretary for Medicaid
Florida Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 8
Tallahassee, FL 32308

Dear Mr. Senior:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving your request to extend Florida's section 1115 demonstration project, titled Managed Medical Assistance Program (MMA) (Project Number 11-W-00206/4). The demonstration extension succeeds the temporary one month extension of the demonstration that was granted on June 30, 2014, extending the previously approved demonstration through July 31, 2014. This extension is approved for three years from July 31, 2014 through June 30, 2017, except for the Low Income Pool (LIP) supplemental payment authority which will be extended through June 30, 2015. This extension retains improvements to the overall demonstration that were added in the June 2013 amendment, including improved stakeholder engagement processes and consumer protections and improved evaluation and quality initiatives.

As noted in our April 11, 2014 Agreement in Principle letter, 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. The terms and conditions for this extension specify that LIP payments will be funded through existing state and local funding arrangements. They also reflect our agreement that CMS will authorize up to $2,167,718,341 (total computable) for LIP in demonstration year (DY) 9. To promote sound decision making going forward, the state will commission a report from an independent entity on Medicaid provider payments in the state. The report will review the adequacy of payment levels, and the adequacy, equity, accountability and sustainability of the state's funding mechanisms for these payments. The report shall recommend reforms to the Florida Medicaid financing system that can allow the state, beginning in state fiscal year 2015-2016, to move toward Medicaid managed care and fee-for-service payments that ensure access for Medicaid beneficiaries to providers throughout the state through such payments rather than through over reliance on supplemental payments. The revised terms and conditions also require measures to strengthen oversight of LIP expenditures, to ensure that payments to providers through the LIP represent only allowable costs. As discussed with you previously, our review indicates that certain payments made to providers through LIP in DYs 1-3

were unallowable; therefore we plan to issue a disallowance in accordance with 42 CFR 430.42 for the amounts we identified ($104,351,578 in total computable, for which the federal share must be returned). You will receive official notification of this disallowance (including your rights to reconsideration and appeal of our decision) in a separate transmittal.

We will continue to work with you to review payments made under subsequent DYs, and if additional overpayments are identified, follow the same procedure. We appreciate the work of you and your staff to develop a new data tool that will help speed and strengthen the reconciliation process. Our financial management staff in our central office and Atlanta Regional office will continue to communicate closely with you and your staff regarding LIP reconciliations.

CMS approval of this section 1115 demonstration extension is subject to the limitations specified in the approved waiver and expenditure authorities and the list of requirements that are not applicable to the expenditure authorities. The state may deviate from the Medicaid State plan requirements only to the extent those requirements have been specifically listed as waived or not applicable to the expenditure authorities. All requirements of the Medicaid program as expressed in law, regulation, and policy statement not expressly waived or identified as not applicable shall apply to Florida's Managed Medical Assistance program. This approval is also conditioned upon continued compliance with the enclosed special terms and conditions (STCs) defining the nature, character, and extent of federal involvement in this project.

These approvals are conditioned upon written acceptance from the state that it agrees with the waiver and expenditure authorities and STCs. This written acceptance is needed for our records within 30 days of the date of this letter.

Your project officer is Ms. Heather Hostetler. Ms. Hostetler's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Division of State Demonstrations and Waivers
7500 Security Boulevard
Mail Stop S2-02-26
Baltimore, MD 21244-1850
Telephone: (410) 786-4515
Facsimile: (410) 786-8534
E-mail: Heather.Hostetler@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Hostetler and to Ms. Jackie Glaze, Associate Regional Administrator in our Atlanta Regional Office. Ms. Glaze's address is:

Jackie Glaze
Centers for Medicare & Medicaid Services
Atlanta Federal Center, 4th Floor
61 Forsyth Street, SW Suite 4T20

Atlanta, GA 30303-8909
Telephone: (404) 562-7417
E-mail: Jackie.Glaze@cms.hhs.gov

If you have questions regarding this approval, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Center for Medicaid & CHIP Services, at (410) 786-5647. Thank you for you and your staffs' thoughtful work on this demonstration extension.

Sincerely,

Cindy Mann
Director

Enclosures

cc: Jackie Glaze, Associate Regional Administrator, Region IV

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

April 14, 2015

Justin Senior
Deputy Secretary for Medicaid
2727 Mahan Drive
Mail Stop #8
Tallahassee, FL 32308

Dear Deputy Secretary Senior:

I am writing to follow up with you on the discussions underway about the status of Florida's Low Income Pool (LIP). The LIP was implemented in 2006 as a time-limited demonstration to support Florida safety net providers that provide uncompensated care to some of the state's most vulnerable residents. As you know, over time CMS has had a number of concerns about the LIP, including its lack of transparency, encouragement toward overreliance on supplemental payments, and distribution of funds based on providers' access to local revenue instead of service to Medicaid patients. Last year, CMS made clear that LIP would not continue in its current form. We extended the Florida Managed Medical Assistance Program demonstration through June 30, 2017, and granted a limited one-year extension of the LIP which otherwise would have expired in 2014. There was also a specific requirement that Florida commission an independent review and analyze and develop a plan to reform Medicaid provider payments and funding mechanisms to ensure quality health care services to Florida's Medicaid beneficiaries throughout the state without the need for LIP funding. We established the goal of the state implementing reformed payment and funding mechanisms in state fiscal year 2015-2016.

When the Affordable Care Act (ACA) was enacted, it established a more comprehensive approach to providing health care coverage, including Medicaid, while supporting hospitals that serve communities with the greatest needs. Medicaid expansion would reduce uncompensated care in the state, and therefore have an impact on the LIP, which is why the state's expansion status is an important consideration in our approach regarding extending the LIP beyond June. We believe that the future of the LIP, sufficient provider rates, and Medicaid expansion are linked in considering a solution for Florida's low income citizens, safety net providers, and taxpayers.

We are encouraged by the State Senate's interest in expanding Medicaid to low-income adults in the state, to cover between 870,000 and 1 million vulnerable Floridians, according to the independent report that the state commissioned from Navigant Health Care. CMS will monitor the progress of this legislation closely and, if enacted, looks forward to working with the state on the substance of the state's expansion approach. With Medicaid expansion, individuals with coverage would be less likely to seek bankruptcy protection or generate unpaid medical bills. In addition, expanding Medicaid would reduce the burden of uncompensated hospital care and provide new revenues to Florida's safety net providers. A new independent analysis of eight expansion states finds that savings and revenues by the end of 2015 across those states are expected to exceed $1.8 billion. State specific studies estimate that, in the first three years of expansion, Florida could realize an $8.9 billion increase in economic activity stemming from Medicaid expansion. Florida could also expect

to reap employment gains; the Kaiser Family Foundation projects that the state could gain 71,000 jobs in the first three years following Medicaid expansion. Additionally, the ACA provides that the federal government will pay 100 percent of the costs for newly-eligible adult beneficiaries through 2016. While the federal contribution gradually declines beginning in 2017, the law requires that federal funding for this group will never be less than 90 percent of the cost of care. This guarantee of federal support for paying for the expansion population can only be modified by legislation passed by Congress and signed into law by the President.

We will approach review of a LIP proposal from Florida based on several key principles. First, coverage rather than uncompensated care pools is the best way to secure affordable 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. Second, Medicaid payments should support services provided to Medicaid beneficiaries and low-income uninsured individuals. Finally, provider payment rates must be sufficient to promote provider participation and access, and should support plans in managing and coordinating care. We also note that transition periods can ease the process of reducing the LIP as the state makes the transition to broader Medicaid coverage for its residents at sustainable rates, and that disproportionate share hospital payments will remain available to support uncompensated care.

I look forward to continuing our discussions on how best to support the health needs of low-income Floridians and Florida's health care system, while at the same time spending federal tax dollars most wisely and meeting the objectives of the Medicaid program and the Affordable Care Act. I am available at your earliest convenience to discuss next steps.

Sincerely,

Vikki Wachino
Acting Director

RICK SCOTT
GOVERNOR

March 4, 2015

The Honorable Barack Obama
President of the United States of America
The White House
1600 Pennsylvania Avenue, NW
Washington, D.C. 20500

Dear Mr. President:

In early February, Eliot Fishman, a director within the Medicaid division of the Centers for Medicare and Medicaid Services (CMS), stated at a conference in Florida that Florida's Low Income Pool (LIP) program will not continue in its present form. This federal matching program provides federal funds that Florida hospitals have depended on to pay for the state's most vulnerable residents. Termination of the federal matching participation would severely hamper future efforts to improve health care services for low income individuals who rely on a certain predictability of funding.

In just the last four years, my administration has worked with CMS to successfully put in place Statewide Managed Care and Diagnosis Related Group based payment for hospital services in Medicaid. These patient-centered reforms are the most significant in the history of Florida's Medicaid program and, as noted by CMS, are key structural elements to build on in continuing to move toward delivery based models that ensure access to cost-effective quality care for recipients.

My "Keep Florida Working" Budget builds on these structural elements, with the first ever statewide initiative in Medicaid, to pay directly for quality outcomes. Like the major reforms it is built on, this new, patient-centered initiative will further reward the delivery of high-value, quality-driven health care services in an efficient manner, to the benefit of both Medicaid recipients and state and federal taxpayers.

In our current discussions with CMS, Florida is not proposing to continue the LIP Waiver in its present form, but to maximize the value of our tax dollars to further the same goals for the Medicaid program that we have shared with CMS over the last four years. This request is not associated with Medicaid expansion in any way and your administration has already made it clear that whether or not a state expands Medicaid does not impact the continuation of similar programs within that state.

THE CAPITOL
TALLAHASSEE, FLORIDA 32399 • (850) 488-2272 • FAX (850) 922-4292

California, for example, has expanded Medicaid and their supplement funding continues at more than $5 billion a year. Texas, by contrast, has not expanded Medicaid and their supplemental funding continues at nearly $7.5 billion a year. As was noted in the independent evaluation of Florida's Medicaid program that the federal government required for this year, "When considering the total population that Medicaid funding will cover, California and Texas are both receiving substantially more supplemental funding than Florida."

