On June 27, 2007, CMS' provided some comments regarding the Reimbursement and Funding Methodology document. CMS' comments are provided below, in italics, with the Agency's response following.

Hospital Medicaid

- For Medicaid hospital cost, the use of ws E-3, Part III, line 6 does incorporate the cost center apportionment process we would expect for hospital inpatient and outpatient costs. However, line 6 does include line 3 (interns and residents), line 4 (organ acquisition), and line 5 (cost of teaching physicians). It is not certain how these amounts are computed for FL hospitals within the 2552 for Medicaid. The use of these lines needs to be clarified. It should be noted that organ acquisition and cost of physicians are also listed as Additional Cost Items to be added back to the 2552-computed ws E-3 Medicaid cost. Is there a duplicate here?

Medicaid costs are computed based on the step-down process established through the CMS-2552 report created by federal Centers for Medicare and Medicaid Services (CMS). The allocation of total costs is first performed which is then applied to Medicaid costs, using the worksheets listed below with specific designation for Medicaid. Costs of each of the components of the hospital are separately determined following a common step-down of all overhead costs. A summary of the relevant worksheets is provided below:

- Worksheets S - Provider certification, settlement summary, and statistical information.
- Worksheet A - Reclassification and Adjustment of Trial Balance Expenses.
- Worksheets B – Cost Allocation (General Services, Capital Related, & Statistical Basis)
- Worksheets C – Computation of Ratio of Cost to Charges
- Worksheets D – Apportionment of Inpatient Services Costs
- Worksheets E – Calculation of Medicare Settlement
- Worksheets 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 lines above, which include Interns and Residents, Organ Acquisition, and Cost of Teaching Physicians. These specific lines allow for providers to document costs that, for Medicare purposes, may have been removed (e.g. GME costs are reimbursed separately for Medicare purposes) on previous worksheets (W/S A-8-2). Medicaid cost reporting allows for all the costs of interns and residents, organ acquisition, and teaching physicians. A discussion of each line is provided below.

W/S E-3, Part III, Lines 3 and 5, allows for the costs of interns and residents and teaching physicians. Medicare requires providers to remove these costs in the normal step-down process as they are reimbursed separately. Medicaid does not reimburse separately for the costs of interns and residents or teaching physicians. Therefore, in order to capture all allowable costs, the provider may add these costs on this line.

The CMS-2552 cost report was created for Medicare purposes. The State of Florida uses it for Medicaid purposes as well. Organ acquisition costs are allowable costs and are present in W/S D-6 series. Although these costs flow to W/S E-3, Part III for the

Medicare settlement, these costs do not automatically flow to W/S E-3, part III for the Medicaid settlement. Therefore, providers need to manually add these costs on line 4 of W/S E-3, Part III, Title XIX.

In situations where providers do not manually enter the costs for interns and residents and organ acquisition on lines 3 and 4, respectively, providers may enter the costs on the Additional Cost line. The intent is to include costs on the Additional Costs line only in situations where it is not included in line 6.

- FL needs to explain what is the source of the Medicaid program data used in the provider's ws E-3, Part III. Does the provider use updated MMIS data supplied by the State?

The providers use the MMIS data as part of their cost reporting preparation. The MMIS data used includes total Medicaid charges, Medicaid paid patient days, and Medicaid reimbursement. The CMS-2552 worksheets where MMIS data may be found include W/S S-2 (days), W/S D-4 (IP charges), W/S D, Part V (OP charges), W/S E-3 (charge information), and W/S E-3 (reimbursement).

Hospital Underinsured/Uninsured

- CMS policy definition of underinsured and uninsured include Medicaid eligibles whose Medicaid benefits have been exhausted, Medicaid eligibles whose Personal Injury Protection Insurance does not pay for Medicaid claim in whole (not sure whether FL is including this shortfall in Hospital Medicaid portion of computation or in the Hospital Underinsured/Uninsured portion of computation), patients with third party insurance that does not cover particular services, patient with insurance who has reached coverage limits, any unpaid balance for patients with insurance other than contractual allowances, etc.

- FL's proposed computation for the hospital underinsured/uninsured cost is materially different from CPE requirements. The FL approach is to take all eligible underinsured and uninsured charges and convert those charges to cost using a facility wide cost-to-charge ratio. CPE requirements dictate the use of cost center apportionment. Furthermore, per FL's approach, the underinsured/uninsured charges applied to the cost to charge ratio are already net of recovered charges/payments. This may or may not be appropriate depending on the situation. For example, this method may work when you have a patient whose third party insurance would cover some charges but not other charges - so you only include the non-covered charges as underinsured charges. However, this method would not work if you have an insured patient who self-paid a portion of the bill; in that case, the entire charges should be included as uninsured charges, and the payment is only used as an offset once the uninsured cost is computed. Generally, the proper computation would be you only include the specific charge for the service that is eligible as uninsured/underinsured and you apply the cost-to-charge ratio to the eligible charge to compute the uninsured/underinsured cost of furnishing that particular service; then you subtract from the computed cost any partial payment that is made for that particular service to arrive at the net or uncompensated cost.

