DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

State Demonstrations Group

May 5, 2022

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

Dear Mr. Wallace:

Thank you to you and your staff for submitting the Reimbursement and Funding Methodology Document (RFMD) for Florida's Low-Income Pool (LIP), in accordance with the special terms and conditions of the state's section 1115(a) demonstration, titled "Managed Medical Assistance (MMA) Program" (Project No. 11-W-00206/4). The state's RFMD for demonstration year (DY) 16, which was submitted to CMS on April 21, 2022, is approved. A copy of the approved RFMD is enclosed with this letter.

If you have questions or concerns, please contact your assigned project officer, LT Jack Nocito. His contact information is as follows:

LT Jack Nocito
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop: S2-01-16
Baltimore, MD 21244-1850
E-mail: Jack.Nocito@cms.hhs.gov

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

Sincerely,

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure
cc: Tandra Hodges, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

Reimbursement and Funding Methodology For Demonstration Year 16

Florida's 1115 Managed Medical Assistance Waiver

Low Income Pool

August 31, 2021
Revised April 21, 2022

Table of Contents

I. OVERVIEW 3
II. REIMBURSEMENT METHODOLOGY 4
III. DEFINITIONS 4
IV. LIP PERMISSIBLE EXPENDITURES 5
V. PLANNING AND RECONCILIATION 5
VI. REDISTRIBUTION 6
VII. CONCLUSION 7
APPENDIX A - SFY 2018-19 LIP DISTRIBUTION & FUNDING METHODOLOGY 8
APPENDIX B - LIP SPECIAL TERMS AND CONDITIONS 10
APPENDIX C - HOSPITAL COST LIMIT REPORTING 16
APPENDIX D - MEDICAL SCHOOL PHYSICIAN PRACTICES COST LIMIT REPORTING 20
APPENDIX E - FQHC COST LIMIT REPORTING 21
APPENDIX F - RHC COST LIMIT REPORTING 24
APPENDIX G – COMMUNITY BEHAVIORAL HEALTH PROVIDERS COST LIMIT REPORTING 27

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 January 15, 2021 to submit a Low Income Pool (LIP) cost review protocol for Demonstration Year (DY) 16. The STCs approved on January 15, 2021 allow for the extension of the waiver and the Low Income Pool program through 2030.

LIP is defined in STC 61 (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 64a (see Appendix B) requires the submittal of the RFMD for DY 16 prior to August 31 of the DY for CMS approval. The state may not claim federal financial participation (FFP) for LIP payments in that DY until after the RFMD for that DY has been approved by CMS.

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 65-67 (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 residents of Florida. CMS does not require Florida to assist with the funding of any other state’s Medicaid program, but allows Florida to use its state share specifically for the benefit of its residents. 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. The State has adopted a distribution methodology based on costs associated with uncompensated medical care as charity care which is defined in STC 66a (see Appendix B).

Because the available funds are not sufficient to cover all uninsured charity care, 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 DY16 LIP will be modeled based on the cost of uncompensated care as defined in STC 65 (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) verifies providers meet all of the DY 16 LIP participation requirements; 2) receives executed Letters of Agreement from participating cities, counties, municipalities, and health care taxing districts; 3) receives the state share of funding; and 4) verifies the submission of all required LIP Cost Limit documentation.

III. Definitions

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

Demonstration Year – July 1 – June 30

Demonstration Year 16 – July 1, 2021 – June 30, 2022

Uninsured: Persons with no source of third party coverage on the date of service captured within a defined cost reporting period. Persons with third party coverage will be considered uninsured if on the dates of service their benefits are fully exhausted. Persons will not be considered uninsured if their claim was denied by insurance for billing errors such as untimely filings or the service was non-covered under Medicaid.

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. For providers with a charity care policy that includes a sliding fee scale, the discounted charges will be considered uninsured charity while the portion of the claim assigned as the patient liability/ nominal fee will not be considered uninsured charity. 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 66 "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 reimbursement 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. AHCA has contracted with a CPA firm to perform and examination to determine whether LIP payments were made in excess of the LIP cost limit calculated in accordance with the RFMD. Providers submit a LIP cost reconciliation roughly 2 years after the original payment. The examination is completed 3 years after the original payment.

