PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2018-D49

PROVIDERS –
Akin Gump 2006-2008 Florida Low Income Pool Waiver Days Groups

Provider Nos.: Various (See Appendix A)

vs.

MEDICARE CONTRACTOR –
First Coast Service Options, Inc.

HEARING DATE –
May 23, 2017

Cost Reporting Period Ended –
2006-2008

CASE NOs. –

13-1460GC, 14-0565GC, 14-0773GC & 14-3216G

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ISSUE STATEMENT:

Whether a certain category of Medicaid waiver days should be included in the numerator of the Medicaid fraction used to calculate the Providers' disproportionate share hospital ("DSH") payments. The specific days at issue are attributable to patients who received assistance under Florida's Low-Income Pool Medicaid waiver.[1]

DECISION:

After considering the Medicare law and regulations, stipulations of fact, arguments presented, and evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor properly excluded the Low-Income Pool § 1115 Waiver days from the numerator of the Medicaid fraction when calculating the Providers' DSH payments.

INTRODUCTION:

The cases under appeal consist of multiple acute care hospitals in Florida (collectively referred to as "Hospitals" or "Providers").[2] These Hospitals provided inpatient services to individuals who were uninsured or underinsured, and received payment under a Medicaid § 1115 waiver program known as the Florida Low-Income Pool program. The Centers for Medicare & Medicaid Services ("CMS") approved the Florida Low-Income Pool § 1115 Waiver to allow federal Medicaid matching payments to cover some of the costs of services to these individuals. The Providers would like to include the Florida Low-Income Pool inpatient days when calculating the Medicare DSH payments on their cost reports. First Coast Service Options (the "Medicare Contractor") excluded these days when finalizing the DSH payments for these Hospitals for fiscal years ("FYs") 2006 – 2008.

The Providers timely appealed the exclusion of these days from the DSH calculations and satisfied all jurisdictional requirements for a hearing before the Board. The Board approved a hearing on the record which was held on May 23, 2017. Stephanie A. Webster, Esq., at Akin Gump Strauss Hauer & Feld LLP represented the Providers. Edward Lau, Esq., of Federal Specialized Services represented the Medicare Contractor.

STATEMENT OF THE FACTS:

A. BACKGROUND ON THE MEDICARE DSH CALCULATIONS

The Medicare program pays acute care hospitals for inpatient services through Medicare's inpatient prospective payment system ("IPPS").[3] Under IPPS, Medicare pays hospitals predetermined, standardized amounts per discharge, subject to certain payment adjustments.[4]

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[1] Providers' Consolidated Final Position Paper, at 1.
[2] *See* Appendix A for a list of Hospitals in Case Nos. 13-1460GC, 14-0565GC, 14-0773GC, and 14-3216G.
[3] *See* 42 U.S.C. § 1395ww(d) (2008).
[4] *See generally* 42 C.F.R. Part 412 (2008).

One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low-income patients.[5]

The Medicare DSH adjustment is calculated based on the sum of two fractions known as the Medicare fraction and the Medicaid fraction.[6] The Medicaid fraction is calculated by including in the numerator the number of inpatient days of service for Medicaid eligible patients who are not entitled to Medicare Part A, and dividing that number by the total number of hospital inpatient days.[7] The specific issue in this case is whether the numerator of the Providers' Medicaid fractions should include patient days for individuals whose inpatient services were partially paid under the Low-Income Pool portion of Florida's § 1115 waiver.

B. BACKGROUND ON MEDICAID STATE PLANS AND § 1115 WAIVERS

Medicaid is a joint federal and state program established in Title XIX of the Social Security Act (the "Act").[8] To participate in the Medicaid program and receive federal matching funds (commonly referred to as Federal Medicaid Assistance Percentage or "FMAP")[9], a state must enter into an agreement ("State plan") with the Federal government describing the individuals covered, services provided, reimbursement methodologies for providers, and other administrative activities.

