

Reimbursement and Funding Methodology

Florida Medicaid Reform Section 1115 Waiver

Low Income Pool



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I. Overview

In accordance with the Special Terms and Conditions (STCs) for waiver number 11-W-00206/4, Medicaid reform Section 1115 Demonstration the State of Florida, Agency for Health Care Administration (AHCA), Medicaid program, (the State) submits to the Centers for Medicare and Medicaid Services (CMS) this Reimbursement and Funding Methodology Document. This document fulfills STC Pre-Implementation Milestone requirement number 100(a).

In addition to the Reimbursement and Funding Methodology document, the State is providing the definition of expenditures eligible for Federal matching funds and the entities eligible to receive reimbursement.

Permissible expenditures are discussed in STC 94;

“Funds from the LIP may be used for health care expenditures (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act. These healthcare expenditures may be incurred by the State, by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services for the uninsured, Medicaid shortfall (after all other Title XIX payments are made) may include premium payments, payments for provider access systems (PAS) and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the State and CMS.”

Included in this document is the methodology used for the distribution of the \$1 billion annual LIP funds as provided for in the STC. Provider's in receipt of LIP funds 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 III 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.

- A. The LIP is defined in STC 91 to “...ensure continued government support for the provision of health care services to Medicaid, underinsured and uninsured populations.”

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

1. Although the State appreciates the \$1 billion available through the LIP, it is important to recognize that the \$1 billion is insufficient to fund a statewide benefit for the uninsured determined by a broad based methodology incorporating more than one healthcare service. Florida simply has too many uninsured individuals (estimated between 2.8 million

and 3.2 million)¹ and healthcare services are too expensive to provide broad benefits to all potential eligibles.

2. 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 (see Appendix A for a flow chart of local government funds provided for the LIP 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's Medicaid program, but allows Florida to use its state share specifically for the benefit of its citizens. The State has adopted a similar philosophy for how local funds are considered within the LIP. Although the State is not promoting a predetermined benefit for the local governments providing funding, the State does recognize that it is inappropriate to require a local government to assist with the funding of a benefit for providers outside that local government's area without consideration of the benefits received by providers within its political subdivision. The State believes it is sound public policy to provide each local government the assurance that its providers will not receive less from LIP than if the local government provided direct financial assistance to its providers.

3. An evaluation of services typically covered within a coverage model generally results in a broad array of services that vary in cost per unit and the financial risk for the insured related to the use of such services. An individual may be able to afford a dental visit or a single pharmaceutical, but would incur significant financial risk if a lengthy or acute hospital stay was required. Therefore, consistent with the prioritization of covered services in Medicare Part A and the general insurance market, the State recognizes a priority of services subject to coverage from the LIP. Just as Medicare and commercial coverage attempts to cover hospital services first, the LIP recognizes that the uninsured must have their hospital risk addressed first. Subsequent to addressing the hospital risk, the LIP can then address subsequent services such as physician services, clinic services, drugs or limited benefit packages as they present lower risks than critical hospital services.

4. Barring sufficient funding for a methodology that allows adequate coverage of needed services for Florida's uninsured, the State has adopted a basic distribution methodology similar to CMS' methodology of providing a predetermined pool to fund the uninsured, underinsured and Medicaid shortfalls. In accordance with STC 101 "Providers with access

¹ Florida Health Insurance Study 2004

to the LIP and services funded from the LIP shall be known as the provider access system[s]" (PAS). The State has created separate and unique payment methodologies that recognize different PAS options. These PAS distributions will be used to contribute primarily toward healthcare services provided to the uninsured and underinsured, although the distributions alone will not totally fund such services. Providers will be asked to report the number of services made available through programs receiving LIP funding, and no LIP funding will exceed the cost of such services.

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

1. Hospital services are prioritized in the distribution methodology;
2. 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 Medicaid, the uninsured and the underinsured; and
3. Providers will receive less than 100% of the cost of services for the uninsured, underinsured, and Medicaid shortfalls.

C. The following is a detailed description of the State's recommended Reimbursement and Funding Methodology document for LIP expenditures for state fiscal year (SFY) 2006-07. Attachment A is for reference only, and provides CMS with a point of reference for the anticipated distribution of funds within the various PAS. The Agency for Health Care Administration (AHCA) must wait for legislative appropriation authority, in addition to CMS approving the Funding and Reimbursement Methodology, before any distributions can be made. The State asks that CMS please note that charity care and Medicaid days serve as the primary allocation statistics.

II. Recommended Reimbursement Methodology

The State's recommended distributions of the LIP funds are separated into seven distinct categories. Some of the providers may be eligible to receive a LIP distribution in more than one category. The categories vary based on type of provider and services offered. These categories include some funding for hospital providers who received hospital inpatient Upper Payment Limit (UPL) distributions. It is essential to these safety-net providers that AHCA maintain at least a portion of the vital levels of funding as part of the transition from UPL to the LIP. Below is a description of the five PAS categories as approved by the Florida Legislature in the General Appropriations Act (GAA) for SFY 2006-07 and proposed to CMS for inclusion in the LIP Reimbursement and Funding Methodology. For your reference Attachment A provides the anticipated distributions by provider and by category based on the methodologies discussed below.

- A. The first PAS category represents distributions that existed during SFY 2005-2006 as part of the UPL. The hospitals that receive these distributions are considered some of Florida's core safety-net providers serving a significant portion of Florida's Medicaid, uninsured and underinsured population. There are five categories representing the transition from UPL to LIP which total \$141,060,821 of the \$1 billion. The transition programs are described below.
1. Of the total amount, \$106,098,400 is for distributions to hospitals that serve as a safety-net hospital in providing emergency, specialized pediatric trauma services and inpatient hospital care as part of the PAS.
 2. AHCA recommends continuing distributions to specialty pediatric centers. To qualify for a specialty pediatric payment, a hospital must be licensed as a children's specialty hospital and its combined Medicaid managed care and fee for service days as a percentage to total inpatient days must equal or exceed 30 percent. The total distribution of \$2,000,000 shall be distributed equally to the qualifying hospitals.
 3. The Level I and II trauma hospitals shall receive a total distribution of \$12,375,000. Of this amount, \$5,355,000 shall be distributed equally among hospitals that are a Level I trauma center; \$4,500,000 shall be distributed equally among hospitals that are either a Level II or pediatric trauma center; and \$2,520,000 shall be distributed equally among hospitals that are both a Level II and pediatric trauma center.
 4. Distributions to primary care hospitals will be made to the hospitals who participated in the Primary Care Disproportionate Share Hospital (DSH) program, s. 409.9117, F.S., in State Fiscal Year 2003-2004. They shall be paid \$12,203,921 distributed in the same proportion as the Primary Care DSH payments for 2003-2004. Payments may not be made to a hospital unless the hospital agrees to:
 - a) Cooperate with a Medicaid prepaid health plan, if one exists in the community;
 - b) Ensure the availability of primary and specialty care physicians to Medicaid recipients who are not enrolled in a prepaid capitated arrangement and who are in need of access to such physicians;
 - c) Coordinate and provide primary care services free of charge, except copayments, to all persons with incomes up to 100 percent of the federal poverty level who are not otherwise covered by Medicaid or another program administered by a governmental entity, and to provide such services based on a sliding fee scale to all persons with incomes up to 200 percent of the federal poverty level who are not otherwise covered by Medicaid or another program administered by a governmental entity, except that eligibility may be limited to persons

who reside within a more limited area, as agreed to by the agency and the hospital;

