RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

May 26, 2015

Ms. Heather Hostetler
Project Officer
Centers for Medicare and Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Dear Ms. Hostetler:

Enclosed for your review is a request to amend Florida's 1115 Managed Medical Assistance (MMA) Waiver to redesign elements of the Low Income Pool (LIP) and extend the program until June 30, 2017. The newly redesigned LIP ensures access to care for low income populations that are not eligible to participate in Medicaid or other subsidized coverage programs and complements the MMA program by strengthening connections between critical safety net providers and the MMA program.

The request to redesign and continue funding of LIP is in response to discussions with the Centers for Medicare and Medicaid Services about how best to structure the pool in light of new and different coverage opportunities for low income Floridians: Florida's Medicaid program's shift to the MMA program as well as opportunities available under the Affordable Care Act.

In compliance with 42 CFR 431.408 and STCs #7 and #15 of the MMA Waiver including: the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the SSA as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, the Agency for Health Care Administration (Agency), held a 30-day public notice and public comment period that began April 21, 2015 and ended May 22, 2015, for the MMA Waiver Amendment.

We appreciate your consideration of this request and your efforts in working with our staff on amending Florida's 1115 Medicaid MMA Waiver. Should you have any questions, please contact Heather Morrison of my staff at (850) 412-4034. We look forward to continuing to work with you.

Sincerely,

[redacted]

Justin M. Senior
Deputy Secretary for Medicaid

JMS/lm
Enclosures
cc: Jackie L. Glaze, CMS-RO

Florida Managed Medical Assistance Program
1115 Research and Demonstration Waiver

Amendment Request
Low Income Pool

May 26, 2015

Posted on Agency Website
http://ahca.myflorida.com/medicaid/statewide_mc/mma_fed_auth_amend_waiver_2015-04.shtml

Florida Agency for Health Care Administration

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I. Purpose, Goals and Objectives

A. Statement of Purpose

The State is seeking federal authority to amend Florida's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4) to redesign elements of the Low Income Pool (LIP) and extend the program until June 30, 2017. The newly redesigned LIP ensures access to care for low income populations that are not eligible to participate in Medicaid or other subsidized coverage programs and complements the MMA program by strengthening connections between critical safety net providers and the MMA program.

The request to redesign and continue funding of LIP is in response to discussions with the Centers for Medicare and Medicaid Services (CMS) about how best to structure the pool in light of new and different coverage opportunities for low income Floridians: Florida's Medicaid program's shift to the MMA program as well as opportunities available under the Affordable Care Act (ACA).

The State contracted with Navigant Consulting, Incorporated (Inc.)[1] to conduct the CMS required study on the LIP program (See appendix B). The study concluded that the LIP program would need to continue in Florida even if all coverage options were fully exploited. This conclusion is consistent with other sources, including the Urban Institute, which have estimated that Florida providers would continue to experience significant uncompensated care costs even after implementation of the ACA. In response to these findings and discussions with CMS, the redesigned LIP program contains the following features:

- Reduced linkage of payments to local source of funding and
- Continued focus on maintaining access and quality of care to vulnerable populations.

The State is not requesting authority to make any changes to the MMA program as authorized under this waiver. The State is seeking waiver and expenditure authority to redesign and extend the LIP program. Specifically, the State seeks expenditure authority of Section 1115(a)(2) of the Social Security Act for expenditures for uncompensated care costs incurred by providers for health care services to uninsured and or underinsured, and associated projects to support such care through the redesigned LIP program (See item three in Section VII Waiver and Expenditure Authorities of this document).

B. Goals and Objectives

Historically, the goal of the LIP program has been to provide additional support to safety net hospitals, rural hospitals, trauma centers, and other provider access systems that have served the Medicaid and uninsured populations. Since implementation in 2006, the LIP program has increased emphasis on primary care, emergency room diversion, and other quality initiatives. Teaching physicians were added for the period July 1, 2014 to June 30, 2015, Demonstration Year (DY) 9, for continued support of these practices that contribute vitally to ensure a strong Florida physician workforce. The redesigned program is critical to sustained access in a higher

[1] http://ahca.myflorida.com/medicaid/Finance/finance/LIP-DSH/LIP/docs/FL_Medicaid_Funding_and_Payment_Study_2015-02-27.pdf

health care coverage environment. The State's LIP program goals are specified in Section 409.91211(1)(c), Florida Statutes.

The redesigned LIP program will accomplish the following access and Medicaid payment goals alongside an initiative to increase Medicaid hospital payment rates:

- Reduced linkage of payments to local source of funding and
- Continued focus on maintaining access and quality of care to vulnerable populations

C. Current Program

The current LIP program total computable dollar limit for expenditures in DY9 is $2,167,718,341 as specified in Special Term and Condition (STC) #68a. This total includes the following elements:

- $1 billion (for DY1 - DY8, LIP funding had a capped allotment of $1 billion disbursed in quarterly payments to providers);
- $963,184,508 (historical spending amount for self-funded hospital rate exemptions and buybacks, conditional on the state's assurance that no such rate exemptions or buybacks will be executed apart from LIP in DY9);
- $204,533,833 (historical supplemental payment amount for physician groups with medical school affiliation, conditional on the state's assurance that no such supplemental payments will be made apart from LIP in DY9).

Demonstration Year 9 served as a "transition year" for the LIP program, to provide time to contract with a vendor (Navigant Consulting, Inc.) to complete the study required by STC 69a (See appendix B). As such, the distributions being made in DY9 are reflective of the DY8 distribution of $1 billion, and incorporate Physician Supplemental funding and LIP 6 (formerly self-funded rate enhancements). These distributions are subject to new "participation requirements" that were added at the renewal of the waiver in STC #78:

a. Hospitals:

I. Must contract with at least fifty percent of the Standard Plan Managed Care Organizations (MCOs) in their corresponding region;
II. Must contract with at least one Specialty Plan serving each specialty population in their corresponding region; and,
III. Participate in the Florida Event Notification program.

b. Medical School Physician Practices: Must participate in the Florida Medical School Quality Network.

c. County Health Departments: Non-hospital institutional providers must continue their participation in LIP programs that support specific projects to increase access to healthcare services for low income/indigent uninsured population in addition to providing access to the Medicaid population

d. Federally Qualified Health Centers: Non-hospital institutional providers must continue their participation in LIP programs that support specific projects to increase access to healthcare services for low income/indigent uninsured population in addition to providing access to the Medicaid population.

D. Federal and State Waiver Authority

The following is a historical description of the federal and state authority granted since authorization of the waiver (Project Number 11-W-00206/4) was obtained in 2005.

1. Initial 5-Year Period (2006 - 2011): On October 19, 2005, Florida's 1115 Research and Demonstration Waiver named "Medicaid Reform" was approved by the Centers for Medicare and Medicaid Services (CMS). The program was implemented in Broward and Duval counties on July 1, 2006 and expanded to Baker, Clay and Nassau counties on July 1, 2007. The LIP program was approved for a capped annual allotment of $1 billion total computable for each of the initial 5-year demonstration periods. The program was terminated August 1, 2014 with the implementation of the MMA program. The State authority to operate this program is located in s. 409.91211, F.S., and sunsetted October 1, 2014.

2. Three-Year Extension Period (2011 - 2014): On December 15, 2011, the State received Federal CMS approval to extend the waiver to maintain and continue operations of Medicaid Reform for the period July 1, 2011 to June 30, 2014. The LIP program was approved for a capped annual allotment of $1 billion total computable for each of the additional 3-year demonstration periods.

3. MMA Waiver Amendment (2013): On June 14, 2013, the State received Federal CMS approval to amend the waiver to terminate the Medicaid Reform program and implement the MMA program as approved by Federal CMS. The name of the waiver was changed to Florida's 1115 Managed Medical Assistance Waiver.

4. Three-Year Waiver Extension (2014 - 2017): On November 27, 2013, the Agency submitted an extension request to extend authority for the 1115 MMA Waiver an additional 3-years (July 31, 2014 - June 30, 2017). The effective dates of the waiver renewal period are July 31, 2014 through June 30, 2017. The Agency received approval of the 3-year extension from Federal CMS on July 31, 2014. The LIP program was authorized to extend for one year, from July 1, 2014 through June 30, 2015 with the total amount not to exceed $2.16 billion. The Special Terms and Conditions (STCs) can be viewed on the Agency for Health Care Administrations (Agency's) website at the following link:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SpecialTermsandConditionsCMSApprovedJuly312014.pdf

Please note the State is not requesting authority to make any changes to the MMA program as authorized under this waiver. The State is seeking waiver and expenditure authority to redesign and extend the LIP program. Specifically, the State seeks expenditure authority of Section 1115(a)(2) of the Social Security Act for expenditures for uncompensated care costs incurred by providers for health care services to uninsured and or underinsured, and associated projects to support such care through the redesigned LIP program (See item three in Section VII Waiver and Expenditure Authorities of this document).

E. Federal Waiver Amendment Requirements

The State is submitting the MMA Waiver amendment to Federal CMS in accordance with STCs #7 and #15 of the MMA Waiver and Title 42 Code of Federal Regulations (CFR), Section (s.) 431.408. The following is a description of the required public notice document.

Public Notice Document: The State posted the "Public Notice" document to solicit public input 30 days prior to submission of the amendment request to Federal CMS. This public notice document is required to include a comprehensive description of the amendment application that contains sufficient detail to ensure meaningful input from the public, including:

(A) Demonstration of Public Notice 42 CFR §431.408 and tribal consultation: The state must provide documentation of the State's compliance with public notice process as specified in 42 CFR §431.408 and documentation that the tribal consultation requirements outlined in STC 15 have been met.

(B) Demonstration Amendment Summary and Objectives: The State must provide a detailed description of the amendment, including; what the State intends to demonstrate via the amendment as well as impact on beneficiaries with sufficient supporting documentation, the objective of the change and desired outcomes including a conforming Title XIX and/or Title XXI state plan amendment, if necessary.

(C) Waiver and Expenditure Authorities: The State must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested for the amendment

(D) A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

(E) An up-to-date CHIP allotment neutrality worksheet, if necessary; and

(F) Updates to existing demonstration reporting, quality and evaluation plans: A description of how the evaluation design, comprehensive quality strategy and quarterly and annual reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

II. Public Process

This section of the document provides a summary of public notice and input process used by the State in compliance with 42 CFR 431.408 and STCs #7 and #15 of the MMA Waiver including: the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to s. 1902(a)(73) of the Social Security Act (Act) as amended by s. 5006(e) of the American Recovery and Reinvestment Act of 2009.

A. Consultation with Indian Health Programs

The Agency consulted with the Indian Health Programs[2] located in Florida through written correspondence, to solicit input on the amendment request. Appendix A of this document provides the correspondence sent on April 20, 2015, to the Seminole Tribe and Miccosukee Tribe request input on the amendment request. The Agency did not receive any feedback from the Seminole or the Miccosukee Tribes.

B. Public Notice Process

The following list describes the notification process used to inform stakeholders of the public meetings to be held to solicit input on the amendment request.

- Published public notices for the three public meetings in the Florida Administrative Register (FAR) in compliance with Chapter 120, Florida Statutes.
- Emailed the meeting information to individuals and organizations from the interested parties list that was created during the development of the initial waiver application and has been updated regularly thereafter.
- Released Agency Alerts announcing the meetings.
- Posted on the Agency's home website a prominent link to the website where the following information can be found: the public meeting schedule including dates, times and locations, as well as this public notice document for the amendment request. The meeting materials and the public notice document can be viewed by clicking on the following link:

  http://ahca.myflorida.com/medicaid/statewide_mc/mma_fed_auth_amend_waiver_2015-04.shtml

C. Florida Medicaid Advisory Meetings

The Agency asked for input on this amendment request from the members of the Medicaid Medical Care Advisory Committee (MCAC) and the public at large. The public meeting notices were published in the FAR. During the meetings, the Agency provided a description of the amendment request and used the meetings to seek and to obtain input on the amendment request. The agenda and presentation materials were posted on the Agency's website provided above.

- MCAC public meeting was held in Orlando, FL on April 29, 2015.
- Public meeting was held in Miami, FL on April 30, 2015.
- Public meeting was held in Tallahassee, FL on May 1, 2015.

[2] The State of Florida has two federally recognized tribes: Seminole Tribe and Miccosukee Tribe; and does not have any Urban Indian Organizations.

Florida Medicaid's Medical Care Advisory Committee

The MCAC is mandated in accordance with Title 42, CFR s. 431.12, based on Section. 1902(a)(4) of the Social Security Act. The purpose of the MCAC is to provide input on a variety of Medicaid program issues, and to make recommendations to the Agency on Medicaid policies, rules and procedures.

The MCAC is comprised of: board-certified physicians and other representatives of the health professions who are familiar with the medical needs of low-income people; members of consumer groups, including at least four representatives of Medicaid recipients; and representatives of state agencies involved with the Medicaid program, including the secretaries of the Florida Department of Children and Families, the Florida Department of Health and the Florida Department of Elder Affairs, or their designees.

D. Public Meetings

The State published a public meeting notice in the FAR on April 21, 2015 inviting all interested parties to the three public meetings listed in the table below, which provides the dates, times and locations. Individuals who were unable to attend the meeting in person could participate via conference call by using the toll-free number provided in the FAR notice. During the meetings, the Agency provided an overview of the MMA Waiver and description of the amendment request and allowed time for public comments.

Table 1
Schedule of Public Meetings

Location	Date	Time
Orlando University of Central Florida College of Medicine Lewis Auditorium Health Sciences Campus 6850 Lake Nona Blvd Orlando, FL 32827-7408 Conference Call in # 1-877-809-7263 Participant Code #498 365 37	April 29, 2015	2:00pm – 4:00pm
Miami Agency for Health Care Administration 8333 NW 53rd Street Suite 200 Doral, FL 33166 Conference Call in # 1-877-299-4502 Participant Code 229 029 90#	April 30, 2015	2:00pm – 4:00pm
Tallahassee Agency for Health Care Administration 2727 Mahan Drive Building 3 Conference Room A Tallahassee, FL 32308 Conference Call in #1-877-299-4502 Participant Code #265 591 27#	May 1, 2015	2:00pm – 4:00pm

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting was asked to advise the agency at least 7 days before the workshop/meeting by contacting Heather Morrison at (850) 412-4034 or by email at Heather.Morrison@ahca.myflorida.com.

Individuals who are hearing or speech impaired were advised to contact the agency using the Florida Relay Service, 1 (800) 955-8771 (TTY) or 1 (800) 955-8770 (Voice).

E. Public Notice Document Made Available to the Public

The Agency posted on its website (link provided on page 5) beginning April 21, 2015 through May 22, 2015, the public notice document, the approved MMA Waiver documents (STCs of the waiver and the waiver and expenditure authorities document) and the Florida law (Part IV of Chapter 409, Florida Statutes) that established the MMA program.

F. Submission of Written Comments

The Agency's website provided the public the option of submitting written comments on the amendment request by mail or email (address located below). In addition, the Agency asked attendees of the public meetings to submit written comments.

Mail comments and suggestions to:

1115 MMA Amendment Request
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

The public may also e-mail comments and suggestions to:

FLMedicaidWaivers@ahca.myflorida.com

H. Summary of Public Comments

The following summarizes the public comments received during the 30-day comment period for the Low Income Pool (LIP) waiver amendment request that began April 21, 2015 and ended May 22, 2015. The State considered all comments received in preparing the amendment request. The comments received are grouped by topic.

General Comments

- the LIP funds allow many facilities and providers to continue to provide uncompensated care to some of Florida's most vulnerable citizens;
- the need for further redesigning the elements of the LIP program;
- the use of LIP funds are instrumental in helping providers bring needed services to the communities that they serve;
- extending LIP in its current form does not address the long-range need to stabilize the health care system in Florida;

- the need to implement the Florida Senate plan in its entirety, including the expansion of Medicaid;
- the LIP program being characterized as an uncompensated care pool, rather than a limited expansion of coverage;
- the need for improved transparency within the current Medicaid hospital funding and payment mechanism;
- continuation of LIP funding is critical for access to care for all Floridians.

Medicaid Expansion

- the need for LIP funding and Medicaid expansion to adequately care for Florida's patient population;
- even with an expansion of Medicaid there may be hundreds of thousands of people uninsured;
- the need to completely cover the uninsured and have them enroll in managed care;
- the need to establish a transition plan for expansion;
- Medicaid expansion will not reduce the level of uncompensated care provided by a specialty licensed children's hospital for children under 18 years of age;
- to not continue the LIP funding and to just expand Medicaid.

Recipients Related Comments

- significant hardship will be experienced by Florida families who cannot afford treatment for serious illnesses;
- prenatal care services may no longer be available to recipients in rural counties, who go to county health departments for services.

Providers/Rates

- the LIP funds allow many facilities and providers to continue to provide uncompensated care to some of Florida's most vulnerable citizens and participants in the Statewide Medicaid Managed Care program;
- provider payments must be sufficient, and an increase in the base rate should be included;
- need for increased protection for safety net providers;
- need for fairness for all providers;
- the proposed redesigned LIP model is a huge step toward getting subsidized rates back to where they need to be.

Hospitals

- if the LIP program is not renewed or replaced prior to July 1st, many hospitals will be forced to cut millions of dollars from their budgets, resulting in eliminating and reducing services and number of employees, and possibly shutting down;
- the burden of shutting down hospitals would be catastrophic to the medical community;

- LIP payments should be directed to hospitals that serve more Medicaid and charity patients and to providers based on policy-based standards, instead of hospitals that have Intergovernmental Transfer dollars;
- transitional care centers, which reduce re-admissions among patients that are recently discharged from hospitals, would not be sustainable;
- the LIP program should reflect the need to rebalance the contracted rates paid to hospitals by managed care organizations and the state should tie in the Drug-Related Group Base Enhancements payments to a rebasing of the contracted rates;
- the proposed LIP model is a huge step toward getting subsidized rates back to where they need to be, without hurting safety net hospitals;
- the proposed LIP design supports access to care for low-income patients and continues to foster and protect its safety net providers.

Emergency Room Visits

- the LIP funding for hospitalization aids in reducing emergency visits;
- many emergency room diversion programs have been set up due to the LIP funding.

County Health Departments

- the county health departments (CHDs) are dependent on LIP funding;
- a loss of LIP funding would potentially result in the inability of counties to continue to provide services and result in increasing health care costs dramatically;
- the loss of LIP funding would negatively impact the infrastructure of CHDs.
-

Medical Schools

- the LIP funding is a critical support to our medical schools as they care for indigent patients and at the same time educate medical students and residents, our future physicians;
- there are over two million Medicaid patient encounters in Florida’s medical schools;
- supplemental payments for Florida's medical education program greatly enhance those programs and provide access to Medicaid, uninsured, and underinsured patients;
- the impact of losing LIP funding for these physicians would have a ripple effect on future doctors and the willingness and/or ability to take care of patients in Florida;
- there are real savings to the Medicaid program as a whole, as a result of being able to deploy the LIP funding in order to build new federally qualified health centers for medical students to train in and to learn how to deliver comprehensive primary care in a health and medical home;
- the risk medical schools cutting residency programs if LIP funding is no longer available.

III. Redesigned LIP Program Overview

The State is requesting authority for the redesigned LIP program which shares some characteristics with the existing program, but has been adjusted in key areas to support federal and state goals. The general structure is similar to the current model, which contains several categories that target different provider access systems using different criteria and methodologies for fund allocation. However, the core categories that target access to hospital services particularly, LIP 4 – 6, have been redesigned with the addition of a new LIP 7 category. The approximately $1.7 billion included in these categories generally targets hospitals that have historically served low income and vulnerable populations, and are expected to bear the brunt of residual uncompensated care cost when all coverage opportunities are considered. Florida believes this level of funding is supported by the Urban Institute estimate [3]that Florida would continue to experience significant levels of uncompensated care if all coverage components of the ACA were implemented.

Of particular note is the reallocation of funds from LIP 6 to LIP 4 and the addition of the new category LIP 7. These changes are designed to reduce the linkage between local funding and fund distribution that was inherent in the legacy rate enhancement system and the DY9 LIP 6 transition funding. Some funds remain in LIP 6 as a continued transition through DYs 10 and 11. Legislation that would implement this model has been proposed, and can be found the following link:

http://ahca.myflorida.com/medicaid/statewide_mc/pdf/mma/Florida_Senate_Medicaid_Hospital_Funding_Programs_Packet_2015-04-01.pdf

In addition to the restructured funding in this amendment request, the State expects to enhance reporting on LIP program activities and funding to improve transparency and facilitate understanding of this critical funding stream. The State is committed to working with CMS on the details of the types of reporting that will accomplish these goals.

The following table provides the funding for the redesigned LIP program with a description of the different subcomponents provided in the narrative.

Table 2 LIP Overview	
Special LIP	$115,742,353
LIP 4	$1,249,597,300
LIP 5	$2,419,573
LIP 6	$244,372,316
LIP 7	$233,719,378
Other Provider Programs	$321,867,421
Total	$2,167,718,341

[3] http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412485-State-Progress-Toward-Health-Reform-Implementation-Slower-Moving-States-Have-Much-to-Gain.PDF.

A. Special LIP Summary

Special LIP is a subcomponent within the LIP program that designates funding to cover certain hospital provider type access systems, with associated requirements to enhance existing, or initiate new, quality-of-care initiatives to improve their quality measures and identified patient outcomes, and to provide required documentation of this to the Agency. This component of the LIP program is proposed to continue in similar fashion as it does in the current program.

- Rural hospital LIP distributions are provided to statutorily defined rural hospitals. These facilities ensure access to medical care for individuals in the state's rural areas.
- Trauma hospital LIP distributions are provided to hospitals that have designated or provisional trauma centers.
- Safety-net hospital LIP distributions are provided to safety-net hospitals to help ensure critical access to medical care throughout the state.
- Hospital Specialty Pediatric LIP distributions are made to free-standing children's hospitals.
- Funding for hospitals that meet specific quality measures. These hospital distributions are provided for the specialty children's hospitals based on an allocation methodology incorporating both quality and core measures as well as the following six outcome measures:
    1. Mortality Hospital Risk Adjusted Rate (HRAR) Acute Myocardial Infarction (AMI) without transfers.
    2. Mortality HRAR Congestive Heart Failure (CHF)
    3. Mortality HRAR Pneumonia
    4. Risk Adjusted Readmission Rate (RARR) AMI
    5. RARR CHF
    6. RARR Pneumonia

B. LIP 4 Hospital Provider Access Systems

Funds in LIP 4 are first allocated to hospitals where local government funds are transferred to the State of Florida for use in the LIP program and former exemption programs. Distributions in LIP 4 are contingent upon a Letter of Agreement (LOA) between the Agency and the local government.

C. LIP 5 Distribution Pool

The LIP funds in the LIP 5 category are provided to statutorily defined rural hospitals that ensure access to medical care for those individuals in the rural parts of Florida, where access can be particularly challenging. Rural hospitals that receive this distribution report a combined uncompensated care amount of $66.8 million based on the reported FY 2013 FHURS data.

D. LIP 6 Distribution Pool

The LIP 6 category was added in DY9 to accommodate funding that had previously been associated with self-funded rate enhancements. The LIP program funds in this new LIP 6 category are significantly reduced from the current program to reduce the linkage between

distributions and direct local government contribution, one of the primary goals of the redesign. Residual funding in this category is left in place to assist with a two year transition.

