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State/Territory Name: Florida

State Plan Amendment (SPA) #: 11-009

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS for MEDICARE & MEDICAID SERVICES

Centers for Medicaid and CHIP Services

Mr. Justin M. Senior
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

JUL 11 2012

RE: State Plan Amendment FL 11-009

Dear Mr. Senior:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 11-009. Effective July 1, 2011 this amendment proposes to adjust reimbursement for hospital services. Specifically this amendment proposes to reduce reimbursement rates by $394,928,848 and deny payment for provider preventable conditions. However, the reductions will be offset by an increase in intergovernmental transfers of funds. The net effect of the amendment will be an increase in provider payments of $859,958,243 total computable ($480,532,291 FFP) for the 12 months ending June 30, 2012.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CPR Part 447. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of July 1, 2011. We are enclosing the CMS-179 and the amended approved plan pages.

We appreciate the State providing information by region and county that demonstrates Medicaid beneficiaries have adequate access to hospital services. CMS will continue to request information about access in conjunction with the State increasing its reliance on local government to fund the non-federal share of payment to offset reduced State funding.

If you have any questions, please call Stanley Fields at (502) 223-5332.

Sincerely

//s//

Cindy Mann
Director, CMCS

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: 2011-009	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, 2011	

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 AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: CFR 42 447	7. FEDERAL BUDGET IMPACT: (in thousands) FFY 2010-11 $120,133 FFY 2011-12 $360,399
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A Part I	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-A Part I

10. SUBJECT OF AMENDMENT: Inpatient Hospital Reimbursement Plan

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: Reviewed by the Deputy Secretary for Medicaid who is the Governor's designee.

12. SIGNATURE OF STATE AGENCY OFFICIAL: //s//	16. RETURN TO: Mr. Justin M. Senior Acting Deputy Secretary for Medicaid Agency for Health Care Administration 2727 Mahan Drive, Mail Stop #8 Tallahassee, FL 32308 Attention: Robin Ingram
13. TYPED NAME: Mr. Justin M. Senior	
14. TITLE: Acting Deputy Secretary for Medicaid	
15. DATE SUBMITTED: 09/23/11	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 09/23/14	18. DATE APPROVED: 07/11/12
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/11	20. SIGNATURE OF REGIONAL OFFICIAL: //s//
21. TYPED NAME: Cindy Mann	22. TITLE: Director, CMCS

23. REMARKS:

FLORIDA TITLE XIX INPATIENT HOSPITAL

REIMBURSEMENT PLAN

VERSION XXXVIII

EFFECTIVE DATE July 1, 2011

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 provider with no cost history, excluding new providers resulting from a change in ownership where the previous provider participated in the program, the interim per diem rate shall be the lesser of:

1. the county reimbursement ceiling, if applicable; or
2. the budgeted rate approved by AHCA based on this plan.

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) as incorporated by reference in Rule 61H1-20.007, F.A.C., except as modified by the method of reimbursement and cost finding of Title XVIII (Medicare) Principles of Reimbursement described in 42 CFR 413.5 - 413.35 and further interpreted by the Provider Reimbursement Manual CMS PUB. 15-1, as incorporated by reference in Rule 59G-6.010, F.A.C., or as further modified by this plan.

E. 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 5 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.

F. A hospital which voluntarily or involuntarily ceases to participate in the Florida Medicaid Program or experiences a change of ownership shall file a clearly marked "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:

1. the capital stock of a corporation is sold; or
2. 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.

G. All Medicaid participating hospitals, are required to maintain the Florida Medicaid Log and financial and statistical records in accordance with 42 CFR 413.24 (a)-(c). In addition, a separate log shall be maintained to account for concurrent and non-concurrent nursery days. For purposes of this plan, statistical records shall include beneficiaries'

medical records. 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). Beneficiaries' medical records shall be released to the above named persons for audit purposes upon proof of a beneficiary's consent to the release of medical records such as the Medicaid Consent Form, AHCA-Med Form 1005.

H. 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.

I. 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.

I. For cost reports received on or after October 1, 2003, 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.

J. 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."

K. AHCA reserves the right to submit any provider found to be out of compliance with any of the policies and procedures regarding cost reports to the Bureau of Medicaid Program Integrity for investigations.

L. Providers shall be subject to sanctions pursuant to s. 409.913(15)(c), F.S., for late cost reports. The amount of the sanctions can be found in 59G-9.070, Florida Administrative Code. A cost report is late if it is not received by AHCA, Bureau of Medicaid Program Analysis, on the first cost report cut-off acceptance date after the cost report due date.

M. Effective July 1, 2011, the Agency shall implement a methodology for establishing base reimbursement rates for each hospital based on allowable costs. The base reimbursement rate is defined in section V.A.1. through 9., V.B., and V.C of the Agency's hospital reimbursement plan. Rates shall be calculated annually and take effect July 1 of each year based on the most recent complete and accurate cost report submitted by each hospital. Adjustments may not be made to the rates after September 30 of the state fiscal year in which the rate takes effect. Errors in cost reporting or calculation of rates discovered after September 30 must be reconciled in a subsequent rate period. The Agency may not make any adjustment to a hospital's reimbursement rate more than 5 years after a hospital is notified of an audited rate established by the agency. The requirement that the agency may not make any adjustment to a hospital's reimbursement rate more than 5 years after a hospital is notified of an audited rate established by the agency is remedial and shall apply to actions by providers involving Medicaid claims for hospital services. Hospital rates shall be subject to such limits or ceilings as may be established in law or described in the Agency's hospital reimbursement plan.

II. Audits

A. Background

Medicaid (Title XIX), Maternal and Child Health and Crippled Children's Services (Title V), and Medicare (Title XVIII) require that inpatient hospital services be reimbursed on a reasonable cost basis. To assure that payment of reasonable cost is being achieved, a comprehensive hospital audit program has been established to reduce the cost of auditing submitted cost reports under the

above three programs, and to avoid duplicate auditing effort. The purpose is to have one audit of a participating hospital that shall serve the needs of all participating 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 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-4.150, 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.

Amendment 2011-009
Effective July 1, 2011
Supersedes 2010-005
Approval JUL 11 2012

E. Overpayments and Underpayments

1. Overpayments for those years or partial years as determined by desk or field audit 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 audits of outpatient hospital services shall be reported separately from 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. Effective July 1, 2011, any overpayment or underpayment that resulted from a rate adjustment, prior to July 1 of each state fiscal year, will continue to be adjusted after September 30 of each state fiscal year.

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 28-106, F.A.C, and 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 413.5 - 413.35 (excluding 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 Social Security Act (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 440.10 (for the care and treatment of patients with disorders other than mental diseases) and 42 CFR 440.140 (for individuals age 65 or older in institutions for mental diseases), in order to meet the requirements of Sections 1902(a)(13) and (20) of the Social Security Act;
2. The requirements established by the Agency for establishing and maintaining health standards under the authority of 42 CFR 431.610 (b); and
3. Any other requirements for licensing under Chapter 395.003, Florida Statutes, which are necessary for providing inpatient hospital services.

B. Medicaid reimbursement shall be limited to an amount, if any, by which the per diem calculation for an allowable claim exceeds the amount of third party benefits during the Medicaid benefit period.

Approval JUL 11 2012

C. Hospital inpatient general routine operating costs shall be the lesser of allowable costs, direct and indirect, incurred or the limits established by HHS under 42 CFR 413.30.

D. Malpractice insurance costs shall be apportioned to Medicaid in the ratio of Medicaid Patient Days to Total Patient Days.

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

F. 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 AHCA on a random basis to determine if the costs are allowable in accordance with Section III of this plan. All such orders determined by the Utilization and Quality Control Peer Review Organization (PRO) or the hospital's utilization review (UR) committee to be unnecessary or not related to the spell of illness shall require appropriate adjustments to the Florida Medicaid Log.

G. The allowable costs of nursery care for Medicaid eligible infants shall include direct and indirect costs incurred on all days these infants are in the hospital.

H. The revenue assessments, and any fines associated with those assessments, mandated by the Health Care Access Act of 1984, Section 395.7015, 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.

I. For purposes of this plan, gains or losses resulting from a change of ownership will not be included in the determination of allowable cost for Medicaid reimbursement.

IV. Standards

A. In accordance with Chapter 120, Florida Statutes, 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. 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. An inpatient variable cost county reimbursement ceiling shall be established for and applied to general hospitals. An inpatient county reimbursement ceiling shall not be applied to specialized, statutory teaching, rural, CHEP hospitals, or those hospitals included in Section V. A. except as described in V.A. of the Plan. An inpatient fixed cost reimbursement ceiling shall be established for all hospitals except rural hospitals and specialized psychiatric hospitals. Out-of-state hospitals shall be considered to be general hospitals under this plan.

C. Reimbursement ceilings shall be established prospectively for each Florida County. Beginning with the July 1, 1991, rate period, additional ceilings based on the target rate system shall be imposed. The target rate ceiling shall be the approved rate of increase in the prospective payment system for the Medicare Inpatient Hospital Reimbursement Program as determined by the Department of HHS. For fiscal year 1991-1992, the allowable rate of increase shall be 3.3 percent. Effective July 1, 1995, the target rate ceiling shall be calculated from an annually adjusted Data Resource Inc. (DRI, or its successor) inflation factor. The DRI (or its successor) inflation factor for this time period is 3.47 percent. With the adjustment of this DRI (or its successor) factor, the allowable rate of increase shall be 2.2 percent. Effective July 1, 1996, and for subsequent state fiscal years, the allowable rate of increase shall be calculated by an amount derived from the DRI (or its successor) inflation index described in appendix A. The allowable rate of increase shall be calculated by dividing the inflation index value for the midpoint of the next state fiscal year by the inflation index value for the midpoint of the current state fiscal year and then multiply this amount by 63.4 percent. The allowable rate of increase shall be recalculated for each July rate setting period and shall be the same during the remainder of the state fiscal year. These target ceilings shall apply to inpatient variable cost per diems (facility specific target ceilings) and county ceilings (county target ceilings) and shall be used to limit per diem increases during state fiscal years. The facility specific target and county target ceilings shall

apply to all general hospitals. Rural, specialized, statutory teaching, Community Hospital Education Program (CHEP) hospitals, and those hospitals included in Section V. A. of the Plan are exempt from both target ceilings in accordance with Section V.A.

