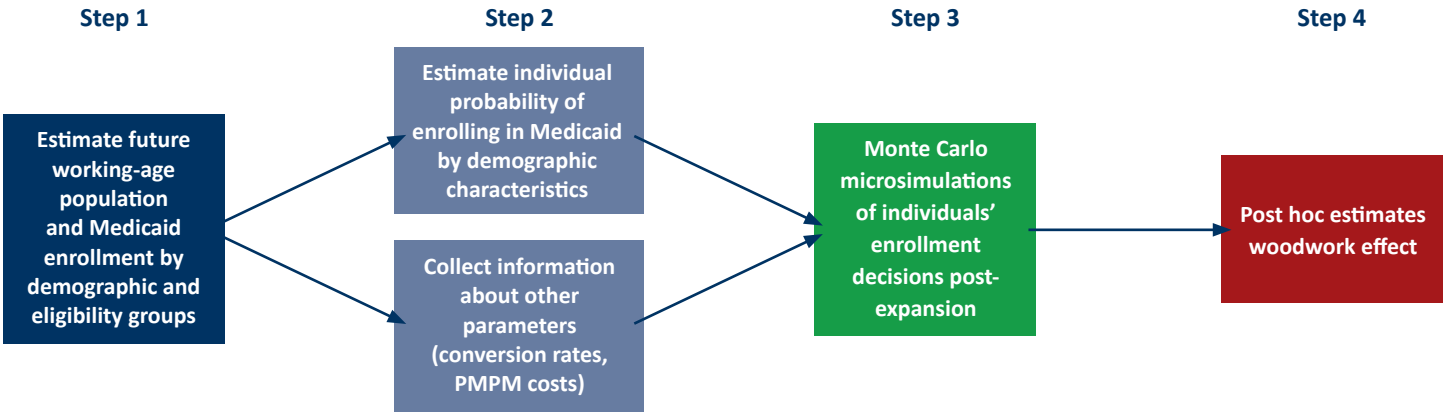
APPENDIX
(Research Methodology)

SUMMARY

This appendix provides a detailed explanation of the research methodology and procedures Leavitt Partners used to estimate the potential enrollment and cost effects of Medicaid expansion in the state of Florida. Details concerning the data resources, statistical models, and research processes are subsequently provided. First, the population sizes and Medicaid enrollment totals of various demographic and program eligibility groups out to 2024. Then, the experience of persons in prior expansion states were used to predict the likelihood that individuals with those demographic characteristics in Florida would enroll in Medicaid post-expansion. Using secondary research and expert input, parameters were generated for the rate of conversion from base to expansion for specific groups in the base Medicaid program and the cost per member per month (PMPM) for each group. With this data, a Monte Carlo microsimulation (10,000 iterations) estimated a range of likely enrollment and budgetary impacts.

Figure 1: Methodology Process



The following sections in this document describe in more detail how the process illustrated above is accomplished, and includes explanations of key program features, data sources, and estimation procedures. The paper also presents some preliminary results from the Florida analysis.

FLORIDA MEDICAID CURRENT PROGRAM CATEGORIES

SUPPLEMENTAL SECURITY INCOME (SSI)

Generally, enrollees in this category are eligible for Supplemental Security Income (SSI) and/ or have been deemed to have sufficient functional limitations or are above 65 and below the income level for people with disabilities, which is about 88 percent of the federal poverty level (FPL) in Florida.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) PARENTS

This category includes low income children eligible for Medicaid, as well as their parents if the family income is below 32 percent of the FPL and meet the income criteria for inclusion in the Medicaid program. Pregnant women below 196 percent of the FPL, eligible under SOBRA,[1] are included in this category as well for rate setting purposes, though information on enrollment and supplemental payments for delivery services are available. The paper reports pregnant women and TANF parents as separate categories in the paper's results.

FAMILY PLANNING WAIVER

This is a limited benefit program that provides family planning services to enrollees under 196 percent of the FPL. It is provided with a 90 percent federal match rate.

BREAST AND CERVICAL CANCER (BCC) PROGRAM

This is a special program for uninsured women under 200 percent of the FPL diagnosed with breast or cervical cancer. Expenditures for these services are matched at the enhanced Federal Medical Assistance Percentage (FMAP) used for the Children's Health Insurance Program (CHIP).

MEDICALLY NEEDY

Persons with assets or income above the Medicaid eligibility standards who are otherwise eligible for Medicaid and have accumulated significant medical bills may receive Medicaid benefits on a medically needy basis by spending down to certain income levels. There are medically needy pathways for both disabled individuals (SSI) and parents (TANF).

LONG-TERM CARE (LTC)

While long-term care (LTC) services are not covered for the expansion population, the research does include simulations of LTC enrollment and costs for the base program in the estimates.

DATA SOURCES

To simulate Medicaid expansion enrollment and costs in Florida, the data sources listed below. Official data sources from Florida's Agency for Health Care Administration (AHCA) and the Census Bureau were used where possible, supplemented when necessary by data from other states and non-government third parties.

- Monthly Medicaid enrollment and eligibility reports from AHCA for January 2014 through February 2019, which includes enrollment breakdowns by age, eligibility category, race, gender, and region.[2]
- Managed care rate data by rate cell and region covering the periods from 2016 – 2019.[3]
- Population demographic data from the American Community Survey (ACS) Public Use Microdata Sample (PUMS), which contains individual-level responses to the ACS for the years 2008 – 2017.[4]

[1]This eligibility category was established under the Sixth Omnibus Reconciliation Act of 1986, hence the acronym "SOBRA" commonly used to identify the group.
[2]The AHCA's Finance and Analytics website includes enrollment reports at http://www.fdhc.state.fl.us/Medicaid/Finance/data_analytics/enrollment_report/index.shtml and eligibility reports at http://www.fdhc.state.fl.us/Medicaid/Finance/data_analytics/eligibles_report/index.shtml.
[3]AHCA's Finance and Analytics site posts managed care capitation rates at http://www.fdhc.state.fl.us/medicaid/Finance/data_analytics/actuarial/index.shtml.
[4]American Community Survey Public Use Microdata Sample, 2008 – 2017. US Census Bureau. https://www.census.gov/programs-surveys/acs/technical-documentation/pums/about.html.

- Income and eligibility threshold trends for 2014 – 2019 compiled by the Kaiser Family Foundation and Georgetown University Center for Children and Families.[5]
- The Medicaid-to-Medicare fee index calculated by Urban Institute researchers in March 2017.[6]
- Data from comparable programs in Florida's Medicaid program were used to estimate costs in the family planning and breast and cervical cancer programs with appropriate adjustments for cost and geography that will be explained below.
- State estimates from a Kaiser Family Foundation report on the medically needy[7] and a Florida Legislature Office of Economic and Demographic Research report that included estimates of medically needy spending[8] were used to estimate costs for the medically needy.
- 2016 report from Robert Wood Johnson Foundation State Health Reform Assistance Network examining the impact of Medicaid expansion in 11 states and the District of Columbia related to budget savings and revenue gains.[9]

PREPARING THE SIMULATION DATASET

POPULATION AND ENROLLMENT DISTRIBUTIONS

Using February 2019 Florida Medicaid enrollment data, a joint distribution of Medicaid enrollees was first created by the following factors:

- Age (19 – 20, 21 – 35, 36 – 54, and 55 – 64)
- Gender
- Pregnancy
- Parental status, based on enrollment category
- Disability status, based on enrollment category
- Race and ethnicity (white non-Hispanic, black non-Hispanic, other)[10]
- Medicaid region (there are eleven Medicaid rate-setting regions in Florida, as well as a 12th that captures out-of-state enrollees)
- Major enrollment category (SSI, TANF parents, pregnant women, family planning, breast and cervical cancer, long-term care, and medically needy).

