FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION
Better Health Care for all Floridians

Draft Summary
Low Income Pool (LIP) Council
Wednesday, January 9, 2013
10:00 a.m. - 4:00 p.m.

Members Present
Phil Williams, LIP Chairman
Hugh Greene
William Robinson
Dee Schaeffer
Charlotte Mather
John Benz
Mike Marks

Members Absent
Dr. Edwin Pigman (Resigned)
Dave Ross
Dr. Mark McKenney
Ray Reed
Fred Ashworth

Members Attending by Phone
Kevin Kearns
Mark Knight
Steve Mason
Gary Uber
Lewis Seifert
Mike Hutchins
Dr. Karen Chapman
Dr. Ron Wiewora
Steve Harr
Patrick Schlenker
Steve Short
Michael Gingras

AHCA Staff and Presenters
Tom Wallace
Lecia Behenna
Bill Perry
Ryan Perry
Nicole Maldonado
Kelvin Faison
Mal Ferguson

Welcome

The Low Income Pool (LIP) Council meeting was conducted at the Agency for Health Care Administration (Agency) in Tallahassee, Florida. Mr. Phil Williams, LIP Council Chairman and Assistant Deputy Secretary for Medicaid Finance, opened the meeting with a welcome and a brief roll call.

Approval of Minutes

The December 20, 2012 minutes were moved for approval, seconded, and adopted with no objections.

Updates

The Agency provided an update on the 1115 Waiver. LIP Council member Steve Short made a motion to request from federal CMS an increase in LIP program funding above the current $1billion as part of the 1115 Waiver amendment. The motion was seconded by Dee Schaeffer and passed with no objections.

As part of a discussion between Agency staff and federal CMS staff on the topic, it should be clarified that this will be an appropriate topic for the 1115 wavier extension, not the current pending waiver amendments.

Ms. Behenna discussed where the Agency was with the current year LIP IGT need. Currently, the LIP program is approximately $27 million short on IGTs, creating a total reduction of $63 million. The Agency is currently in conversations with four counties and three taxing districts in an effort to close the gap. Subsequent updates will be provided.

Models for SFY 2013-14

Model 2 – Bill Robinson

Model 2 was presented by Bill Robinson:

General - Uses Base Model approved at the December 12, 2012 LIP Council meeting and recommends $22.2 million previously undistributed funding in Special LIP:

LIP ($1.0 billion)

- LIP 4 Required IGT's to fund LIP, Exemptions and Buybacks- $688.2M
  Including $2.8 million unidentified ($708.9 million required in SFY 2012-13; $685.4 million currently available)
- LIP 4 Allocation Factor – 8.5% funds $58.5 million
- LIP 5 Proportional Pool - $2.4 million – rural hospitals only
- Special LIP – Increase from $113.6 million to $135.8 million or $22.2 million
  - Quality - $15.0M to $30.0 million- same methodology
  - Primary Care - $10.0 million to 12.0 million – restores SFY12-13 LIP Council and House recommended levels for Broward Health System (2 hospitals)
  - Safety Net - $72.7 million to $ 75.1 million or $2.4 million- restores SFY 12-13 LIP Council and House recommended levels for 18 hospitals
  - Trauma - $8.8 million to $11.6 million or $2.8 million – restores SFY 12-13 LIP Council and House recommended level payments and adds payments on prorated basis to balance model
  - Rural ($5.6 million) and Specialty Peds ($1.4 million) unchanged

***Note: funds all hospitals in above categories recommended by Senate in SFY 2012-13 Appropriations.

- Non Hospital LIP - $115.3 million – continues LIP STC/Enhanced new primary care initiatives

DSH

- $245.9 million – recognizes new limits except in Rural, needs to be finalized

Buy-backs

- $130.5 million
- Same policy and methodology as SFY 2012-13

Exemptions

- $636.7 million (including $9.9 million Liver Global Fee)
- Uses SFY 2010-11 Medicaid Cost Report Volumes, SFY 2012-13 rates and SFY 2012-13 Tier percentages
- Tier %'s as follows:
    - Childrens: 89.00%
    - Statutory Teaching and Public: 71.00%
    - Trauma, GAA, Special: 66.48%
    - CHEP: 66.48%
    - Utilization over 15%: 66.48%
    - Utilization 11% to 14.9%: 66.48%

Model 3 – Bill Robinson

Model 3 was presented by Bill Robinson:

General: Uses Base Model approved at the December 12, 2012 LIP Council meeting, but instead of funding $22.2 million in Special LIP, the model requires additional $20.5 million in IGT's to fund an additional $49.6 million in Exemptions.