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), Appendix F for Rural Health Centers (RHC), and Appendix G for Community Behavioral Health providers. 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 DY16 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 65, STC 66, and STC 67 (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 65 (see Appendix B). This updated version of the Reimbursement and Funding Methodology Document is submitted to CMS in order to update the April 17, 2019 DY13 document.

APPENDIX A - SFY 2020-21 LIP Distribution & Funding Methodology

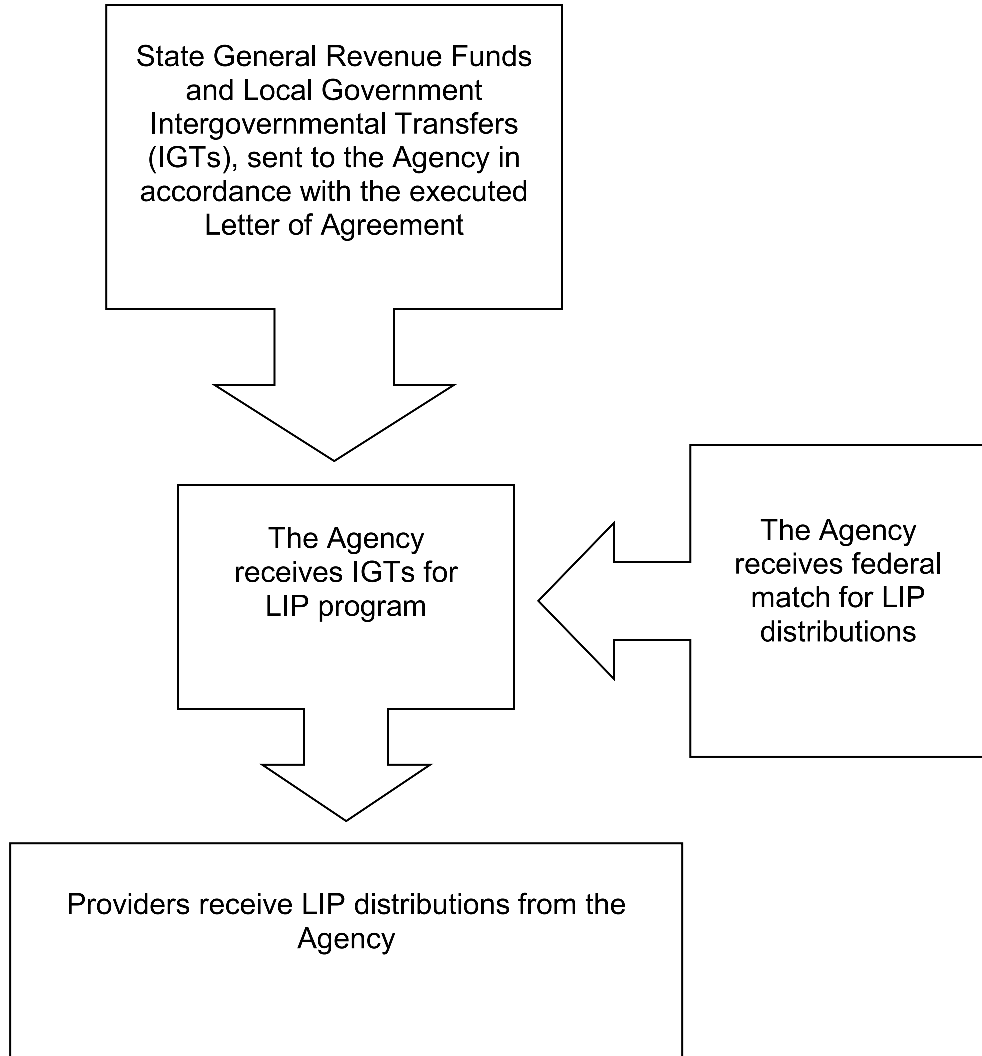
All providers who qualify for a LIP distribution will be reimbursed a percentage of their charity care costs based on the amount of uninsured charity care costs as a percentage of their privately insured patient care costs as determined by the Medicare cost principles.

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/index.shtml .

Flow of Intergovernmental Transfers Provided for the LIP Program



APPENDIX B - LIP Special Terms and Conditions

61.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 total computable (TC) dollar limit is enumerated in STC 62(a).