This exercise yielded a percentage of enrolled persons in each of the demographic profiles, or cells, jointly defined by these factors. A similar distribution was created with the same cells, for the Florida working-age population based on a weighted average of the ACS PUMS data for 2017 (weighted 4x), 2016 (2x), and 2015 (1x).

Thus, each unique demographic profile defined by the listed factors has an estimate of the percent of Medicaid enrollees and the percent of all working age adults who fit that profile. For Medicaid enrollment, the percentages sum to 100 within each major enrollment category. The population percentages are based on all working-age adults. This distribution is used in combination with the forecasts described below to project the sizes of these cells in each month out to 2024.

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[5]Referenced for aged/ blind/ disabled eligibility limits: Molly O'Malley Watts, Watts Health Policy; Elizabeth Cornachione and MaryBeth Musumeci, Kaiser Family Foundation, Medicaid Financial Eligibility for Seniors and People with Disabilities in 2015, (Washington, DC, Kaiser Family Foundation, February 2016) adjusted to reflect 2017 SSI Standard and 2017 FPL and updated to reflect state policy changes as of January 1, 2017. Results reported at https://www.kff.org/medicaid/state-indicator/medicaid-eligibility-through-the-aged-blind-disabled-pathway/. Referenced for all other eligibility categories: Kaiser Family Foundation, Annual Updates on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP; https://www.kff.org/medicaid/report/annual-updates-on-eligibility-rules-enrollment-and/; Results reported at https://www.kff.org/state-category/medicaid-chip/, "Trends in Income Eligibility Limits for Adults."

[6]Stephen Zuckerman, Laura Skopec, and Marni Epstein, "Medicaid Physician Fees after the ACA Primary Care Fee Bump," Urban Institute, March 2017. Original report at http://www.urban.org/research/publication/medicaid-physician-fees-after-aca-primary-care-fee-bump. Compiled results at https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index.

[7]https://www.kff.org/wp-content/uploads/2013/01/4096.pdf

[8]http://edr.state.fl.us/Content/presentations/affordable-care-act/SB2-AHousePresentation_ImpactAnalysisAsFiled.pdf

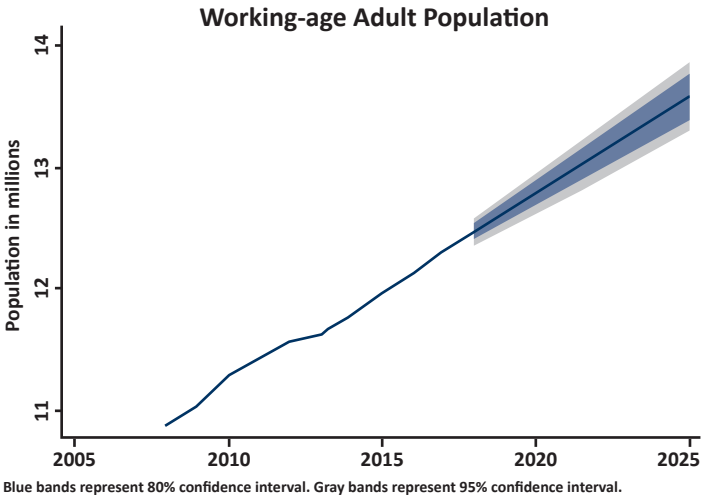
[9]States Expanding Medicaid See Significant Budget Savings and Revenue Gains, State Health Reform Assistance Network, March 2016, https://mazusw1wa001.azurewebsites.net/Insights/White-Papers/2016/States-Expanding-Medicaid-See-Significant-Budget-S

[10]The AHCA reports do not make clear the exact definitions of the three racial categories, particularly the assignment of Hispanics to the other category. Assuming all Hispanics are included in the "other" category yields a comparison to ACS data that is better than the alternatives, but some discrepancies in racial distribution across the two data sets do remain. The assumption on racial categorization likely biases the results on cost and enrollment upward, if at all.

FORECASTING

The total annual working age adult population of Florida was projected using autoregressive integrated moving average (ARIMA) models, a commonly used time series forecasting method, implemented in R's auto.arima package.[11] These projections were made out to 2024. The ACS data—used as the basis of these forecasts—is available through 2017 and projections begin in 2018. Forecast results are depicted in the figure below. The total forecasts and most recent available distributions were used because forecasts within each demographic profile were not feasible. Attempts to use time series methods to project specific group sizes directly did not produce reliable forecasts because of relatively short time series and/or very volatile trends.

Figure 2: Florida Population Ages 19 – 64, Historical and Forecasted



Source: Leavitt Partners analysis: ARIMA model forecasts and historical trends from ACS PUMS data.

Available data does not allow estimation of a reliable time series model to predict Medicaid enrollment. Instead, compound monthly growth rates (CMGR) were used for each eligibility category and/or region grouping in the AHCA data. The CMGRs are calculated using monthly enrollment data from January 2017 through March 2019.[12]

These growth rates were calculated for each group specifically, and range from -23.0 percent to 4.7 percent, with an unweighted average of 0.0006 percent. The TANF base program groups had an unweighted average CMGR of 0.0003 percent, while the SSI base program group averaged a -1.6 percent growth (unweighted). The largest positive and negative growth rates tended to be in the dual eligible groups and some of the SSI groups (base and long-term care) in smaller regions. The small weight on those more extreme growth rates for small groups means they do not affect the overall forecasts as much, so resulting growth rates in the model will be closer to zero. Specific CMGRs that went into the model as inputs are available upon request. One way to get an approximate view of the CMGRs by major category is to calculate the annual growth rates of the model enrollment results and divide by 12 to put the growth in monthly terms, shown in the table below.

[11]Specifically, the best model function of the auto.arima package in R is employed, which selects an optimal model by minimizing information criteria statistics.
[12]There was a large change in enrollment from July to August 2016 due to a change in the way Florida counted SSI beneficiaries. The reported enrollment before 2017 is excluded to avoid this change, which would skew the estimated growth rates.

Table 1: Compound Monthly Growth Rates from Model Results

Eligibility Category	CMGR from Model Results
Overall	-0.1%
TANF	-0.3%
Pregnant Women	-0.5%
SSI (Blind and/or disabled)	0.2%
Medically Needy	0.9%
Long-term Care	0.6%
Family Planning	-0.4%
Breast and Cervical Cancer	0.9%

These estimates of total population size and eligibility category enrollment were used to estimate total population and enrollment in each cell of the distribution created above. It is assumed that the population and enrollment distributions created above remain constant over time. This allowed for the application of each cell's percent of the total population to the total population forecast to obtain an estimate of the population size in that cell. The same was done for each Medicaid enrollment category, using the appropriate forecasts. A simulation dataset of the number of working-age people and Medicaid enrollees in each cell in each month from 2018 to 2024 was thus obtained. Given the inability to estimate more robust time series models at the group level, the research illustrates the assumption of a constant distribution was the best that could be made for this analysis.

