
State Demonstrations Group

May 20, 2016

Mr. Justin Senior
Deputy Secretary for Medicaid
State of Florida, Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 8
Tallahassee, FL 32308

Dear Mr. Senior:

Thank you to you and your staff for your work on the Reimbursement and Funding Methodology document (RFMD) for Florida's Low-Income Pool (LIP), which is a component of the state's section 1115 demonstration, entitled "Florida Managed Medical Assistance Program." We are writing to approve the state's latest revisions of the RFMD for demonstration year (DY) 11, which was originally submitted to CMS on November 25, 2015. A copy of the approved RFMD is enclosed with this letter.

We understand that legislation concerning distribution of funding under LIP has passed and was signed by the Governor on March 17, 2016. As you continue your oversight of that portion of the demonstration, we advise that you keep in mind the following features of the state legislation that could result in violations of the demonstration's Special Terms and Conditions (STC) or federal regulations.

Paragraph 71(b)(i) of the demonstration's STCs requires that "[a]ll providers ... that meet LIP provider participation requirements and that furnished uncompensated charity care must receive some amount of payment." A funding arrangement for LIP that did not provide a payment to all qualifying providers, as is possible under the new laws, would not be consistent with this provision.

Please also be aware that STC 92(e) requires that "[u]nder all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures." Re-assignment of add-on rate adjustment amounts between hospitals in consideration for provision of IGT funds would violate this STC language. Such re-assignment also could constitute an impermissible provider-related donation, which will result in loss of federal financial participation for Florida, following this STC and 42 CFR § 433.67(b).

Finally, as indicated in the Waiver Authorities document sent to Florida on October 15, 2015, Florida has not asked for, nor has it received, any waiver of section 1902(a)(2) of the Social Security Act, which requires the state to "assure 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."

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To ensure ongoing compliance with these, and all other, STCs under the demonstration, we request that the Agency for Health Care Administration develop a LIP monitoring plan so as to ensure these future STC violations are not realized.

If you have additional questions or concerns, please contact your assigned project officer, Mr. Adam Goldman. His contact information is as follows:

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Official communications regarding program matters should also be sent simultaneously to Ms. Jackie Glaze, Associate Regional Administrator for our Atlanta Regional Office. Her contact information is as follows:

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We look forward to continuing to work together to ensure that the investment we have made supports true uncompensated care provided to the Medicaid, underinsured, and uninsured populations of Florida.

Sincerely,

/s/

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

cc:
Jackie Glaze, ARA, Region IV, CMS Atlanta Regional Office

Reimbursement and Funding Methodology For Demonstration Year 11

Florida's 1115 Managed Medical Assistance Waiver

Low Income Pool

November 30, 2015



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I. Overview

In accordance with the Special Terms and Conditions (STCs) for waiver number 11-W-00206/4, Managed Medical Assistance Program (MMA) Section 1115 Demonstration, the State of Florida, Agency for Health Care Administration (Agency), Medicaid program (the State), submits to the Centers for Medicare and Medicaid Services (CMS) this Reimbursement and Funding Methodology Document (RFMD). This document fulfills the request by CMS in the STCs approved October 15, 2015, to submit a Low Income Pool (LIP) Cost protocol for Demonstration Year (DY) 11 by November 30, 2015.

LIP is defined in STC 67 (see Appendix B) as government support for safety net providers for the costs of uncompensated charity care for low-income individuals that are uninsured. Uncompensated care includes charity care for the uninsured but does not include uncompensated care for insured individuals, “bad debt,” or Medicaid and CHIP shortfall. Health care costs may be incurred by the state or by providers to furnish uncompensated medical care as charity care for low-income individuals that are uninsured (uninsured charity care). The definition also excludes the estimated impact on uncompensated care that would result from Medicaid expansion, or that has resulted from Marketplace coverage, under the Affordable Care Act. STC 70 (see Appendix B) requires the submittal of the RFMD prior to November 30, 2015.

Included in this Reimbursement and Funding Methodology Document, the State is providing the definition of expenditures eligible for Federal matching funds and the entities eligible to receive reimbursement. Permissible expenditures are discussed in STC 71, 73, and 74 (see Appendix B).

Providers in receipt of LIP funds for the reimbursement of uncompensated care that they provide are required to submit documentation of their permissible expenditures which will be used to calculate a Low Income Pool Cost Limit (LIP Cost Limit). Permissible expenditures are discussed in Section IV of this document. Upon review of the permissible expenditures, the Agency will reconcile the LIP distributions against the LIP Cost Limit. Section V, Planning and Reconciliation, reviews this process.

