Reimbursement and Funding Methodology

Florida Medicaid Reform Section 1115 Waiver

Low Income Pool

February 1, 2013

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

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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 the request by CMS in the Waiver extension approval letter dated December 15, 2011, to submit a LIP protocol by February 1, 2012, and each successive February 1 of the renewal period.

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 54:

> "Funds from the LIP may be used for health care costs (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act. These health care costs may be incurred by the State, by hospitals, clinics, or by other provider types to furnish medical care for the uninsured and underinsured for which compensation is not available from other payors, including other Federal or State programs. Such costs 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. These health care costs may also include costs for Medicaid services that exceed Medicaid payments (after all other title XIX payments are made, including disproportionate share hospital payments)."

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.

STC 51 specifies that the Low Income Pool:

> "…provides government support for the safety net providers that furnish uncompensated care to the Medicaid, underinsured and uninsured populations. The LIP is also designed 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 as described in paragraph 61(a). The LIP consists of a capped annual allotment of $1 billion total computable for each year of the Demonstration extension."

State's Perspective on Waiver Payments

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

i. 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 (estimates between 3.7 to 3.9 million)[1] and health care services are too expensive to provide broad benefits to all potential eligibles.

ii. 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.

iii. 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 attempt to cover hospital services

[1] U.S. Census SFY 2011-12, Current Population Survey (CPS), and Keiser Family Foundation

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.

iv. 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 of the original demonstration waiver, "Providers with access 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, as adopted by the Low Income Pool Council, 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.

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. Payments to providers will not exceed 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. The Florida Legislature amended the statutory provisions specific to the LIP Council during the 2009 Legislative session. These provisions increased the number of members to be appointed to the Council as well as specified criteria for the seats. After review of LIP Council recommendations 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 all LIP Cost Limit and Milestone documentation required to be submitted 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
- Demonstration Year 6 – July 1, 2011 – June 30, 2012
- Demonstration Year 7 – July 1, 2012 – June 30, 2013
- Demonstration Year 8 – July 1, 2013 – June 30, 2014

Uninsured: Persons with no source of third party coverage on the date of service captured within a defined cost reporting period.

Underinsured: These are persons without third party coverage for a particular service rendered on the date(s) of service captured within a defined cost reporting period. This means a patient had third party coverage, but the particular service provided was not covered as part of the individual's benefit package. For example, a patient had insurance coverage for inpatient hospital services but his or her covered benefit

package did not include outpatient hospital services. In this example, the individual would be considered insured for any inpatient hospital services received. This person would be considered *underinsured* for any outpatient hospital services received and, accordingly, costs associated with a particular outpatient hospital service could be included (to the extent it was otherwise eligible) as a cost when calculating underinsured uncompensated care costs for the LIP. Similarly, a patient with coverage where a lifetime or annual benefit cap is applied would be considered underinsured for services furnished beyond that cap. Before reporting any expenditure as an eligible cost in calculating the uncompensated care for the underinsured for the purpose of claiming LIP funding, the State expects providers to employ their standard practices for billing, and payment collection from any individual and/or legally liable third party payer for services provided. The cost of uncompensated care specifically excludes charges/cost associated with any unpaid service costs, including unpaid deductible and coinsurance amounts for services which are covered by a patient's insurance plan. While these amounts may be written off as bad debts or charity care, they are not eligible costs that may be claimed through the LIP. In reporting a patient's liability, the provider must distinguish between amounts due for copays and deductibles and amounts due for services not covered by a third party payer. The cost of uncompensated care eligible for the LIP may not include any cost shortfalls for services covered by other liable third parties.

IV. LIP Permissible Expenditures (Cost Limit Computation)

LIP is subject to specific Special Terms and Conditions (STCs) which require a calculated cost limit for providers. All LIP payments to providers and all expenditures described as LIP permissible expenditures must not exceed the cost of services for the uninsured, underinsured and Medicaid shortfalls as defined and discussed in this document.

57. ***Low Income Pool Permissible Hospital Expenditures***. Hospital cost expenditures from the LIP will be paid at cost and are 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.

58. ***Low Income Pool Permissible Non-Hospital Based Expenditures.*** To ensure services are paid at cost, the Reimbursement and Funding Methodology document defines the cost reporting strategies required to support non-hospital based LIP expenditures.

