HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 285 Medicaid Low-Income Pool and Disproportionate Share Program
SPONSOR(S): Health Care Regulation Policy Committee, Patronis and others
TIED BILLS: **IDEN./SIM. BILLS:** CS/CS/SB 556

	REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1)	Health Care Regulation Policy Committee	7 Y, 0 N, As CS	Calamas	Calamas
2)	Health & Family Services Policy Council	23 Y, 0 N	Lowell	Gormley
3)	Health Care Appropriations Committee		Hicks	Pridgeon
4)	Full Appropriations Council on General Government & Health Care		Hicks	Leznoff
5)				

SUMMARY ANALYSIS

Section 409.911(9), F.S., establishes the Low Income Pool (LIP) Council for the purpose of making recommendations to AHCA and the Legislature regarding the financing and distribution of LIP and disproportionate share (DSH) funds.

The bill alters the membership of the LIP Council by adding two members appointed by the Speaker of the House of Representatives, two members appointed by the Senate President, one representative of federally qualified health centers, one representative of the Department of Health, and one representative of the Agency for Health Care administration to serve as a nonvoting chair. This increases the membership from 17 to 24. The bill establishes criteria for the legislative appointments.

The bill also prohibits lobbyists from sitting on the LIP Council, except for those employed full time by a public entity.

The bill has no fiscal impact on state or local government.

The effective date of the bill is July 1, 2009.

HOUSE PRINCIPLES

Members are encouraged to evaluate proposed legislation in light of the following guiding principles of the House of Representatives

- Balance the state budget.
- Create a legal and regulatory environment that fosters economic growth and job creation.
- Lower the tax burden on families and businesses.
- Reverse or restrain the growth of government.
- Promote public safety.
- Promote educational accountability, excellence, and choice.
- Foster respect for the family and for innocent human life.
- Protect Florida's natural beauty.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Medicaid and Medicaid Supplemental Payments

Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration and financed by federal and state funds.[1] Local funds are also used as part of the state match requirement. County governments are required to pay a share of costs for nursing home services and limited inpatient care. Some counties voluntarily participate in a transfer of additional governmental funds in order to finance certain supplemental Medicaid payments. Key characteristics of Florida's Medicaid program may be summarized as follows:

- 2.3 million eligibles.
- $15.7 billion estimated spending in Fiscal Year 2008-09.
- Federal-state matching program – 55.40 percent federal share; and 44.60 percent state share.
- Florida will spend approximately $6,709 per eligible in Fiscal Year 2008-2009.
- 45 percent of all Medicaid expenditures cover:
  - Hospitals;
  - Nursing homes;
  - Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs); and,
  - Low Income Pool and Disproportionate Share supplemental payments.

Supplemental Medicaid payments to providers are intended to ensure access to hospital inpatient and specialty care for Medicaid recipients and access to primary care and safety-net hospitals for the uninsured. Similar to other Medicaid expenditures, the Low Income Pool (LIP) and Disproportionate Share (DSH) programs are financed by federal and state funds. The source of the state match for LIP and DSH is primarily from voluntary contributions of counties and local taxing districts through intergovernmental transfers (IGTs), the process of transferring public funds between government entities.

The DSH payments are directed toward hospitals serving a disproportionate share of low-income individuals who either are part of the Medicaid program or are uninsured. Under federal Medicaid law,

[1] Sections 409.901(2) and (14), F.S. The Medicaid DME and medical supplies program is authorized by Title XIX of the Social Security Act and 42 C.F.R. Part 440.70. The program was implemented through ch. 409, F.S., and Chapter 59G, F.A.C.

each state receives an annual DSH allotment. Florida's federal DSH allotment for FY 2008-2009 is $188,384,000. The Florida DSH programs are codified in law in ss. 409.911 – 409.9119, F.S.

Prior to Medicaid Reform, Florida provided supplemental payments to hospitals under the federal Upper Payment Limit (UPL) regulations. These regulations place a ceiling on the maximum amount of payments that can be made to Medicaid providers. Since Florida reimbursement levels are significantly below the federally-defined maximums, the regulations allowed enhancements to the normal reimbursement programs. These enhanced payments were financed through voluntary IGTs. Recommendations for distribution of funds available under the UPL were developed by the DSH Council, the precursor to the LIP Council.

