

Florida Managed Medical Assistance Program 1115 Research and Demonstration Waiver

Public Notice Document Low Income Pool Amendment Request

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Posted on Agency Website

http://ahca.myflorida.com/medicaid/statewide_mc/mma_fed_auth_amend_waiver_2015-04.shtml

Florida Agency for Health Care Administration



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I. Purpose, Goals and Objectives

A. Statement of Purpose

The State is seeking federal authority to amend Florida's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4) to redesign elements of the Low Income Pool (LIP) and extend the program until June 30, 2017. The newly redesigned LIP ensures access to care for low income populations that are not eligible to participate in Medicaid or other subsidized coverage programs and complements the MMA program by strengthening connections between critical safety net providers and the MMA program.

The request to redesign and continue funding of LIP is in response to discussions with the Centers for Medicare and Medicaid Services (CMS) about how best to structure the pool in light of new and different coverage opportunities for low income Floridians: Florida's Medicaid program's shift to the MMA program as well as opportunities available under the Affordable Care Act (ACA).

The State contracted with Navigant Consulting, Incorporated (Inc.)¹ to conduct the CMS required study on the LIP program (See appendix B). The study concluded that the LIP program would need to continue in Florida even if all coverage options were fully exploited. This conclusion is consistent with other sources, including the Urban Institute, which have estimated that Florida providers would continue to experience significant uncompensated care costs even after implementation of the ACA. In response to these findings and discussions with CMS, the redesigned LIP program contains the following features:

- Reduced linkage of payments to local source of funding and
- Continued focus on maintaining access and quality of care to vulnerable populations.

The State is not requesting authority to make any changes to the MMA program as authorized under this waiver. The State is seeking waiver and expenditure authority to redesign and extend the LIP program. Specifically, the State seeks expenditure authority of Section 1115(a)(2) of the Social Security Act for expenditures for uncompensated care costs incurred by providers for health care services to uninsured and or underinsured, and associated projects to support such care through the redesigned LIP program (See item three in Section VII Waiver and Expenditure Authorities of this document).

B. Goals and Objectives

Historically, the goal of the LIP program has been to provide additional support to safety net hospitals, rural hospitals, trauma centers, and other provider access systems that have served the Medicaid and uninsured populations. Since implementation in 2006, the LIP program has increased emphasis on primary care, emergency room diversion, and other quality initiatives. Teaching physicians were added for the period July 1, 2014 to June 30, 2015, Demonstration Year (DY) 9, for continued support of these practices that contribute vitally to ensure a strong Florida physician workforce. The redesigned program is critical to sustained access in a higher

¹ http://ahca.myflorida.com/medicaid/Finance/finance/LIP-DSH/LIP/docs/FL_Medicaid_Funding_and_Payment_Study_2015-02-27.pdf

health care coverage environment. The State's LIP program goals are specified in Section 409.91211(1)(c), Florida Statutes.

The redesigned LIP program will accomplish the following access and Medicaid payment goals alongside an initiative to increase Medicaid hospital payment rates:

- Reduced linkage of payments to local source of funding and
- Continued focus on maintaining access and quality of care to vulnerable populations

C. Current Program

The current LIP program total computable dollar limit for expenditures in DY9 is \$2,167,718,341 as specified in Special Term and Condition (STC) #68a. This total includes the following elements:

- \$1 billion (for DY1 - DY8, LIP funding had a capped allotment of \$1 billion disbursed in quarterly payments to providers);
- \$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 DY9);
- \$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 DY9).

Demonstration Year 9 served as a "transition year" for the LIP program, to provide time to contract with a vendor (Navigant Consulting, Inc.) to complete the study required by STC 69a (See appendix B). As such, the distributions being made in DY9 are reflective of the DY8 distribution of \$1 billion, and incorporate Physician Supplemental funding and LIP 6 (formerly self-funded rate enhancements). These distributions are subject to new "participation requirements" that were added at the renewal of the waiver in STC #78:

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.

D. Federal and State Waiver Authority

The following is a historical description of the federal and state authority granted since authorization of the waiver (Project Number 11-W-00206/4) was obtained in 2005.

1. Initial 5-Year Period (2006 - 2011): On October 19, 2005, Florida's 1115 Research and Demonstration Waiver named "Medicaid Reform" was approved by the Centers for Medicare and Medicaid Services (CMS). The program was implemented in Broward and Duval counties on July 1, 2006 and expanded to Baker, Clay and Nassau counties on July 1, 2007. The LIP program was approved for a capped annual allotment of \$1 billion total computable for each of the initial 5-year demonstration periods. The program was terminated August 1, 2014 with the implementation of the MMA program. The State authority to operate this program is located in s. 409.91211, F.S., and sunsetted October 1, 2014.

2. Three-Year Extension Period (2011 - 2014): On December 15, 2011, the State received Federal CMS approval to extend the waiver to maintain and continue operations of Medicaid Reform for the period July 1, 2011 to June 30, 2014. The LIP program was approved for a capped annual allotment of \$1 billion total computable for each of the additional 3-year demonstration periods.

