DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

**State Demonstrations Group**

MAR 15 2018

Beth Kidder
Deputy Secretary for Medicaid
State of Florida, Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 8
Tallahassee, FL 32308

Dear Ms. Kidder:

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(a) demonstration, titled Managed Medical Assistance (MMA) Program (Project No. 11-W-00206/4). We are writing to approve the state's latest revisions of the RFMD for demonstration year (DY) 12—which were submitted to CMS on March 15, 2018. A copy of the approved DY12 RFMD is enclosed with this letter.

If you have questions or concerns, please contact your assigned project officer, Ms. Vanessa Khoo. Her contact information is as follows:

Vanessa Khoo
Centers for Medicare & Medicaid Services
7500 Security Boulevard
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Baltimore, MD 21244-1850
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E-mail: Vanessa.khoo@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Khoo and to Mr. Charles Friedrich, Acting Associate Regional Administrator, in our Atlanta Regional Office. Mr. Friedrich's contact information is as follows:

Charles Friedrich
Centers for Medicare & Medicaid Services
Atlanta Federal Center, 4th Floor
61 Forsyth Street, SW Suite 4T20
Atlanta, GA 30303-8909
Telephone: (404) 562-7404
E-mail: Charles.Friedrich@cms.hhs.gov

We look forward to continuing to partner with you and your staff throughout the course of the MMA demonstration program.

Sincerely,

[redacted]

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

cc: Charles Friedrich, Acting Associate Regional Administrator, CMS Region IV

# Reimbursement and Funding Methodology For Demonstration Year 12

# Florida's 1115 Managed Medical Assistance Waiver

# Low Income Pool

**February 23, 2018**

## Table of Contents

## 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). The RFMD was originally submitted on August 30, 2017 to fulfill the request by CMS in the STCs approved August 3, 2017 to submit a Low Income Pool (LIP) cost review protocol for Demonstration Year (DY) 12 by August 31, 2017. This RFMD is an updated version of the RFMD that was submitted on August 30, 2017 to align with the STCs that were amended on December 20, 2017.

LIP is defined in STC 60 (see Appendix B) as government support for safety net providers for the costs of uncompensated charity care for low-income individuals who are uninsured. Uncompensated care includes charity care for the uninsured but does not include uncompensated care for insured individuals, "bad debt," or Medicaid and Children's Health Insurance Program (CHIP) shortfall. STC 63a (see Appendix B) requires the submittal of the RFMD prior to August 1, 2017.

Included in this RFMD, 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 STCs 64-67 (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:

A. 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 assurance to each local government that its providers will not receive

less from LIP than if the local government provided direct financial assistance to its providers.

B. An evaluation of services typically included 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 services such as physician services, clinic services, drugs or limited benefit packages as they present lower risks than critical hospital services.

C. 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 medical care as charity care which is defined in STC 64a (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 uncompensated charity care; and

iii. LIP payments to providers will not be in excess of total incurred costs of Medicaid covered services for the uninsured, charity care recipients.

## II. Reimbursement Methodology

The financing and fund distributions for DY12 LIP will be modeled based on the cost of uncompensated care as defined in STC 64 (see Appendix B). 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 69 (see Appendix B). The distribution will be made to qualifying providers after the Agency: 1) receives executed Letters of Agreement from participating cities, counties, municipalities, and health care taxing districts; 2) receives the state share of funding; 3) verifies the submission of all required LIP Cost Limit documentation; and 4) providers meet all of the DY 12 LIP participation requirements.

## III. Definitions

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

Demonstration Year – July 1 – June 30

Demonstration Year 12 – July 1, 2017 – June 30, 2018

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 operated by the provider and that adheres to the principles of the Healthcare Financial Management Association. The service is provided regardless of the recipient's ability to pay.

## IV. LIP Permissible Expenditures

LIP is subject to specific STCs 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

### A. Planning

According to the STC 65, "The State 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 costs, 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.

