

Low Income Pool Council Recommendations for State Fiscal Year 2013-2014

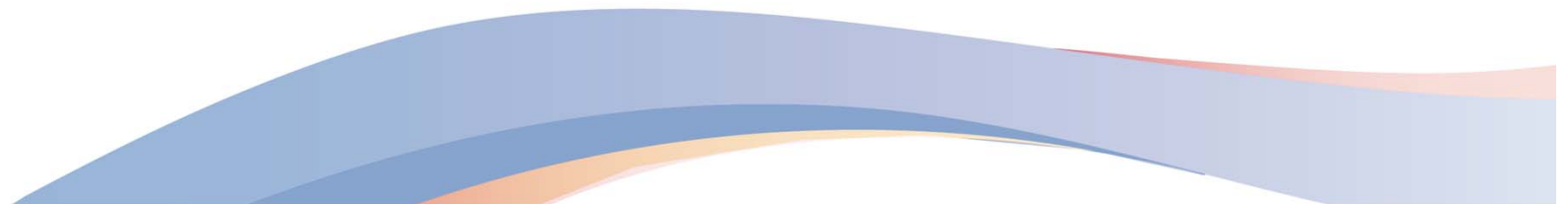
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House Health Care Appropriations Subcommittee

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Low Income Pool (LIP) Program

- The Low-Income Pool (LIP) program was implemented July 1, 2006 as part of the Medicaid Reform 1115 Research and Demonstration Waiver, and the waiver was extended for three years December 15, 2011.
- Per Special Term and Condition (STC) #51 of the 1115 Wavier:
 - “The Low Income Pool provides government support for the safety net providers that furnish uncompensated care to the Medicaid, underinsured and uninsured populations. The LIP is also designed to establish new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations.”

Low Income Pool – Provider Access Systems

- Funding in the LIP Program allows many Provider Access Systems (PAS) in Florida to receive additional payments to cover the cost of providing services to Medicaid, uninsured, and underinsured individuals. PAS entities are defined in the waiver as providers with access to LIP funding and services funded from LIP.
- PAS entities include entities such as hospitals, clinics, or other provider types and entities designated by Florida Statutes to improve health services access in rural communities, which incur uncompensated medical care costs in providing medical services to the uninsured and underinsured.

Low Income Pool Council

- Council Authority and Membership:
 - The Low Income Pool (LIP) Council is created by Section 409.911(10), F.S.
 - » Twenty-four members including representatives from local governments, various public, teaching, rural, for-profit, not-for-profit hospitals, federally qualified health centers, the Department of Health, and the Agency for Health Care Administration (the Agency).
 - » Twenty members are appointed by the Secretary of AHCA. Two members are appointed by the Senate President; two by the Speaker of the House of Representatives.
 - » The Council is Chaired by the Agency's Secretary or designee. The Chair is a non-voting member.

Low Income Pool Council

- Per the statute, the Council is an advisory body responsible for:
 - Providing recommendations on the financing of and distribution of funds for the LIP and Disproportionate Share Hospital (DSH) programs.
 - Advising the Agency on the development of the LIP Plan required by the waiver.
 - Advising the Agency on the distribution of hospital funds used to adjust inpatient hospital rates, rebase rates, or otherwise exempt hospitals from reimbursement limits and restore reductions to rates, as financed by intergovernmental transfers.
 - Submitting its findings and recommendations to the Governor and the Legislature no later than February 1 each year.

Low Income Pool Permissible Expenditures

- “Funds from the LIP may be used for health care costs (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act. These health care costs may be incurred by the State, by hospitals, clinics, or by other provider types to furnish medical care for the uninsured and underinsured for which compensation is not available from other payors, including other Federal or State programs. Such costs may include premium payments, payments for provider access systems (PAS) and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the State and CMS. These health care costs may also include costs for Medicaid services that exceed Medicaid payments (after all other Title XIX payments are made, including disproportionate share hospital payments).”

* Special Term and Condition #54

Medicaid Payments to Hospitals:

- Under the Medicaid program, rates for institutional providers, such as hospitals, are set on a facility specific basis, based on each facility's reported costs.
- Rate are established once a year, and are all inclusive, “per diem” rates, based on reported costs for services provided by the hospital to Medicaid recipients on a fee-for-service basis.
- Rates are set for Inpatient and Outpatient services.
- Hospital inpatient rates are set to move from per diem to DRG effective July 1, 2013.