D. The initial reimbursement ceilings shall be determined prospectively and shall be effective from July l, 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 H. below. Inpatient reimbursement ceilings set under the provisions of the Plan for the July 1, 2003 rate setting will be effective October 1, 2003. Effective July 1, 2011, there will be one rate setting period from July 1 through June 30.

E. Changes in individual hospital per diem rates shall be effective from July 1 through June 30 of each year. Inpatient reimbursement rates set under the provisions of the Plan for the July 1, 2003 rate setting will be effective October 1, 2003. Effective July 1, 2011, there will be one rate setting period from July 1 through June 30. F. 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. For subsequent periods, all cost reports postmarked by March 31 and received by AHCA by April 15 shall be used to establish the reimbursement ceilings. For the initial period within 20 days after publication, a public hearing, if requested, shall be held so that interested members of the public shall be afforded the opportunity to review and comment on the proposed reimbursement ceilings. Subsequent rate periods shall not be automatically subject to public hearing.

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

H. The prospectively determined individual hospital's 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 3 years of the effective date that the rate was established, or if the change is not

material. Effective July 1, 2011, a hospital must submit an amended cost report by September 15 of the state fiscal year the rates are effective to have the amended cost report recognized in the final rates set at September 30.

3. Further desk or on-site 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. Effective October 1, 2013, for cost reports received prior to October 1, 2003, all desk or onsite audits of these cost reports shall be final and not subject to reopening.

   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. The charge structure of a hospital changes and invalidates the application of the lower of cost or charges limitations.

I. Any rate adjustment or denial of a rate adjustment by AHCA may be appealed by the provider in accordance with Section 120.57, Florida Statutes.

J. Under no circumstances shall any rate adjustment exceed the reimbursement ceiling, except as provided for in Sections IV.B and C.

K. The Agency shall distribute monies as appropriated to hospitals providing a disproportionate share of Medicaid or charity care services by increasing Medicaid payments to hospitals as required by Section 1923 of the Act.

L. The Agency shall distribute monies as appropriated to hospitals determined to be disproportionate share providers by allowing for an outlier adjustment in Medicaid payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally

high costs or exceptionally long lengths of stay for individuals under one year of age as required by Section 1923 of the Act.

M. Effective July 1, 2006, in accordance with the approved Medicaid Reform Section 1115 Demonstration, Special Terms and Conditions 100(c), a hospital's inpatient reimbursement rate will be limited by allowable Medicaid cost, as defined in Section III of this plan, utilizing Form CMS-2552-96 (or its successor).

V. Methods

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 for Inpatient Variable Cost.

1. Review and adjust the hospital cost report available to AHCA as of each April 15 as follows:
   a. To reflect the results of desk audits;
   b. To exclude from the allowable costs, any gains and losses resulting from a change of ownership and included in clearly marked "Final" cost reports.
2. Reduce a hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.30.
3. Determine allowable Medicaid variable costs defined in Section XII of this plan.
4. Adjust allowable Medicaid variable costs for the number of months between the midpoint of the hospital's fiscal year and December 31 the midpoint of the following rate semester. The adjustment shall be made utilizing the latest available projections as of December 31for the Data Resources Incorporated (DRI) (or its successor) National and Regional Hospital Input Price Indices as detailed in Appendix A.
5. Divide the inflated allowable Medicaid 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. For hospitals participating in the Florida Medicaid Program that are located out of State, the FPLI used shall be equal to 1.00.

6. Divide the results of Step 5 for each hospital by the sum of its Medicaid regular inpatient days plus Medicaid non-concurrent nursery days resulting in a variable cost per diem rate. Medicaid non-concurrent nursery days are inpatient nursery days for a Medicaid eligible newborn whose mother is not an inpatient in the same hospital at the same time.

7. Array the per diem rates in Step 6 from the lowest to the highest rate for all general hospitals within the State with the associated Medicaid patient days.

8. For general hospitals in a county, set the county ceiling for variable costs at the lower of:

   a. The cost based county ceiling which is the per diem rate associated with the 70th percentile of Medicaid days from Step 7 times the FPLI component utilized in Step 5 for the county;

   b. The target county ceiling that is the prior January rate semester's county ceiling plus an annually adjusted factor using the DRI (or its successor) inflation table. Effective July 1, 1995, the DRI (or its successor) inflation factor is 3.47 percent. With the adjustment of this DRI (or its successor) factor, the allowable rate of increase shall be 2.2 percent. Effective July 1, 1996, and for subsequent state fiscal years, the allowable rate of increase shall be calculated by an amount derived from the DRI (or its successor) inflation index described in appendix A. The allowable rate of increase shall be calculated by dividing the inflation index value for the midpoint of the next state fiscal year by the inflation index value for the midpoint of the current state fiscal year and then multiply this amount by 63.4 percent. The allowable rate of increase shall be recalculated for each July rate setting period and shall be the same during the remainder of the state fiscal year.

9. Specialized, statutory teaching, and rural hospitals are excluded from the calculation and application of the reimbursement county ceilings in V.A.1 through 8., above. Community Hospital Education Program (CHEP) hospitals and those hospitals included in 10, 11, 12, and 13 below are included in the calculation of the ceilings in V.A. 1 through 8, above, but are exempt from the application of these ceilings.

10. Effective July 1, 2001, inpatient reimbursement ceilings will be eliminated for hospitals whose sum of charity care and Medicaid days as a percentage of adjusted patient 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 1997 audited DSH data available as of March 1, 2001, in determining eligibility for these adjustments to ceilings. Effective July 1, 2003, the fourteen and one-half percent (14.5%) will be changed to eleven percent (11%) to eliminate the inpatient 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 1997, 1998, and 1999 audited DSH data available as of March 1, 2003. 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 1997, 1998, and 1999 that is available. For those hospitals with only one year of audited DSH data, the Agency shall eliminate the inpatient reimbursement ceilings for only those hospitals with 1999 audited DSH data. Hospital inpatient rates set under the provisions of the Plan for the July 1, 2003 rate setting will be effective October 1, 2003. Effective July 1, 2004, inpatient reimbursement ceilings will be eliminated for hospitals whose sum of charity care and Medicaid days, as a percentage of adjusted patient days, equals or exceeds eleven (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. Effective July 1, 2005, inpatient reimbursement ceilings will be eliminated for hospitals whose sum of charity care and Medicaid days, as a percentage of adjusted patient days, equals or exceeds 11 percent. The Agency will 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. If the prescribed three years of audited DSH

data is not available for the non-state government owned or operated facility, the Agency shall use the average of the 1999, 2000, and 2001 audited DSH data that is available for the non-state government owned or operated facility. Any hospital that met the 11 percent threshold in the State Fiscal Year 2004-2005 and was also exempt from the inpatient reimbursement ceilings shall remain exempt from the inpatient reimbursement ceilings for State Fiscal Year 2005-2006 subject.

11. Effective July 1, 2001, inpatient 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 in determining eligibility for these adjustments to ceilings. Effective July 1, 2003, the Agency will use the average of the 1997, 1998, and 1999 audited DSH data available as of March 1, 2003. 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 1997, 1998, and 1999 that is available. Hospital inpatient rates set under the provisions of the Plan for the July 1, 2003 rate setting will be effective October 1, 2003. Effective July 1, 2004, 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. Effective July 1, 2005, inpatient reimbursement ceilings will be eliminated for hospitals whose Medicaid days as a percentage of total hospital days exceed 7.3%, and are a designated or provisional trauma center. This provision shall apply to all hospitals that are a designated or provisional trauma center on July 1, 2005 and any hospitals that become a designated or provisional trauma center during the State Fiscal year 2005-2006. Effective July 1, 2005, the Agency will 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.

Amendment 2011-009
Effective July 1, 2011
Supersedes 2010-005
Approval JUL 11 2012

12. Effective July 1, 2004 an inpatient ceiling shall not be applied to hospitals with a Level III Neonatal Intensive Care Unit that has a minimum of three of the following designated tertiary services regulated under the certificate of need program: pediatric bone marrow transplantation, pediatric open heart surgery, pediatric cardiac catheterization and pediatric heart transplantation.

13. Effective July 1, 2005 an inpatient ceiling shall not be applied to 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, 2006, the Agency will eliminate the inpatient reimbursement ceilings for hospitals whose charity care and Medicaid days, as a percentage of total adjusted hospital days, equal or exceed 11 percent. For any non-state government owned or operated facility that does not qualify for the elimination of the inpatient ceilings in this Plan, the non-state government owned or operated facility shall be exempt from the inpatient reimbursement ceilings. 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.

15. Effective July 1, 2006, the Agency will eliminate the inpatient hospital 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. This provision shall apply to all hospitals that are a designated or provisional trauma centers on July 1, 2006 and any hospitals that 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.

16. Effective July 1, 2006, the Agency will eliminate the inpatient reimbursement ceilings 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.

