Reimbursement and Funding Methodology For Demonstration Year 9

Florida's 1115 Managed Medical Assistance Waiver

Low Income Pool

July 10, 2015

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I. Overview

In accordance with the Special Terms and Conditions (STCs) for waiver number 11-W-00206/4, Managed Medical Assistance Program (MMA) Section 1115 Demonstration, the State of Florida, Agency for Health Care Administration (Agency), Medicaid program (the State), submits to the Centers for Medicare and Medicaid Services (CMS) this Reimbursement and Funding Methodology Document (RFMD). This document fulfills the request by CMS in the Waiver approval letter dated July 31, 2014, to submit a Low Income Pool (LIP) Cost protocol for Demonstration Year (DY) 9 by September 29, 2014.

LIP is defined in STC 67 (see Appendix B) as a fund that provides 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. STC 70 (see Appendix B) requires the submittal of the RFMD.

Included in this 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 68, 69, and 71 (see Appendix B).

Providers in receipt of LIP funds for the reimbursement of uncompensated care that they provide 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 IV 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.

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. 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. 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 Medicaid program, 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.

ii. 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 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.

iii. 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 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:

i. Hospital services are prioritized in the distribution methodology;
ii. 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
iii. Payments to providers will not exceed the cost of services for the uninsured, underinsured, and Medicaid shortfalls.

II. Reimbursement Methodology

The financing and fund distributions for Demonstration Year Nine (DY 9) of the Low Income Pool was modeled after prior years' distribution methodologies. Once the Florida Legislature reviews and approves the methodology it becomes part of the annual General Appropriations Act (GAA). This methodology is described in Appendix A . The LIP fund distributions 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 hospitals, County Health Departments (CHDs), Federal Qualified Health Centers (FQHCs) and other Safety Net providers. Distributions are subject to PAS's meeting LIP Participation Requirements outlined in STC 78 (see Appendix B). 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 required LIP Cost Limit and Milestone documentation. Distributions for each Demonstration Year may begin effective July 1.

III. Definitions

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

Demonstration Year (DY) – July 1 – June 30

- Demonstration Year 9 – July 1, 2014 – June 30, 2015

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

LIP is subject to specific Special Terms and Conditions (STCs) (see Appendix B) which require a calculated cost limit and cost review protocol for providers. All LIP payments to providers and all expenditures described as LIP permissible expenditures can be viewed in Appendix C.

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 or cost review protocol for calculating the cost limit. The following sections provide the required detail.

V. Planning and Reconciliation

i. Planning

According to the STC number 74, "The State agrees that it shall not receive FFP [Federal Financial Participation] 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 payments greater than cost, the Agency will perform a cost/payment reconciliation prior to any LIP distributions.

ii. 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 Appendix D (for Hospitals) and Appendix E (for FQHCs and CHDs) 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 reimbursements, 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. Conclusion

This LIP Reimbursement and Funding Methodology Document is submitted to satisfy STCs 68, 69, and 70 (see Appendix B) as well as the requirement set forth in the waiver approval letter received July 31, 2014. This updated version of the Reimbursement and Funding Methodology Document is submitted to CMS in order to update the January 29, 2014 document.

APPENDIX A - SFY 2014-15 LIP Distribution & Funding Methodology

LIP Distribution - General Appropriations Act Methodology

Low Income Pool Funding (LIP)	
General Revenue	$9,119,726
Grants and Donations Trust Fund	$867,606,672
Medical Care Trust Fund	$1,291,241,942
Total	**$2,167,968,340**
Special LIP	
Rural	$5,622,242
Proportional Primary Care Hospitals	$12,004,728
Trauma Level I	$3,772,467
Trauma Level II or Pediatric Trauma	$3,300,257
Trauma Level II and Pediatric Trauma	$1,753,963
Safety Net	$73,129,526
Specialty Pediatrics	$1,409,166
Quality Measures (STC 61)	$15,000,000
Independent Report	$500,000
Total Special LIP	**$116,492,350**

Special LIP Summary – Hospital Provider Access Systems:

- Rural LIP distributions are provided to providers who qualify for Rural Disproportionate Share Hospital (DSH) / Rural Financial Assistance Program (RFAP) payments. The distributions are made in proportion to their Rural DSH/RFAP payments.

- Trauma LIP distributions are provided to designated or provisional trauma centers divided into three categories, Level I trauma center, Level II or pediatric trauma center, or Level III and pediatric trauma center. The distributions are divided equally to the provider within the individual categories.

