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State/Territory Name: Florida

State Plan Amendment (SPA) #: 08-17

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

December 16, 2011

Mr. Justin Senior
Acting Deputy Secretary for Medicaid
Florida Agency for Health Care Administration
227 Mahan Drive
Mail Stop 8
Tallahassee, Florida 32308

RE: Florida Title XIX State Plan Amendment, Transmittal # FL 08-017

Dear Mr. Senior:

We have reviewed the proposed amendment to the Florida State Plan (SPA FL 08-017) that was received in the Regional Office on September 23, 2008. The amendment modifies Title XIX Outpatient Hospital Reimbursement Plan payment methodology, effective July 1, 2008, in accordance with Florida House Bill 5001, 2008-09 General Appropriations Act, and specific Florida Appropriation 211 and House Bill 5085, Section 5, which amended Section 409.908 of Florida State Statutes. Based on the HCFA 179 submitted by the State, Federal budget impact would be (-$2,014,000) in FFY 2007-08; and (-$9,492,000) in FFY 2008-09.

Based on the information provided, we are now ready to approve Medicaid State Plan Amendment FL 08-017. This SPA was approved on December 16, 2011. The effective date of this amendment is July 1, 2008. We are enclosing the approved form HCFA-179 and the approved plan pages.

If you have any questions or need further assistance, please contact Donald Graves at 919-929-2999, or Etta Hawkins at 404-562-7429.

Sincerely,

//s//

Jackie Glaze
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 08-017

2. STATE: Florida

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2008

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447

7. FEDERAL BUDGET IMPACT: IN THOUSANDS
a. FFY 2007-08 $(2,014)
b. FFY 2008-09 $(9,492)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Exhibit I, Version XVIII

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Exhibit I, Version XVII

10. SUBJECT OF AMENDMENT:
Payment Methodology for Outpatient Hospital Reimbursement

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:
Will forward when received.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
//s//

13. TYPED NAME: Mr. Carlton D. Snipes

14. TITLE: Deputy Secretary for Medicaid

15. DATE SUBMITTED: 09/29/08

16. RETURN TO:
Mr. Carlton D. Snipes
Agency Secretary for Medicaid
2727 Mahan Drive , Mail Stop #8
Tallahassee, FL 32308

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 09/23/11

18. DATE APPROVED: 12/16/11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
07/01/08

20. SIGNATURE OF REGIONAL OFFICIAL:
//s//

21. TYPED NAME:
Jackie Glaze

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children Health Opns

23. REMARKS:
Approved with the follow9ing changes to item 8 as authorized by state agency on email dated 12/07/11:

Block# 7a changed to read: FFY 2007-08 (3,553)

Block# 7b changed to read: FFY 2008-09 (15,721)

FLORIDA TITLE XIX OUTPATIENT HOSPITAL

REIMBURSEMENT PLAN

VERSION XVIII

EFFECTIVE DATE: July 1, 2008

I. Cost Finding and Cost Reporting

A. Each hospital participating in the Florida Medicaid Hospital Program shall submit a cost report postmarked no later than five calendar months after the close of its cost-reporting year. A hospital filing a certified cost report that has been audited by the independent auditors of the hospital shall be given a 30-day extension if the Agency for Health Care Administration (AHCA) is notified in writing that a certified report is being filed. The hospital cost reporting year adopted for the purpose of this plan shall be the same as that for Title XVIII or Title V cost reporting, if applicable. A complete, legible copy of the cost report shall be submitted to the Medicare intermediary and to AHCA, Bureau of Medicaid Program Analysis, Cost Reimbursement.

B. Cost reports available to AHCA as of March 31, 1990, shall be used to initiate this plan.

C. All hospitals are required to detail their costs for their entire reporting year, making appropriate adjustments as required by this plan for determination of allowable costs. New hospitals shall adhere to requirements of Section 2414.1, Provider Reimbursement Manual (CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.010, Florida Administrative Code, F.A.C.) A prospective reimbursement rate, however, shall not be established for a new hospital based on a cost report for a period less than 12 months. For a new hospital or a new

provider with no cost history, excluding new providers resulting from a change in ownership where the previous provider participated in the program, the interim rate shall be the lesser of: the county reimbursement ceiling for variable costs (including outpatient fixed costs); or the budgeted rate in compliance with CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C. and Section III of the Plan, as applied to the budget submitted by the provider. Interim rates shall be cost settled for the interim rate period. Interim per diem rates shall not be approved for new providers resulting from a change in ownership. Medicaid reimbursement is hospital specific and is not provider specific.

D. The cost report shall be prepared in accordance with generally accepted accounting principles as established by the American Institute of Certified Public Accountants (AICPA) except as modified by the method of reimbursement and cost finding of Title XVIII (Medicare) Principles of Reimbursement described in 42 Code of Federal Regulations (CFR) 413.35 - 413.50, further interpreted by the Provider Reimbursement Manual (CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C.). and as further modified by this plan.

E. Hospitals shall file a legible and complete cost report within five months, or 6 months if a certified report is being filed, after the close of its reporting period. Medicare-granted exceptions to these time limits shall be accepted by AHCA.

F. If a provider submits a cost report late, after the five month period, and that cost report would have been used to set a lower reimbursement rate for a rate semester had it been submitted within five months, then the provider's rate for that rate semester shall be retroactively calculated using the new cost report, and full

payments at the recalculated rate shall be affected retroactively. Medicare granted exceptions to these time limits shall be accepted by AHCA.

G. A hospital which voluntarily or involuntarily ceases to participate in the Florida Medicaid Program or experiences a change of ownership shall file a final cost report in accordance with Section 2414.2, CMS_PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C. For the purposes of this plan, filing a final cost report is not required when: the capital stock of a corporation is sold; or partnership interest is sold as long as one of the original general partners continues in the partnership or one of the original limited partners becomes a general partner, or control remains unchanged. Any change of ownership shall be reported to AHCA within 45 days after such change of ownership.

H. All Medicaid participating hospitals are required to maintain the Florida Medicaid Log and financial and statistical records regarding outpatients in accordance with 42 CFR 413.24(a)-(c). For purposes of this plan, statistical records shall include the medical records of eligible Medicaid recipients. These records shall be available upon demand to representatives, employees or contractors of AHCA, the Auditor General of the State of Florida, the General Accounting Office (GAO) or the United States Department of Health and Human Services (HHS). A Medicaid recipient's medical records shall be released to the above named persons for audit purposes upon proof of the recipient's consent such as the Medicaid consent form, AHCA-Med Form 1005 as incorporated by reference in Rule 59G-5.080 (2), F.A.C.

I. Records of related organizations as defined by 42 CFR 413.17 shall be available upon demand to representatives, employees or contractors of AHCA, the Auditor General, GAO, or HHS.

J. AHCA shall retain all uniform cost reports submitted for a period of at least five years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of 45 CFR 205.60. Access to submitted cost reports shall be in conformity with Chapter 119, Florida Statutes. Upon request for a copy of any cost report, the hospital involved shall be notified as to the party making the request and the information requested. Unless prohibited by a court of competent jurisdiction, the cost report shall be released to the requestor 15 days from receipt of the request by AHCA.

K. For cost reports received on or after October 1, 2003, all desk or onsite audits of these cost reports shall be final and shall not be reopened past three years of the date that the audit adjustments are noticed through a revised per diem rate completed by the Agency.

Exception to the above mentioned time limit:

The aforementioned limitation shall not apply when Medicare audit reopenings result in the issuance of revised Medicaid cost report schedules. A cost report may be reopened for inspection, correction, or referral to a law enforcement agency at any time by the Agency or its contractor if program payments appear to have been obtained by fraud, similar fault, or abuse.

L. Cost reports submitted on or after July 1, 2004, must include the following statement immediately preceding the dated signature of the provider's administrator or chief financial officer: "I certify that I am familiar with the laws

and regulations regarding the provision of health care services under the Florida Medicaid program, including the laws and regulations relating to claims for Medicaid reimbursements and payments, and that the services identified in this cost report were provided in compliance with such laws and regulations."

II. Audits

A. Background

A hospital common audit program has been established to reduce the cost of auditing submitted cost reports and avoid duplicate auditing efforts. The purpose is to have one audit of a participating hospital which shall serve the needs of all governmental programs reimbursing the hospital for services rendered.

B. Common Audit Program

AHCA has entered into written agreements with Medicare intermediaries for participation in a common audit program of Titles V, XVIII, and XIX. Under this agreement, the intermediaries shall provide AHCA the result of desk reviews and field audits of those participating hospitals located in Florida, Georgia, and Alabama.

C. Other Hospital Audits

For those hospitals not covered by the common audit agreement with Medicare intermediaries, AHCA shall be responsible for performance of desk and field audits. AHCA shall:

1. Determine the scope and format for on-site audits;
2. Desk audit all cost reports within 6 months after their submission to AHCA;

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3. Ensure all audits are performed in accordance with generally accepted auditing standards of the AICPA as incorporated by reference in Rule 61H1-20.008 F.A.C;
4. Ensure that only those expense items that the plan has specified as allowable costs under Section III of this plan have been included by the hospital in the computation of the costs of the various services provided under Rule 59G-4.160 F.A.C;
5. Review to determine that the Florida Medicaid Log is properly maintained and current in those hospitals where its maintenance is required;
6. Issue, upon the conclusion of each full scope audit, a report which shall meet generally accepted auditing standards of the AICPA as incorporated by reference in Rule 61H1-20.008, F.A.C. and shall declare the auditor's opinion as to whether, in all material respects, the cost submitted by a hospital meets the requirements of this plan.

D. Retention

All audit reports received from Medicare intermediaries or issued by AHCA shall be kept in accordance with 45 CFR 205.60.

E. Overpayments and Underpayments

1. Overpayments for those years or partial years as determined by desk or field audits using prior approved State plans shall be reimbursable to AHCA, as shall overpayments attributable to unallowable costs only.
2. Overpayments in outpatient hospital services shall not be used to offset underpayments in inpatient hospital services and, conversely,

overpayments in inpatient hospital services shall not be used to offset underpayments in outpatient hospital services.

3. The results of desk or field audits of outpatient hospital services shall be identified separately from the results of desk or field audits of inpatient hospital services.
4. Any overpayment or underpayment that resulted from a rate adjustment due to an error in either reporting or calculation of the rate shall be refunded to AHCA or to the provider as appropriate.
5. Any overpayment or underpayment that resulted from a rate based on a budget shall be refunded to AHCA or to the provider as appropriate.
6. The terms of repayments shall be in accordance with Section 414.41, Florida Statutes.
7. All overpayments shall be reported by AHCA to HHS as required.
8. Information intentionally misrepresented by a hospital in the cost report shall result in a suspension of the outpatient hospital from the Florida Medicaid Program.

F. Appeals

For audits conducted by AHCA a concurrence letter that states the results of an audit shall be prepared and sent to the provider, showing all adjustments and changes and the authority for such. Providers shall have the right to a hearing in accordance with Section 120.57, Florida Statutes, for any or all adjustments made by AHCA. For cost reports received on or after October 1, 2003, all desk or onsite audits of these cost reports shall be final and shall not be reopened past three years

of the date that the audit adjustments are noticed through a revised per diem rate completed by the Agency.

Exception to the above mentioned time limit:

The aforementioned limitation shall not apply when Medicare audit reopenings result in the issuance of revised Medicaid cost report schedules. A cost report may be reopened for inspection, correction, or referral to a law enforcement agency at any time by the Agency or its contractor if program payments appear to have been obtained by fraud, similar fault, or abuse.

III. Allowable Costs

Allowable costs shall be determined using generally accepted accounting principles, except as modified by Title XVIII (Medicare) Principles of Reimbursement as described in 42 CFR 413.35 - 413.50, the inpatient routine nursing salary cost differential, and the guidelines in the Provider Reimbursement Manual (CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C.,) and as further modified by Title XIX of the Act, this plan, requirements of licensure and certification, and the duration and scope of benefits provided under the Florida Medicaid Program. These include:

A. Costs incurred by a hospital in meeting:

1. The definition of a hospital contained in 42 CFR 440.20 and 42 CFR 440.140 in order to meet the requirements of Sections 1902(a)(13) and (20) of the Social Security Act;
2. The requirements established by the State Agency responsible for establishing and maintaining health standards under the authority of 42 CFR 431.610; and

3. Any other requirements for licensing under the State law which are necessary for providing outpatient hospital services.

B. Medicaid reimbursements shall be limited to an amount, if any, by which the rate calculation for an allowable claim exceeds the amount of a third party recovery during the Medicaid benefit period. In addition, the reimbursement shall not exceed the amount according to 42 CFR 447.321.

C. Malpractice insurance costs shall be apportioned to Medicaid in the ratio of Medicaid Outpatient costs to Total Hospital Costs.

D. Under this plan, hospitals shall be required to accept Medicaid reimbursement as payment in full for covered services provided during the benefit period and billed to the Medicaid program; therefore, there shall be no payments due from Medicaid recipients. As a result, for Medicaid cost reporting purposes, there shall be no Medicaid bad debts generated by Medicaid recipients. Bad debts shall not be considered as an allowable expense.

E. All physician orders and records that result in costs being passed on by the hospital to the Florida Medicaid Program through the cost report shall be subject to review by the Agency or the Agency's authorized representative.

F. Certain revenue centers are not reimbursed by Medicaid. Service rendered under these centers shall not be recorded on the Medicaid log and shall not be billed to Medicaid. The list of covered revenue centers is attached as Appendix A. Modifications of this list subsequent to the implementation of this plan shall appear in the Florida Medicaid Information System Update. Beginning November 1, 2004, revenue code 510, Clinic/General (see Appendix A) is reimbursable by Medicaid, in accordance with the most recent version of the Medicaid Outpatient

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Hospital Coverage and Limitations Handbook, for health care services, in outpatient clinic facilities where a non-state government owned or operated facility assumed the fiscal and operating responsibilities of one or more primary care centers previously operated by the Florida Department of Health or the local county government.

G. The revenue assessments, and any fines associated with those assessments, mandated by the Health Care Access Act of 1984, Section 395.701, Florida Statutes, shall not be considered an allowable Medicaid cost and shall not be allocated as a Medicaid allowable cost for purposes of cost reporting.

IV. Standards

A. In accordance with Chapter 120, F.S., Administrative Procedures Act, and 42 CFR 447.205, this plan shall be promulgated as an Administrative Rule and as such shall be made available for public inspection. A public hearing shall be held so that interested members of the public shall be afforded the opportunity to review and comment on this plan.

B. Reimbursement ceilings shall be established prospectively for each Florida county. Beginning with the July 1, 1993 rate period, additional ceilings based on the Target Rate System shall also be imposed. For purposes of establishing reimbursement ceilings, each hospital within the state shall be classified as general, teaching, specialized, rural, or as a Community Hospital Education Program (CHEP) hospital. Outpatient reimbursement ceilings shall be established for and applied to general hospitals. Rural and specialized psychiatric hospitals shall be excluded from the calculation and application of the outpatient reimbursement ceilings. Statutory teaching, specialized, Community Hospital

Education Program (CHEP) hospitals, and those hospitals defined in Section V.A. 9 through 14 shall be included in the calculation but are exempt from the application of the outpatient reimbursement ceilings.

C. The initial reimbursement ceilings shall be determined prospectively and shall be effective from July 1, 1990, through December 31, 1990. For subsequent periods, the reimbursement ceilings shall be effective from January l through June 30 and July l through December 31 of the appropriate years except as provided in G. below.

D. Changes in individual hospital rates shall be effective from July l through December 31 and January l through June 30 of each year. Hospital outpatient rates set under plan provisions for the July 1, 2003 rate semester will be effective October 1, 2003.

E. For the initial period, the last cost report received from each hospital as of March 31, 1990, shall be used to establish the reimbursement ceilings. In the absence of sufficient information from the above source, claims payment data from the Medicaid fiscal agent, shall be used. Should none of the above sources provide acceptable information, the hospital shall be excluded from the reimbursement ceiling calculations. The hospital shall then have a rate assigned that equals the lowest computed rate in the county in which the hospital is located, or the lowest rate in the AHCA District in which the hospital is located, if there are no other hospitals in the county in question.

F. For subsequent periods, all cost reports received by AHCA as of each April 15 and October 15 shall be used to establish the reimbursement ceilings.

G. The individual hospital's prospectively determined rate shall be adjusted only under the following circumstances:

1. An error was made by the fiscal intermediary or AHCA in the calculation of the hospital's rate.
2. A hospital submits an amended cost report to supersede the cost report used to determine the rate in effect. There shall be no change in rate if an amended cost report is submitted beyond three years of the effective date the rate was established, or if the change is not material.
3. Further desk or field audits of cost reports used in the establishment of the prospective rate disclose material changes in these reports. For cost reports received on or after October 1, 2003, all desk or onsite audits of these cost reports shall be final and shall not be reopened past three years of the date that the audit adjustments are noticed through a revised per diem rate completed by the Agency.

   Exception to the above mentioned time limit:

   The aforementioned limitation shall not apply when Medicare audit reopenings result in the issuance of revised Medicaid cost report schedules. A cost report may be reopened for inspection, correction, or referral to a law enforcement agency at any time by the Agency or its contractor if program payments appear to have been obtained by fraud, similar fault, or abuse.
4. Where the charge structure of a hospital changes and the application of the lower of cost or charges limitations is reconsidered.

H. Any rate adjustment or denial of a rate adjustment by AHCA may be appealed by the provider in accordance with Rule 28-106, F.A.C., and Section 120.57 Florida Statutes.

I. Under no circumstances shall any rate adjustment exceed the reimbursement ceiling established, except as provided for in IV B.

J. In accordance with Section 2303 of Public Law 98-369, the Deficit Reduction Act of 1984, the reimbursement rates for laboratory and pathology services shall be the lower of: the hospital's charges or; the Medicaid fee schedule technical component as provided for in Rule 59G-4.160, F.A.C.

V. Method

This section defines the methodologies to be used by the Florida Medicaid Program in establishing reimbursement ceilings and individual hospital reimbursement rates.

A. Setting Reimbursement Ceilings.

1. Review and adjust the hospital cost report available to AHCA as of each April 15 and October 15 as follows:
   a. To reflect the results of desk or field audits.
   b. To reduce the Medicaid outpatient costs and charges for laboratory and pathology costs and charges.
2. Reduce a hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.9.
3. Determine Medicaid outpatient variable costs defined in Section X.
4. Adjust Medicaid outpatient variable costs for the number of months between the midpoint of the hospital's fiscal year and either September 30, or March 31, the midpoint of the rate semester for which the new rate is

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being calculated. The adjustment shall be made utilizing the latest available projections as of March 31 or September 30 for the Data Resources Incorporated (DRI) Type Hospital Market Basket Index as detailed in Appendix B.

5. Divide the inflated Medicaid outpatient variable costs by the latest available Health Care component of the Florida Price Level Index (FPLI) for the county in which the hospital is located.

6. Divide the results of Step 5 for each hospital by its total Medicaid outpatient occasions of service excluding occasions of service for laboratory and pathology resulting in an occasions of service rate.

7. Array the occasions of service rates in Step 6 from the lowest to the highest rate with the associated occasions of service.

8. Establish the reimbursement ceilings as the lower of:

   a. The cost based ceilings for variable costs per occasion of service at the occasion of service rate associated with the 80th percentile of occasions of service, times the FPLI component utilized in Step 5 for the county in which the hospital is located. Rural and specialized psychiatric hospitals are excluded from the calculation and application of this cost based ceiling.

      The following types of hospitals are included in the calculation, but are exempt from the application of this cost based ceiling except for the limitations described in 9 through 14 below:

      i. Statutory teaching hospitals

      ii. Specialized hospitals

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iii. Community Hospital Education Program (CHEP)

iv. Those mentioned in 9 through 14 below

v. Hospitals with Level III Neonatal Intensive Care Units that have a minimum of three of the following designated tertiary services as regulated under the certificate of need program: pediatric bone marrow transplantation, pediatric open heart surgery, pediatric cardiac catheterization and pediatric heart transplantation.

For hospitals participating in the Florida Medicaid Program that are located out of State, the FPLI used shall be equal to 1.00.

b. For rate periods beginning with the July 1, 1993 rate period, the target ceiling shall be calculated by multiplying the previous rate period's ceiling by the target inflation factor as calculated in the following formula:

$$1 + 1.4 \times \left[\frac{\text{Midpoint of the prospective rate period using appendix B}}{\text{Midpoint of the current rate period using Appendix B}} - 1 \right]$$

This target ceiling shall not apply to rural, specialized, statutory teaching, Community Hospital Education Program (CHEP) hospitals, and those hospitals defined in 9 through 14 below.

This target ceiling shall not apply to the following:

i. Statutory teaching hospitals

ii. Specialized hospitals

iii. Community Hospital Education Program (CHEP)

iv. Those mentioned in 9 through 14 below

v. Hospitals with Level III Neonatal Intensive Care Units that have a minimum of three of the following designated tertiary services as regulated under the certificate of need program: pediatric bone marrow transplantation, pediatric open heart surgery, pediatric cardiac catheterization and pediatric heart transplantation.

9. Effective July 1, 2001, outpatient reimbursement ceilings will be eliminated for hospitals whose charity care and Medicaid days as a percentage of total hospital days equals or exceeds fifteen percent. Effective July 1, 2002, the fifteen percent (15%) will be changed to fourteen and one-half percent (14.5%). The Agency shall use the disproportionate share hospital 1997 audited data available as of March 1, 2001, to determine eligibility for the elimination of ceilings. Effective July 1, 2003, the fourteen and one-half percent (14.5%) will be changed to eleven percent (11%) to eliminate the outpatient reimbursement ceilings for hospitals whose charity care and Medicaid days as a percentage of total adjusted hospital days equals or exceeds 11 percent. The Agency will use the average of the 1998, 1999, and 2000 audited DSH data available as of March 1, 2004. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency will use the average of the audited DSH data for 1998, 1999,

and 2000 that is available. Hospital outpatient rates set under plan provisions for the July 1, 2003, rate semester will be effective October 1, 2003.

10. Effective July 1, 2001, outpatient reimbursement ceilings will be eliminated for hospitals whose Medicaid days as a percentage of total hospital days exceed 9.6% and are a trauma center. The Agency shall use the 1997 audited DSH data available as of March 1, 2001, to determine eligibility for the elimination of ceilings.

11. Effective July 1, 2003, outpatient reimbursement ceilings will be eliminated for hospitals whose Medicaid days, as a percentage of total hospital days, exceed 9.6 percent, and are trauma centers. The Agency will use the average of the 1998, 1999, and 2000 audited DSH date available as of March 1, 2004. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency will use the average of the audited DSH data for 1998, 1999, and 2000 that is available. Hospital outpatient rates set under plan provisions for the July 1, 2003, rate semester will be effective October 1, 2003.

12. Effective July 1, 2005, outpatient reimbursement ceilings shall be eliminated for hospitals whose charity care and Medicaid days as a percentage of total adjusted hospital days equals or exceeds 11 percent. The Agency shall use the average of the 1999, 2000, and 2001 audited DSH data available as of March 1, 2005. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency will use the average of the audited DSH data for 1999, 2000, and 2001 that are available. Any hospital that met the 11 percent threshold in state

fiscal year 2004-2005 and was also exempt from the outpatient reimbursement ceilings shall remain exempt from the outpatient reimbursement ceilings for State Fiscal Year 2005-2006, subject to the payment limitations imposed in this paragraph.

13. Effective July 1, 2005, outpatient reimbursement ceilings shall be eliminated for hospitals that have a minimum of ten licensed Level II neonatal intensive care beds and are located in Trauma Services Area 2.

14. Effective July 1, 2005, the outpatient reimbursement ceilings shall be eliminated for hospitals whose Medicaid days, as a percentage of total hospital days, exceed 7.3 percent, and are designated or provisional trauma centers. This provision shall apply to all hospitals that are designated or provisional trauma centers on July 1, 2005, or become a designated or provisional trauma center during state fiscal year 2005-2006. The agency shall use the average of the 1999, 2000 and 2001 audited DSH data available as of March 1, 2005. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the agency will use the average of the audited DSH data for 1999, 2000, and 2001 that are available.

15. Effective July 1, 2006, outpatient hospital rates shall be adjusted to eliminate the outpatient reimbursement ceilings for hospitals whose charity care and Medicaid days as a percentage of total adjusted hospital days equals or exceeds 11 percent. Effective July 1, 2006, the Agency shall use the average of the 2000, 2001, and 2002 audited DSH data available as of March 1, 2006. In the event the Agency does

not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2000, 2001, and 2002 that are available. For any non-state government owned or operated facility that does not qualify for the elimination of the outpatient ceilings under this section, the non-state government owned or operated facility hospital shall be exempt from the outpatient reimbursement ceilings.

16. Effective July 1, 2006, outpatient reimbursement ceilings for hospitals that have a minimum of ten licensed Level II neonatal intensive care beds and are located in Trauma Services Area 2 are eliminated.

17. Effective July 1, 2006, outpatient reimbursement ceilings for hospitals whose Medicaid days, as a percentage of total hospital days, exceed 7.3 percent, and are designated or provisional trauma centers are eliminated. This provision shall apply to all hospitals that are designated or provisional trauma centers on July 1, 2006, or become a designated or provisional trauma center during State Fiscal Year 2006-2007. The Agency shall use the average of the 2000, 2001, and 2002 audited DSH data available as of March 1, 2006. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2000, 2001, and 2002 that are available.

18. Effective July 1, 2007, the outpatient reimbursement ceilings will be eliminated for hospitals whose charity care and Medicaid days as a percentage of total adjusted hospital days equals or exceeds 11 percent. For any non-state government owned or

operated facility that does not qualify for the elimination of the outpatient ceilings under this provision of proviso or any other proviso listed, the non-state government owned or operated facility shall be exempt from the outpatient reimbursement ceilings. The Agency shall use the average of the 2001, 2002, and 2003 audited DSH data available as of March 1, 2007. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2001, 2002, and 2003 that are available.

19. Effective July 1, 2007, the outpatient reimbursement ceilings will be eliminated for hospitals that have a minimum of ten licensed Level II Neonatal Intensive Care Beds and are located in Trauma Services Area 2.

20. Effective July 1, 2007, the outpatient reimbursement ceilings will be eliminated for hospitals whose Medicaid days, as a percentage of total hospital days, exceed 7.3 percent, and are designated or provisional trauma centers. This provision shall apply to all hospitals that are designated or provisional trauma centers on July 1, 2007, or become a designated or provisional trauma center during state fiscal year 2007-2008. The Agency shall use the average of the 2001, 2002, and 2003 audited DSH data available as of March 1, 2007. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2001, 2002, and 2003 that are available.

21. Effective July 1, 2008, outpatient reimbursement ceilings for hospitals will be eliminated for those hospitals whose charity care and Medicaid days as a percentage of total adjusted hospital days equals or exceeds 11 percent. The Agency shall use the average of the 2002, 2003, and 2004 audited DSH data available as of

March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003, and 2004 that are available.

22. Effective July 1, 2008, outpatient hospital reimbursement ceilings will be eliminated for hospitals whose Medicaid days, as a percentage of total hospital days, exceed 7.3 percent, and are designated or provisional trauma centers. This provision shall apply to all hospitals that are designated or provisional trauma centers on July 1, 2008, or become a designated or provisional trauma center during Fiscal Year 2008-2009. Included in these funds are the annualized amounts to offset the reductions taken against certified trauma centers as identified in section 13, chapter 2007-326, Laws of Florida. The Agency shall use the average of the 2002, 2003, and 2004 audited DSH data available as of March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003, and 2004 that are available.

B. Setting Individual Hospital Rates.

1. Review and adjust the hospital cost report available to AHCA as of each April 15 and October 15 as follows:

   a. To reflect the results of desk and field audits.

   b. To reduce the Medicaid outpatient costs and charges for laboratory and pathology costs and charges.

2. Reduce the hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.9.

3. Determine Medicaid outpatient variable costs as defined in Section X.

4. Adjust Medicaid outpatient variable costs for the number of months between the midpoint of the hospital's fiscal year and September 30 or March 31, the midpoint of the following rate semester. The adjustment shall be made utilizing the DRI Regional Hospital Input Price Index as detailed in Appendix B.

5. Establish the variable cost rate as the lower of:

   a. The inflated rate by dividing the inflated allowable Medicaid outpatient variable costs by the total Medicaid outpatient occasions of service for the hospital excluding occasions of service for laboratory and pathology.

   b. The target rate by inflating the variable cost rate in the previous rate period by the target inflation factor calculated in V.A.8.b. above in establishing target ceilings. This target rate shall not apply to rural, specializd, statutory teaching, Community Hospital

Education Program (CHEP) hospitals, and those hospitals defined in Section V.A. 9 through 14.

i. Set the rate for the hospital as the lower of the result of Step 5. above, the reimbursement ceiling in V.A.8 for the county in which the hospital is located, or the result of inflated Medicaid outpatient charges divided by total Medicaid outpatient occasions of service excluding charges and occasions of service for laboratory and pathology.

ii. Hospital outpatient rates set under plan provisions for the July 1, 2003, rate semester will be effective October 1, 2003.

iii. Effective July 1, 2004, and ending June 30, 2005, each outpatient rate shall be reduced by a proportionate percentage until an aggregate total estimated savings of $14,103,000 is achieved. In reducing hospital outpatient rates, rural hospitals and hospitals with twenty thousand (20,000) or more combined Medicaid managed care and fee-for-service inpatient days shall not have their outpatient rates reduced below the final rates that are effective on June 30, 2004. The 2002 Financial Hospital Uniform Reporting System (FHURS) data shall be used to determine the combined inpatient Medicaid days.

6. Effective July 1, 2005, a recurring rate reduction shall be established until an aggregate total estimated savings of $16,796,807 is achieved each year. This reduction is the Medicaid Trend Adjustment. In reducing hospital outpatient rates, rural hospitals and hospitals with twenty thousand (20,000) or more

combined Medicaid managed care and fee-for-service inpatient days shall not have their outpatient rates reduced below the final rates that are effective on the prior June 30 of each year. The 2002 Financial Hospital Uniform Reporting System (FHURS) data shall be used to determine the combined inpatient Medicaid days.

a. The July 1, 2005 and January 1, 2006 reimbursement rates shall be adjusted as follows:

    i. Restore the $14,103,000 outpatient hospital reimbursement rate reduction set forth in Section V.B.iii above to the June 30,2005 reimbursement rate;

    ii. Determine the lower of the June 30, 2005 rate with the restoration of the $14,103,000 reduction referenced in (i) above or the July 1, 2005 or January 1, 2006 rates, as applicable, before the application of the Medicaid Trend Adjustment described in (6) above;

b. Effective July 1, 2006, the reduction implemented during the period July 1, 2005, through June 30, 2006, shall become a recurring annual reduction. This recurring reduction, called the Medicaid Trend Adjustment, shall be applied proportionally to all rates on an annual basis.

c. Effective July 1, 2007, and ending June 30, 2008, the Medicaid Trend Adjustment will be removed for all hospitals whose Medicaid charity

care days as a percentage to total adjusted days equals or exceeds 30 percent and have more than 10,000 Medicaid days or hospital system that established a Provider Service Network during the prior state fiscal year. The aggregate Medicaid Trend Adjustment listed in V.B.6 above will be reduced by $3,110,871. The Agency shall use the average of the 2001, 2002 and 2003 audited DSH data available as of March 1, 2007.

7. Effective January 1, 2008, an additional Medicaid Trend Adjustment shall be applied to achieve a recurring annual reduction of $17,211,796.
8. Effective January 1, 2008, and ending June 30, 2008, the Medicaid Trend Adjustment shall be removed for all certified trauma centers and hospitals defined in section 408.07(45), 2007 Florida Statutes. The aggregate Medicaid Trend Adjustment found in V.C.7 above shall be reduced by up to $2,034,032.
9. Effective July 1, 2008, an additional Medicaid Trend Adjustment shall be applied to achieve a recurring annual reduction of $36,403,451. In establishing rates through the normal process, prior to including this reduction, if the unit cost is equal to or less than the unit cost used in establishing the budget, no additional reduction in rates is necessary. In establishing rates through the normal process, prior to including this reduction, if the unit cost is greater than the unit cost used in establishing the budget, then rates shall be reduced by an amount required to achieve this

reduction, but shall not be reduced below the unit cost used in establishing the budget.

10. The Agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs for two fiscal years effective July 1, 2009.

11. Effective July 1, 2008, a buy back provision for the Medicaid trend adjustment will be applied against the Medicaid outpatient rates for the following three categories of hospitals.

    a. Budget authority up to $3,515,024 is provided to the first category of hospitals, which are those hospitals that are part of a system that operate a provider service network in the following manner: $831,338 is for hospitals in Broward Health; $823,362 is for hospitals in the Memorial Healthcare System; and $601,863 to Shands Jacksonville and $1,258,461 to Shands Gainesville. In the event that the above amounts exceed the amount of the Medicaid trend adjustment applied to each hospital, the excess funds will be used to buy back other Medicaid reductions in the outpatient rate.

    b. Budget authority up to $5,203,232 shall be used for the second category to buy back the Medicaid trend adjustment

that is being applied against the Medicaid outpatient rates for those hospitals that are licensed as a children's specialty hospital and whose Medicaid days plus charity care days divided by total adjusted patient days equals or exceeds 30 percent. In the event the above amounts exceed the amount of the Medicaid trend adjustment applied to each hospital, the excess funds will be used to buy back other Medicaid reductions in the inpatient rate.

c. Budget authority up to $2,170,197 shall be used for the third category to buy back the additional Medicaid trend adjustment that is being applied to rural hospitals under Specific Appropriation 211 for Fiscal Year 2008-2009. In the event that the funds under this category exceed the amount of the Medicaid trend adjustment, then any excess funds will be used to buyback other Medicaid reductions in the outpatient rate for those individual hospitals.

For this provision the Agency shall use the average of 2002, 2003, and 2004 audited DSH data available as of March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003 and 2004 that are available.

12. Effective July 1, 2008, budget authority up to $19,906,103 is provided for a buy back provision for state or local government owned or operated hospitals, teaching hospitals as defined in section 408.07 (45) or 395.805, Florida Statutes, which have 70 or more full-time equivalent resident physicians and those hospitals whose Medicaid and charity care days divided by total adjusted days exceeds 25 percent to buy back the Medicaid outpatient trend adjustment shall be applied to their individual hospital rates and other Medicaid reductions to their outpatient rates up to actual Medicaid outpatient cost. The Agency shall use the average of the 2002, 2003, and 2004 audited DSH data available as of March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003 and 2004 that are available.

VI. Payment Assurance

The State shall pay each hospital for services provided in accordance with the requirements of the most recent version of the Florida Title XIX State Plan. The payment amount shall be determined for each hospital according to the standards and methods set forth in the most recent version of the Florida Title XIX Outpatient Hospital Reimbursement Plan.

VII. Provider Participation

This plan is designed to assure adequate participation of hospitals in the Medicaid Program, the availability of hospital services of high quality to recipients, and services

which are comparable to those available to the general public. This is in accordance with 42 CFR 447.204.

VIII. Revisions

The plan shall be revised as operating experience data are developed and the need for changes is necessary in accordance with modifications in the Code of Federal Regulations.

IX. Payment in Full

Participation in the Program shall be limited to hospitals of service which accept as payment in full for covered services the amount paid in accordance with the most recent version of the Florida Title XIX Outpatient Hospital Reimbursement Plan.

X. Definitions

A. Acceptable Cost Report - A completed, legible cost report that contains all relevant schedules, worksheets and supporting documents.

B. Adjusted patient days - The sum of acute care patient days and intensive care patient days as reported to the Agency for Health Care Administration divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues

C. AHCA - Agency for Health Care Administration, also known as the Agency.

D. Allowable Costs - An item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with generally accepted accounting principles except as modified by the Principles of Reimbursement for Provider Costs, as defined in CMS PUB. 15-1 as incorporated by reference in 59G-6.010 F.A.C., and as further defined in the most recent version of the Florida Title XIX Outpatient Hospital Reimbursement Plan.

E. Buy-Back – The buy back provision allows a hospital to decrease their Medicaid Trend Adjustment from the established percent down to zero percent.

F. Community Hospital Education Program (CHEP) hospitals – Hospitals that participate in a program established by the Community Hospital Education Act (381.0403, F.S.) and administered by the Department of Health. CHEP hospitals offer continuing medical education programs for interns and residents established on a statewide basis. The CHEP program provides financial support for interns and residents based on policies recommended and approved by the Community Hospital Education Council and the Department of Health.

G. Cost Reporting Year - A 12-month period of operation based upon the provider's accounting year.

H. Eligible Medicaid Recipient - "Recipient" or "Medicaid recipient" means any individual whom the department, or the Social Security Administration on behalf of the agency, determines is eligible, pursuant to federal and state law, to receive medical or allied care, goods, or services for which the department may make payments under the Medicaid program and is enrolled in the Medicaid program. For the purposes of determining third party liability, the term includes an individual formerly determined to be eligible for Medicaid, an individual who has received medical assistance under the Medicaid program, or an individual on whose behalf Medicaid has become obligated.

H. Florida Medicaid Log - A schedule to be maintained by a hospital listing each Medicaid patient's recipient number, dates of admission and discharge, and the charges and payments for services and goods received from the hospital's revenue centers.

I. Florida Price Level Index - A spatial index which measures differences from county to county in the cost of purchasing a specified market basket of items at a particular point in time. The items in the market basket range from various food products to hospital lab fees, and are grouped into the components of food, housing, apparel, transportation, and health, recreation and personal services. A county index for each of the five components is developed bi-annually by the Florida Executive Office of the Governor. County indices are population weighted to average 100 percent. An index of 1.1265 for a given county means that the basket of goods in that county costs 12.65 percent more than the State average. Changes to the methodology utilized in the development of the FPLI will constitute changes in this plan and will require a formal plan amendment.

J. General hospital – A hospital in this state that is not classified as a specialized hospital.

K. HHS - Department of Health and Human Services

L. CMS PUB. 15-1 - Health Insurance Manual No. 15, also known as the Provider Reimbursement Manual, as incorporated by reference in Rule 59G-6.010, F.A.C..

M. Medicaid Outpatient Charges - Usual and customary charges for outpatient services rendered to Medicaid patients excluding charges for laboratory and pathology services. These charges shall be the allowable charges as reconciled with the hospital Medicaid log and found on the Medicaid paid claims report.

N. Medicaid Outpatient Occasions of Service - The number of distinct revenue center code line items listed on a valid claim that a hospital has submitted to the fiscal agent, excluding laboratory and pathology revenue center code line items, and that

have been paid by the fiscal agent, which represent covered Medicaid outpatient services.

O. Medicaid Outpatient Variable Costs - Allowable operating costs excluding laboratory and pathology costs less return on equity as apportioned to Medicaid by cost finding methods in the CMS 2552 cost report.

P. Non-Covered Services - Those goods and services which are not medically necessary for the care and treatment of outpatients as defined in CMS PUB 15.1 as incorporated by reference in Rule 59G-6.010, F.A.C.

Q. Provider Service Network (PSN) – is defined in s. 409.912, F.S., as a network established or organized and operated by a health care provider, or group of affiliated health care providers, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers.

R. Rate Semester - January 1 through June 30 of a given year, or July 1 through December 31 of a given year.

S. Reimbursement Ceiling - The upper limit for Medicaid Outpatient Variable Cost rate reimbursement for an individual hospital.

T. Reimbursement Ceiling Period - January 1 through June 30 of a given year or July 1 through December 31, of a given year.

U. Rural Hospital - An acute care hospital licensed under Florida Statutes, Chapter 395 with 100 licensed beds or less, which has an emergency room and is located in an area defined as rural by the United States Census, and which is:

1. The sole provider within a county with a population density of no greater than 100 persons per square mile; or

2. An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county; or
3. A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or less per square mile.
4. A hospital in a constitutional charter county with a population of over 1 million persons that has imposed a local option health service tax pursuant to law and in an area that was directly impacted by a catastrophic event on August 24, 1992, for which the Governor of Florida declared a state of emergency pursuant to chapter 125, and has 120 beds or less that serves an agricultural community with an emergency room utilization of no less than 20,000 visits and a Medicaid inpatient utilization rate greater than 15 percent;

5. A hospital with a service area that has a population of 100 persons or fewer per square mile. As used in this subparagraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Policy Analysis at the Agency for Health Care Administration; or

6. A hospital designated as a critical access hospital, as defined in s. 408.07(15).

   Population densities used in this paragraph must be based upon the most recently completed United States census. A hospital that received funds under s. 409.9116 for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2012, if the hospital continues to have 100 or fewer licensed beds and an emergency room, or meets the criteria of subparagraph 4. An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this paragraph shall be granted such designation upon application, including supporting documentation to the Agency for Health Care Administration.

V. Specialized Hospital - A licensed hospital primarily devoted to TB, psychiatric care, pediatric, eye, or cardiac care and treatment; or a licensed hospital that has ten or more residency training programs.

W. Title XVIII - Health Insurance for the Aged, Blind or Disabled (Medicare) as provided for in the Social Security Act (42 U.S.C. 1395-1395xx).

X. Title XIX - Grants to States for medical assistance programs (Medicaid) as provided for in the Social Security Act (42 U.S.C. 1396-1396p).

Y. Total Outpatient Charges - Total patient revenues assessed for all outpatient services excluding charges for laboratory and pathology.

APPENDIX A TO FLORIDA TITLE XIX OUTPATIENT HOSPITAL REIMBURSEMENT PLAN

OUTPATIENT REVENUE CENTER CODES

CODE	DESCRIPTION
250	Pharmacy/General
251	Pharmacy/Generic
252	Pharmacy/NonGeneric
254	Drugs Incident to Other Diagnostic Services
255	Drugs Incident to Radiology
258	Pharmacy/IV Solutions
259	Other Pharmacy
260	IV Therapy
261	Infusion Pump
262	IV Therapy/Pharmacy Services
264	IV Therapy/Supplies
269	Other IV Therapy
270	General Classification
271	Medical Surgical- Nonsterile supplies
272	Medical/Surgical - Sterile Supplies
275	Pacemaker
276	Intraocular Lens
278	Subdermal Contraceptive Implant
279	Burn Pressure Garment Fitting
300	Laboratory/General
301	Laboratory/Chemistry
302	Laboratory/Immunology
304	Laboratory/Non-Routine Dialysis
305	Laboratory/Hematology
306	Laboratory/Bacteriology and Microbiology
307	Laboratory/Urology
310	Pathological Laboratory/General
311	Pathological Laboratory/Cytology
312	Pathological Laboratory/Histology
314	Pathological Laboratory/Biopsy
320	Diagnostic Radiology/General
321	Diagnostic Radiology/Angiocardiography
322	Diagnostic Radiology/Arthrography
323	Diagnostic Radiology/Arteriography

324	Diagnostic Radiology/Chest
329	Other Radiology Diagnostic
330	Therapeutic Radiology/General
331	Therapeutic Radiology/Injected
332	Therapeutic Radiology/Oral
333	Therapeutic Radiology/Radiation Therapy
335	Therapeutic Radiology/Chemotherapy - IV
339*	Other Radiology Therapeutic
340	Nuclear Medicine/General
341	Nuclear Medicine/Diagnostic
342	Nuclear Medicine/Therapeutic
343	Diagnostic Radiopharmaceuticals
344	Therapeutic Radiopharmaceuticals
349	Other Nuclear Medicine
350	Computed Tomographic (CT) Scan/General
351	Computed Tomographic (CT) Scan/Head
352	Computed Tomographic (CT) Scan/Body
359	Other CT Scans
360	Operating Room Services/General
361	Operating Room Services/Minor Surgery
362	Operating Room Services/Bone Marrow Transplant
369*	Other Operating Room Services
370	Anesthesia/General
371	Anesthesia Incident to Radiology
372	Anesthesia Incident to Other Diagnostic Services
379	Other Anesthesia
380	Blood/General
381	Blood/Packed Red Cells
382	Blood/Whole
383	Blood/Plasma
384	Blood/Platelets
385	Blood/Leucocytes
386	Blood/Other Components
387	Blood/Other Derivatives
389	Other Blood
390	Blood Storage and Processing/General
391	Blood Storage and Processing/Administration
399	Other Processing and Storage
400	Imaging Services/General
401	Imaging Services/Mammography
402	Imaging Services/Ultrasound
403	Screening Mammography

404 Positron Emission Tomography
409 Other Imaging Services

410 Respiratory Services/General (All Ages)
412 Respiratory Services/Inhalation (All Ages)
413 Respiratory Services/Hyperbaric Oxygen Therapy (All Ages)
419 Other Respiratory Services
421 Physical Therapy/Visit Charge (All Ages)
424 Physical Therapy/Evaluation or Re-evaluation(All Ages)
Note: Effective 1/1/99
431 Occupational Therapy/Visit Charge (Under 21 only)
434 Occupation Therapy/Evaluation or Re-evaluation (Under 21)
Note: Effective 1/1/99
441 Speech-Language Pathology/Visit Charge (Under 21 only)
444 Speech-Language Pathology/Evaluation or Re-evaluation Under 21) Note: Effective 1/1/99
450 Emergency Room/General
451 EMTALA Emergency Medical Screening Services
(Effective 7/1/96)

- EMTALA: Emergency Medical Treatment and Active Labor Act
- Use 451 when the recipient needs no ER care beyond the EMTALA emergency medical screening
- Code W1700 must be used with code 451; example 451(W1700)

Note: No MediPass authorization required

460 Pulmonary Function/General
469 Other Pulmonary Function
471 Audiology/Diagnostic
472 Audiology/Treatment
480 Cardiology/General
481 Cardiology/Cardiac Cath Laboratory
482 Cardiology/Stress Test
483 Cardiology/Echocardiology
489 Other Cardiology
490 Ambulatory Surgical Care
510 Clinic/General

- Note: Please reference the most recent version of the Medicaid Outpatient Hospital Coverage and Limitations Handbook

513 Psychiatric Clinic
Note: Use code 513, pychiatric clinic, with code 914, psychiatric individual therapy services, or with 918, psychiatric testing, when either of these codes is appropriate and applicable.
610 MRI Diagnostic/General
611 MRI Diagnostic/Brain
612 MRI Diagnostic/Spine
614 MRI - Other
615 Magnetic Resonance Angiography (MRA) - Head & Neck
616 MRA - Lower Extremities
618 MRA - Other
619 Other MRT
621 Supplies Incident to Radiology
622 DressingsSupplies Incident to Other Diagnostic Services
623 Surgical Dressings
634 Erythropoietin (EPO) less than 10,000 units
635 Erythropoietin (EPO) 10,000 or more units
636 Pharmacy/Coded Drugs
637 Self-Administered Drugs (Effective 10/1/97)
Note: Use code 637 exclusively to bill self-administered drugs not covered by Medicare for dually-eligible Medicare and Medicaid recipients. Code 637 must only be billed with the Total Charge 001 revenue code. Payment will be made for 637 only.
700 Cast Room/General
710 Recovery Room/General
721 Labor - Delivery Room/Labor
722 Labor - Delivery Room/Delivery
723 Labor Room/Delivery/Circumcision
730 EKG - ECG/General
731 EKG - ECG/Holter Monitor
732 Telemetry
740 EEG/General
749 Other EEG
750 Gastro-Intestinal Services/General
759 Other Gastro - Intestinal
761 Treatment Room
762 Observation Room
790 Lithotripsy/General
821 Hemodialysis Outpatient/Composite
831 Peritoneal Dialysis Outpatient/Composite Rate
880 Miscellaneous Dialysis/General
881* Ultrafiltration
901 Psychiatric/Psychological - Electroshock Treatment

914 Psychiatric/Psychological - Clinic Visit/Individual Therapy
918 Psychiatric/Testing (Effective 1/1/99)
Note: Bill 513, psychiatric clinic, with this service,
920 Other Diagnostic Services/General
921 Other Diagnostic Services/Peripheral Vascular Lab
922 Other Diagnostic Services/Electromyelgram
924 Other Diagnostic Services/Allergy Test
943 Other Therapeutic Services/Cardiac Rehabilitation
944 Other Therapeutic Services/Drug Rehabilitation
945 Other Therapeutic Services/Alcohol Rehabilitation

*Exempt from $1500 outpatient cap limit.

APPENDIX B TO FLORIDA TITLE XIX OUTPATIENT HOSPITAL REIMBURSEMENT PLAN ADJUSTMENTS TO ALLOWABLE MEDICAID VARIABLE COSTS

An example of the technique to be utilized to adjust allowable Medicaid variable costs for inflation in the computation of the reimbursement limits is detailed below. Assume the following DRI Quarterly Indices:

	1996	1997	1998	1999	2000
Q1	213.0	237.7	250.1	278.1	308.0
Q2	217.8	234.5	256.5	285.9	314.9
Q3	222.7	237.9	263.2	294.0	322.0
Q4	227.7	243.8	270.4	301.2	329.3

The elements in the above table represent a weighted composite index based on the following weights and the components:

COMPONENTS	WEIGHTS
Payroll and Professional Fees	55.57%
Employee Benefits	7.28%
Dietary and Cafeteria	3.82%
Fuel and Other Utilities	3.41%
Other	29.92%
	100.00%

Based on the quarterly indices, monthly indices are calculated by averaging pairs of quarterly indices and interpolating between these averages as follows:

QUARTER	INDEX	AVERAGE INDEX	MONTH
1	213.0		
		215.4	MARCH 31
2	217.8		
		220.3	JUNE 30
3	222.7		
		225.2	SEPT. 30
4	227.7		

April 30 Index = (June 30 Index/March 31 Index)$^{1/3}$ (March 31 Index)

= (220.3/215.4)$^{1/3}$ (215.4)
= 217.0

May 31 Index = (June 30 Index/March 31 Index)$^{2/3}$ (March 31 Index)

= (220.3/215.4)$^{2/3}$ (215.4)

= 218.7

All other monthly indices can be calculated in a similar fashion. To determine the applicable inflation factor for a given hospital for the first semester of 1999-2000 the index for September 30, 1999, the midpoint of the rate semester, is divided by the index for the midpoint of the Provider's Fiscal Year. For example, if a hospital has a fiscal year end of November 30, 1996 then its midpoint is May 31, and the applicable inflation is:

September 1999 Index/May 1996 Index = 297.6/218.7 = 1.3607

Therefore, the hospitals reported variable cost Medicaid rate is multiplied by 1.3607 to obtain the estimated average variable Medicaid rate for the first rate semester of FY 1999-2000. Similar calculations utilizing March 31, as the midpoint yield adjustments for the second semester of FY 1999-2000.