To the extent that there are LIP expenditures a hospital provider wants to make against the LIP cost limit, and the methodology for capturing such expenditures is not stated in this protocol, the expenditures will need to be approved by CMS and the State prior to the submission of the reconciliation for the applicable period for the expenditures. The protocol will be prospectively modified to include such prior approval, and the claiming

protocol will be prospectively incorporated into the protocol when it is next updated. The STCs also require a detailed process for calculating the cost limit. The following sections provide the required detail.

A. Hospital's LIP Cost Limit

1. Hospital's 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 annual rate setting. 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 MMIS and other 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 MMIS and other 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. For this calculation, a usable organ is defined as the number of organs excised and furnished to an organ procurement organization. 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's 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's Uninsured/Underinsured

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 recent 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 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 hospitals 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. Unallowable LIP Expenditures

According to STC 54, "Funds from the LIP may be used for health care costs (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act." The following costs may not be claimed as LIP expenditures. Please note that this listing is not exhaustive but is meant to be representative of the types of cost that may not be claimed. If a provider or the State is unclear about the allowability of a cost, the onus is on the provider and the State to clarify the allowability and provide the cost documentation to support the cost in question. Such

expenditures need to be approved by CMS and the State prior to the submission of the reconciliation for the applicable period for the expenditures. The State of Florida is available to provide technical assistance about which cost may be claimed as LIP expenditures.

- Cost associated with funding LIP expenditures, including intergovernmental transfers (IGTs).
- Cost of capital goods that are purchased on behalf of another agency.
- Over-allocation of cost shared by multiple programs.

5. Hospital's Additional Allowable Cost

Uncompensated costs for the following items for Medicaid, the uninsured and the underinsured are allowable under the terms of the LIP.

Physician and Non-Physician Practitioner Professional Costs

a. The professional component of physician costs are identified from each hospital's most recently filed CMS-2552 cost report Worksheet A-8-2, Column 4. These professional costs are:

   i. Limited to allowable and auditable physician compensations that have been incurred by the hospital;
   ii. For the professional, direct patient care furnished by the hospital's physicians in all applicable sites of service, including sites that are not owned or operated by an affiliated government entity;
   iii. Identified as professional costs on Worksheet A-8-2, Column 4 of the cost report of the hospital claiming payment (or, for registry physicians only, Worksheet A-8, if the physician professional compensation cost is not reported by the hospital on Worksheet A-8-2 because the registry physicians are contracted solely for direct patient care activities (i.e., no administrative, teaching, research, or any other provider component or non-patient care activities));
   iv. Supported by a time study, accepted by Medicare for Worksheet A-8-2 reporting purposes, that identified the professional, direct patient care activities of the physicians (not applicable to registry physicians discussed above); and
   v. Removed from hospital costs on Worksheet A-8.

b. The professional costs on Worksheet A-8-2, Column 4 (or Worksheet A-8 for registry physicians) are subject to further adjustments and offsets, including any necessary adjustment to bring the costs in line with Medicare cost principles. However, Medicare physician reasonable compensation equivalents are not applied for physician professional cost determination purposes. There will be revenue offsets to account for revenues received for services furnished by such

professionals to non-patients (patients for whom the hospital does not directly bill) and any other applicable non-patient care revenues that were not previously offset or accounted for by the application of time study.

c. Reimbursement for other professional practitioner service costs that have also been identified and removed from hospital costs on the CMS-2552 cost report. The practitioner types to be included are:

   i. Certified Registered Nurse Anesthetists
   ii. Nurse Practitioners
   iii. Physician Assistants
   iv. Dentists
   v. Certified Nurse Midwives
   vi. Clinical Social Workers
   vii. Clinical Psychologists
   viii. Optometrists

d. To the extent these practitioners' professional compensation costs are not included in Worksheet A-8-2, Column 4, but are removed from hospital costs through an A-8 adjustment on the 2552 cost report, these costs may be recognized if they meet the following criteria:

   i. The practitioners must engage in the direct provision of care in addition to being Medicaid-qualified practitioners for whom the services are billable under Medicaid separate from hospital services;
   ii. For all non-physician practitioners, there must be an identifiable and auditable data source by practitioner type;
   iii. A CMS-approved time study must be employed to allocate practitioner compensation between clinical and non-clinical costs; and
   iv. The clinical costs resulting from the CMS-approved time study are subject to further adjustments and offsets, including adjustments to bring the costs in line with Medicare cost principles and offset of revenues received for services furnished by such practitioners to non-patients (patients for whom the hospital does not directly bill) and other applicable non-patient care revenues that were not previously offset or accounted for by the application of CMS-approved time study.