3. MMA Waiver Amendment (2013): On June 14, 2013, the State received Federal CMS approval to amend the waiver to terminate the Medicaid Reform program and implement the MMA program as approved by Federal CMS. The name of the waiver was changed to Florida's 1115 Managed Medical Assistance Waiver.

4. Three-Year Waiver Extension (2014 - 2017): On November 27, 2013, the Agency submitted an extension request to extend authority for the 1115 MMA Waiver an additional 3-years (July 31, 2014 - June 30, 2017). The effective dates of the waiver renewal period are July 31, 2014 through June 30, 2017. The Agency received approval of the 3-year extension from Federal CMS on July 31, 2014. The LIP program was authorized to extend for one year, from July 1, 2014 through June 30, 2015 with the total amount not to exceed \$2.16 billion. The Special Terms and Conditions (STCs) can be viewed on the Agency for Health Care Administrations (Agency's) website at the following link:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SpecialTermsandConditionsCMSApprovedJuly312014.pdf

Please note the State is not requesting authority to make any changes to the MMA program as authorized under this waiver. The State is seeking waiver and expenditure authority to redesign and extend the LIP program. Specifically, the State seeks expenditure authority of Section 1115(a)(2) of the Social Security Act for expenditures for uncompensated care costs incurred by providers for health care services to uninsured and or underinsured, and associated projects to support such care through the redesigned LIP program (See item three in Section VII Waiver and Expenditure Authorities of this document).

E. Federal Waiver Amendment Requirements

The State will submit the MMA Waiver amendment to Federal CMS in accordance with STCs #7 and #15 of the MMA Waiver and Title 42 Code of Federal Regulations (CFR), Section (s.) 431.408. The following is a description of the required public notice document.

Public Notice Document: The State is posting this “Public Notice” document to solicit public input 30 days prior to submission of the amendment request to Federal CMS. This public notice document is required to include a comprehensive description of the amendment application that contains sufficient detail to ensure meaningful input from the public, including:

- (A) Demonstration of Public Notice 42 CFR §431.408 and tribal consultation: The state must provide documentation of the State’s compliance with public notice process as specified in 42 CFR §431.408 and documentation that the tribal consultation requirements outlined in STC 15 have been met.
- (B) Demonstration Amendment Summary and Objectives: The State must provide a detailed description of the amendment, including; what the State intends to demonstrate via the amendment as well as impact on beneficiaries with sufficient supporting documentation, the objective of the change and desired outcomes including a conforming Title XIX and/or Title XXI state plan amendment, if necessary.
- (C) Waiver and Expenditure Authorities: The State must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested for the amendment
- (D) A data analysis worksheet which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
- (E) An up-to-date CHIP allotment neutrality worksheet, if necessary; and
- (F) Updates to existing demonstration reporting, quality and evaluation plans: A description of how the evaluation design, comprehensive quality strategy and quarterly and annual reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

II. Public Process

This section of the document provides a summary of public notice and input process used by the State in compliance with 42 CFR 431.408 and STCs #7 and #15 of the MMA Waiver including: the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to s. 1902(a)(73) of the Social Security Act (Act) as amended by s. 5006(e) of the American Recovery and Reinvestment Act of 2009.

A. Consultation with Indian Health Programs

The Agency consulted with the Indian Health Programs² located in Florida through written correspondence, to solicit input on the amendment request. Appendix A of this document provides the correspondence sent on April 20, 2015, to the Seminole Tribe and Miccosukee Tribe request input on the amendment request.

B. Public Notice Process

The following list describes the notification process used to inform stakeholders of the public meetings to be held to solicit input on the amendment request.

- Publish public notices for the three public meetings in the Florida Administrative Register (FAR) in compliance with Chapter 120, Florida Statutes (F.S.).
- Email the meeting information to individuals and organizations from the interested parties list that was created during the development of the initial waiver application and has been updated regularly thereafter.
- Release Agency Alerts announcing the meetings.
- Post on the Agency's home website a prominent link to the website where the following information can be found: the public meeting schedule including dates, times and locations, as well as this public notice document for the amendment request. The meeting materials and the public notice document can be viewed by clicking on the following link:

http://ahca.myflorida.com/medicaid/statewide_mc/mma_fed_auth_amend_waiver_2015-04.shtml

C. Florida Medicaid Advisory Meetings

The Agency is asking for input on this amendment request from the members of the Medicaid Medical Care Advisory Committee (MCAC) and the public at large. The public meeting notices will be published in the FAR. During the meetings, the Agency will provide a description of the amendment request and will seek to obtain input on the amendment request. The agenda and presentation materials will be posted on the Agency's website provided above.

- MCAC public meeting will be held in Orlando, FL on April 29, 2015.
- Public meeting will be held in Miami, FL on April 30, 2015.
- Public meeting will be held in Tallahassee, FL on May 1, 2015.