Should your administration decline to accept a new LIP model and therefore terminate this program, I will not support using any state funds to backfill this federal program. Florida taxpayers fund our federal government and deserve to get a return on their investment. Moreover, we have worked hard to turn Florida's economy around and cannot afford to fund programs started by the federal government.

As with previous negotiations, we are optimistic that you will not terminate LIP and we will be able to reach an agreement on how best to structure this program in a way that protects both our state's most vulnerable residents as well as state and federal taxpayers.

Sincerely,

Rick Scott
Governor

Congress of the United States
Washington, DC 20515

April 14, 2015

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
201 Independence Avenue, S.W., Room 445-G
Washington, D.C. 20201

Dear Acting Administrator Slavitt:

Over the past three months, Florida has been working with the Centers for Medicare and Medicaid Services (CMS) to determine the future of the Low Income Pool (LIP) in order to prevent disruption of access to quality health care for low income individuals in the State of Florida. Currently, the LIP includes approximately $2.1 billion in annual funding. These dollars, among other things, allow local governments to make investments in their own health care delivery systems, fund hospitals for providing services to the current Medicaid population, fund the faculties at Florida's medical schools for services provided to the current Medicaid population, and offset losses providers incur from rendering services to uninsured and underinsured Floridians. The LIP program, however, is in many ways separate and apart from any decision to expand Medicaid as envisioned under the Affordable Care Act.

Uncompensated care will still exist in Florida with or without the expansion of Medicaid, and thus it is important to continue the LIP so that the federal government and Florida continue to support providers who serve this ongoing uninsured population.

Time is of the essence. Florida's House of Representatives and Senate must propose, negotiate, and finalize the state's budget by the second half of April 2015. CMS therefore must agree in principle on the LIP in the first half of April 2015. This agreement in principle need only express the total dollar value of the LIP going forward, along with any general parameters around the flow of the funds.

CMS has stated that it will not provide LIP funds to pay for costs associated with uninsured Floridians who would become insured if the state expanded the Medicaid program.

Florida has sought out independent studies that estimate the amount of uninsured costs that would remain in the state even if Florida were to expand its Medicaid program. In a report from 2012, the Urban Institute, in conjunction with the Robert Wood Johnson Foundation, estimated that **Florida would still have nearly $1.6 billion in costs related to uncompensated care even after it expanded its Medicaid program.** This $1.6 billion dollar figure is particularly reliable, in that it comes from an independent source and predates the current negotiations.

Additionally, the LIP currently includes incentives of over $400 million annually that are fully independent of any political decision around Medicaid expansion. These funds

support Florida's medical schools, county health departments, local health centers, and poison control initiatives.

CMS should not destabilize, eliminate, or hold these programs hostage to an expansion decision. Continuing LIP, at approximately the current level of funding, would treat Florida equally with other states, like California, that have both expanded Medicaid and continue to receive uncompensated care funds for their remaining uninsured populations. Florida strongly believes $1.6 billion in remaining uncompensated care, coupled with the over $400 million in support of the medical schools and other providers, should be the basis of a renewed LIP.

Florida is willing to address other concerns expressed by CMS during the current LIP discussions, such as streamlining and refining the rate of return local governments receive for participation and tweaking the funds' distribution to more closely follow the patient.

Florida is asking CMS to treat the state consistently with other states that have expanded, like California, and to support health care providers in the state that provide services to people who would remain uninsured even if Florida Medicaid expanded. Florida is also asking CMS to continue to support institutions and initiatives, like medical schools, that are critical to Florida's health care system and that have nothing to do with the expansion decision.

As members of the Florida Congressional delegation, we ask that you strongly support Florida's efforts in this regard, and urge CMS to agree in principle to continue LIP funding near the current level of funding prior to mid-April.

Sincerely,

Ted S. Yoho, D.V.M.
Member of Congress

Marco Rubio
United States Senate

Gus Bilirakis
Member of Congress

Ileana Ros-Lehtinen
Member of Congress

Richard Nugent
Member of Congress

Curt Clawson
Member of Congress

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

April 15, 2015

Victoria Wachino
Acting Director
Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Dear Vikki:

Thank you for your letter of April 14, 2015 regarding the future of Florida's Low Income Pool (LIP). Your letter, for the first time, clearly links a continued LIP with Medicaid expansion. In NFIB v. Sebelius 132 S. Ct. 2566 (2012), the U.S. Supreme Court explicitly warned the federal government against attempting to coerce states into participating in Medicaid expansion – yet that appears to be exactly what the federal government is attempting here. Regardless, our Agency lacks the authority to expand the Medicaid program. As such, in our role we can only focus on LIP and its features going forward. As we agree upon a renewed LIP, we are also willing to grant the federal government flexibility, but cannot adopt the burden of oversight or additional financial participation in the expansion of Medicaid without a change in state law.

Over the past several months, our Agency has proposed multiple LIP models that address the concerns you raise in your letter. We will now promptly file a formal amendment to our 1115 waiver that will renew the LIP for two years, and that will address the concerns you have raised. It is worth noting that the LIP program is separate and apart from any decision to expand Medicaid. As even the Urban Institute acknowledges, almost $1.6 billion in uncompensated care would exist post expansion. Florida children's hospitals would receive virtually no benefit from an expansion but stand to lose $125 million without the renewal of the LIP program.

This year, 1.6 million Floridians purchased health plans in the federal exchange. Because of this, any Medicaid expansion in Florida would likely force hundreds of thousands of Floridians between 100% and 138% of the poverty line off of private coverage they have chosen and into a welfare and entitlement program. CMS should thoroughly review this new reality as it considers approaches to coverage expansions in Florida and around the country.

As you know, federal law requires the federal government to pay the full cost of those who currently fall in the so-called Medicaid "coverage gap" through calendar year 2016. The federal government is currently doing this for those between 100% and 138% of the poverty line. As we submit our renewed LIP model, please note that we are willing to give the federal government permission to cover all Floridians they identify as long as they 100% support their policies on the federal exchange. Under current law this permission cannot involve any additional state dollars from Florida. Also, the Floridians you choose to cover must have free reign to choose their health coverage on the exchange, just like those between 100% and 138% of the poverty line currently do, and the federal government must not restrict or interfere with their choices.

We hope the federal government receives our LIP amendment cordially, and recognizes it for the opportunity it presents for every Floridian to have access to quality, affordable private health insurance through the free market. Our Agency has worked hard to establish a strong and productive relationship with CMS over the past five years. We will continue our efforts to foster a strong relationship in the future.

Thank you for your time and consideration.

Sincerely,

Justin M. Senior
Deputy Secretary for Medicaid

From the office of
GOVERNOR
RICK SCOTT
COMMUNICATIONS OFFICE
PRESS RELEASE
@FLGovScott www.FLGov.com

FOR IMMEDIATE RELEASE
April 16, 2015

CONTACT: GOVERNOR'S PRESS OFFICE
(850) 717-9282
media@eog.myflorida.com

Governor Rick Scott to Take Legal Action Against Obama for Stopping Federal Funds to Force State Further Into Obamacare

TALLAHASSEE, Fla. – Today, Governor Rick Scott announced that he will take legal action against President Obama's federal healthcare agency for stopping Low Income Pool (LIP) healthcare funds to Florida in order to force the state to take Legislative action to expand Medicaid under Obamacare.

Governor Rick Scott said, "It is appalling that President Obama would cut off federal healthcare dollars to Florida in an effort to force our state further into Obamacare. The President's healthcare agency sent us a letter this week saying the 'the future of LIP' and 'Medicaid expansion are linked.' But, the Supreme Court has already ruled in NFIB v. Sebelius that the President cannot force Medicaid expansion on states. In fact, the Court ruled that the President could not use 'gun to the head' approaches in pushing for Medicaid expansion.

"Not only does President Obama's end to LIP funding in Florida violate the law by crossing the line into a coercion tactic for Obamacare, it also threatens poor families' access to the safety net healthcare services they need. The population in Florida served under the LIP program is different from the population that would be covered under any Medicaid expansion, as is well documented in a recent Urban Institute report that said Florida would still have $1.6 billion in uncompensated care costs with or without an expansion of Medicaid.

"We will fight to protect the healthcare of Floridians, and their right to be free from federal overreach. Our citizens already pay federal taxes that go into the federal LIP program. Now, President Obama has decided that the state must take on a larger Medicaid program, forcing our taxpayers to pay even more to government, before they get their own federal tax dollars back. This is outrageous, and specifically what the Supreme Court warned against.

"Our democracy is designed so that state governments can make the decision to not take on federal programs that will ultimately cost state taxpayers billions of dollars. We will not pass this cost on to our citizens in Florida and we will continue to fight for the federal LIP dollars our citizens already pay for with their federal taxes."

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Florida Times Union: UF Health Jacksonville shouldn't worry yet about loss of LIP, lawmakers say

Posted: April 11, 2015 - 10:51pm

By TIA MITCHELL
tia.mitchell@jacksonville.com

TALLAHASSEE — If Florida doesn't find a way to continue a program that helps hospitals treat uninsured patients, UF Health Jacksonville could cease to exist, its administrators and community supporters say.

The hospital receives $95 million in so-called federal Low Income Pool money, a program that helps hospitals and health clinics pay for the services they provide to uninsured or under-insured patients. Without that money, roughly 20 percent of its annual budget, UF Health Jacksonville would run out of cash in six months and could face higher interest rates and problems with creditors, chief executive Russell Armistead said.

Baptist Health president and CEO Hugh Greene said Jacksonville's other hospitals lack back the beds and emergency capacity to make up for the loss, evoking an image of M*A*S*H-like tents set up outside emergency rooms to handle the overflow.

John Delaney, University of North Florida president and chairman of JAX Chamber, said quality doctors would transfer to hospitals in other cities and more than 5,000 people could lose their jobs. "Someone is going to die," he said.