COSTS PER MEMBER PER MONTH (PMPM)

Managed care rates in Florida for the base programs (including maternity kick payments for delivery services and supplemental payments for cancer and teaching hospitals in some regions, and excluding dental and LTC) have been either flat or declining within specific regions and cells for the past few years. As such, there is no way to reliably project cost increases for these categories. Cost can not be expected to continue to decline as they have. The paper makes the assumption that within each region and rate cell, rates will remain at their most recent reported levels (which are in effect through September 2019). The discuss the uncertainty simulated around these estimates is discussed below. The paper does allow for the overall statewide rates to change based on changes in the relative enrollment mix across region, as indicated by enrollment forecasts.

Managed care rate data and a method similar to that employed for Medicaid enrollment, based on compound annual growth rates, were used to project PMPM costs for long-term care and dental benefits. Projections were made for each rate cell and region.

Once all these forecasts were made, appropriate rates and payments were blended to obtain PMPM cost estimates for each category. These estimates take into account age, region, HIV and other special plan enrollment, and the split between home- and community-based services (HCBS) and institutional care in the LTC group. Maternity kick payments, which are disbursed on a one-time basis, were apportioned on a PMPM basis with the assumption that pregnant women are enrolled in Medicaid for an average of 7.7 months.[13]

Fee for service populations in Florida Medicaid include the medically needy, family planning program participants, and breast and cervical cancer program participants. Data on spending for these programs was not directly available, so many inferences and assumptions had to be made for these categories. For the medically needy, the research relied on 2011 data reported in a Kaiser Family Foundation report. Inflating these numbers forward yielded estimates consistent with a Florida Legislature EDR report from 2015. The paper estimates the 2016 PMPM cost for TANF medically needy enrollees to be $1,293.72, and the cost for SSI medically needy enrollees to be $6,467.70. These rates were blended into an enrollment weighted average for purposes of the simulation model.

[13]This figure is consistent with experience reported in Utah; see https://medicaid.utah.gov/Documents/pdfs/annual reports/medicaid annual reports/MedicaidAnnualReport_2017.pdf.

Family planning and breast and cervical cancer program costs were based on figures for similar programs in Florida. The Florida PMPM costs were adjusted using a Medicare-based geographic cost adjustment and the Medicaid-to-Medicare fee index reported by KFF. The Florida Medicaid payments for these programs were first converted to Medicare rates, using Florida's fee index of 0.85. Then the geographic adjustment for Medicare prices were applied. Finally, Florida's fee index (0.56) was applied to convert back to Medicaid rates. This yielded 2017 PMPMs of $2,516.56 for breast and cervical cancer programs and $8.30 for the limited-benefit family planning program.[14] PMPMs for these two programs and the medically needy were inflated using the CPI-U for the southern region, which was 2.224 percent in early 2019.[15]

For the childless adults not previously eligible for Medicaid, it is assumed that their costs will look similar to those of (non-pregnant, non-disabled) TANF parents, but with a 9 percent upward adjustment. The upward adjustment is justified based on projections given in a Centers for Medicare & Medicaid Services (CMS) Office of the Actuary report from 2017, which uses experience from early expansion states.[16]

UPTAKE

To predict new enrollment in Medicaid expansion (uptake rates) in Florida, the paper estimated a logistic regression model of Medicaid enrollment among working age populations in Medicaid expansion states. The model controlled for the factors used in the joint distribution (listed above), as well as the following variables:

- The state's uninsured rate in the year prior to expansion.
- The state's most recent program participation rate, as calculated by the Urban Institute and reported by Kaiser Family Foundation.[17]
- A 0/1 indicator for whether the state expanded Medicaid through an 1115 waiver.
- Indicator variables for the number of years from expansion to account for any ramping up of the expansion program.
- A continuous year term to capture the changing levels of uptake over time. The paper tested quadratic and cubic specifications, which were found to be less efficient than the linear specification according to Bayes Information Criteria.

Finally, the paper controlled for whether the person's household income was over 138 percent of the FPL. The results of the regression model are shown in the table below.

Table 2: Logistic Regression Model of Medicaid Uptake in Expansion States after Expansion

	Change in Odds Ratio	Std. Error
Age (Baseline: 19-20)		
21-35	1.650	0.010
36-54	1.531	0.009
55-64	1.620	0.010
Female	0.818	0.002
Pregnant	1.756	0.014
Parent	1.485	0.004
Disabled	103.319	0.970
Native American	1.678	0.016

[14]The family planning PMPMs line up well with figures given in a 2018 Florida State University evaluation report on the program, online at http://www.ahca.myflorida.com/medicaid/Policy_and_Quality/Quality/performance_evaluation/MER/contracts/med184/MED184_Deliverable_7_Final_Evaluation_Report.pdf.

[15]Medicaid PMPM inflation has exhibited slower growth than PMPM rates for commercial payers and Medicare and is therefore more accurately reflected by the CPI-U than by the health care price index

[16]https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2017.pdf

[17]The KFF page is https://www.kff.org/medicaid/state-indicator/medicaidchip-parent-participation-rates, which cites the following source: Urban Institute tabulations of 2013/2015 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS) from: Genevieve Kenney, Jennifer Haley, Clare Pan, Victoria Lynch, and Matthew Buettgens. Medicaid/CHIP Participation Rates Rose among Children and Parents in 2015, The Urban Institute, Washington, DC, May 17, 2017. http://www.urban.org/sites/default/files/publication/90346/2001264-medicaid-chip-pariticipation-rates-rose-among-children-and-parents-in-2015_1.pdf

	Change in Odds Ratio	Std. Error
Race (baseline: African American, not Hispanic) Hispanic and Other Races White, not Hispanic	 0.718 0.485	 0.003 0.002
Over 138% FPL	0.117	0.000
Year	0.958	0.002
Years from Expansion	1.240	0.003
State Expanded through 1115 Waiver	0.960	0.004
Uninsured Rate in Rate before Expansion	1.552	0.054
Medicaid Participation before Expansion	7.740	0.197
Model Constant	3.20E+36	1.44E+37
Number of Observations Psuedo R-Squared	6,336,208 0.262	

Source: Leavitt Partners Analysis of ACS data from Medicaid expansion states.

Note: Due to large sample size, all coefficients are statistically different from 0, with $p < 0.001$ in all cases.

The paper estimated uptake models that included state average monthly unemployment rate as a control for economic conditions, but the resulting uptake estimates were unreasonably low when compared to actual experience. Model fit did not improve at all with inclusion of the unemployment rate variable, so it was excluded from the final version.