² The State of Florida has two federally recognized tribes: Seminole Tribe and Miccosukee Tribe; and does not have any Urban Indian Organizations.

Florida Medicaid's Medical Care Advisory Committee

The MCAC is mandated in accordance with Title 42, CFR s. 431.12, based on Section. 1902(a)(4) of the Social Security Act. The purpose of the MCAC is to provide input on a variety of Medicaid program issues, and to make recommendations to the Agency on Medicaid policies, rules and procedures.

The MCAC is comprised of: board-certified physicians and other representatives of the health professions who are familiar with the medical needs of low-income people; members of consumer groups, including at least four representatives of Medicaid recipients; and representatives of state agencies involved with the Medicaid program, including the secretaries of the Florida Department of Children and Families, the Florida Department of Health (DOH) and the Florida Department of Elder Affairs, or their designees.

D. Public Meetings

The State will publish a public meeting notice in FAR on April 21, 2015 inviting all interested parties to the three public meetings listed in the table below, which provides the dates, times and locations. Individuals who will be unable to attend the meeting in person can participate via conference call by using the toll-free number provided in the FAR notice. During the meetings, the Agency will provide an overview of the MMA Waiver and description of the amendment request and allow time for public comments. Table 1 provides the schedule of public meetings to be held regarding the proposed amendment.

Table 1 Schedule of Public Meetings		
Location	Date	Time
Orlando University of Central Florida College of Medicine Lewis Auditorium Health Sciences Campus 6850 Lake Nona Blvd Orlando, FL 32827-7408 Conference Call in # 1-877-809-7263 Participant Code #498 365 37	April 29, 2015	2:00pm – 4:00pm
Miami Agency for Health Care Administration 8333 NW 53rd Street Suite 200 Doral, FL 33166 Conference Call in # 1-877-299-4502 Participant Code 229 029 90#	April 30, 2015	2:00pm – 4:00pm
Tallahassee Agency for Health Care Administration 2727 Mahan Drive Building 3 Conference Room A Tallahassee, FL 32308 Conference Call in #1-877-299-4502 Participant Code #265 591 27#	May 1, 2015	2:00pm – 4:00pm

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 7 days before the workshop/meeting by contacting Heather Morrison at (850) 412-4034 or by email at Heather.Morrison@ahca.myflorida.com.

If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1 (800) 955-8771 (TTY) or 1 (800) 955-8770 (Voice).

E. Public Notice Document Made Available to the Public

The Agency will post on its website (link provided on page 5) beginning April 21, 2015 through May 22, 2015, this public notice document, the approved MMA Waiver documents (STCs of the waiver and the waiver and expenditure authorities document) and the Florida law (Part IV of Chapter 409, F.S.) that established the MMA program.

F. Submission of Written Comments

The Agency's website provides the public the option of submitting written comments on the amendment request by mail or email (address located below). In addition, the Agency will ask attendees of the public meetings to submit written comments.

Mail comments and suggestions to:

1115 MMA Amendment Request
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

The public may also e-mail comments and suggestions to:

FLMedicaidWaivers@ahca.myflorida.com

III. Redesigned LIP Program Overview

The State is requesting authority for the redesigned LIP program which shares some characteristics with the existing program, but has been adjusted in key areas to support federal and state goals. The general structure is similar to the current model, which contains several categories that target different provider access systems using different criteria and methodologies for fund allocation. However, the core categories that target access to hospital services particularly, LIP 4 – 6, have been redesigned with the addition of a new LIP 7 category. The approximately \$1.7 billion included in these categories generally targets hospitals that have historically served low income and vulnerable populations, and are expected to bear the brunt of residual uncompensated care cost when all coverage opportunities are considered. Florida believes this level of funding is supported by the Urban Institute estimate ³that Florida would continue to experience significant levels of uncompensated care if all coverage components of the ACA were implemented.

Of particular note is the reallocation of funds from LIP 6 to LIP 4 and the addition of the new category LIP 7. These changes are designed to reduce the linkage between local funding and fund distribution that was inherent in the legacy rate enhancement system and the DY9 LIP 6 transition funding. Some funds remain in LIP 6 as a continued transition through DYs 10 and 11. Legislation that would implement this model has been proposed, and can be found the following link:

http://ahca.myflorida.com/medicaid/statewide_mc/pdf/mma/Florida_Senate_Medicaid_Hospital_Funding_Programs_Packet_2015-04-01.pdf

In addition to the restructured funding in this amendment request, the State expects to enhance reporting on LIP program activities and funding to improve transparency and facilitate understanding of this critical funding stream. The State is committed to working with CMS on the details of the types of reporting that will accomplish these goals.

The following table provides the funding for the redesigned LIP program with a description of the different subcomponents provided in the narrative.

Table 2 LIP Overview	
Special LIP	\$115,742,353
LIP 4	\$1,249,597,300
LIP 5	\$2,419,573
LIP 6	\$244,372,316
LIP 7	\$233,719,378
Other Provider Programs	\$321,867,421
Total	\$2,167,718,341

³ <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412485-State-Progress-Toward-Health-Reform-Implementation-Slower-Moving-States-Have-Much-to-Gain.PDF>.

