LIP MILESTONE REPORTING DOCUMENT

TERMS and DEFINITIONS

The following describes the data elements to be reported to the Agency for Health care Administration each year as required by the Special Terms and Conditions attached to the State of Florida Medicaid Reform waiver.

The reporting period for each year is the State fiscal year (July 1 to June 30), except for Federally Qualified Health Center (FQHC) sites that already report data via UDS on a regular basis. Other exceptions to this reporting period (e.g., calendar year, provider fiscal year) must be approved by the Agency.

Definitions:

Column A: - Definitions are dependent on row definitions. See below.

Column B: Medicaid – Because Medicaid reform relies heavily on managed care as a payment mechanism for Medicaid services, figures in this column should reflect both regular fee-for-service Medicaid as well as managed care Medicaid services/recipients.

Column C: Uninsured/Underinsured – Consistent with the LIP Cost Limit reporting form, this column includes all patients for whom the provider has written off any amount to charity adjustments or bad debt expense during the reporting period. This does not include general balance sheet allowances posted for accounting purposes, but only those amounts for which specifically identified collection efforts have actually ceased.

Definition of Hospital Services

Unduplicated Count of Individuals Served – The intent of this section is to report a single patient as a counted unit only one time during the reporting period within each applicable cell of this report. Patients who were both Medicaid during one part of the reporting period, and uninsured/underinsured during another portion of the reporting period, would be counted as a single unit in each column.

Line 1: Inpatient – Count of unique patients formally admitted to the hospital during the reporting period, regardless of admission source. Count is also regardless of whether the patient was also an outpatient during the reporting period.

Line 2: Outpatient – Count of unique patients who were treated on an outpatient basis by the provider during the reporting period, regardless of whether the patient was also an inpatient during some portion of the reporting period. However, patients who begin their care as outpatients and are formally admitted as inpatients during the course of treatment are counted as inpatients only (for that particular course of treatment).

Line 3: Unduplicated (IP & OP Combined) Count – Count of all unique patients treated by the provider during the reporting period, regardless of whether the patient was treated on an inpatient or outpatient basis. For example, a patient who was treated three times on an outpatient basis and twice on an inpatient basis only counts as one unit on this line. This number should be less than the sum of Line 1 and Line 2.

Types of Hospital Services Provided – The intent of this section is to furnish data on the volume of services furnished by each provider. A patient receiving multiple services on a single day should be counted only as a single encounter (in order of priority based on report line number). A patient receiving multiple services on multiple days would be counted as one encounter for each of those days.

Line 4: Hospital Discharges – Count the number of patient discharges occurring during the reporting period for each column.

Line 5: Case Mix Index – Report the inpatient case mix index associated with the discharges reported on Line 4. This is the average DRG weight for these discharged patients.

Line 6: Hospital Inpatient (Days) – Report Hospital Inpatient services based on the number of patient days incurred (census days) during the reporting period.

Line 7: Emergency Care (encounters) – Report Emergency Services based on the number of emergency room encounters that occur during the reporting period, excluding those patients who became inpatients in connection with their emergency room visit.

Lines 7a – 7f: ER Outpatient Visits by Level – In order to estimate the relative intensity of emergency room services over time, report the number of emergency room encounters by visit level as defined by the listed CPT codes. If possible, report by Medicaid and Uninsured/Underinsured. If that level of detail is not available, report in Column A for the full hospital. Consistent with Line 7, report only outpatient encounters.

Line 8: Hospital Outpatient (OP)* (encounters) – This line includes patients receiving hospital outpatient services on any day in the reporting period, but not emergency room services on that same day., and not being admitted as inpatients in connection with those outpatient services. This includes patients receiving outpatient diagnostic services (lab, radiology, etc.), outpatient surgery, endoscopies, therapy, or other outpatient, hospital-based services.

Line 9; Affiliated Services** (encounters) – This line includes patients receiving services from the hospital that are not traditionally considered "hospital" services, but which may be owned and operated by a hospital. This includes primary care/preventive care clinic visits, specialist visits, surgical care furnished in a physician office, home health services, durable medical equipment, prosthetic/orthotic devices (not associated with outpatient therapy visits), and nursing home care (skilled or intermediate).

