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State/Territory Name: Florida

State Plan Amendment (SPA) #: 17-0008

This file contains the following documents in the order listed:

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

March 23, 2018

Ms. Beth Kidder
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

RE: Title XIX State Plan Amendment, FL 17-0008

Dear Ms. Kidder:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number FL 17-0008. The Request for Additional Information response was received in the Atlanta regional office on February 19, 2018. This SPA was initially submitted on September 25, 2017 with the stated purpose to update the Outpatient Hospital reimbursement methodology with rate adjustments approved during the 2017 Florida Legislative Session and includes technical and editorial changes.

Based on the information provided, the Medicaid State Plan Amendment FL 17-0008 was approved on March 22, 2018. The effective date of this amendment is July 1, 2017. We are enclosing the approved HCFA-179 and the plan pages.

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

Sincerely,

//s//

Charles Friedrich
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: 2017-008	2. STATE Florida
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2017	

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

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN x☐ 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: a. FFY 2016-2017 ($1,287) b. FFY 2017-2018 ($3,862) $
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:

To update the reimbursement rates for services in Outpatient Hospitals.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
x☐ OTHER, AS SPECIFIED:
Reviewed by the Deputy Secretary for Medicaid who is the Governor's designee.

12. SIGNATURE OF STATE AGENCY OFFICIAL: //s//	16. RETURN TO: Ms. Beth Kidder Deputy Secretary for Medicaid Agency Secretary for Medicaid 2727 Mahan Drive, Mail Stop #8 Tallahassee, FL 32308 Attention: Abigail Moody
13. TYPED NAME: Ms. Beth Kidder	
14. TITLE: Deputy Secretary for Medicaid	
15. DATE SUBMITTED:09/25/17	

17. DATE RECEIVED: 09/25/17	18. DATE APPROVED: 03/22/18
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/17	20. SIGNATURE OF REGIONAL OFFICIAL: //s//
21. TYPED NAME: Charles Friedrich	22. TITLE: Acting Associate Regional Administrator Division of Medicaid & Children Health Opns

23. REMARKS: Approved with the following change to block 8 and 9 as authorized by state on response dated 12/01/17.

Block number 8 changed to read: Attachment 4.19-B Exhibit I and 4.19-B page 33a

Block number 9 changed to read: Attachment 4.19-B Exhibit I and 4.19-B page 33a

METHODS USED IN ESTABLISHING PAYMENT RATES

7/1/2017

CLINIC SERVICES: Ambulatory Surgical Centers

Ambulatory surgical centers are reimbursed using the Enhanced Ambulatory Patient Grouping (EAPG) reimbursement methodology for hospital outpatient services as directed in section 409.905(6)(b), Florida Statutes. In addition, the defined methods are outlined in Attachment 4.19-B, Exhibit I (Florida Title XIX Outpatient Hospital Reimbursement Plan).

FLORIDA TITLE XIX OUTPATIENT HOSPITAL

REIMBURSEMENT PLAN

VERSION XXVIII

EFFECTIVE DATE: July 1, 2017

I. Purpose of the Plan

This Outpatient Hospital Reimbursement Plan establishes the methodology for calculating the line item reimbursement rates for covered Florida Medicaid outpatient hospital services. Other rates established for non-line item payments are referenced in the coverage policy. In addition, policy for coverage of Florida Medicaid outpatient hospital services is established in the Florida Medicaid Outpatient Hospital Services Coverage policy incorporated by reference in Rule 59G-4.160, F.A.C.

II. Standard

A. Each hospital participating in the Florida Medicaid program shall be paid based on a prospective payment system for outpatient services.

B. AHCA reserves the right to submit any provider found to be out of compliance with any of the policies and procedures regarding reimbursement to the Bureau of Medicaid Program Integrity for investigation.

C. AHCA shall implement a methodology for establishing base reimbursement rates for each hospital. The base reimbursement rate is defined in Section III of AHCA's Outpatient Hospital Reimbursement Plan. Rates shall be calculated annually and take effect July 1 of each year.

D. Any change in this Plan in this Section regarding Administrative Hearings is remedial in nature, confirms and clarifies existing law, and applies to all proceedings pending on or commenced after July 1, 2015.