Council Challenges in the Development of recommendations for SFY 2013-2014

- Reductions to Medicaid reimbursement rates for hospitals and the use of Intergovernmental Transfer (IGT) funds as a source of funds for rate buy-backs and the resulting impact on IGTs as matching funds under the LIP program.
- Commitment of Funding: While the model adopted by the Council for its SFY 2013-14 recommendations assumes that the currently participating 27 local governments can meet the need via their voluntary contributions of IGTs, there is no assurance that this is the case. Given the State's economic climate, a request for increased state General Revenue funds is not feasible.
- The Council received multiple updates from AHCA staff and consultants regarding the inpatient Diagnostic Related Groups (DRG) reimbursement methodology development.

Low Income Pool Council

- The Council held 8 public meetings during state fiscal year 2012-13 between August 30, 2012, and January 22, 2013.
- A total of 15 different funding models, and variations of those models, were considered by the Council.
- At its January 22, 2013, meeting, the Council adopted the recommended model--Model 11--with one negative vote and one abstaining vote.

LIP Council Recommendations

Following are the LIP Council recommended funding levels for SFY 2013-14 (in millions):

	Council Recommended
Low Income Pool -	\$1,000.2
Exemptions Program -	\$676.4*
Disproportionate Share -	\$245.8
Medicaid “Buy-Backs” Program -	<u>\$130.5</u>
Total	\$2.05 billion

Comparison of SFY 2012-13 Appropriation to SFY 2013-14 LIP Council Recommendations (in millions)

Low Income Pool:	<u>SFY 2012-13 GAA</u>	<u>Recommended for SFY 2013-14</u>
• LIP Hospital	\$ 771.5	\$766.9
• Special LIP	113.4	118.0
• LIP Non-Hospital	<u>115.3</u>	<u>115.3</u>
• Total LIP (millions)	\$1,000.2	\$1,000.2
 Related Programs:		
• Disproportionate Share Hospital	\$ 260.0	\$245.8
• Exemptions	648.5	676.4
• Medicaid “Buy-Back” Program	<u>130.5</u>	<u>130.5</u>
• Total LIP Related (millions)	\$ 1,039.1	\$1,052.7
 Total LIP and Related Programs	 <u>\$2,039.3</u>	 <u>\$2,052.9</u>

Summary of Funding Sources: SFY 2013-2014 Recommendations

Where do the dollars come from?

State General Revenue	\$ 18.6 million
Local Taxes & Other Agencies	\$ 829.7 million
Federal Funds	<u>\$ 1,204.6 million</u>
Total	\$ 2,052.9 billion

Sources of Matching Funds

Matching funds (all programs):

- \$18.6 million in total state GR match.
- \$829.7 million in local Intergovernmental Transfers (IGTs) are provided using local tax dollars, other Agencies' funds and public hospital operating funds. Twenty-seven local governments contribute these funds.
- The Council Recommendations for SFY 2013-14 include a decrease of \$15.9 million in local IGTs.

Hospital IGT Contributors

State and Local Government	Statewide Issues	DSH	LIP & Program Exemptions	Total
General Revenue	-	-	250,000	250,000
General Revenue Recurring	-	750,000	14,326,670	15,076,670
Citrus County Hospital Board	-	-	7,215,882	7,215,882
Hernando County	-	-	981,938	981,938
Duval County	1,506,817	4,711,475	2,664,256	8,882,548
Halifax Hospital Medical Center Taxing District	-	2,143,644	18,109,172	20,252,816
Health Care District of Palm Beach County	-	-	3,500,000	3,500,000
Health Central	-	-	2,370,438	2,370,438
Hillsborough County	-	3,322,203	-	3,322,203
H. Lee Moffitt (GR)	-	-	4,645,451	4,645,451
Indian River Taxing District	-	-	8,915,254	8,915,254
Lake Shore Hospital Authority	-	-	2,571,995	2,571,995
Lee Memorial Health System	-	5,425,469	16,377,741	21,803,210
Marion County	-	-	2,085,150	2,085,150
Miami-Dade County	12,094,236	38,573,306	316,170,556	366,838,098
North Broward Hospital District (Broward Health)	4,216,371	18,670,014	143,290,372	166,176,757
North Lake Hospital Taxing District	-	-	187,622	187,622
Orange County	-	2,878,180	-	2,878,180
Highlands County	-	-	565,209	565,209
Sarasota County Public Hospital Board	-	-	19,232,905	19,232,905
South Broward Hospital District	2,761,135	12,450,124	102,874,740	118,085,999
Santa Rosa County	-	-	122,483	122,483
Suwannee County Board of Co. Comm	-	-	224,283	224,283
Munroe Hospital Board (DSH)	-	941,251	-	941,251
Gulf County	-	-	417,604	417,604
IGT UNDETERMINED	2,188,721	900,781	17,057,748	20,147,250
Taylor County	-	-	-	-
Bay County	-	-	5,348,464	5,348,464
North Brevard Hospital District	-	-	1,055,929	1,055,929
IGT GME Consortium	-	790,114	-	790,114
Manatee County	-	-	2,039,290	2,039,290
DSH (Shands-UF General Revenue)	-	5,852,899	-	5,852,899
Total Government Transfer (Hospitals)	22,767,280	97,409,460	692,601,152	812,777,892