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APPENDIX C TO FLORIDA TITLE XIX OUTPATIENT HOSPITAL REIMBURSEMENT PLAN

Medicaid Trend Adjustment Percentages

	Effective Date	Percentages	Reduction Amount
1.	**July 1, 2008**		
	First Cut	3.141039%	$16,796,807
	Second Cut	3.255973%	$17,211,796
	Third Cut	7.05107%	$36,403,451

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

December 16, 2011

Date	Signature
12/16/11	
12/16/11	
12-16-11	

Mr. Justin Senior
Acting Deputy Secretary for Medicaid
Florida Agency for Health Care Administration
227 Mahan Drive
Mail Stop 8
Tallahassee, Florida 32308

RE: Florida Title XIX State Plan Amendment, Transmittal # FL 08-017

Dear Mr. Senior:

We have reviewed the proposed amendment to the Florida State Plan (SPA FL 08-017) that was received in the Regional Office on September 23, 2008. The amendment modifies Title XIX Outpatient Hospital Reimbursement Plan payment methodology, effective July 1, 2008, in accordance with Florida House Bill 5001, 2008-09 General Appropriations Act, and specific Florida Appropriation 211 and House Bill 5085, Section 5, which amended Section 409.908 of Florida State Statutes. Based on the HCFA 179 submitted by the State, Federal budget impact would be (-$2,014,000) in FFY 2007-08; and (-$9,492,000) in FFY 2008-09.

Based on the information provided, we are now ready to approve Medicaid State Plan Amendment FL 08-017. This SPA was approved on December 16, 2011. The effective date of this amendment is July 1, 2008. We are enclosing the approved form HCFA-179 and the approved plan pages.

If you have any questions or need further assistance, please contact Donald Graves at 919-929-2999, or Etta Hawkins at 404-562-7429.

Sincerely,

Jackie Glaze
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosures

Holly, Mary V. (CMS/CMCHO)

From: Payne, Candice J. (CMS/CMCS)
Sent: Friday, December 16, 2011 1:20 PM
To: Billy, Indy A. (CMS/CMCS); Hentz, Cynthia J. (CMS/CMCS); Rich, Irvin J. (CMS/NC); Miller, Angel L. (CMS/NC); Grano, Nancy E. (CMS/NC); McCarthy, Julie (CMS/CMCHO); Mills, Stephen C. (CMS/NC); Melendez, Michael (CMS/CMCHO); Mirach, Harry A. (CMS/CMCHO); Holly, Mary V. (CMS/CMCHO); DaSilva, Gilson F. (CMS/CMCHO); Easley, Marguerite (CMS/CMCHO); Noonan, Darlene F. (CMS/CMCHO); Gilbert, Rosario G. (CMS/SC); Glaze, Jackie L. (CMS/CMCHO); Franklin, Shantell L. (CMS/MC); Brown, Carolyn D. (CMS/MC); Mertel, Jan E. (CMS/WC); Garza, Maria I. (CMS/WC); Marks, Marsha L. (CMS/SC); Hatcher, Karen S. (CMS/MC); Strom, Mandy L. (CMS/MC); Turner, Trudy J. (CMS/WC); Kenline, Carolyn C. (CMS/CMCHO); Novo, Don (CMS/CMCHO); Pratt, Theresa A. (CMS/CMCS); Buress, Sharonda L. (CMS/CMCS); Lloyd, Beth E. (CMS/CMCS); Harris, Melissa L. (CMS/CMCS); Cooley, Mark S. (CMS/CMCS); Tavener, Linda A. (CMS/CMCS); Dobson, Camille (CMS/CMCS); Howell, Kimberly M. (CMS/CMCS); McKesson, Ruth M. (CMS/CMCS); Hain, Ginni M. (CMS/CMCS); Trudel, Roy R. (CMS/CMCS); Fine, Joseph L. (CMS/CMCS); Klimon, Nancy L. (CMS/CMCS); Freeze, Janet G. (CMS/CMCS); Poisal, Kathryn J. (CMS/CMCS); Gaskins, Sheri P. (CMS/CMCS); Nablo, Linda (CMS/CMCS); Murphy, Terri L. (CMS/CMCS); Gerhardt, Christine R. (CMS/CMCS); Terwilliger, Lane M. (CMS/CMCS); Jensen, Kirsten (CMS/CMCS); Schmidt, Donna W. (CMS/CMCS); Ambrosini, Ellen M. (CMS/CMCS); Berger, Michael L. (CMS/CMCS); Hance, Mary Beth E. (CMS/CMCS); Murphy, Linda S. (CMS/CMCS); Dailey, Barbara A. (CMS/CMCS); Jackson, Gary (CMS/CMCS)
Cc: Allen, Richard C. (CMS/CMCHO); Brooks, Bill D. (CMS/CMCHO); Johnson, Verlon (CMS/OA); Mccullough, Francis T. (CMS/CMCHO); McGreal, Richard R. (CMS/NC); Nagle, Gloria (CMS/CMCHO); Peverly, Carol J. (CMS/CMCHO); Scott, James G. (CMS/CMCHO); Alexander, Wendy J. (CMS/CMCS); Bosstick, Suzanne R. (CMS/CMCS); Boston, Beverly A. (CMS/CMCS); Corbin, Angela T. (CMS/CMCS); Delozier, Adrienne M. (CMS/CMCS); Edwards, Barbara C. (CMS/CMCS); Fan, Kristin A. (CMS/CMCS); Heffron, Dianne E. (CMS/CMCS); Moore, Tonya A. (CMS/CMCS); Olin, Elaine M. (CMS/CMCS); Raschke, Karen S. (CMS/CMCS); Reed, Maria R. (CMS/CMCS); Ryan, Jennifer (CMS/CMCS); Wachino, Victoria A. (CMS/CMCS)
Subject: OSNs approved 12/16

Hi all! The OSNs below are approved by CMCS/OCD. They are ordered first by due date, second by CO date received, and then by SPA/waiver number. We will have more coming today and realize that ID SPA 11-010 and AR SPA 11-10 must be done today. Thanks all!

Due Date	CO Date Received	SPA/waiver number	OSN description
ASAP	12/13/11	MI PACE	Approval of states to update its PACE rates for FY 2012
12/19/11	11/17/11	CA SPA 05-010	Approval of SPA to remove supervision requirements for credentialed speech-language pathologists.
12/19/11	12/08/11	OH SPA 11-012	Approval of SPA implements mandatory pre-print pages describing the State's plan to implement an asset verification system.
12/19/11	12/08/11	PA SPA 11-013	Approval of SPA to modify its rate setting methodology for its Program of All Inclusive Care for the Elderly (PACE) Program. The Commonwealth currently reimburses at a percentage (85%) of the UPL. PA will determine the statewide PACE rates annually after negotiation with the PACE organizations. The SPA provides that the rates will be a percentage of the UPL which is less than the UPL rate.

Due Date	CO Date Received	SPA/waiver number	OSN description
12/22/11	12/07/11	LA 121.05.05	Approval of HCBS waiver amendment to change the units of time providers can bill and revise how they manage the waiting list for the waiver
12/22/11	12/08/11	FL SPA 08-017	Approval of SPA reducing outpatient hospital rates for FYE 9/30/09. It exempts certain classes of hospitals from outpatient reimbursement ceilings based on utilization thresholds and services provided.
12/25/11	12/09/11	WA SPA 11-031	Approval of SPA that enacts a 7% increase in rates for all 17 levels of Medicaid rates paid to Licensed Boarding Homes that have contracts to provide Assisted Living, Adult Residential Care, and Enhanced Adult Residential Care services.
12/26/11	12/06/11	KS SPA 11-12	Approval of SPA to allow Licensed Clinical Addictions Counselors to be enrolled and reimbursed by Medicaid
12/27/11	12/07/11	AR SPA 11-09	Approval of SPA to implement comprehensive tobacco cessation services for pregnant women
12/27/11	12/9/11	TX 0403.01.05	Approval of 1915 (c) waiver amendment would increase factor c to reflect the projected unduplicated count for waiver year 5; and revised Appendix J to reflect the projected unduplicated count for waiver year 5 and demonstrate cost neutrality.
12/27/11	12/13/11	NH 0060.R05.03	Approval of 1915 (c) waiver amendment to establish a new service definition for non-medical transportation to enable participants to gain access to community services and resources as specified in the plan of care.
12/28/11	11/17/11	AZ SPA 11-009B	Approval of SPA to reduce outpatient hospital rates by 5%. This amendment is one of several rate reduction SPAs.
12/28/11	11/17/11	AZ SPA 11-009C	Approval of SPA to reduce rates by 5% for an array of services including lab/x-ray, dental, family planning, behavioral health, and others. This amendment is one of several rate reduction SPAs.
12/28/11	11/18/11	MI 4119.R05.01	Approval of HCBS waiver amendment for the Children's Waiver program to: (1) reflect CMS' approval of a 1915(b)(4) waiver, MI-16, (2) increase Factor C and institute an any-point-in-time limit, for waiver years 2-5; and (3) revises amount, frequency, and duration of respite services.
12/28/11	11/21/11	MA SPA 11-008	Approval of SPA to implement section 2302 related to concurrent hospice care for children.
12/28/11	11/28/11	MD SPA 11-20	Approval of SPA to deem coverage for newborns of all women whose births are covered by Medicaid, including an alien for labor and deliver as an emergency medical service.
12/28/11	12/01/11	ND SPA 11-020	Approval of SPA to cover the connectivity code billed by enrolled providers who render covered services

Due Date	CO Date Received	SPA/waiver number	OSN description
			via telemedicine, and adds home health telemonitoring as a covered service.
12/28/11	12/07/11	MA SPA 11-010	Approval of SPA to implement freestanding birth centers
12/28/11	12/08/11	A SPA 11-00	Approval of SPA to modify the description of dentures in the plan. This amendment doesn't change the current coverage of dental care or dentures, but it removes the reference to e tractions and alveoloplasty in preparation for dentures from the description of denture services as these are covered under dental services.
12/28/11	12/0 /11	WA SPA 11-023	Approval of SPA to re-establish the School- ased Healthcare Services program for children in special education. These services had previously been eliminated from coverage effective 1/1/11 due to budgetary constraints.
12/28/11	12/13/11	WI SPA 11-05	Approval of SPA raises the Medicaid e emption amount fro irrevocable burial trust from 3k to .5
12/29/11	11/10/11	N SPA 11-0	Approval of SPA to implement tobacco cessation services for pregnant women
12/29/11	11/25/11	IN 0378.R02.02	Approval of HC S waiver amendment to developmental disabilities waiver. The amendment modifies provider qualifications to require accreditation, add a new reserved waiver capacity category, and define contractor responsibilities (fiscal agent, eligibility contractor, case management agency)
12/29/11	11/30/11	NY SPA 11-73	Approval of SPA to reimburse pharmacies for diabetes self-management training provided by a licensed pharmacist who is affiliated with an accredited pharmacy
12/29/11	12/02/11	WA SPA 11-007	Approval of SPA to implement concurrent hospice care for children, and provide comprehensive coverage language in the State plan for hospice services.
12/29/11	12/ /11	T SPA 11-023-C	Approval of SPA to revise the payment methodology for all hospitals for outpatient services to comply with Medicare OPPS 2011 payment provisions.
12/31/11	12/01/11	UT 01.R15	Approval of 1 15(b) waiver renewal for 5 years a prepaid mental health plan waiver, with no substantive changes to the waiver.
12/31/11	12/ /11	UT 02.R0	Approval of 1 15(b) waiver renewal for 5 years a physical health waiver, with no substantive changes to the waiver.
01/02/12	12/13/11	CO SPA 11-012	Approval of SPA to add language to cover the costs of monitoring equipment used to monitor and manage the client's care
01/04/12	12/07/11	NC SPA 11-0	Approval of SPA to eliminate optional adult optical services

Due Date	CO Date Received	SPA/waiver number	OSN description
01/10/12	12/08/11	WA 00 .R0 .02	Approval of 1 15(c) waiver amendment to change the administrative authority responsibility from the Aging and Disability Services Administration (ADSA) to the Health Care Authority (HCA) which is the single State Medicaid Agency/
02/06/12	11/30/11	NE SPA 11-30	Approval of SPA to change the current tribal consultation response timeframe language from 0 days to 30 days.
02/19/12	12/13/11	MI SPA 10-010	Approval of SPA to implement a non-emergency medical transportation program.

FL- 08-017 90th Day 12/22/11

Holly, Mary V. (CMS/CMCHO)

From: CMS OSN
Sent: Thursday, December 08, 2011 3:52 PM
To: Payne, Candice J. (CMS/CMCS); Armstead, Sherry D. (CMS/CMCS); CMS OSN
Cc: Pratt, Theresa A. (CMS/CMCS); Hentz, Cynthia J. (CMS/CMCS); CMS R5DMCHOP2; Allen, Richard C. (CMS/CMCHO); Battaglia, Laurie H. (CMS/CPI); Bosstick, Suzanne R. (CMS/CMCS); Brown, Carolyn D. (CMS/MC); Couch, Thomas R. (CMS/SC); Crystal, Frances C. (CMS/CMCS); Easley, Marguerite (CMS/CMCHO); Egan, Roseanne (CMS/CMHPO); Fan, Kristin A. (CMS/CMCS); Farrell, Billy B. (CMS/SC); Farris, James R. (CMS/CQISCO); Fico, Joseph A. (CMS/WC); Franklin, Shantell L. (CMS/MC); Freund, Alan F. (CMS/CMCHO); Garner, Angela D. (CMS/CMCS); Garner, Jackie S. (CMS/CMCHO); Gaskins, Sheri P. (CMS/CMCS); Glaze, Jackie L. (CMS/CMCHO); Hain, Ginni M. (CMS/CMCS); Hardwick, Claire M. (CMS/CMCS); Hatcher, Karen S. (CMS/MC); Hughes, Ruth A. (CMS/CMCHO); John, Abraham (CMS/CMCS); Johnson, Verlon (CMS/OA); Kahn, Mary M. (CMS/OEA); Lee, Hye Sun (CMS/CMCHO); Lloyd, Beth E. (CMS/CMCS); Mackay, Charles K. (CMS/CMCS); Marks, Marsha L. (CMS/SC); Mccloy, Tamara M. (CMS/CMHPO); McGreal, Richard R. (CMS/NC); McKesson, Ruth M. (CMS/CMCS); Meacham, David L. (CMS/WC); Melendez, Michael (CMS/CMCHO); Mertel, Jan E. (CMS/WC); Meyers, Anna C. (CMS/CMCS); Mirach, Harry A. (CMS/CMCHO); Nagle, Gloria (CMS/CMCHO); Noonan, Darlene F. (CMS/CMCHO); OConnor, Nancy B. (CMS/CMHPO); Poisal, Kathryn J. (CMS/CMCS); Pratt, Theresa A. (CMS/CMCS); Reed, Larry L. (CMS/CMCS); Reed, Maria R. (CMS/CMCS); Reese, Yolanda (CMS/CMCS); Scott, James G. (CMS/CMCHO); Smith, Carrie A. (CMS/CMCS); Strauss, Richard (CMS/CMCS); Tarantino, Jan V. (CMS/OCSQ); Tavener, Linda A. (CMS/CMCS); Trudel, Roy R. (CMS/CMCS); Truman, Joel S. (CMS/CPI); Wilson, Derrick A. (CMS/OEA); Alberino, Julie R. (CMS/CMCHO); Holligan, Ricardo E. (CMS/NC); Khan, Farooq A. (CMS/OSORA); Turner, Trudy J. (CMS/WC); Boston, Beverly A. (CMS/CMCS); Nose, Stephen (CMS/WC); Allen, Richard C. (CMS/CMCHO); Holly, Mary V. (CMS/CMCHO); Grano, Nancy E. (CMS/NC); Garner, Angela D. (CMS/CMCS); Harris, Monica F. (CMS/CPI); Keller, Betty S. (CMS/CMCS); Hoang, Dzung A. (CMS/CMCHO); Holmes, William J. (CMS/WC); Corddry, Mary C. (CMS/CMCS); Riddle, Cynthia A. (CMS/CMCHO); Peverly, Carol J. (CMS/CMCHO); McCarthy, Daniel P. (CMS/CMCS); Marchioni, Mary A. (CMS/WC); Gerhardt, Christine R. (CMS/CMCS); Rich, Irvin J. (CMS/NC); Heffron, Dianne E. (CMS/CMCS); Klimon, Nancy L. (CMS/CMCS); Billy, Indy A. (CMS/CMCS); Gerrits, Diane T. (CMS/CMCS); Randle, Ronetta D. (CMS/CMCS); Boben, Paul J. (CMS/CMCS); Harris, Melissa L. (CMS/CMCS); Chen, Jenny C. (CMS/CMCHO); Jones, Mary B. (CMS/WC); Hicks, Daphne D. (CMS/CMCHO); Taube, Angela B. (CMS/CMCS); Mills, Stephen C. (CMS/NC); Williams, Barbara A. (CMS/CMCS); Williamson, Barbara (CMS/CMCHO); Weidler, Timothy A. (CMS/MC); Hughes, Ruth A. (CMS/CMCHO); Watchorn, Marge L. (CMS/CMCS); Dobson, Camille (CMS/CMCS); Buress, Sharonda L. (CMS/CMCS); Holt, Kathryn (CMS/CMCHO); McCarthy, Julie (CMS/CMCHO); Gilbert, Rosario G. (CMS/SC); Moore, Tonya A. (CMS/CMCS); Corbin, Angela T. (CMS/CMCS); CMS SPA_Waivers_Seattle_R10; Gillette, Nicole (CMS/CMCS); Anthony, Jodie M. (CMS/CMCS); Proper, Cindy M.(CMS/CMCS); Taube, Angela B. (CMS/CMCS); Tankersley, Michael (CMS/CMCS); Ker, Kara (CMS/CMCS); Jarosinski, Donna Y. (CMS/CMCS); Mikow, Asher S. (CMS/CMCS); McCarthy, Robert D. (CMS/CMCHO); Feild, Rosemary A. (CMS/NC); Fine, Joseph L. (CMS/CMCS); Chickering, Maria (CMS/CDMCHO); Kaufman, Nicole L. (CMS/CMCS); Straley, Kyle (CMS/MC); Garza, Maria I. (CMS/WC); Joyce, Tannisse L. (CMS/MC); McGreal, Richard R. (CMS/NC); Glaze, Jackie L. (CMS/CMCHO); Johnson, Verlon (CMS/OA); Brooks, Bill D. (CMS/CMCHO); Scott, James G. (CMS/CMCHO); Allen, Richard C. (CMS/CMCHO); Nagle, Gloria (CMS/CMCHO); Jensen, Richard (CMS/CMCS); Nablo, Linda (CMS/CMCS); Lillie-Blanton, Marsha D. (CMS/CMCS); Hain, Ginni M. (CMS/CMCS); Lollar, Ralph F. (CMS/CMCS); Reed, Larry L. (CMS/CMCS); Hall, Mike. (CMS/CMCS); Pratt, Theresa A. (CMS/CMCS); Olin, Elaine M. (CMS/CMCS); Freeze, Janet G. (CMS/CMCS); Heffron, Dianne E. (CMS/CMCS); Wachino, Victoria A. (CMS/CMCS); Reed, Maria R. (CMS/CMCS); Ryan, Jennifer (CMS/CMCS); Jensen, Richard (CMS/CMCS); Lillie-Blanton, Marsha D. (CMS/CMCS); Edwards, Barbara C. (CMS/CMCS); Burnett, Jennifer (CMS/CMCS); Williams, John H. (CMS/CMCS); Raschke, Karen S. (CMS/CMCS); Gorman, James L. (CMS/CMCS); Hulbert, Melissa S. (CMS/CMCS); Perkins, Ronald W. (CMS/CMCS); DaSilva, Gilson F. (CMS/CMCHO); Novo, Don (CMS/CMCHO); Guhl, John R. (CMS/CMCHO); Mccullough, Francis T. (CMS/CMCHO); Cooley, Mark S. (CMS/CMCS); Siler-Price, Mara (CMS/CMCHO); Friedman, Richard H. (CMS/CMCS); Schmidt, Donna W. (CMS/CMCS); Strom, Mandy L. (CMS/MC); Ambrosini,

Cc:	Ellen M. (CMS/CMCS); Sciulli, Margherita R. (CMS/CMCS); Armstead, Sherry D. (CMS/CMCS)
Subject:	OSN's Received 12/08/11
Attachments:	FL OSN 08-017 (REVISED 12 03 2011) (2).docx; AK11-006 OSN.DOCX; GU 11-004 OSN 12-7-11.docx; hbp OH SPA 11-012 OSN.DOCX; OSN WA 0049 R06 02.doc

Sherry, the following notifications have been received for OCD approval. Please have these OSNs reviewed and reply to all once approval has been determined. Thanks.

FMG
Florida SPA 08-017 – 90th day 12/22

CAHPG
Alaska SPA 11-006 90th day 12/28
Guam (GU) SPA 11-004 - 90th day 01/04
Ohio SPA 11-012 – 90th day 12/19

DEHPG/DLTSS
Washington Community Options Program Entry System (COPES) Waiver Number 0049.R06.02 - 90th day 01/10

OS Notification
December 7, 2011

State/Title/Plan Number: Florida State Plan Amendment 08-017 - Outpatient Hospital Reimbursement payment methodology

Type of Action: Approval

Required Date for State Notification: The 90th day is December 22, 2011

Fiscal Impact: FFY 2007-08 - $ (3,553,013) FFY 2008-09 - $ (15,721,736)

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: N/A

Number of Potential Newly Eligible People: N/A or **Eligibility Simplification:** No

Provider Payment Increase: No **or Decrease:** Yes

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: None

Reduces Benefits: No –

Detail:
Effective July 1, 2008 this amendment proposes to reduce outpatient hospital rates to achieve a savings of $45,504,314 total funds for Federal fiscal year ending September 30, 2009. The amendment also exempts certain classes of hospitals from outpatient reimbursement ceilings based on utilization thresholds and services provided. This reduction will be reduced by any funds provided by local governments through intergovernmental transfers (IGTs). The State estimates that for Federal Fiscal year ending September 30, 2009 the increased IGTs from local governments of $4,849,717 plus the federal match of $6,038,736 for a total of $10,888,453 will minimize the reductions for certain categories of hospitals.

Florida utilizes several sources for the state matching funds for Medicaid payments including both Local Government funds as well as State funds. Outlined below are the sources of funds for State Fiscal Year ending 06/30/2009.

General Funds	**$91,147,031**
Tobacco Settlement Funds	**$25,329,039**
Local Government Funds	**$71,309,086**
Public Assistance Funds	**$75,000,000 (Provider Tax)**
Total State Funds	**$262,785,156**
Total Federal Funds	**$328,391,655**
Total All Funds	**$591,176,811**

The increased state match from local governments that supports this amendment is outlined below. For the detailed explanation above these amounts have been adjusted from the 12 months of the state fiscal year to the 15 months that match the Federal Fiscal year for purposes of determining the FFP impact for the CMS 179.

Buyback:

Broward Health	$370,278
Memorial Health System	$366,725
Shands Jacksonville	$268,070
Shands Gainsville	$560,519
Childrens Hospital	$2,317,520
Rural Hospitals	$966,606
Total	$4,849,717

Delays in the approval of this SPA resulted from the State's need to prepare an acceptable Upper Payment Limit Demonstration. This plan has companion inpatient spa FL-08-016.

Recovery Act Impact: Based on the information provided by the State, there are no issues regarding: 1) MOE; 2) local Match; 3) prompt pay; 4) rainy day funds; or 5) eligible expenditures (e.g. no DSH or other enhance match payments). The funding questions were answered satisfactorily. The State is not in violation of the Recovery Act requirements noted above as ARRA was not enacted until 2009.

Other Considerations: None

CMS Contact: Jackie Glaze
Associate Regional Administrator – Atlanta RO
Division of Medicaid and Children's Health Operations
404-562-7417

Holly, Mary V. (CMS/CMCHO)

From: Holly, Mary V. (CMS/CMCHO)
Sent: Tuesday, December 06, 2011 10:33 AM
To: CMS OSN
Cc: Graves, Donald (CMS/CMCHO); Gaskins, Sheri P. (CMS/CMCS); Hawkins, Etta (CMS/CMCHO); Staton, Sidney H. (CMS/CMCHO); Kimble, Davida R. (CMS/CMCHO); Gilbert, Rosario G. (CMS/SC)
Subject: FW: FL-08-017 Outpatient Hospital Reimbursement payment methodology
Attachments: FL OSN 08-017.docx

Region 4 would like to withdraw the attached FL-08-017 OSN sent on 12/02/11.

From: Holly, Mary V. (CMS/CMCHO)
Sent: Friday, December 02, 2011 1:31 PM
To: CMS OSN
Cc: Graves, Donald (CMS/CMCHO); Hawkins, Etta (CMS/CMCHO); Staton, Sidney H. (CMS/CMCHO); Kimble, Davida R. (CMS/CMCHO); Gilbert, Rosario G. (CMS/SC)
Subject: FL-08-017 Outpatient Hospital Reimbursement payment methodology

Approval Florida State Plan Amendment # 08-017 Outpatient Hospital Reimbursement payment methodology.

Required Date for State Notification: December 22, 2011.

FL-08-017 90th day = 12/20/11

Holly, Mary V. (CMS/CMCHO)

From: CMS OSN
Sent: Friday, December 02, 2011 3:36 PM
To: Payne, Candice J. (CMS/CMCS); CMS OSN
Cc: Pratt, Theresa A. (CMS/CMCS); Hentz, Cynthia J. (CMS/CMCS); CMS R5DMCHOP2; Allen, Richard C. (CMS/CMCHO); Battaglia, Laurie H. (CMS/CPI); Bosstick, Suzanne R. (CMS/CMCS); Brown, Carolyn D. (CMS/MC); Couch, Thomas R. (CMS/SC); Crystal, Frances C. (CMS/CMCS); Easley, Marguerite (CMS/CMCHO); Egan, Roseanne (CMS/CMHPO); Fan, Kristin A. (CMS/CMCS); Farrell, Billy B. (CMS/SC); Farris, James R. (CMS/CQISCO); Fico, Joseph A. (CMS/WC); Franklin, Shantell L. (CMS/MC); Freund, Alan F. (CMS/CMCHO); Garner, Angela D. (CMS/CMCS); Garner, Jackie S. (CMS/CMCHO); Gaskins, Sheri P. (CMS/CMCS); Glaze, Jackie L. (CMS/CMCHO); Hain, Ginni M. (CMS/CMCS); Hardwick, Claire M. (CMS/CMCS); Hatcher, Karen S. (CMS/MC); Hughes, Ruth A. (CMS/CMCHO); John, Abraham (CMS/CMCS); Johnson, Verlon (CMS/OA); Kahn, Mary M. (CMS/OEA); Lee, Hye Sun (CMS/CMCHO); Lloyd, Beth E. (CMS/CMCS); Mackay, Charles K. (CMS/CMCS); Marks, Marsha L. (CMS/SC); Mccloy, Tamara M. (CMS/CMHPO); McGreal, Richard R. (CMS/NC); McKesson, Ruth M. (CMS/CMCS); Meacham, David L. (CMS/WC); Melendez, Michael (CMS/CMCHO); Mertel, Jan E. (CMS/WC); Meyers, Anna C. (CMS/CMCS); Mirach, Harry A. (CMS/CMCHO); Nagle, Gloria (CMS/CMCHO); Noonan, Darlene F. (CMS/CMCHO); OConnor, Nancy B. (CMS/CMHPO); Poisal, Kathryn J. (CMS/CMCS); Pratt, Theresa A. (CMS/CMCS); Reed, Larry L. (CMS/CMCS); Reed, Maria R. (CMS/CMCS); Reese, Yolanda (CMS/CMCS); Scott, James G. (CMS/CMCHO); Smith, Carrie A. (CMS/CMCS); Strauss, Richard (CMS/CMCS); Tarantino, Jan V. (CMS/OCSQ); Tavener, Linda A. (CMS/CMCS); Trudel, Roy R. (CMS/CMCS); Truman, Joel S. (CMS/CPI); Wilson, Derrick A. (CMS/OEA); Alberino, Julie R. (CMS/CMCHO); Holligan, Ricardo E. (CMS/NC); Khan, Farooq A. (CMS/OSORA); Turner, Trudy J. (CMS/WC); Boston, Beverly A. (CMS/CMCS); Nose, Stephen (CMS/WC); Allen, Richard C. (CMS/CMCHO); Holly, Mary V. (CMS/CMCHO); Grano, Nancy E. (CMS/NC); Garner, Angela D. (CMS/CMCS); Harris, Monica F. (CMS/CPI); Keller, Betty S. (CMS/CMCS); Hoang, Dzung A. (CMS/CMCHO); Holmes, William J. (CMS/WC); Corddry, Mary C. (CMS/CMCS); Riddle, Cynthia A. (CMS/CMCHO); Peverly, Carol J. (CMS/CMCHO); McCarthy, Daniel P. (CMS/CMCS); Marchioni, Mary A. (CMS/WC); Gerhardt, Christine R. (CMS/CMCS); Rich, Irvin J. (CMS/NC); Heffron, Dianne E. (CMS/CMCS); Klimon, Nancy L. (CMS/CMCS); Billy, Indy A. (CMS/CMCS); Gerrits, Diane T. (CMS/CMCS); Randle, Ronetta D. (CMS/CMCS); Boben, Paul J. (CMS/CMCS); Harris, Melissa L. (CMS/CMCS); Chen, Jenny C. (CMS/CMCHO); Jones, Mary B. (CMS/WC); Hicks, Daphne D. (CMS/CMCHO); Taube, Angela B. (CMS/CMCS); Mills, Stephen C. (CMS/NC); Williams, Barbara A. (CMS/CMCS); Williamson, Barbara (CMS/CMCHO); Weidler, Timothy A. (CMS/MC); Hughes, Ruth A. (CMS/CMCHO); Watchorn, Marge L. (CMS/CMCS); Dobson, Camille (CMS/CMCS); Buress, Sharonda L. (CMS/CMCS); Holt, Kathryn (CMS/CMCHO); McCarthy, Julie (CMS/CMCHO); Gilbert, Rosario G. (CMS/SC); Moore, Tonya A. (CMS/CMCS); Corbin, Angela T. (CMS/CMCS); CMS SPA_Waivers_Seattle_R10; Gillette, Nicole (CMS/CMCS); Anthony, Jodie M. (CMS/CMCS); Proper, Cindy M.(CMS/CMCS); Taube, Angela B. (CMS/CMCS); Tankersley, Michael (CMS/CMCS); Ker, Kara (CMS/CMCS); Jarosinski, Donna Y. (CMS/CMCS); Mikow, Asher S. (CMS/CMCS); McCarthy, Robert D. (CMS/CMCHO); Feild, Rosemary A. (CMS/NC); Fine, Joseph L. (CMS/CMCS); Chickering, Maria (CMS/CDMCHO); Kaufman, Nicole L. (CMS/CMCS); Straley, Kyle (CMS/MC); Garza, Maria I. (CMS/WC); Joyce, Tannisse L. (CMS/MC); McGreal, Richard R. (CMS/NC); Glaze, Jackie L. (CMS/CMCHO); Johnson, Verlon (CMS/OA); Brooks, Bill D. (CMS/CMCHO); Scott, James G. (CMS/CMCHO); Allen, Richard C. (CMS/CMCHO); Nagle, Gloria (CMS/CMCHO); Jensen, Richard (CMS/CMCS); Nablo, Linda (CMS/CMCS); Lillie-Blanton, Marsha D. (CMS/CMCS); Hain, Ginni M. (CMS/CMCS); Lollar, Ralph F. (CMS/CMCS); Reed, Larry L. (CMS/CMCS); Hall, Mike. (CMS/CMCS); Pratt, Theresa A. (CMS/CMCS); Olin, Elaine M. (CMS/CMCS); Freeze, Janet G. (CMS/CMCS); Heffron, Dianne E. (CMS/CMCS); Wachino, Victoria A. (CMS/CMCS); Reed, Maria R. (CMS/CMCS); Ryan, Jennifer (CMS/CMCS); Jensen, Richard (CMS/CMCS); Lillie-Blanton, Marsha D. (CMS/CMCS); Edwards, Barbara C. (CMS/CMCS); Burnett, Jennifer (CMS/CMCS); Williams, John H. (CMS/CMCS); Raschke, Karen S. (CMS/CMCS); Gorman, James L. (CMS/CMCS); Hulbert, Melissa S. (CMS/CMCS); Perkins, Ronald W. (CMS/CMCS); DaSilva, Gilson F. (CMS/CMCHO); Novo, Don (CMS/CMCHO); Guhl, John R. (CMS/CMCHO); Mccullough, Francis T. (CMS/CMCHO); Cooley, Mark S. (CMS/CMCS); Siler-Price, Mara (CMS/CMCHO); Friedman, Richard H. (CMS/CMCS); Schmidt, Donna W. (CMS/CMCS); Strom, Mandy L. (CMS/MC); Ambrosini,

Withdrawn DSN on 12/06/11.

OS Notification
November 17, 2011

State/Title/Plan Number: Florida State Plan Amendment 08-017
To amend Outpatient Hospital Reimbursement payment methodology

Type of Action: Approval

Required Date for State Notification: The 90th day is December 22, 2011

Fiscal Impact: FFY 2007-08 - $ (2,014,000) FFY 2008-09 - $ (9,442,000)

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: N/A

Number of Potential Newly Eligible People: N/A or **Eligibility Simplification:** No

Provider Payment Increase: No **or Decrease:** No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: None

Reduces Benefits: No -

Detail:

This State Plan Amendment is effective July 1, 2009. This SPA revises the payment methodology for outpatient hospital payments in order to achieve a recurring rate reduction and to allow hospitals to buy back their rate reductions if they meet certain criteria.

Delays in the approval of this SPA resulted from the State's need to prepare an acceptable Upper Payment Limit Demonstration.

Recovery Act Impact: Based on the information provided by the State, there are no issues regarding: 1) MOE; 2) local Match; 3) prompt pay; 4) rainy day funds; or 5) eligible expenditures (e.g. no DSH or other enhance match payments). The funding questions were answered satisfactorily. The State is not in violation of the Recovery Act requirements noted above as ARRA was not enacted until 2009.

Other Considerations: None

CMS Contact: Jackie Glaze
Associate Regional Administrator – Atlanta RO
Division of Medicaid and Children's Health Operations
404-562-7417

OS Notification
November 17, 2011

State/Title/Plan Number: Florida State Plan Amendment 08-017 – SPA Purpose

Type of Action: Approval

Required Date for State Notification: The 90th day is ~~November~~ Dec 22, 2011

Fiscal Impact: FFY 2007-08 - $ (2,014,000) FFY 2008-09 - $ (9,442,000)

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: N/A

Number of Potential Newly Eligible People: N/A or **Eligibility Simplification:** No

Provider Payment Increase: No **or Decrease:** No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: None

Reduces Benefits: No -

Detail:

This State Plan Amendment is effective July 1, 2009. This SPA revises the payment methodology for outpatient hospital payments in order to achieve a recurring rate reduction and to allow hospitals to buy back their rate reductions if they meet certain criteria.

Delays in the approval of this SPA resulted from the State's need to prepare an acceptable Upper Payment Limit Demonstration.

Recovery Act Impact: Based on the information provided by the State, there are no issues regarding: 1) MOE; 2) local Match; 3) prompt pay; 4) rainy day funds; or 5) eligible expenditures (e.g. no DSH or other enhance match payments). The funding questions were answered satisfactorily. The State is not in violation of the Recovery Act requirements noted above as ARRA was not enacted until 2009.

Other Considerations: None

CMS Contact: Jackie Glaze
Associate Regional Administrator – Atlanta RO
Division of Medicaid and Children's Health Operations
404-562-7417

Cc: Ellen M. (CMS/CMCS); Sciulli, Margherita R. (CMS/CMCS)
Subject: OSN's Received 12/02/11
Attachments: AK11-003 OSN.DOCX; FL OSN 08-017.docx; ID11-010 OSN.DOCX; OSN WA11-007.doc

Candice, the following notifications have been received for OCD approval. Please have these OSNs reviewed and reply to all once approval has been determined. Thanks.

FMG
Alaska SPA 11-003 – 90th day 12/22
Florida SPA 08-017– 90th day 12/22
Idaho SPA 11-010 – 90th 12/16
Washington SPA 11-007 – 12/29

OS Notification
December 2, 2011

State/Title/Plan Number: Florida State Plan Amendment 08-017
To amend Outpatient Hospital Reimbursement payment methodology

Type of Action: Approval

Required Date for State Notification: The 90th day is December 22, 2011

Fiscal Impact: FFY 2007-08 - $ (2,014,000) FFY 2008-09 - $ (9,442,000)

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: N/A

Number of Potential Newly Eligible People: N/A or **Eligibility Simplification:** No

Provider Payment Increase: No **or Decrease:** No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: None

Reduces Benefits: No -

Detail:

This State Plan Amendment is effective July 1, 2009. This SPA revises the payment methodology for outpatient hospital payments in order to achieve a recurring rate reduction and to allow hospitals to buy back their rate reductions if they meet certain criteria.

Delays in the approval of this SPA resulted from the State's need to prepare an acceptable Upper Payment Limit Demonstration.

Recovery Act Impact: Based on the information provided by the State, there are no issues regarding: 1) MOE; 2) local Match; 3) prompt pay; 4) rainy day funds; or 5) eligible expenditures (e.g. no DSH or other enhance match payments). The funding questions were answered satisfactorily. The State is not in violation of the Recovery Act requirements noted above as ARRA was not enacted until 2009.

Other Considerations: None

CMS Contact: Jackie Glaze
Associate Regional Administrator – Atlanta RO
Division of Medicaid and Children's Health Operations
404-562-7417

FL-08-017 90th day 12/22/11

Holly, Mary V. (CMS/CMCHO)

From:	Holly, Mary V. (CMS/CMCHO)
Sent:	Friday, December 02, 2011 1:31 PM
To:	CMS OSN
Cc:	Graves, Donald (CMS/CMCHO); Hawkins, Etta (CMS/CMCHO); Staton, Sidney H. (CMS/CMCHO); Kimble, Davida R. (CMS/CMCHO); Gilbert, Rosario G. (CMS/SC)
Subject:	FL-08-017 Outpatient Hospital Reimbursement payment methodology
Attachments:	FL OSN 08-017.docx

Approval Florida State Plan Amendment # 08-017 Outpatient Hospital Reimbursement payment methodology.

Required Date for State Notification: December 22, 2011.

OS Notification
December 2, 2011

State/Title/Plan Number: Florida State Plan Amendment 08-017
To amend Outpatient Hospital Reimbursement payment methodology

Type of Action: Approval

Required Date for State Notification: The 90th day is December 22, 2011

Fiscal Impact: FFY 2007-08 - $ (2,014,000) FFY 2008-09 - $ (9,442,000)

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: N/A

Number of Potential Newly Eligible People: N/A or **Eligibility Simplification:** No

Provider Payment Increase: No **or Decrease:** No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: None

Reduces Benefits: No -

Detail:

This State Plan Amendment is effective July 1, 2009. This SPA revises the payment methodology for outpatient hospital payments in order to achieve a recurring rate reduction and to allow hospitals to buy back their rate reductions if they meet certain criteria.

Delays in the approval of this SPA resulted from the State's need to prepare an acceptable Upper Payment Limit Demonstration.

Recovery Act Impact: Based on the information provided by the State, there are no issues regarding: 1) MOE; 2) local Match; 3) prompt pay; 4) rainy day funds; or 5) eligible expenditures (e.g. no DSH or other enhance match payments). The funding questions were answered satisfactorily. The State is not in violation of the Recovery Act requirements noted above as ARRA was not enacted until 2009.

Other Considerations: None

CMS Contact: Jackie Glaze
Associate Regional Administrator – Atlanta RO
Division of Medicaid and Children's Health Operations
404-562-7417

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

CENTERS for MEDICARE & MEDICAID SERVICES

MEMORANDUM

Date: November 21, 2011

To: Jackie Glaze, Associate Regional Administrator
Division of Medicaid and Children's Health

From: Donald Graves, Financial Management Specialist
Division of Medicaid and Children's Health
Etta Hawkins, State Coordinator
Division of Medicaid and Children's Health

Subject: Florida 08-017- Approval

Background

This amendment is on the 2nd clock. The formal RAI was received on September 23, 2011; the 90th day is December 22, 2011. This SPA was initially submitted on September 23, 2008 with a stated purpose of amending the Title XIX Outpatient Hospital Reimbursement Plan payment methodology, effective July 1, 2008, in accordance with Florida House Bill 5001, 2008-09 General Appropriations Act, and specific Florida Appropriation 211 and House Bill 5085, Section 5, which amended Section 409.908 of Florida State Statutes. Based on the HCFA 179 submitted by the State, Federal budget impact would be neutral -$2,014,000 in FFY 2007-08; and -$9,492,000 in FFY 2008-09. Processing of this SPA was delayed because CMS requested a full UPL Demonstration. The State complied with a successfully completed a UPL Demonstration during the processing of this SPA.

Issues Identified during Review

Issue we identified during the review included: 1) clarification of language and changes ; 2) explanation for the State's buy-back provisions and the Medicaid Trend Adjustment; and 3) development and submission of a UPL Demonstration; and 4) appropriately updating the affected pages of the State Plan. The State responded to the Standard Funding Questions and the responses were satisfactory. ARRA, access and the Tribal questions do not apply as this SPA was submitted prior to the enactment of the American Recovery and Reinvestment Act (ARRA), which occurred on February 17, 2009.

179 pen and ink changes:

No pen and ink changes were requested.

Significant Notation:

The (draft) OSN has already been forwarded to CO for coordination purposes. The draft letter to the State is dated December 2, 2011 to allow ample time for processing. (These items are referred to as draft until signed by the ARA).

Recommendation
We recommend approval of this State Plan Amendment.

If NIPT SPA, is checklist attached? Yes ☑ No ☐

State Representative: Concur/Approve Yes ☑ No ☐ Non- concur/Disapprove (Provide rationale)

Etta Hawkins 11/29/11
Etta Hawkins, State Coordinator

NIPT Representative: Concur/Approve Yes ☑ No ☐ Non- concur/Disapprove (Provide rationale)

Etta Hawkins for Donald Graves
Donald Graves, RO NIPT Lead

Branch Chief: Concur/Approve Yes ☑ No ☐ Non-Concur/Disapprove (Provide rationale)

Clarence Lam acting FMB1 manager for Davida Kimble
Davida Kimble, Branch Chief
Financial & Program Management Branch 1

ARA: Concur/Approve 11/29/11 Yes ☐ No ☐ Non-Concur/Disapprove (Provide rationale)

Jackie Glaze
Jackie Glaze
Associate Regional Administrator

FL-08-017

Holly, Mary V. (CMS/CMCHO)

From: Elmore, Elaine (CMS/CMCHO)
Sent: Monday, June 08, 2009 4:23 PM
To: Holly, Mary V. (CMS/CMCHO)
Cc: Moore, Yvette (CMS/SC); Halter, Mark D. (CMS/MC)
Subject: FW: FL SPAs 08-016, 08-017,08-018, and 08-019

FYI

From: Freeze, Janet G. (CMS/CMSO)
Sent: Monday, June 08, 2009 3:48 PM
To: Ingram, Robin; Hudson, Michele
Cc: Hagler, Wesley; Stephens, Edwin; Williams, Phil; Elmore, Elaine (CMS/CMCHO); Halter, Mark D. (CMS/MC); FIELDS, STANLEY (CMS/SC); Gaskins, Sheri P. (CMS/CMSO); Day, Venesa J. (CMS/CMSO); Fan, Kristin A. (CMS/CMSO); Weidler, Timothy A. (CMS/MC); Tavener, Linda A. (CMS/CMSO); Freeze, Janet G. (CMS/CMSO)
Subject: RE: FL SPAs 08-016, 08-017,08-018, and 08-019

Hello Robin and Michele-

This email is a follow up to our recent discussions regarding the impact of the State withdrawing their response for additional information (RAIs) for the above referenced State Plan amendments (SPA) and the requirements to complete the upper payment limit (UPL) demonstrations. We appreciate your request to withdraw the RAIs for these four SPAs until we can finalize the plan language and the UPL demonstrations. As I committed to you during our call on June 2, outlined below is a list of issues and requirements that have been identified to date related to the review and approval of the SPAs.

SPA 08-016

As we previously discussed with you there are three methods that can be used to complete the inpatient hospital UPL demonstrations which are:

Inpatient Hospital

1. Cost – Estimate the cost of providing Medicare services to Medicaid recipients by applying the Medicare cost principles. Since you use the CMS 2552 to establish providers Medicaid rates the Medicare allowable cost can be obtained from these cost reports.
2. Payment to Discharge – Estimate the Medicare payment for Medicaid recipients by determining the average Medicare payments per Medicare discharge and applying this amount to Medicaid discharges. This method would require that you adjust for the difference in acuity between Medicare and Medicaid patients.
3. Diagnosis Related Group (DRG) – Estimate the Medicare payment for Medicaid recipients using the Medicare DRG weights and payment amounts. This method would require the use of the Medicare DRG Grouper to estimate payments.

Based on my staffs recent discussions with you and review of hospital cost report files previously provided it appears that method 1, the cost method, would be the best approach for Florida. The cost report files contain the Medicaid charge and cost information needed to complete the UPL calculations.

The other remaining items previously requested for this SPA are:
1. On page 24, item 26 you discuss the buy back provision but we cannot determine the method that will be used to apply the buy back. Please provide a description of how the methodology will work and an example of the calculation.
2. On Page 34, item 20 you the included language that an additional Medicaid Trend Adjustment shall be applied to achieve a recurring annual reduction of $154,333,435. However, this section does not describe the

methodology that will be used to attain this level of reduction. Please provide a description of the methodology that will be used to apply the reduction.

SPA 08-017

For an outpatient hospital services UPL demonstration the methods that can be used are:

Outpatient Hospital

1. Ratio of Cost to Charges – Estimate the Medicare payment for Medicaid recipients by applying the Medicare ratio of cost to charges to Medicaid charges. The Medicare ratio can be found on the CMS 2552 cost reports.
2. Ratio of Payment to Charges – Estimate the Medicare payment for Medicaid recipients by applying the Medicare ratio of payments to charges to Medicaid Charges. This information is also available from the CMS 2552 cost reports.

As noted above, the cost reports and supplemental information filed with Florida Medicaid contain the information to complete the UPL calculations using the method described in item 1.

The other remaining items previously communicated for this SPA that we request you provide are:
1. In response to RAI question #1, the State indicates that the language "Included in these funds are the annualized amounts to offset the reductions taken against certified trauma centers as identified in section 13, chapter 2007-326, Laws of Florida" instructs the agency to move forward in the same manner for SFY 2008-09. In addition, the agency describes that the Florida Legislature reduced designated or provisional Trauma Hospital's reduction from a 3% cut to a 1% cut. The language in the State plan does not adequately describe this situation regarding the rate cut of 1%. For plan comprehensiveness, the State plan should be amended to delete the "annualized amount" language and simply state that these hospitals received a 1% cut.
2. In response to RAI question #2, the State still needs to address the second point in the question which asks for clarifying language to be added to the State plan.
3. In response to RAI question #2, the State provided attachment 1 for additional details. Without proper headings or a descriptive narrative, the attachment is unclear. We request that the State revise this attachment to better match the description provided in the response to #2.
4. In response to RAI questions #2 and #3, the State provided the same response to both questions. For clarity purposes, can you elaborate on how the budgeted unit cost and calculated unit cost is determined? Can you provide a visual example to go with steps 1 thru 6. Attachment 1 is vague and does not appear to coincide with the steps provided.
5. In response to RAI question #3, the State still needs to provide SPA language that clarifies how the rates will be "established at a level to ensure no increase in statewide expenditures. . . . " We request that the State plan be amended.
6. In response to RAI question #4, the State did not adequately describe the process for the buy back provision. The State only described which hospitals are eligible to buy back their rate. We need more information on the Buy Back process itself. For example, the State plan (page 26) references that hospitals in Broward Health would receive $831,338 of the $3,515,024 budget authority. How does the $831,338 aggregate amount buy back the rate? If this amount is applied against the Broward Health's Medicaid Trend Adjustment, how and when in the process does this occur? How is the Medicaid Trend Adjustment calculated for each hospital both included and excluded in the buy back provision? More information is needed to better understand Florida's Buy Back provision and the Medicaid Trend Adjustment.
7. In response to RAI question #5, the State indicates that they pay cost by using the CMS 2552. While we agree that the State is permitted to do a cost UPL, we are unclear as to how this is achieved. We included guidance in the RAI, on the February 10, 2009 conference call, and in Stanley Fields February 12, 2009 follow up email to Michele Hudson describing typical methods states use to demonstrate a UPL. However, the State failed to provide any details or methodology for this calculation. Moreover, the State failed to include any information regarding the limit described at 1903(i)(7) for clinical diagnostic laboratory services which require that states pay no more than the Medicare fee on a per test basis. These issues remain unresolved as we have no basis in which to evaluate the State's cost based UPL as required at 42 CF 447.321.

SPA 08-018

For clinic services the methods that can be used to complete the UPL calculations are:

Clinic Services

1. Medicare Payment—Estimate the Medicare payment for Medicaid recipients by comparing the non-facility professional fee for service rate from the RBRVS system to the Medicaid rate on a per CPT basis.

2. Cost—The State must demonstrate that their state-developed cost report captures at least the same type of information and follows the same cost determination process as the CMS 222 and its instructions. Please refer to the RAI for 08-018 for further guidance.

Based on the draft UPL demonstration you submitted for our review you have elected to use method #2. We have reviewed the example cost report, instructions, and follow up emails and are okay with using it to demonstrate Medicaid allowable cost. However, the spreadsheet titled "County Health Department UPL", which appears to compare an old encounter rate to a new encounter rate, will need further explanation.

Our questions regarding the spreadsheet are as follows:

1. How was the initial "July 08 Prospective rate" (Col C.) determined? We were unable to trace Alachua's submitted cost report example to the UPL spreadsheet. Please provide a narrative that will aid us in tracing the reported amount from the UPL spreadsheet to Alachua's cost report.
2. How were the Medicaid Trend Adjustments calculated? Please provide a sample calculation and explain its variables.