### B. 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:

- Must be authorized or not prohibited under state or local laws or regulations;
- Must 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;

- Must be consistent with policies, regulations, and procedures that apply uniformly to both federal awards and other activities of the governmental unit;

- Must, except as otherwise provided for, be determined in accordance with generally accepted accounting principles;

- Must not be included as a cost or used to meet cost sharing or matching requirements of any other federal award;

- Must be a net of all applicable credits; and

- Must be adequately documented.

The LIP Cost Limits will be calculated using the data described in Appendix C for hospitals, Appendix D for medical school physician practices, Appendix E for federally qualified health centers (FQHC), and Appendix F for Rural Health Centers (RHC). The LIP Cost Limit calculation is the total allowable expenditures less any reimbursement from the uninsured charity care recipients. For each hospital, reimbursement should also include a percentage of the net of its Medicaid Disproportionate Share Hospital (DSH) payment that exceeds the total Medicaid uncompensated care (Medicaid shortfall) reported on the DSH Audit for the corresponding state fiscal year.

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. 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 amount for the demonstration year.

## VI. Redistribution

As reflected in the LIP participation requirements in STC 69 (see Appendix B), the State and participating providers who plan to participate in LIP for DY12 will provide assurance that LIP claims include only costs associated with uncompensated care that is furnished through a charity care program operated by the provider and that adheres to the principles of the Healthcare Financial Management Association.

If the participating provider's LIP payments exceed its allowable uninsured charity costs, as described above, then that provider shall return the LIP overpayment to the State and the State will do a prior period adjustment on CMS-64 Line 10B returning the overpayment to CMS in the quarter the State receives the provider overpayment. After the provider has refunded the overpayment, the State will have the option to redistribute all, or a portion, of the overpayment to other participating LIP providers within the provider group, that have not exceeded their own cost limit. All redistributions must meet the requirements described in STC 64 (see Appendix B). These redistributions are made at the State's discretion and

must be approved by CMS prior to submitting to providers. The redistribution will be applied against the original demonstration year LIP distribution and the State must report the redistributions as a prior period adjustment on CMS-64, Line 8. The redistributions shall be effective for DY12 going forward and will not apply retroactively to a prior demonstration year's LIP distributions.

## VII. Conclusion

This LIP Reimbursement and Funding Methodology Document is submitted to satisfy STC 63 (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 DY11 document.

