Amended Special Term and Condition 105

Reconciliation draft Review Tool and Written Procedures for Reconciliation of LIP Expenditures to Allowable Provider Costs

Table of Contents

List of Tables

1 Summary

1.1 *Introduction*

In November of 2009, the Agency for Health Care Administration (Agency, AHCA) requested of the Centers for Medicare & Medicaid Services (CMS) an amendment to the Special Terms and Conditions (STC) 105 of the Florida Medicaid Reform Waiver, Section 1115. This amendment allowed for the release of an additional $300 million in Low Income Pool (LIP) funds to the State for State Fiscal Year (SFY) 2010-11 that could have otherwise been retained by the federal government.

The amendment resulted in revisions to STC 105 which incorporate compliance with milestones related to the Financial Management Review and the approved Reimbursement and Funding Methodology document (RFMD) that modified the way cost limits must be calculated for SFY 2009-10, SFY 2010-11, and all future years; the requirement that entities begin reporting data ***quarterly***. The revisions also call for retroactive adjustment and reconciliation of all previous waiver Demonstration Year (DY) cost limit calculations using a regressive trend percentage. The following is the original and amended STC language as approved by CMS. This document provides the information required in 1)(a) of the amended STC 105.

Original STC 105

At the beginning of demonstration year 5, $700 million will be available. An additional $300 million will be available at the time the demonstration is operating on a statewide basis for a total of $1 billion.

Amended STC 105

At the beginning of demonstration year 5, $700 million will be available. At the beginning of demonstration year 5, an additional $150 million will be available at the completion of milestones due on or before demonstration year 4 ending June 30, 2010. An additional $150 million will be available at the completion of milestones due on or before October 31, 2010.

1) The Florida Agency for Health Care Administration will:

   (a) Develop a draft reconciliation review tool and instructions, in consultation with CMS, to be used for the reconciliation of LIP expenditures by April 30, 2010. CMS will have 30 days to review the draft reconciliation tool, request additional information or approve the tool. The 'tool' will implement the following recommendations provided to the State in the Financial Management Review (FMR).

      i. Written procedures to calculate the Medicaid Shortfall Amount will be provided to participating providers to ensure correct calculations.

ii. Written instructions and definitions and review procedures regarding allowable costs will be provided to participating providers to ensure that only allowable costs are being included.
iii. Written procedures will be provided to participating providers to ensure that the LIP cost limit forms are consistently completed.

(b) Provide CMS a schedule for the completion of provider reconciliations statewide for demonstration years 1, 2, 3, and 4 by June 30, 2010.

(c) Provide completed reconciliations, by demonstration year and by provider, for all providers for demonstration years 1 and 2 by October 31, 2010. Demonstration year 1 LIP expenditure reconciliations must use the DSH audit reports for verification of reconciliation results and method.

(d) Provide completed reconciliations for all providers for demonstration year 3 by March 31, 2011.

(e) Provide reconciliations for providers for demonstration year 4 by March 31, 2011.

For LIP hospitals that receive DSH funding, DSH audit results and a supplemental LIP report for primary care and ancillary provider distributions and STC #96, may be used as part of the LIP reconciliation. The results of the reconciliations must be reported to CMS with summary by provider and in aggregate for the LIP with sufficient details included or made available upon request for validation.

2) The Florida Agency for Health Care Administration will provide:

(a) A report of the LIP dollars currently allocated (by the State and/or health system) to participating providers that are within the operating budgets for State fiscal year 2009 – 2010 (SFY) to fund alternative delivery systems that provide ambulatory and preventive care services in non-inpatient settings by May 31, 2010. The report will provide a baseline assessment of current administrative capabilities and develop a reporting process to prospectively track the use of LIP funds allocated to hospital entities and subsequently used to fund uncompensated care in ambulatory and preventative care settings.

(b) An update with SFY 2010-11 projections for LIP dollars allocated (as described in 2 a) to participating providers by June 30, 2010. This update will include descriptions of increases to allocations and changes to current allocations.

Table 1 – CMS Deadlines to Implement Amended STC 105

Deadline	Milestone(s)	Description
April 30, 2010	1(a)	A review tool and instructions to be used for the reconciliation of the LIP expenditures to allowable provider costs. Specifically: ► Written procedures to calculate the Medicaid Shortfall Amount. ► Written instructions, definitions and review procedures regarding allowable costs that may be included. ► Written procedures that help ensure that LIP cost limit forms are consistently completed.
May 31, 2010	2(a)	► A report of the LIP dollars currently allocated to fund alternative delivery systems that provide ambulatory and preventative care services in non-inpatient settings.
June 30, 2010	1(b)	► Schedule for the completion of provider reconciliations statewide for Demonstration Years 1, 2, 3, and 4
June 30, 2010	2(b)	► SFY 10-11 projections for LIP dollars allocated to providers as in 2(a) describing increases and changes to current allocations.
October 31, 2010	1(c)	► Completed LIP reconciliations, by Demonstration Year, by provider, for all providers for Demonstration Years 1 and 2.[1]
March 31, 2011	1(d), 1(e)	► Completed LIP reconciliations by provider for providers for Demonstration Years 3 and 4.

1.2 *Purpose*

The purpose of this document is to meet Milestone 1(a) requirements of the terms of the amendment by providing a review tool and instructions to be used for the reconciliation of the LIP payments to provider costs limits.[2] Specifically this document provides:

- Written procedures to calculate the Medicaid uninsured/underinsured cost limits for LIP provider access systems.
- Written instructions, definitions and review procedures regarding allowable costs that may be included.
- Written procedures that help ensure that LIP cost limit forms are consistently completed.

[1] According to CMS, "Demonstration Year 1 LIP expenditure reconciliations must use the DSH audit reports for verification of reconciliation results and method." This means that any hospital that received DSH and LIP funds must provide copies of their DSH audits with their reconciliation reports.
[2] See CMS signed amendment approval letter, received by AHCA January 29, 2010.

1.3 *Reconciliation Results and Required Actions*

After the new methodologies have been used to calculate any overpayments, entities should total any and all overpayments as a single aggregated number. This overpayment will be deducted from the entity's current year LIP allocation. The balance of a provider's LIP funds will be disbursed as it has been in past years.

In the event that the aggregate overpayment exceeds the current year LIP payment, the entity would provide a repayment of this amount to the Agency. If payments do exceed the cost limits, the provider must return the excess amount to the state. Once the state has received the returned funds, appropriate documentation will be made and the federal share will be calculated and returned to CMS. The excess will be returned to the state and the Federal share will be reported on the 64 report to CMS.

1.3.1 Requirements for Future Reporting

Allowable and Unallowable cost will be reported on an ongoing basis using the methodologies established in this document. Each entity must report these cost calculations quarterly.

2 Cost Limit Reconciliation Procedures -- Hospitals

To reconcile cost limits using the new procedures, a spreadsheet has been provided with this document in a separate Excel 2007 file (Hospital Cost Limit Calculation Form). The steps for completing the spreadsheet are found in the form and in the tables below.

Hospitals should use the steps listed in the tables which follow to complete the Hospital Cost Limit Calculation Form. This form contains locked formulas or equations that reflect the various policy decisions that have been approved by AHCA and CMS.

The definitions below should be used when completing the data entry to calculate cost limits.

Definitions:

- State Fiscal Year: July 1 – June 30.
- Date of Service: Admission date (Medicaid date of service).
- As Filed Cost Report: The most recent Medicare cost report submitted to the Agency.
- Uninsured/Underinsured: Persons with no source of third party coverage for the services provided.
- Allowable uninsured/underinsured costs: Cost of services provided to Uninsured/Underinsured persons. Also includes services that were provided, but not covered by the recipient's insurance plan. Examples include, benefits exhausted, preexisting conditions, specific exclusions of services from the individual's policy.
- Non-allowable uninsured/underinsured costs: Costs of any unpaid deductible, coinsurance amounts and portions of charges written off as bad debts or charity care that pertain to services furnished to individuals with third party coverage.
- Third Party Coverage: Includes any item or service covered by an individual's insurance.

2.1 *Hospital Medicaid Fee-For-Service (FFS)*

Hospital Medicaid FFS costs are determined by first deriving appropriate per diems and cost-to-charge ratios. These are then used to calculate Medicaid routine costs, the Medicaid ancillary costs and the Medicaid organ acquisition costs, which are in turn added to calculate Total Hospital Medicaid FFS allowable costs.