E. Certain revenue codes are not reimbursed by Florida Medicaid. Service rendered under these codes shall not be recorded on the Florida Medicaid log and shall not be billed to Florida Medicaid. The list of covered revenue codes 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 Outpatient Hospital Services Coverage policy incorporated by reference in Rule 59G-4.160, F.A.C. Revenue code 510, Clinic/General is reimbursable by Florida Medicaid, in accordance with the most recent version of the Florida Medicaid Outpatient Hospital Services Coverage policy, 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.

III. EAPG Reimbursement

This section defines the methods used by the Florida Medicaid Program for reimbursement of hospital outpatient visits using a prospective payment system based on Enhanced Ambulatory Patient Groups (EAPGs), effective July 1, 2017. The EAPG payment methodology categorizes for purposes of calculating reimbursement the amount and type of outpatient services used in ambulatory visits by grouping together procedures, medications and materials that share similar characteristics and resource utilization. Each category is assigned an EAPG code and each EAPG code is assigned a relative weight used in calculating payment. EAPG grouping and payment is used for all services and items furnished during an outpatient visit, unless otherwise specified in this plan.

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.

A. Applicability

AHCA calculates reimbursement for hospital outpatient visits using an EAPG-based methodology. This methodology applies to all in-state and out-of-state general acute care hospitals, rural hospitals, children's specialty hospitals, teaching hospitals, cancer specialty hospitals, rehabilitation specialty

hospitals, long term acute care specialty hospitals, critical access hospitals, and state-owned psychiatric specialty hospitals.

For hospitals reimbursed via the EAPG-based methodology, all outpatient services provided at these facilities and billed on a UB-04 paper claim form or an 837I electronic claim are covered by the EAPG payment with the following exceptions – services covered under the transplant global fee are reimbursed as described in section VIII.1 of Attachment 4.19-A and vagus nerve stimulators are reimbursed as described in Attachment 4.19-B.

B. EAPG Codes and Relative Weights

1. AHCA utilizes Enhanced Ambulatory Patient Groups (EAPGs) created by 3M Health Information Systems (HIS) for assigning classifications to services and materials identified on outpatient claims.
2. The EAPG relative weights utilized are national EAPG relative weights calculated by 3M HIS using a database containing millions of hospital outpatient visits. The relative weights are available on the AHCA website at,

   http://ahca.myflorida.com/medicaid/cost_reim/hospital_rates.shtml
3. EAPG version 3.12 codes and national relative weights are being used for hospital outpatient pricing in SFY 2017-2018.

C. Hospital Base Rate

1. One standardized EAPG hospital base rate is calculated using historical claims data.

   For State Fiscal Year (SFY) 2017-2018, some hospitals receive the standardized base rate and other hospitals receive a base rate that is higher or lower than the standardized base rate. Each hospital's base rate is determined so that their modeled change in annual Medicaid reimbursement resulting from the shift from cost-based per-service rates to EAPG rates is no greater than five percent (changes in automatic rate enhancement distributions in SFY 2017-2018 are unrelated to the shift to EAPG pricing and are not included in the EAPG base rate adjustments). A hospital is given an EAPG base rate for SFY 2017-2018 that is less than the standardized base rate if the

hospital's Medicaid outpatient reimbursement estimated when using the standardized EAPG base rate is more than five percent above reimbursement estimated using SFY 2016-2017 cost-based per-service rates. The reduced base rate limits the hospital's projected gains from the shift to EAPG payment. Similarly, a hospital is given an EAPG base rate for SFY 2017-2018 that is greater than the standardized base rate if the hospital's Medicaid outpatient reimbursement estimated when using the standardized EAPG base rate is more than five percent below reimbursement estimated using SFY 2016-2017 cost-based per-service rates. The increased base rate limits the hospital's projected losses from the shift to EAPG payment. The estimates of hospital-specific change in Medicaid outpatient reimbursement used in setting SFY 2017-2018 EAPG base rates exclude automatic rate enhancements. Because of this exclusion, a hospital's overall estimated decrease in Medicaid outpatient reimbursement may be greater than five percent. The hospital EAPG base rates are available on the AHCA website at http://ahca.myflorida.com/medicaid/cost_reim/hospital_rates.shtml.