# APPENDIX A - SFY 2017-18 LIP Distribution & Funding Methodology

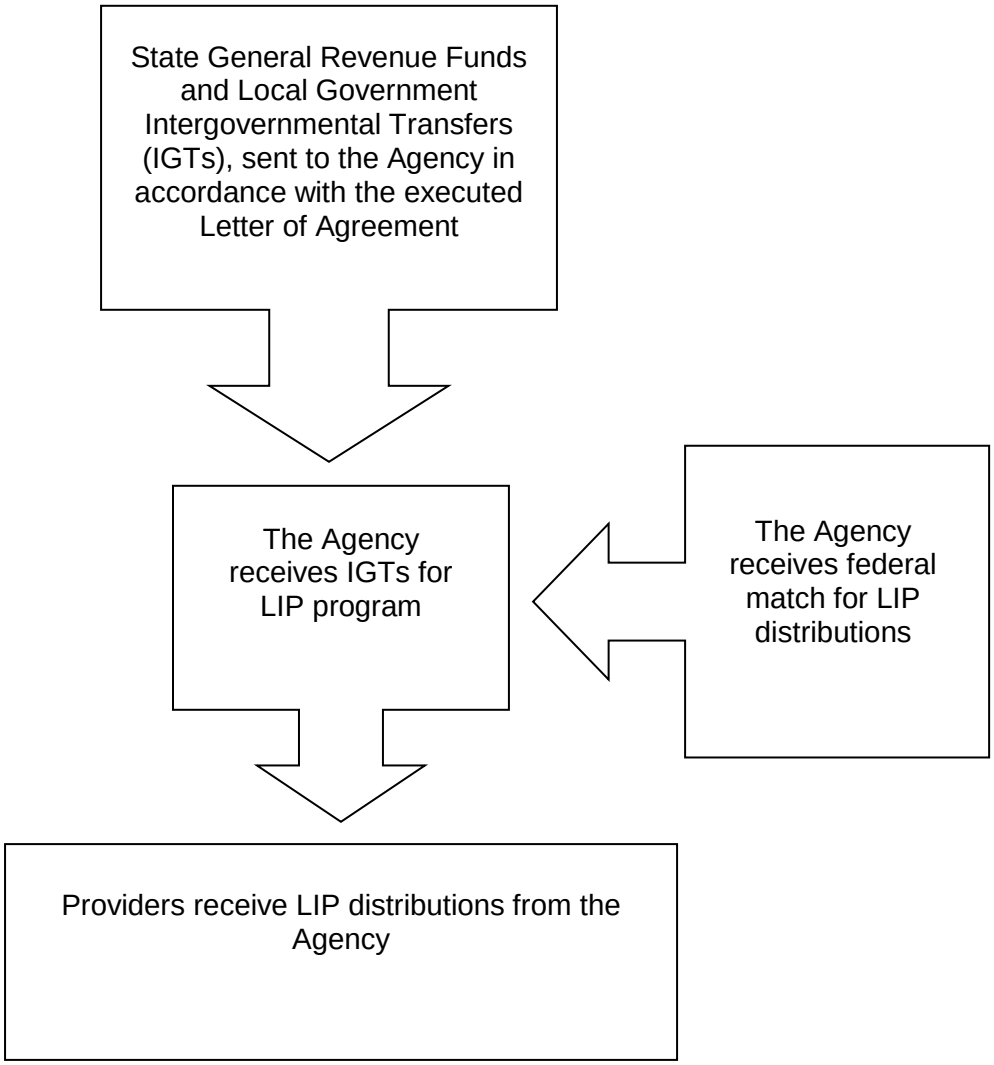
All providers who qualify for a LIP distribution will be reimbursed a percentage of their charity care costs based on the amount of uninsured charity care costs as a percentage of their privately insured patient care costs as determined by the Medicare cost principles.

Participating providers will provide assurance that LIP claims include only costs associated with uncompensated care furnished through a charity care program and 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 one 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/funding_reports.shtml.

## Flow of Intergovernmental Transfers Provided for the LIP Program



# APPENDIX B - LIP Special Terms and Conditions

**60. Low Income Pool Definition**. The LIP provides government support for safety net providers for the costs of uncompensated charity care for low-income individuals who are uninsured. Uncompensated care (UC) includes charity care for the uninsured but does not include UC for insured individuals, "bad debt," or Medicaid and CHIP shortfall. The resulting TC dollar limit is enumerated in STC 61(a).

**61. Availability of Low Income Pool Funds**. The following STC presents the TC dollar limit for LIP spending for the current approval period, DY 12 through 16, subject to the assurances that follow.

a. **Total LIP Amount.** The TC dollar limit for LIP expenditures in each DY will be $1,508,385,773.

b. **Assurance.** As reflected in the LIP participation requirements in STC 69, the state and providers that are participating in LIP will provide assurance that LIP claims include only costs associated with UC that is furnished through a charity care program and that adheres to the principles of the HFMA operated by the provider.

**62. Capped Annual Allotments.** All annual LIP funds must be expended by September 30 following each authorized DY. Any amount not expended cannot be rolled over to the next DY. Capped annual allotment amounts that are not distributed because of penalties, recoupment due to payments exceeding UC cost, or are otherwise due to violating the terms of the approved STCs cannot be rolled over to another DY and are not recoverable.

