Reimbursement and Funding Methodology

Florida Medicaid Reform Section 1115 Waiver

Low Income Pool

Submitted June 26, 2009

Table of Contents

I. Overview

In accordance with the Special Terms and Conditions (STCs) for waiver number 11-W-00206/4, Medicaid Reform Section 1115 Demonstration, the State of Florida, Agency for Health Care Administration (AHCA), Medicaid program (the State), submits to the Centers for Medicare and Medicaid Services (CMS) this Reimbursement and Funding Methodology document. This document fulfills STC Pre-Implementation Milestone requirement number 100(a), in addition to STCs 93, 97, 98, and 101.

In addition to the Reimbursement and Funding Methodology document, the State is providing the definition of expenditures eligible for Federal matching funds and the entities eligible to receive reimbursement. Permissible expenditures are discussed in STC 94:

> *"Funds from the LIP 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, 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."*

Included in this document is the methodology used for the distribution of the $1 billion annual LIP funds as provided for in the STCs. Providers in receipt of LIP funds are required to submit documentation of their permissible expenditures which will be used to calculate a Low Income Pool Cost Limit (LIP Cost Limit). Permissible expenditures are discussed in Section III of this document. Upon review of the permissible expenditures, the Agency will reconcile the LIP distributions against the LIP Cost Limit. Section V, Planning and Reconciliation, reviews this process.

A. The LIP is defined in STC 91 to "…ensure continued government support for the provision of health care services to Medicaid, underinsured and uninsured populations."

   Certain basic parameters of the LIP require consideration to gain an appropriate perspective for the State's proposal for LIP distributions:

   1. Although the State appreciates the $1 billion available through the LIP, it is important to recognize that the $1 billion is insufficient to fund a statewide benefit for the uninsured determined by a broad based methodology incorporating more than one health care service. Florida simply has too many uninsured individuals (estimated between 2.8 million

and 3.2 million)[1] and health care services are too expensive to provide broad benefits to all potential eligibles.

2. Local governments funding the LIP through intergovernmental transfers (IGTs) have a vested interest in ensuring that their localities benefit from the funding they provide for the program. The funding mechanism is an important component of the LIP, just as the State's funding of the Medicaid program is a primary determinant of how the State operates its Title XIX program (see Appendix A for a flow chart of local government funds provided for the LIP program). Florida has a vested interest in using its State share, coupled with Federal matching dollars, to benefit the citizens of Florida. CMS does not require Florida to assist with the funding of any other State's Medicaid programs, but allows Florida to use its State share specifically for the benefit of its citizens. The State has adopted a similar philosophy for how local funds are considered within the LIP. Although the State is not promoting a predetermined benefit for the local governments providing funding, the State does recognize that it is inappropriate to require a local government to assist with the funding of a benefit for providers outside that local government's area without consideration of the benefits received by providers within its political subdivision. The State believes it is sound public policy to provide each local government the assurance that its providers will not receive less from LIP than if the local government provided direct financial assistance to its providers.

3. An evaluation of services typically covered within a coverage model generally results in a broad array of services that vary in cost per unit and the financial risk for the insured related to the use of such services. An individual may be able to afford a dental visit or a single pharmaceutical, but would incur significant financial risk if a lengthy or acute hospital stay was required. Therefore, consistent with the prioritization of covered services in Medicare Part A and the general insurance market, the State recognizes a priority of services subject to coverage from the LIP. Just as Medicare and commercial coverage attempts to cover hospital services first, the LIP recognizes that the uninsured must have their hospital risk addressed first. Subsequent to addressing the hospital risk, the LIP can then address subsequent services such as physician services, clinic services, drugs or limited benefit packages as they present lower risks than critical hospital services.

4. Barring sufficient funding for a methodology that allows adequate coverage of needed services for Florida's uninsured, the State has adopted a basic distribution methodology similar to CMS' methodology of providing a predetermined pool to fund the uninsured, underinsured, and Medicaid shortfalls. In accordance with STC 101, "Providers with access

[1] Florida Health Insurance Study 2004

to the LIP and services funded from the LIP shall be known as the provider access system[s] (PAS)". A more detailed definition of a PAS is as follows:

> *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 shall be known as Provider Access Systems. Provider Access Systems funded from the LIP shall provide services to Medicaid recipients, the uninsured, and the underinsured. Provider Access Systems shall be required to report data related to the number of individuals served and the types of services provided from the LIP funding.*

The State has created separate and unique payment methodologies that recognize different PAS options. These PAS distributions will be used to contribute primarily toward health care services provided to the uninsured and underinsured, although the distributions alone will not totally fund such services. Providers will be asked to report the number of services made available through programs receiving LIP funding, and no LIP funding will exceed the cost of such services.

