



The Option of Using Certified Public Expenditures as Part of the Medicaid Reimbursement for Florida's Public Hospitals

*Report to the Florida Legislature
January 2013*



Executive Summary

Federal rules allow certain health care provider organizations to utilize certified public expenditures (CPEs) to draw down federal funds to compensate for unreimbursed cost for medical care provided to Medicaid recipients.

The Florida Legislature directed the Agency for Health Care Administration to develop proposed methodology to utilize CPEs as a funding mechanism, and to submit a report containing same to the Governor and Legislature by January 31, 2013.

While Florida utilizes CPEs in its School Based Services program, its Physician Supplemental Payment program and certain components of its Disproportionate Share Hospital program, it does not currently utilize CPEs as part of its methodology to reimburse public hospitals.

This report focuses on the option to utilize CPEs of public hospitals to drawn down additional federal funding to support that provider type.

In order for CPEs to be utilized for the financing of the non-federal share of expenditures, payments must be limited to the costs incurred by the certifying entity and must be determined through a Centers for Medicare and Medicaid Services (CMS) approved detailed protocol for determining allowable cost and CMS must approve the definition of, and the identified sources of non-federal share, for which the state wishes to claim Federal Financial Participation. A proposed protocol is attached as Attachment A and could serve as the CPE methodology for Florida Medicaid if approved by CMS and assuming the Legislature authorizes CPE as an enhanced funding mechanism for public hospital services.

Utilizing CPEs as part of a methodology for reimbursing public hospitals in Florida is an available option. According to Sellers Dorsey, a national healthcare consulting firm, Florida's largest public hospital is estimated to see an increase in Federal funding of \$30-\$60 million annually if CMS were to allow the use of CPEs to help fund public hospital uncompensated care costs. However, when considering whether to implement a CPE methodology for public hospitals, careful consideration must be given to the potential impact on funding for health care providers in Florida on a broader basis.

Background

Under federal rules and regulations, health care provider organizations, including public hospitals, that are owned by states, counties, cities, or other public entities can participate in certified public expenditure (CPE) programs. In a CPE, the state is able to certify unreimbursed Medicaid eligible costs expended by the public health care organization and draw down the applicable federal Medicaid matching funds associated with those costs. These initiatives are available for all types of publicly-owned providers, including hospitals, nursing homes, and clinics.¹

This report examines the option of using CPEs as a way to assist in funding Medicaid inpatient hospital expenses in Florida. Specifically, during the 2012 session the Florida legislature provided via HB 5001, the General Appropriations Act for State Fiscal Year 2012-13:

¹ <http://www.sellersdorsey.com/sellers-dorsey/services/medicaid-financing-solutions/certified-public-expenditures.aspx>

From the funds in Specific Appropriations 174, the Agency for Health Care Administration, pursuant to Paragraph 69 of the Special Terms and Conditions for the Florida Medicaid Reform Section 1115 Demonstration waiver, as approved by the federal Centers for Medicare and Medicaid Services on December 15, 2011, shall develop a cost reimbursement methodology to utilize certified public expenditures as a funding mechanism for the Medicaid program, including a detailed explanation of the process by which the state would identify those costs eligible under the Medicaid program for purposes of certifying the public expenditures. The methodology must adhere to all requirements of state law and federal regulations or waiver authority. The agency, through a competitive procurement under chapter 287, Florida Statutes, may engage a consultant to develop the methodology. The agency shall submit a report containing the methodology and the policy implications of implementing the methodology no later than January 31, 2013, to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Federal Law

The basis for the CPE program is found in federal regulation under 42 CFR 433.51 which states:

- (a) Funds from units of government may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (b) and (c) of this section.*
- (b) The funds from units of government are appropriated directly to the State or local Medicaid agency, or are transferred from other units of government (including Indian tribes) to the State or local agency and are under its administrative control, or are certified by the contributing unit of government as representing expenditures eligible for FFP under this section. Certified public expenditures must be expenditures within the meaning of 45 CFR 95.13 that are supported by auditable documentation in a form approved by the Secretary that, at a minimum—*
 - (1) Identifies the relevant category of expenditures under the State plan;*
 - (2) Explains whether the contributing unit of government is within the scope of the exception to limitations on provider-related taxes and donations;*
 - (3) Demonstrates the actual expenditures incurred by the contributing unit of government in providing services to eligible individuals receiving medical assistance or in administration of the State plan; and*
 - (4) Is subject to periodic State audit and review.*
- (c) The funds from units of government are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.*