A. Special LIP Summary

Special LIP is a subcomponent within the LIP program that designates funding to cover certain hospital provider type access systems, with associated requirements 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. This component of the LIP program is proposed to continue in similar fashion as it does in the current program.

- Rural hospital LIP distributions are provided to statutorily defined rural hospitals. These facilities ensure access to medical care for individuals in the state's rural areas.
- Trauma hospital LIP distributions are provided to hospitals that have designated or provisional trauma centers.
- Safety-net hospital LIP distributions are provided to safety-net hospitals to help ensure critical access to medical care throughout the state.
- Hospital Specialty Pediatric LIP distributions are made to free-standing children's hospitals.
- Funding for hospitals that meet specific quality measures. These hospital distributions are provided for the specialty children's hospitals based on an allocation methodology incorporating both quality and core measures as well as 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

B. LIP 4 Hospital Provider Access Systems

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 program and former exemption programs. Distributions in LIP 4 are contingent upon a Letter of Agreement (LOA) between the Agency and the local government.

C. LIP 5 Distribution Pool

The LIP funds in the LIP 5 category are provided to statutorily defined rural hospitals that ensure access to medical care for those individuals in the rural parts of Florida, where access can be particularly challenging. Rural hospitals that receive this distribution report a combined uncompensated care amount of \$66.8 million based on the reported FY 2013 FHURS data.

D. LIP 6 Distribution Pool

The LIP 6 category was added in DY9 to accommodate funding that had previously been associated with self-funded rate enhancements. The LIP program funds in this new LIP 6 category are significantly reduced from the current program to reduce the linkage between

distributions and direct local government contribution, one of the primary goals of the redesign. Residual funding in this category is left in place to assist with a two year transition.

E. LIP 7 Distribution Pool

The funds in LIP 7 are provided for hospitals that target areas with particular access challenges. This distribution is not linked to the amount of local government contributions an individual hospital provides. Hospitals will participate in one of four groups based on the defined criteria below:

- Essential Community Providers (ECP) as defined by 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 – Any hospital not included in Groups 1 through 3.

F. Other Provider Programs

Other LIP Provider programs is a component within the LIP program that designates funding to cover mostly non-hospital provider type access systems that play critical roles in maintaining health care access and quality for low income populations. This component of LIP program is proposed to continue in similar fashion as it does in the current program.

- Teaching Physicians – 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. This funding is necessary to sustain needed practical training to the physician work force which is important to access to care, and even more critical as more Floridians gain coverage through newly available opportunities. These distributions are for medical schools that meet participation requirements in the LIP program.
- Primary Care Initiatives – Funds are provided to make payments to Federally Qualified Health Centers (FQHCs), County Health Departments, county and local community initiatives. These payments support primary care services in medically underserved areas targeting low-income, uninsured, and underinsured individuals, as well as providing funding towards ER diversion programs.
- Tier-one Milestone Distributions have been required by the STCs for several years and are proposed to continue in similar fashion to the current program. The CMS Tier-one Milestone 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 programs will be required to create new or enhance 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.

- Premium Assistance Programs – Funds are provided to make health insurance premium payments for low-income residents enrolled in the Premium Assistance Programs.
- Poison Control Programs – Funds are provided to make LIP payments to hospitals providing poison control programs.

G. Participation Requirements

All provider access systems who will receive LIP funds will be required to meet certain participation requirements as a condition of receiving funds. Participation will be tested on a quarterly basis. Exemptions to the requirements may be granted by the State if a hospital can provide documentation that demonstrates a good faith effort was made in contract negotiations.

a. Hospitals.

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

IV. Budget Neutrality

A. Budget Neutrality Compliance

The Agency is required to provide financial data demonstrating the detailed and aggregate historical expenditures, and project budget neutrality status for the requested waiver extension period (July 1, 2015 – June 30, 2017) and cumulatively over the lifetime of the waiver. The Agency is also required to provide up-to-date responses to the Federal CMS Financial Management standard questions. The following addresses the items specified above and documents that the waiver is budget neutral.

1. General Budget Neutrality Requirements

A requirement of any 1115 Research and Demonstration Waiver is that the program must meet a budget neutrality (BN) test and provide documentation that the demonstration did not cost the program more than would have been experienced without the waiver. In addition, prior to an extension of the 1115 waiver, a projection and extension of new budget neutrality benchmarks using rebased trends must be provided for the requested waiver extension period.

The established STCs of the 1115 MMA Waiver, as agreed upon by the State and CMS, are provided in the approved waiver document. To comply with the STCs, the Agency must pass the budget neutrality “test” as well as provide quarterly reporting of the expenditures and member months for the waiver, which is used to monitor the budget neutrality. Florida’s 1115 MMA Waiver is budget neutral and is in compliance with all STCs specific to budget neutrality.