- Generally CMS does not use the terms charity care and bad debts in describing uninsured/underinsured charges. As FL's document points out, hospitals may have different criteria of what goes into charity care and bad debts. It may be preferable to simply use the terms uninsured/underinsured charges on the forms and then define what CMS will agree can go into these charges. That way, based on the definition, a hospital can pull the eligible charges from its own systems, regardless of whether it's bad debt or charity care or something else.

Florida is not claming any Certified Public Expenditures (CPEs) for the Low Income Pool (LIP) program. The state, non-federal share, is from local tax funds provided by counties and health care taxing districts and from state General Revenue appropriated by the legislature. The Agency is unaware of CMS' policy for uninsured and underinsured. Hospital accounting practices are set up to separate charity charges from bad debt charges. Providers concur that a portion of bad debt charges may qualify as charity, but for the fact that appropriate documentation may not have been provided from the patient. Worksheet S-10 of the CMS-2552 states that uncompensated care is defined as charity care and bad debt.

The guidelines for worksheet S-10 further describe charity care as the measure of revenue forgone, at full established rates. Bad debt is the unpaid dollar amount for services rendered, for which the provider expected payment. Charity and bad debt are documented by hospital providers as the revenue forgone, at full established rates, the unpaid dollar amount for services rendered.

If the charges are for a patient who has proper documentation to qualify for a charity account then these charges are written off to a charity account. Otherwise, the unpaid charges are written off to a bad debt account.

Florida allows only charges not paid in a provider's calculations, full charges are not included. Therefore, the specific charges included are allowable (eligible) charges. The cost to charge ratio (the same practice that is applied to uncompensated costs on worksheet S-10) is applied to all eligible uncompensated charges. Providers do not have the ability to retrospectively calculate this through the cost report. Only charges not paid are written off, not the full charges. The administrative burden to document full charges, run them through the cost reporting process, and then subtract the payments is enormous.

Due to the fact that providers routinely track bad debt separately from charity as part of their basic accounting practices and that these separate figures are used in various audits, the Agency recommends keeping the terms charity and bad debt on the Cost Limit data worksheets.

- There is no inflation applied to this shortfall as opposed to the Medicaid shortfall. What period's data is being used in the underinsured/uninsured cost computation to not require an inflation factor?

The data used is from the same period as the provider's Medicaid cost data. It was an oversight to not include inflation to this portion of the calculation. The forms are being updated and the same inflation factor as used for Medicaid costs will be allowed.

FQHC

- It is unclear why a cost to charge ratio is used for the Medicaid portion of shortfall computation while a Medicaid encounter rate is used for the uninsured portion of shortfall computation. This is also inconsistent with FL's narrative on page 18, where it says the cost per visit will come from the Medicare cost report.

The LIP Cost Limit calculation for the Federally Qualified Health Centers (FQHCs) includes a Medicaid shortfall calculation and an uninsured/underinsured shortfall calculation. Due to the challenges of gathering all FQHC Medicaid shortfall information in a standard format for the purposes of the LIP Cost Limit, it was determined that the providers would document only their Medicaid shortfall for services provided in an inpatient setting. The cost to charge ratio is used for the Medicaid portion of the FQHCs shortfall computation rather than a Medicaid encounter rate, which is used for the underinsured and uninsured shortfall. The Medicaid encounter rate (PPS rate), is based on the average of 1999 and 2000 reimbursement rates that have been annually inflated by the Medicare Economic Index (MEI). This rate does not include the Medicaid inpatient costs for services rendered in an inpatient setting. Some of the costs for services rendered by FQHC staff are reimbursed through the fee-for-services schedule. This reimbursement is included in the calculation of the Medicaid shortfall. The full cost is determined by applying the Medicaid inpatient services cost to Medicaid inpatient charges ratio to the visits. Applying the PPS rate to these services would be inappropriate as the rate is not inclusive of any of these costs.

The narrative on page 19 (formally page 18) states that FQHC providers may use the average Medicare cost per visit, multiplied by the number of Medicaid visits as a proxy for their shortfall computation. The Medicare rate does not include all Medicaid allowable costs (e.g. dental, radiology, obstetrics/gynecology). Due to the inconsistency between the Medicare rate and services provided for Medicaid recipients, it was determined that the shortfall was best calculated using the Medicaid rate. The Reimbursement and Funding Methodology document has been updated to reflect this final method in the LIP Cost Limit calculation for FQHCs.

- Page 33 says most recently completed period's UDS report is used. Note that there is no inflation factor applied, as there was for hospital Medicaid shortfall computation.

The Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA) collects data from FQHCs supported by HRSA Bureau of Primary Health Care grants through the Uniform Data System (UDS), in accordance with Section’s 329 and 330. The UDS data is therefore used as the primary source of data for the FQHC LIP Cost Limit calculations. The worksheet has been updated to reflect an inflation factor for the Medicaid shortfall computation due to the fact that the UDS data is historical.