- d) Contract with any federally qualified health center, if one exists within the agreed geopolitical boundaries, concerning the provision of primary care services, in order to guarantee delivery of services in a nonduplicative fashion, and to provide for referral arrangements, privileges, and admissions, as appropriate. The hospital shall agree to provide at an onsite or offsite facility primary care services within 24 hours to which all Medicaid recipients and persons eligible under this paragraph who do not require emergency room services are referred during normal daylight hours;
- e) Cooperate with the agency, the county, and other entities to ensure the provision of certain public health services, case management, referral and acceptance of patients, and sharing of epidemiological data, as the agency and the hospital find mutually necessary and desirable to promote and protect the public health within the agreed geopolitical boundaries;
- f) In cooperation with the county in which the hospital resides, develop a low-cost, outpatient, prepaid health care program to persons who are not eligible for the Medicaid program, and who reside within the area;
- g) Provide inpatient services to residents within the area who are not eligible for Medicaid or Medicare, and who do not have private health insurance, regardless of ability to pay, on the basis of available space, except that nothing shall prevent the hospital from establishing bill collection programs based on ability to pay;
- h) Work with the Florida Healthy Kids Corporation and business health coalitions, as appropriate, to develop a feasibility study and plan to provide a low-cost comprehensive health insurance plan to persons who reside within the area and who do not have access to such a plan;
- i) Work with public health officials and other experts to provide community health education and prevention activities designed to promote healthy lifestyles and appropriate use of health services; and
- j) Work with the local health council to develop a plan for promoting access to affordable health care services for all persons who reside within the area, including, but not limited to, public health services, primary care services, inpatient services, and affordable health insurance generally.

Any hospital that fails to comply with any of the provisions of this subsection, or any other contractual condition, may not receive payments under this section until full compliance is achieved.

5. The final category to receive a distribution representing the transition from UPL to LIP is for rural hospitals. The total distribution for rural hospitals is \$8,383,500 which shall be distributed in the same proportion as the rural Disproportionate Share (s. 409.9116, F.S.) Hospital payments. A primary element in the rural DSH formula is the sum of charity care days and Medicaid days divided by total patient days. In computing the total amount earned by each rural hospital, the agency uses the average of the 3 most recent years of actual data, from the Florida Hospital Uniform Reporting System (FHURS). In order to receive payments under this section, a hospital must be a rural hospital as defined in s. 395.602, F.S., and must meet the following additional requirements:

- a) Agree to conform to all agency requirements to ensure high quality in the provision of services, including criteria adopted by agency rule concerning staffing ratios, medical records, standards of care, equipment, space, and such other standards and criteria as the agency deems appropriate as specified by rule;
- b) Agree to accept all patients, regardless of ability to pay, on a functional space-available basis;
- c) Agree to provide backup and referral services to the county health departments and other low-income providers within the hospital's service area, including the development of written agreements between these organizations and the hospital; and
- d) For any hospital owned by a county government which is leased to a management company, agree to submit on a quarterly basis a report to the Agency, in a format specified by the Agency, which provides a specific accounting of how all funds dispersed under this act are spent.

B. The second PAS category is designated for public, non-state owned, hospitals. The distributions are separated into four tiers described below. The total distributions to the providers in this category are \$578,000,000.

1. Public hospitals receiving local tax support and greater than 150,000 Medicaid and charity care days shall be paid \$313,473,121 to be allocated to each hospital based on their percentage of Medicaid and charity care days to the total.
2. Public hospitals or systems receiving local tax support and the hospital or system have less than 150,000 Medicaid and charity care days, but the hospital or system have more than 45,000 Medicaid and charity care days shall be paid \$204,526,879. These funds shall be allocated

to the hospitals based on their percentage of Medicaid and charity care days to the total for all the hospitals in this group. If a system has more than 65,000 Medicaid and charity care days then the days for each of their hospitals shall receive a weight of 1.24.

3. Public hospitals or systems receiving local tax support and having less than 45,000 Medicaid and charity care days, but the hospital or system has more than 8,500 Medicaid and charity care days shall be paid \$50,000,000. These funds shall be allocated to the hospitals based on their percentage of Medicaid and charity care days to the total for all the hospitals in this group.
4. Public hospitals or systems, except hospitals classified as rural, with no local tax support shall be paid \$10,000,000. These funds shall be allocated to each of the hospitals based on each hospital's percentage of Medicaid and charity care days to the total for the hospitals in that group.

These payments are referred to as LIP 1 on Attachment A.

- C. A third PAS category is for providers in communities where the local government support for health care expenditures for the uninsured or underinsured to hospitals is greater than \$1,000,000. These providers will receive a total distribution of \$180,000,000. To be included in this grouping, the local government must provide a minimum of \$1,000,000 in financial support for the hospitals in its political boundary. Payments will be allocated to each of the hospitals based on its percentage of charity care days to the total charity care days for all the hospitals in the group. In allocating the payments, each hospital will be capped at 120 percent of the amount of local funding it would have received from its local government for uninsured and underinsured individuals without the low income pool program. Any funds that remain unspent after the first allocation shall then be reallocated to the hospitals based on their percentage of charity care days to the total charity care days for the group. These payments are referred to as LIP 2 on Attachment A.
- D. The fourth PAS category will be for hospitals that do not receive local government support for health care expenditures for the uninsured or underinsured or whose local governments provide \$1,000,000 or less in support for the uninsured or underinsured. Additionally, to receive funds under this provision, a hospital's Medicaid days, charity care days and fifty percent of bad-debt days divided by the hospital's total days must equal or exceed ten percent. Payments shall be allocated to hospitals that qualify under this provision based on their percentage of Medicaid days, charity care days and fifty percent of bad-debt days to the total Medicaid days, charity care days and fifty percent of bad-

debt days for all the hospitals that qualify under this provision. Payments made under this section are referred to as LIP 3 on Attachment A. The total distribution for this category shall be \$80,489,174.

There is no overlap with a PAS in LIP 1, LIP 2 or LIP 3.

- E. The State recommends PAS distributions of \$3,173,750 to hospitals who operate poison control programs. The Florida Poison Information Center Network (FPICN), which was created in 1989 by an act of the Florida Legislature (s. 395.1027, F.S), consists of Poison Centers in Tampa, Jacksonville, and Miami; and a data center located in Jacksonville. Pursuant to s. 395.1027, F.S.:

“There shall be created three certified regional poison control centers, one each in the north, central, and southern regions of the state. Each regional poison control center shall be affiliated with and physically located in a certified Level I trauma center. Each regional poison control center shall be affiliated with an accredited medical school or college of pharmacy. The regional poison control centers shall be coordinated under the aegis of the Division of Children's Medical Services Prevention and Intervention in the department.

Each regional poison control center shall provide the following services:

- a. Toll-free access by the public for poison information;*
- b. Case management of poison cases,*
- c. Professional consultation to health care practitioners;*
- d. Prevention education to the public; and*
- e. Data collection and reporting.”*

These three nationally accredited poison control centers provide emergency services to the entire state and are operational 24 hours a day, 7 days a week.

- F. Distributions to the Federal Qualified Health Centers (FQHC), in the amount of \$15,276,255 represent the sixth PAS recommended by the State. There are two ways an FQHC can qualify for a LIP distribution. One method is for the FQHC to qualify for matching funds from the Florida Department of Health (DOH), the total distribution for this method shall be \$7,276,255. AHCA and DOH are working together to determine the methodology for the remaining \$8,000,000 distributions.

Of the \$7,276,255, DOH will match, up to a total per State Fiscal Year, of \$1,500,000, any local government IGT provided to AHCA on behalf of an FQHC for a LIP distribution. The participating FQHCs must go through an intense competitive review process with DOH in order to qualify for these funds. The

FQHCs must show that they are increasing access to primary care services in rural and underserved areas of Florida by expanding their services.

Eligible applicants include health centers funded by the federal government under Section 330 of the Public Health Service Act (42 U.S.C. 254b et seq.).