2. Base rates and other EAPG pricing methodology parameters are established by AHCA to achieve budget neutrality, and to be compliant with federal upper payment limit requirements.
3. EAPG base rates and projected changes in hospital Medicaid outpatient reimbursement are calculated using historical claims data from a twelve-month period, referred to as the "base year". Because of Florida Medicaid's implementation of statewide mandatory Medicaid managed care, the base year historical claims dataset includes claims from both the fee-for-service and managed care programs. In general, claim data from the base year is used to simulate future outpatient Medicaid claim payments for the purpose of setting the EAPG base rates and other EAPG provider policy adjustors. The claim payments from the base year may be adjusted for Medicaid volume, inflation, changes in payment method, and other program changes as applicable so that the base year data approximates the upcoming rate year as closely as possible. For SFY 2017-2018 rate setting, some procedure codes and EAPG codes were added to claim service lines in the base year historical claims dataset to approximate anticipated changes in hospital billing practices

once EAPG payment is implemented. Under the EAPG payment method, service line procedure code is the primary data element used in determining the EAPG code and relative weight. However, procedure code is not required for most types of services under the cost-based payment method used in SFY 2016-2017.

4. Annual Updates:
    a. Base year historical claims used to calculate the EAPG base rate had a claim header level first date of service between April 1, 2015 and March 31, 2016.
    b. Total outpatient reimbursement amount used to ensure budget neutrality was the sum of per-service and laboratory fee schedule payments applied to the base year claims using SFY 2016-2017 Florida Medicaid rates and pricing rules and then adjusted based on Legislative direction for SFY 2017-2018. The only budgetary adjustment applied for SFY 2017-2018 that had an affect on the EAPG base rate was a shift of $17. 3 million out of hospital outpatient claim payments and into supplemental graduate medical education payments.
    c. The EAPG base rate was calculated with an assumption that overall Florida Medicaid outpatient case mix will increase by two (2) percent above the case mix measured on claims in the base year. Case mix was predicted to increase by two (2) percent because of appropriate changes in hospital billing practices necessary to achieve appropriate reimbursement under the EAPG payment method. The result of these assumptions was a reduction of the standardized EAPG base rate by about two (2) percent over what would be calculated if case mix was assumed to be unchanged.

D. Per Service Rate Enhancement Payments

1. A per-payable-service rate enhancement called an “automatic rate enhancement” is applied to each payable claim line for hospital outpatient services.
2. An annual allocation of automatic rate enhancement payments are identified for each qualifying hospital in the Medicaid Hospital Funding Program Fiscal Year Final Conference Report, which is part of the General Appropriations Act determined by the Florida Legislature. Separate

allocations are made for hospital inpatient and hospital outpatient services. These allocations are included in the provider rate worksheets available on the AHCA website at http://ahca.myflorida.com/medicaid/cost_reim/hospital_rates.shtml.

3. For each hospital receiving automatic rate enhancements, a per-payable-service-line payment amount is calculated by dividing the full, annual allotment by the number of Medicaid outpatient payable service lines in the base year for both the fee-for-service and managed care programs.
4. Only a portion of the annual allotment is distributed through fee-for-service claims. The rest is included in managed care capitation rates and is to be distributed by managed care plans through their claim payments.
5. Claim service lines that receive a bundled EAPG payment will still receive an automatic rate enhancement payment.
6. Claim service lines adjudicated after a recipient reaches his/her annual hospital outpatient benefit limit will have the automatic rate enhancement payment set to $0.
7. Claim service lines that receive a status of "Denied" will have the automatic rate enhancement payment set to $0.

E. Policy Adjustors

1. Policy adjustors are numerical multipliers included in the EAPG claim service line payment calculation that allow AHCA to increase or decrease payments to categories of services and/or categories of providers.
2. Only one policy adjustor, a provider policy adjustor, has been built into the EAPG-based payment method and is applied to two categories of hospitals – rural hospitals and hospitals with very high Medicaid outpatient utilization.
    a. Rural hospitals are identified in section 395.602, F.S.
    b. High Medicaid outpatient utilization hospitals are those who have 55 percent or more of their total annual outpatient charges resulting from care provided to Medicaid recipients.

c. All other hospitals receive a provider policy adjustor of 1.0, which generates no payment adjustment.

F. EAPG Service Line Payment Adjustments

1. Under the EAPG payment methodology some claim service lines will pay in full, in which case the Payment Adjustment Factor gets set to 1.0.
2. Other lines may bundle indicating that payment for these lines is included in payment for other lines on the claim. For bundled lines, the Payment Adjustment Factor gets set to zero.
3. Still other service lines on the claim may pay at a discounted rate. For all except bilateral services, the Payment Adjustment Factor gets set to 0.50 on discounting claim lines. For bilateral procedures, the Payment Adjustment Factor gets set to 1.50.