Steps:

Table 2 – Procedures for Calculating Hospital Medicaid Fee-For-Service Allowable Costs

Line	Action	Procedure
1	**Determine Routine Cost Per Diems**	Use steps from Lines 2-4 For the State Fiscal Year (LIP Payment year), the routine per diems and ancillary cost-to-charge ratios for the cost centers are to be determined using the hospital's Medicare cost report (CMS 2552) on file with Florida Medicaid for the first rate semester of each State Fiscal Year.
2	Identify hospital's total days by routine cost center	The hospital's total days by routine cost center are identified from Worksheet S-3, Part 1, Column 6. NOTE: The Adult and Pediatric (A&P) days include observation bed days in the total A&P patient day count. Enter these days into the Total Hospital Days column in Reference Row Numbers 25-32 of the form.
3	Identify Total Hospital Costs by routine cost center	Identify Total Hospital Costs by routine cost center from Worksheet B, Part I, Column 25. (These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.) NOTE: The A&P costs exclude swing bed nursing facility costs and non medically necessary private room differential costs from the A&P costs. Enter these costs into the Total Hospital Costs column in Reference Row Numbers 25-32 of the form.
4	Identify routine cost center per diem	For each routine cost center, a per diem is calculated by dividing total costs from Line 3 by total days from Line 2, (Reference Row Numbers 25-32). This step will be calculated for you.
5		**Routine Service Cost Per deims** will be displayed in Reference Row Numbers 25-32 of the form.
6	**Determine Ancillary Cost-To-Charge Ratios**	Use steps from Lines 7-9
7	Identify Total Hospital Costs by ancillary cost center	Identify Total Hospital Costs by ancillary cost center from Worksheet B, Part I, Column 25. (These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.) NOTE: The A&P costs exclude swing bed nursing facility costs and non-medically necessary private room differential costs from the A&P costs. Enter these costs into the Total Hospital Costs column in Reference Row Numbers 39-66 of the form.
8	Identify hospital's total charges by ancillary cost center	The hospital's total charges by ancillary cost center are identified from Worksheet C, Part I, Column 8. Enter these charges into the Total Hospital Charges column in Reference Row Numbers 39-66 of the form.

Comment [LN1]: Once AHCA makes all final edits, layout should be reviewed. Rows in tables should not be allowed to break across pages like this. However, this cannot be corrected until all text and layout is finalized.

9	Identify ancillary cost center cost to charge ratio	For each ancillary cost center, a cost to charge ratio is calculated by dividing the total ancillary costs from Line 7 by the total charges from Line 8, (Reference Row Numbers 39-66 of the form) This step will be calculated for you.
10		**Ancillary Cost Center Cost to Charge Ratios** will display in Reference Row Numbers 39-66 of the form.
11	**Determine Medicaid FFS Allowable Costs**	Use steps from Lines 12-15
12	Identify Medicaid FFS routine cost center costs	Enter the hospital's actual Medicaid days by routine cost center, as obtained from hospital cost report(s) (Worksheet S-3, Part I, Column 5, Title XIX) for the State Fiscal Year into the Actual Medicaid Days by Routine Cost Center column in Reference Row Numbers 25-32 of the form. NOTE: For hospitals whose cost report year is different from the State's Fiscal Year, hospitals should use the hospital cost reports that cover the span of July 1 through June 30. (This may require more than one hospital cost report.) Using these cost report(s), Medicaid FFS days should be proportionally allocated (by month) to the State Fiscal Year. The days are multiplied by the per diems from Line 4 (Reference Row Number 25-32) for each respective routine cost center to determine the Medicaid FFS allowable costs for each routine cost center. This step will be calculated for you and the results will display in Medicaid Allowable Cost by Routine Cost Center column in Reference Row Numbers 25-32 of the form. (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.)
13	Identify Medicaid FFS ancillary costs	Enter the hospital's actual Medicaid FFS allowable charges by ancillary cost center as obtained from hospital cost report(s) for the State Fiscal Year into the Allowed Medicaid Fee-For Service column in Reference Row Numbers 39-66 of the form. NOTE: For hospitals whose cost report year is different from the State's Fiscal Year, hospitals should use the hospital cost reports that cover the span of July 1 through June 30. (This may require more than one hospital cost report.) Using these cost report(s), Medicaid FFS ancillary charges should be proportionally allocated (by month) to the State Fiscal Year. Medicaid FFS allowable charges for observation beds must be included. These Medicaid FFS allowable charges are multiplied by the cost to charge ratios from Line 10 (Reference Row Numbers 39-66) for each respective ancillary cost center to determine the Medicaid FFS allowable costs for each ancillary cost center. This step will be calculated for you and the results will display in the Allowed Medicaid Fee-For-Service Cost by Ancillary Cost Center column in Reference Row Numbers 39-66 of the form.

		(The Medicaid FFS allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.)
14	Identify Medicaid allowable share of organ acquisition costs	First, determine the **ratio of Medicaid usable organs:** Identify from auditable provider records the number of Medicaid usable organs and enter this number into Reference Row Number 74 of the form. (These are counted as the number of Medicaid recipients who received an organ transplant.) NOTE: For hospitals whose cost report year is different from the State's Fiscal Year, hospitals should use the hospital cost reports that cover the span of July 1 through June 30. (This may require more than one hospital cost report.) Using these cost report(s), the number of Medicaid recipients who received an organ transplant should be proportionally allocated (by month) to the State Fiscal Year. Next, identify the hospitals total usable organs from Worksheet D-6, Part III, under the Part B cost column, line 54, and enter this number into Reference Row Number 75 of the form. The ratio of Medicaid usable organs will be calculated for you as the total useable organs are divided by the Medicaid useable organs. This calculation will be done for you and will be displayed in Reference Row Number 76 of the form. Next, enter the **total organ acquisition costs** from Worksheet D-6, Part III, under the Part A cost column line 53, into Reference Row Number 77 of the form. NOTE: For hospitals whose cost report year is different from the State's Fiscal Year, hospitals should use the hospital cost reports that cover the span of July 1 through June 30. (This may require more than one hospital cost report.) Using these cost report(s), total organ acquisition costs should be proportionally allocated (by month) to the State Fiscal Year. The ratio of Medicaid useable organs is multiplied by total organ acquisition cost for you. Total organ acquisition costs will be displayed in Reference Row Number 78 of the form.
15		The Medicaid FFS allowable costs are determined by adding the Medicaid routine costs from Line 12, the Medicaid ancillary costs from Line 13, and the Medicaid organ acquisition costs from Line 14. (Reference Row Numbers 34, 68, 78) This will be calculated for you and the **Medicaid Fee-For-Service Costs** will display in Reference Row Number 82 of the form.

2.2 *Hospital Medicaid Managed Care*

Hospital Medicaid managed care cost is determined by first deriving appropriate per diems and cost-to-charge ratios. These are then used to calculate Medicaid managed care routine costs, the Medicaid managed care ancillary costs, and the Medicaid managed care organ acquisition costs, which are in turn added to calculate Hospital Medicaid managed care allowable costs.

Steps:

Table 3 – Procedures for Calculating Hospital Managed Care Costs

Line	Action	Procedure
1	**Determine Routine Cost Per Diems**	Use steps from Lines 2-4 For the State Fiscal Year (LIP Payment year), the routine per diems and ancillary cost-to-charge ratios for the cost centers are to be determined using the hospital's Medicare cost report (CMS 2552) on file with Florida Medicaid for the first rate semester of each State Fiscal Year.
2	Identify hospital's total days by routine cost center	The hospital's total days by routine cost center are identified from Worksheet S-3, Part 1, Column 6. NOTE: The A&P days include observation bed days in the total A&P patient day count. Enter these days into the Total Hospital Days column in Reference Row Numbers 25-32 of the form.
3	Identify Total Hospital Costs by routine cost center	Identify Total Hospital Costs by routine cost center from Worksheet B, Part I, Column 25. (These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.) NOTE: The A&P costs exclude swing bed nursing facility costs and non medically necessary private room differential costs from the A&P costs. Enter these costs into the Total Hospital Costs column in Reference Row Numbers 25-32 of the form.
4	Identify routine cost center per diem	For each routine cost center, a per diem is calculated by dividing total costs from Line 3 by total days from Line 2, (Reference Row Numbers 25-32). This step will be calculated for you.
5		**Routine Service Cost Per deims** will be displayed in Reference Row Numbers 25-32 of the form.
6	**Determine Ancillary Cost-To-Charge Ratios**	Use steps from Lines 7-9
7	Identify Total Hospital Costs by ancillary cost center	Identify Total Hospital Costs by ancillary cost center from Worksheet B, Part I, Column 25. (These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.) NOTE: The A&P costs exclude swing bed nursing facility costs and non-medically necessary private room differential costs from the A&P costs.