2. Florida’s 1115 Research and Demonstration Waiver

This amendment impacts the LIP program, which is Medicaid Eligibility Group (MEG) 3, of the 1115 Research and Demonstration Waiver. For MEGs 1 and 2, the State is in substantial compliance with BN as indicated in the CMS final approved BN for the 2014 Extension, and no changes are being made to those MEGs.

MEG 3 was established in the initial waiver application as approved by Federal CMS. The MEG is also referred to as the LIP program and is not directly linked to Medicaid eligibility. Expenditures for the LIP program are authorized to provide services to the uninsured and underinsured. Distributions to qualifying providers under the LIP program are determined by the type of facility and services, as well as the volume of Medicaid days in addition to allowable uninsured and underinsured expenditures incurred in previous operating years. Payments to providers are not paid through the claims processing system, but are lump sum payments made directly to the provider to offset the allowable uncompensated services. The limit for the LIP program is established in the BN and is reported in accordance with the requirements of the STCs of the waiver specific to BN. However, the program requirements and monitoring are subject to the STCs of the waiver established for the LIP program.

To provide for Florida’s Medicaid, underinsured and uninsured populations, the Agency is seeking LIP program funding of \$2.16 billion to be maintained for the upcoming waiver extension period of July 1, 2015 through June 30, 2017.

The LIP program expenditures are not included in the calculation of per-member per-month (PMPM) for the budget neutrality test.

Table 3 below provides MEG 3 (LIP) cumulative expenditures for each Demonstration Year beginning with DY1 (July 1, 2006 – June 30, 2007) through DY9, Quarter 2 (October 1, 2014 – December 31, 2014).

Table 3			
MEG 3 Total Expenditures: Low Income Pool			
DY*	Total Paid	DY Limit	% of DY Limit
DY1	\$998,806,049	\$1,000,000,000	99.88%
DY2	\$999,632,926	\$1,000,000,000	99.96%
DY3	\$877,493,058	\$1,000,000,000	87.75%
DY4	\$1,122,122,816	\$1,000,000,000	112.21%
DY5	\$997,694,341	\$1,000,000,000	99.77%
DY6	\$807,232,567	\$1,000,000,000	80.72%
DY7	\$1,019,291,544	\$1,000,000,000	101.93%
DY8	\$1,156,397,442	\$1,000,000,000	115.64%
DY9	\$690,421,416	\$2,167,718,341	31.85%
Total MEG 3	\$8,669,092,159	\$10,167,718,341	85.26%

The projection of budget neutrality benchmarks for the requested period of July 1, 2015 - June 30, 2017 for the redesigned LIP program is included in the following table.

Table 4	
LIP Benchmark	
DY	MEG 3
DY10	\$2,167,718,341
DY11	\$2,167,718,341

B. Financial Management Standard Questions

1. Section 1903(a)(1) of the Act provides that Federal matching funds are only available for expenditures made by states for services under the approved state plan. Do providers receive and retain the total Medicaid expenditures claimed by the state (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the state, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the state (i.e., general fund, medical services account, etc.)

Response: Providers retain 100 percent of all payments made relating to this program. If an error occurs and payments are returned to the State, the State will track and report appropriately. The federal share is calculated and returned to CMS.

2. Section 1902(a)(2) of the Act provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and state share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

- (i) a complete list of the names of entities transferring or certifying funds;
- (ii) the operational nature of the entity (state, county, city, other);
- (iii) the total amounts transferred or certified by each entity;
- (iv) clarify whether the certifying or transferring entity has general taxing authority; and,
- (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Response: Florida Medicaid provides payments to institutional providers through per diem rates except for hospital inpatient which is through DRG payments. The State's share of payments is appropriated by the Florida Legislature from the State's general revenue, public medical assistance trust fund and through intergovernmental transfers. Each year the state estimates expenditures for the upcoming year by applying an inflationary factor to current year payments as well as making adjustments for estimated changes in caseload and utilization. The estimated expenditures are adopted by the Social Services Estimating

Conference and ultimately approved by the Florida Legislature in the General Appropriations Act (GAA).

3. Section 1902(a)(30) of the Act requires that payments for services be consistent with efficiency, economy and quality of care. Section 1903(a)(1) of the Act provides for Federal financial participation to states for expenditures for services under an approved state plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

Response: No supplemental Special Medicaid Payments (SMP) are being made in addition to provider Medicaid reimbursement rates. The only additional payments being made to hospital providers are those payments permitted through the Low Income Pool (LIP) program and the disproportionate share (DSH) program, for the continuation of government support for services to low income and vulnerable populations.

4. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (state owned or operated, non-state government owned or operated and privately owned or operated). Please provide a current (i.e. applicable to current rate year) UPL demonstration.