Federal law provides flexibility in operating states' Medicaid programs through multiple waivers of federal requirements. To address the medical needs of its residents and demonstrate new approaches in providing health care that are likely to promote Medicaid program objectives, a state may choose to apply for, and include in its state plan, a demonstration program under §1115 of the Act.[10] The Secretary has delegated the administration of these demonstration projects to CMS which approves, and provides federal matching funds for, various waivers that expand both the populations who qualify for Medicaid and the health services available under a waiver. [11]

For purposes of the Medicaid fraction, "a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver."[12] When determining the number of patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A (the numerator of the Medicaid fraction), the regulation allows hospitals to "include all days attributable to populations eligible

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[5] 42 C.F.R. § 412.106.
[6] *Id*.
[7] 42 C.F.R. § 412.106(b)(4).
[8] 42 U.S.C. § 1396; *see also* 42 C.F.R. § 430.0.
[9] Social Security Act § 1905(b); 42 U.S.C. § 1396d(b).
[10] Social Security Act § 1115; 42 U.S.C. § 1315.
[11] 42 U.S.C. § 1315(a)(2)(A).
[12] 42 C.F.R. § 412.106(b)(4)(i).

for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act."[13]

C. FLORIDA'S § 1115 WAIVER FOR ITS MEDICAID PROGRAM

CMS approved the State of Florida's § 1115 waiver for the 5-year period, from July 1, 2006 through June 30, 2011.[14] The waiver contains four program elements: (1) payment of risk-adjusted premiums for Medicaid enrollees in managed care plans; (2) enhanced benefit accounts to provide incentives to Medicaid enrollees for healthy behaviors; (3) an employer-sponsored insurance option to pay premiums for Medicaid-eligible individuals to purchase insurance through their employer; and, (4) a Low-Income Pool designed "to provide direct payment and distributions to safety net providers in the state for the purpose of providing coverage to the uninsured through provider access systems ("PAS")."[15]

The fourth program element, the Low-Income Pool, is the portion of Florida's § 1115 waiver at issue here. The primary objectives of the Florida Low-Income Pool were to:

- Ensure availability of needed health care services to Medicaid, underinsured and uninsured populations.
- To provide access for Florida's most vulnerable, low-income population at their most acute time of need.
- Assure reasonable payment to the providers for those services.

Although the Florida Low-Income Pool Reimbursement and Funding Methodology allows Low-Income Pool funds to pay medical care costs or premiums, importantly Florida also chose to create a PAS to distribute Low-Income Pool payments directly to hospitals, clinics and other provider types.[16] Florida adopted a "basic distribution methodology" which paid hospitals, County Health Departments, Federally Qualified Health Clinics, and other Safety Net providers on July 1st of each year. These distributions were based on a formula using a provider's costs, but not directly related to specific claims for the care of uninsured or underinsured individuals.[17] Hospital Low-Income Pool payments were totaled and compared to the total cost of providing medical services to the uninsured and Medicaid-eligible population, less reimbursement from Medicaid, or from other collection efforts. If the Florida Low-Income Pool payment exceeded the total costs, the provider must refund the overpayment amount.[18]

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[13] 42 C.F.R. § 412.106(b)(4)(ii).
[14] Exhibit P-4.
[15] *Id.* at 2.
[16] *Id.*
[17] Hospitals and other providers participating in PAS had to report the number of uninsured/underinsured individuals who received services, the number of days and types of hospital services provided. Exhibit P-10 at 54. Also *see* Exhibit P-8.
[18] Reimbursement and Funding Methodology, Florida Medicaid Reform Section 1115 Waiver Low Income Pool (June 26, 2006), *available at* https://ahca.myflorida.com/Medicaid/Finance/finance/LIP-DSH/LIP/docs/fl_lip_reimbursement_and_funding_062606.pdf.

