August 13, 2015

Mr. Justin Senior
Deputy Secretary for Medicaid
2727 Mahan Drive – Mail Stop #8
Tallahassee, FL 32308

Dear Mr. Senior,

On behalf of our 200 hospitals and health systems members, the Florida Hospital Association is submitting the following comments regarding the latest draft to the Special Terms & Conditions (STC) for the Managed Medical Assistance Program, specific to section XIV pertaining to the Low Income Pool (LIP) program.

STC 67 suggests the elimination of bad debt being used as uncompensated care because those individuals may have insurance. However, in the case of a low income individual being under-insured due to limited policy benefits – the portion of non-payment should still be considered charity care. In previous Demonstration Years, this was an allowable uncompensated care cost that would be reported.

STC 68a states that in Demonstration Year (DY) 11, the allocation for the Low Income Pool (LIP) program will be $608 million. "The change represents a transition to a LIP program that reflects the cost to providers of uncompensated care for uninsured individuals in the state, and that no longer pays for care that may be or has been provided through available coverage options." The Agency for Healthcare Administration (AHCA) has indicated there may be an error in the Centers for Medicare and Medicaid Services (CMS) calculation of the $608 million figure for Florida's hospitals uncompensated care costs. A position that is supported by Myers and Stauffer. The State should have the opportunity to correct the calculation error in setting the LIP program limit for DY 11.

The Health Financial Management Association (HFMA) Principles and Practices Board Statement 15 provides direction for reporting charity care and bad debt separately is referenced throughout the STCs. The HFMA principles allow, and FHA supports, portions of bad debt to be reported as uncompensated care.

STC 69 requires all LIP program distributions for DY 10 and DY 11 to be completed by June 30th of the DY. Funds not distributed by June 30th cannot be rolled over. CMS should provide flexibility on the deadline for payments to allow a cushion for clerical errors at the end of the State's fiscal year.

STC 70(b) discusses reductions in the LIP program allotment to account for payments in excess of the uninsured cost filed through the Cost Reconciliation Reports. CMS should provide ample notice to the State of any potential reductions in the LIP program allotment for DY 11 for payments in excess of allowed uncompensated care costs.

STC 71(b)(i) puts providers into two categories, hospitals and non-hospitals (FQHCs, CHDs, and Medical School Physician Practices). Since the funding has been reduced, we support hospital-only participation in the LIP program.

Lastly, we respectfully request a 30-day comment period to thoroughly vet the aforementioned issues. We look forward to working with the State and CMS on a final product. Please reach out to me with any further questions and/or concerns.

Sincerely,

Ellen Anderson
Vice President, State Advocacy

cc: Ms. Heather Hostetler, Project Officer, CMS