Low Income Pool and other related programs
A presentation for the Intergovernmental Transfer (IGT) Workgroup
Agency for Health Care Administration

Wednesday, September 22, 2010

By: Clark R. Scott, Low Income Pool Council member 2009-11
Why should counties care about Low Income Pool and other related programs?

The distribution of Low Income Pool (LIP) and other related program funding exceeds $2 billion annually.

<table>
<thead>
<tr>
<th>Program</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Income Pool</td>
<td>$1,000 million</td>
</tr>
<tr>
<td>Disproportionate Share Hospital Programs (DSH)</td>
<td>$ 260 million</td>
</tr>
<tr>
<td>Exemption Program</td>
<td>$ 704 million</td>
</tr>
<tr>
<td>“Buy-back” Program</td>
<td>$ 61 million</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$ 2,025 million</strong></td>
</tr>
</tbody>
</table>

Approximately **96%** of the non-federal share of these distributions is financed by counties and special taxing districts.
What is the Low Income Pool?

The Low Income Pool program is a unique partnership of local government (counties and special taxing districts), state government, and the federal government.

The Low Income Pool (LIP) is a Medicaid special financing strategy where the state uses tax-based resources from local government entities to match federal Medicaid funds to increase federal financial participation in Florida Medicaid.
What is the Low Income Pool (LIP) Council?

The Low Income Pool Council was established during the 2005 Special Session, for the purpose of making recommendations on the financing of the LIP and Disproportionate Share Hospital (DSH) programs, and the distribution of their funds. In addition, the Council is charged with advising the Agency for Health Care Administration (the Agency) on the inpatient rates, rebase rates, or other exemptions for hospitals from reimbursement limits as financed by intergovernmental transfers (IGTs).
Low Income Pool as part of Florida Medicaid

The Medicaid program is a state administered program that is funded by both the Federal government and the state of Florida. There are Federal requirements that must be met, and those are specified in the Florida State plan as approved by the centers for Medicare and Medicaid Services (CMS).

For SFY 2010-11, the Governor recommended that Florida Medicaid be appropriated $19.8 billion.
## Governor's SFY2010-11 Recommended Budget for AHCA

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADMIN &amp; SUPT (PROGRAM)</td>
<td>$ 33.5M</td>
</tr>
<tr>
<td>HEALTH CARE REGULATION</td>
<td>$ 49.4M</td>
</tr>
<tr>
<td>CHILD SPECIAL HEALTH CARE</td>
<td>$ 522.4M</td>
</tr>
<tr>
<td>EXECUTIVE DIRECT &amp; SUPT</td>
<td>$ 222.8M</td>
</tr>
<tr>
<td>MEDICAID LONG TERM CARE</td>
<td>$4,623.2M</td>
</tr>
<tr>
<td>MEDICAID SERV FOR INDIV</td>
<td>$15,133.3M</td>
</tr>
<tr>
<td>Agency for Health Care Admin</td>
<td>$20,584.6M</td>
</tr>
</tbody>
</table>
Governor's SFY2010-11 Budget (Medicaid LT Care and Serv for Indiv)

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Inpatient Services</td>
<td>$ 3.7B</td>
<td>19%</td>
</tr>
<tr>
<td>Hospital Outpatient Services</td>
<td>$ 1.5B</td>
<td>8%</td>
</tr>
<tr>
<td>Low Income Pool</td>
<td>$ 1.1B</td>
<td>6%</td>
</tr>
<tr>
<td>Prepaid Health Plans - HMOs</td>
<td>$ 2.9B</td>
<td>15%</td>
</tr>
<tr>
<td>Prescribed Medicines/Drugs</td>
<td>$ 1.5B</td>
<td>7%</td>
</tr>
<tr>
<td>Reg Disproportionate Share</td>
<td>$ .2B</td>
<td>1%</td>
</tr>
<tr>
<td>Nursing Home Care</td>
<td>$ 2.6B</td>
<td>13%</td>
</tr>
<tr>
<td>Other Medicaid</td>
<td>$ 6.2B</td>
<td>31%</td>
</tr>
<tr>
<td>Total Operations + Workload</td>
<td>$ 19.8B</td>
<td></td>
</tr>
</tbody>
</table>
How has the Federal Share of Medicaid Changed over time?

