LOW INCOME POOL COUNCIL
August 8, 2013

LIP Redesign

3-Year Waiver Extension Request Timeline

- **July-August** – Develop a proposal to redesign the LIP program.
- **September** – Prepare a written description of the proposal to redesign the LIP program along with any other changes to the waiver for inclusion in the public notice document.
- **October** – Publish the public notice document on the Agency's website for 30 days to solicit public input on waiver extension request.
- **November 1-21** – Prepare the final waiver extension request for submission to Federal CMS.
- **November 22** – Submit the extension request to Federal CMS.

Low Income Pool Overview

LIP
History

- Created as a result of the original 1115 Waiver that established Managed Medicaid Pilot program.
- The Managed Medicaid Pilot waiver was:

  "contingent upon federal approval to preserve the upper-payment-limit funding mechanism for hospitals, including a guarantee of a reasonable growth factor, a methodology to allow the use of a portion of these funds to serve as a risk pool for demonstration sites, provisions to preserve the state's ability to use intergovernmental transfers, and provisions to protect the disproportionate share program…"
  409.91211(1)(b) F.S.

LIP
History… Continued

- **Objectives from originating statute[1]:**
  - Assure a broad and fair distribution of available funds based on the access provided by Medicaid participating hospitals, regardless of their ownership status, through their delivery of inpatient or outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;
  - Assure accessible emergency inpatient and outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;
  - Enhance primary, preventive, and other ambulatory care coverages for uninsured individuals;
  - Promote teaching and specialty hospital programs;
  - Promote the stability and viability of statutorily defined rural hospitals and hospitals that serve as sole community hospitals;
  - Recognize the extent of hospital uncompensated care costs;
  - Maintain and enhance essential community hospital care;
  - Maintain incentives for local governmental entities to contribute to the cost of uncompensated care;
  - Promote measures to avoid preventable hospitalizations;
  - Account for hospital efficiency; and
  - Contribute to a community's overall health system.

[1] Section 409.91211(1)(c) Florida Statutes

LIP Funding
Based on 2013 GAA

• Special LIP		$115,992,350
– Rural	$5,622,242	
– Primary Care Hospitals	$12,004,728	
– Trauma Level I	$3,772,467	
– Trauma Level II or Pediatric Trauma	$3,300,257	
– Trauma Level II and Pediatric Trauma	$1,753,963	
– Safety Net	$73,129,526	
– Specialty Pediatrics	$1,409,166	
– Quality Measures (STC61)	$15,000,000	
• LIP 4		$764,504,489
• LIP 5		$2,419,573
• Other Provider Access Systems		$117,333,588
Total LIP Program		$1,000,250,000

GR	$9,208,486
IGT's	$404,194,840
Federal	$586,846,674

Special LIP Allocations
$115,992,350

- **Rural** – $5.6 million, Providers who qualify for Rural Disproportionate Share Hospital / Rural Financial Assistance Program payments. Distributions made in proportion to their Rural DSH/FAP payments.
- **Proportional Primary Care** - $12.0 million, Providers who received Primary Care DSH payments during State Fiscal Year 2003-04.
- **Trauma** – $8.7 million, Designated or provisional trauma centers that meet any of the following: Level I trauma center; Level II or pediatric trauma center; or Level II and pediatric trauma center.
- **Safety-Net** – $73.1 million, Based on various specific legislative issues or hold harmless payments from previous DSH programs no longer funded.
- **Specialty Pediatric** – $1.4 million, Specialty pediatric hospitals with 2,000 or more Medicaid days from average of 05', 06', and 07' audited DSH data. Payments are equally distributed.
- **Quality Measures** – $15 million, Required to enhance existing, or initiate new, quality-of-care initiatives and requires reporting of the measures to the agency.
  - $400 thousand to specialty children hospitals incorporating quality measures developed by the agency;
  - $7.3 million distributed using "core measures" developed by CMS;
  - $7.3 million distributed equally based on specified outcome measures.

LIP 4 & LIP 5

- **LIP 4** - $764.5 million, Funds are allocated to hospitals where local government funds have been transferred to the State for use in the LIP and Exemptions/DRG Add-on programs. Distribution is based on the amount of the local government contribution multiplied by the factor or 8.5%.
- **LIP 5** – $2.4 million, Provides funds for rural hospitals with Medicaid, charity and 50 percent of bad debt days equal to or greater than 10% of total. Distribution based on the qualified hospitals percent of Medicaid, charity care, and bad debt days to total of all qualified hospitals.

Other Provider Access Systems

$117,333,588

- **Poison Control Programs ($3.2 million)**– Provides funding for hospitals providing poison control programs in collaboration with the Department of health.
- **FQHC ($18.3 million)–** Provides funding for FQHC's supporting primary care services in medically underserved areas.
- **County Initiatives, Dept. of Health ($4.5 million)** – Provides funding for county health initiatives emphasizing the expansion of primary care services and rural health networks.
- **Hospital Based Primary Care Initiatives ($3.0 million)** – Provides funding for hospitals with hospital based primary care initiatives in collaboration with the Dept. of Health.
- **Premium Assistance Programs (Miami-Dade) ($250 thousand)** – Provides health insurance premium payments for enrollees of the Miami-Dade Premium Assistance Program.
- **Health Care District of Palm Beach County ($15.8 million)** – Provides funding for premium assistance programs operated by the Palm Beach County Health Care District.
- **Manatee ER Diversion ($1.2 million)** – Primary care and emergency room diversion program in Manatee, Sarasota and Desoto Counties.
- **County Health Department Primary Care Initiatives ($2.0 million)** – Enhance primary care health services for low-income, uninsured and underinsured individuals.
- **Primary Care Projects ($34.0 million) –** Increases access to primary care services.
- **Primary Care Projects Tier-One Milestones ($35.0 million)** – Establishment of new, or enhancement of existing, innovative primary care programs that meaningfully enhance the quality of care and health of low-income populations.