The other remaining items previously communicated for this SPA we request that you provide are:

1. In response to RAI question #2, the State needs to address how they prepare cost reports in accordance with Medicare reimbursement principles. We are unclear about the State's cost finding methods in accordance with Medicare since Medicare does not provide for clinic cost reports outside of the FQHC Cost Report, CMS 222. As such, the State's response does not answer the question. (Note: This issue has been resolved with the email communication from Wes Hagler on 6/2/09.)
2. In response to RAI question #4, the State responded that they added a reference that their encounter rates are established in accordance with 42 CFR 440.90. We believe the State misinterpreted the question. The regulation at 440.90 is not a payment rule but a coverage rule. The question posed to the State attempted to clarify whether these county health department clinics are indeed eligible as a clinic under 440.90 and as further described in section 4320 of the State Medicaid Manual. As previously requested, the State should provide language in the SPA assuring that these clinics are in compliance with 42 CFR 440.90. The State should delete the language that was previously added to page 8 and provide the coverage assurance in an earlier section, such as in the opening paragraph under "Cost finding and Cost reporting."
3. In response to RAI question #7, the State fails to address the second point in the question which asks for clarifying language to be added to the State plan.
4. In response to RAI question #7, the State provided attachment 1 for additional details. Without proper headings or a descriptive narrative, the attachment is unclear and does not follow the methodology described in the answer to question #7. We request that the State revise this attachment to better match the description provided in the response to #7 to clearly show the rate setting process.
5. In response to RAI question #10, the State provided a blank spreadsheet with no instructions. This is not adequate to understand Florida's cost reporting process for CHDs. (Note: This issue is resolved per the 5/5/09, 5/26/09, and 6/2/09 communication from Wes Hagler.)
6. In response to RAI question #11, the State indicates that they pay cost by using the CMS 2552. While we agree that the State is permitted to do a cost UPL for clinic services, we are unclear as to how the State utilizes the CMS 2552 because this cost report is specifically for hospital services and not clinic services. We included guidance in the RAI, on the February 10, 2009 conference call, and in Stanley Fields February 12, 2009 follow up email to Michele Hudson describing typical methods states use to demonstrate a UPL. In addition, as stated in the above question, the State failed to demonstrate that their cost report and cost process follows the items outlined in question #11, items 1-5 which, among other things, asks that the State demonstrate that their report captures at least the same information as the FQHC Cost Report CMS 222. This report as discussed in this question is the most comparable cost report for clinic services. Since the State failed to provide any details or methodology for this calculation, these issues remain unresolved as we have no basis in which to evaluate the State's cost based UPL as required at 42 CF 447.321. The State should provide the information as requested above regarding the spreadsheet titled, "County Health Department UPL."
7. In response to Standard Funding Question #2, please confirm that the appropriations are to the Medicaid Agency.

Coverage Concerns with Clinic Services (sent to State 3/31/09)

As the State is aware, CMS reviews the corresponding coverage or reimbursement pages for each SPA submitted. While we have some comments and concerns regarding the coverage of the clinic services as currently found on pages 30, 30a, 30b, and 30c of Attachment 3.1-A in the FL State Plan, we have the most

concern with the coverage of birthing centers on page 30. In addition to our comments and concerns, we also want to provide some specific information about the coverage of birthing centers that may help the State in its decisions concerning this SPA.

"Birthing center services" are not a recognized service within the scope of "medical assistance" under section 1905(a) of the Social Security Act (the Act), and "birthing center facility services" are not a recognized provider type under that section. Thus, payment to birthing centers is not consistent with the requirements of sections 1902(a)(10)(A) and 1902(a)(32) of the Act. Section 1905(a) of the Act defines those services eligible for medical assistance under Medicaid, generally based on the type of provider or practitioner. Birthing centers are not a recognized type of provider or facility eligible for payment under that section. Accordingly, there is no section in the State plan applicable to birthing center services.

Nurse midwife services are a recognized service under section 1905(a)(17) of the Act. The State plan may provide for higher payments to nurse midwives practicing at birthing centers in order to recognize the higher costs that may be incurred by such nurse midwives, however, there is no authority to provide for direct payment to birthing centers for facility services. Birthing centers may receive the payments on behalf of the nurse midwife if the provisions of 42 C.F.R 447.10(g) are met. This regulation requires that for individual practitioners, payment made be made to –(1) The employer of the practitioner, if the practitioner is required as a condition of employment to turn over his fees to the employer; (2) the facility in which the service is provided, if the practitioner has contract under which the facility submits the claim.

The State includes coverage of birthing centers under the clinic benefit on page 30 of Attachment 3.1-A. While, per 42 CFR 440.90(a), clinic services are those furnished at the clinic by or under the direction of a physician or dentist, the State's response received on 3/16/09 doesn't confirm that birthing centers meet this requirement. However, birthing centers could be covered as clinics if they meet the physician supervision requirement. And, from the above information, birthing centers may bill Medicaid for the nurse midwife's services.

Therefore, in the short term, we would like for the State to advise us of:

1. Whether you want the birthing centers to be covered as clinics (which means that the birthing centers must meet the physician supervision requirement)
   Note: If the State chooses to remove the birthing centers from the clinic section in Item 9 of the SPA, it should delete page 30 of Attachment 3.1-A.
2. Whether you want the birthing center to bill Medicaid for the nurse midwife's services.

a. If the State chooses this item 2 alternative, the State should submit Attachment 3.1-A, Item 17 for Nurse Mid-Wife services along with a corresponding 4.19-B reimbursement page. In Item 17, the State can note that some of the services are provided at birthing centers and other settings.
b. If the State chooses that reimbursement for this service should be made through the nurse midwife benefit at 42 CFR 440.165 instead of the clinic benefit then either the birthing center or the nurse midwife may bill the State (42 CFR 447.10(g)) for the nurse midwife service under 1905(a)(17).

SPA 08-019

For Nursing Facility's the methods that can be used to complete the UPL calculations are:

Nursing Facility

1. Cost - Estimate the cost of providing Medicare services to Medicaid recipients by applying the Medicare cost principles. Since you use the CMS 2540 to establish providers' Medicaid rates, the Medicare allowable cost can be obtained from these cost reports.
2. Resource Utilization Groups (RUGS) – Estimate the payment of providing the Medicare services to Medicaid recipients by classifying the Medicaid recipients days using the Medicare RUGs system and pricing the days using Medicare payment amounts.

While the State elected to use the method described in number 2, Resource Utilization Groups, it is our understanding from follow up discussion you do not have access to the information through your MMIS and MDS data to accurately complete the UPL calculations using this approach. Based on our review of your cost report information for nursing facilities the ancillary, routine cost, and charge information appear to be available to complete the UPL calculations using the cost method described in item 1 above.

After you and your staff review our suggestions and the list of outstanding items, please respond with your concerns or issues regarding the completion of these tasks. CMS will then contact you to arrange a series of meetings to discuss these issues.

Thank you for your time and attention to these SPAs. As always, please let us know if we can provide further technical assistance.

Janet Freeze

From: Freeze, Janet G. (CMS/CMSO)
Sent: Wednesday, June 03, 2009 5:09 PM
To: 'Ingram, Robin'
Cc: Hudson, Michele; Hagler, Wesley; Stephens, Edwin; Williams, Phil; Elmore, Elaine (CMS/CMCHO); Halter, Mark D. (CMS/MC); FIELDS, STANLEY (CMS/SC); Gaskins, Sheri P. (CMS/CMSO); Day, Venesa J. (CMS/CMSO); Fan, Kristin A. (CMS/CMSO); Weidler, Timothy A. (CMS/MC); Tavener, Linda A. (CMS/CMSO)
Subject: RE: FL SPAs 08-016, 08-017,08-018, and 08-019

Hello Robin-

This is to acknowledge receipt of Florida's request to withdraw the RAI responses for the 4 SPAs listed. We have advised CMS leadership that the SPA disapproval packages for these SPAs can be withdrawn.

As a starting point to begin the work necessary to complete the review process for these SPAs, we will send to the State a very concise summary of where we are on each SPA that will also briefly describe CMS' suggestions to the State as to what actions are necessary to approve these SPAs. We will then schedule calls with the State in order to discuss and resolve the issues.

We appreciate your cooperation and look forward to resolving the remaining issues on these SPAs.

Janet Freeze
Janet Freeze, J.D. | Acting Director, Division of Reimbursement and State Financing | Financial Management Group | Center for Medicaid and State Operations | Centers for Medicare & Medicaid Services | 410-786-5917 | janet.freeze@cms.hhs.gov

From: Ingram, Robin [mailto:ingramr@ahca.myflorida.com]
Sent: Wednesday, June 03, 2009 4:52 PM
To: Freeze, Janet G. (CMS/CMSO)
Cc: Hudson, Michele; Hagler, Wesley; Stephens, Edwin; Williams, Phil; Elmore, Elaine (CMS/CMCHO); Halter, Mark D. (CMS/MC); FIELDS, STANLEY (CMS/SC); Gaskins, Sheri P. (CMS/CMSO); Day, Venesa J. (CMS/CMSO); Fan, Kristin A. (CMS/CMSO); Weidler, Timothy A. (CMS/MC); Tavener, Linda A. (CMS/CMSO)
Subject: RE: FL SPAs 08-016, 08-017,08-018, and 08-019

With regard to Florida SPAs 08-016, 08-017, 08-018, and 08-019, the State respectfully requests RAI responses sent to CMS 3/16/09 be withdrawn. The State also requests the 90-day clock for review of the RAIs be officially stopped, with review and discussion proceeding off the clock until resolution.

Thank you very much -

Robin R. Ingram
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mailstop #8
Tallahassee, Florida 32309
Phone: (850)414-0633
FAX: (850)488-2520

Email: ingramr@ahca.myflorida.com

Cover Florida Web Button

From: Freeze, Janet G. (CMS/CMSO) [mailto:Janet.Freeze@cms.hhs.gov]
Sent: Wednesday, June 03, 2009 2:11 PM
To: Ingram, Robin
Cc: Hudson, Michele; Hagler, Wesley; Stephens, Edwin; Williams, Phil; Elmore, Elaine (CMS/CMCHO); Halter, Mark D. (CMS/MC); FIELDS, STANLEY (CMS/SC); Gaskins, Sheri P. (CMS/CMSO); Day, Venesa J. (CMS/CMSO); Fan, Kristin A. (CMS/CMSO); Weidler, Timothy A. (CMS/MC); Tavener, Linda A. (CMS/CMSO)
Subject: RE: FL SPAs 08-016, 08-017,08-018, and 08-019

Hello Ms. Ingram-

Thank you for sending your questions. The CMS response to each question is included below:

1. *How long the State has to respond with information requested once the RAIs have been taken off the clock;*
   There is no deadline imposed on the State. However, we recommend that the State respond with requested clarifications, documentation or other information as soon as possible.

2. *How long CMS would have to act on new RAI responses from the State;*
   Technically, new RAI responses from the State would start a new 90-day clock. However, practically speaking, what happens is that once CMS and the State have resolved the remaining issues while the SPAs are off the clock, the State would formally resubmit the RAI responses and any amended SPA pages required. The resubmission starts a new 90-day clock. The approval would then follow very shortly thereafter (because of the need to get the SPA approval package cleared through the CMS Regional Office, the official approval usually occurs within one to two weeks).

3. *The removal of the RAIs from the clock not only does not jeopardize the July 1, 2008 effective date for all four SPAs, but actually preserves this effective date;*
   This is correct: After the State withdraws the RAI responses (this is done via an email from an authorized State Medicaid person), the State and CMS would have time off the clock to finish the SPA review process. Once the issues are resolved and a formal resubmission of the RAI responses is received for each SPA along with any necessary amended plan pages, the SPAs would be approved with the originally requested effective date.

4. *CMS will move on formal approval quickly once all additional information has been supplied or a compromise has been reached.*
   CMS remains committed to resolving these SPAs as quickly as possible.

I hope these responses are helpful and provide the State with the assurances you need to alleviate any remaining concerns that you may have regarding taking these SPAs off the clock. Please let me know if the State needs any additional information. As you know, time is of the essence and we hope that you are willing to stop the clock and thereby avoid disapprovals.

Regards,

Janet Freeze

From: Ingram, Robin [mailto:ingramr@ahca.myflorida.com]
Sent: Tuesday, June 02, 2009 4:36 PM
To: Freeze, Janet G. (CMS/CMSO)
Cc: Hudson, Michele; Hagler, Wesley; Stephens, Edwin; Williams, Phil; Elmore, Elaine (CMS/CMCHO); Halter, Mark D. (CMS/MC); FIELDS, STANLEY (CMS/SC); Gaskins, Sheri P. (CMS/CMSO)
Subject: FL SPAs 08-016, 08-017,08-018, and 08-019

Janet:
Thank you so much for your time and effort toward resolution of the issues and questions for these SPAs. Some concerns may be alleviated with certain assurances from CMS. We appreciate your consideration for the following requests from the state, and thank you in advance for putting the process in writing.

If the State chooses to remove the RAIs from the clock, we would like these specific questions answered in writing:

1. How long the State has to respond with information requested once the RAIs have been taken off the clock;
2. How long CMS would have to act on new RAI responses from the State;
3. The removal of the RAIs from the clock not only does not jeopardize the July 1, 2008 effective date for all four SPAs, but actually preserves this effective date;
4. CMS will move on formal approval quickly once all additional information has been supplied or a compromise has been reached.

We look forward to receiving your responses.
Kindest Regards,

Robin R. Ingram
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mailstop #8
Tallahassee, Florida 32309
Phone: (850)414-0633
FAX: (850)488-2520
Email: ingramr@ahca.myflorida.com

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FL-08-017

Holly, Mary V. (CMS/CMCHO)

From: FIELDS, STANLEY (CMS/SC)
Sent: Thursday, June 04, 2009 8:29 AM
To: Noonan, Darlene F. (CMS/SC); Holly, Mary V. (CMS/CMCHO); Kimble, Davida R. (CMS/CMCHO)
Cc: FIELDS, STANLEY (CMS/SC)
Subject: FW: FL SPAs 08-016, 08-017,08-018, and 08-019

FYI

From: Ingram, Robin [mailto:ingramr@ahca.myflorida.com]
Sent: Wednesday, June 03, 2009 4:52 PM
To: Freeze, Janet G. (CMS/CMSO)
Cc: Hudson, Michele; Hagler, Wesley; Stephens, Edwin; Williams, Phil; Elmore, Elaine (CMS/CMCHO); Halter, Mark D. (CMS/MC); FIELDS, STANLEY (CMS/SC); Gaskins, Sheri P. (CMS/CMSO); Day, Venesa J. (CMS/CMSO); Fan, Kristin A. (CMS/CMSO); Weidler, Timothy A. (CMS/MC); Tavener, Linda A. (CMS/CMSO)
Subject: RE: FL SPAs 08-016, 08-017,08-018, and 08-019

With regard to Florida SPAs 08-016, 08-017, 08-018, and 08-019, the State respectfully requests RAI responses sent to CMS 3/16/09 be withdrawn. The State also requests the 90-day clock for review of the RAIs be officially stopped, with review and discussion proceeding off the clock until resolution.

Thank you very much -

Robin R. Ingram
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mailstop #8
Tallahassee, Florida 32309
Phone: (850)414-0633
FAX: (850)488-2520
Email: ingramr@ahca.myflorida.com

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From: Freeze, Janet G. (CMS/CMSO) [mailto:Janet.Freeze@cms.hhs.gov]
Sent: Wednesday, June 03, 2009 2:11 PM
To: Ingram, Robin
Cc: Hudson, Michele; Hagler, Wesley; Stephens, Edwin; Williams, Phil; Elmore, Elaine (CMS/CMCHO); Halter, Mark D. (CMS/MC); FIELDS, STANLEY (CMS/SC); Gaskins, Sheri P. (CMS/CMSO); Day, Venesa J. (CMS/CMSO); Fan, Kristin A. (CMS/CMSO); Weidler, Timothy A. (CMS/MC); Tavener, Linda A. (CMS/CMSO)
Subject: RE: FL SPAs 08-016, 08-017,08-018, and 08-019

Hello Ms. Ingram-

Thank you for sending your questions. The CMS response to each question is included below:

1. *How long the State has to respond with information requested once the RAIs have been taken*

1. How long the State has to respond with information requested once the RAIs have been taken off the clock;
2. How long CMS would have to act on new RAI responses from the State;
3. The removal of the RAIs from the clock not only does not jeopardize the July 1, 2008 effective date for all four SPAs, but actually preserves this effective date;
4. CMS will move on formal approval quickly once all additional information has been supplied or a compromise has been reached.

We look forward to receiving your responses.
Kindest Regards,

Robin R. Ingram
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mailstop #8
Tallahassee, Florida 32309
Phone: (850)414-0633
FAX: (850)488-2520
Email: ingramr@ahca.myflorida.com

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Holly, Mary V. (CMS/CMCHO)

From: Elmore, Elaine (CMS/CMCHO)
Sent: Tuesday, April 21, 2009 11:24 AM
To: Halter, Mark D. (CMS/MC)
Cc: Miles, Melissa (CMS/CMCHO); Holly, Mary V. (CMS/CMCHO)
Subject: RE: FL 08-017 Off the Clock

I have not heard from her.

From: Halter, Mark D. (CMS/MC)
Sent: Tuesday, April 21, 2009 10:57 AM
To: Elmore, Elaine (CMS/CMCHO)
Subject: FW: FL 08-017 Off the Clock

Elaine, Have you heard anything additional from Sheri on the status of this SPA since your below email? Thanks, Mark

From: Elmore, Elaine (CMS/CMCHO)
Sent: Monday, March 23, 2009 10:00 AM
To: Halter, Mark D. (CMS/MC); Miles, Melissa (CMS/CMCHO); Alexander, Patrick M. (CMS/SC); Dubois, Anna M. (CMS/CMCHO)
Subject: FW: FL 08-017 Off the Clock

Please note that I've asked Mary to put the SPA back on the correct SPW page. Incidentally, Sheri Gaskins told me that what FL has submitted on this SPA is totally unacceptable. I believe she is working on a disapproval letter, but she said we will continue to work with FL toward correction, but she was somewhat discouraged.

Elaine Elmore
Health Insurance Specialist
Centers for Medicare & Medicaid Services
Atlanta Regional Office
404-562-7408
Fax No. 404-562-7481

From: Elmore, Elaine (CMS/CMCHO)
Sent: Monday, March 23, 2009 9:56 AM
To: Holly, Mary V. (CMS/CMCHO)
Subject: FL 08-017 Off the Clock

FL 08-017 is still listed on the Off The Clock Report, but the RAI response was received on 3/16/09. Please move the SPA off this SPW page and put it back on the regular SPW page. Thanks.

Elaine Elmore
Health Insurance Specialist
Centers for Medicare & Medicaid Services
Atlanta Regional Office
404-562-7408

Fax No. 404-562-7481

Holly, Mary V. (CMS/CMCHO)

From: Holly, Mary V. (CMS/CMCHO)
Sent: Tuesday, March 17, 2009 11:28 AM
To: Halter, Mark D. (CMS/MC); Alexander, Patrick M. (CMS/SC); Brown, Sally E. (CMS/SC); Dubois, Anna M. (CMS/CMCHO); Elmore, Elaine (CMS/CMCHO); Miles, Melissa (CMS/CMCHO); Moore, Yvette (CMS/SC); Gaskins, Sheri P. (CMS/CMSO); CMS SPA
Subject: FW: FL-08-017 RAI
Attachments: State RAI Response FL-08-017.pdf; SPA Review Sheet for FL-08-017 RAI Response.doc

Attached is the State's response to RAI for FL-08-017 with review sheet. The new 90th day is 06/14/09.

From: CMS SPA_Waivers_Atlanta_R04
Sent: Monday, March 16, 2009 5:25 PM
To: Holly, Mary V. (CMS/CMCHO); Noonan, Darlene F. (CMS/SC)
Subject: FW: FL-08-017 RAI

From: Ingram, Robin[SMTP:INGRAMR@AHCA.MYFLORIDA.COM]
Sent: Monday, March 16, 2009 5:20:17 PM
To: Holly, Mary V. (CMS/CMCHO); Stephens, Edwin; CMS SPA_Waivers_Atlanta_R04
Cc: Kimble, Davida R. (CMS/CMCHO); Dubois, Anna M. (CMS/CMCHO); Johnson, Andriette E. (CMS/SC); Roberts, Shantrina D. (CMS/CMCHO); Noonan, Darlene F. (CMS/SC); Wilkerson, Joyce C. (CMS/SC); Gaskins, Sheri P. (CMS/CMSO)
Subject: RE: FL-08-017 RAI
Auto forwarded by a Rule

Attached are responses from the State to CMS' Requests for Additional Information for State Plan Amendment TN#2008-017.
Thank you very much –

Robin R. Ingram
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mailstop #8
Tallahassee, Florida 32309
(850)414-0633 FAX: (850)488-2520

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From: Holly, Mary V. (CMS/CMCHO) [mailto:Mary.Holly@CMS.hhs.gov]
Sent: Thursday, December 18, 2008 10:55 AM

To: Stephens, Edwin; Ingram, Robin; CMS SPA
Cc: Kimble, Davida R. (CMS/CMCHO); Dubois, Anna M. (CMS/CMCHO); Johnson, Andriette E. (CMS/SC); Roberts, Shantrina D. (CMS/CMCHO); Noonan, Darlene F. (CMS/SC); Wilkerson, Joyce C. (CMS/SC); Gaskins, Sheri P. (CMS/CMSO)
Subject: FL-08-017 RAI

Please find attached RAI for FL-08-017. If you have any questions or need any assistance, please contact Davida Kimble at 404-562-7493. The original will go out in the mail today.

FLORIDA
STATE PLAN AMENDMENT REVIEW SHEET

TRANSMITTAL: 08-017 (RAI) **DATE ASSIGNED:** 09/30/08 **RO LEAD:** Mark Halter/Patrick Alexander

COVERAGE COORD: Venesa Day **ELIGIBILITY COORD:** Sally Brown

STATE COORD: Elaine Elmore/Melissa Miles **FIN ANALYST:** Mark Halter/Patrick Alexander

STATE COORD: **FIN ANALYST:**

IT ANALYST: **RO FUNDING SPEC:** Anna Dubois

RO FUNDING SPEC: **RO NIRT ANALYST:** Stanley Fields

NIRT ANALYST: Venesa Day **CO FUNDING SPEC:** Sharon Sims

PHARMT ANALYST: Bernadette Leeds **NIPT ANALYST:** Yvette Moore/Sheri Gaskins

TITLE/SUBJECT:
Payment Methodology for Outpatient Hospital Reimbursement (4.19-B)

DATE FORWARDED TO:

NIRT: N/A NIPT: 03/17/09 PHARMT: N/A CMS SPA: 03/17/09

****

TYPE OF TRANSMITTAL

____	New Plan Amendment	____	Revised Pages
____	Comments From CO	____	Withdrawal/RAI
X	Response From State	____	Withdrawal/SPA
____	Other		

ACTION DATES

Date Rec'd in CMS	03/16/09
15-Day Status	
60th Day Alert	05/15/09
90th Day	06/14/09
RO NIPT Overview Tool Due Date	10/17/08 (Due 20 days after receipt of SPA)

REVIEWER'S RECOMMENDATION

____	Draft Letter to CO	____	Partial Disapproval
____	Official Letter to SA	____	Partial Approval
		____	Recommending Disapproval
		____	Recommending Approval

COMMENTS AND/OR INSTRUCTIONS

15-Day Status:

PRIMARY REVIEWER/DATE

CONCURRENCES

SIGNATURE/TITLE/DATE

SIGNATURE/TITLE/DATE

Holly, Mary V. (CMS/CMCHO)

From: CMS SPA_Waivers_Atlanta_R04
Sent: Monday, March 16, 2009 5:25 PM
To: Holly, Mary V. (CMS/CMCHO); Noonan, Darlene F. (CMS/SC)
Subject: FW: FL-08-017 RAI
Attachments: State RAI Response FL-08-017.pdf

From: Ingram, Robin[SMTP:INGRAMR@AHCA.MYFLORIDA.COM]
Sent: Monday, March 16, 2009 5:20:17 PM
To: Holly, Mary V. (CMS/CMCHO); Stephens, Edwin; CMS SPA_Waivers_Atlanta_R04
Cc: Kimble, Davida R. (CMS/CMCHO); Dubois, Anna M. (CMS/CMCHO); Johnson, Andriette E. (CMS/SC); Roberts, Shantrina D. (CMS/CMCHO); Noonan, Darlene F. (CMS/SC); Wilkerson, Joyce C. (CMS/SC); Gaskins, Sheri P. (CMS/CMSO)
Subject: RE: FL-08-017 RAI
Auto forwarded by a Rule

Attached are responses from the State to CMS' Requests for Additional Information for State Plan Amendment TN#2008-017.
Thank you very much –

Robin R. Ingram
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mailstop #8
Tallahassee, Florida 32309
(850)414-0633 FAX: (850)488-2520

Cover Florida Web Button

From: Holly, Mary V. (CMS/CMCHO) [mailto:Mary.Holly@CMS.hhs.gov]
Sent: Thursday, December 18, 2008 10:55 AM
To: Stephens, Edwin; Ingram, Robin; CMS SPA
Cc: Kimble, Davida R. (CMS/CMCHO); Dubois, Anna M. (CMS/CMCHO); Johnson, Andriette E. (CMS/SC); Roberts, Shantrina D. (CMS/CMCHO); Noonan, Darlene F. (CMS/SC); Wilkerson, Joyce C. (CMS/SC); Gaskins, Sheri P. (CMS/CMSO)
Subject: FL-08-017 RAI

Please find attached RAI for FL-08-017. If you have any questions or need any assistance, please contact Davida Kimble at 404-562-7493. The original will go out in the mail today.

CHARLIE CRIST
GOVERNOR

FLORIDA MEDICAID

Better Health Care for all Floridians

HOLLY BENSON
SECRETARY

March 16, 2009

Mary Kaye Justis, RN, MBA
Acting Associate Regional Administrator
Division of Medicaid and Children's Health
Center for Medicare and Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

Attention: Davida Kimble

RE: Florida SPA 08-017

Dear Mrs. Justis:

We have received your request for clarifications and/or additional information for proposed State Plan Amendment (SPA) 08-017. This amendment will revise the payment methodology for Outpatient Hospital Services. Our responses can be found below:

1. ***Please explain the following sentence in paragraph 22 on page 21 "Included in these funds are the annualized amounts to offset the reductions taken against certified trauma centers as identified in section 13, chapter 2007-326, Laws of Florida."***

   During the special legislative session of SFY 2007-08, the Florida Legislature directed the Agency to reduce inpatient and outpatient reimbursement rates for hospitals by approximately 3%. The Florida Legislature also stated that designated or provisional Trauma Hospital's would only a receive 1% reduction (the Trauma hospitals were given back 2% of the 3% cut). The language "*Included in these funds are the annualized amounts to offset the reductions taken against certified trauma centers as identified in section 13, chapter 2007-326. Laws of Florida*", instructs the Agency to move forward in the same manner for SFY 2008-09.

2. ***Please explain the SPA language found in paragraph 9 on page 25 "if the unit cost is greater than the unit cost used in establishing the budget, then rates shall be….". Regarding this section, how is the unit cost established? What is the process/method that the state undertakes to determine this provision? Please provide more comprehensive materials that will clearly explain and detail the methodology the State used to achieve the reduction. For plan comprehensiveness purposes, clarifying language should be included in the plan language regarding the methodology/process of the reduction.***

Effective July 1, 2008, the following method was applied to the rate setting process to ensure compliance with Section 409.908 Florida Statutes.

1. There are two specific types of unit cost: *Budgeted unit cost* is unit cost as established and approved by the Florida Legislature in the General Appropriations Act. The *calculated unit cost* is the unit cost that is actually applied to a provider's reimbursement rate which is based on the cost supplied to Florida Medicaid in a provider's most recent cost report.
2. A budgeted unit cost is determined based on estimated State annual budget for outpatient hospital services;
3. Outpatient hospital rates are established through the normal process;
4. An annual expenditure is determined based on current rates;
5. A calculated unit cost (similar to a weighted average) is computed based on current rates; and
6. The calculated unit cost based on current rates is compared to budgeted unit cost based on State budget:
    a. If the *calculated* unit cost is less than the *budgeted* unit cost then no action is required;
    b. If the *calculated* unit cost for current rates is greater than the *budgeted* unit cost for the State budget, then the rates will be reduced by an amount required to achieve the reduction, but shall not be reduced below the *budgeted* unit cost.

Please reference Attachment 1 for additional detail of the unit cost as applied to Outpatient Hospital services.

3. ***On page 26 paragraph 10 please provide SPA language that clarifies how the rates will be establish at a level to ensure no increase in statewide expenditures resulting from a change in unit cost for two fiscal years effective July 1, 2009. In addition please provide more information on the following:***
a) Why is this language necessary in the state plan, to what affect will this achieve?

Effective July 1, 2009, as mandated by the Florida Legislature, hospital rates in the aggregate will not be allowed to increase more than the unit cost; that was part of the calculation of reimbursement rates used in developing the General Appropriations Act (GAA) for State Fiscal Year 2008-2009. The methodology (as described in 3.b. below) that is used to *set* the unit cost will be the same methodology that is used to *maintain* the unit cost for the next two years. Therefore, rates in the aggregate will not be permitted to increase more than unit cost for two state fiscal years.

b) The method the State undertakes to achieve this particular section of the state plan, this will include any supporting documents with the calculation.

Effective July 1, 2008, the following method was applied to the rate setting process to ensure compliance with Section 409.908 Florida Statutes.

1. There are two specific types of unit cost: *Budgeted unit cost* is unit cost as established and approved by the Florida Legislature in the General Appropriations Act. The *calculated unit cost* is the unit cost that is actually applied to a provider's reimbursement rate which is based on the cost supplied to Florida Medicaid in a provider's most recent cost report.
2. A budgeted unit cost is determined based on estimated State annual budget for outpatient hospital services;
3. Outpatient hospital rates are established through the normal process;
4. An annual expenditure is determined based on current rates;
5. A calculated unit cost (similar to a weighted average) is computed based on current rates; and
6. The calculated unit cost based on current rates is compared to budgeted unit cost based on State budget:

    a. If the *calculated* unit cost is <u>less than</u> the *budgeted* unit cost then no action is required;
    b. If the *calculated* unit cost for current rates is <u>greater than</u> the *budgeted* unit cost for State budget, then the rates will be reduced by an amount required to achieve the reduction, but shall not be reduced below the unit cost.

Please refer to Attachment 1 for additional detail of the unit cost as applied to outpatient hospitals.

4. Please provide a more detailed explanation of the buy back provisions for the Medicaid trend adjustments as indicated in paragraph 11 on page 26 and paragraph 12 on page 27/28. In addition, it will be necessary to include information with respect to the following:

a) An example of the process/method that the State undertakes to determine this provision, including any supporting materials.

In accordance with House Bill 5001, 2008-09 General Appropriations Act, Specific Appropriation 211, the buy back provision allows hospitals that meet specific criteria the opportunity to buy back a portion of their rate reduction. Therefore, the determination of which hospitals are included in the buy back provision is simply the procedure of

determining which hospitals are included in the following categories of hospitals and applying the buy back against their respective rate reductions:

a. Hospital Systems that operate a Provider Service Network;
b. Children's Specialty Hospitals with Medicaid and Charity Care Days that equal or exceed 30 percent of total days;
c. Rural Hospitals;
d. Public Hospitals; and
e. Teaching Hospitals as defined in Florida Statutes with seventy or more FTE resident Physicians and whose Medicaid and Charity Care days exceed 25 percent of total days.

b) An explanation of any implications with respect to Federal share of the payments.

Absent the cuts mandated, the buy backs would not be included in SPA 08-017. The rates without the buy backs would decrease the federal share required as compared to the reduced rates with buy backs. Had the reductions not been taken, the federal share would be greater. Please reference the chart below to see the detail of the buy backs:

7/1/2008	$545,419,038	Annualized outpatient reductions estimated.	
	$302,162,147	Federal Share not blended	0.554
	$243,256,891	State Share	
	$475,006,983	Annualized Outpatient with all reductions estimated	
	$263,153,869	Federal Share not blended	
	$211,853,115	State Share	
	$509,560,963	Annualized Outpatient with all reductions and buy backs estimated	
	$282,296,774	Federal Share not blended	
	$227,264,190	State Share	
	$19,865,373	Federal amount saved vs. non-reduced rates	

5. ***Please explain how the State determines that Medicaid payments to providers do not exceed the amount according to 42 CFR 447.321. To that end, please submit an upper payment limit demonstration for outpatient hospital services. The following is presented as guidance in demonstrating the Upper Payment Limit (UPL) for outpatient hospital services.***

   Florida Medicaid reimburses hospital outpatient services with an occasion of service rate using a cost based prospective methodology that is detailed in the Title XIX Outpatient Hospital Reimbursement Plan. Individual facility costs are reported annually using the CMS 2552 cost report with specific information added for Florida Medicaid purposes.

   Allowable Medicaid costs are costs set in accordance with the Principles of Reimbursement for Provider Costs as defined in CMS Pub. 15-1, and are further defined in the Title XIX Outpatient Hospital Reimbursement Plan. Allowable Medicaid costs are the basis for reimbursement, with upper limits applied (class and target ceilings) and subject to a downward Medicaid trend adjustment. Some providers may be reimbursed at or near Medicaid allowable cost while the remaining providers are reimbursed far less than their actual allowable Medicaid costs.

   It is the position of the Agency for Health Care Administration (Agency) that allowable Medicaid costs are a reasonable substitute for what Medicare would have paid for the same claims. Since, by classification of hospital, we pay less than allowable Medicaid costs in the aggregate, we feel an actual comparison is not necessary.

   The Agency believes that allowable Medicaid cost should be permissible as a reasonable substitute for what Medicare would pay. We do not pay 100% of allowable cost in the aggregate for any class of hospital facility. The Agency therefore meets the requirements of UPL in federal rule.

   Federal regulations at 42 CFR 447.321 establish an UPL for outpatient hospital services. When a state proposes increases in outpatient hospital reimbursement, approval of the SPA is subject to the provision by the State of a demonstration that the payments can be made within the UPL limit. In order to establish that the payments meet the regulatory requirements, the State must demonstrate that, for each category of hospital services (State government-owned or operated facilities, non state government-owned or operated facilities and privately-owned and operated facilities), payment does not exceed, in the aggregate for each category, the reasonable estimate of the amount

that would be paid for the services furnished by the group of facilities under Medicare payment principles.

Because the UPL is an estimate of the amount that Medicare would pay or the cost it would reimburse for services, we require the State to make a direct link in its UPL to Medicare through the Medicare Cost Report CMS 2552-96.

When the State uses cost, the link to Medicare is made through reference to ancillary and outpatient hospital services cost center cost-to-charge ratios as found at Worksheet C, column 9, lines 37-68 or Worksheet D, Part V, Column 1.01, lines 37-68. These ratios include all cost regardless of payer for all ancillary and outpatient cost centers and charges made to all payers including Medicaid. CMS does not accept a UPL that is inflated by adjusting Medicare's allowed cost as reported on these worksheets.

The applicable outpatient hospital service payment reference for a payment-to-charge UPL demonstration may be found on Worksheet E, Part B of the CMS 2552-96. While Worksheet E represents what Medicare pays for services within hospitals, the State must make certain adjustments in order to reflect equivalent Medicaid outpatient hospital provider services that may be included in the UPL demonstration. For example, all lines that report payments associated with physician services must be removed. Additionally, the State must ensure that bad debts are not over-reported by including deductibles and coinsurance and reimbursable bad debt in Medicare payments. If deductible and coinsurance are added on to the Medicare payment, the State should remove reimbursable bad debts included in the Medicare payment. The resulting payments reported from Worksheet E should represent allowable Medicare payments for purposes of the UPL demonstration. The source of Medicare charge data, reflected in the ratio's denominator, must come from Worksheet D, Part V and Part VI of the Medicare Cost Report.

We note that a payment-to-charge ratio UPL methodology may not be inclusive of the full scope of outpatient hospital services because payments and charges on the Medicare cost report do not include payments and charges reimbursed on a fee for service basis through the Medicare Part B Carrier. For example, durable medical equipment payments and charges are not included on Worksheets E and D. CMS does not require that the ratio be adjusted for these excluded services.

CMS requires the use of the Medicare Market Basket/Global Insight Factor to trend cost. The State must demonstrate any proposed factor for trending volume.

6. ***If the State plans to include clinical diagnostic laboratory services in its outpatient hospital services UPL, then it must show this as a separate calculation. These services are subject to a separate UPL test at 1903(i)(7) of the Social Security Act, which requires that payment not exceed the Medicare rate on a per test basis. Please demonstrate that the State does not exceed Medicare fee rates per 1903(i)(7).***

Funding Questions:

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

1. ***Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)***

   Providers retain 100 percent of all payments made relating to this program. If an error occurs and payments are returned to the state, the state will track and report appropriately. The federal share is calculated and returned to CMS.

2. ***Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of***

Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

(i) a complete list of the names of entities transferring or certifying funds;
(ii) the operational nature of the entity (state, county, city, other);
(iii) the total amounts transferred or certified by each entity;
(iv) clarify whether the certifying or transferring entity has general taxing authority: and,
(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Please reference the following attachments for details regarding the funding of the state share of each type of Medicaid payment:

Attachment 2 - "State FY 2008-09 Appropriations for Services Provided Under Section 4.19B of the State Plan,"
Attachment 3 - "FY 2008-09 Medicaid Issues Funded with County Intergovernmental Transfers," and,
Attachment 4 - "FY 2008-09 Intergovernmental Transfers by Local Government."

3. ***Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.***

No supplemental Special Medicaid Payments (SMP) are being made in addition to provider Medicaid per diem rates. The only additional payments being made to hospital providers are those payments permitted through the Low Income Pool (LIP) program, for the continuation of government support for services to Medicaid, uninsured, and underinsured populations.

For clinic or outpatient hospital services please provide a detailed description of the methodology used by the State to estimate the UPL for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

Florida Medicaid reimburses hospital outpatient services with an occasion of service rate using a costs based prospective methodology. Individual facility costs are reported annually using the CMS 2552 cost report with specific information added for Florida Medicaid purposes.

Allowable Medicaid costs are costs set in accordance with the Principles of Reimbursement for Provider Costs as defined in CMS Pub. 15-1, and are further defined in the Title XIX Outpatient Hospital Reimbursement Plan. Allowable Medicaid costs are the basis for reimbursement, with upper limits applied (class and target ceilings) and subject to a downward Medicaid trend adjustment. Some providers may be reimbursed at or near Medicaid allowable cost while the remaining providers are reimbursed far less than their actual allowable Medicaid costs.

It is the position of the Agency for Health Care Administration (Agency) that allowable Medicaid costs are a reasonable substitute for what Medicare would have paid for the same claims. Since, by classification of hospital, we pay less than allowable Medicaid costs in the aggregate, the rates paid are within the requirements of the federal UPL regulations.

The Agency believes that allowable Medicaid cost should be permissible as a reasonable substitute for what Medicare would pay. We do not pay 100% of allowable cost in the aggregate for any class of hospital facility. The Agency therefore believes it should be clear that we are well within the UPL for each class of hospital facility.

4. ***Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?***

Payments to providers relating to outpatient hospital services would not exceed, in the aggregate, reasonable costs of providing services. If payments do exceed reasonable cost of providing services, the provider must return the excess amount to the state. Once the state has received the returned funds, appropriate documentation is made and the federal share is calculated and returned to CMS. The excess is returned to the state and the Federal share is reported on the 64 report to CMS.

Thank you for the opportunity to provide clarifications and additional information on SPA TN#08-017. If you have any questions on this RAI response, please contact Michele Hudson at (850) 414-2756.

Sincerely,

for Carlton D. Snipes
Deputy Secretary for Medicaid

CDS/es
Attachments
cc: Wesley Hagler, Medicaid Program Analysis
Michele Hudson, Bureau Chief, Medicaid Program Analysis
Phil Williams, Assistant Deputy Secretary for Medicaid Finance
Chris Osterlund, Assistant Deputy Secretary for Medicaid Operations

Florida State Plan Amendment 08-017
Attachment 1
Outpatient Hospital Unit Cost Calculations

	Inpatient Weighted Average Rate setting	Claims		Outpatient weighted average Rate setting	Claims	
1/1/2006	$1,202.83	$1,311.07	1.089992428	$107.57	$218.38	2.030181268
7/1/2006	$1,292.94	$1,354.47	1.047583921	$117.04	$250.43	2.139767013
1/1/2007	$1,337.48	$1,412.31	1.055950931	$122.34	$243.92	1.993819057
7/1/2007	$1,393.44	$1,452.58	1.042441079	$119.13	$246.90	2.072501877
1/1/2008	$1,406.96	$1,486.96	1.056859385	$117.34	$240.81	2.052248849
1/1/2009	$1,593.57	$1,676.04	1.051750465	$138.37	$282.21	2.039523261
allowed before Buy Back		$1,560.84	6.87% cut		$231.24	18.06% cut
Allowed after buy Back		$1,685.65	8.00% buy back		$246.92	6.78% buy back

Fixed amount

	1339754.72	$1,676.04	$2,245,482,500.74	1963692	$282.21	$554,173,519.00	
Total cut			($154,333,435)			($36,403,451)	
	1339754.72	$1,560.84	$2,091,149,065.74	1963692	$263.67	$517,770,068.00	6.57%
Total restore			$167,204,828			$30,794,556	
	1339754.72	$1,685.65	$2,258,353,893.74	1963692	$279.35	$548,564,624.00	5.95%

ATTACHMENT 2
Florida State Plan Amendment 08-017
State FY 2008-09 Appropriations for Services Provided Under Section 4.19B of the State Plan

HOSPITAL OUTPATIENT BUDGET FY 2008-09

		General Revenue Fund (State)	Tobacco Settlement Trust Fund (State)	Grants & Donations Trust Fund	Medical Care Trust Fund (Federal)	Public Medical Assistance Trust Fund (State)	Refugee Assistance Trust Fund (Federal)	Total All Funds
A	FY 2008-09 Hospital Outpatient Services Legislative Appropriation	$91,211,922	$25,329,039	$71,309,086	$327,404,515	$75,000,000	$1,130,101	$591,384,663
	Less Non-Title XXI	($64,891)	$0	$0	($142,961)	$0	$0	($207,852)
	Total Hospital Outpatient-Title XIX	$91,147,031	$25,329,039	$71,309,086	$327,261,554	$75,000,000	$1,130,101	$591,176,811
B	**Source of Medicaid Total Hospital Outpatient Funding:**							
	State General Revenue	$91,211,922	$0	$0	$0	$0	$0	$91,211,922
	State Trust Funds - Tobacco Settlement	$0	$25,329,039	$0	$0	$0	$0	$25,329,039
	State Trust Funds - State Retained Share of Fraud/Abuse Recoveries	$0	$0	$4,849,717	$0	$0	$0	$4,849,717
	Intergovernmental Transfers (From Local Governments)	$0	$0	$66,459,369	$0	$0	$0	$66,459,369
	Provider Taxes (Assessment on Hospital Net Operating Revenues)	$0	$0	$0	$0	$75,000,000	$0	$75,000,000
	Cigarette Taxes (By Statute, Medicaid Receives a Portion of Tax)	$0	$0	$0	$0	$0	$0	$0
	Enhanced Federal Medical Assistance (Medicaid Expansion Under XXI)	($64,891)	$0	$0	($142,961)	$0	$0	($207,852)
	Federal Medical Assistance Payments (Title XIX)	$0	$0	$0	$327,404,515	$0	$1,130,101	$328,534,616
	Total	$91,147,031	$25,329,039	$71,309,086	$327,261,554	$75,000,000	$1,130,101	$591,176,811
C	**DSH Payments**	$0	$0	$0	$0	$0	$0	$0
	Source of Funds:							
	State General Revenue (In AHCA & In Other State Agencies)	$0	$0	$0	$0	$0	$0	$0
	State Trust Funds - Tobacco Settlement	$0	$0	$0	$0	$0	$0	$0
	State Trust Funds - State Retained Share of Fraud/Abuse Recoveries	$0	$0	$0	$0	$0	$0	$0
	Intergovernmental Transfers (From Local Governments)	$0	$0	$0	$0	$0	$0	$0
	Provider Taxes (Assessment on Hospital Net Operating Revenues)	$0	$0	$0	$0	$0	$0	$0
	Cigarette Taxes (By Statute, Medicaid Receives a Portion of Tax)	$0	$0	$0	$0	$0	$0	$0
	Enhanced Federal Medical Assistance (Medicaid Expansion Under XXI)	$0	$0	$0	$0	$0	$0	$0
	Federal Medical Assistance Payments (Title XIX)	$0	$0	$0	$0	$0	$0	$0
	Total	$0	$0	$0	$0	$0	$0	$0
D	**Special Medicaid Payments**	$0	$0	$0	$0	$0	$0	$0
	Source of Special Medicaid Payment Funds:							
	State General Revenue (In AHCA & In Other State Agencies)	$0	$0	$0	$0	$0	$0	$0
	State Trust Funds - Tobacco Settlement	$0	$0	$0	$0	$0	$0	$0
	State Trust Funds - State Retained Share of Fraud/Abuse Recoveries	$0	$0	$0	$0	$0	$0	$0
	Intergovernmental Transfers (From Local Governments)	$0	$0	$0	$0	$0	$0	$0
	Provider Taxes (Assessment on Hospital Net Operating Revenues)	$0	$0	$0	$0	$0	$0	$0

ATTACHMENT 2
Florida State Plan Amendment 08-017
State FY 2008-09 Appropriations for Services Provided Under Section 4.19B of the State Plan

HOSPITAL OUTPATIENT BUDGET FY 2008-09

	General Revenue Fund (State)	Tobacco Settlement Trust Fund (State)	Grants & Donations Trust Fund	Medical Care Trust Fund (Federal)	Public Medical Assistance Trust Fund (State)	Refugee Assistance Trust Fund (Federal)	Total All Funds
Cigarette Taxes (By Statute, Medicaid Receives a Portion of Tax)	$0	$0	$0	$0	$0	$0	$0
Enhanced Federal Medical Assistance (Medicaid Expansion Under XXI)	$0	$0	$0	$0	$0	$0	$0
Federal Medical Assistance Payments (Title XIX)	$0	$0	$0	$0	$0	$0	$0
Total	$0	$0	$0	$0	$0	$0	$0
E **Per Diem Payments**	$91,147,031	$25,329,039	$71,309,086	$327,261,551	$75,000,000	$1,130,101	$591,176,811
Source of Funds:							
State General Revenue (In AHCA & In Other State Agencies)	$91,211,922	$0	$0	$0	$0	$0	$91,211,922
State Trust Funds - Tobacco Settlement	$0	$25,329,039	$0	$0	$0	$0	$25,329,039
State Trust Funds - State Retained Share of Fraud/Abuse Recoveries	$0	$0	$4,849,717	$0	$0	$0	$4,849,717
Intergovernmental Transfers (From Local Governments)	$0	$0	$66,459,368	$0	$0	$0	$66,459,368
Provider Taxes (Assessment on Hospital Net Operating Revenues)	$0	$0	$0	$0	$75,000,000	$0	$75,000,000
Cigarette Taxes (By Statute, Medicaid Receives a Portion of Tax)	$0	$0	$0	$0	$0	$0	$0
Enhanced Federal Medical Assistance (Medicaid Expansion Under XXI)	($64,891)	$0	$0	($142,961)	$0	$0	($207,852)
Federal Medical Assistance Payments (Title XIX)	$0	$0	$0	$327,404,515	$0	$1,130,101	$328,534,616
Total	$91,147,031	$25,329,039	$71,309,085	$327,261,554	$75,000,000	$1,130,101	$591,176,810

FY 2008-09 MEDICAID ISSUES FUNDED WITH COUNTY INTERGOVERNMENTAL TRANSFERS
Florida State Plan Amendment 08-017
Attachment 3

Issue APPROPRIATIONS	County Transfers	General Revenue	Tobacco Trust Fund	Other State Funds	Medical Care TF	Total Funds	
Hospital Outpatient Services							
Hospital Outpatient Ceiling for Adults $500 to $1,000	$5,247,192	$0	$0	$0	$6,533,661	$11,780,853	
Hospital Outpatient Variable Cost Ceilings	$10,337,748	$0	$0	$0	$12,872,283	$23,210,031	
Hospital Outpatient Ceiling for Adults $1,000 to $1,500	$7,182,339	$0	$0	$0	$8,943,254	$16,125,593	
Remove Hospital Outpatient Reimbursement Ceilings/Teaching, Specialty, CHEP	$16,605,046	$0	$0	$0	$20,676,153	$37,281,199	
Eliminate Outpatient Reimbursement Ceilings -11% Screen	$4,943,712	$0	$0	$0	$6,155,777	$11,099,489	
Eliminate Outpatient Reimbursement Ceilings - 7.3% Screen/Trauma	$6,596,153	$0	$0	$0	$8,213,350	$14,809,503	
Payment to Hospitals-Outpatient Provider Clinics	$6,681,000	$0	$0	$0	$8,319,000	$15,000,000	
Medicaid Trend Adjustment Buy Back - PSNs, Childrens and Rural Hospitals	$0	$0	$0	$4,849,717	$6,038,736	$10,888,453	(8)
Medicaid Trend Adjustment Buy Back - Public and Teaching Hospitals	$8,866,178	$0	$0	$0	$11,039,925	$19,906,103	
Total Hospital Outpatient Services	$66,459,368	$0	$0	$4,849,717	$88,792,139	$160,101,224	
Hospital Inpatient Services							
Remove Hospital Inpatient Reimbursement Ceilings/Teaching, Specialty, CHEP	$148,851,661	$0	$0	$13,675,000	$202,373,791	$364,900,452	(1)
Eliminate Inpatient Reimbursement Ceilings -11% Screen	$46,339,212	$0	$0	$0	$57,700,329	$104,039,541	
Eliminated Inpatient Reimbursement Ceilings -Trauma Centers/Medicaid days 7.3%	$51,864,174	$0	$0	$0	$64,579,863	$116,444,037	
Special Medicaid Payments-Liver Transplant Facilities	$4,423,713	$0	$0	$0	$5,508,287	$9,932,000	
Medicaid Trend Adjustment Buy Back - PSNs, Childrens and Rural Hospitals	$4,806,048	$0	$0	$20,150,282	$31,074,945	$56,031,275	(8)
Medicaid Trend Adjustment Buy Back - Public and Teaching Hospitals	$49,597,763	$0	$0	$0	$61,575,790	$111,173,553	
Total Hospital Inpatient Services	$305,882,571	$0	$0	$33,825,282	$422,813,005	$762,520,858	
Low Income Pool Provider Access System Payments							
Low Income Pool - Primary Care Hospitals	$4,245,134	$0	$0	$0	$5,273,104	$9,518,238	
Low Income Pool - Provisional Trauma Centers	$4,318,860	$0	$0	$0	$5,364,682	$9,683,542	
Low Income Pool - Rural Hospitals	$2,816,764	$0	$0	$0	$3,498,850	$6,315,614	
Low Income Pool - Safety Net Hospitals	$28,790,908	$250,000	$0	$4,750,306	$41,663,301	$75,454,515	(4)(6)
Low Income Pool - Poison Control Hospitals	$0	$0	$0	$1,415,071	$1,757,734	$3,172,805	(5)
Low Income Pool - Specialty Pediatric Hospitals	$705,996	$0	$0	$0	$876,956	$1,582,952	
Low Income Pool - Hospitals Providers Access System	$389,222,032	$0	$0	$0	$483,473,107	$872,695,139	
Low Income Pool - Federally Qualified Health Centers	$5,190,605	$0	$0	$1,622,605	$8,463,046	$15,276,256	(7)
Low Income Pool - Primary Care & ER Diversion in Manatee, Sarasota and Desoto	$0	$0	$535,200	$0	$664,800	$1,200,000	
Low Income Pool - County Health Initiatives	$2,921,719	$0	$0	$0	$3,629,220	$6,550,939	
Total Low Income Pool Provider Access System Payments	$438,212,018	$250,000	$535,200	$7,787,982	$554,664,800	$1,001,450,000	
Nursing Home Special Medicaid Payments	$4,822,535	$0	$0	$0	$5,990,324	$10,812,859	
Disproportionate Share Hospital Programs							
Regular Disproportionate Share	$91,303,247	$0	$0	$6,198,263	$121,111,741	$218,613,251	(2)(3)
Total DSH Programs Funded with IGTs	$91,303,247	$0	$0	$6,198,263	$121,111,741	$218,613,251	
Total FY 2008-09	$906,679,739	$250,000	$535,200	$52,661,244	$1,193,372,009	$2,153,498,192	