<table>
<thead>
<tr>
<th>Federal Fiscal Year</th>
<th>Federal</th>
<th>Non-Federal</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/04 - 9/30/05</td>
<td>58.90%</td>
<td>41.10%</td>
<td>-0.03%</td>
</tr>
<tr>
<td>10/1/05 - 9/30/06</td>
<td>58.89%</td>
<td>41.11%</td>
<td>-0.01%</td>
</tr>
<tr>
<td>10/1/06 - 9/30/07</td>
<td>58.76%</td>
<td>41.24%</td>
<td>-0.13%</td>
</tr>
<tr>
<td>10/1/07 - 9/30/08</td>
<td>56.83%</td>
<td>43.17%</td>
<td>-1.93%</td>
</tr>
<tr>
<td>10/1/08 - 9/30/09</td>
<td>55.40%</td>
<td>44.60%</td>
<td>-1.43%</td>
</tr>
<tr>
<td>10/1/09 - 9/30/10</td>
<td>54.98%</td>
<td>45.02%</td>
<td>-0.42%</td>
</tr>
</tbody>
</table>
How has the Federal Share of Medicaid Changed over time?

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Current</th>
<th>Enhanced</th>
<th>Diff</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/2008 – 12/31/08</td>
<td>55.40%</td>
<td>63.03%</td>
<td>7.63%</td>
</tr>
<tr>
<td>1/1/2009 – 9/30/09</td>
<td>55.40%</td>
<td>67.64%</td>
<td>12.24%</td>
</tr>
<tr>
<td>10/1/2009 – 6/30/10</td>
<td>54.98%</td>
<td>67.64%</td>
<td>12.66%</td>
</tr>
<tr>
<td>7/1/2010 – 12/31/10</td>
<td>54.98%</td>
<td>66.44%</td>
<td>11.46%</td>
</tr>
</tbody>
</table>

**Future**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SFY 2010-11 (with ARRA)</td>
<td>64.83% blended</td>
<td></td>
</tr>
<tr>
<td>SFY 2011-12 (no ARRA)</td>
<td>56.31%</td>
<td></td>
</tr>
</tbody>
</table>
When was the Low Income Pool created?

On October 19, 2005, the Centers for Medicare and Medicaid Services (CMS), approved the 1115 Research and Demonstration Waiver Application for the State of Florida, relating to Medicaid reform. The parameters of LIP are defined in Special Term and Conditions (STC) 91 through 106 of this waiver. The Florida Legislature passed House Bill (HB) 3B on December 8, 2005 authorizing implementation of the waiver effective July 1, 2006.
Why was the Low Income Pool created?

From the Waiver, Special Terms and Conditions (STC), #91, the Low Income Pool (LIP) is "established to ensure continued government support for the provision of health care services to Medicaid, underinsured and uninsured populations. The low-income pool consists of a capped annual allotment of $1 billion total computable for each year of the 5 year demonstration period." Florida's waiver is scheduled to expire on June 30, 2011, unless renewed or modified prior to that date. A renewal request has already been submitted.
What did Florida do before the Low Income Pool was created?

From July 1, 2000 until June 30, 2006, the Upper Payment Limit (UPL) program was in place in Florida. The UPL program restricts payments to only qualifying hospitals. The limit for UPL is based on a specific annual calculation using historical fee-for-service hospital costs and Medicaid expenditures. In SFY 2005-06, UPL expenditures were $631 million. With the effort to create a statewide Medicaid managed care system, it was anticipated that managed care expansion would result in fewer fee-for-service days, thus reducing the UPL maximum available. As of July 2006, Florida replaced the upper payment limit supplemental payments to hospital providers with the Low Income Pool (LIP).
Why fund the Low Income Pool (and related programs)?