**63. LIP Reimbursement and Funding Methodology.** The Reimbursement and Funding Methodology Document (RFMD) is prepared by the state for approval by CMS and documents LIP permissible expenditures, including the non-federal share and TC expenditures. The RFMD provides that TC LIP payments to providers for UC costs must be supported by UC 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 UC as charity care are limited to the uncompensated portion of providers' allowable costs and, in the aggregate, the authorized LIP pool amount for the DY.

a. Prior to August 1, 2017, the state must submit a draft of the DY 12 RFMD to CMS for approval–and CMS will work with Florida towards an approval by September 30, 2017. The state may not claim FFP for LIP payments in DY 12 until after the RFMD is approved by CMS.

1. Beginning in DY 13, in the event the RFMD methodology remains unaltered from the previous DY, the state will submit an attestation attached to the previous DY's RFMD stating that "the methodology contained herein remains in effect for the current DY XX," where XX represents the relevant DY.
2. Beginning in DY 13, in the event the RFMD's methodology is altered from the previous DY, in part or in whole, the state will follow the initial RFMD submission process outlined for DY 12 (see STC 70) RFMDs and/or attestations will be due for

each DY to CMS on July 31 and, like all deliverables, should be submitted through the PMDA Portal.[1]

b. For each DY, the state must reconcile LIP payments made to providers to ensure that they do not exceed allowed UC costs, using the CMS approved RFMD cost review protocol. The state must submit a LIP Cost Reconciliation report to CMS within three 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 UC costs, the federal portion of any excess payment must be returned to CMS by submitting a decreasing expenditure adjustment (on Form CMS-64, 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 the DY for which the LIP Cost Reconciliation Report is overdue.

c. A provider may at any time during a DY disclose to the state that LIP payments to that provider exceeded allowed UC costs. If a provider refunds an overpayment to the state, the state must report that refund by including a decreasing expenditure adjustment on Line 10B of the CMS-64 for the quarter that it was received. If the provider reports an overpayment and does not refund that overpayment, the state has one year from the date of discovery, to have the provider refund the overpayment on the CMS-64. If the provider does not refund that overpayment within one year from the date of discovery, the state must refund the overpayment on the CMS-64. Any overpayments that have not been refunded to CMS may be subject to interest as defined under 42 CFR 433.320(a)(4).

d. A provider is not eligible for an LIP payment or continued LIP payments if (i) the provider is identified in a disallowance notice from CMS to the State as having received an LIP overpayment in a specified amount in a prior year; and (ii) the provider has not entered into a repayment agreement satisfactory to the State within 30 days after the date by which the State must credit CMS with the federal share of the specified overpayment, or (iii) the provider is in breach of a repayment agreement. A provider that is ineligible for LIP payments on the basis of the above may re-establish eligibility by making repayment arrangements satisfactory to the state.

e. Payments from LIP to hospitals are to be considered Medicaid hospital revenue for the purpose of determining the hospital-specific disproportionate share hospital **(**DSH) limits defined in section 1923(g) of the Act.

f. For the purposes of this STC, allowed UC cost follows the definitions described in STC 65 below.

**64. 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. 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 who are

[1] Available at https://portal.cms.gov/wps/portal/unauthportal/home/.

uninsured. The costs must be incurred pursuant to a charity care program that adheres to the principles of the HFMA.

1. Providers may be categorized in up to three groups: hospitals, Medical School Physician Practices, and FQHCs/RHCs. Each group may be divided into up to five tiered subgroups, any of which may be based on ownership, UC Ratio, or ownership and UC Ratio. UC Ratio is defined as the amount of a provider's uncompensated uninsured charity care costs (defined in (a) above), expressed as a percentage of its privately insured patient care costs. To define subgroups by UC Ratio, providers must be ranked based on their relative UC Ratios, and may be formed into subgroups based on contiguous ranges of UC Ratios. Hospital ownership subgroups may consist of one or more of the following categories: local government, state government, or private and may be grouped by the hospital's publically owned, statutory teaching, and freestanding children's hospital status. For each DY, up to $50,000,000 of the capped annual allotment of the LIP may be apportioned to FQHCs/RHCs.