Providers were required to file a "[Low-Income Pool] Milestone Reporting Requirement document" and perform a "Low-Income Pool Cost Limit calculation" in order to receive Florida Low-Income Pool distributions.[19] The State must report back to CMS regarding the "impact the Low-Income Pool had on the rate of uninsurance in Florida . . ."[20] "Individual patient accounts are not submitted to, or tracked by, the State or AHCA."[21] A portion of the Florida Low-Income Pool payments may be used for the improvement or continuation of specialty health care services such as capacity building and infrastructure, hospital trauma services, hospital neonatal services, rural hospital services, pediatric hospital services, teaching or specialty hospital services, or safety net providers.[22]

D. PARTIES' CONTENTIONS

In the final settlement of cost reports for fiscal years 2006-2008, the Medicare Contractor excluded all Florida Low-Income Pool § 1115 Waiver days from the numerator of the Providers' DSH calculations, because it determined that Florida's Low-Income Pool payments should be characterized as charity care days or general assistance days which do not count for DSH purposes.[23] The Contractor relied on the Third Circuit's decision in *Nazareth Hospital v. Secretary of HHS*, 747 F.3d 172 (3d Cir. 2014), which differentiated §1115 waiver days which should be counted for the DSH calculation, from charity care and general assistance days which should not be counted.[24]

The Providers argue that the Medicare Contractor erred in excluding Florida Low-Income Pool § 1115 Waiver days from the final settlement of the cost reports because the plain text of the statute and regulations make clear that any inpatient day under a § 1115 waiver project must be included in the Medicaid fraction.[25] They maintain that Florida Low-Income Pool § 1115 Waiver patient days should be counted in the Medicaid fraction because the patients served under the Low-Income Pool § 1115 Waiver are undeniably "eligible for inpatient hospital services."[26] They argue that there is no difference between inpatient services which are paid for directly through a "pool fund" from individuals whose services are paid for on a fee-for-service basis.

The Providers further argue that CMS, in approving Florida's Low-Income Pool § 1115 Waiver project, intended to benefit a specifically identifiable population of uninsured and underinsured beneficiaries[27] as defined by the Special Terms and Conditions of the waiver and the Reimbursement and Funding Methodology.[28] Under the terms of this program, this population cannot be equated with a hospital's charity care program or Medical assistance to general assistance beneficiaries. The language of the DSH regulation allows hospitals to include all days

[19] Exhibits P-7 and P-8.
[20] Exhibit I-2, at 7 ("Annual Report").
[21] Exhibit P-7, at 1. AHCA is the Florida Agency for Healthcare Administration.
[22] Exhibit I-2, at 25.
[23] Medicare Contractor's Final Position Paper, at 3.
[24] *Id.* at 5.
[25] Providers' Consolidated Final Position Paper, at 6-10.
[26] *Id.* at 10.
[27] Providers' Response to MAC's Supplemental Brief, at 4-7.
[28] *Id.*

attributable to populations eligible for Title XIX matching payments in its DSH calculation.[29] According to the Providers, it is clear under the Low-Income Pool § 1115 Waiver's Special Terms and Conditions, that Florida will receive federal matching funds for Low-Income Pool payments made to providers for medical services provided to the Florida Low-Income Pool population,[30] and the days associated with these patients should be counted in the DSH calculation.

Additionally, the Providers assert that the Florida Low-Income Pool § 1115 Waiver program meets the terms of the DSH regulation as the regulation allows the inclusion of "all days attributable to *populations* eligible for Title XIX…", that is, counting of individuals in the aggregate.[31] They urge that under the terms of the regulation, it is sufficient that the hospitals know and can identify services provided directly to the Low-Income Pool eligibility group,[32] and that the Low-Income Pool payments are used for health care expenditures (medical costs or premiums) that would be within the definition of medical assistance in the Medicaid Act.[33] The Providers further assert that the Florida Low-Income Pool § 1115 Waiver program clearly provides medical assistance payments for services provided to *individuals*, not providers.

