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State/Territory Name: Florida

State Plan Amendment (SPA) #:12-017

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Additional Companion letter
- 3) Summary Form (with 179-like data)
- 4) Approved SPA Pages

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



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

January 21, 2014

Mr. Justin Senior
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mailstop #20
Tallahassee, Florida 32308

RE: Florida Title XIX State Plan Amendment, Transmittal # FL 12-017

Dear Mr. Senior:

We have reviewed the proposed amendment to the Florida State Plan (State Plan Amendment FL 12-017). The Request for Additional Information (RAI) response was received in the Regional Office on December 12, 2013. This SPA was initially submitted on September 27, 2012 with a stated purpose of amending the Title XIX Outpatient Hospital Reimbursement Plan payment methodology, effective July 1, 2012. Based on the HCFA 179 submitted by the State, Federal budget impact would be \$15,018,000 in FFY 2011-12 and \$57,881,000 in FFY 2012-13.

Based on the information provided, we are now ready to approve Medicaid State Plan Amendment FL 12-017. This SPA was approved on January 21, 2014. The effective date of this amendment is July 1, 2012. We are enclosing the approved form HCFA-179 and the approved plan pages.

If you have any questions or need further assistance, please contact Sid Staton at 850-878-3486 or sidney.staton@cms.hhs.gov.

Sincerely,

//s//

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

Enclosures

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



Division of Medicaid & Children's Health Operations

January 21, 2014

Mr. Justin Senior
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mailstop #20
Tallahassee, Florida 32308

RE: Florida State Plan Amendment 12-017

Dear Mr. Senior:

This letter is being sent as a companion to our approval of Florida State Plan Amendment (SPA) 12-017 which was submitted to revise the payment methodology for outpatient hospital services. Specifically, this amendment proposed to revise the rate setting method to update rates annually on July 1 based on the most recent, complete, and accurate cost report submitted by each hospital. This SPA also revises the timeframe within which the overpayments and underpayments that result from rate adjustments must be addressed and allows providers to lower the reduction in the annual trend adjustment through the State Buy-Back program.

Our review of FL SPA 12-017 included a corresponding page coverage review of the outpatient hospital services. The state limits outpatient hospital services to "a maximum of \$1,500 for non-EPSDT recipients...per fiscal year." Based on that review and companion letter issued with the approval of FL11-010, we have determined that page 22 of Attachment 3.1-A of the Florida state plan may not be consistent with statute, regulations and CMS guidance.

Under section 1902(a)(10)(B), states are permitted to impose amount, duration, and scope limitations on benefits, but implementing regulations at 42 CFR 440.230 require states to provide each Medicaid service in a way that is "sufficient in amount, duration and scope to reasonably achieve its purpose."

The state has provided an assurance that beneficiaries will not be billed and expected to pay for any care that may not be covered. However, we are unable to determine how this payment limit will impact providers and consequently beneficiaries' access to hospital services furnished in an outpatient setting.

In order to obtain a better understanding of the \$1500 limit placed on Outpatient Hospital Services found on Attachment 3.1-A page 22, we are asking the following sufficiency questions:

1) What is the impetus/reason for this \$1500 limitation on non-EPSDT recipients?

If the reason is budgetary, please provide the assumptions used to support the savings

a. If the reason for the limitation is to prevent duplication of services, abuse or inappropriate utilization, please provide the evidence that supports this reasoning.

b. What other approaches/initiatives/processes have you tried or considered to address this matter?

2) Does the limitation apply to services performed through managed care contracts, fee-for-service (FFS) or both?

3) Please describe what occurs to beneficiaries who are impacted by this \$1500 limitation. Can additional services beyond the limit be provided based on a determination of medical necessity? Is there an exception or prior authorization process for beneficiaries who require services beyond the limitation?

4) If the limit cannot be exceeded based on a determination of medical necessity:

a. How do those affected by the limitation obtain the medical services they need beyond the stated limits?

b. Is the provider or practitioner expected to absorb the costs of providing services that exceed the \$1500 limit?

c. If the beneficiary's covered services are reduced, is the beneficiary notified of his/her appeals rights per 42 CFR 431.206?

5) How is the limitation tracked?

6) Are both providers and beneficiaries informed in advance so they know they have reached the limit? Please summarize the process.

7) How is the state imposing the limit? Does the state do retrospective reviews of claims? If so, please describe the process.

8) Using claims data within the last 12 months, what percentage of Medicaid beneficiaries reached the \$1500 cap on impacted outpatient hospital services? Please provide this information for the following eligibility groups:

a) Aged, Blind and Disabled

i) Non-Dually Eligible Adults (for analyses of primary services for which Medicare would be primary payer)

ii) Dually Eligible

b) Pregnant Women

c) Parents/Caretakers /Other Non-Disabled Adults

Mr. Justin Senior

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- 9) It appears that the \$1500 exempts outpatient hospital emergency services, outpatient surgeries and life sustaining treatments such as chemotherapy and dialysis. Are there any other exemptions to the limitation? How were these exemptions determined to be appropriate?

Please respond to this letter and the related concerns raised in the companion letter to FL 11-010 within 90 days with a State plan amendment that addresses the issues described above or a corrective action plan describing how you will resolve the issues identified above. During the 90-day period, we are happy to provide any technical assistance that you need. Failure to adequately address and correct the concerns within 90 days of this letter will necessitate issuance of an official CMS Compliance Letter.

If you have any questions or need any further assistance, please contact Etta Hawkins, R.Ph. at (404) 562-7429.

Sincerely,

//s//

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

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 2012-017	2. STATE Florida
FOR: HEALTH CARE FINANCING ADMINISTRATION		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, 2012	
5. TYPE OF PLAN MATERIAL (Check One):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447		7. FEDERAL BUDGET IMPACT: (in thousands) FFY 2011-12 \$15,018 FFY 2012-13 \$57,881	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B Exhibit I		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-B Exhibit I	
10. SUBJECT OF AMENDMENT: Outpatient Hospital Reimbursement Plan			
11. GOVERNOR'S REVIEW (Check One):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Reviewed by the Deputy Secretary for Medicaid who is the Governor's designee.	
12. SIGNATURE OF STATE AGENCY OFFICIAL:		16. RETURN TO:	
13. TYPED NAME: Mr. Justin M. Senior		Mr. Justin M. Senior Deputy Secretary for Medicaid Agency for Health Care Administration 2727 Mahan Drive, Mail Stop #8 Tallahassee, FL 32308	
14. TITLE: Deputy Secretary for Medicaid		Attention: April Cook	
15. DATE SUBMITTED: 09-27-12			

FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED: 09-27-12	18. DATE APPROVED: 01-21-14
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 07-01-12	20. SIGNATURE OF REGIONAL OFFICIAL: //s//
21. TYPED NAME: Jackie Glaze	22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Opns
23. REMARKS:	

**FLORIDA TITLE XIX OUTPATIENT HOSPITAL
REIMBURSEMENT PLAN
VERSION XXIII**

EFFECTIVE DATE: July 1, 2012

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 Finance, Cost Reimbursement.
- B. Cost reports available to AHCA as of March 31, 1990, shall be used to initiate this plan.
- C. All hospitals are required to detail their costs for their entire reporting year, making appropriate adjustments as required by this plan for determination of allowable costs. New hospitals shall adhere to requirements of Section 2414.1, Provider Reimbursement Manual (CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.010, Florida Administrative Code, F.A.C.) A prospective reimbursement rate, however, shall not be established for a new hospital based on a cost report for a period less than 12 months. For a new hospital or a new provider with no cost history, excluding new providers resulting from a change in ownership where the previous provider participated in the program, the interim rate shall be the lesser of: the county reimbursement ceiling for variable costs (including outpatient fixed costs); or the budgeted rate in compliance with CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C. and

Section III of the Plan, as applied to the budget submitted by the provider. Interim rates shall be cost settled for the interim rate period. Interim per diem rates shall not be approved for new providers resulting from a change in ownership. Medicaid reimbursement is hospital specific and is not provider specific.

- D. The cost report shall be prepared in accordance with generally accepted accounting principles as established by the American Institute of Certified Public Accountants (AICPA) except as modified by the method of reimbursement and cost finding of Title XVIII (Medicare) Principles of Reimbursement described in 42 Code of Federal Regulations (CFR) 413.35 - 413.50, further interpreted by the Provider Reimbursement Manual (CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C.) and as further modified by this plan.
- E. Hospitals shall file a legible and complete cost report within five months, or 6 months if a certified report is being filed, after the close of its reporting period. Medicare-granted exceptions to these time limits shall be accepted by AHCA.
- F. If a provider submits a cost report late, after the five month period, and that cost report would have been used to set a lower reimbursement rate for a rate semester had it been submitted within five months, then the provider's rate for that rate semester shall be retroactively calculated using the new cost report, and full payments at the recalculated rate shall be affected retroactively. Medicare granted exceptions to these time limits shall be accepted by AHCA.
- G. A hospital which voluntarily or involuntarily ceases to participate in the Florida Medicaid Program or experiences a change of ownership shall file a final cost report in accordance with Section 2414.2, CMS_PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C. For the purposes of this plan, filing a final cost report is not required when: the capital stock of a corporation is sold; or partnership interest is sold as long as one of the original general partners continues in the partnership or one of the original limited partners becomes a general partner, or control remains unchanged. Any change of ownership shall be reported to AHCA within 45 days after such change of ownership.