Source of Other State Funds for FY 2008-2009:

(1) Transfer from Department of Health (See Specific Appropriation 648)	$13,675,000
(2) Transfer from Department of Health (See Specific Appropriation 648)	$825,000
(3) Transfer from Department of Health (See Specific Appropriation 652)	$5,373,263
(4) Transfer from Department of Health (See Specific Appropriation 626)	$450,000
(5) Transfer from Department of Health (See Specific Appropriation 624)	$1,415,071
(6) Transfer from Department of Health (See Specific Appropriation 652)	$4,300,306
(7) Transfer from Department of Health (See Specific Appropriation 644)	$1,622,605
(8) Transfer from Department of Health (See Specific Appropriation 652 & 652A)	25,000,000
	$52,661,245

Florida State Plan Amendment 08-017
2008-09 Intergovernmental Transfers by Local Government
Attachment 4

Source of Funding	Derivation of Funds	Funding Amount	Total as Non-Federal Share for SFY 2007-2008 LIP	Funding Mechanism	Will the source identified in the first column be responsible for the transfer?	Will the transfer from the identified source be sent directly to the Agency?
Brevard County	General Fund	Appropriated once a year by the County	112,610	IGT	Yes	Yes
Broward County	General Fund	Appropriated once a year by the County	36,824	IGT	Yes	Yes
Children's Services Council of St. Lucie County	Ad Valorem Property Tax	.915 Mills with a maximum of .50 Mills	155,235	IGT	Yes	Yes
Citrus County Hospital Board	Ad Valorem Property Tax	.95 Mills. The amount of taxes levied is determined by Trustees, based on the operating and capital needs of the Hospital. A budget is prepared each year that indicates the amount of tax support required. The Trustees evaluate and validate the budget need and set taxes appropriately. The Trustees are charged with providing for the appropriate level of health care in the community.	4,426,197	IGT	Yes	Yes
Collier County	Ad Valorem Property Tax	Appropriated once a year by the County	1,939,964	IGT	Yes	Yes
Columbia County	Ad Valorem Property Tax	Appropriated once a year by the County	12,939	IGT	Yes	Yes
Duval County	General Funds and General Revenue	The 3 major sources of revenue come from Ad Valorem taxes, state revenue sharing and the operating contribution from the Jacksonville Electric Authority, which included both electric and water/sewer fees. Amount decided every year by the County	11,604,165	IGT	Yes	Yes
Escambia County	County General Revenue	Appropriated once a year by the County	47,246	IGT	Yes	Yes

Florida State Plan Amendment 08-017
2008-09 Intergovernmental Transfers by Local Government
Attachment 4

Source of Funding	Derivation of Funds	Funding Amount	Total as Non-Federal Share for SFY 2007-2008 LIP	Funding Mechanism	Will the source identified in the first column be responsible for the transfer?	Will the transfer from the identified source be sent directly to the Agency?
Gulf County	Sales Tax	1/2 cent	1,020,225	IGT	Yes	Yes
Halifax Hospital Medical Center Taxing District	Ad Valorem Property Tax	3.0 Mills	18,116,560	IGT	Yes	Yes
Health Care District of Palm Beach County	Ad Valorem Property Tax	1.08 Mills	12,728,930	IGT	Yes	Yes
Hernando County	Ad Valorem Property Tax	0.1306 Mills	16,881	IGT	Yes	Yes
Hillsborough County	Sales Tax	1/2 Cent	18,232,543	IGT	Yes	Yes
Indian River Taxing District	Ad Valorem Property Tax	.66296 Mills	5,724,815	IGT	Yes	Yes
Lake Shore Hospital Authority	Ad Valorem Property Tax	1.75 Mills, may levy up to 3 mills	1,640,311	IGT	Yes	Yes
Leon County	Ad Valorem Property Tax	.06 Mills	196,339	IGT	Yes	Yes
Manatee County	Ad Valorem Property Tax	Appropriated once a year by the County	305,057	IGT	Yes	Yes
Marion County	Ad Valorem Property Tax	Appropriated once a year by the County	2,298,058	IGT	Yes	Yes
Miami-Dade County	Sales Tax	1/2 Cent, budgeted at 95% of the total	190,819,525	IGT	Yes	Yes

Florida State Plan Amendment 08-017
2008-09 Intergovernmental Transfers by Local Government
Attachment 4

Source of Funding	Derivation of Funds	Funding Amount	Total as Non-Federal Share for SFY 2007-2008 LIP	Funding Mechanism	Will the source identified in the first column be responsible for the transfer?	Will the transfer from the identified source be sent directly to the Agency?
Nassau	County General Revenue	Appropriated once a year by the County	67,849	IGT	Yes	Yes
North Brevard Hospital District			1,145,074	IGT	YES	YES
North Broward Hospital District	Ad Valorem Property Tax	Levied by the District	87,246,421	IGT	Yes	Yes
North Lake Hospital Taxing District	Ad Valorem Property Tax	1 Mil on the dollar of the value of all nonexempt property within that area of Lake County which comprises the North Lake County Hospital District.	7,179,766	IGT	Yes	Yes
Orange County	County General Revenue, Ad Valorem Tax	Appropriated once a year by the County	5,873,167	IGT	Yes	Yes
Osceola County	Ad Valorem Property Tax	Appropriated once a year by the County	14,391	IGT	Yes	Yes
Pinellas County	Ad Valorem Property Tax	.40 Mills	13,742,218	IGT	Yes	Yes
Polk County	County General Revenue	Appropriated once a year by the County	447,646	IGT	Yes	Yes
Sarasota County Public Hospital Board	Ad Valorem Property Tax	.80 Mills, authority to levy up to 2 mills	12,265,947	IGT	Yes	Yes
South Broward Hospital District	Ad Valorem Property Tax	Maximum limit 2.5 Mills	36,193,184	IGT	Yes	Yes
South Lake Taxing District			4,192,710	IGT	Yes	Yes

Florida State Plan Amendment 08-017
2008-09 Intergovernmental Transfers by Local Government
Attachment 4

Source of Funding	Derivation of Funds	Funding Amount	Total as Non-Federal Share for SFY 2007-2008 LIP	Funding Mechanism	Will the source identified in the first column be responsible for the transfer?	Will the transfer from the identified source be sent directly to the Agency?
St. Johns County	Ad Valorem Property Tax	Appropriated once a year by the County	155,235	IGT	Yes	Yes
Sumter County	County General Revenue	Appropriated once a year by the County	103,942	IGT	Yes	Yes
West Volusia Hospital Authority	Ad Valorem Property Tax	1.26190 Mills	10,272	IGT	Yes	Yes
Total Local Governments			446,720,000	IGT	Yes	Yes
Undetermined Source of Funds	FQHC Program 1		65,200			
Total Proposed Source of Funds			**446,785,000**			

received 20 March 09 MV

FLORIDA MEDICAID

CHARLIE CRIST
GOVERNOR

Better Health Care for all Floridians

HOLLY BENSON
SECRETARY

March 16, 2009

Mary Kaye Justis, RN, MBA
Acting Associate Regional Administrator
Division of Medicaid and Children's Health
Center for Medicare and Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

Attention: Davida Kimble

RE: Florida SPA 08-017

Dear Mrs. Justis:

We have received your request for clarifications and/or additional information for proposed State Plan Amendment (SPA) 08-017. This amendment will revise the payment methodology for Outpatient Hospital Services. Our responses can be found below:

1. ***Please explain the following sentence in paragraph 22 on page 21 "Included in these funds are the annualized amounts to offset the reductions taken against certified trauma centers as identified in section 13, chapter 2007-326, Laws of Florida."***

   During the special legislative session of SFY 2007-08, the Florida Legislature directed the Agency to reduce inpatient and outpatient reimbursement rates for hospitals by approximately 3%. The Florida Legislature also stated that designated or provisional Trauma Hospital's would only a receive 1% reduction (the Trauma hospitals were given back 2% of the 3% cut). The language "*Included in these funds are the annualized amounts to offset the reductions taken against certified trauma centers as identified in section 13, chapter 2007-326, Laws of Florida",* instructs the Agency to move forward in the same manner for SFY 2008-09.

2. ***Please explain the SPA language found in paragraph 9 on page 25 "if the unit cost is greater than the unit cost used in establishing the budget, then rates shall be….". Regarding this section, how is the unit cost established? What is the process/method that the state undertakes to determine this provision? Please provide more comprehensive materials that will clearly explain and detail the methodology the State used to achieve the reduction. For plan comprehensiveness purposes, clarifying language should be included in the plan language regarding the methodology/process of the reduction.***

Effective July 1, 2008, the following method was applied to the rate setting process to ensure compliance with Section 409.908 Florida Statutes.

1. There are two specific types of unit cost: *Budgeted unit cost* is unit cost as established and approved by the Florida Legislature in the General Appropriations Act. The *calculated unit cost* is the unit cost that is actually applied to a provider's reimbursement rate which is based on the cost supplied to Florida Medicaid in a provider's most recent cost report.
2. A budgeted unit cost is determined based on estimated State annual budget for outpatient hospital services;
3. Outpatient hospital rates are established through the normal process;
4. An annual expenditure is determined based on current rates;
5. A calculated unit cost (similar to a weighted average) is computed based on current rates; and
6. The calculated unit cost based on current rates is compared to budgeted unit cost based on State budget:
    a. If the *calculated* unit cost is <u>less than</u> the *budgeted* unit cost then no action is required;
    b. If the *calculated* unit cost for current rates is <u>greater than</u> the *budgeted* unit cost for the State budget, then the rates will be reduced by an amount required to achieve the reduction, but shall not be reduced below the *budgeted* unit cost.

Please reference Attachment 1 for additional detail of the unit cost as applied to Outpatient Hospital services.

3. ***On page 26 paragraph 10 please provide SPA language that clarifies how the rates will be establish at a level to ensure no increase in statewide expenditures resulting from a change in unit cost for two fiscal years effective July 1, 2009. In addition please provide more information on the following:***
a) Why is this language necessary in the state plan, to what affect will this achieve?

Effective July 1, 2009, as mandated by the Florida Legislature, hospital rates in the aggregate will not be allowed to increase more than the unit cost; that was part of the calculation of reimbursement rates used in developing the General Appropriations Act (GAA) for State Fiscal Year 2008-2009. The methodology (as described in 3.b. below) that is used to *set* the unit cost will be the same methodology that is used to *maintain* the unit cost for the next two years. Therefore, rates in the aggregate will not be permitted to increase more than unit cost for two state fiscal years.

b) The method the State undertakes to achieve this particular section of the state plan, this will include any supporting documents with the calculation.

Effective July 1, 2008, the following method was applied to the rate setting process to ensure compliance with Section 409.908 Florida Statutes.

1. There are two specific types of unit cost: *Budgeted unit cost* is unit cost as established and approved by the Florida Legislature in the General Appropriations Act. The *calculated unit cost* is the unit cost that is actually applied to a provider's reimbursement rate which is based on the cost supplied to Florida Medicaid in a provider's most recent cost report.
2. A budgeted unit cost is determined based on estimated State annual budget for outpatient hospital services;
3. Outpatient hospital rates are established through the normal process;
4. An annual expenditure is determined based on current rates;
5. A calculated unit cost (similar to a weighted average) is computed based on current rates; and
6. The calculated unit cost based on current rates is compared to budgeted unit cost based on State budget:

    a. If the *calculated* unit cost is <u>less than</u> the *budgeted* unit cost then no action is required;
    b. If the *calculated* unit cost for current rates is <u>greater than</u> the *budgeted* unit cost for State budget, then the rates will be reduced by an amount required to achieve the reduction, but shall not be reduced below the unit cost.

Please refer to Attachment 1 for additional detail of the unit cost as applied to outpatient hospitals.

4. Please provide a more detailed explanation of the buy back provisions for the Medicaid trend adjustments as indicated in paragraph 11 on page 26 and paragraph 12 on page 27/28. In addition, it will be necessary to include information with respect to the following:

a) An example of the process/method that the State undertakes to determine this provision, including any supporting materials.

In accordance with House Bill 5001, 2008-09 General Appropriations Act, Specific Appropriation 211, the buy back provision allows hospitals that meet specific criteria the opportunity to buy back a portion of their rate reduction. Therefore, the determination of which hospitals are included in the buy back provision is simply the procedure of

determining which hospitals are included in the following categories of hospitals and applying the buy back against their respective rate reductions:

a. Hospital Systems that operate a Provider Service Network;
b. Children's Specialty Hospitals with Medicaid and Charity Care Days that equal or exceed 30 percent of total days;
c. Rural Hospitals;
d. Public Hospitals; and
e. Teaching Hospitals as defined in Florida Statutes with seventy or more FTE resident Physicians and whose Medicaid and Charity Care days exceed 25 percent of total days.

b) An explanation of any implications with respect to Federal share of the payments.

Absent the cuts mandated, the buy backs would not be included in SPA 08-017. The rates without the buy backs would decrease the federal share required as compared to the reduced rates with buy backs. Had the reductions not been taken, the federal share would be greater. Please reference the chart below to see the detail of the buy backs:

7/1/2008	$545,419,038	Annualized outpatient reductions estimated.	
	$302,162,147	Federal Share not blended	0.554
	$243,256,891	State Share	
	$475,006,983	Annualized Outpatient with all reductions estimated	
	$263,153,869	Federal Share not blended	
	$211,853,115	State Share	
	$509,560,963	Annualized Outpatient with all reductions and buy backs estimated	
	$282,296,774	Federal Share not blended	
	$227,264,190	State Share	
	$19,865,373	Federal amount saved vs. non-reduced rates	

5. ***Please explain how the State determines that Medicaid payments to providers do not exceed the amount according to 42 CFR 447.321. To that end, please submit an upper payment limit demonstration for outpatient hospital services. The following is presented as guidance in demonstrating the Upper Payment Limit (UPL) for outpatient hospital services.***

   Florida Medicaid reimburses hospital outpatient services with an occasion of service rate using a cost based prospective methodology that is detailed in the Title XIX Outpatient Hospital Reimbursement Plan. Individual facility costs are reported annually using the CMS 2552 cost report with specific information added for Florida Medicaid purposes.

   Allowable Medicaid costs are costs set in accordance with the Principles of Reimbursement for Provider Costs as defined in CMS Pub. 15-1, and are further defined in the Title XIX Outpatient Hospital Reimbursement Plan. Allowable Medicaid costs are the basis for reimbursement, with upper limits applied (class and target ceilings) and subject to a downward Medicaid trend adjustment. Some providers may be reimbursed at or near Medicaid allowable cost while the remaining providers are reimbursed far less than their actual allowable Medicaid costs.

   It is the position of the Agency for Health Care Administration (Agency) that allowable Medicaid costs are a reasonable substitute for what Medicare would have paid for the same claims. Since, by classification of hospital, we pay less than allowable Medicaid costs in the aggregate, we feel an actual comparison is not necessary.

   The Agency believes that allowable Medicaid cost should be permissible as a reasonable substitute for what Medicare would pay. We do not pay 100% of allowable cost in the aggregate for any class of hospital facility. The Agency therefore meets the requirements of UPL in federal rule.

   Federal regulations at 42 CFR 447.321 establish an UPL for outpatient hospital services. When a state proposes increases in outpatient hospital reimbursement, approval of the SPA is subject to the provision by the State of a demonstration that the payments can be made within the UPL limit. In order to establish that the payments meet the regulatory requirements, the State must demonstrate that, for each category of hospital services (State government-owned or operated facilities, non state government-owned or operated facilities and privately-owned and operated facilities), payment does not exceed, in the aggregate for each category, the reasonable estimate of the amount

that would be paid for the services furnished by the group of facilities under Medicare payment principles.

Because the UPL is an estimate of the amount that Medicare would pay or the cost it would reimburse for services, we require the State to make a direct link in its UPL to Medicare through the Medicare Cost Report CMS 2552-96.

When the State uses cost, the link to Medicare is made through reference to ancillary and outpatient hospital services cost center cost-to-charge ratios as found at Worksheet C, column 9, lines 37-68 or Worksheet D, Part V, Column 1.01, lines 37-68. These ratios include all cost regardless of payer for all ancillary and outpatient cost centers and charges made to all payers including Medicaid. CMS does not accept a UPL that is inflated by adjusting Medicare's allowed cost as reported on these worksheets.

The applicable outpatient hospital service payment reference for a payment-to-charge UPL demonstration may be found on Worksheet E, Part B of the CMS 2552-96. While Worksheet E represents what Medicare pays for services within hospitals, the State must make certain adjustments in order to reflect equivalent Medicaid outpatient hospital provider services that may be included in the UPL demonstration. For example, all lines that report payments associated with physician services must be removed. Additionally, the State must ensure that bad debts are not over-reported by including deductibles and coinsurance and reimbursable bad debt in Medicare payments. If deductible and coinsurance are added on to the Medicare payment, the State should remove reimbursable bad debts included in the Medicare payment. The resulting payments reported from Worksheet E should represent allowable Medicare payments for purposes of the UPL demonstration. The source of Medicare charge data, reflected in the ratio's denominator, must come from Worksheet D, Part V and Part VI of the Medicare Cost Report.

We note that a payment-to-charge ratio UPL methodology may not be inclusive of the full scope of outpatient hospital services because payments and charges on the Medicare cost report do not include payments and charges reimbursed on a fee for service basis through the Medicare Part B Carrier. For example, durable medical equipment payments and charges are not included on Worksheets E and D. CMS does not require that the ratio be adjusted for these excluded services.

CMS requires the use of the Medicare Market Basket/Global Insight Factor to trend cost. The State must demonstrate any proposed factor for trending volume.

6. ***If the State plans to include clinical diagnostic laboratory services in its outpatient hospital services UPL, then it must show this as a separate calculation. These services are subject to a separate UPL test at 1903(i)(7) of the Social Security Act, which requires that payment not exceed the Medicare rate on a per test basis. Please demonstrate that the State does not exceed Medicare fee rates per 1903(i)(7).***

Funding Questions:

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

1. ***Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)***

   Providers retain 100 percent of all payments made relating to this program. If an error occurs and payments are returned to the state, the state will track and report appropriately. The federal share is calculated and returned to CMS.

2. ***Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of***

Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

(i) a complete list of the names of entities transferring or certifying funds;
(ii) the operational nature of the entity (state, county, city, other);
(iii) the total amounts transferred or certified by each entity;
(iv) clarify whether the certifying or transferring entity has general taxing authority: and,
(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Please reference the following attachments for details regarding the funding of the state share of each type of Medicaid payment:

Attachment 2 - "State FY 2008-09 Appropriations for Services Provided Under Section 4.19B of the State Plan,"
Attachment 3 - "FY 2008-09 Medicaid Issues Funded with County Intergovernmental Transfers," and,
Attachment 4 - "FY 2008-09 Intergovernmental Transfers by Local Government."

3. ***Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.***

No supplemental Special Medicaid Payments (SMP) are being made in addition to provider Medicaid per diem rates. The only additional payments being made to hospital providers are those payments permitted through the Low Income Pool (LIP) program, for the continuation of government support for services to Medicaid, uninsured, and underinsured populations.

For clinic or outpatient hospital services please provide a detailed description of the methodology used by the State to estimate the UPL for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

Florida Medicaid reimburses hospital outpatient services with an occasion of service rate using a costs based prospective methodology. Individual facility costs are reported annually using the CMS 2552 cost report with specific information added for Florida Medicaid purposes.

Allowable Medicaid costs are costs set in accordance with the Principles of Reimbursement for Provider Costs as defined in CMS Pub. 15-1, and are further defined in the Title XIX Outpatient Hospital Reimbursement Plan. Allowable Medicaid costs are the basis for reimbursement, with upper limits applied (class and target ceilings) and subject to a downward Medicaid trend adjustment. Some providers may be reimbursed at or near Medicaid allowable cost while the remaining providers are reimbursed far less than their actual allowable Medicaid costs.

It is the position of the Agency for Health Care Administration (Agency) that allowable Medicaid costs are a reasonable substitute for what Medicare would have paid for the same claims. Since, by classification of hospital, we pay less than allowable Medicaid costs in the aggregate, the rates paid are within the requirements of the federal UPL regulations.

The Agency believes that allowable Medicaid cost should be permissible as a reasonable substitute for what Medicare would pay. We do not pay 100% of allowable cost in the aggregate for any class of hospital facility. The Agency therefore believes it should be clear that we are well within the UPL for each class of hospital facility.

4. ***Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?***

Payments to providers relating to outpatient hospital services would not exceed, in the aggregate, reasonable costs of providing services. If payments do exceed reasonable cost of providing services, the provider must return the excess amount to the state. Once the state has received the returned funds, appropriate documentation is made and the federal share is calculated and returned to CMS. The excess is returned to the state and the Federal share is reported on the 64 report to CMS.

Thank you for the opportunity to provide clarifications and additional information on SPA TN#08-017. If you have any questions on this RAI response, please contact Michele Hudson at (850) 414-2756.

Sincerely,

for Carlton D. Snipes
Deputy Secretary for Medicaid

CDS/es
Attachments
cc: Wesley Hagler, Medicaid Program Analysis
Michele Hudson, Bureau Chief, Medicaid Program Analysis
Phil Williams, Assistant Deputy Secretary for Medicaid Finance
Chris Osterlund, Assistant Deputy Secretary for Medicaid Operations

Florida State Plan Amendment 08-017
Attachment 1
Outpatient Hospital Unit Cost Calculations

	Inpatient Weighted Average Rate setting	Claims		Outpatient weighted average Rate setting	Claims	
1/1/2006	$1,202.83	$1,311.07	1.089992428	$107.57	$218.38	2.030181268
7/1/2006	$1,292.94	$1,354.47	1.047583921	$117.04	$250.43	2.139767013
1/1/2007	$1,337.48	$1,412.31	1.055950931	$122.34	$243.92	1.993819057
7/1/2007	$1,393.44	$1,452.58	1.042441079	$119.13	$246.90	2.072501877
1/1/2008	$1,406.96	$1,486.96	1.056859385	$117.34	$240.81	2.052248849
1/1/2009	$1,593.57	$1,676.04	1.051750465	$138.37	$282.21	2.039523261
allowed before Buy Back		$1,560.84	6.87% cut		$231.24	18.06% cut
Allowed after buy Back		$1,685.65	8.00% buy back		$246.92	6.78% buy back

Fixed amount

	1339754.72	$1,676.04	$2,245,482,500.74	1963692	$282.21	$554,173,519.00	
Total cut			($154,333,435)			($36,403,451)	
	1339754.72	$1,560.84	$2,091,149,065.74	1963692	$263.67	$517,770,068.00	6.57%
Total restore			$167,204,828			$30,794,556	
	1339754.72	$1,685.65	$2,258,353,893.74	1963692	$279.35	$548,564,624.00	5.95%

ATTACHMENT 2
Florida State Plan Amendment 08-017
State FY 2008-09 Appropriations for Services Provided Under Section 4.19B of the State Plan

HOSPITAL OUTPATIENT BUDGET FY 2008-09

		General Revenue Fund (State)	Tobacco Settlement Trust Fund (State)	Grants & Donations Trust Fund	Medical Care Trust Fund (Federal)	Public Medical Assistance Trust Fund (State)	Refugee Assistance Trust Fund (Federal)	Total All Funds
A	FY 2008-09 Hospital Outpatient Services Legislative Appropriation	$91,211,922	$25,329,039	$71,309,086	$327,404,515	$75,000,000	$1,130,101	$591,384,663
	Less Non-Title XXI	($64,891)	$0	$0	($142,961)	$0	$0	($207,852)
	Total Hospital Outpatient-Title XIX	$91,147,031	$25,329,039	$71,309,086	$327,261,554	$75,000,000	$1,130,101	$591,176,811
B	**Source of Medicaid Total Hospital Outpatient Funding:**							
	State General Revenue	$91,211,922	$0	$0	$0	$0	$0	$91,211,922
	State Trust Funds - Tobacco Settlement	$0	$25,329,039	$0	$0	$0	$0	$25,329,039
	State Trust Funds - State Retained Share of Fraud/Abuse Recoveries	$0	$0	$4,849,717	$0	$0	$0	$4,849,717
	Intergovernmental Transfers (From Local Governments)	$0	$0	$66,459,369	$0	$0	$0	$66,459,369
	Provider Taxes (Assessment on Hospital Net Operating Revenues)	$0	$0	$0	$0	$75,000,000	$0	$75,000,000
	Cigarette Taxes (By Statute, Medicaid Receives a Portion of Tax)	$0	$0	$0	$0	$0	$0	$0
	Enhanced Federal Medical Assistance (Medicaid Expansion Under XXI)	($64,891)	$0	$0	($142,961)	$0	$0	($207,852)
	Federal Medical Assistance Payments (Title XIX)	$0	$0	$0	$327,404,515	$0	$1,130,101	$328,534,616
	Total	$91,147,031	$25,329,039	$71,309,086	$327,261,554	$75,000,000	$1,130,101	$591,176,811
C	**DSH Payments**	$0	$0	$0	$0	$0	$0	$0
	Source of Funds:							
	State General Revenue (In AHCA & In Other State Agencies)	$0	$0	$0	$0	$0	$0	$0
	State Trust Funds - Tobacco Settlement	$0	$0	$0	$0	$0	$0	$0
	State Trust Funds - State Retained Share of Fraud/Abuse Recoveries	$0	$0	$0	$0	$0	$0	$0
	Intergovernmental Transfers (From Local Governments)	$0	$0	$0	$0	$0	$0	$0
	Provider Taxes (Assessment on Hospital Net Operating Revenues)	$0	$0	$0	$0	$0	$0	$0
	Cigarette Taxes (By Statute, Medicaid Receives a Portion of Tax)	$0	$0	$0	$0	$0	$0	$0
	Enhanced Federal Medical Assistance (Medicaid Expansion Under XXI)	$0	$0	$0	$0	$0	$0	$0
	Federal Medical Assistance Payments (Title XIX)	$0	$0	$0	$0	$0	$0	$0
	Total	$0	$0	$0	$0	$0	$0	$0
D	**Special Medicaid Payments**	$0	$0	$0	$0	$0	$0	$0
	Source of Special Medicaid Payment Funds:							
	State General Revenue (In AHCA & In Other State Agencies)	$0	$0	$0	$0	$0	$0	$0
	State Trust Funds - Tobacco Settlement	$0	$0	$0	$0	$0	$0	$0
	State Trust Funds - State Retained Share of Fraud/Abuse Recoveries	$0	$0	$0	$0	$0	$0	$0
	Intergovernmental Transfers (From Local Governments)	$0	$0	$0	$0	$0	$0	$0
	Provider Taxes (Assessment on Hospital Net Operating Revenues)	$0	$0	$0	$0	$0	$0	$0

ATTACHMENT 2
Florida State Plan Amendment 08-017
State FY 2008-09 Appropriations for Services Provided Under Section 4.19B of the State Plan

HOSPITAL OUTPATIENT BUDGET FY 2008-09

	General Revenue Fund (State)	Tobacco Settlement Trust Fund (State)	Grants & Donations Trust Fund	Medical Care Trust Fund (Federal)	Public Medical Assistance Trust Fund (State)	Refugee Assistance Trust Fund (Federal)	Total All Funds
Cigarette Taxes (By Statute, Medicaid Receives a Portion of Tax)	$0	$0	$0	$0	$0	$0	$0
Enhanced Federal Medical Assistance (Medicaid Expansion Under XXI)	$0	$0	$0	$0	$0	$0	$0
Federal Medical Assistance Payments (Title XIX)	$0	$0	$0	$0	$0	$0	$0
Total	$0	$0	$0	$0	$0	$0	$0
E Per Diem Payments	$91,147,031	$25,329,039	$71,309,086	$327,261,554	$75,000,000	$1,130,101	$591,176,811
Source of Funds:							
State General Revenue (In AHCA & In Other State Agencies)	$91,211,922	$0	$0	$0	$0	$0	$91,211,922
State Trust Funds - Tobacco Settlement	$0	$25,329,039	$0	$0	$0	$0	$25,329,039
State Trust Funds - State Retained Share of Fraud/Abuse Recoveries	$0	$0	$4,849,717	$0	$0	$0	$4,849,717
Intergovernmental Transfers (From Local Governments)	$0	$0	$66,459,368	$0	$0	$0	$66,459,368
Provider Taxes (Assessment on Hospital Net Operating Revenues)	$0	$0	$0	$0	$75,000,000	$0	$75,000,000
Cigarette Taxes (By Statute, Medicaid Receives a Portion of Tax)	$0	$0	$0	$0	$0	$0	$0
Enhanced Federal Medical Assistance (Medicaid Expansion Under XXI)	($64,891)	$0	$0	($142,961)	$0	$0	($207,852)
Federal Medical Assistance Payments (Title XIX)	$0	$0	$0	$327,404,515	$0	$1,130,101	$328,534,616
Total	$91,147,031	$25,329,039	$71,309,085	$327,261,554	$75,000,000	$1,130,101	$591,176,810

FY 2008-09 MEDICAID ISSUES FUNDED WITH COUNTY INTERGOVERNMENTAL TRANSFERS
Florida State Plan Amendment 08-017
Attachment 3

Issue APPROPRIATIONS	County Transfers	General Revenue	Tobacco Trust Fund	Other State Funds	Medical Care TF	Total Funds	
Hospital Outpatient Services							
Hospital Outpatient Ceiling for Adults $500 to $1,000	$5,247,192	$0	$0	$0	$6,533,661	$11,780,853	
Hospital Outpatient Variable Cost Ceilings	$10,337,748	$0	$0	$0	$12,872,283	$23,210,031	
Hospital Outpatient Ceiling for Adults $1,000 to $1,500	$7,182,339	$0	$0	$0	$8,943,254	$16,125,593	
Remove Hospital Outpatient Reimbursement Ceilings/Teaching, Specialty, CHEP	$16,605,046	$0	$0	$0	$20,676,153	$37,281,199	
Eliminate Outpatient Reimbursement Ceilings -11% Screen	$4,943,712	$0	$0	$0	$6,155,777	$11,099,489	
Eliminate Outpatient Reimbursement Ceilings - 7.3% Screen/Trauma	$6,596,153	$0	$0	$0	$8,213,350	$14,809,503	
Payment to Hospitals-Outpatient Provider Clinics	$6,681,000	$0	$0	$0	$8,319,000	$15,000,000	
Medicaid Trend Adjustment Buy Back - PSNs, Childrens and Rural Hospitals	$0	$0	$0	$4,849,717	$6,038,736	$10,888,453	(8)
Medicaid Trend Adjustment Buy Back - Public and Teaching Hospitals	$8,866,178	$0	$0	$0	$11,039,925	$19,906,103	
Total Hospital Outpatient Services	$66,459,368	$0	$0	$4,849,717	$88,792,139	$160,101,224	
Hospital Inpatient Services							
Remove Hospital Inpatient Reimbursement Ceilings/Teaching, Specialty, CHEP	$148,851,661	$0	$0	$13,675,000	$202,373,791	$364,900,452	(1)
Eliminate Inpatient Reimbursement Ceilings -11% Screen	$46,339,212	$0	$0	$0	$57,700,329	$104,039,541	
Eliminated Inpatient Reimbursement Ceilings -Trauma Centers/Medicaid days 7.3%	$51,864,174	$0	$0	$0	$64,579,863	$116,444,037	
Special Medicaid Payments-Liver Transplant Facilities	$4,423,713	$0	$0	$0	$5,508,287	$9,932,000	
Medicaid Trend Adjustment Buy Back - PSNs, Childrens and Rural Hospitals	$4,806,048	$0	$0	$20,150,282	$31,074,945	$56,031,275	(8)
Medicaid Trend Adjustment Buy Back - Public and Teaching Hospitals	$49,597,763	$0	$0	$0	$61,575,790	$111,173,553	
Total Hospital Inpatient Services	$305,882,571	$0	$0	$33,825,282	$422,813,005	$762,520,858	
Low Income Pool Provider Access System Payments							
Low Income Pool - Primary Care Hospitals	$4,245,134	$0	$0	$0	$5,273,104	$9,518,238	
Low Income Pool - Provisional Trauma Centers	$4,318,860	$0	$0	$0	$5,364,682	$9,683,542	
Low Income Pool - Rural Hospitals	$2,816,764	$0	$0	$0	$3,498,850	$6,315,614	
Low Income Pool - Safety Net Hospitals	$28,790,908	$250,000	$0	$4,750,306	$41,663,301	$75,454,515	(4)(6)
Low Income Pool - Poison Control Hospitals	$0	$0	$0	$1,415,071	$1,757,734	$3,172,805	(5)
Low Income Pool - Specialty Pediatric Hospitals	$705,996	$0	$0	$0	$876,956	$1,582,952	
Low Income Pool - Hospitals Providers Access System	$389,222,032	$0	$0	$0	$483,473,107	$872,695,139	
Low Income Pool - Federally Qualified Health Centers	$5,190,605	$0	$0	$1,622,605	$8,463,046	$15,276,256	(7)
Low Income Pool - Primary Care & ER Diversion in Manatee, Sarasota and Desoto	$0	$0	$535,200	$0	$664,800	$1,200,000	
Low Income Pool - County Health Initiatives	$2,921,719	$0	$0	$0	$3,629,220	$6,550,939	
Total Low Income Pool Provider Access System Payments	$438,212,018	$250,000	$535,200	$7,787,982	$554,664,800	$1,001,450,000	
Nursing Home Special Medicaid Payments	$4,822,535	$0	$0	$0	$5,990,324	$10,812,859	
Disproportionate Share Hospital Programs							
Regular Disproportionate Share	$91,303,247	$0	$0	$6,198,263	$121,111,741	$218,613,251	(2)(3)
Total DSH Programs Funded with IGTs	$91,303,247	$0	$0	$6,198,263	$121,111,741	$218,613,251	
Total FY 2008-09	$906,679,739	$250,000	$535,200	$52,661,244	$1,193,372,009	$2,153,498,192	

Source of Other State Funds for FY 2008-2009:

(1) Transfer from Department of Health (See Specific Appropriation 648)	$13,675,000
(2) Transfer from Department of Health (See Specific Appropriation 648)	$825,000
(3) Transfer from Department of Health (See Specific Appropriation 652)	$5,373,263
(4) Transfer from Department of Health (See Specific Appropriation 626)	$450,000
(5) Transfer from Department of Health (See Specific Appropriation 624)	$1,415,071
(6) Transfer from Department of Health (See Specific Appropriation 652)	$4,300,306
(7) Transfer from Department of Health (See Specific Appropriation 644)	$1,622,605
(8) Transfer from Department of Health (See Specific Appropriation 652 & 652A)	25,000,000
	$52,661,245

Florida State Plan Amendment 08-017
2008-09 Intergovernmental Transfers by Local Government
Attachment 4

Source of Funding	Derivation of Funds	Funding Amount	Total as Non-Federal Share for SFY 2007-2008 LIP	Funding Mechanism	Will the source identified in the first column be responsible for the transfer?	Will the transfer from the identified source be sent directly to the Agency?
Brevard County	General Fund	Appropriated once a year by the County	112,610	IGT	Yes	Yes
Broward County	General Fund	Appropriated once a year by the County	36,824	IGT	Yes	Yes
Children's Services Council of St. Lucie County	Ad Valorem Property Tax	.915 Mills with a maximum of .50 Mills	155,235	IGT	Yes	Yes
Citrus County Hospital Board	Ad Valorem Property Tax	.95 Mills. The amount of taxes levied is determined by Trustees, based on the operating and capital needs of the Hospital. A budget is prepared each year that indicates the amount of tax support required. The Trustees evaluate and validate the budget need and set taxes appropriately. The Trustees are charged with providing for the appropriate level of health care in the community.	4,426,197	IGT	Yes	Yes
Collier County	Ad Valorem Property Tax	Appropriated once a year by the County	1,939,964	IGT	Yes	Yes
Columbia County	Ad Valorem Property Tax	Appropriated once a year by the County	12,939	IGT	Yes	Yes
Duval County	General Funds and General Revenue	The 3 major sources of revenue come from Ad Valorem taxes, state revenue sharing and the operating contribution from the Jacksonville Electric Authority, which included both electric and water/sewer fees. Amount decided every year by the County.	11,604,165	IGT	Yes	Yes
Escambia County	County General Revenue	Appropriated once a year by the County	47,246	IGT	Yes	Yes

Florida State Plan Amendment 08-017
2008-09 Intergovernmental Transfers by Local Government
Attachment 4

Source of Funding	Derivation of Funds	Funding Amount	Total as Non-Federal Share for SFY 2007-2008 LIP	Funding Mechanism	Will the source identified in the first column be responsible for the transfer?	Will the transfer from the identified source be sent directly to the Agency?
Gulf County	Sales Tax	1/2 cent	1,020,225	IGT	Yes	Yes
Halifax Hospital Medical Center Taxing District	Ad Valorem Property Tax	3.0 Mills	18,116,560	IGT	Yes	Yes
Health Care District of Palm Beach County	Ad Valorem Property Tax	1.08 Mills	12,728,930	IGT	Yes	Yes
Hernando County	Ad Valorem Property Tax	0.1306 Mills	16,881	IGT	Yes	Yes
Hillsborough County	Sales Tax	1/2 Cent	18,232,543	IGT	Yes	Yes
Indian River Taxing District	Ad Valorem Property Tax	.66296 Mills	5,724,815	IGT	Yes	Yes
Lake Shore Hospital Authority	Ad Valorem Property Tax	1.75 Mills, may levy up to 3 mills	1,640,311	IGT	Yes	Yes
Leon County	Ad Valorem Property Tax	.06 Mills	196,339	IGT	Yes	Yes
Manatee County	Ad Valorem Property Tax	Appropriated once a year by the County	305,057	IGT	Yes	Yes
Marion County	Ad Valorem Property Tax	Appropriated once a year by the County	2,298,058	IGT	Yes	Yes
Miami-Dade County	Sales Tax	1/2 Cent, budgeted at 95% of the total	190,819,525	IGT	Yes	Yes

Florida State Plan Amendment 08-017
2008-09 Intergovernmental Transfers by Local Government
Attachment 4

Source of Funding	Derivation of Funds	Funding Amount	Total as Non-Federal Share for SFY 2007-2008 LIP	Funding Mechanism	Will the source identified in the first column be responsible for the transfer?	Will the transfer from the identified source be sent directly to the Agency?
Nassau	County General Revenue	Appropriated once a year by the County	67,849	IGT	Yes	Yes
North Brevard Hospital District			1,145,074	IGT	YES	YES
North Broward Hospital District	Ad Valorem Property Tax	Levied by the District	87,246,421	IGT	Yes	Yes
North Lake Hospital Taxing District	Ad Valorem Property Tax	1 Mil on the dollar of the value of all nonexempt property within that area of Lake County which comprises the North Lake County Hospital District.	7,179,766	IGT	Yes	Yes
Orange County	County General Revenue, Ad Valorem Tax	Appropriated once a year by the County	5,873,167	IGT	Yes	Yes
Osceola County	Ad Valorem Property Tax	Appropriated once a year by the County	14,391	IGT	Yes	Yes
Pinellas County	Ad Valorem Property Tax	.40 Mills	13,742,218	IGT	Yes	Yes
Polk County	County General Revenue	Appropriated once a year by the County	447,646	IGT	Yes	Yes
Sarasota County Public Hospital Board	Ad Valorem Property Tax	.80 Mills, authority to levy up to 2 mills	12,265,947	IGT	Yes	Yes
South Broward Hospital District	Ad Valorem Property Tax	Maximum limit 2.5 Mills	36,193,184	IGT	Yes	Yes
South Lake Taxing District			4,192,710	IGT	Yes	Yes

Florida State Plan Amendment 08-017
2008-09 Intergovernmental Transfers by Local Government
Attachment 4

Source of Funding	Derivation of Funds	Funding Amount	Total as Non-Federal Share for SFY 2007-2008 LIP	Funding Mechanism	Will the source identified in the first column be responsible for the transfer?	Will the transfer from the identified source be sent directly to the Agency?
St. Johns County	Ad Valorem Property Tax	Appropriated once a year by the County	155,235	IGT	Yes	Yes
Sumter County	County General Revenue	Appropriated once a year by the County	103,942	IGT	Yes	Yes
West Volusia Hospital Authority	Ad Valorem Property Tax	1.26190 Mills	10,272	IGT	Yes	Yes
Total Local Governments			446,720,000	IGT	Yes	Yes
Undetermined Source of Funds	FQHC Program 1		65,200			
Total Proposed Source of Funds			**446,785,000**			

FLORIDA
STATE PLAN AMENDMENT REVIEW SHEET

TRANSMITTAL: 08-017 **DATE ASSIGNED:** 09/30/08 **RO LEAD:** Davida Kimble

COVERAGE COORD: Venesa Day **ELIGIBILITY COORD:** Sally Brown

STATE COORD: Andriette Johnson **FIN ANALYST:** Davida Kimble

STATE COORD: **FIN ANALYST:**

IT ANALYST: **RO FUNDING SPEC:** Anna Dubois

RO FUNDING SPEC: **RO NIRT ANALYST:** Stanley Fields

NIRT ANALYST: Venesa Day **CO FUNDING SPEC:** Sharon Sims

PHARMT ANALYST: Bernadette Leeds **NIPT ANALYST:** Sheri Gaskins

TITLE/SUBJECT:
Payment Methodology for Outpatient Hospital Reimbursement (4.19-B)

DATE FORWARDED TO:

NIRT: N/A NIPT: 09/30/08 PHARMT: N/A CMS SPA: 09/30/08

****

TYPE OF TRANSMITTAL

X	New Plan Amendment	____	Revised Pages
____	Comments From CO	____	Withdrawal/RAI
____	Response From State	____	Withdrawal/SPA
____	Other		

ACTION DATES

Date Rec'd in CMS	09/29/08
15-Day Status	
60th Day Alert	11/28/08
90th Day	12/28/08
RO NIPT Overview Tool Due Date	10/17/08 (Due 20 days after receipt of SPA)

REVIEWER'S RECOMMENDATION

____	Draft Letter to CO	____	Partial Disapproval	____	Recommending Disapproval
____	Official Letter to SA	____	Partial Approval	____	Recommending Approval

COMMENTS AND/OR INSTRUCTIONS

15-Day Status:

PRIMARY REVIEWER/DATE

CONCURRENCES

SIGNATURE/TITLE/DATE

SIGNATURE/TITLE/DATE

SIGNATURE/TITLE/DATE

FLORIDA MEDICAID

CHARLIE CRIST
GOVERNOR

HOLLY BENSON
SECRETARY

September 22, 2008

Ms. Mary Kaye Justis
Acting Associate Regional Administrator
Division of Medicaid & Children's Health
Centers for Medicare and Medicaid Services
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303-8909

Dear Ms. Justis:

Enclosed for your consideration is a Title XIX amendment to our Medicaid State Plan. The amendment number is TN 2008-017: Payment Methodology for Outpatient Hospital Reimbursement. The Florida Title XIX Outpatient Hospital Reimbursement Plan payment methodology has been amended, effective July 1, 2008, in accordance with House Bill 5001, 2008-09 General Appropriations Act, Specific Appropriation 211 and House Bill 5085, Section 5, which amended section 409.908, Florida Statutes.

The Governor's office has reviewed the amendment in compliance with the provisions of the Presidential Executive Order No. 12372 and section 216.212, Florida Statutes.

Please advise us if you have any questions concerning this amendment.

Sincerely,

Carlton D. Shipes
Deputy Secretary for Medicaid

CDS/ri
Enclosures
cc: Andriette Johnson, CMS
Stanley Fields, CMS

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS NOT AVAILABLE.

AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid

RULE NO.:	RULE TITLE:
59G-6.020	Payment Methodology for Inpatient Hospital Services

PURPOSE AND EFFECT: To incorporate changes to the Florida Title XIX Inpatient Hospital Reimbursement Plan payment methodology, effective July 1, 2008, in accordance with House Bill 5001, 2008-09 General Appropriations Act, Specific Appropriations 206, 207, 238, and 239 and House Bill 5085, Section 5, which amended Section 409.908(23), Florida Statutes.

SUBJECT AREA TO BE ADDRESSED:

1. The Agency shall implement a recurring methodology in the Title XIX Inpatient Hospital Reimbursement Plan to achieve a $154,333,435 rate reduction. In establishing rates through the normal process, prior to including this reduction, if the unit cost is equal to or less than the unit cost used in establishing the budget, no additional reduction in rates is necessary. In establishing rates through the normal process, prior to including this reduction, if the unit cost is greater than the unit cost used in establishing the budget, then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the unit cost used in establishing the budget.

2. The Agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs for two fiscal years effective July 1, 2009. Reimbursement rates for the two fiscal years shall be as provided in the General Appropriations Act.

3. Any hospital will be exempt from the inpatient targets and ceilings if that hospital was identified by the Agency for Health Care Administration as qualifying for the exemption pursuant to Section 409.905(5)(c), Florida Statutes in fiscal year 2007-08 and did not receive funding in the final General Appropriations Act for Fiscal Year 2007-08. Any hospital that was exempt under Section 409.905(5)(c), Florida Statutes, in state fiscal year 2007-08 is not eligible to receive funds under this provision.

4. Hospitals will be exempt from the inpatient reimbursement ceilings whose charity care and Medicaid days, as a percentage of total adjusted hospital days, equals or exceeds 11 percent. The Agency shall use the average of the 2002, 2003, and 2004 audited DSH data available as of March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003 and 2004 that are available. For those hospitals qualifying using audited DSH data received between January 30, 2008, and March 1, 2008, and who were excluded from the LIP Council recommendations may be exempt from the inpatient ceilings.

5. The inpatient reimbursement ceilings will be eliminated for hospitals that have a minimum of ten licensed Level II Neonatal Intensive Care Beds and are located in Trauma Services Area 2.

6. The inpatient hospital reimbursement ceilings will be eliminated for hospitals whose Medicaid days as a percentage of total hospital days exceed 7.3 percent, and are designated or provisional trauma centers. This provision shall apply to all hospitals that are designated or provisional trauma centers on July 1, 2008, and any hospitals that become a designated or provisional trauma center during state fiscal year 2008-2009. Included in these funds are the annualized amounts to offset the reductions taken against certified trauma centers as identified in Section 12, Chapter 2007-326, Laws of Florida. The Agency shall use the average of the 2002, 2003 and 2004 audited DSH data available as of March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003, and 2004 that are available.

7. The inpatient reimbursement ceilings will be eliminated for teaching, specialty, Community Hospital Education Program hospitals and Level III Neonatal Intensive Care Units that have a minimum of three of the following designated tertiary services as regulated under the Certificate of Need Program: pediatric bone marrow transplantation, pediatric open heart surgery, pediatric cardiac catheterization and pediatric heart transplantation. Included in these funds are the annualized amounts to offset the reductions taken against hospitals defined in Section 408.07(45), Florida Statutes, that are not certified trauma centers, as identified in Section 12, Chapter 2007-326, Laws of Florida.

8. A buy back provision will be applied to the Medicaid trend adjustment that is being applied against the Medicaid inpatient rates for the following three categories of hospitals. Of these funds, $34,484,976 is provided to the first category of hospitals, which are those hospitals that are part of a system that operates a provider service network in the following manner: $20,000,000 is for Jackson Memorial Hospital; $3,968,662 is for hospitals in Broward Health; $2,376,638 is for hospitals in the Memorial Healthcare System; and $3,428,386 is for Shands Jacksonville and $4,711,290 is for Shands Gainesville. In the event the above amounts exceed the amount of the Medicaid trend adjustment applied to each hospital, the excess funds will be used to buy back other Medicaid reductions in the inpatient rate. Of the above funds, $18,125,729 shall be used for the second category to buy back the Medicaid trend adjustment that is being applied against the Medicaid inpatient rates for those hospitals that are licensed as a children's specialty hospital and whose Medicaid days plus charity care days divided by total adjusted patient days equals or exceeds 30 percent. In the event that the funds under this category exceed the amount of the Medicaid trend adjustment,

then any excess funds will be used to buy back other Medicaid reductions in the inpatient rate for those individual hospitals. Of the above funds, $3,420,570 shall be used for the third category to buy back the additional Medicaid trend adjustment that is being applied to rural hospitals under Specific Appropriation 206 for fiscal year 2008-2009. In the event the funds under this category exceed the amount of the Medicaid trend adjustment, then any excess funds will be used to buy back other Medicaid reductions in the inpatient rate for those individual hospitals. For this provision the Agency shall use the 2002, 2003, and 2004 audited DSH data available as of March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003, and 2004 that are available.