Finally, the Providers argue that the fact that the federal matching funds are computed in the aggregate rather than with respect to each individual Low-Income Pool § 1115 Waiver patient is of no consequence, as this is no different than a State seeking matching funds for medical assistance to traditional Medicaid eligibility groups on an aggregate basis. The fact that CMS approved a § 1115 waiver project, specifically created a Medicaid eligibility group defined as uninsured and underinsured individuals, and funded their medical assistance through Low-Income Pool payments to the Providers, should be sufficient to allow the inclusion of these patient days in the Medicaid fraction.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

The purpose of the Florida Low-Income Pool § 1115 Waiver program was to maintain the State's commitment to providing resources to assist safety-net hospitals to provide needed care to the Medicaid, underinsured, and uninsured populations; and to extend financial resources to additional hospitals and non-hospital providers of care."[34] The Low-Income Pool § 1115 Waiver program provided one billion dollars in direct payment and distributions to safety-net providers to offset uncompensated costs of providing health care services to uninsured and underinsured populations.[35]

Payment of these funds under Florida's Low-Income Pool § 1115 Waiver, however, is not dependent on a determination of Medicaid eligibility of particular individuals. Instead, the state

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[29] *Id*. at 2-3.
[30] *Id.* at 8.
[31] Providers' Consolidated Final Position Paper, at 10-11.
[32] *Id.* at 11.
[33] *Id.* at 6.
[34] Exhibit P-11, at 10.
[35] *Id.*

provides funds under this program to hospitals based on each hospital's costs of providing undetermined services to an indeterminate population, simply those who are "uninsured and underinsured." For a hospital to receive a distribution from the fund, they are required to "submit documentation of their permissible expenditures which will be used to calculate a Low-Income Pool Cost Limit."[36]

The Board finds that the Medicare Contractor's exclusion of Florida Low-Income Pool § 1115 Waiver days from the DSH calculation complies with the 2005 federal statute and regulation. Prior to January 2000, the federal DSH regulation, 42 CFR § 412.106(b)(4), limited the inclusion of patient days for individuals who qualified under a § 1115 waiver *who were or could have been made eligible under a State Medicaid plan*.[37] CMS expanded this definition in an interim final rule published January 20, 2000, to include "*all days attributable to populations eligible for Title XIX matching payments"* through a waiver approved under section 1115 of the Social Security Act.

Under both versions of the regulation, it is clear that the Secretary intended to limit the inclusion of patient days in the DSH calculation to *individuals* who become eligible under the terms of a waiver program, or who receive specific medical services provided under a waiver program. It is not intended to include payments made to a hospital to compensate it for services provided to an unspecified population whose patient days will, then, be included in the Medicaid fraction.

The Board's determination on this issue is consistent with CMS' response to hospitals in states without a Medicaid expansion waiver, on concerns they were disadvantaged because they could not count general assistance or charity care days in the DSH calculation.[38] In the preamble of the August 1, 2000, regulation, CMS stated:

> While we initially determined that States under a Medicaid expansion waiver could not include those expansion waiver days as part of the Medicare DSH adjustment calculation, *we have since consulted extensively with Medicaid staff and have determined that section 1115 expansion waiver days are utilized by patients whose care is considered to be an approved expenditure under Title XIX.* While this does advantage some States that have a section 1115 expansion waiver in place, these days are considered to be Title XIX days by Medicaid standards.[39]

These regulatory changes appear to make certain important clarifications. After August 2000, CMS' Medicare DSH policy focused on *patient days for individuals* who were receiving benefits under an expansion waiver. The regulation focuses on patients, not an amorphous population as the Providers argue. Florida's Low-Income Pool § 1115 Waiver provides a gross payment to hospitals—a "distribution," to reimburse them for services provided to uninsured and

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[36] Reimbursement and Funding Methodology, Florida Medicaid Reform Section 1115 Waiver Low Income Pool (June 26, 2006), *available at* https://ahca.myflorida.com/Medicaid/Finance/finance/LIP-DSH/LIP/docs/fl_lip_reimbursement_and_funding_062606.pdf.
[37] 42 C.F.R. § 412.106(b)(4) (emphasis added).
[38] 65 Fed. Reg. 47054, 47087 (Aug. 1, 2000).
[39] *Id.* (emphasis added).

underinsured individuals as an undifferentiated group, not identified or qualified individually for waiver services.[40] The Board finds that this is an important distinction and the Medicare Contractor properly excluded these patient days from the DSH calculation.