Response: On March 18, 2013, Federal CMS issued a State Medicaid Director's Letter (SMDL #13-003) describing the mutual federal and state obligations and accountability on the part of the state and federal governments for the integrity of the Medicaid program. Among the obligations included: ongoing consistency with the applicable federal UPL requirements described in regulation for certain services. The regulations implement, in part, section 1902(a)(30)(A) of the Act which requires that Medicaid rates are consistent with efficiency, economy and quality of care. Starting in 2013, states are required to submit UPL demonstrations on an annual basis. Previously this information was collected or updated only when a state was proposing an amendment to a reimbursement methodology in its Medicaid state plan. Beginning in 2013, states must submit UPL demonstrations for inpatient hospital services, outpatient hospital services and nursing facilities.

For Florida State Fiscal Year 2014-15, the UPL analysis involves estimating Medicare payment for a set of Medicaid claims and comparing those payments to actual payments made by Medicaid. The claim data and hospital Medicare cost data are aligned so that they are from the same time frame. In addition, inflation factors are applied as appropriate to make payment and cost amounts comparable under the same time frame. Also if appropriate, other adjustments may be made to the baseline claim data to align with Medicaid program changes that have occurred between the timeframe of the baseline claim data and the UPL rate year.

Comparisons of Medicaid payments to estimated Medicare payments (the UPLs) are made separately for hospital inpatient and outpatient services. Also, the comparisons are made for three categories of providers: (1) state owned (2) non-state government owned; and (3) privately owned hospitals.

A UPL analysis has been completed to accompany both the SFY 2014-15 inpatient and outpatient reimbursement state plan amendments.

Estimated Medicare payments which determine the UPL were calculated using a detailed costing method. For each hospital, information extracted from Medicare cost reports were

used to calculate cost-based per diems for each routine cost center and cost-to-charge ratios for each ancillary cost center. In addition, a mapping of revenue codes to cost centers was created. This mapping allowed a cost center to be identified for each claim detail line based on the revenue code submitted on the line. Costs on detail lines that mapped to routine cost centers were calculated by multiplying the cost center's cost per diem times the number of applicable days indicated on the line. Costs on detail lines that mapped to ancillary cost centers were calculated by multiplying the charges on the line by the cost center's cost-to-charge ratio. Total costs on all claim lines for a provider were summed to get the UPL amount per provider and then summed by category of provider to get the UPL amount for the three UPL categories: state-owned, non-state government owned, and privately owned (all others).

The UPL for each of the three UPL categories was calculated using the detailed costing demonstration method. For each hospital, information extracted from Medicare cost reports was used to calculate cost-based per diems for each routine cost center and cost-to-charge ratios for each ancillary cost center. Standard cost centers as defined by CMS were used. In addition, a mapping was created to assign revenue codes to cost centers. This allowed each claim detail line item to be assigned a cost center. Hospital costs on detail lines that mapped to routine cost centers were calculated by multiplying the cost center's cost per diem times the number of applicable days indicated on the line. Hospital costs on detail lines that mapped to ancillary cost centers were calculated by multiplying the charges on the line by the cost center's cost-to-charge ratio. The hospital cost amounts on all the claim lines for a hospital were summed to get the total cost for the hospital, and total hospital cost was used as the upper payment limit.

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to Federal CMS on the quarterly expenditure report?

Response: Payments to providers would not exceed reasonable costs of providing services. This redesigned LIP program may require further discussion and re-definition of the methodology for calculating "reasonable costs". If payments do exceed reasonable cost of providing services, the provider must return the excess amount to the State. Once the State has received the returned funds, appropriate documentation is made and the federal share is calculated and returned to Federal CMS. The excess is returned to the state and the Federal share is reported on the 64 Report to Federal CMS.

V. Quality and Evaluation

A. Overview of Quality

The primary focus of the proposed amendment for a restructured LIP program is around maintaining access for low income populations in Florida. While the level of uninsurance and uncompensated care may decline with the implementation of the ACA, experts estimate a significant level of uncompensated care will remain. LIP program funds assist in maintaining critical access to health care for populations unable to afford the cost of care out of pocket. In addition to the focus on access, the proposed LIP program includes quality initiatives related to encouraging primary care, reducing unnecessary emergency room visits, and preventing unnecessary hospital readmissions through better discharge planning and patient follow up.

B. Overview of Independent Evaluation

The Agency proposes revising Domain 5 to reflect the redesign of the LIP program. The research questions and analyses for Domains 6-9 will be continued as these areas are ongoing and continue to be relevant to the quality improvement activities supported by LIP funding.

Domain 5 – The effect of the LIP program: (1) the funding of the number of people receiving services from, and the number of services being provided, by providers in LIP Pools 4, 5, 6, and 7, that would otherwise be uncompensated; (2) the funding of teaching physicians on the physician workforce for the future; and 3) provider participation in the Event Notification Service and its impact on improving care coordination and outcomes for patients served by those providers.

