

XIV. LOW INCOME POOL

1. **Low Income Pool Definition.** The LIP ensures continued government support for the safety net providers that furnish uncompensated care to the Medicaid, underinsured and uninsured populations. The LIP is also designed to establish new, or significantly enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations. Initiatives must broadly drive from the three overarching goals of CMS' Three-Part Aim as described in paragraph 70(a). The LIP consists of a capped annual allotment of \$1 billion total computable for each year of the Demonstration extension.
2. **Availability of Low Income Pool Funds.** Funds in the LIP are available to the State on an annual basis subject to any penalties that are assessed by CMS for the failure to meet milestones as discussed in Section XV "Low Income Pool Milestones". Funds available through the LIP may be reduced to recoup payments made to providers that are determined by CMS to have been made in excess of allowable costs. Any necessary recoupments will be achieved through a reduction of FFP claimed against current LIP payments. Available funds not distributed in a DY may be rolled over to the next DY. All LIP funds must be expended by June 30, 2014. LIP dollars that are lost as a result of penalties or recoupment are surrendered by the State and not recoverable.
3. **LIP Reimbursement and Funding Methodology.** LIP permissible expenditures defining State authorized expenditures from and entities eligible to receive LIP reimbursement are defined in the Reimbursement and Funding Methodology document dated June 26, 2009. This document limits LIP payments to allowable costs incurred by providers and requires the State to reconcile LIP payments to auditable costs. CMS is currently working with the State on reconciliations for DY 1, 2, and 3. Reconciliations for DY 4 and 5 are not yet available. CMS and the State will finalize DY 1, 2, and 3 reconciliations within 60 days of the acceptance of these STCs. DY 4 reconciliations are due by January 1, 2012. DY 5 reconciliations are due by January 1, 2013.

If the reconciliations for DY 1, 2, and 3 identify LIP payments in excess of allowable cost consistent with paragraph 63 and the Reimbursement and Funding Methodology document implementing the LIP, the State must modify the Reimbursement and Funding Methodology applicable to DY 6 to ensure that payments under the LIP are consistent with the LIP goals and that providers will not receive payments that exceed their costs utilizing the cost reconciliation information to inform payment methodology modifications. CMS will also work with the State to identify modifications to the Methodology to address any cost documentation or audit processes necessary to fully meet cost reconciliation requirements. Any changes required by CMS will be applied prospectively to payments and audits for DY 6. The State may claim LIP payments based on the existing Methodology during the 60 day reconciliation finalization period. Claims after that period can only be made on the modified final Reimbursement and Funding Methodology approved by February 1, 2012. Changes to the Reimbursement

and Funding Methodology document requested by the State must be approved by CMS and are only approved for DY 6 LIP expenditures.

DY 4 reconciliation results will be reflected in the Reimbursement and Funding Methodology document for DY 7. If the final reconciliations for DY 4 result in a finding that payments were made in excess of cost, the Reimbursement and Funding Methodology must be further modified to ensure that payments in DY 7 will not result in payments in excess of allowable cost particularly methodologies that provide payments to providers that have received payments during the prior demonstration period in excess of allowable costs as defined in paragraph 63 and the Reimbursement and Funding Methodology. Any required modifications to the DY 7 annual Reimbursement and Funding Methodology document must be approved by CMS before FFP will be made available for DY 7 LIP pool payments.

DY 5 reconciliation results will be reflected in the Reimbursement and Funding Methodology document for DY 8. If the final reconciliations for DY 5 result in a finding that payments were made in excess of cost, the Reimbursement and Funding Methodology must be further modified to ensure that payments in DY 8 will not result in payments in excess of allowable cost, particularly methodologies that provide payments to providers that have received payments during the prior demonstration period in excess of allowable costs as defined in paragraph 63 and the Reimbursement and Funding Methodology. Any required modifications to the DY 8 annual Reimbursement and Funding Methodology document must be approved by CMS before FFP will be made available for DY 8 LIP pool payments.

The State shall by February 1, 2012 and each successive February 1st of the renewal period, submit a protocol to ensure that the payment methodologies for distributing LIP funds to providers supports the goals of the LIP as described in paragraph 60 and that providers receiving LIP payments do not receive payments in excess of their cost of providing services. FFP is not available for LIP payments until the protocol is finalized and approved by CMS.

4. **Low Income Pool Permissible Expenditures.** Funds from the LIP 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, 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.
5. **Low Income Pool Expenditures - Non-Qualified Aliens.** LIP funds cannot be used for costs associated with the provisions of health care to non-qualified aliens.