So where is the panic among elected officials in Tallahassee?

There isn't any. Not yet.

Members of the House and Senate both say they are optimistic a solution can be reached.

UF Health Jacksonville treats more than 4,000 patients a year through its trauma center, the only place in the region that people with the most severe injuries can receive treatment. The hospital reported last year 602,602 patients arrived via ambulance, nearly 90,000 people came through the emergency room and 2,865 births occurred in the facility.

The impact goes beyond the hospital, its patients and employees.

If the hospital closes, patients would be spread throughout the other hospitals in the region, not only lengthening wait times and competition for beds but also increasing those hospitals' share of Medicaid patients and the lower reimbursements that come with them.

Contrary to Gov. Rick Scott's recent negative outlook on the current funding impasse, most lawmakers believe Florida and the federal Centers for Medicare and Medicaid Services continue to negotiate in good faith to renew LIP past its June expiration date.

They believe an agreement will be worked out, though they admit it might not come in enough time to finalize the state budget by May 1 when the legislative session is scheduled to end.

No one knows what the revised version of LIP will look like and whether the money coming to Florida may decrease from the currently allocated $2.2 billion.

That is what worries Armistead.

Of the state's 14 safety net hospitals, those that shoulder the bulk of charity health care and Medicaid costs, Armistead said UF Health Jacksonville is among the best run but also among the most cash-strapped.

Florida counties support local hospitals in a variety of ways. Broward County's hospital taxing districts collect nearly $164 million in taxes to supplement hospital care, and Miami-Dade's Jackson Memorial Hospital gets $228 million from a half-penny sales tax.

In comparison, Jacksonville writes a check: $26 million this year. There are no plans to boost that amount.

Delaney thinks nearby counties, like Clay and Nassau, should pitch in because UF Health Jacksonville has the region's trauma center. There aren't plans for that either.

The state sends these local dollars to Washington, where the complicated LIP formula allows the money to multiple and come back to be shared by hospitals and health clinics statewide. That is how UF Health Jacksonville's share increases to $95 million.

"If I lose some part of that money, I am losing money," Armistead said. "So the LIP program is critical to us."

Lawmakers have started to play the blame game on why the state has yet to work out an agreement.

The state has known since April 2014 that the LIP program would expire June 30 unless Florida worked out substantial changes to address Washington's concerns about where the money comes from and how it is allocated.

Florida has swapped ideas back and forth with the feds, but there is still no official state proposal in the form of an amendment or extension to the Medicaid waiver that authorizes the LIP program.

“It would be premature to submit a final amendment at this point in negotiations with CMS,” said Katherine Riviere, a spokeswoman for Agency for Health Care Administration Secretary Liz Dudek, in an email.

Earlier this month, Dudek put out a statement saying the federal government had suddenly walked away from its talks with Florida for two weeks. “For CMS to discontinue LIP negotiations now is troubling and could signal the abrupt end of this federal health care program in Florida,” she said.

The next day, it came to light that the chief CMS negotiator was on a pre-planned international vacation, scheduled to coincide with the Passover holiday. The federal government said it is still communicating with Florida and open to any ideas the state has.

Still, Gov. Rick Scott blasted the federal government for being disingenuous about wanting to collaborate. He said inaction on LIP caused him to change his mind on supporting Medicaid expansion.

The timing seemed unusual since two Senate Republicans had just returned from their own trip to Washington with a glowing evaluation of relations with CMS.

Sens. Garrett Richter, R-Naples, and Rene Garcia, R-Hialeah, were pushing the Senate’s own proposal to keep LIP going.

Some House Republicans did not approve, saying the pair should have left talks up to the governor’s office.

“I think that when you negotiate, you negotiate through one person and not multiple people,” House Speaker Steve Crisafulli said last week. “And I think it’s probably confused the process and weakened the conversations that were taking place at earlier times with the governor’s office.”

Senate President Andy Gardiner, and Orlando Republican who is vice president of a safety net hospital, said his colleagues weren’t trying to insert themselves into LIP negotiations but rather went to the source to get a better understanding of where talks stand.

“People want to try to point fingers; the reality is again we’ve known this for a year,” he said.

Although LIP and Medicaid expansion are two separate topics, one affects the other.

Medicaid expansion would get more Floridians health coverage, meaning there would be fewer uninsured people showing up in hospital ERs and health clinics. That would mean less need for LIP.

One wouldn’t completely replace the need for the other, Armistead said.

He expects UF Health Jacksonville to receive $30 million to $35 million if Medicaid expansion is approved in Florida, a long shot this year with the House and Senate taking opposing views.

“If they don’t fix the LIP program, it wouldn’t matter,” Armistead said. “If they couldn’t fix LIP and we got Medicaid expansion, I would lose $95 million and gain $35 million. I would still go broke.”

Rep. Travis Cummings, R-Orange Park, is considered one of the First Coast delegation’s health-care chiefs. He doesn’t think UF Health Jacksonville should ring the alarm yet. “I’m still optimistic, thinking that something will be worked out in terms of that continued federal partnership,” he said.

Cummings said cooler heads should prevail among elected officials and a LIP deal be worked out, though perhaps later in the year than many people would like.

Although the LIP program expires June 30, the money actually wouldn’t run out until Oct. 1 when the federal fiscal year begins, health experts say. That gives Florida a few months of wiggle room.

If that final agreement factors out to a loss in money for Jacksonville’s safety net hospital, the legislative delegation will consider its options, Cummings said. The House has said it will not use general fund dollars to make up any LIP losses, but he believes a special case could be made.

“If there is any one that really has a significant case and it’s valid, it’s proven, it’s not just rhetoric, we know that,” he said.

QUOTE OF THE DAY

"However many holy words you read, however many you speak, what good will they do you if you do not act on upon them?" Buddha

House reckless, Senate sensible on health funding

BRADENTON HERALD EDITORIAL | Chambers dug in on Medicaid expansion

The Republican versus Republican wrestling match over health care funding is intensifying as the deadline in the Legislature's regular session nears. This high stakes game of chicken will likely result in a special session, though the end game is difficult to imagine given the current state of rigid.

Last week, the war of words between the Senate president and House speaker hardened. The House keeps digging in deeper and deeper on a fiscally reckless position and partisan opposition to accepting billions in federal aid connected to accepting some form of Medicaid expansion.

This is a disservice to the 800,000 working poor who cannot afford health insurance but don't qualify for Medicaid or Affordable Care Act policies. They are trapped in the coverage gap unless Florida embraces the higher income level limits for ACA policies set in Medicaid expansion.

This is also a disservice to the business and health care communities, especially Florida's safety-net hospitals — which all stand to suffer the financial consequences of the House's irresponsible position.

The state's premier business organizations, medical providers, consumer advocacy groups and others continue to issue a clarion call for accepting the federal aid, citing the creation of thousands of jobs and huge savings to the state budget. Representatives of those stakeholders descended on the Florida Capitol to express those views.

Influential business organizations also made a new case for the federal aid, predicting Florida companies would face $253 million in tax penalties for failing to provide health policies for full-time employees who fall in the coverage gap.

But the House remains stuck on no — in direct opposition to conservative ideals covering job creation and fiscal discipline. The Senate plan to accept the federal aid embraces those and another one, a private market solution instead of a federal program — which Medicaid officials are willing to consider. Ten states with Republican governors have taken Medicaid expansion money, overcoming stubborn partisan opposition to anything connected to Obamacare.

Just days ago, the federal Centers for Medicare & Medicaid Services made it abundantly clear that Low Income Pool payments for charity care is inexorably tied to Medicaid expansion.

But Florida's House leadership and Gov. Rick Scott reacted with surprise.

Scott went so far as to include LIP money in his budget outline, assuming CMS would grant Florida a second deadline extension even though the state did not expand Medicaid.

House Speaker Steve Crisafulli, R-Merritt Island, stated Wednesday that CMS never linked the two programs, a point hotly disputed in the Senate.

Without LIP, which expires in June, the House stands to blow a $1.3 billion hole in the 2015-2016 budget and cripple safety-net hospitals. Does the House expect those medical facilities to simply absorb the losses for uncompensated care?

The chief executive of UF Health Jacksonville, which is set to receive $95 million in LIP funding this year, recently told the Florida Times-Union Editorial Board the hospital would close if those funds disappear — insisting he wasn't being alarmist.

In a memo to all senators last week, Senate President Andy Gardiner, R-Orlando, provided evidence and backed the Jacksonville hospital position: "On average, Medicaid payments to Florida hospitals at current levels equate to only 49 percent of costs." Furthermore, with the elimination of $1.3 billion in LIP payments, "Many hospitals will be unable to sustain a cut this large."

On Thursday, Crisafulli upped the ante by stating the House would not allocate state funds to cover the loss of federal LIP money regardless of the possible ramifications — hospital closures.

The stakes couldn't be higher, but the state of the House-Senate acrimony gives little sign of simmering down. With the session two weeks away from its May 1 finish, the two chambers stand $4 billion apart on the budget.

The Senate plan to accept $2 billion in federal funds so low-income residents can obtain private health care coverage is the only sensible, responsible and pragmatic way forward. As a bonus, it would retrieve Florida income tax money taxpayers sent to the IRS.

Gardiner expressed an openness last week to discuss alternatives with the governor and House for a "comprehensive Florida solution."

Something's got to give. Currently, the House has no solution. Good governance requires one.

House must abandon its brinkmanship

NJ OUR VIEW

With two weeks left in this year's regular session, the Florida Legislature is not any closer to resolving an intra-party dispute over Medicaid and funding indigent health care.

In fact, the two sides are further apart than they've ever been, and time is running out on reaching an agreement.

The federal government has notified the state that in June it will stop funding its half of the $2.2 billion Low-Income Pool, which helps cover the costs of charity care at hospitals across the state. Losing that money would deal a severe blow to local hospitals — Halifax Health, which provides about $50 million in uncompensated care and community health programs annually, would forfeit $14 million, and Bert Fish Medical Center would be denied about $2 million.