17. Effective July 1, 2007, inpatient reimbursement ceilings will be eliminated for hospitals whose charity care and Medicaid days, as a percentage of total adjusted hospital days, equal or exceed 11 percent. 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.

18. Effective July 1, 2007, the inpatient 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 will be eliminated.

19. Effective July 1, 2007, the inpatient hospital 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 will be eliminated. This provision shall apply to all hospitals that are designated or provisional trauma centers on July 1, 2007 and any hospitals that 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.

20. Effective July 1, 2007, 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.

21. Effective July 1, 2008 and ending June 30, 2009, 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.

22. Effective July 1, 2008, 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. 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.

23. Effective July 1, 2008, 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.

24. Effective July 1, 2008, 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. 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.

25. Effective July 1, 2008, 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.

26. Effective July 1, 2008, 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.

a. Budget authority up to $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.

b. Budget authority up to $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.

c. Budget authority up to $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.

27. Effective July 1, 2008, budget authority up to $111,355,553 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 inpatient trend adjustment shall be 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.

28. Effective July 1, 2009, inpatient hospital reimbursement ceilings will be eliminated for hospitals whose charity care and Medicaid days, as a percentage of total adjusted hospital days, equal or exceed 11 percent. For any non-state government owned or operated hospital or any leased non-state government owned or operated hospital found to have sovereign immunity or hospital with graduate medical education positions that does not qualify for the elimination of the inpatient ceilings under this section, such hospitals shall be exempt from the inpatient reimbursement ceilings contingent on the hospital or local governmental entity providing the required state match. The agency shall use the average

of the 2003, 2004 and 2005 audited DSH data available as of March 1, 2009. 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 2003, 2004 and 2005 that are available.

29. Effective July 1, 2009, inpatient hospital 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.

30. Effective July 1, 2009, 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, 2009 and any hospitals that become a designated or provisional trauma center during Fiscal Year 2009-2010. 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 2003, 2004 and 2005 audited Disproportionate Share Hospital (DSH) data available as of March 1, 2009. In the event the agency does not have the prescribed three years of audited Disproportionate Share Hospital (DSH) data for a hospital, the agency shall use the average of the audited DSH data for 2003, 2004 and 2005 that are available.

31. Effective July 1, 2009, inpatient hospital 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.

32. Effective July 1, 2009, a buy back provision will be applied to the the Medicaid trend adjustment that is being applied against the Medicaid inpatient rates for the following three categories of hospitals:

a. $38,503,310 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: $18,152,419 is for Jackson Memorial Hospital; $5,407,484 is for hospitals in Broward Health; $5,457,550 is for hospitals in the Memorial Healthcare System; and $2,748,092 is for Shands Jacksonville and $6,737,765 is for Shands Gainesville. In the event that the above amounts exceed the amount of the Medicaid trend adjustment applied to each hospital, then the excess funds will be used to buy back other Medicaid reductions in the inpatient rate not to exceed the base rate effective July 1, 2009.

b. $21,365,269 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 not to exceed the base rate effective July 1, 2009.

c. $10,031,002 shall be used for the third category to buy back the Medicaid trend adjustment that is being applied against the Medicaid inpatient rates to rural hospitals. 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 not to exceed the base rate effective July 1, 2009.

d. For this section the Agency shall use the 2003, 2004 and 2005 audited DSH data available as of March 1, 2009. 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 2003, 2004 and 2005 that are available.

33. $212,264,180 shall be used for non state government owned or operated hospitals, including any leased non state government owned or operated hospital found to have sovereign immunity, teaching hospitals as defined in section 408.07 (45) or 395.805, Florida Statutes, which have seventy or more full-time equivalent resident physicians and for designated trauma hospitals may 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 not to exceed the base rate effective July 1, 2009.

34. Effective July 1, 2010, eliminate the inpatient reimbursement ceilings for hospitals whose charity care and Medicaid days, as a percentage of total adjusted hospital days, equal or exceed 11 percent. For any public hospital or any leased public hospital found to have sovereign immunity or hospital with graduate medical education positions that does not qualify for the elimination of the inpatient ceilings under this section or any other section, such hospitals shall be exempt from the inpatient reimbursement ceilings. The agency shall use the average of the 2003, 2004 and 2005 audited DSH data available as of March 1, 2009. 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 2003, 2004 and 2005 that are available. Any hospital that was exempt from the inpatient reimbursement ceiling in the prior state fiscal year, due to their charity care and Medicaid days as a percentage to total adjusted hospital days equaling or exceeding 11 percent, but

no longer meets the 11 percent threshold, because of updated audited DSH data, shall remain exempt from the inpatient reimbursement ceilings for a period of two years.

35. Effective July 1, 2010, 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.

36. Effective July 1, 2010, 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, 2010, and any hospitals that becomes a designated or provisional trauma center during Fiscal Year 2010-2011. 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 2003, 2004 and 2005 audited Disproportionate Share Hospital (DSH) data available as of March 1, 2009. In the event the agency does not have the prescribed three years of audited Disproportionate Share Hospital (DSH) data for a hospital, the agency shall use the average of the audited DSH data for 2003, 2004 and 2005 that are available.

37. Effective July 1, 2010, 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.

38. Effective July 1, 2010, 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:

1. $31,984,943 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: $18,773,903 is for Jackson Memorial Hospital; $2,133,277 is for hospitals in Broward Health; $4,906,684 is for hospitals in the Memorial Healthcare System; and $760,226 is for Shands Jacksonville and $5,410,853 is for Shands Gainesville. In the event that the above amounts exceed the amount of the Medicaid trend adjustment applied to each hospital, then the excess funds will be used to buy back other Medicaid reductions in the inpatient rate not to exceed the base rate effective July 1, 2010.
2. $12,139,819 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 not to exceed the base rate effective July 1, 2010.
3. $5,475,985 shall be used for the third category to buy back the Medicaid trend adjustment that is being applied against the Medicaid inpatient rates to rural hospitals. 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 not to exceed the base rate effective July 1, 2010.

The agency shall use the 2003, 2004 and 2005 audited DSH data available as of March 1, 2009. 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 2003, 2004 and 2005 that are available.

39. Effective July 1, 2010, non state or local government owned or operated hospitals , including any leased non state or local government owned or operated hospitals found to have sovereign immunity, teaching hospitals as defined in section 408.07 (45) or 395.805, Florida Statutes, which have seventy or more full-time equivalent resident physicians, hospitals with graduate medical education positions that do not otherwise qualify, and for designated trauma hospitals 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.

40. Effective July 1, 2010, hospitals not previously provided this authority, may 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.

41. Effective July 1, 2010, any hospital, not elsewhere qualifying for an exemption that has local funds available for intergovernmental transfers may be exempt from inpatient reimbursement limitations.

42. Effective July, 2010, the Agency will adjust the Medicaid rate for any rural hospital that moved into a replacement facility during calendar year 2009 to reflect Medicaid costs for the period of time from moving into the replacement facility to when the rate would reflect the costs of the replacement facility through the routine rate setting process. To qualify for this adjustment, a hospital must have a combined Medicaid and charity care utilization rate of at least 25 percent based on the most recent information reported to the Agency for Health Care Administration prior to moving into the replacement facility.

43. Effective July 1, 2011, $543,389,836 is available for non state or local government owned or operated hospitals, including any leased non state or local government owned or operated hospitals found to have sovereign immunity, teaching hospitals as defined in section 408.07 (45) or 395.805, Florida Statutes, which have seventy or more full-time equivalent resident physicians, hospitals with graduate medical education positions that

do not otherwise qualify, and for designated trauma hospitals to buy back the Medicaid inpatient trend adjustment applied to their individual hospital rates and Medicaid inpatient cost.

44. Effective July 1, 2011, $286,624,908 is available to hospitals that are eligible 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.

45. Effective July 1, 2011, $424,872,347 is available for exemptions from inpatient reimbursement limitations.

46. Effective July 1, 2011, any provider's base rate adjusted in accordance with Section V.C and identified in Section V.A. shall have their rates adjusted not to exceed the base rate determined in accordance with Section V.C.

B. Setting Reimbursement Ceilings for Fixed Cost

1. Compute the fixed costs per diem rate for each hospital by dividing the Medicaid depreciation by the total Medicaid days.

2. Calculate the fixed cost ceiling for each hospital by multiplying Step 1 by 80%. This fixed cost ceiling shall not apply to rural hospitals and specialized psychiatric hospitals.

C. Setting Individual Hospital Rates.

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

   a. To reflect the results of desk reviews or audits;

   b. To exclude from the allowable cost any gains and losses resulting from a change of ownership and included in clearly marked "Final" cost reports.

2. Reduce the hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.30.

3. Determine allowable Medicaid variable costs as in V.A.3.

4. Adjust allowable Medicaid variable costs for the number of months between the midpoint of the hospital's fiscal year and December 31the midpoint of the following rate semester. The adjustment shall be made utilizing the latest available projections as of December 31

for the DRI (or its successor) National and Regional Hospital Input Price Index as detailed in Appendix A.