		Enter these costs into the Total Hospital Costs column in Reference Row Numbers 39-66 of the form.
8	Identify hospital's total charges by ancillary cost center	The hospital's total charges by ancillary cost center are identified from Worksheet C, Part I, Column 8. Enter these charges into the Total Hospital Charges column in Reference Row Numbers 39-66 of the form.
9	Identify ancillary cost center cost to charge ratio	For each ancillary cost center, a cost to charge ratio is calculated by dividing the total ancillary costs from Line 7 by the total charges from Line 8, (Reference Row Numbers 39-66 of the form) This step will be calculated for you.
10		**Ancillary Cost Center Cost to Charge Ratios** will display in Reference Row Numbers 39-66 of the form.
11	**Determine Hospital Managed Care Costs for Medicaid**	Use steps from Lines 12-15
12	Identify Medicaid managed care routine cost center costs	Enter the hospital's actual Medicaid managed care days by routine cost center, as obtained from auditable hospital records for the State Fiscal Year into the Actual Medicaid Managed Care Days by Routine Cost Center column in Reference Row Numbers 25-32 of the form. NOTE: For hospitals whose cost report year is different from the State's Fiscal Year, hospitals should use the hospital cost reports that cover the span of July 1 through June 30. (This may require more than one hospital cost report.) Using these auditable records, Medicaid Managed Care days should be proportionally allocated (by month) to the State Fiscal Year. The days are multiplied by the per diems from Line 5 for each respective routine cost center to determine the Medicaid managed care allowable costs for each routine cost center. This step will be calculated for you and the results will display in the Medicaid Managed Care Allowable Costs column in Reference Row Numbers 25-32 of the form. (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)
13	Identify Medicaid managed care ancillary costs	Enter the hospital's actual Medicaid managed care allowable charges by ancillary cost center, as obtained from auditable hospital records for the State Fiscal Year into the Allowed Medicaid Managed Care Charges by Ancillary Cost Center column in Reference Row Number 39-66 of the form. NOTE: For hospitals whose auditable records period are different from the State's Fiscal Year, hospitals should use the hospital auditable records that cover the span of July 1 through June 30. (This may require more than one period of auditable records.) Using these records, Medicaid managed care ancillary charges should be proportionally allocated (by month) to the State Fiscal Year. These Medicaid managed care allowable ancillary charges are multiplied by the cost to charge ratios from Line 10 for each respective ancillary cost center to determine the Medicaid managed care allowable costs for each ancillary cost

		center. This step will be calculated for you and the results will display in the Allowed Medicaid Managed Care Cost by Ancillary Cost Center column in Reference Row Numbers 39-66 of the form. (The Medicaid managed care allowable ancillary charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.)
14	Identify Medicaid managed care allowable share of organ acquisition costs	First, determine the **ratio of Medicaid managed care usable organs**: Identify from auditable provider records the number of Medicaid managed care usable organs and enter this number into Reference Row Number 74 of the form. (These are counted as the number of Medicaid managed care recipients who received an organ transplant.) NOTE: For hospitals whose auditable records period are different from the State's Fiscal Year, hospitals should use the hospital auditable records that cover the span of July 1 through June 30. (This may require more than one period of auditable records.) Using these records, Medicaid managed care usable organs should be proportionally allocated (by month) to the State Fiscal Year. Next, identify the hospitals total usable organs from Worksheet D-6, Part III, under the Part B cost column, line 54 and enter this number into Reference Row Number 75 of the form. The ratio of Medicaid managed care usable organs will be calculated for you as the total useable organs are divided by the Medicaid managed care useable organs. Next, enter the **total organ acquisition costs** from Worksheet D-6 Part III under the Part A cost column line 53, into Reference Row Number 77 of the form. NOTE: For hospitals whose cost report year is different from the State's Fiscal Year, hospitals should use the hospital cost reports that cover the span of July 1 through June 30. (This may require more than one hospital cost report.) Using these cost report(s), Medicaid total organ acquisition costs should be proportionally allocated (by month) to the State Fiscal Year. The ratio of Medicaid managed care useable organs is multiplied by total organ acquisition cost for you. The total Medicaid managed care allowable share of organ acquisition costs will be displayed in Reference Row Number 78 of the form.
15		The Medicaid managed care allowable costs are determined by adding the Medicaid managed care routine costs from Line 12, the Medicaid managed care ancillary costs from Line 13, and the Medicaid managed care organ acquisition costs from Line 14. (Reference Rows 34, 68,78) This will be calculated for you and the **Medicaid managed care allowable costs** will display in Reference Row Number 82 of the form.

2.3 *Hospital Uncompensated Care*

Hospital uncompensated care is determined by first deriving appropriate per diems and cost-to-charge ratios. These are then used to calculate uninsured routine costs, the uninsured ancillary costs and the uninsured organ acquisition costs, which are in turn added, to calculate Hospital uncompensated care allowable costs.

Actual uninsured data for services furnished during the payment year are used to the extent such data can be verified to be complete and accurate. The data sources utilized to determine eligible costs under this section must be derived from hospitals' audited financial statements and other auditable documentation.

Steps:

Table 4 – Procedures for Calculating Hospital Total Uncompensated Care Actual Cost

Line	Action	Procedure
1	**Determine Routine Cost Per Diems**	Use steps from Lines 2-10 For the State Fiscal Year (LIP Payment year), the routine per diems and ancillary cost-to-charge ratios for the cost centers are to be determined using the hospital's Medicare cost report (CMS 2552) on file with Florida Medicaid for the first rate semester of each State Fiscal Year.
2	Identify hospital's total days by routine cost center	The hospital's total days by routine cost center are identified from Worksheet S-3, Part 1, Column 6. NOTE: The A&P days include observation bed days in the total A&P patient day count. Enter these days into the Total Hospital Days column in Reference Row Numbers 25-32 of the form.
3	Identify Total Hospital Costs by routine cost center	Identify Total Hospital Costs by routine cost center from Worksheet B, Part I, Column 25. (These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.) NOTE: The A&P costs exclude swing bed nursing facility costs and non medically necessary private room differential costs from the A&P costs. Enter these costs into the Total Hospital Costs column in Reference Row Numbers 25-32 of the form.
4	Identify routine cost center per diem	For each routine cost center, a per diem is calculated by dividing total costs from Line 3 by total days from Line 2 (Reference Row Numbers 25-32). This step will be calculated for you.
5		**Routine Service Cost Per deims** will be displayed in Reference Row Numbers 25-32 of the form.
6	**Determine Ancillary**	Use steps from Lines 7-9

	Cost-To-Charge Ratios	
7	Identify Total Hospital Costs by ancillary cost center	Identify Total Hospital Costs by ancillary cost center from Worksheet B, Part I, Column 25. (These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.) NOTE: The A&P costs exclude swing bed nursing facility costs and non-medically necessary private room differential costs from the A&P costs. Enter these costs into the Total Hospital Costs column in Reference Row Numbers 39-66 of the form.
8	Identify hospital's total charges by ancillary cost center	The hospital's total charges by ancillary cost center are identified from Worksheet C, Part I, Column 8. Enter these charges into the Total Hospital Charges column in Reference Row Numbers 39-66 of the form.
9	Identify ancillary cost center cost to charge ratio	For each ancillary cost center, a cost to charge ratio is calculated by dividing the total ancillary costs from Line 7 by the total charges from Line 8 (Reference Row Numbers 39-66 of the form) This step will be calculated for you.
10		**Ancillary Cost Center Cost to Charge Ratios** will display in Reference Row Numbers 39-66 of the form.
11	**Determine Hospital Costs for Uncompensated Care**	Use steps from Lines 12-15 The data sources used to determine eligible costs under this section must be derived from the hospitals audited financial statements and other auditable documentation.
12	Identify uninsured routine cost center costs	Identify the hospital's uninsured days by routine cost center for individuals with no source of third party coverage. NOTE: For hospitals whose auditable records period are different from the State's Fiscal Year, hospitals should use the hospital auditable records that cover the span of July 1 through June 30. (This may require more than one period of auditable records.) Using these records, uninsured days should be proportionally allocated (by month) to the State Fiscal Year. Enter these days into the Uncompensated Care Days by Routine Cost Center column in Reference Row Numbers 25-32 of the form. The uninsured days are multiplied by the per diems from Line 5 for each respective routine cost center to determine the uncompensated care costs for each routine cost center. This step will be calculated for you and the results will display in the Uncompensated Care Allowable Costs by Routine Cost Center in Reference Row Numbers 25-32 of the form. (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.)
13	Identify uninsured	Identify the hospital's inpatient and outpatient actual charges by ancillary cost