State’s Perspective on Waiver Payments

Certain basic parameters of the LIP require consideration to gain an appropriate perspective for the State’s proposal for LIP distributions:

- i. Local governments funding the LIP through intergovernmental transfers (IGTs) have a vested interest in ensuring that their localities benefit from the funding they provide for the program. The funding mechanism is an important component of the LIP, just as the State’s funding of the Medicaid program is a primary determinant of how the State operates its Title XIX program. Florida has a vested interest in using its State share, coupled with Federal matching dollars, to benefit the citizens of Florida. CMS does not require Florida to assist with the funding of any other State Medicaid program, but allows Florida to use its State share specifically for the benefit of its citizens. The State has adopted a similar philosophy for how local funds are considered within the LIP. Although the State is not promoting a predetermined benefit for the local governments providing funding, the State does recognize that it is inappropriate to require a local government to assist with the funding of a benefit for providers outside that local

government's area without consideration of the benefits received by providers within its political subdivision. The State believes it is sound public policy to provide each local government the assurance that its providers will not receive less from LIP than if the local government provided direct financial assistance to its providers.

- ii. An evaluation of services typically covered within a coverage model generally results in a broad array of services that vary in cost per unit and the financial risk for the insured related to the use of such services. An individual may be able to afford a dental visit or a single pharmaceutical, but would incur significant financial risk if a lengthy or acute hospital stay was required. Therefore, consistent with the prioritization of covered services in Medicare Part A and the general insurance market, the State recognizes a priority of services subject to coverage from the LIP. Just as Medicare and commercial coverage attempt to cover hospital services first, the LIP recognizes that the uninsured must have their hospital risk addressed first. Subsequent to addressing the hospital risk, the LIP can then address subsequent services such as physician services, clinic services, drugs or limited benefit packages as they present lower risks than critical hospital services.
- iii. Barring sufficient funding for a methodology that allows adequate coverage of needed services for Florida's uninsured charity care, the State has adopted a distribution methodology based on costs associated with uncompensated care as charity care which is defined in STC 71 (see Appendix B).

Due to the limitation of funds, the distribution methodology incorporates the above as follows:

- i. Hospital services are prioritized in the distribution methodology;
- ii. Providers within a local area will not receive less than they would have received if they were to obtain funding directly from their local governments for services related to uninsured charity care; and
- iii. Payments to providers will not exceed the cost of services for the uninsured charity care recipients.

II. Reimbursement Methodology

The financing and fund distributions for Demonstration Year Eleven (DY 11) of the Low Income Pool will be modeled based on the cost of uncompensated care as defined in STC 71. Once the Florida Legislature reviews and approves the methodology, it becomes part of the annual General Appropriations Act (GAA). The current methodology guidance is described in Appendix A. Distributions are subject to providers meeting LIP Participation Requirements outlined in STC 77 (see Appendix B). The distribution will be made to qualifying providers after the Agency receives executed Letters of Agreement with participating cities, counties and health care taxing districts, receipt of the State, non-Federal share, and all required LIP Cost Limit documentation as well as meeting all of the DY 11 LIP participation requirements. Distributions may begin effective July 1.

III. Definitions

State Fiscal Year (SFY) - July 1 – June 30

Demonstration Year (DY) – July 1 – June 30

- Demonstration Year 11 – July 1, 2016 – June 30, 2017

Uninsured: Persons with no source of third party coverage on the date of service captured within a defined cost reporting period. Persons enrolled in Medicaid will be considered uninsured if at the dates of service their Medicaid benefits are exhausted.

Uninsured Charity Care: Healthcare services that have been or will be provided but are never expected to be reimbursed by the recipient of the services or third party payor, that were furnished through a charity care program for individuals with incomes up to at least 200 percent of the federal poverty level that adheres to the principles of the Healthcare Financial Management Association operated by the provider. The service is provided regardless of the recipient's ability to pay.

IV. LIP Permissible Expenditures

LIP is subject to specific Special Terms and Conditions (STCs) (see Appendix B) which require a calculated cost limit and cost review protocol for providers. All LIP payments to providers and all expenditures described as LIP permissible expenditures can be viewed in Appendix B.