B. Due to the limitation of funds, the distribution methodology incorporates the above as follows:

1. Hospital services are prioritized in the distribution methodology;
2. Providers within a local area will not receive less than they would have received if they were to obtain funding directly from their local governments for services related to Medicaid, the uninsured, and the underinsured; and
3. Providers will receive less than 100% of the cost of services for the uninsured, underinsured, and Medicaid shortfalls.

II. Reimbursement Methodology

In Chapter 2005-358, Laws of Florida, the Agency was instructed to create a Low Income Pool Council by July 1, 2006. The statute provides instructions for the criteria to use in the structure of the Council. The Council's charge is to make recommendations on the financing of the Low Income Pool and the distributions of its funds to the Governor and the Legislature by February 1 *each* year. After review and action by the Florida Legislature the distribution methodology becomes part of the annual General Appropriations Act (GAA). The State's recommended distributions of the LIP funds may be separated into distinct categories. Some of the providers may be eligible to receive a LIP distribution in more than one category. The categories may vary based on

services offered or type of provider such as but not limited to hospitals, County Health Departments (CHDs), Federal Qualified Health Centers (FQHCs) and other Safety Net providers. These distributions will be made to qualifying providers after the Agency receives executed Letters of Agreement with participating counties and health care taxing districts, receipt of the State, non-Federal share, and proper LIP Cost Limit and Milestone documentation by participating providers. Distributions for each Demonstration Year may begin effective July 1.

III. Definitions

State Fiscal Year (SFY) - July 1 – June 30

Demonstration Year – July 1 – June 30

- Demonstration Year 1 – July 1, 2006 – June 30, 2007
- Demonstration Year 2 – July 1, 2007 – June 30, 2008
- Demonstration Year 3 – July 1, 2008 – June 30, 2009
- Demonstration Year 4 – July 1, 2009 – June 30, 2010
- Demonstration Year 5 – July 1, 2010 – June 30, 2011

Uninsured: Persons with no source of third party coverage.

Underinsured: Persons with no source of third party coverage for services provided. Unallowable uncompensated care cost includes any unpaid deductible and coinsurance amounts pertaining to services furnished to individuals with third party coverage, and any charges written off as bad debts or charity care (to the extent that some of the services related to the bad debt and charity care accounts meet the definition of uninsured/underinsured, the days and charges for such services should already be included in the cost apportionment process).

IV. Low Income Pool Permissible Expenditures (Cost Limit Computation)

LIP is subject to specific Special Terms and Conditions (STCs) which require a calculated cost limit for providers. The Specific STCs that govern the expenditures included in the calculation of the cost limit are STCs 97, 98, and 100a.

> *97. **Low Income Pool Permissible Hospital Expenditures.** Hospital cost expenditures from the LIP will be paid at cost and will be further defined in the Reimbursement and Funding Methodology Document utilizing methodologies from the CMS-2552 cost report plus mutually agreed upon additional costs. The State agrees that it shall not receive FFP for Medicaid and LIP payments to hospitals in excess of cost and this requirement is further clarified with the submission of a corresponding State Plan Amendment, as outlined in the pre-implementation milestones in Section XVI, "Low Income Pool Milestones."*

*98. **Low Income Pool Permissible Non-Hospital Based Expenditures**. To ensure services are paid at cost, CMS and the State will agree upon cost-reporting strategies and define them in the Reimbursement and Funding Methodology document for expenditures for non-hospital based services.*

100 a. The State's submission and CMS approval of a Reimbursement and Funding Methodology document for LIP expenditures, definition of expenditures eligible for Federal matching funds under the LIP and entities eligible to receive reimbursement.

The STCs also require a detailed process for calculating the cost limit. The following sections provide the required detail.