- It appears, from page 19, there are going to [be] uninsured/underinsured costs that will be added in [their] entirety to the non-hospital computed shortfall costs. It is unclear how this is incorporated into the FQHC or CHD cost limit computation worksheets.

Although the instructions allow for this, the FQHCs are not utilizing this option. The intent of the LIP Cost Limit worksheet is to confirm that no Provider Access System is receiving a LIP payment in excess of its costs for serving the Medicaid, uninsured, and underinsured populations. Due to the fact that each FQHC’s Medicaid, uninsured, and

underinsured shortfalls exceed the provider's LIP payments without including any uninsured and/or underinsured costs in their entirety, the providers have decided to not incorporate this option.

- Narrative on page 24 mentions excluding costs for non-qualified aliens in the FQHC uninsured shortfall computation. How does the worksheet accomplish this? (Is this applicable to all other uninsured shortfall computations, such as for hospitals?)

Please see response below for all providers.

CHD Providers

- It is unclear how a Medicaid reimbursement rate is used as a cost proxy and yet there would still be a shortfall if providers are reimbursed on that rate.

The County Health Departments (CHDs) Medicaid reimbursement rate is calculated annually based on allowable costs and visits as defined by Medicaid. Although the Medicaid shortfall is very minimal, the opportunity for documenting the shortfall is permissible. The Medicaid shortfall calculation includes Medicaid fee-for-service expenditures as well as Medicaid HMO expenditures. The CHD reimbursement rate is used as the proxy for all Medicaid expenditures. Medicaid encounters (fee-for-service and HMO) are provided on the worksheet. These encounters are multiplied by the Medicaid reimbursement rate. The reimbursement received (through fee-for-service and HMO) is documented on a subsequent line. The shortfall is the difference between the calculated costs and the actual reimbursement.

- Page 24 says it's the latest completed cost report, also used for rate setting. Note that there is no inflation factor applied, as there was for hospital Medicaid shortfall computation.

The CHD cost based rates are inflation adjusted annually as part of rate setting. There is no need to apply an inflation factor to the shortfall.

- It appears, from page 19, there are going to [be] uninsured/underinsured costs that will be added in [their] entirety to the non-hospital computed shortfall costs. It is unclear how this is incorporated into the FQHC or CHD cost limit computation worksheets.

The CHD rates are based on total allowable costs divided by total clinical visits, as defined by Medicaid. Therefore, any costs that would meet this requirement are captured in the reimbursement rate. The Reimbursement and Funding Methodology document has been updated to reflect this.

- Narrative on page 25 mentions excluding costs for non-qualified aliens in the CHD uninsured shortfall computation. How does the worksheet accomplish this? (Is this applicable to all other uninsured shortfall computations, such as for hospitals?)

As a public health policy, none of the Provider Access Systems (PAS) ask patients directly if they are a "non-qualified alien". In response to the Medicare Prescription Drug,

Improvement and Modernization Act of 2003, Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, physicians, hospitals, and ambulance providers may apply for reimbursement for services provided to undocumented aliens. It is unclear if non-qualified aliens, as referenced in the Special Terms and Conditions, are the same as undocumented aliens. The assumption has been made that they are the same. Providers may not ask the individual of his or her alien status, but rather confirm this through a set of questions, recommended by federal CMS, where the individual may self-attest. Reimbursement is allowed for emergency services only and up to the point that the patient is stabilized. Should any provider receive reimbursement through Section 1011, this reimbursement will be documented on the provider's LIP Cost Limit worksheet on the line titled "Medicaid eligible and other payments." Some of the hospital providers are participating in Section 1011 reimbursement.

It is considered by the health care providers (e.g. hospitals, FQHCs, and CHDs) that to ask a patient about his or her alien status is counter productive to good public health policy. To do so may discourage necessary care, especially for communicable diseases. Individuals are tracked by payor source (either an insurance provider or private pay), not immigration status. The total costs of any self-attested undocumented alien is therefore included in the overall provider's cost to charge ratio. Tracking the individual costs is extremely burdensome and not part of any of the provider's accounting practices. Providers are able to identify reimbursement for Section 1011 services and therefore will be reduced the calculated uninsured and underinsured costs by the full payments received.

The LIP Cost Limit calculations are created to satisfy STCs #97 and #98, permissible hospital and non-hospital expenditures, where "the State agrees that it shall not receive FFP for Medicaid and LIP payments to hospitals in excess of cost" (STC #97). The overall shortfall for all Provider Access Systems is approximately $3.5 billion. The $1 billion annual allotment of LIP funding represents 29% of the total shortfall. Of the total $3.5 billion shortfall, the uninsured and underinsured portion is approximately $2.8 billion. In spite of the challenges in capturing total costs for undocumented (non-qualified) aliens, the total LIP funding is insufficient to cover the calculated Provider Access System shortfalls. It is confirmed that the aggregate Medicaid, uninsured, and underinsured shortfall is far above the annual LIP allotment. In addition, before any individual provider LIP distribution is made, that provider's shortfall is reviewed to assure that each provider's LIP payment will not exceed that provider's cost for serving Medicaid, uninsured, and underinsured individuals.