9. A buy back provision for public hospitals, teaching hospitals as defined in Section 408.07(45) or 395.805, Florida Statutes, which have 70 or more full-time equivalent resident physicians and those hospitals whose Medicaid and charity care days divided by total adjusted days exceeds 25 percent to buy back the Medicaid inpatient trend adjustment applied to their individual hospital rates and other Medicaid reductions to their inpatient rates up to actual Medicaid inpatient cost. The Agency shall use the average of 2002, 2003, and 2004 audited DSH data available as of March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003 and 2004 that are available.

10. $148,382,079 is provided for disproportionate share payments to public hospitals.

11. $58,231,172 is provided for disproportionate share payments to defined statutory teaching hospitals; prior to the distribution of these funds to the statutorily defined teaching hospitals, $6,487,220 shall be allocated to Shands Jacksonville Hospital, $2,660,440 shall be distributed to Tampa General Hospital, and $1,083,512 shall be distributed to Shands Teaching Hospital.

12. $12,000,000 is provided for disproportionate share payments to family practice teaching hospitals.

13. $62,290,337 is provided for disproportionate share payments to mental heath programs.

14. 2,444,444 is provided for specialty disproportionate share programs.

SPECIFIC AUTHORITY: 409.919 FS.

LAW IMPLEMENTED: 409.908 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE DATE, TIME AND PLACE SHOWN BELOW:

DATE AND TIME: July 24, 2008, 10:00 a.m. – 11:00 a.m.

PLACE: Agency for Health Care Administration, 2727 Mahan Drive, Building 3, Conference Room D, Tallahassee, FL 32301

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Edwin Stephens, Medicaid Program Analysis, Agency for Health Care Administration, 2727 Mahan Drive, Building 3, Room 2149-A, Tallahassee, Florida 32308, (850)414-2759 or stephense@ahca.myflorida.com

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS NOT AVAILABLE.

AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid

RULE NO.:	RULE TITLE:
59G-6.030	Payment Methodology for Outpatient Hospital Services

PURPOSE AND EFFECT: To incorporate changes to the Florida Title XIX Outpatient Hospital Reimbursement Plan payment methodology, effective July 1, 2008, in accordance with House Bill 5001, 2008-09 General Appropriations Act, Specific Appropriation 211 and House Bill 5085, Section 5, which amended Section 409.908(23), Florida Statutes.

SUBJECT AREA TO BE ADDRESSED:

1. As a result of implementing a reduction in outpatient hospital reimbursement rates, the Agency shall implement a recurring methodology in the Title XIX Outpatient Hospital Reimbursement Plan to achieve a $36,403,451 rate reduction. In establishing rates through the normal process, prior to including this reduction, if the unit cost is equal to or less than the unit cost used in establishing the budget, then no additional reduction in rates is necessary. In establishing rates through the normal process, prior to including this reduction, if the unit cost is greater than the unit cost used in establishing the budget, then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the unit cost used in establishing the budget.

2. The Agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs for two fiscal years effective July 1, 2009. Reimbursement rates for the two fiscal years shall be as provided in the General Appropriations Act.

3. Outpatient reimbursement ceilings for hospitals will be eliminated for those hospitals whose charity care and Medicaid days as a percentage of total adjusted hospital days equals or exceeds 11 percent. The Agency shall use the average of the 2002, 2003 and 2004 audited DSH data available as of March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003, and 2004 that are available.

4. Outpatient reimbursement ceilings will be eliminated for hospitals that have a minimum of ten licensed Level II Neonatal Intensive Care Beds and are located in Trauma Services Area 2.

5. Outpatient hospital reimbursement ceilings will be eliminated for hospitals whose Medicaid days, as a percentage of total hospital days, exceed 7.3 percent, and are designated or provisional trauma centers. This provision shall apply to all hospitals that are designated or provisional trauma centers on July 1, 2008, or become a designated or provisional trauma center during Fiscal Year 2008-2009.

Included in these funds are the annualized amounts to offset the reductions taken against certified trauma centers as identified in Section 13, Chapter 2007-326, Laws of Florida. The Agency shall use the average of the 2002, 2003, and 2004 audited DSH data available as of March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003 and 2004 that are available.

6. A buy back provision for the Medicaid trend adjustment will be applied against the Medicaid outpatient rates for the following three categories of hospitals. Of these funds $3,515,024 is provided to the first category of hospitals, which are those hospitals that are part of a system that operate a provider service network in the following manner: $831,338 is for hospitals in Broward Health; $823,362 is for hospitals in the Memorial Healthcare System; and $601,863 to Shands Jacksonville and $1,258,461 to Shands Gainesville. In the event that the above amounts exceed the amount of the Medicaid trend adjustment applied to each hospital, the excess funds will be used to buy back other Medicaid reductions in the outpatient rate. Of the above funds, $5,203,232 shall be used for the second category to buy back the Medicaid trend adjustment that is being applied against the Medicaid outpatient rates for those hospitals that are licensed as a children's specialty hospital and whose Medicaid days plus charity care days divided by total adjusted patient days equals or exceeds 30 percent. In the event the above amounts exceed the amount of the Medicaid trend adjustment applied to each hospital, the excess funds will be used to buy back other Medicaid reductions in the inpatient rate. Of the above funds, $2,170,197 shall be used for the third category to buy back the additional Medicaid trend adjustment that is being applied to rural hospitals under Specific Appropriation 211 for Fiscal Year 2008-2009. In the event that the funds under this category exceed the amount of the Medicaid trend adjustment, then any excess funds will be used to buyback other Medicaid reductions in the outpatient rate for those individual hospitals. For this provision the Agency shall use the average of 2002, 2003 and 2004 audited DSH data available as of March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003 and 2004 that are available.

7. A buy back provision will be applied for teaching hospitals as defined in Section 408.07(45) or 395.805, Florida Statutes, which have 70 or more full-time equivalent resident physicians and those hospitals whose Medicaid and charity care days divided by total adjusted days exceeds 25 percent to buy back the Medicaid outpatient trend adjustment applied to their individual hospital rates and other Medicaid reductions to their outpatient rates up to actual Medicaid outpatient cost. The Agency shall use the 2002, 2003 and 2004 audited DSH data available as of March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003 and 2004 that are available.

SPECIFIC AUTHORITY: 409.919 FS.

LAW IMPLEMENTED: 409.908 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE DATE, TIME AND PLACE SHOWN BELOW:

DATE AND TIME: July 24, 2008, 10:00 a.m. – 11:00 a.m.

PLACE: 2727 Mahan Drive, Conference Room D, Building 3, Tallahassee, Florida 32301

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Edwin Stephens, Medicaid Program Analysis, Agency for Health Care Administration, 2727 Mahan Drive, Building 3, Room 2149A, Tallahassee, Florida 32308, (850)414-2759 or stephense@ahca.myflorida.com

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS NOT AVAILABLE.

AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid

RULE NO.:	RULE TITLE:
59G-6.090	Payment Methodology for County Health Departments

PURPOSE AND EFFECT: To incorporate changes to the Florida Title XIX Payment Methodology for County Health Departments Reimbursement Plan (the Plan) effective July 1, 2008. In accordance with House Bill 5001, 2008-09 General Appropriations Act, Specific Appropriation 229, and House Bill 5085, Section 5, which amended Section 409.908(23), Florida Statues, the Florida Title XIX Payment Methodology for County Health Departments Reimbursement Plan will be amended.

SUBJECT AREA TO BE ADDRESSED:

1. As a result of modifying the reimbursement for county health department rates, the Agency shall implement a recurring methodology in the Title XIX County Health Department Reimbursement Plan to achieve a $7,426,780 recurring rate reduction. In establishing rates through the normal process, prior to including this reduction, if the unit

cost is equal to or less than the unit cost used in establishing the budget, then no additional reduction in rates is necessary. In establishing rates through the normal process, prior to including this reduction, if the unit cost is greater than the unit cost used in establishing the budget, then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the unit cost used in establishing the budget.

2. The Agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs for two fiscal years effective July 1, 2009. Reimbursement rates for the two fiscal years shall be as provided in the General Appropriations Act.

SPECIFIC AUTHORITY: 409.919 FS.

LAW IMPLEMENTED: 409.908 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE DATE, TIME AND PLACE SHOWN BELOW:

DATE AND TIME: July 24, 2008, 11:00 a.m. – 12:00 Noon

PLACE: 2727 Mahan Drive, Conference Room D, Building 3, Tallahassee, Florida 32301

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Edwin Stephens, Medicaid Program Analysis, Agency for Health Care Administration, 2727 Mahan Drive, Building 3, Room 2149A, Tallahassee, Florida 32308, (850)414-2756 or at stephene@ahca.myflorida.com

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS NOT AVAILABLE.

DEPARTMENT OF MANAGEMENT SERVICES

Division of Retirement – Local Retirement

RULE NOS.:	RULE TITLES:
60T-1.001	Scope and Purpose
60T-1.002	Definitions
60T-1.003	Actuarial Reports
60T-1.004	Actuarial Impact Statements
60T-1.005	Review of Actuarial Reports and Actuarial Impact Statements
60T-1.006	Defined Contribution Plans
60T-1.007	Funding
60T-1.008	Additional Benefits Funded by Experience
60T-1.009	Additional Filing Requirements

PURPOSE AND EFFECT: Amend this chapter which sets forth the rules under which municipal and special district units of government are to provide information on their retirement systems plans to the Department of Management Services, Division of Retirement, (Bureau of Program Services) pursuant to Part VII of Chapter 112, Florida Statutes (F.S.). The provisions of this chapter is applicable to all counties, municipal governments, and special districts (or agencies and instrumentalities thereof), which state universities, community colleges and district schools that operate or administer a retirement system or plan for public employees funded in whole or in part by public funds.

SUBJECT AREA TO BE ADDRESSED: The participation of local governments in the Florida State Retirement System, as provided in Part VII, Chapter 112, Florida Statutes.

SPECIFIC AUTHORITY: 112.665(1) FS.

LAW IMPLEMENTED: 112.661(9), 112.61, 112.625, 112.63, 112.665, 112.64, 112.661(9) FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE DATE, TIME AND PLACE SHOWN BELOW:

DATE AND TIME: July 14, 2008, 9:00 a.m.

PLACE: Department of Management Services, Director's Conference Room Suite 208, 1317 Winewood Blvd., Building 8, Tallahassee, Florida 32399-1560, (850)488-5706

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 48 hours before the workshop/meeting by contacting: Richard Clifford at (850)488-5706, or Toll Free (877)377-1737. If you are hearing or speech impaired, please contact the agency by calling (800)877-1113. If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice).

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Garry Green, Operations and Management Consultant Manager, Department of Management Services, Division of Retirement, 1317 Winewood Blvd., Bldg. 8, Tallahassee, FL 32399-1560, (850)488-5706

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

60T-1.001 Scope and Purpose.

(1) This chapter sets forth the rules under which municipal and special district units of government are to provide information on their retirement plans ~~systems~~ to the Department of Management Services, Division of Retirement, ~~(Bureau of Program Services)~~ pursuant to Part VII of Chapter 112, F.S. ~~Florida Statutes.~~ The provisions of this chapter shall be applicable to all counties, municipal governments, ~~and~~ special districts (or agencies and instrumentalities thereof), state universities, community colleges and district schools that ~~which~~ operate or administer a retirement ~~system or~~ plan for public employees funded in whole or in part by public funds. This chapter shall not apply to counties, municipalities, special districts, state universities, community colleges, or district schools ~~or~~ with respect to any of their employees which

Ingram, Robin

From: Milligan, Lauren [Lauren.Milligan@dep.state.fl.us]
Sent: Tuesday, September 23, 2008 4:30 PM
To: Ingram, Robin
Subject: RE: SPA 2008-017

Ms. Robin R. Ingram
Division of Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Building 3, M.S. 8
Tallahassee, FL 32308-5403

RE: U.S. Department of Health and Human Services - Medicaid State Plan Amendment 2008-017: Payment Methodology for Outpatient Hospital Reimbursement

Dear Robin:

The referenced federal grant application was received by the State Clearinghouse on September 23, 2008, in accordance with Presidential Executive Order 12372 and Gubernatorial Executive Order 95-359, and was forwarded to the Executive Office of the Governor, Office of Policy and Budgeting on an informational basis.

The Governor's Office has 21 days to review and contact the State Clearinghouse if further review is needed. To date, the State Clearinghouse has not received any comments from the Governor's Office regarding this project. Therefore, no further review is required.

Pursuant to Presidential Executive Order 12372, this project is in accordance with state plans, programs, procedures and objectives, and is approved for submission to the federal funding agency. Please attach a copy of this message to your application facesheet or cover form and forward to the federal funding agency. This action will assure the federal agency of your compliance with Florida's review requirements and reduce the chance of unnecessary delays in processing your application.

If you have any questions concerning the state intergovernmental review process, please don't hesitate to contact me at (850) 245-2170. Thank you.

Yours sincerely,

Lauren P. Milligan

Lauren P. Milligan, Environmental Manager
Florida State Clearinghouse
Florida Department of Environmental Protection
3900 Commonwealth Blvd, M.S. 47
Tallahassee, FL 32399-3000
ph. (850) 245-2170
fax (850) 245-2190

FLORIDA TITLE XIX OUTPATIENT HOSPITAL

REIMBURSEMENT PLAN

VERSION XVIII

EFFECTIVE DATE: July 1, 2008

I. Cost Finding and Cost Reporting

A. Each hospital participating in the Florida Medicaid Hospital Program shall submit a cost report postmarked no later than five calendar months after the close of its cost-reporting year. A hospital filing a certified cost report that has been audited by the independent auditors of the hospital shall be given a 30-day extension if the Agency for Health Care Administration (AHCA) is notified in writing that a certified report is being filed. The hospital cost reporting year adopted for the purpose of this plan shall be the same as that for Title XVIII or Title V cost reporting, if applicable. A complete, legible copy of the cost report shall be submitted to the Medicare intermediary and to AHCA, Bureau of Medicaid Program Analysis, Cost Reimbursement.

B. Cost reports available to AHCA as of March 31, 1990, shall be used to initiate this plan.

C. All hospitals are required to detail their costs for their entire reporting year, making appropriate adjustments as required by this plan for determination of allowable costs. New hospitals shall adhere to requirements of Section 2414.1, Provider Reimbursement Manual (CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.010, Florida Administrative Code, F.A.C.) A prospective reimbursement rate, however, shall not be established for a new hospital based on a cost report for a period less than 12 months. For a new hospital or a new

provider with no cost history, excluding new providers resulting from a change in ownership where the previous provider participated in the program, the interim rate shall be the lesser of: the county reimbursement ceiling for variable costs (including outpatient fixed costs); or the budgeted rate in compliance with CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C. and Section III of the Plan, as applied to the budget submitted by the provider. Interim rates shall be cost settled for the interim rate period. Interim per diem rates shall not be approved for new providers resulting from a change in ownership. Medicaid reimbursement is hospital specific and is not provider specific.

D. The cost report shall be prepared in accordance with generally accepted accounting principles as established by the American Institute of Certified Public Accountants (AICPA) except as modified by the method of reimbursement and cost finding of Title XVIII (Medicare) Principles of Reimbursement described in 42 Code of Federal Regulations (CFR) 413.35 - 413.50, further interpreted by the Provider Reimbursement Manual (CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C.). and as further modified by this plan.

E. Hospitals shall file a legible and complete cost report within five months, or 6 months if a certified report is being filed, after the close of its reporting period. Medicare-granted exceptions to these time limits shall be accepted by AHCA.

F. If a provider submits a cost report late, after the five month period, and that cost report would have been used to set a lower reimbursement rate for a rate semester had it been submitted within five months, then the provider's rate for that rate semester shall be retroactively calculated using the new cost report, and full

payments at the recalculated rate shall be affected retroactively. Medicare granted exceptions to these time limits shall be accepted by AHCA.

G. A hospital which voluntarily or involuntarily ceases to participate in the Florida Medicaid Program or experiences a change of ownership shall file a final cost report in accordance with Section 2414.2, CMS_PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C. For the purposes of this plan, filing a final cost report is not required when: the capital stock of a corporation is sold; or partnership interest is sold as long as one of the original general partners continues in the partnership or one of the original limited partners becomes a general partner, or control remains unchanged. Any change of ownership shall be reported to AHCA within 45 days after such change of ownership.

H. All Medicaid participating hospitals are required to maintain the Florida Medicaid Log and financial and statistical records regarding outpatients in accordance with 42 CFR 413.24(a)-(c). For purposes of this plan, statistical records shall include the medical records of eligible Medicaid recipients. These records shall be available upon demand to representatives, employees or contractors of AHCA, the Auditor General of the State of Florida, the General Accounting Office (GAO) or the United States Department of Health and Human Services (HHS). A Medicaid recipient's medical records shall be released to the above named persons for audit purposes upon proof of the recipient's consent such as the Medicaid consent form, AHCA-Med Form 1005 as incorporated by reference in Rule 59G-5.080 (2), F.A.C.

I. Records of related organizations as defined by 42 CFR 413.17 shall be available upon demand to representatives, employees or contractors of AHCA, the Auditor General, GAO, or HHS.

J. AHCA shall retain all uniform cost reports submitted for a period of at least five years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of 45 CFR 205.60. Access to submitted cost reports shall be in conformity with Chapter 119, Florida Statutes. Upon request for a copy of any cost report, the hospital involved shall be notified as to the party making the request and the information requested. Unless prohibited by a court of competent jurisdiction, the cost report shall be released to the requestor 15 days from receipt of the request by AHCA.

K. All desk or onsite audits of cost reports shall be final and shall not be reopened past three years of the date that the audit adjustments are noticed through a revised per diem rate completed by the Agency.

Exception to the above mentioned time limit:

The aforementioned limitation shall not apply when Medicare audit reopenings result in the issuance of revised Medicaid cost report schedules. A cost report may be reopened for inspection, correction, or referral to a law enforcement agency at any time by the Agency or its contractor if program payments appear to have been obtained by fraud, similar fault, or abuse.

L. Cost reports submitted on or after July 1, 2004, must include the following statement immediately preceding the dated signature of the provider's administrator or chief financial officer: "I certify that I am familiar with the laws and regulations regarding the provision of health care services under the Florida

Medicaid program, including the laws and regulations relating to claims for Medicaid reimbursements and payments, and that the services identified in this cost report were provided in compliance with such laws and regulations."

II. Audits

A. Background

A hospital common audit program has been established to reduce the cost of auditing submitted cost reports and avoid duplicate auditing efforts. The purpose is to have one audit of a participating hospital which shall serve the needs of all governmental programs reimbursing the hospital for services rendered.

B. Common Audit Program

AHCA has entered into written agreements with Medicare intermediaries for participation in a common audit program of Titles V, XVIII, and XIX. Under this agreement, the intermediaries shall provide AHCA the result of desk reviews and field audits of those participating hospitals located in Florida, Georgia, and Alabama.

C. Other Hospital Audits

For those hospitals not covered by the common audit agreement with Medicare intermediaries, AHCA shall be responsible for performance of desk and field audits. AHCA shall:

1. Determine the scope and format for on-site audits;
2. Desk audit all cost reports within 6 months after their submission to AHCA;

3. Ensure all audits are performed in accordance with generally accepted auditing standards of the AICPA as incorporated by reference in Rule 61H1-20.008 F.A.C;

4. Ensure that only those expense items that the plan has specified as allowable costs under Section III of this plan have been included by the hospital in the computation of the costs of the various services provided under Rule 59G-4.160 F.A.C;

5. Review to determine that the Florida Medicaid Log is properly maintained and current in those hospitals where its maintenance is required;

6. Issue, upon the conclusion of each full scope audit, a report which shall meet generally accepted auditing standards of the AICPA as incorporated by reference in Rule 61H1-20.008, F.A.C. and shall declare the auditor's opinion as to whether, in all material respects, the cost submitted by a hospital meets the requirements of this plan.

D. Retention

All audit reports received from Medicare intermediaries or issued by AHCA shall be kept in accordance with 45 CFR 205.60.

E. Overpayments and Underpayments

1. Overpayments for those years or partial years as determined by desk or field audits using prior approved State plans shall be reimbursable to AHCA, as shall overpayments attributable to unallowable costs only.

2. Overpayments in outpatient hospital services shall not be used to offset underpayments in inpatient hospital services and, conversely,

overpayments in inpatient hospital services shall not be used to offset underpayments in outpatient hospital services.

3. The results of desk or field audits of outpatient hospital services shall be identified separately from the results of desk or field audits of inpatient hospital services.
4. Any overpayment or underpayment that resulted from a rate adjustment due to an error in either reporting or calculation of the rate shall be refunded to AHCA or to the provider as appropriate.
5. Any overpayment or underpayment that resulted from a rate based on a budget shall be refunded to AHCA or to the provider as appropriate.
6. The terms of repayments shall be in accordance with Section 414.41, Florida Statutes.
7. All overpayments shall be reported by AHCA to HHS as required.
8. Information intentionally misrepresented by a hospital in the cost report shall result in a suspension of the outpatient hospital from the Florida Medicaid Program.

F. Appeals

For audits conducted by AHCA a concurrence letter that states the results of an audit shall be prepared and sent to the provider, showing all adjustments and changes and the authority for such. Providers shall have the right to a hearing in accordance with Section 120.57, Florida Statutes, for any or all adjustments made by AHCA. All desk or onsite audits of cost reports shall be final and shall not be reopened past three years of the date that the audit adjustments are noticed through a revised per diem rate completed by the Agency.

Exception to the above mentioned time limit:

The aforementioned limitation shall not apply when Medicare audit reopenings result in the issuance of revised Medicaid cost report schedules. A cost report may be reopened for inspection, correction, or referral to a law enforcement agency at any time by the Agency or its contractor if program payments appear to have been obtained by fraud, similar fault, or abuse.

III. Allowable Costs

Allowable costs shall be determined using generally accepted accounting principles, except as modified by Title XVIII (Medicare) Principles of Reimbursement as described in 42 CFR 413.35 - 413.50, the inpatient routine nursing salary cost differential, and the guidelines in the Provider Reimbursement Manual (CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C.,) and as further modified by Title XIX of the Act, this plan, requirements of licensure and certification, and the duration and scope of benefits provided under the Florida Medicaid Program. These include:

A. Costs incurred by a hospital in meeting:

1. The definition of a hospital contained in 42 CFR 440.20 and 42 CFR 440.140 in order to meet the requirements of Sections 1902(a)(13) and (20) of the Social Security Act;
2. The requirements established by the State Agency responsible for establishing and maintaining health standards under the authority of 42 CFR 431.610; and
3. Any other requirements for licensing under the State law which are necessary for providing outpatient hospital services.

B. Medicaid reimbursements shall be limited to an amount, if any, by which the rate calculation for an allowable claim exceeds the amount of a third party recovery during the Medicaid benefit period. In addition, the reimbursement shall not exceed the amount according to 42 CFR 447.321.

C. Malpractice insurance costs shall be apportioned to Medicaid in the ratio of Medicaid Outpatient costs to Total Hospital Costs.

D. Under this plan, hospitals shall be required to accept Medicaid reimbursement as payment in full for covered services provided during the benefit period and billed to the Medicaid program; therefore, there shall be no payments due from Medicaid recipients. As a result, for Medicaid cost reporting purposes, there shall be no Medicaid bad debts generated by Medicaid recipients. Bad debts shall not be considered as an allowable expense.

E. All physician orders and records that result in costs being passed on by the hospital to the Florida Medicaid Program through the cost report shall be subject to review by the Agency or the Agency's authorized representative.

F. Certain revenue centers are not reimbursed by Medicaid. Service rendered under these centers shall not be recorded on the Medicaid log and shall not be billed to Medicaid. The list of covered revenue centers is attached as Appendix A. Modifications of this list subsequent to the implementation of this plan shall appear in the Florida Medicaid Information System Update. Beginning November 1, 2004, revenue code 510, Clinic/General (see Appendix A) is reimbursable by Medicaid, in accordance with the most recent version of the Medicaid Outpatient Hospital Coverage and Limitations Handbook, for health care services, in outpatient clinic facilities where a non-state government owned or operated

facility assumed the fiscal and operating responsibilities of one or more primary care centers previously operated by the Florida Department of Health or the local county government.

G. The revenue assessments, and any fines associated with those assessments, mandated by the Health Care Access Act of 1984, Section 395.701, Florida Statutes, shall not be considered an allowable Medicaid cost and shall not be allocated as a Medicaid allowable cost for purposes of cost reporting.

IV. Standards

A. In accordance with Chapter 120, F.S., Administrative Procedures Act, and 42 CFR 447.205, this plan shall be promulgated as an Administrative Rule and as such shall be made available for public inspection. A public hearing shall be held so that interested members of the public shall be afforded the opportunity to review and comment on this plan.

B. Reimbursement ceilings shall be established prospectively for each Florida county. Beginning with the July 1, 1993 rate period, additional ceilings based on the Target Rate System shall also be imposed. For purposes of establishing reimbursement ceilings, each hospital within the state shall be classified as general, teaching, specialized, rural, or as a Community Hospital Education Program (CHEP) hospital. Outpatient reimbursement ceilings shall be established for and applied to general hospitals. Rural and specialized psychiatric hospitals shall be excluded from the calculation and application of the outpatient reimbursement ceilings. Statutory teaching, specialized, Community Hospital Education Program (CHEP) hospitals, and those hospitals defined in Section V.A.

9 through 14 shall be included in the calculation but are exempt from the application of the outpatient reimbursement ceilings.

C. The initial reimbursement ceilings shall be determined prospectively and shall be effective from July 1, 1990, through December 31, 1990. For subsequent periods, the reimbursement ceilings shall be effective from January l through June 30 and July l through December 31 of the appropriate years except as provided in G. below.

D. Changes in individual hospital rates shall be effective from July l through December 31 and January l through June 30 of each year. Hospital outpatient rates set under plan provisions for the July 1, 2003 rate semester will be effective October 1, 2003.

E. For the initial period, the last cost report received from each hospital as of March 31, 1990, shall be used to establish the reimbursement ceilings. In the absence of sufficient information from the above source, claims payment data from the Medicaid fiscal agent, shall be used. Should none of the above sources provide acceptable information, the hospital shall be excluded from the reimbursement ceiling calculations. The hospital shall then have a rate assigned that equals the lowest computed rate in the county in which the hospital is located, or the lowest rate in the AHCA District in which the hospital is located, if there are no other hospitals in the county in question.

F. For subsequent periods, all cost reports received by AHCA as of each April 15 and October 15 shall be used to establish the reimbursement ceilings.

G. The individual hospital's prospectively determined rate shall be adjusted only under the following circumstances:

1. An error was made by the fiscal intermediary or AHCA in the calculation of the hospital's rate.

2. A hospital submits an amended cost report to supersede the cost report used to determine the rate in effect. There shall be no change in rate if an amended cost report is submitted beyond three years of the effective date the rate was established, or if the change is not material.

3. Further desk or field audits of cost reports used in the establishment of the prospective rate disclose material changes in these reports. All desk or onsite audits of cost reports shall be final and shall not be reopened past three years of the date that the audit adjustments are noticed through a revised per diem rate completed by the Agency.

   Exception to the above mentioned time limit:

   The aforementioned limitation shall not apply when Medicare audit reopenings result in the issuance of revised Medicaid cost report schedules. A cost report may be reopened for inspection, correction, or referral to a law enforcement agency at any time by the Agency or its contractor if program payments appear to have been obtained by fraud, similar fault, or abuse.

4. Where the charge structure of a hospital changes and the application of the lower of cost or charges limitations is reconsidered.

H. Any rate adjustment or denial of a rate adjustment by AHCA may be appealed by the provider in accordance with Rule 28-106, F.A.C., and Section 120.57 Florida Statutes.

I. Under no circumstances shall any rate adjustment exceed the reimbursement ceiling established, except as provided for in IV B.

J. In accordance with Section 2303 of Public Law 98-369, the Deficit Reduction Act of 1984, the reimbursement rates for laboratory and pathology services shall be the lower of: the hospital's charges or; the Medicaid fee schedule technical component as provided for in Rule 59G-4.160, F.A.C.

V. Method

This section defines the methodologies to be used by the Florida Medicaid Program in establishing reimbursement ceilings and individual hospital reimbursement rates.

A. Setting Reimbursement Ceilings.

1. Review and adjust the hospital cost report available to AHCA as of each April 15 and October 15 as follows:
   a. To reflect the results of desk or field audits.
   b. To reduce the Medicaid outpatient costs and charges for laboratory and pathology costs and charges.
2. Reduce a hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.9.
3. Determine Medicaid outpatient variable costs defined in Section X.
4. Adjust Medicaid outpatient variable costs for the number of months between the midpoint of the hospital's fiscal year and either September 30, or March 31, the midpoint of the rate semester for which the new rate is being calculated. The adjustment shall be made utilizing the latest available projections as of March 31 or September 30 for the Data

Resources Incorporated (DRI) Type Hospital Market Basket Index as detailed in Appendix B.

5. Divide the inflated Medicaid outpatient variable costs by the latest available Health Care component of the Florida Price Level Index (FPLI) for the county in which the hospital is located.

6. Divide the results of Step 5 for each hospital by its total Medicaid outpatient occasions of service excluding occasions of service for laboratory and pathology resulting in an occasions of service rate.

7. Array the occasions of service rates in Step 6 from the lowest to the highest rate with the associated occasions of service.

8. Establish the reimbursement ceilings as the lower of:

   a. The cost based ceilings for variable costs per occasion of service at the occasion of service rate associated with the 80th percentile of occasions of service, times the FPLI component utilized in Step 5 for the county in which the hospital is located. Rural and specialized psychiatric hospitals are excluded from the calculation and application of this cost based ceiling.

      The following types of hospitals are included in the calculation, but are exempt from the application of this cost based ceiling except for the limitations described in 9 through 14 below:

      i. Statutory teaching hospitals

      ii. Specialized hospitals

      iii. Community Hospital Education Program (CHEP)

      iv. Those mentioned in 9 through 14 below

v. Hospitals with Level III Neonatal Intensive Care Units that have a minimum of three of the following designated tertiary services as regulated under the certificate of need program: pediatric bone marrow transplantation, pediatric open heart surgery, pediatric cardiac catheterization and pediatric heart transplantation.

For hospitals participating in the Florida Medicaid Program that are located out of State, the FPLI used shall be equal to 1.00.

b. For rate periods beginning with the July 1, 1993 rate period, the target ceiling shall be calculated by multiplying the previous rate period's ceiling by the target inflation factor as calculated in the following formula:

$$1 + 1.4 \times \left[\frac{\text{Midpoint of the prospective rate period using appendix B}}{\text{Midpoint of the current rate period using Appendix B}} - 1 \right]$$

This target ceiling shall not apply to rural, specialized, statutory teaching, Community Hospital Education Program (CHEP) hospitals, and those hospitals defined in 9 through 14 below.

This target ceiling shall not apply to the following:

i. Statutory teaching hospitals

ii. Specialized hospitals

iii. Community Hospital Education Program (CHEP)

iv. Those mentioned in 9 through 14 below

v. Hospitals with Level III Neonatal Intensive Care Units that have a minimum of three of the following designated tertiary services as regulated under the certificate of need program: pediatric bone marrow transplantation, pediatric open heart surgery, pediatric cardiac catheterization and pediatric heart transplantation.

9. Effective July 1, 2001, outpatient reimbursement ceilings will be eliminated for hospitals whose charity care and Medicaid days as a percentage of total hospital days equals or exceeds fifteen percent. Effective July 1, 2002, the fifteen percent (15%) will be changed to fourteen and one-half percent (14.5%). The Agency shall use the disproportionate share hospital 1997 audited data available as of March 1, 2001, to determine eligibility for the elimination of ceilings. Effective July 1, 2003, the fourteen and one-half percent (14.5%) will be changed to eleven percent (11%) to eliminate the outpatient reimbursement ceilings for hospitals whose charity care and Medicaid days as a percentage of total adjusted hospital days equals or exceeds 11 percent. The Agency will use the average of the 1998, 1999, and 2000 audited DSH data available as of March 1, 2004. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency will use the average of the audited DSH data for 1998, 1999, and 2000 that is available. Hospital outpatient rates set under plan provisions for the July 1, 2003, rate semester will be effective October 1, 2003.

10. Effective July 1, 2001, outpatient reimbursement ceilings will be eliminated for hospitals whose Medicaid days as a percentage of total hospital days exceed 9.6% and are a trauma center. The Agency shall use the 1997 audited DSH data available as of March 1, 2001, to determine eligibility for the elimination of ceilings.

11. Effective July 1, 2003, outpatient reimbursement ceilings will be eliminated for hospitals whose Medicaid days, as a percentage of total hospital days, exceed 9.6 percent, and are trauma centers. The Agency will use the average of the 1998, 1999, and 2000 audited DSH date available as of March 1, 2004. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency will use the average of the audited DSH data for 1998, 1999, and 2000 that is available. Hospital outpatient rates set under plan provisions for the July 1, 2003, rate semester will be effective October 1, 2003.

12. Effective July 1, 2005, outpatient reimbursement ceilings shall be eliminated for hospitals whose charity care and Medicaid days as a percentage of total adjusted hospital days equals or exceeds 11 percent. The Agency shall use the average of the 1999, 2000, and 2001 audited DSH data available as of March 1, 2005. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency will use the average of the audited DSH data for 1999, 2000, and 2001 that are available. Any hospital that met the 11 percent threshold in state fiscal year 2004-2005 and was also exempt from the outpatient reimbursement ceilings shall remain exempt from the outpatient reimbursement ceilings for State

Fiscal Year 2005-2006, subject to the payment limitations imposed in this paragraph.

13. Effective July 1, 2005, outpatient reimbursement ceilings shall be eliminated for hospitals that have a minimum of ten licensed Level II neonatal intensive care beds and are located in Trauma Services Area 2.

14. Effective July 1, 2005, the outpatient reimbursement ceilings shall be eliminated for hospitals whose Medicaid days, as a percentage of total hospital days, exceed 7.3 percent, and are designated or provisional trauma centers. This provision shall apply to all hospitals that are designated or provisional trauma centers on July 1, 2005, or become a designated or provisional trauma center during state fiscal year 2005-2006. The agency shall use the average of the 1999, 2000 and 2001 audited DSH data available as of March 1, 2005. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the agency will use the average of the audited DSH data for 1999, 2000, and 2001 that are available.

15. Effective July 1, 2006, outpatient hospital rates shall be adjusted to eliminate the outpatient reimbursement ceilings for hospitals whose charity care and Medicaid days as a percentage of total adjusted hospital days equals or exceeds 11 percent. Effective July 1, 2006, the Agency shall use the average of the 2000, 2001, and 2002 audited DSH data available as of March 1, 2006. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2000, 2001, and 2002 that are

available. For any non-state government owned or operated facility that does not qualify for the elimination of the outpatient ceilings under this section, the non-state government owned or operated facility hospital shall be exempt from the outpatient reimbursement ceilings.

16. Effective July 1, 2006, outpatient reimbursement ceilings for hospitals that have a minimum of ten licensed Level II neonatal intensive care beds and are located in Trauma Services Area 2 are eliminated.

17. Effective July 1, 2006, outpatient reimbursement ceilings for hospitals whose Medicaid days, as a percentage of total hospital days, exceed 7.3 percent, and are designated or provisional trauma centers are eliminated. This provision shall apply to all hospitals that are designated or provisional trauma centers on July 1, 2006, or become a designated or provisional trauma center during State Fiscal Year 2006-2007. The Agency shall use the average of the 2000, 2001, and 2002 audited DSH data available as of March 1, 2006. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2000, 2001, and 2002 that are available.

18. Effective July 1, 2007, the outpatient reimbursement ceilings will be eliminated for hospitals whose charity care and Medicaid days as a percentage of total adjusted hospital days equals or exceeds 11 percent. For any non-state government owned or operated facility that does not qualify for the elimination of the outpatient ceilings under this provision of proviso or any other proviso listed, the non-state

government owned or operated facility shall be exempt from the outpatient reimbursement ceilings. The Agency shall use the average of the 2001, 2002, and 2003 audited DSH data available as of March 1, 2007. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2001, 2002, and 2003 that are available.

19. Effective July 1, 2007, the outpatient reimbursement ceilings will be eliminated for hospitals that have a minimum of ten licensed Level II Neonatal Intensive Care Beds and are located in Trauma Services Area 2.

20. Effective July 1, 2007, the outpatient reimbursement ceilings will be eliminated for hospitals whose Medicaid days, as a percentage of total hospital days, exceed 7.3 percent, and are designated or provisional trauma centers. This provision shall apply to all hospitals that are designated or provisional trauma centers on July 1, 2007, or become a designated or provisional trauma center during state fiscal year 2007-2008. The Agency shall use the average of the 2001, 2002, and 2003 audited DSH data available as of March 1, 2007. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2001, 2002, and 2003 that are available.

21. Effective July 1, 2008, outpatient reimbursement ceilings for hospitals will be eliminated for those hospitals whose charity care and Medicaid days as a percentage

of total adjusted hospital days equals or exceeds 11 percent. The Agency shall use the average of the 2002, 2003, and 2004 audited DSH data available as of March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003, and 2004 that are available.

22. Effective July 1, 2008, outpatient hospital reimbursement ceilings will be eliminated for hospitals whose Medicaid days, as a percentage of total hospital days, exceed 7.3 percent, and are designated or provisional trauma centers. This provision shall apply to all hospitals that are designated or provisional trauma centers on July 1, 2008, or become a designated or provisional trauma center during Fiscal Year 2008-2009. Included in these funds are the annualized amounts to offset the reductions taken against certified trauma centers as identified in section 13, chapter 2007-326, Laws of Florida. The Agency shall use the average of the 2002, 2003, and 2004 audited DSH data available as of March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003, and 2004 that are available.

B. Setting Individual Hospital Rates.

1. Review and adjust the hospital cost report available to AHCA as of each April 15 and October 15 as follows:
   a. To reflect the results of desk and field audits.
   b. To reduce the Medicaid outpatient costs and charges for laboratory and pathology costs and charges.
2. Reduce the hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.9.
3. Determine Medicaid outpatient variable costs as defined in Section X.
4. Adjust Medicaid outpatient variable costs for the number of months between the midpoint of the hospital's fiscal year and September 30 or March 31, the midpoint of the following rate semester. The adjustment shall be made utilizing the DRI Regional Hospital Input Price Index as detailed in Appendix B.
5. Establish the variable cost rate as the lower of:
   a. The inflated rate by dividing the inflated allowable Medicaid outpatient variable costs by the total Medicaid outpatient occasions of service for the hospital excluding occasions of service for laboratory and pathology.
   b. The target rate by inflating the variable cost rate in the previous rate period by the target inflation factor calculated in V.A.8.b. above in establishing target ceilings. This target rate shall not apply to rural, specializd, statutory teaching, Community Hospital Education Program (CHEP) hospitals, and those hospitals defined in Section V.A. 9 through 14.

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i. Set the rate for the hospital as the lower of the result of Step 5. above, the reimbursement ceiling in V.A.8 for the county in which the hospital is located, or the result of inflated Medicaid outpatient charges divided by total Medicaid outpatient occasions of service excluding charges and occasions of service for laboratory and pathology.

ii. Hospital outpatient rates set under plan provisions for the July 1, 2003, rate semester will be effective October 1, 2003.

iii. Effective July 1, 2004, and ending June 30, 2005, each outpatient rate shall be reduced by a proportionate percentage until an aggregate total estimated savings of $14,103,000 is achieved. In reducing hospital outpatient rates, rural hospitals and hospitals with twenty thousand (20,000) or more combined Medicaid managed care and fee-for-service inpatient days shall not have their outpatient rates reduced below the final rates that are effective on June 30, 2004. The 2002 Financial Hospital Uniform Reporting System (FHURS) data shall be used to determine the combined inpatient Medicaid days.

6. Effective July 1, 2005, a recurring rate reduction shall be established until an aggregate total estimated savings of $16,796,807 is achieved each year. This reduction is the Medicaid Trend Adjustment. In reducing hospital outpatient rates, rural hospitals and hospitals with twenty thousand (20,000) or more combined Medicaid managed care and fee-for-service inpatient days shall not have their outpatient rates reduced below the final rates that are effective on

the prior June 30 of each year. The 2002 Financial Hospital Uniform Reporting System (FHURS) data shall be used to determine the combined inpatient Medicaid days.

a. The July 1, 2005 and January 1, 2006 reimbursement rates shall be adjusted as follows:

    i. Restore the $14,103,000 outpatient hospital reimbursement rate reduction set forth in Section V.B.iii above to the June 30,2005 reimbursement rate;

    ii. Determine the lower of the June 30, 2005 rate with the restoration of the $14,103,000 reduction referenced in (i) above or the July 1, 2005 or January 1, 2006 rates, as applicable, before the application of the Medicaid Trend Adjustment described in (6) above;

b. Effective July 1, 2006, the reduction implemented during the period July 1, 2005, through June 30, 2006, shall become a recurring annual reduction. This recurring reduction, called the Medicaid Trend Adjustment, shall be applied proportionally to all rates on an annual basis.

c. Effective July 1, 2007, and ending June 30, 2008, the Medicaid Trend Adjustment will be removed for all hospitals whose Medicaid charity care days as a percentage to total adjusted days equals or exceeds 30

percent and have more than 10,000 Medicaid days or hospital system that established a Provider Service Network during the prior state fiscal year. The aggregate Medicaid Trend Adjustment listed in V.B.6 above will be reduced by $3,110,871. The Agency shall use the average of the 2001, 2002 and 2003 audited DSH data available as of March 1, 2007.

7. Effective January 1, 2008, an additional Medicaid Trend Adjustment shall be applied to achieve a recurring annual reduction of $17,211,796.
8. Effective January 1, 2008, and ending June 30, 2008, the Medicaid Trend Adjustment shall be removed for all certified trauma centers and hospitals defined in section 408.07(45), 2007 Florida Statutes. The aggregate Medicaid Trend Adjustment found in V.C.7 above shall be reduced by up to $2,034,032.
9. Effective July 1, 2008, an additional Medicaid Trend Adjustment shall be applied to achieve a recurring annual reduction of $36,403,451. In establishing rates through the normal process, prior to including this reduction, if the unit cost is equal to or less than the unit cost used in establishing the budget, no additional reduction in rates is necessary. In establishing rates through the normal process, prior to including this reduction, if the unit cost is greater than the unit cost used in establishing the budget, then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the unit cost used in establishing the budget.

10. The Agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs for two fiscal years effective July 1, 2009.
11. Effective July 1, 2008, a buy back provision for the Medicaid trend adjustment will be applied against the Medicaid outpatient rates for the following three categories of hospitals.
    a. Budget authority up to $3,515,024 is provided to the first category of hospitals, which are those hospitals that are part of a system that operate a provider service network in the following manner: $831,338 is for hospitals in Broward Health; $823,362 is for hospitals in the Memorial Healthcare System; and $601,863 to Shands Jacksonville and $1,258,461 to Shands Gainesville. In the event that the above amounts exceed the amount of the Medicaid trend adjustment applied to each hospital, the excess funds will be used to buy back other Medicaid reductions in the outpatient rate.
    b. Budget authority up to $5,203,232 shall be used for the second category to buy back the Medicaid trend adjustment that is being applied against the Medicaid outpatient rates for those hospitals that are licensed as a children's specialty

hospital and whose Medicaid days plus charity care days divided by total adjusted patient days equals or exceeds 30 percent. In the event the above amounts exceed the amount of the Medicaid trend adjustment applied to each hospital, the excess funds will be used to buy back other Medicaid reductions in the inpatient rate.

c. Budget authority up to $2,170,197 shall be used for the third category to buy back the additional Medicaid trend adjustment that is being applied to rural hospitals under Specific Appropriation 211 for Fiscal Year 2008-2009. In the event that the funds under this category exceed the amount of the Medicaid trend adjustment, then any excess funds will be used to buyback other Medicaid reductions in the outpatient rate for those individual hospitals.

For this provision the Agency shall use the average of 2002, 2003, and 2004 audited DSH data available as of March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003 and 2004 that are available.

12. Effective July 1, 2008, budget authority up to $19,906,103 is provided for a buy back provision for state or local government owned or operated hospitals,

teaching hospitals as defined in section 408.07 (45) or 395.805, Florida Statutes, which have 70 or more full-time equivalent resident physicians and those hospitals whose Medicaid and charity care days divided by total adjusted days exceeds 25 percent to buy back the Medicaid outpatient trend adjustment shall be applied to their individual hospital rates and other Medicaid reductions to their outpatient rates up to actual Medicaid outpatient cost. The Agency shall use the average of the 2002, 2003, and 2004 audited DSH data available as of March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003 and 2004 that are available.

VI. Payment Assurance

The State shall pay each hospital for services provided in accordance with the requirements of the most recent version of the Florida Title XIX State Plan. The payment amount shall be determined for each hospital according to the standards and methods set forth in the most recent version of the Florida Title XIX Outpatient Hospital Reimbursement Plan.

VII. Provider Participation

This plan is designed to assure adequate participation of hospitals in the Medicaid Program, the availability of hospital services of high quality to recipients, and services which are comparable to those available to the general public. This is in accordance with 42 CFR 447.204.

VIII. Revisions

The plan shall be revised as operating experience data are developed and the need for changes is necessary in accordance with modifications in the Code of Federal Regulations.

IX. Payment in Full

Participation in the Program shall be limited to hospitals of service which accept as payment in full for covered services the amount paid in accordance with the most recent version of the Florida Title XIX Outpatient Hospital Reimbursement Plan.

X. Definitions

A. Acceptable Cost Report - A completed, legible cost report that contains all relevant schedules, worksheets and supporting documents.

B. Adjusted patient days - The sum of acute care patient days and intensive care patient days as reported to the Agency for Health Care Administration divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues

C. AHCA - Agency for Health Care Administration, also known as the Agency.

D. Allowable Costs - An item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with generally accepted accounting principles except as modified by the Principles of Reimbursement for Provider Costs, as defined in CMS PUB. 15-1 as incorporated by reference in 59G-6.010 F.A.C., and as further defined in the most recent version of the Florida Title XIX Outpatient Hospital Reimbursement Plan.

E. Community Hospital Education Program (CHEP) hospitals – Hospitals that participate in a program established by the Community Hospital Education Act

(381.0403, F.S.) and administered by the Department of Health. CHEP hospitals offer continuing medical education programs for interns and residents established on a statewide basis. The CHEP program provides financial support for interns and residents based on policies recommended and approved by the Community Hospital Education Council and the Department of Health.

F. Cost Reporting Year - A 12-month period of operation based upon the provider's accounting year.

G. Eligible Medicaid Recipient - "Recipient" or "Medicaid recipient" means any individual whom the department, or the Social Security Administration on behalf of the agency, determines is eligible, pursuant to federal and state law, to receive medical or allied care, goods, or services for which the department may make payments under the Medicaid program and is enrolled in the Medicaid program. For the purposes of determining third party liability, the term includes an individual formerly determined to be eligible for Medicaid, an individual who has received medical assistance under the Medicaid program, or an individual on whose behalf Medicaid has become obligated.

H. Florida Medicaid Log - A schedule to be maintained by a hospital listing each Medicaid patient's recipient number, dates of admission and discharge, and the charges and payments for services and goods received from the hospital's revenue centers.

I. Florida Price Level Index - A spatial index which measures differences from county to county in the cost of purchasing a specified market basket of items at a particular point in time. The items in the market basket range from various food products to hospital lab fees, and are grouped into the components of food,

housing, apparel, transportation, and health, recreation and personal services. A county index for each of the five components is developed bi-annually by the Florida Executive Office of the Governor. County indices are population weighted to average 100 percent. An index of 1.1265 for a given county means that the basket of goods in that county costs 12.65 percent more than the State average. Changes to the methodology utilized in the development of the FPLI will constitute changes in this plan and will require a formal plan amendment.

J. General hospital – A hospital in this state that is not classified as a specialized hospital.

K. HHS - Department of Health and Human Services

L. CMS PUB. 15-1 - Health Insurance Manual No. 15, also known as the Provider Reimbursement Manual, as incorporated by reference in Rule 59G-6.010, F.A.C..

M. Medicaid Outpatient Charges - Usual and customary charges for outpatient services rendered to Medicaid patients excluding charges for laboratory and pathology services. These charges shall be the allowable charges as reconciled with the hospital Medicaid log and found on the Medicaid paid claims report.

N. Medicaid Outpatient Occasions of Service - The number of distinct revenue center code line items listed on a valid claim that a hospital has submitted to the fiscal agent, excluding laboratory and pathology revenue center code line items, and that have been paid by the fiscal agent, which represent covered Medicaid outpatient services.

O. Medicaid Outpatient Variable Costs - Allowable operating costs excluding laboratory and pathology costs less return on equity as apportioned to Medicaid by cost finding methods in the CMS 2552 cost report.

P. Non-Covered Services - Those goods and services which are not medically necessary for the care and treatment of outpatients as defined in CMS PUB 15.1 as incorporated by reference in Rule 59G-6.010, F.A.C.

Q. Provider Service Network (PSN) – is defined in s. 409.912, F.S., as a network established or organized and operated by a health care provider, or group of affiliated health care providers, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers.

R. Rate Semester - January 1 through June 30 of a given year, or July 1 through December 31 of a given year.

S. Reimbursement Ceiling - The upper limit for Medicaid Outpatient Variable Cost rate reimbursement for an individual hospital.

T. Reimbursement Ceiling Period - January 1 through June 30 of a given year or July 1 through December 31, of a given year.