	ancillary costs	center for individuals with no source of third party coverage. NOTE: For hospitals whose auditable records period are different from the State's Fiscal Year, hospitals should use the hospital auditable records that cover the span of July 1 through June 30. (This may require more than one period of auditable records.) Using these records, uninsured charges should be proportionally allocated (by month) to the State Fiscal Year. These allowable uninsured charges are multiplied by the cost to charge ratios from Line 10 for each respective ancillary cost center to determine the uninsured allowable ancillary costs for each cost center. This step will be calculated for you and the results will display in the Allowed Uncompensated Care Charges column in Reference Row Numbers 39-66 of the form. (The uninsured 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.)
14	Identify Uninsured Care Organ Acquisition Costs	First, find the **ratio of the uninsured usable organs to total usable organs**: Enter the number of uninsured usable organs as identified from provider records into Reference Row Number 74 of the form. NOTE: For hospitals whose auditable records period are different from the State's Fiscal Year, hospitals should use the hospital auditable records that cover the span of July 1 through June 30. (This may require more than one period of auditable records.) Using these records, uninsured useable organs should be proportionally allocated (by month) to the State Fiscal Year. Enter the hospital's total usable organs from Worksheet D-6, Part III, under the Part B, cost column line 54, into Reference Row Number 75 of the form. NOTE: For hospitals whose cost report year is different from the State's Fiscal Year, hospitals should use the hospital cost reports that cover the span of July 1 through June 30. (This may require more than one hospital cost report.) Using these cost report(s), total usable organs should be proportionally allocated (by month) to the State Fiscal Year. The ratio of the uninsured usable organs to total usable organs will be calculated for you. Next, enter the **total organ acquisition costs** from Worksheet D-6, Part III, under the Part A, cost column line 53, into Reference Row Number 77 of the form. The ratio is multiplied by total organ acquisition costs for you. The total uninsured care organ acquisition costs will be displayed in Reference Row Number 78 of the form. ("Uninsured 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 days and charges from the Medicaid or Medicaid managed care portion of this methodology.)
15		The eligible Uninsured Care costs are determined by adding the uninsured care routine costs from Line 12, uninsured ancillary costs from Line 13 and uninsured organ acquisition costs from Line 14. (Reference Row Numbers 34, 68, 78) This will be calculated for you and the **Hospital Actual Costs for Uncompensated Care** will display in Reference Row Number 82 of the form.

2.4 *Hospital Provider Additional Medicaid Costs*

STC 97 requires that the Agency use 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 may be included as additional costs. The additional costs for the Medicaid population may include:[3]

Table 5 – Procedure for Calculating Additional Medicaid Costs

Line	Action	Cost Description
1	**Determine Hospital Provider Additional Medicaid Costs**	Use lines 2-11
2	**Identify Part A provider component services in excess of Reasonable Compensation Equivalent (RCE) limits.**	Providers may include costs for Part A provider component services, but RCE limits must be applied to these limits. Enter costs into Reference Row Number 89.
3	**Identify Part B professional component services (not separately billable to individual patients)**	The costs are for services allowable under the terms of the waiver and provided to Medicaid beneficiaries or the uninsured. Enter costs into Reference Row Number 90.
4	**Identify Physician unmet guarantee amounts and other subsidies**	The costs are for services allowable under the terms of the waiver and provided to Medicaid beneficiaries or the uninsured. Enter costs into Reference Row Number 91.
5	**Identify Non-physician practitioner costs**	The costs are for services allowable under the terms of the waiver and provided to Medicaid beneficiaries or the uninsured. Enter costs into Reference Row Number 92.
6	**Identify Outpatient clinical laboratory services**	The costs are for services allowable under the terms of the waiver and provided to Medicaid beneficiaries or the uninsured. Enter costs into Reference Row Number 93.

[3] Note: Hospital-based physician services (not already included on Worksheet E-3, Part III, line 5) and Provider-based ambulance services are costs that are no longer allowable additional costs. Also note that County Based Insurance Program costs are now allowed as additional costs.

7	**Identify Provider-based transplant services indirect organ acquisition costs (not already included on Worksheet E-3, Part III, line 4)**	The costs are for services allowable under the terms of the waiver and provided to Medicaid beneficiaries or the uninsured. However, the State would need to follow the Medicare cost reporting process for determining these costs. Enter costs into Reference Row Number 94.
8	**Identify Provider-based clinic services**	The costs are for services allowable under the terms of the waiver and provided to Medicaid beneficiaries or the uninsured; and if these clinics are treated as outpatient departments of the hospital and not hospital based FQHCs or RHCs. Enter costs into Reference Row Number 95.
9	**Identify Patient and community education programs, excluding cost of marketing activities**	The costs are for services allowable under the terms of the waiver and provided to Medicaid beneficiaries or the uninsured. Enter costs into Reference Row Number 96.
10	**Identify Services contracted to other providers**	The costs are for services allowable under the terms of the waiver and provided to Medicaid beneficiaries or the uninsured. Enter costs into Reference Row Number 97.
11	**Identify County based insurance programs**	The cost that is reimbursed below Medicaid rates for allowable Medicaid costs. Enter costs into Reference Row Number 98

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

Table 6 – Methods for Determining Additional Costs

Method	Description
1	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
2	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 with 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.

The costs represented on worksheet E-3, part III, column 1, line 6 of CMS-2552 are the total costs for each provider, based on the cost allocation established in the CMS-2552 report. The allocation of total costs is first performed through the initial worksheets. Costs of each of the components of the hospital are separately determined following a common step-down of all

overhead costs. The appropriate cost to charge ratio (CCR) is applied to the various approved Medicaid cost centers. A summary of relevant worksheets is provided below.

Table 7 – Relevant Worksheets for Additional Cost Limits

Worksheet	Description
S	Provider certification, settlement summary, and statistical information
A	Reclassification and Adjustment of Trial Balance expenses
B	Cost Allocation (General Services, Capital Related, & Statistical Basis)
C	Computation of Ratio of Cost to Charges
D	Apportionment of Inpatient Services Costs
E	Calculation of Medicare Settlement
G	Financial Statements

Worksheet (W/S) E-3, Part III, calculates reimbursement for Title XIX, Medicaid. Line 6 of W/S E-3, Part III, is the sum of the preceding lines, which includes interns and residents (line 3), organ acquisitions (line 4), and teaching physicians (line 5). These specific lines are costs that would otherwise have been removed from the allocation process due to Medicare reimbursement policies. Teaching costs, for example, are paid separately by Medicare and therefore these costs are adjusted out on W/S A-8. Medicaid reimburses for all these allowable costs centers, and therefore they are added back into the cost report via W/S E-3, lines 3-5.

2.5 *Hospital Payments and Recoveries (e.g., Revenues)*

Hospital payments and recovery data should be entered into the cost limit calculations form following to the steps below. All of the following payments and recoveries offset the costs computed in the methodologies above.

Table 8 – Procedures for Calculating Hospital Payments and Recoveries

Line	Action	Procedure
1	Identify Medicaid Reimbursements	Enter Medicaid payments received during the State Fiscal Year into Reference Row Number 110.
2	Identify Payments Medicaid Managed Care Organizations (MCO)	Enter payments received from Medicaid Managed Care Organizations (MCO) for the State Fiscal Year into Reference Row Number 111.
3	Identify Medicaid Behavioral Health Organizations (BHOs)	Enter payments received from Medicaid Behavioral Health Organizations (BHOs) for the State Fiscal Year into Reference Row Number 112.
4	Identify Payments from the Uninsured	Enter payments received from the uninsured for the State Fiscal Year into Reference Row Number 113.
5	Identify Supplemental payments	Enter supplemental payments received during the State Fiscal Year into Reference Row Number 114. (e.g., LIP)
6	Identify Amount of GME funds received	Enter the amount of GME funds received that exceeded the hospital's Medicaid

	that exceeded the hospital's Medicaid GME expenditures	GME expenditures for the State Fiscal Year into Reference Row Number 115.
7	Identify Any DSH payments received	Enter DSH payments received for the State Fiscal Year into Reference Row Number 116.
8	Identify Other sources including any related patient co-payments, or payments from other non-State payers	Enter any payments received from other sources including any related patient co-payments, or payments from other non-State payers for the State Fiscal Year as needed beginning in Reference Row 117.
		Total Hospital Payments and Recoveries will be displayed on Reference Row 120.

Payments to the hospital from uninsured individuals for their care for the Fiscal Year are identified from the hospital's records. Such uninsured data must be supported by auditable documentation.

NOTE: For hospitals whose auditable records period are different from the State's Fiscal Year, hospitals should use the hospital auditable records that cover the span of July 1 through June 30. (This may require more than one period of auditable records.)

Using these records, uninsured revenues should be proportionally allocated (by month) to the State Fiscal Year.

2.6 *Cost Limit Reconciliation Results*

Table 9 – Cost Limit Reconciliation Results

Line	Action	Procedure
	Determining the Cost Limit Reconciliation Results	Results from Instruction Sections 2.1 through 2.5 are summed to determine the Cost Limit Reconciliation Results.
1		**Cost Limit Reconciliation Results are displayed in Reference Row Numbers 129-139.**

2.7 *Hospital Reconciliations for SFY 2006-07 through 2008-09 (Quarterly Report)*

In November of 2009, the Agency for Health Care Administration (Agency, AHCA) requested the Centers for Medicare & Medicaid Services (CMS) an amendment to Special Terms and Conditions (STC) 105 of the Florida Medicaid Reform Waiver, Section 1115. This amendment allowed for the release of an additional $300 million in Low Income Pool (LIP) funds to the State for State Fiscal Year 2010-11that could have otherwise been retained by the federal government.