G. Recipient Annual Benefit Limit

1. Reimbursement for hospital outpatient care to adults is limited to $1,500 per state fiscal year per recipient.
2. Exempt from this annual limit are Medicaid recipients under the age of 21, renal dialysis services, and any other services identified by the Agency.
3. The $1,500 annual benefit limit is applied only to services provided to recipients enrolled in the Medicaid fee-for-service program.

H. EAPG Payment Calculation

1. <u>EAPG Payment:</u>

   a. EAPG Base Payment is calculated with the following formula:

   EAPG Payment = Hospital Base Rate * EAPG Relative Weight * Policy Adjustor
   * Payment Adjustment Factor

   b. Claim service line allowed amount is calculated with the following formula:

   Line Item Allowed Amount = (EAPG Payment + Automatic Rate Enhancement)
   - Reduction for Annual Benefit Limit

i. If the recipient's annual hospital outpatient reimbursement has exceeded the limit then the "Reduction for Annual Benefit Limit" will be set equal to (EAPG Payment + Automatic Rate Enhancement) so that the Medicaid allowed amount is $0.

ii. If the sum of (EAPG Payment + Automatic Rate Enhancement) on the service line being processed is an amount that will put the recipient over his/her annual benefit limit, then the value for field "Reduction for Annual Benefit Limit" will get set so that the Medicaid allowed amount on the claim service line is enough to set total hospital outpatient reimbursement to the limit for the recipient.

2. Charge cap: No charge cap will be applied under the EAPG payment method. Thus, the full EAPG payment will be applied even if the Medicaid allowed amount is greater than the submitted charges on an individual service line or overall for the outpatient claim.

3. Third party liability: EAPG reimbursement 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 Florida Medicaid benefit period.

I. Cost Settlement

Hospitals reimbursed using the EAPG-based outpatient prospective payment method are not subject to retrospective cost settlement.

J. Frequency of EAPG Payment Parameter Updates

1. New versions of EAPGs are released annually and include a new set of relative weights and average lengths of stay. AHCA will install a new version of EAPGs no more frequently than once per year and no less frequently than once every two years. Installation of new versions of EAPGs and associated relative weights will occur at the beginning of a state fiscal year and will coincide with a recalculation of hospital base rates and EAPG policy adjustors. When installing new versions of EAPG codes and relative weights, AHCA will install the most current version that is available at the time the annual rate setting process is performed.

2. New hospital base rates are calculated annually based on the most currently available historical claim data and become effective at the beginning of each state fiscal year.
3. The annual allocation of automatic rate enhancements is reset each year and becomes effective at the beginning of each state fiscal year.
4. Per-payable-service automatic rate enhancement amounts are re-calculated and become effective at the beginning of the state fiscal year. The volume of payable Medicaid outpatient service lines used in the calculation of the per-service amount is determined using the same historical claim dataset used for calculation of hospital base rates.
5. New values for the policy adjustors are calculated annually and become effective at the beginning of each state fiscal year.

IV. Medicare Crossover Pricing

A. Crossover claims are claims for services provided to recipients who are dually eligible for Medicare and Medicaid. Medicare reviews and pays for the medical services before Medicaid as Medicaid is the payer of last resort. If Medicare considered the claim payable and reduced payment because of coinsurance or patient deductible, then a crossover claim may be submitted to Medicaid for consideration of additional payment.

B. Medicaid's financial obligation for reimbursement on the Medicare crossover claims is based on the Medicare allowable amount, not on the provider's billed charges.

C. Medicaid pays the lower of:

- A calculated coinsurance equal to [Medicare Paid Amount / 0.78] * 20%
- The Medicare coinsurance plus deductible as reported on the claim, versus
- [Medicaid allowed amount] minus [Medicare payment amount].

D. If the Medicare payment amount is equal to or greater than the Medicaid allowed amount, then Medicaid reimbursement will be zero.

E. For hospital outpatient Medicare crossover claims, the Medicaid allowed amount will be determined using the EAPG pricing methodology.

V. Payment Assurance

The State shall pay each hospital for services provided in accordance with the requirements of the most recent version of the Florida Title XIX Outpatient Hospital Reimbursement 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.

