Outpatient Prospective Payment System Design for Florida Medicaid

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1 Introduction

This document describes a recommended design for an Outpatient Prospective Payment System (OPPS) to meet the needs of the Florida Medicaid program. Florida Medicaid currently reimburses hospital outpatient services using hospital specific cost-based rates which pay a flat rate referred to as a "per diem" to each payable revenue code submitted on an outpatient claim. Hospital outpatient payments are then cost settled based on audited cost reports and retrospectively adjusted a few years after payments were made for outpatient medical care provided to Medicaid fee-for-service recipients.

The study and design of an OPPS for Florida Medicaid was authorized by the Florida Legislature during the 2015 Legislative Session. Specific language in the General Appropriations Act regarding this study is,

> "From the funds in Specific Appropriation 181, $500,000 in nonrecurring funds from the Medical Care Trust Fund is provided to the Agency for Health Care Administration to contract with an independent consultant to develop a plan to convert Medicaid payments for outpatient services from a cost based reimbursement methodology to a prospective payment system. The study shall identify steps necessary for the transition to be completed in a budget neutral manner. The report shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than November 30, 2015."[1]

The Florida Agency for Health Care Administration (AHCA), which administers the Medicaid program in Florida, contracted with Navigant Consulting, Inc. (Navigant) to perform this study and author this report.

During the time period of July through November 2015, Navigant and AHCA collaborated in the design of an OPPS that will allow the Agency to shift away from cost-based rates and the current retrospective cost settlement process. This effort included five meetings between Navigant and an Agency Governance Committee comprised of AHCA management staff. In addition, four public meetings were held during this timeframe to communicate to, and solicit feedback from, the medical provider community regarding the proposed new OPPS.

Recommendations for the new OPPS were determined based on the guiding principles described in Chapter 2 of this report. In addition, historical outpatient claim data was used to model options for the new prospective payment system, and many options selected for the payment method were based on results of these models. Chapter 3 includes a detailed description of the historical claims dataset and the data processing performed to model a new OPPS for Florida Medicaid. This is followed by Chapter 4, which describes outpatient prospective payment systems and compares the two most commonly used categorization schemes for OPPSs, Enhanced Ambulatory Patient Groupings (EAPGs) and Ambulatory Patient

[1] The Florida State Senate Bill No. 2500-A; Chapter 2015-232.

Classifications (APCs). Subsequent chapters, 5 through 14, describe options available within an OPPS payment method, which Navigant refers to as "payment policy options." Included in each of these chapters is a discussion of the option and a recommendation for the Florida Medicaid OPPS. Chapter 15 offers more detail explaining concerns about the impact of the new OPPS on the 340B Drug Pricing Program, and Chapter 16 discusses potential timing for implementation. Following this text, Appendix A in this document summarizes the policy recommendations in a concise table. Finally, a few additional appendices are included which contain data tables and figures that compare payments under the current method to payments under the proposed new method.

2 Evaluating an Outpatient Prospective Payment Method

Developing a Medicaid outpatient payment method requires balancing a variety of trade-offs and competing priorities. Payment methods have an impact on beneficiaries, medical providers, taxpayers, and program administrators, each with their own point of view on what makes a payment method successful. To balance the priorities of these different stakeholders, it is helpful to establish a set of guiding principles that describe the goals of the payment method and offer a structure against which various system design options can be evaluated. The list below offers a series of guiding principles and discusses how these principles can affect an outpatient payment method.

- **Efficiency.** A payment method should be consistent with promoting provider efficiency, rewarding providers that increase efficiency while continuing to provide quality care. To enable this, the payment method should minimize reliance on individual provider charges or costs, and create opportunities for providers to increase margins by more effectively managing resources. For example, in the design of an OPPS payment system, selecting a single standardized base rate can create incentives for providers to better manage their resources to achieve improved margins. Conversely, establishing facility-specific base rates that fluctuate annually with increases or decreases in facility-specific costs would provide little incentive for cost effectiveness.