A. HOSPITALS

1. Hospital Medicaid Fee-For-Service (FFS)

For the State payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are to be determined using the hospital's Medicare cost report (CMS 2552) on file with Florida Medicaid for the first rate semester of each State Fiscal Year. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2

The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing

bed nursing facility costs and non medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid FFS inpatient routine cost center costs for the payment year, the hospital's actual inpatient Medicaid days by cost center, as obtained from auditable hospital records for the period covered by the as-filed cost report will be used. The days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term care services are excluded.

Step 5

To determine Medicaid FFS ancillary costs for the payment year, the hospital's actual Medicaid FFS allowable charges, as obtained from auditable hospital records for the period covered by the as-filed cost report will be used. Medicaid FFS allowable charges for observation beds must be included in line 62. These Medicaid FFS allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid FFS allowable costs for each cost center. The Medicaid FFS allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.

Step 6

The Medicaid allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. Medicaid "usable organs" are counted as the number of Medicaid patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid days and charges in Steps 4 and 5 above, or any Medicaid managed care or uninsured days and charges in Steps 4 and 5 of those portions of this protocol.

Step 7

The Medicaid FFS allowable costs are determined by adding the Medicaid routine costs from Step 4, the Medicaid ancillary costs from Step 5 and the Medicaid organ acquisition costs from Step 6.

2. Hospital Medicaid Managed Care

For the State payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's Medicare cost report(s) (CMS 2552) covering the payment year, as filed with Florida Medicaid. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2

The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows: Step 4

To determine the Medicaid managed care inpatient routine costs for the payment year, the hospital's actual Medicaid managed care inpatient days by cost center, as obtained from auditable hospital records and other applicable sources for the period covered by the as-filed cost report will be used. The days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid managed care allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term care services are excluded.

Step 5

To determine the Medicaid managed care ancillary costs for the payment year, the hospital's actual Medicaid managed care charges, as obtained from auditable hospital records and other applicable sources for the period covered by the as-filed cost report will be used. Medicaid managed care allowable charges for observation beds must be included in line 62. These Medicaid managed care allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid managed care allowable costs for each cost center. The Medicaid managed care allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.

Step 6

The Medicaid managed care allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid managed care usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Medicaid managed care usable organs" are counted as the number of Medicaid managed care patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid managed care days and charges in Steps 4 and 5 above (or any Medicaid days or uninsured days in Steps 4 and 5 of those portions of this protocol).

Step 7

The Medicaid managed care allowable costs are determined by adding the Medicaid managed care routine costs from Step 4, the Medicaid managed care ancillary costs from Step 5 and the Medicaid managed care organ acquisition costs from Step 6.

3. Hospital Uncompensated Care

For the payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's most recently as filed Medicare cost report (CMS 2552), as-filed with Florida Medicaid. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital actual costs are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted and stepped down through the A and B worksheet series.

Step 2

The hospital's total actual days by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total actual charges by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total actual costs from Step 1 by total actual days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total actual costs from Step 1 by the total actual charges from Step 2. The A&P routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the as-filed cost report year are used to determine the hospital's actual costs for the payment year. The data sources utilized to determine eligible costs under this section must be derived from the hospital's audited financial statements and other auditable documentation. The hospital costs for care provided to those with no source of third party coverage (i.e., uninsured cost) for the payment year are determined as follows:

Step 4

To determine the uninsured routine cost center costs for the payment year, the hospital's actual inpatient days by cost center for individuals with no source of third party coverage are used. The actual uninsured days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the low income uncompensated care inpatient costs for each cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term care services are excluded.

Step 5

To determine the uninsured ancillary cost center actual costs for the payment year, the hospital's inpatient and outpatient actual charges by cost center for individuals with no source of third party coverage are used. These allowable uninsured charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the uninsured allowable costs for each cost center. The uninsured care charges for the payment year should only pertain to inpatient and outpatient hospital services and should exclude charges pertaining to any professional services or non-hospital component services such as hospital-based providers.

Step 6

The uninsured care share of organ acquisition costs is determined by first finding the ratio of uninsured care usable organs to total usable organs. This is determined by dividing the number of uninsured usable organs as identified from provider records by the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Uninsured usable organs" are counted as the number of patients who received an organ transplant and had no insurance. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid or uninsured days and charges in Steps 4 and 5 above or Steps 4 and 5 of the Medicaid (or Medicaid managed care) portion of this protocol.