LIP ($1.0 billion)

- LIP 4 Required IGT's to fund LIP, Exemptions and Buybacks- $708.7 million Including $23.3 million unidentified (note: $708.9 million required in SFY 2012-13)
- LIP 4 Allocation Factor – 8.5% funds $60.2 million
- LIP 5 Proportional Pool - $2.4 million – rural hospitals only
- Special LIP – $113.6 million unchanged
    - Quality - $15.0 million - same methodology
    - Primary Care - $10.0 million
    - Safety Net - $72.7 million
    - Trauma - $8.8 million
    - Rural ($5.6 million) and Specialty Peds ($1.4 million) unchanged
- Non Hospital LIP - $115.3 million – continues LIP STC/Enhanced new primary care initiatives

DSH

- $245.9 million – recognizes new limits except in Rural, needs to be finalized

Buy-backs

- $130.5 million
- Same policy and methodology as SFY 2012-13

Exemptions - $686.3 million

- $636.7 million (including $9.9 million Liver Global Fee)
- Uses SFY 2010-11 Medicaid Cost Report volumes, SFY 2012-13 rates and SFY 2012-13 Tier percentages
- Additional - $49.6 million, $49.6 million added prorata to base tiers, as follows:
    - Childrens: 89.00% to 96.04%
    - Statutory Teaching and Public: 71.00% to 76.62%
    - Trauma, GAA, Special: 66.48% to 71.74%
    - CHEP: 66.48% to 71.74%
    - Over 15%: 66.48% to 71.74%
    - Utilization 11% to 14.9%: 66.48% to 71.74%

Model 4 – Dee Schaeffer

Model 4 was presented by Dee Schaeffer:

General: Uses Base Model approved at the December 20, 2012 LIP Council meeting, but instead of funding $22.2 million in Special LIP, the model funds $5.4 million in Special LIP and it requires additional $16.4 million in IGT's to fund an additional $39.7 million in Exemptions.

LIP ($1.0 billion)

- LIP 4 Required IGT's to fund LIP, Exemptions and Buybacks- $704.6 million. Including $19.2 million unidentified (note: $708.9 million required in SFY 2012-13)
- LIP 4 Allocation Factor – 8.5% funds $59.9 million
- LIP 5 Proportional Pool - $2.4 million – rural hospitals only
- Special LIP – $118 million
    - Quality - $15.0 million - same methodology
    - Primary Care - $10.0 million to $12.0 million – restores SFY 2012-13 LIP Council and House recommended levels for Broward Health System (2 hospitals)
    - Safety Net - $72.7 million to $75.1 million – restores SFY 2012-13 LIP Council and House levels for 18 hospitals
    - Trauma - $8.8 million – Adds new provisional hospital in Level II (or Peds); adjusts hospital funding from $206,266 to $194,133 to maintain silo total.
    - Rural ($5.6 million) and Specialty Peds ($1.4 million) unchanged
- Non Hospital LIP - $115.3 million – continues LIP STC/Enhanced new primary care initiatives

DSH

- $245.9 million – recognizes new limits except in Rural, needs to be finalized

Buy-backs

- $130.5 million
- Same policy and methodology as SFY 2012-13

Exemptions - $666.5 million

- Base
  - $626.7 million (including $9.9 million Liver Global Fee)
  - Uses SFY 2010-11 Medicaid Cost Report volumes, SFY 2012-13 rates and SFY 2012-13 Tier percentages
- Additional - $39.7 million
  - $39.7 million added prorata to base tiers as follows:
    - Children's: 89.00% to 96.51%
    - Statutory Teaching and Public: 71.00% to 75.51%
    - Trauma, GAA, Special: 66.48% to 70.68%
    - CHEP: 66.48% to 70.68%
    - Over 15%: 66.48% to 70.68%
    - Utilization 11% to 14.9%: 66.48% to 70.68%

Model 5 – John Benz

Model 5 was presented by John Benz:

General: Uses Base Model approved at the December 20, 2012 LIP Council meeting, but instead of funding $22.2 million in Special LIP, the model requires additional $20.5 million in IGT's to fund an additional $49.6 million in Exemptions.