E. LIP 7 Distribution Pool

The funds in LIP 7 are provided for hospitals that target areas with particular access challenges. This distribution is not linked to the amount of local government contributions an individual hospital provides. Hospitals will participate in one of four groups based on the defined criteria below:

- Essential Community Providers (ECP) as defined by CMS;
- Regional Perinatal Intensive Care Centers (RPICC);
- Statutory Teaching Hospitals (ST); and
- Trauma Centers.

Group 1 – Any hospital that is an ECP, RPICC, ST, and a Level I Trauma Center.
Group 2 – Any hospital that meets three of the defined criteria.
Group 3 – Any hospital that meets two of the defined criteria.
Group 4 – Any hospital not included in Groups 1 through 3.

F. Other Provider Programs

Other LIP Provider programs is a component within the LIP program that designates funding to cover mostly non-hospital provider type access systems that play critical roles in maintaining health care access and quality for low income populations. This component of LIP program is proposed to continue in similar fashion as it does in the current program.

- Teaching Physicians – Funding for teaching physicians are for services provided by doctors of medicine and osteopathy, as well as other licensed health care practitioners acting under the supervision of those doctors pursuant to existing statutes and written protocols, employed by or under contract with a medical school in Florida. This funding is necessary to sustain needed practical training to the physician work force which is important to access to care, and even more critical as more Floridians gain coverage through newly available opportunities. These distributions are for medical schools that meet participation requirements in the LIP program.
- Primary Care Initiatives – Funds are provided to make payments to Federally Qualified Health Centers (FQHCs), County Health Departments, county and local community initiatives. These payments support primary care services in medically underserved areas targeting low-income, uninsured, and underinsured individuals, as well as providing funding towards ER diversion programs.
- Tier-one Milestone Distributions have been required by the STCs for several years and are proposed to continue in similar fashion to the current program. The CMS Tier-one Milestone are for the establishment of new, or enhancement of existing, innovative primary care programs that meaningfully enhance the quality of care and the health of low-income populations. The programs will be required to create new or enhance primary care programs to provide the services most needed by the local community, such as needed physician, dental, nurse practitioner, or pharmaceutical services; expand local capacity to treat patients; and provide for extended service hours. Additionally, reduction of unnecessary emergency room visits and preventable hospitalizations will be components of new or enhanced primary care programs.

- Premium Assistance Programs – Funds are provided to make health insurance premium payments for low-income residents enrolled in the Premium Assistance Programs.
- Poison Control Programs – Funds are provided to make LIP payments to hospitals providing poison control programs.

G. Participation Requirements

All provider access systems who will receive LIP funds will be required to meet certain participation requirements as a condition of receiving funds. Participation will be tested on a quarterly basis. Exemptions to the requirements may be granted by the State if a hospital can provide documentation that demonstrates a good faith effort was made in contract negotiations.

a. **Hospitals.**

   i. Must contract with at least one Specialty Plan serving each specialty population in their corresponding region; and,

   ii. Continue to participate in the Florida Event Notification program.

b. **Medical School Physician Practices.** Must participate in the Florida Medical School Quality Network.

c. **County Health Departments.** Non-hospital institutional providers must continue their participation in LIP programs that support specific projects to increase access to healthcare services for low income/indigent uninsured population in addition to providing access to the Medicaid population.

d. **Federally Qualified Health Centers.** Non-hospital institutional providers must continue their participation in LIP programs that support specific projects to increase access to healthcare services for low income/indigent uninsured population in addition to providing access to the Medicaid population.

IV. Budget Neutrality

A. Budget Neutrality Compliance

The Agency is required to provide financial data demonstrating the detailed and aggregate historical expenditures, and project budget neutrality status for the requested waiver extension period (July 1, 2015 – June 30, 2017) and cumulatively over the lifetime of the waiver. The Agency is also required to provide up-to-date responses to the Federal CMS Financial Management standard questions. The following addresses the items specified above and documents that the waiver is budget neutral.

1. General Budget Neutrality Requirements

A requirement of any 1115 Research and Demonstration Waiver is that the program must meet a budget neutrality (BN) test and provide documentation that the demonstration did not cost the program more than would have been experienced without the waiver. In addition, prior to an extension of the 1115 waiver, a projection and extension of new budget neutrality benchmarks using rebased trends must be provided for the requested waiver extension period.

The established STCs of the 1115 MMA Waiver, as agreed upon by the State and CMS, are provided in the approved waiver document. To comply with the STCs, the Agency must pass the budget neutrality "test" as well as provide quarterly reporting of the expenditures and member months for the waiver, which is used to monitor the budget neutrality. Florida's 1115 MMA Waiver is budget neutral and is in compliance with all STCs specific to budget neutrality.

2. Florida's 1115 Research and Demonstration Waiver

This amendment impacts the LIP program, which is Medicaid Eligibility Group (MEG) 3, of the 1115 Research and Demonstration Waiver. For MEGs 1 and 2, the State is in substantial compliance with BN as indicated in the CMS final approved BN for the 2014 Extension, and no changes are being made to those MEGs.

MEG 3 was established in the initial waiver application as approved by Federal CMS. The MEG is also referred to as the LIP program and is not directly linked to Medicaid eligibility. Expenditures for the LIP program are authorized to provide services to the uninsured and underinsured. Distributions to qualifying providers under the LIP program are determined by the type of facility and services, as well as the volume of Medicaid days in addition to allowable uninsured and underinsured expenditures incurred in previous operating years. Payments to providers are not paid through the claims processing system, but are lump sum payments made directly to the provider to offset the allowable uncompensated services. The limit for the LIP program is established in the BN and is reported in accordance with the requirements of the STCs of the waiver specific to BN. However, the program requirements and monitoring are subject to the STCs of the waiver established for the LIP program.

To provide for Florida's Medicaid, underinsured and uninsured populations, the Agency is seeking LIP program funding of $2.16 billion to be maintained for the upcoming waiver extension period of July 1, 2015 through June 30, 2017.

The LIP program expenditures are not included in the calculation of per-member per-month (PMPM) for the budget neutrality test.

Table 3 below provides MEG 3 (LIP) cumulative expenditures for each Demonstration Year beginning with DY1 (July 1, 2006 – June 30, 2007) through DY9, Quarter 2 (October 1, 2014 – December 31, 2014).

Table 3 MEG 3 Total Expenditures: Low Income Pool			
DY*	**Total Paid**	**DY Limit**	**% of DY Limit**
DY1	$998,806,049	$1,000,000,000	99.88%
DY2	$999,632,926	$1,000,000,000	99.96%
DY3	$877,493,058	$1,000,000,000	87.75%
DY4	$1,122,122,816	$1,000,000,000	112.21%
DY5	$997,694,341	$1,000,000,000	99.77%
DY6	$807,232,567	$1,000,000,000	80.72%
DY7	$1,019,291,544	$1,000,000,000	101.93%
DY8	$1,156,397,442	$1,000,000,000	115.64%
DY9	$690,421,416	$2,167,718,341	31.85%
Total MEG 3	**$8,669,092,159**	**$10,167,718,341**	**85.26%**

The projection of budget neutrality benchmarks for the requested period of July 1, 2015 - June 30, 2017 for the redesigned LIP program is included in the following table.

Table 4 LIP Benchmark	
DY	**MEG 3**
DY10	$2,167,718,341
DY11	$2,167,718,341

B. Financial Management Standard Questions

1. Section 1903(a)(1) of the Act provides that Federal matching funds are only available for expenditures made by states for services under the approved state plan. Do providers receive and retain the total Medicaid expenditures claimed by the state (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the state, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the state (i.e., general fund, medical services account, etc.)

   Response: Providers retain 100 percent of all payments made relating to this program. If an error occurs and payments are returned to the State, the State will track and report appropriately. The federal share is calculated and returned to CMS.

2. Section 1902(a)(2) of the Act provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and state share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

   (i) a complete list of the names of entities transferring or certifying funds;
   (ii) the operational nature of the entity (state, county, city, other);
   (iii) the total amounts transferred or certified by each entity;
   (iv) clarify whether the certifying or transferring entity has general taxing authority; and,
   (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

   Response: Florida Medicaid provides payments to institutional providers through per diem rates except for hospital inpatient which is through DRG payments. The State's share of payments is appropriated by the Florida Legislature from the State's general revenue, public medical assistance trust fund and through intergovernmental transfers. Each year the state estimates expenditures for the upcoming year by applying an inflationary factor to current year payments as well as making adjustments for estimated changes in caseload and utilization. The estimated expenditures are adopted by the Social Services Estimating

Conference and ultimately approved by the Florida Legislature in the General Appropriations Act (GAA).

3. Section 1902(a)(30) of the Act requires that payments for services be consistent with efficiency, economy and quality of care. Section 1903(a)(1) of the Act provides for Federal financial participation to states for expenditures for services under an approved state plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

   Response: No supplemental Special Medicaid Payments (SMP) are being made in addition to provider Medicaid reimbursement rates. The only additional payments being made to hospital providers are those payments permitted through the Low Income Pool (LIP) program and the disproportionate share (DSH) program, for the continuation of government support for services to low income and vulnerable populations.

4. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (state owned or operated, non-state government owned or operated and privately owned or operated). Please provide a current (i.e. applicable to current rate year) UPL demonstration.

   Response: On March 18, 2013, Federal CMS issued a State Medicaid Director's Letter (SMDL #13-003) describing the mutual federal and state obligations and accountability on the part of the state and federal governments for the integrity of the Medicaid program. Among the obligations included: ongoing consistency with the applicable federal UPL requirements described in regulation for certain services. The regulations implement, in part, section 1902(a)(30)(A) of the Act which requires that Medicaid rates are consistent with efficiency, economy and quality of care. Starting in 2013, states are required to submit UPL demonstrations on an annual basis. Previously this information was collected or updated only when a state was proposing an amendment to a reimbursement methodology in its Medicaid state plan. Beginning in 2013, states must submit UPL demonstrations for inpatient hospital services, outpatient hospital services and nursing facilities.

   For Florida State Fiscal Year 2014-15, the UPL analysis involves estimating Medicare payment for a set of Medicaid claims and comparing those payments to actual payments made by Medicaid. The claim data and hospital Medicare cost data are aligned so that they are from the same time frame. In addition, inflation factors are applied as appropriate to make payment and cost amounts comparable under the same time frame. Also if appropriate, other adjustments may be made to the baseline claim data to align with Medicaid program changes that have occurred between the timeframe of the baseline claim data and the UPL rate year.

   Comparisons of Medicaid payments to estimated Medicare payments (the UPLs) are made separately for hospital inpatient and outpatient services. Also, the comparisons are made for three categories of providers: (1) state owned (2) non-state government owned; and (3) privately owned hospitals.

   A UPL analysis has been completed to accompany both the SFY 2014-15 inpatient and outpatient reimbursement state plan amendments.

   Estimated Medicare payments which determine the UPL were calculated using a detailed costing method. For each hospital, information extracted from Medicare cost reports were

used to calculate cost-based per diems for each routine cost center and cost-to-charge ratios for each ancillary cost center. In addition, a mapping of revenue codes to cost centers was created. This mapping allowed a cost center to be identified for each claim detail line based on the revenue code submitted on the line. Costs on detail lines that mapped to routine cost centers were calculated by multiplying the cost center's cost per diem times the number of applicable days indicated on the line. Costs on detail lines that mapped to ancillary cost centers were calculated by multiplying the charges on the line by the cost center's cost-to-charge ratio. Total costs on all claim lines for a provider were summed to get the UPL amount per provider and then summed by category of provider to get the UPL amount for the three UPL categories: state-owned, non-state government owned, and privately owned (all others).

The UPL for each of the three UPL categories was calculated using the detailed costing demonstration method. For each hospital, information extracted from Medicare cost reports was used to calculate cost-based per diems for each routine cost center and cost-to-charge ratios for each ancillary cost center. Standard cost centers as defined by CMS were used. In addition, a mapping was created to assign revenue codes to cost centers. This allowed each claim detail line item to be assigned a cost center. Hospital costs on detail lines that mapped to routine cost centers were calculated by multiplying the cost center's cost per diem times the number of applicable days indicated on the line. Hospital costs on detail lines that mapped to ancillary cost centers were calculated by multiplying the charges on the line by the cost center's cost-to-charge ratio. The hospital cost amounts on all the claim lines for a hospital were summed to get the total cost for the hospital, and total hospital cost was used as the upper payment limit.

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to Federal CMS on the quarterly expenditure report?

   Response: Payments to providers would not exceed reasonable costs of providing services. This redesigned LIP program may require further discussion and re-definition of the methodology for calculating "reasonable costs". If payments do exceed reasonable cost of providing services, the provider must return the excess amount to the State. Once the State has received the returned funds, appropriate documentation is made and the federal share is calculated and returned to Federal CMS. The excess is returned to the state and the Federal share is reported on the 64 Report to Federal CMS.

V. Quality and Evaluation

A. Overview of Quality

The primary focus of the proposed amendment for a restructured LIP program is around maintaining access for low income populations in Florida. While the level of uninsurance and uncompensated care may decline with the implementation of the ACA, experts estimate a significant level of uncompensated care will remain. LIP program funds assist in maintaining critical access to health care for populations unable to afford the cost of care out of pocket. In addition to the focus on access, the proposed LIP program includes quality initiatives related to encouraging primary care, reducing unnecessary emergency room visits, and preventing unnecessary hospital readmissions through better discharge planning and patient follow up.

B. Overview of Independent Evaluation

The Agency proposes revising Domain 5 to reflect the redesign of the LIP program. The research questions and analyses for Domains 6-9 will be continued as these areas are ongoing and continue to be relevant to the quality improvement activities supported by LIP funding.

Domain 5 – The effect of the LIP program: (1) the funding of the number of people receiving services from, and the number of services being provided, by providers in LIP Pools 4, 5, 6, and 7, that would otherwise be uncompensated; (2) the funding of teaching physicians on the physician workforce for the future; and 3) provider participation in the Event Notification Service and its impact on improving care coordination and outcomes for patients served by those providers.

> Analyses for this redesigned domain will include examining and describing the number of people receiving services, and the numbers and types of services provided by providers receiving LIP funds through Pools 4, 5, 6, and 7, that would otherwise be uncompensated. Analyses will also look at how many physicians are being trained through the funding of teaching physicians and in what area of medicine (e.g., primary care, particular specialties). The impact of participation in the Event Notification Service will be examined in terms of LIP provider participation, Medicaid managed care plan participation, and how the managed care plans are using the Event Notification Service to follow up with and better coordinate care for enrollees who have been served by the hospitals receiving LIP funding.

Domain 6 – The effect of LIP funding on disparities in the provision of health services, both geographically and by population groups.

Domain 7 – The impact of Tier-One milestone initiatives on access to care and quality of care (including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity).

Domain 8 – The impact of LIP funding and Tier-One milestone initiatives on population health.

Domain 9 – The impact of LIP funding and Tier-One milestone initiatives on per-capita costs (including Medicaid, uninsured, and underinsured populations) and the cost-effectiveness of care.

VI. Program Objectives

This section of the document provides a description of the program objectives of this amendment waiver.

A. Program Objectives

The program objectives of this waiver amendment are to redesign the LIP program to ensure that it meets the continuing needs of low income and vulnerable populations in Florida, while adapting to the changing health care delivery environment brought about through ACA implementation. The redesigned program presented here considers the findings of Navigant Consulting, Inc., in its February 27, 2015 study of hospital financing in Florida, as well as subsequent discussions between the State and CMS. Safety net hospitals, rural hospitals, trauma centers, and other provider access systems that have historically played a critical role in serving the Medicaid and uninsured populations will continue to do so, and significant amounts of uncompensated care are expected to be incurred, despite all coverage opportunities available under the ACA.

This redesigned LIP program targets funding more broadly over hospitals that provide care to vulnerable populations, as compared to the current LIP program. It is paired with a general increase in hospital payments in the Medicaid program, which also more broadly disperses payment and strengthens the proportion of hospital payment directly related to Medicaid utilization. Finally, it continues to include funding for teaching physicians and other provider types that have unique and critical roles in the health care system that cannot be fully addressed through market-based payments.

The State recognizes that a significant additional objective associated with the redesigned LIP is enhanced reporting of LIP activities and fund flows. Florida expects details of those enhancements to be developed jointly between the State and CMS over the coming months.

VII. Waiver and Expenditure Authorities

The following waiver and expenditure authorities document was issued by CMS on July 31, 2014.

WAIVERS FOR FLORIDA'S
MANAGED MEDICAL ASSISTANCE SECTION 1115 DEMONSTRATION

NUMBER: 11-W-00206/4

TITLE: Managed Medical Assistance Program

AWARDEE: Agency for Health Care Administration

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project.

The following waivers are granted under the authority of section 1115(a)(1) of the Social Security Act (Act) and shall enable the State to implement the Florida Managed Medical Assistance Program section 1115 demonstration (formerly titled Medicaid Reform) consistent with the approved Special Terms and Conditions (STCs). These waivers are effective beginning July 31, 2014, through June 30, 2017.

Title XIX Waivers

1. Statewideness/Uniformity **Section 1902(a)(1)**

To enable Florida to operate the demonstration and provide managed care plans or certain types of managed care plans, including provider sponsored networks, only in certain geographical areas.

2. Amount, Duration, and Scope and Comparability **Section 1902(a)(10)(B) and 1902(a)(17)**

To enable Florida to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, based on differing managed care arrangements, or in the absence of managed care arrangements, as long as the benefit package meets certain actuarial benefit equivalency and benefit sufficiency requirements. This waiver does not permit limitation of family planning benefits. (Also this waiver is to permit Florida to offer different benefits to demonstration Population A than to the categorically needy group, through June 30, 2015.)

3. Income and Resource Test **Section 1902(a)(10)(C)(i)**

To enable Florida to exclude funds in an enhanced benefit account from the income and resource tests established under state and federal law for purposes of determining Medicaid eligibility. This authority expires on June 30, 2015.

4. Freedom of Choice Section **1902(a)(23)(A)**

To enable Florida to require mandatory enrollment into managed care plans with restricted networks of providers. This does not authorize restricting freedom of choice of family planning providers.

EXPENDITURE AUTHORITIES FOR FLORIDA'S
MANAGED MEDICAL ASSISTANCE SECTION 1115 DEMONSTRATION

NUMBER: 11-W-00206/4

TITLE: Managed Medical Assistance Program

AWARDEE: Agency for Health Care Administration

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall, for the period of this demonstration from July 31, 2014, through June 30, 2017, be regarded as expenditures under the state's Title XIX plan.

The following expenditure authorities shall enable Florida to operate the Florida Managed Medical Assistance program section 1115 demonstration (formerly titled Medicaid Reform).

1. **Demonstration Population A.** Expenditures for health care related costs not to exceed the amount of the individual's enhanced benefit account, for individuals who lose eligibility for Medicaid or demonstration Population A benefits. This expansion population shall be allowed to retain access to the enhanced benefits account for up to 1 year, except in the instance of termination of the demonstration. This authority expires June 30, 2015.

2. Expenditures for payments to managed care organizations, in which individuals who regain Medicaid eligibility within six months of losing it may be re-enrolled automatically into the last plan in which they were enrolled, notwithstanding the limits on automatic re-enrollment defined in section 1903(m)(2)(H) of the Act.

3. Expenditures made by Florida for uncompensated care costs incurred by providers for health care services to uninsured and or underinsured, and associated projects to support such care, subject to the restrictions placed on the Low Income Pool, as defined in the STCs. This authority expires June 30, 2015.

4. Expenditures for benefits under the enhanced benefits account program. This authority expires June 30, 2015.

5. Expenditures for the Program for All Inclusive Care for Children services and the Healthy Start program as previously approved under the 1915(b) waiver (control #FL-01) and as described in STCs 64 and 65.

Medicaid Requirements Not Applicable to the Expenditure Authorities:

Through June 30, 2015, in order to permit the demonstration project to function as amended, in addition to and/or consistent with previously approved waiver and expenditure authorities described above, the following Medicaid requirements are not applicable to the expenditure authorities:

1. Provision of Medical Assistance **Section 1902(a)(10)(A)**

To enable Florida to limit the medical assistance for demonstration Population A (individuals

who lose eligibility for Medicaid or demonstration Population A benefits) to health care related costs not to exceed the amount of the individual's enhanced benefit account.

2. Amount, Duration, and Scope and Comparability **Section 1902(a)(10)(B) and 1902(a)(17)**

To enable Florida to vary the amount, duration, and scope of benefits offered to demonstration Population A from that offered to other beneficiaries under the plan, and to enable benefits for Population A to be non-comparable to those offered to the categorically needy group.

3. Provider Agreements Section 1902(a)(27)

To permit the provision of care by entities who have not executed a provider agreement with the State Medicaid Agency for the purpose of providing enhanced benefits under the enhanced benefits account program

Appendix A
Letters to the Miccosukee Tribe and the Seminole Tribe

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

April 20, 2015

Ms. Connie Whidden, MSW
Health Director
Seminole Tribe of Florida
3006 Josie Billie Avenue
Hollywood, FL 33024

Dear Ms. Whidden:

This letter is being sent to notify the Seminole Tribe of Florida that the State of Florida plans to submit an amendment to Florida's 1115 Managed Medical Assistance Waiver to the Centers for Medicare and Medicaid Services. The proposed amendment will extend the funding for the Low Income Pool for from July 1, 2015 to June 30, 2015. A full description of the proposed amendment is located on the Agency for Health Care Administrations (Agency) website at the following link:

http://ahca.myflorida.com/medicaid/statewide_mc/mma_fed_auth_amend_waiver_2015-04.shtml

The Agency will conduct a 30-day public notice and comment period prior to the submission of the proposed amendment request to CMS. The 30-day public notice and public comment period will begin April 21, 2015 through May 22, 2015 The Agency has scheduled three public meetings to solicit meaningful input on the proposed waiver amendment from the public. The meetings will be held in:

- Orlando, Florida on April 29, 2015, 2:00 p.m. – 4:00 p.m. at the University of Central Florida, College of Medicine, Lewis Auditorium Health Sciences Campus, 6850 Lake Nona Blvd, Orlando, FL 32827. To participate by phone, please call 1(877)809 - 7263 and enter the participant passcode: 498 365 37#.
- Miami, Florida on April 30, 2015, 2:00 p.m. – 4:00 p.m. at the Agency for Health Care Administration, 8333 NW 53rd Street, Suite 200, Doral, FL 33166. To participate by phone, please call 1-877-299-4502 and enter the participant passcode: 229 029 90#.
- Tallahassee, Florida on May 1, 2015, 2:00 p.m. – 4:00 p.m. at the Agency for Health Care Administration, 2727 Mahan Drive Building 3, Conference Room A, Tallahassee, FL 32308. To participate by phone, please call 1 877 299.4502 and enter the participant passcode: 265 591 27#.

If you have any questions about this amendment or would like to hold a call please contact Heather Morrison of my staff via email at Heather.Morrison@ahca.myflorida.com or by phone at (850) 412-4034.

Sincerely,

/s/

Justin M. Senior
Deputy Secretary for Medicaid

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

April 20, 2015

Ms. Cassandra Osceola
Health Director
Miccosukee Tribe of Florida
P.O. Box 440021, Tamiami Station
Miami, FL 33144

Dear Ms. Osceola:

This letter is being sent to notify the Miccosukee Tribe of Florida that the State of Florida plans to submit an amendment to Florida's 1115 Managed Medical Assistance Waiver to the Centers for Medicare and Medicaid Services. The proposed amendment will extend the funding for the Low Income Pool for from July 1, 2015 to June 30, 2015. A full description of the proposed amendment is located on the Agency for Health Care Administrations (Agency) website at the following link:

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If you have any questions about this amendment or would like to hold a call please contact Heather Morrison of my staff via email at Heather.Morrison@ahca.myflorida.com or by phone at (850) 412-4034.