VI. Provider Participation

This plan is designed to assure adequate participation of hospitals in the Florida 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.

VII. Revisions

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

VIII. Payment in Full

Participation in the Program shall be limited to hospitals of service which accept as payment in full for covered services the amount paid in accordance with the most recent version of the state plan.

IX. Glossary

A. Adjusted patient days - The sum of acute care patient days and intensive care patient days as reported to AHCA divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues

B. AHCA - Agency for Health Care Administration.

C. Automatic Rate Enhancement – A per-payable service rate enhancement applied to each payable claim line.

D. Base rate - A hospital's reimbursement rate assigned to each hospital that is multiplied by an EAPG relative weight and policy adjustor in the calculation of the EAPG base payment.

E. Benefit period - The period of time where medical benefits for services covered by the Florida Medicaid program, with certain specified maximum limitations, are available to the Florida Medicaid beneficiary.

F. EAPGs - Enhanced Ambulatory Patient Groups

G. Eligible Florida Medicaid recipient - "Recipient" or "Florida Medicaid recipient" means any individual whom the Florida Department of Children and Families, or the SSA on behalf of AHCA, 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 Florida Medicaid program and is enrolled in the Florida Medicaid program. For the purposes of determining third party liability, the term includes an individual formerly determined to be eligible for Florida Medicaid, an individual who has received medical assistance under the Florida Medicaid program, or an individual on whose behalf Florida Medicaid has become obligated.

H. Florida Medicaid log - A schedule to be maintained by a hospital listing each Florida 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 codes.

I. Florida Medicaid outpatient charges – the hospital's usual and customary charges for outpatient services rendered to patients excluding charges for laboratory and pathology services. These charges shall be the allowable charges as reconciled with the hospital Florida Medicaid log and found on the Florida Medicaid paid claims report.

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

K. HHS - Department of Health and Human Services.

L. CMS PUB. 15-1 - Health Insurance Manual No. 15, also known as the Provider Reimbursement

Manual, as incorporated by reference in Rule 59G-6.031, F.A.C.

M. Non-covered services - Those goods and services which are not medically necessary for the care and treatment of outpatients.

N. 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.

O. Rate semester - The rate semester begins on July 1 and runs through June 30.

P. Rural hospital - An acute care hospital licensed under Chapter 395, F.S., 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.
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.
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 Florida 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 Transparency at AHCA.

6. A hospital designated as a critical access hospital, as defined in s. 408.07 F.S. 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 F.S. 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, 2021, if the hospital continues to have up to 100 licensed beds and an emergency room. 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 AHCA.
7. A hospital that was licensed to continue to be a rural hospital during fiscal year 2010-2011 or 2011-2012 shall continue to be a rural hospital from the date of designation through June 30, 2021, if the hospital continues to have up to 100 licensed beds and an emergency room.

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

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

S. Title XVIII - Health Insurance for the Aged, Blind or Disabled (Medicare) as provided for in the SSA, certified in 42 United States Code (U.S.C.) 1395-1395(xx).

T. Title XIX - Grants to States for medical assistance programs (Medicaid) as provided for in the SSA, certified in 42 U.S.C. 1396-1396(p).

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

Amendment: 2017-008
Effective Date: July 1, 2017
Supersedes: 2016-034
Approval Date: 03/22/18

