Agenda Item 8

Florida Medicaid Reform
Reimbursement and Funding Methodology Document
CMS Comments

1. **Section II C (Provider access system category three….hospitals in communities where local government provides more than $1M.)** The State indicates that hospitals will be capped at 120 percent of the amount of local funding it would have received from its local government. How does the State determine the amount that the local provider would have provided?

2. **Section II F (Distributions to Federally Qualified Health Centers.)** Has OCHA and the Florida Department of Health determined the methodology for how FQHCs can qualify for the $15.3 million in LIP funds being allocated? Can the State clarify the reasoning for making LIP payments to FQHCs?

3. **Section III A, 4 g– (Hospital underinsured and uninsured costs.)** The State indicates that providers may incur costs that are strictly for programs of services furnished to uninsured and underinsured patients. Does the State intend to include any "State only" insurance products or programs in this category of costs eligible for reimbursement?

4. **Section III B, 1 a – (Expenditures for non-hospital providers.)** Can the State specifically identify in the document what entities and providers are being classified as "non-hospital providers and eligible for LIP payments under this methodology?

5. **Section III B, 1 a – (Expenditures for non-hospital providers.)** In establishing costs for providers filing Medicare-only cost reports, the State describes a methodology utilizing the average Medicare per patient visit multiplied by the number of Medicaid visits. Can the State explain how such Medicaid encounter data would be accumulated and reported?

6. **Section III B, 1 b – (Expenditures for non-hospital providers.)** The State has identified (in sections c, d and e) a proposal for calculating distribution, but these allocations don't seem to be directed toward costs. If the State is proposing that its reconciliation process will capture the actual costs of these providers than the proposed methodologies work as interim payments. How does the State propose to reconcile if it cannot capture the costs for these types of providers?

7. **Section IV C – (Shortfall for Medicaid, Uninsured, and Underinsured costs.)** The State has indicated that all provider types will be required to complete the LIP Cost Limit Calculation worksheet. Non-hospital providers will be required to submit a Permissible Expenditures Certification Form to provide some level of accountability and assurance. How often and to what level of detail does the State intend to review and audit submissions from non-hospital providers?

8. **Section V A – (Planning and Reconciliation.)** The State is indicating that distributions will be made monthly or quarterly and could vary by provider type. What is the distribution schedule that the State has decided upon for each type of provider?

9. **Section V B – (Planning and Reconciliation.)** The reconciliation process indicates the cost limit for each provider will be determined during the first quarter of the State fiscal year. Payments will then be made as long as there is a positive remaining balance of the LIP Cost Limit. Will there be a final reconciliation each year (for each provider) based upon LIP payments made during a State fiscal year compared to the provider costs incurred during that same fiscal year?

10. As outlined in the Special Terms and Condition paragraph 101, the final Reimbursement and Funding Methodology document must include a reporting methodology for the number of individuals and types of services provided through the LIP. Can the State provide a draft of its proposed methodologies to meet this requirement?

11. Has the State identified the "source of funds" for the $4.9 million in funds noted as "undetermined" in the State's correspondence of June 1, 2006?