Medicaid reimbursement limitations have been placed on hospital payments over the past twenty years. AHCA has stated that hospitals not participating in these types of programs are reimbursed at approximately 56.4% of their cost of providing services to Medicaid recipients. The Legislature has recognized the impact of the low reimbursement rate and has included these programs in the General Appropriations Act.
Who funds the non-federal portion of Low Income Pool?

Under current federal law, states have the opportunity to use tax-based resources from both local governmental entities and the state to match federal Medicaid funds. Local governments, such as counties, hospital taxing districts and other state agencies (e.g. Florida Department of Health) provide funding through intergovernmental transfers for the non-federal share of the $1 billion LIP distributions. For SFY 2010-11, the Federal Medical Assistance Percentage (FMAP) is 64.83%; and the non-federal share is 35.17% or about $352 million.
Who funds the non-federal portion of Low Income Pool?

The same federal law applies to the other related programs (DSH, Exemption, and “Buy-back”). The total funding needed to finance the non-federal portions of the LIP program plus the other related programs is approximately $812 million.
Who funds the non-federal portion of Low Income Pool?

Twenty-four local governmental entities (eleven counties and thirteen special districts) provide approximately 96% of the IGTs that support payments to 164 hospitals and dozens of other health care providers such as health departments, community health centers, and county health plans. In addition, the Florida Department of Health and other local governments provide matching funds for LIP grants awarded to county health departments and community health centers throughout Florida.
Who funds the non-federal portion of Low Income Pool?

IGTs provided by these 24 local governments to finance the non-federal portion of the LIP, Exemption, and “Buy-back” programs are combined. This mixing of IGTs is necessary to ensure that the entities providing the financing are not financially penalized in the process. The combining of the IGTs creates an interdependence of the LIP program with other related programs. Separate IGTs are submitted for the DSH program by those provider entities with DSH hospitals within their jurisdiction.
The 24 local governments that contribute IGTs

Bay County
Citrus County Hospital Board
Collier County
Duval County
Gulf County
Halifax Hospital Medical Center Taxing District
Health Care District of Palm Beach County
Health Central
Hillsborough County
Indian River Taxing District
Lake Shore Hospital Authority
Lee Memorial Health System
The 24 local governments that contribute IGTs

Manatee County
Marion County
Miami-Dade County
North Brevard Hospital District
North Broward Hospital District
North Lake Hospital Taxing District
Orange County
Pinellas County
Sarasota County Public Hospital Board
South Broward Hospital District
St. Johns County
South Lake Hospital Taxing District
Who receives the Low Income Pool funds?

Special Terms and Conditions # 94 states that "LIP funds may be used for health care expenditures (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act. These health care expenditures may be incurred by the State, by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services for the uninsured, Medicaid shortfall (after all other Title XIX payments are made) may include premium 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."
Who receives the Low Income Pool funds?

SFY 2010-11

Hospital based Provider Access Systems = 92%

Other Provider Access Systems = 8%
What is a Provider Access System (PAS)?

A Provider Access System (PAS) is defined in the LIP Reimbursement and Funding Methodology document. 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, and which receive a Low Income Pool (LIP) payment are known as Provider Access Systems.
What are the components of the Low Income Pool program?

Low Income Pool – Hospitals = $821,140,327  
Special LIP Hospital Payments = $101,791,612  
LIP Non-Hospital Providers = $77,318,054

(These amounts are based on the SFY1011 model provided to the LIP Council on July 21, 2010, prior to the extension of the enhanced FMAP. The amounts have not been adjusted to reflect the impact of recent legislation that extended the enhanced FMAP for an additional six months.)
Low Income Pool – Hospitals
$821,140,327