5. The variable cost per diem shall be the lesser of:

   a. The inflated allowable Medicaid variable costs divided by the sum of Medicaid inpatient days plus Medicaid non-concurrent nursery days for the hospital, or

   b. The facility specific target ceiling that is the prior rate semester's variable cost per diem plus an annually adjusted factor using the DRI (or its successor) inflation table. Effective July 1, 1995, the DRI (or its successor) inflation factor is 3.47 percent. With the adjustment of this DRI (or its successor) factor, the allowable rate of increase shall be 2.2 percent. Effective July 1, 1996, and for subsequent state fiscal years, the allowable rate of increase shall be calculated by an amount derived from the DRI (or its successor) inflation index described in appendix A. The allowable rate of increase shall be calculated by dividing the inflation index value for the midpoint of the next state fiscal year by the inflation index value for the midpoint of the current state fiscal year and then multiply this amount by 63.4 percent. The allowable rate of increase shall be recalculated for each July rate setting period and shall be the same during the remainder of the state fiscal year. The facility specific target ceiling shall apply to all hospitals except rural, specialized, statutory teaching, and Community Hospital Education Program (CHEP) hospitals and those hospitals included in Section V.A. 10, 11 and 12.

6. a. Establish the variable costs component of the per diem as the lower of the result of Step 5 or the reimbursement ceiling determined under V.A.8. for the county in which the hospital is located.

   b. A temporary exemption from the county ceiling for a period not to exceed 12 months shall be granted to an in-state general hospital by AHCA if all of the following criteria are met:

(1) The hospital has been voluntarily disenrolled for a period of not less than 180 days in the 365 days immediately prior to the date of application for this exemption. The hospital shall have been a fully participating Medicaid provider prior to their last disenrollment;

(2) During the 6-month period prior to the last voluntary disenrollment, the hospital provided the largest proportionate share of Medicaid services of all hospitals in the county, as measured by total Medicaid costs for the period;

(3) On the date of the last voluntary disenrollment, less than 51 percent of the private, non-governmental hospitals in the county were participating in the Medicaid Program;

(4) During the 6-month period prior to the last voluntary disenrollment, the hospital treated over 50 percent of the indigent patients in the county who required hospital services during that time period. Indigent patients are those eligible for Medicaid or classified as indigent by a county-approved social services or welfare program.

If an exemption is granted to a hospital, the hospital shall agree to remain in the Medicaid Program and accept Medicaid eligible patients for a period of not less than 3 years from the date of re-enrollment. The exemption shall be granted to a hospital only once since original construction, regardless of changes in ownership or control. If a hospital disenrolls prior to the fulfillment of its 3-year enrollment agreement, AHCA shall recoup funds paid to the hospital in excess of the amount that would have been paid if the county ceiling had been imposed during the first 12 months which shall be defined as excess amount, according to the following schedule. If a hospital is re-enrolled under the ceiling exemption provision for less than 12 months, the Agency shall recoup 100 percent of the excess amount. For each month of enrollment subsequent to the first year of re-enrollment under the ceiling exemption provision, 1/24 of the excess amount

shall be no longer owed so that after 36 months of re enrollment AHCA shall recoup none of the excess amount.

Example 1: Hospital reenrolls under the ceiling exemption provision on July 1, 1984, and disenrolls on November 30, 1984. During this 5-month period the hospital receives an excess amount of $10,000. Recoupment would be calculated as:

$10,000 - ((0 months x 1/24) x (10,000)) = $10,000

Example 2: Hospital re-enrolls under the ceiling exemption provision on July 1, 1984, and disenrolls on December 31, 1986. During the first 12 months the hospital receives an excess amount of $20,000. Recoupment would be calculated as:

$20,000 - ((18 months x 1/24) x (20,000)) = $ 5,000

7. Compute the fixed costs component of the per diem by dividing the Medicaid depreciation by the total Medicaid days.

8. Established the fixed costs component of the per diem as the lower of Step 7 or the reimbursement ceiling determined under V.B.2.

9. Calculate the overall per diem by adding the results of Steps 6 and 8.

10. Set the per diem rate for the hospital as the lower of the result of Step 9 or the result of inflated Medicaid charges divided by total Medicaid days.

11. For hospitals with less than 200 total Medicaid patient days, or less than 20 Medicaid patient admissions, the per diem rate shall be computed using the principles outlined in Steps 1 through 10 above, but total costs, charges, and days shall be utilized, instead of the Medicaid apportioned costs, charges and days.

12. Effective July 1, 2001, the Medicaid inpatient per diem rate will be adjusted for Lake Wales Hospital, Winter Haven Hospital, Health Central Hospital and Larkin Community Hospital in accordance with section 409.905(5)(c), Florida Statutes:
The Agency for Health Care Administration shall adjust a hospital's current inpatient per diem rate to reflect the cost of serving the Medicaid population at that institution if:

a. The hospital experiences an increase in Medicaid caseload by more than 25 percent in any year, primarily resulting from the closure of a hospital in the same service area occurring after July 1, 1995;

b. The hospital's Medicaid per diem rate is at least 25 percent below the Medicaid per patient cost for that year; or

c. The hospital is located in a county that has five or fewer hospitals, began offering obstetrical services on or after September 1999, and has submitted a request in writing to the Agency for a rate adjustment after July 1, 2000, but before September 30, 2000, in which case such hospital's Medicaid inpatient per diem rate shall be adjusted to cost, effective July 1, 2002.

13. No later than October 1 of each year the Agency must provide estimated costs for any adjustment in a hospital inpatient per diem pursuant to this paragraph to the Executive Office of the Governor, the House of Representatives General Appropriations Committee, and the Senate Budget Committee.

14. Effective July 1, 2002, the Medicaid inpatient per diem rate will be adjusted for New Port Richey hospital in accordance with section 409.905(5)(c), Florida Statutes. Hospital inpatient rates set under the provisions of the Plan for the July 1, 2003 rate setting will be effective October 1, 2003.

15. Effective July 1, 2004 and ending June 30, 2005, each inpatient rate shall be reduced proportionately until an aggregate total estimated savings of $69,662,000 is achieved. In reducing hospital inpatient 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 inpatient 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.

16. Effective July 1, 2005, a recurring rate reduction shall be established until an aggregate total estimated savings of $100,537,618 is achieved each year. This reduction is the Medicaid Trend Adjustment. In reducing hospital inpatient 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 inpatient 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 $69,662,000 inpatient hospital reimbursement rate reduction set forth in Section V.C.15 above to the June 30, 2005 reimbursement rate;

   ii. Determine the lower of the June 30, 2005 rate with the restoration of the $69,662,000 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 (16) 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.

17. Effective July 1, 2007 and ending June 30, 2008, the Medicaid Trend Adjustment shall be removed for all hospitals whose Medicaid and charity care days as a percentage to total adjusted days equals or exceeds 30 percent and have more than 10,000 Medicaid days, or a hospital or hospital system that established a provider service network during the prior state fiscal year. The aggregate Medicaid Trend Adjustment found in V.C.16 above shall be reduced by up to $25,352,420. The Agency shall use the average of the 2001, 2002 and 2003 audited DSH data available as of March 1, 2007.

18. Effective January 1, 2008, an additional Medicaid Trend Adjustment shall be applied to achieve a recurring annual reduction of $68,640,064.

19. 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), Florida Statutes.

The aggregate Medicaid Trend Adjustment found in V.C.18 above shall be reduced by up to$12,067,473.

20. Effective July 1, 2008, an additional Medicaid Trend Adjustment shall be applied to achieve a recurring annual reduction of $154,333,435. In establishing rates through the normal process, prior to including this reduction, if the rate setting unit cost is equal to or less than thelegislative unit cost , no additional reduction in rates is necessary. In establishing rates through the normal process, prior to including this reduction, if the rate setting unit cost is greater than the legislative unit cost , then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the legislative unit cost.

21. 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.

22. Effective March 1, 2009, the Agency for Health Care Administration shall implement a recurring methodology to reduce individual hospital rates proportionately until the required $84,675,876 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. 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 25 percent may 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.

23. Effective January 1, 2010, an additional Medicaid trend adjustment shall be applied to achieve an annual recurring reduction of $9,635,295. In establishing rates through the normal process, prior to including this reduction, if the rate setting unit cost is equal to or less than the legislative unit cost, then no additional reduction in rates is necessary. In establishing rates through the normal process,

prior to including this reduction, if the rate setting unit cost is greater than the legislative unit cost, then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the legislative unit cost.

24. Effective July 1, 2011, an additional Medicaid Trend Adjustment shall be applied to achive an annual recurring reduction of $394,928,848 as a result of modifying the reimbursement for inpatient hospital rates. In establishing rates through the normal process, prior to including this reduction, if the rate setting unit cost is equal to or less than the legislative unit cost, then no additional reduction in rates is necessary. In establishing rates through the normal process, prior to including this reduction, if the rate setting unit cost is greater than the legislative unit cost, then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the legislative unit cost. 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 and rural hospitals as defined in s. 395.602, are excluded from this reduction.

25. Effective July 1, 2011, a rate reduction in the amount of $12,608,937 shall be applied as a result of modifying the reimbursement for inpatient hospital rates for 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 and rural hospitals as defined in section 395.602, Florida Statutes. In establishing rates through the normal process, prior to including this reduction, if the rate setting unit cost is equal to or less than the legislative unit cost, then no additional reduction in rates is necessary. In establishing rates through the normal process, prior to including this reduction, if the rate setting unit cost is greater than the legislative unit cost, then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the legislative unit cost.

26. Effective July 1, 2011, the Agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs.

27. For a period of five years from the opening of Nemours' hospital, the reimbursement rate will be based on the average of the current Medicaid payment rates accepted by the two Class II children's hospitals (All Children's Hospital and Miami Children's Hospital).

VI. Disproportionate Share Hospital (DSH) Reimbursement Methods

A. Determination of Individual Hospital Regular Disproportionate Share Payments for Disproportionate Share Hospitals (DSH).

