APPROVED AND ADOPTED 1/11/07

Meeting Minutes

Low Income Pool (LIP) Council
Tampa International Airport
Tampa Aviation Authority Board Room
3rd Floor Main Terminal
5503 West Spruce Street
Tampa, Florida 33607
December 11, 2006
10:00am – 4:00pm

Members Present

1. **Paul Belcher, Chairman**
2. **Paul Rosenberg, Shands Hospital**
3. **Tony Carvalho, Statutory Teaching Hospital Council**
4. **Michael Gingras, Heath Management Associations**
5. **Steve Mason, Baycare Health System**
6. **Dee Schaeffer, Halifax Community Health System**
7. **Mike Hutchins, Baptist Health Care (Phone)**
8. **Lewis Seifert, Adventist Health System**
9. **Charlotte Mather, North Broward Hospital District**
10. **Randy Lewis for Pete Clarke, Orange County Government (Phone)**
11. **Marvin O'Quinn, Jackson Hospital (Phone)**
12. **Dwight Chenette, Health Care District of Palm Beach County**
13. **Loren Dyer for Steve Short, Tampa General Hospital (Phone)**
14. **Hugh Greene, Baptist Health**
15. **Frank Sacco, Memorial Health Systems (Phone)**
16. **Dave Ross, Tenet Health Systems**
17. **Mike Marks, Hospital Corporation of America**

Members Absent

None

Others Participating in Person

1. Lecia Behenna, AHCA
2. Genevieve Carroll, AHCA
3. Mark Lundberg, DOH
4. John Owens, FHS
5. James Estes, FHS

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6. Phil Street, DOH
7. Doug Mannheimer, Broad & Cassel
8. Lance DeLaruelle, Bethesda
9. Niccie L. McKay, PhD, University of Florida
10. George Barton, Naples Community Hospital
11. Loren Dyer, Tampa General Hospital
12. Scott Hopes, FACHC
13. Andy Behrman, FACHC
14. Eric Prutsman, Orlando Regional Healthcare
15. Belita Moreton, Shands Healthcare
16. Keith Arnold, Lee Memorial
17. Joe Horsey, HCA
18. Kay Bowman, HCA
19. Robert Butler, WellCare
20. Shira Kastan, Miami Children's Hospital
21. Brian Jogerst, All Children's, Miami Children's and Baptist/Jacksonville
22. Dave Musgrave, Shands Jacksonville
23. Ronald Castanza, HCA
24. Robin Gaffney, HCA
25. John Benz, MHS
26. Clare Clements, FACHS
27. Patrick Hanlon, Baycare
28. Dennis Fuller, Shands
29. Bob Harmon, MD, Duval County Health Department
30. Belinda Johnson-Cornett, Duval County Health Department
31. Bonnie Sorensen, MD, DOH
32. Bobby Jernigan, Florida Commission for the Transportation Disadvantaged

Others Participating by Telephone

33. Christine Sexton, Florida Medical Business
34. Mirène D. Charles, Mount Sinai Medical Center
35. Jeanette Nunez, Jackson Memorial
36. Dawn Credle, Memorial Healthcare System
37. Matt Muhart, MHS
38. Marty Lucia, Miami-Dade
39. Janet Perkins, Miami-Dade
40. Michael Sheedy, Florida Catholic Conference
41. Carl Tremonti, Baycare Health Systems
42. Edward C. Mesco, Tenet Health Systems
43. David A. Pizzi, BCBS
44. J. Eric Pridgeon, House Healthcare Council
45. Scott Davis, Memorial Healthcare System
46. Sean P. White, Bethesda Healthcare System
47. Barbara Reardon, CMS
48. Margaret Brennan, Orange County Government

49. Arnie Paniagua, Jackson
50. Brian Clark, EOG
51. Jeff Harris, Spivey/Harris
52. Lisa M. Bacot, Florida Commission for the Transportation Disadvantaged
53. Leah McCallister, DOH
54. Frank Barrett, Jackson
55. Clark Scott, Pinellas County Human Services Department
56. Tom Magri, Bethesda Memorial Hospital
57. Christine Neuhoff, Shands HealthCare
58. Craig Jenkins, HCDPBC
59. Geoffrey Becker, Metz Law
60. Kathy Holzer, FHA
61. Steve Grigas, NBHD

Roll Call and Introductory Remarks

Paul Belcher, Council Chairman, opened the meeting of the LIP Council (the Council) with a roll call of members present in person or by telephone and those individuals filling in for a member unable to participate.