As previously noted, federal law allows the use of CPEs to draw down federal funds for a variety of health care provider organizations owned by public entities, including public hospitals. This report focuses on the option to utilize CPEs of public hospitals to draw down additional federal funding to support that provider type.

There are two primary requirements in order to receive federal match under a CPE methodology. First, hospitals are required to expend local funds in lieu of state funds. Second, hospitals cannot be reimbursed for more than the cost of providing the service. Therefore, the State's payments to participating hospitals equal the federal matching amount for allowable

Medicaid costs; the state makes payments to the qualifying hospitals in the amount of the federal share, based on the current Federal Medical Assistance Percentage (FMAP). The state is then reimbursed by the federal government for the amount of these payments. Under a CPE arrangement, no additional state General Revenue is expended. Due to the nature of the way that hospital services are provided and billed, there can be a lag between when the service is provided, when the hospital bills the State and when the information is available to calculate the actual cost of the service for a given service year. Payments for hospital inpatient services made during a given fiscal year under a CPE arrangement are therefore usually based on an estimate of costs for that year. Federal requirements mandate that payments made using CPE are cost settled once the actual costs for a service year can be calculated. Supplemental payments are made to hospitals which serve a high number of low-income uninsured individuals and are provided to offset the hospitals' uncompensated care for providing services to these individuals. These costs are made up to the hospital's limit, as calculated according to federal requirements.

Current Situation in Florida²

During SFY 2010-11, the Agency received from local governments and other state agencies over \$1.3 billion in funds representing the state share for Medicaid expenditures in addition to the General Revenue and other state trust fund dollars appropriated directly to the Agency for this purpose.

- Intergovernmental transfers (IGTs) of nearly \$1.2 billion were received by the Agency in the form of electronic fund transfers (EFTs) and checks from local governments such as counties, health care taxing districts, and hospital authorities.
- Certified public funds of slightly more than \$198.2 million were approved during SFY 2010-11. A public fund is considered certified when the contributing public agency certifies that the expenditures are eligible for Federal Financial Participation (FFP) in accordance with 42 CFR 433.51.

Just under \$15.8 million in General Revenue was appropriated to the Agency to be used as IGT funds for specified purposes for SFY 2010-11.

Local government IGTs and federal matching funds (Medical Care Trust Fund) for SFY 2010-11 were distributed through the Medicaid programs listed below:

1. Nursing Home Special Medicaid Payment Program
2. School Based Services Program
3. Hospital Outpatient and Inpatient Services
4. Low Income Pool Program
5. Medicaid Disproportionate Share Hospital Program
6. Physician Supplemental Payment Program

CPEs were used in three of the above Medicaid programs, the School Based Services Program, the Medicaid Disproportionate Share (DSH) Hospital Program, and the Physician Supplemental Payment Program. The DSH hospital program also utilizes IGTs.

² See the Agency for Health Care Administration (AHCA) Report on Local Funding Revenue Maximization and Local Funding for Medicaid Inpatient Reimbursement for SFY 2010-11

School Based Services Program,

Florida school districts and the School for Deaf and Blind may enroll as providers of a variety of Medicaid services. Qualified school district staff or contracted personnel who provide certain health care services to Medicaid eligible students will receive payment consisting of the federal share of the established fee. Types of reimbursable services under this program are: therapy, behavioral, nursing, transportation, and augmentative and communication services.

Matching requirements for this program are certified public expenditures (CPE) that are certified quarterly by the school district and come from the district's non-federal expenditures. Major sources of the non-federal match are county property taxes and Florida lottery proceeds. The federal funds for this program were nearly \$16.3 million for SFY 2010-11.