This is the core component of the LIP Program, and it contains two distribution methodologies to allocate funding to hospitals:
The *Allocation Factor Distribution* and the *Proportional Distribution*
The allocation factor distribution is $761,501,028 to hospitals based on IGTs contributed and a 15 percent allocation factor which is applied to local matching funds provided for the Exemption and the LIP programs, only. IGTs of $111 million provided by these same local taxing authorities do not qualify for the allocation factor.
The proportional distribution of the remaining funds after the first distribution, are allocated based on a hospital’s Medicaid, charity care, and 50% bad debt days to the total for all qualifying hospitals. To receive funds in this distribution, the hospital’s Medicaid, charity care, and bad debt days divided by total days must equal or exceed 10 percent. Financial reports are used as the data source to compute the Medicaid, charity care, and bad debt days. A total of $59,639,299 is distributed in this category.
## Special LIP Hospital Payments

$101,791,612

Distributions include the payments for primary care, trauma, rural, specialty pediatric, and safety-net hospital providers. The total LIP distributions are as follows:

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care hospitals</td>
<td>$ 9,927,653</td>
</tr>
<tr>
<td>Trauma hospitals</td>
<td>$ 9,561,157</td>
</tr>
<tr>
<td>Rural hospitals</td>
<td>$ 6,235,796</td>
</tr>
<tr>
<td>Specialty pediatric hospitals</td>
<td>$ 1,562,946</td>
</tr>
<tr>
<td>Safety-net hospitals</td>
<td>$74,504,060</td>
</tr>
</tbody>
</table>
LIP Non-Hospital Providers $77,318,054

The non-hospital component consists of initiatives focused on primary care, emergency room diversion, disease management, poison control, and continuation of two premium assistance programs for the uninsured. Direct health care services are primarily delivered through either federally qualified health centers, hospitals that operate primary care clinics, or county health departments.
Distributions to Non-hospital Providers

$3,172,805 to Poison Control Programs operated by hospitals
$11,000,000 to Federally Qualified Health Centers (FQHCs) under contract with the Agency
$7,276,256 to FQHCs in collaboration with the State Department of Health
$9,550,939 to continue county health department initiatives emphasizing primary care services
$3,000,000 for hospital-based primary care initiatives administered through the Agency
Distributions to Non-hospital Providers

$250,000 for a premium assistance program in Dade County
$15,867,014 for a premium assistance program in Palm Beach County
$1,200,000 for an emergency room diversion program for Manatee County
$1 million is to be provided for Primary Care Residency slots
$25,001,040 for primary care enhancement grants
What are the other related programs?
The Legislature tasked the LIP council with providing a recommendation on the financing of the Low Income Pool and Disproportionate Share Hospital (DSH) programs, and the distribution of their funds. In addition, the Council is charged with advising the Agency on the impatient rates, rebase rates, or other exemptions for hospitals from reimbursement limits as financed by IGTs. As a consequence of this multitasking, the Low Income Pool is interdependent with DSH programs, the Exemption program, and the Medicaid “Buy-Back” program.
What is the Disproportionate Share Hospital (DSH) Program?

Federal regulations permit State Medicaid programs to make supplemental payments to hospitals that provide a high proportion of their care to Medicaid recipients and the uninsured. These payments, known as disproportionate share hospital (DSH) payments, are similar in structure to the LIP payments.
What is the Disproportionate Share Hospital (DSH) Program?

Like LIP, IGTs from counties and special taxing districts are matched by Federal funds at the FMAP rate. Unlike LIP, the DSH program did not receive an ARRA enhanced rate, so the FMAP for the DSH program is currently about 55%. DSH payments are not reimbursement for specific patient services, but are a supplemental payment based on a hospital meeting qualifying eligibility. DSH payments are made to hospitals meeting DSH program eligibility defined in both Federal regulations and Florida statutes.
Disproportionate Share Hospital programs
$259,962,883

Regular DSH program (eligibility defined by Social Security Act as hospitals with a Medicaid inpatient utilization rate greater than one standard deviation above the statewide mean or a hospital with a low-income utilization rate of 25 percent or greater)