   The resulting net clinical non-physician practitioner compensation costs are allowable costs. The compensation costs for each non-physician practitioner type are identified separately.

e. Professional costs incurred for freestanding clinics (clinics that are not recognized as hospital outpatient departments on the 2552) are separately reimbursable as clinic costs and therefore are not included in this protocol.

f. Hospitals may additionally include physician support staff compensation, data processing, and patient accounting costs as physician-related costs to the extent that:

   i. These costs are removed from hospital inpatient and outpatient costs because they have been specifically identified as costs related to physician professional services;
   ii. They are directly identified on worksheet A-8 as adjustments to hospital costs;
   iii. They are otherwise allowable and auditable provider costs; and
   iv. They are further adjusted for any non-patient-care activities such as research based on physician time studies.

   If these are removed as A-8 adjustments to the hospital's general service cost centers, these costs should be stepped down to the physician cost centers based on the accumulated physician professional compensation costs. Other than the physician and non-physician practitioner compensation costs and the A-8 physician-related adjustments discussed above, no other costs are allowed.

g. Total billed professional charges by cost center related to physician services are identified from hospital records. Similarly, for each non-physician practitioner type, the total billed professional charges are identified from hospital records.

h. A physician cost to charge ratio for each cost center is calculated by dividing the total costs for each cost center as established in paragraphs a-f of subsection 5 by the total billed professional charges for each cost center as established in paragraph g of subsection 5. For each non-physician practitioner type, a cost to charge ratio is calculated by dividing the total costs for each practitioner type as established in paragraphs a-f of subsection 5 by the total billed professional charges for each practitioner type as established in paragraph g of subsection 5.

i The total professional charges for each cost center related to eligible Medicaid and uninsured physician services, billed directly by the hospital, are identified using auditable MMIS paid claims report and other hospital financial records. Hospitals must map the charges to their cost centers using information from their hospital billing systems. Each charge may only be mapped to one cost center to prevent

duplicate mapping and claiming. These charges must be associated with services furnished during the period covered by the latest as-filed cost report.

For each non-physician practitioner type, the eligible Medicaid and uninsured professional charges, billed directly by the hospital, are identified using auditable MMIS paid claims report and other hospital financial records. Hospitals must map the charges to non-physician practitioner type using information from their hospital billing systems. Each charge may only be mapped to one practitioner type to prevent duplicate mapping and claiming. These charges must be associated with services furnished during the period covered by the latest as-filed cost report.

j. The total Medicaid and uninsured costs related to physician practitioner professional services are determined for each cost center by multiplying total Medicaid and uninsured charges as established in paragraph i of subsection 5 by the respective cost to charge ratio for the cost center as established in paragraph h of subsection 5.

   For each non-physician practitioner type, the total Medicaid and uninsured costs related to non-physician practitioner professional services are determined by multiplying total Medicaid and uninsured charges as established in paragraph i of subsection 5 by the respective cost to charge ratios as established in paragraph h of subsection 5.

k. The total Medicaid and uninsured costs eligible for claiming are determined by subtracting all revenues received for the Medicaid and uninsured physician/practitioner services from the Medicaid and uninsured costs as established in paragraph j of subsection 5. All revenues received for the Medicaid and uninsured professional services will be offset against the computed cost; these revenues include payments from or on behalf of patients and payments from other payers.

l. The costs are for services allowable under the terms of the waiver and provided to Medicaid beneficiaries or the uninsured.

Outpatient Clinical Laboratory Services

To the extent that Medicaid does not separately reimburse for these services outside of hospital outpatient reimbursement, these costs would be computed as part of hospital outpatient cost computation. Otherwise, these costs can be separately accounted for. The total laboratory cost incurred are reported by hospitals in Cost Center #44 on the CMS-2552 and would be allowable as apportioned to Medicaid, the uninsured, and the underinsured using the standard CMS-2552

methodology (i.e., applying cost-to-charge ratio to the allowable Medicaid and uninsured/underinsured laboratory charges).

Provider-based Transplant Services Organ Acquisition Costs from Worksheet D-6 Part III Line 53 Column 1.