- **Access.** A payment method should promote beneficiary access to care. This guiding principle is consistent with the requirements specified in federal regulation. In the State Plan for Medical Assistance (State Plan), AHCA must make certain assurances to the federal Centers for Medicare and Medicaid Services (CMS) with respect to its level of payments to Medicaid providers. In particular, the State Plan must:

  > "… provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan … as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care ***and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are***

available to the general population in the geographic area[.]" 42 U.S.C. § 1396a(a)(30)(A) ("Section 30(A)") (emphasis added).

Within an outpatient payment method, policy adjustors, provider peer groups (used for setting base rates), and outlier payment parameters are items that can be adjusted to affect access to care.

» **Equity.** A payment method should generate fair payments both across providers and across types of care. Generally, providers should be paid similar amounts for the same services, with the potential exception being when there are necessary and measurable differences in the costs associated with those similar services. Within an OPPS utilizing either EAPGs or APCs, the payment amount for an individual outpatient service is calculated by multiplying a provider base price times an EAPG or APC relative weight. Both types of relative weights are determined using average costs from many providers, so the relative weights help ensure similar payment for similar services, independent of where those services are provided. If adjustments do need to be made for reasonable, measurable differences in provider cost structures, those can be made through modifications to the provider base price via rate adjustments (for example, wage area adjustments) and/or provider peer groupings (for example, giving specialty children's hospitals a separate base rate than other hospitals or giving Ambulatory Surgical Centers (ASCs) a separate base rate than hospitals).

» **Predictability.** A payment method should generate stable, predictable payments. Both the state Medicaid agency and providers have to manage their budgets, and that can best be facilitated through a payment method which generates consistent, predictable reimbursements. OPPS payment methods are predictable if patient acuity and volume are understood.

» **Transparency.** A payment method that is transparent promotes trust from provider administrators, clinicians, legislators, and Medicaid program administrators. An OPPS payment method can be made transparent by selecting a grouping algorithm that is openly documented, and by making relative weights, provider base rates, and pricing logic publicly available.

» **Simplicity.** A payment method that is relatively simple will be easier to implement, easier for provider organizations to understand, and easier to administer and maintain. For a Medicaid program, implementing a new OPPS will require significant MMIS changes, regulation changes, and program monitoring changes. For providers, a change in payment method may impact medical coding practices, billing procedures, and internal information systems. The complexity of these changes is limited if the payment method is kept relatively simple. At the same time, over-simplifying the payment method may negatively impact payment equity and, in turn, negatively impact access to care.

» **Quality.** It is generally known that it is a mission of all healthcare providers to offer high quality care. Payment methods should be consistent with promoting quality care where possible. In truth, very few payment methods specifically reward quality. Most payment methods, including most outpatient payment methods, pay the same independent of whether high quality care is provided. At the same time, some payment components, such as outlier payment parameters, can contribute to (or detract from) facilitating the effective use of provider resources in a way that is consistent with the provider's mission to provide high quality care.

From a logistical point of view, a payment method is a framework or structure created to determine reimbursement for medical services and supplies. The structure includes organization of data, numerical formulas, and specific parameters or values used in the formulas. This structure should be carefully developed as it controls the distribution of large amounts of state and federal funding, and is intended to meet the needs of people and organizations with competing priorities. The guiding principles presented above can be helpful in evaluating various options for the payment structure so that the final design best meets the needs of beneficiaries, providers, taxpayers and program administrators.

3 OPPS Payment Modeling

3.1 Dataset Description

Modeling of a new payment method is generally performed using historical claim data. For this study, the dataset used included claims from State Fiscal Year (SFY) 2013/14 – that is, claims with first date of service between July 1, 2013 and June 30, 2014. The claim data included services provided to recipients in both the fee-for-service program and Medicaid managed care program. Given this time frame, the managed care encounter claims came from both Medicaid managed care plans defined for the five pilot counties prior to implementation of the Managed Medical Assistance (MMA) program, and from MMA plans.[2] Also, Medicare crossover claims were excluded from the dataset as were claims denied for payment. Lastly, in cases where claims were adjusted, only the final claim in each "adjustment chain" was included.