- Safety-Net LIP distributions are based on various specific legislative issues or hold harmless payments from previous DSH programs no longer funded.

- Specialty Pediatric LIP distributions are made to the specialty pediatric hospitals with 2,000 or more Medicaid days using the average of the 2005, 2006, and 2007 audited DSH data available as of March 1, 2014. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2005, 2006, and 2007 that are available. The payments are equally distributed.

- Quality Measures are based on the Special Terms and Conditions (STCs) as updated by the Centers for Medicare and Medicaid Services (CMS) in accordance with the extension of the CMS 1115 Waiver. Of the total, $400,000 is provided for the specialty children's hospitals to be distributed based on an allocation methodology incorporating

quality measures that shall be developed by the Agency for the specialty children's hospitals. $7,300,000 shall be allocated using the core measures as determined by CMS. The remaining $7,300,000 shall be distributed equally using the following six outcome measures:

1. Mortality Hospital Risk Adjusted Rate (HRAR) Acute Myocardial Infarction (AMI) without transfers.
2. Mortality HRAR Congestive Heart Failure (CHF)
3. Mortality HRAR Pneumonia
4. Risk Adjusted Readmission Rate (RARR) AMI
5. RARR CHF
6. RARR Pneumonia

- Hospitals receiving an allocation in this category are required to enhance existing, or initiate new, quality-of-care initiatives to improve their quality measures and identified patient outcomes, and to provide required documentation of this to the Agency.

The Special LIP distribution detail is incorporated in the Medicaid Supplemental Hospital Funding Programs – Fiscal Year 2014-2015, Table 1. The distribution amounts for the Quality Measures (STC 61) category shall remain as represented in Table 1. The individual amounts for Rural Hospitals may be modified depending on updated Florida Hospital Uniform Reform System (FHURS) data, used in the Rural DSH calculations.

During the one year LIP extension, the Agency for Health Care Administration is required to commission a report from an independent entity on Medicaid provider payment that reviews the adequacy of payment levels, and the adequacy, equity, accountability and sustainability of the State's funding mechanisms for LIP payments. The report must recommend reforms to the Florida Medicaid financing system that can allow the state, beginning in SFY 2015, to move toward Medicaid fee-for-service and managed care payments that ensure access for Medicaid beneficiaries to providers without payments through LIP. A final report is due no later than March 1, 2015.

LIP – 4	
LIP - 4	**$764,004,489**

Funds in LIP - 4 are first allocated to hospitals where local government funds are transferred to the State of Florida for use in the LIP and Exemption programs. The distribution is the local government fund multiplied by an allocation factor. For State Fiscal Year 2014-2015, the allocation factor is 108.5 percent.

Distributions in LIP - 4 are contingent upon a Letter of Agreement (LOA) between the Agency for Health Care Administration and the local government. Distributions in this category may be modified during the state fiscal year based on the LOA contracting process.

The LIP - 4 distribution detail is incorporated in the Medicaid Supplemental Hospital Funding Programs – Fiscal Year 2014-2015, Table 2, column “Preliminary Amount of Local Funding.”

LIP – 5	
LIP - 5	**$2,419,573**

Rural hospitals with Medicaid, charity and 50 percent of bad debt days equal to or greater than 10 percent are eligible for the $2,419,573 LIP - 5 pool. Distributions are based on the percent of Medicaid, charity, and bad debt days to total of all qualified hospitals using the 2011 FHURS.

The LIP - 5 distribution detail is incorporated in the Medicaid Supplemental Hospital Funding Programs – Fiscal Year 2014-2015, Table 2, column “Proportional Adjustments For Rural Hospitals.”

LIP – 6	
LIP - 6	**$963,184,508**

The funds in LIP - 6 are provided for hospitals to receive a distribution on a quarterly basis, as delineated in Medicaid Supplemental Hospital Funding Programs – Fiscal Year 2014-2015, Table 2a.

Distributions in LIP - 6 are contingent on the nonfederal share of matching funds being provided by local governmental entities to support the distribution. In the event the qualified nonfederal share of matching funds is not provided by local governmental entities to support the distribution for an individual hospital the Agency may allow another hospital with access to qualified nonfederal share of matching funds to participate in the LIP 6 distribution not to exceed the $963,184,508 threshold.