Typical hospital reporting and tracking mechanisms maintain separate records for these services from services furnished in the hospital. Therefore, it is generally not possible to keep a count of non-hospital services that does not duplicate some outpatient hospital services. Since the non-hospital services are truly separate services from the hospital services, an unduplicated count between these two would necessarily understate the actual amount of services furnished by the provider as a whole. Therefore, report on this line all patients receiving any of these services, regardless of whether they also received any hospital inpatient or outpatient services.

Line 10: Prescription Drugs (number of prescriptions filled – Report the total number of prescriptions filled for take-home use/self-administration, regardless of whether the patient also received hospital outpatient or affiliated services on the date the prescriptions were filled.

Lines 11-21: *Hospital Outpatient Care & **Hospital Affiliated Services – Check those boxes in Column A that correspond to the types of services furnished by the provider during the reporting period.

Line 22: Additional Services Provided with LIP Distributions – To assist program evaluators in understanding the impact of the Medicaid reform waiver, and the Low Income Pool in particular, list any new services added by the provider, or existing services expanded by the provider, which benefit Medicaid, Uninsured or Underinsured patients, and which were added or expanded at least in part due to the availability of LIP funds.

Definition of Non-Hospital Provider Services

Unduplicated Count of Individuals Served – The intent of this section is to report a single patient as a counted unit only one time during the reporting period within each applicable cell of this report. Patients who were both Medicaid during one part of the reporting period, and uninsured/underinsured during another portion of the reporting period, would be counted as a single unit in each column. Lines 23-26 represent different types of providers who might participate in the distribution of Low Income Pool funds.

For each line (27-36) report one unit for each patient encounter each calendar day. A patient who receives multiple types of services on one day would be counted only as one unit, in order of priority based on the order presented below.

Line 27: Primary Care Encounters – encounters with a licensed health care practitioner (including RNs) for acute and preventive care services, well child services, adult physicals, etc., in a clinical setting on an outpatient basis. Includes, but not limited to, immunization services, infectious disease control services (STD, HIV/AIDS, TB), and care for acute and episodic illnesses and injuries.

Line 28: OB/GYN Encounters – encounters with a licensed health care practitioner (including RNs) for clinical prenatal care services, annual GYN exams, and other encounters for which the primary purpose of the visit was for pregnancy testing, family planning services, or prenatal care services.

Line 29: Disease Management Encounters – encounters associated with counseling, patient education, coordination with providers, care coordination, and similar services for specific clients with a diagnosis of a chronic or infectious disease as indicated by ICD-9 code or a specific well-defined health based criteria. Includes, but not limited to, congestive heart failure, diabetes, and asthma.

Line 30: Mental Health/Substance Abuse Encounters – encounters with professionals or trained paraprofessionals operating under practice guidelines and authority of a professional for which the primary purpose of the visit was for a mental health and/or substance abuse condition. Includes care coordination and home visits.

Line 31: Dental Encounters – encounters for professional dental treatment services such as exams, x-rays, treatment such as amalgams and repair of dentures, cleanings, and oral health education. Services are provided either directly by, or under the supervision of, a licensed dentist. This would not include fluoride mouth-rinse services.

Line 32: Prescriptions Filled – number of prescriptions filled by an in-house pharmacy, prescriptions purchased by the provider for the patient from a retail pharmacy or other licensed pharmacy, and/or prescriptions filled by a nurse issuance drug room operating under protocol.

Line 33: Laboratory Services – offsite laboratory services purchased by the provider subsequent to a clinical encounter.

Line 34: Radiology Services – offsite radiology services purchased by the provider subsequent to a clinical encounter.

Line 35: Specialty Encounter (list by specialty type) – encounter for specialized health services provided by a professional to diagnose or treat a specific condition that is beyond the scope of the primary care provider.

Line 36: Care Coordination Encounter – encounter with a professional or trained paraprofessional who may assist the patient to access health care services, access pharmaceuticals, follow provider advice, refer patients for services, and follow-up to ensure needed services are received.

Line 37: Additional Services Provided with LIP Distributions – To assist program evaluators in understanding the impact of the Medicaid reform waiver, and the Low Income Pool in particular, list any new services added by the provider, or existing services expanded by the provider, which benefit Medicaid, Uninsured or Underinsured patients, and which were added or expanded at least in part due to the availability of LIP funds.