- H. All Medicaid participating hospitals are required to maintain the Florida Medicaid Log and financial and statistical records regarding outpatients in accordance with 42 CFR 413.24(a)-(c). For purposes of this plan, statistical records shall include the medical records of eligible Medicaid recipients. These records shall be available upon demand to representatives, employees or contractors of AHCA, the Auditor General of the State of Florida, the General Accounting Office (GAO) or the United States Department of Health and Human Services (HHS). A Medicaid recipient's medical records shall be released to the above named persons for audit purposes upon proof of the recipient's consent such as the Medicaid consent form, AHCA-Med Form 1005.
- I. Records of related organizations as defined by 42 CFR 413.17 shall be available upon demand to representatives, employees or contractors of AHCA, the Auditor General, GAO, or HHS.
- J. AHCA shall retain all uniform cost reports submitted for a period of at least five years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of 45 CFR 205.60. Access to submitted cost reports shall be in conformity with Chapter 119, Florida Statutes.
- K. All desk or onsite audits of cost reports shall be final and shall not be reopened past three years of the date that the audit adjustments are noticed through a revised per diem rate completed by the Agency.
- Exception to the above mentioned time limit:
- The aforementioned limitation shall not apply when Medicare audit reopenings result in the issuance of revised Medicaid cost report schedules. A cost report may be reopened for inspection, correction, or referral to a law enforcement agency at any time by the Agency or its contractor if program payments appear to have been obtained by fraud, similar fault, or abuse.
- L. Cost reports submitted on or after July 1, 2004, must include the following statement immediately preceding the dated signature of the provider's administrator or chief financial officer: "I certify that I am familiar with the laws and regulations regarding the provision of health care services under the Florida Medicaid program, including the laws and regulations relating to claims for

Medicaid reimbursements and payments, and that the services identified in this cost report were provided in compliance with such laws and regulations.”

- M. 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.
- N. 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 Finances, on the first cost report acceptance cut-off date after the cost report due date.
- O. 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 8. And V.B. of the Agency’s Outpatient 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 October 31 of the state fiscal year in which the rate takes effect. Errors in cost reporting or calculation of rates discovered after October 31 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. Specific exemptions to the limits or ceilings may be provided in the General Appropriations Act.

A. Background

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

B. Common Audit Program

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

C. Other Hospital Audits

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

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

D. Retention

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

E. Overpayments and Underpayments

1. Overpayments for those years or partial years as determined by desk or field audits using prior approved State plans shall be reimbursable to AHCA, as shall overpayments attributable to unallowable costs only.
2. Overpayments in outpatient hospital services shall not be used to offset underpayments in inpatient hospital services and, conversely, overpayments in inpatient hospital services shall not be used to offset underpayments in outpatient hospital services.
3. The results of desk or field audits of outpatient hospital services shall be identified separately from the results of desk or field audits of inpatient hospital services.
4. Any overpayment or underpayment that resulted from a rate adjustment due to an error in either reporting or calculation of the rate shall be refunded to AHCA or to the provider as appropriate.
5. Any overpayment or underpayment that resulted from a rate based on a budget shall be refunded to AHCA or to the provider as appropriate.
6. The terms of repayments shall be in accordance with Section 414.41, Florida Statutes.
7. All overpayments shall be reported by AHCA to HHS as required.
8. Information intentionally misrepresented by a hospital in the cost report shall result in a suspension of the outpatient hospital from the Florida Medicaid Program.
9. 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.
10. Effective July 1, 2012, 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 October 31 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 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.

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

A. Costs incurred by a hospital in meeting:

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

3. Any other requirements for licensing under the State law which are necessary for providing outpatient hospital services.
- B. Medicaid reimbursements shall be limited to an amount, if any, by which the rate calculation for an allowable claim exceeds the amount of a third party recovery during the Medicaid benefit period. In addition, the reimbursement shall not exceed the amount according to 42 CFR 447.321.
- C. Malpractice insurance costs shall be apportioned to Medicaid in the ratio of Medicaid Outpatient costs to Total Hospital Costs.
- D. Under this plan, hospitals shall be required to accept Medicaid reimbursement as payment in full for covered services provided during the benefit period and billed to the Medicaid program; therefore, there shall be no payments due from Medicaid recipients. As a result, for Medicaid cost reporting purposes, there shall be no Medicaid bad debts generated by Medicaid recipients. Bad debts shall not be considered as an allowable expense.
- E. All physician orders and records that result in costs being passed on by the hospital to the Florida Medicaid Program through the cost report shall be subject to review by the Agency or the Agency's authorized representative.
- F. Certain revenue centers are not reimbursed by Medicaid. Service rendered under these centers shall not be recorded on the Medicaid log and shall not be billed to Medicaid. The list of covered revenue centers is attached as Appendix A. Modifications of this list subsequent to the implementation of this plan shall appear in the most recent version of the Florida Medicaid Hospital Services Coverage and Limitations Handbook incorporated by reference in Rule 59G-4.160, F.A.C.. Beginning November 1, 2004, revenue code 510, Clinic/General (see Appendix A) is reimbursable by Medicaid, in accordance with the most recent version of the Medicaid Hospital Services Coverage and Limitations Handbook, for health care services, in outpatient clinic facilities where a non-state government owned or operated facility assumed the fiscal and operating responsibilities of one or more primary care centers previously operated by the Florida Department of Health or the local county government.

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

- A. In accordance with Chapter 120, F.S., Administrative Procedures Act, and 42 CFR 447.205, this plan shall be promulgated as an Administrative Rule and as such shall be made available for public inspection. A public hearing shall be held so that interested members of the public shall be afforded the opportunity to review and comment on this plan.
- B. Reimbursement ceilings shall be established prospectively for each Florida county. Beginning with the July 1, 1993 rate period, additional ceilings based on the Target Rate System shall also be imposed. For purposes of establishing reimbursement ceilings, each hospital within the state shall be classified as general, teaching, specialized, rural, or as a Community Hospital Education Program (CHEP) hospital. Outpatient reimbursement ceilings shall be established for and applied to general hospitals. Rural and specialized psychiatric hospitals shall be excluded from the calculation and application of the outpatient reimbursement ceilings. Statutory teaching, specialized, Community Hospital Education Program (CHEP) hospitals, and those hospitals defined in Section V.A. 9 through 14 shall be included in the calculation but are exempt from the application of the outpatient reimbursement ceilings.
- C. The initial reimbursement ceilings shall be determined prospectively and shall be effective from July 1, 1990, through December 31, 1990. For subsequent periods, the reimbursement ceilings shall be effective from January 1 through June 30 and July 1 through December 31 of the appropriate years except as provided in G. below. Effective July 1, 2011, there will be one rate setting period from July 1 through June 30.
- D. Changes in individual hospital rates shall be effective from July 1 through June 30 of each year. Hospital outpatient rates set under plan provisions for the July 1, 2003 rate semester will be effective October 1, 2003. . Effective July 1, 2011, there will be one rate setting period from July 1 through June 30.

- E. For the initial period, the last cost report received from each hospital as of March 31, 1990, shall be used to establish the reimbursement ceilings. In the absence of sufficient information from the above source, claims payment data from the Medicaid fiscal agent, shall be used. Should none of the above sources provide acceptable information, the hospital shall be excluded from the reimbursement ceiling calculations. The hospital shall then have a rate assigned that equals the lowest computed rate in the county in which the hospital is located, or the lowest rate in the AHCA District in which the hospital is located, if there are no other hospitals in the county in question.
- F. For subsequent periods, all cost reports received by AHCA as of each April 15 shall be used to establish the reimbursement ceilings.
- G. The individual hospital's prospectively determined rate shall be adjusted only under the following circumstances:
1. An error was made by the fiscal intermediary or AHCA in the calculation of the hospital's rate.
 2. A hospital submits an amended cost report to supersede the cost report used to determine the rate in effect. There shall be no change in rate if an amended cost report is submitted beyond three years of the effective date the rate was established, or if the change is not material.
 3. 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.
 4. Effective July 1, 2012, a hospital must submit an amended cost report by October 15 of the state fiscal year the rates are effective to have the amended cost report recognized in the final rates set at October 31.
 5. Further desk or field audits of cost reports used in the establishment of the prospective rate disclose material changes in these reports. For cost reports received on or after October 1, 2003, all desk or onsite audits of these cost reports shall be final and shall not be reopened past three years of the date that the audit adjustments are noticed through a

revised per diem rate completed by the Agency. 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.