1. No hospital may be defined or deemed as a disproportionate share hospital unless the hospital has a Medicaid inpatient utilization rate of not less than one percent. In order to qualify for reimbursement, a hospital shall meet either of the minimum federal requirements specified in Section 1923(b) of the Act. The Act specifies that hospitals must meet one of the following requirements:

   a. The Medicaid inpatient utilization rate is greater than one standard deviation above the statewide mean, or;

   b. The low-income utilization rate is at least 25%.

2. Additionally, the Act specifies that in order for the hospital to qualify for reimbursement, the hospital must have at least two obstetricians or physicians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the State Medicaid Plan. This does not apply to hospitals where:

   a. The inpatients are predominantly individuals under 18 years of age, or

   b. Non-emergency obstetric services were not offered as of December 21, 1987.

3. a. The hospital Medicaid inpatient utilization rate in 1.a. above shall be calculated once a year based on cost reports used for the July 1 rate setting.

   b. The low-income utilization rate in 1.b. above shall also be calculated once a year every July 1.

4. Effective July 1, 2003, the Agency shall use the following methodology to distribute payments under the Regular DSH program for state fiscal year 2003-2004 and forward. The Agency shall only distribute regular DSH payments to those hospitals that meet the requirements of Section VI.A. 1., above, and to non-state government owned or operated facility. The following methodology shall be used to distribute disproportionate share

payments to hospitals that meet the federal minimum requirements and to non-state government owned or operated facilities.

a. For hospitals that meet the requirements of Section VI.A.1., above, and do not qualify as a non-state government owned or operated facility, the following formula shall be used:

DSHP = (HMD/TSMD) * $1 million

Where:

DSHP = disproportionate share hospital payment

HMD = hospital Medicaid days

TSMD = total state Medicaid days

Any funds not allocated to hospitals qualifying under this section shall be redistributed to the non-state government owned operated hospitals with greater than 3,100 Medicaid days.

b. The following formulas shall be used to pay disproportionate share dollars to non-state government owned or operated facilities:

For state mental health hospitals:

DSHP = (HMD/TMDMH) * TAAMH

The total amount available for the state mental health hospitals shall be the difference between the federal cap for Institutions for Mental Diseases and the amounts paid under the mental health disproportionate share program in Section VI.D.

For non-state government owned or operated hospitals with 3,100 or more Medicaid days:

DSHP = [(.82 * HCCD/TCCD) + (.18 * HMD/TMD)] * TAAPH

TAAPH = TAA – TAAMH

For non-state government owned or operated hospitals with less than 3,100 Medicaid days, a total of $750,000 shall be distributed equally among these hospitals.

Where:

TAA = total available appropriation (as found in Appendix B)

TAAPH = total amount available for non-state government owned or operated facility

TAAMH = total amount available for mental health hospitals

DSHP = disproportionate share hospital payments

HMD = hospital Medicaid days

TMDMH = total state Medicaid days for mental health hospitals

TMD = total state Medicaid days for public non-state hospitals

HCCD = hospital charity care dollars

TCCD = total state charity care dollars for public non-state hospitals

For funds appropriated for public disproportionate share payments for state fiscal years beginning July 1, 2004 and later, the TAAPH shall be reduced by $6,365,257 before computing the DSHP for each non-state government owned or operated facility. The $6,365,257 shall be distributed equally between the non-state government owned or operated facilities that are also designated statutory teaching hospitals.

In computing the above amounts for non-state government owned or operated facilities and hospitals that qualify under Section VI.A.2., above, the average of the 2004, 2005, and 2006 audited disproportionate share data will be used to determine each hospital's Medicaid days and charity care for the 2011-2012 state fiscal year. For the 2011-12 State Fiscal Year, the Agency shall use the average of 2004, 2005, and 2006 audited DSH data available as of March 1, 2010.

5. The total of all disproportionate share payments shall not exceed the amount appropriated, or the federal government's upper payment limits. Payments shall comply with the limits set forth in Section 1923(g-j) of the Social Security Act. Overpayments made in the disproportionate share program will be handled in compliance with 42 CFR

Part 433, Subpart F. Should a DSH overpayment be determined, the State will redistribute the recouped overpayment to the providers in the same category of DSH based on the proportion of the original distribution defind in the General Appropriations Act and Florida Statutes.

6. In no case shall total payments to a hospital under this section, with the exception of public non-state facilities or state facilities, exceed the total amount of uncompensated charity care of the hospital, as determined by the Agency according to the most recent calendar year audited data available at the beginning of each state fiscal year.

7. The total amount calculated to be distributed shall be made in quarterly payments subsequent to each quarter during the fiscal year.

8. Payments to each disproportionate share hospital shall result in payments of at least the minimum payment adjustment specified in the Act. The Act specifies that the payment adjustment must at a minimum provide either:

   a. An additional payment amount equal to the product of the hospital's Medicaid operating cost payment times the hospital's disproportionate share adjustment percentage in accordance with Section 1886(d)(5)(F)(iv) of the Social Security Act, or

   b. A minimum specified additional payment amount (or increased percentage amount) and for an increase in such payment amount in proportion to the percentage by which the hospital's Medicaid utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate for hospital's receiving Medicaid payments in the state.

B. Determination of an outlier adjustment in Medicaid payment amounts for Disproportionate Share Hospitals for medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age in Regional Perinatal Intensive Care Centers (RPICC). Exceptionally high costs are costs attributable to critically ill and/or extremely small (low birth weight) individuals who receive services in Neonatal Intensive

Care Units (NICU) of hospitals that qualify for outlier payment adjustments. Exceptionally long lengths of stay are stays in excess of forty-five days.

1. Disproportionate Share Hospitals that qualify under VI.A., above, for regular disproportionate share hospital payments and meet all of the following requirements shall qualify for an outlier adjustment in payment amounts. For state fiscal year 2002-2003, and 2003-2004 forward, payments under this Section will be limited to the hospitals that received a payment under this Section in state fiscal year 2001-2002.

   a. Agree to conform to all Agency requirements to assure high quality in the provision of service, including criteria adopted by Department of Health rule 64C-6.003, F.A.C., concerning staffing ratios, medical records, standards of care, equipment, space and such other standards and criteria as specified by this rule, as well as meeting the RPICC designation pursuant to 383.15 – 383.21, F.S.

   b. Agree to provide information to the Agency, in a form and manner to be prescribed by rule 64C-6.002, F.A.C., of the Department of Health, concerning the care provided to all patients in neonatal intensive care centers and high-risk maternity care.

   c. Agree to accept all patients for neonatal intensive care and high-risk maternity care, regardless of ability to pay, on a functional space-available basis.

   d. Agree to develop arrangements with other maternity and neonatal care providers in the hospital's region for the appropriate receipt and transfer of patients in need of specialized maternity and neonatal intensive care services.

   e. Agree to establish and provide a developmental evaluation and services program for certain high-risk neonates, as prescribed and defined by rule of the department.

   f. Agree to sponsor a program of continuing education in perinatal care for health care professionals within the region of the hospital, as specified by rule.

g. Agree to provide backup and referral services to the department's county public health units and other low-income perinatal providers within the hospital's region, including the development of written agreements between these organizations and the hospital.

h. Agree to arrange for transportation for high-risk obstetrical patients and neonates in need of transfer from the community to the hospital or from the hospital to another more appropriate facility.

2. Hospitals that fail to comply with any of the above conditions, or the rules of the department under Chapter 64C-6, F.A.C., shall not receive any payment under this subsection until full compliance is achieved. A hospital that is non-compliant in two or more consecutive quarters, shall not receive its share of the funds. Any forfeited funds shall be distributed by the remaining participating program hospitals.

3. Outlier payment amounts earned by disproportionate share hospitals that meet all of the qualifications in 1.a. through 1.h., above, shall be in addition to each hospital Medicaid per diem rate.

4. For state fiscal year 2002-2003and 2003-2004 forward, the outlier payments will be made only to those hospitals that received an outlier payment in state fiscal year 2001-2002. The individual hospital payments in 2002-2003 and 2003-2004 forward shall be made in the same proportion as the individual hospital payments were made in state fiscal year 2001-2002. The total outlier payments may not exceed the total amount appropriated as found in Appendix B.

5. Effective for state fiscal year 2003-2004 forward, the following formula shall be used by the Agency to calculate the total amount earned for hospitals that qualify to participate in the RPICC program:

TAE = HDSP/THDSP

Where:

TAE = total amount earned by a RPICC.

HDSP = the prior state fiscal year RPICC disproportionate share payment to the individual hospital.

THDSP = the prior state year total RPICC disproportionate share payment to all hospitals.

6. Effective for state fiscal year 2003-2004 forward, the total additional payment for hospitals that participate in the RPICC program shall be calculated by the Agency as follows:

TAP = TAE x TA

Where:

TAP = total additional payment for a RPICC.

TAE = total amount earned by a RPICC.

TA = total appropriation for the RPICC disproportionate share program. (as found in Appendix B)

7. Distribute the outlier payments in four equal installments during the state fiscal year.

C. Determination of Disproportionate Share Payments for Teaching Hospitals.

1. Disproportionate share payments shall be paid to statutorily defined teaching hospitals for their increased costs associated with medical education programs and for tertiary health care services provided to the indigent. In order to qualify for these payments, a teaching hospital must first qualify for regular disproportionate share hospital payments based on the criteria contained in Section VI.A., above. For state fiscal year 2002-2003 forward, only hospitals that qualified as a statutory teaching hospital and received a payment under this Section in state fiscal year 2001-2002, shall qualify to receive payments in state fiscal year 2002-2003 forward.