Step 7

The eligible uninsured care costs are determined by adding the uninsured care routine costs from Step 4, uninsured ancillary costs from Step 5 and uninsured organ acquisition costs from Step 6.

Actual uninsured data for services furnished during the payment year are used to the extent such data can be verified to be complete and accurate.

The data sources utilized to determine eligible costs under this section must be derived from hospitals' audited financial statements and other auditable documentation.

4. Hospital Provider Additional Medicaid Costs

a. Part A provider component services in excess of Reasonable Compensation Equivalent (RCE) limits.
Providers may include costs for Part A provider component services, but RCE limits must be applied to these limits.

b. Part B professional component services (not separately billable to individual patients)
The costs are for services allowable under the terms of the waiver and provided to Medicaid beneficiaries or the uninsured.

c. Physician unmet guarantee amounts and other subsidies
The costs are for services allowable under the terms of the waiver and provided to Medicaid beneficiaries or the uninsured.

d. Non-physician practitioner costs
The costs are for services allowable under the terms of the waiver and provided to Medicaid beneficiaries or the uninsured.

e. Outpatient clinical laboratory services
The costs are for services allowable under the terms of the waiver and provided to Medicaid beneficiaries or the uninsured.

f. Provider-based transplant services indirect organ acquisition costs (not already included on Worksheet E-3, Part III, line 4
The costs are for services allowable under the terms of the waiver and provided to Medicaid beneficiaries or the uninsured. However, the State would need to follow the Medicare cost reporting process for determining these costs.

g. Provider-based clinic services
The costs are for services allowable under the terms of the waiver and provided to Medicaid beneficiaries or the uninsured; and if these clinics are treated as outpatient departments of the hospital and not hospital based FQHCs or RHCs.

h. Patient and community education programs, excluding cost of marketing activities
The costs are for services allowable under the terms of the waiver and provided to Medicaid beneficiaries or the uninsured.

i. Services contracted to other providers
The costs are for services allowable under the terms of the waiver and provided to Medicaid beneficiaries or the uninsured.

j. County based insurance programs
The cost that is reimbursed below Medicaid rates for allowable Medicaid costs.

5. Hospital Payments and Recoveries

All of the following payments and recoveries, shall be offset against the costs computed in Sections above: Managed Care Organizations (MCO); Behavioral Health Organization's (BHOs); the Medicaid enrollees and the uninsured; supplemental payments; the amount of GME funds received that exceeded the hospital's Medicaid GME expenditures; any DSH payments received; and other sources including any related patient co-payments, or payments from other non-State payers. Payments to the hospital from uninsured individuals for their care for the fiscal year are identified from the hospital's records. Such uninsured data must be supported by auditable documentation.

6. Hospital Reconciliation for SFY 2006-07 through 2008-09

For Demonstration Year (DY) 1, DY2 and DY3, the State will use the original Cost Limit established for each provider and conduct the required reconciliation using the following method.

The state will implement new reporting criteria by date of service beginning July 1, 2009 to capture the uninsured costs with indicators to distinguish allowable and non-allowable costs. Non-allowable costs include co-pays, deductibles and costs incurred during coverage gaps. Providers will be required to report the data to the Agency on a quarterly basis. This data will be gathered and used for prior year reconciliation purposes.

The State will use the data reported on a quarterly basis to establish a provider specific baseline for uninsured cost. The data will distinguish between allowable and non-allowable uninsured cost which will be used to determine the ratio of unallowable cost that would have been expected in the previous operating years. The established cost limit will be reduced using the calculated ratio net of trend adjustments. The trend adjustment will allow for growth in the non-allowable cost that would not have been present during the period which is reconciled. The result will provide an adjusted cost limit that will be used to complete the reconciliation.
The payments to the provider through the Low Income Pool program and Disproportionate Share Hospital Program will be totaled for the period being reconciled. This total will then be compared to the total cost of the allowed uninsured and Medicaid shortfall costs. If the total payments are at or below the total costs, the requirement of not exceeding the cost limit is met. If the payments exceed the cost, the provider will be required to refund the overpayment amount.

In the event of an overpayment, the State will return the federal share through the standard process currently used by the State.