An FQHC must serve new patients by requesting funding for operating costs or for capital improvement projects. Applicants must provide comprehensive primary and preventive health services in compliance with federal laws and expectations and must meet the requirements outlined in s. 409.9125(5) F.S., the “Community Health Center Access Program Act”.

- G. The remaining \$2,000,000 PAS is for distributions to county health initiatives emphasizing the expansion of primary care services. Of the \$2,000,000, \$1,000,000 is provided to St. Johns River Rural Health Network to develop and fund Provider Access Systems for Medicaid and the uninsured in rural areas. Of this amount, \$600,000 will be designated for use in Baker, Clay and Nassau Counties, the rural component of the pilot for Medicaid Reform. An allocation of \$200,000 for Bradford County and \$200,000 for Union County will be designated for services to low income, uninsured adults. The remaining \$1,000,000 is provided to expand primary care services to low income, uninsured individuals to be allocated as follows: \$200,000 to Sarasota County, \$200,000 to Charlotte County, \$200,000 to Lee County, \$200,000 to Okaloosa County and \$200,000 to Walton County. Program specifics will be finalized in consultation with respective county governments.

III. Low Income Pool Permissible Expenditures

In accordance with STC 97, 98 and 100(a), the State is required to submit permissible expenditures for hospitals and non-hospital based providers to ensure services are paid at cost. The permissible expenditures are referred to by the State as the LIP Cost Limit. Below are the factors the State is recommending for inclusion in the LIP Cost Limits.

A. Hospital Expenditures

The following paragraphs are separated into two categories. The first category is eligible hospital Medicaid expenditures with the second focusing on hospital Uninsured/Underinsured expenditures. STC 97 requires;

“Hospital cost expenditures from the LIP will be paid at cost and will be further defined in the Reimbursement and Funding methodology Document utilizing methodologies from the CMS-2552 cost report plus

mutually agreed upon additional costs. The State agrees that it shall not receive FFP [Federal Financial Participation] for Medicaid and LIP payments to hospitals in excess of cost....”

1. Hospital Medicaid Expenditures

Medicaid costs eligible for FFP will be broken out into components:

- a. Hospital Base Costs
 - determined by methodologies in the CMS-2552 report applicable to hospitals, and
- b. Additional Hospital Provider Costs
 - costs incurred by the hospital provider, but excluded from the calculation of fee for service (FFS) reimbursement rates using cost reporting methodologies, or
 - an appropriate proxy for costs incurred but excluded from the calculation of the FFS rates.

The Agency will use each hospital’s most recently filed CMS-2552 cost report and supporting documents for all of the calculations discussed in this section titled Hospital Expenditures (see Appendix B for a sample of provider cost reports).

2. Hospital Provider Additional Medicaid Costs

STC 97 requires that the Agency utilizes methodologies from CMS-2552 cost report plus mutually agreed upon additional costs. Hospital providers may have costs incurred but excluded from the calculation of FFS reimbursement rates using cost reporting methodologies. Any net shortfall in Medicaid reimbursement below these costs should be included as additional costs. The additional costs for the Medicaid population may include;

- a. Hospital-based physician services
 - 1) Part A provider component services in excess of Reasonable Compensation Exception (RCE) limits
 - 2) Part B professional component services (not separately billable to individual patients)
- b. Physician unmet guarantee amounts and other subsidies
- c. Non-physician practitioner costs
- d. Outpatient clinical laboratory services
- e. Provider-based ambulance services
- f. Provider-based transplant services indirect organ acquisition costs
- g. Provider-based clinic services
- h. Patient and community education programs, excluding cost of marketing activities

- i. Services contracted to other providers.

These additional costs can be determined by one of the following methods:

- for additional costs, apply a ratio of Medicaid costs (before additions) to total costs (before additions) to the additional costs to obtain the Medicaid portion of the additional costs;
- for additional services, apply a ratio of the costs-to-charges for these services to Medicaid charges for these services to obtain the Medicaid portion of costs for these services.

It is anticipated that all additional costs can be appropriately accounted for through one of the above methods. Medicaid costs for LIP providers include the costs associated for providing services to Medicaid Managed Care individuals.

The total amount for Medicaid costs will be documented on worksheet E-3, Part III, Column 1, line 6 of the CMS-2552 report submitted to the Agency. Additional costs will be documented in detail via the LIP Cost Limit Calculation worksheet (see Appendix C).

3. Hospital Provider Costs for Medicaid Eligibles

Some patients are eligible for Medicaid, but their services are not paid for by the Medicaid program. In some cases, patients have exhausted Medicaid benefit limits. Since qualification for Medicaid eligibility is the same as the State's charity definition for DSH allocation purposes, patients who qualify for Medicaid, but no longer have coverage, have been treated as charity patients.

In other cases, some other form of insurance applies, such as Personal Injury Protection (PIP) insurance, which makes a nominal payment for services. To the extent there is a shortfall in payments compared to the cost of these services, the shortfall should be included in the LIP Cost Limit.

4. Hospital Underinsured and Uninsured Costs

- a. The LIP is established to "ensure continued government support for the provision of healthcare services to Medicaid, underinsured and uninsured populations" (STC 91). The LIP Medicaid expenditures have been identified above. Before defining the LIP expenditures for the underinsured and uninsured, it is important to understand how these expenditures are identified by hospitals.

- b. A definition of “uninsured” is straightforward: the patient has no insurance whatsoever. Charges for services to uninsured patients are most often written off as charity care. However, some patients with no insurance coverage may not meet a provider’s charity care criteria; this may be due to having income or assets exceeding thresholds, or simply failure to submit information to qualify as a charity case. The conclusion is that not all uninsured (and unpaid) patient services become classified as charity care.
- c. This definition also would exclude patients with insurance that does not cover their particular services, or patients with insurance who reach coverage limits. Those patients could be includable under the definition of “underinsured.”
- d. When a patient has some insurance coverage, portions of a claim may go unpaid for reasons other than contractual agreements between the provider and the payer (e.g., patient co-payment requirements, or coverage limitations). In some situations the unpaid balance of a claim for a patient who has some insurance coverage may qualify as charity. Due to the challenges in gathering documentation to justify the distinction between charity and bad debt, there may be cases where the unpaid balance may be written off as bad debt even though it could be charity. Hospitals account for the unpaid balance differently. Once the unpaid balance is written off it is often not possible to differentiate how much of the total (total bad debt or total charity) is due to an inability to pay or an unwillingness to pay.
- e. Section 112(b) of the 1999 Balanced Budget Refinement Act (BBRA, “requires hospitals to submit cost reports containing data on the cost incurred by the hospital for providing inpatient and outpatient services for which the hospital is not compensated.” This is accomplished on Worksheet S-10 of the CMS-2552 hospital cost report. The definition of this uncompensated care amount includes charity and bad debt write-offs. Therefore, for purposes of the LIP, the definition of uninsured and underinsured will be consistent with CMS’ requirements in reporting this information under the BBRA.
- f. Costs of these services can be calculated by applying an average cost-to-charge ratio for the provider to the charges written off as bad debt or charity. This method is consistent with the method used by CMS in the CMS-2552 hospital cost report Worksheet S-10. Costs may include additional costs as noted above in the section titled “Hospital Provider Additional Medicaid Costs”, applicable to the uninsured and underinsured populations. To the

extent there are charges associated with the additional costs (e.g., outpatient clinical laboratory services), those charges should be included in the cost-to-charge ratio as well. Other additional costs (e.g., physician subsidies) do not have related charges to consider.

- g. Providers may also incur costs that are strictly for programs of services furnished to uninsured and underinsured patients. To the extent that they are separately identifiable, these costs should be added in their entirety to the costs of underinsured and uninsured services. Examples of costs include:
 - 1) non-provider-based clinics under the provider's license
 - 2) services contracted to other providers, including services to treat uninsured patients
 - 3) costs associated with securing free drugs for indigent patients
 - 4) drugs and supplies furnished to non-Medicaid patients in inpatient and outpatient settings
- h. It is recommended that the entirety of these costs be included in the LIP Cost Limit.