Sincerely,

/s/

Justin M. Senior
Deputy Secretary for Medicaid

Appendix B
Public Comments

Public Meeting, Orlando FL
April 29, 2015

Catherine Moffitt: Thank you, Sir. Thank you, Deputy Secretary. I am on the Medical chair Advisory Committee and I've been in attendance for the meeting, just so you know. And I represent the Florida Association of Health Plans. On a personal note, as a physician and a graduate of a Florida medical school, I just want to lend my strong endorsement to everything that you said. And I was a beneficiary of the Florida medical education system and I bear witness to the long standing and significant benefits of the medical education in the State of Florida so I'm a strong proponent as a member of this committee to the Agency's amendment for the LIP funding. On behalf of the Florida Association of Health Plans, just briefly, continuation of the LIP funding we believe is critical for access to care to all Floridians .The LIP funds allow many facilities and providers to continue to provide uncompensated care to some of Florida's most vulnerable citizens and participants in the state-wide Medicaid Managed Care program . We believe the LIP funding is mission critical to the sustainability and continuation of the program because it allows hospitals and providers to continue to offer richer provider networks for both the MMA program and to others that receive uncompensated care. So thank you for your efforts and we support this.

Jim Guth: Yeah, I'm sorry, my name is Jim Guth. My handwriting is poor, but I'm not a doctor. First of all I want to thank you for your opportunity to come and talk to us here. I appreciate the time that you have taken to do that. I will start off by telling you that I am a supporter of the LIP program and I would endorse what you're doing here. I am not a supporter of some of the strings that come attached from the Federal Government. And I have grave concerns over those and I would encourage you to consider that you are going to need a plan B. According to the newspapers, at least, we've been issued pretty much a threat that if we fail to expand Medicaid, the LIP program will not be renewed and if that's the case, I will assure you that in my discussions with the state legislature there's no appetite to let the LIP program fail or to leave that part of the population unsupported, but there is also not a particular good appetite to expend Medicaid.so I think you need to start looking at a plan B and maybe that is that Florida needs to take over the entire funding. It's a possibility that there's probably a plan C or D out there some place. I'm not in that mode, I'm not a professional in this category. But I will tell you that as we look and continue down this path, you can negotiate all day long with your federal counterparts, but I have a concern that in the long run we are going to run into a stone wall here. So I, for one, if that continues, am ready to throw my endorsement on Florida taking over the entire safety net if that's what' s required to do. And frankly I think we can do it and we can do it well.

Lois Adams: Thank you very much. I appreciate the opportunity. I have been a provider of healthcare for this state for at least 50 years, so I have seen Medicaid from the very beginning to where it is now. I have some concerns. When we talk about the other provider programs, they mention pharmaceutical services, expanding that to treat patients. I'd like to know what you mean by that. You know pharmacists are becoming closer and closer to being providers and recognized as providers for billing purposes, so I need to talk to you about that. But there's another segue, I don't know if that's a segue for this; however, we experience these low income patients on an ongoing basis with our cystic fibrosis programs. And some of those studies for -- take, you know, very, very intense complex illnesses. They do not get the medicine they need

because it's not on the state formulary, but on the plan formularies. It's on the national formulary, but not their particular one because it might be a little more expensive. But it's sure a lot less expensive than having them hospitalized. so this is just one of the things our girls in reimbursement stay on the phones on an ongoing basis to these plans and try to get things covered which should be covered because of the illness. So I think there really needs to take a really good look at some of these plans and how they are operating and where is this money going. Thank you.

Vonda Sexton: Welcome to the Lake Nona Medical City. We're the home of Nemours Children's Hospital just down the road. I'm Vonda Sexton. I'm Managing Director of Strategy and Business Development. And as all you know, Nemours is one of three free-standing children's hospitals in the State of Florida. I'm here to tell you today because Nemours and the children and families we serve are directly impacted by the changes in the Low Income Pool. Since we opened two-and-a-half years ago we have cared for children in 64 of the 67 counties in the State of Florida. The draw is our highly specialized programs. There are two pediatric interventional radiologists in the State of Florida and there are only 150 in the entire country. They practice at Nemours Children's Hospital. There is only one muscular dystrophy program in Central Florida. It is down the street here at Nemours. There only one surgeon that cares for intestinal failure program in the State of Florida and he is now in the operating room at Nemours. These programs and others I did not mention save and improve the lives of the Florida children and they are all in jeopardy. If the LIP program is not renewed or replaced prior to July 1st, Nemours Children's Hospital will be forced to cut $10 million from our budget. And there's no way for us to do this without creating significant hardship for Florida families. Families who already struggle. Many will be forced to leave the state for care, some may not be able to access care at all, and Nemours is not looking for a handout. More than half of the families we serve have insurance through Medicaid. Each interaction with a patient on insurance brings in far less than we spend on their care and only works because of the LIP program. It provides supplemental payments which reduces, but does not eliminate, the financial shortfalls of Medicaid. Even with the LIP program in 2014, Nemours Foundation provided over 111 million dollars in uncompensated care for children in the State of Florida. And some of you may not be aware that we built the Nemours Children's Hospital with not one penny of tax payer money. It was entirely paid by the Nemours Foundation. While failing to renew or replace the LIP program would create a financial hit for Nemours, it would really hit the families and the patients that we care for. Historically the state has seen helping children with complex diseases as their duty and as Floridians we have seen it as an obligation. The Nemours Foundation supports your efforts to amend Florida's 1115 Managed Medicaid Program and we are hopeful that redesigning elements of the LIP program will extend the program for years to come. Thank you.

Jeanette Schreiber: Good afternoon again. I'm Jeanette Schreiber and I'm with UCF, but I'm here to provide some public comments on behalf of the state-wide association, which is the Florida council of Medical School Deans. Florida is actually unique in having a state-wide organization that includes the leaders of all of our medical schools across the state, public and private, allopathic and osteopathic, all work together on matters of importance to all such as this one. I have to thank you for the comments that have already been made in support of Florida's medical education and that's why I'm here on behalf of the council. Florida Medical School Deans support this proposed amendment of AHCA to extend the Low Income Pool and that's because it's been mentioned it provides critical support to our medical schools as they both care for indigent patients and at the same time educate medical students and residents, our future physicians. So we urge CMS to adopt a transitional redesign of some sort for that continues the faculty position supplemental payments for at least the two-year duration of the 1115 waiver extension that's ongoing as part of the proposed amendment. Our nine accredited medical

schools across Florida and our faculty practice plans provide truly vital access to medical care for Florida's most vulnerable populations while training the next generation of doctors and that both our established medical schools, which have been doing this year after year after year and new medical schools like UCF here where we are just beginning our clinical programs that will provide further access for this population over time. These training programs which are actually considered essential provider Medicaid services under the managed care law, these services truly depend on continuing the supplemental funding that's part of the LIP program that will otherwise end June 30th of this year, just a few short months. The supplemental payments that have already been mentioned greatly enhance Florida's medical education program as well as providing us access to Medicaid, uninsured, and underinsured patients. And last year alone the faculty physicians and other providers through the medical schools provided over 2 million Medicaid patient encounters across the state. So while the medical schools and all of us work together on redesigning LIP and restructuring the programs, it really is vital that patients continue on a transitional manner to have this access to care. The medical schools have been part of this transition to Medicaid managed care that we've been involved in, but that has not in any way diminished the need for the supplemental funding for medical education, as well as for the continued access to care .our medical schools are and remain totally committed to working with AHCA and CMS to establish new programs and enhance the existing programs that we have in ways that will improve quality of care, that will improve the health of all the patients that we see and will ultimately reduce per capita costs. You may recognize that triple aim of health care transformation. Medical schools are all in. So let me just thank you again on behalf of the Council of Medical School Deans. Thank you to Deputy Secretary and AHCA for recognizing the critical need of these supplemental funds and for all that you do to serve this population. So thank you for allowing us to make these comments.

Bryan Campbell: Thank you for the opportunity to speak and thank you for taking forward this waiver. And the Duval Medical Society and the five medical societies that we support in Northeast Florida stand behind the proposed amendment as a temporary solution to provide health for those who need it in our community. As you know, UF Health Jacksonville is one of the largest recipients of the LIP funds, approximately 95 million is the budget amount. And CEO Russ Armistead has said that if those funds are not received, that UF Health Jacksonville will have to consider closing its doors in six months. UF Health Jacksonville is every year 1.2 million ambulatory visits, 90,000 emergency room visits, 40 percent of which are no pay, 35,000 admissions, 4,000 serious trauma cases. It is the only Trauma 1 hospital in the entire Northeast Florida Region and certainly if it were to close, the burden on the Northeast Florida medical community would be catastrophic. The impact is not limited to medical care. UF Health is one of Jacksonville’s largest employers and is the city’s largest employer of minorities. The hospital is home to 360 medical residencies. We’ve heard a lot about medical education today. The impact of losing these physicians would have a ripple effect on future doctors and the willingness and/or ability to take care of patients in Northeast Florida. And while we support the amendment to the LIP waiver request, we do have other concerns, as senate President Andy Gardiner, that AHCA must also submit a Medicaid expansion plan such as the FHIX as proposed by the Florida senate. The LIP funds by themselves as were put forth in the Navigant study last week are not adequate to fill the gap for health care in the uninsured and underinsured in Florida. Both of these solutions are required to adequately care for our patients. Thank you.

Andy Behrman: Thank you. Andy Behrman and I represent the Federally Qualified Health Centers through the Florida Association of Community Health Centers. And first we would also like to echo the comments thanking the agency, Justin and Liz, for the great work in putting this amendment together. We do have a few things that I think are important to make sure that CMS

hears and that is what exactly does it mean to the other providers in the system and what the LIP funding has done for that, so I want to give you a little bit of information about that. First of all, the community health centers in Florida last year saw just a little bit over 1.1 million patients of which over half of a million of those are uninsured. Since the life of LIP, I'll call it, over the last number of years, our uninsured population has grown by 39 percent. But the use of LIP funds have been instrumental in helping us to bring needed services to the communities that we serve and we do serve in every community in all counties except three. For example, dental encounters are up145 percent. These are numbers that are related to Low Income Pool funding that we've been able to utilize. Behavioral health services up 264 percent. We've doubled our work force. Again, a lot of this has to do with the funding that the Low Income Pool has provided to us. We have over 200 new locations around the state serving the uninsured population and most of that or a good portion of that has also been from LIP. And as Justin mentioned earlier, one of the key elements in this is keeping people out of the emergency rooms. A major focus of community health centers activities and a requirement actually that we have established for all of the FQACs in the state is that at some point or another you must develop an ER diversion program if it's possible in the community that you serve along with the local hospital. And I'm very happy to say that over the life of the program so far we've been able to establish 30 of those ER diversion programs. We would like to see more obviously on specific primary care related projects, certainly that's something that we are going to be putting in writing to the agency and see what that will yield. But we again are very grateful for the amendment to the waiver and support it fully. Thank you.

Scott Hopes: Thank you, Mr. Deputy Secretary. I join our partners from the University of Florida and University of South Florida with regards to, you know, our support for the actions that the Agency's taking. It's really only this year where our supplemental payments for the medical school faculty plans are in LIP. I wear a couple of hats. I'm on the Board of Trustees of the University of South Florida and also a graduate of UF Health some 30 plus years ago. But I think what is important for our Federal partners in this to understand is when the teaching faculty supplemental payments for Medicaid were rolled into LIP, it put us in this much larger basket. And with regards to our relationship with partners that benefit from the Low Income Pool, for instance in the Tampa Bay area, the University of South Florida, the USF Health system, which incorporates both nursing education, physicians, we have more than 500 faculty physicians, more than 600 residents, but we also train pharmacists, physical therapists, health educators. And we have a unique partnership in the Tampa Bay Area with Mr. Behrman's members and the Federally Qualified Health Centers where our students rotate through those Federally Qualified Health Centers in nursing, physical therapy, pharmacy, physician, you know, physicians in training. And we're dependent on their primary care network with regards to our relationship as both tertiary and quaternary partners and the ER diversion programs have been built through the Low Income Pool funding. And so that's independent of any Medicaid expansion. As you mentioned in your presentation, these types of innovations that are resulting in real savings to the Medicaid program as a whole are a result of being able to deploy those dollars in order to build new Federally Qualified Health Centers for our students to train in and to learn how to deliver comprehensive primary care in a health and medical home. And so I think it's important for the folks in Baltimore to understand how we have deployed these dollars in a way that far exceeds the traditional Medicaid program and indeed that's what these waivers are all about. Thank you.

Steve Harr: Thank you. Let me first of all thank you for coming to Orlando and allowing us to avoid the long arduous trek up to Tallahassee because that's a boring drive. Orlando Health is an organization of six hospitals located in central Florida. On an annual basis we treat 87,000 inpatient admissions, 25,000 short-stay admissions, and about 320,000 emergency department

visits. We're a statutory teaching hospital. We have approximately 260 residents and fellows. We have affiliations and support medical school, student rotations from the university of central Florida, Florida State University, and the University of Florida. We are a Level 1 Trauma Center. We have a Level 1 Trauma center for pediatrics at the Arnold Palmer Hospital. We also support adult trauma, Level 1 Trauma at Orlando Regional Medical center. We are a regional perinatal intensive care center. We have the largest neonatal intensive care unit in the country. And on an annual basis at the Arnold Palmer Medical center we'll deliver about14, 500 babies every year. The reason I should bore you with all these numbers is because 26 percent, one out of four of the patients we serve at Orlando Health are beneficiaries of the Medicaid program. 50 percent of those 14,500deliveries will be covered by the Medicaid program. We are truly a safety net provider and as such we are extremely dependent on the Low Income Pool program. Without renewal of the program, we stand to see a reduction in Medicaid reimbursement or reimbursement or funding to Orlando Health of about65 million dollars on an annual basis. As such we are totally supportive of the expansion of the Low Income Pool program. We applaud your work. And we would like to add the comment that failure to continue the Low Income Pool for Orlando Health will jeopardize our ability to continue to support our safety net mission .It will challenge our long-term financial sustainability and it will also increase the pressure that we are always facing to shift unreimbursed expenses to the private sector employers which will further aggregate the difficulty that employers are currently having supporting insurance for their employees and will further aggregate the uninsured in the State of Florida. So we support the extension of the Low Income Pool program. Thank you.

Mike Griffin: Thank you. I'm Mike Griffin, vice President of Public Affairs for Florida Hospital. Thank you so much for doing this today. Welcome to Orlando and my alma mater. Thanks. Florida Hospital is the largest -- one of the country's largest not-for-profit health care systems with 22 campuses serving communities throughout the state. Last year Florida Hospital provided $200 million in uncompensated care and received $90 million in LIP funds. We are the third --we are the second largest Medicaid provider in the State of Florida. Our interest is in creating a sustainable healthcare system that significantly reduces Florida's uninsured rate, currently the fourth highest in the nation. The Low Income Pool as we see it really only maintains the current situation in which the uninsured often must go to emergency rooms for medical care. The LIP program should be renewed. It's vital that it is renewed. But as a bridge that moves us closer to the goal of enrolling the uninsured in real insurance plans. Far from being a broken system, Florida's Medicaid Managed care Program has been praised as a national model largely to the work of your organization for cost control and quality care. Transitioning 800,000 uninsured Floridians into managed care would give them affordable access to checkups, preventative treatment, health screenings, medications, and management of chronic conditions. Replacing emergency treatment with such comprehensive care will improve enrollee health, create a financial stability in the health care marketplace, reduce costs for uninsured patients, save state and local dollars spent on the uninsured, and we believe reduce the need for LIP. We support the position of Florida senate and CMS that the LIP program should be combined with an expansion of Florida's Managed Care Program to create a more holistic solution to the problem of the uninsured. Again, thank you very much for the opportunity. We'll have written comments also that we'll submit to CMS as well. Thank you.

Maria McCorkle: Good afternoon and thank you for the opportunity to be here. I don't represent a hospital. I don't represent an insurance plan. Who I do represent is almost-two-year-old Anna McCorkle and almost four-year-old Connor McCorkle, two children right here in central Florida who are critically ill. And we don't stand to face disruption if this program is not continued, we stand to face devastation. Simply because hospitals like the Nemours have given my family hope, they've given my family answers, and they've given my family a future. Connor and Anna

are like most children their age. They don't want to take naps, they enjoy fighting with each other, and they love playing outside. But unlike other children their age, my children do not run, my children do not jump, my children can't climb stairs, my children cannot dress or feed themselves simply because they inherited a muscular dystrophy from me, their mother, a dominantly inherited one that is so rare that there are really no specialists on it except for one. A super hero right there at Nemours named Richard Finkel who gave my family answers when prior to him arriving here, no one could tell us what was wrong with my son or even if he would survive his childhood. And when you're a parent, when you're told they don't know if your son is going to make it to his teenage years, it's a devastating diagnosis without even having a diagnosis. To be told that your unborn child may have the same disease. How do you live like that when you don't have doctors that can give you the answers? When Nemours came into our lives, it was a miracle in every way a miracle can be. And that's why I have to stand here today as a parent, as the proud wife of a firefighter who would be here today if he wasn't on shift, to tell you that this program needs to be continued. This amendment needs to be adopted. And the critically ill children in central Florida need facilities like Nemours to continue to bring in the experts we desperately need so that parents like me can give answers to their children. Thank you for the opportunity to just share my story and the story of my two children and please remember that my children, it's not their fault that they're sick. They are not a burden, they are not political pawns, but they are the future of this great state and this great country. Thank you.

Jim Callahan: Yes. I just received short notice of this meeting a few hours ago and so I haven't had time to get back to the organizations I work with to be authorized to speak on their behalf, so I'm speaking on my own behalf. I support the Affordable Care Act and my understanding from Amy Baker's presentation for the Florida Economic and Demographic Research Committee of the Florida House - Florida Legislature, that there will be a gap even if the Senate plan is passed. And I believe some other speakers have referenced that. And the people I work with and myself support universal health care and so if we need both programs to cover everybody, we need both programs. I think I'll just limit my remarks to that.

Public Meeting, Miami FL
April 30, 2015

Mr. Wake: Hi, my name is Anita Wake. I'm representing All Children's Hospital, John Hopkins Medicine in St. Petersburg, Florida. I first just want to take a moment to thank AHCA and Jackson, and Secretary Dudek for their leadership on this issue. As one of only three specialty licensed children's hospitals in Florida the -- like all Children's, are very unique. We are completely and fully dedicated to the health and well-being of children, and we are the state's highest Medicaid provider, with seventy percent of our patients benefiting from Medicaid. We treat Florida's sickest children, and we're devoted to providing these services despite the fact that Medicaid reimbursements often do not cover the cost of our care. We understand that the future of the low-income pool program is unknown right now, but the loss of those dollars would put into jeopardy over 55 million dollars that All Children's currently receives from the program. We're very much looking forward to the ongoing discussion to resolve this issue, and hope that the ultimate model keeps in mind the unique challenges of specialty licensed children's hospitals like All Children's. Thank you.

Ms. Bishop: Yes, I have a question about a statement. Isn't it a fact that the LIP program was a pilot program that was being explored by Agency for Healthcare Administration? And if so, it's such a program that would benefit a lot of citizens of the state of Florida, knowing the strife that is going on between AHCA, the Governor-- and the Obama administration, the Affordable Care Act, a.k.a Obamacare—I would have thought that AHCA should have put in some sort of Plan B

so that the citizens of the state of Florida would not be hanging, not knowing what's going to happen come July 1st.It is a program that could benefit a lot of people, and now we just don't know what's gonna happen. The Florida Legislatures-- without being, you know, finished with the issues, and I just feel that it's (unintelligible) a pilot program. Like most pilot programs, you don't know for sure that it's gonna be continued to be funded. We, as the state, should have been looking at a Plan B. And another question is would expanding the affordable care act, a.k.a Obamacare, help alleviate some of these problems that we're gonna have? Because we're going to have to expand the affordable care act in the state of Florida to cover the needs of the residents in that (unintelligible).And I just wanted to say also I am administrator. You didn't mention anything as it relates to waiver, but they too fall under the 1116 waiver, and there's gonna be a lot of senior citizens that are low-income that may be displaced because the funding will not be there to take care of them. So that's my point, and I could just hope for the benefit of the citizens of the State of Florida that this matter quickly resolve by CMS, AHCA, and the governor. And that's my comment, thank you.

Ms. Abrish: My name is Carol Abrish, and I have a specific question regarding the LIP payments that they come across on the back page of the agreement as non-specific. We have several facilities that get paid for specific accounts through this program, and I'm wondering how the facility is supposed to reconcile when no account and facility information is provided on that bulk check amount.

Dr. Lubarksy: Thank you, Justin, Iappreciate that. Hi, my name is Dave Lubarsky.
I am the Chief Medical Officer at the University of Miami Health System, and I'm here on behalf of the Council if Florida's Medical School Deans. The council includes the leaders of Florida's nine public and private osteopathic and allopathic medical schools. The council provides unprecedented levels of collaboration and cooperation among Florida's medical schools on topics of mutual interest, and is truly unique in the nation. Florida's Medical School Deans support Florida's Agency for Healthcare Administration's request to extend Florida's low- income pool program, or similar program beyond June 30, 2015. We urge the centers for Medicare and Medicaid services to adopt a transitional redesign of LIP that continues faculty positions, supplemental payments for the two year duration of the 1115waiver extension period as included in the proposed amendment to Florida's managed medical assistance program waiver. Our nine accredited medical schools and their faculty practice plans provide access to vital medical care for vulnerable populations while training the next generation of physicians. Florida's medical schools are considered statewide essential providers of Medicaid services. These physician training and patient care services depend on the continuation of critical supplement funding for teaching faculty beyond June 30, 2015. The Medicaid supplemental faculty physician payments have greatly enhanced Florida's graduate medical education, and provided much needed access to physician and health practitioner services for the state's Medicaid, uninsured, and under insured populations. Last year faculty physicians, resident physicians, and health care practitioners from Florida's medical schools provided over two million patient encounters for the Medicaid program. While all of Florida's medical schools work with AHCA and CMS on innovations and restructuring of these programs, it is vital that patients continue to have access to care during the transition period. The graduate medical education responsibilities of Florida medical schools and the access need for patients have not diminished at all during the state wide Medicaid managed care implementation. Our medical schools will continue to work with ACA to establish new and enhance existing programs with innovations that meaningfully improve the quality of care and health of low-income persons, expand access, and reduce per capita costs. The Council of Florida's Medical School Deans is committed to working with AHCA and CMS on behalf of our faculty physicians, clinicians, medical students, resident physicians, and most importantly the patients we serve to help ensure the promise of a

statewide transformation and restructuring of the Medicaid program to achieve the triple aim of better care, better health, and lower costs. So that's the message on behalf of the Council of Florida Medical School Deans. And I'm gonna just add one word as a practicing physician at the University of Miami where I take care of Medicaid patients, and the ability to keep our doors open with unlimited access to everybody regardless of what insurance carrier they have, and our commitment to community service at the University of Miami depends on the continuation of this LIP program, and we really need this in order to serve the people that we care about. Thank you very much.