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

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

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

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

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

A. Setting Reimbursement Ceilings.

1. Review and adjust the hospital cost report available to AHCA as of each April 15 as follows:
 - a. To reflect the results of desk or field audits.

Hospital Outpatient Plan Version XXIII
Attachment 4.19-B
Exhibit I

- b. To reduce the Medicaid outpatient costs and charges for laboratory and pathology costs and charges.
2. Reduce a hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.9.
3. Determine Medicaid outpatient variable costs defined in Section X.
4. Adjust Medicaid outpatient variable costs for the number of months between the midpoint of the hospital's fiscal year and December 31 the midpoint of the rate semester for which the new rate is being calculated. The adjustment shall be made utilizing the latest available projections as of December 31 the Data Resources Incorporated (DRI) Type Hospital Market Basket Index as detailed in Appendix B.
5. Divide the inflated Medicaid outpatient variable costs by the latest available Health Care component of the Florida Price Level Index (FPLI) for the county in which the hospital is located.
6. Divide the results of Step 5 for each hospital by its total Medicaid outpatient occasions of service excluding occasions of service for laboratory and pathology resulting in an occasions of service rate.
7. Array the occasions of service rates in Step 6 from the lowest to the highest rate with the associated occasions of service.
8. Establish the reimbursement ceilings as the lower of:
 - a. The cost based ceilings for variable costs per occasion of service at the occasion of service rate associated with the 80th percentile of occasions of service, times the FPLI component utilized in Step 5 for the county in which the hospital is located. Rural and specialized psychiatric hospitals are excluded from the calculation and application of this cost based ceiling.

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

- i. Statutory teaching hospitals
- ii. Specialized hospitals
- iii. Community Hospital Education Program (CHEP)
- iv. Those mentioned in 9 through 14 below
- v. Hospitals with Level III Neonatal Intensive Care Units that have a minimum of three of the following designated tertiary services as regulated under the certificate of need program: pediatric bone marrow transplantation, pediatric open heart surgery, pediatric cardiac catheterization and pediatric heart transplantation.

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

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

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

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

This target ceiling shall not apply to the following:

- i. Statutory teaching hospitals
- ii. Specialized hospitals
- iii. Community Hospital Education Program (CHEP)

- iv. Those mentioned in 9 through 14 below
 - v. Hospitals with Level III Neonatal Intensive Care Units that have a minimum of three of the following designated tertiary services as regulated under the certificate of need program: pediatric bone marrow transplantation, pediatric open heart surgery, pediatric cardiac catheterization and pediatric heart transplantation.
9. Effective July 1, 2001, outpatient reimbursement ceilings will be eliminated for hospitals whose charity care and Medicaid days as a percentage of total hospital days equals or exceeds fifteen percent. Effective July 1, 2002, the fifteen percent (15%) will be changed to fourteen and one-half percent (14.5%). The Agency shall use the disproportionate share hospital 1997 audited data available as of March 1, 2001, to determine eligibility for the elimination of ceilings. Effective July 1, 2003, the fourteen and one-half percent (14.5%) will be changed to eleven percent (11%) to eliminate the outpatient reimbursement ceilings for hospitals whose charity care and Medicaid days as a percentage of total adjusted hospital days equals or exceeds 11 percent. The Agency will use the average of the 1998, 1999, and 2000 audited DSH data available as of March 1, 2004. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency will use the average of the audited DSH data for 1998, 1999, and 2000 that is available. Hospital outpatient rates set under plan provisions for the July 1, 2003, rate semester will be effective October 1, 2003.
10. Effective July 1, 2001, outpatient reimbursement ceilings will be eliminated for hospitals whose Medicaid days as a percentage of total hospital days exceed 9.6% and are a trauma center. The Agency shall use the 1997 audited DSH data available as of March 1, 2001, to determine eligibility for the elimination of ceilings.
11. Effective July 1, 2003, outpatient reimbursement ceilings will be eliminated for hospitals whose Medicaid days, as a percentage of total hospital days, exceed 9.6 percent, and are trauma centers. The Agency will use the average of the 1998, 1999, and 2000 audited DSH data available as of March 1, 2004. In the event the Agency does not have the prescribed three years of audited DSH

data for a hospital, the Agency will use the average of the audited DSH data for 1998, 1999, and 2000 that is available. Hospital outpatient rates set under plan provisions for the July 1, 2003, rate semester will be effective October 1, 2003.

12. Effective July 1, 2005, outpatient reimbursement ceilings shall be eliminated for hospitals whose charity care and Medicaid days as a percentage of total adjusted hospital days equals or exceeds 11 percent. The Agency shall use the average of the 1999, 2000, and 2001 audited DSH data available as of March 1, 2005. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency will use the average of the audited DSH data for 1999, 2000, and 2001 that are available. Any hospital that met the 11 percent threshold in state fiscal year 2004-2005 and was also exempt from the outpatient reimbursement ceilings shall remain exempt from the outpatient reimbursement ceilings for State Fiscal Year 2005-2006, subject to the payment limitations imposed in this paragraph.
13. Effective July 1, 2005, outpatient reimbursement ceilings shall be eliminated for hospitals that have a minimum of ten licensed Level II neonatal intensive care beds and are located in Trauma Services Area 2.
14. Effective July 1, 2005, the outpatient reimbursement ceilings shall be eliminated for hospitals whose Medicaid days, as a percentage of total hospital days, exceed 7.3 percent, and are designated or provisional trauma centers. This provision shall apply to all hospitals that are designated or provisional trauma centers on July 1, 2005, or become a designated or provisional trauma center during state fiscal year 2005-2006. The agency shall use the average of the 1999, 2000 and 2001 audited DSH data available as of March 1, 2005. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the agency will use the average of the audited DSH data for 1999, 2000, and 2001 that are available.
15. Effective July 1, 2006, outpatient hospital rates shall be adjusted to eliminate the outpatient reimbursement ceilings for hospitals whose charity care and Medicaid days as a percentage of total adjusted hospital days equals or exceeds 11 percent.

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Effective July 1, 2006, the Agency shall use the average of the 2000, 2001, and 2002 audited DSH data available as of March 1, 2006. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2000, 2001, and 2002 that are available. For any non-state government owned or operated facility that does not qualify for the elimination of the outpatient ceilings under this section, the non-state government owned or operated facility hospital shall be exempt from the outpatient reimbursement ceilings.

16. Effective July 1, 2006, outpatient reimbursement ceilings for hospitals that have a minimum of ten licensed Level II neonatal intensive care beds and are located in Trauma Services Area 2 are eliminated.
17. Effective July 1, 2006, outpatient reimbursement ceilings for hospitals whose Medicaid days, as a percentage of total hospital days, exceed 7.3 percent, and are designated or provisional trauma centers are eliminated. This provision shall apply to all hospitals that are designated or provisional trauma centers on July 1, 2006, or become a designated or provisional trauma center during State Fiscal Year 2006-2007. The Agency shall use the average of the 2000, 2001, and 2002 audited DSH data available as of March 1, 2006. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2000, 2001, and 2002 that are available.
18. Effective July 1, 2007, the outpatient reimbursement ceilings will be eliminated for hospitals whose charity care and Medicaid days as a percentage of total adjusted hospital days equals or exceeds 11 percent. For any non-state government owned or operated facility that does not qualify for the elimination of the outpatient ceilings under this provision of proviso or any other proviso listed, the non-state government owned or operated facility shall be exempt from the outpatient reimbursement ceilings. The Agency shall use the average of the 2001, 2002, and 2003 audited DSH data available as of March 1, 2007. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2001, 2002, and 2003 that are available.

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19. Effective July 1, 2007, the outpatient reimbursement ceilings will be eliminated for hospitals that have a minimum of ten licensed Level II Neonatal Intensive Care Beds and are located in Trauma Services Area 2.
20. Effective July 1, 2007, the outpatient reimbursement ceilings will be eliminated for hospitals whose Medicaid days, as a percentage of total hospital days, exceed 7.3 percent, and are designated or provisional trauma centers. This provision shall apply to all hospitals that are designated or provisional trauma centers on July 1, 2007, or become a designated or provisional trauma center during state fiscal year 2007-2008. The Agency shall use the average of the 2001, 2002, and 2003 audited DSH data available as of March 1, 2007. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2001, 2002, and 2003 that are available.
21. Effective July 1, 2008, outpatient reimbursement ceilings for hospitals will be eliminated for those hospitals whose charity care and Medicaid days as a percentage of total adjusted hospital days equals or exceeds 11 percent. The Agency shall use the average of the 2002, 2003, and 2004 audited DSH data available as of March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003, and 2004 that are available.
22. Effective July 1, 2008, outpatient hospital reimbursement ceilings will be eliminated for hospitals whose Medicaid days, as a percentage of total hospital days, exceed 7.3 percent, and are designated or provisional trauma centers. This provision shall apply to all hospitals that are designated or provisional trauma centers on July 1, 2008, or become a designated or provisional trauma center during Fiscal Year 2008-2009. Included in these funds are the annualized amounts to offset the reductions taken against certified trauma centers as identified in section 13, chapter 2007-326, Laws of Florida. The Agency shall use the average of the 2002, 2003, and 2004 audited DSH data available as of March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003, and 2004 that are available.