Low-Income Pool and Low-Income Pool Council

During the 2005 Legislative Session, the Legislature authorized AHCA to apply for a Medicaid reform waiver[2] contingent on the ability of the state to maintain supplemental payments to hospitals. This contingency was met by the waiver terms and conditions authorizing creation of a Low Income Pool to "provide direct payment and distributions to safety net providers in the state for the purpose of providing coverage to the uninsured".[3] This change in format for supplemental provider payments was accompanied by a significant increase in the federally-approved level of this type of supplemental spending. The federal waiver sets a capped annual allotment of $1 billion for each year of the 5-year demonstration period for the LIP.[4] The LIP program also authorized supplemental Medicaid payments to provider access systems, such as federally qualified health centers, county health departments, and hospital primary care programs, to cover the cost of providing services to Medicaid recipients, the uninsured and the underinsured.

The waiver and the LIP expire in 2011, unless renewed.

Florida law provides that distribution of the Low-Income Pool funds should:[5]

- Assure a broad and fair distribution of available funds based on the access provided by Medicaid participating hospitals, regardless of their ownership status, through their delivery of inpatient or outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;
- Assure accessible emergency inpatient and outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;
- Enhance primary, preventive, and other ambulatory care coverages for uninsured individuals;
- Promote teaching and specialty hospital programs;
- Promote the stability and viability of statutorily defined rural hospitals and hospitals that serve as sole community hospitals;
- Recognize the extent of hospital uncompensated care costs;
- Maintain and enhance essential community hospital care;
- Maintain incentives for local governmental entities to contribute to the cost of uncompensated care;
- Promote measures to avoid preventable hospitalizations;
- Account for hospital efficiency; and
- Contribute to a community's overall health system.

Section 409.911(9), F.S., required AHCA to establish a LIP Council for the purpose of providing advice and making recommendations to AHCA, for distribution of the LIP funds each year. The LIP Council reports its

[2] Implementation of the Medicaid reform waiver was authorized in HB 3-B during the 2005 B Special Legislative Session. Currently, the waiver is operational in Broward, Duval, Baker, Clay and Nassau Counties.
[3] Application for 1115 Research and Demonstration Waiver, August 30, 2005, approved by CMS as updated on October 19, 2005, at 5.
[4] Centers For Medicare & Medicaid Services Special Terms and Conditions, Section 1115 Demonstration Waiver No. 11-W-00206/4, Florida Agency for Health Care Administration, at 24.
[5] Section 409.91211(c), F.S.

findings and recommendations to the Legislature and the Governor by February 1 of each year.[6] Specifically, the LIP Council is required to:[7]

- Make recommendations on the financing of the LIP and the disproportionate share hospital program and the distribution of their funds;
- Advise AHCA on the development of the LIP plan required by the federal Centers for Medicare and Medicaid Services pursuant to the Medicaid reform waiver; and
- Advise AHCA on the distribution of hospital funds used to adjust inpatient hospital rates, rebase rates, or otherwise exempt hospitals from reimbursement limits as financed by IGTs.

LIP Council recommendations are advisory in nature, and are presented each year to the appropriations committees of the Legislature. The Legislature's decisions regarding the distribution of LIP funds as well as allocations of other resources available due to the contributed IGTs are expressed in proviso of the General Appropriations Act.

According to AHCA, the Council functions as a liaison among and between the counties and taxing districts that provide the IGTs, the entities seeking LIP funding, and the providers that receive the funding. Council members work with their counties or taxing districts to educate them on the available LIP funds and obtain a complete understanding of the funds each is willing to provide for the LIP and at what level each is willing to provide funding. Some Council members also contract with consultants to prepare LIP distribution models for review prior to making model requests from AHCA. This allows the Council members to review multiple models with different scenarios to see which model they would like the Agency to prepare for presentation at a Council meeting, which reduces AHCA's workload.[8] In preparation for developing the Council recommendations for FY2009-10, the members reviewed nearly 20 different models for how the funds might be distributed. All models are posted online. The recommended model was selected based on a voice vote of the membership.