6. **Low Income Pool Permissible Expenditures 10 percent Sub Cap.** Up to 10 percent 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. 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 62.
7. **Low Income Pool Permissible Hospital Expenditures.** Hospital cost expenditures from the LIP will be paid at 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.
8. **Low Income Pool Permissible Non-Hospital Based Expenditures.** To ensure services are paid at cost, the Reimbursement and Funding Methodology document defines the cost reporting strategies required to support non-hospital based LIP expenditures.
9. **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 MILESTONES

10. **Aggregate LIP Funding.** At the beginning of each DY, \$1 billion in LIP funds will be available to the State. These amounts will be reduced by any milestone penalties that are assessed by CMS. Two tiers of milestones, as described in paragraph's 70 and 71, must be met for the State and facilities to have access to 100 percent of the annual LIP funds. Funds not distributed in a DY may be rolled over to the next DY.
11. **Tier - One Milestone.** Tier-one milestones are defined as follows:
 - a) Development and implementation of a State initiative that requires Florida to allocate \$50 million annually in LIP funding to establish new, or significantly enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations. Initiatives must broadly drive from the three overarching goals of CMS' Three-Part Aim.
 - i. Better care for individuals including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity;
 - ii. Better health for populations by addressing areas such as poor nutrition,

physical inactivity, and substance abuse; and,
iii. Reducing per-capita costs.

Expenditures incurred under this program must be permissible LIP expenditures as defined under Section XIV, Low Income Pool. The State will utilize DY 6 (7/1/2011 – 6/30/2012) to develop the program. The program must be implemented with LIP funds allocated and expenditures incurred in DY's 7 and 8 (7/1/2012 – 6/30/2013 and 7/1/2013 – 6/30/2014).

- 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. The State shall submit to CMS, within 30 days from the date of formal approval of the waiver extension request, a schedule for the completion of the LIP Provider Access Systems (PAS) reconciliations for the 3-year extension period. CMS will provide comments to the State on the reconciliation schedules within 30 days. The State will submit the final reconciliation schedule to CMS within 60 days of the original submission date.
- c) Timely submission of all Demonstration deliverables as described in the STCs including the submission of Quarterly and Annual Reports.
- d) Development and submission of an annual "Milestone Statistics and Findings Report" and a "Primary Care and Alternative Delivery Systems Expenditure Report". Within 60 days following the acceptance of the terms and conditions, the State must submit templates for these reports and anticipated timelines for report submissions.

CMS will assess penalties on an annual basis for the State's failure to meet tier-one milestones or components of tier-one milestones. Penalties of \$6 million will be assessed annually for each tier-one milestone that is not met. Penalties will be determined by December 31st of each DY and assessed to the State in the following DY. LIP dollars that are lost as a result of tier-one penalties not being met, are surrendered by the State.

12. **Tier-Two Milestones.** Tier-two milestones initiatives must drive from the three overarching goals of Three-Part Aim as described in paragraph 70(a). The initiatives will focus specifically on: infrastructure development; innovation and redesign; and population focused improvement. Participating facilities must implement new, or significantly enhance existing, health care initiatives, investments, or activities with the goal of meaningfully improving the quality of care and the health of populations served (including low income populations) and meet established hospital specific targets, to receive 100 percent of allocated LIP funding. Tier-two milestones apply to facilities that receive the largest annual allocations of LIP funds and put at risk 3.5 percent of each of these facilities annual LIP allocation. The milestones apply to the 20 hospitals which are allocated the largest annual amounts in LIP funding. If the total annual LIP funds allocated for the 20 hospitals, do not total at least \$700 million, the population of hospitals must be expanded until \$700 million is reached.

Hospitals will be required to select and participate in 3 initiatives. Depending on the

breadth of health care activities undertaken by a facility, CMS may consider exceptions to the requirement that three initiatives must be implemented.

Once a facility is identified as a top 20 hospital, it must continue to achieve milestones to receive future DY LIP funding regardless of whether it drops out of the top 20 category. Exceptions to this requirement may be considered by CMS. Hospitals entering the top 20 category in future DYs will be subject to timelines similar to program planning/success and execution timelines.

A top 20 hospital cannot select quality improvement initiatives under which it is currently receiving or may be eligible to receive other Federal dollars unless the LIP outcome goals are enhanced over previously established targets.

Within 90 days following the acceptance of the terms and conditions, CMS and the State will, through a collaborative process, finalize the plan and procedures including the specific health care initiatives, investments, and activities, and the applicable standards, measures, and evaluation measures and protocols that will allow for the implementation and monitoring of tier-two milestones and evaluation of the impact of these initiatives. The specific metrics chosen should support the measurements required in STC 89 (a)(viii-x). CMS must approve the final plan and procedures which will require that tier-two facilities receiving funds in SFY 2011-2012 must submit its milestone plan by March 31, 2012, including baseline data and outcome targets, to meet their DY 6 (SFY 2011-2012) tier-two milestone.

