Low Income Pool Monitoring Plan

Developed by the LIP/DSH/GME Unit on April 4, 2017

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Changes Subject to the Demonstration Amendment Process

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Any Changes to the Demonstration are Subject to the Amendment Process

1. Changes related to demonstration features, such as, Low Income Pool (LIP), and other comparable program and budget elements must be submitted to the Centers for Medicare and Medicaid Services (CMS) as amendments to the demonstration.
2. All amendment requests are subject to approval at the discretion of the Secretary of Health and Human Services in accordance with section 1115 of the Social Security Act (the Act).
3. The state must not implement changes to these elements without prior approval by CMS of the amendment to the demonstration.
4. Amendments to the demonstration are not retroactive and federal financial participation (FFP) will not be available for changes to the demonstration that have not been approved through the amendment process.

Amendment Process

Amendment Process

1. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved.

2. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with the Special Terms and Conditions (STCs), including but not limited to failure by the state to submit required elements of a viable amendment request as found in the STCs, reports and other deliverables required in the approved STCs in a timely fashion according to the deadlines specified.

3. CMS encourages the state to undertake a robust public process to ensure community engagement in the development and submission of amendments to the demonstration. Amendment requests must be accompanied by information that includes but is not limited to the following:

Amendment Process (Cont'd)

a. Public Notice: The state does not need to comply with the state public notice and comment process outlined in 42 CFR §431.408 until such time that CMS issues policy guidance to the contrary. However CMS encourages the state to comply with state public notice and comment process outlined in 42 CFR §431.408 in the event it seeks to amend the demonstration that modifies benefits, cost-sharing, eligibility, or delivery system changes. CMS will post and accept public comments on all amendments.

b. Tribal Consultation: The state must provide documentation of the state's compliance with the tribal consultation requirements outlined in STC 15 for demonstration amendments. Such documentation shall include a summary of the tribal comments and identification of proposal adjustments made to the amendment request due to the tribal input.

c. Demonstration Amendment Summary and Objectives: The state must provide a detailed description of the amendment including what the state intends to demonstrate via the and amendment as well as impact on beneficiaries with sufficient supporting documentation and the objective of the change and desired outcomes including a conforming Title XIX and/or Title XXI state plan amendment, if necessary.

d. Waiver and Expenditure Authorities: The state must provide a list, along with a programmatic description, of the waivers and expenditure authorities that are being requested for the amendment.

Amendment Process (Cont'd)

e. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment.

f. An up-to-date Children's Health Insurance Program (CHIP) allotment neutrality worksheet, if necessary.

g. Updates to existing demonstration reporting, quality and evaluation plans: A description of how the evaluation design, comprehensive quality strategy and quarterly and annual reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

Availability of Low Income Pool Funds

Availability of Low Income Pool Funds

1. **Total LIP Amount**. The total computable dollar limit for LIP expenditures in Demonstration Year (DY) 10 will be $1 billion. The total computable dollar limit for LIP expenditures in DY 11 will be $607,825,452 million.

2. **Assurance**. As reflected in the LIP participation requirements in STC 77, in DY 11, the state and participating providers who plan to participate in LIP for DY 11 will provide assurance that LIP claims include only costs associated with uncompensated care that is furnished through a charity care program for individuals with incomes up to at least 200 percent of the federal poverty level that adheres to the principles of the Healthcare Financial Management Association operated by the provider.

Capped Annual Allotments

Capped Annual Allotments

1. All annual LIP funds must be expended by July 31 following each authorized demonstration year. Any amount not expended does not roll over.
2. Capped annual allotment amounts that are not distributed because of penalties, recoupment due to payments exceeding uncompensated care cost, or are otherwise due to violating the terms of the approved STCs cannot be rolled over to another DY and are not recoverable.
3. LIP dollars that are lost as a result of penalties or recoupment are surrendered by the state and not recoverable.

Low Income Pool Reimbursement Funding Methodology

Low Income Pool Reimbursement Funding Methodology

1. The Reimbursement and Funding Methodology Document (RFMD) is prepared by the state and documents LIP permissible expenditures, including the non-federal share and the total computable expenditures. The RFMD provides that total computable LIP payments to providers for uncompensated care costs must be supported by uncompensated care costs incurred and reported by providers as charity care on the provider's financial records. Through the RFMD, the state must demonstrate that it has reconciled LIP payments to auditable costs. LIP provider payments for uncompensated care as charity care are limited to the uncompensated portion of providers' allowable costs and, in the aggregate, the authorized LIP pool amount for the demonstration year.