The costs are for services allowable under the terms of the waiver and provided to Medicaid beneficiaries or the uninsured. Costs are for direct organ acquisition costs identified on Worksheet D-6 Part III Line 53 Column 1; and must be appropriately apportioned using a ratio of Medicaid to Total Organs or Uninsured/Underinsured to Total Organs according to Medicare cost reporting requirements.

Provider-based Clinic Services

To the extent that Medicaid does not separately reimburse for these services outside of hospital outpatient reimbursement, these costs would be computed as part of hospital outpatient cost computation. If these clinics are free standing (not treated as hospital outpatient departments) clinics, their costs should be captured using the free standing clinic protocol that must be approved by CMS and the State.

6. Hospital's Possible Allowable Cost

The State may include additional hospital cost items in the calculation of the LIP cost limit once the State and CMS agree upon a subsequent protocol that defines allowable services and costs under a specific category; as well as a detailed cost finding methodology and specific documentation vehicle. The State may not make claims for costs under these categories until related protocols are approved by CMS.

a. Unmet guarantee amounts for employed and contracted physicians: An unmet guarantee amount equals the difference between the cost incurred by a hospital to employ a physician (exclusive of overhead) and the amount of revenue for professional services for dates of service that fall within the period for which the physician cost was reported. In short, it represents the shortfall between professional earnings and salaries and wage cost for employed physicians. When an unmet guarantee has been identified by a hospital, this cost may be reimbursed through the LIP in the following manner:
b. Step I: Physician compensation will be identified in accordance with the amount reported in the hospital's general ledger and is exclusive of allocated overhead.
c. Step II: Payments for professional services for the same period of time for physician cost is subtracted from Step I cost. The difference equals the gross unmet guarantee, which means it is inclusive of cost

associated with services provided to all patients regardless of insurance type and includes self paying patients.

d. Step III: To determine the amount that may be allocated as a waiver cost, the amount calculated in Step II is multiplied by the ratio of charges associated with services delivered to patients eligible under the waiver to total charges produced by the individual physicians for all services irrespective of patient type or insurance coverage.

e. The LIP-participating hospital must provide a separate calculation for each physician and use data for all steps that fall within the same reporting period by dates of service.

f. Patient and community education programs, excluding cost of marketing activities;

g. Services contracted to other providers; county based insurance programs

h. LIP Permissible Expenditures 10 percent Sub Cap, per STC 56:

> "Up to 10 percent of the capped annual allotment of the LIP funds may be used for hospital expenditures other than payments to providers for the provision of health care services to an uninsured or underinsured individual. Payments from this sub-cap may be used for the improvement or continuation of specialty health care services that benefit the uninsured and underinsured, such as capacity building and infrastructure, hospital trauma services, hospital neonatal services, rural hospital services, pediatric hospital services, teaching or specialty hospital services, or safety net providers. The reimbursement methodologies for these expenditures and the non-Federal share of funding for such expenditures will be defined in the Reimbursement and Funding Methodology Document…"

7. 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 Organizations (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.

8. Hospital Reconciliation for DY1, DY2, and DY3

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 implemented 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 were required to report the data to the Agency on a quarterly basis during SFY 2009-10. This data was gathered and used for prior year reconciliation purposes.

The State used the data reported on a quarterly basis during SFY 2009-10 to establish a provider specific baseline for uninsured cost. The data was used to distinguish between allowable and non-allowable uninsured cost which was used to determine the ratio of unallowable cost that would have been expected in the previous operating years. The established cost limit was reduced using the calculated ratio net of trend adjustments. The trend adjustment allowed for growth in the non-allowable cost that would not have been present during the period which was reconciled. The result provided an adjusted cost limit that was used to complete the reconciliation. The payments to the provider through the Low Income Pool program and Disproportionate Share Hospital Program were totaled for the periods reconciled. This total was then compared to the total cost of the allowed uninsured and Medicaid shortfall costs. If the total payments were at or below the total costs, the requirement of not exceeding the cost limit was met.

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%.

9. Hospital Cost Limit Reconciliation for DY4 – DY8

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. For purposes of this reconciliation, the same steps as outlined for the payment year method are carried out except that the per diems and cost-to-charge ratios and other cost report data are computed based on the as-filed cost report for the payment year, and actual Medicaid, uninsured, under-insured days, charges, payments, and other Medicaid, uninsured, under-insured data for the actual payment year are derived from MMIS paid claims report and other auditable provider records.