U. Rural Hospital - An acute care hospital licensed under Florida Statutes, Chapter 395 with 100 licensed beds or less, which has an emergency room and is located in an area defined as rural by the United States Census, and which is:

1. The sole provider within a county with a population density of no greater than 100 persons per square mile; or
2. An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county; or

3. A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or less per square mile.

4. A hospital in a constitutional charter county with a population of over 1 million persons that has imposed a local option health service tax pursuant to law and in an area that was directly impacted by a catastrophic event on August 24, 1992, for which the Governor of Florida declared a state of emergency pursuant to chapter 125, and has 120 beds or less that serves an agricultural community with an emergency room utilization of no less than 20,000 visits and a Medicaid inpatient utilization rate greater than 15 percent;

5. A hospital with a service area that has a population of 100 persons or fewer per square mile. As used in this subparagraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Policy Analysis at the Agency for Health Care Administration; or

6. A hospital designated as a critical access hospital, as defined in s. 408.07(15).

Population densities used in this paragraph must be based upon the most

recently completed United States census. A hospital that received funds under s. 409.9116 for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2012, if the hospital continues to have 100 or fewer licensed beds and an emergency room, or meets the criteria of subparagraph 4. An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this paragraph shall be granted such designation upon application, including supporting documentation to the Agency for Health Care Administration.

V. Specialized Hospital - A licensed hospital primarily devoted to TB, psychiatric care, pediatric, eye, or cardiac care and treatment; or a licensed hospital that has ten or more residency training programs.

W. Title XVIII - Health Insurance for the Aged, Blind or Disabled (Medicare) as provided for in the Social Security Act (42 U.S.C. 1395-1395xx).

X. Title XIX - Grants to States for medical assistance programs (Medicaid) as provided for in the Social Security Act (42 U.S.C. 1396-1396p).

Y. Total Outpatient Charges - Total patient revenues assessed for all outpatient services excluding charges for laboratory and pathology.

APPENDIX A TO FLORIDA TITLE XIX OUTPATIENT HOSPITAL REIMBURSEMENT PLAN

OUTPATIENT REVENUE CENTER CODES

CODE	DESCRIPTION
250	Pharmacy/General
251	Pharmacy/Generic
252	Pharmacy/NonGeneric
254	Drugs Incident to Other Diagnostic Services
255	Drugs Incident to Radiology
258	Pharmacy/IV Solutions
259	Other Pharmacy
260	IV Therapy
261	Infusion Pump
262	IV Therapy/Pharmacy Services
264	IV Therapy/Supplies
269	Other IV Therapy
270	General Classification
271	Medical Surgical- Nonsterile supplies
272	Medical/Surgical - Sterile Supplies
275	Pacemaker
276	Intraocular Lens
278	Subdermal Contraceptive Implant
279	Burn Pressure Garment Fitting
300	Laboratory/General
301	Laboratory/Chemistry
302	Laboratory/Immunology
304	Laboratory/Non-Routine Dialysis
305	Laboratory/Hematology
306	Laboratory/Bacteriology and Microbiology
307	Laboratory/Urology
310	Pathological Laboratory/General
311	Pathological Laboratory/Cytology
312	Pathological Laboratory/Histology
314	Pathological Laboratory/Biopsy
320	Diagnostic Radiology/General
321	Diagnostic Radiology/Angiocardiography
322	Diagnostic Radiology/Arthrography
323	Diagnostic Radiology/Arteriography
324	Diagnostic Radiology/Chest

TN No: 08-017
Supersedes: 08-003
Approval Date:
Effective Date: July 1, 2008

329	Other Radiology Diagnostic
330	Therapeutic Radiology/General
331	Therapeutic Radiology/Injected
332	Therapeutic Radiology/Oral
333	Therapeutic Radiology/Radiation Therapy
335	Therapeutic Radiology/Chemotherapy - IV
339*	Other Radiology Therapeutic
340	Nuclear Medicine/General
341	Nuclear Medicine/Diagnostic
342	Nuclear Medicine/Therapeutic
343	Diagnostic Radiopharmaceuticals
344	Therapeutic Radiopharmaceuticals
349	Other Nuclear Medicine
350	Computed Tomographic (CT) Scan/General
351	Computed Tomographic (CT) Scan/Head
352	Computed Tomographic (CT) Scan/Body
359	Other CT Scans
360	Operating Room Services/General
361	Operating Room Services/Minor Surgery
362	Operating Room Services/Bone Marrow Transplant
369*	Other Operating Room Services
370	Anesthesia/General
371	Anesthesia Incident to Radiology
372	Anesthesia Incident to Other Diagnostic Services
379	Other Anesthesia
380	Blood/General
381	Blood/Packed Red Cells
382	Blood/Whole
383	Blood/Plasma
384	Blood/Platelets
385	Blood/Leucocytes
386	Blood/Other Components
387	Blood/Other Derivatives
389	Other Blood
390	Blood Storage and Processing/General
391	Blood Storage and Processing/Administration
399	Other Processing and Storage
400	Imaging Services/General
401	Imaging Services/Mammography
402	Imaging Services/Ultrasound
403	Screening Mammography
404	Positron Emission Tomography

409 Other Imaging Services

410 Respiratory Services/General (All Ages)
412 Respiratory Services/Inhalation (All Ages)
413 Respiratory Services/Hyperbaric Oxygen Therapy (All Ages)
419 Other Respiratory Services
421 Physical Therapy/Visit Charge (All Ages)
424 Physical Therapy/Evaluation or Re-evaluation(All Ages)
Note: Effective 1/1/99
431 Occupational Therapy/Visit Charge (Under 21 only)
434 Occupation Therapy/Evaluation or Re-evaluation (Under 21)
Note: Effective 1/1/99
441 Speech-Language Pathology/Visit Charge (Under 21 only)
444 Speech-Language Pathology/Evaluation or Re-evaluation Under 21) Note: Effective 1/1/99
450 Emergency Room/General
451 EMTALA Emergency Medical Screening Services
(Effective 7/1/96)

- EMTALA: Emergency Medical Treatment and Active Labor Act
- Use 451 when the recipient needs no ER care beyond the EMTALA emergency medical screening
- Code W1700 must be used with code 451; example 451(W1700)

Note: No MediPass authorization required

460 Pulmonary Function/General
469 Other Pulmonary Function
471 Audiology/Diagnostic
472 Audiology/Treatment
480 Cardiology/General
481 Cardiology/Cardiac Cath Laboratory
482 Cardiology/Stress Test
483 Cardiology/Echocardiology
489 Other Cardiology
490 Ambulatory Surgical Care
510 Clinic/General

- Note: Please reference the most recent version of the Medicaid Outpatient Hospital Coverage and Limitations Handbook

513 Psychiatric Clinic
Note: Use code 513, pychiatric clinic, with code 914, psychiatric individual therapy services, or with 918, psychiatric testing, when either of these codes is appropriate and applicable.
610 MRI Diagnostic/General

611 MRI Diagnostic/Brain
612 MRI Diagnostic/Spine
614 MRI - Other
615 Magnetic Resonance Angiography (MRA) - Head & Neck
616 MRA - Lower Extremities
618 MRA - Other
619 Other MRT
621 Supplies Incident to Radiology
622 DressingsSupplies Incident to Other Diagnostic Services
623 Surgical Dressings
634 Erythropoietin (EPO) less than 10,000 units
635 Erythropoietin (EPO) 10,000 or more units
636 Pharmacy/Coded Drugs
637 Self-Administered Drugs (Effective 10/1/97)
Note: Use code 637 exclusively to bill self-administered drugs not covered by Medicare for dually-eligible Medicare and Medicaid recipients. Code 637 must only be billed with the Total Charge 001 revenue code. Payment will be made for 637 only.
700 Cast Room/General
710 Recovery Room/General
721 Labor - Delivery Room/Labor
722 Labor - Delivery Room/Delivery
723 Labor Room/Delivery/Circumcision
730 EKG - ECG/General
731 EKG - ECG/Holter Monitor
732 Telemetry
740 EEG/General
749 Other EEG
750 Gastro-Intestinal Services/General
759 Other Gastro - Intestinal
761 Treatment Room
762 Observation Room
790 Lithotripsy/General
821 Hemodialysis Outpatient/Composite
831 Peritoneal Dialysis Outpatient/Composite Rate
880 Miscellaneous Dialysis/General
881* Ultrafiltration
901 Psychiatric/Psychological - Electroshock Treatment
914 Psychiatric/Psychological - Clinic Visit/Individual Therapy
918 Psychiatric/Testing (Effective 1/1/99)
Note: Bill 513, psychiatric clinic, with this service,
920 Other Diagnostic Services/General

921	Other Diagnostic Services/Peripheral Vascular Lab
922	Other Diagnostic Services/Electromyelgram
924	Other Diagnostic Services/Allergy Test
943	Other Therapeutic Services/Cardiac Rehabilitation
944	Other Therapeutic Services/Drug Rehabilitation
945	Other Therapeutic Services/Alcohol Rehabilitation

*Exempt from $1500 outpatient cap limit.

APPENDIX B TO FLORIDA TITLE XIX OUTPATIENT HOSPITAL REIMBURSEMENT PLAN
ADJUSTMENTS TO ALLOWABLE MEDICAID VARIABLE COSTS

An example of the technique to be utilized to adjust allowable Medicaid variable costs for inflation in the computation of the reimbursement limits is detailed below. Assume the following DRI Quarterly Indices:

	1996	1997	1998	1999	2000
Q1	213.0	237.7	250.1	278.1	308.0
Q2	217.8	234.5	256.5	285.9	314.9
Q3	222.7	237.9	263.2	294.0	322.0
Q4	227.7	243.8	270.4	301.2	329.3

The elements in the above table represent a weighted composite index based on the following weights and the components:

COMPONENTS	WEIGHTS
Payroll and Professional Fees	55.57%
Employee Benefits	7.28%
Dietary and Cafeteria	3.82%
Fuel and Other Utilities	3.41%
Other	29.92%
	100.00%

Based on the quarterly indices, monthly indices are calculated by averaging pairs of quarterly indices and interpolating between these averages as follows:

QUARTER	INDEX	AVERAGE INDEX	MONTH
1	213.0		
		215.4	MARCH 31
2	217.8		
		220.3	JUNE 30
3	222.7		
		225.2	SEPT. 30
4	227.7		

April 30 Index = (June 30 Index/March 31 Index)$^{1/3}$ (March 31 Index)

$= (220.3/215.4)^{1/3}\ (215.4)$
$= 217.0$

May 31 Index = (June 30 Index/March 31 Index)$^{2/3}$ (March 31 Index)

$= (220.3/215.4)^{2/3}\ (215.4)$

= 218.7

All other monthly indices can be calculated in a similar fashion. To determine the applicable inflation factor for a given hospital for the first semester of 1999-2000 the index for September 30, 1999, the midpoint of the rate semester, is divided by the index for the midpoint of the Provider's Fiscal Year. For example, if a hospital has a fiscal year end of November 30, 1996 then its midpoint is May 31, and the applicable inflation is:

September 1999 Index/May 1996 Index = 297.6/218.7 = 1.3607

Therefore, the hospitals reported variable cost Medicaid rate is multiplied by 1.3607 to obtain the estimated average variable Medicaid rate for the first rate semester of FY 1999-2000. Similar calculations utilizing March 31, as the midpoint yield adjustments for the second semester of FY 1999-2000.

q:\ruleplan\plans\oh\v6cln.doc

FL-08-017

Holly, Mary V. (CMS/CMCHO)

From: Holly, Mary V. (CMS/CMCHO)

Sent: Thursday, December 18, 2008 10:55 AM

To: 'stephene@ahca.myflorida.com'; 'Ingram, Robin'; CMS SPA

Cc: Kimble, Davida R. (CMS/CMCHO); Dubois, Anna M. (CMS/CMCHO); Johnson, Andriette E. (CMS/SC); Roberts, Shantrina D. (CMS/CMCHO); Noonan, Darlene F. (CMS/SC); Wilkerson, Joyce C. (CMS/SC); Gaskins, Sheri P. (CMS/CMSO)

Subject: FL-08-017 RAI

Attachments: FL-08-017, RAI to the State (12-18-08).pdf

Please find attached RAI for FL-08-017. If you have any questions or need any assistance, please contact Davida Kimble at 404-562-7493. The original will go out in the mail today.

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

December 17, 2008

Mr. Carlton D. Snipes
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #8
Tallahassee, Florida 32308

Attention: Edwin Stephens

RE: Florida SPA 08-017

Dear Mr. Snipes:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 08-017. This amendment will revise the payment methodology for Outpatient Hospital Reimbursement to achieve a recurring rate reduction.

Please be advised that on November 7, 2008, the Centers for Medicare and Medicaid Services published the Final Rule on "Clarification of Outpatient Hospital Facility (Including Outpatient Hospital Clinic) Services Definition" (CMS 2213 –F). Since the rule is effective on December 8, 2008, States that are not in compliance must submit a separate state plan amendment for outpatient hospital services to demonstrate compliance with the rule. To assist the State to come into compliance with the new rule CMS suggests that the State submit the 3.1-A/B sections and the corresponding 4.19-B reimbursement section.

Based on our review of SPA 08-017 we have determined that more information is needed to assure the SPA fully conforms to the statutory and regulatory requirements necessary for approval. Please provide the following clarifications and/or additional information:

1. Please explain the following sentence in paragraph 22 on page 21 "Included in these funds are the annualized amounts to offset the reductions taken against certified trauma centers as identified in section 13, chapter 2007-326, Laws of Florida."

2. Please explain the SPA language found in paragraph 9 on page 25 "if the unit cost is greater than the unit cost used in establishing the budget, then rates shall be….". Regarding this section, how is the unit cost established? What is the process/method that the state undertakes to determine this provision? Please provide more comprehensive materials that will clearly explain and detail the methodology the State used to achieve the reduction. For plan comprehensiveness purposes, clarifying language should be included in the plan language regarding the methodology/process of the reduction.

3. On page 26, paragraph 10 please provide SPA language that clarifies how the rates will be establish at a level to ensure no increase in statewide expenditures resulting from a change in unit cost for two fiscal years effective July 1, 2009. In addition please provide more information on the following:
   a) Why is this language necessary in the state plan, to what affect will this achieve?
   b) The method the State undertakes to achieve this particular section of the state plan, this will include any supporting documents with the calculation.

4. Please provide a more detailed explanation of the buy back provisions for the Medicaid trend adjustments as indicated in paragraph 11 on page 26 and paragraph 12 on page 27/28. In addition, it will be necessary to include information with respect to the following:
   a) An example of the process/method that the State undertakes to determine this provision, including any supporting materials.
   b) An explanation of any implications with respect to Federal share of the payments.

5. Please explain how the State determines that Medicaid payments to providers do not exceed the amount according to 42 CFR 447.321. To that end, please submit an upper payment limit demonstration for outpatient hospital services. The following is presented as guidance in demonstrating the Upper Payment Limit (UPL) for outpatient hospital services.

   Federal regulations at 42 CFR 447.321 establish an UPL for outpatient hospital services. When a state proposes increases in outpatient hospital reimbursement, approval of the SPA is subject to the provision by the State of a demonstration that the payments can be made within the UPL limit. In order to establish that the payments meet the regulatory requirements, the State must demonstrate that, for each category of hospital services (State government-owned or operated facilities, non state government-owned or operated facilities and privately-owned and operated facilities), payment does not exceed, in the aggregate for each category, the reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles.

   Because the UPL is an estimate of the amount that Medicare would pay or the cost it would reimburse for services, we require the State to make a direct link in its UPL to Medicare through the Medicare Cost Report CMS 2552-96.

   When the State uses cost, the link to Medicare is made through reference to ancillary and outpatient hospital services cost center cost-to-charge ratios as found at Worksheet C, column 9, lines 37-68 or Worksheet D, Part V, Column 1.01, lines 37-68. These ratios include all cost regardless of payer for all ancillary and outpatient cost centers and charges made to all payers including Medicaid. CMS does not accept a UPL that is inflated by adjusting Medicare's allowed cost as reported on these worksheets.

The applicable outpatient hospital service payment reference for a payment-to-charge UPL demonstration may be found on Worksheet E, Part B of the CMS 2552-96. While Worksheet E represents what Medicare pays for services within hospitals, the State must make certain adjustments in order to reflect equivalent Medicaid outpatient hospital provider services that may be included in the UPL demonstration. For example, all lines that report payments associated with physician services must be removed. Additionally, the State must ensure that bad debts are not over-reported by including deductibles and coinsurance and reimbursable bad debt in Medicare payments. If deductible and coinsurance are added on to the Medicare payment, the State should remove reimbursable bad debts included in the Medicare payment. The resulting payments reported from Worksheet E should represent allowable Medicare payments for purposes of the UPL demonstration. The source of Medicare charge data, reflected in the ratio's denominator, must come from Worksheet D, Part V and Part VI of the Medicare Cost Report.

We note that a payment-to-charge ratio UPL methodology may not be inclusive of the full scope of outpatient hospital services because payments and charges on the Medicare cost report do not include payments and charges reimbursed on a fee for service basis through the Medicare Part B Carrier. For example, durable medical equipment payments and charges are not included on Worksheets E and D. CMS does not require that the ratio be adjusted for these excluded services.

CMS requires the use of the Medicare Market Basket/Global Insight Factor to trend cost. The State must demonstrate any proposed factor for trending volume.

6. If the State plans to include clinical diagnostic laboratory services in its outpatient hospital services UPL, then it must show this as a separate calculation. These services are subject to a separate UPL test at 1903(i)(7) of the Social Security Act, which requires that payment not exceed the Medicare rate *on a per test basis.* Please demonstrate that the State does not exceed Medicare fee rates per 1903(i)(7).

Funding Questions:

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the

methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:
   (i) a complete list of the names of entities transferring or certifying funds;
   (ii) the operational nature of the entity (state, county, city, other);
   (iii) the total amounts transferred or certified by each entity;
   (iv) clarify whether the certifying or transferring entity has general taxing authority: and,
   (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the State to estimate the UPL for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

This Request for Additional Information (RAI) stops the 90-day clock for the approval process on this SPA, which would have expired on December 28, 2008. Further, in accordance with the CMS guidelines to All State Medicaid Directors dated January 2, 2001, we request that you provide a formal response to this request for additional information no later than 90 days from the date of this letter. If you do not provide us with a formal response by that date, we will conclude that the State has not established that the proposed SPA is consistent with all statutory and regulatory requirements. Accordingly, at that time, we will initiate disapproval action on the amendment. In addition, because this SPA was submitted after January 2, 2001, and is effective on or after January 1, 2001, please be advised that we will defer any Federal Financial Participation (FFP) that you claim for payments made in accordance with this proposed SPA until it is approved. Upon CMS approval, FFP will be available for the period beginning with the effective date through the date of actual approval.

If you have any questions on this RAI please contact Davida Kimble at 404 562-7496.

Sincerely,

Mary Kaye Justis, RN, MBA
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

FL-08-017

Holly, Mary V. (CMS/CMCHO)

From: Kimble, Davida R. (CMS/CMCHO)
Sent: Sunday, December 07, 2008 11:33 AM
To: Holly, Mary V. (CMS/CMCHO)
Subject: RE: FL-08-017

Yes I know I am working with CO and Joyce. We are also working on FL 08-18. Draft RAIs have been sent to Sheri and Joyce.

Davida Kimble
Financial Analyst

Centers for Medicare & Medicaid Services

404-562-7496

From: Holly, Mary V. (CMS/CMCHO)
Sent: Fri 12/5/2008 4:58 PM
To: Kimble, Davida R. (CMS/CMCHO)
Subject: FL-08-017

Davida you need to do a RAI or OSN on FL-08-017 by 12/09/08.

Holly, Mary V. (CMS/CMCHO)

From: Noonan, Darlene F. (CMS/SC)
Sent: Monday, December 08, 2008 3:00 PM
To: Holly, Mary V. (CMS/CMCHO)
Subject: FW: FL SPA 08-017
Attachments: FL RAI 08-017.doc

Draft RAI for file

From: Dubois, Anna M. (CMS/CMCHO)
Sent: Thursday, December 04, 2008 8:51 AM
To: Noonan, Darlene F. (CMS/SC)
Subject: FW: FL SPA 08-017

FYI

From: Kimble, Davida R. (CMS/CMCHO)
Sent: Wednesday, December 03, 2008 2:22 PM
To: Gaskins, Sheri P. (CMS/CMSO); Wilkerson, Joyce C. (CMS/SC)
Cc: Dubois, Anna M. (CMS/CMCHO)
Subject: FL SPA 08-017

Attached please find the draft RAI for the above SPA. Please review and make changes as necessary.

Davida Kimble

Financial Analyst
Division of Medicaid and Children's Health
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW
Suite 4T20
Atlanta, Georgia 30303-8909
404-562-7496

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

December 5, 2008

Mr. Carlton D. Snipes
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #8
Tallahassee, Florida 32308

Attention: Edwin Stephens

RE: Florida SPA 08-017

Dear Mr. Snipes

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 08-017. This amendment will revise payment method for Outpatient Hospital Reimbursement to achieve a recurring rate reduction. .

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2) 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart F. Before we can continue processing this amendment, we need additional or clarifying information.

The regulation at 42 CFR 447.252(b) requires that the State plan include a comprehensive description of the methods and standards used to set payment rates. Section 6002 of the State Medicaid Manual explains further that the State plan must be comprehensive enough to determine the required level of FFP and to allow interested parties to understand the rate setting process and the items and services that are paid through these rates. Further, since the plan is the basis for Federal financial participation, it is important that the plan's language be clear and unambiguous. Therefore, we have the following questions/concerns regarding TN 08-017.

1. Please submit a recent upper payment limit demonstration for outpatient services.

2. Please explain the following sentence in paragraph 22 on page 21 "Included in these funds are the annualized amounts to offset the reductions taken against certified trauma centers as identified in section 13, chapter 2007-326, Laws of Florida."

3. Please explain the SPA language found in paragraph 9 on page 25 "if the unit cost is greater than the unit cost used in establishing the budget, then rates shall be….".

4. On page 26 paragraph 10 please provide SPA language the clarifies how the rates will be establish at a level to ensure no increase in statewide expenditures resulting from a change in unit cost for two fiscal years effective July 1, 2009.

5. Please explain the buy back provision for Medicaid trend adjustments in paragraph 11 on page 26.

Funding Questions:

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please

describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

(i) a complete list of the names of entities transferring or certifying funds;
(ii) the operational nature of the entity (state, county, city, other);
(iii) the total amounts transferred or certified by each entity;
(iv) clarify whether the certifying or transferring entity has general taxing authority: and,
(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

If you have any questions on this request for additional information please contact Davida Kimble at 404 562-7496. This written request for additional information stops the 90-day clock for the approval process on this SPA, which would have expired on December 28, 2008. Further, in accordance with the CMS guidelines to All State Medicaid Directors dated January 2, 2001, we request that you provide a formal response to this request for additional information no later than 90 days from the date of this letter. If you do not provide us with a formal response by that date, we will conclude that the State has not established that the proposed SPA is consistent with all statutory and regulatory requirements. Accordingly, at that time, we will initiate disapproval action on the amendment. In addition, because this SPA was submitted after January 2, 2001, and is effective on or after January 1, 2001, please be advised that we will defer any FFP that you claim for payments made in accordance with this proposed SPA until it is approved. Upon CMS approval, FFP will be available for the period beginning with the effective date through the date of actual approval.

Sincerely,

Mary Kaye Justis, RN, MBA
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Holly, Mary V. (CMS/CMCHO)

From: Johnson, Andriette E. (CMS/SC)
Sent: Tuesday, October 07, 2008 1:31 PM
To: Ross, Mark S. (CMS/CMSO)
Cc: Dubois, Anna M. (CMS/CMCHO); Kimble, Davida R. (CMS/CMCHO); Gaskins, Sheri P. (CMS/CMSO); Nimmons, Rita E. (CMS/SC); Hodges, Tandra L. (CMS/SC); Holly, Mary V. (CMS/CMCHO)
Subject: FL-08-017

Mark thank you for your response. I agree, there are no coverage issues for FL out patient services SPA 08-017.

I'll forward this note to other CMS staff involved with this SPA.

Andriette

Andriette P. Johnson Florida Medicaid State Coordinator ; 61 Forsyth Street S.W. Suite 4-T-20; Atlanta, GA 30303-8909; Telephone Number: (404) 562-7410; Fax Number: (404) 562-7481; email: andriette.johnson@cms.hhs.gov

From: Ross, Mark S. (CMS/CMSO)
Sent: Tuesday, October 07, 2008 1:23 PM
To: Johnson, Andriette E. (CMS/SC)
Subject: RE: FL-08-017

Andriette—I have no coverage concerns with this o/p hospital payment SPA since we have recently approved FL 07-010 and 08-003 that both involved o/p services.

Mark.

From: Zelinger, Gerald D. (CMS/CMSO)
Sent: Friday, October 03, 2008 10:03 AM
To: Ross, Mark S. (CMS/CMSO)
Subject: FW: FL-08-017
Importance: High

This is a look see for Mark.

From: CMS SPA_Waivers_FCHPG_DBEMC_CO
Sent: Friday, October 03, 2008 8:41 AM
To: Zelinger, Gerald D. (CMS/CMSO)
Subject: FW: FL-08-017
Importance: High

Please assign. Thanks

From: CMS SPA
Sent: Thursday, October 02, 2008 11:02 AM
To: CMS SPA_Waivers_FMG_DRSF_NIPT_CO; CMS SPA_Waivers_FCHPG_DBEMC_CO
Subject: FW: FL-08-017
Importance: High

FL-08-017 SPA for processing

From: Holly, Mary V. (CMS/CMCHO)
Sent: Tuesday, September 30, 2008 3:08 PM
To: Kimble, Davida R. (CMS/CMCHO); Brown, Sally E. (CMS/SC); Johnson, Andriette E. (CMS/SC); Dubois, Anna M. (CMS/CMCHO); Gaskins, Sheri P. (CMS/CMSO); CMS SPA; Noonan, Darlene F. (CMS/SC)
Cc: 'Ingram, Robin'
Subject: FL-08-017

The attached SPA was received 09/29/08. The 90th day is 12/28/08. The RO Lead is Davida Kimble and CO Lead is Sheri Gaskins. I am attaching the electronic plan pages submitted by the State.

FL-08-017

Holly, Mary V. (CMS/CMCHO)

From: Kimble, Davida R. (CMS/CMCHO)

Sent: Friday, October 03, 2008 12:44 PM

To: Gaskins, Sheri P. (CMS/CMSO)

Cc: Holly, Mary V. (CMS/CMCHO); Dubois, Anna M. (CMS/CMCHO); Johnson, Andriette E. (CMS/SC); Noonan, Darlene F. (CMS/SC)

Subject: FL SPA 08-017

Attachments: FL 08-017 NIPT RO overview doc.doc; FL-08-003 Approved Atch 4.19-B Exhibit I (Clean) (04-24-08).doc; 3.1-A page 22 and 23.doc; 3.1-b page 21 and 22.doc

Davida Kimble

Financial Analyst
Division of Medicaid and Children's Health
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW
Suite 4T20
Atlanta, Georgia 30303-8909
404-562-7496

Regional Office Non-Institutional Reimbursement SPA Overview

This is a tool developed to assist in the initial information gathering necessary to review a non-institutional payment State plan amendment (SPA). This tool was designed to provide an overview of the basic data elements on which a Medicaid reimbursement SPA review is based. The tool is intended to address the minimum information necessary to begin the review process and in no way is meant to be an all-inclusive review guide. Any additional information, comments issue analysis and/or local environmental information (such as provider or government issues that may be interrelated to the SPA submission) should be included as such information will greatly enhance the review process. This tool will facilitate a collaborative RO/CO review of Medicaid non-institutional reimbursement SPAs.

The regional office analyst should provide to the central office analyst a completed overview within 20 days of the regional office receipt of the SPA from the state. This time frame corresponds with previous guidance on the review process. Shortly after receipt in the central office, the RO/CO analysts should participate in a joint conference call to identify outstanding issues regarding the SPA. This process represents the analytical aspect of the review. The information provided on the front end by the region is intended to identify the substance of the issues within the pending SPA. Central office input should be focused on identifying policy issues in other regions or within other SPAs that might impact the SPA under review. Central Office will also provide perspective on emerging national reimbursement issues and policy decisions to better ensure consistent treatment of all Medicaid reimbursement SPAs.

The goal of this tool and previous SPA processing guidance is to create a more efficient and effective review that capitalizes on all aspects of our regional and central office structure and strengths, ultimately producing a more consistent application of CMS policy as regards Medicaid State plan reimbursement.

When conducting the initial review, it is important to note that CMS reviews all provisions on submitted reimbursement pages, not just the provisions directly modified under the SPA. In addition, CMS reviews all coverage pages approved or proposed that correspond to those reimbursement methodologies under the submitted SPA. Similarly, CMS reviews reimbursement methodologies, approved or proposed, for all services submitted on coverage pages.

SPA#: FL 08-017

Service/s: Outpatient Hospital Reimbursement (4.19-B)

1. Verify that public notice has been given or that the state believes the change does not warrant notice. (Notice is required for any significant change in methods or standards of setting payment rates 42 CFR 447.205).

   Date of Public Notice/ Reason: **6/27/2008.**

2. Verify effective date of SPA is at least one day after date of public notice (42 CFR 447.256).

   Effective Date: July 1, 2008 this is after the public notice dated 6/27/2008.

3. Verify 90th day (special attention is needed for the 60th day if it is on the second clock).

   90th Day: December 28, 2008

4. Do submitted pages overlap with pages in another pending SPA? If so, identify those pages and corresponding spas. **No**

   SPA (s) and Page Numbers:

5. Does the CMS-179 identify the budget impact and does it make sense (e.g. if the state is reducing reimbursement rates does it show a cost savings?) Yes

   Budget Impact FFY 2007-08 ($2,014) FFY 2008-09 ($9,492)
Believe the dates should be 2009 and 2010 changing the budget impact.

6. Does the total computable amount in the public notice appear reasonable in relation to the FFP reported on the CMS-179?

   YES **NO** If no, why? **Believe the dates should be 2009 and 2010 changing the budget impact.**

7. Identify the existing state plan pages that are being superseded in order to identify the change/s being made by the SPA. (Those approved pages must be provided to CO).

   Superseded page: Hospital Outpatient Version XVII Attachement 4.9-B Exhibit I

   Date sent to CO: October 3, 2008

8. Identify the companion coverage pages (if a reimbursement SPA) and the companion reimbursement pages (if a coverage SPA) so that both coverage and reimbursement can be reviewed. (Those pages must also be provided to CO).

   Existing Page(s) Number of Companion section: Attachment 3.1-A pages 22-23 and Attachment 3.1-B pages 21-22

   Date sent to CO: October 3, 2008

9. Are there any FMRs related to the new SPA? If so, what are the issues?Are there any FMRs related to the new SPA? If so, what are the issues? **NO**

   FMR #: Issues:

10. Does the SPA involve a known "problematic/contentious" issue, such as TCM, rehab or a newly proposed service not previously covered?

    YES **NO** Issue/ New Service:

FEE SCHEDULE PAYMENTS

11. If the SPA provides for fee schedule payments, does it permit payment "up to charges"? In general, CMS does not permit payment up to charges.

    YES **NO**

12. Does the SPA, or the State plan, contain language that governmental and private providers of the same service are reimbursed pursuant to the same, published fee schedule?

    YES **NO**

13. Does the SPA describe where the fee schedule is published?

    YES **NO**

    Where is it published?

SCHOOL-BASED SERVICES Does not Apply to this SPA

14. If the SPA is a SBS SPA, does it pay fee schedule rates?

    YES NO **N/A**

15. Does the SPA make clear that the rates are the same as the community rates paid to other providers of the same service?

    YES NO **N/A**

16. If the rates are different, or if the state is using CPEs as the source of the non-Federal share, the state must demonstrate that those rates are no higher than cost, following the CMS cost identification methodology.

TARGETED CASE MANAGEMENT Does not Apply to this SPA

17. Is payment based on a 15 minute unit of a practitioner's time?

    YES NO **N/A**

18. Is the service provided to an eligible population?

    YES NO **N/A** If Yes, what population?

19. Does the reimbursement methodology meet CMS requirements, as described in the TCM valuation methodology?

    YES NO **N/A**

PRACTITIONER SUPPLEMENTAL PAYMENTS

20. Do the payments, in total, equal 100% or less of the Medicare rates for those services? If so, the rates are acceptable if adequately described in the plan.

    YES NO **N/A** If Yes, what percent of Medicare?

21. If payments will exceed 100% of Medicare, the state must demonstrate that the payments will not exceed the average commercial rate, using CMS's methodologies. Which methodology did the State use? (Note: if the State used another methodology please indicate that in the "other" space.)

    ACR: Medicare Equivalent of the ACR: Other:

OUTPATIENT HOSPITAL SERVICES

22. Has the state submitted an updated upper payment limit demonstration within the last year?

    YES NO If Yes, provide SPA #: **N/A**

22. Which method of calculating the UPL did the State use?

    Cost: Payment: Other: **N/A**

23. Does it demonstrate that all payments (regular, enhanced, and supplemental) made to that class of provider (state government owned or operated, non state-government owned or operated, and private), including the proposed payment, may be made within the UPL?

    YES NO **N/A**

24. Does the state adequately describe in the plan the methodology for setting the payment?

    NO

25. If a supplemental payment, does the plan describe how the payment will be allocated among providers and when it will be paid to providers?

    How (aggregate, add-on, other): N/A

    When/ Frequency:

CLINIC PAYMENTS Does not Apply to this SPA

26. Has the state submitted an updated upper payment limit demonstration within the last year?

    YES NO If Yes, provide SPA #:

27. Does it meet CMS requirements, as described in the CMS clinic UPL evaluation methodology?

    YES NO

28. Does it demonstrate that all payments (regular, enhanced, and supplemental) made to that class of provider, including the proposed payment, may be made within the UPL?

    YES NO

29. Does the plan adequately describe the payment methodology?

YES NO

30. If a supplemental payment, does the plan describe how the payment will be allocated among providers and when it will be paid to providers?

    How (aggregate, add-on, other): When/ Frequency:

31. Does this SPA propose payment that is 100% or less of the Medicare rate?

    YES NO

32. If there are other clinic services on the same page, is payment 100% or less of the Medicare rate?

33. Is the payment change for End Stage Renal Disease (ESRD) centers or ambulatory surgical centers (ASCs)? If so, and the state is paying at or below what Medicare pays for the services, the UPL for this class of provider has been met and an overall clinic UPL need not be provided.

    YES NO At or below Medicare?

FUNDING

34. Has the state submitted responses to the standard funding questions with the original SPA (some do)?
    RO will send the funding question to the State. Questions 35-37 to be answered once funding questions have been answered.

35. Are the services funded with CPEs, IGTs or appropriations to the Medicaid agency?

    CPEs IGTs Appropriations to the Medicaid Agency?

36. If the service is funded with IGTs, is it clear from the responses that the IGT is made to the Medicaid agency before the Medicaid agency pays the provider for the services?

    YES NO

37. If the service is funded with IGTs or appropriations, does the provider receive and retain 100% of the payment?

    YES NO

NOTES:

Page 25 number 9, In establishing rates through the normal process, prior to including this reduction, if the unit cost is equal to or less than the unit cost used in establishing the budget, no additional reduction in rates is necessary. In establishing rates through the normal process, prior to including this reduction, if the unit cost is greater than the unit cost used to establishing the budger, the rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the unit cost used in establishing the budget.
I believe we should as the State for clarification and possible sample calulations.

Holly, Mary V. (CMS/CMCHO)

From: Holly, Mary V. (CMS/CMCHO)
Sent: Friday, September 23, 2011 2:42 PM
To: Graves, Donald (CMS/CMCHO); Gaskins, Sheri P. (CMS/CMCS); Halter, Mark D. (CMS/MC); Purify, Alisa A. (CMS/CMCHO); Staton, Sidney H. (CMS/CMCHO); CMS SPA; Kimble, Davida R. (CMS/CMCHO); Gilbert, Rosario G. (CMS/SC)
Cc: 'Ingram, Robin'
Subject: FL-08-017 Response to the RAI with Review Sheet
Attachments: FL-SPA 2008-017 Response to Additional Questions 09-23-11.pdf

Attached is the State response to FL-08-017 RAI with review sheet. The new 76th day is 12-08-11 and 90th day is 12-22-11.

FLORIDA
STATE PLAN AMENDMENT REVIEW SHEET

TRANSMITTAL: 08-017 (RAI) **DATE ASSIGNED:** 09/30/08 **RO LEAD:** Donald Graves

COVERAGE COORD:	Venesa Day	**ELIGIBILITY COORD:**	Rita Nimmons
STATE COORD:	Etta Hawkins	**FIN ANALYST:**	Mark Halter
STATE COORD:		**FIN ANALYST:**	
IT ANALYST:	David Hinson	**RO FUNDING SPEC:**	Alisa Purify
RO FUNDING SPEC:	Sid Staton	**RO NIRT ANALYST:**	Stanley Fields
NIRT ANALYST:	Sheri Gaskins	**CO FUNDING SPEC:**	Robert Lane
PHARMT ANALYST:	Bernadette Leeds	**NIPT ANALYST:**	Donald Graves/Sheri Gaskins

TITLE/SUBJECT:
Payment Methodology for Outpatient Hospital Reimbursement (4.19-B)

DATE FORWARDED TO:

NIRT: N/A NIPT: 09-23-11 PHARMT: N/A CMS SPA: 09-23-11

****

TYPE OF TRANSMITTAL

____	New Plan Amendment	____	Revised Pages
____	Comments From CO	____	Withdrawal/RAI
X	Response From State	____	Withdrawal/SPA
____	Other		

ACTION DATES

Date Rec'd in CMS	09-23-11
15-Day Status	
76th Day Alert	12-08-11
90th Day	12-22-11
RO NIPT Overview Tool Due Date	10/17/08 (Due 20 days after receipt of SPA)

REVIEWER'S RECOMMENDATION

____	Draft Letter to CO	____	Partial Disapproval	____	Recommending Disapproval
____	Official Letter to SA	____	Partial Approval	____	Recommending Approval

COMMENTS AND/OR INSTRUCTIONS

15-Day Status:

PRIMARY REVIEWER/DATE

CONCURRENCES

SIGNATURE/TITLE/DATE

SIGNATURE/TITLE/DATE

SIGNATURE/TITLE/DATE

From: CMS SPA_Waivers_Atlanta_R04
To: Holly, Mary V. (CMS/CMCHQ); Noonan, Darlene F. (CMS/CMCHQ); Gilbert, Rosario G. (CMS/SC)
Subject: FW: FL SPA 08-017 Response to Additional Questions
Date: Friday, September 23, 2011 1:50:14 PM
Attachments: FL SPA 2008-017 Response to Additional Questions.pdf

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From: Ingram, Robin[SMTP:ROBIN.INGRAM@AHCA.MYFLORIDA.COM]
Sent: Friday, September 23, 2011 1:50:03 PM
To: CMS SPA_Waivers_Atlanta_R04
Cc: Stephens, Edwin
Subject: FL SPA 08-017 Response to Additional Questions
Auto forwarded by a Rule

Attached are the State's responses to additional questions from CMS.
Thanks.

Robin Ingram - GOVERNMENT ANALYST II

AHCA Medicaid Directors Office - DIVISION OF MEDICAID
850-412-4017 (Office) - Robin.Ingram@ahca.myflorida.com

FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

September 23, 2011

Ms. Jackie Glaze
Associate Regional Administrator
Division of Medicaid and Children's Health
Centers for Medicare and Medicaid Services
61 Forsyth Street Suite 4T20
Atlanta, Georgia 30303-8909

Attention: Davida Kimble

RE: Florida SPA 08-017

Dear Ms. Glaze:

We have received your request for clarifications and/or additional information on proposed Florida Medicaid State Plan Amendment (SPA) 08-017. Our responses can be found below:

1. ***Please explain the following sentence in paragraph 22 on page 21 "Included in these funds are the annualized amounts to offset the reductions taken against certified trauma centers as identified in section 13, chapter 2007-326, Laws of Florida."***

   During the special legislative session of SFY 2007-08, the Florida Legislature directed the Agency for Health Care Administration (Agency) to cut inpatient and outpatient reimbursement rates for hospitals by approximately 3%. The Florida Legislature also stated that designated or provisional Trauma Hospital's would only receive a 1% cut (the Trauma hospitals were given back 2% of the 3% cut). The language "*Included in these funds are the annualized amounts to offset the reductions taken against certified trauma centers as identified in section 13, chapter 2007-326, Laws of Florida*" instructs the Agency to move forward in the same manner for SFY 2008-09.

2. ***Please explain the SPA language found in paragraph 9 on page 25 "if the unit cost is greater than the unit cost used in establishing the budget, then rates shall be...." Regarding this section, how is the unit cost established? What is the process/method that the state undertakes to determine this provision? Please provide more comprehensive materials that will clearly explain and detail the methodology the State used to achieve the reduction. For plan comprehensiveness purposes, clarifying language should be included in the plan language regarding the methodology/process of the reduction.***

Effective July 1, 2008, the following method was applied to the rate setting process to ensure compliance with the directives of the Florida Legislature.

1. There are two specific types of unit cost: *Budgeted unit cost* is unit cost as established and approved by the Florida Legislature in the General Appropriations Act. The *calculated unit cost* is the unit cost that is actually applied to a provider's reimbursement rate which is based on the costs supplied to Florida Medicaid in a provider's most recent cost report.
2. A budgeted unit cost is determined based on the State annual budget for outpatient hospital services;
3. Outpatient hospital rates are established through the normal process;
4. An annual expenditure is determined based on current rates;
5. A calculated unit cost (similar to a weighted average) is computed based on current rates; and
6. The calculated unit cost based on current rates is compared to budgeted unit cost based on State budget:
    a. If the *calculated* unit cost is <u>less than</u> the *budgeted* unit cost, then no action is required;
    b. If the *calculated* unit cost for current rates is <u>greater than</u> the *budgeted* unit cost for the State budget, then the rates will be reduced by an amount required to achieve the reduction, but shall not be reduced below the *budgeted* unit cost.

Please reference Attachment 1 for additional detail of the unit cost as applied to Outpatient Hospital services.

3. On page 26 paragraph 10 please provide SPA language that clarifies how the rates will be establish at a level to ensure no increase in statewide expenditures resulting from a change in unit cost for two fiscal years effective July 1, 2009. In addition please provide more information on the following:

a) Why is this language necessary in the state plan, to what affect will this achieve?

Effective July 1, 2009, as mandated by the Florida Legislature, hospital rates, in the aggregate, will not be allowed to increase more than the June 30, 2009, unit cost. The same methodology that is used to *set* the unit cost will be the same methodology that is used to *maintain* the unit cost for the next two years. Therefore, rates in the aggregate will not be permitted to increase more than unit cost for two state fiscal years.

b) The method the State undertakes to achieve this particular section of the state plan, this will include any supporting documents with the calculation.

Effective July 1, 2008, the following method was applied to the rate setting process to ensure compliance with the directives of the Florida Legislature.

1. There are two specific types of unit cost: *Budgeted unit cost* is unit cost as established and approved by the Florida Legislature in the General Appropriations Act. The *calculated unit cost* is the unit cost that is actually

applied to a provider's reimbursement rate which is based on the costs supplied to Florida Medicaid in a provider's most recent cost report.
2. A budgeted unit cost is determined based on the State annual budget for outpatient hospital services;
3. Outpatient hospital rates are established through the normal process;
4. An annual expenditure is determined based on current rates;
5. A calculated unit cost (similar to a weighted average) is computed based on current rates; and
6. The calculated unit cost based on current rates is compared to budgeted unit cost based on State budget:

    a. If the *calculated* unit cost is <u>less than</u> the *budgeted* unit cost, then no action is required;
    b. If the *calculated* unit cost for current rates is <u>greater than</u> the *budgeted* unit cost for State budget, then the rates will be reduced by an amount required to achieve the reduction, but shall not be reduced below the unit cost.

Please reference Attachment 1 for additional detail of the unit cost as applied to outpatient hospitals.

4. Please provide a more detailed explanation of the buy back provisions for the Medicaid trend adjustments as indicated in paragraph 11 on page 26 and paragraph 12 on page 27/28. In addition, it will be necessary to include information with respect to the following:

a) An example of the process/method that the State undertakes to determine this provision, including any supporting materials.

In accordance with House Bill 5001, 2008-09 General Appropriations Act, Specific Appropriation 211, the buy back provision allows hospitals that meet specific criteria the opportunity to buy back a portion of their rate reduction. Therefore, to determine which hospitals are included in the buy back provision, the procedure is simply to determine which hospitals are included in the following categories of hospitals and apply the buy back against their respective rate reductions:

a. Hospital Systems that operate a Provider Service Network;
b. Children's Specialty Hospitals with Medicaid and Charity Care Days that equal or exceed 30 percent of total days;
c. Rural Hospitals;
d. Public Hospitals; and
e. Teaching Hospitals as defined in Florida Statutes with seventy or more FTE resident Physicians and whose Medicaid and Charity Care days exceed 25 percent of total days.

b) An explanation of any implications with respect to Federal share of the payments.

Absent the cuts mandated, the buy backs would not be included in SPA 08-017. The rates without the buy backs would decrease the federal share required as compared to the cut rates with buy backs. Had the cuts not been taken, the federal share would be greater. Please reference the chart below to see the detail of the buy backs:

7/1/2008	$545,419,038	Annualized Outpatient cuts estimated.	
	$302,162,147	Federal Share not blended	0.554
	$243,256,891	State Share	
	$475,006,983	Annualized Outpatient with all cuts estimated	
	$263,153,869	Federal Share not blended	
	$211,853,115	State Share	
	$509,560,963	Annualized Outpatient with all cuts and buy backs estimated	
	$282,296,774	Federal Share not blended	
	$227,264,190	State Share	
	$19,865,373	Federal amount saved vs. uncut rates	

5. Please explain how the State determines that Medicaid payments to providers do not exceed the amount according to 42 CFR 447.321. To that end, please submit an upper payment limit demonstration for outpatient hospital services. The following is presented as guidance in demonstrating the Upper Payment Limit (UPL) for outpatient hospital services.

Federal regulations at 42 CFR 447.321 establish an UPL for outpatient hospital services. When a state proposes increases in outpatient hospital reimbursement, approval of the SPA is subject to the provision by the State of a demonstration that the payments can be made within the UPL limit. In order to establish that the payments meet the regulatory requirements, the State must demonstrate that, for each category of hospital services (State government-owned or operated facilities, non state government-owned or operated facilities and privately-owned and operated facilities), payment does not exceed, in the aggregate for each category, the reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles.

Because the UPL is an estimate of the amount that Medicare would pay or the cost it would reimburse for services, we require the State to make a direct link in its UPL to Medicare through the Medicare Cost Report CMS 2552-96.

When the State uses cost, the link to Medicare is made through reference to ancillary and outpatient hospital services cost center cost-to-charge ratios as found at Worksheet C, column 9, lines 37-68 or Worksheet D, Part V, Column 1.01, lines 37-68. These ratios include all cost regardless of payer for all ancillary and outpatient cost centers and charges made to all payers including Medicaid. CMS does not accept a UPL that is inflated by adjusting Medicare's allowed cost as reported on these worksheets.

The applicable outpatient hospital service payment reference for a payment-to-charge UPL demonstration may be found on Worksheet E, Part B of the CMS 2552-96. While Worksheet E represents what Medicare pays for services within hospitals, the State must make certain adjustments in order to reflect equivalent Medicaid outpatient hospital provider services that may be included in the UPL demonstration. For example, all lines that report payments associated with physician services must be removed. Additionally, the State must ensure that bad debts are not over-reported by including deductibles and coinsurance and reimbursable bad debt in Medicare payments. If deductible and coinsurance are added on to the Medicare payment, the State should remove reimbursable bad debts included in the Medicare payment. The resulting payments reported from Worksheet E should represent allowable Medicare payments for purposes of the UPL demonstration. The source of Medicare charge data, reflected in the ratio's denominator, must come from Worksheet D, Part V and Part VI of the Medicare Cost Report.

We note that a payment-to-charge ratio UPL methodology may not be inclusive of the full scope of outpatient hospital services because payments and charges on the Medicare cost report do not include payments and charges reimbursed on a fee for service basis through the Medicare Part B Carrier. For example, durable medical equipment payments and charges are not included on Worksheets E and D. CMS does not require that the ratio be adjusted for these excluded services.

CMS requires the use of the Medicare Market Basket/Global Insight Factor to trend cost. The State must demonstrate any proposed factor for trending volume.

6. If the State plans to include clinical diagnostic laboratory services in its outpatient hospital services UPL, then it must show this as a separate calculation. These services are subject to a separate UPL test at 1903(i)(7) of the Social Security Act, which requires that payment not exceed the Medicare rate on a per test basis. Please demonstrate that the State does not exceed Medicare fee rates per 1903(i)(7).

Florida Medicaid has submitted the hospital UPL demonstration. Based upon conversations with CMS staff, it is believed the hospital UPL demonstration is being approved.

Funding Questions:

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

1. ***Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)***

   Providers retain 100 percent of all payments made relating to this program. If an error occurs and payments are returned to the state, the state will track and report appropriately. The federal share is calculated and returned to CMS.

2. ***Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring***

the funds. If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

(i) a complete list of the names of entities transferring or certifying funds;
(ii) the operational nature of the entity (state, county, city, other);
(iii) the total amounts transferred or certified by each entity;
(iv) clarify whether the certifying or transferring entity has general taxing authority: and,
(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Please reference the following attachments for details regarding the funding of the state share of each type of Medicaid payment:

Attachment 2: State FY 2008-09 Appropriations for Services Provided Under Section 4.19B of the State Plan
Attachment 3: FY 2008-09 Medicaid Issues Funded with Intergovernmental Transfers
Attachment 4: FY 2008-09 IGTs by Local Government for the Title XIX Outpatient Hospital Reimbursement Plan

3. ***Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.***

No supplemental Special Medicaid Payments (SMP) are being made in addition to provider Medicaid per diem rates. The only additional payments being made to hospital providers are those payments permitted through the Low Income Pool (LIP) program or disproportionate share (DSH) program, for the continuation of government support for services to Medicaid, uninsured, and underinsured populations.

For clinic or outpatient hospital services please provide a detailed description of the methodology used by the State to estimate the UPL for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

Florida Medicaid reimburses hospital outpatient services with an occasion of service rate using a cost based prospective methodology. Individual facility costs are reported annually using the CMS 2552 cost report with specific information added for Florida Medicaid purposes.

Allowable Medicaid costs are costs set in accordance with the Principles of Reimbursement for Provider Costs, as defined in CMS Publication 15-1 and further defined in the Title XIX Inpatient Hospital Reimbursement Plan. Allowable Medicaid costs are the basis for reimbursement, with upper limits applied (class and target ceilings) and subject to a downward Medicaid Trend Adjustment. Some providers may

be reimbursed at or near allowable Medicaid costs while the remaining providers are reimbursed far less than their actual allowable Medicaid costs.