For example: if the data reported for provider shows a 3% increase in uninsured cost and identifies 2% of the overall costs of the uninsured as unallowable cost, the previous year cost would need to be reduced by 2% to reflect the unallowable cost that would have been expected. If the proportion of the unallowable cost compared to the allowable cost increased, the previous year would not be decreased by 2% due to the fact that the proportion of the unallowable cost would be less than that used to calculate the 2%.

7. Hospital Reconciliation Beginning SFY 2009-10

The CMS 2552 costs determined through the method described for the payment year will be reconciled to the as filed CMS 2552 cost report for the payment year once the cost report has been filed with the Medicare Fiscal Intermediary (FI). If, at the end of the interim reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the Federal government and if an underpayment is determined, the State will make the applicable claim from the Federal government. For purposes of this reconciliation, the same steps as outlined for the payment year method are carried out except for the changes noted below:

Steps 1 – 3

Days, costs, and charges from the as filed CMS 2552 cost report for the payment year are used.

Steps 4, 5

Actual Medicaid paid days and charges from MMIS paid claims data for services furnished during the payment year are used.

Step 6

Organ acquisition costs and total usable organs from the as filed CMS 2552 cost report for the payment year are used.

For hospitals whose cost report year is different from the State's fiscal year, the State will proportionally allocate to the State fiscal year the costs of two cost report periods encompassing the State fiscal year. To do so, the State will obtain the actual Medicaid FFS, Medicaid managed care, and uninsured days and charges for the hospital's cost reporting periods, and compute the aggregate Medicaid FFS, Medicaid managed care, and uninsured costs for the reporting periods. These costs will then be proportionally allocated to the State fiscal year. All allocations will be made based upon number of months. (For example, a hospital's cost reporting period ending 12/31/07 encompasses one-half of the State plan rate year ending 6/30/2007, and one- half of the State plan rate year ending 6/30/2008. To fulfill reconciliation requirements for State plan rate year 2007-08, the hospital would match one-half of the Medicaid FFS, Medicaid managed care, and uninsured costs from its reporting period ending 12/31/2007, and one-half of the Medicaid FFS, Medicaid managed care, and uninsured costs from its reporting period ending 12/31/2008, to the State plan rate year.) The State will ensure that the total costs claimed in a State plan rate year will not exceed the costs justified in the underlying hospital cost reports for the applicable years.

B. FQHCs

1. FQHC Medicaid and Medicaid Managed Care

For the payment year, the allowable costs applicable to FQHC services are determined using the FQHC Form CMS-222-92, as filed with the Fiscal Intermediary:

a. Determine allowable Medicare Rate per covered visit from Worksheet C part I, line 9.
b. Determine Medicaid encounters for the payment year from auditable FQHC reports. Apply Medicaid encounters to allowable Medicare Rate per covered visit from step a. This will result in total Medicaid costs.
c. Determine allowable cost per vaccine injection from Worksheet b-1 line 12.
d. Determine Medicaid vaccinations for the payment year from auditable FQHC records.
e. Apply Medicaid vaccinations to allowable cost per vaccine injection from step d. This will result in total Medicaid cost for vaccinations.
f. Sum the result of step c and step f to determine total allowable Medicaid cost for the payment year.
g. Offset all applicable revenues received by the FQHC against the total Medicaid costs determined in Step e. to determine Medicaid shortfall.

2. FQHC Uninsured / Underinsured

For the payment year, the allowable cost applicable to FQHC services are determined using the FQHC Form CMS-222-92, as filed with the fiscal intermediary:

a. Determine allowable Medicare Rate per covered visit from Worksheet C part I line 9.
b. Determine encounters attributable to the uninsured for the payment year from auditable FQHC reports.
c. Apply encounters attributable to the uninsured to allowable Medicare Rate per covered visit from step b. This will result in total uninsured costs.
d. Determine allowable cost per vaccine injection from Worksheet b-1 line 12.
e. Determine uninsured vaccinations for the payment year from auditable FQHC records.
f. Apply uninsured vaccinations to allowable cost per vaccine injection from step d. This will result in total Medicaid cost for vaccinations.
g. Sum the result of step c and step f to determine total allowable uninsured cost for the payment year.
h. Offset all revenues (those received by or on behalf of those with no source of third party coverage and / or grant dollars) against the total Uninsured costs in Step g to determine uninsured shortfall.