In order for the Agency to certify the qualified nonfederal share of matching funds, a local governmental entity must submit a final, executed letter of agreement to the Agency, which must be received by October 1 of the fiscal year and provide the total amount of nonfederal share of matching funds authorized by the entity under this paragraph or the General Appropriations Act. These distributions are for hospitals that meet participation requirements in the Low Income Pool as agreed upon between the Agency and the Centers for Medicare and Medicaid Services (CMS), and as a further condition of receipt of funds through the Low Income Pool program, participating hospitals shall not include these values in reimbursement made to the hospital from managed care plans.

Other Provider Access Systems	
Poison Control Programs	$3,172,805
Federally Qualified Health Clinics (FQHC)	$18,276,256
County Initiative – Department of Health (DOH)	$4,534,727
Hospital Based Primary Care Initiatives	$3,000,000
Health Care District of Palm Beach County - Premium Assistance Programs	$15,867,014
Miami Dade – Premium Assistance Programs	$250,000
Manatee ER Diversion	$1,200,000

Hospital Primary Care	$34,032,786
Primary Care Initiatives per Tier-one Milestones (STC 61)	$35,000,000
County Health Department - Primary Care Initiative	$2,000,000
Teaching Physicians	$204,533,833
Total Other LIP Provider Access Systems	**$321,867,421**

Poison Control Programs - Funds are provided to make Medicaid low-income pool payments to hospitals. These payments shall be used, in collaboration with the Department of Health, to provide funding for hospitals providing poison control programs.

FQHC - Funds are provided to make Medicaid low-income pool payments to Federally Qualified Health Centers. These payments may be used to provide funding for Federally Qualified Health Centers supporting primary care services in medically underserved areas.

County Initiative – Department of Health (DOH) - Funds are provided for county health initiatives emphasizing the expansion of primary care services and rural health networks. The DOH will develop the funding criteria processes, which include assessing statewide benefits, sustainability, access to primary care improvements, ER diversion potential, and health care innovations that are replicable and with a three-year limit on low-income pool funding.

Hospital Based Primary Care Initiatives - Funds are provided to make Medicaid low-income pool payments to hospitals. These payments shall be used, in collaboration with the DOH, to provide funding for hospitals with hospital based primary care initiatives.

Miami Dade – Premium Assistance Programs - Funds are provided to make health insurance premium payments for low-income residents enrolled in the Miami-Dade Premium Assistance Program.

Health Care District of Palm Beach County (HCDPBC) Premium Assistance Program - Funds are provided to make Medicaid low-income pool payments for premium assistance programs operated by Palm Beach County Health Care District.

Manatee ER Diversion - Funds are provided to continue the primary care and emergency room diversion program in Manatee, Sarasota and DeSoto counties.

County Health Department - Primary Care Initiative -Funds are provided for county health department clinics to enhance primary care health services, targeting low-income, uninsured, and under-insured individuals, in the following counties:

Bay.....$518,987
Okaloosa.....$555,412
Walton.....$172,760
Holmes.....$150,000
Washington.....$150,000
Jackson.....$152,476
Gadsden.....$150,365
Gulf.....$150,000

Primary Care Projects (New Primary Care Initiatives) – Funds are provided to continue the primary care grants.

Funding for Hospitals with Primary Care services is provided to providers who received Primary Care DSH payments during State Fiscal Year 2003-2004. The funds shall be distributed as specified in Table 1 in the column labeled “Primary Care” as incorporated in the Medicaid Supplemental Hospital Funding Programs – Fiscal Year 2014-2015.

The Other Provider Access Systems distributions are incorporated in the Medicaid Supplemental Hospital Funding Programs – Fiscal Year 2014-2015, Table 3, after the Hospital Provider Access Systems.

Tier-one Milestone Distributions (STC 61) are included as a portion of the total of the $50 million in new funds required by updated STCs from CMS. The distribution of the $35 million in this section will be determined by the Agency based upon the requirements herein. A total of $20 million will be used for the start-up of new primary care programs and a total of $15 million will be used to meaningfully enhance existing primary care programs. There is a cap of $4 million per grant proposal. The CMS Tier-one Milestones are for the establishment of new, or enhancement of existing, innovative primary care programs that meaningfully enhance the quality of care and the health of low income populations. The new or enhanced primary care programs must broadly drive from the three overarching goals of CMS’s Three-Part Aim.