Top 15 Hospitals

- The required Top 15 Hospitals Tier-two milestones initiatives driven from the three overarching goals of CMS' Three-Part Aim:
  - Better care for individuals including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity;
  - Better health for populations by addressing areas such as poor nutrition, physical inactivity, and substance abuse; and,
  - Reducing per-capita costs.

- The initiatives focus specifically on while following the three tier aim:
  - infrastructure development;
  - innovation and redesign;
  - and population focused improvement.

- These initiatives must show their metrics on the development of the programs in quarterly reporting that is then in turn submitted to Federal CMS. Should the programs not meet the metrics or goals the hospital will be loose 3.5 percent of each of the facility's annual LIP allocation.

Medicaid Reimbursement Rate Enhancements

Hospital Medicaid Reimbursement Rate Enhancements

Medicaid Hospital Reimbursement Rate Enhancements				
Program	**Total**	**GR**	**IGT**	**Federal**
Enhancements with IGT connection to LIP:				
Exemptions to Ceilings/DRG Add-on (Table 3a)	$666.5	$10.0	$265.4	$391.0
Buyback of Rate Adjustments/DRG Add-on (Table 4)	$130.5	$0.0	$53.9	$76.6
Total Enhancements with connection to LIP	*$797.0*	*$10.0*	*$319.4*	*$467.6*
Self-funded Enhancements:				
Self-funded Exemptions/DRG Add-on	$385.5	$0	$159.3	$226.2
Self-funded Buyback of Rate Adjustments/DRG Add-on	$685.0	$0	$283.1	$401.9
Total Self-funded Enhancements	*$1,070.5*	*$0*	*$442.4*	*$628.1*
Total Medicaid Hospital Reimbursement Enhancements	**$1,867.5**	**$10.0**	**$761.8**	**$1,095.7**

Note: Funding Listed in Millions

Hospital Medicaid Reimbursement Rate Enhancements With IGT Connection to LIP

- **Exemptions to Ceilings (DRG Add-on)**– $666.5m[1]
  - 70 Hospitals Qualify
    - 77 Percent of Total Medicaid Inpatient Claims[2]
      - The top 20 of these hospitals do 53 Percent of Total Medicaid Inpatient Claims
    - 65 Percent of Total Medicaid Outpatient Claims [2]
      - The top 20 of these do 40 Percent of Total Medicaid Outpatient Claims
    - 16 Contribute IGT's
- **Buyback of Rate Adjustments (DRG Add-on)** - $130.5m[3]
  - 60 Hospitals Qualify
    - 57 Percent of Total Medicaid Inpatient Claims[1]
    - 48 Percent of Total Medicaid Outpatient Claims[1]
    - 17 Contribute IGT's

[1] From Table 3a of the 2013 GAA, Medicaid Hospital Funding Programs; (i.e. Automatic Exemptions)
[2] Medicaid Fee-for-service paid claims with dates of service from July 1, 2011 – June 30, 2012.
[3] From Table 4 of the 2013 GAA, Medicaid Hospital Funding Programs; (i.e. Automatic Buybacks)

Other Hospital Medicaid Reimbursement Issues Funded with IGT's and tied to LIP

- **Liver Global Transplant Fee** - $9.9 million
  - Medicaid payment via global fee for Liver Transplants
- **Statewide Issues** - $55.1 million
  - Increases the annual outpatient total Medicaid expenditure cap from $1,000 to $1,500 per year.

Reimbursement Connection To LIP

LIP Funding		$1 Billion
LIP IGT's	$358.4	
Total Hospital Medicaid Reimbursement Issues with Connection to LIP	$346.2	
Total Match-able IGT's	$704.6	
Allocation Factor	8.5%	
Grand Total Match-able IGTs	$764.5	
Balance		$235.5