B. Expenditures for Non-Hospital Providers

1. Non-hospital providers - Medicaid

- a. Not all providers of services to Medicaid, underinsured and uninsured populations are required to file cost reports with AHCA. Some providers file cost reports with their Medicare fiscal intermediary, but such cost reports may exclude any calculation of Medicaid reimbursable costs (eg. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)). Medicaid costs for providers filing Medicare-only cost reports will be determined using the average Medicare cost per patient visit, multiplied by the number of Medicaid visits reported in the cost report or as determined by ACHA Medicaid claims listings.
- b. Some providers are not required to file any cost reports at all. Examples include practitioners, freestanding diagnostic centers, durable medical equipment suppliers, pharmacies, and assisted living facilities participating in the Medicaid waiver. These providers are paid at rates that are independent of individual provider costs. For these providers, an appropriate proxy for costs is needed.
- c. The appropriate proxy for Medicaid costs for health care practitioners (psychiatrists, clinical psychologists, physician assistants, clinical social workers, nurse practitioners, nurse

midwives, certified registered nurse anesthetists), freestanding diagnostic centers, and for durable medical equipment suppliers will be determined by applying the applicable Medicare fee schedule to the services furnished by such practitioners to Medicaid eligible individuals.

- d. The appropriate proxy for Medicaid costs for pharmacies will be determined by applying the lesser of: the average wholesale price (AWP) minus 15.4 percent, the wholesaler acquisition cost (WAC) plus 5.75 percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge billed by the provider, s. 409.912(39)(a)2., F.S.
- e. The appropriate proxy for Medicaid costs for assisted living facilities in the Medicaid waiver should be the Medicaid waiver fee schedule rate.

2. Non-Hospital Providers - Underinsured/Uninsured Costs

- a. Providers may also incur costs that are strictly for programs of services furnished to uninsured patients. To the extent they are separately identifiable, these costs should be added in their entirety to the costs of underinsured and uninsured services. Examples of such costs include:
 - 1) non-provider-based clinics under the provider's license
 - 2) services contracted to other providers, including services to treat uninsured patients
 - 3) costs associated with securing free drugs for indigent patients
 - 4) drugs and supplies furnished to non-Medicaid patients in inpatient and outpatient settings
- b. It is recommended that costs specifically identifiable for underinsured and uninsured patients should be fully included in the LIP Cost Limit.

In order to provide assurance and accountability on behalf of the non-hospital providers submitting permissible expenditure data to the Agency, the Agency will require these providers to submit a Permissible Expenditures Certification Form. A sample of this form is provided in Appendix D.

IV. Shortfall for Medicaid, Uninsured, and Underinsured Costs

- A. Permissible expenditures from the LIP fund may be made for the uncompensated medical care costs of Medicaid, underinsured and uninsured populations. The STCs explicitly indicate that the Medicaid portion would be

the Medicaid “shortfall.” The shortfall is the difference between Medicaid costs and Medicaid payments to the provider. In calculating the Medicaid shortfall, the costs will be reduced by the Medicaid payment .

- B. The amount of charity and bad debt used to compute costs of services to underinsured and uninsured populations will be net of recoveries. Therefore, recoveries of bad debts or payments on charity accounts will be deducted from bad debt and charity write-offs, respectively, before application of any cost-to-charge ratio or inclusion in supplemental cost report forms.
- C. The shortfall for Medicaid, uninsured and underinsured costs is the LIP Cost Limit. All provider types will be required to complete the LIP Cost Limit Calculation worksheet (see Appendix C for an example). The data used will be obtained from a cost report, such as Form CMS 2552 for hospitals, plus any other additional reporting documentation (such as Audited Financial Statements or the provider’s trail balance). As hospitals are the largest provider type for which the Agency will calculate a LIP Cost Limit, hospitals will be used in the example below for the completion of the form.
 - 1. The provider will provide the basic information such as the provider name, Medicaid provider identification number and provider fiscal year period represented.
 - 2. Calculation of the Medicaid shortfall (hospitals):
 - a. In accordance with Section III, A of this document, providers will document Medicaid reimbursable cost as provided on Worksheet E-3, Part III, Column 1, line 6 of the Form CMS-2552. This will be documented on line 1 of the LIP Cost Limit Calculation worksheet.
 - b. Additional costs will be documented in detail on the LIP Cost Limit Calculation worksheet and subtotaled on line 2.
 - c. The additional costs represent total costs (or services, see Section III, A, 2 for the recommended calculation for additional services) to the provider. In order to capture the Medicaid portion of the additional costs, the provider will apply the ratio of Medicaid cost to total hospital cost. Line 3 of the LIP Cost Limit Calculation worksheet represents total hospital cost, from Worksheet C, Column 5, line 101 of the CMS-2552.
 - d. Line 4 is the calculation of the ratio of Medicaid costs to total hospital costs (Worksheet E-3, Part III, Column 1, line 6 divided by Worksheet C, Column 5, line 101 of the Form CMS-2552), referred to as Medicaid utilization.
 - e. Medicaid utilization is multiplied by additional costs to arrive at Medicaid additional costs, line 5.

- f. Line 5a is provided for situations where there is a need to calculate costs associated with additional services.
- g. Additional Medicaid costs (line 5 and 5a) are added to Medicaid costs (line 1) to arrive at total permissible Medicaid expenditures (line 6).
- h. In order to arrive at a Medicaid shortfall, Medicaid payments for the same provider fiscal period are documented on line 7.
- i. Total Medicaid costs (line 6) less Medicaid payments (line 7) represent the Medicaid shortfall, line 8.
- j. LIP distributions are made based on estimated current year activities. Due to the fact that the data used to calculate the Medicaid cost shortfall is for prior period activity, an inflation factor is applied to the Medicaid shortfall. Where a cost report is used to determine a prospective payment rate for a provider, an inflation factor is included in the rate calculation to adjust historical costs to a current period level. The Agency will use this inflation factor as applicable for the LIP Cost Limit calculation.
- k. The total Medicaid shortfall is documented on line 10 as the product of the inflation factor multiplied by the total Medicaid shortfall.

3. Calculation of the uninsured and underinsured shortfall:

- a. The provider's total charity care charges will be documented on line 11. The source of this information will be documented on the LIP Cost Limit Calculation worksheet.
- b. The provider's total bad debts charges (net of Medicare bad debts) will be reported in line 12. The sum of charity and bad debt should equal the total reported on Worksheet S-10 of the CMS-2552.
- c. Charges for other Medicaid eligibles (as discussed in Section III, A, 3 of this document) will be listed on line 13.
- d. Lines 14 and 15 provide additional space to provide a detailed breakdown of other Medicaid eligibles if applicable.
- e. The total of charity, bad debt and Medicaid eligible charges is calculated on line 16.
- f. The total hospital costs (the sum of lines 2 and 3) is reported on line 17. This will be used to obtain a total hospital cost-to-charge ratio which will be applied to the uninsured and underinsured charges.
- g. Total hospital charges, from Worksheet C, Column 8, line 101 of CMS-2552, will be documented on line 18.
- h. The charges related to additional costs (as noted on line 2, "Additional costs") are to be recorded on line 19.
- i. The sum of line 18 and 19 is the total adjusted hospital charges.
- j. Line 21 is adjusted ratio of costs to charges (line 17 divided by line 20).
- k. The cost of the uninsured and underinsured is obtained by multiplying line 16 x line 21.
- l. The amount of charity and bad debt used to compute costs of services to uninsured and underinsured populations will be net of

recoveries. Therefore, recoveries of bad debts or payments on charity accounts will be deducted from bad debt and charity write-offs respectively, before application of any cost-to-charge ratio or inclusion in supplemental cost report forms. Payments for Medicaid eligibles and any other identified applicable payment not already included in any of the above calculations will be documented on line 23.