2. Prior to November 30, 2015, the state must submit a draft of DYs 10 and 11 (2016-2017) RFMD to CMS for approval and CMS will work with Florida towards approval by January 31, 2016. However, Florida may not claim FFP for LIP payments in DY 11 until after a revised RFMD is approved by CMS.

3. For each DY, the state must reconcile LIP payments made to providers to ensure that they do not exceed allowed uncompensated care costs, using the CMS approved RFMD cost review protocol. The state must submit a LIP Cost Reconciliation report to CMS within two years after the end of each DY showing cost reconciliation results by provider.

Low Income Pool Reimbursement Funding Methodology (Cont'd)

4. To the extent that payments are found to exceed allowed uncompensated care costs, the federal portion of any excess payment must be returned to CMS by submitting a decreasing expenditure adjustment (Line 10B).

5. If the state has not submitted its LIP Cost Reconciliation Report for a DY within the timeframe described above, CMS may issue a deferral or disallowance for an amount not to exceed the total of the state's submitted LIP expenditures for that DY.

6. A provider may at any time during a demonstration year disclose to the state that LIP payments to that provider exceeded allowed uncompensated care costs. The state must report that overpayment on the CMS-64 by submitting a decreasing expenditure adjustment (Line 10B) by the next quarter and no later than one year from the date of disclosure.

7. Payments from LIP to hospitals are to be considered Medicaid hospital revenue for the purpose of determining the hospital-specific DSH limits defined in section 1923(g) of the Act.

Low Income Pool Permissible Expenditures

Low Income Pool
Permissible Expenditures

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.

1. In Demonstration Year 11 (SFY 2016-2017), these health care costs may be incurred by the state or by providers to furnish uncompensated medical care as charity care for low-income individuals that are uninsured. The costs must be incurred pursuant to a charity care program that adheres to the principles of the Healthcare Financial Management Association.

    a. Providers may be categorized in up to two groups: hospitals and Medical School Physician Practices. Each group may be divided into up to four tiered subgroups, based on subdividing a list of the providers ranked by their amount of uncompensated charity care cost or charges as a percentage of their privately insured patient care cost or charges—that ratio is the sole basis on which tiered groups may be defined.

Low Income Pool
Permissible Expenditures (cont'd)

b. All providers in either group that meet LIP provider participation requirements and that furnished uncompensated charity care must receive some amount of payment with the amounts paid being proportional to the ratio (i.e. subgroup members that provide greater proportions of uncompensated charity care will fall into tiers with higher percentages of uncompensated care payments).

c. All providers that must receive some amount of payment must be paid the same percentage of their charity care cost within each group (or within each tiered subgroup).

d. Determination of may be effectuated using contemporaneous uncompensated care data, or equivalent data from a prior year not more than three years prior to the DY.

Low Income Pool
Permissible Expenditures (cont'd)

1. Low Income Pool Hospital Expenditures:
    a. Hospital cost expenditures from the LIP will be paid up to cost and are further defined in the RFMD utilizing methodologies from the CMS-2552 cost report plus mutually agreed upon additional costs.
    b. The state agrees that it shall not receive FFP for Medicaid and LIP payments to hospitals in excess of cost.
2. Low Income Pool Non-Hospital Based Expenditures:
    a. To ensure services are paid up to or at cost, the RFMD defines the cost reporting strategies required to support non-hospital based LIP expenditures.
3. Low Income Pool Permissible Sources of Funding Criteria
    a. Sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations.
    b. Federal funds received from other federal programs (unless expressly authorized by federal statute to be used for matching purposes) shall be impermissible.

Low Income Pool Provider Participation Requirements

Low Income Pool Provider Participation Requirements

- **Hospitals** and **Medical School Physician Practices** who receive LIP funds have certain participation requirements. If they do not meet the participation requirements, they cannot receive LIP funds.
- The state may grant an exemption to a hospital of the requirement number 2 upon finding that the hospital has demonstrated that it was refused a contract despite a good faith negotiation with a Specialty Plan. A letter of denial, or some other comparable evidence, will be required to make such a finding.