Note: Amounts shown in Millions unless specified

Self Funded Medicaid Hospital Reimbursement Rate Enhancements

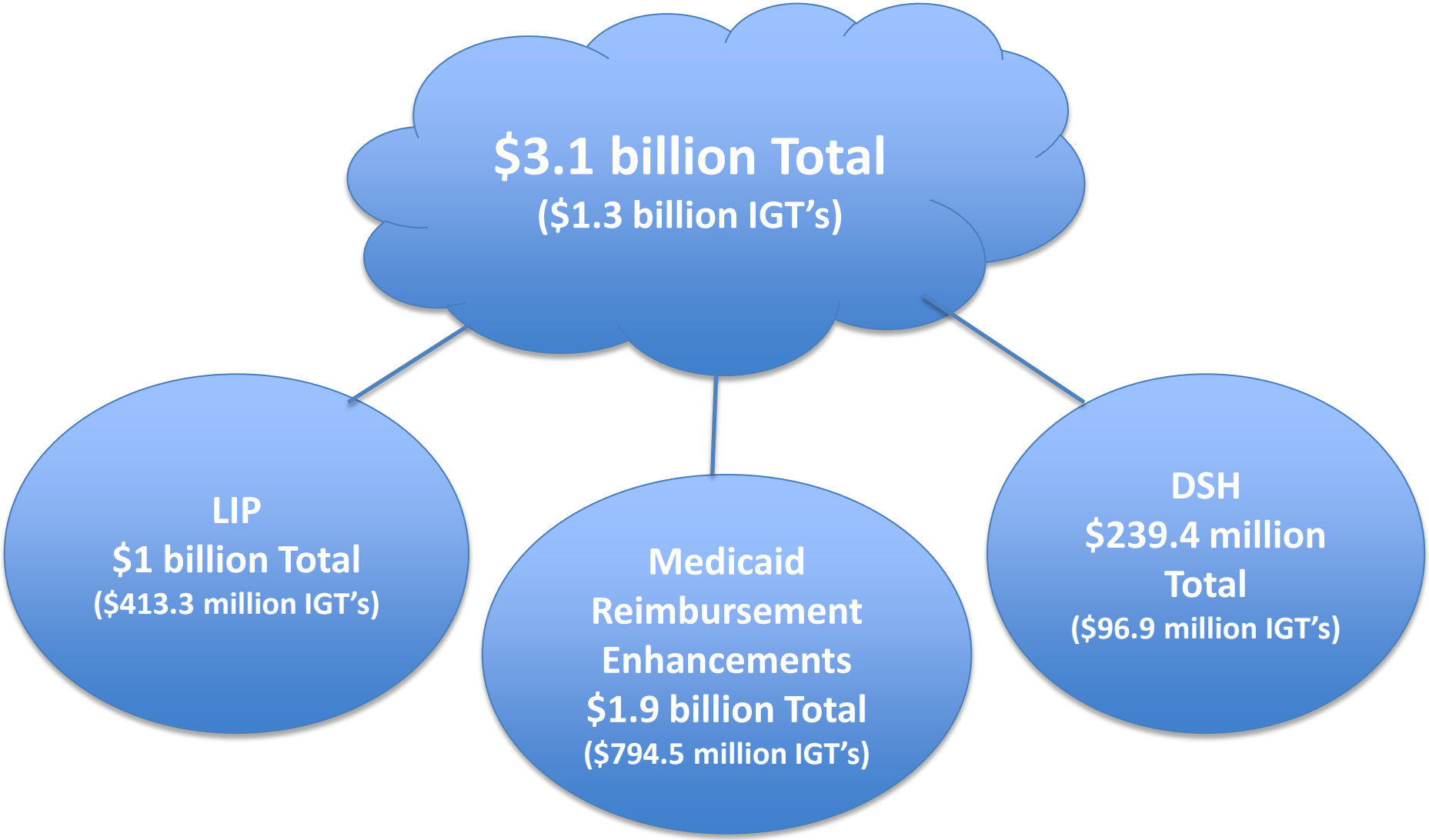
- **Self Funded Exemptions (DRG Add-on)** - $385.5m
  - Funds are provided to allow for adjustments for reimbursement rates for any hospital that has local funds available for intergovernmental transfers.
  - 10 percent of the Federal funds associated with the inpatient portion of this issue shall be used to increase the base rate (DRG's) for all hospitals.
- **Self Funded Buyback of Rate Adjustments** - $685.0m
  - Public, teaching, and designated trauma hospitals-$445.9m.
  - All other hospitals with IGT's available - $239.1m
    - 10 percent of the Federal funds associated with the inpatient portion of this issue shall be used to increase the base rate (DRG's) for all hospitals

Disproportionate Share Hospital

• Regular / Public	$142,895,266
• PSN	$8,685,414
• Family Practice Teaching DSH	$12,769,621
• Graduate Medical Education	$63,887,468
• Specialty Children's	$753,926
Total DSH Distributions	**$228,991,695**

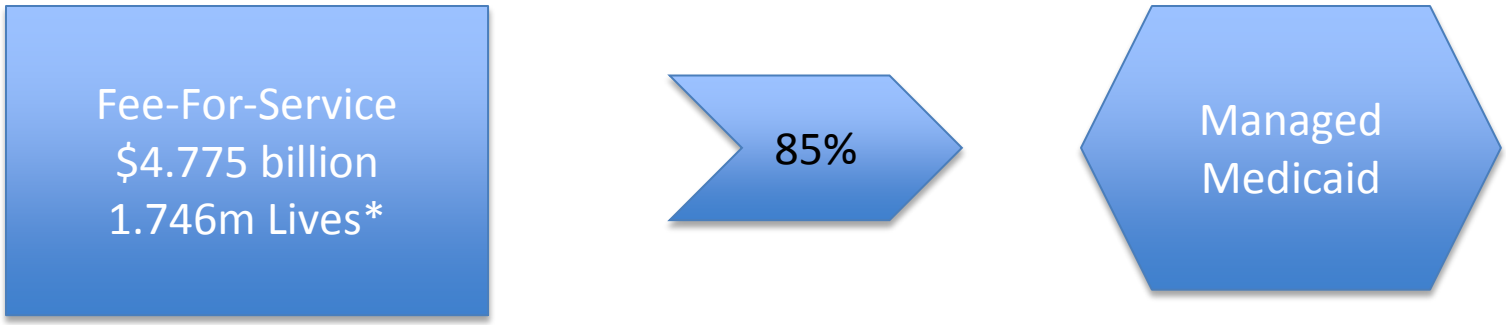
Rural/Rural Financial Assistance Programs $10,385,261

IGT Funded Programs



Importance of IGT's for Reimbursement

Fee-For-Service Funding Per 2013 GAA						
	Total	GR	PMATF	GDTF	RATF	MCTF
Inpatient	$3,543.5	$351.6	$441.8	$647.6	$4.4	$2,097.9
Outpatient	$1,231.5	$218.3	$105.0	$183.7	$2.7	$721.7
Total	$4,775.0	$570.0	$546.9	$831.3	$7.1	$2,819.7



*July 2013 Comprehensive Medicaid Managed Care Enrollment Report; fee-for-service and MediPass