Second, the federal DSH regulation specifies that the services provided to these patients must be "*considered to be an approved expenditure under Title XIX.*" The waiver describes payment for care to the "Medicaid, underinsured, and uninsured populations." The waiver does not adequately describe the exact nature of what is being paid for and whether it would be an "approved expenditure under Title XIX."

The Board has issued two decisions finding that patient days from a Section 1115 waiver program qualify for inclusion in the DSH calculation. In a Massachusetts Section 1115 waiver which provided premiums subsidies for individuals whose income exceeds traditional Medicaid eligibility standards, the Board reasoned that the premium subsidy was provided to a discrete number of eligible individuals to purchase health care from the same managed care plans that provided health care to traditional Medicaid-eligible individuals.[41] In contrast to the Florida Low-Income Pool § 1115 Waiver, the Massachusetts program established eligibility criteria for applicants and provided a clearly established benefit—premium subsidy to enroll in a managed care plan which provided the same benefits as provided to traditional Medicaid-eligible individuals.

Similarly in its decision in *CCT&B 2005-2006 Hurricane Katrina § 1115 Waiver UCP Days Group*[42], the Board majority found that inpatient days paid for under Mississippi's Section 1115 waiver, which provided inpatient care to individuals who were uninsured as a result of job loss or other displacement due to Hurricane Katrina, should be counted in the DSH calculation. In its decision, the Board majority noted two important facts--that the State of Louisiana made expedited determinations of eligibility for specific individuals and that hospitals made claims specific to these individuals--were significant in its decision to include these patient days in the DSH calculation and distinguish that program from the Florida Low-Income Pool § 1115 Waiver.

More recently, the Board issued a decision in *Florida Section 1115 DSH Waiver Days Groups*[43], directly addressing the counting of Florida Low-Income Pool § 1115 Waiver patient days in the DSH Medicaid fraction. In that case, the Board found that "the lack of a defined group of

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[40] The Board recognizes that under the terms of the Low-Income Pool hospitals are required to identify particular patients for whom services were provided. However, identification of eligible individuals under the terms of the waiver is not the focus of waiver requirements; it is the determination of the amount of the Florida Low-Income Pool distribution based on the costs of providing services to uninsured and underinsured individuals to the hospitals.

[41] *Southwest Consulting UMass Memorial Health Care and Steward Health 2009 DSH CCHIP Section 1115 Waiver Days Groups v. National Government Services, Inc.*, PRRB Dec. No. 2017-D4, 2017 WL 909303, at *6 (Jan. 27, 2017) *rev'd* 2017 WL 2403398 (CMS Administrator Review, Mar. 21, 2017).

[42] *CCT&B 2005-2006 Hurricane Katrina § 1115 Waiver UCP Days Group v. Novitas Solutions, Inc.*, PRRB Dec. No. 2016-D18, 2016 WL 6299482 (Sep. 16, 2016) *rev'd* 2016 WL 7744987 (CMS Administrator Review, Nov. 18, 2016).

[43] *Florida Section 1115 DSH Waiver Days Groups v. First Coast Service Options*, PRRB Dec. No. 2018-D21 (Feb. 8, 2018).

eligible or Section 1115 waiver individuals" differentiated the Florida Low-Income Pool § 1115 Waiver program from either the Massachusetts or Katrina waiver-eligible individuals.[44] This same analysis is applicable to the instant case.