It is the Agency's position that allowable Medicaid costs are a reasonable substitute for what Medicare would have paid for the same claims. Since, by classification of hospital, we pay less than allowable Medicaid costs in the aggregate, the rates paid are within the requirements of the federal UPL regulations.

The Agency believes that allowable Medicaid costs should be permissible as a reasonable substitute for what Medicare would pay. The Agency does not pay 100% of allowable cost in the aggregate for any class of hospital facility. Therefore, the Agency believes it should be clear that each class of hospital facility is well within the UPL.

Based on conversation with CMS, a detailed UPL calculation has been submitted and we believe, based upon follow-up discussions with CMS staff, the UPL demonstration is being approved.

4. ***Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?***

   Payments to providers relating to outpatient hospital services would not exceed, in the aggregate, reasonable costs of providing services. If payments do exceed reasonable cost of providing services, the provider must return the excess amount to the state. Once the state has received the returned funds, appropriate documentation is made and the federal share is calculated and returned to CMS. The excess is returned to the state and the Federal share is reported on the 64 report to CMS.

Thank you for the opportunity to provide clarifications and additional information on Florida SPA 08-017. If you have any questions, please contact Tom Wallace at (850) 412- 4101.

Sincerely,

Justin Senior
Acting Deputy Secretary for Medicaid

JS/es
Attachments
Cc: Rydell Samuel, Cost Reimbursement Administrator
Tom Wallace, Acting Chief, Medicaid Program Analysis
Phil Williams, Assistant Deputy Secretary for Medicaid Finance

Florida State Plan Amendment 08-017
Attachment 1
Outpatient Hospital Unit Cost Calculations

	Inpatient Weighted Average Rate setting	Claims		Outpatient weighted average Rate setting	Claims	
1/1/2006	$1,202.83	$1,311.07	1.089992428	$107.57	$218.38	2.030181268
7/1/2006	$1,292.94	$1,354.47	1.047583921	$117.04	$250.43	2.139767013
1/1/2007	$1,337.48	$1,412.31	1.055950931	$122.34	$243.92	1.993819057
7/1/2007	$1,393.44	$1,452.58	1.042441079	$119.13	$246.90	2.072501877
1/1/2008	$1,406.96	$1,486.96	1.056859385	$117.34	$240.81	2.052248849
1/1/2009	$1,593.57	$1,676.04	1.051750465	$138.37	$282.21	2.039523261
allowed before Buy Back		$1,560.84	6.87% cut		$231.24	18.06% cut
Allowed after buy Back		$1,685.65	8.00% buy back		$246.92	6.78% buy back

Fixed amount

	1339754.72	$1,676.04	$2,245,482,500.74	1963692	$282.21	$554,173,519.00	
Total cut			($154,333,435)			($36,403,451)	
	1339754.72	$1,560.84	$2,091,149,065.74	1963692	$263.67	$517,770,068.00	6.57%
Total restore			$167,204,828			$30,794,556	
	1339754.72	$1,685.65	$2,258,353,893.74	1963692	$279.35	$548,564,624.00	5.95%

ATTACHMENT 2
Florida State Plan Amendment 08-017
State FY 2008-09 Appropriations for Services Provided Under Section 4.19B of the State Plan

HOSPITAL OUTPATIENT BUDGET FY 2008-09

		General Revenue Fund (State)	Tobacco Settlement Trust Fund (State)	Grants & Donations Trust Fund	Medical Care Trust Fund (Federal)	Public Medical Assistance Trust Fund (State)	Refugee Assistance Trust Fund (Federal)	Total All Funds
A	FY 2008-09 Hospital Outpatient Services Legislative Appropriation	$91,211,922	$25,329,039	$71,309,086	$327,404,515	$75,000,000	$1,130,101	$591,384,663
	Less Non-Title XXI	($64,891)	$0	$0	($142,961)	$0	$0	($207,852)
	Total Hospital Outpatient-Title XIX	$91,147,031	$25,329,039	$71,309,086	$327,261,554	$75,000,000	$1,130,101	$591,176,811
B	**Source of Medicaid Total Hospital Outpatient Funding:**							
	State General Revenue	$91,211,922	$0	$0	$0	$0	$0	$91,211,922
	State Trust Funds - Tobacco Settlement	$0	$25,329,039	$0	$0	$0	$0	$25,329,039
	State Trust Funds - State Retained Share of Fraud/Abuse Recoveries	$0	$0	$4,849,717	$0	$0	$0	$4,849,717
	Intergovernmental Transfers (From Local Governments)	$0	$0	$66,459,369	$0	$0	$0	$66,459,369
	Provider Taxes (Assessment on Hospital Net Operating Revenues)	$0	$0	$0	$0	$75,000,000	$0	$75,000,000
	Cigarette Taxes (By Statute, Medicaid Receives a Portion of Tax)	$0	$0	$0	$0	$0	$0	$0
	Enhanced Federal Medical Assistance (Medicaid Expansion Under XXI)	($64,891)	$0	$0	($142,961)	$0	$0	($207,852)
	Federal Medical Assistance Payments (Title XIX)	$0	$0	$0	$327,404,515	$0	$1,130,101	$328,534,616
	Total	$91,147,031	$25,329,039	$71,309,086	$327,261,554	$75,000,000	$1,130,101	$591,176,811
C	**DSH Payments**	$0	$0	$0	$0	$0	$0	$0
	Source of Funds:							
	State General Revenue (In AHCA & In Other State Agencies)	$0	$0	$0	$0	$0	$0	$0
	State Trust Funds - Tobacco Settlement	$0	$0	$0	$0	$0	$0	$0
	State Trust Funds - State Retained Share of Fraud/Abuse Recoveries	$0	$0	$0	$0	$0	$0	$0
	Intergovernmental Transfers (From Local Governments)	$0	$0	$0	$0	$0	$0	$0
	Provider Taxes (Assessment on Hospital Net Operating Revenues)	$0	$0	$0	$0	$0	$0	$0
	Cigarette Taxes (By Statute, Medicaid Receives a Portion of Tax)	$0	$0	$0	$0	$0	$0	$0
	Enhanced Federal Medical Assistance (Medicaid Expansion Under XXI)	$0	$0	$0	$0	$0	$0	$0
	Federal Medical Assistance Payments (Title XIX)	$0	$0	$0	$0	$0	$0	$0
	Total	$0	$0	$0	$0	$0	$0	$0
D	**Special Medicaid Payments**	$0	$0	$0	$0	$0	$0	$0
	Source of Special Medicaid Payment Funds:							
	State General Revenue (In AHCA & In Other State Agencies)	$0	$0	$0	$0	$0	$0	$0
	State Trust Funds - Tobacco Settlement	$0	$0	$0	$0	$0	$0	$0
	State Trust Funds - State Retained Share of Fraud/Abuse Recoveries	$0	$0	$0	$0	$0	$0	$0
	Intergovernmental Transfers (From Local Governments)	$0	$0	$0	$0	$0	$0	$0
	Provider Taxes (Assessment on Hospital Net Operating Revenues)	$0	$0	$0	$0	$0	$0	$0

ATTACHMENT 2
Florida State Plan Amendment 08-017
State FY 2008-09 Appropriations for Services Provided Under Section 4.19B of the State Plan

HOSPITAL OUTPATIENT BUDGET FY 2008-09

	General Revenue Fund (State)	Tobacco Settlement Trust Fund (State)	Grants & Donations Trust Fund	Medical Care Trust Fund (Federal)	Public Medical Assistance Trust Fund (State)	Refugee Assistance Trust Fund (Federal)	Total All Funds
Cigarette Taxes (By Statute, Medicaid Receives a Portion of Tax)	$0	$0	$0	$0	$0	$0	$0
Enhanced Federal Medical Assistance (Medicaid Expansion Under XXI)	$0	$0	$0	$0	$0	$0	$0
Federal Medical Assistance Payments (Title XIX)	$0	$0	$0	$0	$0	$0	$0
Total	$0	$0	$0	$0	$0	$0	$0
E Per Diem Payments	$91,147,031	$25,329,039	$71,309,086	$327,261,554	$75,000,000	$1,130,101	$591,176,811
Source of Funds:							
State General Revenue (In AHCA & In Other State Agencies)	$91,211,922	$0	$0	$0	$0	$0	$91,211,922
State Trust Funds - Tobacco Settlement	$0	$25,329,039	$0	$0	$0	$0	$25,329,039
State Trust Funds - State Retained Share of Fraud/Abuse Recoveries	$0	$0	$4,849,717	$0	$0	$0	$4,849,717
Intergovernmental Transfers (From Local Governments)	$0	$0	$66,459,368	$0	$0	$0	$66,459,368
Provider Taxes (Assessment on Hospital Net Operating Revenues)	$0	$0	$0	$0	$75,000,000	$0	$75,000,000
Cigarette Taxes (By Statute, Medicaid Receives a Portion of Tax)	$0	$0	$0	$0	$0	$0	$0
Enhanced Federal Medical Assistance (Medicaid Expansion Under XXI)	($64,891)	$0	$0	($142,961)	$0	$0	($207,852)
Federal Medical Assistance Payments (Title XIX)	$0	$0	$0	$327,404,515	$0	$1,130,101	$328,534,616
Total	$91,147,031	$25,329,039	$71,309,085	$327,261,554	$75,000,000	$1,130,101	$591,176,810

FY 2008-09 MEDICAID ISSUES FUNDED WITH COUNTY INTERGOVERNMENTAL TRANSFERS

Florida State Plan Amendment 08-017

Attachment 3

Issue APPROPRIATIONS	County Transfers	General Revenue	Tobacco Trust Fund	Other State Funds	Medical Care TF	Total Funds	
Hospital Outpatient Services							
Hospital Outpatient Ceiling for Adults $500 to $1,000	$5,247,192	$0	$0	$0	$6,533,661	$11,780,853	
Hospital Outpatient Variable Cost Ceilings	$10,337,748	$0	$0	$0	$12,872,283	$23,210,031	
Hospital Outpatient Ceiling for Adults $1,000 to $1,500	$7,182,339	$0	$0	$0	$8,943,254	$16,125,593	
Remove Hospital Outpatient Reimbursement Ceilings/Teaching, Specialty, CHEP	$16,605,046	$0	$0	$0	$20,676,153	$37,281,199	
Eliminate Outpatient Reimbursement Ceilings -11% Screen	$4,943,712	$0	$0	$0	$6,155,777	$11,099,489	
Eliminate Outpatient Reimbursement Ceilings - 7.3% Screen/Trauma	$6,596,153	$0	$0	$0	$8,213,350	$14,809,503	
Payment to Hospitals-Outpatient Provider Clinics	$6,681,000	$0	$0	$0	$8,319,000	$15,000,000	
Medicaid Trend Adjustment Buy Back - PSNs, Childrens and Rural Hospitals	$0	$0	$0	$4,849,717	$6,038,736	$10,888,453	(8)
Medicaid Trend Adjustment Buy Back - Public and Teaching Hospitals	$8,866,178	$0	$0	$0	$11,039,925	$19,906,103	
Total Hospital Outpatient Services	$66,459,368	$0	$0	$4,849,717	$88,792,139	$160,101,224	
Hospital Inpatient Services							
Remove Hospital Inpatient Reimbursement Ceilings/Teaching, Specialty, CHEP	$148,851,661	$0	$0	$13,675,000	$202,373,791	$364,900,452	(1)
Eliminate Inpatient Reimbursement Ceilings -11% Screen	$46,339,212	$0	$0	$0	$57,700,329	$104,039,541	
Eliminated Inpatient Reimbursement Ceilings -Trauma Centers/Medicaid days 7.3%	$51,864,174	$0	$0	$0	$64,579,863	$116,444,037	
Special Medicaid Payments-Liver Transplant Facilities	$4,423,713	$0	$0	$0	$5,508,287	$9,932,000	
Medicaid Trend Adjustment Buy Back - PSNs, Childrens and Rural Hospitals	$4,806,048	$0	$0	$20,150,282	$31,074,945	$56,031,275	(8)
Medicaid Trend Adjustment Buy Back - Public and Teaching Hospitals	$49,597,763	$0	$0	$0	$61,575,790	$111,173,553	
Total Hospital Inpatient Services	$305,882,571	$0	$0	$33,825,282	$422,813,005	$762,520,858	
Low Income Pool Provider Access System Payments							
Low Income Pool - Primary Care Hospitals	$4,245,134	$0	$0	$0	$5,273,104	$9,518,238	
Low Income Pool - Provisional Trauma Centers	$4,318,860	$0	$0	$0	$5,364,682	$9,683,542	
Low Income Pool - Rural Hospitals	$2,816,764	$0	$0	$0	$3,498,850	$6,315,614	
Low Income Pool - Safety Net Hospitals	$28,790,908	$250,000	$0	$4,750,306	$41,683,301	$75,454,515	(4)(6)
Low Income Pool - Poison Control Hospitals	$0	$0	$0	$1,415,071	$1,757,734	$3,172,805	(5)
Low Income Pool - Specialty Pediatric Hospitals	$705,996	$0	$0	$0	$876,956	$1,582,952	
Low Income Pool - Hospitals Providers Access System	$389,222,032	$0	$0	$0	$483,473,107	$872,695,139	
Low Income Pool - Federally Qualified Health Centers	$5,190,605	$0	$0	$1,622,605	$8,463,046	$15,276,256	(7)
Low Income Pool - Primary Care & ER Diversion in Manatee, Sarasota and Desoto	$0	$0	$535,200	$0	$664,800	$1,200,000	
Low Income Pool - County Health Initiatives	$2,921,719	$0	$0	$0	$3,629,220	$6,550,939	
Total Low Income Pool Provider Access System Payments	$438,212,018	$250,000	$535,200	$7,787,982	$554,664,800	$1,001,450,000	
Nursing Home Special Medicaid Payments	$4,822,535	$0	$0	$0	$5,990,324	$10,812,859	
Disproportionate Share Hospital Programs							
Regular Disproportionate Share	$91,303,247	$0	$0	$6,198,263	$121,111,741	$218,613,251	(2)(3)
Total DSH Programs Funded with IGTs	$91,303,247	$0	$0	$6,198,263	$121,111,741	$218,613,251	
Total FY 2008-09	$906,679,739	$250,000	$535,200	$52,661,244	$1,193,372,009	$2,153,498,192	

Source of Other State Funds for FY 2008-2009:

(1) Transfer from Department of Health (See Specific Appropriation 648)	$13,675,000
(2) Transfer from Department of Health (See Specific Appropriation 648)	$825,000
(3) Transfer from Department of Health (See Specific Appropriation 652)	$5,373,263
(4) Transfer from Department of Health (See Specific Appropriation 626)	$450,000
(5) Transfer from Department of Health (See Specific Appropriation 624)	$1,415,071
(6) Transfer from Department of Health (See Specific Appropriation 652)	$4,300,306
(7) Transfer from Department of Health (See Specific Appropriation 644)	$1,622,605
(8) Transfer from Department of Health (See Specific Appropriation 652 & 652A)	25,000,000
	$52,661,245

Florida State Plan Amendment 08-017
2008-09 Intergovernmental Transfers by Local Government
Attachment 4

Source of Funding	Derivation of Funds	Funding Amount	Total as Non-Federal Share for SFY 2007-2008 LIP	Funding Mechanism	Will the source identified in the first column be responsible for the transfer?	Will the transfer from the identified source be sent directly to the Agency?
Brevard County	General Fund	Appropriated once a year by the County	112,610	IGT	Yes	Yes
Broward County	General Fund	Appropriated once a year by the County	36,824	IGT	Yes	Yes
Children's Services Council of St. Lucie County	Ad Valorem Property Tax	.915 Mills with a maximum of .50 Mills	155,235	IGT	Yes	Yes
Citrus County Hospital Board	Ad Valorem Property Tax	.95 Mills. The amount of taxes levied is determined by Trustees, based on the operating and capital needs of the Hospital. A budget is prepared each year that indicates the amount of tax support required. The Trustees evaluate and validate the budget need and set taxes appropriately. The Trustees are charged with providing for the appropriate level of health care in the community.	4,426,197	IGT	Yes	Yes
Collier County	Ad Valorem Property Tax	Appropriated once a year by the County	1,939,964	IGT	Yes	Yes
Columbia County	Ad Valorem Property Tax	Appropriated once a year by the County	12,939	IGT	Yes	Yes
Duval County	General Funds and General Revenue	The 3 major sources of revenue come from Ad Valorem taxes, state revenue sharing and the operating contribution from the Jacksonville Electric Authority, which included both electric and water/sewer fees. Amount decided every year by the County.	11,604,165	IGT	Yes	Yes
Escambia County	County General Revenue	Appropriated once a year by the County	47,246	IGT	Yes	Yes

Florida State Plan Amendment 08-017
2008-09 Intergovernmental Transfers by Local Government
Attachment 4

Source of Funding	Derivation of Funds	Funding Amount	Total as Non-Federal Share for SFY 2007-2008 LIP	Funding Mechanism	Will the source identified in the first column be responsible for the transfer?	Will the transfer from the identified source be sent directly to the Agency?
Gulf County	Sales Tax	1/2 cent	1,020,225	IGT	Yes	Yes
Halifax Hospital Medical Center Taxing District	Ad Valorem Property Tax	3.0 Mills	18,116,560	IGT	Yes	Yes
Health Care District of Palm Beach County	Ad Valorem Property Tax	1.08 Mills	12,728,930	IGT	Yes	Yes
Hernando County	Ad Valorem Property Tax	0.1306 Mills	16,881	IGT	Yes	Yes
Hillsborough County	Sales Tax	1/2 Cent	18,232,543	IGT	Yes	Yes
Indian River Taxing District	Ad Valorem Property Tax	.66296 Mills	5,724,815	IGT	Yes	Yes
Lake Shore Hospital Authority	Ad Valorem Property Tax	1.75 Mills, may levy up to 3 mills	1,640,311	IGT	Yes	Yes
Leon County	Ad Valorem Property Tax	.06 Mills	196,339	IGT	Yes	Yes
Manatee County	Ad Valorem Property Tax	Appropriated once a year by the County	305,057	IGT	Yes	Yes
Marion County	Ad Valorem Property Tax	Appropriated once a year by the County	2,298,058	IGT	Yes	Yes
Miami-Dade County	Sales Tax	1/2 Cent, budgeted at 95% of the total	190,819,525	IGT	Yes	Yes

Florida State Plan Amendment 08-017
2008-09 Intergovernmental Transfers by Local Government
Attachment 4

Source of Funding	Derivation of Funds	Funding Amount	Total as Non-Federal Share for SFY 2007-2008 LIP	Funding Mechanism	Will the source identified in the first column be responsible for the transfer?	Will the transfer from the identified source be sent directly to the Agency?
Nassau	County General Revenue	Appropriated once a year by the County	67,849	IGT	Yes	Yes
North Brevard Hospital District			1,145,074	IGT	YES	YES
North Broward Hospital District	Ad Valorem Property Tax	Levied by the District	87,246,421	IGT	Yes	Yes
North Lake Hospital Taxing District	Ad Valorem Property Tax	1 Mil on the dollar of the value of all nonexempt property within that area of Lake County which comprises the North Lake County Hospital District.	7,179,766	IGT	Yes	Yes
Orange County	County General Revenue, Ad Valorem Tax	Appropriated once a year by the County	5,873,167	IGT	Yes	Yes
Osceola County	Ad Valorem Property Tax	Appropriated once a year by the County	14,391	IGT	Yes	Yes
Pinellas County	Ad Valorem Property Tax	.40 Mills	13,742,218	IGT	Yes	Yes
Polk County	County General Revenue	Appropriated once a year by the County	447,646	IGT	Yes	Yes
Sarasota County Public Hospital Board	Ad Valorem Property Tax	.80 Mills, authority to levy up to 2 mills	12,265,947	IGT	Yes	Yes
South Broward Hospital District	Ad Valorem Property Tax	Maximum limit 2.5 Mills	36,193,184	IGT	Yes	Yes
South Lake Taxing District			4,192,710	IGT	Yes	Yes

Florida State Plan Amendment 08-017
2008-09 Intergovernmental Transfers by Local Government
Attachment 4

Source of Funding	Derivation of Funds	Funding Amount	Total as Non-Federal Share for SFY 2007-2008 LIP	Funding Mechanism	Will the source identified in the first column be responsible for the transfer?	Will the transfer from the identified source be sent directly to the Agency?
St. Johns County	Ad Valorem Property Tax	Appropriated once a year by the County	155,235	IGT	Yes	Yes
Sumter County	County General Revenue	Appropriated once a year by the County	103,942	IGT	Yes	Yes
West Volusia Hospital Authority	Ad Valorem Property Tax	1.26190 Mills	10,272	IGT	Yes	Yes
Total Local Governments			446,720,000	IGT	Yes	Yes
Undetermined Source of Funds	FQHC Program 1		65,200			
Total Proposed Source of Funds			**446,785,000**			

Florida State Plan Amendment 08-017
2008-09 Intergovernmental Transfers by Local Government
Attachment 4

FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

September 23, 2011

Ms. Jackie Glaze
Associate Regional Administrator
Division of Medicaid and Children's Health
Centers for Medicare and Medicaid Services
61 Forsyth Street Suite 4T20
Atlanta, Georgia 30303-8909

Attention: Davida Kimble

RE: Florida SPA 08-017

Dear Ms. Glaze:

We have received your request for clarifications and/or additional information on proposed Florida Medicaid State Plan Amendment (SPA) 08-017. Our responses can be found below:

1. ***Please explain the following sentence in paragraph 22 on page 21 "Included in these funds are the annualized amounts to offset the reductions taken against certified trauma centers as identified in section 13, chapter 2007-326, Laws of Florida."***

   During the special legislative session of SFY 2007-08, the Florida Legislature directed the Agency for Health Care Administration (Agency) to cut inpatient and outpatient reimbursement rates for hospitals by approximately 3%. The Florida Legislature also stated that designated or provisional Trauma Hospital's would only receive a 1% cut (the Trauma hospitals were given back 2% of the 3% cut). The language "*Included in these funds are the annualized amounts to offset the reductions taken against certified trauma centers as identified in section 13, chapter 2007-326, Laws of Florida*" instructs the Agency to move forward in the same manner for SFY 2008-09.

2. ***Please explain the SPA language found in paragraph 9 on page 25 "if the unit cost is greater than the unit cost used in establishing the budget, then rates shall be...." Regarding this section, how is the unit cost established? What is the process/method that the state undertakes to determine this provision? Please provide more comprehensive materials that will clearly explain and detail the methodology the State used to achieve the reduction. For plan comprehensiveness purposes, clarifying language should be included in the plan language regarding the methodology/process of the reduction.***

Effective July 1, 2008, the following method was applied to the rate setting process to ensure compliance with the directives of the Florida Legislature.

1. There are two specific types of unit cost: *Budgeted unit cost* is unit cost as established and approved by the Florida Legislature in the General Appropriations Act. The *calculated unit cost* is the unit cost that is actually applied to a provider's reimbursement rate which is based on the costs supplied to Florida Medicaid in a provider's most recent cost report.
2. A budgeted unit cost is determined based on the State annual budget for outpatient hospital services;
3. Outpatient hospital rates are established through the normal process;
4. An annual expenditure is determined based on current rates;
5. A calculated unit cost (similar to a weighted average) is computed based on current rates; and
6. The calculated unit cost based on current rates is compared to budgeted unit cost based on State budget:
    a. If the *calculated* unit cost is less than the *budgeted* unit cost, then no action is required;
    b. If the *calculated* unit cost for current rates is greater than the *budgeted* unit cost for the State budget, then the rates will be reduced by an amount required to achieve the reduction, but shall not be reduced below the *budgeted* unit cost.

Please reference Attachment 1 for additional detail of the unit cost as applied to Outpatient Hospital services.

3. On page 26 paragraph 10 please provide SPA language that clarifies how the rates will be establish at a level to ensure no increase in statewide expenditures resulting from a change in unit cost for two fiscal years effective July 1, 2009. In addition please provide more information on the following:

a) Why is this language necessary in the state plan, to what affect will this achieve?

Effective July 1, 2009, as mandated by the Florida Legislature, hospital rates, in the aggregate, will not be allowed to increase more than the June 30, 2009, unit cost. The same methodology that is used to *set* the unit cost will be the same methodology that is used to *maintain* the unit cost for the next two years. Therefore, rates in the aggregate will not be permitted to increase more than unit cost for two state fiscal years.

b) The method the State undertakes to achieve this particular section of the state plan, this will include any supporting documents with the calculation.

Effective July 1, 2008, the following method was applied to the rate setting process to ensure compliance with the directives of the Florida Legislature.

1. There are two specific types of unit cost: *Budgeted unit cost* is unit cost as established and approved by the Florida Legislature in the General Appropriations Act. The *calculated unit cost* is the unit cost that is actually

applied to a provider's reimbursement rate which is based on the costs supplied to Florida Medicaid in a provider's most recent cost report.
2. A budgeted unit cost is determined based on the State annual budget for outpatient hospital services;
3. Outpatient hospital rates are established through the normal process;
4. An annual expenditure is determined based on current rates;
5. A calculated unit cost (similar to a weighted average) is computed based on current rates; and
6. The calculated unit cost based on current rates is compared to budgeted unit cost based on State budget:

    a. If the *calculated* unit cost is <u>less than</u> the *budgeted* unit cost, then no action is required;
    b. If the *calculated* unit cost for current rates is <u>greater than</u> the *budgeted* unit cost for State budget, then the rates will be reduced by an amount required to achieve the reduction, but shall not be reduced below the unit cost.

Please reference Attachment 1 for additional detail of the unit cost as applied to outpatient hospitals.

4. Please provide a more detailed explanation of the buy back provisions for the Medicaid trend adjustments as indicated in paragraph 11 on page 26 and paragraph 12 on page 27/28. In addition, it will be necessary to include information with respect to the following:

a) An example of the process/method that the State undertakes to determine this provision, including any supporting materials.

In accordance with House Bill 5001, 2008-09 General Appropriations Act, Specific Appropriation 211, the buy back provision allows hospitals that meet specific criteria the opportunity to buy back a portion of their rate reduction. Therefore, to determine which hospitals are included in the buy back provision, the procedure is simply to determine which hospitals are included in the following categories of hospitals and apply the buy back against their respective rate reductions:

a. Hospital Systems that operate a Provider Service Network;
b. Children's Specialty Hospitals with Medicaid and Charity Care Days that equal or exceed 30 percent of total days;
c. Rural Hospitals;
d. Public Hospitals; and
e. Teaching Hospitals as defined in Florida Statutes with seventy or more FTE resident Physicians and whose Medicaid and Charity Care days exceed 25 percent of total days.

b) An explanation of any implications with respect to Federal share of the payments.

Absent the cuts mandated, the buy backs would not be included in SPA 08-017. The rates without the buy backs would decrease the federal share required as compared to the cut rates with buy backs. Had the cuts not been taken, the federal share would be greater. Please reference the chart below to see the detail of the buy backs:

7/1/2008	$545,419,038	Annualized Outpatient cuts estimated.	
	$302,162,147	Federal Share not blended	0.554
	$243,256,891	State Share	
	$475,006,983	Annualized Outpatient with all cuts estimated	
	$263,153,869	Federal Share not blended	
	$211,853,115	State Share	
	$509,560,963	Annualized Outpatient with all cuts and buy backs estimated	
	$282,296,774	Federal Share not blended	
	$227,264,190	State Share	
	$19,865,373	Federal amount saved vs. uncut rates	

5. ***Please explain how the State determines that Medicaid payments to providers do not exceed the amount according to 42 CFR 447.321. To that end, please submit an upper payment limit demonstration for outpatient hospital services. The following is presented as guidance in demonstrating the Upper Payment Limit (UPL) for outpatient hospital services.***

Federal regulations at 42 CFR 447.321 establish an UPL for outpatient hospital services. When a state proposes increases in outpatient hospital reimbursement, approval of the SPA is subject to the provision by the State of a demonstration that the payments can be made within the UPL limit. In order to establish that the payments meet the regulatory requirements, the State must demonstrate that, for each category of hospital services (State government-owned or operated facilities, non state government-owned or operated facilities and privately-owned and operated facilities), payment does not exceed, in the aggregate for each category, the reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles.

Because the UPL is an estimate of the amount that Medicare would pay or the cost it would reimburse for services, we require the State to make a direct link in its UPL to Medicare through the Medicare Cost Report CMS 2552-96.

When the State uses cost, the link to Medicare is made through reference to ancillary and outpatient hospital services cost center cost-to-charge ratios as found at Worksheet C, column 9, lines 37-68 or Worksheet D, Part V, Column 1.01, lines 37-68. These ratios include all cost regardless of payer for all ancillary and outpatient cost centers and charges made to all payers including Medicaid. CMS does not accept a UPL that is inflated by adjusting Medicare's allowed cost as reported on these worksheets.

The applicable outpatient hospital service payment reference for a payment-to-charge UPL demonstration may be found on Worksheet E, Part B of the CMS 2552-96. While Worksheet E represents what Medicare pays for services within hospitals, the State must make certain adjustments in order to reflect equivalent Medicaid outpatient hospital provider services that may be included in the UPL demonstration. For example, all lines that report payments associated with physician services must be removed. Additionally, the State must ensure that bad debts are not over-reported by including deductibles and coinsurance and reimbursable bad debt in Medicare payments. If deductible and coinsurance are added on to the Medicare payment, the State should remove reimbursable bad debts included in the Medicare payment. The resulting payments reported from Worksheet E should represent allowable Medicare payments for purposes of the UPL demonstration. The source of Medicare charge data, reflected in the ratio's denominator, must come from Worksheet D, Part V and Part VI of the Medicare Cost Report.

We note that a payment-to-charge ratio UPL methodology may not be inclusive of the full scope of outpatient hospital services because payments and charges on the Medicare cost report do not include payments and charges reimbursed on a fee for service basis through the Medicare Part B Carrier. For example, durable medical equipment payments and charges are not included on Worksheets E and D. CMS does not require that the ratio be adjusted for these excluded services.

CMS requires the use of the Medicare Market Basket/Global Insight Factor to trend cost. The State must demonstrate any proposed factor for trending volume.

6. If the State plans to include clinical diagnostic laboratory services in its outpatient hospital services UPL, then it must show this as a separate calculation. These services are subject to a separate UPL test at 1903(i)(7) of the Social Security Act, which requires that payment not exceed the Medicare rate on a per test basis. Please demonstrate that the State does not exceed Medicare fee rates per 1903(i)(7).

Florida Medicaid has submitted the hospital UPL demonstration. Based upon conversations with CMS staff, it is believed the hospital UPL demonstration is being approved.

Funding Questions:

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

1. ***Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)***

   Providers retain 100 percent of all payments made relating to this program. If an error occurs and payments are returned to the state, the state will track and report appropriately. The federal share is calculated and returned to CMS.

2. ***Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring***

the funds. If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

(i) a complete list of the names of entities transferring or certifying funds;
(ii) the operational nature of the entity (state, county, city, other);
(iii) the total amounts transferred or certified by each entity;
(iv) clarify whether the certifying or transferring entity has general taxing authority: and,
(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Please reference the following attachments for details regarding the funding of the state share of each type of Medicaid payment:

Attachment 2: State FY 2008-09 Appropriations for Services Provided Under Section 4.19B of the State Plan
Attachment 3: FY 2008-09 Medicaid Issues Funded with Intergovernmental Transfers
Attachment 4: FY 2008-09 IGTs by Local Government for the Title XIX Outpatient Hospital Reimbursement Plan

3. ***Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.***

No supplemental Special Medicaid Payments (SMP) are being made in addition to provider Medicaid per diem rates. The only additional payments being made to hospital providers are those payments permitted through the Low Income Pool (LIP) program or disproportionate share (DSH) program, for the continuation of government support for services to Medicaid, uninsured, and underinsured populations.

For clinic or outpatient hospital services please provide a detailed description of the methodology used by the State to estimate the UPL for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

Florida Medicaid reimburses hospital outpatient services with an occasion of service rate using a cost based prospective methodology. Individual facility costs are reported annually using the CMS 2552 cost report with specific information added for Florida Medicaid purposes.

Allowable Medicaid costs are costs set in accordance with the Principles of Reimbursement for Provider Costs, as defined in CMS Publication 15-1 and further defined in the Title XIX Inpatient Hospital Reimbursement Plan. Allowable Medicaid costs are the basis for reimbursement, with upper limits applied (class and target ceilings) and subject to a downward Medicaid Trend Adjustment. Some providers may

be reimbursed at or near allowable Medicaid costs while the remaining providers are reimbursed far less than their actual allowable Medicaid costs.

It is the Agency's position that allowable Medicaid costs are a reasonable substitute for what Medicare would have paid for the same claims. Since, by classification of hospital, we pay less than allowable Medicaid costs in the aggregate, the rates paid are within the requirements of the federal UPL regulations.

The Agency believes that allowable Medicaid costs should be permissible as a reasonable substitute for what Medicare would pay. The Agency does not pay 100% of allowable cost in the aggregate for any class of hospital facility. Therefore, the Agency believes it should be clear that each class of hospital facility is well within the UPL.

Based on conversation with CMS, a detailed UPL calculation has been submitted and we believe, based upon follow-up discussions with CMS staff, the UPL demonstration is being approved.

4. ***Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?***

   Payments to providers relating to outpatient hospital services would not exceed, in the aggregate, reasonable costs of providing services. If payments do exceed reasonable cost of providing services, the provider must return the excess amount to the state. Once the state has received the returned funds, appropriate documentation is made and the federal share is calculated and returned to CMS. The excess is returned to the state and the Federal share is reported on the 64 report to CMS.

Thank you for the opportunity to provide clarifications and additional information on Florida SPA 08-017. If you have any questions, please contact Tom Wallace at (850) 412- 4101.

Sincerely,

Justin Senior
Acting Deputy Secretary for Medicaid

JS/es
Attachments
Cc: Rydell Samuel, Cost Reimbursement Administrator
Tom Wallace, Acting Chief, Medicaid Program Analysis
Phil Williams, Assistant Deputy Secretary for Medicaid Finance

Florida State Plan Amendment 08-017
Attachment 1
Outpatient Hospital Unit Cost Calculations

	Inpatient Weighted Average Rate setting	Claims		Outpatient weighted average Rate settin	Claims	
1/1/2006	$1,202.83	$1,311.07	1.089992428	$107.57	$218.38	2.030181268
7/1/2006	$1,292.94	$1,354.47	1.047583921	$117.04	$250.43	2.139767013
1/1/2007	$1,337.48	$1,412.31	1.055950931	$122.34	$243.92	1.993819057
7/1/2007	$1,393.44	$1,452.58	1.042441079	$119.13	$246.90	2.072501877
1/1/2008	$1,406.96	$1,486.96	1.056859385	$117.34	$240.81	2.052248849
1/1/2009	$1,593.57	$1,676.04	1.051750465	$138.37	$282.21	2.039523261
allowed before Buy Back		$1,560.84	6.87% cut		$231.24	18.06% cut
Allowed after buy Back		$1,685.65	8.00% buy back		$246.92	6.78% buy back

Fixed amount

	1339754.72	$1,676.04	$2,245,482,500.74	1963692	$282.21	$554,173,519.00	
Total cut			($154,333,435)			($36,403,451)	
	1339754.72	$1,560.84	$2,091,149,065.74	1963692	$263.67	$517,770,068.00	6.57%
Total restore			$167,204,828			$30,794,556	
	1339754.72	$1,685.65	$2,258,353,893.74	1963692	$279.35	$548,564,624.00	5.95%

ATTACHMENT 2
Florida State Plan Amendment 08-017
State FY 2008-09 Appropriations for Services Provided Under Section 4.19B of the State Plan

HOSPITAL OUTPATIENT BUDGET FY 2008-09

		General Revenue Fund (State)	Tobacco Settlement Trust Fund (State)	Grants & Donations Trust Fund	Medical Care Trust Fund (Federal)	Public Medical Assistance Trust Fund (State)	Refugee Assistance Trust Fund (Federal)	Total All Funds
A	FY 2008-09 Hospital Outpatient Services Legislative Appropriation	$91,211,922	$25,329,039	$71,309,086	$327,404,515	$75,000,000	$1,130,101	$591,384,663
	Less Non-Title XXI	($64,891)	$0	$0	($142,961)	$0	$0	($207,852)
	Total Hospital Outpatient-Title XIX	$91,147,031	$25,329,039	$71,309,086	$327,261,554	$75,000,000	$1,130,101	$591,176,811
B	**Source of Medicaid Total Hospital Outpatient Funding:**							
	State General Revenue	$91,211,922	$0	$0	$0	$0	$0	$91,211,922
	State Trust Funds - Tobacco Settlement	$0	$25,329,039	$0	$0	$0	$0	$25,329,039
	State Trust Funds - State Retained Share of Fraud/Abuse Recoveries	$0	$0	$4,849,717	$0	$0	$0	$4,849,717
	Intergovernmental Transfers (From Local Governments)	$0	$0	$66,459,369	$0	$0	$0	$66,459,369
	Provider Taxes (Assessment on Hospital Net Operating Revenues)	$0	$0	$0	$0	$75,000,000	$0	$75,000,000
	Cigarette Taxes (By Statute, Medicaid Receives a Portion of Tax)	$0	$0	$0	$0	$0	$0	$0
	Enhanced Federal Medical Assistance (Medicaid Expansion Under XXI)	($64,891)	$0	$0	($142,961)	$0	$0	($207,852)
	Federal Medical Assistance Payments (Title XIX)	$0	$0	$0	$327,404,515	$0	$1,130,101	$328,534,616
	Total	$91,147,031	$25,329,039	$71,309,086	$327,261,554	$75,000,000	$1,130,101	$591,176,811
C	**DSH Payments**	$0	$0	$0	$0	$0	$0	$0
	Source of Funds:							
	State General Revenue (In AHCA & In Other State Agencies)	$0	$0	$0	$0	$0	$0	$0
	State Trust Funds - Tobacco Settlement	$0	$0	$0	$0	$0	$0	$0
	State Trust Funds - State Retained Share of Fraud/Abuse Recoveries	$0	$0	$0	$0	$0	$0	$0
	Intergovernmental Transfers (From Local Governments)	$0	$0	$0	$0	$0	$0	$0
	Provider Taxes (Assessment on Hospital Net Operating Revenues)	$0	$0	$0	$0	$0	$0	$0
	Cigarette Taxes (By Statute, Medicaid Receives a Portion of Tax)	$0	$0	$0	$0	$0	$0	$0
	Enhanced Federal Medical Assistance (Medicaid Expansion Under XXI)	$0	$0	$0	$0	$0	$0	$0
	Federal Medical Assistance Payments (Title XIX)	$0	$0	$0	$0	$0	$0	$0
	Total	$0	$0	$0	$0	$0	$0	$0
D	**Special Medicaid Payments**	$0	$0	$0	$0	$0	$0	$0
	Source of Special Medicaid Payment Funds:							
	State General Revenue (In AHCA & In Other State Agencies)	$0	$0	$0	$0	$0	$0	$0
	State Trust Funds - Tobacco Settlement	$0	$0	$0	$0	$0	$0	$0
	State Trust Funds - State Retained Share of Fraud/Abuse Recoveries	$0	$0	$0	$0	$0	$0	$0
	Intergovernmental Transfers (From Local Governments)	$0	$0	$0	$0	$0	$0	$0
	Provider Taxes (Assessment on Hospital Net Operating Revenues)	$0	$0	$0	$0	$0	$0	$0

ATTACHMENT 2
Florida State Plan Amendment 08-017
State FY 2008-09 Appropriations for Services Provided Under Section 4.19B of the State Plan

HOSPITAL OUTPATIENT BUDGET FY 2008-09

	General Revenue Fund (State)	Tobacco Settlement Trust Fund (State)	Grants & Donations Trust Fund	Medical Care Trust Fund (Federal)	Public Medical Assistance Trust Fund (State)	Refugee Assistance Trust Fund (Federal)	Total All Funds
Cigarette Taxes (By Statute, Medicaid Receives a Portion of Tax)	$0	$0	$0	$0	$0	$0	$0
Enhanced Federal Medical Assistance (Medicaid Expansion Under XXI)	$0	$0	$0	$0	$0	$0	$0
Federal Medical Assistance Payments (Title XIX)	$0	$0	$0	$0	$0	$0	$0
Total	$0	$0	$0	$0	$0	$0	$0
E Per Diem Payments	$91,147,031	$25,329,039	$71,309,086	$327,261,554	$75,000,000	$1,130,101	$591,176,811
Source of Funds:							
State General Revenue (In AHCA & In Other State Agencies)	$91,211,922	$0	$0	$0	$0	$0	$91,211,922
State Trust Funds - Tobacco Settlement	$0	$25,329,039	$0	$0	$0	$0	$25,329,039
State Trust Funds - State Retained Share of Fraud/Abuse Recoveries	$0	$0	$4,849,717	$0	$0	$0	$4,849,717
Intergovernmental Transfers (From Local Governments)	$0	$0	$66,459,368	$0	$0	$0	$66,459,368
Provider Taxes (Assessment on Hospital Net Operating Revenues)	$0	$0	$0	$0	$75,000,000	$0	$75,000,000
Cigarette Taxes (By Statute, Medicaid Receives a Portion of Tax)	$0	$0	$0	$0	$0	$0	$0
Enhanced Federal Medical Assistance (Medicaid Expansion Under XXI)	($64,891)	$0	$0	($142,961)	$0	$0	($207,852)
Federal Medical Assistance Payments (Title XIX)	$0	$0	$0	$327,404,515	$0	$1,130,101	$328,534,616
Total	$91,147,031	$25,329,039	$71,309,085	$327,261,554	$75,000,000	$1,130,101	$591,176,810

FY 2008-09 MEDICAID ISSUES FUNDED WITH COUNTY INTERGOVERNMENTAL TRANSFERS

Florida State Plan Amendment 08-017

Attachment 3

Issue APPROPRIATIONS	County Transfers	General Revenue	Tobacco Trust Fund	Other State Funds	Medical Care TF	Total Funds	
Hospital Outpatient Services							
Hospital Outpatient Ceiling for Adults $500 to $1,000	$5,247,192	$0	$0	$0	$6,533,661	$11,780,853	
Hospital Outpatient Variable Cost Ceilings	$10,337,748	$0	$0	$0	$12,872,283	$23,210,031	
Hospital Outpatient Ceiling for Adults $1,000 to $1,500	$7,182,339	$0	$0	$0	$8,943,254	$16,125,593	
Remove Hospital Outpatient Reimbursement Ceilings/Teaching, Specialty, CHEP	$16,605,046	$0	$0	$0	$20,676,153	$37,281,199	
Eliminate Outpatient Reimbursement Ceilings -11% Screen	$4,943,712	$0	$0	$0	$6,155,777	$11,099,489	
Eliminate Outpatient Reimbursement Ceilings - 7.3% Screen/Trauma	$6,596,153	$0	$0	$0	$8,213,350	$14,809,503	
Payment to Hospitals-Outpatient Provider Clinics	$6,681,000	$0	$0	$0	$8,319,000	$15,000,000	
Medicaid Trend Adjustment Buy Back - PSNs, Childrens and Rural Hospitals	$0	$0	$0	$4,849,717	$6,038,736	$10,888,453	(8)
Medicaid Trend Adjustment Buy Back - Public and Teaching Hospitals	$8,866,178	$0	$0	$0	$11,039,925	$19,906,103	
Total Hospital Outpatient Services	$66,459,368	$0	$0	$4,849,717	$88,792,139	$160,101,224	
Hospital Inpatient Services							
Remove Hospital Inpatient Reimbursement Ceilings/Teaching, Specialty, CHEP	$148,851,661	$0	$0	$13,675,000	$202,373,791	$364,900,452	(1)
Eliminate Inpatient Reimbursement Ceilings -11% Screen	$46,339,212	$0	$0	$0	$57,700,329	$104,039,541	
Eliminated Inpatient Reimbursement Ceilings -Trauma Centers/Medicaid days 7.3%	$51,864,174	$0	$0	$0	$64,579,863	$116,444,037	
Special Medicaid Payments-Liver Transplant Facilities	$4,423,713	$0	$0	$0	$5,508,287	$9,932,000	
Medicaid Trend Adjustment Buy Back - PSNs, Childrens and Rural Hospitals	$4,806,048	$0	$0	$20,150,282	$31,074,945	$56,031,275	(8)
Medicaid Trend Adjustment Buy Back - Public and Teaching Hospitals	$49,597,763	$0	$0	$0	$61,575,790	$111,173,553	
Total Hospital Inpatient Services	$305,882,571	$0	$0	$33,825,282	$422,813,005	$762,520,858	
Low Income Pool Provider Access System Payments							
Low Income Pool - Primary Care Hospitals	$4,245,134	$0	$0	$0	$5,273,104	$9,518,238	
Low Income Pool - Provisional Trauma Centers	$4,318,860	$0	$0	$0	$5,364,682	$9,683,542	
Low Income Pool - Rural Hospitals	$2,816,764	$0	$0	$0	$3,498,850	$6,315,614	
Low Income Pool - Safety Net Hospitals	$28,790,908	$250,000	$0	$4,750,306	$41,663,301	$75,454,515	(4)(6)
Low Income Pool - Poison Control Hospitals	$0	$0	$0	$1,415,071	$1,757,734	$3,172,805	(5)
Low Income Pool - Specialty Pediatric Hospitals	$705,996	$0	$0	$0	$876,956	$1,582,952	
Low Income Pool - Hospitals Providers Access System	$389,222,032	$0	$0	$0	$483,473,107	$872,695,139	
Low Income Pool - Federally Qualified Health Centers	$5,190,605	$0	$0	$1,622,605	$8,463,046	$15,276,256	(7)
Low Income Pool - Primary Care & ER Diversion in Manatee, Sarasota and Desoto	$0	$0	$535,200	$0	$664,800	$1,200,000	
Low Income Pool - County Health Initiatives	$2,921,719	$0	$0	$0	$3,629,220	$6,550,939	
Total Low Income Pool Provider Access System Payments	$438,212,018	$250,000	$535,200	$7,787,982	$554,664,800	$1,001,450,000	
Nursing Home Special Medicaid Payments	$4,822,535	$0	$0	$0	$5,990,324	$10,812,859	
Disproportionate Share Hospital Programs							
Regular Disproportionate Share	$91,303,247	$0	$0	$6,198,263	$121,111,741	$218,613,251	(2)(3)
Total DSH Programs Funded with IGTs	$91,303,247	$0	$0	$6,198,263	$121,111,741	$218,613,251	
Total FY 2008-09	$906,679,739	$250,000	$535,200	$52,661,244	$1,193,372,009	$2,153,498,192	

Source of Other State Funds for FY 2008-2009:

(1) Transfer from Department of Health (See Specific Appropriation 648)	$13,675,000
(2) Transfer from Department of Health (See Specific Appropriation 648)	$825,000
(3) Transfer from Department of Health (See Specific Appropriation 652)	$5,373,263
(4) Transfer from Department of Health (See Specific Appropriation 626)	$450,000
(5) Transfer from Department of Health (See Specific Appropriation 624)	$1,415,071
(6) Transfer from Department of Health (See Specific Appropriation 652)	$4,300,306
(7) Transfer from Department of Health (See Specific Appropriation 644)	$1,622,605
(8) Transfer from Department of Health (See Specific Appropriation 652 & 652A)	25,000,000
	$52,661,245

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Source of Funding	Derivation of Funds	Funding Amount	Total as Non-Federal Share for SFY 2007-2008 LIP	Funding Mechanism	Will the source identified in the first column be responsible for the transfer?	Will the transfer from the identified source be sent directly to the Agency?
Brevard County	General Fund	Appropriated once a year by the County	112,610	IGT	Yes	Yes
Broward County	General Fund	Appropriated once a year by the County	36,824	IGT	Yes	Yes
Children's Services Council of St. Lucie County	Ad Valorem Property Tax	.915 Mills with a maximum of .50 Mills	155,235	IGT	Yes	Yes
Citrus County Hospital Board	Ad Valorem Property Tax	.95 Mills. The amount of taxes levied is determined by Trustees, based on the operating and capital needs of the Hospital. A budget is prepared each year that indicates the amount of tax support required. The Trustees evaluate and validate the budget need and set taxes appropriately. The Trustees are charged with providing for the appropriate level of health care in the community.	4,426,197	IGT	Yes	Yes
Collier County	Ad Valorem Property Tax	Appropriated once a year by the County	1,939,964	IGT	Yes	Yes
Columbia County	Ad Valorem Property Tax	Appropriated once a year by the County	12,939	IGT	Yes	Yes
Duval County	General Funds and General Revenue	The 3 major sources of revenue come from Ad Valorem taxes, state revenue sharing and the operating contribution from the Jacksonville Electric Authority, which included both electric and water/sewer fees. Amount decided every year by the County.	11,604,165	IGT	Yes	Yes
Escambia County	County General Revenue	Appropriated once a year by the County	47,246	IGT	Yes	Yes

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Source of Funding	Derivation of Funds	Funding Amount	Total as Non-Federal Share for SFY 2007-2008 LIP	Funding Mechanism	Will the source identified in the first column be responsible for the transfer?	Will the transfer from the identified source be sent directly to the Agency?
Gulf County	Sales Tax	1/2 cent	1,020,225	IGT	Yes	Yes
Halifax Hospital Medical Center Taxing District	Ad Valorem Property Tax	3.0 Mills	18,116,560	IGT	Yes	Yes
Health Care District of Palm Beach County	Ad Valorem Property Tax	1.08 Mills	12,728,930	IGT	Yes	Yes
Hernando County	Ad Valorem Property Tax	0.1306 Mills	16,881	IGT	Yes	Yes
Hillsborough County	Sales Tax	1/2 Cent	18,232,543	IGT	Yes	Yes
Indian River Taxing District	Ad Valorem Property Tax	.66296 Mills	5,724,815	IGT	Yes	Yes
Lake Shore Hospital Authority	Ad Valorem Property Tax	1.75 Mills, may levy up to 3 mills	1,640,311	IGT	Yes	Yes
Leon County	Ad Valorem Property Tax	.06 Mills	196,339	IGT	Yes	Yes
Manatee County	Ad Valorem Property Tax	Appropriated once a year by the County	305,057	IGT	Yes	Yes
Marion County	Ad Valorem Property Tax	Appropriated once a year by the County	2,298,058	IGT	Yes	Yes
Miami-Dade County	Sales Tax	1/2 Cent, budgeted at 95% of the total	190,819,525	IGT	Yes	Yes

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Source of Funding	Derivation of Funds	Funding Amount	Total as Non-Federal Share for SFY 2007-2008 LIP	Funding Mechanism	Will the source identified in the first column be responsible for the transfer?	Will the transfer from the identified source be sent directly to the Agency?
Nassau	County General Revenue	Appropriated once a year by the County	67,849	IGT	Yes	Yes
North Brevard Hospital District			1,145,074	IGT	YES	YES
North Broward Hospital District	Ad Valorem Property Tax	Levied by the District	87,246,421	IGT	Yes	Yes
North Lake Hospital Taxing District	Ad Valorem Property Tax	1 Mil on the dollar of the value of all nonexempt property within that area of Lake County which comprises the North Lake County Hospital District.	7,179,766	IGT	Yes	Yes
Orange County	County General Revenue, Ad Valorem Tax	Appropriated once a year by the County	5,873,167	IGT	Yes	Yes
Osceola County	Ad Valorem Property Tax	Appropriated once a year by the County	14,391	IGT	Yes	Yes
Pinellas County	Ad Valorem Property Tax	.40 Mills	13,742,218	IGT	Yes	Yes
Polk County	County General Revenue	Appropriated once a year by the County	447,646	IGT	Yes	Yes
Sarasota County Public Hospital Board	Ad Valorem Property Tax	.80 Mills, authority to levy up to 2 mills	12,265,947	IGT	Yes	Yes
South Broward Hospital District	Ad Valorem Property Tax	Maximum limit 2.5 Mills	36,193,184	IGT	Yes	Yes
South Lake Taxing District			4,192,710	IGT	Yes	Yes

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Source of Funding	Derivation of Funds	Funding Amount	Total as Non-Federal Share for SFY 2007-2008 LIP	Funding Mechanism	Will the source identified in the first column be responsible for the transfer?	Will the transfer from the identified source be sent directly to the Agency?
St. Johns County	Ad Valorem Property Tax	Appropriated once a year by the County	155,235	IGT	Yes	Yes
Sumter County	County General Revenue	Appropriated once a year by the County	103,942	IGT	Yes	Yes
West Volusia Hospital Authority	Ad Valorem Property Tax	1.26190 Mills	10,272	IGT	Yes	Yes
Total Local Governments			446,720,000	IGT	Yes	Yes
Undetermined Source of Funds	FQHC Program 1		65,200			
Total Proposed Source of Funds			**446,785,000**			

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FLORIDA TITLE XIX OUTPATIENT HOSPITAL

REIMBURSEMENT PLAN

VERSION XVIII

EFFECTIVE DATE: July~~anuary~~ 1, 2008

I. Cost Finding and Cost Reporting

A. Each hospital participating in the Florida Medicaid Hospital Program shall submit a cost report postmarked no later than five calendar months after the close of its cost-reporting year. A hospital filing a certified cost report that has been audited by the independent auditors of the hospital shall be given a 30-day extension if the Agency for Health Care Administration (AHCA) is notified in writing that a certified report is being filed. The hospital cost reporting year adopted for the purpose of this plan shall be the same as that for Title XVIII or Title V cost reporting, if applicable. A complete, legible copy of the cost report shall be submitted to the Medicare intermediary and to AHCA, Bureau of Medicaid Program Analysis, Cost Reimbursement.