- m. Directly identified costs of services to the uninsured and underinsured patients (such as costs of medications provided through a provider-owned outpatient clinic) are noted on line 24.
- n. LIP distributions are made based on estimated current year activities. Due to the fact that the data used to calculate the uninsured and underinsured cost shortfall is for prior period activity, an inflation factor is applied to the net uninsured and underinsured shortfall. Where a cost report is used to determine a prospective payment rate for a provider, an inflation factor is included in the rate calculation to adjust historical costs to a current period level. The Agency will use this inflation factor as applicable for the LIP Cost Limit calculation. The total in line 25 is the sum of line 22 (cost of uninsured and underinsured services) less line 23 (Medicaid eligible and other payments) plus line 24 (directly identified costs) multiplied by the inflation factor provide on line 9. The result is the total uninsured and underinsured shortfall.

- 4. The total LIP Cost Limit is the sum of line 10 (the Medicaid shortfall) and line 25 (the undinsured and underinsured shortfall).

V. Planning and Reconciliation

A. Planning

According to the STC number 97 and 98, “the State agrees that it shall not receive FFP for Medicaid and LIP payments to hospitals in excess of cost.” The previous paragraphs provide the methodology for the LIP distributions (Section II) and the calculation of the permissible expenditures (Section III) which will be used to calculate the provider’s total allowable cost, referred to as the LIP Cost Limit. In order to assure no provider will receive greater than cost, the Agency will perform a cost/payment reconciliation prior to any LIP distributions as described below.

Provider LIP Cost Limits will be calculated once a year, prior to the annual LIP distributions. LIP distributions are anticipated to be made monthly or quarterly, this could vary by provider type. The LIP distributions for the five year demonstration period of this waiver are dependent upon the Agency receiving spending authority through the general appropriations act from the

State legislature. The State legislature will receive recommendations from the Low Income Pool Council (LIP Council), but their final appropriation is based on decisions made during the annual legislative session.

In accordance with House Bill 3B (HB 3B), implemented during Special Session 2005, the legislature directed the Agency to create a LIP Council. The LIP Council is comprised of 17 members including representatives from public, non-profit, teaching, rural, and for-profit hospitals in addition to representatives from units of local government which contribute funding. The LIP Council's responsibility, in accordance with HB 3B is to;

- “(a) Make recommendations on the financing of the low-income pool and the disproportionate share hospital program and the distribution of their funds.*
- (b) Advise the Agency for Health Care Administration on the development of the low-income pool plan required by the federal Centers for Medicare and Medicaid Services pursuant to the Medicaid reform waiver.*
- (c) Advise the Agency for Health Care Administration on the distribution of hospital funds used to adjust inpatient hospital rates, rebase rates, or otherwise exempt hospitals from reimbursement limits as financed by intergovernmental transfers.*
- (d) Submit its findings and recommendations to the Governor and the Legislature no later than February 1 of each year.”*

The LIP Council will work closely with the Agency with special consideration focused on all STCs related to the LIP. Due to the fact that the LIP is dependent upon annual appropriations by the State legislature, the current Reimbursement and Funding Methodology document is subject to revision. Funding for existing PAS may continue, new PAS may be approved and funding amounts among the PAS programs may be modified. As this occurs, the Agency will communicate the changes to CMS, through a revised Reimbursement and Funding Methodology document. It is unknown what the magnitude of the changes will be at this time. However, it is anticipated that subsequent revisions will not be substantial. The total amount of the funding remains \$1billion per year for the five year demonstration period.

The State fiscal year begins July 1st. Upon the Governor's approval of the state's general appropriations, which often occurs during the month prior to July 1st, the Agency will submit the revised Reimbursement and Funding Methodology document to CMS. Should the legislature appropriate funding to a new program, such as the St. John's River Rural Health Network (appropriated to receive \$1million during state fiscal year 2006-07), the Agency might need additional time to submit the details of the methodology to that particular program in a subsequently revised document during the year. The Agency has communicated to all the providers eligible for LIP that distributions to PAS categories will not be made until CMS approves the

methodology for that PAS. Although the state fiscal year begins July 1st distributions are not anticipated to occur until the months following. The Agency will submit to CMS revisions to the Reimbursement and Funding Methodology document upon final state legislative funding authority, subject to the Governor's approval of the budget. The Agency requests CMS review the document and submit its comments within thirty-days upon receipt of the revised document.

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 LIP Cost Limits will be calculated using the data described in Section III of this document. The data used will be based on the most current provider cost report submitted to the Agency. The LIP Cost Limit calculation is the total allowable expenditures less any reimbursement from Medicaid, the underinsured or the uninsured. The reimbursement includes Medicaid claims payment for services rendered to Medicaid recipients to each provider and, for hospitals, DSH payments. Payments on behalf of the underinsured and uninsured are already included in the cost limit, as detailed in Section III. The remaining amount is the Medicaid, underinsured and uninsured shortfall. This amount, referred to as the LIP Cost Limit, is the maximum amount a provider is eligible to receive in a LIP distribution.

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 a Medicaid, underinsured, and uninsured 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 Medicaid, underinsured and uninsured shortfall.

Medicaid reimbursement for hospital providers is calculated every January and July, in accordance to the Florida Title XIX Hospital Reimbursement Plan (the Plan). The reimbursement rate calculation places limitations on the calculated reimbursement, referred to as ceilings and targets. The limits are often below the provider's reported Medicaid cost. The use of provider reimbursement rates limited by ceilings and targets creates an immediate Medicaid shortfall. Some providers, such as statutory teaching hospitals and rural hospitals, are exempt from these limitations. For these providers, their Medicaid reimbursement represents their Medicaid cost, as allowed in the Plan. The Medicaid shortfall could therefore be minimal for these providers. A shortfall could still exist due to the fact that there may be legislative reductions to the reimbursement rate above and beyond the cost calculation as well as additional costs not routinely captured by the Plan, as detailed in

Section III A(2) of this document. LIP distributions to hospital providers will allow for any calculated Medicaid shortfall in addition to the underinsured and uninsured shortfall.

VI. Form

Data submitted to AHCA in support of the LIP Cost Limit calculations may be more extensive than the as-filed cost report forms would include. Examples include: supplemental cost report pages used to compute costs of underinsured or uninsured services, or documentation of Medicaid eligible services. This additional documentation should be subject to attestation similar to the attestation applied to the filed cost report, and subject to audit at the discretion of AHCA. Providers will be required to submit the form shown in Appendix C which calculates their LIP Cost Limit along with supporting certification documentation as shown in Appendix D.