3. FQHC Provider Additional Uninsured / Underinsured Costs

a. Lab - Cost per encounter for uninsured if services are being paid for by the FQHC. For Medicaid to capture the shortfall, these costs should only be included if the FQHC bills Medicaid or Medicare.
b. X-ray - Cost per encounter for uninsured if services are being paid for by the FQHC. For Medicaid to capture the shortfall, these costs should only be included if the FQHC bills Medicaid or Medicare.
c. Pharmacy - Cost per encounter for uninsured if services are being paid for by the FQHC. For Medicaid to capture the shortfall, these costs should only be added if the FQHC bills Medicaid or Medicare
d. Dental – Cost per encounter for dental can be captured for both Medicaid shortfall and uninsured due to the fact that Dental cost is not included in the Medicare rate.
e. Mental Health – Cost per encounter for Medicare, excluding services allowable by Medicaid, should be added for both uninsured and Medicaid.

4. FQHC Reconciliation for SFY 2006-07 through 2008-09

The state will implement new reporting criteria by date of service beginning July 1, 2009 to capture the uninsured costs with indicators to distinguish allowable and non-allowable costs. Non-allowable costs include co pays, deductibles and costs incurred during coverage gaps. Providers will be required to report the data to the Agency on quarterly bases.

For Demonstration Year (DY) 1, DY2 and DY3, the State will use the original Cost Limit established for each provider and conduct the required reconciliation using the following method.

The State will use the data reported on a quarterly basis to establish a provider specific baseline for uninsured cost. The data will distinguish between allowable and non-allowable uninsured cost which will be used to determine the ratio of unallowable cost that would have been expected in the previous operating years. The established cost limit will be reduced using the calculated ratio net of trend adjustments. The trend adjustment will allow for growth in the non-allowable cost that would not have been present during the period which is reconciled. The result will provide an adjusted cost limit that will be used to complete the reconciliation.
The payments to the provider through the Low Income Pool program and Disproportionate Share Hospital Program will be totaled for the period being reconciled. This total will then be compared to the total cost of the allowed uninsured and Medicaid shortfall costs. If the total payments are at or below the total costs, the requirement of not exceeding the cost limit is met. If the payments exceed the cost, the provider will be required to refund the overpayment amount.

In the event of an overpayment the State will return the federal share through the standard process currently used by the State.

5. FQHC Reconciliation Beginning SFY 2009-10

The CMS-222-92 costs determined through the method described for the payment year will be reconciled to the as-filed CMS-222-92 cost report for the payment year once the cost report has been filed with the Medicare fiscal intermediary (FI). If, at the end of the reconciliation process, it is determined that a FQHC received an overpayment, the overpayment will be properly credited to the Federal government and if an underpayment is determined, the State will make the applicable claim from the Federal government. For purposes of this reconciliation the same steps as outlined for the payment year method are carried out.

For FQHC whose cost report year is different from the State's fiscal year, the State will proportionally allocate to the rate year the costs of two cost report periods encompassing the plan payment year.

C. CHDs

1. CHD Medicaid and Medicaid Managed Care

For the payment year, the allowable costs applicable to CHD services are determined using the CHD's approved Medicaid Cost Report.

a. Determine allowable Medicaid Rate per covered visit from Worksheet 3 Attachment 6 Part D line 1.
b. Determine Medicaid encounters for the payment year from Florida Department of Health LIP Encounters Milestone Report.
c. Apply Medicaid encounters to allowable Medicaid Rate per covered visit from step b. This will result in total Medicaid costs.
d. Offset all applicable Medicaid revenues received by the CHD against the total Medicaid costs determined in Step c to determine Medicaid shortfall.

2. CHD Uninsured Cost

For the payment year, the allowable costs applicable to CHD services are determined using the CHD's approved Medicaid Cost Report.

a. Determine allowable Medicaid Rate per covered visit from Worksheet 3 Attachment 6 Part D line 1.
b. Determine encounters attributable to the uninsured for the payment year from Florida Department of Health LIP Encounters Milestone Report.
c. Apply encounters attributable to the uninsured to allowable Medicaid Rate per covered visit from step b. This will result in total uninsured costs.
d. Offset all revenues (those received by or on behalf of those with no source of third party coverage and / or grant dollars) against the total Uninsured costs determine uninsured shortfall.