1. Better care for individuals, including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity.

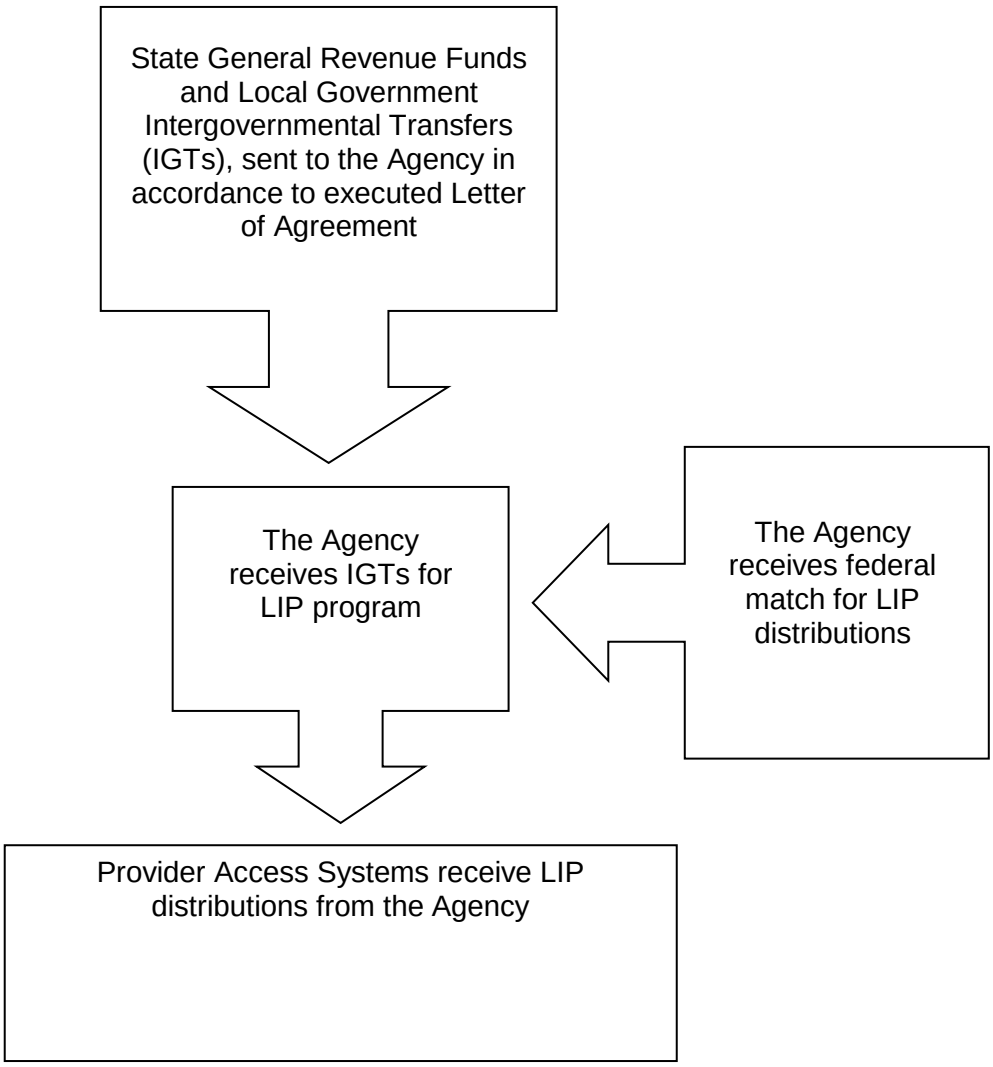
2. Better health for populations by addressing areas such as poor nutrition, physical activity, and substance abuse; and

3. Reducing per capita-costs.

Within these broad goals, the Agency will establish further requirements for new or enhanced primary care programs to provide the services most needed by the local community, such as needed physician, dental, nurse practitioner, or pharmaceutical services; expand local capacity to treat patients; and provide for extended service hours. Additionally, reduction of unnecessary emergency room visits and preventable hospitalizations will be components of new or enhanced primary care programs.

Funding for Teaching Physicians are for services provided by doctors of medicine and osteopathy, as well as other licensed health care practitioners acting under the supervision of those doctors pursuant to existing statutes and written protocols, employed by or under contract with a medical school in Florida. These distributions are for Medical Schools that meet participation requirements in the Low Income Pool.

