

ATTACHMENT F - INSTITUTIONS Cost Sheet Template
 Use for MMHI AND WMHI/WRC
 NOTE: A separate cost proposal must be completed for each institution

		Column A	Column B	Column C	Column D	Column E	Column F	Column G
State Fiscal Year	Primary Pay Source for Client Group	Projected Client Days in Year	Projected Annual Revenue From Billing Medicaid Fee-For-Service (include dispensing fee) NOTE: Enter \$0 if Medicaid FFS will not be billed.	Projected Annual Manufacturer Rebates Paid to State of Wisconsin for Medicaid Fee-For-Service Claims in Column B. NOTE: Enter \$0 if Medicaid FFS will not be billed.	Vendor's Proposed Daily Rate (beyond Medicaid FFS and other 3rd party billing) per Client day charged to facility	Vendor's Annual Projected Total Charge to facility	Net Annual Costs	Net Cost Per Day Per Client
SFY 10	Medicaid	State Data*				A x D	(B - C + E)	F / A
	Medicare Part A	State Data*				A x D	(B - C + E)	F / A
	Medicare Part D	State Data*				A x D	(B - C + E)	F / A
	Commercial Insurance	State Data*				A x D	(B - C + E)	F / A
	No Insurance	State Data*				A x D	(B - C + E)	F / A
	TOTAL	State Data*						
SFY 11	Medicaid	State Data*				A x D	(B - C + E)	F / A
	Medicare Part A	State Data*				A x D	(B - C + E)	F / A
	Medicare Part D	State Data*				A x D	(B - C + E)	F / A
	Commercial Insurance	State Data*				A x D	(B - C + E)	F / A
	No Insurance	State Data*				A x D	(B - C + E)	F / A
	TOTAL	State Data*						
SFY 12	Medicaid	State Data*				A x D	(B - C + E)	F / A
	Medicare Part A	State Data*				A x D	(B - C + E)	F / A
	Medicare Part D	State Data*				A x D	(B - C + E)	F / A
	Commercial Insurance	State Data*				A x D	(B - C + E)	F / A
	No Insurance	State Data*				A x D	(B - C + E)	F / A
	TOTAL	State Data*						

INSTRUCTIONS

This template should be used for RFP responses for Mendota Mental Health Institute, Winnebago Mental Health Institute, and Wisconsin Resource Center. For the purposes of this RFP, it is assumed the census at the Institutions will be the same in SFY 2010 through SFY 2012.

For Medicaid-eligible groups, the Vendor can choose one of two basic approaches for reimbursement:

1. Bill Medicaid Fee-For-Service (FFS) for drug costs and dispensing costs. The Vendor could include a facility per-client charge to cover administrative costs for services required under the RFP that are

beyond the scope of Medicaid FFS covered services.

2. Commit to not billing Medicaid FFS for drug and dispensing costs. Under this option, the Vendor would bill the facility a single daily rate per client that covers drug costs, dispensing services and other services required under the RFP.

Under the first approach, the State will be able to claim drug manufacturer rebates. In comparing cost proposals, the State will net out projected manufacturers' rebates in determining the net cost to the State. Under the second approach, the State will not be able to bill drug manufacturers for rebates, and thus, will use the Vendor's facility charge per patient day as the net cost to the State.

Column A: The State will provide point-in-time data for each Institution. Population data identifies clients by the primary payment source; individuals may have more than one payment source. Population data must be multiplied by 365 to produce an annual estimate of client days.

- Column B:
1. If the Vendor intends to bill Medicaid FFS for prescriptions covered by Medicaid, the Vendor should enter the total projected reimbursement from Medicaid FFS, including the dispensing fee, in Column B.
 2. The Vendor can choose not to bill Medicaid FFS, but that will preclude the ability of the State to claim rebates from drug manufacturers under FFS Medicaid.
 3. If the vendor chooses not to bill Medicaid FFS, "\$0" should be entered in columns B and C.
 4. If the Vendor intends to use pharmaceutical management tools to improve drug utilization and to lower costs, the Vendor may project a lower cost based on improved utilization. The Vendor must attach a description of proposed cost-saving techniques and revised assumptions regarding drug utilization. The State will review this projection, and may alter the Vendor's projection if the proposed cost-saving techniques are not supported by evidence.
 5. The State will review the Medicaid FFS projection even if the Vendor's is not proposing new utilization savings measures to insure that the projection is consistent with current utilization and FFS maximum fees.

- Column C:
1. If the Vendor intends to bill Medicaid FFS for prescriptions covered by Medicaid, the Vendor should enter in Column C the total projected manufacturer' rebates from Medicaid FFS that would be paid to the State, based on the projection in Column B.
 2. The State will review this projection, and may alter the Vendor's projection if the amount in Column B is modified or if the assumed rebates are inconsistent with rebates currently collected by the State under Medicaid FFS.

- Column D:
1. The Vendor is required to provide a proposed per diem rate for each group (Medicaid Only, Medicare Part A, Medicare Part D, Commercial Insurance, and No Insurance). The proposed per diem rate can vary by year and the Vendor's proposal could tie the per diem rate to a published drug price index. The proposed per diem is expected to be an all-inclusive rate that covers all services and pharmacy costs required under the proposal.
 2. If the Vendor intends to bill Medicaid FFS for drug costs and dispensing costs, the daily rate can only include costs for services required under the RFP that are not covered under the Medicaid FFS maximum fee and dispensing fee.
 3. It is expected the daily rate should reflect offsets from billing Medicare Part D and other third party liability revenues.
 4. The Vendor is responsible for determining whether any third-party liability exists, for collecting third-party liability amounts, and all administrative costs associated with third-party liability tasks.

Column E: This column is derived by multiplying Column A by Column D and represents the total projected charge to the facility. It does not include Medicaid FFS claims, Medicare Part D billings, private insurance billings or other third-party reimbursements paid by non-state programs.

Column F: This column is derived from the sum of Medicaid FFS claims (Column B) and the total projected Vendor charges to the facility (Column E) less FFS manufacturer rebates (Column C).

Column G: This column is derived by dividing net annual costs (Column F) by the number of projected client days (Column A) to obtain a net cost per client day.