Florida school districts and the School for Deaf and Blind may also enroll as providers of Medicaid administrative services in addition to the provision of direct services. Types of administrative activities reimbursed by Medicaid are: Medicaid outreach, eligibility assistance, program planning and development, and care planning and coordination. Qualified school district expenditures are reimbursed quarterly for the federal share.

Matching requirements for this program are certified public expenditures that are certified quarterly by the school district and come from the district's non-federal expenditures. Major sources of the non-federal match are county property taxes and Florida lottery proceeds.

The Federal Financial Participation (FFP) for the administrative portion of school based services programs is fifty-percent (50%) federal and fifty-percent (50%) CPE. Direct services are matched at the regular FMAP. Federal funds in excess of more than \$67.5 million were drawn during SFY 2010-11 for this program.

Disproportionate Share Hospital (DSH) Program

There are eight DSH programs authorized in sections 409.911-409.9118, F.S. The Regular DSH program, the first to be implemented, was created to compensate hospitals that provided a disproportionate share of Medicaid and/or charity care services.

- Regular DSH, July 1, 1988
- Regional Perinatal Intensive Care Center (RPICC) DSH, July 1, 1989
- Teaching/GME DSH, July 1, 1991
- Mental Health DSH, October 1, 1992
- Rural DSH, May 1, 1994
- Primary Care DSH, July 1, 1997
- Specialty DSH, July 1, 1997
- Specialty Hospitals for Children DSH, July 1, 2000

CPEs are utilized in two of the DSH programs. The Specialty and Mental Health DSH programs are for state-owned or operated facilities, the state share for which is funded by certified public expenditures by sister state agencies. The Mental Health DSH program helps fund the state mental health hospitals operated by the Department of Children and Families. Similarly, the Specialty DSH program helped fund A.G. Holley Hospital, the state's tuberculosis hospital, operated by the Department of Health. A portion of the state appropriated funds are recognized as CPE funds and serve as the state share funding for drawing down the federal DSH funding.

Physician Supplemental Payment Program

The physician supplemental payment program provides supplemental Medicaid payments to Medicaid providers through the use of certified state expenditures.

As initially authorized in the General Appropriations Act for SFY 2002-2003 and the General Appropriations Act for SFY 2003-2004, the Agency was authorized to implement a Physician Supplemental Payment program. On November 18, 2002, the Agency submitted State Plan Amendment (SPA) 02-16 to CMS to implement the program. On February 13, 2003, the Legislative Budget Commission approved the budget amendment authorizing the Agency to expend the funds once the program was approved by CMS. The plan was approved by CMS on April 23, 2004, and had an effective date of October 1, 2002.

The physician supplemental payment program allows for supplemental payments for services provided by doctors of medicine and osteopathy employed by or under contract with either (1) a medical school that is part of the public university system (Florida State University, the University of Florida, and the University of South Florida); (2) a private medical school that places over fifty percent (50%) of its residents with a public hospital (The University of Miami); and (3) Nova Southeastern University. For three quarters of SFY 2002-03 and for all of SFY 2003-04 through SFY 2010-11, the supplemental payments were based on the difference between the lower of fifty-four and thirty-four one hundredths percent (54.34%) of the provider's usual and customary charges or fifty-four and thirty-four one hundredths percent (54.34%) of the charge ceiling established by the Agency and the actual payment by Medicaid to the physician or osteopathic physician under the current physician fee schedule.

Potential Changes in Florida

Subject to approval by CMS, both State and local governments are allowed to participate in the financing of the non-federal share of medical expenditures eligible for Federal Financial Participation under 42 CFR 433. Generally, these expenditures can be classified into two separate groups: Medicaid related and waiver related. Medicaid services and expenditures are those services and expenditures currently approved under the Medicaid State Plan. Waiver related services and expenditures are these services and expenditures covered under the Florida Medicaid Reform 1115 waiver. In addition to Medicaid, these waiver services also include services for uninsured and underinsured populations.