LIP

Under The 1115 Waiver Extension

LIP
Goals & Challenges

- **Goals**
  - Increase the LIP Funding
  - Maintain Reimbursement Enhancements
  - Continue Broad Participation
    - Hospital Providers
    - Non-Hospital Providers
    - Initiatives (Premium Assistance, Primary Care etc…)
- **Challenges**
  - House Bill 7107 (2011 Legislature)
    - Intergovernmental Transfers
    - Low Income Pool
    - Access to Care Partnership
    - Hospital Rate Distribution
  - Cost Limits
  - IGTs
  - CMS's requirement to create more quality based /"metric" gauged programs

House Bill 7107
IGT's

409.97 State and local Medicaid partnerships.—
(1) INTERGOVERNMENTAL TRANSFERS.—In addition to the contributions required pursuant to s. 409.915, beginning in the 2014-2015 fiscal year, the agency may accept voluntary transfers of local taxes and other qualified revenue from counties, municipalities, and special taxing districts. Such transfers must be contributed to advance the general goals of the Florida Medicaid program without restriction and must be executed pursuant to a contract between the agency and the local funding source. Contracts executed before October 31 shall result in contributions to Medicaid for that same state fiscal year. Contracts executed between November 1 and June 30 shall result in contributions for the following state fiscal year. Based on the date of the signed contracts, the agency shall allocate to the low-income pool the first contributions received up to the limit established by subsection (2). No more than 40 percent of the low-income pool funding shall come from any single funding source. Contributions in excess of the low-income pool shall be allocated to the disproportionate share programs defined in ss. 409.911(3) and 409.9113 and to hospital rates pursuant to subsection (4). The local funding source shall designate in the contract which Medicaid providers ensure access to care for low-income and uninsured people within the applicable jurisdiction and are eligible for low-income pool funding. Eligible providers may include hospitals, primary care providers, and primary care access systems.

House Bill 7107
LIP

(2) LOW-INCOME POOL.—The agency shall establish and maintain a low-income pool in a manner authorized by federal waiver. The low-income pool is created to compensate a network of providers designated pursuant to subsection (1). Funding of the low-income pool shall be limited to the maximum amount permitted by federal waiver minus a percentage specified in the General Appropriations Act. The low-income pool must be used to support enhanced access to services by offsetting shortfalls in Medicaid reimbursement, paying for otherwise uncompensated care, and financing coverage for the uninsured. The low-income pool shall be distributed in periodic payments to the Access to Care Partnership throughout the fiscal year. Distribution of low-income pool funds by the Access to Care Partnership to participating providers may be made through capitated payments, fees for services, or contracts for specific deliverables. The agency shall include the distribution amount for each provider in the contract with the Access to Care Partnership pursuant to subsection (3). Regardless of the method of distribution, providers participating in the Access to Care Partnership shall receive payments such that the aggregate benefit in the jurisdiction of each local funding source, as defined in subsection (1), equals the amount of the contribution plus a factor specified in the General Appropriations Act.

House Bill 7107
Access To Care Partnership

(3) ACCESS TO CARE PARTNERSHIP.—The agency shall contract with an administrative services organization that has operating agreements with all health care facilities, programs, and providers supported with local taxes or certified public expenditures and designated pursuant to subsection (1). The contract shall provide for enhanced access to care for Medicaid, low-income, and uninsured Floridians. The partnership shall be responsible for an ongoing program of activities that provides needed, but uncovered or undercompensated, health services to Medicaid enrollees and persons receiving charity care, as defined in s. 409.911. Accountability for services rendered under this contract must be based on the number of services provided to unduplicated qualified beneficiaries, the total units of service provided to these persons, and the effectiveness of services provided as measured by specific standards of care. The agency shall seek such plan amendments or waivers as may be necessary to authorize the implementation of the low-income pool as the Access to Care Partnership pursuant to this section.

House Bill 7107
Rate Distribution

(4) HOSPITAL RATE DISTRIBUTION.—

(a) The agency is authorized to implement a tiered hospital rate system to enhance Medicaid payments to all hospitals when resources for the tiered rates are available from general revenue and such contributions pursuant to subsection (1) as are authorized under the General Appropriations Act.

1. Tier 1 hospitals are statutory rural hospitals as defined in s. 395.602, statutory teaching hospitals as defined in s. 408.07(45), and specialty children's hospitals as defined in s. 395.002(28).
2. Tier 2 hospitals are community hospitals not included in Tier 1 that provided more than 9 percent of the hospital's total inpatient days to Medicaid patients and charity patients, as defined in s. 409.911, and are located in the jurisdiction of a local funding source pursuant to subsection (1).
3. Tier 3 hospitals include all community hospitals.

(b) When rates are increased pursuant to this section, the Total Tier Allocation (TTA) shall be distributed as follows:

1. Tier 1 (T1A) = 0.35 x TTA.
2. Tier 2 (T2A) = 0.35 x TTA.
3. Tier 3 (T3A) = 0.30 x TTA.

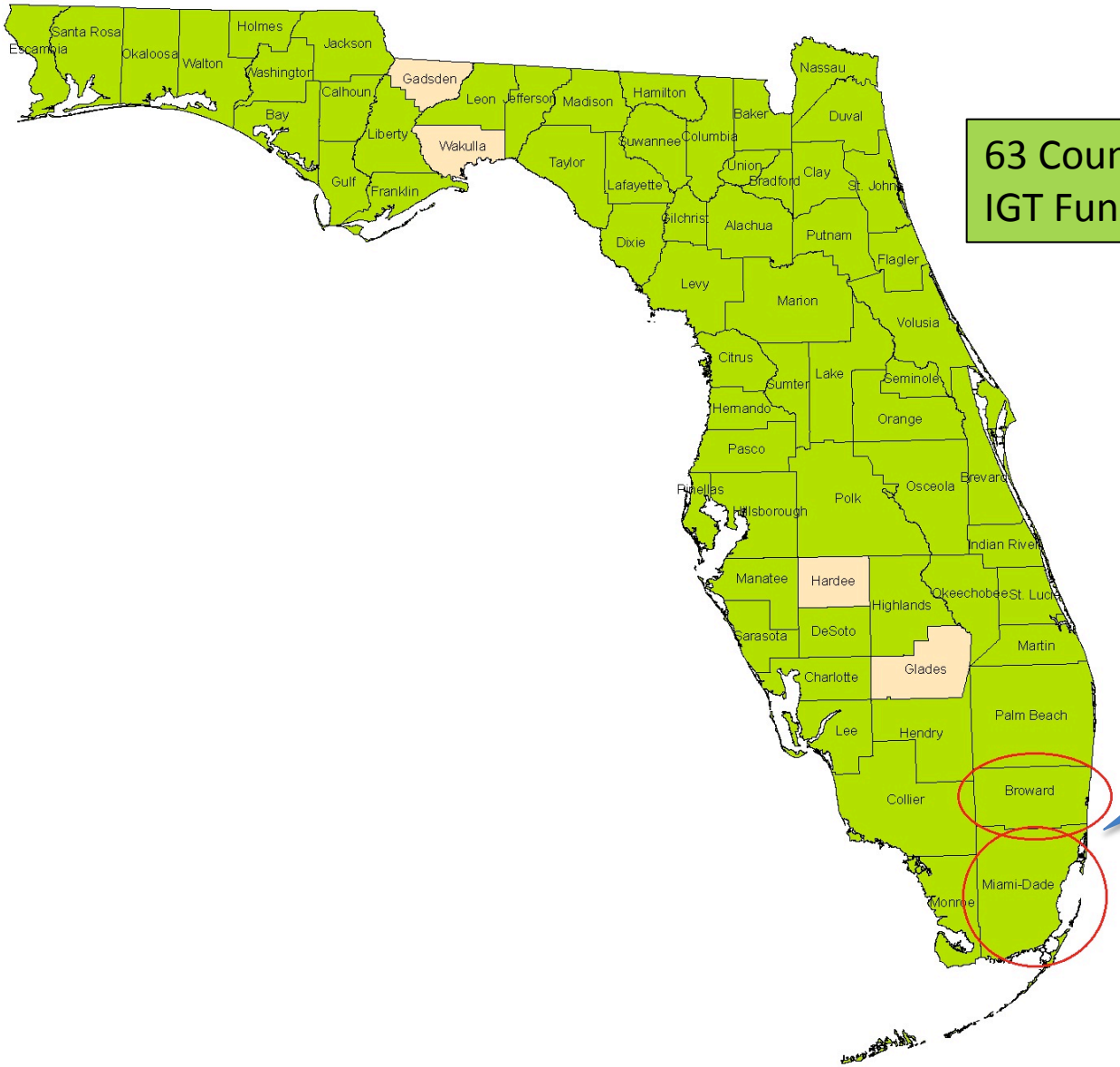
(c) The tier allocation shall be distributed as a percentage increase to the hospital specific base rate (HSBR) established pursuant to s. 409.905(5)(c). The increase in each tier shall be calculated according to the proportion of tier-specific allocation to the total estimated inpatient spending (TEIS) for all hospitals in each tier:

1. Tier 1 percent increase (T1PI) = T1A/Tier 1 total estimated inpatient spending (T1TEIS).
2. Tier 2 percent increase (T2PI) = T2A /Tier 2 total estimated inpatient spending (T2TEIS).
3. Tier 3 percent increase (T3PI) = T3A/ Tier 3 total estimated inpatient spending (T3TEIS).

(d) The hospital-specific tiered rate (HSTR) shall be calculated as follows:

1. For hospitals in Tier 3: HSTR = (1 + T3PI) x HSBR.
2. For hospitals in Tier 2: HSTR = (1 + T2PI) x HSBR.
3. For hospitals in Tier 1: HSTR = (1 + T1PI) x HSBR.

Counties Benefiting from IGT Funded Programs



63 Counties are benefiting from IGT Funded Programs

Provides 80% of IGTs

Texas

Texas
Overview of Supplemental Funding Pools

From Texas Medicaid Transformation 1115 Waiver

Program Structure

- **Uncompensated Care Pool (UC Pool)**
  - Designed to subsidize specifically identified unreimbursed costs incurred by hospitals and physicians for patient care services provided to Medicaid and Uninsured patients. [1]
  - Medicaid Fee-for-service and Managed Care unreimbursed costs included. [1]
  - UC payments must not exceed the cost of services provided to Medicaid and Uninsured patients. [1]
  - Hospitals that receive payments from the pool must participate in an RHP and are required to report on certain measures (Potentially Preventable Admissions; Potentially Preventable Re-admissions; Potentially Preventable Complications). [2]
- **Delivery System Reform Incentive Pool (DSRIP) [2]**
  - Designed for the development of a program or activity that supports hospitals' efforts to enhance access to health care, the quality of care, and the health of patients and families they serve.
- **Regional Health Partnerships[2]**
  - Developed to more effectively and efficiently, deliver care and provide increased access for low-income individuals.
  - Includes a variety of providers.
  - Anchored financially by (i.e. single point of contact for the RHP) by a public hospital (or; in areas with no public hospital, anchored financially by the governmental entity providing IGT's to support funding pool payments) that will be responsible for developing the RHP's DSRIP plan in coordination with other identified RHP providers.
  - All providers must have an agreement with an RHP to withdraw funds out of either pool.