2. All providers that must receive some amount of payment (following (1) above) must be paid the same percentage of their charity care cost within each subgroup.

3. Within each group and ownership subgroup, providers in tiers with a lower range of UC Ratios cannot be paid a greater share of their charity care cost than providers in tiers with higher UC Ratios.

4. Determination of (1) through (3) may be effectuated using hospital-specific cost data for the DY for which payments are being allocated, or for a prior year not more than three years prior to that DY.

**65. Low Income Pool Permissible Hospital Expenditures.** Hospital cost expenditures from the LIP will be paid up to cost and are further defined in the RFMD utilizing methodologies from the CMS-2552 cost report plus mutually agreed upon additional costs that will be defined in the RFMD. The state shall not receive FFP for Medicaid and LIP payments to hospitals in excess of cost.

**66. Low Income Pool Permissible Non-Hospital-Based Expenditures.** To ensure services are paid up to or at cost, the RFMD defines the cost reporting strategies required to support non-hospital based LIP expenditures.

**67. 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 as sources of non-federal funding.

## XIV. LOW INCOME POOL PROVIDER PARTICIPATION REQUIREMENTS AND DELIVERABLES

**68. Aggregate LIP Funding**. Up to $1,508,385,773 in LIP funds will be available to the state each DY. That amount will be reduced by any penalties that are assessed by CMS pursuant to STC 62 and/or reconciliation overpayments as discussed in STC 63. Provider Participation requirements, described in STC 69 must be met for the state to draw and providers to be paid from the annual LIP funds for payment to providers.

**69. LIP Provider Participation Requirements**. Hospitals, Medical School Physician Practices, and FQHCs/RHCs must meet the participation requirements set forth in this STC to be eligible to receive LIP funds. The state may grant an exemption to a hospital with respect to the requirement in (a)(ii) below, upon finding that the hospital has demonstrated that it was refused a contract despite a good faith negotiation with a Specialty Plan**.** A letter from a Specialty Plan declining to enter a contract, or some other comparable evidence, will be required to make such a finding.

a. **Hospitals.**

1. Must contract with at least fifty percent of the Standard Plan MCOs in their corresponding region

2. Must contract with at least one Specialty Plan for each target population that is served by a specialty plan in their corresponding region

3. Must participate in the Florida Event Notification System[2] program, except that participation is voluntary for hospitals with 25 or fewer beds.

4. The state and participating providers will provide assurance that LIP claims include only costs associated with UC furnished through a charity care program and that adheres to the principles of the HFMA and is operated by the provider**.**

5. 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**

1. Must participate in the Florida Medical Schools Quality Network

2. The state and participating providers will provide assurance that LIP claims include only costs associated with UC through the provider's charity care program and that meets the principles of the HFMA.

3. Participating providers must be enrolled Medicaid providers and have a minimum of 1 percent Medicaid utilization. The state will review data submitted by the participating providers to determine the percentage of Medicaid utilization.

c. **Federally Qualified Health Centers and Rural Health Clinics**

1. Must contract with each Standard Plan MCO in their region.

2. As part of the contract with the MCO, must agree that it will receive from the MCO the full amount it would receive under the state plan if not contracting with an MCO, meaning that no supplemental wrap-around payments from the state will be necessary.

[2] Available at https://www.florida-hie.net/ens/index.html.

3. Must be enrolled in Medicaid.

**70. Deliverable Requirements.** By June 1 of each year, the state must submit to CMS a report detailing for the upcoming demonstration year, the projected LIP providers, the estimated per provider amount of uncompensated care to be furnished through charity care, and the estimated IGTs associated with each provider. By October 1 of each year, for the demonstration year just ended, the state must submit to CMS the final report of the LIP providers, final 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.

