Low Income Pool Program- Brief Overview

On October 19, 2005, the Centers for Medicare and Medicaid Services (CMS), approved the 1115 Research and Demonstration Waiver Application for the State of Florida, relating to Medicaid reform. The Florida Legislature passed House Bill (HB) 3B on December 8, 2005, authorizing the implementation of the waiver effective July 1, 2006. In the Waiver Special Terms and Conditions (STC), #91, the Low Income Pool (LIP) is "established to ensure continued government support for the provision of health care services to Medicaid, underinsured and uninsured populations. The low-income pool consists of a capped annual allotment of $1 billion total computable for each year of the 5 year demonstration period." The parameters of LIP are defined in STCs 91 through 106.

STC #94 states that "LIP funds may be used for health care expenditures (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act. These health care expenditures may be incurred by the State, by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services for the uninsured, Medicaid shortfall (after all other Title XIX payments are made), may include premium 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." A Provider Access System is further clarified, in the Reimbursement and Funding Methodology document (May 29, 2007 submission, page 5);

> *Entities such as hospitals, clinics, or other provider types and entities designated by Florida Statute to improve health services access in rural communities, which incur uncompensated medical care costs in providing medical services to the uninsured and underinsured, and which receive a Low Income Pool (LIP) payment shall be known as Provider Access Systems. Provider Access Systems funded from the LIP shall provide services to Medicaid recipients, the uninsured, and the underinsured. Provider Access*
> *Systems shall be required to report data related to the number of individuals served and the types of services provided from the LIP funding.*

In accordance with STC #93 and #100, the State submitted to CMS, on June 26, 2006, the Reimbursement and Funding Methodology document for LIP expenditures, which included the definition of expenditures eligible for federal matching funds under the LIP and entities eligible to receive reimbursement. Subsequently, there have been multiple revisions and resubmissions of The Reimbursement and Funding Methodology document. LIP Provider Access System categories and qualifying criteria for participation are described in greater detail in the Reimbursement and Funding Methodology document. Funding for the state, non-federal share of the LIP program is provided through local government entities, such as counties and hospital taxing districts, and other state agencies (see Table 6 of the LIP model).

As one of the conditions of the LIP, the hospital inpatient Upper Payment Limit (UPL) program was terminated. The UPL program was effective from SFY 2000-01 through SFY 2005-06 and included only hospitals. The LIP program allows for the continued support to many hospitals that may have participated in the UPL, in addition to over 60 additional hospitals that were not UPL participants. LIP hospitals are included as the LIP Provider Access Systems. In addition to hospitals, other entities such as Federally Qualified Health Centers (FQHCs), County Health Departments (CHDs), and the St Johns River Rural Health Network (SJRRHN), are included as LIP Provider Access Systems.

The Provider Access Systems are required to annually submit expenditure documents to the Agency to confirm the LIP distributions are not in excess of the provider's shortfall costs for serving Medicaid, underinsured, and uninsured populations. In addition, the Provider Access Systems must document the numbers and types of services provided with LIP funding.