Flow of Intergovernmental Transfers Provided for the LIP Program



APPENDIX B - LIP Special Terms and Conditions

67. Low Income Pool Definition. The LIP 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 79(a).

68. Availability of Low Income Pool Funds. The following paragraph presents the total computable dollar limit for LIP spending in DY 9, adjustments of the total amount, and LIP subpools.

a. Total LIP Amount for DY 9. The total computable dollar limit for LIP expenditures in DY 9 will be $2,167,718,341, which equals the total of the following:

    i. $1 billion (LIP dollar limit for DY prior to DY 9), plus

    ii. $963,184,508 (historical spending amount for self-funded hospital rate exemptions and buybacks, conditional on the state's assurance that no such rate exemptions or buybacks will be executed apart from LIP in DY 9), plus

    iii. $204,533,833 (historical supplemental payment amount for physician groups with medical school affiliation, conditional on the state's assurance that no such supplemental payments will be made apart from LIP in DY 9).

b. Possible Reductions to Allowable DY 9 LIP Expenditures. Allowable LIP expenditures for DY 9 will be reduced to the extent that CMS determines that the state has incurred a penalty for failure to meet a tier one milestone, following paragraph 79.

c. Assurances. The state provides the following assurances that the payments discussed in paragraphs (a)(ii) and (a)(iii) will not be made apart from LIP in DY 9.

    i. Self-funded hospital rate exemptions and buybacks: Florida Title XIX IP Hospital Reimbursement Plan Version XLI. Effective July 1, 2014, the DRG payment will not include any self-funded per claim IGT rate enhancement. Florida Title XIX OP Hospital Reimbursement Plan Version XXV. Effective July 1, 2014, the outpatient rates will not include any self-funded IGT rate enhancement for exemptions and buybacks.

ii. Supplemental payments for medical school affiliated physician groups:

For services provided on and after January 1, 2014 through June 30, 2014, the total computable amount will not exceed $83,384,893. This supplemental payment will end on June 30, 2014.

69. LIP Subpools. The following describe portions of the LIP that either may or must be used for a specific purpose.

a. Report on Medicaid provider payment. The state must commission a report from an independent entity on Medicaid provider payment in the state that reviews the adequacy of payment levels, and the adequacy, equity, accountability and sustainability of the State's funding mechanisms for these payments. $500,000 (total computable) of the total computable dollar limit for LIP in DY 9 is set aside for commissioning this report, and cannot be used for any other purpose. (The state may use more than $500,000 of LIP for this report, and any amount beyond the $500,000 would count against the overall LIP limit for DY 9.) Expenditures for the creation of the report will be considered Medicaid administrative expenditures and be eligible for FFP at the usual matching rate for administrative expenditures. The report must meet the following criteria:

i. Goal of the Report. The goal is to develop sustainable, transparent, equitable, appropriate, accountable, and actuarially sound Medicaid payment systems and funding mechanisms that will ensure quality health care services to Florida's Medicaid beneficiaries throughout the state without the need for LIP funding.

ii. Framework of the Report. The report must include a detailed description and analysis of the current Medicaid provider payment (all provider types) and financing system, with a major focus on services currently supported with intergovernmental transfers (IGT) or LIP funds. The report must also include how the state funds the various payments and how payments to providers correspond to amounts reported on the CMS-64. The report must note any gaps in payment as well as overages in the current funding structure.

A. In particular, the report must include detailed information on the historical methods of funding hospital payments, the interaction between state funded payments and provider funded payments, and describe the composition of payments, including base and supplemental payments.

B. The report must analyze the adequacy of current payment levels for Medicaid providers, and the adequacy, equity, accountability and sustainability of the state's funding mechanisms for these payments. The report will primarily focus on the types of providers supported by IGT or LIP funds.

C. The report must also include an analysis of how future changes in Medicaid, including possible Medicaid expansion would affect Medicaid payment amounts and structure, including fee-for-service payments, managed care, and LIP.

D. Finally, the report must recommend reforms to the Florida Medicaid financing system that can allow the state, beginning in state fiscal year 2015-2016, to move toward Medicaid fee-for-service and managed care payments to providers that ensure access and quality of care for Medicaid beneficiaries without the need for LIP funds. These payments should be based on a rationalized, non-facility specific payment mechanism, which can be applicable to future changes in Medicaid including Medicaid expansion. This type of rationalized payment mechanism would not include payment based on facility specific costs or local tax revenue and would discontinue incentive payments through the LIP.

iii. Deadlines, Monitoring and Funding.