From the start, the Florida House and Senate, both controlled by Republican majorities, have disagreed on what to do. To maintain a LIP funding stream and avert a crisis, the Senate has proposed accepting additional Medicaid funds from Washington and using them to create the Florida Health Insurance Affordability Exchange. FHIX would provide private-policy health coverage for the 800,000 Floridians not already covered by Medicaid. Able-bodied recipients would be required to pay modest premiums and be employed, looking for work or enrolled in school. Proponents argue this would inject some market forces into the health insurance system.

The House, though, has refused even to consider the Senate plan, maintaining that it merely applies lipstick to a Medicaid pig. Most House Republicans oppose Medicaid expansion of any type on the grounds that it's a component of the reviled Obamacare, that the program doesn't actually provide quality health care, and that the feds can't be trusted to keep their promise to fund 100 percent of the expansion the first three years and 90 percent of it thereafter.

Two weeks ago, Gov. Rick Scott said he was reversing his previous (tepid) support for expanded Medicaid and criticized the Senate plan for undermining the state's negotiations with Washington to continue LIP funding. Then last Thursday, the governor announced that his office would sue the Obama administration for making LIP's future contingent on the state expanding Medicaid.

Scott and the House Republicans are digging in for trench warfare when they should be exploring ways to cover the $1.3 billion LIP shortfall. Not only have they not developed an alternative to the Senate plan, they haven't even budgeted a contingency to assist hospitals losing LIP money. Of course, if the state made up the difference, that would necessitate cuts in other spending — and/or reductions in the $690 million package of tax cuts the House has passed.

The Medicaid split has caused the House and Senate spending plans to be more than $4 billion apart, and with neither side budging, it's increasingly likely that the Legislature will fail to pass a reconciled budget by the May 1 deadline. Lawmakers then will be forced to hold a special session.

This is pure brinkmanship by the House — staring down not only the Senate but also the Obama administration, and expecting one or both to blink. Its dangerous game of obstinacy is sowing political chaos and threatens economic harm. The cost of doing nothing: Hospitals could be forced to cut personnel and services; taxes and insurance premiums could rise to cover shortfalls at safety-net hospitals.

We call on this area's legislative delegation to help break the impasse. Reps. David Santiago, Fred Costello and Paul Renner — all Republicans — should push the House leadership to work toward a solution that rescues area hospitals and avoids a train wreck.

opinion

A VERSE FOR TODAY
"If a kingdom is divided against itself, that kingdom cannot stand."
Mark 3:24

Tell Scott, speaker to work for citizens

Florida's leaders are playing politics with health care.

Hospitals are paying millions in charity care.

Employees are paying hidden taxes on their premiums of about $1,500 a year to provide that charity care.

But Gov. Rick Scott — aka "Mr. Jobs" — is willing to turn down 71,000 jobs in the first three years following Medicaid expansion.

He's playing politics with the state's economy.

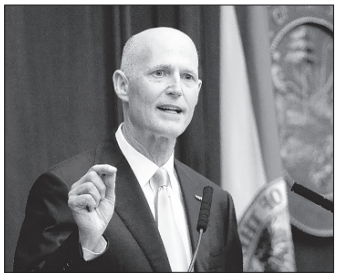
Scott — aka "Mr. Business" — is turning down the proposed Medicaid expansion plans supported by the Florida Chamber of Commerce and the Associated Industries of Florida. In the first three years of Medicaid expansion, Florida could realize an $8.8 billion increase in economic activity.

Why would he turn down business expansion? Politics.

At stake is a program to pay for charity health care that the federal government always intended to be temporary, the Low Income Pool.

The federal government didn't care for the way Florida was managing those funds. As Vikki Wachino, acting director of the Centers for Medicare and Medicaid Services wrote to Florida's health care administrators, Florida's program suffered from a lack of transparency, an overreliance on supplemental payments and too little focus on Medicaid patients.

The federal government presumed that Medicaid expansion would lessen the need for this Low Income Pool, which is why the two programs are linked.



Associated Press

Tell Florida Gov. Rick Scott you expect him to work with the federal government to protect the health care of Florida's citizens, expand business and create jobs.
Website contact: tinyurl.com/4lgyzz2
Phone: (850) 717-9337

Scott and House Speaker Steve Crisafulli are righteously indignant over that linkage. How, they fume, could the federal government dare do that?

Well, because it could. And it did.

Other states with Republican governors and legislatures have been able to accept Medicaid expansion funds in ways that reflect the culture of their states.

And Wachino confirmed that she would be willing to work with Florida.

"We are encouraged by the state Senate's interest in expanding Medicaid to low-income adults in the state to cover between 870,000 and 1 million vulnerable Floridians," she wrote, adding that CMS "will monitor the progress of this legislation closely and, if enacted, looks forward to working with the state on the substance of the state's expansion approach."

Associated Press

Tell House Speaker Steve Crisafulli, R-Merritt Island, that he should work with the federal government to expand health care for Florida's citizens.
Email: Steve.Crisafulli@myfloridahouse.gov
Phone: (850) 717-5051

That hardly sounds like stubbornness.

But the intransigence of Scott and Crisafulli knows no end. Scott has promised to sue the federal government, demanding the Low Income Pool money. Crisafulli has said the state won't fill the funding gap if Low Income Pool funds are lost, meaning a health care disaster would take place in Florida.

Anyone who cares about people, who cares about jobs, who cares about business, must become engaged.

The local legislative delegation should press state leaders to engage with the federal government and resolve this standoff.

Citizens should call or write the two main roadblocks, Scott and Crisafulli, as well as members of the delegation.

Contacts are included on this page. Wachino's letter is on the opposite page.

If necessary, the Legislature should meet in special session to make sure funding for Florida's safety-net hospitals is maintained. But even more important, state leaders must follow the advice of major business groups and expand Medicaid. That will ensure continuation of the Low Income Pool funds for hospitals like UF Health Jacksonville.

Jobs are at stake. Business expansion is at stake. Health is at stake.

Lives are at stake.

CONTACT LEGISLATORS

Sen. Aaron Bean (R): (850) 487-5004, bean.aaron.web@flsenate.gov
Sen. Rob Bradley (R): (850) 487-5007, bradley.rob.web@flsenate.gov
Sen. Audrey Gibson (D): (850) 487-5009, gibson.audrey.web@flsenate.gov
Sen. Travis Hutson (R): (850) 487-5006, hutson.travis.web@flsenate.gov
Rep. Janet Adkins (R): (850) 717-5011, janet.adkins@myfloridahouse.gov
Rep. Travis Cummings (R): (850) 717-5018, travis.cummings@myfloridahouse.gov
Rep. Jay Fant (R): (850) 717-5015, jay.fant@myfloridahouse.gov
Rep. Reggie Fullwood (D): (850) 717-5013, reggie.fullwood@myfloridahouse.gov
Rep. Mia Jones (D): (850) 717-5014, mia.jones@myfloridahouse.gov
Rep. Charles McBurney (R): (850) 717-5016, charles.mcburney@myfloridahouse.gov
Rep. Lake Ray (R): (850) 717-5012, lake.ray@myfloridahouse.gov

Opinion

EDITORIAL

Stop gouging us and cover the poor

Because Legislature rejects Obamacare, you pay twice for uninsured

It's bad enough that you pay for your own health insurance while also covering the unpaid hospital bills for the poor. In Florida, the pain is worse than that.

By rejecting an expansion of Medicaid, the House of Representatives is standing guard over a broken system that forces you to pay *twice* to care for the working poor:

» Your next hospital visit will cost $1,700-$2,300 more for you and your health insurer to cover the costs of treating the uninsured. Hospital companies call that "cost shifting." The Florida Chamber of Commerce calls it a "hidden tax" of 8 percent.

» Your federal taxes already pay to solve that problem under the Affordable Care Act by expanding Medicaid coverage for about 800,000 uninsured people in Florida. But because the Legislature has turned away $2.8 billion a year for that purpose, your tax dollars instead care for the poor in California, New York and other states — while the cost-shifting continues in the private sector here.

This situation doesn't just deny scores of low-income Florida workers a chance to get preventative care or to visit doctors' offices and urgent-care clinics instead of waiting to go to high-cost emergency rooms.

Plain and simple, it is a rip-off for patients, taxpayers and employers.

We urge House leaders including Speaker Steve Crisafulli, R-Merritt Island, and Ritch Workman, R-Melbourne, to stop the gouging. With time running out in the Legislative session, they should at least open negotiations with the Senate on a plan it passed to accept Medicaid dollars and enroll the poor in privatized managed-care plans.

And if you are tired of paying twice, we urge you to call or email your state representative to say so.

It could get worse

Failure to act in Tallahassee could significantly worsen the shift of costs — from the uninsured, to hospitals, to you — as the feds phase-out an older $2 billion fund from Medicaid that pays for some indigent care. The expansion of Medicaid under Obamacare was meant to supplant it. Gov. Rick Scott has sued to try to keep the money, even as he condemns federal involvement in health care.

To be sure, we understand the reluctance by Crisafulli and other Republicans to enroll those 800,000 low-income people in traditional Medicaid. That program has been a nightmare of red tape, ballooning state costs and few choices for enrollees.

"It's not about the money, it's about the product," Crisafulli said at the start of the Legislative session.

But Florida isn't stuck with traditional Medicaid. It spent years developing a privatized and successful alternative that contained costs and curbed fraud. Now it's the heart of the Senate plan backed by Senate President Andy Gardiner, R-Orlando, who represents north Brevard.

AP

Rep. Steve Crisafulli

AP

Sen. Andy Gardiner

LEADERSHIP CONTACTS

House Speaker Steve Crisafulli, R-Merritt Island
850-717-5050
Steve.Crisafulli@myflorida-house.gov
Senate President Andy Gardiner, R-Orlando
850-487-5013
Gardiner.Andy.web@flsenate.gov

Failure to act in Tallahassee could significantly worsen the shift of costs — from the uninsured, to hospitals, to you — as the feds phase-out an older $2 billion fund from Medicaid ...

