FLORIDA TITLE XIX OUTPATIENT HOSPITAL

REIMBURSEMENT PLAN

VERSION XIX

EFFECTIVE DATE: March 1, 2009

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

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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.

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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.

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

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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

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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;

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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.

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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.

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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

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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.

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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

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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

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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.

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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:

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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:

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

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

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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.

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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

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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

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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

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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.

2. 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.
3. Hospital outpatient rates set under plan provisions for the July 1, 2003, rate semester will be effective October 1, 2003.
4. 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

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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

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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.

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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

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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.

13. Effective March 1, 2009, the Agency for Health Care Administration shall implement a recurring methodology to reduce individual outpatient hospital rates proportionately until the required $20,952,069 savings is achieved. 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 are excluded from this reduction. The Agency may amend its current facility fees and physician services to allow for payments to hospitals providing primary care to low-income individuals and participating in the Primary Care DSH program in Fiscal Year 2003-2004 provided such hospital implements an emergency room diversion program so that non-emergent patients are triaged to lesser acute settings.

14. Public hospitals, teaching hospitals as defined in section 408.07 (45) or section 395.805, Florida Statutes, which have seventy or more full-time equivalent resident physicians, designated trauma centers and those hospitals whose Medicaid and charity care days divided by total adjusted days exceeds twenty five percent are

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allowed 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.

15. 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.

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.

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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

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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

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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

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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.

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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

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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

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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

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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
622 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

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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)

$$= (220.3/215.4)^{2/3} (215.4)$$
$$= 218.7$$

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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
2.	**March 1, 2009**		
	First Cut	3.096567%	$16,796,807
	Second Cut	3.112936%	$17,211,796
	Third Cut	6.744282%	$36,403,451
	Fourth Cut	4.321883%	$20,952,069

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