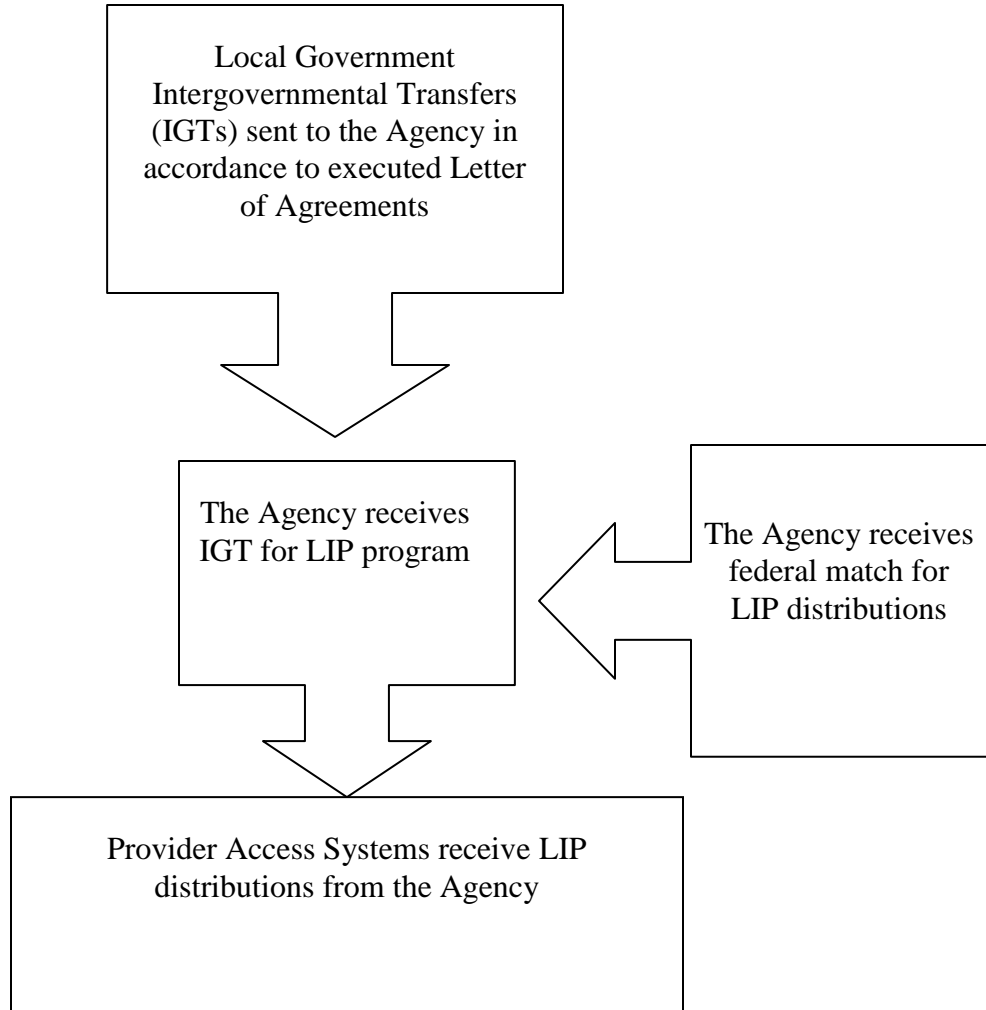
VII. Conclusion

This LIP Reimbursement and Funding Methodology document is submitted to satisfy STCs 93, 97, 98, and 100(a) set forth in the Medicaid Reform Section 1115 Demonstration.

APPENDIX A

Flow Chart of Local Government Funds Provided for the LIP Program

Flow of Local Government Funds Provided for the Florida Medicaid Low Income Pool Program



APPENDIX B
SAMPLE COST REPORT FORMS

HOSPITAL

3690 (Cont.)

FORM CMS-2552-96

05-04

CALCULATION OF REIMBURSEMENT SETTLEMENT		PROVIDER NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET E-3, PART III
		COMPONENT NO.: _____		
Check Applicable Boxes	<input type="checkbox"/> Title V <input type="checkbox"/> Title XVIII <input type="checkbox"/> Title XIX	<input type="checkbox"/> Hospital <input type="checkbox"/> Subprovider <input type="checkbox"/> SNF	<input type="checkbox"/> NF <input type="checkbox"/> ICF/MR	<input type="checkbox"/> PPS <input type="checkbox"/> TEFRA <input type="checkbox"/> Other

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

	Title V or Title XIX	Title XVIII SNF PPS	
	1	2	
COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services		1
2	Medical and other services		2
3	Interns and residents (see instructions)		3
4	Organ acquisition (certified transplant centers only)		4
5	Cost of teaching physicians (see instructions)		5
6	Subtotal (sum of lines 1 through 5)		6
7	Inpatient primary payer payments		7
8	Outpatient primary payer payments		8
9	Subtotal (line 6 less sum of lines 7 and 8)		9
COMPUTATION OF LESSER OF COST OR CHARGES			
10	Routine service charges		10
11	Ancillary service charges		11
12	Interns and residents service charges		12
13	Organ acquisition charges, net of revenue		13
14	Teaching physicians		14
15	Incentive from target amount computation		15
16	Total reasonable charges (sum of lines 10 through 15)		16
CUSTOMARY CHARGES			
17	Amount actually collected from patients liable for payment for services on a charge basis		17
18	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		18
19	Ratio of line 17 to line 18 (not to exceed 1.000000)		19
20	Total customary charges (see instructions)		20
21	Excess of customary charges over reasonable cost (complete only if line 20 exceeds line 9) (see instructions)		21
22	Excess of reasonable cost over customary charges (complete only if line 9 exceeds line 20) (see instructions)		22
23	Cost of covered services (line 9)		23
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)			
24	Other than outlier payments		24
25	Outlier payments		25
26	Program capital payments		26
27	Capital exception payments (see instructions)		27
28	Routine service other pass through costs		28
29	Ancillary service other pass through costs		29
30	Subtotal (sum of lines 23 through 29)		30
31	Customary charges (title XIX PPS covered services only)		31
32	Titles V or XIX PPS, lesser of lines 30 or 31; non PPS and title XVIII enter amount from line 30		32
33	Deductibles (exclude professional component)		33

FORM CMS-2552-96 (6/2003) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3633.3)

HOME HEALTH

06-01

FORM HCFA 1728-94

3290 (Cont.)

APPORTIONMENT OF PATIENT SERVICE COSTS

PROVIDER NO.:

PERIOD:

WORKSHEET C
PARTS III, IV & V

PART III - SUPPLIES AND DRUGS COST COMPUTATION

	From Wkst B, Col. 6, Line:	Total Cost	Total Charges from HHA Record	Ratio (Col 2 ÷ 3)	Medicare Covered Charges			Cost of Services			
					Part A	Part B		Part A	Part B		
						Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	1	2	3	4	5	6	7	8	9	10	
15	Cost of Medical Supplies - Pre 10/1/2000										15
15.01	Cost of Medical Supplies - Post 9/30/2000										15.01
16	Cost of Drugs - Pre 10/1/2000										16
16.01	Cost of Drugs - Post 9/30/2000										16.01

PART IV - COMPARISON OF THE LESSER OF THE AGGREGATE MEDICARE COST, THE AGGREGATE OF THE MEDICARE COST PER VISIT LIMITATION AND THE AGGREGATE PER BENEFICIARY COST LIMITATION

	Medicare Program Unduplicated Census Count For Each MSA Pre 10/1/2000 (4)	Per Beneficiary Annual Limitation Per MSA/Non-MSA (From Your Intermediary)	Cost of Medicare Services			Total (Sum of Cols 3 & 4)	
			Part A	Part B			
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	1	2	3	4	5	6	
17	Total Cost of Medicare Services (Sum of the amounts from each Wkst. C, Pt. II, cols. 8, 9 & 11, respectively, lines 1-6 (exclusive of subscripts))						17
18	Cost of Medical Supplies (from Part III, columns 8 and 9, line 15 (exclusive of line 15.01))						18
19	Total (Sum of lines 17 and 18)						19
20	Total Cost Per Visit Limitation for Medicare Services (Sum of the amounts from each Wkst. C, Pt. II, cols. 8, 9 & 11, respectively, line 14)						20
21	Cost of Medical Supplies (from Part III, columns 8 and 9, line 15 (exclusive of line 15.01))						21
22	Total (Sum of lines 20 and 21)						22