V. Planning and Reconciliation

i. Planning

According to the STC number 73, "The State agrees that it shall not receive FFP [Federal Financial Participation] for Medicaid and LIP payments to hospitals in excess of cost." The previous sections provide the methodology for the LIP distributions and the calculation of the permissible expenditures which will be used to calculate the providers' total allowable cost, referred to as the LIP Cost Limit. The date of discovery for any overpayments identified in the LIP Cost Limit Reconciliation will be the date in which the Agency submits the initial reconciliation to CMS.

ii. Reconciliation

During the first quarter of the state fiscal year (July – September), the LIP Cost Limits will be determined for each provider receiving a LIP distribution. The State will perform an initial desk review of all expenditures claimed by providers to determine whether reported costs support the objective of the LIP, which is payment up to 100 percent of incurred cost for Medicaid covered services delivered by Medicaid qualified providers to uninsured charity care patients receiving care from LIP. While a provider may receive payment upon completion of the desk review, this process does not represent a final review of cost. Therefore, a provider may be required to remit an amount back to the State for unallowable costs after a more intensive review of submitted costs.

All costs submitted by providers are reviewed in light of the following cost principles:

- Be authorized or not prohibited under State or local laws or regulations;

- Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal awards, or other governing regulations as to the types or amounts of cost items;
- Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit;
- Except as otherwise provided for, be determined in accordance with generally accepted accounting principles;
- Not be included as a cost or used to meet cost sharing or matching requirements of any other Federal award;
- Be net of all applicable credits; and
- Be adequately documented.

The Hospital LIP Cost Limits will be calculated using the data described in Appendix C. The LIP Cost Limit calculation is the total allowable expenditures less any reimbursement from the uninsured charity care recipients. The reimbursement includes DSH payments.

Prior to making a LIP distribution, the LIP Cost Limit for each individual provider will be reviewed. The LIP distribution will be subtracted from the LIP Cost Limit. As long as there is a positive remaining balance of the LIP Cost Limit, there exists an uninsured charity care shortfall. Should the resulting calculation show that the anticipated LIP distribution will exceed the LIP Cost Limit, the provider's distribution will be reduced accordingly. The Agency assures that no provider will receive a LIP distribution in excess of the uninsured charity care shortfall and must demonstrate that it has reconciled LIP payments to auditable costs. LIP provider payments for uncompensated care as charity care are limited to the uncompensated portion of providers' allowable costs and, in the aggregate, the authorized LIP pool amount for the demonstration year.

In cases in which Medicaid reimbursements are above hospital cost of care, the payments above cost offset some of the hospitals' shortfall from care provided to the uninsured charity care.

VI. Conclusion

This LIP Reimbursement and Funding Methodology Document is submitted to satisfy STC 70 (see Appendix B). This updated version of the Reimbursement and Funding Methodology Document is submitted to CMS in order to update the November 30, 2015, DY10 document.

APPENDIX A - SFY 2016-17 LIP Distribution & Funding Methodology

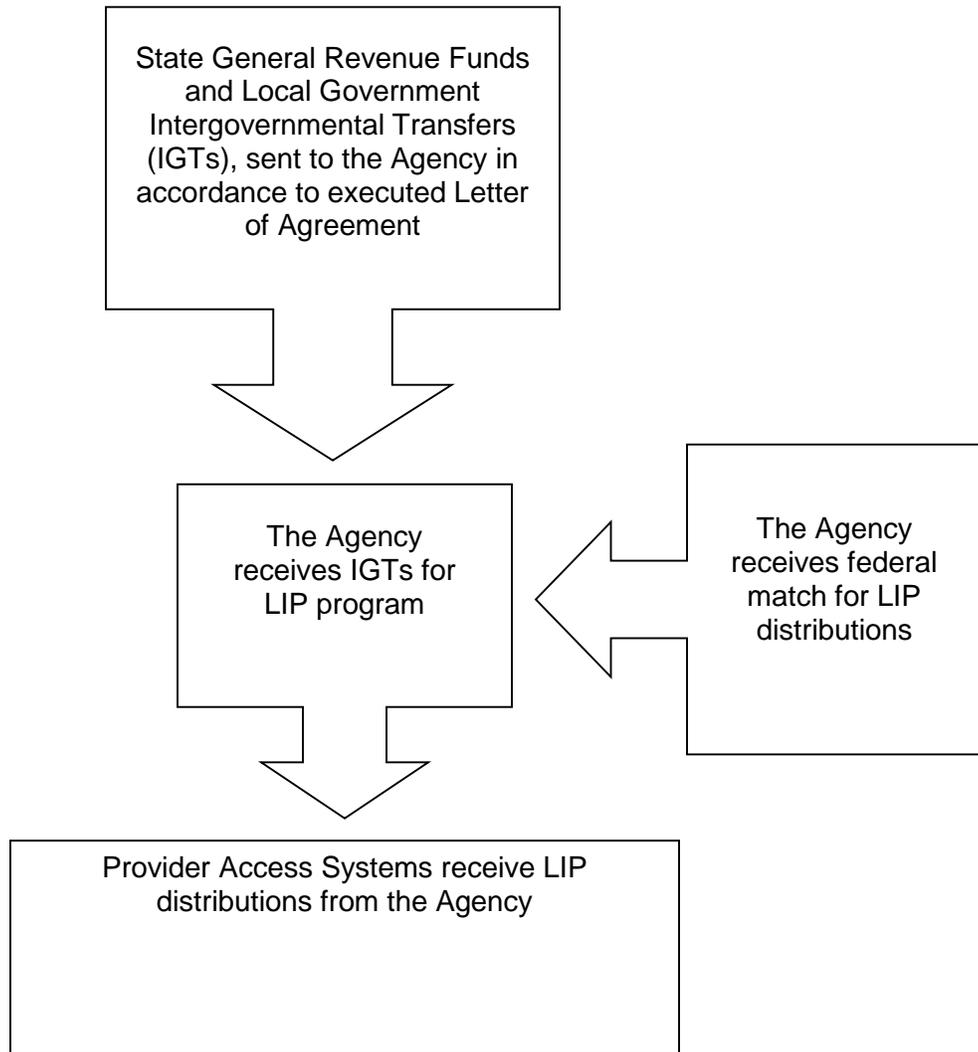
All providers who qualify for a LIP distribution will be reimbursed a percentage of their charity care costs based on the amount of uninsured charity care cost or charges as a percentage of their privately insured patient care cost or charges.