23. Effective July 1, 2009, outpatient reimbursement ceilings will be eliminated for hospitals whose charity care and Medicaid days as a percentage of total adjusted hospital days equals or exceeds 11 percent. For any non-state government owned or operated hospital or any leased non-state government owned hospital found to have sovereign immunity or hospital with graduate medical education positions that does not qualify for the elimination of the outpatient ceilings under this provision, such hospitals shall be exempt from the outpatient reimbursement ceilings contingent on the public 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.
24. Effective July 1, 2009, outpatient reimbursement ceilings will be eliminated for hospitals that have a minimum of ten licensed Level II Neonatal Intensive Care Beds and are located in Trauma Services Area 2.
25. Effective July 1, 2009, the outpatient reimbursement ceilings will be eliminated for hospitals whose Medicaid days, as a percentage of total hospital days, exceed 7.3 percent, and are designated or provisional trauma centers. This provision shall apply to all hospitals that are designated or provisional trauma centers on July 1, 2009 or 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 13, chapter 2007-326, Laws of Florida. 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.
26. Effective July 1, 2010, the outpatient hospital reimbursement ceilings will be eliminated for hospitals whose charity care and Medicaid days as a percentage of total adjusted hospital days equals or exceeds 11 percent. For any 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 outpatient ceilings, such hospitals shall be exempt from the outpatient 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 outpatient 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 meet the 11 percent threshold, because of updated audited DSH data shall remain exempt from the outpatient reimbursement ceilings for a period of two years.

27. Effective July 1, 2010, the outpatient 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.
28. Effective July 1, 2010, the outpatient reimbursement ceilings will be eliminated for hospitals whose Medicaid days, as a percentage of total hospital days, exceed 7.3 percent, and are designated or provisional trauma centers. This provision shall apply to all hospitals that are designated or provisional trauma centers on July 1, 2010 or become 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 13, chapter 2007-326, Laws of Florida. 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, 2012, \$45,159,962 is provided for hospitals to allow for exemptions from outpatient reimbursement limitations.

B. Setting Individual Hospital Rates.

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

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- a. To reflect the results of desk and field audits.
 - b. To reduce the Medicaid outpatient costs and charges for laboratory and pathology costs and charges.
2. Reduce the hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.9.
 3. Determine Medicaid outpatient variable costs as defined in Section X.
 4. Adjust Medicaid outpatient variable costs for the number of months between the midpoint of the hospital's fiscal year and December 31 the midpoint of the following rate semester. The adjustment shall be made utilizing the DRI Regional Hospital Input Price Index as detailed in Appendix B.
 5. Establish the variable cost rate as the lower of:
 - a. The inflated rate by dividing the inflated allowable Medicaid outpatient variable costs by the total Medicaid outpatient occasions of service for the hospital excluding occasions of service for laboratory and pathology.
 - b. The target rate by inflating the variable cost rate in the previous rate period by the target inflation factor calculated in V.A.8.b. above in establishing target ceilings. This target rate shall not apply to rural, specialized, statutory teaching, Community Hospital Education Program (CHEP) hospitals, and those hospitals defined in Section V.A. 9 through 14.
 - i. Set the rate for the hospital as the lower of the result of Step 5. above, the reimbursement ceiling in V.A.8 for the county in which the hospital is located, or the result of inflated Medicaid outpatient charges divided by total Medicaid outpatient occasions of service excluding charges and occasions of service for laboratory and pathology.
 - ii. Hospital outpatient rates set under plan provisions for the July 1, 2003, rate semester will be effective October 1, 2003.

- iii. Effective July 1, 2004, and ending June 30, 2005, each outpatient rate shall be reduced by a proportionate percentage until an aggregate total estimated savings of \$14,103,000 is achieved. In reducing hospital outpatient rates, rural hospitals and hospitals with twenty thousand (20,000) or more combined Medicaid managed care and fee-for-service inpatient days shall not have their outpatient rates reduced below the final rates that are effective on June 30, 2004. The 2002 Financial Hospital Uniform Reporting System (FHURS) data shall be used to determine the combined inpatient Medicaid days.
6. Effective July 1, 2005, a recurring rate reduction shall be established until an aggregate total estimated savings of \$16,796,807 is achieved each year. This reduction is the Medicaid Trend Adjustment. In reducing hospital outpatient rates, rural hospitals and hospitals with twenty thousand (20,000) or more combined Medicaid managed care and fee-for-service inpatient days shall not have their outpatient rates reduced below the final rates that are effective on the prior June 30 of each year. The 2002 Financial Hospital Uniform Reporting System (FHURS) data shall be used to determine the combined inpatient Medicaid days.
 - a. The July 1, 2005 and January 1, 2006 reimbursement rates shall be adjusted as follows:
 - i. Restore the \$14,103,000 outpatient hospital reimbursement rate reduction set forth in Section V.B.iii above to the June 30, 2005 reimbursement rate;
 - ii. Determine the lower of the June 30, 2005 rate with the restoration of the \$14,103,000 reduction referenced in (i) above or the July 1, 2005 or January 1, 2006 rates, as applicable, before the application of the Medicaid Trend Adjustment described in (6) above;
 - b. Effective July 1, 2006, the reduction implemented during the period July 1, 2005, through June 30, 2006, shall become a recurring annual reduction. This recurring reduction, called the Medicaid Trend Adjustment, shall be applied proportionally to all rates on an annual basis.

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- c. Effective July 1, 2007, and ending June 30, 2008, the Medicaid Trend Adjustment will be removed for all hospitals whose Medicaid charity care days as a percentage to total adjusted days equals or exceeds 30 percent and have more than 10,000 Medicaid days or hospital system that established a Provider Service Network during the prior state fiscal year. The aggregate Medicaid Trend Adjustment listed in V.B.6 above will be reduced by \$3,110,871. The Agency shall use the average of the 2001, 2002 and 2003 audited DSH data available as of March 1, 2007.
7. Effective January 1, 2008, an additional Medicaid Trend Adjustment shall be applied to achieve a recurring annual reduction of \$17,211,796.
8. Effective January 1, 2008, and ending June 30, 2008, the Medicaid Trend Adjustment shall be removed for all certified trauma centers and hospitals defined in section 408.07(45), 2007 Florida Statutes. The aggregate Medicaid Trend Adjustment found in V.C.7 above shall be reduced by up to \$2,034,032.
9. Effective July 1, 2008, an additional Medicaid Trend Adjustment shall be applied to achieve a recurring annual reduction of \$36,403,451. In establishing rates through the normal process, prior to including this reduction, if the unit cost is equal to or less than the unit cost used in establishing the budget, no additional reduction in rates is necessary. In establishing rates through the normal process, prior to including this reduction, if the unit cost is greater than the unit cost used in establishing the budget, then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the unit cost used in establishing the budget.
10. The Agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs for two fiscal years effective July 1, 2009.
11. Effective July 1, 2008, a buy back provision for the Medicaid trend adjustment will be applied against the Medicaid outpatient rates for the following three categories of hospitals.
 - a. Budget authority up to \$3,515,024 is provided to the first category of hospitals, which are those hospitals that are part of a system that

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

- b. Budget authority up to \$5,203,232 shall be used for the second category to buy back the Medicaid trend adjustment that is being applied against the Medicaid outpatient rates for those hospitals that are licensed as a children's specialty hospital and whose Medicaid days plus charity care days divided by total adjusted patient days equals or exceeds 30 percent. In the event the above amounts exceed the amount of the Medicaid trend adjustment applied to each hospital, the excess funds will be used to buy back other Medicaid reductions in the inpatient rate.
- c. Budget authority up to \$2,170,197 shall be used for the third category to buy back the additional Medicaid trend adjustment that is being applied to rural hospitals under Specific Appropriation 211 for Fiscal Year 2008-2009. In the event that the funds under this category exceed the amount of the Medicaid trend adjustment, then any excess funds will be used to buyback other Medicaid reductions in the outpatient rate for those individual hospitals.