Analyses for this redesigned domain will include examining and describing the number of people receiving services, and the numbers and types of services provided by providers receiving LIP funds through Pools 4, 5, 6, and 7, that would otherwise be uncompensated. Analyses will also look at how many physicians are being trained through the funding of teaching physicians and in what area of medicine (e.g., primary care, particular specialties). The impact of participation in the Event Notification Service will be examined in terms of LIP provider participation, Medicaid managed care plan participation, and how the managed care plans are using the Event Notification Service to follow up with and better coordinate care for enrollees who have been served by the hospitals receiving LIP funding.

Domain 6 – The effect of LIP funding on disparities in the provision of health services, both geographically and by population groups.

Domain 7 – The impact of Tier-One milestone initiatives on access to care and quality of care (including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity).

Domain 8 – The impact of LIP funding and Tier-One milestone initiatives on population health.

Domain 9 – The impact of LIP funding and Tier-One milestone initiatives on per-capita costs (including Medicaid, uninsured, and underinsured populations) and the cost-effectiveness of care.

VI. Program Objectives

This section of the document provides a description of the program objectives of this amendment waiver.

A. Program Objectives

The program objectives of this waiver amendment are to redesign the LIP program to ensure that it meets the continuing needs of low income and vulnerable populations in Florida, while adapting to the changing health care delivery environment brought about through ACA implementation. The redesigned program presented here considers the findings of Navigant Consulting, Inc., in its February 27, 2015 study of hospital financing in Florida, as well as subsequent discussions between the State and CMS. Safety net hospitals, rural hospitals, trauma centers, and other provider access systems that have historically played a critical role in serving the Medicaid and uninsured populations will continue to do so, and significant amounts of uncompensated care are expected to be incurred, despite all coverage opportunities available under the ACA.

This redesigned LIP program targets funding more broadly over hospitals that provide care to vulnerable populations, as compared to the current LIP program. It is paired with a general increase in hospital payments in the Medicaid program, which also more broadly disperses payment and strengthens the proportion of hospital payment directly related to Medicaid utilization. Finally, it continues to include funding for teaching physicians and other provider types that have unique and critical roles in the health care system that cannot be fully addressed through market-based payments.

The State recognizes that a significant additional objective associated with the redesigned LIP is enhanced reporting of LIP activities and fund flows. Florida expects details of those enhancements to be developed jointly between the State and CMS over the coming months.

VII. Waiver and Expenditure Authorities

The following waiver and expenditure authorities document was issued by CMS on July 31, 2014.

WAIVERS FOR FLORIDA'S MANAGED MEDICAL ASSISTANCE SECTION 1115 DEMONSTRATION

NUMBER: 11-W-00206/4

TITLE: Managed Medical Assistance Program

AWARDEE: Agency for Health Care Administration

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project.

The following waivers are granted under the authority of section 1115(a)(1) of the Social Security Act (Act) and shall enable the State to implement the Florida Managed Medical Assistance Program section 1115 demonstration (formerly titled Medicaid Reform) consistent with the approved Special Terms and Conditions (STCs). These waivers are effective beginning July 31, 2014, through June 30, 2017.

Title XIX Waivers

1. Statewideness/Uniformity

Section 1902(a)(1)

To enable Florida to operate the demonstration and provide managed care plans or certain types of managed care plans, including provider sponsored networks, only in certain geographical areas.

2. Amount, Duration, and Scope and Comparability

Section 1902(a)(10)(B) and 1902(a)(17)

To enable Florida to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, based on differing managed care arrangements, or in the absence of managed care arrangements, as long as the benefit package meets certain actuarial benefit equivalency and benefit sufficiency requirements. This waiver does not permit limitation of family planning benefits. (Also this waiver is to permit Florida to offer different benefits to demonstration Population A than to the categorically needy group, through June 30, 2015.)

3. Income and Resource Test

Section 1902(a)(10)(C)(i)

To enable Florida to exclude funds in an enhanced benefit account from the income and resource tests established under state and federal law for purposes of determining Medicaid eligibility. This authority expires on June 30, 2015.

4. Freedom of Choice Section

1902(a)(23)(A)

To enable Florida to require mandatory enrollment into managed care plans with restricted networks of providers. This does not authorize restricting freedom of choice of family planning providers.

**EXPENDITURE AUTHORITIES FOR FLORIDA'S
MANAGED MEDICAL ASSISTANCE SECTION 1115 DEMONSTRATION**

NUMBER: 11-W-00206/4

TITLE: Managed Medical Assistance Program

AWARDEE: Agency for Health Care Administration

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall, for the period of this demonstration from July 31, 2014, through June 30, 2017, be regarded as expenditures under the state's Title XIX plan.

The following expenditure authorities shall enable Florida to operate the Florida Managed Medical Assistance program section 1115 demonstration (formerly titled Medicaid Reform).