Participating providers will provide assurance that LIP claims include only costs associated with uncompensated care furnished through the a charity care program for individuals with incomes up to at least 200 percent of the federal poverty level that adheres to the principles of the Healthcare Financial Management Association and is operated by the provider.

Participating providers must be enrolled Medicaid providers and have a minimum of 1 percent Medicaid utilization.

The detailed LIP distribution will be made available by the Agency for Health Care Administration when approved by the Legislature and will be located on the Agency's website at <http://ahca.myflorida.com/Medicaid/Finance/finance/LIP-DSH/LIP/index.shtml>.

Flow of Intergovernmental Transfers Provided for the LIP Program



APPENDIX B - LIP Special Terms and Conditions

67. **Low Income Pool Definition.** In Demonstration Year 10, the LIP provides transitional government support for the safety net providers that furnish uncompensated care to the Medicaid, underinsured and uninsured populations. In Demonstration Year 11 (SFY 2016-2017) the LIP provides government support for safety net providers for the costs of uncompensated charity care for low-income individuals that are uninsured. Uncompensated care includes charity care for the uninsured but does not include uncompensated care for insured individuals, “bad debt,” or Medicaid and CHIP shortfall. The definition also excludes the estimated impact on uncompensated care that would result from Medicaid expansion, or that has resulted from Marketplace coverage, under the Affordable Care Act. This is reflected in the total computable dollar limit discussed in STC 68.
68. **Availability of Low Income Pool Funds.** The following paragraph presents the total computable dollar limit for LIP spending in DYs 10 and 11, subject to assurances.
- a. **Total LIP Amount.** The total computable dollar limit for LIP expenditures in DY 10 will be \$1 billion. The total computable dollar limit for LIP expenditures in DY 11 will be \$607,825,452 million.
 - b. **Assurance.** As reflected in the LIP participation requirements in STC 77, in DY 11, the state and participating providers who plan to participate in LIP for DY11 will provide assurance that LIP claims include only costs associated with uncompensated care that is furnished through a charity care program for individuals with incomes up to at least 200 percent of the federal poverty level that adheres to the principles of the Healthcare Financial Management Association operated by the provider.
69. **Capped Annual Allotments.** All annual LIP funds must be expended by July 31 following each authorized demonstration year. Any amount not expended does not roll over. Capped annual allotment amounts that are not distributed because of penalties, recoupment due to payments exceeding uncompensated care cost, or are otherwise due to violating the terms of the approved STCs cannot be rolled over to another DY and are not recoverable. LIP dollars that are lost as a result of penalties or recoupment are surrendered by the state and not recoverable.
70. **LIP Reimbursement and Funding Methodology.** The Reimbursement and Funding Methodology Document (RFMD) is prepared by the state and documents LIP permissible expenditures, including the non-federal share and the total computable expenditures. The RFMD provides that total computable LIP payments to providers for uncompensated care costs must be supported by uncompensated care costs incurred and reported by providers as charity care on the provider’s financial records. Through the RFMD, the state must demonstrate that it has reconciled LIP payments to auditable costs. LIP provider payments for uncompensated care as charity care are limited to the uncompensated portion of providers’ allowable costs and, in the aggregate, the authorized LIP pool amount for the demonstration year.
- a. Prior to November 30, 2015, the state must submit a draft of DYs 10 and 11 (2016-2017) RFMDs to CMS for approval and CMS will work with Florida towards approval