3. CHD Reconciliation Beginning SFY 2006-07

The costs determined through the method described for the payment year will be reconciled to the desk audited CHD Medicaid cost report for the payment year. If, at the end of the reconciliation process, it is determined that a CHD received an overpayment, the overpayment will be properly credited to the federal government and if an underpayment is determined,

the State will make the applicable claim from the Federal government. For purposes of this reconciliation, the same steps as outlined for the payment year method are carried out.

(The CHDs' Medicaid Cost Reports and LIP Cost Limit Reports are both compiled based on the Florida state fiscal year, July – June.)

V. Planning and Reconciliation

A. Planning

According to the STC number 97, "The State agrees that it shall not receive FFP for Medicaid and LIP payments to hospitals in excess of cost…" The previous sections provide the methodology for the LIP distributions and the calculation of the permissible expenditures which will be used to calculate the providers' total allowable cost, referred to as the LIP Cost Limit. In order to assure that no provider will receive greater than cost, the Agency will perform a cost/payment reconciliation prior to any LIP distributions as described below.

Provider LIP Cost Limits will be calculated prior to the initial annual LIP distributions and later in an actual reconciliation. A Provider Access System (PAS) must submit the LIP Cost Limit and LIP Milestone documents annually in order to receive its calculated LIP distribution. On May 24, 2007, the Agency created a LIP web-reporting tool to allow PAS provider entities to submit the provider LIP Cost Limit and LIP Milestone data via a dedicated internet website. The LIP Cost Limit data for the existing SFY and the prior year LIP Milestone data must be completed prior to any LIP distributions in a subsequent fiscal year. LIP distributions are anticipated to be made monthly or quarterly. This could vary by provider type in a subsequent fiscal year. The LIP distributions for the five year demonstration period of this waiver are dependent upon the Agency receiving annual spending authority through the General Appropriations Act from the Florida legislature. The Agency, the Governor, and Florida legislature will receive recommendations from the Low Income Pool Council (LIP Council), but the legislature's final appropriation is based on decisions made during the annual legislative session.

The LIP Council works closely with the Agency with special consideration focused on all STCs related to the LIP. Due to the fact that the LIP is dependent upon annual appropriations by the State legislature, the LIP distributions may vary from year to year. Funding for existing PAS programs may continue, new PAS programs may be approved, and funding amounts among the PAS programs may be modified. As this occurs, the Agency will communicate the changes to CMS. It is unknown what the magnitude of the

changes will be from year to year. The total amount of the funding remains $1 billion per year for the five year demonstration period.

The State fiscal year begins July 1st. Upon the Governor's approval of the State's General Appropriations Act, which often occurs during the month prior to July 1st, the Agency will update CMS on LIP distributions. The Agency has communicated to all the providers eligible for LIP that distributions to PAS categories will not be made until CMS approves the methodology for that PAS. Although the state fiscal year begins July 1st, distributions are not anticipated to occur until the months following.

B. Reconciliation

During the first quarter of the state fiscal year (July – September), the LIP Cost Limits will be determined for each provider receiving a LIP distribution. The LIP Cost Limits will be calculated using the data described in Section IV of this document. The LIP Cost Limit calculation is the total allowable expenditures less any reimbursement from Medicaid, the underinsured, or the uninsured. The reimbursement includes Medicaid claims payment for services rendered to Medicaid recipients to each provider and for hospitals, DSH payments. Payments on behalf of the underinsured and uninsured are already included in the cost limit. The remaining amount is the Medicaid, underinsured and uninsured shortfall. This amount, referred to as the LIP Cost Limit, is the maximum amount a provider is eligible to receive in a LIP distribution.

Prior to making a LIP distribution, the LIP Cost Limit for each individual provider will be reviewed. The LIP distribution will be subtracted from the LIP Cost Limit. As long as there is a positive remaining balance of the LIP Cost Limit, there exists a Medicaid, underinsured, and uninsured shortfall. Should the resulting calculation show that the anticipated LIP distribution will exceed the LIP Cost Limit, the provider's distribution will be reduced accordingly. The Agency assures that no provider will receive a LIP distribution in excess of the Medicaid, underinsured, and uninsured shortfall.