2. On or before September 15 of each year, the Agency for Health Care Administration shall calculate an allocation fraction to be used for distributing funds to state statutory teaching hospitals. Subsequent to the end of each quarter of the state fiscal year, the Agency shall distribute to each statutory teaching hospital, an amount determined by multiplying one-fourth of the funds appropriated for this purpose times such hospital's

allocation fraction. The allocation fraction for each such hospital shall be determined by the sum of three primary factors, divided by three. The primary factors are:

a. The number of nationally accredited graduate medical education programs offered by the hospital, including programs accredited by the Accreditation Council for Graduate Medical Education and the combined Internal Medicine and Pediatrics programs acceptable to both the American Board of Internal Medicine and the American Board of Pediatrics at the beginning of the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of programs, where the total is computed for all state statutory teaching hospitals;

b. The number of full-time equivalent trainees in the hospital, which comprises two components:

(1) The number of trainees enrolled in nationally accredited graduate medical education programs. Full time equivalents are computed using the fraction of the year during which each trainee is primarily assigned to the given institution, over the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of full-time equivalent trainees enrolled in accredited graduate programs, where the total is computed for all state statutory teaching hospitals.

(2) The number of medical students enrolled in accredited colleges of medicine and engaged in clinical activities, including required clinical clerkships and clinical electives. Full-time equivalents are computed using the fraction of the year during which each trainee is primarily assigned to the given institution, over the course of the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital

represents of the total number of full-time equivalent students enrolled in accredited colleges of medicine, where the total is computed for all state statutory teaching hospitals.

The primary factor for full-time equivalent trainees is computed as the sum of these two components, divided by two.

c. A service index which comprises three components:

(1) The Agency for Health Care Administration Service Index, computed by applying the standard Service Inventory Scores established by the Agency for Health Care Administration to services offered by the given hospital, as reported on the Agency for Health Care Administration Worksheet A-2, located in the Budget Review Section of the Division of Health Policy and Cost Control for the last fiscal year reported to the Agency before the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total Agency for Health Care Service Index values where the total is computed for all state statutory teaching hospitals;

(2) Volume-weighted service index, computed by applying the standard Service Inventory Scores established by AHCA under 409.9113 F.S., to the volume of each service, expressed in terms of the standard units of measure reported on the Agency for Health Care Administration Worksheet A-2 for the last fiscal year reported to the Agency before the date on which the allocation factor is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total volume-weighted service index values, where the total is computed for all state statutory teaching hospitals;

(3) Total Medicaid payments to each hospital for direct inpatient and outpatient services during the fiscal year preceding the date on which the allocation factor is calculated. This includes payments made to

each hospital for such services by Medicaid prepaid health plans, whether the plan was administered by the hospital or not. The numerical value of this factor is the fraction that each hospital represents of the total of such Medicaid payments, where the total is computed for all statutory teaching hospitals.

3. The following formula shall be utilized by the department to calculate the maximum additional disproportionate share payment for statutorily defined teaching hospitals:

TAP = THAF x A

Where:

TAP = total additional payment.

THAF = teaching hospital allocation factor.

A = amount appropriated for a teaching hospital disproportionate share program. (as found in Appendix B)

4. Effective July 1, 2011, the funds for statutory teaching hospitals are allocated based on a formula using the 2009 accepted FHURS data for medical programs, students, residents, service values and Medicaid payments.

D. Mental Health Disproportionate Share Payments

The following formula shall be used by the Agency to calculate the total amount earned for hospitals that participate in the mental health disproportionate share program:

$$TAP = \left(\frac{DSH}{TDSH}\right) \times TA$$

Where:

TAP = total additional payment for a mental health hospital

DSH = total amount earned by a mental health hospital under s. 409.911

TDSH = sum of total amount earned by each hospital that participates in the mental health hospital disproportionate share program

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TA = total appropriation for the mental health disproportionate share program (as found in Appendix B). Includes additional disproportionate share amounts provided by the Medicare Prescription Drug, Improvement and Modernization Act of 2003,

In order to receive payments under this section, a hospital must participate in the Florida Title XIX program and must:

1. Agree to serve all individuals referred by the Agency who require inpatient psychiatric services, regardless of ability to pay.
2. Be certified or certifiable to be a provider of Title XVIII services.
3. Receive all of its inpatient clients from admissions governed by the Baker Act as specified in chapter 394.

E. Determination of Rural Hospital Disproportionate Share/financial assistance program. In order to receive payments under this section, a hospital must be a rural hospital as defined in s. 395.602, Florida Statutes, and must meet the following additional requirements:

1. Agree to conform to all Agency requirements to ensure high quality in the provision of services, including criteria adopted by Agency rule concerning staffing ratios, medical records, standards of care, equipment, space, and such other standards and criteria as the Agency deems appropriate as specified by rule.
2. Agree to accept all patients, regardless of ability to pay, on a functional space-available basis.
3. Agree to provide backup and referral services to the county public health units and other low-income providers within the hospital's service area, including the development of written agreements between these organizations and the hospital.
4. For any hospital owned by a county government that is leased to a management company, agree to submit on a quarterly basis a report to the Agency, in a format specified by the Agency, which provides a specific accounting of how all funds dispersed under this act are spent.

a. The following formula shall be used by the Agency to calculate the total amount earned for hospitals that participate in the rural hospital disproportionate share program or the financial assistance program:

TAERH = (CCD + MDD)/TPD

Where:

CCD = total charity care-other, plus charity care-Hill Burton, minus 50 percent of unrestricted tax revenue from local governments, and restricted funds for indigent care, divided by gross revenue per adjusted patient day; however, if CCD is less than zero, then zero shall be used for CCD

MDD = Medicaid inpatient days plus Medicaid HMO inpatient days.

TPD = total inpatient days.

TAERH = total amount earned by each rural hospital

In computing the total amount earned by each rural hospital, the Agency must use the average of the three (3) most recent years of actual data reported in accordance with s.408.061 (4), Florida Statutes. The Agency shall provide a preliminary estimate of the payments under the rural disproportionate share and financial assistance programs to the rural hospitals by August 31 of each state fiscal year for review. Each rural hospital shall have 30 days to review the preliminary estimates of payments and report any errors to the Agency. The Agency shall make any corrections deemed necessary and compute the rural disproportionate share and financial assistance program payments.

b. In determining the payment amount for each rural hospital under this section, the Agency shall first allocate all available state funds by the following formula:

DAER = (TAERH x TARH)/STAERH

Where:

DAER = distribution amount for each rural hospital.

STAERH = sum of total amount earned by each rural hospital.

TAERH = total amount earned by each rural hospital.

TARH = total amount appropriated or distributed under this section. (as found in Appendix B)

Federal matching funds for the disproportionate share program shall then be calculated for those hospitals that qualify for disproportionate share payments under this section.

5. For state fiscal year 1996-97 and subsequent years, the following steps shall be used to determine the rural disproportionate share payment amount for each hospital.

a. The Agency shall first determine a preliminary payment amount for each rural hospital by allocating all available state funds using the following formula.

PDAER=(TAERH x TARH)/STAERH

Where:

PDAER = preliminary distribution amount for each rural hospital.

TAERH = total amount earned by each rural hospital.

TARH = total amount appropriated or distributed under this section.

STAERH = sum of total amount earned by each rural hospital.

b. Federal matching funds for the disproportionate share program shall then be calculated for those hospitals that qualify for disproportionate share in section (E)(1) above.

c. The state funds only payment amount is then calculated for each hospital using the formula:

SFOER = Maximum value of (1)SFOL - PDAER or (2) 0

Where:

SFOER = state funds only payment amount for each rural hospital

SFOL = state funds only payment level, which is set at 4% of TARH.

d. The adjusted total amount allocated to the rural disproportionate share program shall then be calculated using the following

formula:

ATARH = (TARH - SSFOER)

Where:

ATARH = adjusted total amount appropriated or distributed under this section (as found in Appendix B)

SSFOER = Sum of the state funds only payment amount (5)(a) for all rural hospitals.

e. The determination of the amount of rural DSH funds is calculated by the following formula:

TDAERH = ((TAERH x ATARH)/STAERH)

Where:

TDAERH = total distribution amount for each rural hospital.

f. Federal matching funds for the disproportionate share program shall then be calculated for those hospitals that qualify for disproportionate share in section (5)(e)above.

g. State funds only payment amounts (5)(c)are then added to the results of (5)(f) to determine the total distribution amount for each rural hospital.

TDAERH = (TDAERH + SFOER)

F. Determination of Disproportionate Share Payments for Specialty Hospitals

1. The following formula shall be used by the Agency to calculate the total amount available for hospitals that participate in the specialty hospital disproportionate share program:

TAE=(MD/TMD) x TA

Where:

TAE=total amount earned by a specialty hospital.

TA=total appropriation for payments to hospitals that qualify under this

program. (as found in Appendix B)

MD=total Medicaid days for each qualifying hospital.

TMD=total Medicaid days for all hospitals that qualify under this program.

2. In order to receive payments under this section, a hospital must be licensed in accordance with part I of chapter 395, participate in the Florida Title XIX program, and meet the following requirements:

   a. Be certified or certifiable to be a provider of Title XVIII services.

   b. Receive all of its inpatient clients through referrals or admissions from county public health departments, as defined in chapter 154.

   c. Require a diagnosis for the control of a communicable disease for all admissions for inpatient treatment.