	MSA Code (3)						(Col 1 x 2)
	0	1	2	3	4	5	
23	Per Beneficiary Cost Limitation for MSA:						23
23.01	Per Beneficiary Cost Limitation for MSA:						23.01
23.02	Per Beneficiary Cost Limitation for MSA:						23.02
23.03	Per Beneficiary Cost Limitation for MSA:						23.03
23.04	Per Beneficiary Cost Limitation for MSA:						23.04
23.05	Per Beneficiary Cost Limitation for MSA:						23.05
23.06	Per Beneficiary Cost Limitation for MSA:						23.06
23.07	Per Beneficiary Cost Limitation for MSA:						23.07
23.08	Per Beneficiary Cost Limitation for MSA:						23.08
23.09	Per Beneficiary Cost Limitation for MSA:						23.09
24	Aggregate Per Beneficiary Cost Limitation (Sum of lines 23 and subscripts thereof)						24

PART V - OUTPATIENT THERAPY REDUCTION COMPUTATION

Patient Services	From Wkst. C, Part I, Col. 4, Line:	Average Cost Per Visit	Part B Subject to Deductibles and Coinsurance								
			Medicare Program Visits for Services Before 1/1/98	Medicare Program Costs for Services Before 1/1/98	Medicare Program Visits for Services 1/1/98-12/31/98	Medicare Program Visits for Services 1/1/99-9/30/00	Medicare Program Visits for Services on or after 10/1/00	Medicare Program Costs for Services 1/1/98-12/31/98	Application of the Reasonable Cost Reduction	Reasonable Costs Net of Adjustments	
			3	4	5	5.01	5.02	6	7	8	
25	Physical Therapy										25
26	Occupational Therapy										26
27	Speech Pathology										27
28	Total (Sum of lines 25-27)										28

(3) The MSA codes flow from Worksheet S-3, Part III, line 29 and subscripts as indicated.

(4) The sum of column 1, line 24 must equal Worksheet S-3, Part I, column 2, line 10.01.

FORM HCFA-1728-94-C (6-2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN HCFA PUB. 15-II, SEC. 3215 - 3215.5)

HOSPICE

09-00

FORM CMS-1984-99

3890 (Cont.)

CALCULATION OF PER DIEM COST	PROVIDER NO. _____	PERIOD: FROM _____ TO _____	WORKSHEET D
-------------------------------------	------------------------------	--	--------------------

COMPUTATION OF PER DIEM COST		TITLE XVIII (1)	TITLE XIX (2)	OTHER (3)	TOTAL (4)	
1	Total cost (Worksheet B, line 100, col 7, less line 53, col. 7)					1
2	Total Unduplicated Days (Worksheet S-1, line 12, col. 6)					2
3	Average cost per diem (line 1 divided by line 2)					3
4	Unduplicated Medicare Days (Worksheet S-1, line 12, col.1)					4
5	Average Medicare cost (line 3 times line 4)					5
6	Unduplicated Medicaid Days (Worksheet S-1, line 12, col. 2)					6
7	Average Medicaid cost (line 3 times line 6)					7
8	Unduplicated SNF days (Worksheet S-1, line 12, col. 3)					8
9	Average SNF cost (line 3 times line 8)					9
10	Unduplicated NF days (Worksheet S-1, line 12, col. 4)					10
11	Average NF cost (line 3 times line 10)					11
12	Other Unduplicated days (Worksheet S-1, line 12, col. 5)					12
13	Average cost for other days (line 3 times line 12)					13
14	Total cost (see instructions)					14
15	Total days (see instructions)					15

DIALYSIS FACILITY

3490 (Cont.)

Form CMS-265-94

12-05

COMPUTATION OF AVERAGE COST
PER TREATMENT

FACILITY NO.:

REPORTING PERIOD
FROM _____
TO _____

WORKSHEET C

	TOTAL			NUMBER OF TREATMENTS (Pre 4/1/2005, see instructions)	MEDICARE					
	NUMBER OF TREATMENTS	COSTS (TRANSFERRED FROM WKST. B., COL.11)	AVERAGE COST OF TREATMENTS (COL.2/COL.1)		NUMBER OF TREATMENTS (Post 4/1/2005, see instructions)	TOTAL EXPENSES (COL.4 x COL.3)	PAYMENT RATE (Pre 4/1/2005, see instructions)	PAYMENT RATE (Post 4/1/2005, see instructions)	TOTAL PAYMENT DUE (COL.4 x COL.6)	
	1	2	3		4	5	6	6.01	7	
1	Maintenance-Hemodialysis	Line 7								1
2	Maintenance-Peritoneal Dialysis	Line 8								2
3	Training-Hemodialysis	Line 9								3
4	Training-Peritoneal Dialysis	Line 10								4
5	Training-CAPD	Line 11								5
6	Training-CCPD	Line 12								6
7	Home Program-Hemodialysis	Line 13								7
8	Home Program-Peritoneal Dialysis	Line 14								8
9	Home Program-CAPD	Patient Wks Line 15								9
10	Home Program-CCPD	Patient Wks Line 16								10
11	Totals Sum of Lines 1-8 (Cols. 1 & 4) Sum of Lines 1-10 (Cols. 2,5, & 7)									11

FORM CMS-265-94 (12-2005) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3412)

OUTPATIENT THERAPY/CORF

12-04

FORM CMS 2088-92

1890 (Cont.)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR OUTPATIENT REHABILITATION SERVICES-TITLE XVIII	PROVIDER NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET D
CORF	OPT	CMHC	

PART I - COMPUTATION OF REIMBURSEMENT SETTLEMENT			
DESCRIPTION	1	1.01	
1	Cost of provider services (see instructions)		1
1.01	CMHC PPS payments including outlier payments		1.01
1.02	1996 CMHC specific payment to cost ratio (obtain this ratio from your intermediary)		1.02
1.03	Line 1, column 1.01 times 1.02		1.03
1.04	Line 1.01 divided by line 1.03		1.04
1.05	CMHC transitional corridor payment		1.05
1.1	Cost of CORF services prior to 1/1/1998 (see instructions)		1.1
2	Adjustment for the cost of services covered by Workers' Compensation, and other primary payers (see instructions)		2
3	Subtotal (line 1 plus line 1.1 minus line 2) (For CMHCs see instructions)		3
4	Deductibles billed to program patients. (Do not include coinsurance)		4
5	Total amount reimbursable to provider prior to application of Lesser of reasonable cost or customary charges (line 3 minus line 4)		5
6	Excess of reasonable cost over customary charges (see instructions)		6
7	Subtotal (line 5 minus line 6)		7
8	80 percent of costs (line 7 x 80 percent)		8
9	Coinsurance billed to program patients (see instructions)		9
10	Net cost for comparison (line 7 minus line 9)		10
11	Reimbursable bad debts (see instructions)		11
11.01	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		11.01
12	TOTAL COST-- (line 11 plus the lesser of line 8 or line 10)		12
13	Recovery of unreimbursed cost under the lesser of cost or charges (from Worksheet D-1, Part I, line 3)		13
14	80% of recovery of unreimbursed cost under the lesser of cost or charges (line 13 X 80 percent)		14
15	Total cost (line 12 plus line 14) (see instructions)		15
16	Sequestration adjustment (see Instructions)		16
16.5	Other Adjustments (see instructions) (specify)		16.5
17	Adjusted total cost (line 15 minus the sum of lines 16 and 16.5) (see instructions)		17
18	Interim Payments		18
18.5	Tentative settlement (For intermediary use only)		18.5
19	Balance due Provider/Program (line 17 minus line 18) (Indicate overpayment in brackets)		19

NOTE: FOR CORF SERVICES RENDERED PRIOR TO JANUARY 1, 1998 CORFS COMPLETE LINE 22.1 ONLY AS THESE SERVICES ARE NOT SUBJECT TO THE LESSER OF REASONABLE COSTS OR CUSTOMARY CHARGES, BUT ARE REIMBURSED BASED ON REASONABLE COSTS. FOR CORF RENDERED ON OR AFTER JANUARY 1, 1998, COMPLETE LINE 21 THROUGH 29 AS THESE SERVICES AS SUBJECT TO LCC.

