Reimbursement and Funding Methodology For Demonstration Year 10

Florida's 1115 Managed Medical Assistance Waiver

Low Income Pool

November 30, 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 STCs approved October 15, 2015, to submit a Low Income Pool (LIP) Cost protocol for Demonstration Year (DY) 10 by November 30, 2015.

LIP is defined in STC 67 (see Appendix B) as a fund that provides transitional government support for the safety net providers that furnish uncompensated care to the Medicaid, underinsured and uninsured populations. STC 70 (see Appendix B) requires the submittal of the RFMD prior to November 30, 2015.

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 71, 72, 73, and 74 (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 of that local government's area without consideration of the benefits received by providers within its political subdivision. The State believes that 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 71(a), "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 (see Appendix B).

The State has created separate and unique payment methodologies that recognize different provider access system (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 Ten (DY 10) 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. Distributions are subject to PAS's meeting LIP Participation Requirements outlined in STC 77 (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 10 – July 1, 2015 – June 30, 2016

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 B.

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 73, "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. The date of discovery for any overpayments identified in the LIP Cost Limit Reconciliation will be the date in which the Agency submits the initial reconciliation to CMS.

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.

For DY10, providers must submit the annual LIP Cost Limit report to the Agency for state fiscal year July 1, 2013 through June 30, 2014. The Agency must submit the reconciliation to CMS no later than May 30, 2016.

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 Hospital LIP Cost Limits will be calculated using the data described in Appendix C. 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.

For all hospitals, the Agency will ensure that the sum of Medicaid, DSH, and LIP reimbursements do not exceed total hospital cost for care of Medicaid beneficiaries plus the underinsured and uninsured.

VI. Conclusion

This LIP Reimbursement and Funding Methodology Document is submitted to satisfy STC 70 (see Appendix B). This updated version of the Reimbursement and Funding Methodology Document is submitted to CMS in order to update the July 10, 2015 document for DY9.

APPENDIX A - SFY 2015-16 LIP Distribution & Funding Methodology

LIP Distribution - General Appropriations Act Methodology

Low Income Pool Funding (LIP)	
General Revenue	$450,000
Grants and Donations Trust Fund	$395,250,000
Medical Care Trust Fund	$604,300,000
Total	**$1,000,000,000**
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	$4,125,321
Trauma Level II and Pediatric Trauma	$1,753,963
Safety Net	$72,879,526
Specialty Pediatrics	$1,409,166
Quality Measures (STC 61)	$15,000,000
Total Special LIP	**$116,567,413**

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/FAP 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 2007, 2008, and 2009 audited DSH data available as of March 1, 2015. 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 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 Table 1. The distribution amounts for the Quality Measures category shall remain as represented in Table 1. The individual amounts for Rural Hospitals may be modified depending on updated Florida Hospital Uniform Reporting System (FHURS) data, used in the Rural DSH calculations.

LIP – 4	
LIP - 4	**$364,049,900**
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 former exemption programs. The distribution is the local government fund multiplied by an allocation factor. For State Fiscal Year 2015-2016, the allocation factor is 108.0 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.	

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 2013 FHURS.	

LIP - 6 Phase-out	
LIP - 6	**$94,646,902**
LIP 6 payments are in the process of phasing-out and are provided for hospitals to receive a distribution on a quarterly basis in explicit amounts.	

LIP – 7	
LIP - 7	**$217,782,379**

The funds in LIP 7 are provided for hospitals to receive a distribution on a quarterly basis.

Distributions in LIP 7 are based on tertiary, critical-need groupings and Medicaid utilization. Hospitals will participate in one of four groups based on the defined criteria below:

- Essential Community Providers (ECP) as defined by the federal Centers for Medicare & Medicaid Services (CMS);
- Regional Perinatal Intensive Care Centers (RPICC);
- Statutory Teaching Hospitals (ST); and
- Trauma Centers.

Group 1 – Any hospital that is an ECP, RPICC, ST, and a Level I Trauma Center.
Group 2 – Any hospital that meets three of the defined criteria.
Group 3 – Any hospital that meets two of the defined criteria.
Group 4 – Specially designated licensed cancer center.