[1] Attachment H Part 1: UC Claiming Protocol for Hospitals and Physician Groups; Special Terms and Conditions ; Title XIX No. 11-W-00278/6, Texas Health Care Transformation and Quality Improvement Program

[2] Attachment J: Program Funding and Mechanics Protocol; Special Terms and Conditions ; Title XIX No. 11-W-00278/6, Texas Health Care Transformation and Quality Improvement Program

Uncompensated Care Pool Hospitals

Payments from this pool will help defray uncompensated costs of care provided to Medicaid or Demonstration eligibles or to individuals who have no source of third party coverage.[1]

- **Hospitals must apply each year**
  - The application collects the cost and payment data on services eligible for reimbursement under the UC pool. [1]
  - Cost Limits Apply
    - Total payment under Medicaid State Plan, Disproportionate Share, UC payments, cannot exceed the actual cost of providing services to Medicaid beneficiaries and uninsured as defined in the cost claiming protocol. [1]
- **Costs included in the application[2]**
  - Medicaid Fee-For-Service, Managed Medicaid, and Uninsured
    - Physician costs related to direct patient care services
    - Mid-level professional costs related to direct patient care services
    - Pharmacy costs related to the "Texas Vendor Drug" program
    - Excess "Medicaid DSH" costs not reimbursed via the Medicaid DSH program
- **Quarterly Payments**

[1] Special Terms and Conditions No. 44; Title XIX No. 11-W-00278/6, Texas Health Care Transformation and Quality Improvement Program
[2] Texas Medicaid 1115 Waiver Uncompensated Care Application Overview; Power-point presentation 8/2/2012; Uncompensated Care Protocol Part B
http://www.hhsc.state.tx.us/1115-Waiver-Resources.shtml

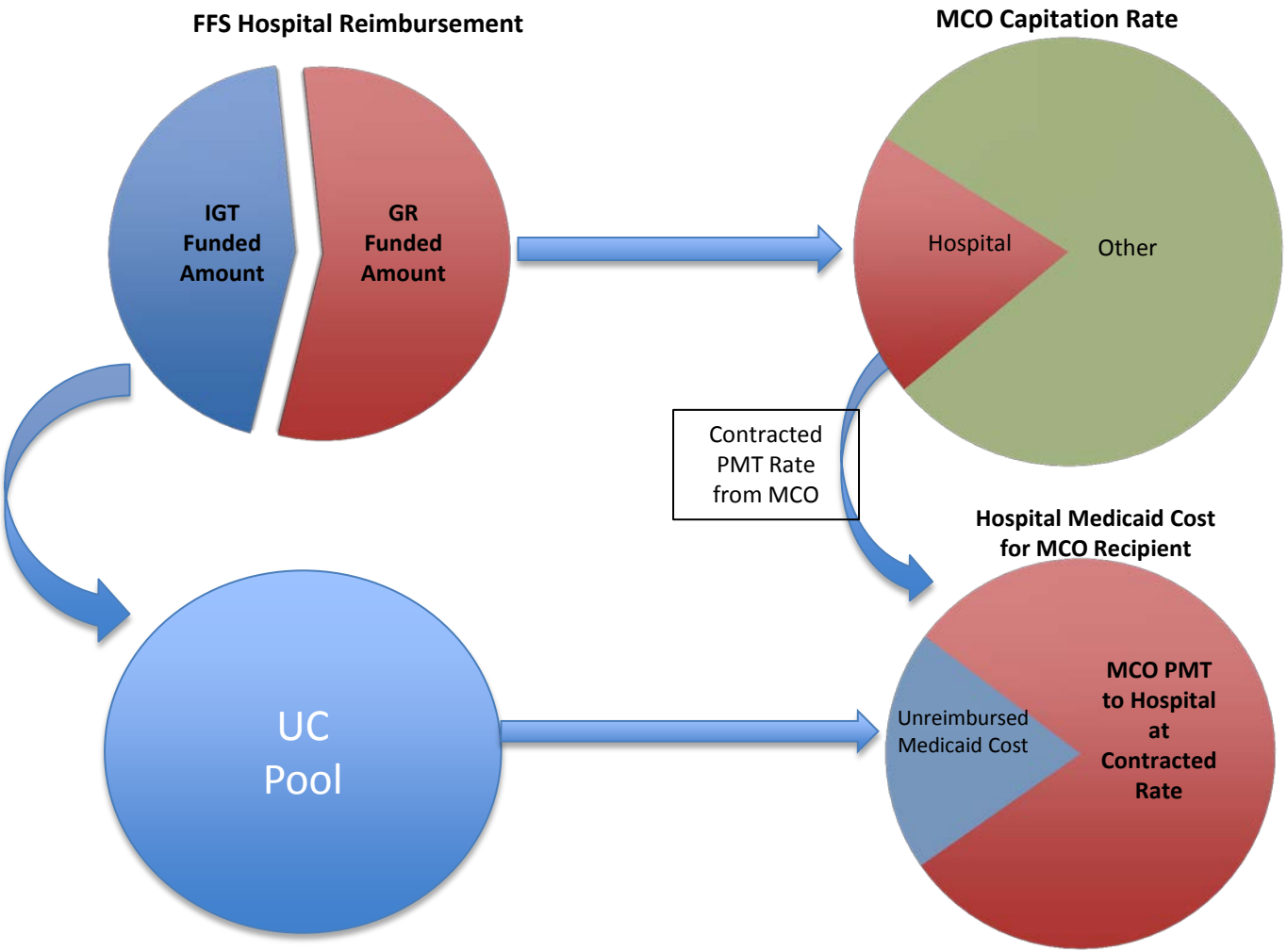
Uncompensated Care Pool Cost Claiming

Uncompensated Care = Medicaid Shortfall + Uninsured cost

- **Where:**
  - Medicaid Shortfall = Medicaid Cost – Medicaid Payment
  - Uninsured Cost = Cost of serving the uninsured for same Medicaid services up to Medicaid cost.