G. Determination of Primary Care Disproportionate Share Payments

1. Disproportionate Share Hospitals that qualify under VI.A. above for regular disproportionate share hospital payments and meet all of the following requirements shall qualify for payments under the primary care disproportionate share program. For state fiscal year 2002-2003 and 2003-2004 forward, hospitals that qualified and received a payment under this Section will qualify to receive a payment.

   a. Agree to cooperate with a Medicaid prepaid health plan, if one exists in the community.

   b. Agree to ensure the availability of primary and specialty care physicians to Medicaid recipients who are not enrolled in a prepaid capitated arrangement and who are in need of access to such physicians.

   c. Agree to coordinate and provide primary care services free of charge, except co-payments, to all persons with incomes up to 100 percent of the federal poverty

level, and to provide such services based on a sliding fee scale to all persons with incomes up to 200 percent of the federal poverty level, except that eligibility may be limited to persons who reside within a more limited area, as agreed to by the Agency and the hospital.

d. Agree to contract with any federally qualified health center, if one exists within the agreed geopolitical boundaries, concerning the provision of primary care services, in order to guarantee delivery of services in a nonduplicative fashion, and to provide for referral arrangements, privileges, and admissions, as appropriate. The hospital shall agree to provide at an onsite or offsite facility, primary care services within 24 hours to which all Medicaid recipients and persons eligible under this paragraph who do not require emergency room services are referred during normal daylight hours.

e. Agree to cooperate with the Agency, the county, and other entities to ensure the provision of certain public health services, case management, referral and acceptance of patients, and sharing of epidemiological data, as the Agency and the hospital find mutually necessary and desirable to promote and protect the public health within the agreed geopolitical boundaries.

f. Agree to, in cooperation with the county in which the hospital resides, develop a low-cost, outpatient, prepaid health care program to persons who are not eligible for the Medicaid program, and who reside within the area.

g. Agree to provide inpatient services to residents within the area who are not eligible for Medicaid or Medicare, and who do not have private health insurance, regardless of ability to pay, on the basis of available space, except that nothing shall prevent the hospital from establishing bill collection programs based on ability to pay.

h. Agree to work with the Florida Healthy Kids Corporation, and business health coalitions, as appropriate, to develop a feasibility study and plan to provide a low-cost comprehensive health insurance plan to persons who reside within the area and who do not have access to such a plan.

i. Agree to work with public health officials and other experts to provide community health education and prevention activities designed to promote healthy lifestyles and appropriate use of health services.

j. Agree to work with the local health council to develop a plan for promoting access to affordable health care services for all persons who reside within the area, including, but not limited to, public health services, primary care services, inpatient services, and affordable health insurance generally.

2. Any hospital that fails to comply with any of the provisions of this subsection, or any other contractual condition, may not receive payments under this section until compliance is achieved.

3. Hospitals that wish to participate in the primary care disproportionate share program must certify to the Agency that they meet the requirements of 1. a.-j. above prior to any qualifying hospital receiving payment under this program.

4. For state fiscal year 2002-2003 and 2003-2004 forward, payments to hospitals that qualify under this Section shall be in the same proportion as payments made in state fiscal year 2001-2002. Total payments for Primary Care DSH shall be limited to total amount appropriated in Appendix B.

5. Effective for State fiscal year 2003-2004 forward, the following formula shall be used to calculate the total amount earned for each hospital:

TAE=HDSP/THDSP

Where:

TAE=total amount earned by a hospital participating in the primary care disproportionate share program.

HDSP = the prior state fiscal year primary care disproportionate share payment to the individual hospital.

THDSP = the prior state fiscal year total primary care disproportionate share payments to all hospitals.

6. The total additional payment for hospitals that participate in the primary care disproportionate share program shall be calculated by the Agency as follows:

TAP = TAE * TA

Where:

TAP = total additional payment for a primary care hospital.

TAE = total amount earned by a primary care hospital.

TA = total appropriation for the primary care disproportionate share program (As found in Appendix B).

H. Disproportionate Share Program for Children's Hospitals

1. For state fiscal year 2002-2003 and 2003-2004 forward, no disproportionate share payments shall be made to the children's disproportionate share hospital program. The Agency for Health Care Administration shall use the following formula to calculate the total amount earned for hospitals that participate in the children's hospital disproportionate share program:

TAE = DSR x BMPD x MD

Where:

TAE = total amount earned by a children's hospital

DSR = disproportionate share rate

BMPD = base Medicaid per diem

MD = Medicaid Days

2. The Agency shall calculate the total additional payment for hospitals that participate in the children's hospital disproportionate share program as follows:

$$TAP = \frac{(TAE \times TA)}{STAE}$$

Where:

TAP = total additional payment for a children's hospital.

TAE = total amount earned by a children's hospital

TA = total appropriation for the children's hospital disproportionate share program. (as found in Appendix B)

STAE = sum of total amount earned by each hospital that participates in the children's hospital disproportionate share program.

3. A hospital may not receive any payments under this section until it achieves full compliance with the applicable rules of the Agency. A hospital that is not in compliance for two or more consecutive quarters may not receive its share of the funds. Any forfeited funds must be distributed to the remaining participating children's hospitals that are in compliance.

I. Disproportionate Share Payments for Provider Service Network (PSN) Hospitals

1. The following formula shall be used to to pay disproportionate share dollars to provider service network (PSN) hospitals:

DSHP = TAAPSNH X (IHPSND X THPSND)

Where:

DSHP = Disproportionate share hospital payments.

TAAPSNH = Total amount available for PSN hospitals.

IHPSND = Individual hospital PSN days.

THPSND = Total of all hospital PSN days.

2. Distributions are made to qualifying Provider Service Network hospitals or systems proportionally based on Fiscal Year 2006-2007 Provider Service Network patient days from qualifying Provider Service Network hospitals or systems. The Provider Service Network inpatient days used in distributing these funds shall be based on the utilization for the following individual hospitals or hospital systems only: Jackson Memorial Hospital - 15,464 days; Broward Health - 18,109 days; Memorial Healthcare System - 12,047 days; Shands Teaching - Gainesville - 1,581 days; and Shands Teaching - Jacksonville - 13,227 days.

VII. Medicaid Global Fee Reimbursement Methods

A. Methods Used in Establishing Payment Rates

Reimbursement for adult (age 21 and over) heart, liver, lung, intestinal/multivisceral and pediatric (age 20 and under) lung and intestinal/multivisceral transplant surgery services will be paid the actual billed charges up to a global maximum rate established by the Agency. These payments will be made to physicians and facilities that have met specified guidelines and are established as designated transplant centers as appointed by the Secretary of the Agency. The global maximum reimbursement for transplant surgery services is an all-inclusive payment and encompasses 365 days of transplant related care. Only one provider may bill for the transplant phase.

Effective July 1, 2010, global maximum rates for transplantation surgery are as follows:

Adult Heart	
Facility	Physician
$135,000	$27,000

Adult Liver	
Facility	Physician
$95,600	$27,000

Adult Lung	
Facility	Physician
$205,000	$33,000

Pediatric Lung	
Facility	Physician

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$280,000	$40,800

Adult and Pediatric Intestinal/Multi-visceral	
Facility	Physician
$450,000	$50,000

B. Effective July 1, 2005, approved lung transplant facilities will be reimbursed a global fee for providing lung transplant services to Medicaid recipients.

C. Effective July 1, 2009, Florida Medicaid will make payments for multi-visceral transplant and intestine transplants in Florida. The agency shall establish a reasonable global fee for these transplant procedures and the payments shall be used to pay approved multi-visceral transplant and intestine transplant facilities a global fee for providing transplant services to Medicaid beneficiaries.

D. Effective July 1, 2010, approved intestinal/multivisceral transplant centers will be reimbursed with a global fee for providing intestinal/multivisceral transplants to Medicaid recipients.

VIII. Payment Assurance

The State shall pay each hospital for services provided in accordance with the requirements of the Florida Title XIX State Plan and applicable State and Federal rules and regulations. The payment amount shall be determined for each hospital according to the standards and methods set forth in the Florida Title XIX Inpatient Hospital Reimbursement Plan.

IX. 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 that are comparable to those available to the general public.

X. 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.

XI. Payment in Full

Participation in the Medicaid Program shall be limited to hospitals that accept, as payment in full for covered services, the amount paid in accordance with the Florida Title XIX Inpatient Hospital Reimbursement Plan.

XII. Definitions

A. Actual audited data or actual audited experience - Data reported to the Agency for Health Care Administration which has been audited in accordance with generally accepted auditing standards of the AICPA as incorporated by reference in Rule 61H1-20.008, F.A.C. by the Agency or representatives under contract with the Agency.

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 (GAAP), except as modified by the Principles of Reimbursement for Provider Costs, as defined in CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C., except as further modified by the Florida Title XIX Inpatient Hospital Reimbursement Plan.

E. Base Rate – A hospital's per diem reimbursement rate before a Medicaid trend adjustment or a buy back is applied.

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

G. Charity care or uncompensated charity care - That portion of hospital charges reported to the Agency for which there is no compensation, other than restricted or unrestricted revenues provided to a hospital by local governments or tax districts regardless of the method of payment, for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 200 percent of the federal poverty level, unless the amount of hospital charges due

from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds four times the federal poverty level for a family of four be considered charity. Each hospital will determine which patients are charity care patients by a verifiable process subject to the above provisions. In addition, each hospital must provide appropriate documentation of amounts reported as charity care.

For all patients claimed as charity care, appropriate documentation shall include one of the following forms:

1. W-2 withholding forms.
2. Paycheck stubs.
3. Income tax returns.
4. Forms approving or denying unemployment compensation or workers' compensation.
5. Written verification of wages from employer.
6. Written verification from public welfare agencies or any governmental Agency which can attest to the patient's income status for the past twelve (12) months.
7. A witnessed statement signed by the patient or responsible party, as provided for in Public Law 70-725, as amended, known as the Hill-Burton Act, except that such statement need not be obtained within 48 hours of the patient's admission to the hospital, as required by the Hill-Burton Act. The statement shall include an acknowledgment that, in accordance with Section 817.50, Florida Statutes, providing false information to defraud a hospital for the purposes of obtaining goods or services is a misdemeanor in the second (2nd) degree.
8. A Medicaid remittance voucher which reflects that the patient's Medicaid benefits for that Medicaid fiscal year have been exhausted.