Specific:
LIP ($1.0 billion)

- LIP 4 Required IGT's to fund LIP, Exemptions and Buybacks- $708.7 million Including $23.3 million unidentified (note: $708.9 million required in SFY 2012-13)
- LIP 4 Allocation Factor – 8.5% funds $60.2 million
- LIP 5 Proportional Pool - $2.4 million – rural hospitals only
- Special LIP – $113.6 million unchanged
  - Quality - $15.0 million - same methodology
  - Primary Care - $10.0 million
  - Safety Net - $72.7 million
  - Trauma - $8.8 million
  - Rural ($5.6 million) and Specialty Peds ($1.4 million) unchanged
- Non Hospital LIP - $115.3 million – continues LIP STC/Enhanced new primary care initiatives

DSH

- $245.9 million – recognizes new limits except in Rural, needs to be finalized

Buy-backs

- $130.5 million
- Same policy and methodology as SFY 2012-13

Exemptions - $686.3 million

- Base
  - $636.7 million (including $9.9 million Liver Global Fee)
  - Uses SFY 2010-11 Medicaid Cost Report volumes, SFY 2012-13 rates and SFY 2012-13 Tier percentages
- Additional - $49.6 million
  - $49.6 million added prorata to hospitals with pediatric days (excluding normal newborns) above 30,000 total days
    - Excludes free standing children's hospitals
    - Excludes hospitals not currently exempt under the Low Income Pool
    - Data based on twelve months of pediatric activity for the period ended March 31, 2012 – Data from the Agency
    - Dollars allocated based on each qualifying hospital's pediatric days to the total days for all qualifying hospitals

DRG Update

The Agency introduced the topic of DRGs. As part of the introductory remarks specific to the DRG topic, the Chair noted for the benefit of Council members and others that the Agency had on January 8, 2013, resolved an issue with 3M regarding the Agency's ability to share with interested parties the same DRG database that had previously been shared with the Florida hospital Association. With resolution to this issue, those wishing to receive the database need to enter a data sharing agreement with the Agency, and the previously required 3M APR-DRG licensing agreement is not needed. To receive the Agency's data sharing agreement, interested parties need to follow up with Tom Wallace of Agency staff.

Malcolm Ferguson, a representative of the consulting group Navigant, gave a presentation and answered questions about the inpatient hospital DRG conversion. Mal also provided DRG simulation results by provider for the LIP Council to review (simulation 17).

During the DRG presentation, Council members had multiple questions that generated extensive discussion. One of the first issues raised was specific to the adjustment being applied for the documentation and coding improvement (DCI) issue. As a means of addressing the concerns raised by Council members, a motion was made seconded, and adopted without objection that the Agency implements a reconciliation process using an appropriate timeline following the application of the DCI adjustment.

Other topics of concern raised during the discussion of the DRG topic addressed: transition period, wage index, teaching/graduate medical education adjustment, and capital costs, as well as general concerns specific to policy decisions, policy adjustors, and implementation timeline. There was also discussion of possible delay of implementation, the need for an industry Technical Advisory Panel (TAP) to advise the Agency on preparation for implementation during the delay, implementation of a parallel system (current and DRG systems simultaneously), and several other topics. A related motion was made, but subsequently tabled. There was also concern expressed regarding the opportunity for industry input along the way.

The Chairman reminded the group that 4 well-attended stakeholder meetings had occurred over a series of months specific to the DRG development process. There was ample opportunity for input at those meetings. In addition, numerous groups sought and were granted meetings with Agency personnel on various aspects of the development process. Details from these meetings were shared with Navigant and MGT consulting staff. Details from all of this input were brought to the Agency's Governance group as part of its deliberations.

The Chairman also reminded the Council that what the Agency has done with the DRG development was what was directed by the Legislature and the Governor. Council recommendations that might be counter to this may not be well received. As an example, the Chairman reminded the Council that a previous attempt by the Council to seek additional state General Revenue funding via Council recommendations had been determined to be unacceptable to the Agency in a prior year.

LIP Council Member Requests

During the LIP Council meeting, several LIP Council members made requests of the Agency:

- Mike Marks requested a breakdown of cost limit capacity by Hospital
- Dee Schaeffer requested that the Agency provide where Florida falls in the National average by DSH limits based on per capita instead of federal limit.
- Mike Marks requested additional information on John Benz's Model 5. Mr. Marks asked for a more extensive breakdown of the Florida Pediatric Activity, specifically the providers that fell below the 30,000 day cut off.

Upcoming Events

The Agency reminded the Council about the next LIP Council meeting scheduled for January 16, 2013. A deadline for model requests was announced for Friday January 11, 2013, at noon. The model requests will be handled as first model submitted, first model completed.

Adjournment

The meeting was adjourned at 12:18 p.m.