ADMINISTRATIVE COSTS

In determining the administrative costs, an average per member cost was calculated after deducting the school based administrative costs which are clearly not applicable to the administrative cost of this population. The paper did retain all other administrative costs and included all populations within the calculation. The paper did not attempt to risk adjust the administrative costs, nor did it deduct other administrative costs or eliminate populations from the calculation. The paper assumes the adult expansion population would be quickly incorporated into managed care where much of the administrative activities that would vary based on the risk of the population would occur. Activities will be weighted to functions like eligibility determinations, Medicaid Management Information System (MMIS), Early Intervention Services (EIS), and other system programming and operations, program integrity, quality oversight, etc.

The 2016 CMS expenditure report shows AHCA's Medicaid administrative costs to be 3.45 percent of the program's total cost.[18] Total Medicaid and CHIP expenditures were $23,105,784,125, so total administrative costs were $769,286,722. However, $259,460,994 of the administrative costs were for school-based services. This was deducted from the total administrative cost leaving $509,825,728 in net administrative costs. The net federal participation rate after netting out the school-based component is approximately 62 percent.

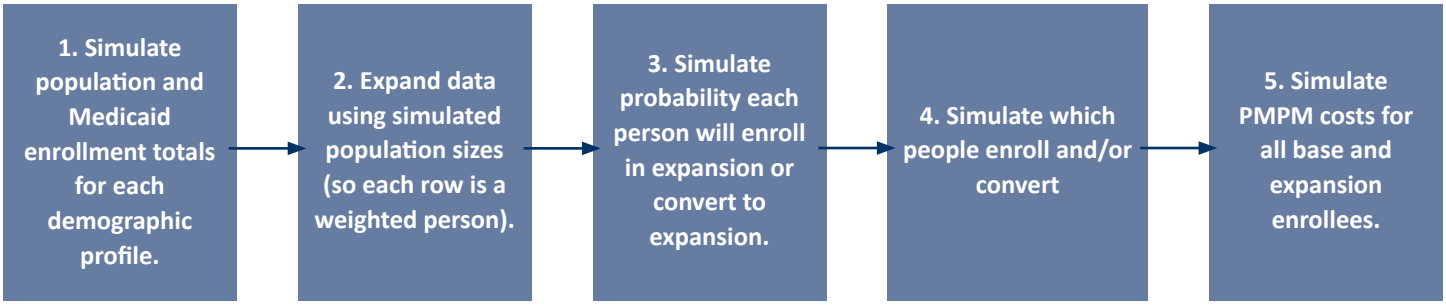
With a December 2016 total Medicaid CHIP enrollment of 3,945,000,[19] the per enrollee total computable administrative cost is approximately $106.22 per year per average monthly enrollee. Based on the 62 percent match rate, the state share equates to $40.36 per year.

[18]See Medicaid.gov report, *What Are Annual Expenditures for Medicaid and CHIP?* (The report uses 2016 reported cost figures) https://www.medicaid.gov/state-overviews/scorecard/national-context/annual-expenditures/index.html.
[19]Medicaid and CHIP December 2016 enrollment report: https://www.medicaid.gov/medicaid/program-information/downloads/updated-december-2016-enrollment-data.pdf.

MICROSIMULATION

The parameters from the uptake regression model were applied to the simulation dataset, including standard errors. This resulted in a dataset with population sizes and Medicaid enrollment numbers for each demographic profile, along with predicted probabilities of uptake and conversion for a person in that profile and PMPM costs for base and expansion persons as appropriate. Each demographic profile in each month has a weight for total population size and Medicaid enrollment in the group, as determined by applying the distribution percentages to the forecast totals. Each profile also has a standard error (from the forecasts) on these population and enrollment totals.

Figure 3: Logistic Regression Model of Medicaid Uptake in Expansion States after Expansion



A Monte Carlo microsimulation model with 10,000 iterations was then ran with this data. Each iteration proceeded as follows:

1. Starting with the dataset described in the paragraph above, simulate population size and Medicaid enrollment by demographic group.
2. Expand the dataset to the person level, each person in the dataset representing approximately 100 actual working-age Florida residents, with weights to preserve the total simulated sizes in each demographic profile.
3. Simulate, for each weighted person, the probability of uptake (eligible, but not enrolled in base program) or conversion (enrolled in base program), as appropriate for each person.
4. Pick a random number between 0 and 1 from a uniform distribution and compare to the predicted probabilities, to simulate which of the people in the data set will take up or convert.
5. Simulate the total PMPM cost for each person simulated to be enrolled in the expansion portion of the program. Base program costs were fixed at the levels calculated above, inflated annually as described above.

The parameters being simulated are described below in more detail:

- The size of the population and the number of Medicaid enrollees in each demographic group, based on the forecast estimates and standard errors. Where compound growth rates were used to forecast, the standard error is based on the standard error of the mean growth rate. For ARIMA model forecasts, the standard errors were obtained directly from the model. Once this step was complete, the dataset was expanded and the rest of the parameters were simulated at the individual level, with each record representing approximately 100 people. Actual weights varied depending on the population size, but the simulated total population counts were preserved in the weighting for each iteration.
- The likelihood that working-age adults in Florida not already on Medicaid would enroll as a result of the expansion. These simulated parameters were based on the predicted probabilities and standard errors from the regression model of uptake. Uptake probabilities were constrained to be between 0 and 1.
- The likelihood some groups already enrolled in Medicaid would be converted from the base program to the expansion. All conversion probabilities were constrained to be between 0 and 1. Note that all conversion parameters are based on predicted overall conversion and may not necessarily represent a behavioral response by specific individuals. The shifts could be either actual individual-level shifts from the base program to expansion or overall shifts as some individuals leave the program and similar others enter under new eligibility options. Specific subgroup parameters were simulated as follows:
    - Blind and/or disabled: To simulate the cumulative percent of blind and/or disabled individuals in the base program

who would convert to the expansion (including newly enrolled base-eligible disabled persons who opt to forego a disability assessment), the following formula is used.

Equation 1: Simulated SSI Conversion Calculation

$$conv(year) = \begin{cases} if\ year < years: & \left(\frac{max\ conv - first\ year\ conv}{years}\right) * year + first\ year\ conv \\ else: & max\ conv \end{cases}$$

Year represents the year from expansion, starting at 0. *First year conv* is the estimated conversion percentage in the first year of expansion (year 0). *Max conv* is the estimated percentage of converted enrollees in the long term. The function causes conversion in each year to level off after this maximum level is reached. The *years* term represents the number of years it will take to reach that maximum conversion rate. Together, these three parameters estimate a linear ramp-up in conversion. This ramp-up is important to consider because of the time it will take to process new disability applications for Medicaid. It is possible for the ramp-up to be slightly nonlinear, but the paper opted to to assume linearity for efficiency in estimating the model and because of the essentially linear nature of disability application processing (meaning nonlinearity is unlikely to occur in reality). Based on expert experience, the paper estimates that the first-year conversion rate to be approximately 1.25 percent, with a standard deviation of +/- 0.25 percent. A 2016 study of pre-Affordable Care Act (ACA) Medicaid expansion and SSI enrollment found that SSI participation declined by about 7.4 percent in states that expanded their adult Medicaid eligibility, with a standard error of 2.4 percent.[20] The paper uses these estimates in simulating the long-term conversion parameter. Finally, the conversion is expected to level off in year 3 from expansion, +/- 1 year, and constrained to be between year 1 and year 5. The paper simulates these parameters once per iteration, but each base-enrolled blind and/or disabled person is assigned a random number to determine whether they convert or not based on that iteration's simulated conversion probabilities.