Unlike Massachusetts or Katrina, the Florida Low-Income Pool pays funds to hospitals for an indeterminate group of patients: an "uninsured" patient with no insurance or no source of third party coverage or an "underinsured" patient, whose insurance or third party coverage does not pay all of the costs of inpatient care. The Board notes that while the waiver's Special Terms and Conditions specify that some parts of the waiver program expand Medicaid eligibility to additional individuals and allow additional individuals to enroll in Medicaid managed care programs,[45] the Low-Income Pool section of the waiver is silent on the eligibility or enrollment of specific individuals for participation in hospital reimbursement for their care.[46]

Instead the Florida Low-Income Pool calculates additional payment to the hospital which is not commensurate with the actual cost of care provided to eligible individuals. Under Florida's Low-Income Pool, individuals are not "eligible to enroll" - they simply receive medical care from one of the safety net hospitals and the hospital is fully or partially reimbursed for their care. These individuals did not enroll and may not even know that the waiver paid/reimbursed the hospital for the care that was provided. Rather the payment was a "distribution" of a pool of funds based not on individuals' claims but on a formula for the distribution of funds between hospitals and other health care facilities.

The Board finds that the lack of a defined group of eligible Medicaid or Section 1115 waiver individuals is significant because, according to the federal DSH regulation *for the purpose of computing the Medicaid fraction*, a *patient* must be "deemed eligible for Medicaid on a given day only if the *patient is eligible* for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day. . ."[47]

Under the Florida Low-Income Pool §1115 Waiver program, patients who receive services from Low Income Pool facilities: (1) are not required to apply for the hospital's charity care program; (2) do not apply for or receive a Medicaid card or certificate of coverage; (3) do not have a right of reconsideration on appeal; and, (4) do not receive a bill or notification when a claim is paid. Patients included on the Milestone report are not based upon an established eligibility criterion but are based upon each providers' charity and bad debt policies, which will vary between providers. These facts clearly indicate that it is not the individual patients whose eligibility is established and benefits paid on their behalf and the Board cannot find that this process satisfies the terms of the DSH regulation.

Finally, the most recent amendment to the DSH regulation in 2003 clarified that in order for Section 1115 patients days to be included in the DSH calculation, these days must be for "*populations who receive benefits under the demonstration project that are similar to those*

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[44] *Id.* at 10.
[45] Exhibit P-4 at 8-13.
[46] *Id.* at 24-27.
[47] 42 C.F.R. § 412.106(b)(4)(i) (emphasis added).

available to traditional Medicaid beneficiaries"[48] and could not include individuals who received limited benefits, specifically citing family planning services.[49] The Board concludes that, in the present case, it cannot determine whether the benefit to the patient was *similar to those available to traditional Medicaid beneficiaries,* limited or otherwise. The patient benefits under the Florida waiver cannot be ascertained with any certainty, and cannot, therefore, be counted in the Medicaid fraction.

DECISION:

After considering the Medicare law and regulations, stipulations of fact, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor properly excluded Florida's Low-Income Pool § 1115 Waiver days from the numerator of the Medicaid fraction when calculating the Providers' DSH payments.

BOARD MEMBERS PARTICIPATING:

Charlotte Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A Evarts, Esq.

FOR THE BOARD:

/s/
Board Member

DATE: September 21, 2018

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[48] 68 Fed. Reg. 27154, 27207 (May 19, 2003) (emphasis added).
[49] *Id.* ("Because of the differences between expansion populations in these limited benefit demonstrations and traditional Medicaid beneficiaries, we are proposing that the Medicare DSH calculation should exclude from treatment as Medicaid patient days those patient days attributable to limited benefit section 1115 expansion waiver populations.")

APPENDIX A
SCHEDULE OF PROVIDERS

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Schedule of Providers in Group

Group Name: Baptist Health South Florida 2006-2007 Florida LIP Days Group

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Representative Akin Gump Strauss Hauer & Feld LLP

Date Prepared 3/18/2016

Case No: 13-1460GC

Issue: Whether Florida LIP Waiver days were properly treated in the calculation of the Medicare DSH payment.

Lead Intermediary: First Coast Service Options, Inc.

	Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
1	10-0008	Baptist Hospital of Miami (Miami, Miami-Dade, FL)	First Coast Service Options, Inc.	9/30/2007	2/28/2013	8/22/2013	175	14, 24	$1,607,462	Direct Add	8/22/2013
2	10-0154	South Miami Hospital (South Miami, Miami-Dade, FL)	First Coast Service Options, Inc.	9/30/2007	2/28/2013	8/22/2013	175	11, 21	$681,346	Direct Add	8/22/2013
3	10-0296	Doctors Hospital (Coral Gables, Miami-Dade, FL)	First Coast Service Options, Inc.	9/30/2007	2/28/2013	8/22/2013	175	12, 14, 15, 25, 26	$421,246	Direct Add	8/22/2013

Total Amount of Reimbursement: $2,710,054

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Schedule of Providers in Group

Group Name: Orlando Health 2008 DSH Florida LIP Waiver Days Group

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Representative: Akin Gump Strauss Hauer & Feld LLP

Date Prepared: 11/2/2016

Case No: 14-0565GC

Issue: Whether Florida LIP Waiver days were properly treated in the calculation of the Medicare DSH payment?

Lead Intermediary: First Coast Service Options - FL

	Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
1	10-0006	Orlando Regional Healthcare (Orlando, Orange, FL)	First Coast Service Options, Inc.	9/30/2008	5/28/2013	11/22/2013	178	14, 36, 64	$8,416,855	Direct Add	11/22/201
2	10-0030	Health Central (Ocoee, Orange, FL)	First Coast Service Options, Inc.	9/30/2008	5/10/2013	11/5/2013	179	11, 13, 19	$2,826,317	Direct Add	11/5/201
3	10-0051	South Lake Hospital (Clermont, Lake, FL)	First Coast Service Options, Inc.	9/30/2008	5/2/2013	10/29/2013	180	9, 20	$2,425,399	14-0329	11/5/201

Total Amount of Reimbursement: $13,668,571

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Schedule of Providers in Group

Group Name: Baptist Health South Florida 2008 Florida LIP Days Group
Page No. 1 of 1
Representative Akin Gump Strauss Hauer & Feld LLP
Date Prepared 2/3/2015
Case No: 14-0773GC
Issue: Whether Florida LIP Waiver days were properly treated in the calculation of the Medicare DSH payment.
Lead Intermediary: First Coast Service Options - FL

Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
1 10-0008	Baptist Hospital of Miami (Miami, Miami-Dade, FL)	First Coast Service Options - FL	9/30/2008	5/28/2013	11/15/2013	171	9, 21, 33	$2,503,746	Direct Add	11/15/2013
2 10-0125	Homestead Hospital (Homestead, Miami-Dade, FL)	First Coast Service Options - FL	9/30/2008	5/28/2013	11/15/2013	171	7, 14, 20	$1,125,607	Direct Add	11/15/2013
3 10-0154	South Miami Hospital (South Miami, Miami-Dade, FL)	First Coast Service Options - FL	9/30/2008	5/28/2013	11/15/2013	171	7, 15, 23	$875,599	Direct Add	11/15/2013
4 10-0296	Doctors Hospital (Coral Gables, Miami-Dade, FL)	First Coast Service Options - FL	9/30/2008	5/28/2013	11/15/2013	171	7, 15, 26	$461,975	Direct Add	11/15/2013

Total Amount of Reimbursement: $4,966,927

Schedule of Providers in Group

Group Name: Akin Gump 2006-2007 DSH Florida LIP Waiver Days Group

Page No. [illegible]

Representative Akin Gump Strauss Hauer & Feld LLP

Date Prepared 7/8/2015

Case No: [illegible]

Issue: Whether Florida LIP Waiver days were properly treated in the calculation of the Medicare DSH payment.

Lead Intermediary: First Coast Service Options, Inc.

Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
1 10-0006	Orlando Health (Orlando, Orange, FL)	First Coast Service Options, Inc.	9/30/2007	2/28/2013	8/15/2013 10/21/2013	168	11, 33, 34, 64	$8,965,311	13-2777	4/11/2014
2 10-0128	Tampa General Hospital (Tampa, Hillsborough, FL)	First Coast Service Options, Inc.	9/30/2006	9/14/2009	3/12/2010	179	19	$2,021,528	10-0783	4/11/201[illegible]

Total Amount of Reimbursement: $10,986,839