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

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12. Effective July 1, 2008, budget authority up to \$19,906,103 is provided for a buy back provision for state or local government owned or operated hospitals, teaching hospitals as defined in section 408.07 (45) or 395.805, Florida Statutes, which have 70 or more full-time equivalent resident physicians and those hospitals whose Medicaid and charity care days divided by total adjusted days exceeds 25 percent to buy back the Medicaid outpatient trend adjustment shall be applied to their individual hospital rates and other Medicaid reductions to their outpatient rates up to actual Medicaid outpatient cost. The Agency shall use the average of the 2002, 2003, and 2004 audited DSH data available as of March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003 and 2004 that are available.
13. Effective March 1, 2009, the Agency for Health Care Administration shall implement a recurring methodology to reduce individual outpatient hospital rates proportionately until the required \$20,952,069 savings is achieved. Hospitals that are licensed as a children's specialty hospital and whose Medicaid days plus charity care days divided by total adjusted patient days equals or exceeds 30 percent are excluded from this reduction. The Agency may amend its current facility fees and physician services to allow for payments to hospitals providing primary care to low-income individuals and participating in the Primary Care DSH program in Fiscal Year 2003-2004 provided such hospital implements an emergency room diversion program so that non-emergent patients are triaged to lesser acute settings.
14. Public hospitals, teaching hospitals as defined in section 408.07 (45) or section 395.805, Florida Statutes, which have seventy or more full-time equivalent resident physicians, designated trauma centers and those hospitals whose Medicaid and charity care days divided by total adjusted days exceeds twenty five percent are allowed to buy back the Medicaid outpatient trend adjustment applied to their individual hospital rates and other Medicaid reductions to their outpatient rates up to actual Medicaid outpatient cost.15. The agency shall use the 2002, 2003 and 2004 audited DSH data available as of March 1, 2008. In the event the agency does not have the prescribed three

years of audited DSH data for a hospital, the agency shall use the average of the audited DSH data for 2002, 2003 and 2004 that are available.

15. Effective July 1, 2009, the Agency shall implement a recurring methodology in the Title XIX Outpatient Hospital Reimbursement Plan to achieve a \$10,403,322 reduction. 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 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.
16. Effective July 1, 2009, a buy back provision will be applied to the Medicaid trend adjustment that is being applied against the Medicaid outpatient rates for the following three categories of hospitals:
 - a. \$6,711,233 is provided to the first category of hospitals, which are those hospitals that are part of a system that operate a provider service network in the following manner: \$2,762,760 is for Jackson Memorial Hospital; \$803,934 is for hospitals in Broward Health; \$1,211,814 is for hospitals in the Memorial Healthcare System; and \$795,574 to Shands Jacksonville and \$1,137,151 to 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 outpatient rate not to exceed the base rate effective July 1, 2009.
 - b. \$5,985,074 shall be used for the second category to buy back the Medicaid trend adjustment that is being applied against the Medicaid outpatient rates for those hospitals that are licensed as a children's specialty hospital and whose Medicaid days plus charity care days divided by total adjusted patient days equals or exceeds 30 percent. In the event 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 outpatient rate not to exceed the base rate effective July 1, 2009..

- c. \$5,749,538 shall be used for the third category to buy back the Medicaid trend adjustment that is being applied against the Medicaid outpatient rates for 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 outpatient rate for those individual hospitals.
 - d. The agency shall use the average of 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.
17. \$45,154,079 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 s. 408.07 (45) or 395.805, Florida Statutes, which have seventy or more full-time equivalent resident physicians and designated trauma hospitals are eligible to buy back the Medicaid outpatient trend adjustment applied to their individual hospital rates and other Medicaid reductions to their outpatient rates up to actual Medicaid outpatient cost. . This section of proviso does not include the buy back of the Medicaid outpatient trend adjustment applied to the individual state mental health hospitals.
18. Effective July 1, 2010, \$12,226,583 is provided to buy back the Medicaid trend adjustment that is being applied against the Medicaid outpatient rates for the following three categories of hospitals not to exceed the base rate effective July 1, 2010:
- a. \$3,372,389 is provided to the first category of hospitals, which are those hospitals that are part of a system that operate a provider service network in the following manner:
 - \$570,978 is for Jackson Memorial Hospital;
 - \$458,668 is for hospitals in Broward Health;
 - \$840,958 is for hospitals in the Memorial Healthcare System;

\$256,166 to Shands Jacksonville and

\$1,245,619 to Shands Gainesville.

- b. \$4,221,468 shall be used for the second category of hospitals to buy back the Medicaid trend adjustment that is being applied against the Medicaid outpatient rates for those hospitals that are licensed as a children's specialty hospital and whose Medicaid days plus charity care days divided by total adjusted patient days equals or exceeds 30 percent. In the event 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 outpatient rate not to exceed the base rate effective July 1, 2010.
- c. \$4,632,726 shall be used for the third category of hospitals to buy back the Medicaid trend adjustment that is being applied against the Medicaid outpatient rates for 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 outpatient rate for those individual hospitals not to exceed the base rate effective July 1, 2010.

The Agency shall use the average of 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.

- 18. State government owned or operated facilities, including any leased public hospital found to have sovereign immunity, teaching hospitals as defined in ss. 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 designated trauma hospitals may buy back the Medicaid outpatient trend adjustment applied to their individual hospital rates and other Medicaid reductions to their outpatient rates up to actual Medicaid outpatient cost not to exceed the base rate effective July 1, 2010.

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- a. Hospitals may buy back the Medicaid outpatient trend adjustment applied to their individual hospital rates and other Medicaid reductions to their outpatient rates up to actual Medicaid outpatient cost.; and
 - b. Any hospital that has local funds available for intergovernmental transfers, not elsewhere qualifying for an exemption, may be exempt for outpatient reimbursement limitations funds.
19. 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.
20. Effective July 1, 2011, \$99,045,233 will be used for a reduction in outpatient hospital reimbursement 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.
21. Effective July 1, 2011, \$3,886,602 will be used as a result of implementing a reduction in outpatient hospital reimbursement 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.

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22. Effective July 1, 2011, \$115,394,825 is provided for non state or local government owned or operated hospitals, including any leased non state or local government owned or operated hospital found to have sovereign immunity, teaching hospitals as defined in s. 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 designated trauma hospitals to buy back the Medicaid outpatient trend adjustment applied to their individual hospital rates not to exceed the base rate effective July 1, 2011.
23. Effective July 1, 2011, \$80,007,502 is provided for hospitals to buy back the Medicaid outpatient trend adjustment applied to their individual hospital rates and other Medicaid reductions to their outpatient rates not to exceed actual Medicaid outpatient cost.
24. Effective July 1, 2011, \$68,528,485 is provided for hospitals to allow for exemptions from outpatient reimbursement limitations for any hospital that has their rate adjusted for these ceilings and exemptions not to exceed the base rate effective July 1, 2011.
25. Effective July 1, 2011, any provider's base rate adjusted in accordance with Section V.B and identified in Section V.B. shall have their rates adjusted not to exceed the base rate determined in accordance with Section V.B.
26. Effective July 1, 2012, the Agency shall implement a recurring methodology in the Title XIX Outpatient Hospital Reimbursement Plan to achieve a \$65,288,483 reduction. 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 section 395.602, Florida Statutes, are excluded from this reduction.

27. Effective July 1, 2012, \$16,209,998 is provided to partially restore the reduction in outpatient hospitals.
28. Effective July 1, 2012, \$74,147,055 is provided for non-state or local government owned or operated hospitals, including any leased public 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, hospitals with graduate medical education positions that do not otherwise qualify, and designated trauma hospitals to buy back the Medicaid outpatient trend adjustment applied to their individual hospital rates and other Medicaid reductions to their outpatient rates not to exceed actual Medicaid outpatient cost.
29. Effective July 1, 2012, \$33,633,109, is provided for hospitals to buy back the Medicaid outpatient trend adjustment applied to their individual hospital rates and other Medicaid reductions to their outpatient rates not to exceed actual Medicaid outpatient cost.
30. Effective July 1, 2012, \$287,396 is provided to buy back the Fiscal Year 2011-2012 Outpatient Medicaid Trend Adjustment for Putnam Community Medical Center.
31. Effective July 1, 2012, 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).

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

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

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.

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

- A. Acceptable Cost Report - A completed, legible cost report that contains all relevant schedules, worksheets and supporting documents.
- B. Adjusted patient days - The sum of acute care patient days and intensive care patient days as reported to the Agency for Health Care Administration divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues
- C. AHCA - Agency for Health Care Administration, also known as the Agency.
- D. Allowable Costs - An item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with generally accepted accounting principles except as modified by the Principles of Reimbursement for Provider Costs, as defined in CMS PUB. 15-1 as incorporated by reference in 59G-6.010 F.A.C., and as further defined in the most recent version of the Florida Title XIX Outpatient Hospital Reimbursement Plan.
- E. 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. 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.