by January 31, 2016. However, Florida may not claim federal financial participation for LIP payments in DY 11 until after a revised RFMD is approved by CMS.

- b. For each DY, the state must reconcile LIP payments made to providers to ensure that they do not exceed allowed uncompensated care costs, using the CMS approved RFMD cost review protocol. The state must submit a LIP Cost Reconciliation report to CMS within two years after the end of each DY showing cost reconciliation results by provider. CMS will review the state's reconciliation and share any findings with the state. To the extent that payments are found to exceed allowed uncompensated care costs, the federal portion of any excess payment must be returned to CMS by submitting a decreasing expenditure adjustment (Line 10B). If the state has not submitted its LIP Cost Reconciliation Report for a DY within the timeframe described above, CMS may issue a deferral or disallowance for an amount not to exceed the total of the state's submitted LIP expenditures for that DY.
- c. A provider may at any time during a demonstration year disclose to the state that LIP payments to that provider exceeded allowed uncompensated care costs. The state must report that overpayment on the CMS-64 by submitting a decreasing expenditure adjustment (Line 10B) by the next quarter and no later than one year from the date of disclosure.
- d. Payments from LIP to hospitals are to be considered Medicaid hospital revenue for the purpose of determining the hospital-specific DSH limits defined in section 1923(g) of the Act.
- e. For the purposes of this paragraph, allowed uncompensated care cost follows the definitions described in paragraph 71.

71. Low Income Pool Permissible Expenditures. Funds from the LIP may be used for health care costs (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act.

- a. In DY 10 (SFY 2015-2016), these health care costs may be incurred by the state, or by hospitals, clinics, or by other provider types to furnish medical care for Medicaid, uninsured and underinsured populations for which compensation is not available from other payors, including other federal or state programs. Such costs 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. These health care costs may also include costs for Medicaid services that exceed Medicaid payments (after all other title XIX payments are made, including disproportionate share hospital payments).
- b. In Demonstration Year 11 (SFY 2016-2017), these health care costs may be incurred by the state or by providers to furnish uncompensated medical care as charity care for low-income individuals that are uninsured. The costs must be incurred pursuant to a charity care program that adheres to the principles of the Healthcare Financial Management Association.
 - i. Providers may be categorized in up to two groups: hospitals and Medical School Physician Practices. Each group may be divided into up to four tiered subgroups, based on subdividing a list of the providers ranked by their amount of

uncompensated charity care cost or charges (defined as in (b) above) as a percentage of their privately insured patient care cost or charges—that ratio is the sole basis on which tiered groups may be defined.

- ii. All providers in either group that meet LIP provider participation requirements and that furnished uncompensated charity care must receive some amount of payment with the amounts paid being proportional to the ratio defined in (i) above (i.e. subgroup members that provide greater proportions of uncompensated charity care will fall into tiers with higher percentages of uncompensated care payments).
 - iii. All providers that must receive some amount of payment (following (ii) above) must be paid the same percentage of their charity care cost within each group (or within each tiered subgroup).
 - iv. Determination of (i) through (iii) may be effectuated using contemporaneous uncompensated care data, or equivalent data from a prior year not more than three years prior to the DY.
72. **Low Income Pool Permissible Expenditures 10 percent Sub Cap.** For DY 10, up to \$100 million 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. Hospital costs funded by these payments cannot be included as allowable costs for purposes of any federally- supported program. 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 70.
73. **Low Income Pool Permissible Hospital Expenditures.** Hospital cost expenditures from the LIP will be paid up to 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.
74. **Low Income Pool Permissible Non-Hospital Based Expenditures.** To ensure services are paid up to or at cost, the Reimbursement and Funding Methodology document defines the cost reporting strategies required to support non-hospital based LIP expenditures.
75. **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 PROVIDER PARTICIPATION REQUIREMENTS AND DELIVERABLES

76. **Aggregate LIP Funding.** In DY 10, up to \$1 billion in LIP funds will be available to the state and in DY 11, up to \$607,825,452 million in LIP funds will be available to the state. This amount will be limited by any penalties that are assessed by CMS pursuant to STC 78 and/or reconciliation overpayments as discussed in STC 70. Provider Participation requirements, described in STC 77 must be met for the state and facilities to have access to 100 percent of the annual LIP funds.