Chairman Belcher opened this meeting by welcoming all those in attendance and thanking the Tampa Aviation Authority for the use their board room. Due to the size and complexity of this meeting's agenda, the meeting material was disseminated much later than was planned and the Chairman Belcher assured the LIP Council members that he would work closely with Agency staff for the next meeting to try and get the material out to all Council members earlier. Chairman Belcher specified this with a plan to e-mail all meeting material directly to the LIP Council members as has been done in the past and the link to the new LIP website would be sent to interested parties as soon as the material is available on the website.

Finally, the Chairman Belcher wanted to begin the agenda items with a very clear premise: this meeting lays the foundation of the final recommendations the LIP Council must submit to the Florida legislature by February 1, 2007. The Council would not arrive at a final conclusion during this particular meeting, but this meeting would begin the process of determining the *final* data models and analysis that the LIP Council would ultimately offer to the Florida Legislature as its formal recommendations.

With only two meetings left for the LIP Council to discuss these final recommendations, the Chairman Belcher wanted all the members to focus their attention on a central set of concerns:

1. How is the LIP program going to handle the growth in the LIP program if the 1 billion dollars is spent before the end of the first year? In other words, if the

annualized cost of the growth is the program exceeds the 1 billion dollar annual allotment, what options does the LIP program have?

2. The decrease in the Federal match rate and the increase in the State match is being done with no new payments, just additional cost to the State. How will the LIP Council address this issue?
3. The growth in the exemption program. The State is currently $140 million over their appropriated level with $94 million of that putting direct pressure on the LIP program. The LIP Council must present the Florida legislature with a comprehensive yet balanced approach for solutions.

With these intertwined issues given to the LIP Council for much further consideration, Chairman Belcher moved to the agenda items for discussion.

Approval of October 20, 2006, Minutes

The Council members were asked to approve the meeting minutes from the November 29, 2006, LIP Council meeting. The minutes were unanimously approved and adopted.

Discussion of IGT Possibilities

Genevieve Carroll discussed a handout that displayed the Intergovernmental Transfers (IGTs) received by the Agency for State Fiscal Year (SFY) 2006-07 for the Disproportionate Share (DSH) program, the Low Income Pool (LIP) program and hospital exemption issues. This spreadsheet laid out the IGTs by local government/taxing district that provided an IGT for SFY 2006-07 and in what category they submitted their respective IGT: LIP program & hospital exemptions, DSH, and/or Statewide Issues (SWI). A projection was then made for these same local governments/taxing districts for the same categories for SFY 2007-08. Using the projected 2007-08 estimates of IGTs, the Agency would be $33.8 million short of the $94 million needed in IGTs for SFY 2007-08. Tony Carvalho asked why there was $7,034,783 noted as additional IGT needed but in a different column from the aggregate. Ms. Carroll noted that the $7 million put off to a different column was strictly for the DSH program and her intent was to keep the category of where the IGT is applied separate from the other categories. Mr. Carvalho understood this clarification but wanted to be clear that the $33 million IGT deficit would really be $40 million if it included the DSH IGT also.

Chairman Belcher added that the participants supplying the IGTs need to understand three important principles:

1. All participants need to verify the IGT is still available;
2. The current distribution affects additional contributions needed; and

3. Cost limit affects IGT and no provider at anytime may exceed its cost limit

Paul Rosenberg asked if any data was available showing significant money available in areas with cost limit restrictions. And if so, if a local government or taxing district was over cost limit, could they still send up an IGT? Ms. Carroll said this could be done but the local government or taxing district would get no benefit back.