Dr. Davis: Thank you, Justin. I appreciate the opportunity to comment today by making the trip down here. We appreciate the efforts by the Agency to involve us favorably with the Center for Medical Healthcare Services. I am Scott Davis, with Memorial Healthcare System South Broward Hospital District. The low-income pool for us is about 100 million dollars a year. It's real money. It adds up fast, and the loss of that money doesn't make the patients any healthier. They still come to the ERs, they'll come to our hospital. We still have to take care of them and cover that cost somehow so it, it's very helpful to see that the Agency understands that expansion is not an adequate solution to a problem, uncompensated care still exists well beyond that, and the amount of uncompensated care that we incur even after the low-income pool dollars is still significant. The audits that we're going through right now with the Agency's contractors on the dish limits and such are still showing a-- a significant uncompensated care amount that still remains. We were hopeful at one point that there would be an expansion beyond the 2.1 million--2.1 billion dollars. We understand the realities of federal budgeting and the limits that we face there, so we're hopeful that the negotiations come to a favorable solution. One aspect of CMS's response to the Agency's proposal that I haven't seen addressed that perhaps we might be able to address in a fashion is that the low-income pool isn't really an uncompensated care pool, not like what other states have that is truly limited to uncompensated care. We wrote into the—the special terms and conditions, that the purpose of the low- income pool is to provide coverage to the uninsured and under insured. So while that coverage determination is rather uniquely determined in Florida compared to other states, it is a separate Medicaid eligibility group, it's a separate cadre of eligible individuals after a fashion based on the kinds of reports that we turn into the state, and perhaps CMS could look at that as another way of slicing these dollars that is not just given back to those who are putting up the funds but is giving back to those who are providing the services. Thank you.

Dr. Sanadi: Thank you, Mr. Senior. Thank you for holding the hearings. Nabil El Sanadi, President and CEO of Broward Health. I'm also a practicing emergency physician. We are responsible for about 1.3 million people north of (unintelligible) Road, south, south of the Hillsboro line. It is a taxing district. We have about fifteen hundred beds between four hospitals, and other access points for Medicaid patients. Thirty percent of the patients that come to us are Medicaid patients. We depend on over 107 million dollars' worth of LIP funding. Without that funding, we will continue to keep our doors open. The emergency departments that see over three hundred thousand patients will continue to see those patients, in care, in-patient facilities, which include about a hundred and sixty seven pediatric beds, we have a level two NICU and a level three NICU set of facilities so we are dependent for children as far as those points. So with that, we are also a statutory teaching hospital system, we have over a hundred residents. We have over nine teaching programs. We have an affiliation with three medical schools, so for the teaching programs we are also dependent on those funds. With that we will continue to keep our doors open. We will do the acute care as far a sin-patient care. The post-acute care, physical therapy, occupational therapy, and other preventative measures may actually suffer, and as a practicing emergency physician the additional unintended consequences, or the ripple effect of not funding FQAs or poison control centers will increase the volume of business in the

emergency department so we're keenly aware of how important this is. We appreciate all your hard work. We thank you for giving that explanation as far as detail. We encourage you to continue to push, and whatever we need to support your initiatives as far as the federal program, we will do that. I also have additional comments on this. I have a card for the court reporter.

Dr. Migoya: Thank you for allowing us to speak here today, Justin. I am Carlos Migoya, President and CEO of Jackson Health System. I'm also the current Chairman of the Safety Net Hospitals for the State of Florida, and I'm here directly speaking on behalf of Jackson, but I can tell you that also the safety net hospitals in the entire state support the current plan that we have today. On behalf of the taxpayer owners of Jackson Health System, we support the LIP replacement model submitted to the federal center of Medicare, Medicaid, CMS by AHCA, and believe that the proposal provides sound steps toward the next generation of low-income patient access and care financing models. The proposal recognizes that disproportionate volume of patient care provided by safety net hospitals while addressing federal CMS policies. Jackson Health System would lose approximately 200million dollars if the current LIP model is repealed without an appropriate replacement. This would not only wipe out the surpluses that Jackson is reinvesting in its programs for Miami-Dade residents, it would leave a huge hole of more than 185 million dollars parenting key services and centers of excellence. Jackson already spends far more than—on uncompensated care than it receives in local tax funding. Jackson is also Florida's largest provider of Medicaid care, funding more than four out of every ten patients at Jackson. Since Medicaid only reimburses less than half of the actual cost, Jackson will be forced to eliminate and reduce programs and services if LIP is not renewed or replaced. We support the total level funding request of 2.1 billion dollars approximately in state, local, and federal funds, and we also support increasing the DRG pediatric reimbursements from sixty to eighty percent, which helps offset losses incurred when caring for children whose treatment exceed sixty thousand dollars and severe levels of three and four treatment and care. We support long, long term sustainable solutions to funding high quality of care for the uninsured and underinsured, which are key elements of a strong community that attracts businesses and families. We also support the growth and strength of one of the country's strongest academic medical partnerships, between Jackson and the University of Miami. This partnership not only brings world class medical care to our community, it feeds our economic health. The vast majority of physicians live and do business near where they complete their graduate medical education. Jackson today has approximately eleven hundred physicians in training. In addition to that Jackson is, as you know, the largest provider of IGT funding in the states. This year's funding approximately 409 million dollars in intergovernmental transfers, which is approximately forty three percent of the overall IGT transfers. And based on that, on that funding, we also support the consolidated IGT pool that's being recommended, as well and incentivizing and protecting those contributors of IGT monies. And also addressing the new LIP cost cap policies where hospitals whose IGTs are used to subsidize the state wide Medicaid managed care capitation rate should all receive an exception from their cost cap equivalent to the amount of the IGT. So thank you again on behalf of Jackson Health System, and as well as the Safety Net Hospitals, thank you.

Mr. Harmatz: Thank you. First of all thank you, Justin. I can't imagine how tired you are. I do. You're -- you're hanging in there, and we really appreciate your leadership in, in trying to do the best thing for everybody in a difficult situation. I had a—a few comments, or questions, and I don't know if you're able to respond now, but is this IGT amount going to be approximately the same under the proposal as it currently is? Okay. I think the – the most critical thing, and I think, you know, the people in this room understand it as well because it's been really well covered in the local press, is that even if we had doubled the LIP, it is nowhere near enough to cover the

cost of caring for the uninsured in Miami-Dade County, or statewide. Miami-Dade of course has most of the state's uninsured, and even though we are very fortunate here to have a—an exceptionally strong safety net, and a publicly funded hospital, they -- Jackson only, its maturity care program there covers less than twenty percent of people who would be eligible for coverage if the state accepted federal funding under the ACA. And -- and with that --and there are constraints because the only get a certain amount of dollars, but it's a--it is a block grant so to speak as opposed to an entitlement, so if, you know, currently the program--the safety net can--covers about twenty percent, and even for those people care is often extremely difficult to access because there are co- pays of specialty care $40,and in-patient, our out-patient procedure $100,so people below a hundred percent of poverty, or a hundred and thirty eight percent, simply can't afford it, and that is really, you know, a problem. And if you think that we, you know, we have an accessible safety net that can really serve the underinsured with LIP, and again you can double, or triple or quadruple LIP, is a myth, and that we certainly need, as you said in your--in your comments, and I apologize being late, but I was listening to it -- there will, of course, be people who are gonna remain uninsured even with expansion, and there needs to be some kind of funding mechanism to make ensure that the safety nets that have, like Jackson-- that have made a commitment to care of everybody in the community regardless of national origin, be, you know, sustaining and, and supportive, but you would have to keep coming back. And because now this is really before the citizens of the state and the Legislature to use this opportunity to open the dialogue again to keeping both LIP and the Medicaid expansion, because that is the only way we're gonna have any kind of rational hope of dealing with the problem of the uninsured.

Ms. Russell: Thank you, Justin, and thank you to the Agency for -- on behalf of all Floridians. I appreciate the opportunity to address you today. I represent Chamber South, the Chamber of Commerce for Greater South Miami-Dade, South Miami, Pinecrest, Palmetto Bay, Cutler Bay, Perrine, Cutler Ridge (unintelligible) Tamiami Trail. We represent thousands of employees and their families, and they need the safety net that Jackson provides, as well as CHI. I have numbers of my Board who unanimously support the Medicaid expansion. The entire Board unanimously supported the Medical expansion, and they were from for profit hospitals, not for profit hospitals, and safety net providers across South Dade. That's our service area. I wanted specifically to say that we support the total funding level request of 2 plus billion dollars. The long term sustainable solution is to find funding, high quality care of the uninsured and under insured. I've seen it first hand as the Mayor of a small town—former Mayor of a small town. The needs are so great, and access to the services are so difficult and so challenging for some of these families, and it continues to cause the cycles of poverty to repeat. If we cannot provide good healthcare to children and young adults, and the elderly, there's no one to care for the little children, and there's no chance they can get a good education, and it just creates something that's a cycle that we need to see end. We support long term, sustainable solutions to funding high quality care for the uninsured and underinsured. There are key elements of a strong community, and a strong economic community as well. It was mentioned earlier that so many physicians live and work near where they trained, or they relocate here because it's so beautiful. My father is a retired doctor and has stayed in Florida, and they invest a great deal of money in our local economy, so the economic benefit to the rest of the people that aren't benefiting from this safety net funding is--is tremendous. There's a huge economic impact. So there's a human impact and an economic impact. We support -- we also support the strength and growth of one of the country's strongest academic medical partnerships with Jackson and the University of Miami. What they're doing, and continue to do for the residents of South Dade where we live is, is remarkable. And that is all I have to say, thank you.

Ms. Ferro: Nice to see you in Miami, Justin, and not Tallahassee. My name is Lani Ferro, and I am the director of Governmental Affairs for Miami Children's Health System, and I'm going to echo some of the comments made by our colleagues at All Children's. Florida's three specialty licensed children's hospitals will lose approximately 117 million dollars towards care of Florida's most vulnerable population of children if the, the low-income pool program is not extended. Nicklaus Children's Hospital, a part of Miami Children's Health System, treats many of Florida's most critically ill children, providing access to high quality specialty care for those who come to us from all sixty seven counties, and we're dedicated to providing care for children regardless of their ability to pay. The loss of 52 million dollars to Nicklaus Children's Hospital will provide a devastating financial impact to our organization, equating to a significant overall loss in reimbursement. Specialty licensed children's hospitals face unique challenges, as approximately seventy percent of our patients receive health insurance coverage from Medicaid and other government sponsored programs. And while negotiations have resulted in discussion about the future of Florida's Medicaid System, the funding provide by the low-income pool program is utilized for purposes completely separate for those prescribed in Medicaid expansion. In working with your fantastic team, we were advised that eight hundred and seventy thousand new lives will be eligible for Medicaid coverage under Medicaid expansion. However, for the population under eighteen years of age, there will be no new eligible lives, and so specialty licensed children's hospitals would not receive an increase in Medicaid patients, or dollars to offset the loss of low-income pool dollars. Ultimately, the cost of uncompensated care will continue to create challenges for us. Such a large loss would require us to analyze our most expensive programs, statewide referral centers, and possibly jeopardize access to specialty pediatric care and programs unique to Nicklaus Children's Hospital. So we support modification of the current model to direct LIP funds into reimburse rates and policy based methodologies. We support restructured hospital distribution to continue to encourage access. We support the continuation of graduate medical education dollars used through that pool. As the largest pediatric graduate medical education provider in Florida, it's-- it is a huge, huge deal for us. We support a consolidated IGT pool, and a transition period that will ensure no gaps in access. And thank you so much to your team for all the great work, and for always representing the children's hospitals. We appreciate that.

Ms. Baker: Martha Baker. I'm an RN at Jackson Health system, and President of our healthcare union, and partners with the, the leadership team at Jackson to get a largest safety net hospital turned around and sustainable. Obviously we're very dependent on that 200 million dollars, the LIP dollars that Mr. Migoya talked about, certainly speaking in favor of the redesigning to maintain that dollars available to our safety net hospitals, especially Jackson. And while we've struggled through the last four or five years with redesign and restructure and sustainability, the next decade is crucial that those safety net dollars, you know, come to us to fulfill our mission and maintain the open doors. And again, we just-- we look forward to, in your presentation the healthcare reform not only in this state, but in this country, but al so that we accomplish your criteria of quality outcomes, shifting people from ERs to primary care, and I think Jackson has on its strategic plan for the next decade to do nearly everything in your-- in your program that-- that you point those dollars towards. And we look forward to continuing receiving those dollars and really reforming Jackson to be a leader again in this state, in this country, so thank you.

Mr. Kearns: I meant to check it. Thank you, Justin. Kevin Kearns, CEO of Prestige Health Choice, a managed care company in Florida, and I'm representing Prestige and our partner community health centers here to voice strong support for the LIP proposal that's gone up to CMS. Having served on a LIP Council fora number of years, I certainly recognized it was temporary. I certain recognized it was imperfect, but I also understood it's critical. It's critical to the healthcare access in this state. It's been critical for many years now, and particularly this

year. I hope this gets to CMS. Particularly this year, I think it's critical we continue the funding. Tomorrow marks the one year anniversary of the beginning of the statewide Medicaid managed care program that you alluded to earlier. You hear a lot of talk about Medicaid and the challenges with Medicaid. This is not the same Medicaid system of a year ago, or two years ago, or five years ago. This is a brand new Medicaid system with unprecedented accountability and controls, and a focus on quality, but part of that is we need to make sure we have the LIP program in place to do it, so of all years to do away with LIP,I would say this is not the year to do it. This is such an important year to make sure that this historic transformation in Florida continues. We recognize at Prestige how important the LIP program is to our partners over at Jackson, to our community health center partners, and they are an integral part of what we're able to do that keeps the health care system alive in--in Florida, and this would be a major, major challenge if we had to go without LIP dollars. So again, I thank you for the opportunity, and I just want to voice our strong support for the proposal that you've submitted up to CMS. Thank you.

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Ms. Jernigan: Hi. I am Lisa Jernigan. I am from the Tallahassee Memorial Family Medicine Residency Program, I am the Associate Director there. We interact with the LIP funding pool in many different ways. One of the most important steps we interact with is in the provision of prenatal care and working out in the counties, with counties health departments, who has become largely dependent on the funding since shared Medicaid went away. If LIP goes away, I am dreadfully afraid that the infrastructure in the local health departments will also, for all intent and purposes disappear. And in some counties there would be places open every day where they can go for any kind of prenatal concern. We have to have a certain amount of infrastructure there to provide in service, and that has been dramatically reduced over the last few years, and I'm very concerned that it will go away entirely. We have had many near misses where we picked up things just in time out there and these women will not find their way to Tallahassee for care. We work in five counties around here and it would be dreadful. The other thing we fund here in Tallahassee is the transitional care center at Tallahassee Memorial Hospital which takes people who have just been hospitalized and provides them a place to go if they have no primary care at home. This is a very inventive program that is being copied all over the country which would dramatically reduce the rates. Without the funding that is threatened. We also have a therapeutic lifestyle change research and treatment program at our program that is getting very good results, and again, set to nation or statewide having been funded via LIP. Also as we talked about, the Emergency Room funds, critical access funds. So I would strongly recommend that this be continued and strengthened as much as it possibly can be for those issues at hand.

Ms. Zeiler: Happy Friday. Thank you, Karen Zeiler from the Florida Hospital Association. I appreciate the opportunity to be here with you all today to comment. We represent over 200 hospitals and health systems throughout the state of Florida. Florida hospitals are on the front lines of care. They are open 24 hours a day, seven days a week, 365 days a year. We serve all patient regardless of their ability to pay. We are an economic driver in the community. We are a large employer and employ many, over hundreds and thousands of individuals throughout the state of Florida. And we approve access for all Floridians from newborns to seniors. We appreciate this opportunity. We, as you mentioned, Justin, the February Navigant study did show that with the loss of the Low Income Pool rates would be inadequate for Florida's hospitals. So we think, we appreciate the fact that you have put in for a request of $2.2 billion dollars. We have also reviewed the CMS correspondence that came out a couple of weeks ago where they provided guiding principles for how they would be reviewing the supplemental

funding. Those included re-coverage rather than uncompensated care pools are the best way to secure access. Medicaid payments should support services to Medicaid beneficiaries and low income individuals. Provider payment rates must be sufficient and transition can ease the process of reducing Low Income Pool as states make the transition to broader coverage. As you mentioned in your presentation, this amendment does not include changing eligibility or coverage or expanding that coverage. And with the first point from CMS being coverage rather than uncompensated care pools are the best way to secure access. We would support the inclusion of that. In addition, those provider payment rates must be sufficient. We are hopeful that you will include the increase in the base rate. I know you had the attachment of the Senate sustainability model as part of the sufficient. So we are hopeful that you will include that base rate increase as well. And last, where it says transition to meet the process of reducing Low Income Pool it states make transition, again, when CMS provided the special terms and conditions that we are currently operating under, they said they would do a one year extension, and we believe that extending coverage could help as we move towards broader reforms. The Florida Hospital Association supports the expansion of coverage to over a million Floridians. We support at a minimum the current level of $2.1billion dollars in supplemental funding, ensuring basic sufficiency of payment rates for all hospitals, prioritizing supplemental funding for those who need it most. Reducing the burden on transferring hospitals and funding the Florida Medicaid program and improving transparency, equity and predictability of supplemental funding. We will submit these comments in writing as well, and we appreciate it and look forward to working with you. Thank you.

Mr. Arons: Thank you. And good afternoon. Thank you, Mr. Senior, for having these hearings. My name is Paul Arons. I'm a retired physician in Tallahassee. Prior to my retirement, I was Board certified in practice for a number of health care and health departments of both Alachua County and Leon County, and for 18 years I was the Medical Director of the HIV AIDS program for the state of Florida. So my focus is on primary care and health. The first thing I want to do is just talk about one of the slides that was in Mr. Senior's presentation. Slide number 15 on page 8, and it is the pie chart. I just want to - it says in the fine print, rates that are reflected in this chart are representational only. My understanding is that if we were to expand Medicaid or some form of expanding the coverage to draw down the Federal dollars of the Affordable Care Act, that would equal approximately $5 million dollars a year and that what we are requesting in the LIP program is $2 billion. So I would just respectfully say that the pieces of the pie are reversed on this chart. And if you use it going forward I would suggest that the section in blue would represent LIP and then the section in red really represents the expansion. Primarily what I wanted to point out and what I point out in making that mark is that really there is no difference between the Low Income Pool and expanding health care coverage. It is not standard additional Medicaid, some form of expansion such as the Senate fix plan. I just wanted to read one sentence from the letter that CMS sent to Medicaid on April 14. It says 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 the Medicaid expansion. That is exactly why I believe that these two issues are completely linked, and that I hope that Medicaid would reconsider that at least, that you would entertain the idea of including expansion of health care coverage rather than taking it off the table in this application for LIP. As you point out, neither one of these is sufficient, but together as with the pie chart that you have, there would be such a great step forward. The estimates are that up to a billion would be used to cover, no health care coverage would be covered by expansion and that would take some of the pressure off the LIP fund. So I just want to reemphasize that that attitude on the part of CMS that these dollars should pay for what the dollars are intended to do. It is not coerce that has been interpreted by the State government. It is just common sense, it is fact. And there are apparently 55 billion of our taxpayer dollars that

would be accessible to be drawn down back to the state of Florida cover people with health care, which we are simply forfeiting by letting them go to other states. In conclusion I just want to say I've seen the Governor speak on a number of occasions. He has a very can do attitude about tracking assistances and jobs for the state of Florida. And so I think any issues about whether there would be enough health care providers under expanded health care coverage to serve the population that needs care, I think that same attitude could be applied, and if you build it they will come. So just want to urge and plea with you to include both of these elements in the plans that are being considered for the Low Income Pool and for covering the million people that need coverage. Thank you very much.

Mr. Carvalho: I know it is a challenge here, but I will try to do my best. Thank you, Deputy Senior for the opportunity to speak. I'm going to segment my comments into in three major areas, rates, consequences and equity. But I want to make some initiate comments. One is I want to compliment the Agency for their LIP reform model. I think it addresses many of the CMS concerns. I think it protects safety net providers, and I think it's fair to all providers. Sorry. I apologize. Okay. I would want to make a few comments that I want to ask the audience's patience, but before I get into the areas on rates, consequences and equities, it is important to note that the reform model includes some of the existing parameters that are in the current LIP model. And the Navigant report was a very good and thorough reform, and I believe that a number of comments within the Navigant report really didn't receive the attention they should have, and if you would bear with me I am going to read a very short, two short comments from the Navigant report to ensure they are in record for CMS to review. During the interview, and this is a quote, "During the interviews various stakeholders while researching this report we learned there is a concern about lack of transparency available within the current Florida Medicaid hospital funding and payment mechanism. Our conclusion in contrast is that documentation on the program is readily available in play". That is the first comment I wanted to emphasize. The second one in another section of the report is that although a 104 hospitals that contributed ITTs have received ITT payments in fiscal year 2012and '13, compromised only 40 percent of the in state hospitals. They account for 77 percent of the Medicaid business for state fiscal year '12/'13. Thus payments are better for providers who do a significant amount of Medicaid business. This is consistant with the State's goals stated in the State fiscal year 2015, 1115 demonstration waiver. The State will continue to foster and protect the safety net hospitals. Now they get paid 120. And then the last comment I want to make of the Navigant report will be a segue into my rate discussion. There's been there's been a lot of debate over the amount of uninsured that would be covered or not covered by the LIP program related to expansion. But the fact of the matter is that the LIP program really does not primarily supports Medicaid rates for patients who are in the non-expansion population. This is a permissible expenditure. If you can find it under the special term and conditions in the 1115 Waiver 93 which basically says the primary purpose for the LIP program is to fund the uninsured, under-insured and the cost of Medicaid. So the fact that a majority of our Medicaid program or our LIP program funds and subsidizes the basic Medicaid program is not contrary to the current terms, the special terms and conditions. Obviously the Federal government, CMS is asking for some changes. They are asking for different accountability and they are asking that we ensure that none of the dollars are used for the expansion population. But I just wanted to point out and emphasize that the way the LIP program has been managed and implemented by the Legislature and the Agency up until now is well within the terms and conditions available or provided. Let's talk about rates for a minute. The next three sections, rates, consequences and equity we would encourage CMS to include or to look at closely when they consider the efficacy of the Agency model that they are submitting. In rates, in demonstration year one, 2005/'06, which was the funds that supported Medicaid hospital rates was much lower than it is today. In fact it was $468 million dollars. In demonstration year nine, so nine years later in '14/'15, the

amount of dollars that are LIP related or have a basis in the cost of providing Medicaid, some of this has been moved to the expanded LIP program, but the basis for this reimbursement, is the cost basis of providing care to the Medicaid population is $1.7 billion dollars. So we have gone from $468 million to $1.7 billion dollars. Now, I'm not saying this to vilify anybody, but because some people and particularly this out of context of just looking at the beginning year and the next year, it might look like it state of Florida is abusing the LIP program and using it to subsidize the Medicaid program. What happened in the first year of the LIP program is the great depression began. The Legislature and the Executive Branch and the Federal government worked very hard to prevent crisis in government. They provided an extra supplemental match for the Medicaid program, and what happened we were, the hospitals safety nets worked with the Legislature and the Executive Branch to manage a billion dollars of rake ups over the recessionary period to ensure that Medicaid payments were sufficient to allow access to providers - patients to have access to providers. The State cut a billion dollars and we worked with that because they were struggling to ensure a balanced budget that met the needs of the state of Florida in the worse recession that we have seen in 100 years. We did that primarily with ITTs and that is why we have seen the support, the subsidy in the LIP program go from $468 million to $1.7 billion dollars. Let's take a picture of rates where we are today, because obviously we're talking about a new LIP program and how that would affect rates. The Navigant report said without LIP the cost of pay ratio is 79 percent for the pay to cost ratio, whatever quarter that goes, but that is really misleading as a correct number and I don't think they did it in intentionally, but when they say without LIP they didn't include the consequences of losing LIP with regards to ITTs that are put into the line items of the hospital inpatient and outpatient categories. In fact, if you -- if LIP was eliminated the cost to pay ration would drop to 48 percent. And what does that mean? That means that the state sponsored rate, the general revenue, and by the way the hospital tax of $500 billion dollars is treated as general revenue, counting all of that and the Federal share that is drawn down, would only pay 48 percent of the cost of providing Medicare care, hospital Medicare pay. That is a significant problem. I think it would be fair to say and Navigant has pointed out that we would have a naturally unsound system if that happened, and I guess without preaching on doom I am mentioning this because I feel it is very important for the Federal government to realize how we got where we are, and that this model, this reform model takes a gigantic step towards getting those subsidized rates back to where they need to be. In fact, it reduces the amount off ITTs that are used to subsidize rates by $516 million dollars. But it does it in a way that doesn't hurt safety net providers and we commend the Agency for doing that and we hope that the Federal government takes a very close look at that transition. We cannot move a billion dollars of cuts out of the LIP program overnight, but I think this is a very good start. A few comments about consequences. Let's take a worst-case scenario and then you can divide it by half and it is still a pretty bad scenario. If LIP were to go away and if it was sun-setted without replacement, I am the President of the Safety Net Hospital Alliance of Florida. Our Alliance represents a large teaching, the statutory teaching, the large public and the children's hospitals of this state. If LIP were to go away, there has been a lot of discussion about margins. Our margin collectively for our hospitals is 3.8 percent. If LIP goes away and is not replaced our margin goes into the red collectively 5.05 percent. What does that mean? What is the consequences of that? Well, I want to just give you a couple of examples and hopefully a couple of examples for CMS to consider, not that they've said they are not going to approve any LIP, but just to see what consequences would be on Florida. The fourth largest teaching hospitals in this state, Jackson Memorial, Tampa General, the University of Florida at Shands and University of Florida at Jacksonville hospitals provide nearly 40, between 40 and 50 percent of the total residencies that are trained in this state. The safety net hospitals just released a study showing that in the next 10 years probably the largest health crisis we're going to face in this state is a shortage of doctors, and we need every resident program, every resident slot we can get. Those four hospitals provide 1,530 resident slots in probably 50 different disciplines. If