1. **Demonstration Population A.** Expenditures for health care related costs not to exceed the amount of the individual's enhanced benefit account, for individuals who lose eligibility for Medicaid or demonstration Population A benefits. This expansion population shall be allowed to retain access to the enhanced benefits account for up to 1 year, except in the instance of termination of the demonstration. This authority expires June 30, 2015.
2. Expenditures for payments to managed care organizations, in which individuals who regain Medicaid eligibility within six months of losing it may be re-enrolled automatically into the last plan in which they were enrolled, notwithstanding the limits on automatic re-enrollment defined in section 1903(m)(2)(H) of the Act.
3. Expenditures made by Florida for uncompensated care costs incurred by providers for health care services to uninsured and or underinsured, and associated projects to support such care, subject to the restrictions placed on the Low Income Pool, as defined in the STCs. This authority expires June 30, 2015.
4. Expenditures for benefits under the enhanced benefits account program. This authority expires June 30, 2015.
5. Expenditures for the Program for All Inclusive Care for Children services and the Healthy Start program as previously approved under the 1915(b) waiver (control #FL-01) and as described in STCs 64 and 65.

Medicaid Requirements Not Applicable to the Expenditure Authorities:

Through June 30, 2015, in order to permit the demonstration project to function as amended, in addition to and/or consistent with previously approved waiver and expenditure authorities described above, the following Medicaid requirements are not applicable to the expenditure authorities:

1. Provision of Medical Assistance

Section 1902(a)(10)(A)

To enable Florida to limit the medical assistance for demonstration Population A (individuals

who lose eligibility for Medicaid or demonstration Population A benefits) to health care related costs not to exceed the amount of the individual's enhanced benefit account.

2. Amount, Duration, and Scope and Comparability

**Section 1902(a)(10)(B)
and 1902(a)(17)**

To enable Florida to vary the amount, duration, and scope of benefits offered to demonstration Population A from that offered to other beneficiaries under the plan, and to enable benefits for Population A to be non-comparable to those offered to the categorically needy group.

3. Provider Agreements Section 1902(a)(27)

To permit the provision of care by entities who have not executed a provider agreement with the State Medicaid Agency for the purpose of providing enhanced benefits under the enhanced benefits account program

Appendix A

Letters to the Miccosukee Tribe and the Seminole Tribe



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

April 20, 2015

Ms. Connie Whidden, MSW
Health Director
Seminole Tribe of Florida
3006 Josie Billie Avenue
Hollywood, FL 33024

Dear Ms. Whidden:

This letter is being sent to notify the Seminole Tribe of Florida that the State of Florida plans to submit an amendment to Florida's 1115 Managed Medical Assistance Waiver to the Centers for Medicare and Medicaid Services. The proposed amendment will extend the funding for the Low Income Pool for from July 1, 2015 to June 30, 2015. A full description of the proposed amendment is located on the Agency for Health Care Administrations (Agency) website at the following link:

http://ahca.myflorida.com/medicaid/statewide_mc/mma_fed_auth_amend_waiver_2015-04.shtml

The Agency will conduct a 30-day public notice and comment period prior to the submission of the proposed amendment request to CMS. The 30-day public notice and public comment period will begin April 21, 2015 through May 22, 2015. The Agency has scheduled three public meetings to solicit meaningful input on the proposed waiver amendment from the public. The meetings will be held in:

- Orlando, Florida on April 29, 2015, 2:00 p.m. – 4:00 p.m. at the University of Central Florida, College of Medicine, Lewis Auditorium Health Sciences Campus, 6850 Lake Nona Blvd, Orlando, FL 32827. To participate by phone, please call 1(877)809 - 7263 and enter the participant passcode: 498 365 37#.
- Miami, Florida on April 30, 2015, 2:00 p.m. – 4:00 p.m. at the Agency for Health Care Administration, 8333 NW 53rd Street, Suite 200, Doral, FL 33166. To participate by phone, please call 1-877-299-4502 and enter the participant passcode: 229 029 90#.
- Tallahassee, Florida on May 1, 2015, 2:00 p.m. – 4:00 p.m. at the Agency for Health Care Administration, 2727 Mahan Drive Building 3, Conference Room A, Tallahassee, FL 32308. To participate by phone, please call 1 877 299.4502 and enter the participant passcode: 265 591 27#.

If you have any questions about this amendment or would like to hold a call please contact Heather Morrison of my staff via email at Heather.Morrison@ahca.myflorida.com or by phone at (850) 412-4034.

Sincerely,

/s/

Justin M. Senior
Deputy Secretary for Medicaid



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

April 20, 2015

Ms. Cassandra Osceola
Health Director
Miccosukee Tribe of Florida
P.O. Box 440021, Tamiami Station
Miami, FL 33144

Dear Ms. Osceola:

This letter is being sent to notify the Miccosukee Tribe of Florida that the State of Florida plans to submit an amendment to Florida's 1115 Managed Medical Assistance Waiver to the Centers for Medicare and Medicaid Services. The proposed amendment will extend the funding for the Low Income Pool for from July 1, 2015 to June 30, 2015. A full description of the proposed amendment is located on the Agency for Health Care Administrations (Agency) website at the following link:

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Sincerely,

/s/

Justin M. Senior
Deputy Secretary for Medicaid