Primary Care (PSN) program
Family Practice Teaching program
Graduate Medical Education (GME) program
Specialty Children’s Hospital program
Rural Hospital program
Florida Statutes 409.911
Disproportionate share program

Subject to specific allocations established within the General Appropriations Act and any limitations established pursuant to chapter 216, the agency shall distribute, pursuant to this section, moneys to hospitals providing a disproportionate share of Medicaid or charity care services by making quarterly Medicaid payments as required. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.
Although, by statute, counties are exempt from being required to contribute toward the cost of the DSH program, some counties do agree to contribute to the DSH program as a part of their overall Low Income Pool participation.
How is the Exemption program related to Medicaid hospital cost reimbursement?

Hospitals that participate in the Florida Medicaid Program are reimbursed in accordance with the Florida Title XIX Hospital Inpatient / Outpatient Reimbursement Plan (the Plan). The Plan is incorporated by reference into Chapter 59G–6.010 of the Florida Administrative Code (FAC) and details the methods and standards by which facilities are reimbursed.
How is the Exemption program related to Medicaid hospital cost reimbursement?

Medicaid Hospital reimbursement rates are set twice a year: July and January. Hospitals are required to submit annual cost reports to the Agency for Health Care Administration for the purposes of rate setting. Medicaid reimburses licensed, Medicaid participating hospitals for inpatient and outpatient services using two distinct reimbursement rates for inpatient (24 hours or more) and outpatient (less than 24 hours) services.
How is the Exemption program related to Medicaid hospital cost reimbursement?

Medicaid reimburses for inpatient hospital service based on reported costs. Inpatient per diem rates are determined by dividing Medicaid allowable costs by Medicaid days. Outpatient reimbursement rates are determined based on a payment plan that determines a per occasion of service rate. Currently, hospital providers are reimbursed prospectively, meaning the actual costs from a prior year are inflated forward to the current rate period using a nationally recognized inflation index.
What is the Exemption Program?

Many hospital providers are currently subject to limitations or provider targets that adjust allowable costs on the provider cost reports submitted to the Agency.

Under specific legislation, qualifying hospitals may be exempt from certain cost limitations. These facilities are known as exempt hospitals. Hospitals that do not qualify are considered non-exempt.
What is the Exemption Program?

A summary analysis of the percentage of allowable costs that are reimbursed through the current methodology of rate setting based on the January 1, 2010 rate setting:

Exempt Hospitals – 85.66% of costs
Non-exempt Hospitals – 56.74% of costs

The volume of hospitals reimbursed at exempt or non-exempt rates as of January 1, 2010:

76 Exempt Hospitals (31.4%)
166 Non-exempt Hospitals (68.6%)
What is the Exemption Program?

The cost of the Exemption program is the cost associated with exempting those hospitals from certain cost limitations, thus increasing the hospital's reimbursement rate to cover a higher percentage of the hospital's costs to provide health services to Medicaid participants.
Hospitals in the Exemption program
$704,143,503

Due to financing availability within the LIP process, only certain hospitals qualify for exemption from cost limitations. These hospitals are:

Specialized Hospitals (Children, State, etc.)
Statutory Teaching Hospitals
Community Hospital Education Program (CHEP) Hospitals
Trauma Hospitals that also provide greater than 7.3% Medicaid (days)
All hospitals providing 11% or greater Medicaid + Charity (days)
What is the “Buy-back” program?

The “Buy-back” program is similar to the Exemption program; however, the program is used to offset additional reimbursement rate reductions applied by the Legislature as a result of budget cutting activities. These rate reductions are reflected as a Medicaid trend adjustment on each hospital’s rate sheet developed by the Agency as part of the twice annual hospital rate setting process.
What is the “Buy-back” program?

The “Buy-back” program restores the rates to a level where the restored rates would reflect the individual hospital per diem prior to Medicaid trend adjustments being applied under the current State Plan reimbursement methodology. The financing mechanism for the “Buy-back” program is applied exactly the same as the Exemption program.
What is the “Buy-back” program?