A. A final report will be due no later than March 1, 2015.
B. A draft of the report will be due to CMS no later than January 15, 2015. Monthly monitoring calls with the state beginning in August 2014 will include an update of progress on the report.
C. CMS reserves the right to apply a penalty up to $500,000 if the state does not submit a final report, including all requested analyses and recommendations, by the March 1, 2015 deadline.

b. LIP Tier I Milestones: State initiative to establish new, or enhance existing, innovative programs. $50 million of the LIP must be used for the development and implementation of a state initiative to establish new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations in accordance with the requirements of STC 79. This amount of LIP cannot be used for any other purpose. (The state may use more than $50 million of LIP for these innovative programs, and any amount beyond the $50 million would count against the overall LIP limit for DY 9.) Further requirements for the state initiative can be found in paragraph 79(a) (LIP Tier I Milestones).

c. Low Income Pool Permissible Expenditures 10 percent Sub Cap. Up to $100 million of the capped annual allotment of the LIP funds may be used for hospital expenditures other than for the provision of health care services to an uninsured or underinsured individual, as discussed in paragraph 73.

d. Any LIP amounts not set aside per subparagraphs (a) and (b) and not used for the purposes discussed in the subparagraph (c) may be used for payments to providers that furnish uncompensated care to the Medicaid, underinsured and uninsured populations, consistent with paragraph 71 and the Reimbursement and Funding Methodology Document discussed in paragraph 70.

e. All LIP funds must be expended by June 30, 2015. 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 FY and are not recoverable. LIP dollars that are lost as a result of penalties or recoupment are surrendered by the state and not recoverable.

70. LIP Reimbursement and Funding Methodology. 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. Through the RFMD, the state must demonstrate that it has reconciled LIP payments to auditable costs. LIP provider payments for uncompensated care are limited to the uncompensated portion of providers' allowable costs and, in the aggregate, the authorized LIP pool amount for the demonstration year.

a. The state must submit a draft RFMD for CMS approval by September 29, 2014, that incorporates a cost review protocol that employs a modified DSH survey tool to report additional cost for the underinsured, and that includes cost documentation standards for new LIP provider types in DY 9.

b. For each DY, the state must reconcile LIP payments made to providers to ensure that they do not include unallowed uncompensated care costs, using the CMS approved RFMD cost review protocol. CMS will review the state's reconciliation and share any findings with the state. To the extent that payments are found to include any unallowed uncompensated care costs, the federal portion of any excess payment must be returned to CMS.

71. 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. These health care costs may be incurred by the state, by hospitals, clinics, or by other provider types to furnish medical care for Medicaid, uninsured and underinsured populations 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).

72. Low Income Pool Expenditures - Non-Qualified Non-Citizens. LIP funds cannot be used for costs associated with the provisions of health care to non-qualified non-citizens subject to the 5 year waiting period in accordance with sections 8 U.S.C. 1613 and 1641.

73. Low Income Pool Permissible Expenditures 10 percent Sub Cap. Up to $100 million 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. Hospital costs funded by these payments cannot be included as allowable costs for purposes of any federally-supported program. 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 as discussed in paragraph 70.

74. Low Income Pool Permissible Hospital Expenditures. Hospital cost expenditures from the LIP will be paid up to 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.

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

76. Permissible Sources of Funding Criteria. Sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. Federal funds received from other federal programs (unless expressly authorized by federal statute to be used for matching purposes) shall be impermissible.

77. Aggregate LIP Funding. At the beginning of DY 9, up to $2.16 billion in LIP funds will be available to the state. This amount will be reduced by any milestone penalties that are assessed by CMS and reconciliation overpayments as discussed in STC 68. Provider Participation requirements, described in STC 78 and all Tier I Milestones, as described in paragraph 79, must be met for the state and facilities to have access to 100 percent of the annual LIP funds. Tier II Milestone initiatives are suspended for DY 9.

78. LIP Provider Participation Requirements. Provider access systems (hospitals, County Health Departments, and Federally Qualified Health Centers) 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 in (a)(ii) 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.

a. Hospitals.
    i. Must contract with at least fifty percent of the Standard Plan Managed Care Organizations (MCOs) in their corresponding region;

    ii. Must contract with at least one Specialty Plan serving each specialty population in their corresponding region; and,

    iii. Participate in the Florida Event Notification program.

b. Medical School Physician Practices. Must participate in the Florida Medical School Quality Network.

c. County Health Departments. Non-hospital institutional providers must continue their participation in LIP programs that support specific projects to increase access to healthcare services for low income/indigent uninsured population in addition to providing access to the Medicaid population.

d. Federally Qualified Health Centers. Non-hospital institutional providers must continue their participation in LIP programs that support specific projects to increase access to healthcare services for low income/indigent uninsured population in addition to providing access to the Medicaid population.