LIP goes away and there is no replacement they lose collectively $742 million dollars. Now, I can't make -- I can't tell you with absolute certainty today that if $742 million dollars is taken out of their bottom line that they're going to cut residency programs, but you know what, they're not going to turn away people in their trauma centers who are critically ill and possibly near death. These are programs that they will have to consider cutting. And many others, and many other very important programs to the community life, refuge centers, life trauma centers. Another example and the last one of consequences, and there is many, I could go on for a while and I know you don't want me to, the children's hospitals. The children's hospitals are disproportionately affected by Medicaid because nearly 60 to 70 percent, depending on which children's hospitals you are talking is their payor mix is Medicaid because children qualify for Medicaid at the much higher level than the adult population. So they are much more reliant on Medicaid. The 14 hospitals, children's hospitals that provide 90 percent of the pediatric neonatal care in the severity levels of three and four. So we're talking about the really, really sick neonates and the really, really sick pediatric patients. They provide, these 14 hospitals provide 90 percent of that care. If LIP goes away they would be cut by $354 million dollars. This would be catastrophic and I think everybody I hope that all levels government and providers realize that. Lastly, in closing I want to talk about equity. And this I feel very passionate about. I think CMS has been very flexible over the years in working with our LIP program. We really appreciated them working through the transition last year with the leadership of AHCA to find a way to expand LIP for $1.9 billion dollars, but I believe equity is an incredibly important factor that CMS needs to consider when they start to address what is the right LIP level for Florida. Let me give you some examples. In the disproportionate share program, Florida ranks 43rd. Now Medicaid disproportionate share is similar to LIP, it is not a question here, okay. It's going to continue, it's not part of the waiver. We get $200 billion dollars in Medicaid disproportion share. California gets $1.6 billion dollars, Texas gets a trillion dollars and New York gets a billion dollars. Louisiana gets $700 million dollars. We get $200 million dollars. Now, what CMS will say, and I've talked to our congressional delegation and I've talked to officials at CMS and they are absolutely correct, that those Medicaid dish numbers have been fixed by Congress. They are capped and CMS has no about to change them. What CMS does have the ability to do is to recognize on the supplemental payment side of the equation, the equation that is not the Medicaid dish, is that Florida ranks near the bottom of Medicaid dish. They should take that into consideration when they are setting our level of Medicaid dish. It's important. Louisiana gets $700 million and we get $200 million and your comparable states, New York and California and Texas are all of billion plus. That is ridiculous and that should be taken in consideration. But it gets worse than that. Those other big you threw me off my game. What is worse is when you look at Texas and California and the supplemental payments they get like LIP that we're talking about today, okay, Texas gets - we get $1.3 billion dollars in supplemental payments. This was a study done, 1.9 now, but this was a study done before that additional increase, but even if you put the 1.9 in there, you are going 1 to be shocked at the difference. In Texas their Medicaid dish and their supplemental payment program is seven and-a-half billion dollars. In California their Medicaid and supplemental payment programs are five billion dollars. Basically and we know that Congress is wanting to cut supplemental payments and they're wanting to say supplemental payments need to be phased out as states consider expansion. You could cut Texas and California's supplemental payments in half, you could cut them by 50 percent and they would be equal or still greater than what Florida gets. These are things that CMS needs to consider when they review our LIP proposal. In closing I thank you for your patience. We, the safety net hospitals continue to look forward to working with the Agency, with CMS, with our Legislature and the congressional delegation, and I thank you for your time and your patience.

Mr. Fogarty: Good afternoon and thank you for the opportunity to speak. I am John Fogarty. I serve as the Dean at Florida State University College of Medicine, and also the Chair of Council

of Florida Medical School Deans here in Florida. The Council includes the leaders of Florida's nine public/private osteopathic and aliphatic medical schools and provides unprecedented levels of cooperation and collaboration among the medical schools in areas of mutual interest and concern around the state. I'm here to express our support for the Florida Agency for Health Care Administration request to extend Florida's Low Income Pool program and for similar programs beyond June 30th. 2015. I have provided a more detailed letter to Mr. Senior earlier today that expresses the opinions of the Council of Florida Medical School Deans our recommendations and our background for those. I know that several of my colleagues have been presenting at these forums in the past two days, and one of the reasons why one of us is at each one of them is because we feel very, very strongly about this. We urge the Center, CMS, to adopt a transitional redesign of LIP that continues faculty positions supplemental payments for the two-year duration of the 1115 Waiver extension period. That is included in the proposed amendment so well described by Mr. Senior today. Our nine accredited Florida medical schools and their faculty practice plans provide critical access to the essential medical care of the vulnerable populations in the state of Florida while training the next generation of physicians that Tony Cavalho stressed so well. The Florida's medical schools are considered statewide essential providers of Medicaid services both in primary care and particularly in specialty care in our academic hospitals in our programs. In our physician training programs, patient care services depend upon the continuation of these critical supplemental funding for our teaching faculty. As we have expanded out the number of medical schools in this state we are reaching a crisis where we don't have enough residency training programs for these medical students as they are graduating. So we have had conversations throughout the state and also the nation to try to increase GME funding. This would be a terrible time to decrease funding overall to the State's medical schools while we are trying to expand residency programs and increase enough physicians to manage the workforce of Florida. The last year faculty physicians, resident physicians and health care practitioners from Florida's medical schools provided over two million Medicaid patient encounters and we desire to work with AHCA and CMS on any innovation and restructuring in these programs. It is vital that the patients continue to have access to care during this transition period. Of note as we were going through some Medicaid managed care programs, it's important that you recognize that the Florida medical schools have not diminished their care, essential care and services of the vulnerable populations or decreased our emphasis on medical education. So in summary the Council of Florida Medical Schools Deans is committed to working with AHCA and CMS on behalf of our faculty physicians, clinicians, medical students, resident physicians and in particular our patients that we serve to help ensure the promise of statewide transformation and restructuring in the Medicaid program to achieve better health care, better outcome and lower costs. Thank you.

Mr. Poole: Hello. I'm David pool I'm Director of Legislative Affairs for the AIDSHealthcare Foundation and the Positive Health Care aligned with our business in the Southern Bureau. Thank you for the opportunity to provide these brief comments and for recognizing the Secretary for the leadership and your leadership just in challenging times. We at the HF are reassured that you both are at the helm and also recognize the limitations and constraints under which you both operate. We recognize that LIP provides compensation to hospitals that serve those individuals who all not eligible for the statewide Medicaid Managed Care Program or other Federal programs and who are now realized as uncompensated care. We can fully appreciate the importance of having a source of funds to assist with uncompensated care as we provide care to over 416,000 patients living with HIV disease worldwide, many without any form of insurance public or private. So we absolutely support an AHCA doing what it needs to do to keep the hospital safety net intact. Uncompensated care represents nearly $3billion dollars in hospital costs for those who cannot afford to pay for their care. Elimination of LIP funding will result in a renegotiation of contracts between hospitals and insurance and can result in a cost

shift of business and individuals who purchase commercial insurance. This is not an acceptable outcome when Federal dollars are available to offset these funds through you proposed amendment or by perhaps pursuing the expansion of Medicaid under the Affordable CareAct. We would like to go on record as stating the events of the past nine weeks, and most especially over the past several days of one chamber of the Florida Legislature failing to complete the people's business is perverse, absurd and we understand not under your purview. In light of these events we would like to emphasize and recommend that continued serious consideration be given to working on providing the Center for Medicaid and Medicare Services, CMS, with a proposal, perhaps the Florida Senate version, for participating in Medicaid expansion in a manner that satisfies the concerns regarding reverse cost shifting back to Florida in later years. As we now fully understand that CMS is drawing a definitive line between these two issues of LIP and ACA our comments may not be as relevant for the purposes of this hearing. We however believe they are very relevant. We all know, those of us in this room that have been working in the health care and public and private payor environment for decades, these issues of uncompensated care are inextricably connected from a public policy and funding perspective. We also appreciate the Governor's formation of a health commission, which has been replicated throughout the United States, but we need action now, not next year after a commission makes recommendations that might be implemented in the years to come. These issues demand true leadership by people who understand that Floridians and their current safety net providers need long term sustained relief now. In conclusion, we implore AHCA and our elected officials to absolutely make it a priority to address the LIP funding issue as with this waiver proposal. We also implore AHCA and our elected officials to make it a priority for participation in the ACA Medicaid expansion in whatever innovative manner that builds consensus and provides for a viable solution to ensure reliable access to care and treatment for the already challenged gap population of Floridians making below 100 percent of the Federal poverty level, and in our case at AHF, such as the HIV positive Floridians who are not eligible for other programs. Thank you for the opportunity to speak.

Mr. Daniels: Hello. My name is Michael Daniels and I'm the Executive Director of the Florida Alliance for Assistive Services and Technology, FAAST. I'm here today to speak in support of the Low Income Pool amendment. And I will preface my comments by being in support of it in terms of the acquisition of and access to assistive technology. FAAST has five regional demonstration centers across Florida and one of those regional demonstration centers is in Tampa General Hospital. I have seen estimations in which if these funds are lost that Tampa General will lose in the neighborhood of 60 to 70 million dollars. My concern is that the administration of Tampa General will have to make real tough decisions and those tough decisions could impact rehabilitation medicine. Our regional demonstration is in the rehab hospital at Tampa General. That center serves about 15,000 Floridians ever year. Its goal is to do device demonstrations, device loans and customized services. Our goal is to reduce technology abandonment or technology that is purchased by for Medicaid. And I'm afraid if these funds are lost again those services could be lost. The second aspect I would like to talk about is the rural hospitals. Again, if these funds are lost for rural hospitals they'll have to make difficult decisions. In some counties the only practitioners, specifically physical therapists and occupational therapists and speech language pathologists, the only place that you can get an evaluation is in a hospital. Again if these funds are lost, these funds are lost, decisions will have to be made and who's to say that therapy, you know, therapies will be lost. You need a licensed physical therapist and occupational therapist to complete the Florida Medicaid form for power and manual mobility. You also need a licensed speech language pathologist for an augmented or alternative speech generating device. And so that is why we speak in support of the amendment. Thank you.

Ms. Jones: Thank you all so much. And just to thank you for all the time and effort you have put into this and to the Secretary as well. We know that this has not been easy for you, but we do recognize that the knowledge that you have gained through this process is one that will benefit us as we go forward. Good afternoon, I am State Representative Mia Jones and I have the pleasure of representing District 14 in the Florida House of Representatives from Jacksonville, Florida. I serve as Leader - Democratic Leader Pro Tem and also as our Ranking Member for health and human services. We have submitted for the record a written statement on behalf of the Democrats in the Florida House and we look forward to that entire statement being submitted to CMS.I would like to highlight the most important parts of that statement today before you. We urge the Agency to represent the entirety of the Florida Senate's plan and negotiations with CMS. The Senate's plan offers a comprehensive look at our health care system as we know it today. We know that implementing any form of LIP on its own will only be a band aid, and we know that that band aid is not going sustain us as a state long term. We also recognize that having a transitional LIP plan is one that is necessary in order for us to make this transition seamless. So as you are presenting to CMS we would ask that you make that clear. That we know that LIP is not the answer and that the Senate's plan does include a comprehensive approach to addressing the full health care needs of Florida. The House Democrats recognize the importance of adopting a long term plan to stabilize our health care system here, and the Senate's plan in our view, although it is not perfect, offers the best chance at this time for us to begin to create a sustainable health care plan that will be in the best interest for our state. Though I am the only House Democratic member that will speak today, I would like to recognize the members that have joined me. Leader Pafford, Leader Cruz, Representative Williams and Representative Torres and Representative Richardson and Representative Douglas. Wow, I didn't see all of you come in. And as I take my seat, I simply want to say that we have been on this road for a long time. And now is the time for us as a state to be able to stand proudly and to be able to say that we are addressing not only the needs of the hospitals, but the needs of all Floridians who are not currently being able to receive quality health care and are having to go to our Emergency Rooms or having to go without care at all. So today we would ask that you would represent again a full plan of the Senate and we look forward to as a state being able to stand together and to say that we have put all citizens of Florida in the best possible position. Thank you.

Public Comments Received 4/21/15– 5/22/15
Amendment Request for the 1115 Managed Medical Assistance Waiver - LIP

From: Ubaldo Alvarez
Sent: Monday, April 20, 2015 1:58 PM
To: FLMedicaidWaivers
Subject: LIP

Anything that moves Florida away from the disaster created by Obamacare will be good for the State. Please stop this culture of government dependency that burdens those of us who choose to work and have clean and organize lives over those who abuse drugs, choose not to work and for whom a monthly check from this government, along with other benefits such as Medicaid, low income housing, food stamps, etc are already a lifestyle thanks to Obama and his followers. Thanks for reading my comments.

From: Mr. Guzman
Sent: Monday, April 27, 2015 4:24 PM
To: FLMedicaidWaivers
Subject: 1115 MMA Waiver Amendment Request

The LIP is ending, Florida needs to embrace Medicaid expansion under Obamacare.

Mr. Guzman

From: Anna Santilli
Sent: Tuesday, April 28, 2015 10:15 PM
To: FLMedicaidWaivers
Subject: LIP Funding

Florida should accept the Medicaid expansion under the Affordable Care Act. LIP only helps pay for hospitals giving treatment to Floridians who are unable to pay. It is fiscally and morally irresponsible. Fiscally irresponsible since it covers only high cost medical care for situations that could be better handled in a doctor's office if the patient could afford to see a doctor. Hospital lose money constantly.
On the other hand, Medicaid provides insurance so a person can see a doctor instead of going to emergency room. It is a no-brainer when it comes to the fiscal side. LIP is morally irresponsible as it does not offer Health Care. When people do not have access to health care, illnesses that could be detected earlier and treated to better outcomes, often result in critical hospital care, and very often death.

The fact that the health and well-being of millions of Floridians is not of the utmost concern to this agency and the state government is morally repugnant. We should and can be better then this.

Forget the LIP funding and force the legislature to offer more health care, not sick care, to more Floridians.

Thank you.

From: Jim Callahan
Sent: Wednesday, April 29, 2015 2:49 PM
To: FLMedicaidWaivers
Subject: Comment on LIP Presentation 4/29/2015@UCF Medical School

Florida Senate proposal, as analyzed by Amy Baker and staff of EDR may still leave over 450,000 uninsured.

Impact Analysis

LIP, IGTs and SB 2512
The Florida Legislature
Office of Economic and
Demographic Research
April 21, 2015
page 15
FY 2016-2017
549,486 FHIX Enrollment Subtotal
451,419 Number of individuals no longer benefiting after full implementation

http://edr.state.fl.us/Content/returnoninvestment/EconomicAnalysisofPPACAandMedicaidExpansion.pdf

So, it looks like their are more than 450,000 persons "no longer benefiting after full implementation" who I assume will need LIP services.

I mention this because this, because this almost half, is in contrast to the one-quarter shown in the LIP presentation pie chart (slide 16?).

I support Healthcare expansion under the ACA.

THE FLORIDA SENATE

SENATOR ANDY GARDINER
President

April 27, 2015

Vikki Wachino, Acting Director
Centers for Medicare and Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Dear Acting Director Wachino:

The attached letter was submitted as part of the public comment process on Florida's application to amend its MMA waiver (Project Number 11-W-00206/4). As you know, the uncertainty regarding any possible extension and modification of the Low Income Pool is a significant factor in the Legislature's current budget negotiations.

We understand no firm decisions will be made until after a thorough review the application submitted by the Agency for Health Care Administration (AHCA). However, if you are able to elaborate on your initial guidance now that a formal application has been submitted, that information may help us more accurately assess the fiscal and economic landscape for the state's budget.

Thank you for considering this request for more information.

Sincerely,

[redacted]

Andy Gardiner
President

Cc: Justin Senior, Deputy Secretary for Medicaid, Florida Agency for Health Care Administration

Enclosures

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

THE FLORIDA SENATE
SENATOR ANDY GARDINER
President

April 27, 2015

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

RE: 1115 MMA Amendment Request to Extend LIP through June 30, 2017

Dear Mr. Senior:

On behalf of the Florida Senate, I offer the following comments as input to your request to amend Florida's Managed Medical Assistance (MMA) 1115 Research and Demonstration Waiver (Project Number 11-W-00206/4). We support extension of LIP, but we are concerned that the request may need to be modified in order to secure full federal approval.

In a letter to you from Acting Director Vikki Wachino dated April 14, 2015, four specific guidelines were outlined:

1. 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.

2. Medicaid payments should support services provided to Medicaid beneficiaries and low-income uninsured individuals.

3. Payment rates should be sufficient to promote provider participation and access, and should support plans in managing and coordinating care.

4. A transition period may ease the process of reducing the LIP.

We believe your proposal meets guidelines #2 and #3, but is not responsive to #1 and #4.

Specifically, we are concerned that with no suggestion of expanded coverage, such as the one recommended by the Florida Senate, the state may not be successful in gaining authority to spend $2.2 billion in LIP payments. Without additional coverage, your LIP model may not be construed as a first step in a transition plan. This assessment is summarized in the attached table.

As you know, the Legislature is responsible for constructing a balanced budget that meets Floridians' need for education, public safety, environmental protection, and other important governmental functions, as well as health care. Failure to use available federal resources for expanding coverage will create negative fiscal and economic consequences for the state that are simply unnecessary.

We ask you to modify your amendment request by attaching a proposal for expanding coverage that can be implemented with Legislative approval.

Sincerely,

[redacted]

Andy Gardiner
President

Cc: The Honorable Rick Scott, Governor
The Honorable Steve Crisafulli, Speaker
Liz Dudek, Secretary, AHCA

Enclosure

Principle	Senate Proposal With Expansion	AHCA Proposal Without Expansion
1. Coverage rather than uncompensated care pools	Senate's Coverage Proposal • The first phase enrolls people in the reformed managed care plans (MMA plans) authorized under Florida's 1115 waiver. • The next phase is a transition to a Florida-based marketplace that allows consumers to purchase coverage using their risk-adjusted premium assistance. The coverage choices are broad, but both MMA plans and other ACA-compliant plans will be offered along with other health-related products and services. o Enrollees must meet specific work and cost-sharing requirements; o Enrollees' risk-adjusted premium is a defined contribution and can be saved in an individual account for cost sharing obligations or other future health-related expenses. • The final phase of the expansion anticipates integration of the Florida Health Insurance Affordability Exchange (FHIX) with the Florida Healthy Kids program. • Continued implementation is contingent on specific thresholds of federal participation and approval of key policy parameters.	No coverage proposal.
2. Medicaid payments should support services provided to Medicaid beneficiaries and low-income uninsured individuals	• LIP payments are directed to hospitals that serve more Medicaid and charity patients. • The number of hospitals receiving pool payments is increased. • The direct correlation between intergovernmental transfers (IGTs) and payments is reduced. • Policy criteria are used to select and pay providers who deliver specialized, but financially risky services such as trauma centers, specialized perinatal care, primary care, and emergency department diversion programs.	Same
3. Payment rates should be sufficient.	• Hospital rates are increased by $202.9 million	Same
4. A transition period may ease the process of reducing the LIP.	• First year LIP funding = $2.1 billion • Reductions possible in future years	• One pool distribution model through 2017. • No expansion, • No transition.

288155

Duval County Medical Society
1301 Riverplace Blvd. Suite 1638 Jacksonville, FL 32207
p: (904) 355-6561
w: dcmsonline.org

To: Office of the Deputy Secretary for Medicaid, Agency for Health Care Administration

From: Bryan Campbell, Executive Vice President, Duval County Medical Society

Date: April 29, 2015

Subj: Proposed Amendment to 1115 MMA Waiver

The Duval County Medical Society (DCMS) is the largest County Medical Society in the state of Florida, with more than 1900 members, MDs and DOs dedicated to the mission of helping care for the health of our Northeast Florida community. The DCMS stands behind the proposed amendment to the 1115 MMA Waiver as a temporary solution to help provide care to those who most need it in our community.

Jacksonville is home to UF Heath Jacksonville, one of Florida's safety net hospitals and one of the facilities that would be most dramatically impacted by the loss of Low Income Pool (LIP) funds. Without the more than $95 million in LIP funds designated for 2015-2016, UF Health CEO Russ Armistead has stated that the hospital would likely be forced to close or greatly reduce services within six months.

UF Health Jacksonville is the only Level One Trauma Center in Northeast Florida. Each year, the hospital has more than 1.2 million ambulatory visits, 90,000 emergency room visits, 35,000 admissions and more than 4,000 serious trauma cases. If UF Health were to close, the burden on the entire Northeast Florida medical community would be catastrophic.

The impact is not limited simply to medical care. UF Health is one of Jacksonville's largest employers, and is the city's largest employer of minorities. The hospital is home to 360 medical residencies. The impact of losing these positions would have a ripple effect on future doctors and their willingness/ability to take care of patients in Northeast Florida.

While the DCMS supports the amendment to the LIP Waiver Request, we echo the concerns of Senate President Andy Gardiner that AHCA must also submit a Medicaid expansion plan, such as the Florida Health Insurance Exchange (FHIX) as proposed by the Florida Senate. LIP funds by themselves are not adequate to fill the gap for healthcare for the uninsured and underinsured in Florida. Both of these solutions are required to adequately care for our patient population.