Source: Attachment H Part 1: UC Claiming Protocol for Hospitals and Physician Groups; Special Terms and Conditions ; Title XIX No. 11-W-00278/6, Texas Health Care Transformation and Quality Improvement Program

Uncompensated Care Pool
Medicaid Cost Claiming in Managed Care Environment



Delivery System Reform Incentive Pool
DSRIP

- Available for the development of a program of activity that supports hospitals' efforts to enhance access to health care, the quality of care, and the health of the patients and families they serve.
- Administered by each RHP
  - RHP must demonstrate need; Provide a plan; Select a minimum number of projects from Categories 1&2 based on "Tier" status.
  - RHP's are categorized into four "Tiers"(1-4) based on percentages of the population under 200% FPL compared to statewide in their area.

	Share of population under 200% FPL	**Min. number of Cat. 1 & 2 projects**	**Min. number of Cat. 2 projects**
Tier 1	>15%	20	10
Tier 2	7-15%	12	6
Tier 3	3-7%	8	4
Tier 4	<3%, no public hospital or public hospitals serve <1% UC	4	2

- Funding is available under 4 Categories:
  1. Infrastructure and Development
  2. Program Innovation and Redesign
  3. Quality Improvements
  4. Population Focused Improvements

Source: Attachment J: Program Funding and Mechanics Protocol; Special Terms and Conditions ; Title XIX No. 11-W-00278/6, Texas Health Care Transformation and Quality Improvement Program

DSRIP Payments

- **DSRIP Fund Allocation**
  - Formula that takes into account the RHP's role in the safety net system.
    - RHP's that shoulder the larger burden of Medicaid care and serve a lager share of low-income populations shall be allocated a higher share of DSRIP funds.
      - Variables selected:
        - » Percent of state population with income below 200 percent of FPL.
        - » Percent of Texas Medicaid acute care payments in fiscal year 2011 (fee-for-service, primary care case management, mco, pharmacy).
        - » Percent of Texas Medicaid supplemental payments in fiscal year 2011.

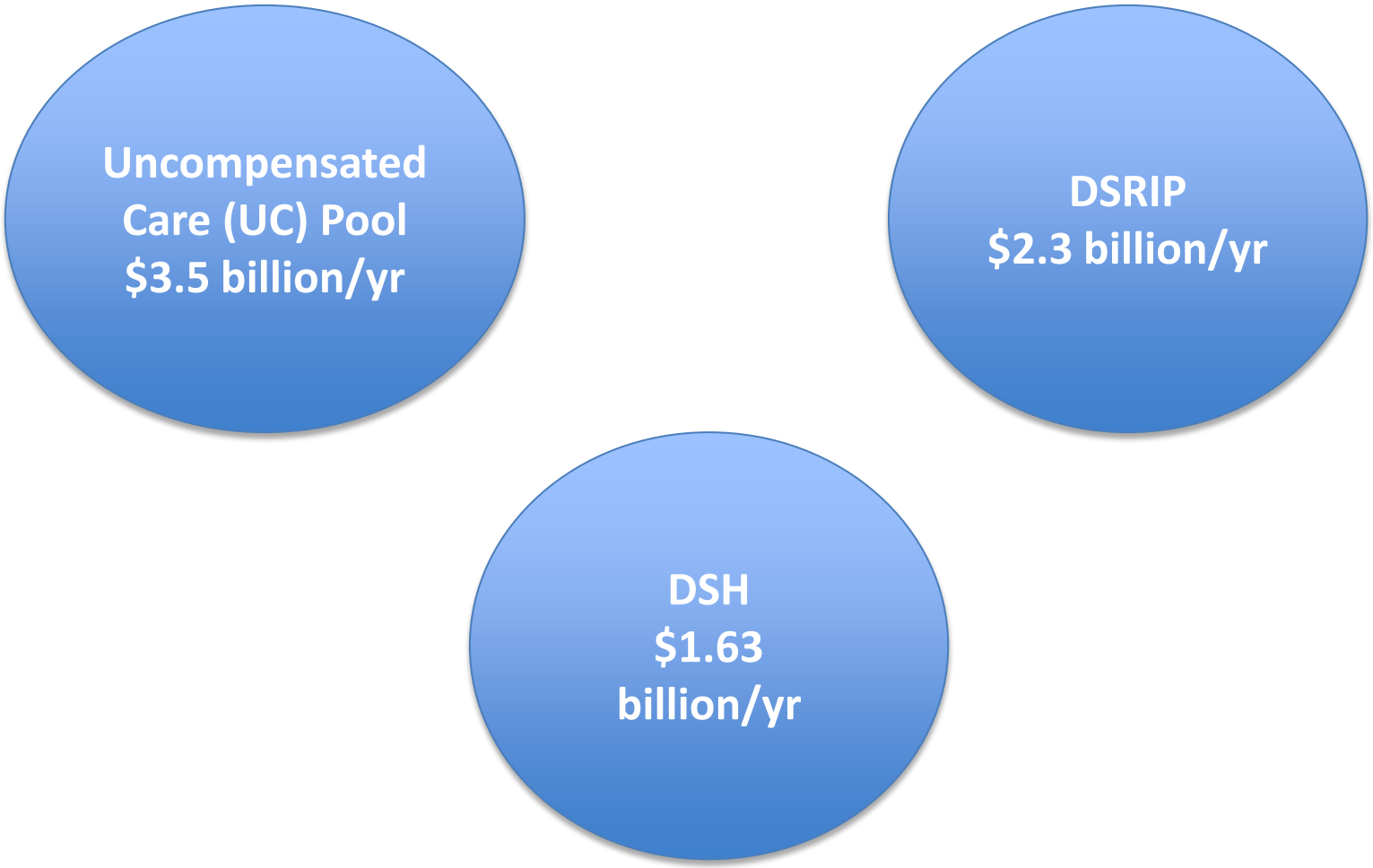
Source: Attachment J: Program Funding and Mechanics Protocol; Special Terms and Conditions ; Title XIX No. 11-W-00278/6, Texas Health Care Transformation and Quality Improvement Program