Under that pilot program — advanced by Gov. Jeb Bush for Broward, Duval and several rural counties —the state enrolled nearly 3 million patients in their choice of managed care plans, then used Medicaid dollars to pay their premiums instead of paying providers directly.

Per-patient spending stayed flat. State taxpayers saved $118 million per year. Patient health and satisfaction improved, surveys found. HMOs assumed responsibility for preventing fraud.

The conservative Heritage Foundation called it "one of the most comprehensive, innovative and significant Medicaid reforms of the past decade." Applied statewide, the Florida could save $900 million per year, Heritage found.

Build on success

Now, the Legislature should expand its creation, for everyone's sake. The U.S. Department of Health and Human Services has blessed it. The Chamber of Commerce and powerful hospital lobby have pledged their support.

And its potential for cost containment should reassure fiscal conservatives who fear that a gradual, 10 percent reduction in federal funding will somehow leave Florida with a much bigger share of costs.

That could be a rip-off for the state budget, conservative lawmakers have said.

But their refusal to act on a Medicaid expansion has perpetuated another rip-off for patients, employers and federal taxpayers — and could soon make it worse.

THE NEWS-PRESS
VIEWS

Tell us what you think. Include your name, address and daytime phone number. Letters must be 200 words or less. Op-ed pieces must be 600 words or less. All submissions will be verified and may be edited. **Mail:** P.O. Box 10, Fort Myers, FL 33902 **Email:** mailbag@news-press.com **Phone:** 239-335-0390 **Fax:** 239-334-0708

EDITORIAL

WE DESERVE MEDICAID EXPANSION FUNDS

STAFF ILLUSTRATION BY MERRY ECCLES

Florida organizations shouldn't have to pay for Legislature's fight

The Florida Legislature and Gov. Rick Scott seem more interested in digging their collective heels into the self-induced mayhem that is Medicaid expansion than coming up with a workable plan that takes the weight off Florida taxpayers, reduces the burden on hospital systems and gives the state's uninsured some relief.

This has become a political war – with no end or unified plan in sight – and we suffer because of it. The federal government is sitting on $50 billion of our money that could go to expanding Medicaid to about 800,000 of the uninsured over the next 10 years. That money provides much-needed relief to heath care operations, like the Lee Memorial Health Systems, currently subsidizing those without health insurance and reduce the risk of insurance premiums rising and health programs sinking.

The News-Press, along with other media groups throughout the state, are urging Legislators today to find a pathway to agreement and take the money.

Here is the Medicaid expansion scorecard as we know it today, but it changes by the minute and remains a disjointed mess of political and flip-flopping wills:

» Gov. Rick Scott, who once supported accepting the $50 billion, then shifted to chastising the federal government for imposing a deadline this year to pull $2.2 billion from the Low Income Pool, which also serves thousands of uninsured, to suing the federal government on Thursday for linking an extension of that pool to whether or not the state accepts about $2.8 billion annually in Medicaid expansion.

The Senate has approved a plan that would use the $2.8 billion in expansion funding to help low income Floridians purchase private health

See Money, Page 38A

Inside

State Rep. Matt Caldwell and state Sen. Garrett Richter present opposing views.
Page 35A

OPINION

MIAMI HERALD | EDITORIAL

Litigation isn't leadership

OUR OPINION: Gov. Scott goes to court with a dishonest argument over Medicaid expansion

Don't be fooled by Gov. Rick Scott's phony lawsuit against the federal government over Medicaid expansion. It's a politically inspired grandstand play that utterly fails to protect the interests of the people of Florida.

Ostensibly, the lawsuit is about the end of a federal program called LIP (Low Income Pool) that partially reimburses hospitals that care for indigent and low-income uninsured patients. In effect, it has been superseded by Obamacare, which offers the states federal funding to expand Medicaid.

The problem is that the state's Republican leaders want the $2.2 billion that LIP provides, but they reject Medicaid expansion — for purely political reasons. Hence Mr. Scott's lawsuit, which defies logic: It demands that the federal government offer Florida one pot of money even while the state rejects another.

Memo to Mr. Scott: The Supreme Court said that states don't have to accept Medicaid expansion as part of the Affordable Care Act, but it never said rejection was a *good* idea. It ruled that states can opt out of the program — and the money that comes with it — leaving them to face the consequences.

In budgetary terms, accepting federal funding to expand Medicaid would be the smart decision. In human terms, it makes even more sense: As reporter Dan Chang explains in an in-depth report that begins today in the Herald, an estimated 850,000 uninsured Floridians would be newly eligible for coverage under a Florida Senate plan that accepts federal funds to establish a state-run private insurance exchange for low-income residents.

The stumbling block is that Mr. Scott and like-minded Republicans in the House say they don't trust the feds to keep their promise to pay for covering more Floridians. They cite withdrawal of the LIP money as both a form of coercion and as proof that the government can't be trusted to keep its word.

This is a fundamentally dishonest argument.

In the first place, LIP is a discretionary program, a contract with the state that has expired. The Affordable Care Act, in contrast, provides money guaranteed *by law*. Second, state officials weren't blindsided. They've known for years that LIP money would disappear. It was *always* tied to Medicaid expansion, for obvious reasons.

Other states are eagerly taking the money. Most recently, Indiana, a red state, became the 28th state — and the 10th with a Republican governor — to receive approval for an expansion plan. Why can't Florida do the same?

The absence of healthcare coverage is most acute in Miami-Dade County, as today's stories in the Herald explain in painful detail. Yet some Dade legislators — like Rep. Michael Bileca, a former member of the Jackson Health System board of trustees, and Erik Fresen, now in his last term — are not on board with Medicaid expansion. What a shame.

Meanwhile, the bad choices made by state leaders have wreaked havoc on the budget. It faces a $1.3-billion shortfall with the loss of LIP funding. Yet even though this was known to everyone, Mr. Scott irresponsibly presented a budget that ignored this crucial reality.

The Senate plan offers a way out of this budget mess by accepting Medicaid money, which would make the federal government more amenable to negotiate a new LIP contract to cover costs not met by expansion, but the House has refused to go along.

This is where a strong governor would step in and bring both sides together to craft a compromise. Instead, Gov. Scott has chosen litigation over leadership. His disappointing performance won't resolve the budget crisis, and it will do nothing to help the 850,000 Floridians who would benefit by Medicaid expansion.

THE READERS' FORUM

Florida Senate's FHIX is an affordable healthcare option

A recent United Way study reported that 45 percent of Florida's working families struggle to make ends meet and to afford the basic necessities such as housing, food, transportation, childcare and healthcare. In Miami-Dade, the number is as high as 50 percent. For these hardworking families a single crisis, often a healthcare emergency, can result in financial chaos.

The fact is, Florida has among the highest rates and numbers of people without health-insurance coverage in the nation, according to the Kaiser Family Foundation. Miami-Dade County ranks first in the state with 35 percent of residents uninsured. Three out of four uninsured Floridians work full or part time and do not have access to affordable health insurance through their employers. They are veterans, moms and dads and young people just entering the workforce, who earn less than $16,000 a year.

When our residents don't have health insurance and can't afford care, they avoid going to the doctor and usually wait until they are forced to go to the hospital. This is not an issue that just affects those without health insurance. Lack of coverage has impacts on our community, businesses and hospitals, as well as on the individuals and families who are paying monthly health-insurance premiums.

Finding a way to get more people covered is a community responsibility. At United Way, we focus on education, financial stability and health as the building blocks of our community's well-being. Access to affordable healthcare is central to this vision. That is why in November 2014 the United Way of Miami-Dade took a position in support of extending healthcare coverage to uninsured Florida residents.

The state Senate's Florida Health Insurance Exchange (FHIX), developed and championed by Hialeah's State Sen. Rene Garcia, who chairs the Appropriations Subcommittee on Health and Human Services, under the leadership of Senate President Andy Gardiner, does just that.

The Senate's proposed FHIX would use more than $50 billion in available funds to extend healthcare coverage to approximately 800,000 low-income, working Floridians through a private option plan that promotes personal responsibility and healthy lifestyles. The cost of the program is already paid through taxes on health insurers and medical equipment, and reductions in Medicare and Medicaid payments to hospitals.

But time is running out. We encourage the Florida House to use the remaining days of the 2015 Legislative Session to pass the Senate's FHIX plan — a common-sense solution that's in the best interest of South Florida and all Floridians.

— Harve A. Mogul, president and CEO, United Way of Miami-Dade
Marielena Villamil, board member, United Way of Miami-Dade

Opinion

Orlando Sentinel
Nancy A. Meyer Publisher and CEO
Paul Owens Opinions Editor

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WHAT WE THINK

Listen to reason on health care

Florida House leaders are dead set against a bipartisan Senate plan to provide private health insurance to 800,000 working poor Floridians with billions of federal dollars — so dead set against it that they've thrown this year's legislative session into chaos.

Leaders in both chambers conceded this week that the deadlock would prevent them from agreeing on a budget, their lone constitutional obligation, before the regular session ends.

Meanwhile, Gov. Rick Scott is so dead set against the same plan that he actually announced Thursday that he'll sue the federal government for trying to "force" Florida into accepting all those billions to expand coverage.

Welcome to Tallahassee, where reason often gets shouted down by politics.

The federal dollars that the Senate plan would utilize were authorized under the Affordable Care Act, and that's the rub for the House and the governor. They'll turn the money down to say hell no to Obamacare, even if it costs 800,000 of their constituents without health care a shot at insurance. How noble of them.

Here's the latest cover story for the House and the governor on why they oppose the Senate plan: The feds can't be trusted to honor their funding commitment because they're ending another program, called LIP, that has reimbursed hospitals in the state for charity care. Which is baloney.

Scott's lawsuit will accuse the Obama administration of ending LIP to force Florida to expand coverage under the ACA. In fact, federal officials chose to continue LIP funding for Florida beyond its original expiration date a year ago, but warned the state at the time that it wouldn't get another extension — at least not without changes in the program.