The amendment to STC 105 creates milestones for compliance with the RFMD which requires hospitals to report quarterly data to capture the uninsured costs of patients served beginning July 1, 2009. The data reported through a new methodology will distinguish between allowable and unallowable uninsured/underinsured cost based on the definitions of uninsured/underinsured costs contained in Section III of the Reimbursement and Funding Methodology Document (RFMD) as submitted on June 26, 2009 and approved by CMS, December 2, 2009. These data will be used to calculate the percentage of unallowable uninsured costs, which will then be used to adjust the cost limit calculations from waiver DY 1-3.

Each hospital will use the reporting methodology below to capture allowable and unallowable uninsured/underinsured costs for dates of service beginning July 1, 2009, utilizing the Hospital Uninsured/Underinsured Quarterly Reporting Form -1. The methodology guides respondents to capture uninsured cost as defined in the March 20, 2008 RFMD, (**Section 1**; below) then requires respondents to capture uninsured costs using the new definition as defined in the RFMD dated June 26, 2009 (**Section 2**, below). The methodology compares the two cost calculations and the computed difference results in the unallowable costs. This difference is used to derive a "percent of unallowable uninsured cost" ratio that AHCA will use to adjust the cost limit calculations for DY 1-3.

Definitions:

- State Fiscal Year: July 1 – June 30.
- Date of Service: Admission date (Medicaid date of service).
- As Filed Cost Report: The most recent Medicare cost report submitted to the Agency.
- Uninsured/underinsured: Persons with no source of third party coverage for the services provided.
- Allowable uninsured/underinsured costs: Cost of services provided to Uninsured/Underinsured persons. Also includes services that were provided, but not covered by the recipient's insurance plan. Examples include, benefits exhausted, preexisting conditions, specific exclusions of services from the individual's policy.
- Non-allowable uninsured/underinsured costs: Costs of any unpaid deductible, coinsurance amounts and portions of charges written off as bad debts or charity care (under the June 26, 2009 RFMD requirements) that pertain to services furnished to individuals with third party coverage.
- Third Party Coverage: Includes any item or service covered by an individual's insurance.

2.7.1 Hospital Uninsured/Underinsured Quarterly Reporting Form 1.0 -- Section 1:

Section 1 below is the procedure for reporting total uninsured/underinsured costs using the definitions of uninsured/underinsured from the **March 20, 2008** RFMD.

Table 10 – Section 1 Procedure for Reporting Total Uninsured/Underinsured Costs - March 20, 2008 RFMD.

Lines	Action	Procedure
1	**Capture Total Uninsured/Underinsured Costs Using 3/20/08 RFMD**	Use Lines 2-4 The hospital will capture the total uninsured/underinsured costs using the definitions required in the March 20, 2008 RFMD. The hospital will use its most recently submitted CMS – 2552 cost report to complete this methodology. For purposes of completing this section, the hospital will use charity and bad debt data, based on write off date for the State Fiscal Year beginning 7/1/09.
2	Calculate the hospital's total cost to charge ratio	Enter Total Hospital Costs from CMS – 2552, Worksheet C, column 5, Line 101, of the hospital's most recently submitted cost report on Reference Row Number 22 of the form. Enter total hospital charges from CMS – 2552, Worksheet C, column 8, Line 101 of the hospital's most recently submitted cost report on Reference Row Number 23 of the form. The hospital's total cost to charge ratio will display on Reference Row Number 24 of the form.
3	Identify total bad debt and charity write-offs (charges)	Enter Total Bad Debt and Charity write-offs (charges) for the (State Fiscal Year) quarter being reported from hospital records on Reference Row Numbers 30 and 31 of the form. Total Bad Debt and Charity write-offs (charges) will be added and displayed on Reference Row Number 32 of the form.
4		The **Total Uninsured/Underinsured Costs** will be calculated for you by multiplying Lines 2 by Line 3 (Reference Row Numbers 24 and 32) and will be displayed on Reference Row Number 34 of the form.

2.7.2 Hospital Uninsured/Underinsured Quarterly Reporting Form 1.0 -- Section 2

Section 2 below is the procedure to report total uninsured/underinsured costs using the definitions of uninsured/underinsured from the June 26, 2009 RFMD. Recognizing that hospitals have different levels of detail in their patient accounting capabilities, hospitals may use ***one*** of the following methods to report total allowable uninsured/underinsured costs:

- Detailed Method
- Allocation Method – respondents have an option to report routine costs by:

i. Uninsured Days

ii. Uninsured Charges

Table 11 – Procedure for Reporting Total Allowable Uninsured/Underinsured Costs

Lines	Action	Procedure
1	**Capture Total Uninsured/Underinsured Costs Using the 6/26/09 RFMD**	Use Lines 1 – 45 The hospital will capture the total uninsured/underinsured costs using the definitions of uninsured/underinsured as required in the June 26, 2009 RFMD. The hospital shall use its most recently submitted CMS – 2552 cost report to complete this methodology. Facilities should choose one of the following methods below: • Detailed Method (Lines 2 – 13) • Allocation Method (Lines 16 – 45)
2	**Detailed Method**	To be used by facilities whose accounting systems can capture allowable uninsured costs by routine and ancillary cost centers.
3	**Calculate Total Allowable Uninsured/Underinsured Routine Cost**	Use Lines 4-7
4	Capture allowable uninsured/underinsured days by routine cost centers	Capture allowable uninsured/underinsured days for the reporting period from hospital records and enter them by routine cost centers as listed in CMS 2552, Worksheet S-3, part 1, column 6, Lines 5 through 11. Enter into the Uninsured/Underinsured Days column in reference Row Numbers 47-53 of the form.
5	Identify individual per-diem amounts by routine cost centers	Enter the individual per-diem amounts by routine cost centers from the hospital's most recently filed CMS-2552 cost report Title XIX, Worksheet D-1, part II, Lines 38 and 42-47 into the Per-diem column on Reference Row Numbers 47-53 of the form
6	Identify total allowable uninsured/underinsured costs by routine cost center	Line 4 is multiplied by Line 5 for you (Reference Row Numbers 47-53 of the form) and the total allowable uninsured/underinsured costs by routine cost center is displayed in the Total Allowable Uninsured/Underinsured column on Reference Row Numbers 47-53 of the form.
7		The **Total Uninsured/Underinsured Routine Costs** will be calculated for you and displayed on Reference Row Number 55 of the form.
8	**Calculate Total Allowable Uninsured/Underinsured Ancillary Cost**	Use Lines 9-12

9	Capture allowable uninsured/underinsured charges by ancillary cost centers	Capture allowable uninsured/underinsured charges by ancillary cost center for the reporting period from hospital records and enter them by ancillary cost center as listed in CMS 2552, Worksheet C, part I, column 8, Lines 37-101 into the Allowable Uninsured/Underinsured column on Reference Row Numbers 60-87 of the form.
10	Identify cost to charge ratios by ancillary cost center	Enter the cost to charge ratios by ancillary cost center from the hospital's most recently filed CMS-2552 cost report (Worksheet C, part I, column 9) into the Cost to Charge Ratio column on Reference Row Numbers 60-87 of the form.
11	Total allowable uninsured/underinsured costs by ancillary cost center	Line 9 will be multiplied by Line 10 (Reference Row Numbers 60-87) to calculate the allowable uninsured/underinsured costs by ancillary cost center. These results will be displayed in the Total Allowable Uninsured/Underinsured Costs By Ancillary Cost Center column on Reference Row Numbers 60-87 of the form.
12		**Total Allowable Uninsured/Underinsured Ancillary Costs** will be displayed on Reference Row Number 89 of the form.
13		Line 7 and 12 (Reference Row Numbers 55-89) will be summed for you and the **Total Allowable Uninsured/Underinsured Costs** will be displayed on Reference Row Number 91 of the form.

The Ratio of Non-Allowable Uninsured/Underinsured Costs using the Detailed Methodology is calculated as follows:

Table 12 – Procedure For Calculating The Percentage Of Non-Allowable Uninsured/Underinsured Costs

14	**Calculate Ratio of Non-Allowable Uninsured/Underinsured Costs**	Line 13 from Section 2 is subtracted from Line 4 of Section 1 (Reference Row Number 91and 34) and then divided by Line 4 of Section 1 for you. Example Line 4 : Total uninsured/underinsured costs using 3/20/08 RFMD = $1,500,000 Line 13: Total uninsured/underinsured costs using 6/26/09 RFMD = $1,050,000 Line 4: $1,500,000 Less: Line 13: $1,050,000 Non-allowable uninsured/underinsured costs: $450,000 Non-allowable uninsured/underinsured costs: $450,000/Line 4 $1,500,000 = 30% unallowable uninsured/underinsured costs.
15		The **Ratio of Non-Allowable Uninsured/Underinsured Costs** using the Detailed Method will by displayed on Reference Row Number 94 of the form.