- H. Cost Reporting Year - A 12-month period of operation based upon the provider's accounting year.
- I. Eligible Medicaid Recipient - "Recipient" or "Medicaid recipient" means any individual whom the department, or the Social Security Administration on behalf of the agency, determines is eligible, pursuant to federal and state law, to receive medical or allied care, goods, or services for which the department may make payments under the Medicaid program and is enrolled in the Medicaid program. For the purposes of determining third party liability, the term includes an individual formerly determined to be eligible for Medicaid, an individual who has received medical assistance under the Medicaid program, or an individual on whose behalf Medicaid has become obligated.
- J. Filing Due Date - No later than five (5) calendar months after the close of the hospital's cost-reporting year.
- K. 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.
- L. Florida Price Level Index - A spatial index which measures differences from county to county in the cost of purchasing a specified market basket of items at a particular point in time. The items in the market basket range from various food products to hospital lab fees, and are grouped into the components of food, housing, apparel, transportation, and health, recreation and personal services. A county index for each of the five components is developed bi-annually by the Florida Executive Office of the Governor. County indices are population weighted to average 100 percent. An index of 1.1265 for a given county means that the basket of goods in that county costs 12.65 percent more than the State average. Changes to the methodology utilized in the development of the FPLI will constitute changes in this plan and will require a formal plan amendment.
- M. General hospital – A hospital in this state that is not classified as a specialized hospital.
- N. HHS - Department of Health and Human Services

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- O. Late Cost Report - A cost report is late when it is filed with AHCA, Bureau of Medicaid Program Analysis after the Filing Due Date and after the Rate Setting Due Date.
- P. Legislative Unit Cost - The average weighted per diem of the State anticipated expenditure after all rate reductions but prior to any buy back.
- Q. CMS PUB. 15-1 - Health Insurance Manual No. 15, also known as the Provider Reimbursement Manual, as incorporated by reference in Rule 59G-6.010, F.A.C..
- R. Medicaid Outpatient Charges - Usual and customary charges for outpatient services rendered to Medicaid patients excluding charges for laboratory and pathology services. These charges shall be the allowable charges as reconciled with the hospital Medicaid log and found on the Medicaid paid claims report.
- S. Medicaid Outpatient Occasions of Service - The number of distinct revenue center code line items listed on a valid claim that a hospital has submitted to the fiscal agent, excluding laboratory and pathology revenue center code line items, and that have been paid by the fiscal agent, which represent covered Medicaid outpatient services.
- T. Medicaid Outpatient Variable Costs - Allowable operating costs excluding laboratory and pathology costs less return on equity as apportioned to Medicaid by cost finding methods in the CMS 2552 cost report.
- U. Non-Covered Services - Those goods and services which are not medically necessary for the care and treatment of outpatients as defined in CMS PUB 15.1 as incorporated by reference in Rule 59G-6.010, F.A.C.
- V. 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.
- W. 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, the rate semester begins on July 1 and runs through June 30.

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- X. **Rate Setting Due Date** - All cost reports postmarked by March 31 and received by AHCA by April 15 shall be used to establish the reimbursement rates
- Y. **Rate Setting Unit Cost** - The weighted average per diem after all rate reductions but prior to any buy backs based on submitted cost reports.
- Z. **Reimbursement Ceiling** - The upper limit for Medicaid Outpatient Variable Cost rate reimbursement for an individual hospital.
- AA. **Reimbursement Ceiling Period** - January 1 through June 30 of a given year or July 1 through December 31, of a given year.
- BB. **Rural Hospital** - An acute care hospital licensed under Florida Statutes, Chapter 395 with 100 licensed beds or less, which has an emergency room and is located in an area defined as rural by the United States Census, and which is:
1. The sole provider within a county with a population density of no greater than 100 persons per square mile; or
 2. An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county; or
 3. A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or less per square mile.
 4. A hospital in a constitutional charter county with a population of over 1 million persons that has imposed a local option health service tax pursuant to law and in an area that was directly impacted by a catastrophic event on August 24, 1992, for which the Governor of Florida declared a state of emergency pursuant to chapter 125, and has 120 beds or less that serves an agricultural community with an emergency room utilization of no less than 20,000 visits and a Medicaid inpatient utilization rate greater than 15 percent;
 5. A hospital with a service area that has a population of 100 persons or fewer per square mile. As used in this subparagraph, the term "service area" means the fewest number of zip

codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Policy Analysis at the Agency for Health Care Administration; or

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

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

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

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

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

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

This Outpatient Hospital Reimbursement Plan establishes the methodology for calculating the line item reimbursement rates for covered Medicaid outpatient hospital services. Other rates established for non-line item payments, such as but not limited to, lab and pathology services, are referenced in the handbook. In addition, policy for coverage of Medicaid outpatient hospital services is established in

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the Florida Medicaid Hospital Services Coverage and Limitations Handbook incorporated by reference
in Rule 59G-4.160, F.A.C.

APPENDIX A TO FLORIDA TITLE XIX OUTPATIENT HOSPITAL
REIMBURSEMENT PLAN

OUTPATIENT REVENUE CENTER CODES**

<u>CODE</u>	<u>DESCRIPTION</u>
250	Pharmacy/General
251	Pharmacy/Generic
252	Pharmacy/NonGeneric
254	Drugs Incident to Other Diagnostic Services
255	Drugs Incident to Radiology
258	Pharmacy/IV Solutions
259	Other Pharmacy
260	IV Therapy
261	Infusion Pump
262*	IV Therapy/Pharmacy Services
264*	IV Therapy/Supplies
269*	Other IV Therapy
270	General Classification
271	Medical Surgical- Nonsterile supplies
272	Medical/Surgical - Sterile Supplies
275	Pacemaker
276*	Intraocular Lens
278	Subdermal Contraceptive Implant
279*	Burn Pressure Garment Fitting
300	Laboratory/General
301	Laboratory/Chemistry
302	Laboratory/Immunology
304	Laboratory/Non-Routine Dialysis
305	Laboratory/Hematology
306	Laboratory/Bacteriology and Microbiology
307	Laboratory/Urology
310	Pathological Laboratory/General
311	Pathological Laboratory/Cytology
312	Pathological Laboratory/Histology
314	Pathological Laboratory/Biopsy
320	Diagnostic Radiology/General
321	Diagnostic Radiology/Angiocardiology
322	Diagnostic Radiology/Arthrography
323	Diagnostic Radiology/Arteriography
324	Diagnostic Radiology/Chest
329	Other Radiology Diagnostic
330*	Therapeutic Radiology/General
331*	Therapeutic Radiology/Injected
332*	Therapeutic Radiology/Oral
333*	Therapeutic Radiology/Radiation Therapy
335*	Therapeutic Radiology/Chemotherapy - IV
339*	Other Radiology Therapeutic
340	Nuclear Medicine/General
341	Nuclear Medicine/Diagnostic
342	Nuclear Medicine/Therapeutic
343	Diagnostic Radiopharmaceuticals

344	Therapeutic Radiopharmaceuticals
349	Other Nuclear Medicine
350	Computed Tomographic (CT) Scan/General
351	Computed Tomographic (CT) Scan/Head
352	Computed Tomographic (CT) Scan/Body
359	Other CT Scans
360*	Operating Room Services/General
361*	Operating Room Services/Minor Surgery
362*	Operating Room Services/Bone Marrow Transplant
369*	Other Operating Room Services
370	Anesthesia/General
371	Anesthesia Incident to Radiology
372	Anesthesia Incident to Other Diagnostic Services
379	Other Anesthesia
380	Blood/General
381	Blood/Packed Red Cells
382	Blood/Whole
383	Blood/Plasma
384	Blood/Platelets
385	Blood/Leucocytes
386	Blood/Other Components
387	Blood/Other Derivatives
389	Other Blood
390	Blood Storage and Processing/General
391	Blood Storage and Processing/Administration
399	Other Processing and Storage
400	Imaging Services/General
401	Imaging Services/Mammography
402	Imaging Services/Ultrasound
403	Screening Mammography
404	Positron Emission Tomography
409	Other Imaging Services
410	Respiratory Services/General (All Ages)
412	Respiratory Services/Inhalation (All Ages)
413	Respiratory Services/Hyperbaric Oxygen Therapy (All Ages)
419	Other Respiratory Services
421	Physical Therapy/Visit Charge (All Ages)
424	Physical Therapy/Evaluation or Re-evaluation(All Ages) <u>Note: Effective 1/1/99</u>
431	Occupational Therapy/Visit Charge (Under 21 only)
434	Occupation Therapy/Evaluation or Re-evaluation (Under 21) <u>Note: Effective 1/1/99</u>
441	Speech-Language Pathology/Visit Charge (Under 21 only)
444	Speech-Language Pathology/Evaluation or Re-evaluation Under 21) <u>Note: Effective 1/1/99</u>
450*	Emergency Room/General
451	EMTALA Emergency Medical Screening Services
460	Pulmonary Function/General
469	Other Pulmonary Function
471	Audiology/Diagnostic
472	Audiology/Treatment
480	Cardiology/General
481	Cardiology/Cardiac Cath Laboratory
482	Cardiology/Stress Test