However, if the federal government were to renege on the ACA funding, the Senate plan stipulates that the expansion of healthcare coverage it finances in Florida would automatically end. State taxpayers would not be left holding the bag.

House leaders and Scott are well aware of this fact, but it's not convenient for their cover story.

The ACA gives states the option of using federal dollars to expand health coverage to their uninsured residents who make too much to qualify for Medicaid but too little to be eligible for federal health-insurance subsidies. In Florida, that's at least 800,000 people.

When those Floridians get sick or hurt, they often end up in hospital emergency rooms. Some of the cost of that care gets shifted to businesses that pay for insurance, making them less competitive, and families with coverage, squeezing their budgets.

So to those who object to paying anything to provide care to the uninsured, we've got news: You're already paying, but not as efficiently as you would if they had insurance.

The federal offer under the ACA was to pay 100 percent of the cost for states of expanding health coverage for three years, 2014-16, and no less than 90 percent in later years. Florida would have received $15 billion from Washington during that three-year period to expand coverage to working poor Floridians if lawmakers had passed another bipartisan Senate plan in 2013, but the House also balked two years ago.

Most other states, including several led by Republicans, have said yes to the offer. How has it worked out?

Consider Kentucky. It expanded coverage starting in 2014, and 375,000 Kentuckians have signed up. A study released in February from Deloitte Consulting LLC and the University of Louisville's Urban Studies Institute found that the expansion will add $30 billion and 40,000 jobs to the state's economy through 2021.

Perhaps even more notable, the additional costs for Kentucky in later years, as federal funding ratchets back, will be more than covered by savings for state and local governments in other health-care programs and additional taxes generated by the expansion. That means Kentucky taxpayers will end up ahead, not behind, by expanding health care.

Scott, in a statement attempting to justify his lawsuit, said an end to LIP funding by the Obama administration "threatens poor families' access to the safety net health-care services they need." Oh, how ironic. If the governor were truly committed to providing health care to poor families, he wouldn't be standing in the way of Florida accepting billions more for that purpose. He would have made sure two years ago that Florida said yes to expanding health coverage.

It's not too late for him, and House leaders, to listen to reason, and change their minds.

OPINION: THE DEBATE STARTS HERE

OUR VIEWS
HEALTH CARE FUNDING

Health care ego clash no help to state, its people

One of the more disturbing scenes in American cinema is the chicken run race from the 1955 classic "Rebel Without a Cause." This past week, Florida's Medicaid/budget debacle looked a lot like that scene.

Gov. Rick Scott is Buzz, adjusting his leather jacket, bent out of shape over the latest health-funding knife fight with the Obama administration: "She signals. We head for the edge. And the first man who jumps is a chicken. All right?"

It's Senate President Andy Gardiner in the Medicaid expansion car, looking like James Dean, coolly checking to be sure that the escape door is working. Gardiner's the one with the plan; Scott's the one with the hubris, threatening to sue the feds for tying safety-net hospital funding to Medicaid expansion. House Speaker Steve Crisafulli is right there with him. Will Scott and Crisafulli take Florida over a cliff? It's looking that way.

The Senate has advanced a compromise called FHIX that would give Florida a unique twist on Medicaid expansion. It would allow more low-income Floridians access to Medicaid-managed care plans, and it would create a state-run, online health insurance exchange.

Florida businesses are paying an extra 8 percent a year in insurance premiums to absorb the cost of the uninsured.

We've said it before: It's nobody's perfect solution, but it's a compromise that leaves Floridians in a much safer position.

If it becomes law, Florida's looming health and budget crises would be resolved:

■ Safety-net hospitals would be assured that their low-income patients had coverage, and so they wouldn't need a massive state bailout or face layoffs and closures. As it stands, hospitals are facing possible losses of up to $2 billion in expiring Low Income Pool (LIP) funding for uninsured people, with nothing to offset that hit.

■ Budget uncertainty would be settled, allowing Scott to have his much-touted tax cuts and education spending increases. That's because the federal government would send up to $5 billion into the state to cover the newly insured.

■ Real people would be helped. An estimated 800,000 unfortunate low-income Floridians are in the health coverage gap. They don't qualify for Medicaid or Obamacare subsidies. They have few options but to show up at the emergency room.

■ Businesses would be helped. Forcing the uninsured to use emergency rooms is just about the worst, most costly possible way to deliver health care, and those costs inevitably get shifted to those who can pay.

Mark Wilson, president of the Florida Chamber of Commerce, met with The Palm Beach Post editorial board last week. He said businesses have been told they are paying an extra 8 percent a year in insurance premiums to absorb the uninsured cost shift right now. He figures it could rise to 20 percent if LIP goes away, as the federal government has promised. The chamber is proposing FHIX tweaks that would require the 8 percent cost shift be returned to businesses in the form of lower hospital prices. "That would pick up a lot of support from a lot of people," he said.

Wilson said the chamber also wants an aggressive push to lower health-care costs by fighting Medicaid fraud, solving medical malpractice, expanding telemedicine and increasing the scope of practice of nurse practitioners. Finally, the chamber wants a commitment to capping how much of the state budget can go to Medicaid.

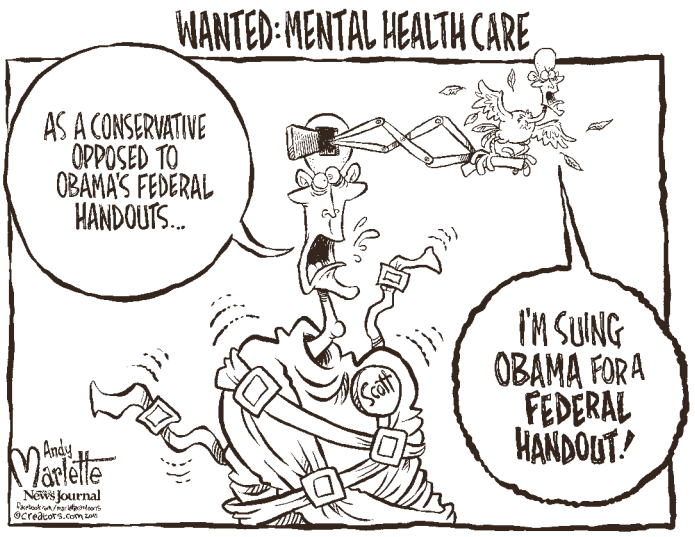
"Ten years ago, Medicaid was 21 percent of the state budget," Wilson said. "Today it's 29.2 percent. It's continuing to go up. What we have said is, let's cap Medicaid expenditures at 32 percent of the state budget" to force more attention on lowering costs.

What's the alternative to passing FHIX? Senate budget chief Tom Lee, a Republican from Brandon, said it's something "nobody wanted."

Driving off a cliff.

"The (Senate) president doesn't get a health-care solution. The governor doesn't get his tax cuts. And we put $2 billion in reserves and wait and see what the federal government says," Lee told the News Service of Florida.

There's so much drama and ego wrapped up in this battle over federal health care funding that the point of it all seems to have been lost. Real people need health care. Employers need cost relief. Hospitals need certainty. What no one needs is pointless ego trips. Scott is looking more and more like a rebel without a cause.



EDITORIAL

Scott is wrong on Medicaid

Gov. Rick Scott won his first term in office by demonizing President Obama and denouncing handouts and spending by the federal government. Now in his second term, Gov. Scott is suing the Obama administration for not handing over more than $1 billion in federal money.

Welcome to Florida: the mentally unstable state.

This is what our battle over Medicaid expansion has become. Our governor will now spend your tax dollars in order to sue the president in opposition to an issue that he once supported. If it wasn't so stupid, wasteful and tragic, it might be funny.

First of all, it should be noted that the conservative, Republican-dominated state Senate has come up with a private-sector-based plan for Medicaid expansion money. This is the Florida Senate of Don Gaetz. They're not playing by Obamacare's rules. They've made up their own rules and the federal government is poised to go along.

It should further be noted that a majority of Floridians support this expansion, as do hospitals, state medical groups, business interests and the Chamber of Commerce – hardly a gaggle of left-wing radicals.

Simply put, Medicaid expansion means that the federal government will give us back roughly $15 billion of our tax dollars through 2016. Floridians have already surrendered these taxes to the federal government. If we don't take them back, someone else will.

Like Obamacare or hate it, there is no fiscal rationale for refusing to take back our own money. Yet the Florida House has stubbornly dug in to oppose it.

Worse yet, the governor, who once supported Medicaid expansion is now against it. Not only is he against it, he's suing the Obama administration for more than $1 billion in federal Low Income Pool funds, a program that essentially gives charity money to hospitals for treating the poor.

The state has known for several years that the program was expiring in June. For the governor to pretend otherwise is blatant dishonesty.

Furthermore, Medicaid expansion would go beyond charity money. It would go for purchasing private-sector insurance for the same poor Floridians whose hospital bills are subsidized by the LIP funds. Is either solution perfect? No. But isn't a private-sector-based solution more palatable to ideological conservatives than a direct handout?

Essentially, the governor and House Republicans have fallen back on the bizarre logic that the federal government cannot be trusted so therefore, we should not take our own tax dollars from them to expand Medicaid. At the same time, however, they apparently believe the federal government *should* be trusted to provide a handout of $1 billion in LIP funds.

The logic in this debate is flawed.

"It is appalling that President Obama would cut off federal health care dollars to Florida in an effort to force our state further into Obamacare," Scott said on his decision to sue the president.

Governor, with all due respect, you are the one blocking federal health-care dollars to Florida. This is not about your perverse fantasy of battling Obamacare. This is about a solution created by smart, Republican state senators to work around Obamacare, which, like it or not, is the law of the land. This is about taking our fortunes back from the federal government. This is about the wellness and the jobs that can be created with those fortunes. This is about state control and giving a homegrown solution created by Florida lawmakers a chance to work for Floridians – more than 800,000 low-income Floridians, for whom the economy "is not working." This is about doing the right thing for our economy and citizens who are most vulnerable.