Table 13 – Procedure for Reporting Uninsured/Underinsured Routine Costs

16	**Allocation Method**	To be used by facilities whose accounting systems prohibit the capture of allowable uninsured/underinsured costs by routine and ancillary cost centers.			
17	Routine Costs	Calculation of routine uninsured/underinsured costs may be calculated using one of the following methods: 1) Total uninsured/underinsured costs using uninsured patient days (Lines 18-25) 2) Total uninsured/underinsured costs using uninsured charges (Lines 26-36)			
	1. Method to Calculate Routine Costs Using Uninsured/Underinsured Patient Days			**2. Method to Calculate Routine Costs Using Uninsured/Underinsured Patient Charges**	
18	Identify Total Allowable Uninsured/Underinsured Patient Days	Enter total allowable uninsured/underinsured patient days for the quarter being reported on Reference Row Number 104 of the form.	26	Identify Total Allowable Uninsured/Underinsured Charges	Enter total allowable uninsured/underinsured charges for the quarter being reported on Reference Row Number 121 of the form.
19	Identify Total Patient Days	Enter total patient days from the most recently filed CMS-2552, Worksheet S-3, Part I, Column 6, Line 12 on Reference Row Number 107 of the form.	27	Identify Total Charges	Enter total charges from the most recently filed CMS-2552, Worksheet C, Column 8, Line 103 into Reference Row Number 124 of the form.
20	Identify Total Patient Days by Routine Cost Center	Enter total patient days by routine cost center from the most recently filed CMS-2552, Worksheet, S-3, Part I, Column 6, Lines 5 – 11 on Reference Row Numbers 108-114 of the form.	28	Identify Total Charges by Routine Cost Center	Enter total charges by routine cost center as listed in the most recently filed CMS-2552, Worksheet C, Column 8, Lines 25-33 into the Total Charges column on Reference Row Numbers 124-131 of the form.
21	Ratio of Total Patient Days by Routine Cost Center to Total Patient Days	A ratio of total patient days by each routine cost center from Line 20 to the total patient days from Line 19 (Reference Row Number 108-114) will be displayed in the Ratio column on Reference Row Numbers 108-114 of the form.	29	Ratio of Total Charges by Routine Cost Center to Total Charges	A ratio of total charges by each routine cost center from Line 28 to the total patient days from Line 27 (Reference Row Number 124-131) will be displayed in the "Ratio" column on Reference Row Numbers 124-131 of the form.
22	Total Allowable Uninsured/Underinsured Days by Routine Cost Center	The total allowable uninsured/underinsured days by routine cost center are calculated automatically in the form by multiplying the results of Lines 20 by Lines 21 (Reference Row Number 108-114) and are displayed in the Total Allowable Uninsured/Underinsured Days by Routine Cost Center column on Reference Row Numbers 108-114 of the form.	30	Total Allowable Uninsured/Underinsured Charges by Routine Cost Center	The total allowable uninsured/underinsured charges by routine cost center will be calculated by multiplying the results of Line 28 by Line 29 (Reference Row Number 124-131) and are displayed in the Total Allowable Uninsured/Underinsured Charges by Routine Cost Center column on Reference Row Numbers 124-131 of the form.

23	Identify Per diems by Routine Cost Center	Enter the routine cost center per diems from the most recently filed CMS-2552, Title XIX, Worksheet D-1, Part II, Line 38, 42-47 into the Per-diem column on Reference Row Numbers 108-114 of the form.	31	Identify Total Patient Days by Routine Cost Center	Enter total patient days by routine cost center as listed in the most recently filed CMS-2552 Worksheet S-3, Column 6, Lines 5-12 into the Total Patient Days by Routine Cost Center column on Reference Row Numbers 124-131 of the form.
24	Total Allowable Uninsured/Underinsured Costs by Routine Cost Center	Line 22 is multiplied by Line 23 (Reference Row Number 108-114) to calculate the Total allowable uninsured/underinsured costs by routine cost center and are displayed on Reference Row Numbers 108-114 of the form.	32	Calculate Average Charge Per Day	Divide the results of Line 30 by Line 31 (Reference Row Number 124-131) to calculate the average charge per day. This is done for you and the results are displayed in the column Average Charge Per Day on Reference Row Numbers 124-131 of the form.
25		The **Total Allowable Routine Costs for the Uninsured/Underinsured** is displayed on Reference Row Number 116 of the form.	33	Calculate Uninsured/Underinsured Days	Calculate the number of Uninsured/Underinsured days by dividing the results of Line 32 by Line 30 (Reference Row Number 124-131). This is done for you and the results are displayed in the Uninsured/Underinsured Days column on Reference Row Numbers 124-131 of the form.
			34	Per deims by Routine Cost Center	Enter the routine cost center per deims from the most recently filed CMS-2552, Title XIX, Worksheet D-1, Part II, Line 38, 42-47 into the Per-diem column on Reference Row Numbers 124-131 of the form.
			35	Calculate Total Allowable Uninsured/Underinsured Costs by Routine Cost Center	Multiply the results from Line 33 by Line 34 (Reference Row Number 124-131) to calculate the total allowable uninsured/underinsured costs by routine cost center. This is done for you and is displayed in the Total Allowable Uninsured/Underinsured Costs by Routine Cost Center column on Reference Row Numbers 124-131 of the form.
			36		The **Total Allowable Routine Costs for the Uninsured/Underinsured** will be displayed in Reference Row Number 133 of the form.

Table 14 – Procedure for Reporting Total Allowable Uninsured/Underinsured Ancillary Costs

37	**Calculate Total Allowable Uninsured/Underinsured Ancillary Cost**	Use Lines 38-49 Total Uninsured/Underinsured Charges by Ancillary Cost Center are calculated by using a ratio of cost to charges.
38	**Determine Total Uninsured/Underinsured Charges by Ancillary Cost Center**	Use Lines 38- 43.
39	Identify total uninsured/underinsured charges	Enter allowable uninsured/underinsured charges for the reporting period into Reference Row Number 138 of the form.
40	Identify total charges	Enter total charges from the most recently filed CMS-2552, Worksheet C, Part I, Col. 8, Line 103 into Reference Row Number 141 of the form.
41	Identify total charges by ancillary cost center	Enter total ancillary charges by cost center from the most recently filed CMS-2552, Worksheet C, Part I, Column 8, Lines 37-101 into Reference Row Numbers 142-169 of the form.
42	Calculate ratio of total charges by ancillary cost center to total charges	A ratio of total charges by each ancillary cost center is calculated by dividing Line 40 by Line 39 (Reference Row Number 142-169) and will be displayed in the Ratio column on Reference Row Numbers 142-169 of the form.
43	Calculate total uninsured/underinsured charges by ancillary cost center	Multiply Line 40 by Line 41 (Reference Row Number 142-169) to calculate the total uninsured/underinsured charges by ancillary cost center. This step will be done for you.
44		**Total Uninsured/Underinsured Charges by Ancillary Cost Center** will display in the Total Uninsured/Underinsured Charges by Ancillary Cost Center column on Reference Row Numbers 142-169 of the form.
45	**Identify Cost to Charge Ratios by Ancillary Cost Center**	Enter the cost to charge ratios by ancillary cost center from CMS – 2552, Worksheet C, part I, column 9 using the hospital's most recently submitted cost report into the Cost to Charge Ratio column on Reference Row Numbers 142-169 of the form.
46	**Calculate Total Allowable Uninsured/Underinsured Costs By Ancillary Costs**	The results from Line 44 will be multiplied by Line 45 (Reference Row Number 142-169) to calculate the total allowable uninsured/underinsured costs by ancillary cost center. This is done for you and the results are displayed in the "Total Allowable Uninsured/Underinsured Ancillary Costs" are displayed in the column on Reference Row Numbers 142-169 of the form.
47	**Calculate Total Allowable Uninsured/Underinsured Ancillary Cost**	Results from Line 46 (Reference Row Numbers 142-169) are added for you.
48		The **Total Allowable Uninsured/Underinsured Ancillary Cost** is displayed on Reference Row Number 171 of the form.

49	**Allocation Method Results**	The total Uninsured/Underinsured costs produced by the allocation method are calculated by adding Line 48 (Reference Row Number 171) to either Line 25 (Reference Row Number 116) or Line 36 (Reference Row Number 133) depending upon which method was selected to calculate routine costs and displayed in the Reference Row Numbers 175-199 of the form. The Ratio of Non-allowable uninsured costs will be displayed on Reference Row Numbers 186 or 199 depending upon which option of routine cost reporting was chose.

The ratio of non allowable uninsured underinsured costs using the allocation methodology is calculated as follows:

Table 15 – Procedure for Calculating the Ratio of Non-Allowable Uninsured Costs

Line	Action	Procedure
	Ratio of Non-Allowable Uninsured Costs	Line 49 from Section 2 (Reference Row Numbers 182 or 195 – depending upon the method chosen to calculate routine costs) is subtracted from Line 4 of Section 1 (Reference Row Number 34) and then divided by Line 4 of Section 1 for you.
1		**Ratio of Non-Allowable Uninsured Costs** displays in either Reference Row numbers 186 or 199.