The main difference between these two groups is specific to the services and expenditures that are allowed under the 1115 waiver. The current 1115 waiver authorizes the Low Income Pool program, which allows certain provider access systems to be reimbursed for services they provide to Medicaid, uninsured and underinsured populations.³ The non-federal share of these reimbursements is provided through Intergovernmental Transfers (IGTs), and are financed by local units of government and approved by CMS.

Regardless if the expenditures are related to services provided through Medicaid or the Medicaid 1115 waiver, if CPEs are utilized for the financing of the non-federal share of expenditures, two specific actions must be taken. First, payments must be limited to the costs incurred by the certifying entity and must be determined through a CMS approved detailed

³ See Florida Medicaid Reform Section 1115 Waiver Reimbursement and Funding Methodology document for the definitions of uninsured and underinsured populations.

protocol for determining allowable costs. Second, CMS must approve the definition of, and the identified sources of non-federal share, for which the state wishes to claim Federal Financial Participation.

Payments must be limited to the costs incurred by the certifying entity and must be determined through a CMS approved detailed protocol for determining allowable costs.

Under the current 1115 waiver, Florida has a CMS approved methodology for determining a hospital's allowable costs for services that can be funded through the Low Income Pool program (LIP). As with CPEs, expenditures for the LIP program cannot exceed a provider's cost of providing the service, therefore an allowable cost limit calculation was developed for providers receiving payments under the LIP program. With slight modifications, this same protocol can be utilized for determining allowable costs for CPEs. Attachment A contains a detailed protocol to determine allowable costs when utilizing CPEs. This protocol is patterned after the current LIP Cost Limit Computation and could serve as the CPE methodology for Florida Medicaid if approved by CMS and assuming the Legislature authorizes CPE as an enhanced funding mechanism for public hospital services.

CMS must approve the definition of, and the identified sources of, non-federal share for which the state wishes to claim Federal Financial Participation.

In states such as California, CMS has defined CPEs as: total computable expenditures for patient care that may be certified by government entities that directly operate health care providers as long as the expenditures are not funded using impermissible provider taxes or donations as defined under section 1903(w) of the Social Security Act or using Federal funds other than Medicaid funds (unless the other federal funding source by law allows use of federal funds for matching purposes, and the federal Medicaid funding is credited to the other federal funding source). The State may not claim federal matching funds for a payment to a provider and also claim federal matching funds on the underlying expenditure certified by the provider, except to the extent that the State has an auditable methodology to prevent duplicate claims (such as one that limits claims for federal matching based on the certified expenditure to the shortfall after accounting for the claimed payment). To ensure that there is no double claiming of federal funding CMS will need to approve a detailed protocol outlining the procedures to be followed for claiming CPEs.

The LIP program relies on funds from local governments as the primary source of the non-federal share of the program. Under LIP, these local funds are transferred to the state as Intergovernmental Transfers (IGT's). Under a CPE process, these same types of local funds could be utilized as the source of non-federal share if such funds were expended locally for public hospital purposes.

For the purposes of this report, it is assumed that expenditures made by or for public hospitals, for allowable Medicaid costs, that are currently unreimbursed by Medicaid or other payors would serve as the certified public expenditures which would draw down federal funds for those public hospitals.

It is anticipated that the cost limit calculation portion of the Reimbursement and Funding Methodology document currently in place for the Low Income Pool (LIP) program could serve as a model for such a Public Hospital CPE methodology. For the purpose of LIP under Florida's 1115 Research and Demonstration waiver (1115), Special Term and Condition (STC) 53, the Agency was directed to develop a Reimbursement and Funding Methodology document

(RFMD) centered around defined allowable costs eligible for reimbursement under the 1115 waiver. The State received approval of the RFMD document on October 16, 2012. A modified version of this document is used as the base for developing the cost limits needed for an expanded CPE program. See Attachment A – Allowable Costs for the protocol for determining allowable costs under a CPE framework.