77. **LIP Provider Participation Requirements.** Hospitals and Medical School Physician Practices who receive LIP funds have certain participation requirements. If they do not meet the participation requirements, they cannot receive LIP funds. The state may grant an exemption to a hospital of the requirement in (a)(ii) upon finding that the hospital has demonstrated that it was refused a contract despite a good faith negotiation with a Specialty Plan. A letter of denial, or some other comparable evidence, will be required to make such a finding.

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.
- iv. In DY 11, the state and participating providers will provide assurance that LIP claims include only costs associated with uncompensated care furnished through the a charity care program for individuals with incomes up to at least 200 percent of the federal poverty level that adheres to the principles of the Healthcare Financial Management Association and is operated by the provider. Such a charity care program must be established prior to the end of DY 10.
- v. In DY 11 for administrative purposes, participating hospitals must be enrolled Medicaid providers and have a minimum of 1 percent Medicaid utilization based on the ratio of Medicaid days to total patient days reported on the most recent accepted Florida Hospital Uniform Reporting System (FHURS) data.

b. **Medical School Physician Practices**

- i. Must participate in the Florida Medical School Quality Network,
- ii. In DY 11, the state and participating providers will provide assurance that LIP claims include only costs associated with uncompensated care through the provider's charity care program for individuals with incomes up to at least 200 percent of the federal poverty level that meets the principles of the Healthcare Financial Management Association. Such a charity care program must be established prior to the end of DY 10.
- iii. In DY 11, participating providers must be enrolled Medicaid providers and have a minimum of 1 percent Medicaid utilization

78. Deliverable Requirements. CMS will reduce available LIP federal funding on an annual basis for the state's failure to meet deliverable requirements. A reduction in available LIP federal funding of \$6 million will be assessed annually for each deliverable requirement that is not met. The annual penalty applies to the demonstration year in which the deliverable is due, even if the deliverable itself pertains to a different demonstration year. LIP federal dollars that are lost as a result of deliverable requirements not being met, are surrendered by the state through a CMS-64 adjustment (Summary Line 9D Other). Deliverable requirements include but are not limited to the following:

- a. Timely submission of an annual estimate and annual final uncompensated care report. Submission by June 1 of each year, detailing for the upcoming demonstration year, the projected LIP providers, the estimated per provider of uncompensated care to be furnished through charity care, and the IGTs associated with each provider. Submission by October 1 of each year, for the demonstration year just ended, the final report of the LIP providers, uncompensated care claimed through charity care and the final IGTs. Both the estimate and final report must also be posted on the state Medicaid website.
- 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.
- c. Timely submission of all demonstration deliverables as described in the STCs including the submission of Quarterly and Annual Reports.
- d. Timely submission of all other reporting requirements under Sections XVI, General reporting Requirements, XIX, Evaluation of the Demonstration and XX, Measurement of Quality of Access to Care and Improvement.

Appendix C – Hospital Cost Cost Review Protocol

Hospital's LIP Cost Limit

1. Hospital's Medicaid Fee-For-Service (FFS)

For the State payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are to be determined using the hospital's Medicare cost report (CMS-2552) on file with Florida Medicaid for the annual rate setting. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified from Worksheet B Part I Column 24, lines 30 through 93. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2

The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 8. The hospital's total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non-medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid FFS inpatient routine cost center costs for the payment year, the hospital's actual inpatient Medicaid days by cost center, as obtained from MMIS and other auditable hospital records for the period covered by the as-filed cost report, will be used. The days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term care services are excluded.

Step 5

To determine Medicaid FFS ancillary costs for the payment year, the hospital's actual Medicaid FFS allowable charges, as obtained from MMIS and other auditable hospital records for the period covered by the as-filed cost report, will be used. Medicaid FFS allowable charges for observation beds must be included in line 62. These Medicaid FFS allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid FFS allowable costs for each cost center. The Medicaid FFS allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.