Claims included in the final dataset were from both hospitals (provider types "01" and "04") and from Ambulatory Surgical Centers (ASCs) (provider type "06"). The hospital claims included were submitted on an institutional claim form (837I or UB-04) and had an outpatient type of bill. The ASC claims were submitted on a professional claim form (837P or CMS-1500). In total there were 4,794,891 outpatient hospital claims with 21,724,655 claim lines and 63,453 ASC claims with 99,979 claim lines. Thus, the initial dataset included 4,858,344 claims and 21,824,634 claim lines prior to manipulation by Navigant.

[2] The Managed Medical Assistance (MMA) program was implemented over a four month period beginning on May 1, 2014 and completing on August 1, 2014. Each month during that timeframe, Medicaid recipients in a few of the 11 regions defined within the State were migrated to an MMA plan. As of August 1, 2014, all 11 regions had been migrated to MMA.

During the outpatient claims analysis, 19 hospitals were identified as having a high percentage of claim lines without procedure codes. These 19 hospitals and all claim lines associated with them were removed from the dataset and not included in any EAPG modeling. (Please see section 3.3 for more information regarding removal of all data from specific hospitals.) In addition, claims were removed from the modeling dataset in cases where every line on the claim received an error EAPG (equal to 999) even after all attempts by Navigant to manually assign a procedure code or EAPG to claim lines. (Please see section 3.4 for more information regarding Navigant's efforts to assign procedure codes and EAPG codes to claim service lines submitted without a procedure code.) In total, 605,974 claims and 2,381,425 claim lines were excluded either because of an insufficient total percentage of procedure codes submitted by the hospital, or because no valid EAPG codes were assigned to the claim.

In addition, 28,895 claim lines were added to the dataset in order to more accurately assign EAPG codes on claims for observation services. The final EAPG dataset includes 19,472,104 claim lines representing 4,252,370 claims. All of these removals and additions of claims is summarized in Table 1.

Table 1. Claim dataset build summary.

Description	Claims	Claim Lines	Submitted Charges	Basline Payment Amount GR/PMATF	Baseline Auto Rate Enhancements	Basline Payment Total
Hospitals - SFY 2013/14	4,794,891	21,724,655	$ 13,048,656,330	$ 1,248,916,963	$ 133,997,697	$ 1,382,914,659
Ambulatory Surgery Centers - SFY 2013/14	63,453	99,979	$ 230,088,766	$ 35,658,535	$ -	$ 35,658,535
Total starting point - SFY 2013/14	**4,858,344**	**21,824,634**	**$ 13,278,745,095**	**$ 1,284,575,497**	**$ 133,997,697**	**$ 1,418,573,194**
Lines Removed - Greater than one-third of claim lines with blank procedure code [1]	557,942	2,325,398	$ 1,413,116,586	$ 117,362,335	$ 38,105,236	$ 155,467,571
Lines Removed - All lines have EAPG '999'	48,032	56,027	$ 52,678,243	$ 6,010,028	$ -	$ 6,010,028
Lines Removed - Total	**605,974**	**2,381,425**	**$ 1,465,794,828**	**$ 123,372,364**	**$ 38,105,236**	**$ 161,477,599**
Lines added - correction for EAPG grouping errors - observation services	-	28,895	$ -	$ -	$ -	$ -
Final Dataset	**4,252,370**	**19,472,104**	**$ 11,812,950,267**	**$ 1,161,203,134**	**$ 95,892,461**	**$ 1,257,095,595**

Note(s):
1) Percentage of claim lines with blank procedure codes was calculated when excluding the following service lines: Pharmacy, Laboratory, Supplies, Therapies, Dialysis, Radiology and Nuclear Medicine.