79. Tier - One Milestone. Tier-one milestones are defined as follows:

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

   i. Better care for individuals including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity;

   ii. Better health for populations by addressing areas such as poor nutrition, physical inactivity, and substance abuse; and,

   iii. Reducing per-capita costs. Expenditures incurred under this program must be permissible LIP expenditures as defined under Section XIV, Low Income Pool. The program must be implemented with LIP funds allocated and expenditures incurred in DY 9. The state can elect to continue or expand the program established for DY 8, or establish a new one.

   As part of the quarterly progress report for the September –December 2014 quarter, the state must include a section summarizing the state initiatives that were implemented for DY 7 and DY 8, including; how they were implemented; what providers or other entities participated; what was accomplished through these initiatives; and a description of its initiatives for DY 9 including changes, improvements or new initiatives implemented based on the state's review.

b. Timely submission of all hospital, FQHC, and County Health Department LIP reconciliations in the format required per the LIP Reimbursement and Funding Methodology protocol.

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

d. Submission of an annual "Milestone Statistics and Findings Report" and a "Primary Care and Alternative Delivery Systems Expenditure Report". Within 60 days following the acceptance of the terms and conditions, the state must submit anticipated timelines for report submissions.

e. 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.

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

Appendix C – List of Expenditures

Expenditures for Reimbursement of Uncompensated Care

STC 69(a) Report on Medicaid provider Payment: Minimum of $500,000.

STC 69(b) LIP Tier I Milestones: State initiative to establish new, or enhance existing innovative programs in accordance with STC 79: Minimum of $50,000,000.

STC 69(c) Low Income Pool Permissible Expenditures 10 percent Sub Cap in accordance with STC 73: Maximum of $100,000,000.

STC 68(a) (iii) Historical supplemental payment for physician groups with medical school affiliation: Maximum of $204,533,833.

STC 69(d) Payments to providers that furnish uncompensated care to the Medicaid, underinsured and uninsured populations, consistent with STC 71 and limited under STC 70 to the uncompensated portion of providers' allowable costs in accordance with STC 74 and STC 75 and to the aggregate limit of funds identified in STC 68 less the amount of item 1, 2, 3 and 4 above: Maximum of $1,812,684,508.

The maximum identified in item 5 will be decreased by the amount of item 1 in which is above $500,000 and the amount in item 2 which is above $ 50 million. The maximum in item 5 will be increased by the amount that is under $100 million in item 3 and the amount that is under $204,533,833 in item 4.

Cost Review Protocol for Reimbursement of Uncompensated Care

Report on Medicaid Provider Payment

a. Per STC 69(a) The State must commission a report from an independent entity on Medicaid provider payment in the State.
b. The $500,000 set aside cannot be used for any other purpose.

LIP Tier I Milestone initiative

a. Per STC 79(a) LIP funds must be used for the development of a State initiative or enhance existing innovative program.
b. $50 million is allocated and cannot be used for any other purpose.

10 Percent Sub Cap

a. Per STC 69(C) LIP funds may be used for hospital expenditures other than for the provision of health care services as described in STC 73.
b. Up to $100 million can be used for this type of expenditure.
c. These cost or funds will not be recognized as part of calculation of the cost for the payment of uncompensated cost to a specific provider.

Supplemental payment for physician groups with medical school affiliation

a. Per STC 68 funds were allocated for payment of physician supplemental to medical school affiliation physicians.
b. Up to $204,533,833 has been allocated for this purpose.

Payments to providers that furnish uncompensated care to the Medicaid, underinsured and uninsured populations.

a. Per STC 69(d) LIP payments may be used for payments to providers that furnish uncompensated care to the Medicaid, underinsured and uninsured populations, consistent with STC 71 and limited under STC 70.
b. Up to $1,808,684,508 has been allocated for this purpose.
c. The limit for payment to individual providers is the uncompensated portion of providers' allowable costs in accordance with STC 74 and STC 75 and to their share of the aggregate limit of funds identified in b above.

Appendix D – Hospital Cost
Cost Review Protocol

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 24, lines 30 through 93. 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 8. 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-4 Part III under the Part B cost column line 62. This ratio is then multiplied by net total organ acquisition costs from Worksheet D-4 Part III under the Part A Column 1 cost column line 61 less line 66. 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. After program organ cost is determined, reduce the cost amount by Medicaid global organ transplant payments and out of state Medicaid organ transplant payments.