COUNCIL OF FLORIDA MEDICAL SCHOOL DEANS

United for Excellence in Medical Education, Research, and Health Care

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EXECUTIVE DIRECTOR
Terry Meek, J.D., M.P.H.

April 29, 2015

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

VIA E-MAIL/ORIGINAL TO FOLLOW VIA U.S. MAIL

Re: Florida Medicaid Reform Amendment Request for Florida's 1115 Managed Medical Assistance (MMA) Waiver to Redesign Elements of the Low Income Pool (LIP) and to Extend the Program until June 30, 2017

Dear Deputy Secretary Senior:

I am writing this letter on behalf of the Council of Florida Medical School Deans (Council of Deans) regarding the Medicaid Reform Amendment Request for Florida's 1115 Managed Medical Assistance (MMA) Waiver to Redesign Elements of the Low Income Pool (LIP) to Extend the Program until June 30, 2017 that was posted on the Agency for Health Care Administration's (AHCA) website on April 20, 2015. The Council of Deans recognizes the substantial work that AHCA staff has dedicated to ensure the provision of important services that are provided to Florida's citizens who are served by the Medicaid program. The Council of Deans asks AHCA's continued support of certain aspects of LIP funding for Florida's medical schools and their faculty physicians that critically impact access to services provided to uninsured/underinsured citizens and beneficiaries of the Medicaid program; development of Florida's future supply of well-trained, quality physicians in disciplines necessary to care for Florida's population in a rapidly changing healthcare marketplace; and assurance of an effective role for the Florida Medical School Quality Network (FMSQN).

As state and federal governments continue to consider Florida's Medicaid program during this time of transition, it is important that funding solutions enable continuation of the unique safety net services provided to patients in the Medicaid program by the state's medical schools. The Council of Deans supports the provisions of the April 20, 2015 Amendment Request relative to medical school teaching physicians and practitioners which provides for $204.5 million in supplemental funding to support access to quality care provided by our state's medical school faculty.

The Council of Deans recommends that as AHCA and the Centers for Medicare and Medicaid Services (CMS) continue to develop Florida's Medicaid program, the following are important considerations. The Medicaid program should:

1. Continue the supplemental Medicaid funding for medical school physicians and practitioners, and structure it in a manner that ensures payments for services provided by medical school physicians and practitioners directly reach the individual medical school or faculty practice plan, as opposed to being diverted to managed care plans or provider service networks.

2. Be designed in a manner that helps develop a strong framework for Florida's medical schools to serve as an active and ongoing partner with AHCA and CMS in furtherance of continued improvements and innovations for Florida's Medicaid program.

3. Consider the unique costs and benefits associated with medical education and training and ensure the valuable contributions that Medicaid providers, including medical schools, physicians, and hospitals that provide for medical education and training, are not lost through Medicaid program policy structure or the marketplace of managed care or provider service network contracting.

Recommendation #1: The Council of Deans recommends that the Medicaid program continues the supplemental Medicaid funding for medical school physicians and practitioners. The Council of Deans urges that payment for such services by medical school physicians and practitioners directly reach the individual medical school or faculty practices, as opposed to being diverted to managed care plans or provider service networks.

Background and Rationale

Florida currently has nine public and private, allopathic and osteopathic medical schools. Some schools have well-established faculty practice plans, while other medical schools have new and emerging faculty practice plans. In the past ten years, Florida has developed four new medical schools. The medical schools provide services through numerous diverse community-based outpatient settings as well as geographically dispersed academic and community hospitals.

Florida's medical schools play a vital role in caring for patients served by Florida's Medicaid program as faculty physicians and practitioners provide essential primary and specialty medical care in clinics, teaching hospitals, health departments and other health care facilities, providing annually more than two million office visits and encounters to patients served by the Medicaid program. Florida's medical school physicians and practitioners have received Medicaid supplemental funding since 2004-05. As reflected in AHCA's April 20, 2015 LIP Amendment Request, teaching physicians and practitioners employed or under contract with Florida's medical schools were added to the LIP program for the period July 1, 2014 to June 30, 2015. Budget authority for medical school physicians is currently provided in the amount of $204.5 million under the physician supplemental payment program.

Services to the state's Medicaid population by medical schools having well-established faculty practice plans have continued to grow, and medical schools with new and emerging faculty practice plans are building additional programs that can enhance the state's capability to provide access and serve patients in the Medicaid program.

Recommendation #2: The Council of Deans recommends that the Medicaid program continues to develop in a manner that ensures a strong framework for Florida's medical schools to serve as an active and ongoing partner with AHCA and CMS in furtherance of continued improvements and innovations for Florida's Medicaid program.

Background and Rationale

Florida's medical schools are prepared to work with AHCA and CMS to implement new patient-centered, managed care delivery models and value-based payment methodologies that reward quality and cost savings in addressing the medical needs of patients served by the Medicaid program. The State of Florida is ideally situated to redefine its partnership with academic medicine in order to leverage the unique clinical service, training, and research development capacities of the state's medical schools to create a platform for bringing innovative, transformative and scientifically leading-edge medicine to persons served by the Medicaid program. Florida's medical schools are well-situated to test effective models for care delivery; disseminate and implement research-based best practices; develop programs to improve clinical outcomes, reduce costs, improve individual and population health; develop training materials and methods for providers; develop programs to increase patients' engagement in their own care and health; and share the benefits of precision medicine and ground-breaking advances in the science of medicine, making such advances available to the Medicaid population.

In addition, as part of Florida's Medicaid reform initiative, the legislature created s. 409.975(2), Florida Statutes. Pursuant to this statute, Florida's medical schools established the Florida Medical Schools Quality Network (Network). Each allopathic and osteopathic accredited medical school is part of the Network. Through this Network, the medical schools are able to work with AHCA to provide an active and ongoing program to improve clinical outcomes in Florida's Medicaid program.

Recommendation #3: The Council of Deans recommends that the Medicaid program continues to recognize the central role that medical schools and their faculty physicians play in assuring the adequacy of the state's physician workforce and continues to ensure that support for the unique costs associated with medical education and training is not lost through Medicaid program policy structure, or the marketplace of managed care or provider service network contracting.

Background and Rationale

Florida's medical schools contribute a substantial amount of medical resources to care for underserved, uninsured, underinsured, rural and inner-city patients. Medical schools further provide significant services for high-risk patients, including high-risk neonates, the elderly, and other persons having complex medical needs. Appropriate Medicaid funding is key to the ability of the medical schools to continue providing care that is needed.

Florida currently ranks 42nd of the 50 states in the number of graduate medical education (GME) positions per 100,000 persons, with approximately 19.0 resident physicians per 100,000 population. Florida's medical schools currently operate GME programs in traditional hospital settings, as well as provide programs in unique settings such as county health departments, prisons, and through multi-site consortia. Given that Florida is one of the fastest growing states in the country, with one of the larger aging physician groups in the nation, a challenge exists in ensuring that Florida will have a sufficient supply of well-trained physicians to provide medical care to Florida's future population. Accordingly, amendments to the Medicaid program waiver should be developed and implemented in a manner that will not be detrimental to medical schools or other providers that sponsor physician residency training. These providers are an important component of Florida's health care system.

In 2011, the Florida legislature passed legislation restructuring the Medicaid program as a fully capitated managed care model. This managed care model transitioned to statewide implementation in 2014. Marketplace decisions present in Medicaid managed care programs will reshape the Medicaid program's role in purchasing health care services for Medicaid recipients. A tenet of the Medicaid program is the desire to ensure the systems of care delivery meet higher standards and ensure delivery of quality services. However, inclusion of providers by managed care or provider service networks is frequently based on economic factors, without taking into account

higher standards and quality provided by medical schools and affiliated physician residency training facilities. Additionally, there are certain added costs associated with providing the State with medical education and training. Examples include, but are not limited to: the additional patient-care staffing required by medical schools and residency training programs, the availability of state-of-the-art equipment and medical personnel needed to provide complex services to patients needing such medical care, and the additional financial burden of providing a substantial amount of uncompensated or undercompensated medical care. The Council of Deans is committed to working with AHCA, CMS, managed care plans and other health care providers on statewide transformation towards patient-centered care delivery and achieving the "Triple Aim" of better care, better health and lower costs. In the meantime, maintaining the transitional LIP or similar funding for medical schools and their faculty physicians is vital in order that patients have access to care. **It is the concern of the Council of Deans that, without considering such factors, through means such as supplemental Medicaid payments to medical school physicians and practitioners, or other effective strategies, Florida will lose the value and enhancements that the medical schools and their health care professionals provide to the state, its communities, and its residents and visitors.**

In conclusion, the Council of Deans reiterates support for the continuation of medical school supplemental funding through LIP as provided for in AHCA's Public Notice Document Low Income Pool Amendment Request as posted on April 20, 2015. Florida's medical schools look forward to working with AHCA in the further development of the Medicaid program to ensure that it remains a premier health care program for Florida's citizens. The Council of Deans appreciates the tremendous effort and dedication that AHCA has shown in leading Florida's Medicaid program. The deans of Florida's medical schools look forward to working with AHCA and the Medicaid program through this LIP amendment process and on an ongoing basis and with the Florida Medical Schools Quality Network as Florida's Medicaid program continues to develop to meet the needs of our state and its citizens.

Sincerely,

[redacted]

John P. Fogarty, M.D.
Chair, Council of Florida Medical School Deans
Dean, Florida State University College of Medicine

[redacted]

Michael L. Good, M.D.
President, Florida Medical Schools Quality Network
Dean, University of Florida College of Medicine

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April 30, 2015

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

RE: Florida 1115 MMA Amendment Request for Low Income Pool Program (LIP) Redesign Approval through June 30, 2017

Dear Mr. Senior:

On behalf of the North Broward Hospital District, d/b/a/ Broward Health, I submit the following comments. Broward Health is a safety net hospital system serving more than two-thirds of the 1.9 million residents in Broward County. We have four hospitals, which include two trauma centers, two comprehensive stroke centers, two primary stroke centers, a children's hospital, and a wide array of other services including numerous outpatient sites and specialty clinics throughout our service area. Our providers see more than 900,000 outpatients and care for more than 62,000 admissions every year. 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.

We are a provider of last resort for all who need health care, regardless of socio-economic status or insurance coverage. Medicaid is 30.3% of the Broward Health system's inpatient days and with Medicaid only reimbursing at 48% of costs, Broward Health will be forced to eliminate and reduce programs, services and employees if Low Income Pool (LIP) replacement is not approved. The Broward Health system in fact will be cut $92.8 Million if the current LIP model is repealed without a commensurate replacement model and amount.

The LIP funding is critical to Broward Health. We support the LIP replacement model submitted to federal CMS by AHCA as the proposal provides a sound step towards a next generation low income patient access and care financing model. The proposal recognizes the disproportionate volume of the patient care provided by safety net hospitals while addressing federal CMS policies. We support the:

- Total funding level request of $2.167 billion.
- Modification of the current model to direct LIP funds into reimbursement rates and policy-based standards, such as critical need services.
- Restructured Hospital Distributions-the LIP Replacement Model more broadly distributes funding and continues to encourage access for vulnerable populations.

- Consolidated IGT Pool- The consolidated IGT pool serves to improve transparency and eliminate "pay for play" of IGT contributors.
- Incentivizing and protection of the IGTs contributed. Contributors of IGTs to the statewide pool are provided an assurance of a payment amount equal to the IGTs contributed, plus a reasonable incentive return.
- Addressing of the shortfall in Florida's DRG Pediatric Services Reimbursement-Florida DRG reimbursement model does not cover the cost of hospital care for medically fragile babies and children. The new LIP replacement model adjusts the DRG pediatric outlier policy to improve the reimbursement to 80% of costs over $60,000 for pediatric patients requiring severity level 3 & 4 treatment.
- Addressing of the New Cost Cap policies - Hospitals whose IGTs are used to subsidize the statewide Medicaid managed care capitation rates shall receive an exemption from their cost cap equivalent to the amount of the IGT.
- Transition Period - The transition to a new LIP model is implied in this model and will minimize financial chaos as Florida moves to a new supplemental funding program.
- Teaching faculty Funding - Medical school faculty support would be continued.

Thank you for the opportunity to submit these comments.

Sincerely,

[redacted]

Nabil El Sanadi, MD
President/CEO

ConsultIdaNP
Your Advocate for Quality Health

Ida Wallace Bennett Family Health

1115 MMA Waiver Amendment Request
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

Regarding: Changes to Florida's 1115 Managed Medical Assistance Waiver program

Proposed changes to Florida's 1115 Managed Medical Assistance waiver program requires Medicaid recipients receiving long term care benefits be enrolled in a managed care organizations, medical assistance plan within thirty days of qualifying to receive long term care benefits. As an Advanced Registered Nurse Practitioner (ARNP) Medicaid enrolled primary care provider, there are concerns that cost and access to primary care for people confined to their homes will continue to be adversely affected.

According to data received from the Agency for Health Care Administration (2015) Florida had 7,459 Advanced Registered Nurse Practitioners enrolled as individual primary care providers in 2009, 7,972 ARNPs in 2010, 7,834 ARNPs in 2011, 8,970 ARNPs in 2012, 10,097 ARNPs in 2013 and 11,051 ARNPs in 2014. This is significant because Florida Statute 409.966(3)(c) Medicaid Managed Care (eligibility plan, selection), states that preference shall be given to plans that have signed contracts with primary and specialty physicians in sufficient numbers, in addition Florida has a shortage of primary care Physicians (Florida Workforce Report, 2013, 2014).

Mandatory Medicaid services are defined in Florida Statute 409.905 (1) and makes paying Advanced Registered Nurse Practitioners for services furnished to Medicaid recipients a requirement of the state in accordance with title XIX of the Social Security Act. The Florida Medicaid Handbook (2014) criteria for ARNPs to enroll and be reimbursed as Medicaid providers is that: the ARNP must be credentialed according the Florida Statute 464 (Nurse Practice Act), must have an individual national provider identification number, an individual Medicaid number, must collaborate with a Medical Doctor, Doctor of Osteopathic Medicine,

Correspond to Ida Wallace Bennett Family Health
Post Office Box 783 • Deerfield Beach • Florida 33441
p: 561-900-6737 f: 954-422-1726 e: arnpvj@icloud.com

or Dentist as stipulated in the Nurse Practice Act, can provide diagnostic and interventional patient care, can bill individually or through a group practice, and are considered primary care providers. Congruent to the Social Security Act, Florida's Agency for Health Care Administration authorizes Advanced Registered Nurse Practitioners to sign Medical certification for Nursing Facility/Home and Community Based services (3008) form. The 3008 Form authorizes patients enrolled in statewide Medicaid Managed Medical Assistance long term care programs to receive benefits in nursing homes or community residences.

Approximately 43% of Florida's Advanced Registered Nurse Practitioners work in primary care (Florida Center for Nursing, 2014). ARNP Medicaid enrolled primary care providers use the same evaluation and management codes to bill for services rendered to Medicaid patients, but ARNPs are paid 80% of the amount allowed payable to Physicians. When Medicaid enrolled ARNPs bill under a Physician, rates are paid up to 100% of the allowed amount.

Proposed changes should include these incentives for Statewide Medicaid Managed Care insurance plans to contract with Medicaid credentialed Advanced Registered Nurse Practitioner primary care providers as individuals or through group practices in Florida's 1115 Managed Medical Assistance and long term care plans.

Sincerely,

[redacted]

Pamela V Johnson ARNP, FNP-BC
President of ConsultIdaNP

Correspond to Ida Wallace Bennett Family Health
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p: 561-900-6737 f: 954-422-1726 e: arnpvj@icloud.com

Florida House of Representatives
Democratic Caucus

Rep. Mark Pafford
Democratic Leader

Rep. Mia Jones
Democratic Leader pro tempore

May 1, 2015

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

RE: 1115 MMA Amendment Request to Extend LIP through June 30, 2017

Dear Mr. Senior:

On behalf of Florida House Democrats, I offer the following comments in response to your request to amend Florida's Managed Medical Assistance (MMA) 1115 Research and Demonstration Waiver (Project Number 11-W-00206/4).

We support a broad and new solution to addressing the purposes of the current Low Income Pool program. By doing so, Florida could take advantage of the immense benefits to the state offered by full implementation of the Affordable Care Act.

House Democrats recognize that AHCA's actions are limited to authority delegated to it by the Legislature. Therefore, we urge the agency to advocate on behalf of the complete plan developed by the Florida Senate, a proposal pending as part of the Legislature's unfinished budget negotiations.

We agree that a transitional form of LIP is absolutely necessary, but is only a piece of the solution, as made clear by correspondence from the Centers for Medicare and Medicaid Services. We recognize CMS has asked Florida to find "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."

It is the position of House Democrats that the plan developed by the Florida Senate and included in its proposed budget represents a legitimate response to this request and is a substantive starting point to further negotiations. We do not believe proposals to extend LIP in its current form are responsive to the CMS request nor do they address the long-range need to stabilize the health care system in Florida.

It is our reading of the Senate proposal that expansion of comprehensive coverage is a necessary complement to continuation of a reformed version of LIP. We urge the agency to represent the entirety of the Senate plan in its application for an extension of the LIP component to Florida's waiver. It is our belief that this represents the best opportunity for success in negotiations with the federal government. That, in turn, would facilitate a program that addresses the legitimate concerns of the people of Florida, businesses in the state and the safety-net hospitals that now provide the bulk of the care to uninsured patients.

We find the analysis of the Senate plan performed by the Legislature's own Office of Demographic & Economic Research compelling and convincing. This detailed analysis from a trusted and accurate source presents an overwhelming argument that this full proposal is good for the state, good for the people of Florida and responsive to our federal partners.

For all these reasons, we ask AHCA to faithfully represent the entirety of the Senate's proposal to federal officials. In this way Florida may anticipate a clear signal from CMS about the suitability of this plan and its chances of successfully reaching an agreement on this critical issue. Doing so vastly improves the chances the Florida Legislature will have the means to make an informed and positive choice about the provision of health care in this state.

Sincerely,

[redacted]

Rep. Mark Pafford
Leader, Florida House Democrats

[redacted]

Rep. Mia Jones
Leader pro tem, Florida House Democrats

[redacted]

Rep. Janet Cruz
Leader-designate, Florida House Democrats

[redacted]

Rep. Evan Jenne
Policy Chair, Florida House Democrats

[redacted]

Rep. David Richardson
Rules Chair, Florida House Democrats

Lisa Jernigan, MD
Associate Director
Tallahassee Memorial HealthCare Family Medicine Residency
Lisa.jernigan@tmh.org

Low Income Pool (LIP) funding is crucially important to the State of Florida at this time.
Physicians from our program provide inpatient care, outpatient care, and travel to five surrounding rural counties to provide prenatal care to low income women. We also deliver those women at Tallahassee Memorial Hospital.
LIP supports the county health departments where much of the prenatal care is provided. As the "Share of Cost" funding was discontinued the county health departments became dependent upon the LIP funds to continue providing care to pregnant women, and indeed to perform many of their clinical functions. The small counties where I work have no providers with a daily presence that are willing to see uninsured women, and in some counties none that are willing to see patients on Medicaid, during their pregnancies. We have developed strong relationships and communication with the nursing and ARNP or midwifery staff in the counties where we work and are thus able to respond to the needs of our patients all week long. Loss of LIP funding would potentially result in the inability of counties to continue to provide this and other crucial public health services. These patients are not able to travel to other towns for care for many reasons. These counties already have high rates of infant mortality, and there are many times that we catch something potentially life threatening in these clinics, particularly pre-eclampsia, pre-term labor, or diabetes complicating pregnancy. Loss of LIP funding at this time would result in an increased number of sick moms and babies, increasing health care costs dramatically. Passage of the Medicaid expansion would potentially help here, but some of the women we serve would not be eligible even for that program, and thus LIP is needed to serve those needs.

LIP funding also supports the Transitional Care Center at TMH, which has been instrumental in reducing re-admissions among patients recently discharged from the hospital by providing care and follow up as they are connected to a primary care home. This has been a revolutionary and highly inventive program that has been copied by hospitals nationwide. Loss of LIP threatens this directly, and will increase health care costs to our community.

LIP funding also supports a therapeutic lifestyle change research and treatment program sponsored by the Family Medicine Residency, where at risk patients learn important self care and prevention skills. This program has proven its value, and is being prepared for sharing with providers nationwide as a result. No insurance product is currently covering this service, and most of our patients who are enrolled are either uninsured or on Medicaid, thus the program is dependent on the LIP grant to continue.

LIP funding also goes to TMH (and other hospitals) directly to offset their increased burden of caring for the uninsured. Without LIP funds hospitals will be financially damaged, and services will be reduced. Passage of the Medicaid Expansion would also reduce this need for LIP.

Jonathan M. Ellen, M.D.
President and Physician-in-Chief
All Children's Hospital Johns Hopkins Medicine
Vice Dean and Professor of Pediatrics
Johns Hopkins University School of Medicine

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all children's hospital
JOHNS HOPKINS MEDICINE

May 4, 2015

Proposed LIP Amendment to 1115 MMA Waiver

Justin Senior
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS 8
Tallahassee, Florida 32308

Dear Mr. Senior:

All Children's Hospital appreciates the Agency for Healthcare Administration's leadership regarding the Low Income Pool funding. Specialty licensed children's hospitals, like All Children's, could lose $55 million towards the care of Florida's sickest children if funding for the Low Income Pool program is not extended.

As one of only three specialty licensed children's hospitals in Florida, the challenges facing hospitals like All Children's are unique. We are completely and solely dedicated to the health and well-being of children, and are the state's highest Medicaid provider, with 70 percent of our patients benefiting from Medicaid. We treat many of Florida's sickest children, and are devoted to providing these vital services, despite the fact that Medicaid reimbursements often do not cover the cost of care. The unknown future of the Low Income Pool (LIP) has put into jeopardy over $55 million in support that All Children's receives. It must be noted that Medicaid expansion would not help make up for the loss of the LIP funding as no additional children under 18 years of age would become eligible for Medicaid and as such, Medicaid expansion would not reduce the level of uncompensated care provided by the specialty licensed children's hospital.

All Children's will always be dedicated to providing care for children. However, the loss of $55 million in LIP dollars will have a devastating impact that will force us to seriously reconsider the level at which we are currently able to provide these services, as well as the scope of our research and education mission tenets. We ask that within your discussions with CMS you continue to promote a model that extends the Low Income Pool program and ensures specialty licensed children's hospitals like All Children's Hospital are protected. We look forward to working with you on solutions.

Sincerely,

Jonathan M. Ellen, M.D.
President and Physician-in-Chief
All Children's Hospital Johns Hopkins Medicine
Vice Dean and Professor of Pediatrics
Johns Hopkins University School of Medicine

From: Tina Biddle
Sent: Tuesday, May 5, 2015 7:57 PM
To: FLMedicaidWaivers
Subject: Proposed Amendment to 1115 MMA Waiver

Speaking as a public health nurse, I have been able to see first-hand just how important the LIP funding is for this state. I work and live in a very poverty stricken county in the panhandle and am able to see the benefits of local resources made possible by this funding: allowing uninsured Floridians access to healthcare, access to educational classes/materials important to help maintain their health, and some advanced care that otherwise they would not be able to access due to cost. The new proposed amendment is of the utmost importance for ALL FLORIDIANS as we strive to make Florida the healthiest state in the nation.