- Pregnant women: Following Manatt's assessment of possible expansion in Alabama,[21] the paper uses a conversion rate for pregnant women of 0.45 (+/-0.2) in year two and beyond, with a ramp-up conversion in year one equal 0.3 (+/- 0.15).
- Family planning, breast and cervical cancer, and medically needy: Enrollees in these programs below 138 percent of the FPL would likely be converted quite readily to Medicaid expansion enrollment, as they are already known to the program. Therefore, a conversion probability of 1 is used for all enrollees in these programs projected to be below 138 percent of the FPL, but with a standard deviation of 0.05 to allow for some drop-off. Any enrollees in these categories that did not convert were included in the base program costs.
- The percent under 138 percent of the FPL for breast and cervical cancer program enrollees was estimated as the percentage of all women in Florida and on Medicaid who were under 138 percent of the FPL in the 2017 ACS PUMS data. The family planning parameter in Table 3 comes from a 2018 state-funded evaluation of the family planning program.[22] The medically needy parameter was calculated based on the estimated enrollment for the Medically needy program in 2016 and the estimated medically needy shift in a 2015 Florida Office of Economic and Demographic Research report.[23]

[20]Burns, Marguerite and Dague, Laura, The Effect of Expanding Medicaid Eligibility on Supplemental Security Income Program Participation (March 22, 2016). Available at SSRN: https://ssrn.com/abstract=2753784 or http://dx.doi.org/10.2139/ssrn.2753784.
[21]https://www.alaha.org/wp-content/uploads/2019/02/MedicaidExpansionReportCostsSavings.pdf
[22]Estimated State Budget Impact of an Oklahoma SoonerCare Expansion [Internet]. Manatt Health for the Oklahoma Hospital Association; 2016. Available from: https://www.manatt.com/getattachment/82559c33-721d-4209-b1b1-8281e9ff616b/attachment.aspx
[23]Impact Analysis of SB 2-A, As Filed (with preliminary number for Proposed Amendment) [Internet]. The Florida Legislature Office of Economic and Demographic Research; Available from: http://edr.state.fl.us/Content/presentations/affordable-care-act/SB2-AHousePresentation_ImpactAnalysisAsFiled.pdf

- The PMPM cost of each person in the expansion population, with simulation parameters as follows:
  - All base and expansion PMPM costs for managed care populations were simulated using the standard errors of their forecasts; as mentioned previously, childless expansion adults have 9 percent higher costs PMPM than TANF parents, with standard errors equal to 10 percent of the estimated PMPM.
  - PMPM costs for the medically needy, family planning program participants, and breast and cervical cancer program participants are simulated as described above. Standard deviations for these fee for service categories were fixed at 10 percent of the estimated PMPM cost. Each point estimate below was inflated by 2.224 percent annually.
  - For the medically needy group, it was necessary to estimate the spend-down amount separately. The paper used ACS data to ascertain the average household income of parents in Florida in 2017 between 27 and 138 percent of the FPL—who would be eligible for conversion from the medically needy program into expansion. This led to a spend-down PMPM of $1,126.49. This figure was simulated with a standard error of about 13.2, based on the standard deviation of income for that range in the ACS data. Spend-down amounts become new costs to the program under expansion, subject to the expansion FMAP for determining state share. However, this amount is not included in any savings calculations as the government was not paying these costs under the status quo.

The simulation model was run assuming the state would begin to implement expansion in 2020. 2018 and 2019 simulations of enrollment and cost did not allow for any conversion or uptake into expansion, and those years' simulation results merely provide for continuity in the time series. Scenarios with different start years but all other parameters the same—with appropriate inflation trends—would produce similar results, though starts after 2020 would result in greater uncertainty in the estimates.

THE WOODWORK EFFECT

The paper models the woodwork effect in a post-hoc fashion. New enrollment in expansion includes some individuals who are eligible for the base Medicaid program but had not enrolled previously. Following Manatt's calculation of a woodwork effect of 2.6 percent in Oklahoma, the paper considers 2.6 percent of new enrollment in Medicaid expansion to be due to the woodwork effect.[24] The sense is that this is a high estimate of the woodwork effect, and that actual experience is likely to be lower as the ACA, with its coverage gains and high visibility in public discourse, continues to become entrenched in the status quo.

To calculate the state share of costs for the new enrollment population, an enrollment-weighted average FMAP for each year is calculated, resulting in a blended federal match rate. Based on this analysis and the assessment of experience in other states, the woodwork effect in Florida is not expected to be very large.

[24]Estimated State Budget Impact of an Oklahoma SoonerCare Expansion. Manatt Health, for the Florida Hospital Association. April 2016. https://www.manatt.com/getattachment/82559c33-721d-4209-b1b1-8281e9ff616b/attachment.aspx.

RESULTS

The tables below show projected costs and enrollment for the working-age population.

Table 3: Projected State Budgetary Impacts of Expansion, In Millions of Dollars

	2018	2019	2020	2021	2022	2023	2024	Total 2020-2024
Total Cost, Status Quo	2,093.3	2,203.1	2,208.0	2,263.3	2,295.5	2,338.5	2,395.1	11,500.5
Total Cost, Expansion Scenario			2,289.3	2,317.7	2,381.0	2,436.4	2,565.4	12,016.9
Net Cost of Expansion to State			81.3	54.4	85.5	124.9	170.2	516.4
Base Program Cost	2,093.3	2,203.1	1,988.9	1,966.0	1,981.7	2,011.3	2,054.4	10,002.3
TANF	503.1	504.7	482.0	469.2	456.9	446.7	439.1	2,294.0
Pregnant Women	324.6	295.7	210.4	167.1	155.3	144.2	133.8	810.8
SSI (Blind and/or disabled)	674.0	16.0	683.4	674.6	670.2	672.7	679.8	3,380.7
Medically Needy	169.0	228.0	140.7	157.7	176.5	197.6	221.5	894.0
Long-term Care	381.3	417.0	435.6	460.2	485.1	511.7	540.8	2,433.4
Family Planning	0.6	0.7	0.1	0.1	0.1	0.1	0.1	0.5
Breast and Cervical Cancer	0.7	1.1	0.9	1.7	1.9	2.2	2.5	9.2
Administrative Costs	40.0	39.8	35.7	35.4	35.6	36.1	36.8	179.7
Expansion Cost			300.4	351.7	399.4	452.1	511.0	2,014.6
New Enrollment			206.0	241.7	282.3	328.3	379.8	1,438.1
Blind and/or Disabled			45.1	53.6	63.3	74.1	86.0	322.2
Parents			2.0	1.4	0.9	0.6	0.4	5.3
Other Adults			137.9	161.6	188.5	218.9	253.1	960.1
Administrative Costs			21.1	25.0	29.5	34.6	40.3	150.6
Conversion			94.4	110.1	117.1	123.8	131.2	576.5
Pregnant Women			16.2	22.9	21.5	20.2	19.0	99.8
SSI (Blind and/or Disabled)			6.6	10.4	13.0	14.2	14.7	59.0
Medically Needed			42.0	47.3	53.5	60.5	68.7	271.9
Family Planning			23.2	22.2	21.4	20.6	20.0	107.4
Breast and Cervical Cancer			2.3	2.6	2.9	3.3	3.8	15.0
Administrative Costs			4.0	4.7	4.8	4.9	5.0	23.4
Savings from Conversion			147.4	209.0	217.6	223.6	229.1	1,026.6
Pregnant Women			46.3	64.7	59.9	55.4	51.1	277.3
SSI (Blind and/or Disabled)			9.0	29.4	36.2	38.9	39.7	163.1
Medically Needy			69.4	77.6	86.2	95.9	106.6	435.7
Breast and Cervical Cancer			12.7	37.4	35.3	33.4	31.6	150.5