This is not about you, Governor.

Floridians don't want to reject the Senate's plan. You do. Floridians don't want to see (or pay for) an extended legislative session. You do. And Floridians don't want to foot the legal bill for another long and fruitless court battle against the federal government. That is all you.

And it's disgraceful.

The Florida Senate is to be commended. Senators have grappled with this issue intellectually and legislatively and developed a meaningful solution that can work for Florida. They've faithfully done the job that voters elected them to do. They have stepped up, solved a problem and done their duty to taxpayers.

Gov. Scott and the House now need to do theirs — by getting out of the way.

More on the issue

See comments to our Facebook page below and viewpoints from State Sen. Greg Evers and state Reps. Mike Hill and Doug Broxson on Page 8F. State Rep. Clay Ingram was invited to participate but declined.

MEDICAID DEBATE

The state House and Senate are divided over whether to provide health care coverage to uninsured Floridians by using billions available under the federal Affordable Care Act, "Obamacare."

We asked our readers to share their opinions on whether or not to use those funds. Here's some of what they had to say on our Facebook page, facebook.com/pnjnews:

CATHY TWODAT CLARKSON: "The ones on Medicaid, yes. The ones who work and were told they could keep their insurance, bring the premiums down to where they were before Obamacare."

JOHN JUSTIN: "Mein Scott said no."

PENNY HILTZMAN: "Yes. Those billions are being spent in other states. The money is there. We should take it and cover the poorest people. Why is that so hard to understand? The red states have the highest number of uninsured because they hate Obama more than they care about their people."

ELLEN DALY: "We all pay for the health care of individuals who show up at the ER without any coverage. All those costs are passed on to everyone. An fyi: Many Medicaid recipients are the elderly and children! Anyone wants stats on that?"

SUSAN REHNBERG ULLOA: "No! No! No! Florida had a good plan for covering the uninsured until Obama stopped Federal funding to Florida to promote his Unaffordable Care Act!"

JOHNNY OWEN: "As long as we have that crook for a governor, the poor and the working class will continue to suffer."

JASMINE CARABALLO: "Some jobs don't even offer benefits to their employees who work full time. It's awful that some have to suffer because they can't afford Obamacare."

PAT DWYER: "I say we save also by removing state representatives and senators' health care plans. It is a great one that will save millions if terminated.They only work part-time anyway."

PATTI MAXWELL: "Why anyone would believe a word coming out of the mouth of our medicare fraud governor is beyond me. Governor Scott made a unilateral decision, with the help of our conservative supreme court, to opt out of the crucial provision to expand medicaid when he had the opportunity. By expanding Medicaid, I mean making it available to those individuals who were at 133 percent below the federal poverty level. As it stands now, Medicaid is pretty much only available to children, pregnant women, parents caring for children at home and people with disabilities. Expanding Medicaid would have lifted those restrictions so that it was based on where individuals fell within the poverty line. Scott then changed his mind and decided to expand Medicaid and the Senate agreed, but it hit a dead end with the GOP-led house. Now we have nearly a million uninsured Floridians. Rick Scott is by far the worst governor in Florida's history. How that crook got elected once, let alone twice is a mystery. Will someone explain to me how you look at someone and tell them they do not deserve health coverage because they're poor? Then explain to me how you live with yourself after doing so?"

LIPO DAVIS: "I think Government-run health care is a very bad idea. The best thing to do is to go back to a free market, devoid of federal government intrusion."

KATHLEEN REED: "Help the old, the weak and the poor."

BRANDY DAILEY RODGERS: "I find it ironic that our dear old governor has such a huge problem expanding Medicaid, when he made the bulk of his millions off of the Medicaid/Medicare program. Go figure. Not everyone who genuinely needs Medicaid is 'lazy' or 'milking the system.' There are a lot of hard-working people who have to ask themselves, do I purchase health insurance or do I buy enough groceries? Do I purchase health insurance or do I pay for the childcare that allows me to work? Those are questions that should never be pondered by anyone."

PENNY HILTZMAN: "Workers that can't afford care are the ones that could get coverage if they expand Medicaid. States that have expanded Medicaid have much fewer uninsured."

SANDRA ALLEN RUBEN: "I have a 50-year old friend who is w/o employment. She applied for Obamacare and her premium would have been over $300 a month. Without income? So much for the indigent getting healthcare."

opinion

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staugustine.com

PUBLISHER:
Delinda D. Fogel
DIRECTOR OF AUDIENCE/EDITOR:
Kathy Nelson
OPINION PAGE EDITOR:
Jim Sutton

EDITORIAL

Lawmakers split on 'LIP' service

Policy and politics are hitting head-on in Tallahassee this week over federal funds for low-income healthcare.

With the House and Senate split on the issue, Gov. Rick Scott turned up the heat from the executive branch Thursday by announcing that he'll file suit against the Obama administration over the withholding of these funds.

Some background. The federal government has told Florida that around $1.3 billion in Low Income Pool (LIP) dollars will be withheld this year because the state has not bought into the Medicaid expansion of President Obama's Affordable Health Care Act.

For his part, Scott, was considered a player in the federal game until, according to capital politicos, the November elections brought about a turnaround.

The issue is not as unexpected as Tallahassee might like constituents to believe. Florida was awarded the LIP dollars last year, only as a temporary extension to give it time to comply. When it did not, the money was pulled. More correctly, the money will be pulled in June.

The money was to be used, basically, for the lowest income patients who cannot afford Obamacare or other federal programs. It's paid for the most part to hospitals for providing the free care.

Flagler Hospital isn't hit as hard as publicly-funded medical centers. But plenty of St. Johns County residents travel to Shands Gainesville and are transported to University of Florida Jacksonville for care. These two facilities would lose $200 million in funding come June — $107 million at Gainesville and $94 million in Jacksonville.

That's then. The issue is red-hot right now in the legislature. Scott and the House are solidly against taking the money. The party line is that the federal government can't be trusted to continue the funding for the agreed upon minimum of 10 years, and that throwing more money at a broken system makes little sense.

The Senate is solidly behind the expansion plan. Its shtick is that the money was paid by Florida taxpayers. Members are calling the withholding of the funds "extortion" by the Obama administration. Our most at-risk residents need the safety net the funds supply, they say.

The Senate includes the $1.3 billion in its budget, the House does not. That's not likely to change. The end result seems likely to be that Scott is going to be given a budget that's missing the $1.3 billion out of the $77 billion total.

While there are no givens with two weeks left in the session, most believe that the state will take the hit, rather than the hospitals, leaving it to cut the budget: Or to use the projected $1 billion in surplus dollars to make up the difference. And that, of course, is money that could go to teacher salaries, tax cuts or historic preservation projects in counties such as ours.

Rep. Cyndi Stevenson said from Tallahassee Friday that the issue is the most divisive facing the legislators as the session winds down. There's a lot of money on the table and a lot of political capital at stake — re-election funds too.

Scott's lawsuit is not likely to settle anything in time to make any kind of difference. Challenging the federal government 45 days into a 60 day session is political grandstanding, though there's an outside chance it may force the feds to rethink things. But if the healthcare feds are anything like the Veterans Administration higher-ups that have been stonewalling our county — we wouldn't look for movement any time soon.

"I think we'll be back in June," Stevenson said, just before ducking into a Tallahassee luncheon Friday before heading home from her first official week in office.

We're not sure where all this is headed, but we are sure that being held hostage by the feds to either embrace Obamacare expansion, or put indigent patients at risk, isn't the way America is supposed to work.

Opinion

SUN SENTINEL EDITORIAL

Stark choices ahead if no one caves

The partisan gridlock in Washington has nothing on the partisan gridlock in Tallahassee, except for one key difference: The Republican Party of Florida controls everything in the state capital and this year, its leaders are waging the ugliest intramural battle we've seen in decades.

With just two weeks to go in the 60-day legislative session, the Florida House and Senate stand $4 billion apart on next year's proposed state budget.

Four billion dollars apart.

And rather than work overtime this weekend, their members are back home, taking time off, barely able to talk to one another. There's no budget discussions going on, no negotiations, nothing.

It's surprising that the standoff has gotten this far because as a rule, state Republicans are generally more disciplined in standing together and keeping their differences private. But given the Florida House's relentless efforts to reject President Obama's signature health care law — no matter the cost — that ship has sailed.

The rhetoric has grown war-like, with the House battling the Senate, the Senate battling Gov. Rick Scott, and the governor battling Washington over a Medicaid expansion plan he initially opposed, then supported and now opposes again.

Indeed, future House speaker Richard Corcoran asked his colleagues to "come to war with us" against the Senate, the federal government, the hospital industry and "all the special interests — all the Gucci-loafing, shoe-wearing special interests powers" that want Medicaid expanded. "If it costs me my political career or yours, so be it."

The Senate is taking the high road, with more measured statements and a more realistic endgame. Its budget would take the Medicaid expansion money, with one big caveat.

Instead of expanding the government-run program, the Senate would create a private-option plan that would draw down available funds, but stay nimble enough to evaporate if the money dries up. It would require people to work, or be looking for work, and pay some type of co-pay. But because it's not known if the plan would pass federal muster, two senators went to Washington recently to inquire, which generated howls from the House and the Governor's Mansion.

House Speaker Steve Crisafulli said Senate Republicans have provided "inaccurate and false hope" and "muddled negotiations" by going to Washington. He and his fellow House leaders want nothing to do with the Senate plan because they don't trust the federal government or its promise to cover 100 percent of the costs for new Medicaid enrollees through 2016, and 90 percent after 2020.

Instead, House leaders want things to stay as they were before Obamacare became the law of the land. Specifically, they want the feds to continue funding the Low Income Pool that reimburses certain hospitals for providing a large volume of charity care.

It must be said that the federal government has worked with state officials during the rollout of the Affordable Care Act, despite their differences.