62. 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 through DY 16.

b. **Assurance**. As reflected in the LIP participation requirements in STC 71, 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.

c. **Reassessment of Hospitals’ Uncompensated Charity Care in DY17.** Low Income Pool limits for DY 17-21 will be revised based on a reassessment of the amount of uncompensated charity care cost provided by Florida hospitals, to take place by March 31, 2022. The state and CMS will collaborate on the reassessment, which will be based on information reported by hospitals for federal fiscal year 2019 on schedule S-10 of the CMS 2552-10 hospital cost report, with adjustment to ensure that LIP payments under this demonstration do not offset hospital costs in the calculation, following a methodology approved by CMS. The results of the reassessment will be used to revise the Total LIP Amount for DY 17-21.
i. If the reassessment discussed in in this STC is not completed to produce an updated LIP limit by July 1, 2022, all payments from the LIP will be unavailable until the reassessment is complete.
ii. When the 2019 S-10 data specified above becomes available, the state and CMS will collaborate to recalculate the Total LIP Amount for DY 17-21 based on this updated information. The recalculated Total LIP Amount will become the final Total LIP Amount for DY 17-21.
iv. The revised Total LIP Amount may not exceed $2,167,718,341 per DY, for the period covered by DY 17-21.

d. Reassessment of Hospitals’ Uncompensated Charity Care in DY22. Low Income Pool limits for DY 22 – DY 24will be revised based on a reassessment of the amount of uncompensated charity care cost provided by Florida hospitals, to take place by March 31, 2027. The state and CMS will collaborate on the reassessment, which will be based on information reported by hospitals for periods beginning in federal fiscal year 2025 on schedule S-10 of the CMS 2552-10 hospital cost report, with adjustment to ensure that LIP payments under this demonstration do not offset hospital costs in the calculation, following a methodology approved by CMS. The results of the reassessment will be used to revise the Total LIP Amount for DY 22 - DY 24.

i. If the reassessment discussed in this STC is not completed to produce an updated LIP limit by July 1, 2027, all payments from the LIP will be unavailable until the reassessment is complete.
ii. When 2025 S-10 data specified above becomes available, the state and CMS will collaborate to recalculate the Total LIP Amount for DY 22 - DY 24 based on this updated information. The recalculated Total LIP Amount will become the final Total LIP Amount for DY 22 - DY24.
iii. The revised Total LIP Amount may not exceed $2,167,718,341 per DY for the period covered by DY 22-24.

63. **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.

64. **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 31 of each DY, the state was required to submit a draft of the RFMD for that DY to CMS for approval. The state could not claim FFP for LIP payments in that DY until after the RFMD was approved by CMS.

    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 that has been examined and attested by an independent accountancy firm to CMS within four years after the end of each DY showing cost reconciliation results by provider as required under 42 C.F.R. § 455.304. 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.

e. 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. 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.

65. **Low Income Pool Permissible Expenditures.** Funds from the LIP may be used to defray the actual uncompensated cost of furnishing medical services described in section 1905(a)(1) et seq. of the Act to uninsured individuals incurred by qualifying providers.

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

i. Providers may be categorized in up to four groups: hospitals, Medical School Physician Practices, FQHCs/RHCs, and Community Behavioral Health Providers. 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, or (for purposes of FQHCs/RHCs only) Section 330 Public Health Service Act grant type, or FQHC Look-Alike status. 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. UC Ratio for FQHCs/RHCs is defined as the amount of a provider's uncompensated uninsured charity care costs (defined in (a) above), expressed as a percentage of its total 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 publicly owned, statutory teaching, freestanding children's, and Regional Perinatal Intensive Care Center hospital status. For each DY, up to $75,000,000 of the capped annual allotment of the LIP may be apportioned to FQHCs/RHCs. FQHCs/RHCs may be tiered in subgroups by the type of Section 330 Public Health Service Act grant type and FQHC Look-Alike status.

ii. 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.

iii. 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.

iv. 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.

66. **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.

67. **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.

68. **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.

