Hospital LIP/DSH Letter of Agreement

THIS LETTER OF AGREEMENT (LOA) made and entered into in duplicate on the _____ day of _____ 20__, by and between «IGT_PROVIDER» (the «TYPE») on behalf of «PROVIDERS COVERED», and the State of Florida, through its Agency for Health Care Administration (the Agency),

1. Per House Bill 50__, the General Appropriations Act of State Fiscal Year 20__- 20__, passed by the 20__ Florida Legislature, «TYPE» and the Agency, agree that «TYPE» will remit to the State an amount not to exceed a grand total of «TOTAL».

    a. The «TYPE» and the Agency have agreed that these funds will only be used to increase the provision of health services for the Medicaid, uninsured, and underinsured people of the «TYPE» and the State of Florida at large.

    b. The increased provision of Medicaid, uninsured, and underinsured funded health services will be accomplished through the following Medicaid programs:

        i. The Disproportionate Share Hospital (DSH) program.

        ii. The annual cap increase on outpatient services for adults from $___ to $____.

        iii. Medicaid Low Income Pool (LIP) payments to rural hospitals, trauma centers, specialty pediatric hospitals, primary care services and other Medicaid participating safety-net hospitals.

        iv. Medicaid LIP payments to hospitals in the approved appropriations categories.

        v. Medicaid LIP payments to Provider Access Systems (PAS) for Medicaid and the uninsured in rural areas.

        vi. Medicaid LIP payments for the expansion of primary care services to low income, uninsured individuals.

2. The «TYPE» will pay the State an amount not to exceed the grand total amount of «TOTAL». The «TYPE» will transfer payments to the State in the following manner:

    a. The first quarterly payment of «M_1ST_QTR» for the months of July, August, and September is due upon notification by the Agency.

    b. Each successive payment of «M_4th_qtr» is due as follows, Month __, 20__, Month __, 20__ and Month __, 20__.

    c. The State will bill the «TYPE» when each quarterly payment is due.

3. Attached are the DSH and LIP schedules reflecting the anticipated annual distributions for State Fiscal Year 20__-20__.

4. The «TYPE» and the State agree that the State will maintain necessary records and supporting documentation applicable to Medicaid, uninsured, and underinsured health services covered by this LOA. Further, the «TYPE» and State agree that the «TYPE» shall have access to these records and the supporting documentation by requesting the same from the State.

5. The «TYPE» and the State agree that any modifications to this LOA shall be in the same form, namely the exchange of signed copies of a revised LOA.

6. The «TYPE» confirms that there are no pre-arranged agreements (contractual or otherwise) between the respective counties, taxing districts, and/or the providers to re-direct any portion of these aforementioned Medicaid supplemental payments in order to satisfy non-Medicaid, non-uninsured, and non-underinsured activities.

7. The «TYPE» agrees the following provision shall be included in any agreements between the «TYPE» and local providers where funding is provided for the Medicaid program. Funding provided in this agreement shall be prioritized so that designated funding shall first be used to fund the Medicaid program (including LIP) and used secondarily for other purposes.

8. This LOA covers the period of Month __, 20__ through Month __, 20__15 and shall be terminated Month __, 20__.

LIP/DSH/SWI Local Intergovernmental Transfers (IGTs)	
Program / Amount	**State Fiscal Year 20__-20__**
Low Income Pool Program	«LIP_PAS_Hospital_LIP»
Disproportionate Share Hospitals Program	«DSH»
Total Funding	**«TOTAL»**

WITNESSETH:

IN WITNESS WHEREOF the parties have duly executed this LOA on the day and year above first written.

«IGT_PROVIDER» State of Florida

_____ _____

Signature Stacey Lampkin
Assistant Deputy Secretary for Medicaid Finance,
Agency for Health Care Administration

_____

Name

_____

Title