	2018	2019	2020	2021	2022	2023	2024	Total 2020-2024
Status Quo Costs*								
Family Planning			0.5	0.5	0.5	0.5	0.5	2.5
Medically Needy (MN)			111.4	124.9	139.7	156.4	175.3	707.7
MN Spend-down			50.3	56.2	62.7	70.1	78.4	317.7
FMAPs**								
Base Program	61.79%	60.87%	61.47%	61.72%	62.13%	62.59%	63.07%	
Enhanced (for BCC)	96.25%	95.61%	84.53%	73.20%	73.49%	73.81%	74.15%	
Expansion, Family Planning	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	
Administrative Costs	62.00%	62.00%	62.00%	62.00%	62.00%	62.00%	62.00%	

Source: Leavitt Partners Analysis

Notes: All years shown here are simulated projections. Expansion implementation is assumed to happen in 2020.

** The first two status quo cost categories are used to account for costs the state would have incurred for converted family planning and medically needy enrollees under the status quo. The medically needy spend-down is a cost the state does not incur, and thus is an entirely new cost to the state for the converted medically needy enrollees.*

*** The base and expansion FMAPs are blended using a weighted average to calculate new expansion costs, with woodwork enrollees receiving the base FMAP and all other new enrollees receiving the expansion FMAP.*

Table 4: Projected Enrollment Impacts of Expansion

	2017	2018	2019	2020	2021	2022	2023	2024
Total Enrollment, Status Quo	988,688	948,275	923,019	902,873	888,447	877,863	871,163	868,471
Total Enrollment, Expansion Scenario				1,380,966	1,443,734	1,518,891	1,606,567	1,705,985
Net Change in Enrollment				478,093	555,287	641,028	735,404	837,514
Base Program	988,688	948,275	923,019	811,061	785,021	773,225	767,013	765,445
TANF	507,777	470,858	445,765	427,212	411,451	397,325	384,873	374,126
Pregnant Women	103,508	93,154	84,437	61,029	48,797	45,863	43,116	40,549
SSI	288,395	287,215	286,207	279,849	279,685	282,474	288,591	297,028
Medically Needy	11,274	15,500	19,954	12,198	13,425	14,814	16,387	18,165
Long-term Care	16,628	18,543	19,777	21,023	22,415	23,961	25,679	27,595
Family Planning	60,633	62,353	66,037	9,564	9,042	8,560	8,113	7,699
Breast and Cervical Cancer	473	652	842	186	206	228	254	283
Total Expansion				569,905	658,713	745,666	839,554	940,540
New Enrollment				478,093	555,287	641,028	735,404	837,514
Parents				131,413	155,059	181,352	210,079	240,746
SSI				2,740	1,991	1,252	741	386
Other Adults				343,940	398,237	458,424	524,584	596,382
Converted				91,812	103,426	104,638	104,150	103,026

	2017	2018	2019	2020	2021	2022	2023	2024
Pregnant Women				18,144	25,560	24,026	22,600	21,244
SSI				10,482	16,503	20,720	22,780	23,778
Medically Needy				9,655	10,627	11,727	12,971	14,379
Family Planning				52,788	49,913	47,251	44,782	42,492
Breast, Cervical Cancer				743	823	914	1,017	1,133
Woodwork %				2.60%	2.60%	2.60%	2.60%	2.60%
Woodwork Enrollees				12,430	14,437	16,667	19,121	21,775

Source: Leavitt Partners Analysis

Notes: 2017 is actual for SFY 2017. 2018 – 2024 are simulated projections. Expansion implementation is assumed to happen in 2020.

FISCAL GAINS

HOSPITAL ASSESSMENT

Some states have seen an increase in revenue resulting from increased provider assessments and taxes. Florida has a 1.5 percent assessment on inpatient revenues and a 1 percent assessment on outpatient revenues. However, it is not clear if there will be an increase in the amount of the assessment due to likely losses in revenue for the currently insured population that moves into Medicaid. Commercial provider rates are likely being paid for the individuals with incomes between 100 percent and 138 percent of the FPL in the Marketplace who will become eligible for Medicaid. Also, some of the uninsured are likely paying privately for some of their care today, reducing some of the expected revenue increase. Basically, the change in hospital revenue that generates the assessments will depend on the differences in commercial and Medicaid rates, the degree to which the uninsured are paying for their care, and the degree of the population shift from the Marketplace to Medicaid.[25] Therefore, the paper assumes no increase in revenue from the hospital assessments.

LOW INCOME POOL (LIP)

The Florida low income pool (LIP) also needs to be addressed. The 1115 demonstration renewal for the LIP approved in August 2017 allowed the state to continue operating the program while increasing the LIP to $1.5 billion—total computable federal and state dollars—annually.[26] The state share required to fund the full amount is $583 million. Given that this program is now funding care provided to the uninsured, it is not clear what will happen to this program under Medicaid expansion. While there will continue to be significant uncompensated care after expansion, it is not known whether the state would continue the program or if CMS would agree to continue the LIP demonstration, or how interested the local government funders would be in continuing the program. So, while the $583 million could be perceived as potential savings under Medicaid expansion, the paper hesitates to assume this for two reasons:

1. The state match does not come from the state general fund, rather it is voluntarily provided by local entities, so even if the program is discontinued, the savings would not be retained by the state and necessarily available to cover the state match for the expansion population.
2. It is unknown if the program would continue. If it should continue at the same funding level, no savings even at the local level would accrue.

CORRECTIONS

As of 2018, the Florida Department of Corrections did not bill Medicaid for currently eligible inmate inpatient hospital care.[27] The paper assumes that the financial benefit under a Medicaid expansion scenario will be compelling enough to change this practice.

[25]For an explanation of the issues involved, see, Sayeh Nikpay, Thomas Buchmueller, Helen Levy, and Simone R. Singh, "The Relationship between Uncompensated Care and Hospital Financial Position: Implications of the ACA Medicaid Expansion for Hospital Operating Margins," *Journal of Health Care Finance*, http://healthfinancejournal.com/~junland/index.php/johcf/article/view/103/107

[26]The precise amount is $1,508,385,773.