Medicaid reimbursement for hospital providers is calculated every January and July, in accordance to the Florida Title XIX Inpatient Hospital Reimbursement Plan (the Plan). The reimbursement rate calculation places limitations on the calculated reimbursement, referred to as ceilings and targets. The limits are often below the provider's reported Medicaid cost. The use of provider reimbursement rates limited by ceilings and targets creates an immediate Medicaid shortfall. Some providers, such as statutory teaching hospitals and rural hospitals, are exempt from these limitations. For these providers, their Medicaid reimbursement represents their Medicaid cost, as allowed in the Plan. The Medicaid shortfall could therefore be minimal for

these providers. A shortfall could still exist due to the fact that there may be legislative reductions to the reimbursement rate apart from the cost calculation as well as additional costs not routinely captured by the Plan. LIP distributions to hospital providers will allow for any calculated Medicaid shortfall in addition to the underinsured and uninsured shortfall.

VI. Source of non-Federal Funds for the LIP

A. The total non-Federal funds for which the Agency enters into contracts for each SFY will be provided to CMS upon request. A copy of all executed Letters of Agreement, including any existing local government provider agreements, will be available to the CMS staff upon request.

VII. Reporting Methodology

In accordance with STC 101, the Reimbursement and Funding Methodology "document shall also include a reporting methodology for the number of individuals and types of services provided through the LIP. This methodology shall include a projection of these amounts for each current year of operation, and final reporting of historical demonstration periods."

The Agency is requesting all providers who receive LIP distributions to complete a LIP Milestone Reporting Requirement document. The report will be completed and submitted to the State no later than July 1st of each state fiscal year, beginning July 1, 2007 through the demonstration period of the waiver.

The reporting document requires providers to record an unduplicated count of Medicaid and uninsured/underinsured visits at their respective facilities funded by LIP resources. In addition, the recipients of LIP funds are required to document the number of services provided to these individuals as one individual may receive multiple services. The data submitted by the providers will exclude non-qualified aliens. The reporting document is to be completed by all providers receiving LIP funds. This information will be used in conjunction with the Medicaid Reform / LIP evaluation by the University of Florida, for STC 102.

The reporting methodology requires the documentation of the number of individuals and types of services provided through the LIP. This will be achieved through the receipt of the LIP Milestone documents from the PAS. The Agency required the PAS to complete a LIP Milestone document based on SFY 2005-06 (referred to as the "Pre-LIP" year data) to establish a base year for comparison against LIP distribution years. The Pre-LIP year and Year 1 LIP Milestone data reports were due July 1 and August 15, respectively beginning in 2007. The Agency, along with the University of Florida LIP Reform evaluation team, will annually review the results of the submitted data. The data will be used in the

Cost Effectiveness Study, required in STC #102. The cost effectiveness study will be reviewed with the Agency and CMS to determine the impact of the LIP on the PAS (STC #102).

VIII. Conclusion

This LIP Reimbursement and Funding Methodology document is submitted to satisfy STCs 93, 97, 98, 100(a) and 101, set forth in the Medicaid Reform Section 1115 Demonstration. STC 100(a), the Pre-Implementation Milestones, calls for the "State's submission and CMS approval of a Reimbursement and Funding Methodology document for LIP expenditures, definition of expenditures eligible for Federal matching funds under the LIP and entities eligible to receive reimbursement." The State satisfied STC 101(a) through its original submission (and subsequent clarification) of this Reimbursement and Funding Methodology document. This document as submitted May 29, 2007, reflected the requirements in STC 101, by detailing the payment mechanisms for expenditures made from the LIP, and included a reporting methodology for the number of individuals and types of services provided through the LIP.

In accordance with #102 of the Special Terms and Conditions of Florida's 1115 Medicaid Reform Waiver, the Agency for Health Care Administration submitted on June 30, 2008 Low Income Pool Program Highlights: Year One (SFY2006-07) as prepared by the University of Florida Evaluation Team. The Agency previously submitted on April 21, 2008, the study to evaluate the cost effectiveness of various Provider Access Systems entitled "Evaluation for the Low-Income Pool Program Using Milestone Data: SFY 2005-06 and SFY 2006-07."

This updated version of the Reimbursement and Funding Methodology document is submitted to CMS in order to update SFY 2009-10 and prospective SFYs cost limit requirements and to address a series of questions raised by CMS.

APPENDIX A

Flow Chart of Local Government Funds Provided for the LIP Program

Flow of Local Government Funds Provided for the Florida Medicaid Low Income Pool Program