Mr. Carvalho asked how many counties/taxing districts has the State not heard from and is there an estimate of how much more IGT money out there is available? Ms. Carroll replied there are only a few million and certainly not the $33 million needed.

Tony Carvalho then confirmed that the cost limit is the maximum of uncompensated care plus the Medicaid shortfall. Ms. Carroll agreed with this definition. Mr. Carvalho then stated that even if $94 million in IGTs was received in full, cuts are still needed. Mr. Carvalho added that 70% of local tax money comes from Dade and Broward counties.

Discussion of Bad Debt and Charity

1. Explanation of reporting and audit requirements

Genevieve Carroll reviewed a summary of adjustments to revenue that included bad debt and charity care. Ms. Carroll noted that the descriptions of these programs were coming from the State of Florida, Hospital Uniform Reporting System (FHURS) Manual, July 1, 2005. Ms. Carroll noted that there technically is no definition of bad debt, just a description of how bed debt is one of the four main categories defined as reductions in gross revenue. Ms. Carroll stated that in the audit review process bad debt is not part of the audit process. Council member Mike Marks asked to respond to Ms. Carroll's introduction. Mr. Marks stated that bad debt *is* audited data because the State requires an audit of bad debt (independent audit of financial statements that includes bad debt). Mr. Marks added that all CFOs attest to a very specific, quantified amount of bad debt and the determination of bad debt is very valid accounting mechanism. Mr. Marks added that the FHURS data is more current than charity care data.

Finally, Mr. Marks added that the previous DSH Council agreed to remove 50% of bad debt while applying a 10% qualification threshold and if the LIP Council removes bad debt then the formula threshold needs to be changed.

2. Impacts of removing bad debt from LIP3 methodology and replacing FHURS with audited DSH data

Ms. Carroll reviewed a spreadsheet that quantified the impact of removing bad debt from LIP 3 Methodology and replacing FHURS with Audited DSH data. Tony Carvalho offered two quick concerns that he called impact and audit process concerns:

- Impact: the 'Effect of Removing bad Debt from LIP 3 and using Audited DSH Data rather than FHURS" shows the impact for how much money is *lost*. How about other changes for providers that do not lose money? Some hospitals should benefit from this change. Chairman Belcher explained that this spreadsheet was not meant to display redistribution of remaining LIP 3 money.

- Audit process: Whether it is bad debt or charity care, the actual amount of uncompensated care claimed usually goes down after an audit because many providers cannot provide sound evidence to justify charity.

The Council discussed that no matter how we may define charity care or bad debt, it is all considered uncompensated care. Charity care audits are done first then bad debt audits and it is never the other way around.

Mr. Carvalho asked if the charity care audits are what First Coast Service Options (FCSO) uses. And if so, if this is different than a FHURS data audit; are hospitals getting audited twice? Ms. Carroll replied that she was confident that the hospitals were not getting audited twice.

Mike Marks emphasized that we need to establish and maintain *consistent* standards.

Mr. Carvalho added that the provision allowing 50% of bad debt to be included was recognition of Florida having the 3rd largest total of hospital bad debt in the nation.

Presentation of LIP Models

a. DSH Model – Projected Distributions and Funding Requirements SFY0708

Genevieve Carroll discussed a summary of the projected DSH payments for SFY 2007-08. This summary was using audited DSH data for 2001, 2002, and 2003 and displayed the payments for both regular DSH and teaching DSH. Mike Marks asked for some detail on the allocation for the teaching DSH category and Ms. Carroll explained that the methodology was laid out in Florida Statute 409.9113. Marvin O'Quinn asked if the payments listed were based on existing IGTs and not projected and Ms. Carroll confirmed that was correct. Chairman Belcher repeated the Council's request for these different models to lay out DSH, LIP and hospital exemptions separately.