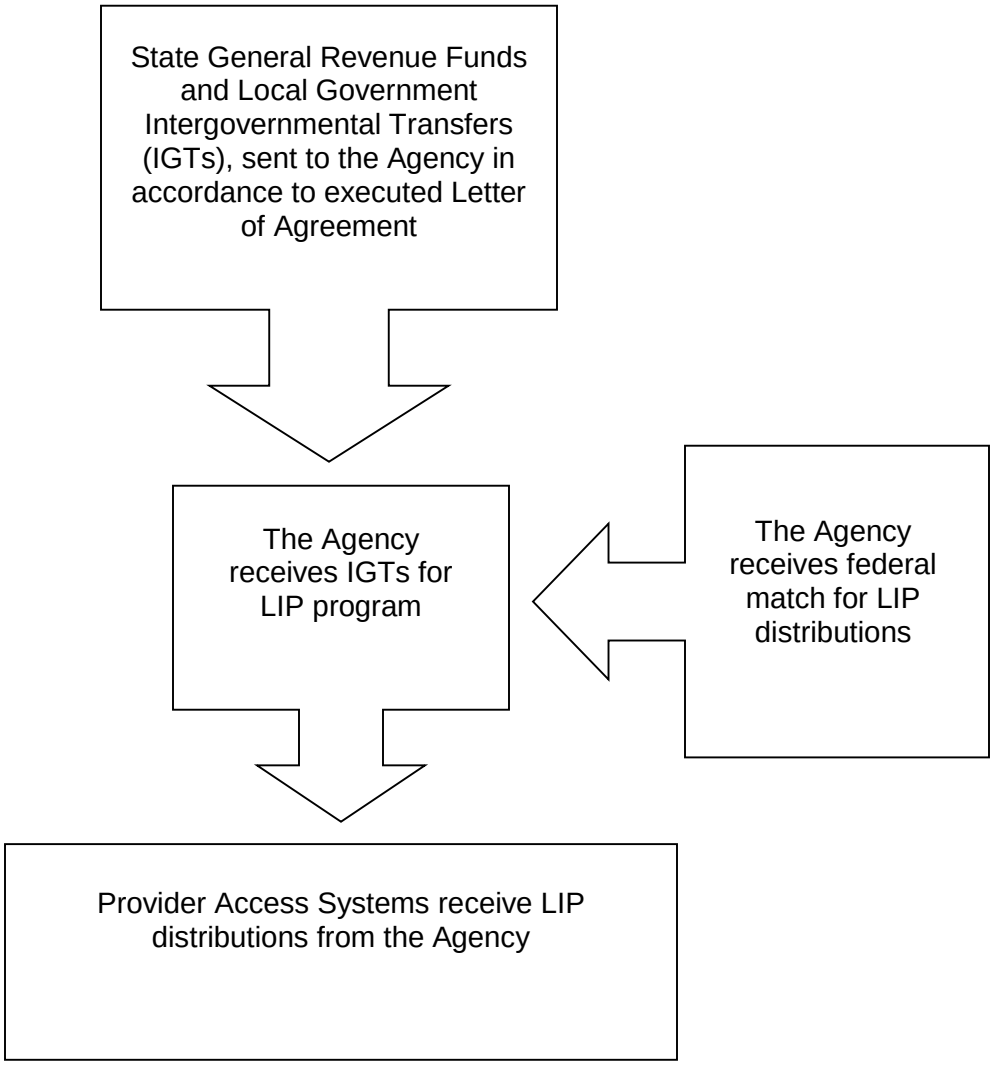
The following dollar amounts within LIP 7 shall be assigned to each group for distribution to the qualifying hospitals;

Group 1 – $109,371,938
Group 2 – $52,627,500
Group 3 – $39,637,116
Group 4 – $16,145,825

The Medicaid fee-for-service and managed care days are based on the 2013 FHURS data filed with the Agency for Health Care Administration. Public hospital systems where all hospital are located in the same county shall have their individual hospital's Medicaid fee-for-service and managed care days combined with the hospital that qualifies in the highest group.

Teaching Physician Supplemental Payments	
Physician Supplemental Payments	**$204,533,833**
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 Low Income Pool.	

Flow of Intergovernmental Transfers Provided for the LIP Program



APPENDIX B - LIP Special Terms and Conditions

67. **Low Income Pool Definition.** In Demonstration Year 10, the LIP provides transitional government support for the safety net providers that furnish uncompensated care to the Medicaid, underinsured and uninsured populations. In Demonstration Year 11 (SFY 2016-2017) the LIP provides government support for safety net providers for the costs of uncompensated charity care for low-income individuals that are uninsured. Uncompensated care includes charity care for the uninsured but does not include uncompensated care for insured individuals, "bad debt," or Medicaid and CHIP shortfall. The definition also excludes the estimated impact on uncompensated care that would result from Medicaid expansion, or that has resulted from Marketplace coverage, under the Affordable Care Act. This is reflected in the total computable dollar limit discussed in STC 68.

68. **Availability of Low Income Pool Funds.** The following paragraph presents the total computable dollar limit for LIP spending in DYs 10 and 11, subject to assurances.

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

b. **Assurance.** As reflected in the LIP participation requirements in STC 77, in DY 11, the state and participating providers who plan to participate in LIP for DY11 will provide assurance that LIP claims include only costs associated with uncompensated care that is furnished through a charity care program for individuals with incomes up to at least 200 percent of the federal poverty level that adheres to the principles of the Healthcare Financial Management Association operated by the provider.