APPENDIX A TO FLORIDA TITLE XIX OUTPATIENT HOSPITAL REIMBURSEMENT PLAN

OUTPATIENT REVENUE CODES**

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

340	Nuclear Medicine/General
341	Nuclear Medicine/Diagnostic
342	Nuclear Medicine/Therapeutic
343	Diagnostic Radiopharmaceuticals
344	Therapeutic Radiopharmaceuticals
349	Other Nuclear Medicine
350	Computed Tomographic (CT) Scan/General
351	Computed Tomographic (CT) Scan/Head
352	Computed Tomographic (CT) Scan/Body
359	Other CT Scans
360*	Operating Room Services/General
361*	Operating Room Services/Minor Surgery
362*	Operating Room Services/Bone Marrow Transplant
369*	Other Operating Room Services
370	Anesthesia/General
371	Anesthesia Incident to Radiology
372	Anesthesia Incident to Other Diagnostic Services
379	Other Anesthesia
380	Blood/General
381	Blood/Packed Red Cells
382	Blood/Whole
383	Blood/Plasma
384	Blood/Platelets
385	Blood/Leucocytes
386	Blood/Other Components
387	Blood/Other Derivatives
389	Other Blood
390	Blood Storage and Processing/General
391	Blood Storage and Processing/Administration
399	Other Processing and Storage
400	Imaging Services/General
401	Imaging Services/Mammography
402	Imaging Services/Ultrasound
403	Screening Mammography
404	Positron Emission Tomography
409	Other Imaging Services
410	Respiratory Services/General (All Ages)
412	Respiratory Services/Inhalation (All Ages)
413	Respiratory Services/Hyperbaric Oxygen Therapy (All Ages)
419	Other Respiratory Services
421	Physical Therapy/Visit Charge (All Ages)
424	Physical Therapy/Evaluation or Re-evaluation (All Ages)
431	Occupational Therapy/Visit Charge (Under 21 only)
434	Occupation Therapy/Evaluation or Re-evaluation (Under 21)
441	Speech-Language Pathology/Visit Charge (Under 21 only)
444	Speech-Language Pathology/Evaluation or Re-evaluation (Under 21)
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
Note: 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 Dressings Supplies Incident to Other Diagnostic Services
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
Note: Use code 637 exclusively to bill self-administered drugs not covered by Medicare for dually-eligible Medicare and Medicaid recipients. Code 637 must only be billed with the Total Charge 001 revenue code. Payment will be made for 637 only.
700 Cast Room/General
710 Recovery Room/General
721 Labor - Delivery Room/Labor
722* Labor - Delivery Room/Delivery
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
820* OPH-Hemodialysis/General
821* Hemodialysis Outpatient/Composite
824* Hemodialysis-Maintenance 100%
829* OPH-Hemodialysis/Other
831* Peritoneal Dialysis Outpatient/Composite Rate
834* Peritoneal Dialysis-Maintenance 100%
839* OPH-Peritoneal Dialysis/Other

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840*	Continuous Capo General
841*	CAPD Composite or Other Rate
844*	CAPD OP/Home-Maintenance 100%
849*	CAPD/Other
850*	Continuous Cycling Dialysis CCPD General
851*	CCPD Composite or Other Rate
854*	CCPD OP/Home-Maintenance 100%
859*	CCPD/Other
880*	Miscellaneous Dialysis/General
881*	Ultrafiltration
901*	Psychiatric/Psychological - Electroshock Treatment
914	Psychiatric/Psychological - Clinic Visit/Individual Therapy
918	Psychiatric/Testing
	Note: Bill 513, psychiatric clinic, with this service,
920	Other Diagnostic Services/General
921	Other Diagnostic Services/Peripheral Vascular Lab
922	Other Diagnostic Services/Electromyelgram
924	Other Diagnostic Services/Allergy Test
943	Other Therapeutic Services/Cardiac Rehabilitation
944	Other Therapeutic Services/Drug Rehabilitation
945	Other Therapeutic Services/Alcohol Rehabilitation

*Exempt from $1500 outpatient cap limit.

APPENDIX B TO FLORIDA TITLE XIX OUTPATIENT HOSPITAL
REIMBURSEMENT PLAN

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 Florida 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 C TO FLORIDA TITLE XIX OUTPATIENT HOSPITAL REIMBURSEMENT PLAN

UPPER PAYMENT LIMIT (UPL) METHODOLOGY

Overview of UPL Analyses

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 Florida Medicaid services. AHCA develops UPL demonstrations in accordance with UPL guidance set forth by the Centers for Medicare and Medicaid Services (CMS). Effective AHCA's SFY 2017-2018 conversion to hospital outpatient payment based on Enhanced Ambulatory Patient Groupings (EAPGs), the hospital outpatient UPL includes all services billed on hospital outpatient claims, including clinical diagnostic lab services.

In general, the UPL analysis involves estimating 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.

The claim data used in a UPL analysis is historical data, usually from a twelve (12) month period. The period for which claims are selected is referred to as the "base" year. The UPL analysis is performed for a specific state fiscal year referred to as the "rate" year. Often the rate year is a current or present-day timeframe. In contrast, the base year is a timeframe in the past because the data needed for a UPL analysis, hospital cost reports and billed claims, are only available for services performed in the past. For example, the UPL analysis for state fiscal year 2017/2018 (the "rate" year) was performed at the beginning of the fiscal year – September 2017. That UPL analysis could not utilize claim data from state fiscal year 2017/2018 (7/1/2017 – 6/30/2018) because the year was not yet complete. Instead, historical claim data that had been received and processed prior to September 2017 was used for the analysis.