CPEs in Other States

Several states have used the authority under 42 CFR 433.51 to implement programs which utilize CPEs. Information from the Centers for Medicare and Medicaid Services regarding those states which participate is included in the table below.

| States that use Certified Public Expenditures | |
|---|---|
| Regions | States |
| I | Connecticut, Massachusetts, Maine |
| II | New Jersey, Virgin Islands (NY has a SPA pending to implement CPE for one hospital) |
| III | Delaware, Pennsylvania, Virginia, West Virginia |
| IV | Florida, Alabama, North Carolina, South Carolina, Tennessee, Kentucky |
| V | Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin |
| VI | Arkansas, Louisiana |
| VII | Iowa, Missouri, Nebraska |
| VIII | Colorado |
| IX | Arizona, California, Hawaii |
| X | Oregon, Washington |

In recent years, federal CMS has approved expansions of two states' CPE programs. For the purpose of providing examples of variation within states' CPE programs, additional information regarding the Washington and California CPE programs is provided below. Each state offers a unique perspective on the use of CPEs. In Washington, the state replaced their IGT program with CPEs and utilize two year retrospective settlement process to estimate prospective payments. California uses CPEs not just for Medicaid, but for their medically indigent adults and the uninsured. They do so by using state, county and local funding including a list of sources one might not ordinarily think of in terms of CPEs including care given at their university hospitals, college students, and unreimbursed local EMS services.

Washington⁴

The Washington Inpatient Hospital CPE program was implemented between 2005 and 2007 as a replacement for their Inter-Governmental Transfer (IGT) program. Prior to state fiscal year (SFY) 2006, Washington State used intergovernmental transfers (IGTs) to fund supplemental Disproportionate Share Hospital (DSH) and upper payment limit (UPL) payments to public hospitals. The IGT transactions netted approximately \$80 million annually in revenue to the State for funding health care services.

The CPE program in Washington is a payment methodology that applies to public hospitals, including government-owned and operated hospitals that are not Critical Access or state psychiatric hospitals. The program's payment methodology applies to inpatient claims and Disproportionate Share Hospital payments. This program allows public hospitals to certify their expenses as the State share in order to receive federal matching Medicaid funds, or Federal Financial Participation (FFP). In so doing, the State does not have to contribute the matching share of these expenditures, saving the State an estimated \$43 million for SFY 2010.

Under the Washington program, hospitals are paid for the cost to provide hospital inpatient services to Medicaid recipients and for uncompensated care. Due to the time lag that can occur between the provision of services and billing Medicaid (reportedly up to two years), payments for hospital inpatient services made during a given fiscal year under CPE are based on an estimate of costs for that year. The costs are estimated using the hospital's most recent Ratio of Costs to Charges (RCC) which is typically based on data from two years prior.

California⁵

California's new section 1115 waiver allows counties to secure a federal match for care to their medically indigent adult (MIA) population, those adults with incomes less than 133% of the federal poverty level (FPL). While this federal match is uncapped, the limiting factor is the availability of certified public expenditures (CPEs).

CPEs are the required match under the California 1115 waiver for coverage of MIAs. CPEs can come from a county, city, special purpose district, Indian tribe or other governmental unit that has taxing authority and direct access to revenues. This also includes state university teaching hospitals with direct appropriations from the state. The funds must be "certified," meaning that the public contributing agency certifies them as expenditures eligible for federal financial participation (FFP). A match can also include philanthropic donations and provider assessments to the extent they fully comply with federal requirements. In general, federal funds cannot be used to match federal funds; in other words, a hospital that receives federal DSH funds cannot then turn around and use those funds as the match for the federal waiver.

⁴ See Wulsin, L. (2011) "Identification of Certified Public Expenditures Under California's Section 1115 Waiver." Insure the Uninsured Project (ITUP)

⁵ See California's "Bridge to Reform" 1115 Waiver Demonstration; and, Wulsin, L. (2011) "Identification of Certified Public Expenditures Under California's Section 1115 Waiver." Insure the Uninsured Project (ITUP)

California currently uses state, county and local funds to pay for care to the uninsured. Counties were asked by the State to review their different fund expenditures to see whether they qualify for matching under the waiver. According to the State, potential CPEs included:

- County health, mental health, public health and substance abuse unmatched funds spent on care to indigent adults
- University of California and District Hospitals Care to MIAs
- City public health departments' preventive health services
- Emergency Medical Services (EMS) funds that reimburse care to indigent uninsured adults
- State university, community college and K-12 health care to low-income students over 18
- Victims of violent crime funds that reimburse care to indigent adults
- Fire department paramedic and medical transportation care to indigent adults
- Hospital funds from state, counties, cities or philanthropies that reimburse care to indigent adults
- Provider fees
- Clinic funds from the State, county or cities used for care to indigent adults
- Sheriff and correctional facility funds that pay for health care to indigent adult detainees
- Indian health services to indigent adults

Also under California's 1115 demonstration waiver, payments to hospitals can include supplemental Medicaid inpatient and outpatient payments to hospitals that meet certain eligibility requirements for participation in California's Construction/Renovation Reimbursement Program. To the extent that the State continues to make these payments, such payments may be funded by the State general fund and by CPEs, and shall be considered Medicaid revenue that must be offset against uncompensated costs eligible for Disproportionate Share Hospital (DSH) payments. These supplemental payments are in addition to the Medicaid rates for inpatient Medicaid services, and the non-Federal share must be funded by State or local general funds.

Conclusions and Implications:

Utilization of CPEs by public hospitals to access federal funding through 42 CFR 433.51 would provide an additional source of funding to cover currently unreimbursed medical services related costs for these entities. If directed to implement a CPE methodology for public hospitals, the Agency could use the methodology represented in Attachment A.

However, when considering whether to implement a CPE methodology for public hospitals, careful consideration must be given to the potential impact on funding for health care providers in Florida on a broader basis. Currently, more the \$1.16 billion in IGTs flows through the Medicaid program in the form of enhanced rates and supplemental payments to provide funding for health care services. The provider access systems that receive these funds include hospitals, clinics and other primary care settings across the State, in rural or underserved counties or localities where public funding or IGTs may not be available. The enhanced rates and supplemental payments allow local funding through IGTs to draw down additional federal funding and be allocated to a large number and variety of provider settings. Under a CPE Methodology for Public Hospitals, federal funding would only be available to the specific hospital for which a local government had made public expenditures. In addition, assuming that counties and other localities have a limited amount of local tax dollars to spend on the provision

of health care services, it is possible that the amount of IGTs contributed by local governments participating in a CPE methodology for public hospitals may be reduced, thus impacting total funding available through the Medicaid program.

As reflected in the proviso directive specific to this review, CPE authorization language was included in the Special Terms and Conditions (STCs) that accompanied the three-year extension of Florida's Medicaid Reform Waiver. It is probably worth noting that the authority is a standard element of 1115 waiver approvals issued by CMS at present. The fact that this language is part of the STCs should not be interpreted to mean that there is any expectation on the part of CMS that the State act on this CPE authority as it appears in the STCs.

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ATTACHMENT A – Allowable Costs:

Note: For the purposes of this attachment, the term “per diem” is used to represent the per diem costs incurred by a facility, and is in no way tied to a per diem reimbursement methodology. The methodology outlined in the attachment is not tied to or dependent upon a per diem reimbursement methodology, and would remain the same if the program reimbursed through a Diagnosis Related Group, or DRG methodology.

I. Protocol for Determining Allowable Costs:

To the extent that there are expenditures a hospital provider wants to make against the cost limit, and the methodology for capturing such expenditures is not stated in this protocol, the expenditures will need to be approved by CMS and the State prior to the submission of the reconciliation for the applicable period for the expenditures. The protocol will be prospectively modified to include such prior approval, and the claiming protocol will be prospectively incorporated into the protocol when the protocol is next updated.

A per diem is calculated by dividing total costs by total days. In this attachment, a per diem is referencing a calculation found in the *Medicare 2552 Cost Report* and is not referring to hospital reimbursement calculations.

A. Hospital’s Cost Limit

1. Hospital’s Medicaid Fee-For-Service (FFS)

For the State 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 annual rate setting. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified 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.