XV. LOW INCOME POOL PROVIDER PARTICIPATION REQUIREMENTS AND DELIVERABLES

69. **LIP Provider Participation Requirements.** In addition to any other applicable requirements, to be eligible for LIP funding, essential providers, must offer to contract with each managed care plan in the state and must make a good faith effort to enter into a network contract with each statewide Medicaid managed care (SMMC) plan and each SMMC specialty plan. "Essential providers" are defined as faculty plans of Florida medical schools and hospitals licensed as specialty children's hospitals.6 If the state determines that an essential provider has not offered and negotiated in good faith to enter into a network contract with each managed care plan, then the state will notify the essential provider at least 90 days in advance of the start of the third quarter of the state fiscal year that LIP payments will not be made to the essential provider beginning with the third quarter of the state fiscal year and informing the essential provider how it may avail itself of hearing rights. Annually, 60 days after the state legislative process has

concluded, the state must submit a letter to CMS indicating Florida legislative approval. The essential provider contracting requirement will be suspended should the Florida legislature no longer require this participation requirement as indicated in the letter submitted to CMS.

Hospitals, Medical School Physician Practices, FQHCs/RHCs, and Community Behavioral Health Providers 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 69(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. The state may grant an exemption to an FQHC/RHC with respect to the requirement in 69(c)(i) below, upon finding that the FQHC/RHC has demonstrated that it was refused a contract despite a good faith negotiation with a Standard Plan. A letter from a Standard Plan declining to enter a contract, 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 MCOs in their corresponding region.

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

iii. Must participate in the Florida Encounter Notification System[5] program, except that participation is voluntary for hospitals with 25 or fewer beds.

iv. 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.

v. 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.

vi. This LIP category also includes Regional Perinatal Intensive Care Centers as an eligible hospital subgroup, effective December 1, 2018. Regional Perinatal Intensive Care Centers have special perinatal intensive care capabilities as defined in section 383.16, Florida Statutes.

b. **Medical School Physician Practices**

i. Must participate in the Florida Medical Schools Quality Network.

ii. 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 adheres to the principles of the HFMA.

iii. 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**

i. Must contract with at least 50 percent of Standard Plan MCOs in their corresponding region.

ii. Must be enrolled in Medicaid.

d. **Community Behavioral Health Providers**

i. Community Behavioral Health providers are providers in the substance abuse and mental health safety net system (Central Receiving Systems) administered by the Florida Department of Children and Families. A Central Receiving System consists of a designated central receiving facility and other service providers that serve as a single point or a coordinated system of entry for individuals needing evaluation or stabilization under section 394.463 or section 397.675, Florida Statutes, or crisis services as defined in section 394.67, Florida Statutes.

ii. Community Behavioral Health providers is a LIP provider category effective as of December 1, 2018.

iii. 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 24. 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 audited 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 organ acquisition revenues received for uninsured charity organs furnished to other providers. "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 acquisition cost by uninsured charity care organ acquisition 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 audited documentation.

B. Unallowable LIP Expenditures

According to STC 66, "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.
- Costs associated with other providers receiving LIP payments
- 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 Medicaid DSH Audit which aligns with the LIP cost reporting period, the State will calculate the percentage of charity care costs (from LIP cost limit form) 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 audited documentation.

D. Hospital Cost Limit Reconciliation

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 LIP demonstration year, the State will proportionally allocate to the LIP demonstration year the costs of two hospital cost report periods encompassing the LIP demonstration 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 LIP demonstration year. All allocations will be made based upon number of days. (For example, a hospital's cost reporting period ending 12/31/2012 encompasses 183 days of the state plan rate year ending 6/30/2012, and 183/365 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 50.14% of the uninsured charity care costs from its reporting period ending 12/31/2012, and 49.86% of the uninsured charity care costs from its reporting period ending 12/31/2013, to the LIP demonstration year. The State will ensure that the total costs claimed in a LIP demonstration 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 71 (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 should exclude non-allowable costs using Medicare cost report principles. 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. Any revenues received from the uninsured charity individuals should be offset against the total uninsured charity cost. The resulting total serves as the cost limit for that state fiscal year's LIP payment. All data provided for cost reporting must be based on audited financial reports.

If at the end of the LIP reconciliation process it is determined that a Medical School Physician Practice received an overpayment, the provider must return to overpayment to the State and those funds may be redistributed to other providers that have not exceeded their cost limit per the requirements under section VI. For purposes of this reconciliation, the same steps as outlined for the payment year method are carried out.

For a Medical School Physician Practice whose cost report year is different from the LIP demonstration year, the State will proportionally allocate the costs of two cost report periods encompassing the LIP demonstration year.