But for financing through the Low Income Pool of the “Buy-back” program, the current impact of these additional Medicaid rate adjustments would be a reduction in qualifying hospital rates of approximately 15%.
Hospitals in LIP financed “Buy-back” program $60,873,479

Due to financing availability within the LIP process, only certain hospitals qualify to have their Medicaid rates bought back. These hospitals include:

- Hospitals operating a Provider Service Network
- Statutory Children’s Hospitals
- Rural Hospitals
- Trauma Hospitals (if funding is available)
What about hospitals that don't qualify for the LIP financed “Buy-back” program?

In an effort to maximize available funding, for SFY 2010-11, the Low Income Pool Council recommended and the Legislature authorized, that any hospital with access to IGTs be allowed to buy back reimbursement rate reductions on a prospective basis. This provision means that hospitals that do not qualify for “Buy-back” program financing through the LIP process may look to other sources of IGT funds for the provision of the non-federal share of buy-back financing.
What is the relationship between the LIP, DSH, Exemption, and “Buy-back” programs and the County Medicaid billing process?

As of January 1, 2010, there were 242 hospitals participating in the Florida Medicaid program. The 242 participating hospitals serve approximately 230,000 Medicaid recipients through inpatient stays.

According to Florida Statutes 409.915 counties are mandated to participate in the cost of providing Medicaid services in the State of Florida.
What is the relationship between the LIP, DSH, Exemption, and “Buy-back” programs and the County Medicaid billing process?

Each county is invoiced for 35% of the total cost paid by the Agency for Medicaid enrolled county residents for inpatient stays in excess of 10 days, but not in excess of 45 days (with some minor exceptions).

Each county is also invoiced for cost paid by the Agency for Medicaid enrolled county residents for nursing home or intermediate facilities care payments in excess of $170 per month, but not to exceed $55 per month.
What is the relationship between the LIP, DSH, Exemption, and “Buy-back” programs and the County Medicaid billing process?

Also according to Florida Statutes 409.915(7) Counties are exempt from contributing toward the cost of new exemptions on inpatient ceilings for statutory teaching hospitals, specialty hospitals, and community hospital education program hospitals that came into effect July 1, 2000, and for special Medicaid payments that came into effect on or after July 1, 2000.
What is the relationship between the LIP, DSH, Exemption, and “Buy-back” programs and the County Medicaid billing process?

LIP and DSH payments are considered special Medicaid payments. These payments do not have an impact on the Medicaid inpatient rate setting process.
Counties should be aware that payments to finance the non-federal cost of the Exemption and “Buy-back” programs will increase the inpatient Medicaid rates paid to participating hospitals. Although counties are exempt from being required to contribute toward the initial cost of new exemptions and are not required to participate in the “Buy-back” program, counties are not exempt from the cost that the resulting increase in the hospital rate will have on the inpatient hospital portion of their county’s State Medicaid bill.
Closing

The United States Government Accountability Office recently did a study on the effect fiscal pressures on state and local governments may have on the delivery of intergovernmental programs (GAO-10-899).
“All levels of government face long-term fiscal challenges which could affect future Federal funding of intergovernmental programs, as well as potential capacity state and local governments to help fund and implement these programs. The interconnectedness which defines intergovernmental programs requires that officials at all levels of government remain aware of and ready to respond to fiscal pressures."
These pressures have implications for a wide range of Federal, state, and local programs, policies, and activities, and include costs associated with health care, physical infrastructure, state and local employee pensions and retiree health benefits, and education, among other areas. Actions to address the nation’s long-term fiscal outlook will be needed at all government levels in coming years and the challenges cannot be adequately met by shifting burdens from one level of government to another.”
Thank you!

Clark R. Scott, CPA, CGFO
HHS Finance Manager
Pinellas County
2189 Cleveland Street, Suite 266
Clearwater, Florida 33765
cscott@pinellascounty.org