Comparisons of Florida 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.

Florida Medicaid Hospital Outpatient UPL Analysis Method

Estimated Medicare payments are calculated using hospital outpatient costs as a proxy for the upper payment limit. The costs are calculated by multiplying each hospital's outpatient cost-to-charge ratio times each claim service line's submitted charge, and summing the resulting estimated hospital cost for all claims in the base-year dataset. The costs are then inflated to the midpoint of the UPL rate year. Historical claim data used for this modelling contain dates of service that were within the cost report timeframes of the most recently available Medicare cost report for each hospital.

Medicaid payments are calculated by applying EAPG pricing using UPL rate year payment rules and parameters to the same twelve (12) months of historical claim data as used for the cost calculations.

Source of Hospital Cost Data

Hospital cost data is retrieved from the most currently available hospital Medicare cost report in the Healthcare Cost Report Information System (HCRIS) at the time the UPL analysis is performed. From these cost reports, an outpatient cost-to-charge ratio (CCR) is calculated using the cost and charge information in Worksheet C Part I for all ancillary cost centers. Specifically, costs and charges are retrieved from cost centers in the following ranges:

'05000' through '07699'
'09000' through '09399'
'09600' through '09999'

For each of these cost centers, total hospital costs are retrieved from column 5 and total hospital charges are retrieved from column 8. For each hospital, the costs and charges are summed and then an outpatient CCR is calculated as (total ancillary cost center cost) divided by (total ancillary cost center charges).

Source of Medicaid Pricing Parameters and Claim Data

EAPG pricing parameters for the UPL rate year are retrieved from the "EAPG Calculator" published by AHCA for the rate year. EAPG rates are updated annually and become effective on the first day of each state fiscal year.

Medicaid claims data used in UPL demonstrations is extracted from a data warehouse fed from the Florida MMIS. For each hospital, claims are selected if they contain a first date of service within the base year. The base year is the timeframe on the most currently available Medicare cost report filed by each hospital.

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), are included in the demonstration. However, a small number of hospitals drop out of the analysis because they did not bill any Medicaid outpatient claims with date of service in the UPL base year.

In addition, only Medicaid fee-for-service claims are included in the claims extract. Medicare crossover claims and Medicaid managed care encounter claims are excluded. Also, all professional services are excluded. Professional services are identified as claim lines with revenue code between "0960" and "0989." Lastly, all recipients eligible for Florida Medicaid are included, independent of place of residence. However, only services payable by Florida Medicaid are included, as only paid claim lines are included.

Calculation of Upper Payment Limit

The upper payment limits for each of the three UPL categories are calculated using an estimate of hospital cost. Hospital cost is calculated by multiplying a hospital-specific cost-to-charge ratio times the billed charges on each claim line. The costs on each line are then summed to get total Medicaid outpatient costs per hospital. And the costs from each hospital are summed to get the total cost for each UPL category.

The costs are inflated forward from the mid-point of the base year (the hospital's cost report year) to the mid-point of the UPL rate year.

Calculation of Medicaid Payment

Medicaid payment is calculated using the UPL rate year EAPG-based payment rules and payment parameters. Claims in the dataset are re-priced using these parameters. Because these parameters are applicable to the UPL rate year, there is no need to apply a forward trending to the claim payments.

Non-Claim Payments and other Adjustments to Medicaid Payment
There are no supplemental payments made outside the claim data applicable for hospital outpatient services, so Medicaid payment is determined using only payments on claims. Also, no adjustments are made to estimate changes in Medicaid utilization between the base year and the UPL rate year. Similarly, no attempt is made to adjust Medicaid payments based on a prediction of future cost settlements resulting from audits of hospital cost reports as there are no cost settlements performed for claims paid via the EAPG-based method.

Comparison of Medicaid Payment to Upper Payment Limit

Final comparison of Florida Medicaid payments to the upper payment limits is 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 are assigned to a UPL category based on a mapping of the thirteen provider categories included in the HCRIS data (electronic version of Medicare cost report 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'

All out-of-state hospitals get mapped to the “private hospital” UPL category independent of their provider category listed in the HCRIS data.

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