Tina Biddle, LPN II (Referrals)
Florida Department of Health

Gregg MacDonald
President, Florida

May 7, 2015

1115 MMA Amendment Request
Justin Senior, Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive MS #8
Tallahassee, FL 32308

Dear Deputy Secretary Senior:

WellCare strongly supports the state's efforts to make improvements to its current Low Income Pool (LIP) program. As a company dedicated to providing services to government sponsored programs we believe that a strong safety net is needed for Florida residents. We also recognize the complexity of this program and appreciate the time and energy spent by the members of the Florida Senate, among others, to develop a program that is both compliant with federal rules and regulations and supportive of our health care safety net and the people served by that safety net.

We support the State's efforts to strengthen the LIP funding in the following manner:

- Allocating the LIP financing to hospitals on a more objective basis – establishing specific and well-defined criteria that achieves the State's goal of better quality and improved access for Medicaid beneficiaries.
- Establishing specific quality goals that hospitals must achieve to receive LIP financing
- The State should require that the Lip-eligible hospitals contract with plans at a rate not to exceed 105% of the Medicaid rate or alternatively, limit participation in the LIP financing to hospitals that do not charge, on average across MCOs in MMA, more than 105% of the Medicaid rate.

While WellCare is generally supportive of the LIP Amendment, we would like to make one suggested change to strengthen the state's effort to move to managed care where its residents receive more coordinated, efficient health care services. We recommend that the state amend the LIP program to reflect the need to rebalance the contracted rates paid to hospitals by managed care organizations. Contracted rates were negotiated prior to the Managed Medical Assistance program which assumed that the LIP 6 funds would be passed through the Medicaid health plan rates as they had been in the past. During the 2014 legislative session, the LIP program was modified.

Office Address: 3031 N Rocky Point Drive West | Suite 600 | Tampa, FL 33607
Telephone: 1-813-206-6356 | E-mail: Gregg.MacDonald@wellcare.com

Under that modification, these funds were removed from the rates. Despite legislation precluding hospitals from being paid twice for the uncompensated care services represented by LIP 6, many hospital systems have proven unwilling to renegotiate their rates to reflect the absence of the LIP 6 funds creating a higher-than-necessary payment to some hospitals which are now receiving both the higher contracted rate and the LIP 6 funds directly from AHCA. We recommend that the state tie the DRG Base Enhancements payments to a rebasing of the contracted rates to more appropriately pay these hospitals.

Thank you for the opportunity to provide these comments. We look forward to our continued work together to improve the quality of care provided to our Medicaid members.

Sincerely,

[redacted]

Gregg MacDonald
President

cc: FAHP
The Honorable Aaron Bean
The Honorable Rene Garcia
The Honorable Andy Gardiner
The Honorable Tom Lee

From: Bob Rinker
Sent: Thursday, May 7, 2015 10:35 AM
To: FLMedicaidWaivers
Subject: Expand Medicaid

As a tax paying resident of Florida, I am in favor of the senate's plan to expand Medicaid coverage in Florida. I have reviewed the governor's objections and do not consider any of them legitimate . It makes much more sense to get people on insurance. The governor and the house are just engaging in political posturing on this issue. Do not continue the low income pool. We need to expand Medicaid. It's the right thing to do.
Bob Rinker

From: Michelle Lucci
Sent: Thursday, May 7, 2015 10:51 AM
To: FLMedicaidWaivers
Subject: 1115 MMA Waiver Amendment request

To Whom It May Concern,

Elected officials in the State of Florida are clearly not governing with the best interests of all residents in mind. Although Florida has some wealthy residents, the majority do not fit into the wealthy bracket. Most resident are low income and below with little or no opportunity to advance up the ladder. Jobs in this state are service based with only one large company headquartered here. Service based jobs are often part-time and offer no benefits, including health care.

It would be in the interests of every resident in this state to expand Medicare under the Affordable Health Care Act. Governor Scott should put aside his hatred and disrespect for our country's President. It only makes him look like a small man when he behaves in the way he does. The federal government is under no obligation to hand us billion dollar checks to pay for care of the uninsured. Suing them and wasting more taxpayer money is shameful.

Do the right thing!

MOFFITT CANCER CENTER

SYLVESTER COMPREHENSIVE CANCER CENTER
UNIVERSITY OF MIAMI HEALTH SYSTEM

May 7, 2015

Justin Senior, Deputy Secretary for Medicaid
Agency for Health Care Administration
Office of the Deputy Secretary for Medicaid
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

Sent via email: FLMedicaidwaivers@ahca.myflorida.com

Re: 1115 MMA Waiver Amendment Request

Dear Mr. Senior:

On behalf of the H. Lee Moffitt Cancer Center & Research Institute and the University of Miami's Sylvester Comprehensive Cancer Center, we offer the following comments as input to your request to amend Florida's Managed Medical Assistance (MMA) 1115 Research and Demonstration Waiver (Project Number 1 I-W-00206/4). We support Florida's Agency for Health Care Administration (AHCA) request to extend a program like Florida's Low Income Pool Program (LIP) beyond June 30, 2015, and urge the Centers for Medicare and Medicaid Services (CMS) to timely adopt a transitional redesign of LIP.

H. Lee Moffitt Cancer Center & Research Institute (Moffitt) and the University of Miami's Sylvester Cancer Comprehensive Center (Sylvester) represent our state's only two stand-alone cancer centers. Under the current proposal, most hospitals experience an increase in funding; however, Moffitt and Sylvester show the two highest decreases in total support. The LIP proposal before you redirects portions of the LIP historically associated with hospitals that have Intergovernmental Transfer (IGT) dollars to providers based on policy-based standards. The revised LIP proposal distributes funds much more broadly than the current LIP, so that many more hospitals benefit from the program. While we support the intent of the proposal, we also would encourage further consideration of adjustments to the model to better support the care and treatment provided by Florida's two Dedicated Cancer Centers.

In addition to being Florida's only two stand-alone cancer centers, our centers are also part of the national Alliance of Dedicated Cancer Centers. The alliance is comprised of 11 of the world's leading cancer centers that share a singular focus on advancing cancer prevention, diagnosis, and treatment. Alliance members take a leadership role in assuring that new knowledge is disseminated to the entire cancer community and that every cancer patient has access to the best available care and treatment. Based on government data, patients initially treated at a Dedicated Cancer Center have better five-year survival rates for all types of cancer than patients treated at other hospitals, including the most common cancers — breast, colorectal, lung, and prostate cancer.

Cancer is a leading cause of death in Florida and our state has the second-highest number of new diagnosed cancer cases in the U.S. Both Moffitt and Sylvester provide critical access to inpatient and outpatient cancer treatment and care to our state's uninsured and Medicaid patients. At the same time, both institutions also conduct significant amounts of research which combined with our state-of-the-art therapies provides the greatest possibility of successful cancer treatment to our patients. Moffitt and Sylvester are committed to working with the AHCA and CMS on behalf of the patients we serve to help ensure a successful statewide transformation of the Medicaid program in Florida.

Sincerely,

[redacted]

Alan F. List, M.D.
President & CEO
H. Lee Moffitt Cancer Center & Research Institute

[redacted]

Richard Ballard
President & CEO
Sylvester Comprehensive Cancer Center

Gregg MacDonald
President, Florida

May 7, 2015

1115 MMA Amendment Request
Justin Senior, Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive MS #8
Tallahassee, FL 32308

Dear Deputy Secretary Senior:

WellCare strongly supports the state's efforts to make improvements to its current Low Income Pool (LIP) program. As a company dedicated to providing services to government sponsored programs we believe that a strong safety net is needed for Florida residents. We also recognize the complexity of this program and appreciate the time and energy spent by the members of the Florida Senate, among others, to develop a program that is both compliant with federal rules and regulations and supportive of our health care safety net and the people served by that safety net.

We support the State's efforts to strengthen the LIP funding in the following manner:

- Allocating the LIP financing to hospitals on a more objective basis – establishing specific and well-defined criteria that achieves the State's goal of better quality and improved access for Medicaid beneficiaries.
- Establishing specific quality goals that hospitals must achieve to receive LIP financing
- The State should require that the Lip-eligible hospitals contract with plans at a rate not to exceed 105% of the Medicaid rate or alternatively, limit participation in the LIP financing to hospitals that do not charge, on average across MCOs in MMA, more than 105% of the Medicaid rate.

While WellCare is generally supportive of the LIP Amendment, we would like to make one suggested change to strengthen the state's effort to move to managed care where its residents receive more coordinated, efficient health care services. We recommend that the state amend the LIP program to reflect the need to rebalance the contracted rates paid to hospitals by managed care organizations. Contracted rates were negotiated prior to the Managed Medical Assistance program which assumed that the LIP 6 funds would be passed through the Medicaid health plan rates as they had been in the past. During the 2014 legislative session, the LIP program was modified.

Office Address: 3031 N Rocky Point Drive West | Suite 600 | Tampa, FL 33607
Telephone: 1-813-206-6356 | E-mail: Gregg.MacDonald@wellcare.com

Under that modification, these funds were removed from the rates. Despite legislation precluding hospitals from being paid twice for the uncompensated care services represented by LIP 6, many hospital systems have proven unwilling to renegotiate their rates to reflect the absence of the LIP 6 funds creating a higher-than-necessary payment to some hospitals which are now receiving both the higher contracted rate and the LIP 6 funds directly from AHCA. We recommend that the state tie the DRG Base Enhancements payments to a rebasing of the contracted rates to more appropriately pay these hospitals.

Thank you for the opportunity to provide these comments. We look forward to our continued work together to improve the quality of care provided to our Medicaid members.

Sincerely

[redacted]

Gregg MacDonald
President

cc: FAHP
The Honorable Aaron Bean
The Honorable Rene Garcia
The Honorable Andy Gardiner
The Honorable Tom Lee

Gregg MacDonald
President, Florida

May 7, 2015

1115 MMA Amendment Request
Justin Senior, Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive MS #8
Tallahassee, FL 32308

Dear Deputy Secretary Senior:

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Thank you for the opportunity to provide these comments. We look forward to our continued work together to improve the quality of care provided to our Medicaid members.

Sincerely,

[redacted]

Gregg MacDonald
President

cc: FAHP
The Honorable Aaron Bean
The Honorable Rene Garcia
The Honorable Andy Gardiner
The Honorable Tom Lee

Memorial Healthcare System

MEMORIAL REGIONAL HOSPITAL • JOE DIMAGGIO CHILDREN'S HOSPITAL
MEMORIAL HOSPITAL WEST • MEMORIAL HOSPITAL MIRAMAR • MEMORIAL HOSPITAL PEMBROKE

May 8, 2015

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

submitted electronically

RE: 1115 MMA Waiver Amendment Request

Dear Mr. Senior:

Thank you for this opportunity to comment on your request to amend Florida's Managed Medical Assistance (MMA) 1115 Research and Demonstration Waiver (Project Number 11-W-00206/4). We appreciate the Agency's efforts to extend the Low Income Pool (LIP) through June 30, 2017, a critical element to help ensure timely access to necessary health care services for the State's Medicaid beneficiaries, the uninsured, and the underinsured. We fully support this extension, and we offer the following comments to help strengthen your request.

CMS Guidelines

Acting Director Vicki Wachino of the Centers for Medicare and Medicaid Services (CMS) provided some specific guidelines for the evaluation of a waiver extension:

1. 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.

2. Medicaid payments should support services provided to Medicaid beneficiaries and low income uninsured individuals.

3. Payment rates should be sufficient to promote provider participation and access, and should support plans in managing and coordinating care.

4. A transition period may ease the process of reducing the LIP.

LIP is Coverage

As a part of the approval of the current waiver, the Agency and CMS agreed to a specific set of Special Terms and Conditions (STCs). As described in the preamble to those STCs:

> *Low-Income Pool (LIP)* will be established and maintained by the state to provide direct payment and distributions to safety net providers in the state for the purpose of **providing coverage** to the uninsured through provider access systems. [Emphasis added].

In other words, the **LIP is *not* an uncompensated care pool as has been implemented in other states' waivers, but rather a limited expansion of coverage for individuals who meet the definition of uninsured or underinsured** for specific encounters for hospital services (and certain LIP-participating non-hospital services). Expenditures under LIP have been consistently reported to CMS as expenditures under Medicaid Eligibility Group (MEG) 3 – LIP.

Therefore, the State proactively (prior to the passage of the Affordable Care Act - ACA) undertook to address a good portion of the cost of uncompensated care through a limited, efficient, retrospectively-determined coverage expansion. There is even reasonable argument that Florida should qualify as an "expansion state" under the definitions in the ACA and receive a higher Federal Medical Assistance Percentage (FMAP) for a portion of its Medicaid program expenditures.

LIP Payments Support Services Provided

As required by the STCs, hospitals that receive LIP payments submit annual LIP Cost Limit reports summarizing the costs of services provided to the patient population defined in the CMS-approved Reimbursement and Funding Methodology document. Based on these reports, providers are either determined to have been paid no more than the cost of services furnished to Medicaid and uninsured patients, or an overpayment amount is identified and recouped from the provider.

No Medicaid payments are unsupported by patient care services actually furnished to eligible individuals.

Dollars Follow the Patient

Although LIP payments are not made on a claim-specific basis, the information regarding the amount of otherwise uncompensated care furnished is used to determine provider eligibility to receive LIP support and certain of the measures to compute the amount of that support. For example, the proposed Specialty Pediatric LIP distributions use audited data from 2007, 2008 and 2009. So **while the current payment is not tied to individual current patients, it does follow the patient, albeit some year later**.

Payment Rates are Limited by Budgetary Concerns

LIP payments do offset a portion of the shortfall between Medicaid cost and Medicaid payments for the regular fee-for-service Medicaid patients. Adequate base payment rates would alleviate that shortfall, but would require a source of the State share of those Medicaid expenditures. Reforms made to Florida's Medicaid program, coupled with expanding use of electronic health records, should yield new efficiencies, but not sufficient by themselves to offset the needed increase in rates. Absent an increase in base rates, the use of LIP to cover this shortfall is necessary because it enables local resources to fund the State share through intergovernmental transfers.

All of Florida's hospitals participate in the Medicaid program, so **hospital provider participation is not an issue** with rates. Expanded services, hours of access, and location of service could be improved *for all patients* with additional funding, *and are at risk* if funding is reduced.

The effect on total provider payments is the same as increasing the base rate, but the different payment mechanism is what enables the State share funding. **CMS should not withhold approval of this extension because we pay providers the same amount out of one pocket versus the other**.

Expansion is Insufficient

The State does still have the option of expanding the Medicaid program under the ACA to cover certain individuals not currently covered by Florida's Medicaid program. The pros and cons of expansion are being debated by our legislature at this time, and do not need repeating here. We were encouraged to see the message from CMS that extension of this waiver is *not* contingent upon expansion of our Medicaid program.

That is not to say that the two are wholly unrelated, and we understand that the Agency is seeking only that amount of LIP funding necessary to cover the estimated uncompensated care expected *as if* expansion was in place. **We strongly support that funding** because even if expansion takes place, a very significant amount of uncompensated care will still occur.

First, even when covered by Medicaid, hospital benefits are limited. For Memorial Healthcare System, the cost of services furnished to Medicaid eligible persons whose benefits were exhausted (or subject to share-of-cost reductions) amounts to almost 40% of the total cost of all Medicaid services.

Memorial Healthcare System also has a higher threshold for qualifying individuals for charity discounts: a full discount for individuals and families up to 200% of the poverty income guidelines, and a sliding scale discount up to 400%. Expansion of Medicaid does not go that far.

The Agency and others have already cited reports about the remaining uninsured after Medicaid expansion. CMS has itself acknowledged that even "universal" insurance coverage under the ACA does not completely eliminate the uninsured volume of services that will be needed. **We encourage CMS to continue helping us fill this gap by extending the funding of our LIP program**, a program that is **already working** to limit the growth of Medicaid expenditures while still encouraging the provision of the highest quality medical services.

We Need to Plan Now

Should CMS grant the requested extension, **we need to begin preparing immediately** for July 1, 2017. The reliance on local sources of funding to support the State share of Medicaid expenditures is an unfortunate reality in a State with no individual income tax source of general revenues. Florida has relied on local sources since the inception of its Medicaid program by requiring a County share for a percentage of the local Medicaid expenditures. The use of IGTs is simply another means of accessing local resources.

Continued local participation needs to be encouraged, and **we will need CMS assistance** to devise a means that is more sophisticated than simply increasing base rates so that those providers with access to local funding sources can continue to support the Medicaid program. Our patients are counting on us to solve this problem.

Thank you for consideration of our comments. We look forward to assisting in any way possible to help achieve this extension request.

Sincerely,

Scott J. Davis, CPA FHFMA
Administrative Director, Reimbursement & Revenue Integrity
Memorial Healthcare System
3501 Johnson Street
Hollywood, FL 33021

(954) 265-5105
SDavis@mhs.net

St. Mary's Medical Center
West Palm Beach, Florida

901 45th Street West Palm Beach, FL 33407
561.844.6300 www.stmarysmc.com

Palm Beach Children's Hospital
at St. Mary's Medical Center

May 8, 2015

1115 MMA Waiver Amendment Request
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, FL 32308

VIA E-MAIL TRANSMISSION:

St. Mary's Medical Center and the Palm Beach Children's Hospital appreciate the opportunity to comment on the proposed Low Income Pool (LIP) amendment. The continuation of a LIP program is vital to our ability to continue to be the safety net hospital for Palm Beach, Martin, St. Lucie, Okeechobee and Indian River Counties receiving over 3,500 transfers each year for advanced levels of care, especially for children.

The Palm Beach Children's Hospital at St. Mary's is a 142 bed embedded Children's Hospital operating under the license of St. Mary's Medical Center. The medical staff consists of over 200 pediatricians representing 34 pediatric subspecialties including Level I Trauma, congenital and open-heart surgery, advanced oncology and Level III Neonatal Intensive Care. Recently the Palm Beach Children's Hospital was asked to submit an application for membership to the Florida Association of Children's Hospitals (FACH) because our mission and pediatric admissions, especially of Medicaid patients, is greater than several of their current members.

St. Mary's is the 12th largest provider of Medicaid in Florida. On a yearly basis, 45% of our patients have Medicaid including 70% of the children admitted to the Palm Beach Children's Hospital at St. Mary's. Charity care and self-pay comprises an additional **10%** of our admissions. If Medicaid only reimburses at 48% of costs and the LIP replacement is not approved, there will be a serious negative impact on our ability to provide care for adults and especially children.

The Palm Beach Children's Hospital at St. Mary's joins with the Florida Association of Children's Hospitals in supporting the LIP Replacement Model submitted to federal CMS by AHCA, and believe that the proposal provides a sound approach to address low-income patient access and a sound financing model. The proposal recognizes that disproportionate volume of patient care provided by safety net hospitals, but is especially important to our children's hospitals, while addressing federal CMS policies.

The Palm Beach Children's Hospital at St. Mary's requests this letter be included in the public records and notes that our comments echo those you recently received from the FACH.

St. Mary's Medical Center and the Palm Beach Children's Hospital supports the:

- **Total funding level request of $2.167 billion** (state/local/federal)
- **Addresses Shortfall in Florida's DRG Pediatric Services Reimbursement**
  Florida's DRG reimbursement model does not cover the cost of hospital care for medically fragile babies and children. The new LIP replacement Model adjusts the DRG pediatric outlier policy to improve reimbursement to 80% of costs over $60,000 for pediatric patients' requiring severity level 3 & 4 treatment.
- **Modification of the current model to direct LIP funds into reimbursement rates and policy-based standards, such as critical-need services.**
- **Restructured Hospital Distributions**
  The LIP Replacement Model more broadly distributes funding and continues to encourage access for vulnerable populations.
- **Consolidated IGT Pool**
  The consolidated IGT pool serves to improve transparency and eliminate 'pay for play' of IGT contributors.
- **Incentivizes and Protects the IGTs Contributed**
  Contributors of the IGTs to the statewide pool are provided an assurance of a payment amount equal to the IGTs contributed, plus a reasonable incentive return.
- **Addresses New LIP Cost Cap Policies**
  Hospitals whose IGTs are used to subsidize the statewide Medicaid managed care capitation rates shall receive an exemption from their cost cap equivalent to the amount of the IGT.
- **Transition Period**
  The transition to a new LIP model is implied in this model, and will minimize financial chaos as Florida moves to a new supplemental funding program.
- **Teaching Faculty Funding**
  Medical school faculty support would be continued.

Your kind consideration of this request is truly appreciated. If you would like additional information about St. Mary's Medical Center and the Palm Beach Children's Hospital please contact me or Assistant Administrator, Don Chester, at 561-881-2892 or email don.chester@tenethealth.com.

Sincerely,

[redacted]

Davide M. Carbone, FACHE
Chief Executive Officer
St. Mary's Medical Center &
Palm Beach Children's Hospital

Cc Don Chester, Assistant Administrator Community and Government Relations
Tom Schlemmer, Chief Financial Officer
Brian Delburn, Manager Government Relations

Florida Association of Children's Hospitals, Inc.

May 13, 2015

1115 MMA Waiver Amendment Request
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, FL 32308

Via Fax: FLMedicaidWaivers@ahca.myflorida.com

RE: 1115 MMA Waiver Amendment Request

The Florida Association of Children's Hospitals submits the following comments regarding the LIP Model to Amend 1115 Waiver

The Florida Association of Children's Hospitals supports the LIP Replacement Model submitted to federal CMS by AHCA and believes that the proposal provides a sound approach to address low-income patient access and a sound financing model. The proposal recognizes the disproportionate volume of the patient care provided by safety net hospitals, particularly important to children's hospitals, while addressing federal CMS policies.

WE WOULD LIKE THE FOLLOWING COMMENTS TO BE INCLUDED IN THE PUBLIC RECORDS.

- **The Florida Association of Children's Hospitals (FACH) is a coalition of 15 children's hospitals. Combined, we provide nearly 57 percent of all pediatric hospital beds in Florida and 65 percent of all inpatient hospital days for children ages 0-17. These hospitals make up the backbone of the state's pediatric healthcare system. The hospitals provide care for the sickest and most vulnerable children; research cures for diseases affecting children; and train pediatricians, pediatrics specialists. and pediatric nurses.**
- **Florida's leading children's hospitals stand to lose a combined $354 million if low-income pool (LIP) funding isn't continued.**
- **If Medicaid only reimburses at 48% of costs, member hospitals will have no option but to eliminate and reduce programs, services and employees given LIP replacement is not approved.**

1650 Margaret St. #217
Jacksonville, Fl 32204

FACH SUPPORTS THE:

- **Total funding level request of $2.167 billion** (state/local/federal)

- **Modification of the current model to direct LIP funds into reimbursement rates and policy-based standards, such as critical-need services.**

- **Restructured Hospital Distributions**
  The LIP Replacement Model more broadly distributes funding and continues to encourage access for vulnerable populations.

- **Consolidated IGT Pool**
  The consolidated IGT pool serves to improve transparency and eliminate 'pay for play' of IGT contributors.

- **Incentivizes and Protects the IGTs Contributed**
  Contributors of IGTs to the statewide pool are provided an assurance of a payment amount equal to the IGTs contributed, plus a reasonable incentive return.

- **Addresses Shortfall in Florida's DRG Pediatric Services Reimbursement**
  Florida's DRG reimbursement model does not cover the cost of hospital care for medically fragile babies and children. The new LIP Replacement Model adjusts the DRG pediatric outlier policy to improve reimbursement to 80% of costs over $60,000 for pediatric patients' requiring severity level 3 & 4 treatment.