b. Special LIP, LIP 1, 2, and 3 Model

Ms. Carroll reviewed three spreadsheets displaying different options specifically in the LIP programs. One spreadsheet displayed the current methodology in LIP 1, 2, and 3 for SFY 2006-07 with the current program totals. These totals were achieved using updated

audited DSH data and FHURS data. The components of the LIP payment category were further broken down and shown as rural, primary care, trauma, safety net and specialty. Mike Marks asked for further detail on the criteria of the safety-net category in the LIP payments and Ms. Carroll agreed that this would be provided at the next meeting. This spreadsheet also detailed the difference between the state share, the federal share between SFY 2006-07 and SFY 2007-08. With the decrease in the federal share and the increase in the state share for SFY 2007-08 quantified, Ms. Carroll emphasized the fact that without the additional state match received, the State will not receive *any* of the federal match. Therefore, the projected LIP payments for SFY 2007-08 did not reflect an increase in the IGTs.

The remaining two spreadsheets focused on two potential options dealing with the impact of the addition IGTs. The first option was an across the board proportional reduction that *includes* the new IGTs as part of the reduction. Tony Carvalho stated that his calculations reflected this proportional reduction as a 5.4% reduction to each LIP silo. Paul Rosenburg added that this option did not give a public hospital an incentive to provide the additional IGTs that are necessary in the LIP program.

The second option was an across the board proportional reduction to the entire LIP program calculating the impact of including the new IGTs as part of the reduction, however, the proportional adjustments were calculated based on net program payments. In other words, in determining the proportion each program is compared to the total, the IGTs were first subtracted. LIP1 program total, for example, is $578M. After removing approximately $431M in IGTs, the net program total is $147M.

c. Exemption Models

The hospital exemption models were displayed two different ways. The first model showed the proposed projected exemption amounts for SFY 2007-08 and then a comparison of these amounts with the proposed full reductions taken. This model laid out each hospital including its exemption category (statutory teaching, specialty, family practice/CHEP, trauma, charity care/Medicaid percentage, or select criteria). Tony Carvalho stated that his calculations showed this proposed full reduction to hospital exemptions equaled 27% as the difference between the State cap and actual cost.

The second hospital exemption model that was proposed projected exemption amounts for SFY 2007-08 and then a comparison of these amounts with the proposed reductions taken with a 50% reduction. Mike Marks asked the Council for some historical perspective on the hospital exemption program. Chairman Belcher asked Tony Carvalho to offer his historical perspective and Mr. Carvalho stated that the main reason was to assist in managing the growing hospital deficit and to help lessen the impact of the different institutions.

Mr. Carvalho continued by offering those in attendance a handout displaying a schedule of appropriations by major category for SFY 2006-07. Mr. Carvalho stated that without the LIP program (and the former upper payment limit program) hospitals would only receive 60% of their actual costs. The State portion of General Revenue was less then

15% of the total General Revenue in comparison to 41% for other major service categories. This calculation was described as the state cap rate and the fully allocated rate. Mr. Carvalho stated that the remaining 40% of a hospital's cost was being picked up by the LIP program. He finished by stating that the LIP program could not continue to absorb the shortfall in the actual cost of straight Medicaid hospital reimbursement.

Options to Address Additional Funding Requirements

Chairman Belcher offered the Council members the following list of potential options to address the $94 million needed in additional IGT for SFY 2007-08:

- Limit Exempt/Rebasing growth rates. Use the previous policy of 8% and 50% reductions or create a new policy to achieve reductions.
- Adjust Exempt/Rebasing utilization to the most current caseload numbers.
- Take across the board reductions in all LIP programs (percentages may vary by LIP category).
- Use of audited data only for LIP 3 saves $14.8 million.
- Eliminate the use of bad debt for a LIP 3 allocation saves $4.6 million.
- Increase the LIP 3 10% qualification threshold.
- Recommend shifting the funding of poison control to GR saves $3.1 million in LIP margin.
- Lower the FQHCs programs and recommend GR to fund statewide rate increases for FQHCs (requires state plan amendment).
- Recommend GR to cover exempt growth rates at 100% or 50% or some other percentage.