Appendix E - FQHC Cost Limit Reporting

Federally Qualified Health Centers LIP Cost Limit

A. FQHC Uninsured Charity Care for Medical and Mental Health Visits

For the payment year, the allowable cost applicable for medical and mental health visits to FQHC services are determined using the FQHC Form CMS-224-14, as filed with the fiscal intermediary:

1. Determine allowable cost per covered visit from Worksheet B part I column 6 line 13.
2. Determine visits attributable to the uninsured charity care for the payment year from FQHC reports. The uninsured charity care visit must be a covered Medicaid service.
3. Multiply visits attributable to the uninsured charity care to allowable cost per covered visit from Step 1. 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 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 Uninsured Charity Care for Dental Visits

For the payment year, the allowable cost applicable for dental services to FQHC services are determined using the FQHC Form CMS-224-14, as filed with the fiscal intermediary:

a. Determine allowable dental service cost from Worksheet A, line 60, Column 7. Note that FQHC provider may use Worksheet A Other FQHC Service cost centers 60.00-69.00. Provider must submit working trial balance support to demonstrate only dental expense are included in the cost report line.

b. Determine total dental visits from FQHC reports.

c. Calculate a dental cost per visit by dividing total in Step a by total in Step b.

d. Determine dental visits attributable to the uninsured charity care for the payment year from FQHC reports. The uninsured charity care dental visit must be a covered Medicaid service.

e. Multiply visits attributable to the uninsured charity care to the dental cost per visit. This will result in total uninsured charity care dental costs.

f. Offset all revenues received from individuals with no third party overage against the total uninsured charity care costs in Step 5 to determine uninsured charity care shortfall for dental services.

C. FQHC Provider Additional Uninsured Costs

FQHC CMS Form 224-14 includes Other FQHC Services (Worksheet A Lines 60-69.01). The portion of uninsured charity care costs for laboratory, X-ray, and pharmacy services that were not included in the cost per visit, will be calculated using the methodology below:

1. Calculate the uninsured charity care utilization by dividing total uninsured charity care medical and mental health visits by total visits within the cost limit form.

2. Determine laboratory, X-ray, and/or pharmacy expense from FQHC CMS Form 224-14 Worksheet A Lines 61, 62, and/or 67, Column 7.

3. Determine the overhead expense related to the add-on costs by multiplying the additional expense total from Step 2 to the general service cost multiplier from Worksheet B, Part I, line 12, column 4. This will result in total expense for additional services.

4. Multiply the uninsured charity utilization calculated in Step 1 against the total cost of additional services from Step 3.

D. FQHC Providers with Low or Zero Utilization Medicare Cost Reports

FQHC providers filing a zero or low utilization FQHC Form CMS 224-14, must provide the uninsured charity care charges, the total cost of care, and the total facility charges to calculate a cost to charge ratio in lieu of the 224-14 cost per visit. The total cost of care should exclude non-allowable costs using Medicare cost report principles. The total allowable cost of care divided by the total facility charges is the FQHC's cost-to-charge ratio. This cost-to-charge ratio is applied to the uninsured charity charges for each FQHC. Any revenues received from the uninsured charity care individuals will be offset against the total uninsured charity cost. The resulting total serves as the cost limit for that state fiscal year's LIP payment. All data provided for cost reporting must be based on audited financial reports.

E. FQHC Reconciliation

The CMS-224-14 costs determined through the method described for the payment year will be reconciled to the as-filed CMS-224-14 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 those funds may be redistributed to other providers that have not exceeded their cost limit per the requirements under section VI. 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 LIP demonstration year, the State will proportionally allocate the costs of two cost report periods encompassing the LIP demonstration year.

Appendix F - RHC Cost Limit Reporting

Rural Health Centers LIP Cost Limit

A. RHC Uninsured Charity Care for Medical and Mental Health Visits

For the payment year, the allowable cost applicable to RHC services are determined using the RHC Form CMS-222-17, as filed with the fiscal intermediary:

1. Determine allowable cost per covered visit from Worksheet C part I line 7.
2. Determine visits attributable to the uninsured charity care for the payment year from RHC reports. The uninsured charity care visit must be a covered Medicaid service.
3. Multiply visits attributable to the uninsured charity care to allowable cost per covered visit from Step 1. 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 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 Uninsured Charity Care Dental Services

For the payment year, the allowable cost applicable for dental services to RHC services are determined using the RHC Form CMS-222-17, as filed with the fiscal intermediary:

a. Determine allowable dental service cost from Worksheet A, line 76, Column 7. Provider must submit WTB support to demonstrate only dental expense are included in the cost report line.

b. Determine total dental visits from RHC reports.

c. Calculate a dental cost per visit by dividing total in Step a by total in Step b.

d. Determine uninsured charity care dental visits for the payment year from RHC reports. The uninsured charity care dental visit must be a covered Medicaid service.

e. Multiply uninsured charity care dental visits to the dental cost per visit. This will result in total uninsured charity care dental costs.

f. Offset all revenues received from individuals with no third party overage against the total uninsured charity care costs in Step 5 to determine uninsured charity care shortfall for dental services.