Two years ago, the U.S. Department of Health & Human Services granted Scott's request for a waiver to treat Medicaid patients through managed-care plans, rather than traditional fee-for-service. And to help hospitals during the transition, it agreed to extend LIP funding through this June, though it made clear another extension would not be granted.

In return, the governor did an about-face and announced his support for expanding Medicaid, saying, "While the federal government is committed to paying 100 percent of the cost of new people in Medicaid, I cannot, in good conscience, deny the uninsured access to care."

STEVE CANNON/AP

Future House Speaker Richard Corcoran invited the Florida Senate to "come to war" with the Florida House of Representatives over a budget battle on the expansion of Medicaid.

But this summer, the extension is set to expire. HHS says the money for charity care now must flow to people through Medicaid expansion plans, rather than to hospitals via LIP. And now, the governor says he opposes the expansion of Medicaid. Plus, he plans to sue the federal government for its "coercion tactics" to force Florida to accept a Medicaid expansion.

It's unfortunate the governor has decided to sue, given his poor and costly track record in suing the federal government.

A lawsuit takes time, and lawmakers have a legal duty to pass a state budget for the fiscal year that begins July 1.

If legislators fail to reach agreement by their scheduled May 1 end, it's likely they'll be called back later for a special session. But absent a governor who can help feuding chambers reach a meeting of the minds, what's the point?

Without a state budget, state agencies, local governments and private vendors can't plan because they don't know what their budgets will look like in July. Is this any way to run government like a business?

No one is yet suggesting the impasse could lead to a state government shutdown, which would affect non-essential employees, not prison guards, for example. Florida last reached the brink of a shutdown in the early 1990s, when a legislative standoff with then-Gov. Lawton Chiles went a couple hours past the June 30 tipping point.

But at the moment, it's hard to see how leaders of the Florida House, especially, can find their way out of the corner they have painted themselves into. And if the more-considered Senate caves, it risks losing its effectiveness.

If Senate leaders do give in, they would likely find the $4 billion difference by eliminating the governor's proposed tax cuts on telephones and textbooks, the proposed increase in education spending, the proposed funds for mental health care, the proposed money for new prison guards and of course, the proposed path for helping poor people get access to health care.

Given the choices before us, it appears the steadfast House loathes the president more than it loves tax cuts, children, public safety and all the people of Florida.

ANOTHER VIEWPOINT

Leaders must find health care solution

El Sanadi

By Nabil El Sanadi

As our Florida state senators and representatives are nearing the end of the legislative session, there remain two looming health care issues: The unresolved Low Income Pool funding, which is dependent on a federal waiver and whether or not Florida will pass a health care expansion bill. Despite the fact that these are two separate programs, the federal government has linked them together.

In a letter sent by the federal government from the Center of Medicare Services to the Florida Agency for Health Care Administration on April 14, it was made clear that the CMS will not fund the Low Income Pool unless the state government agrees to Medicaid expansion, a cornerstone initiative of the Affordable Care Act. We urge federal CMS and state legislators to find a workable solution to fund necessary and essential health care programs so that the most vulnerable in our community can be cared for.

Our government leaders need to ensure that we can continue to serve our citizens and patients.

Broward Health is a safety net hospital system serving more than two-thirds of the 1.9 million residents in Broward County. We have two trauma centers, two comprehensive stroke centers, two primary stroke centers and several cardiac catheterization facilities. We are also a training facility for nursing students, medical students and paramedics. In addition, we graduate more than 100 medical residents every year. These are new doctors that serve our community and our citizens. Our physicians and nurses also conduct medical research to create new life-saving measures.

Even if Broward Health does not receive LIP funds, we will, and must, continue to provide essential acute care services including emergency care and inpatient services. However, we may not be able to continue to provide non-life critical services such as physical and occupational therapy or outpatient services for elective and preventative care. In addition, our ability to continue our academic teaching and mentoring programs may be impacted.

At Broward Health our doors will remain open; we are a provider of last resort for all who need health care, regardless of socio-economic status or insurance coverage. We urge a quick resolution so our health care safety net system is not impacted adversely, and we can continue to serve our citizens and patients by providing the quality health care they need.

Nabil El Sanadi is the president and CEO of Broward Health and a board certified emergency medicine physician.

| OUR OPINION |

Florida needs Medicaid expansion

It's time to grow up and accept the necessity of federal dollars

Our state's leadership is embroiled in a kindergarten-style fight that would be laughable if it didn't have such serious consequences.

It's time to stop the political power games, suck it up and admit that – like it or not – Florida needs to accept Medicaid expansion.

It's the right thing to do financially – the fiscal burden would fall overwhelmingly on the federal government. And it's the right thing to do ethically – we can prevent tremendous suffering and we should.

There is no reasonable argument for what Gov. Scott and House Republicans are doing in refusing to accept Medicaid expansion. The only explanation is that they are posturing for their bases, gathering votes for future elections at the expense of the people they are supposed to be serving.

It's time to get over it.

Here's the crux of the story. LIP – the Low Income Pool of money that provides $2.2 billion annually to Florida hospitals to help treat uninsured patients and supplement payments for Medicaid patients – runs out June 30.

The federal government has informed Florida that it will not renew the funding unless the state expands Medicaid, as 29 other states have done, successfully it seems. The federal government will cover the entire cost of the expanded Medicaid program – 100 percent – through 2016. After that Florida will have to kick in some money, but never more than 10 percent of the cost.

So no expanded Medicaid, no LIP funding. Gov. Scott has said he'll sue the feds over LIP funding, but he's likely to lose. Even Florida Senate President Andy Gardiner — a fellow Republican — has conceded that the federal government isn't obligated to give Florida the money.

The removal of LIP will be a huge problem for our hospitals. Tallahassee Memorial HealthCare received approximately $3.2 million in LIP funding last year.

"The loss of this funding will not stop these patients from accessing our services," said TMH in a statement. "It will place a significant financial strain as we balance our mission to care for our community with the financial realities of providing the human and capital resources to provide that care."

Hospitals will be in an almost unthinkable predicament: They'll have to turn away genuinely sick people without insurance – which TMH says it will not do, and we hope other hospitals won't either – or treat them anyway and raise already-high prices for the paying customers to help cover skyrocketing costs.

In fact, Sen. Bill Montford has said many rural hospitals could close if a deal isn't reached.

What's to be done? The Republicans, who are in control of both branches of the Florida Legislature, are squabbling among themselves.

The Senate seems to contain the only grown-ups in the schoolyard. It has a plan to create a state-run marketplace that would subsidize health insurance for low-income Floridians who are working – essentially Medicaid expansion. Its budget contains both LIP and Medicaid expansion money.

The House and the governor are flat out refusing to consider it. Gov. Scott says he doesn't trust the feds to live up to their end of the bargain, and the Republican House members agree.

There doesn't seem to be any reason to think the federal government will renege – it hasn't in any other state so far.

The truth is, whether it's LIP or Medicaid expansion, it's all federal money – all dollars Floridians have already paid out to Washington, D.C. We want those dollars back, and we're entitled to them. Why does it matter which program they come from?

This is a childish power struggle, which would be of little import except that it's hurting around 800,000 Floridians.

The state budget hinges on this issue. Right now, the two chambers' budgets are about $4 billion apart. The clock is ticking. The Legislature has until May 1 to knock it off.

We urge the governor and House Republicans to stop playing political chess with peoples' lives.

"There comes a point in time where you have to make a decision that's right," said Sen. Montford.

We agree. Do the right thing. The Senate has offered a viable compromise. Take it.

A COLLECTIVE VOICE

Gannett Florida newspapers and websites in Fort Myers, Brevard County, Tallahassee and Pensacola are joining with others this weekend to speak up about the need for our state leaders to resolve an impasse related to Medicaid expansion and the federally funded Low Income Pool.

At least seven news sites will publish commentary about the issues. To read these editorials and columns, turn to Tallahassee.com/opinion, where you will find a list of links to information and opinions about Medicaid expansion, the standoff between the state and federal government and the politics surrounding the issue.

A HEALTHY FLORIDA WORKS

AN OPEN LETTER TO THE FLORIDA HOUSE OF REPRESENTATIVES ON BEHALF OF THE 800,000 UNINSURED AND THE 16 MILLION PAYING FOR IT

As a fiscally conservative and caring Republican, I will ask you to recognize that you were elected to serve the people of Florida.

Your future as a well-intentioned citizen and representative of the people should not be beholden to a few political committee chairs and elected officials who are failing to recognize that our state and our country have changed. I will speak my mind as I am not a politician, nor do I want to be.

I am simply an adopted son of our great country who has been blessed and chooses to express my view in a field that I know "just a little" about – the healthcare needs of those who can least afford to be without it.

We have more than 800,000 uninsured neighbors: our auto mechanics, small business employers and employees, young graduates and young families, and volunteers who help the rest of us carry on with our daily lives. These are people who cannot afford health insurance and do not qualify for Medicaid. Yet, we all pay for their medical care when they show up at the most expensive site of care, an emergency room.

Why not lower our costs by allowing these people to access entry level care at a lower cost setting – the doctor's office – and then, if need be, at the higher cost setting.

Will you stand by the 800,000 uninsured who are currently receiving care in the emergency room and the 16 million Floridians – those who elected you and who are funding the care – and join the Florida Senate to solve this problem?

Will you stop the rhetoric? As most of you will agree, the federal government does not make our money. They get to spend our money, and we, as taxpayers want some of our money returned to us. This is not a win-lose proposition. It's a humanitarian proposition.

It's not a zero sum game. It's about doing the right thing by making sure our tax dollars are returned to Florida and spent on the people of Florida.

Please join the Florida Senate and adopt the Florida Health Insurance Affordability Exchange. It's the right thing to do. It's the conservative and compassionate thing to do. It's the smart thing to do.

Sincerely,
Mike Fernandez
Chairman MBF Healthcare Partners
Coral Gables

Sponsored by a Healthy Florida Works, contact: team@ahealthyfloridaworks.com