Each potential solution was discussed individually and the advantages and disadvantages were highlighted. The option that proposed an increase in the 10% qualification threshold for LIP 3 was displayed in a spreadsheet that showed the impact of the 10% threshold increased from 10% to 15.99% and then from 16% to 20.99%. The main impact of this change was that some hospitals would be dropped out of the LIP program when the qualification threshold is increased. Mike Marks reminded the Council that the legislative mandate for the LIP Council stipulated a "fair and broad distribution" and he felt this might violate that stipulation. Chairman Belcher reassured the Council members that this was simply another attempt to display the status quo compared to a change in the program. The Council would be open to any and all suggestions and would attempt to see these options put into a data model formula. Tony Carvalho emphasized the need to discuss the policy behind these options. Mr. Carvalho was concerned that the State needs to provide the additional General Revenue (GR) because if the exemption program continues as it is currently being funded, the LIP program will be exhausted. Mr. Carvalho finished by stating the LIP program was not intended to be a primary funding source for hospital per diem reimbursement.

Marvin O'Quinn asked to see a summary of all options so his decisions could be made by looking at the big picture. Mr. O'Quinn also stated that since the big hospitals carry such a large financial burden, then they deserve a return on their investment. Frank Sacco

asked for more detail on the criteria of the safety net category in the LIP program. This detail would be helpful in the selection of options. Chairman Belcher promised a short narrative at the next LIP Council meeting of the components that comprise the safety net category.

Steve Mason emphasized the importance of looking at the LIP program from a long term perspective and work together to develop long term strategy that clearly justifies how well we are using LIP funds.

Finally, Chairman Belcher asked Council members whether, in general, they prefer data models done that display across the board reductions, maybe not fixed, but straight proportional reductions? Paul Rosenberg responded by stating that, in general, it was his preference to see across the board, proportional reductions as opposed to policy specific reductions. With that, Chairman Belcher asked that all requests for additional models to be run be sent via e-mail to either Genevieve Carroll or Edwin Stephens at the Agency by Monday, December 18, 2006.

Tony Carvalho had two final requests:

1. The State of Florida must certify the percentage that Medicaid pays for basic hospital reimbursement; and

2. A model that looks at the growth in rebasing funds from the past 5 years and projects the costs forward for the next 5 years and shows the effect this increase will have on the LIP program. He asked that this analysis be done keeping in mind the increase in the federal match is an erosion factor.

Genevieve Carroll agreed to research both of these issues and have data available to discuss at the next LIP Council meeting.

Summary of LIP Projects

Chairman Belcher reviewed two summaries of the LIP projects that were in place during SFY 2006-07 and few new projects that were being proposed for SFY 2007-08. The first summary was a brief description of the goals and objectives of the projects. The second summary was an attempt to compare all projects on the basis of current funding (if applicable), funding requested for SFY 2007-08, and the local match required. Duval County asked for a minor correction indicating that they had funding during SFY 2006-07 when in fact they did not. This change was noted and Chairman Belcher planned to update this summary to show accurate totals of all LIP projects.

LIP Presentations

Overviews of proposed projects were presented by the following:

a. Federally Qualified Health Centers (FQHC) – Andy Behrman (2007-08 funding request - $12.7 million)
b. Department of Transportation - Commission for the Transportation Disadvantaged – Bobby Jernigan (2007-08 funding request - $418,476)
c. Duval County Health Department – Robert Harmon (2007-08 funding request - $4.1 million)
d. Florida Council for Community Mental Health – Bob Sharpe (2007-08 funding request - $2.5 million)
e. Dr. Bonnie Sorenson, Deputy State Health Officer, Florida Department of Health (2007-08 funding request - $12.7 million)

9. Closing Comments – Paul Belcher

Chairman Belcher concluded this meeting of the LIP Council reminding everyone that continued focus on models attempting a balance between the status quo and different changes was going to be a difficult task. Chairman Belcher noted that with any change, there will always be a consequence somewhere else in the LIP Program. Chairman Belcher thanked everyone for participating and with no new business brought before the LIP
Council, this meeting was adjourned.

10. Discussion of Future Meeting Dates – Paul Belcher

The next meeting of the LIP Council was scheduled for January 11, 2007 back at the Tampa Aviation Authority.

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Paul Belcher Date
LIP Council Chairman