Additional Allowable Hospital Provider Cost Limit Reconciliation:
The physician and non-physician practitioner costs determined under subsection 5, which are paid for services furnished during the applicable state fiscal year, are reconciled to the as-filed CMS-2552 for the same year once the cost reports have been filed with the State. If, at the end of the reconciliation process, it is determined that a provider received an overpayment, the overpayment will be properly credited to the Federal government; if a provider was underpaid, and the provider will receive an adjusted payment amount. For purposes of the cost limit reconciliation, the same steps as outlined to determine the cost limit are followed.

The above hospital cost limits must further be reconciled to actual Medicaid and uninsured/underinsured costs as computed based on the finalized cost report for the payment year. Again, the same cost methodology as previously discussed is used, except that the per diems, cost-to-charge ratios, and other cost report data are computed based on the finalized cost report for the payment year.

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 hospital 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 Cost Limit Report

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 e 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 DY1, DY2 and DY3

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 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 for DY4 – DY8

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 an 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 an 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. Medicaid and Medicaid Managed Care

In reporting CHD cost, the provider must demonstrate its methodology for reporting cost that is shared by the provider and any other governmental department or entity. This demonstration must show that cost was allocated on the same basis across all providers and that shared cost was not claimed in excess of 100 percent of the actual, incurred amount.

Total cost, inclusive of indirect and direct cost, may be allocated to Medicaid on the basis of encounters or charges, depending on the methodology normally used by Medicaid to reimburse the provider. For example, if the state plan authorizes an encounter rate, then encounters would serve as the

basis of allocation to the LIP. Conversely, if a provider receives payment for each individual CPT billing code, then charges may be used as the basis for allocation of cost to the LIP.

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 to determine uninsured shortfall.

3. CHD Reconciliation Beginning DY1

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. 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 57, “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, and the three year extension 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 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 and the three year extension 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 State will perform an initial desk review of all expenditures claimed by providers to determine whether reported costs support the objective of the LIP, which is payment up to 100 percent of incurred cost for Medicaid covered services delivered by Medicaid qualified providers to Medicaid beneficiaries, uninsured and underinsured patients receiving care from LIP. While a provider may receive payment upon completion of the desk review, this process does not represent a final review of cost. Therefore, a provider may be required to remit an amount back to the State for unallowable costs after a more intensive review of submitted costs.

All costs submitted by providers are reviewed in light of the following cost principles:

- Be authorized or not prohibited under State or local laws or regulations;
- Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal awards, or other governing regulations as to the types or amounts of cost items;
- Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit;
- Except as otherwise provided for, be determined in accordance with generally accepted accounting principles;
- Not be included as a cost or used to meet cost sharing or matching requirements of any other Federal award;
- Be net of all applicable credits; and
- Be adequately documented.

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 July, in accordance with 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 partially exempt from these limitations. For these providers, their Medicaid reimbursement may represent most of 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

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 61d and 62, the Reimbursement and Funding Methodology document will include a reporting methodology for Milestone Statistics and Findings as well as Primary Care and Alternative Delivery systems. The 15 hospitals receiving the largest LIP distributions will provide reporting for the three programs implemented in compliance with STC 62 Tier-Two Milestones.

The Agency is requesting all providers that receive LIP distributions to complete a LIP Milestone Statistics and Findings Reporting Requirement document. The report

will be completed and submitted to the State no later than October 31 of the following state fiscal year, beginning July 1, 2012 through the demonstration period of the waiver (DY7 – DY8). LIP PAS providers that receive funding for Primary Care and Alternative Delivery systems will complete the Primary Care and Alternate Delivery Expenditure report to be submitted by November 30 of the following state fiscal year.

The respective reporting document will require 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, as specified in STC 55. This information will be used in conjunction with the Medicaid Reform / LIP evaluation pursuant to STC 80.

VIII. Conclusion

This LIP Reimbursement and Funding Methodology document is submitted to satisfy STCs 53, 57, and 58 as well as the requirement set forth in the waiver approval letter received December 15, 2011. This updated version of the Reimbursement and Funding Methodology document is submitted to CMS in order to update the October 4, 2012 document that was approved by CMS October 16, 2012.

B. **APPENDIX A**

Flow of IGTs Provided for the LIP Program