3 Cost Limit Reconciliation Procedures –Federally Qualified Health Centers

To reconcile the cost limits using the new procedures, a spread sheet has been provided along with these instructions as a separate Excel 2007 file. The steps for completing the spreadsheet are in the spread sheet and are in the tables below.

The procedures consist of following the steps listed in the table to complete the "Input" work sheet. This worksheet is linked to a "Results" worksheet that will reflect the final revised cost limit and Medicaid shortfall calculations. The worksheets contain locked formulas or equations that reflect the various policy decisions that have been approved by AHCA and CMS.

3.1 *FQHC Medicaid*

The following procedures are required to calculate the FQHC Medicaid shortfall. For the State Fiscal Year (LIP Payment year), the allowable costs applicable to FQHC services are determined using the using the FQHC Form CMS-222-92, as filed with the Fiscal Intermediary.[4]

Steps:

Table 16 – Procedures for Determining FQHC Medicaid Shortfalls

Line	Action	Procedure
	Determine Total Medicaid Costs	Use steps from Lines 1-3
1	Determine Allowable Medicare Rate/Covered Visit	Enter the allowable Medicare Rate per covered visit from the FQHC Form CMS-222-92, Worksheet C part I, line 9 in Cell B14 of the Input worksheet.
2	Determine Medicaid encounters for the payment year	Determine Medicaid encounters for the State Fiscal Year from auditable FQHC reports and enter this number into Cell B17 of the Input worksheet.
3	Apply Medicaid encounters to allowable Medicare Rate per covered visit	This step will calculate for you on the Results worksheet as Line 1 data are multiplied by Line 2 data.
4		**Total Medicaid Cost** will display in Cell C9 of the Results worksheet.

[4] NOTE: For those FQHCs whose cost report year is different from the State's Fiscal Year, cost reports that cover the span of July 1 through June 30 should be used. (This may require more than one cost report.)

Using these cost report(s), costs should be proportionally allocated (by month) to the State Fiscal Year.

	Determine Total Medicaid Costs for Vaccinations for State Fiscal Year	Use steps from Lines 5 - 6
5	Determine allowable cost per vaccine injection	Input the two amounts from FQHC Form CMS-222-92, Worksheet b-1, Line 12 into Cells B21 and B22 of the Input worksheet. This will calculate the average cost per vaccine, which will be displayed in Cell C11 of the Results worksheet.
6	Determine number of Medicaid vaccinations	Using auditable FQHC reports enter the total number of Medicaid Vaccines administered for the State Fiscal Year into Cell B25 of the Input worksheet. (e.g. UDS Reports, internal records, etc.)
7		**Total Medicaid Costs for Vaccines** will display in Cell C13 of the Results worksheet.
	Determine Total Allowable Medicaid Costs for the State Fiscal Year	The results from Lines 4 and 7 will be added in the Results worksheet.
8		**Total Allowable Medicaid Costs for the State Fiscal Year** will display in Cell C15 in the Results worksheet.
	Determine Medicaid Shortfall	Use the step in Line 9
9	Determine the applicable revenues received by the FQHCs	Enter all applicable revenues received by the FQHC for Medicaid in Cells B30-B38 on the Input worksheet. (This number will be deducted from the Total Allowable Medicaid Costs for the State Fiscal Year.)
10		**The Medicaid Shortfall** will display in Cell C19 of the Results worksheet.

3.2 *FQHC Medicaid Managed Care*

The following procedures are required to calculate the FQHC Medicaid Managed Care shortfall. For the State Fiscal Year (LIP Payment year), the allowable costs applicable to FQHC services are determined using the using the FQHC Form CMS-222-92, as filed with the Fiscal Intermediary.

Steps:

Table 17 – Procedures for Determining FQHC Medicaid Managed Care Shortfalls

Line	Action	Procedure
	Determine Total Medicaid Managed Care Costs	Use steps from Lines 1-3
1	Determine Allowable Medicare Rate/Covered Visit	Enter the allowable Medicare Rate per covered visit from the FQHC Form CMS-222-92, Worksheet C part I, line 9 in Cell B14 of the Input worksheet.
2	Determine Medicaid Managed Care encounters for the payment year	Determine Medicaid Managed Care encounters for the State Fiscal Year from auditable FQHC reports and enter this number into Cell B18 of the Input worksheet.

3	Apply Medicaid Managed Care encounters to allowable Medicare Rate per covered visit	This step will calculate for you on the Results worksheet as Line 1 data are multiplied by Line 2 data.
4		**Total Medicaid Managed Care Cost** will display in Cell C24 of the Results worksheet.
	Determine Total Medicaid Managed Care Costs for Vaccinations for State Fiscal Year	Use steps from Lines 5 - 6
5	Determine allowable cost per vaccine injection	Input the two amounts from FQHC Form CMS-222-92, Worksheet b-1, Line 12 into Cells B21and B22 of the Input worksheet. This will calculate the average cost per vaccine, which will be displayed in Cell C26 of the Results worksheet.
6	Determine number of Medicaid Managed Care vaccinations	Using auditable FQHC reports enter the total number of Medicaid Managed Care Vaccines administered for the State Fiscal Year into Cell B26 of the Input worksheet. (e.g. UDS Reports, internal records, etc.)
7		**Total Medicaid Managed Care Costs for Vaccines** will display in Cell C28 of the Results worksheet.
	Determine Total Allowable Medicaid Managed Care Costs for the State Fiscal Year	The results from Lines 4 and 7 will be added in the Results worksheet.
8		**Total Allowable Medicaid Managed Care Costs for the State Fiscal Year** will display in Cell C30 in the Results worksheet.
	Determine Medicaid Managed Care Shortfall	Use the step in Line 9
9	Determine the applicable revenues received by the FQHCs	Enter all applicable revenues received by the FQHC for Medicaid Managed Care in Cells B43-B51 on the Input worksheet. (This number will be deducted from the Total Allowable Medicaid Managed Care Costs for the State Fiscal Year.)
10		**The Medicaid Managed Care Shortfall** will display in Cell C33 of the Results worksheet.
	Determine Medicaid, Medicaid Managed Care Shortfall	The Total Medicaid, Medicaid Managed Care Shortfall will be automatically added and will display in Cell C37 of the Results worksheet.

3.3 *FQHC Uninsured/Underinsured*

The following procedures are required to calculate the FQHC Uninsured/Underinsured shortfall. For the State Fiscal Year (LIP Payment year), the allowable costs applicable to FQHC services are determined using the using auditable records and the FQHC Form CMS-222-92, as filed with the Fiscal Intermediary.

Steps:

Table 18 – Procedures for Determining FQHC Uninsured Shortfalls

Line	Action	Procedure
	Determine Total Uninsured Costs	Use steps from Lines 1-3
1	Determine Allowable Medicare Rate/Covered Visit	Enter the allowable Medicare Rate per covered visit from the FQHC Form CMS-222-92, Worksheet C part I, line 9 in Cell B14 of the Input worksheet.
2	Determine Uninsured encounters for the payment year	Determine Uninsured encounters for the State Fiscal Year from auditable FQHC reports and enter this number into Cell B57 of the Input worksheet.
3	Apply Uninsured encounters to allowable Medicare Rate per covered visit	This step will calculate for you on the Results worksheet as Line 1 data are multiplied by Line 2 data.
4		**Total Uninsured Cost** will display in Cell C44 of the Results worksheet.
	Determine Total Uninsured Costs for Vaccinations for State Fiscal Year	Use steps from Lines 5 - 6
5	Determine allowable cost per vaccine injection	Input the two amounts from FQHC Form CMS-222-92, Worksheet b-1, line 12 into Cells B21 and B22 of the Input worksheet. This will calculate the average cost per vaccine, which will be displayed in Cell C46 of the Results worksheet.
6	Determine number of Uninsured vaccinations	Using auditable FQHC reports enter the total number of Uninsured Vaccines administered for the State Fiscal Year Cell B58 of the Input worksheet. (e.g. UDS Reports, internal records, etc.)
7		**Total Medicaid Costs for Vaccines** will display in Cell C48 of the Results worksheet.
	Determine Total Allowable Uninsured Costs for the State Fiscal Year	The results from Lines 4 and 7 will be added in the Results worksheet.
8		**Total Allowable Uninsured Costs for the State Fiscal Year** will display in Cell C50 in the Results worksheet.
	Determine Uninsured Shortfall	Use the step in Line 9
9	Determine the applicable revenues received by the FQHCs	Enter all applicable revenues received by the FQHC for Uninsured in Cells B63-B71 on the Input worksheet. (This number will be deducted from the Total Allowable Medicaid Costs for the State Fiscal Year.)
10		**The Uninsured Shortfall** will display in Cell C52 of the Results worksheet.