[27]The Florida Legislature's Office of Program Policy Analysis and Government Accountability, *Florida's Elderly Inmates, A Presentation to the Senate Appropriations Subcommittee on Criminal and Civil Justice*, February 2018, http://www.oppaga.state.fl.us/monitordocs/Presentations/P18-02.PDF

The Florida prison population at the end of January 2019 was 95,723, with an expectation of only minor changes over the next several years.[28] In 2019, health services accounts for $436 million of the corrections budget.[29] This is up from $383 million in 2016 – 2017, when $53,500,000 was reportedly allocated to inpatient hospital expenditures.[30] Assuming an even distribution of cost would provide a base inpatient cost in 2019 of $60.9 million. Several adjustments need to be made to this figure:

- Approximately 95 percent of the inmate population is between age 19 and 64.
- During FY 2017 – 2018, elderly inmates (50 or older) accounted for 47.5 percent of all hospital admissions, and 52.0 percent of all inpatient hospital days, although they only represented 24.2 percent of the total prison population. "Older patients have a longer length of inpatient hospital stay than younger patients. This results in increased costs for hospitalists and other providers…"[31] Approximately 16 percent of this elderly population is over the age of 64.
    - With the weighting of the elderly population costs, the budget attributed to the age 19 through 64 population would be approximately $55.8 million
- Nearly 5 percent of the population does not meet citizenship requirements, however, no reduction from potential fiscal gains is taken as the paper assumes most inpatient hospital services will be paid under Medicaid emergency services program.
- Not all eligible prisoners are likely to cooperate with the Medicaid enrollment process. This was a significant problem that occurred in California until the state made the application process mandatory. the paper assumes a 15 percent reduction based on this factor and other issues that might result in a Medicaid application not being filed or being denied. If a higher loss is seen, the paper also assumes the state will act to aggressively address the issue.
    - With this reduction, potential gross gains are $47.4 million
- Assuming a 90 percent FMAP, the state fiscal gains could be as high as $42.6 million.

This is a bit higher than what has actually been experienced in some other states. For example, Ohio is estimating FY 2021 savings in their correctional system of $18 million.[32] The inpatient expenditure savings is about 7 percent of its total medical budget of $267 million, $19 million (6 percent) savings in the medical budget in Michigan. Overall, this figure could be quite low in terms of all government fiscal gains, as there should also be some potential gains at the county level that are not factored into this estimate.

BEHAVIORAL HEALTH

Florida community mental health and substance abuse providers receive funding to pay for uncompensated care. This money is appropriated by the Florida Legislature from a variety of sources that include block grants as well as state general funds and local financing. This funding amounted to $562,589,890 for client services in SFY 2016. The funding is distributed to local entities that administer the programs (Managing Entities) to pay for services for populations served.

The Florida Fiscal Year 2014 – 2015 Department of Children and Families (DCF) Behavioral Health Planning Tool (Planning Tool) provides information related to distribution of the expenditures for behavioral health services at the Managing Entity level. This information includes the distribution of behavioral health expenditures between adults and children, and the percentages of adult substance use and mental health funding that is expended on services that are not covered by Medicaid. These allocations can then be applied to the dollars the state has identified as being available for Medicaid maximization purposes under a study conducted under the Florida Legislature's direction for FY 2017.[33, 34] The non-Medicaid covered services include residential care, Families and Community Together Inc. (FACT) services, prevention, and forensics. The estimated value of these uncovered services as paid by the Managing Entities was calculated to be $168.9 million. This was adjusted by an increase of 14.9 percent to $194.9 million based on the comparison of the FY 2015 expenditures to the budget for FY 2016, which appears

[28]Criminal Justice Estimating Conference February 22, 2019, accessed April 22, 2019, http://edr.state.fl.us/Content/conferences/criminaljustice/executivesummary.pdf
[29]https://www.politico.com/states/f/?id=00000163-846c-d92c-a17f-edfcfd4b0001 . Recent news accounts quote a $460 million figure; for example, see https://health.wusf.usf.edu/post/future-prison-reform-florida#stream/0
[30]Florida Policy Institute, *Potential Budget Savings and Revenue Gains from Medicaid Expansion in Florida: A Snapshot Based on FY 2016-17 Data*, 2018, http://www.fpi.institute/wp-content/uploads/2018/01/MedicaidExpansionReport.pdf
[31]Florida Department of Corrections, 2017/2018 Annual Report, accessed April 23. 2019, http://www.dc.state.fl.us/pub/annual/1718/FDC_AR2017-18.pdf
[32]https://medicaid.ohio.gov/Portals/0/Resources/Reports/MedicaidExpansion.pdf
[33]With the exception of forensics, these services are identified as uncovered in the *Behavioral Health Services Revenue Maximization Plan*. (See Footnote 10 below.)
[34]https://www.myflfamilies.com/programs/samh/publications/BehavioralHealthPlan-Managing EntitiesFY14-15.pdf

to be $680 million based on the figures in the Maximization Report.[35] It is assumed that these dollars will continue to be used to pay for uncovered services for existing Medicaid populations and therefore not available as fiscal gains under Medicaid expansion.

As required by state legislation,[36] the DCF identified $412,411,814 in general revenue funding appropriated during fiscal year 2016 – 2017 for mental health and substance abuse services that could be eligible as state match for Medicaid funding. It appears that these are the total dollars available from adult population services provided by the Managing Entities.[37, 38] However, as noted above, the paper assumes no change in state policy regarding the supplementing of Medicaid coverage and that there would be a continued need to fund the uncovered Medicaid services as well as a second supplementation for the services that exceed service limitations.

With expansion, it is assumed that the newly eligible population will have the same scope of behavioral health benefits and service limitations, and that those coverage gaps will be filled by the Managing Entities. This assumption leads to the conclusion that an additional and significant portion of what otherwise would be fiscal gains under expansion will be needed to cover the same uncovered services for the newly eligible adult population as the existing population. Estimates vary, but at least 19 percent of the expansion adults have serious mental illness and/or a substance use disorder.[39] This aligns with the prevalence in Florida as described in the Maximizing Report. This would result in approximately 140,000 new Medicaid beneficiaries in the Florida behavioral health system, about a 40 percent increase in the number of Medicaid beneficiaries served. Assuming similar utilization patterns to the existing Medicaid population for these individuals would result in the need for services in the value of $78 million.

In addition to the funding of services not covered by Medicaid described above, some of the available state general funds are used to pay for Medicaid services where service limits have been exceeded. These include services that are Medicaid covered but have amount, duration, or scope limits. The paper assumes that this dynamic will not change, and that with the addition of the adult expansion group, the need will increase. It is not clear how often Medicaid limits are exceeded for the Medicaid eligible population, but The paper has assumed that this reduces the available funds by 5 percent after deducting the estimated value of the uncovered services.[40]

The reduction of the $194.9 million for the existing Medicaid population plus the $78 million for the expanded adults ($272.9 million) and the 5 percent reduction from the remainder—or $7 million—leaves $132.5 million. At a 90 percent FMAP rate, that would provide $119.3 million in potential fiscal gains under a full Medicaid adult expansion.[41]

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[35]There may have also been an increase to $723 million for FY18, but a subsequent decrease of $19 million in 2019, so the paper made no additional base budget changes. http://www.fl-counties.com/2019-state-budget-analysis

[36]Senate Bill 12 (codified in section 394.761(2), F.S.