Low Income Pool Provider Participation Requirements (Cont'd)

Hospitals

1. Must contract with at least fifty percent of the Standard Plan Managed Care Organizations (MCOs) in their corresponding region.
2. Must contract with at least one Specialty Plan serving each specialty population in their corresponding region.
3. Must participate in the Florida Event Notification program.
4. In DY 11, the state and participating providers will provide assurance that LIP claims include only costs associated with uncompensated care furnished through the a charity care program for individuals with incomes up to at least 200 percent of the federal poverty level that adheres to the principles of the Healthcare Financial Management Association and is operated by the provider. Such a charity care program must be established prior to the end of DY 10.
5. In DY 11 for administrative purposes, participating hospitals must be enrolled Medicaid providers and have a minimum of 1 percent Medicaid utilization based on the ratio of Medicaid days to total patient days reported on the most recent accepted Florida Hospital Uniform Reporting System (FHURS) data.

Low Income Pool Provider Participation Requirements (Cont'd)

Medical School Physician Practices

1. Must participate in the Florida Medical School Quality Network.
2. In DY 11, the state and participating providers will provide assurance that LIP claims include only costs associated with uncompensated care through the provider's charity care program for individuals with incomes up to at least 200 percent of the federal poverty level that meets the principles of the Healthcare Financial Management Association. Such a charity care program must be established prior to the end of DY 10.
3. In DY 11, participating providers must be enrolled Medicaid providers and have a minimum of 1 percent Medicaid utilization.

Low Income Pool Deliverable Requirements

Low Income Pool Deliverable Requirements

- CMS will reduce available LIP federal funding on an annual basis for the state's failure to meet deliverable requirements. A reduction in available LIP federal funding of $6 million will be assessed annually for each deliverable requirement that is not met.
- The annual penalty applies to the demonstration year in which the deliverable is due, even if the deliverable itself pertains to a different demonstration year. LIP federal dollars that are lost as a result of deliverable requirements not being met are surrendered by the state through a CMS-64 adjustment (Summary Line 9D Other).

Low Income Pool Deliverable Requirements (Cont'd)

Deliverable requirements include but are not limited to the following:

1. Timely submission of an annual estimate and annual final uncompensated care report.
    a. Submission by June 1 of each year, detailing for the upcoming demonstration year, the projected LIP providers, the estimated per provider of uncompensated care to be furnished through charity care, and the intergovernmental transfers (IGTs) associated with each provider.
    b. Submission by October 1 of each year, for the demonstration year just ended, the final report of the LIP providers, uncompensated care claimed through charity care and the final IGTs. Both the estimate and final report must also be posted on the state Medicaid website.
2. Timely submission of all hospital, FQHC, and County Health Department LIP reconciliations in the format required per the LIP Reimbursement and Funding Methodology protocol.
3. Timely submission of all demonstration deliverables as described in the STCs including the submission of Quarterly and Annual Reports.
4. Timely submission of all other reporting requirements under Sections XVI, General reporting Requirements; XIX, Evaluation of the Demonstration; and XX, Measurement of Quality of Access to Care and Improvement.

Annual Report

Annual Report

1. The state must submit an annual report no later than 120 days after the close of each DY. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.
2. The Annual report must document accomplishments:
    a. Project status
    b. Quantitative and case study findings
    c. Interim evaluation findings
    d. Utilization data
    e. Policy and administrative difficulties in the operation of the demonstration.
3. This report must also contain a discussion of the items that must be included in the quarterly reports required under STC 80 and include a section that provides qualitative and quantitative data that describes the impact the LIP has had on the rate of uninsurance in Florida since implementation of the demonstration.

Schedule Of
State Deliverables For LIP

Within 2 years of the end of each DY	LIP Cost Reconciliation Report	Section XIV, STC 67
June 1, annually	LIP Provider UC and IGT estimate report	Section XV, STC 75(a)
120 days following the end of the demonstration year	Annual Report	Section XVI, STC 81
October 1, annually	LIP Provider, UC and IGT final report	Section XV, STC 75(a)