483	Cardiology/Echocardiology
489	Other Cardiology
490	Ambulatory Surgical Care
510	Clinic/General
	•.Note: Please reference the most recent version of the Medicaid Outpatient Hospital Coverage and Limitations Handbook
513	Psychiatric Clinic
	<u>Note:</u> Use code 513, psychiatric clinic, with code 914, psychiatric individual therapy services, or with 918, psychiatric testing, when either of these codes is appropriate and applicable.
610	MRI Diagnostic/General
611	MRI Diagnostic/Brain
612	MRI Diagnostic/Spine
614	MRI - Other
615	Magnetic Resonance Angiography (MRA) - Head & Neck
616	MRA - Lower Extremities
618	MRA - Other
619	Other MRT
621	Supplies Incident to Radiology
622	DressingsSupplies Incident to Other Diagnostic Services
622	Surgical Dressings
634*	Erythropoietin (EPO) less than 10,000 units
635*	Erythropoietin (EPO) 10,000 or more units
636	Pharmacy/Coded Drugs
637	Self-Administered Drugs (Effective 10/1/97)
	<u>Note:</u> Use code 637 exclusively to bill self-administered drugs not covered by Medicare for dually-eligible Medicare and Medicaid recipients. Code 637 must only be billed with the Total Charge 001 revenue code. Payment will be made for 637 only.
700	Cast Room/General
710	Recovery Room/General
721	Labor - Delivery Room/Labor
722*	Labor - Delivery Room/Delivery
730	EKG - ECG/General
731	EKG - ECG/Holter Monitor
732	Telemetry
739	Other EKG – ECG
740	EEG/General
749	Other EEG
750	Gastro-Intestinal Services/General
759	Other Gastro - Intestinal
761	Treatment Room
762	Observation Room
790*	Lithotripsy/General
821*	Hemodialysis Outpatient/Composite
831*	Peritoneal Dialysis Outpatient/Composite Rate
880*	Miscellaneous Dialysis/General
881*	Ultrafiltration
901*	Psychiatric/Psychological - Electroshock Treatment
914	Psychiatric/Psychological - Clinic Visit/Individual Therapy
918	Psychiatric/Testing (Effective 1/1/99)
	<u>Note:</u> Bill 513, psychiatric clinic, with this service,
920	Other Diagnostic Services/General
921	Other Diagnostic Services/Peripheral Vascular Lab
922	Other Diagnostic Services/Electromyelogram

- 924 Other Diagnostic Services/Allergy Test
- 943 Other Therapeutic Services/Cardiac Rehabilitation
- 944 Other Therapeutic Services/Drug Rehabilitation
- 945 Other Therapeutic Services/Alcohol Rehabilitation

*Exempt from \$1500 outpatient cap limit.

** Note: For current listing of covered outpatient revenue center codes, see the most recent version of the Florida Medicaid Hospital Services Coverage and Limitations Handbook incorporated by reference in Rule 59G-4.160, F.A.C.

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

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

	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>
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:

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

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

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

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

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

$$= 217.0$$

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

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

$$= 218.7$$

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

$$\text{September 1999 Index/May 1996 Index} = 297.6/218.7 = 1.3607$$

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

**APPENDIX C TO FLORIDA TITLE XIX OUTPATIENT HOSPITAL
REIMBURSEMENT PLAN**

Medicaid Trend Adjustment Percentages

	<u>Effective Date</u>	<u>Percentages</u>	<u>Reduction Amount</u>
1.	July 1, 2008		
	First Cut	3.141039%	\$16,796,807
	Second Cut	3.255973%	\$17,211,796
	Third Cut	7.05107%	\$36,403,451
2.	January 1, 2009		
	First Cut	3.096567%	\$16,796,807
	Second Cut	3.112936%	\$17,211,796
	Third Cut	6.744282%	\$36,403,451
3.	March 1, 2009		
	First Cut	3.096567%	\$16,796,807
	Second Cut	3.112936%	\$17,211,796
	Third Cut	6.744282%	\$36,403,451
	Fourth Cut	4.321883%	\$20,952,069
4.	July 1, 2009		
	First Cut	4.00442%	\$16,796,807
	Second Cut	3.190547%	\$17,211,796
	Third Cut	6.916628%	\$36,403,451
	Fourth Cut	4.347763%	\$19,384,437
	Fifth Cut	.0%	\$10,403,322
5.	July 1, 2010		
	First Cut	2.858132%	\$16,796,807
	Second Cut	2.656316%	\$17,211,796
	Third Cut	5.734510%	\$36,403,451
	Fourth Cut	3.548996%	\$19,384,437
	Fifth Cut	.0%	\$10,403,322
	Sixth Cut	.0%	\$54,791,389
6.	July 1, 2011		
	First Cut	2.239302%	\$16,796,807
	Second Cut	2.145548%	\$17,211,796
	Third Cut	4.613485%	\$36,403,451

Fourth Cut	2.817804%	\$19,384,437
Fifth Cut	0.000000%	\$10,403,322
Sixth Cut	0.000000%	\$54,791,389
Seventh Cut	12.519441%	\$99,864,555
7.1 Cut	0.000000%	\$3,886,602

7. July 1, 2012

First Cut	2.255726%	\$16,796,807
Second Cut	1.955169%	\$17,211,796
Third Cut	4.197916%	\$36,403,451
Fourth Cut	2.566436%	\$19,384,437
Fifth Cut	0.000000%	\$10,403,322
Sixth Cut	0.000000%	\$54,791,389
Seventh Cut	12.395520%	\$99,864,555
7.1 Cut	0.000000%	\$3,886,602
Eighth Cut	8.463575%	\$59,734,723

**APPENDIX D TO FLORIDA TITLE XIX OUTPATIENT 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

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 of the Social Security Act, with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19-B:

 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.

 Additional Other Provider-Preventable Conditions identified below (please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied.

The following method will be used to determine the related reduction in payments for Other Provider-Preventable Conditions which includes Never Events as defined by the National Coverage Determination:

- A. Dates of service beginning on or after May 1, 2012:
 - 1. The claims identified with a Present on Admission (POA) indicator of “Y” or “U” and provider-preventable conditions through the claims payment system will be reviewed.
 - 2. When the review of claims indicates an increase of payment to the provider for an identified provider-preventable condition, the amount for the provider-preventable condition will be excluded from the providers’ payment.
- B. No reduction in payment for a provider preventable condition 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.
- C. Reductions in provider payment may be limited to the extent that the following apply:
 - 1. The identified provider-preventable conditions would otherwise result in an increase in payment.
 - 2. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.
 - 3. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.
- D. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

APPENDIX E TO FLORIDA TITLE XIX OUTPATIENT HOSPITAL REIMBURSEMENT PLAN

UPPER PAYMENT LIMIT (UPL) METHODOLOGY

This document describes the methodology used by the Florida Agency for Health Care Administration (AHCA) for calculating the outpatient hospital upper payment limit (UPL) demonstration for Medicaid services. AHCA develops UPL demonstrations in accordance with UPL guidance set forth by the Centers for Medicare and Medicaid Services (CMS).

In general, the UPL analysis involves Medicare payment for a set of Medicaid claims and comparing those payments to actual payments made by Medicaid. Medicare payment can be estimated by re-pricing Medicaid claims using Medicare rules and rates, or by estimating hospital cost for the services identified on the claims. Hospital cost may be used as a proxy for Medicare payment.

Comparisons of Medicaid payments to the upper payment limits are made separately for hospital inpatient and outpatient services. Also, the comparisons are made for three categories of providers, 1) state owned; 2) non-state government owned; and 3) privately owned hospitals.

State Fiscal Year 2012/2013

The following text describes details of the UPL analysis for hospital outpatient services specifically for state fiscal year (SFY) 2012/2013 which covers dates July 1, 2012 through June 30, 2013.

Overview of UPL Method

Estimated Medicare payments which determine the upper payment limit were calculated using two different methods - one method for non-lab services and a second method for lab services.

For non-lab services, hospital outpatient costs were used as a proxy for the upper payment limit. The costs were calculated by applying each hospital's full cost outpatient per diem to each non-lab claim line item and summing those per diems for twelve (12) months of historical claim data for each hospital. Full cost per diems are calculated by AHCA annually as part of the outpatient rate setting process and are based on data included in Medicare cost reports, or in some cases, in Medicaid-specific cost reports filed by hospitals. The costs used to calculate these per diems exclude lab services because Florida Medicaid pays lab services via a fee schedule, not via the cost per diems.