3.2 Re-Pricing Historical Claims

As mentioned in the previous section, the historical claims in our OPPS modeling dataset had dates of service in SFY 2013/14. Total historical payment from state general revenue (GR) and the Public Medical Assistance Trust Fund (PMATF) was used as the basis for the amount of money modeled to be spent under the new OPPS. To get this total historical payment amount, the portion of the current year (SFY 2015/16) outpatient per diem coming from GR and PMATF was applied to each line item with a covered revenue code on both FFS and managed care encounter claims. This resulted in a total historical payment amount (which Navigant refers to as the "baseline payment amount") of $1.16 billion, as shown above in Table 1.

In the calculation of the baseline payment amount, the individual recipient hospital outpatient annual benefit limit of $1,500 was included in the formulas and was applied with the same rules as currently exist in the legacy payment method. As in the legacy payment method, claims were excluded from this limit if they contained at least one surgical procedure code in the exclusion list and/or at least one line item with a revenue code or Healthcare Common Procedure Coding System (HCPCS) procedure code in the exclusion list. Also, the $1,500 annual benefit was not applied to recipients under the age of 21. AHCA understands that some MMA managed care plans have chosen a higher outpatient benefit limit (a value above $1,500), and other plans have chosen to do away with the annual hospital outpatient annual benefit limit all together. However, the benefit limit is considered when calculating MMA capitation rates, so it was applied to the OPPS payment modeling.

3.3 Hospitals Removed from Dataset

Navigant and the AHCA Governance Committee chose to remove 19 hospitals from EAPG modeling due to an insufficient percentage of procedure codes present on claim lines. Under Florida Medicaid's current hospital outpatient payment method, a procedure code must be submitted on a claim line to receive payment for only a small set of services – specifically laboratory services. Most other services may be submitted without a procedure code and will still be considered for reimbursement. However, under the OPPS payment method, the primary field on which payment is determined is the procedure code. Any claim service line submitted without a procedure code will be ignored for the purposes of calculating reimbursement.

In truth, under an APC and/or EAPG-based OPPS, some services may not be covered or may receive payment equal to $0 because payment for the service was bundled in with payment for another service. (Please see Chapter 4 for a detailed discussion of APC and EAPG-based OPPS payment methods.) For these services, payment will be the same whether the services are billed with or without a procedure code. Given this fact, we did not require the claim data to include a procedure on every single service line. But we did feel a reasonably high complement of procedure codes was necessary on each hospital's data in order to accurately model the new OPPS payment method and to estimate a hospital's shift in Medicaid outpatient reimbursement resulting from implementation of an OPPS.

Navigant and the AHCA Governance Committee settled on a threshold of two-thirds. A hospital needed to have procedure codes on at least two-thirds of its service lines to be included in the OPPS modeling. Any hospital with one-third or more of its claim lines missing a procedure code was removed from the modeling.[3] Using this criteria, 19 hospitals were identified as having incomplete data and were dropped from the OPPS modeling dataset.

[3] As described in Section 3.4, procedure codes and/or EAPG codes were "manually" assigned based on revenue code to some claim lines submitted without a procedure code. This "manual" manipulation was only performed for specific service lines for which estimation of a procedure code could be made reasonably accurately. With this "manual" manipulation in mind, the calculation of percentage of service lines without a procedure code by hospital was calculated excluding the service lines for which a procedure code and/or EAPG code could be "manually" assigned.

These hospitals are listed in Table 2. In total, 557,942 claims and 2,325,398 claim lines associated with these 19 hospitals were removed from the dataset.

Table 2. Hospitals removed from OPPS payment modeling due to lack of procedure codes.