# Appendix C – Hospital Cost Limit Reporting
**Cost Review Protocol**

## Hospital LIP Cost Limit

A. Hospital 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 Medicare Fiscal Intermediary. 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 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 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 65 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. 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.

B. Unallowable LIP Expenditures

According to STC 64, "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.
- Coinsurance and deductibles.
- Costs associated with dual eligibles.
- Uninsured costs that do not meet the Uninsured Charity Care definition under Section III. Definitions.

C. 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:

- Medicaid DSH payments received. The Medicaid DSH payment amount will be calculated based on a ratio that excludes Medicaid DSH payments that cover any Medicaid shortfall (Medicaid costs that exceed Medicaid payments). Using the most current Medicaid DSH Audit submitted to CMS that overlaps the LIP Cost reporting period, the State will calculate the percentage of charity care costs (from Worksheet S-10, Line 21, column 1, for the cost report periods overlapping the DSH audit year) to total Medicaid DSH Audit Inpatient/Outpatient Uninsured Cost of Care associated with each Medicaid DSH facility. That percentage will then be applied to the net (after deducting the Medicaid shortfall) of the hospital's Medicaid DSH payment and these calculations will be shown in detail by provider in the cost limit reconciliation provided to CMS. The prorated Medicaid DSH payment will be reported in the LIP Cost Limit revenue section.
- 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.

D. Hospital Cost Limit Reconciliation for DYs 12 - 16

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. 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 or redistributed in accordance with Section VI of this document.

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 12/31/2012 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.

Along with the cost limit submission, the hospitals will submit a reconciliation of charity care costs associated with the reported data on Medicare cost report worksheet S-10. The reconciliation should differentiate between the categories of charity care costs associated with that hospitals charity care program.

# Appendix D – Medical School Physician Practices Cost Limit Reporting

**Medical School Physician Practices LIP Cost Limit**

The Agency provides for supplemental payments for Medicaid eligible services provided by doctors of medicine and osteopathy as well as other licensed health care practitioners that meet the requirements under STC 69 (Appendix B), and are employed by or under contract with either:

1. A medical school that is part of the public university system (Florida International University, Florida State University, University of Central Florida, University of Florida, University of Florida Jacksonville, and University of South Florida);

2. A private medical school that places over fifty percent (50%) of their residents with a public hospital (University of Miami); or

3. Nova Southeastern University.

For the state payment year, each medical school physician practice must provide the charity care charges, the total cost of care, and the total clinical charges. The total cost of care divided by the total clinical charges is the cost to charge ratio. This cost to charge ratio is applied to the charity charges at each faculty practice and serves as the cost limit for that state fiscal year's LIP payment. All data provided for cost reporting must be based on auditable financial reports.

# Appendix E - FQHC Cost Limit Reporting

**Federally Qualified Health Centers LIP Cost Limit**

A. FQHC Uninsured Charity Care

For the payment year, the allowable cost applicable to FQHC services are determined using the FQHC Form CMS-222-14, as filed with the fiscal intermediary:

1. Determine allowable Medicare Rate per covered visit from Worksheet B part I column 6 line 13.

2. Determine encounters attributable to the uninsured charity care for the payment year from auditable FQHC reports.

3. Multiply encounters attributable to the uninsured charity care to allowable Medicare Rate per covered visit from Step 2. This will result in total uninsured charity care costs.

4. Determine allowable cost per vaccine injection from Worksheet B-1 line 12.

5. Determine uninsured charity care vaccinations for the payment year from auditable FQHC records.

6. Multiply uninsured charity care vaccinations to allowable cost per vaccine injection from Step 4. This will result in total uninsured charity care costs for vaccinations.

7. Sum the result of Step 3 and Step 6 to determine total allowable uninsured charity care cost for the payment year.

8. Offset all revenues received from individuals with no source of third party coverage against the total uninsured charity care costs in Step 7 to determine uninsured charity care shortfall.