Texas Waiver Pool Funding for DYs 1-5

Type of Pool	DY 1 (2011-2012)	DY2 (2012-2013)	DY3 (2013-2014)	DY4 (2014-2015)	DY5 (2015-2016)	Totals
UC	3,700,000,000	3,900,000,000	3,534,000,000	3,348,000,000	3,100,000,000	$17,582,000,000
DSRIP	500,000,000	2,300,000,000	2,666,000,000	2,852,000,000	3,100,000,000	$11,418,000,000
Total/DY	4,200,000,000	6,200,000,000	6,200,000,000	6,200,000,000	6,200,000,000	$29,000,000,000
%UC	88%	63%	57%	54%	50%	60%
%DSRIP	12%	37%	43%	46%	50%	40%

Special Terms and Conditions No. 46; Title XIX No. 11-W-00278/6, Texas Health Care Transformation and Quality Improvement Program

Texas


Uncompensated Care (UC) Pool $3.5 billion/yr
DSRIP $2.3 billion/yr
DSH $1.63 billion/yr

Texas
Budget Neutrality

State of Texas HHSC | Texas BN Demonstration_2011 07 06.xls BN Summary | Attachment 1: Texas Waiver Proposal July 13, 2011

Managed Care Hospital Transition 1115 waiver
BUDGET NEUTRALITY SUMMARY

WITHOUT WAIVER SUMMARY	DEMONSTRATION YEARS (DY) DY 01 (SFY 12)	DY 02 (SFY 13)	DY 03 (SFY 14)	DY 04 (SFY 15)	DY 05 (SFY 16)	2012-2016 TOTAL WOW
Aged and Medicare Related	$ 2,430,230,229	$ 2,724,010,802	$ 3,059,666,850	$ 3,445,291,935	$ 3,890,850,141	$ 15,550,049,956
Blind and Disabled	$ 6,928,084,196	$ 7,793,423,767	$ 8,741,459,037	$ 9,805,153,154	$ 10,998,648,555	$ 44,266,768,709
Adults	$ 2,977,660,037	$ 3,248,534,800	$ 3,558,074,699	$ 3,922,797,956	$ 4,325,128,941	$ 18,032,216,432
Children	$ 10,537,216,803	$ 11,491,721,636	$ 14,243,135,977	$ 15,685,427,238	$ 17,112,280,503	$ 69,069,782,157
Other UPL Programs (Not Included in Population)	$ 1,414,594,797	$ 1,493,462,372	$ 1,578,779,307	$ 1,664,798,223	$ 1,757,786,134	$ 7,907,420,834
Total WOW Expenditures	**$ 24,287,806,062**	**$ 26,751,153,377**	**$ 31,179,115,869**	**$ 34,523,468,506**	**$ 38,084,694,274**	**$ 154,826,238,088**

WITH WAIVER SUMMARY	DEMONSTRATION YEARS (DY) DY 01 (SFY 12)	DY 02 (SFY 13)	DY 03 (SFY 14)	DY 04 (SFY 15)	DY 05 (SFY 16)	2012-2016 TOTAL WW
Aged and Medicare Related	$ 1,966,123,637	$ 2,074,418,448	$ 2,242,279,008	$ 2,421,472,812	$ 2,621,971,232	$ 11,326,265,136
Blind and Disabled	$ 5,945,304,780	$ 6,631,521,613	$ 7,379,702,908	$ 8,216,491,988	$ 9,157,310,590	$ 37,330,331,880
Adults	$ 1,871,227,464	$ 1,953,820,896	$ 2,065,663,091	$ 2,201,129,515	$ 2,346,710,754	$ 10,438,551,721
Children	$ 8,745,762,365	$ 9,237,506,110	$ 10,696,939,733	$ 11,729,533,597	$ 12,535,573,554	$ 53,145,315,357
Other UPL Programs (Not Included in Population)	$ -	$ -	$ -	$ -	$ -	$ -
Non-Pool Expenditures	**$ 18,528,418,246**	**$ 19,897,267,067**	**$ 22,584,584,738**	**$ 24,568,627,912**	**$ 26,661,566,130**	**$ 112,240,464,094**
Waiver Pool						
DSHP	$ 500,000,000	$ 500,000,000	$ 500,000,000	$ 400,000,000	$ 400,000,000	**$ 2,300,000,000**
Uncompensated Care Pool Payments	$ 4,207,510,253	$ 5,083,109,048	$ 5,666,171,792	$ 5,732,904,356	$ 5,511,564,072	**$ 26,201,259,520**
Incentive Pool Payments	$ 1,051,877,563	$ 1,270,777,262	$ 2,428,359,339	$ 3,821,936,238	$ 5,511,564,072	**$ 14,084,514,474**
Total WW Expenditures	**$ 24,287,806,062**	**$ 26,751,153,377**	**$ 31,179,115,869**	**$ 34,523,468,506**	**$ 38,084,694,274**	**$ 154,826,238,088**
Expenditures (Over)/Under Cap	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Source: Texas Funding Document; http://www.hhsc.state.tx.us/Wavier1115-Demonstration.pdf

Questions