"Base" Provider Medicaid ID	Provider Name	Claim Lines Excluding Specific Services [1]			Overall Outpatient Totals		
		Blank Claim Lines	Total Claim Lines	Percent of Claims with Blank Procedure Codes	Claim Lines	Submitted Charges	Baseline Payment
000949600	Florida Hospital at Connerton - LTAC	28	28	100%	68	$45,353	$668
008135900	University Behavioral Center	2	2	100%	2	$3,000	$0
008135300	Emerald Coast Behavioral Hospital, LLC	154	154	100%	154	$9,555	$0
010102800	Florida Hospital Tampa	18,271	52,903	35%	173,105	$115,882,262	$7,633,814
010345400	Memorial Hospital Miramar	24,111	30,829	78%	101,409	$60,200,676	$2,991,886
010020000	Memorial Regional Hospital	105,348	137,570	77%	419,733	$335,944,853	$26,409,856
010252100	Memorial Hospital West	40,381	53,903	75%	191,714	$144,551,040	$9,229,487
010222900	Memorial Hospital Pembroke	22,706	31,917	71%	94,442	$52,790,777	$2,912,238
010260100	Florida Hospital Wauchula	6,895	10,392	66%	35,962	$16,621,964	$2,045,480
010003000	UF Health Shands Hospital	60,494	93,064	65%	397,145	$180,094,812	$19,525,367
010090100	Florida Hospital Heartland Med Cntr	14,336	26,776	54%	95,693	$46,143,550	$4,485,171
010190700	Northwest Florida Cmnty Hospital	3,863	7,694	50%	32,071	$10,017,686	$1,790,768
010823300	Windmoor Healthcare, Inc.	14	28	50%	28	$29,100	$0
010067600	UF Health Jacksonville	44,781	92,479	48%	398,500	$230,451,128	$20,048,730
010109500	Florida Hospital Waterman	17,142	36,647	47%	139,059	$70,530,246	$6,867,582
005456800	Florida Hospital Wesley Chapel	6,325	15,385	41%	55,227	$33,596,727	$3,973,165
010094300	Florida Hospital Carrollwood	8,827	22,390	39%	76,348	$49,583,510	$4,193,585
010161300	Florida Hospital North Pinellas	4,779	12,812	37%	42,694	$24,151,233	$2,393,240
010149400	Florida Hospital Zephyrhills	7,091	21,235	33%	72,044	$42,469,113	$2,861,300
Total		**385,548**	**646,208**	**60%**	**2,325,398**	**$1,413,116,586**	**$117,362,335**

Note(s):
1) Amounts in these columns exclude the following service lines: Pharmacy, Laboratory, Supplies, Therapies, Dialysis, Radiology and Nuclear Medicine.

AHCA is hopeful to be able to collect the procedure codes for services performed from these hospitals during the months of December 2015 and January 2016 so that the hospitals may be included in future OPPS modeling. As an example, one hospital, All Children's Hospital, has already submitted to AHCA a separate claim extract that was used to reduce the percentage of service lines with blank procedure codes from 32 percent to 20 percent for this facility. All Children's Hospital is included in the modeling presented in this report.

Lastly, the lack of procedure code data was not an issue for the Ambulatory Surgical Centers (ASCs). ASCs bill on a professional claim form (837P or CMS-1500) for which procedure code is already a required field. Thus, all the historical ASC claim data was sufficient for inclusion in the OPPS modeling.

3.4 Manual Adjustments

Before manual manipulation by Navigant, a total of 3,252,012 claim lines without a procedure code were included in the modeling dataset. Navigant, with help from 3M Health Information Systems (HIS), was able to assign procedure codes and/or EAPG codes to 2,692,359 of those claim lines. In some cases, a procedure code was added and then the claim was processed through the EAPG grouper to assign a valid EAPG code. In other cases, an EAPG code was assigned by Navigant without addition of a procedure code.

This manual manipulation of the data was performed on a select subset of services for which a small number of revenue codes and procedure codes are normally billed, and a small number of EAPG codes gets assigned. Specifically claim service lines with a revenue code identifying one of the following types of service were considered for manual adjustment: pharmacy, laboratory, supplies, therapies, dialysis, or radiology and nuclear medicine. In addition, the adjustments were applied only to service lines billed without a procedure code. For each claim line meeting this criteria, a procedure code was manually assigned based on the types of procedure codes billed on similar claims in the dataset or based on logic provided by 3M HIS. The intention of manually assigning procedure codes was to keep as many claims in the modeling dataset as possible while still maintaining accuracy of modeled payments.