The LIP Council consists of 17 members appointed by the AHCA secretary, as follows:[9]

- 3 representatives of statutory teaching hospitals;
- 3 representatives of public hospitals;
- 3 representatives of nonprofit hospitals;
- 3 representatives of for-profit hospitals;
- 2 representatives of rural hospitals;
- 2 representatives of units of local government which contribute funding; and
- 1 representative of family practice teaching hospitals.

As a statutory advisory body, all LIP Council meetings are subject to the open meeting and records requirements of Florida law. Public notice is provided and all meetings are held either in person or by teleconference. Proceedings of the Council are published on the AHCA website.

2008-09 Low Income Pool Funding and Expenditures

As with the former UPL Program, the LIP consists of federal Medicaid funds and state matching funds provided by local governmental entities through IGTs.[10] Twenty units of local governments contribute more than $800 million in local tax dollars to finance the state match for the Low Income Pool and Disproportionate Share Program. These funds also support the rebasing of hospital per diem rates that would otherwise be limited by statutory ceilings and the availability of general revenue. The sources of IGTs for these Medicaid expenditures are as follows:

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[6] *Id. See, e.g.*, LIP Council Recommendations to Governor and Legislature for SFY 2009-10, *available at* http://ahca.myflorida.com/medicaid/medicaid_reform/lip/lip.shtml (last viewed March 22, 2009).
[7] Section 409.911(9), F.S.
[8] Agency for Health Care Administration 2009 Bill Analysis & Economic Impact Statement, House Bill 285 (2009).
[9] Section 409.911(9), F.S.
[10] Section 409.91211(b), F.S.

Local Government or Special Taxing Authority	IGTs Contributed
Miami-Dade County	355,496,876
Broward County - North / South Broward Hospital Districts	237,599,004
Palm Beach County - Health Care District of Palm Beach County	38,408,380
Volusia County - Halifax Hospital Medical Ctr. Taxing District	33,889,161
Hillsborough County	33,659,294
Pinellas County	24,165,594
Duval County	23,079,734
Sarasota County Public Hospital Board	20,856,614
Lake County - North / South Lake Hospital Taxing District	16,400,949
Orange County	14,588,316
Lee County - Lee Memorial Health System	10,427,172
Indian River Taxing District	9,667,910
Citrus County Hospital Board	7,526,160
Bay County	5,800,000
Marion County	3,803,219
Collier County	2,789,131
Columbia County Lake Shore Hospital Authority	2,789,131
Brevard County - North Brevard Hospital District	1,145,074
Gulf County	1,000,000
St. Johns County	356,563
TOTAL	**$843,448,282**

As a result of these contributions, the state is able to finance nearly $2 billion in expenditures including $1 billion in LIP payments to hospitals and other providers; $663 million in rebased hospital per diem rates for 61 hospitals; $251 million for DSH payments to 65 hospitals; and $64 million in buy back rate reductions to provider service networks, children's hospitals and rural hospitals.

Effect of Proposed Changes

The bill alters the membership of the LIP Council by adding two members appointed by the Speaker of the House of Representatives, two members appointed by the Senate President, one representative of federally qualified health centers, one representative of the Department of Health, and one representative of the Agency for Health Care administration to serve as a nonvoting chair. This increases the membership from 17 to 24.

The bill requires that one of each pair of legislative appointments be a physician, and prohibits more than one of each pair from being a physician. In addition, the bill requires the House Speaker and Senate President to appoint physicians who routinely take calls in a trauma center or a hospital emergency department.

The bill also prohibits persons who qualify as lobbyists under s. 11.045 or s. 112.3215, F.S., from serving on the LIP Council, except for those employed full time by a public entity.

The effective date of the bill is July 1, 2009.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.911, F.S., relating to the disproportionate share program.

Section 2: Provides an effective date of July 1, 2009.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take an action requiring the expenditure of funds. The bill does not reduce the percentage of a state tax shared with counties or municipalities. The bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rulemaking authority pursuant to s. 409.919, F.S.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES

On March 25, 2009, the Health Regulation Policy Committee adopted a strike-all amendment and reported the bill favorably. The amendment alters the membership of the LIP Council, and prohibits lobbyists from serving on the LIP Council, except for those employed full time by a public entity. The amendment effectively removes the fiscal impact of the bill.

The analysis is drafted to the committee substitute.