3.4 *FQHC Provider Additional Medicaid and Uninsured/Underinsured Costs*

Provide additional Medicaid, Medicaid Managed Care, Uninsured/Underinsured costs for Lab, X-ray, Pharmacy, Dental and Mental Health services, if costs are not captured through the calculations in sections 3.1-3.3.

Steps:

Table 19 – Procedures for Calculating FQHC Additional Costs

Line	Action	Procedure
1	**Determine Additional Medicaid and Uninsured/Underinsured Costs**	Use Steps from Lines 1-14
2	**Determine Total Costs with Overhead for Lab** **(Use the same procedures for X-ray, Pharmacy, Dental and Mental Health)**	Use Lines 2-7 Calculate Total Costs with Overhead for Labs; then repeat these steps using the appropriate cost for X-ray, Pharmacy, Dental and Mental Health.
3	Identify the cost of all FQHC services	Enter FQHC costs of all services in Cell B83 of the Input sheet as listed in Worksheet B, Line 12 of the CMS-222-92.
4	Identify FQHC total overhead	Enter FQHC total overhead costs in Cell B84 of the Input sheet as listed in Worksheet B, Line 14 of the CMS-222-92.
5	Identify total Lab costs	Enter Total Lab costs in Cells B89-B92 of the Input sheet as listed in Worksheet A, CMS-222-92.
6	Calculate total lab and lab overhead costs	This is calculated for you and is displayed in Cell C57 of the Results worksheet. The calculation is applied as follows: Total Lab Costs + ((total Lab costs/total cost of all services)* overhead)
7		**Total Costs with Overhead for Lab** will display in Cell C57 of the Results Worksheet.
8	**Determine Costs per Encounter for Lab** **(Use the same procedures for X-ray, Pharmacy, Dental and Mental Health)**	Use Line 8-10
9	Identify total lab encounters	Enter Total Labs ordered in Cell B96 of the Input sheet. (e.g. UDS Report)
10		Lines 7 will be divided by Line 9 and **Lab cost per order** will display in Cell C59 of the Results worksheet.
11	**Identify Medicaid, Medicaid managed care , uninsured encounters for Lab** **(Use the same procedures for X-ray, Pharmacy, Dental and Mental Health)**	Enter Lab orders for Medicaid, Medicaid Managed Care, and Uninsured in Cells B97-B99.
12	**Calculate Each Additional Medicaid and Uninsured/Underinsured Cost**	Line 10 will be multiplied by Line 11 for you to calculate Additional Medicaid and Uninsured/Underinsured Costs
13		**Additional Medicaid and Uninsured/Underinsured Costs for Labs** will be display in Cell C61 of the Results worksheet.

		X-ray will display in Cell C69 of the Results worksheet. **Pharmacy** will display in Cell C77 of the Results worksheet. **Dental** will display in Cell C85 of the Results worksheet. **Mental Health** will display in Cell C92 of the Results worksheet.
14	**Calculate Total Additional Medicaid and Uninsured/Underinsured Costs**	The results from Lines 13 will be added in the Results worksheet.
15		**Total Additional Medicaid and Uninsured/Underinsured Costs** will display in Cell 93 of the Results worksheet.

3.5 *FQHC Reconciliation for SFY 2006-07 through 2008-09*

The State will implement new reporting criteria by date of service for service periods beginning July 1, 2009 to capture the uninsured costs and reimbursements received to offset the uninsured cost. Non-allowable costs include co pays, deductibles and costs incurred during coverage gaps. These costs are not included in the uninsured cost. The uninsured population does not have third party coverage. Providers will be required to report the data to the Agency on quarterly bases.

For DY 1, DY2 and DY3, the State will use the original cost limit established for each provider and conduct the required reconciliation using the following method.

The payments to the provider through the Low Income Pool program will be totaled for the period being reconciled. This total will then be compared to the total cost of the allowed uninsured and Medicaid shortfall costs. If the total payments are at or below the total costs, the requirement of not exceeding the cost limit is met. If the payments exceed the cost, the provider will be required to refund the overpayment amount.

In the event that the aggregate overpayment exceeds the current year LIP payment, the entity would provide a repayment of this amount to the Agency. If payments do exceed the cost limits, the provider must return the excess amount to the state. Once the state has received the returned funds, appropriate documentation will be made and the federal share will be calculated and returned to CMS. The excess will be returned to the state and the Federal share will be reported on the 64 report to CMS.

Steps:

Table 20 – Procedures for Calculating FQHC Quarterly Cost

Line	Action	Procedure
1	**Determine quarterly Uninsured Costs**	Use Steps from Lines 1-4
2	Allowable uninsured Rate/Covered Visit	Enter the allowable cost from the FQHC UDS Form, Table 8A, Rows 4 - 13, Column C. Reference Row Numbers 1 – 5, column D.

3	Determine total encounters for the quarter	Determine total encounters for the quarter from the FQHC UDS form, Table 5, Rows 8,19,20 and 29, column B, enter these amounts into Reference Rows 1 – 5 column F.
4	Determine uninsured encounters for the quarter	Determine uninsured encounters for the quarter from auditable FQHC reports and enter this number into enter these amounts into Reference Rows 1 – 5 column H.
5		**Grand Total uninsured Cost** will display in Cell I29 of the Quarterly Reporting Form worksheet.

Table 21 – Procedures for Calculating FQHC Quarterly Reimbursements

Line	Action	Procedure
1	**Identify Uninsured Reimbursements**	Enter Uninsured payments received during the established quarter Lines 2 – 5.
2	Identify 330 Grant payment amount for quarter	Enter payments received for the quarter from 330 Grant – from the UDS report Table 9E, Row 1g.
3	Identify State Grant payment amount for quarter	Enter payments received for the quarter from State Grant – from the UDS report Table 9E, Row 6g.
4	Identify County / City payments amount for quarter	Enter payments received for the quarter from County / City grants – from the UDS report Table 9E, Row 7g.
5	Identify Payments from the Uninsured	Enter payments received for the quarter from the Uninsured – from the UDS report Table 9E, Row 10g.
		Total FQHC Uninsured Payments will be displayed in cell I39.

4 Cost Limits Reconciliation Procedures -- County Health Departments

The procedure for CHDs to report cost limits consists of the following steps listed in the table below.

4.1 *CHD Medicaid and Medicaid Managed Care*

For the State Fiscal Year (LIP payment year), the allowable costs applicable to CHD services are determined using the CHDs' approved Medicaid Cost Report.

Steps:

Table 22 – Procedures for Reconciling CHD Medicaid and Medicaid Managed Care

Line	Reference Row	Procedure
1	a	Determine allowable Medicaid Rate per covered visit from Worksheet 3 Attachment 6 Part D line 1.
2	b	Determine Medicaid encounters for the payment year from Florida Department of Health LIP Encounters Milestone Report.
3	c	Apply Medicaid encounters to allowable Medicaid Rate per covered visit from step b. This will result in total Medicaid costs. (Line 1 multiplied by Line 2)
4	d	Offset all applicable Medicaid revenues received by the CHD against the total Medicaid costs determined in Line 3 to determine Medicaid shortfall.

4.2 *CHD Uninsured Cost*

For the State Fiscal Year (LIP payment year), the allowable costs applicable to CHD services are determined using the CHDs' approved Medicaid Cost Report.

Steps:

Table 23 – Procedures for Calculating CHD Uninsured Costs

Line	Reference to SFY 06/07 - 08/09 Cost Reports	Procedure
1	a	Determine allowable Medicaid Rate per covered visit from Worksheet 3 Attachment 6 Part D line 1.
2	b	Determine encounters attributable to the uninsured for the payment year from Florida Department of Health LIP Encounters Milestone Report.
3	c	Apply encounters attributable to the uninsured to allowable Medicaid Rate per covered visit from step b. This will result in total uninsured costs. (Line 1 multiplied by Line 2)
4	d	Offset all revenues (those received by or on behalf of those with no source of third party coverage and / or grant dollars) against the total Uninsured costs determine uninsured shortfall.

4.3 *CHD Reconciliation Beginning SFY2006-07*

The costs determined through the method described for the payment year will be reconciled to the desk audited CHD Medicaid cost report for the payment year. If, at the end of the reconciliation process, it is determined that a CHD received an overpayment, the overpayment will be properly credited to the federal government and if an underpayment is determined, the State will make the applicable claim from the Federal government. For purposes of this reconciliation, the same steps as outlined for the payment year method are carried out.

(The CHDs' Medicaid Cost Reports and LIP Cost Limit Reports are both compiled based on the Florida State Fiscal Year, July 1 – June 30.)

References:

Reimbursement and Funding Methodology, Florida Medicaid Reform Section 1115 Waiver, Low Income Pool, Submitted March 20, 2008

Reimbursement and Funding Methodology, Florida Medicaid Reform Section 1115 Waiver, Low Income Pool, Submitted June 26, 2009 and approved December 2, 2009.

CMS signed STC 105 amendment approval letter, received by AHCA January 29, 2010.