B. Cost reports available to AHCA as of March 31, 1990, shall be used to initiate this plan.

C. All hospitals are required to detail their costs for their entire reporting year, making appropriate adjustments as required by this plan for determination of allowable costs. New hospitals shall adhere to requirements of Section 2414.1, Provider Reimbursement Manual (CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.010, Florida Administrative Code, F.A.C.) A prospective reimbursement rate, however, shall not be established for a new hospital based on a cost report for a period less than 12 months. For a new hospital or a new

provider with no cost history, excluding new providers resulting from a change in ownership where the previous provider participated in the program, the interim rate shall be the lesser of: the county reimbursement ceiling for variable costs (including outpatient fixed costs); or the budgeted rate in compliance with CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C. and Section III of the Plan, as applied to the budget submitted by the provider. Interim rates shall be cost settled for the interim rate period. Interim per diem rates shall not be approved for new providers resulting from a change in ownership. Medicaid reimbursement is hospital specific and is not provider specific.

D. The cost report shall be prepared in accordance with generally accepted accounting principles as established by the American Institute of Certified Public Accountants (AICPA) except as modified by the method of reimbursement and cost finding of Title XVIII (Medicare) Principles of Reimbursement described in 42 Code of Federal Regulations (CFR) 413.35 - 413.50, further interpreted by the Provider Reimbursement Manual (CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C.). and as further modified by this plan.

E. Hospitals shall file a legible and complete cost report within five months, or 6 months if a certified report is being filed, after the close of its reporting period. Medicare-granted exceptions to these time limits shall be accepted by AHCA.

F. If a provider submits a cost report late, after the five month period, and that cost report would have been used to set a lower reimbursement rate for a rate semester had it been submitted within five months, then the provider's rate for that rate semester shall be retroactively calculated using the new cost report, and full

payments at the recalculated rate shall be affected retroactively. Medicare granted exceptions to these time limits shall be accepted by AHCA.

G. A hospital which voluntarily or involuntarily ceases to participate in the Florida Medicaid Program or experiences a change of ownership shall file a final cost report in accordance with Section 2414.2, CMS_PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C. For the purposes of this plan, filing a final cost report is not required when: the capital stock of a corporation is sold; or partnership interest is sold as long as one of the original general partners continues in the partnership or one of the original limited partners becomes a general partner, or control remains unchanged. Any change of ownership shall be reported to AHCA within 45 days after such change of ownership.

H. All Medicaid participating hospitals are required to maintain the Florida Medicaid Log and financial and statistical records regarding outpatients in accordance with 42 CFR 413.24(a)-(c). For purposes of this plan, statistical records shall include the medical records of eligible Medicaid recipients. These records shall be available upon demand to representatives, employees or contractors of AHCA, the Auditor General of the State of Florida, the General Accounting Office (GAO) or the United States Department of Health and Human Services (HHS). A Medicaid recipient's medical records shall be released to the above named persons for audit purposes upon proof of the recipient's consent such as the Medicaid consent form, AHCA-Med Form 1005 as incorporated by reference in Rule 59G-5.080 (2), F.A.C.

I. Records of related organizations as defined by 42 CFR 413.17 shall be available upon demand to representatives, employees or contractors of AHCA, the Auditor General, GAO, or HHS.

J. AHCA shall retain all uniform cost reports submitted for a period of at least five years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of 45 CFR 205.60. Access to submitted cost reports shall be in conformity with Chapter 119, Florida Statutes. Upon request for a copy of any cost report, the hospital involved shall be notified as to the party making the request and the information requested. Unless prohibited by a court of competent jurisdiction, the cost report shall be released to the requestor 15 days from receipt of the request by AHCA.

K. ~~For cost reports received on or after October 1, 2003,~~ Aall desk or onsite audits of ~~these~~ cost reports shall be final and shall not be reopened past three years of the date that the audit adjustments are noticed through a revised per diem rate completed by the Agency.

Exception to the above mentioned time limit:

The aforementioned limitation shall not apply when Medicare audit reopenings result in the issuance of revised Medicaid cost report schedules. A cost report may be reopened for inspection, correction, or referral to a law enforcement agency at any time by the Agency or its contractor if program payments appear to have been obtained by fraud, similar fault, or abuse.

L. Cost reports submitted on or after July 1, 2004, must include the following statement immediately preceding the dated signature of the provider's administrator or chief financial officer: "I certify that I am familiar with the laws

and regulations regarding the provision of health care services under the Florida Medicaid program, including the laws and regulations relating to claims for Medicaid reimbursements and payments, and that the services identified in this cost report were provided in compliance with such laws and regulations."

II. Audits

A. Background

A hospital common audit program has been established to reduce the cost of auditing submitted cost reports and avoid duplicate auditing efforts. The purpose is to have one audit of a participating hospital which shall serve the needs of all governmental programs reimbursing the hospital for services rendered.

B. Common Audit Program

AHCA has entered into written agreements with Medicare intermediaries for participation in a common audit program of Titles V, XVIII, and XIX. Under this agreement, the intermediaries shall provide AHCA the result of desk reviews and field audits of those participating hospitals located in Florida, Georgia, and Alabama.

C. Other Hospital Audits

For those hospitals not covered by the common audit agreement with Medicare intermediaries, AHCA shall be responsible for performance of desk and field audits. AHCA shall:

1. Determine the scope and format for on-site audits;
2. Desk audit all cost reports within 6 months after their submission to AHCA;

3. Ensure all audits are performed in accordance with generally accepted auditing standards of the AICPA as incorporated by reference in Rule 61H1-20.008 F.A.C;
4. Ensure that only those expense items that the plan has specified as allowable costs under Section III of this plan have been included by the hospital in the computation of the costs of the various services provided under Rule 59G-4.160 F.A.C;
5. Review to determine that the Florida Medicaid Log is properly maintained and current in those hospitals where its maintenance is required;
6. Issue, upon the conclusion of each full scope audit, a report which shall meet generally accepted auditing standards of the AICPA as incorporated by reference in Rule 61H1-20.008, F.A.C. and shall declare the auditor's opinion as to whether, in all material respects, the cost submitted by a hospital meets the requirements of this plan.

D. Retention

All audit reports received from Medicare intermediaries or issued by AHCA shall be kept in accordance with 45 CFR 205.60.

E. Overpayments and Underpayments

1. Overpayments for those years or partial years as determined by desk or field audits using prior approved State plans shall be reimbursable to AHCA, as shall overpayments attributable to unallowable costs only.
2. Overpayments in outpatient hospital services shall not be used to offset underpayments in inpatient hospital services and, conversely,

overpayments in inpatient hospital services shall not be used to offset underpayments in outpatient hospital services.

3. The results of desk or field audits of outpatient hospital services shall be identified separately from the results of desk or field audits of inpatient hospital services.
4. Any overpayment or underpayment that resulted from a rate adjustment due to an error in either reporting or calculation of the rate shall be refunded to AHCA or to the provider as appropriate.
5. Any overpayment or underpayment that resulted from a rate based on a budget shall be refunded to AHCA or to the provider as appropriate.
6. The terms of repayments shall be in accordance with Section 414.41, Florida Statutes.
7. All overpayments shall be reported by AHCA to HHS as required.
8. Information intentionally misrepresented by a hospital in the cost report shall result in a suspension of the outpatient hospital from the Florida Medicaid Program.

F. Appeals

For audits conducted by AHCA a concurrence letter that states the results of an audit shall be prepared and sent to the provider, showing all adjustments and changes and the authority for such. Providers shall have the right to a hearing in accordance with Section 120.57, Florida Statutes, for any or all adjustments made by AHCA. ~~For cost reports received on or after October 1, 2003,~~ All desk or onsite audits of ~~these~~ cost reports shall be final and shall not be reopened past three

years of the date that the audit adjustments are noticed through a revised per diem rate completed by the Agency.

Exception to the above mentioned time limit:

The aforementioned limitation shall not apply when Medicare audit reopenings result in the issuance of revised Medicaid cost report schedules. A cost report may be reopened for inspection, correction, or referral to a law enforcement agency at any time by the Agency or its contractor if program payments appear to have been obtained by fraud, similar fault, or abuse.

III. Allowable Costs

Allowable costs shall be determined using generally accepted accounting principles, except as modified by Title XVIII (Medicare) Principles of Reimbursement as described in 42 CFR 413.35 - 413.50, the inpatient routine nursing salary cost differential, and the guidelines in the Provider Reimbursement Manual (CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C.,) and as further modified by Title XIX of the Act, this plan, requirements of licensure and certification, and the duration and scope of benefits provided under the Florida Medicaid Program. These include:

A. Costs incurred by a hospital in meeting:

1. The definition of a hospital contained in 42 CFR 440.20 and 42 CFR 440.140 in order to meet the requirements of Sections 1902(a)(13) and (20) of the Social Security Act;
2. The requirements established by the State Agency responsible for establishing and maintaining health standards under the authority of 42 CFR 431.610; and

3. Any other requirements for licensing under the State law which are necessary for providing outpatient hospital services.

B. Medicaid reimbursements shall be limited to an amount, if any, by which the rate calculation for an allowable claim exceeds the amount of a third party recovery during the Medicaid benefit period. In addition, the reimbursement shall not exceed the amount according to 42 CFR 447.321.

C. Malpractice insurance costs shall be apportioned to Medicaid in the ratio of Medicaid Outpatient costs to Total Hospital Costs.

D. Under this plan, hospitals shall be required to accept Medicaid reimbursement as payment in full for covered services provided during the benefit period and billed to the Medicaid program; therefore, there shall be no payments due from Medicaid recipients. As a result, for Medicaid cost reporting purposes, there shall be no Medicaid bad debts generated by Medicaid recipients. Bad debts shall not be considered as an allowable expense.

E. All physician orders and records that result in costs being passed on by the hospital to the Florida Medicaid Program through the cost report shall be subject to review by the Agency or the Agency's authorized representative.

F. Certain revenue centers are not reimbursed by Medicaid. Service rendered under these centers shall not be recorded on the Medicaid log and shall not be billed to Medicaid. The list of covered revenue centers is attached as Appendix A. Modifications of this list subsequent to the implementation of this plan shall appear in the Florida Medicaid Information System Update. Beginning November 1, 2004, revenue code 510, Clinic/General (see Appendix A) is reimbursable by Medicaid, in accordance with the most recent version of the Medicaid Outpatient

Hospital Coverage and Limitations Handbook, for health care services, in outpatient clinic facilities where a non-state government owned or operated facility assumed the fiscal and operating responsibilities of one or more primary care centers previously operated by the Florida Department of Health or the local county government.

G. The revenue assessments, and any fines associated with those assessments, mandated by the Health Care Access Act of 1984, Section 395.701, Florida Statutes, shall not be considered an allowable Medicaid cost and shall not be allocated as a Medicaid allowable cost for purposes of cost reporting.

IV. Standards

A. In accordance with Chapter 120, F.S., Administrative Procedures Act, and 42 CFR 447.205, this plan shall be promulgated as an Administrative Rule and as such shall be made available for public inspection. A public hearing shall be held so that interested members of the public shall be afforded the opportunity to review and comment on this plan.

B. Reimbursement ceilings shall be established prospectively for each Florida county. Beginning with the July 1, 1993 rate period, additional ceilings based on the Target Rate System shall also be imposed. For purposes of establishing reimbursement ceilings, each hospital within the state shall be classified as general, teaching, specialized, rural, or as a Community Hospital Education Program (CHEP) hospital. Outpatient reimbursement ceilings shall be established for and applied to general hospitals. Rural and specialized psychiatric hospitals shall be excluded from the calculation and application of the outpatient reimbursement ceilings. Statutory teaching, specialized, Community Hospital

Education Program (CHEP) hospitals, and those hospitals defined in Section V.A. 9 through 14 shall be included in the calculation but are exempt from the application of the outpatient reimbursement ceilings.

C. The initial reimbursement ceilings shall be determined prospectively and shall be effective from July 1, 1990, through December 31, 1990. For subsequent periods, the reimbursement ceilings shall be effective from January 1 through June 30 and July 1 through December 31 of the appropriate years except as provided in G. below.

D. Changes in individual hospital rates shall be effective from July 1 through December 31 and January 1 through June 30 of each year. Hospital outpatient rates set under plan provisions for the July 1, 2003 rate semester will be effective October 1, 2003.

E. For the initial period, the last cost report received from each hospital as of March 31, 1990, shall be used to establish the reimbursement ceilings. In the absence of sufficient information from the above source, claims payment data from the Medicaid fiscal agent, shall be used. Should none of the above sources provide acceptable information, the hospital shall be excluded from the reimbursement ceiling calculations. The hospital shall then have a rate assigned that equals the lowest computed rate in the county in which the hospital is located, or the lowest rate in the AHCA District in which the hospital is located, if there are no other hospitals in the county in question.

F. For subsequent periods, all cost reports received by AHCA as of each April 15 and October 15 shall be used to establish the reimbursement ceilings.

G. The individual hospital's prospectively determined rate shall be adjusted only under the following circumstances:

1. An error was made by the fiscal intermediary or AHCA in the calculation of the hospital's rate.

2. A hospital submits an amended cost report to supersede the cost report used to determine the rate in effect. There shall be no change in rate if an amended cost report is submitted beyond three years of the effective date the rate was established, or if the change is not material.

3. Further desk or field audits of cost reports used in the establishment of the prospective rate disclose material changes in these reports. ~~For cost reports received on or after October 1, 2003,~~ Aall desk or onsite audits of ~~these~~ cost reports shall be final and shall not be reopened past three years of the date that the audit adjustments are noticed through a revised per diem rate completed by the Agency.

   Exception to the above mentioned time limit:

   The aforementioned limitation shall not apply when Medicare audit reopenings result in the issuance of revised Medicaid cost report schedules. A cost report may be reopened for inspection, correction, or referral to a law enforcement agency at any time by the Agency or its contractor if program payments appear to have been obtained by fraud, similar fault, or abuse.

4. Where the charge structure of a hospital changes and the application of the lower of cost or charges limitations is reconsidered.

H. Any rate adjustment or denial of a rate adjustment by AHCA may be appealed by the provider in accordance with Rule 28-106, F.A.C., and Section 120.57 Florida Statutes.

I. Under no circumstances shall any rate adjustment exceed the reimbursement ceiling established, except as provided for in IV B.

J. In accordance with Section 2303 of Public Law 98-369, the Deficit Reduction Act of 1984, the reimbursement rates for laboratory and pathology services shall be the lower of: the hospital's charges or; the Medicaid fee schedule technical component as provided for in Rule 59G-4.160, F.A.C.

V. Method

This section defines the methodologies to be used by the Florida Medicaid Program in establishing reimbursement ceilings and individual hospital reimbursement rates.

A. Setting Reimbursement Ceilings.

1. Review and adjust the hospital cost report available to AHCA as of each April 15 and October 15 as follows:
   a. To reflect the results of desk or field audits.
   b. To reduce the Medicaid outpatient costs and charges for laboratory and pathology costs and charges.
2. Reduce a hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.9.
3. Determine Medicaid outpatient variable costs defined in Section X.
4. Adjust Medicaid outpatient variable costs for the number of months between the midpoint of the hospital's fiscal year and either September 30, or March 31, the midpoint of the rate semester for which the new rate is

being calculated. The adjustment shall be made utilizing the latest available projections as of March 31 or September 30 for the Data Resources Incorporated (DRI) Type Hospital Market Basket Index as detailed in Appendix B.

5. Divide the inflated Medicaid outpatient variable costs by the latest available Health Care component of the Florida Price Level Index (FPLI) for the county in which the hospital is located.

6. Divide the results of Step 5 for each hospital by its total Medicaid outpatient occasions of service excluding occasions of service for laboratory and pathology resulting in an occasions of service rate.

7. Array the occasions of service rates in Step 6 from the lowest to the highest rate with the associated occasions of service.

8. Establish the reimbursement ceilings as the lower of:

   a. The cost based ceilings for variable costs per occasion of service at the occasion of service rate associated with the 80th percentile of occasions of service, times the FPLI component utilized in Step 5 for the county in which the hospital is located. Rural and specialized psychiatric hospitals are excluded from the calculation and application of this cost based ceiling.

      The following types of hospitals are included in the calculation, but are exempt from the application of this cost based ceiling except for the limitations described in 9 through 14 below:

      i. Statutory teaching hospitals

      ii. Specialized hospitals

iii. Community Hospital Education Program (CHEP)

iv. Those mentioned in 9 through 14 below

v. Hospitals with Level III Neonatal Intensive Care Units that have a minimum of three of the following designated tertiary services as regulated under the certificate of need program: pediatric bone marrow transplantation, pediatric open heart surgery, pediatric cardiac catheterization and pediatric heart transplantation.

For hospitals participating in the Florida Medicaid Program that are located out of State, the FPLI used shall be equal to 1.00.

b. For rate periods beginning with the July 1, 1993 rate period, the target ceiling shall be calculated by multiplying the previous rate period's ceiling by the target inflation factor as calculated in the following formula:

$$1 + 1.4 \times \left[\frac{\text{Midpoint of the prospective rate period using appendix B}}{\text{Midpoint of the current rate period using Appendix B}} - 1 \right]$$

This target ceiling shall not apply to rural, specialized, statutory teaching, Community Hospital Education Program (CHEP) hospitals, and those hospitals defined in 9 through 14 below.

This target ceiling shall not apply to the following:

i. Statutory teaching hospitals

ii. Specialized hospitals

iii. Community Hospital Education Program (CHEP)

iv. Those mentioned in 9 through 14 below

v. Hospitals with Level III Neonatal Intensive Care Units that have a minimum of three of the following designated tertiary services as regulated under the certificate of need program: pediatric bone marrow transplantation, pediatric open heart surgery, pediatric cardiac catheterization and pediatric heart transplantation.

9. Effective July 1, 2001, outpatient reimbursement ceilings will be eliminated for hospitals whose charity care and Medicaid days as a percentage of total hospital days equals or exceeds fifteen percent. Effective July 1, 2002, the fifteen percent (15%) will be changed to fourteen and one-half percent (14.5%). The Agency shall use the disproportionate share hospital 1997 audited data available as of March 1, 2001, to determine eligibility for the elimination of ceilings. Effective July 1, 2003, the fourteen and one-half percent (14.5%) will be changed to eleven percent (11%) to eliminate the outpatient reimbursement ceilings for hospitals whose charity care and Medicaid days as a percentage of total adjusted hospital days equals or exceeds 11 percent. The Agency will use the average of the 1998, 1999, and 2000 audited DSH data available as of March 1, 2004. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency will use the average of the audited DSH data for 1998, 1999,

and 2000 that is available. Hospital outpatient rates set under plan provisions for the July 1, 2003, rate semester will be effective October 1, 2003.

10. Effective July 1, 2001, outpatient reimbursement ceilings will be eliminated for hospitals whose Medicaid days as a percentage of total hospital days exceed 9.6% and are a trauma center. The Agency shall use the 1997 audited DSH data available as of March 1, 2001, to determine eligibility for the elimination of ceilings.

11. Effective July 1, 2003, outpatient reimbursement ceilings will be eliminated for hospitals whose Medicaid days, as a percentage of total hospital days, exceed 9.6 percent, and are trauma centers. The Agency will use the average of the 1998, 1999, and 2000 audited DSH date available as of March 1, 2004. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency will use the average of the audited DSH data for 1998, 1999, and 2000 that is available. Hospital outpatient rates set under plan provisions for the July 1, 2003, rate semester will be effective October 1, 2003.

12. Effective July 1, 2005, outpatient reimbursement ceilings shall be eliminated for hospitals whose charity care and Medicaid days as a percentage of total adjusted hospital days equals or exceeds 11 percent. The Agency shall use the average of the 1999, 2000, and 2001 audited DSH data available as of March 1, 2005. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency will use the average of the audited DSH data for 1999, 2000, and 2001 that are available. Any hospital that met the 11 percent threshold in state

fiscal year 2004-2005 and was also exempt from the outpatient reimbursement ceilings shall remain exempt from the outpatient reimbursement ceilings for State Fiscal Year 2005-2006, subject to the payment limitations imposed in this paragraph.

13. Effective July 1, 2005, outpatient reimbursement ceilings shall be eliminated for hospitals that have a minimum of ten licensed Level II neonatal intensive care beds and are located in Trauma Services Area 2.

14. Effective July 1, 2005, the outpatient reimbursement ceilings shall be eliminated for hospitals whose Medicaid days, as a percentage of total hospital days, exceed 7.3 percent, and are designated or provisional trauma centers. This provision shall apply to all hospitals that are designated or provisional trauma centers on July 1, 2005, or become a designated or provisional trauma center during state fiscal year 2005-2006. The agency shall use the average of the 1999, 2000 and 2001 audited DSH data available as of March 1, 2005. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the agency will use the average of the audited DSH data for 1999, 2000, and 2001 that are available.

15. Effective July 1, 2006, outpatient hospital rates shall be adjusted to eliminate the outpatient reimbursement ceilings for hospitals whose charity care and Medicaid days as a percentage of total adjusted hospital days equals or exceeds 11 percent. Effective July 1, 2006, the Agency shall use the average of the 2000, 2001, and 2002 audited DSH data available as of March 1, 2006. In the event the Agency does

not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2000, 2001, and 2002 that are available. For any non-state government owned or operated facility that does not qualify for the elimination of the outpatient ceilings under this section, the non-state government owned or operated facility hospital shall be exempt from the outpatient reimbursement ceilings.

16. Effective July 1, 2006, outpatient reimbursement ceilings for hospitals that have a minimum of ten licensed Level II neonatal intensive care beds and are located in Trauma Services Area 2 are eliminated.

17. Effective July 1, 2006, outpatient reimbursement ceilings for hospitals whose Medicaid days, as a percentage of total hospital days, exceed 7.3 percent, and are designated or provisional trauma centers are eliminated. This provision shall apply to all hospitals that are designated or provisional trauma centers on July 1, 2006, or become a designated or provisional trauma center during State Fiscal Year 2006-2007. The Agency shall use the average of the 2000, 2001, and 2002 audited DSH data available as of March 1, 2006. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2000, 2001, and 2002 that are available.

18. Effective July 1, 2007, the outpatient reimbursement ceilings will be eliminated for hospitals whose charity care and Medicaid days as a percentage of total adjusted hospital days equals or exceeds 11 percent. For any non-state government owned or

operated facility that does not qualify for the elimination of the outpatient ceilings under this provision of proviso or any other proviso listed, the non-state government owned or operated facility shall be exempt from the outpatient reimbursement ceilings. The Agency shall use the average of the 2001, 2002, and 2003 audited DSH data available as of March 1, 2007. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2001, 2002, and 2003 that are available.

19. Effective July 1, 2007, the outpatient reimbursement ceilings will be eliminated for hospitals that have a minimum of ten licensed Level II Neonatal Intensive Care Beds and are located in Trauma Services Area 2.

20. Effective July 1, 2007, the outpatient reimbursement ceilings will be eliminated for hospitals whose Medicaid days, as a percentage of total hospital days, exceed 7.3 percent, and are designated or provisional trauma centers. This provision shall apply to all hospitals that are designated or provisional trauma centers on July 1, 2007, or become a designated or provisional trauma center during state fiscal year 2007-2008. The Agency shall use the average of the 2001, 2002, and 2003 audited DSH data available as of March 1, 2007. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2001, 2002, and 2003 that are available.

21. Effective July 1, 2008, outpatient reimbursement ceilings for hospitals will be eliminated for those hospitals whose charity care and Medicaid days as a percentage of total adjusted hospital days equals or exceeds 11 percent. The Agency shall use the average of the 2002, 2003, and 2004 audited DSH data available as of March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003, and 2004 that are available.

22. Effective July 1, 2008, outpatient hospital reimbursement ceilings will be eliminated for hospitals whose Medicaid days, as a percentage of total hospital days, exceed 7.3 percent, and are designated or provisional trauma centers. This provision shall apply to all hospitals that are designated or provisional trauma centers on July 1, 2008, or become a designated or provisional trauma center during Fiscal Year 2008-2009. Included in these funds are the annualized amounts to offset the reductions taken against certified trauma centers as identified in section 13, chapter 2007-326, Laws of Florida. The Agency shall use the average of the 2002, 2003, and 2004 audited DSH data available as of March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003, and 2004 that are available.

B. Setting Individual Hospital Rates.

1. Review and adjust the hospital cost report available to AHCA as of each April 15 and October 15 as follows:

   a. To reflect the results of desk and field audits.

   b. To reduce the Medicaid outpatient costs and charges for laboratory and pathology costs and charges.

2. Reduce the hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.9.

3. Determine Medicaid outpatient variable costs as defined in Section X.

4. Adjust Medicaid outpatient variable costs for the number of months between the midpoint of the hospital's fiscal year and September 30 or March 31, the midpoint of the following rate semester. The adjustment shall be made utilizing the DRI Regional Hospital Input Price Index as detailed in Appendix B.

5. Establish the variable cost rate as the lower of:

   a. The inflated rate by dividing the inflated allowable Medicaid outpatient variable costs by the total Medicaid outpatient occasions of service for the hospital excluding occasions of service for laboratory and pathology.

   b. The target rate by inflating the variable cost rate in the previous rate period by the target inflation factor calculated in V.A.8.b. above in establishing target ceilings. This target rate shall not apply to rural, specializd, statutory teaching, Community Hospital

Education Program (CHEP) hospitals, and those hospitals defined in Section V.A. 9 through 14.

i. Set the rate for the hospital as the lower of the result of Step 5. above, the reimbursement ceiling in V.A.8 for the county in which the hospital is located, or the result of inflated Medicaid outpatient charges divided by total Medicaid outpatient occasions of service excluding charges and occasions of service for laboratory and pathology.

ii. Hospital outpatient rates set under plan provisions for the July 1, 2003, rate semester will be effective October 1, 2003.

iii. Effective July 1, 2004, and ending June 30, 2005, each outpatient rate shall be reduced by a proportionate percentage until an aggregate total estimated savings of $14,103,000 is achieved. In reducing hospital outpatient rates, rural hospitals and hospitals with twenty thousand (20,000) or more combined Medicaid managed care and fee-for-service inpatient days shall not have their outpatient rates reduced below the final rates that are effective on June 30, 2004. The 2002 Financial Hospital Uniform Reporting System (FHURS) data shall be used to determine the combined inpatient Medicaid days.

6. Effective July 1, 2005, a recurring rate reduction shall be established until an aggregate total estimated savings of $16,796,807 is achieved each year. This reduction is the Medicaid Trend Adjustment. In reducing hospital outpatient rates, rural hospitals and hospitals with twenty thousand (20,000) or more

combined Medicaid managed care and fee-for-service inpatient days shall not have their outpatient rates reduced below the final rates that are effective on the prior June 30 of each year. The 2002 Financial Hospital Uniform Reporting System (FHURS) data shall be used to determine the combined inpatient Medicaid days.

a. The July 1, 2005 and January 1, 2006 reimbursement rates shall be adjusted as follows:

    i. Restore the $14,103,000 outpatient hospital reimbursement rate reduction set forth in Section V.B.iii above to the June 30,2005 reimbursement rate;

    ii. Determine the lower of the June 30, 2005 rate with the restoration of the $14,103,000 reduction referenced in (i) above or the July 1, 2005 or January 1, 2006 rates, as applicable, before the application of the Medicaid Trend Adjustment described in (6) above;

b. Effective July 1, 2006, the reduction implemented during the period July 1, 2005, through June 30, 2006, shall become a recurring annual reduction. This recurring reduction, called the Medicaid Trend Adjustment, shall be applied proportionally to all rates on an annual basis.

c. Effective July 1, 2007, and ending June 30, 2008, the Medicaid Trend Adjustment will be removed for all hospitals whose Medicaid charity

care days as a percentage to total adjusted days equals or exceeds 30 percent and have more than 10,000 Medicaid days or hospital system that established a Provider Service Network during the prior state fiscal year. The aggregate Medicaid Trend Adjustment listed in V.B.6 above will be reduced by $3,110,871. The Agency shall use the average of the 2001, 2002 and 2003 audited DSH data available as of March 1, 2007.

7. Effective January 1, 2008, an additional Medicaid Trend Adjustment shall be applied to achieve a recurring annual reduction of $17,211,796.
8. Effective January 1, 2008, and ending June 30, 2008, the Medicaid Trend Adjustment shall be removed for all certified trauma centers and hospitals defined in section 408.07(45), 2007 Florida Statutes. The aggregate Medicaid Trend Adjustment found in V.C.7 above shall be reduced by up to $2,034,032.
9. Effective July 1, 2008, an additional Medicaid Trend Adjustment shall be applied to achieve a recurring annual reduction of $36,403,451. In establishing rates through the normal process, prior to including this reduction, if the unit cost is equal to or less than the unit cost used in establishing the budget, no additional reduction in rates is necessary. In establishing rates through the normal process, prior to including this reduction, if the unit cost is greater than the unit cost used in establishing the budget, then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the unit cost used in establishing the budget.

10. The Agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs for two fiscal years effective July 1, 2009.

11. Effective July 1, 2008, a buy back provision for the Medicaid trend adjustment will be applied against the Medicaid outpatient rates for the following three categories of hospitals.

    a. Budget authority up to $3,515,024 is provided to the first category of hospitals, which are those hospitals that are part of a system that operate a provider service network in the following manner: $831,338 is for hospitals in Broward Health; $823,362 is for hospitals in the Memorial Healthcare System; and $601,863 to Shands Jacksonville and $1,258,461 to Shands Gainesville. In the event that the above amounts exceed the amount of the Medicaid trend adjustment applied to each hospital, the excess funds will be used to buy back other Medicaid reductions in the outpatient rate.

    b. Budget authority up to $5,203,232 shall be used for the second category to buy back the Medicaid trend adjustment that is being applied against the Medicaid outpatient rates for those hospitals that are licensed as a children's specialty

hospital and whose Medicaid days plus charity care days divided by total adjusted patient days equals or exceeds 30 percent. In the event the above amounts exceed the amount of the Medicaid trend adjustment applied to each hospital, the excess funds will be used to buy back other Medicaid reductions in the inpatient rate.

c. Budget authority up to $2,170,197 shall be used for the third category to buy back the additional Medicaid trend adjustment that is being applied to rural hospitals under Specific Appropriation 211 for Fiscal Year 2008-2009. In the event that the funds under this category exceed the amount of the Medicaid trend adjustment, then any excess funds will be used to buyback other Medicaid reductions in the outpatient rate for those individual hospitals.

For this provision the Agency shall use the average of 2002, 2003, and 2004 audited DSH data available as of March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003 and 2004 that are available.

12. Effective July 1, 2008, budget authority up to $19,906,103 is provided for a buy back provision for state or local government owned or operated hospitals,

teaching hospitals as defined in section 408.07 (45) or 395.805, Florida Statutes, which have 70 or more full-time equivalent resident physicians and those hospitals whose Medicaid and charity care days divided by total adjusted days exceeds 25 percent to buy back the Medicaid outpatient trend adjustment shall be applied to their individual hospital rates and other Medicaid reductions to their outpatient rates up to actual Medicaid outpatient cost. The Agency shall use the average of the 2002, 2003, and 2004 audited DSH data available as of March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003 and 2004 that are available.

VI. Payment Assurance

The State shall pay each hospital for services provided in accordance with the requirements of the most recent version of the Florida Title XIX State Plan. The payment amount shall be determined for each hospital according to the standards and methods set forth in the most recent version of the Florida Title XIX Outpatient Hospital Reimbursement Plan.

VII. Provider Participation

This plan is designed to assure adequate participation of hospitals in the Medicaid Program, the availability of hospital services of high quality to recipients, and services which are comparable to those available to the general public. This is in accordance with 42 CFR 447.204.

VIII. Revisions

The plan shall be revised as operating experience data are developed and the need for changes is necessary in accordance with modifications in the Code of Federal Regulations.

IX. Payment in Full

Participation in the Program shall be limited to hospitals of service which accept as payment in full for covered services the amount paid in accordance with the most recent version of the Florida Title XIX Outpatient Hospital Reimbursement Plan.

X. Definitions

A. Acceptable Cost Report - A completed, legible cost report that contains all relevant schedules, worksheets and supporting documents.

B. Adjusted patient days - The sum of acute care patient days and intensive care patient days as reported to the Agency for Health Care Administration divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues

C. AHCA - Agency for Health Care Administration, also known as the Agency.

D. Allowable Costs - An item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with generally accepted accounting principles except as modified by the Principles of Reimbursement for Provider Costs, as defined in CMS PUB. 15-1 as incorporated by reference in 59G-6.010 F.A.C., and as further defined in the most recent version of the Florida Title XIX Outpatient Hospital Reimbursement Plan.

E. Community Hospital Education Program (CHEP) hospitals – Hospitals that participate in a program established by the Community Hospital Education Act

(381.0403, F.S.) and administered by the Department of Health. CHEP hospitals offer continuing medical education programs for interns and residents established on a statewide basis. The CHEP program provides financial support for interns and residents based on policies recommended and approved by the Community Hospital Education Council and the Department of Health.

F. Cost Reporting Year - A 12-month period of operation based upon the provider's accounting year.

G. Eligible Medicaid Recipient - "Recipient" or "Medicaid recipient" means any individual whom the department, or the Social Security Administration on behalf of the agency, determines is eligible, pursuant to federal and state law, to receive medical or allied care, goods, or services for which the department may make payments under the Medicaid program and is enrolled in the Medicaid program. For the purposes of determining third party liability, the term includes an individual formerly determined to be eligible for Medicaid, an individual who has received medical assistance under the Medicaid program, or an individual on whose behalf Medicaid has become obligated.

H. Florida Medicaid Log - A schedule to be maintained by a hospital listing each Medicaid patient's recipient number, dates of admission and discharge, and the charges and payments for services and goods received from the hospital's revenue centers.

I. Florida Price Level Index - A spatial index which measures differences from county to county in the cost of purchasing a specified market basket of items at a particular point in time. The items in the market basket range from various food products to hospital lab fees, and are grouped into the components of food,

housing, apparel, transportation, and health, recreation and personal services. A county index for each of the five components is developed bi-annually by the Florida Executive Office of the Governor. County indices are population weighted to average 100 percent. An index of 1.1265 for a given county means that the basket of goods in that county costs 12.65 percent more than the State average. Changes to the methodology utilized in the development of the FPLI will constitute changes in this plan and will require a formal plan amendment.

J. General hospital – A hospital in this state that is not classified as a specialized hospital.

K. HHS - Department of Health and Human Services

L. CMS PUB. 15-1 - Health Insurance Manual No. 15, also known as the Provider Reimbursement Manual, as incorporated by reference in Rule 59G-6.010, F.A.C..

M. Medicaid Outpatient Charges - Usual and customary charges for outpatient services rendered to Medicaid patients excluding charges for laboratory and pathology services. These charges shall be the allowable charges as reconciled with the hospital Medicaid log and found on the Medicaid paid claims report.

N. Medicaid Outpatient Occasions of Service - The number of distinct revenue center code line items listed on a valid claim that a hospital has submitted to the fiscal agent, excluding laboratory and pathology revenue center code line items, and that have been paid by the fiscal agent, which represent covered Medicaid outpatient services.

O. Medicaid Outpatient Variable Costs - Allowable operating costs excluding laboratory and pathology costs less return on equity as apportioned to Medicaid by cost finding methods in the CMS 2552 cost report.

P. Non-Covered Services - Those goods and services which are not medically necessary for the care and treatment of outpatients as defined in CMS PUB 15.1 as incorporated by reference in Rule 59G-6.010, F.A.C.

Q. Provider Service Network (PSN) – is defined in s. 409.912, F.S., as a network established or organized and operated by a health care provider, or group of affiliated health care providers, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers.

R. Rate Semester - January 1 through June 30 of a given year, or July 1 through December 31 of a given year.

S. Reimbursement Ceiling - The upper limit for Medicaid Outpatient Variable Cost rate reimbursement for an individual hospital.

T. Reimbursement Ceiling Period - January 1 through June 30 of a given year or July 1 through December 31, of a given year.

U. Rural Hospital - An acute care hospital licensed under Florida Statutes, Chapter 395 with 100 licensed beds or less, which has an emergency room and is located in an area defined as rural by the United States Census, and which is:

1. The sole provider within a county with a population density of no greater than 100 persons per square mile; or
2. An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county; or

3. A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or less per square mile.

4. A hospital in a constitutional charter county with a population of over 1 million persons that has imposed a local option health service tax pursuant to law and in an area that was directly impacted by a catastrophic event on August 24, 1992, for which the Governor of Florida declared a state of emergency pursuant to chapter 125, and has 120 beds or less that serves an agricultural community with an emergency room utilization of no less than 20,000 visits and a Medicaid inpatient utilization rate greater than 15 percent;

5. A hospital with a service area that has a population of 100 persons or fewer per square mile. As used in this subparagraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Policy Analysis at the Agency for Health Care Administration; or

6. A hospital designated as a critical access hospital, as defined in s. 408.07(15).

Population densities used in this paragraph must be based upon the most

recently completed United States census. A hospital that received funds under s. 409.9116 for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2012, if the hospital continues to have 100 or fewer licensed beds and an emergency room, or meets the criteria of subparagraph 4. An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this paragraph shall be granted such designation upon application, including supporting documentation to the Agency for Health Care Administration.

V. Specialized Hospital - A licensed hospital primarily devoted to TB, psychiatric care, pediatric, eye, or cardiac care and treatment; or a licensed hospital that has ten or more residency training programs.

W. Title XVIII - Health Insurance for the Aged, Blind or Disabled (Medicare) as provided for in the Social Security Act (42 U.S.C. 1395-1395xx).

X. Title XIX - Grants to States for medical assistance programs (Medicaid) as provided for in the Social Security Act (42 U.S.C. 1396-1396p).

Y. Total Outpatient Charges - Total patient revenues assessed for all outpatient services excluding charges for laboratory and pathology.

APPENDIX A TO FLORIDA TITLE XIX OUTPATIENT HOSPITAL REIMBURSEMENT PLAN

OUTPATIENT REVENUE CENTER CODES

CODE	DESCRIPTION
250	Pharmacy/General
251	Pharmacy/Generic
252	Pharmacy/NonGeneric
254	Drugs Incident to Other Diagnostic Services
255	Drugs Incident to Radiology
258	Pharmacy/IV Solutions
259	Other Pharmacy
260	IV Therapy
261	Infusion Pump
262	IV Therapy/Pharmacy Services
264	IV Therapy/Supplies
269	Other IV Therapy
270	General Classification
271	Medical Surgical- Nonsterile supplies
272	Medical/Surgical - Sterile Supplies
275	Pacemaker
276	Intraocular Lens
278	Subdermal Contraceptive Implant
279	Burn Pressure Garment Fitting
300	Laboratory/General
301	Laboratory/Chemistry
302	Laboratory/Immunology
304	Laboratory/Non-Routine Dialysis
305	Laboratory/Hematology
306	Laboratory/Bacteriology and Microbiology
307	Laboratory/Urology
310	Pathological Laboratory/General
311	Pathological Laboratory/Cytology
312	Pathological Laboratory/Histology
314	Pathological Laboratory/Biopsy
320	Diagnostic Radiology/General
321	Diagnostic Radiology/Angiocardiography
322	Diagnostic Radiology/Arthrography
323	Diagnostic Radiology/Arteriography
324	Diagnostic Radiology/Chest

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329	Other Radiology Diagnostic
330	Therapeutic Radiology/General
331	Therapeutic Radiology/Injected
332	Therapeutic Radiology/Oral
333	Therapeutic Radiology/Radiation Therapy
335	Therapeutic Radiology/Chemotherapy - IV
339*	Other Radiology Therapeutic
340	Nuclear Medicine/General
341	Nuclear Medicine/Diagnostic
342	Nuclear Medicine/Therapeutic
343	Diagnostic Radiopharmaceuticals
344	Therapeutic Radiopharmaceuticals
349	Other Nuclear Medicine
350	Computed Tomographic (CT) Scan/General
351	Computed Tomographic (CT) Scan/Head
352	Computed Tomographic (CT) Scan/Body
359	Other CT Scans
360	Operating Room Services/General
361	Operating Room Services/Minor Surgery
362	Operating Room Services/Bone Marrow Transplant
369*	Other Operating Room Services
370	Anesthesia/General
371	Anesthesia Incident to Radiology
372	Anesthesia Incident to Other Diagnostic Services
379	Other Anesthesia
380	Blood/General
381	Blood/Packed Red Cells
382	Blood/Whole
383	Blood/Plasma
384	Blood/Platelets
385	Blood/Leucocytes
386	Blood/Other Components
387	Blood/Other Derivatives
389	Other Blood
390	Blood Storage and Processing/General
391	Blood Storage and Processing/Administration
399	Other Processing and Storage
400	Imaging Services/General
401	Imaging Services/Mammography
402	Imaging Services/Ultrasound
403	Screening Mammography
404	Positron Emission Tomography

409 Other Imaging Services

410 Respiratory Services/General (All Ages)
412 Respiratory Services/Inhalation (All Ages)
413 Respiratory Services/Hyperbaric Oxygen Therapy (All Ages)
419 Other Respiratory Services
421 Physical Therapy/Visit Charge (All Ages)
424 Physical Therapy/Evaluation or Re-evaluation(All Ages)
Note: Effective 1/1/99
431 Occupational Therapy/Visit Charge (Under 21 only)
434 Occupation Therapy/Evaluation or Re-evaluation (Under 21)
Note: Effective 1/1/99
441 Speech-Language Pathology/Visit Charge (Under 21 only)
444 Speech-Language Pathology/Evaluation or Re-evaluation Under 21) Note: Effective 1/1/99
450 Emergency Room/General
451 EMTALA Emergency Medical Screening Services
(Effective 7/1/96)

- EMTALA: Emergency Medical Treatment and Active Labor Act
- Use 451 when the recipient needs no ER care beyond the EMTALA emergency medical screening
- Code W1700 must be used with code 451; example 451(W1700)

Note: No MediPass authorization required

460 Pulmonary Function/General
469 Other Pulmonary Function
471 Audiology/Diagnostic
472 Audiology/Treatment
480 Cardiology/General
481 Cardiology/Cardiac Cath Laboratory
482 Cardiology/Stress Test
483 Cardiology/Echocardiology
489 Other Cardiology
490 Ambulatory Surgical Care
510 Clinic/General

- Note: Please reference the most recent version of the Medicaid Outpatient Hospital Coverage and Limitations Handbook

513 Psychiatric Clinic
Note: Use code 513, pychiatric clinic, with code 914, psychiatric individual therapy services, or with 918, psychiatric testing, when either of these codes is appropriate and applicable.
610 MRI Diagnostic/General

611 MRI Diagnostic/Brain
612 MRI Diagnostic/Spine
614 MRI - Other
615 Magnetic Resonance Angiography (MRA) - Head & Neck
616 MRA - Lower Extremities
618 MRA - Other
619 Other MRT
621 Supplies Incident to Radiology
622 DressingsSupplies Incident to Other Diagnostic Services
623 Surgical Dressings
634 Erythropoietin (EPO) less than 10,000 units
635 Erythropoietin (EPO) 10,000 or more units
636 Pharmacy/Coded Drugs
637 Self-Administered Drugs (Effective 10/1/97)
Note: Use code 637 exclusively to bill self-administered drugs not covered by Medicare for dually-eligible Medicare and Medicaid recipients. Code 637 must only be billed with the Total Charge 001 revenue code. Payment will be made for 637 only.
700 Cast Room/General
710 Recovery Room/General
721 Labor - Delivery Room/Labor
722 Labor - Delivery Room/Delivery
723 Labor Room/Delivery/Circumcision
730 EKG - ECG/General
731 EKG - ECG/Holter Monitor
732 Telemetry
740 EEG/General
749 Other EEG
750 Gastro-Intestinal Services/General
759 Other Gastro - Intestinal
761 Treatment Room
762 Observation Room
790 Lithotripsy/General
821 Hemodialysis Outpatient/Composite
831 Peritoneal Dialysis Outpatient/Composite Rate
880 Miscellaneous Dialysis/General
881* Ultrafiltration
901 Psychiatric/Psychological - Electroshock Treatment
914 Psychiatric/Psychological - Clinic Visit/Individual Therapy
918 Psychiatric/Testing (Effective 1/1/99)
Note: Bill 513, psychiatric clinic, with this service,
920 Other Diagnostic Services/General

921 Other Diagnostic Services/Peripheral Vascular Lab
922 Other Diagnostic Services/Electromyelgram
924 Other Diagnostic Services/Allergy Test
943 Other Therapeutic Services/Cardiac Rehabilitation
944 Other Therapeutic Services/Drug Rehabilitation
945 Other Therapeutic Services/Alcohol Rehabilitation

*Exempt from $1500 outpatient cap limit.

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APPENDIX B TO FLORIDA TITLE XIX OUTPATIENT HOSPITAL REIMBURSEMENT PLAN ADJUSTMENTS TO ALLOWABLE MEDICAID VARIABLE COSTS

An example of the technique to be utilized to adjust allowable Medicaid variable costs for inflation in the computation of the reimbursement limits is detailed below. Assume the following DRI Quarterly Indices:

	1996	1997	1998	1999	2000
Q1	213.0	237.7	250.1	278.1	308.0
Q2	217.8	234.5	256.5	285.9	314.9
Q3	222.7	237.9	263.2	294.0	322.0
Q4	227.7	243.8	270.4	301.2	329.3

The elements in the above table represent a weighted composite index based on the following weights and the components:

COMPONENTS	WEIGHTS
Payroll and Professional Fees	55.57%
Employee Benefits	7.28%
Dietary and Cafeteria	3.82%
Fuel and Other Utilities	3.41%
Other	29.92%
	100.00%

Based on the quarterly indices, monthly indices are calculated by averaging pairs of quarterly indices and interpolating between these averages as follows:

QUARTER	INDEX	AVERAGE INDEX	MONTH
1	213.0		
		215.4	MARCH 31
2	217.8		
		220.3	JUNE 30
3	222.7		
		225.2	SEPT. 30
4	227.7		

April 30 Index = (June 30 Index/March 31 Index)$^{1/3}$ (March 31 Index)

$= (220.3/215.4)^{1/3} (215.4)$
$= 217.0$

May 31 Index = (June 30 Index/March 31 Index)$^{2/3}$ (March 31 Index)

$= (220.3/215.4)^{2/3} (215.4)$

= 218.7

All other monthly indices can be calculated in a similar fashion. To determine the applicable inflation factor for a given hospital for the first semester of 1999-2000 the index for September 30, 1999, the midpoint of the rate semester, is divided by the index for the midpoint of the Provider's Fiscal Year. For example, if a hospital has a fiscal year end of November 30, 1996 then its midpoint is May 31, and the applicable inflation is:

September 1999 Index/May 1996 Index = 297.6/218.7 = 1.3607

Therefore, the hospitals reported variable cost Medicaid rate is multiplied by 1.3607 to obtain the estimated average variable Medicaid rate for the first rate semester of FY 1999-2000. Similar calculations utilizing March 31, as the midpoint yield adjustments for the second semester of FY 1999-2000.

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