- **Addresses New LIP Cost Cap Policies**
  Hospitals whose IGTs are used to subsidize the statewide Medicaid managed care capitation rates shall receive an exemption from their cost cap equivalent to the amount of the IGT.

- **Transition Period**
  The transition to a new LIP model is implied in this model, and will minimize financial chaos as Florida moves to a new supplemental funding program.

- **Teaching Faculty Funding**
  Medical school faculty support would be continued.

Sincerely,

[redacted]

Jerry A. Bridgham, M.D.
President

From: Candice Tettamanti
Sent: Thursday, May 21, 2015 11:41 AM
To: FLMedicaidWaivers
Subject: LIP PUBLIC INPUT

May 20, 2015

Martin Health System welcomes this opportunity to weigh in on the Florida Agency for Health Care Administration's request for an extension of the Low Income Pool waiver.

The purpose of the Medicaid program is to allow low income citizens access to needed medical care. As the Navigant study pointed out, the current Medicaid rates Florida hospitals are paid are inadequate without supplemental funding. Even if our state government agrees on a way to expand Florida's current Medicaid program, hospitals will still need this additional funding. While the renewal application submitted by AHCA may not meet all of the changes requested by CMS, it is a good starting point that would keep the Medicaid program more adequately funded than the idea of letting this waiver expire without a substitute.

Hospitals in Florida are on the front-lines of care serving all patients regardless of their ability to pay. Hospitals in Florida are large employers, sometimes the largest employer for a community. It is not only for the health of our state but also for the good of our economic future that hospitals need CMS to maintain at least the current level of supplemental funding.

We ask that during the approval process, CMS keep these things in mind and do what is right for our state and her citizens. Thank you.

May 22, 2015

Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

1115 MMA Waiver Amendment Request

Dear Mr. Senior,

Right now state officials in Florida disagree over which pot of federal money the state should take to extend health coverage. As Floridians we feel the answer is simple: Florida should obtain all the federal money available to Florida either through federal waivers like the Low Income Pool (LIP) or the Affordable Care Act's Medicaid funding. The need for more affordable health coverage that enables all our state residents – regardless of their income level – to regularly see a family doctor or seek emergency treatment without fear of bankruptcy is too great.

We believe Florida's very high uninsured rate and large population necessitates substantial federal resources. However it is important to recognize that the Low Income Pool does not provide coverage to anyone in Florida. While LIP funds are needed in Florida, they will not address the fundamental challenge facing our health care system – that we have an incredibly high rate of uninsured residents (ranking 50th in the country) for whom primary and preventive care is not routinely available, and for whom medical emergencies result in bad debt for patient and provider alike. Large numbers of uninsured Floridians result in considerable cost-shifting to other payers in the system – most notably employers – who face rising premiums in the face of the state's large coverage gap.

Thank you for your consideration of our views.

[redacted]

Laura Brennaman PhD RN CEN
Health Policy Consultant, Florida CHAIN on behalf of:

Florida CHAIN

The Florida Center for Fiscal and Economic Policy

Organize Now

National MS Society

Florida Institute for Reform & Empowerment

Larry Floriani, Florida State Deputy Director of

Doctors for America

Florida Alliance for Retired Americans

May 22, 2015

BACKGROUND

I. Floridians need real health coverage, not just a Low Income Pool (LIP) Why?

The Low Income Pool (LIP) is not an insurance program or a health care program. It has been a federal/state pool of money used to partially reimburse hospitals and other safety net health care providers for the uncompensated or undercompensated care they provide to Floridians who have not had health insurance or are underinsured.

LIP is not health insurance. It doesn't cover well-child visits, annual physicals or preventive care. It doesn't pay outstanding medical debts or bring anyone peace of mind. Florida taxpayers deserve more than this outdated "band-aid" on their health care system.

Florida has had the LIP since 2005 yet still has the second highest percentage of uninsured adults in the nation. The LIP was not designed to reduce the number of Floridians without health insurance. Other states are seeing their uninsured rates drop while we're keeping roughly 1 million Floridians in this "coverage gap."

However, the LIP has helped some safety net hospitals and clinics remain operational in the face of the enormous amount of uncompensated care caused by the tremendous numbers of uninsured Floridians.

Florida should join other states and build a patient-focused Medicaid system that includes expanding eligibility with the enhanced federal matching dollars available under the Affordable Care Act. Doing so will improve the financial stability of Florida's health care providers as they experience a reduction in uncompensated care costs. It will also improve the financial security of Florida's families as they are able to afford the health coverage they so desperately need.

II. Floridians without insurance include parents, older adults and people we see every day. Most are working.

The majority of people eligible to get health coverage if Florida accepts federal money under the Affordable Care Act are already working. People in this uninsured "coverage gap" largely work in Florida's service industries in jobs like cashiers, cooks, hotel clerks and landscapers and have no option for health insurance through work. They need real health coverage – LIP doesn't provide that.

Uninsured parents with children present in the home account for 28 percent of the population potentially eligible for health coverage if the state accepts federal funding available for Medicaid under the Affordable Care Act. Of those parents, two thirds (63%) are employed and many of them are in jobs supporting Florida's service based, tourist dependent economy. Providing these parents with coverage will directly benefit children as well – who will grow up in families with healthier parents, greater economic security, and who will themselves be less likely to be uninsured.

FLORIDA LEGAL SERVICES, INC.

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BOARD PRESIDENT

May 22, 2015

1115 MMA Amendment Request
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308
FLMedicaidWaivers@ahca.myflorida.com

Re: Comments on Florida's April 20, 2015, Low Income Pool Amendment Request

Dear Mr. Senior:

On behalf of Florida Legal Services, Inc., (FLS) we are submitting these comments on Florida's Low Income Pool Amendment Request (Amendment Request) posted for public comment on April 20, 2015.

FLS is a statewide not for profit law firm representing low-income individuals and families on a range of poverty law issues, including access to health care. We very much appreciate the hard work of the Agency in providing an opportunity for public comment and in person meetings throughout the state. In that regard, we are hopeful that as the state (and CMS) moves forward, there will be full transparency at every stage of the negotiation to allow for public review and comment. However, we would like to express our disappointment that a preliminary agreement between the Centers for Medicare and Medicaid Services (CMS) and the Agency for Health Care Administration (AHCA or the Agency) was made public on May 21, 2015, prior to the end of the public comment period.

As an initial matter, it is important to note that the Amendment Request is identical to the Low Income Pool (LIP) plan proposed by the Florida Senate.[1] The Senate's LIP plan, however, unlike the Amendment Request, is part and parcel of a proposal that includes federal funding to

[1] Press Release, President's Office, Memo: Senate Plan for Medicaid Sustainability (March 19, 2015), *available at* https://www.flsenate.gov/Media/PressRelease/Show/2204.

extend coverage to uninsured low-income Floridians through the Florida Health Insurance Affordability Exchange (FHIX) plan. Senate President Gardiner reiterated this inexorable connection in his April 17, 2015 statement to the Senate, "As you are aware, the Senate proposed and passed a new LIP model ***based on the coverage expansion outlined in the FHIX program***"[2] (emphasis added).

We understand that the Agency lacks authority to include coverage expansion within the waiver amendment process. However, because the Senate's LIP proposal cannot be delinked from FHIX, we want to underscore that the concerns expressed in this comment letter relate strictly to the Amendment Request—and *not* to the Senate's LIP plan.

As consumer advocates, we understand and appreciate the role that LIP has played in sustaining a safety-net for uninsured low-income Floridians. However, LIP–either in its current form or as in the Amendment Request–does not address the problems of the uninsured in Florida in a rational way. A much more reasonable, rational approach is articulated in the principles outlined in CMS's letter of April 14, 2015.[3]

The July 31, 2014, letter sent by CMS to Florida's Deputy Secretary for Medicaid, confirming that LIP would end June 30, 2015, also required the state to commission an independent report that would "review the adequacy of payment levels, and the adequacy, equity, accountability and sustainability of the state's funding mechanisms for these payments."[4] The resulting Navigant Report (the Report) is now being relied on by the State as a reason for continuing LIP and for critiquing the CMS principles in the April 14, 2015, letter.[5]

In fact, the Report's conclusions support CMS' principles (as do we), particularly the first principle that "coverage rather than uncompensated care pools is the best way to secure affordable access to health care for low-income individuals." The Report's authors do note that "…Medicaid expansion would [not] do away with uncompensated care entirely."[6] Thus the

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[2] THE FLORIDA SENATE, WORKSHOP ON THE SENATE PLAN FOR MEDICAID SUSTAINABILITY, at 2 (Apr. 21, 2015), *available at* http://www.faast.org/sites/default/files/Supporting%20042415.pdf.

[3] Letter from Vikki Wachino, Acting Director, Centers for Medicare and Medicaid Servs., to Justin Senior, Deputy Secretary for Medicaid, Fl. Agency for Health Care Administration (Apr.14, 2015) [hereinafter *Vikki Wachino letter*], *available at* http://www.washingtonpost.com/r/2010-2019/WashingtonPost/2015/04/15/Editorial-Opinion/Graphics/florida_medicaid_letter.pdf. ("First, coverage rather than uncompensated care pools is the best way to secure affordable access to health care for low-income individuals. 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.").

[4] Letter from Cindy Mann, Director, Centers for Medicare and Medicaid Servs., to Justin Senior, Deputy Secretary for Medicaid, Fl. Agency for Health Care Administration, at 1 (July 31, 2014), *available at* http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/July312014ApprovalLetter.pdf.

[5] *Vikki Wachino letter*, *supra* note 3.

[6] *See, e.g.*, NAVIGANT HEALTHCARE, STUDY OF HOSPITAL FUNDING AND PAYMENT METHODOLOGIES FOR FLORIDA MEDICAID, PREPARED FOR: FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, at 185 (Feb. 27, 2015) ("The LIP program has been used to incentivize IGTs")[hereinafter *Navigant Report*], *available at* http://ahca.myflorida.com/medicaid/Finance/finance/LIP-DSH/LIP/docs/FL_Medicaid_Funding_and_Payment_Study_2015-02-27.pdf.

authors "hope the **DSH** program could continue even if Florida decided to undergo expansion"[7] (emphasis added). DSH refers to the Disproportionate Share Hospital Program, which is scheduled to be reduced under the Affordable Care Act.[8] By contrast, for LIP, the authors noted that "the **LIP** program on the other hand, could justifiably be reduced if the number of uninsured reduced significantly through expansion."[9] The Report underscored that there *are problems* with limited compensation for uninsured and underinsured, and the best way to mitigate these problems is with some form of Medicaid expansion.[10] In sum, the Navigant authors concluded that "expansion would significantly mitigate the problems associated with limited compensation for uninsured or underinsured."[11]

Indeed, if Florida were to adopt the Senate's plan this would allow enrollment of an estimated 770,000[12] individuals by July 1, 2015, and the opportunity to pay for their coverage at 100% Federal Medical Assistance Percentages (FMAP). This offers the state a critically important and potentially fleeting window of opportunity to mitigate the serious issues confronting our underfunded Medicaid system.[13] Significantly, CMS's letter of May 21, 2015 to the Deputy Secretary for Medicaid raise the question over whether or not "Florida reimbursement rates comply with the requirements of section 1903(a)(30)(A) of the Social Security Act."[14]

Moreover, there is simply not enough funding in the LIP program to reimburse Florida safety-net providers for their potential costs, even if they treated all of the uninsured who would be eligible for Medicaid expansion—not to mention boosting the Medicaid rates for these providers. For example, even in Miami-Dade County, whose public hospital gets far more LIP than any other hospital in the state, the funding is grossly insufficient to provide reimbursement for treating the County's low-income uninsured residents. Jackson Health System has a charity care program available to all county residents regardless of national origin.[15] This program costs the hospital

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[7] *Navigant Report*, *supra* note 6, at 185.

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

[9] *Id.*

[10] *Navigant Report*, *supra* note 6, at 203.

[11] *Id.*

[12] THE FLORIDA LEGISLATURE OFFICE OF ECONOMIC AND DEMOGRAPHIC RESEARCH, IMPACT ANALYSIS, LIP, IGTS, AND SB 2512, at 7 (Apr. 21, 2015), *available at http://edr.state.fl.us/Content/presentations/affordable-care-act/Expansion2015PresentationtoSenate.pdf*.

[13] *Vikki Wachino letter*, *supra* note 3, at 3; *Florida Pediatric Society/The Florida Chapter of the American Academy of Pediatrics v. Dudek*, No. 05-23037-CIV, (S.D. Fla. 2014). The Report also notes that the state of Florida has not yet implemented the sort of rate sustaining measures that have been adopted by other states, e.g. California, to support safety net providers in a managed care environment.

[14] *Vikki Wachino letter*, *supra* note 4, at 3.

[15] Jackson Health System, *Financial Assistance for Medical Care, available at* http://www.jacksonhealth.org/library/financials/financial-assistance-for-medical-care.pdf

$365 million.[16] Hospital officials report that 29,176 county residents are served.[17] That number includes 6,000 who would be ineligible for Medicaid expansion due to immigration status.[18] Thus, netting out the ineligible immigrants, the number served is only about 23,000. This represents less than the 20% of the County's residents in the coverage gap and approximately 12% of those who would be eligible for coverage if the state accepted federal expansion funding.[19]

Further, the lack of current funding (without Medicaid expansion) also contributes to barriers even for those who manage to get into the charity care program. Co-payments for services other than primary care and prescription drugs are fundamentally unaffordable. For example, the co-payments for a specialist visit for a person under 100% FPL is $40. Outpatient procedures, including dental, are $100. It is well established that these co-payments, which far exceed those allowed in the Medicaid program, create serious if not insurmountable barriers to care for indigent individuals. In addition, indigent residents in the charity care program are routinely subject to out of network billing by physicians who are not part of the Jackson charity care program, e.g. anesthesiologists.[20] When advocates and consumers have complained about these barriers, Jackson officials respond that there are inadequate funds to provide uncompensated care.[21]

Should CMS consider granting some or all of the LIP in the Amendment Request, it is critical that any new waiver terms include requirements that the safety-net providers receiving LIP funding (including hospitals and FQHCs) agree not charge co-payments that exceed those

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[16] Daniel Chang, *Advocates for poor say Jackson Health System bars needy from charity care*, MIAMI HERALD, (Aug. 28, 2014), *available at* http://www.miamiherald.com/news/local/community/miami-dade/article1983097.html.

[17] *Id.*

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

[19] According to AHCA, Medicaid recipients in Miami-Dade account for 18.26% of Medicaid recipients in the state of Florida. *(*FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, CURRENT COMPREHENSIVE MEDICAID MANAGED CARE ENROLLMENT REPORTS: SEPTEMBER 2014, at table 5, *available at* http://ahca.myflorida.com/mchq/managed_health_care/MHMO/docs/MC_ENROLL/RF_NR_SMMC/ENR_Sep2014.xls). Assuming that the percent of people in the coverage gap, per county, is roughly equivalent to the percent currently on Medicaid, per county, the number of people in the coverage gap in Miami-Dade County is derived by multiplying the number in the gap statewide, 669,000, (THE HENRY J. KAISER FAMILY FOUNDATION, THE COVERAGE GAP: UNINSURED POOR ADULTS IN STATED THAT DO NOT EXPAND MEDICAID – AN UPDATE (Apr. 17, 2015), *available at* http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/) by 18.26%, totaling approximately 122,000.

According to the Robert Wood Johnson Foundation and the Urban Institute, there are approximately 1,060,000 Floridians eligible for Medicaid expansion. (Stan Dorn, et. al., Robert Wood Johnson Foundation & Urban Institute, WHAT IS THE RESULT OF STATES NOT EXPANDING MEDICAID, at 5 (Aug. 2014), *available at* http://www.urban.org/UploadedPDF/413192-What-is-the-Result-of-States-Not-Expanding-Medicaid.pdf). As stated above, Medicaid recipients in Miami-Dade account for 18.26% of Medicaid recipients in the state of Florida. Assuming that the percent of people eligible for Medicaid expansion, per county, is roughly equivalent to the percent currently on Medicaid, per county, the number of people eligible in Miami-Dade County is derived by multiplying the number eligible statewide, 1,060,000, by 18.26%, totaling approximately 190,000.

[20] *See supra* note 16.

[21] *Id.*

allowed under Medicaid; that hospital LIP recipients comply with the new IRS rules under the ACA;[22] that hospitals establish eligibility for their charity care programs that use the same income methodology as MAGI; that verification of income requirements also be similar and no more onerous than applying for insurance under healthcare.gov; and, that all services provided under the charity care program be included, i.e. no out of network billing allowed.

Additionally, the amendment request, while claiming to address the lack of transparency and accountability, does not provide any plan for how the newly promised "transparency and accountability" would occur. Any potential new program should include very specific monitoring provisions, including for the Tier-one Milestone distributions. Again, the Navigant Report noted the serious lack of funding for monitoring.[23] And for these new monitoring provisions to be meaningful, they must also include funding for monitoring activities by independent entities not associated with the LIP recipient. Ideally, monitoring should include a role for entities that have an institutional connection to low income uninsured individuals, e.g. local legal aid programs. Legal services programs (or other consumer advocates) could fill the current monitoring void and help actually "ensure" some local accountability for what the Amendment Request promises: "*the newly redesigned LIP* ***ensures access*** *to care for low income populations that are not eligible to participate in Medicaid*."[24]

Thank you for your consideration.

Sincerely,

/s/ Miriam Harmatz
Miriam Harmatz
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Florida Legal Services, Inc.
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[22] 26 U.S.C. § 501(r)(3)-(6).

[23] *Navigant Report*, *supra* note 6, at 142.

[24] FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, *Low Income Pool Amendment Request*, at 1 (Apr. 20, 2015), *available at* http://ahca.myflorida.com/medicaid/statewide_mc/pdf/mma/Public_Notice_Document_LIP_Amendment_Req.pdf.

SNHA Safety Net Hospital Alliance of Florida

May 22, 2015

Victoria Wachino, Director
1115 MMA Waiver Amendment Request
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

Dear Director Wachino:

On behalf of the Safety Net Hospital Alliance of Florida I am submitting comments for the Centers for Medicare & Medicaid Services' (CMS) consideration regarding Florida's proposed 1115 Medicaid Managed Assistance (MMA) waiver authorizing a redesigned Low Income Pool (LIP) supplemental funding program. We believe this proposal represents substantial progress toward CMS' stated principles for Medicaid payments. Specifically, the Florida LIP redesign: reimburses providers directly rather than payment through the LIP; supports access to care for low-income patients; and "continues to foster and protect its safety net providers."

The Safety Net Hospital Alliance of Florida's (SNHAF) 14 members represent Florida's top teaching, public, children's, and regional perinatal intensive care center hospitals. SNHAF members shoulder a disproportionate share of Florida's hospital care responsibilities while providing highly specialized medical care and innovation. While SNHAF members account for only 10% of the state's hospitals they provide 100% of all pediatric level one trauma care, over 88% of all level one trauma care, 72% of graduate medical education programs, 41% of all charity care, and 40% of all Medicaid days. In fact, we provide almost 2½ times more charity care days than all of the for-profit hospitals in the state combined.

The SNHAF has been assisting state and national policy makers construct effective Medicaid policy for more than three decades. Last year we worked closely with CMS for their approval of the 2014-15 LIP extension and expansion for demonstration year 9 (DY9) of Florida's MMA waiver. The 2014-15 LIP model averted a Medicaid crisis by providing critical financial support for safety net hospitals during Florida's transition to statewide managed care, thereby protecting access to essential health care services for the medically underserved.

In the DY9 authorizing letter CMS made clear its expectation that there would be future changes in the state's supplemental payment policy. We believe the changes detailed in the supplemental payment program proposal submitted by Florida's Agency for Health Care Administration on April 20th provide a sufficient path to meet those expectations while strengthening a foundation for the expansion of coverage.

In accordance with the DY 9 Special Terms and Conditions, CMS mandated a study of hospital funding and payment methodologies for Florida Medicaid. After completing an exhaustive analysis, Navigant Healthcare found that the LIP funds "are critical for maintaining access to essential hospital services for the State's large Medicaid and uninsured population. Not having these funds available for Florida's hospitals may exacerbate an already tenuous situation." (Navigant pg. 207)

The SNHAF believes the proposed LIP redesign accomplishes three of your stated goals and request's total funding authorization of $2.167 billion (local/state/federal).

Medicaid payments should support services provided to Medicaid beneficiaries and low-income uninsured individuals.

The proposal's new program ties funding of critical-need tertiary care to payments for services. The program creates an "Essential Community Providers (ECP) / Tertiary Services" pool of funding for enhanced payments for all critical-need tertiary services and to federally designated ECPs (such as trauma and regional perinatal intensive care centers) who experience high volumes of Medicaid, uninsured patients and patients with complex care.

It accomplishes three of CMS objectives by uniformly authorizing payments for tertiary care; supporting all critical safety-net hospital services, regardless of the hospitals participation in the consolidated IGT pool (described below); and distinctly tracks tertiary care provided to high volumes Medicaid, uninsured, and complex needs patients.

(Navigant Report, pgs. 180-181) "… The rates can be set by category of hospital to account for justifiable variations in cost structures and different levels of Medicaid utilization." "This option has the distinct advantage of being rationally based, would be consistent with the U.S.C. 1396 (a)(30)(A) standard related to efficiency and economy, and adequate access to quality care, a requirement for CMS."

Provider payment rates must be sufficient to promote provider participation and access, and should support plans in managing and coordinating care.

The proposal both increases access to services for Medicaid beneficiaries and low-income individuals, and promotes provider participation, by directing more funds into Medicaid reimbursement base rates. The proposal increases the amount of funds to support managed care capitated base rates by $203 million. A total of $1 billion is uniformly provided to managed care capitated rates to bring reimbursements more into alignment with the cost of providing care and thereby improving the adequacy of managed care plan networks. This base rate increase addresses Navigant's cautionary finding that the "hospitals that did not receive IGT rate enhancements were paid on average 45% of their costs", resulting in pay-to-cost ratio that is inequitable and not actuarially sound reimbursement. (Navigant Report, pg. 207).

Additionally, where Florida's current DRG reimbursement model does not cover the costs of hospital care for medically fragile children, the proposal addresses this shortcoming by adjusting the DRG pediatric outlier policy and improving reimbursement for the severity levels 3 & 4 treatment to 80% of costs over $60,000. This increase of the pediatric outlier improves a defect in the current DRG model to incentivize access to care for critically ill and injured children.

Enhances transparency and eliminates 'pay-for-play' of IGT contributors by consolidating all IGTs into a single pool.

The proposal eliminates 'pay-for-play' by setting a uniform benefit to IGT contributors by consolidating their contributions into a single transparent funding pool. This new pool complies with Navigant's recommendation "to phase-in the LIP 6 reductions over the span of the two-year 'bridge' period", by reducing the current LIP 6 return on IGT's by 51%. Furthermore, this new consolidated IGT pool exceeds by 30%, the Navigant recommendation for a first year reduction in LIP 6 return on IGTs. (Navigant Report pg. 200)

It is vitally important that Florida's proposal – or something similar – be approved. SNHAF member hospitals' care for the state's most sick and vulnerable citizens and would be jeopardized should their LIP supplemental rate enhancements end precipitously. Allowing the LIP program to expire prematurely will do real and lasting harm to our safety net and teaching hospitals and by extension our communities, friends and loved ones. This commitment, and the financial challenges our safety net hospitals face, is best portrayed by one of our members in a recent letter to Governor Scott (attached).

Sincerely,

[redacted]

Anthony Carvalho
President

Attachment