2012-13 Low Income Pool (LIP) Tier-One Milestone (STC 61) Application

The 2012 Legislature appropriated Low Income Pool (LIP) funds to support projects designed to start-up new primary care or enhance existing primary care programs. $35 million has been provided by the Legislature to fund these projects. A total of $20 million will be used for the start–up of new primary care programs and a total of $15 million will be used to meaningfully enhance existing primary care programs. This appropriation is based on Special Terms and Conditions (STC) #61 found in the 1115 Medicaid Reform Waiver approved by CMS on December 16, 2011.

Each new or enhanced project award representing a combined total of state and federal matching dollars, will be determined via a competitive solicitation. This solicitation will be based on each applicant's ability to provide Primary Care Access Programs as defined in the General Appropriations Act:

> *"…the CMS Tier-one Milestones are for the establishment of new, or enhancement of existing, innovative primary care programs that meaningfully enhance the quality of care and the health of low income populations. The new or enhanced primary care programs must broadly drive from the three overarching goals of CMS's Three-Part Aim… Within these broad goals, the agency will establish further requirements for new or enhanced primary care programs to provide the services most needed by the local community, such as needed physician, dental, nurse practitioner or pharmaceutical services; expand local capacity to treat patients; and provide for extended service hours. Additionally, reduction of the unnecessary emergency room visits and preventable hospitalization will be components of new or enhanced primary care programs."*

STC # 61:

61. Tier-One Milestone. Tier-One Milestones are defined as follows:

    a) Development and implementation of a State initiative that requires Florida to allocate $50 million in total LIP funding in DY 7 and DY 8 to establish new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations. Initiatives must broadly drive from the three overarching goals of CMS' Three-Part Aim:

        i. Better care for individuals including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity;
        ii. Better health for populations by addressing areas such as poor nutrition, physical inactivity, and substance abuse; and,
        iii. Reducing per-capita costs.

Expenditures incurred under this program must be permissible LIP expenditures as defined under Section XIII, Low Income Pool. The State will utilize DY 6 to develop the program. The program must be implemented with LIP funds allocated and expenditures incurred in DYs 7 and 8.

b) Timely submission of all hospital, FQHC, and County Health Department LIP reconciliations in the format required per the LIP Reimbursement and Funding Methodology protocol. The State shall submit to CMS, within 30 days from the date of formal approval of the waiver extension request, a schedule for the completion of the LIP Provider Access Systems (PAS) reconciliations for the 3-year extension period. CMS will provide comments to the State on the reconciliation schedules within 30 days. The State will submit the final reconciliation schedule to CMS within 60 days of the original submission date.

c) Timely submission of all Demonstration deliverables as described in the STCs including the submission of Quarterly and Annual Reports.

d) Development and submission of an annual "Milestone Statistics and Findings Report" and a "Primary Care and Alternative Delivery Systems Expenditure Report". Within 60 days following the acceptance of the terms and conditions, the State must submit templates for these reports and anticipated timelines for report submissions.

CMS will assess penalties on an annual basis for the State's failure to meet tier-one milestones or components of tier-one milestones. Penalties of $6 million will be assessed annually for each tier-one milestone that is not met. Penalties will be determined by December 31st of each DY and assessed to the State in the following DY. LIP dollars that are lost as a result of tier-one penalties not being met, are surrendered by the State.

The maximum dollar amount awarded per project will be $4 million. The $15 million for meaningfully enhanced existing primary care programs will be open competitive with the $4 million cap. The cap will be a combination of the amount awarded through this bid and any amount being received via the $34 million enhanced primary care funding awarded in SFY 2010-11. The $20 million new project funding will be distributed with a $4 million maximum per project, with a total of $6.6 million being awarded to hospital projects, $6.6 million to CHD projects and $6.6 million to FQHC projects. The projects will be selected based on the program's capability to achieve the following program goals:

- Reduce potentially avoidable emergency room visits by developing initiatives to identify persons inappropriately using hospital emergency

rooms or other emergency care services and provide care coordination and referral to primary care providers.

- Reduce potentially avoidable hospitalizations for ambulatory care sensitive conditions, which involve admissions that evidence suggests could have been avoided.
- Expansion of primary care infrastructure to treat patients.
- Expansion of primary care through expanded service hours (e.g., evening or weekend hours).
- Provide the services most needed by the local community, such as the following:
    - Additional physicians
    - Dental care
    - Nurse practitioners
    - Pharmaceutical services

- Better care for individuals, including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity.
- Better health for populations by addressing areas such as poor nutrition, physical activity, and substance abuse; and
- Reducing per capita-costs.

Recipients of the LIP grant award will be required to report qualitative and quantitative data relating to the various initiatives, which would include the following that apply to the initiative:

- The effect of LIP funding on disparities in the provision of health care services, both geographically and by population groups;
- The impact on access to care and quality of care (including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity);
- The impact on population health; and
- The impact on per-capita costs (including Medicaid, uninsured, and underinsured populations) and the cost-effectiveness of care.

The LIP grant award recipient will also be expected to provide quarterly deliverables that will include financial accounting of how project funds have been expended and the recipient will also need to report its progress on implementing all aspects of the applications. In addition to the quarterly reporting requirements, the LIP grant recipient will be required to adhere to all LIP reporting requirements including but limited to the cost limit report, milestone report and the primary care and alternative delivery system report.

Since this funding source will be new to some provider entities, an illustration of a project funding scenario will facilitate understanding of a project's funding needs. The recipient will be required to come up with the state share which will be 42.27% of the total award. For the sake of this example, assume that a proposed project requests $1 million in funding. With the blended federal financial percentage of 57.73% for State Fiscal Year 2012-13, $577,300 of project would be the federal share and $422,700 would be the state share. The

state share funding requirement would be needed from local government sources as intergovernmental transfer (IGT) funds.

Please provide feedback in response to the questions below in a word document that will reflect your project proposal. You may provide as much information as you choose for each question. Please return the completed template by 5:00 pm July 31, 2012 attached to an email to Lip_Providers_Rpts@ahca.myflorida.com.

Application Guidelines

Please include the following:

1. Applicant:
2. Medicaid Provider Number:
3. Provider Type:
4. Amount applying for:
5. Identify as a new or enhanced program:
6. Description of the delivery system and affiliations with other health care service providers:
7. Service Area:
8. Service Area characteristics (including demographics or population served and distribution of current population served by funding source, e.g., Medicaid, Medicare, Uninsured, Commercial insurance, etc.):
9. Organizational Chart and point of contact:
10. Proposed budget for funding detailing the request:
11. Provide a brief summary of your proposed project:
12. Describe plan for identification of participants for inclusion in the population to be served in the project:
13. How will access to primary care access system services be enhanced by this project?
14. Does the enhancement include hours of operation after 5:00 pm and/or on weekends at existing sites, or the establishment of a new clinic site?
15. Describe your capability to serve minority and culturally diverse populations:
16. Describe how you will identify and address health care diversity issues as well as health care literacy barriers:
17. Describe measures and data sources that you will use to evaluate the effectiveness of each initiative comprising your project:
18. Describe data collection and reporting capabilities including systems and staffing resources, provide a reporting template:
19. Provide a letter of commitment from the local match fund source on that entity's letterhead:

Please attach an excel document with your itemized budget for your project. Keep in mind that if you are awarded a project grant, your financial reporting will be compared to this budget during the project period.

Selected entities will be required to complete required documentation needed for identification and payment processes for the Florida Medicaid Management Information System (FMMIS) if not a Medicaid provider at the time of selection.