C. RHC Provider Additional Uninsured Costs

RHC CMS Form 222-17 includes Costs Other Than RHC Services (Worksheet A Lines 75-81). The portion of uninsured charity care cost for pharmacy, and any other allowable Medicaid costs listed in these cost centers using the methodology below:

1. Calculate the uninsured charity care utilization by dividing total uninsured charity care medical and mental health visits by total visits within the cost limit form.

2. Determine pharmacy expense and any other costs listed in the applicable cost centers from RHC CMS Form 222-17 Worksheet A Lines 75, Column 7.

3. Determine the overhead expense related to the add-on costs by dividing the costs by the cost of all services from Worksheet B Part II, Line 14 and multiplying the ratio by total overhead from Worksheet B Part II, Line 16. Add the calculated overhead to the Worksheet A, Column 7 cost, resulting in total expense for additional services.

4. Multiply the uninsured charity utilization calculated in Step 1 against the total cost of additional services from Step 2.

D. RHC Providers with Low or Zero Utilization Medicare 224-17 Cost Reports

Providers filing a zero or low utilization RHC Form CMS 222-17, must provide the uninsured charity care charges, the total cost of care, and the total facility charges to calculate a cost-to-charge ratio in lieu of the 222-17 cost per visit. The total cost of care should exclude non-allowable costs using Medicare cost report principles. The total allowable cost of care divided by the total facility charges is the RHC's cost-to-charge ratio. This cost-to-charge ratio is applied to the uninsured charity charges at each RHC. Any revenues received from the uninsured charity care individuals be offset against the total uninsured charity cost. The resulting total serves as the cost limit for that state fiscal year's LIP payment. All data provided for cost reporting must be based on audited financial reports.

58. Other (describe)

E. RHC Reconciliation

The CMS-222-17 costs determined through the method described for the payment year will be reconciled to the as-filed CMS-222-17 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 those funds may be redistributed to other providers that have not exceeded their cost limit per the requirements under section VI. 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 LIP demonstration year, the State will proportionally allocate the costs of two cost report periods encompassing the LIP demonstration year.

Appendix G – Community Behavioral Health Providers Cost Limit Reporting

Community Behavioral Health Providers LIP Cost Limit

The Agency provides supplemental payments for Medicaid eligible services provided by Community Behavioral Health providers. Community Behavioral Health providers are providers in the substance abuse and mental health safety net system (Central Receiving System) administered by the Florida Department of Children and Families. A Central Receiving System consists of a designated central receiving facility and other service providers that serve as a single point or a coordinated system of entry for individuals needing evaluation or stabilization under section 394.463, or section 397.675, Florida Statutes, or crisis services defined in section 394.67, Florida Statutes.

For the state payment year, each Community Behavioral Health provider must provide the charity care charges, the total cost of care, and the total facility charges. The total cost of care should exclude non-allowable costs using Medicare cost report principles. The total cost of care divided by the total charges is the cost to charge ratio. This cost to charge ratio is applied to the uninsured charity charges at each central receiving system. Any revenues received from the individuals with no third party coverage should be offset against the total uninsured charity cost. The resulting total serves as the cost limit for that state fiscal year's LIP payment. All data provided for cost reporting must be based on audited financial reports.

If at the end of the LIP reconciliation process it is determined that a Community Behavioral Health provider received an overpayment, the provider must return to overpayment to the State and those funds may be redistributed to other providers that have not exceeded their cost limit per the requirements under section VI. For purposes of this reconciliation, the same steps as outlined for the payment year method are carried out.

For a Community Behavioral Health provider whose cost report year is different from the LIP demonstration year, the State will proportionally allocate the costs of two cost report periods encompassing the LIP demonstration year.