Recommended LIP Program

LIP Allocated and Proportional Distributions Recommended Funding of \$766.9 million

- The Council recommends the distribution methodology approved in the 2012 GAA with minor policy modifications
 - Primary Care increased by \$1.95 million
 - Trauma increased by \$206,266
 - Safety Net increased by \$2.46 million
- Allocation factor is 8.5%
- Rural Hospitals are held harmless in this calculation at \$2.4 million.

Special Hospital LIP

Council Recommended funding of \$118.0 million for the following initiatives:

– Rural	\$ 5.6 m
– Primary Care	\$ 12.0 m
– Specialty Pediatric	\$ 1.4 m
– Trauma	\$ 8.8 m
– STC 61 Quality Measures	\$ 15.0 m
– Safety Net	<u>\$ 75.1 m</u>
Total Special LIP	\$ 118.0 m

LIP “Below the Line” Programs

Recommended funding of \$115.3 million

- Initiatives focused on primary care, emergency room diversion, disease management, poison control, and continued initiatives related to premium assistance programs for uninsured and underinsured individuals.
- Federally Qualified Health Centers, County Health Departments, Hospital based Primary Care Programs benefit from continued funding.
- Projects Include:
 - Poison Control Centers
 - Federally Qualified Health Centers
 - County Health Department Initiatives
 - Hospital Based Primary Care Initiatives
 - Premium Assistance Programs
 - Manatee, Sarasota, and Desoto County Emergency Room Diversion
 - STC 61 Tier One Milestone Distribution

Disproportionate Share Hospital Program (DSH)

Recommended funding \$245.8 million

- The DSH Program provides financial support to hospitals serving a significant number of low-income patients.
 - Federally capped program with limited allotments to each state.
 - Seventy hospitals including the rural hospitals are recommended for Medicaid DSH payments.
- The DSH Program distribution method remains the same as current policy and distribution.
- DSH is authorized under federal law and not part of the 1115 Waiver LIP Pool.

Exemption Program

Recommended funding of \$666.5 million*

- Qualifying hospitals are eligible for Medicaid reimbursement that is exempt from specific ceilings and targets
- Exemption Level:
 - Children’s Hospitals 89.967983%
 - Statutory Teaching Hospitals 71.967983%
 - Public Hospitals 71.967983%
 - Trauma Hospitals 67.450583%
 - CHEP, Specialty, and GAA Hospitals 67.450583%
 - Hospitals with greater than 15% Charity Care 67.450583%
 - Hospitals with Charity Care $\geq 11\%$ but $< 15\%$ 67.450583%
 - Trauma Add on 1.5000000%
 - Pediatric Add on 1.5000000%
- Authority for any Medicaid hospital not otherwise qualified to “self-exempt” using local funds

Embedded Children's Hospitals

- Hospitals that serve a substantial volume of pediatric patients.
- Providers defined as those that provided over 30,000 pediatric patient days of inpatient hospital services (excluding normal newborns).
- Proportional allocation of \$19.9 million to the 12 hospitals meeting this criteria.

Buy-Back Program

Recommended funding of \$130.5 million

- Authority was granted in the 2008 Legislative Session to allow qualifying hospitals to “Buy Back” required rate reductions. This results in increased reimbursement paid by Medicaid. The Authority was modified and expanded in the 2009 Session and again in the 2010 and 2011 Sessions.
- Rate Buy-Backs - Medicaid trend adjustments (current year rate cuts) and rate reductions are partially restored for certain hospitals.
- Hospitals with qualifying IGTs will be allowed to maximize funds to restore reimbursement rate reductions.

Questions?



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