Step 2

The hospital’s total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital’s total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day

count and excluding swing bed nursing facility costs and non-medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid FFS inpatient routine cost center costs for the payment year, the hospital's actual inpatient Medicaid days by cost center, as obtained from MMIS and other auditable hospital records for the period covered by the as-filed cost report, will be used. The days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term care services are excluded.

Step 5

To determine Medicaid FFS ancillary costs for the payment year, the hospital's actual Medicaid FFS allowable charges, as obtained from MMIS and other auditable hospital records for the period covered by the as-filed cost report, will be used. Medicaid FFS allowable charges for observation beds must be included in line 62. These Medicaid FFS allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid FFS allowable costs for each cost center. 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.

Step 6

The Medicaid allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. For this calculation, a usable organ is defined as the number of organs excised and furnished to an organ procurement organization. Medicaid "usable organs" are counted as the number of Medicaid patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid days and charges in Steps 4 and 5 above, or any Medicaid managed care or uninsured days and charges in Steps 4 and 5 of those portions of this protocol.

Step 7

The Medicaid FFS allowable costs are determined by adding the Medicaid routine costs from Step 4, the Medicaid ancillary costs from Step 5 and the Medicaid organ acquisition costs from Step 6.

2. Hospital's Medicaid Managed Care

For the State payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's Medicare cost report(s) (CMS-2552) covering the payment year, as filed with Florida Medicaid. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified 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.

Step 2

The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non-medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid managed care inpatient routine costs for the payment year, the hospital's actual Medicaid managed care inpatient days by cost center, as obtained from auditable hospital records and other applicable sources for the period covered by the as-filed cost report, will be used. The days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid managed care allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term care services are excluded.

Step 5

To determine the Medicaid managed care ancillary costs for the payment year, the hospital's actual Medicaid managed care charges, as obtained from auditable hospital records and other applicable sources for the period covered by the as-filed cost report

will be used. Medicaid managed care allowable charges for observation beds must be included in line 62. These Medicaid managed care allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid managed care allowable costs for each cost center. The Medicaid managed care 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.

Step 6

The Medicaid managed care allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid managed care usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Medicaid managed care usable organs" are counted as the number of Medicaid managed care patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid managed care days and charges in Steps 4 and 5 above (or any Medicaid days or uninsured days in Steps 4 and 5 of those portions of this protocol).

Step 7

The Medicaid managed care allowable costs are determined by adding the Medicaid managed care routine costs from Step 4, the Medicaid managed care ancillary costs from Step 5 and the Medicaid managed care organ acquisition costs from Step 6.

3. Hospital's Uninsured/Underinsured

For the payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's most recent as filed Medicare cost report (CMS-2552), as filed with Florida Medicaid. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital actual costs are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted and stepped down through the A and B worksheet series.

Step 2

The hospital's total actual days by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total actual charges by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total actual costs from Step 1 by total actual days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total actual costs from Step 1 by the total actual

charges from Step 2. The A&P routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's actual costs for the payment year. The data sources utilized to determine eligible costs under this section must be derived from the hospitals audited financial statements and other auditable documentation. The hospital costs for care provided to those with no source of third party coverage (i.e., uninsured cost) for the payment year are determined as follows:

Step 4

To determine the uninsured routine cost center costs for the payment year, the hospital's actual inpatient days by cost center for individuals with no source of third party coverage are used. The actual uninsured days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the low income uncompensated care inpatient costs for each cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term care services are excluded.

Step 5

To determine the uninsured ancillary cost center actual costs for the payment year, the hospital's inpatient and outpatient actual charges by cost center for individuals with no source of third party coverage are used. These allowable uninsured charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the uninsured allowable costs for each cost center. 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.

Step 6

The uninsured care share of organ acquisition costs is determined by first finding the ratio of uninsured care usable organs to total usable organs. This is determined by dividing the number of uninsured usable organs as identified from provider records by the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "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 in Steps 4 and 5 above or Steps 4 and 5 of the Medicaid (or Medicaid managed care) portion of this protocol.

Step 7

The eligible uninsured care costs are determined by adding the uninsured care routine costs from Step 4, uninsured ancillary costs from Step 5 and uninsured organ acquisition costs from Step 6.

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.