Hospital initiatives that can be implemented under tier-two milestones, which are tied to the Triple Aim, include the following and are drawn from recent demonstration experiences:

- a) Infrastructure Development – Investments in technology, tools and human resources that will strengthen the organization’s ability to serve its population and continuously improve its services. Examples of such initiatives are:
 - i. Increase in Primary Care capacity including residency programs and externships;
 - ii. Introduction of Telemedicine;
 - iii. Enhanced Interpretation Services and Culturally Competent Care; and,
 - iv. Enhance Improvement Capacity;
- b) Innovation and Redesign – Investments in new and innovative models of care delivery that have the potential to make significant, demonstrated improvements in patient experience, cost, and disease management. Examples of such initiatives are:
 - i. Expansion of Medical Homes;
 - ii. Primary Care Redesign; and,
 - iii. Redesign for Efficiencies (e.g. Program Integrity).
- c) Population-focused Improvement – Investments in enhancing care delivery for the 5 – 10 highest burden (morbidity, cost, prevalence, etc) conditions/services present for the population in question. Examples of such initiatives are:
 - i. Improved Diabetes Care Management and Outcomes;
 - ii. Improved Chronic Care Management and Outcomes;

- iii. Reduction of Readmissions;
- iv. Improved Quality (with attention to reliability and effectiveness, and targeted to particular conditions or high-burden problems);
- v. Emergency Department Utilization and Diversion;
- vi. Reductions in Elective Preterm Births; and,
- vii. PICU and NICU Quality and Safety (e.g. pediatric catheter associated blood stream infection rates).

Between December 1, 2011 and March 31, 2012, the tier-two milestone facilities receiving funds in SFY 2011-2012 must submit a plan/program including baseline data and outcome targets, to meet their DY 6 (SFY 2011-2012) tier-two milestone. Subsequent year LIP funds allocated to these hospitals will be made available based upon the successful execution of the facilities targeted health care initiatives.

The State must assess a penalty of 3.5 percent of a facility's annual LIP allocation for failing to meet tier-two milestones or components of tier-two milestones. Penalties, if applicable, will be determined by December 31st of each DY (with the exception of DY 6, which will be determined by March 31, 2012) and assessed to the facility in the remaining 6 months of the same DY. LIP dollars that are not paid out as a result of tier-two milestones not being met, are surrendered by the facility and State.

XVIII. EVALUATION OF THE DEMONSTRATION

89. **Submission of Draft Evaluation Design.** The State must submit to CMS for approval, within 120 days from the award of the Demonstration, a draft evaluation design. At a minimum, the draft design must include a discussion of the goals, objectives and specific hypotheses that are being tested, including those that focus specifically on target populations for the Demonstration.
- a) Domains of Focus – The State must propose as least one research question that it will investigate within each of the domains listed below. The research questions should focus on processes and outcomes that relate to the CMS Three-Part Aim of better care, better health, and reducing costs. With respect to domains viii, ix, and x, the State must propose two research questions under each domain (one each from Tier-One and Tier-Two milestones).
 - i. The effect of managed care on access to care, quality and efficiency of care, and the cost of care;
 - ii. The effect of customized benefit plans on beneficiaries' choice of plans, access to care, or quality of care;
 - iii. Participation in the Enhanced Benefits Account Program, or its effect on participant behavior or health status;
 - iv. Participation in the Opt Out Program and participant satisfaction, including the effect of changes required under the Demonstration extension;
 - v. The impact of the Demonstration as a deterrent against Medicaid fraud

- and abuse;
- vi. The effect of LIP funding on the number of uninsured and underinsured, and rate of uninsurance;
- vii. The effect of LIP funding on disparities in the provision of healthcare services, both geographically and by population groups;
- viii. The impact of Tier-One and Tier-Two milestone initiatives on access to care and quality of care (including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity);
- ix. The impact of Tier-One and Tier-Two milestone initiatives on population health; and,
- x. The impact of Tier-One and Tier-Two milestone initiatives on per-capita costs and the cost-effectiveness of care.

b) Evaluation Design – The draft design must discuss the outcome measures that shall be used in evaluating the impact of the Demonstration during the period of approval. It shall discuss the data sources, including the use of Medicaid encounter data, and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups. The draft design shall identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

90. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft design within 60 days of receipt, and the State shall submit a final design within 60 days of receipt of CMS' comments. The State must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The State must submit to CMS a draft of the evaluation report within 120 days after the expiration of the current Demonstration period. The State must submit the final evaluation report within 60 days after receipt of CMS' comments.
91. **Cooperation with Federal Evaluators.** Should CMS conduct an evaluation of any component of the Demonstration, the State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.