Charges applicable to Hill-Burton and contractual adjustments should not be claimed as charity care.

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H. Charity care days - The sum of the deductions from revenues for charity care minus 50 percent of restricted and unrestricted revenues provided to a hospital by local governments or tax districts, divided by gross revenues per adjusted patient day.

I. 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.

J. Concurrent nursery days - Inpatient nursery days for a Medicaid-eligible newborn whose mother is also an inpatient in the same hospital at the same time.

K. Cost reporting year - A 12-month period of operations based upon the provider's accounting year.

L. Depreciation - Fixed costs related to buildings, fixtures, and movable equipment as apportioned to Medicaid by cost finding methods used in the CMS 2552 cost report.

M. DOH – Florida Department of Health.

N. Eligible Medicaid recipient - An individual who meets certain eligibility criteria for the Title XIX Medical Assistance Program as established by the State of Florida.

O. Filing Due Date - No later than five (5) calendar months after the close of the hospital's cost-reporting year.

P. 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

Q. Florida Price Level Index - A spatial index that measures the 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. For example, 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.

R. General hospital - A hospital in this state which is not classified as a specialized hospital.

S. HHS - Department of Health and Human Services

T. CMS PUB. 15-1 - Health Insurance Manual No. 15, herein incorporated by reference, also known as the Provider Reimbursement Manual available from the The Centers for Medicare and Medicaid Services.

U. Hospital - means a health care institution licensed as a hospital pursuant to Chapter 395, but does not include ambulatory surgical centers.

V. Inpatient general routine operating costs - Costs incurred for the provision of general routine services including the regular room, dietary and nursing services, and minor medical and surgical supplies.

W. Inpatient hospital services - Services that are ordinarily furnished in a hospital for the care and treatment of an inpatient under the direction of a physician, dentist, or other recognized member of the medical staff and are furnished in an institution that:

1. Is maintained primarily for the care and treatment of patients with disorders other than tuberculosis or mental diseases;
2. Is licensed as a hospital by AHCA;
3. Meets the requirements for participation in Medicare; and
4. Has in effect a utilization review plan, approved by the PRO pursuant to 42 CFR 456.100 (1998), applicable to all Medicaid patients.

X. Late Cost Report - A cost report is late when it is filed with AHCA, Bureau of Medicaid Program

Finance after the Filing Due Date and after the Rate Setting Due Date.

Y. Legislative Unit Cost - The weighted average per diem of the State anticipated expenditure after all rate reductions but prior to any buy back.

Z. Medicaid allowable variable costs - Allowable operating costs less depreciation as apportioned to Medicaid by cost-finding methods in the CMS 2552 cost report.

AA. Medicaid days - The number of actual days attributable to Medicaid patients as determined by the Agency for Health Care Administration.

BB. Medicaid inpatient charges - Usual and customary charges made for inpatient services rendered to Medicaid patients. These charges shall be the allowable charges as reconciled with the hospital Medicaid log and found on the Medicaid paid claims report.

CC. Medicaid covered nursery days - Days of nursery care for a Medicaid eligible infant.

DD. Medicaid depreciation - Depreciation times the ratio of Medicaid charges to total charges divided by Medicaid inpatient days.

EE. Non-concurrent nursery days - Inpatient nursery days for a Medicaid-eligible newborn whose mother is not an inpatient in the same hospital at the same time.

FF. Non-covered services - Those goods and services which are not medically necessary for the care and treatment of inpatients as defined in CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C.

GG. Patient's physician - The physician of record responsible for the care of the patient in the hospital.

HH. PRO - Utilization and quality control peer review organization.

II. 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.

JJ. Rate semester - January 1 through June 30, of a given year or July 1 through December 31, of a given year. Effective July 1, 2011, a rate semester will be from July 1 to June 30 of each year.

KK.

Rate Setting Due Date -

LL. All cost reports postmarked by March 31 and received by AHCA by April 15 shall be used to establish the reimbursement rates

MM. Rate Setting Unit Cost - The weighted average per diem after all rate reductions but prior to any buy backs based on submitted cost reports.

NN. Reasonable cost - The reimbursable portion of all allowable costs. Implicit in the meaning of reasonable cost is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs will not be included under the program. The determination of reasonable cost is made on a specific item of cost basis as well as a per diem of overall cost basis.

OO. Reimbursement ceiling - The upper limit for Medicaid variable cost per diem reimbursement for an individual hospital.

PP. Reimbursement ceiling period - July 1 through June 30 , of a given year.

QQ. 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

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

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

SS. Teaching Hospital - Means any hospital formally affiliated with an accredited medical school that exhibits activity in the area of medical education as reflected by at least seven different resident physician specialties and the presence of 100 or more resident physicians.

TT. Title V - Maternal and Child Health and Crippled Children's Services as provided for in the Social Security Act (42 U.S.C. 1396-1396p).

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

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

WW. Total inpatient charges - Total patient revenues assessed for all inpatient services.

XX. UR Committee - Utilization review committee.

APPENDIX A TO FLORIDA TITLE XIX INPATIENT HOSPITAL
REIMBURSEMENT PLAN
ADJUSTMENTS TO ALLOWABLE MEDICAID VARIABLE COSTS

The technique to be utilized to adjust allowable Medicaid variable costs for inflation in the process of computing the reimbursement limits is detailed below. Assume the following DRI (or its successor) 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
Wages and Salaries	55.57
Employee Benefits	7.28%
All Other Products	3.82%
Utilities	3.41%
All 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, 1996then its midpoint is May 31, and the applicable inflation is:

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

Therefore, the hospital's reported variable cost Medicaid per diem is multiplied by 1.3607 to obtain the estimated average variable Medicaid per diem for the first rate semester of FY1999-2000. Similar calculations utilizing March 31 and the mid point yield adjustments for the second semester of FY1999-2000.

APPENDIX B TO FLORIDA TITLE XIX INPATIENT HOSPITAL REIMBURSEMENT PLAN

Medicaid Trend Adjustment Percentages

	Effective Date	Percentages	Reduction Amount
1.	July 1, 2008		
	First Cut	5.467597%	$100,537,618
	Second Cut	3.071006%	$68,641,064
	Third Cut	5.45000%	$154,333,435
2.	**January 1, 2009**		
	First Cut	4.434310%	$100,537,618
	Second Cut	2.999492%	$68,641,064
	Third Cut	6.877860%	$154,333,435
3.	**March 1, 2009**		
	First Cut	4.434067%	$100,537,618
	Second Cut	2.999356%	$68,641,064
	Third Cut	6.877541%	$154,333,435
	Fourth Cut	4.033571%	$84,675,186
4.	**July 1, 2009**		
	First Cut	5.148770%	$100,537,618
	Second Cut	2.955273%	$68,641,064
	Third Cut	6.774483%	$154,333,435
	Fourth Cut	3.866916%	$84,675,186
	Fifth Cut	.0%	$35,478,571
5.	**January 1, 2010**		
	First Cut	5.067599%	$100,537,618
	Second Cut	2.874361%	$68,641,064
	Third Cut	6.585483%	$154,333,435
	Fourth Cut	3.742465%	$76,712,855
	Fifth Cut	.456110%	$35,478,571
6.	**July 1, 2011**		
	First Cut	4.127263%	$100,537,618
	Second Cut	2.413944%	$68,674,064
	Third Cut	5.513843%	$154,333,435
	Fourth Cut	3.091489%	$76,712,855
	Fifth Cut	0.375210%	$35,478,571
	Sixth Cut	0.000000%	$232,221,607

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Seventh Cut	12.528817%	$394,928,848
7.1 Cut	0.000000%	$12,608,937

APPENDIX C TO FLORIDA TITLE XIX INPATIENT HOSPITAL REIMBURSEMENT PLAN

PAYMENT ADJUSTMENT FOR PROVIDER PREVENTABLE CONDITIONS

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

1. The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions. These requirements apply to inpatient hospitals and inpatient psychiatric hospitals.

2. No reduction in payment for a provider preventable condition (PPC) will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

3. Reductions in provider payment may be limited to the extent that the following apply:

    a. The identified provider-preventable conditions would otherwise result in an increase in payment.

    b. The State can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions in the following manner: Hospitals are paid based on a daily per diem rate. It is the responsibility of the hospital to identify any Health Care-Acquired Condition and not seek payment for any additional days that have lengthened a recipient's stay due to a PPC. In reducing the amount of days the following is required on a claim to identify these non-covered days: Hospitals are to report a value code of '81' on the UB-04 claim form along with any non-covered days and the amount field must be greater than '0'.

4. Hospital records will be retroactively reviewed by Medicaid's contracted Quality Improvement Organization (QIO). If any days are identified that are associated with a lengthened stay due to a PPC then Medicaid will initiate recoupment for the identified overpayment.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19-A.

__X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19 –A.

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

On and after May 1, 2012, Medicaid will make zero payments to providers for Other Provider-Preventable Conditions which includes Never Events (NE) as defined by the National Coverage Determination (NCD). The Never Events (NE) as defined in the NCD includes Inpatient Hospitals, Outpatient Hospitals, Ambulatory Surgical Centers (ASC) and practitioners, and these providers will be required to report NEs.

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