PART II -COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES			
		1	
20	Reasonable cost of services		20
21	Cost of services (from Part I, line 1) (from Part I, line 1, column 1 for CMHCs) (see instructions)		21
21.1	Cost of services (from Part I, line 1.1 for CORFs) (see instructions)		21.1
22	TOTAL charges for medicare services		22
22.1	TOTAL CORF charges for medicare services prior to 1/1/1998		22.1
23	Customary Charges		23
24	Aggregate amount actually collected from patients liable for payment for services on a charge basis.		24
25	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		25
26	Ratio of line 24 to line 25 (not to exceed 1.000000)		26
27	Total customary charges (line 22 x line 26)		27
27.1	Total customary CORF charges prior to 1/1/1998 (line 22.1 x line 26)		27.1
28	Excess of customary charges over reasonable cost (Complete only if line 27 exceeds line 21) (see instructions)		28
29	Excess of reasonable cost over customary charges (Complete only if line 21 exceeds line 27) (see instructions)		29

FORM CMS-2088-92 (12-2004) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15 - II, SEC. 1810, 1810.1 AND 1810.2)

FLORIDA MEDICAID PROGRAM
NURSING HOME SERVICE PROVIDERS

SCHEDULE H

PAGE 2 OF 2

COMPUTATION OF ALLOWABLE MEDICAID COSTS

Provider Name:		Reporting Period
D/B/A:	From	To
Provider No.:		

L I N E	
CALCULATION OF MEDICAID PROPERTY COST PER DIEM:	
1	Total Property Cost (Sch F, Line 35) -
2	Total Patient Days (Sch A, Line 5 (a) - Total) -
3	Property Cost Per Diem (Line 1 / Line 2) -
4	Total Medicaid Patient Days (Sch A, Line 5(b) - Total) -
5	Medicaid Property Cost (Line 3 x Line 4) -
CALCULATION OF MEDICAID OPERATING COST PER DIEM:	
1	Patient Care Operating Costs (Sch G, Col 2, Line 4 + Col 4, Line 4) -
2	Laundry and Linen (Sch G, Col 5, Line 5) -
3	Total Operating Cost (Line 1 + Line 2) -
4	Total Patient Days (Sch A, Line 5(a) - Total) -
5	Total Operating Cost Per Diem (Line 3 / Line 4) -
6	Total Medicaid Patient Days (Sch A, Line 5(b) - Total) -
7	Medicaid Operating Cost (Line 5 x Line 6) -
8	Medicaid Indirect Ancillary Cost (Sch H, Sec A, Col 6, Line 11) -
9	Medicaid Bad Debts -
10	Total Medicaid Operating Cost (Lines 7 + 8 + 9) -
11	Medicaid Operating Cost Per Diem (Line 10 / Line 6) -
APPORTIONMENT OF ALLOWABLE RETURN ON EQUITY CAPITAL OR USE ALLOWANCE	
1	Total Allowable Return on Equity Capital (Sch J, Line 20 or 21) -
2	Total Cost Subject to Allocation (Sch F, Line 48) -
3	Ratio of Allowable Equity to Total Costs (Line 1 / Line 2) -
4	Medicaid Program Cost:
5	Direct Medicaid Patient Care Costs (Sch H, Sec B, Line 7, Col 1) -
6	Indirect Medicaid Patient Care Costs (Sch H, Sec B, Line 7, Col 2) -
7	Medicaid Operating Cost (Sch H, Sec D, Line 10) -
8	Medicaid Property Cost (Sch H, Sec C, Line 5) -
9	Total Medicaid Program Cost (Lines 5 + 6 + 7 + 8) -
10	Medicaid Allowable Return on Equity (Line 3 x Line 9) -
11	Medicaid Return on Equity Per Diem (Line 9 / Sec D, Line 6) -
INITIAL MEDICAID PER DIEM:	
1	Medicaid Patient Direct Care Per Diem (Sch H, Sec B, Line 8, Col 1) -
2	Medicaid Patient Indirect Care Per Diem (Sch H, Sec B, Line 8, Col 2) -
3	Medicaid Property Cost Per Diem (Sch H, Sec C, Line 3) -
4	Medicaid Operating Cost Per Diem (Sch H, Sec D, Line 11) -
5	Medicaid Return on Equity Capital Use Allowance Per Diem (Sch H, Sec E, Line 10) -
6	Initial Medicaid Per Diem (Lines 1 + 2 + 3 + 4 + 5) -

APPENDIX C

EXAMPLE FORM FOR COMPUTING LIP COST LIMIT

LIP COST LIMIT CALCULATION
HOSPITAL PROVIDER TYPE

Provider Name: _____ FYB _____ FYE: _____

Provider Number: _____

MEDICAID SHORTFALL

1. Medicaid reimbursable cost (WSE-3, III, Col. 1, Line 6) _____

Additional Costs:

Description	Source	Amount
<i>Hospital-Based Physicians</i>		
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Total Additional Costs _____

3. Total Hospital Costs (WSC, Col. 5, Line 101) _____

4. Medicaid Utilization (Line 1/Line 3) _____ %

5. Medicaid Additional Costs (Line 2 x Line 4) _____

5a. Other Medicaid Additional Costs (see attached) _____

6. Total Medicaid Costs (Line 1 + Line 5 + Line 5a) _____

7. Current period Medicaid payments
(All sources: PCL, Remits, etc.) _____

8. Medicaid Shortfall (Line 6 – Line 7) _____

9. 1 + Inflation Factor _____

10. Medicaid Shortfall (Line 8 x Line 9) _____

LIP COST LIMIT CALCULATION
HOSPITAL PROVIDER TYPE

Provider Name: _____ FYB _____ FYE: _____

Provider Number: _____

UNDERINSURED AND UNINSURED UNRECOVERED COSTS

11. Charity care _____

12. Bad Debts (net of Medicare bad debts) _____

13. Charges for Medicaid eligible patients _____

14. _____

15. _____

16. Total Charges for underinsured and uninsured patients
(sum of lines 11 to 15) _____

17. Total Hospital Costs, including additional costs
(Line 2 + Line 3) _____

18. Total Hospital charges (WSC, Col. 8, Line 101) _____

19. Charges related to "Additional Costs" on Line 2 _____

20. Total adjusted charges (Line 18 + Line 19) _____

21. Adjusted ratio of costs to charges (Line 17/Line 20) _____

22. Cost of Underinsured and Uninsured Services
(Line 16 x Line 21) _____

23. Medicaid eligible & other payments _____

24. Directly-identified costs of services to uninsured and
underinsured patients _____

25. Total Uninsured and Underinsured Shortfall. _____
[(Line 22 – Line 23 + Line 24) x Line 9]

26. LIP COST LIMIT (LINE 10 + LINE 25) _____

APPENDIX D

LIP Permissible Expenditures Certification Form

Permissible Expenditures Certification Form
for the Florida Low Income Pool

(provider name)

Provider name and address (include county):

Prepared by:

Contact Phone:

Contact email:

Medicaid Provider Number

Reporting Period: From _____ To: _____

**CERTIFICATION BY OFFICER OR ADMINISTRATOR OF _____
(Provider Type)**

I Hereby Certify That I Have Examined The Accompanying Data (Permissible Expenditures) For The Reporting Period Beginning _____ and Ending _____ And That To The Best Of My Knowledge And Belief It Is A True, Correct And Complete Statement Prepared From The Books And Records Of The _____ (provider name) In Accordance With Applicable Instructions, Except As Noted:

I certify that I am familiar with the laws and regulations regarding the provision of health care services under the Florida Medicaid program, including the laws and regulations relating to claims for Medicaid reimbursements and payments, and that the services and expenditures identified in this report were provided in compliance with such laws and regulations.

Signature of Officer or Administrator

Title

Date