[37]AHCA, *Behavioral Health Services Revenue Maximization Plan*, December 2016, Accessed April 16, 2019, https://www.ahca.myflorida.com/medicaid/recent_presentations/SB_12_Behavioral_Health_Services_Revenue_Maximization_Plan_123016.pdf and https://www.ahca.myflorida.com/medicaid/recent_presentations/Senate_Health_Human_Services_Approps_Rev_Max_Report_2017-01-11.pdf

[38]While state general revenue funds are subject to a federal MOE for federal grants, according the state, the MOE can be met when the state dollars are used as the state match to receive federal Medicaid funding for covered services provided to Medicaid recipients.

[39]https://www.openminds.com/store/behavioral-health-service-needs-medicaid-expansion-population/

[40]The services that are covered under Florida Medicaid that have specific coverage limitations that may be exceeded, include: assessment services, group therapy, individual therapy, day treatment, medical services, case management, substance abuse inpatient detoxification, inpatient hospital services

[41]The FPI estimated fiscal gains in this area to be $250 based on an Urban Institute study, but it is unclear how accurate this figure is today.

DISPROPORTIONATE SHARE HOSPITAL (DSH)

The applicable CMS final regulation projected individual state Disproportionate Share Hospital (DSH) reductions based on a $2 billion total national reduction. However, in the Bipartisan Budget Act of 2018, Congress revised the DSH reduction targets, creating the following reduction schedule[42]:

FFY 20	$4 Billion
FFY 21	$8 Billion
FFY 22	$8 Billion
FFY 23	$8 Billion
FFY 24	$8 Billion
FFY 25	$8 Billion

DSH allotments are determined prospectively the year prior to the actual allotment. Under the DSH reduction formula, there are three factors that determine the reduction allocation across the states. These three factors include the state's rate of uninsurance, whether the state targets their DSH payments to hospitals with high volumes of Medicaid patients and high levels of uncompensated care, and whether the state is a "low" or non-low DSH state.[43] The states' rate of uninsurance is the factor most likely to result in a change in a state's allocation based on the state expanding Medicaid. In the reduction calculation, 50 percent of the weight is given based on the relative number of uninsured in the state. As the number of a state's uninsured decreases due to increased Medicaid enrollment following expansion, the amount of the DSH allotment will decrease, resulting in fewer state dollars required to draw down the lost DSH federal dollars. This can be seen as a savings to the state general fund even though there is a loss of hospital reimbursement for this source of funding, which hospitals may not perceive as a savings. It can also be viewed as an offset to the revenue generated to the DSH recipients which are the beneficiaries of the additional reimbursement from the impact of Medicaid expansion on uncompensated care. In this analysis, Leavitt Partners makes a rough calculation of the reduced general fund required to fund the total reduced DSH allotment resulting from the expansion. For the most part, the benefit is not to the Florida general fund as the program is financed primarily through intergovernmental transfers (IGTs) and certified public expenditures (CPEs).[44]

Under the 2017 rule, Florida was scheduled to realize a total DSH reduction of $34,090,343 of which $11,604,440 was a result of the uninsured factor. The other $22,485,894 of the reduction is allocated between the high volume of Medicaid inpatients and the high level of uncompensated care factors.

The federal calculation of the percentage of uninsured individuals in each state "relies on the total population and uninsured population as identified in the most recent '1-year estimates' data available from the ACS conducted by the Census Bureau"[45] to determine the DSH reduction in each state. Given this, the change in the DSH reduction is likely to lag at least a year from expansion implementation, and is not likely to have nearly the full effect until year 5 depending on ramp-up rates. In the model, zero impact is assumed in year 1, 50 percent impact in year 2, and full impact starting year 3 with the same amounts moving forward.

Connecticut, an early expansion state, and Florida are both non-low DSH states and have identical DSH allotments.[46] Connecticut has a 2017 uninsured rate of 5.5 percent, significantly below the Florida rate of 12.9 percent.[47] It is unlikely that Florida would fall below the Connecticut 5.5 percent rate with full Medicaid adult expansion. Leavitt Partners estimates new enrollment would reduce Florida's uninsured rate from 10.6 percent in year 1 to 8.9 percent by year 5, which is somewhat comparable to the 7.9 percent and 8.4 percent for Arkansas and Louisiana respectively. Connecticut's uninsured rate is in line with other expansion states, comparable to the southern state of Kentucky, but over 3 percentage points below the two southern expansion states of Louisiana and Arkansas. Consequently, The paper views Connecticut as the upper boundary

[42]https://www.macpac.gov/subtopic/disproportionate-share-hospital-payments/
[43]A low-DSH state is a state that had FY 2000 DSH expenditures that were less than 3 percent of its total Medicaid expenditures for services.
[44]Study of Hospital Funding and Payment Methodologies for Florida Medicaid, Navigant Healthcare, https://ahca.myflorida.com/medicaid/Finance/finance/LIP-DSH/LIP/docs/FL_Medicaid_Funding_and_Payment_Study_2015-02-27.pdf
[45]https://www.federalregister.gov/documents/2017/07/28/2017-15962/medicaid-program-state-disproportionate-share-hospital-allotment-reductions
[46]Op.cit.
[47]American Community Survey Tables for Health Insurance Coverage, https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.2017.html

for Florida's DSH reduction savings. The estimated uninsured factor 2020 reduction for Connecticut is $27,749,875. Florida's is currently $11,604,440, the difference being $16,145,453. Given that the Florida implementation would not occur until SFY 2021, this figure is quadrupled to $64,581,740 as the base DSH reductions are figured on a pre-2018 base reduction of $2 billion, but with 2018 changes in federal law are scheduled to be $8 billion beginning in 2021. Using the 2020 FMAP for Florida of 61.47 percent, this translates to a maximum reduction of $24,883,344 in state general funds. Based on the estimate of expansion enrollment resulting in an ongoing uninsured rate significantly higher than that of Connecticut, the savings are estimated to grow as the uninsured rate reduces with the phase in of Medicaid enrollment.

Table 5. Potential Dish Savings Estimates

Expansion Year	DSH Savings High Estimate in Millions	DSH Savings More Likely Estimate in Millions
1	0	0
2	$12.9 M	$12.9 M
3	$24.9 M	$13.4 M
4	$24.9 M	$13.9 M
5	$24.9 M	$14.6 M
Total	$87.1 M	$54.9 M

Like the LIP program, allocation of the savings cannot be made to the state Medicaid program as funding for the DSH program is primarily a combination of IGTs and CPEs.[48]

[48]Study of Hospital Funding and Payment Methodologies for Florida Medicaid, Navigant Healthcare, https://ahca.myflorida.com/medicaid/Finance/finance/LIP-DSH/LIP/docs/FL_Medicaid_Funding_and_Payment_Study_2015-02-27.pdf