B. FQHC Provider Additional Uninsured Costs

1. Lab - Cost per encounter for uninsured charity care if services are being paid for by the FQHC.

2. X-ray - Cost per encounter for uninsured charity care if services are being paid for by the FQHC.

3. Pharmacy - Cost per encounter for uninsured charity care if services are being paid for by the FQHC.

4. Dental – Cost per encounter for dental can be captured uninsured charity care due to the fact that dental cost is not included in the Medicare rate.

5. Mental Health – Cost per encounter for Medicare, excluding services allowable by Medicaid, should be added to the uninsured charity care.

C. FQHC Revenue Breakdown

For the payment year, the FQHC Revenue corresponding to the allowable cost are as follows:

1. Self-pay

2. Other (describe)

D. FQHC Reconciliation for DY12

The CMS-222-92 costs determined through the method described for the payment year will be reconciled to the as-filed CMS-222-92 cost report for the payment year once the cost report has been filed with the Medicare fiscal intermediary. If at the end of the LIP reconciliation process it is determined that an FQHC received an overpayment, the provider must return to overpayment to the State and, per the requirements under section VI, those funds may be redistributed to other providers that have not exceeded their cost limit. For purposes of this reconciliation, the same steps as outlined for the payment year method are carried out.

For an FQHC whose cost report year is different from the State's fiscal year, the State will proportionally allocate the costs of two cost report periods encompassing the plan payment year.

# Appendix F - RHC Cost Limit Reporting

**Rural Health Centers LIP Cost Limit**

A. RHC Uninsured Charity Care

For the payment year, the allowable cost applicable to RHC services are determined using the RHC Form CMS-222-92, as filed with the fiscal intermediary:

1. Determine allowable Medicare Rate per covered visit from Worksheet C part I line 9.

2. Determine encounters attributable to the uninsured charity care for the payment year from auditable RHC reports.

3. Multiply encounters attributable to the uninsured charity care to allowable Medicare Rate per covered visit from Step 2. This will result in total uninsured charity care costs.

4. Determine allowable cost per vaccine injection from Worksheet b-1 line 12.

5. Determine uninsured charity care vaccinations for the payment year from auditable RHC records.

6. Multiply uninsured charity care vaccinations to allowable cost per vaccine injection from Step 4. This will result in total uninsured charity care costs for vaccinations.

7. Sum the result of Step 3 and Step 6 to determine total allowable uninsured charity care cost for the payment year.

8. Offset all revenues received from individuals with no source of third party coverage against the total uninsured charity care costs in Step 7 to determine uninsured charity care shortfall.

B. RHC Provider Additional Uninsured Costs

1. Lab - Cost per encounter for uninsured charity care if services are being paid for by the RHC.

2. X-ray - Cost per encounter for uninsured charity care if services are being paid for by the RHC.

3. Pharmacy - Cost per encounter for uninsured charity care if services are being paid for by the RHC.

4. Dental – Cost per encounter for dental can be captured uninsured charity care due to the fact that dental cost is not included in the Medicare rate.

5. Mental Health – Cost per encounter for Medicare, excluding services allowable by Medicaid, should be added to the uninsured charity care.

C. RHC Revenue Breakdown

For the payment year, the RHC Revenue corresponding to the allowable cost are as follows:

58. Self-pay

59. Other (describe)

D. RHC Reconciliation for DY12

The CMS-222-92 costs determined through the method described for the payment year will be reconciled to the as-filed CMS-222-92 cost report for the payment year once the cost report has been filed with the Medicare fiscal intermediary. If at the end of the reconciliation process it is determined that an RHC received an overpayment, the provider must return to overpayment to the State and, per the requirements under section VI, those funds may be redistributed to other providers that have not exceeded their cost limit. For purposes of this reconciliation, the same steps as outlined for the payment year method are carried out.

For an RHC whose cost report year is different from the State's fiscal year, the State will proportionally allocate the costs of two cost report periods encompassing the plan payment year.