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 26. 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 8. 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-4 Part III under the Part B Cost column 2 line 62. This ratio is then multiplied by

total organ acquisition costs from Worksheet D-4 Part III under the Part A Cost column 1 line 61 less line 66. “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). Reduce Medicaid managed care organ transplant cost by organ transplant managed care Medicaid payments.

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 26. 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 8. 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-4 Part III under the Part B Cost column 2 line 62. This ratio is then multiplied by total organ acquisition costs from Worksheet D-4 Part III under the Part A Cost column 1 line 61 less 66. "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. Reduce the cost calculated for uninsured organ transplant cost by uninsured organ transplant payments.

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 71, “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-4 Part III Cost Part A Column 1 Line 61 Less Line 66

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-4 Part III Cost Part A Column 1 Line 61 less line 66; 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 73.

7. Hospital Payments and Recoveries

All of the following payments and recoveries associated with cost derived from LIP permissible expenditures shall be offset against the costs computed in Sections above including but not limited to:

- Payments from Managed Care Organizations (MCO);
- Payments from Behavioral Health Organizations (BHOs);
- Payments from Medicaid enrollees and the uninsured; supplemental payments;
- Statewide Residency Graduate Medical Education (GME) program funds received that exceeded the hospital's Medicaid GME expenditures;
- DSH payments received; and
- any other sources including any related patient co-payments, or payments from other non-State payers.

Physician and non-physician practitioner professional payments are to be separately identified as professional practitioner payments and offset against LIP cost. These payments would be identified, but not limited to, payments received by the hospital for professional services billed under both the hospital and physician billing numbers. In addition, any and all payments received through billings by third parties for the professional service LIP cost claimed, and payments received through billings by the physician related to the cost claimed in this section. These payments are to be separately identified as professional payments, aside from the hospital payments, and offset to LIP cost.

- 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 Cost Limit Reconciliation for DY9

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 12/31/12 encompasses one-half of the State plan rate year ending 6/30/2012, and one-half of the State plan rate year ending 6/30/2013. To fulfill reconciliation requirements for State plan rate year 2012-13, the hospital would match one-half of the Medicaid FFS, Medicaid managed care, and uninsured costs from its reporting period ending 12/31/2012, and one-half of the Medicaid FFS, Medicaid managed care, and uninsured costs from its reporting period ending 12/31/2013, 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.

Appendix E - FQHCs & CHDs Cost Limit Reporting

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 Revenue Breakdown

For the payment year, the CHD Revenue corresponding to the allowable cost are as follows:

a. Fee for Service Revenue
b. Medicaid
c. Self-pay
d. Other (describe)

5. FQHC Reconciliation for DY9

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.

CHDs Cost Limit Report

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.

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 Revenue Breakdown

For the payment year, the CHD Revenue corresponding to the allowable cost are as follows:

a. Fee for Service Revenue
b. Medicaid
c. Self-Pay
d. Other (describe)

4. CHD Reconciliation

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 1st – June 30th.)

Appendix F - Physician Supplemental Cost

The Agency provides for supplemental payments for services provided by doctors of medicine and osteopathy as well as other licensed health care practitioners employed by or under contract with either:

1. A medical school that is part of the public university system (Florida State University, The University of Florida, and The University of South Florida;
2. A private medical school that places over fifty percent (50%) of their residents with a public hospital (The University of Miami); or
3. Nova Southeastern University.

The supplemental payments are based on the difference between the lower of fifty-four and thirty-four one hundredths percent (54.34%) of the provider's usual and customary charges or fifty-four and thirty-four one hundredths percent (54.34%) of the charge ceiling established by the Agency and the actual payment by Medicaid to the physician or osteopathic physician under the current physician fee schedule. For services provided on and after July 1, 2014 through June 30, 2015, the total computable amount will not exceed $204,533,833.

The percentage applied to providers' usual and customary charges or the charge ceiling shall be determined annually. This percentage shall represent the weighted average percentage of usual and customary charges paid by commercial payers weighted by the number of Medicaid allowable procedures for the physicians associated with the designated medical schools. The percentage shall be substantiated by data made available by each medical school or as determined by an independent entity that has sufficient data to determine geographically specific percentages. Geographically specific percentages may be used in determining the statewide percentage, but one statewide percentage shall be used for payment determinations.