Medicaid payments for non-lab services were calculated by applying each hospital's SFY 2012/2013 final outpatient per diem to the same twelve (12) months of historical claim data. Final Medicaid outpatient per diems differ from the full cost per diems because of a variety of rate cuts and rate ceilings which reduce the per diems and rate-cut buy-backs made by some hospitals which increase per diems. Each hospital's final Medicaid outpatient per diem is never more than the hospital's full cost per diem.

For lab services, the upper payment limit was calculated using the 2013 Medicare lab fee schedule. Medicaid payment was taken from the payment amounts on the claim lines.

Source of Hospital Cost Data

Full cost per diems used for the calculation of the upper payment limit were retrieved from AHCA per diem rate worksheets. The specific rate worksheets used for the SFY 2012/2013 UPL were those

calculated at the beginning of the SFY 2012/2013 for the purpose of defining the outpatient payment rates for claims with dates of service in SFY 2012/2013. Hospital cost reports used to set these rates were those received by AHCA by April 15th, 2012. In most cases, these were cost reports for hospital fiscal years ending in 2010 or 2011.

From the per diem rate worksheets, the specific cell used to retrieve the outpatient full cost per diems was in the outpatient column on row AG, which is labeled "Variable Cost Rate: Cost Divided by Medicaid Paid Claims (OP)." In addition, the actual per diems paid by Florida Medicaid, which were determined after applying rate ceilings and rate cuts to the full cost per diems, were retrieved from the outpatient column on row AY, which is labeled "Final Prospective Rates."

Full cost hospital outpatient per diems were calculated by AHCA using the following method:

1. All costs were summed from Worksheet C, Part I, column 1, lines 90 and 91(Outpatient Services Cost Centers).
2. The percentage of the hospital's business coming from outpatient services (versus inpatient services) was calculated using the following formula:

Percentage of business from outpatient services = [(Total outpatient revenue from Worksheet G-2 Parts I and II, column 2, line 28) minus (revenue from non-applicable services such as RHC, FQHC, Hospice, Home Health Agencies, and any other non-hospital services)] divided by [(Total overall revenue from Worksheet G-2 Parts I and II, column 3, line 28) minus (revenue from non-applicable services such as RHC, FQHC, Hospice, Home Health Agencies, and any other non-hospital services)]
3. All costs were summed from Worksheet C, Part I, column 1, lines 50 through 76 (Ancillary Services Cost Centers).
4. Costs identified in step 3 were multiplied by the outpatient percentage identified in step 2 to get the portion of these costs applicable to outpatient services.
5. Costs from steps 1 and 4 were summed.
6. Final outpatient costs were calculated as costs from step 5 minus Medicaid lab costs retrieved from the Title 19 version of Worksheet D, Part 5, column 6, lines 60 (Laboratory) and 61 (PBP Clinic Laboratory Services Prgm. Only).
7. The total number of non-lab claim lines per hospital was obtained from an extract of data out of the MMIS.
8. The non-lab full cost per diem was calculated as total non-lab costs, as determined in Step 6, divided by the total number of non-lab claim lines, as determined in Step 7.

Source of Medicaid Claim and Per Diem Data

Medicaid claims data used in this demonstration was extracted from a data warehouse fed from the Florida MMIS. For each hospital, claims were selected if they contained a first date of service within calendar year 2012, which is the most currently available full twelve months of claim data.

Initially, all in-state and out-of-state Florida hospitals with signed agreements to participate in the Florida Medicaid fee-for-service program, including Critical Access Hospitals (CAHs), were included in the

demonstration. However, a small number of hospitals dropped out of the analysis because they did not bill any Medicaid outpatient claims with date of service in calendar year 2012.

In addition, only Medicaid fee-for-service claims were included in the claims extract. Medicare crossover claims and Medicaid managed care encounter claims were excluded. Also, a step was executed to exclude claim lines for professional services. These were identified as lines with revenue code between "0960" and "0989." In the claim data used for this analysis, no claim lines were found containing a revenue code in this range. Lastly, all recipients eligible for Florida Medicaid were included, independent of place of residence. However, only services payable by Florida Medicaid were included, as only paid claim lines were included.

The Medicaid claim data was extracted using the following process:

- 1) Extracted claims data from a data warehouse that is fed from the MMIS.
 - a. Claims were selected using a single date range that extended from the earliest hospital cost report begin date to the latest hospital cost report end date.
 - b. Only claims with an outpatient claim indicator were selected. This excluded Medicare crossover claims. This criterion also excluded claims from RHCs, FQHCs, free-standing labs, hospice facilities, and home health agencies (all of which are assigned claim types other than outpatient).
- 2) Selected claims with a first date of service within calendar year 2012 – January 1, 2012 through December 31, 2012.

Calculation of Upper Payment Limit

For non-lab services, the upper payment limits for each of the three UPL categories were calculated using a cost comparison. Hospital cost, which was used as the Upper Payment Limit was calculated by applying the full cost per diem from the Medicaid rate worksheets to each non-lab claim line. The costs on each line were then summed to get total Medicaid outpatient non-lab costs per hospital. And the costs from each hospital were summed to get the total cost for each UPL category.

For lab service lines, the upper payment limit was estimated by multiplying billed units on claim lines times the Medicare lab fee schedule rate. Claim lines were identified as lab services if the revenue code was between "0300" and "0319," inclusive, and the procedure code was found in the 2013 or 2012 Medicare lab fee schedule. All other claim lines were considered to be non-lab services.

The full cost per diems retrieved from AHCA's per diem rate worksheets came from costs that were already trended forward from the hospital's fiscal year, as reported on the hospital's cost report, to the midpoint of SFY 2012/2013. Thus, no further inflation factor was applied.

Calculation of Medicaid Payment

For non-lab services, Medicaid payment was calculated by applying the hospital's SFY 2012/2013 Medicaid outpatient per diem to each claim line. The Medicaid payments on all claim lines were summed to get total Medicaid outpatient non-lab payments per hospital. And the Medicaid payments from each hospital were summed to get the total non-lab Medicaid payments for each UPL category.

The Medicaid per diems retrieved from AHCA's per diem rate worksheets were based on costs that were already trended forward from the hospital's fiscal year, as reported on the hospital's cost report, to the midpoint of SFY 2012/2013. Thus, no further inflation factor was applied.

Medicaid payments for lab services were calculated as the sum of the Medicaid payment amounts on the claim lines identified as lab services. As mentioned previously, claim lines were identified as lab services if the revenue code was between "0300" and "0319," inclusive, and the procedure code was found in the 2013 or 2012 Medicare lab fee schedule. All other claim lines were considered to be non-lab services. Medicaid lab payments were NOT trended forward because Florida Medicaid has not increased their lab fee schedule rates in the last few years.

There were no supplemental payments made outside the claim data applicable for this UPL demonstration. Also, no adjustments were made to estimate changes in Medicaid utilization between calendar year 2012 and state fiscal year 2012/2013. Similarly, no attempt was made to adjust Medicaid payments based on a prediction of future cost settlements resulting from audits of hospital cost reports.

Comparison of Medicaid Payment to Upper Payment Limit

Final comparison of Florida Medicaid payments to the upper payment limits was performed by grouping each provider into one of the three UPL categories and summing the dollar amounts for each provider within a UPL category. Hospitals were assigned to a UPL category based on a mapping of the thirteen provider categories included in the HCRIS data to the three UPL categories. This mapping is shown below:

Type	Control
Private	1='1 - Voluntary Nonprofit, Church'
	2='2 - Voluntary Nonprofit, Other'
	3='3 - Proprietary, Individual'
	4='4 - Proprietary, Corporation'
	5='5 - Proprietary, Partnership'
	6='6 - Proprietary, Other'
State owned	10='10 - Governmental, State'
Government owned, non-state	7='7 - Governmental, Federal'
	8='8 - Governmental, City-County'
	9='9 - Governmental, County'
	11='11 - Governmental, Hospital District'
	12='12 - Governmental, City'
	13='13 - Governmental, Other'

Out-of-state hospitals were all mapped to the "private hospital" UPL category.

Results of the outpatient UPL analysis include separate comparisons of lab services and non-lab services. In addition, a combined analysis was performed including all outpatient claims, lab and non-lab.

A spreadsheet with results of the Florida Medicaid outpatient UPL analysis included the following items:

- Medicaid claim extract data request
- Summary by UPL category combined for lab and non-lab services
- Summary by UPL category for non-lab services only
- Details by hospital for non-lab services only

- **Summary by UPL category for lab services only**
- **Details by hospital for lab services only**
- **Details for each unique combination of provider ID and lab procedure code (lab services only)**
- **SFY 2012/2013 non-lab cost-based per diems – both full cost per diem and Medicaid payment per diem**