Step 6

The Medicaid allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-4 Part III under the Part B cost column line 62. This ratio is then multiplied by net total organ acquisition costs from Worksheet D-4 Part III under the Part A Column 1 cost column line 61 less line 66. For this calculation, a usable organ is defined as the number of organs excised and furnished to an organ procurement organization. Medicaid "usable organs" are counted as the number of Medicaid patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid days and charges in Steps 4 and 5 above, or any Medicaid managed care or uninsured charity care days and charges in Steps 4 and 5 of those portions of this protocol. After program organ cost is determined, reduce the cost amount by Medicaid global organ transplant payments and out of state Medicaid organ transplant payments.

Step 7

The Medicaid FFS allowable costs are determined by adding the Medicaid routine costs from Step 4, the Medicaid ancillary costs from Step 5 and the Medicaid organ acquisition costs from Step 6.

2. Hospital's Medicaid Managed Care

For the State payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's Medicare cost report(s) (CMS-2552) covering the payment year, as filed with Florida Medicaid. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified from Worksheet B Part I Column 26. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2

The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 8. The hospital's total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non-medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid managed care inpatient routine costs for the payment year, the hospital's actual Medicaid managed care inpatient days by cost center, as obtained from auditable hospital records and other applicable sources for the period covered by the as-filed cost report will be used. The days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid managed care allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term care services are excluded.

Step 5

To determine the Medicaid managed care ancillary costs for the payment year, the hospital's actual Medicaid managed care charges, as obtained from auditable hospital records and other applicable sources for the period covered by the as-filed cost report will be used. Medicaid managed care allowable charges for observation beds must be included in line 62. These Medicaid managed care allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid managed care allowable costs for each cost center. The Medicaid managed care allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.

Step 6

The Medicaid managed care allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid managed care usable organs as identified from provider records to the hospital's total usable organs from Worksheet

D-4 Part III under the Part B Cost column 2 line 62. This ratio is then multiplied by total organ acquisition costs from Worksheet D-4 Part III under the Part A Cost column 1 line 61 less line 66. "Medicaid managed care usable organs" are counted as the number of Medicaid managed care patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid managed care days and charges in Steps 4 and 5 above (or any Medicaid days or uninsured charity care days in Steps 4 and 5 of those portions of this protocol). Reduce Medicaid managed care organ transplant cost by organ transplant managed care Medicaid payments.

Step 7

The Medicaid managed care allowable costs are determined by adding the Medicaid managed care routine costs from Step 4, the Medicaid managed care ancillary costs from Step 5 and the Medicaid managed care organ acquisition costs from Step 6.

3. Hospital's Uninsured Charity Care

For the payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's most recent as filed Medicare cost report (CMS-2552), as filed with Florida Medicaid. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital actual costs are identified from Worksheet B Part I Column 26. These are the costs that have already been reclassified, adjusted and stepped down through the A and B worksheet series.

Step 2

The hospital's total actual days by routine cost center are identified from Worksheet S-3 Part 1 Column 8. The hospital's total actual charges by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total actual costs from Step 1 by total actual days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total actual costs from Step 1 by the total actual charges from Step 2. The A&P routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's actual costs for the payment year. The data sources utilized to determine eligible costs under this section must be derived from the hospitals audited financial statements and other auditable documentation. The hospital costs for care provided to those

with no source of third party coverage (i.e., uninsured charity care cost) for the payment year are determined as follows:

Step 4

To determine the uninsured charity care routine cost center costs for the payment year, the hospital's actual inpatient days by cost center for individuals with no source of third party coverage are used. The actual uninsured charity care days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the low income uncompensated care inpatient costs for each cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term care services are excluded.

Step 5

To determine the uninsured charity care ancillary cost center actual costs for the payment year, the hospital's inpatient and outpatient actual charges by cost center for individuals with no source of third party coverage are used. These allowable uninsured charity care charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the uninsured charity care allowable costs for each cost center. The uninsured charity care charges for the payment year should only pertain to inpatient and outpatient hospital services and should exclude charges pertaining to any professional services or non-hospital component services such as hospital-based providers.

Step 6

The uninsured charity care share of organ acquisition costs is determined by first finding the ratio of uninsured charity care usable organs to total usable organs. This is determined by dividing the number of uninsured charity care usable organs as identified from provider records by the hospital's total usable organs from Worksheet D-4 Part III under the Part B Cost column 2 line 62. This ratio is then multiplied by total organ acquisition costs from Worksheet D-4 Part III under the Part A Cost column 1 line 61 less 66. "Uninsured charity care usable organs" are counted as the number of patients who received an organ transplant and had no insurance. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid or uninsured charity care days and charges in Steps 4 and 5 above or Steps 4 and 5 of the Medicaid (or Medicaid managed care) portion of this protocol. Reduce the cost calculated for uninsured charity care organ transplant cost by uninsured charity care organ transplant payments.