69. **Capped Annual Allotments.** All annual LIP funds must be expended by July 31 following each authorized demonstration year. Any amount not expended does not roll over. Capped annual allotment amounts that are not distributed because of penalties, recoupment due to payments exceeding uncompensated care cost, or are otherwise due to violating the terms of the approved STCs cannot be rolled over to another DY and are not recoverable. 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 as charity care on the provider's financial records. Through the RFMD, the state must demonstrate that it has reconciled LIP payments to auditable costs. LIP provider payments for uncompensated care as charity care are limited to the uncompensated portion of providers' allowable costs and, in the aggregate, the authorized LIP pool amount for the demonstration year.

    a. Prior to November 30, 2015, the state must submit a draft of DYs 10 and 11 (2016-2017) RFMDs to CMS for approval and CMS will work with Florida towards approval by January 31, 2016. However, Florida may not claim federal financial participation

for LIP payments in DY 11 until after a revised RFMD is approved by CMS.

b. For each DY, the state must reconcile LIP payments made to providers to ensure that they do not exceed allowed uncompensated care costs, using the CMS approved RFMD cost review protocol. The state must submit a LIP Cost Reconciliation report to CMS within two years after the end of each DY showing cost reconciliation results by provider. CMS will review the state's reconciliation and share any findings with the state. To the extent that payments are found to exceed allowed uncompensated care costs, the federal portion of any excess payment must be returned to CMS by submitting a decreasing expenditure adjustment (Line 10B). If the state has not submitted its LIP Cost Reconciliation Report for a DY within the timeframe described above, CMS may issue a deferral or disallowance for an amount not to exceed the total of the state's submitted LIP expenditures for that DY.

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

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

e. For the purposes of this paragraph, allowed uncompensated care cost follows the definitions described in paragraph 71.

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.

a. In DY 10 (SFY 2015-2016), these health care costs may be incurred by the state, or 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).

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

i. Providers may be categorized in up to two groups: hospitals and Medical School Physician Practices. Each group may be divided into up to four tiered subgroups, based on subdividing a list of the providers ranked by their amount of uncompensated charity care cost or charges (defined as in (b) above) as a

percentage of their privately insured patient care cost or charges—that ratio is the sole basis on which tiered groups may be defined.

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

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

iv. Determination of (i) through (iii) may be effectuated using contemporaneous uncompensated care data, or equivalent data from a prior year not more than three years prior to the DY.

72. **Low Income Pool Permissible Expenditures 10 percent Sub Cap.** For DY 10, 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.

73. **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.

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

75. **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.

XV. LOW INCOME POOL PROVIDER PARTICIPATION REQUIREMENTS AND DELIVERABLES

76. **Aggregate LIP Funding.** In DY 10, up to $1 billion in LIP funds will be available to the state and in DY 11, up to $607,825,452 million in LIP funds will be available to the state. This amount will be limited by any penalties that are assessed by CMS pursuant to STC 78 and/or reconciliation overpayments as discussed in STC 70. Provider Participation requirements, described in STC 77 must be met for the state and facilities to have access to 100 percent of the annual LIP funds.

77. **LIP Provider Participation Requirements.** Hospitals and Medical School Physician Practices who receive LIP funds have certain participation requirements. If they do not meet the participation requirements, they cannot receive LIP funds**.** The state may grant an exemption to a hospital of the requirement 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.

        iv. In DY 11, the state and participating providers will provide assurance that LIP claims include only costs associated with uncompensated care furnished through the a charity care program for individuals with incomes up to at least 200 percent of the federal poverty level that adheres to the principles of the Healthcare Financial Management Association and is operated by the provider**.** Such a charity care program must be established prior to the end of DY 10.

        v. In DY 11 for administrative purposes, participating hospitals must be enrolled Medicaid providers and have a minimum of 1 percent Medicaid utilization based on the ratio of Medicaid days to total patient days reported on the most recent accepted Florida Hospital Uniform Reporting System (FHURS) data.

    b. **Medical School Physician Practices**

        i. Must participate in the Florida Medical School Quality Network,

        ii. In DY 11, the state and participating providers will provide assurance that LIP claims include only costs associated with uncompensated care through the provider's charity care program for individuals with incomes up to at least 200 percent of the federal poverty level that meets the principles of the Healthcare Financial Management Association. Such a charity care program must be established prior to the end of DY 10.

iii. In DY 11, participating providers must be enrolled Medicaid providers and have a minimum of 1 percent Medicaid utilization

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

a. Timely submission of an annual estimate and annual final uncompensated care report. Submission by June 1 of each year, detailing for the upcoming demonstration year, the projected LIP providers, the estimated per provider of uncompensated care to be furnished through charity care, and the IGTs associated with each provider. Submission by October 1 of each year, for the demonstration year just ended, the final report of the LIP providers, uncompensated care claimed through charity care and the final IGTs. Both the estimate and final report must also be posted on the state Medicaid website.

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. 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.

Appendix C – 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 that 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. Additionally,

coinsurance and deductibles should be removed from uninsured and underinsured cost data.

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.
- Coinsurance and deductibles.

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 72.

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 and LIP payments received; and
- any other sources including any related patient co-payments, or payments from other non-State payers including third party collection agencies.

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 DY10

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 D – Teaching 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 that meet the requirements under STC 77 (Appendix B), and are 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, 2015 through June 30, 2016, 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.