Step 7

The eligible uninsured charity care costs are determined by adding the uninsured charity care routine costs from Step 4, uninsured charity care ancillary costs from Step 5 and uninsured charity care organ acquisition costs from Step 6.

Actual uninsured charity care data for services furnished during the payment year are used to the extent such data can be verified to be complete and accurate. The data sources utilized to determine eligible costs under this section must be derived

from hospitals' audited financial statements and other auditable documentation. Coinsurance and deductibles should be removed from uninsured charity care costs.

4. Unallowable LIP Expenditures

According to STC 71, "Funds from the LIP may be used for health care costs (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act." The following costs may not be claimed as LIP expenditures. Please note that this listing is not exhaustive but is meant to be representative of the types of cost that may not be claimed. If a provider or the State is unclear about the allowability of a cost, the onus is on the provider and the State to clarify the allowability and provide the cost documentation to support the cost in question. Such expenditures need to be approved by CMS and the State prior to the submission of the reconciliation for the applicable period for the expenditures. The State of Florida is available to provide technical assistance about which cost may be claimed as LIP expenditures.

- Cost associated with funding LIP expenditures, including intergovernmental transfers (IGTs).
- Cost of capital goods that are purchased on behalf of another agency.
- Over-allocation of cost shared by multiple programs.
- Bad Debts
- Medicaid and CHIP Shortfalls
- Uninsured charity care coinsurance and deductibles.

5. Hospital Payments and Recoveries

All of the following payments and recoveries associated with cost derived from LIP permissible expenditures shall be offset against the costs computed in the Sections above including but not limited to:

- Uninsured charity care and supplemental payments.
- Medicaid reimbursement in excess of the hospital cost of care.
- DSH payments received. The DSH payments amount will be calculated based on a ratio that excludes DSH payments that cover any Medicaid shortfalls:
 - Using the most current Federal DSH Audit submitted to CMS (submitted December 31, 2016), the State will calculate the percentage of Charity Care charges to total charges associated with each DSH facility. That percentage will then be applied to the DSH payments for SFY 2016-17 and these calculations will be shown in detail by provider in the cost limit reconciliation provided to CMS.. The prorated DSH payment will be reported in the LIP Cost Limit revenues.
- Any related patient co-payments including third party collection agencies.
- LIP payments received for the benefit of uninsured charity care.
- Payments to the hospital from uninsured charity care individuals for their care for the fiscal year are identified from the hospital's records. Such uninsured charity care data must be supported by auditable documentation.

6. Hospital Cost Limit Reconciliation for DY11

The CMS-2552 costs determined through the method described for the payment year will be reconciled to the as filed CMS-2552 cost report for the payment year once the cost report has been filed with the Medicare Fiscal Intermediary (FI). If, at the end of the interim reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the Federal government.

The above hospital cost limits must further be reconciled to actual uninsured charity costs as computed based on the finalized cost report for the payment year. Again, the same cost methodology as previously discussed is used, except that the per diems, cost-to-charge ratios, and other cost report data are computed based on the finalized cost report for the payment year.

For hospitals whose cost report year is different from the State's fiscal year, the State will proportionally allocate to the State fiscal year the costs of two hospital cost report periods encompassing the State fiscal year. To do so, the State will obtain the actual uninsured charity care days and charges for the hospital's cost reporting periods, and compute the aggregate uninsured charity care costs for the reporting periods. These costs will then be proportionally allocated to the State fiscal year. All allocations will be made based upon number of months. (For example, a hospital's cost reporting period ending 12/31/12 encompasses one-half of the State plan rate year ending 6/30/2012, and one-half of the State plan rate year ending 6/30/2013. To fulfill reconciliation requirements for State plan rate year 2012-13, the hospital would match one-half of the uninsured charity care costs from its reporting period ending 12/31/2012, and one-half of the uninsured charity care costs from its reporting period ending 12/31/2013, to the State plan rate year.) The State will ensure that the total costs claimed in a State plan rate year will not exceed the costs justified in the underlying hospital cost reports for the applicable years.

As reflected in the LIP participation requirements in STC 77, in DY11, the state and participating providers who plan to participate in LIP for DY11 will provide assurance that LIP claims include only costs associated with uncompensated care that is furnished through a charity care program for individuals with incomes up to at least 200 percent of the federal poverty level that adheres to the principles of the Healthcare Financial Management Association operated by the provider.