In the manual claim adjustment process, none of the baseline payment amounts on claim lines were changed, thus ensuring that the total baseline payment amount for these services was not altered. In total, 673,330 claim lines were manually assigned an EAPG for supplies, 1,889,302 claim lines were manually assigned an EAPG for pharmacy services, 93,114 claim lines were assigned a procedure code for therapy services, 28,895 claim lines were added for observation procedures, 7,082 claim lines were assigned a procedure code for radiology and nuclear medicine services, and 636 claim lines were assigned a procedure code for dialysis services. Details of the logic used to assign procedure codes and EAPG codes is given in "Appendix H – Manual Adjustments to Improve EAPG Assignment."

3.5 Description of Grouping and Discounting Options Used

The grouping of claims for OPPS modeling followed the recommendations listed later in this document. Claims were grouped to version 3.10 of the Enhanced Ambulatory Patient Groups (EAPGs) using the 3M Core Grouping Software. Within the Core Grouping Software, several configuration options can be set to customize the grouping and pricing logic. For the most part, we used default options for assignment of EAPG codes (grouping). A few of those options are listed below:

- Claims with more than one date of service were considered separate, independent outpatient visits unless the claim was for observation or emergency department services. Claims were identified as being for observation or emergency department services if at least one of the service lines on the claim contained on of these revenue codes:
    - 0450 – 0459 Emergency Room
    - 0760 – 0769 Specialty Services (includes observation and Treatment Room)

- The following procedure modifiers were allowed to affect assignment of EAPG codes:
    - 25 Separately identifiable evaluation and management service
    - 27 Multiple outpatient hospital evaluation and management encounters on the same date
    - 59 Distinct procedure service
    - GN Service delivered under an outpatient speech-language pathology plan of care
    - GO Service delivered under an outpatient occupational therapy plan of care
    - GP Service delivered under an outpatient physical therapy plan of care
- No limit was put on the minimum number of hours of observation
- Packaging was not performed for radiology services

In addition, multiple discounting options are available to customize the EAPG pricing logic. The options used in our modeling are listed below:

- Discounting at 50 percent was performed for:
    - Clinically similar significant procedures
    - Repeat ancillary procedures
    - Terminated procedures
- Payment enhancement to 150 percent was applied to bilateral procedures
- Procedure discounting was not applied to the following services:
    - Repeat ancillary drugs
    - Repeat ancillary durable medical equipment (DME) codes
    - Cross-type multiple procedures

3.6 Modeling OPPS Pricing

The modeling of OPPS pricing was performed using the recommendations explained in later sections within this document. The only exception is that the documentation and coding adjustment was not applied in the payment modeling. The purpose of the payment modeling is to estimate how Medicaid reimbursements will change with a shift from the current payment method to an OPPS payment method. Including adjustments for documentation and coding in this modeling would have unnecessarily complicated the comparison of payment methods. Summary results of the modeling are included in various Appendices at the end of this document.

The total amount of money available for distribution through EAPG pricing equaled the baseline payments from GR and PMATF. The exact value was $1,161,203,134. This money was distributed through EAPG pricing using two base rates, one for hospitals and one for ASCs, and using one provider policy adjustor applied to hospitals with a high percentage of outpatient utilization coming from Medicaid recipients. The EAPG base rates came out to $388.07 for hospitals and $278.88 for ASCs. In addition, the high Medicaid outpatient utilization policy adjustor came out to 1.4182. These parameters will change in the final rate setting process based on adjustments for improved documentation and coding.

In the OPPS payment modeling, automatic rate enhancements were applied to providers who are receiving automatic rate enhancements on outpatient services during state fiscal year (SFY) 2015/16. Applied rate enhancements totaled $95,892,461 and were distributed to the same hospitals and in the same amounts as defined in the SFY 2015/16 General Appropriations Act.[4] To ensure that specific rate enhancement amounts were distributed to specific hospitals, as is done in the legacy payment method, the automatic rate enhancements were distributed in the model as per-service-line supplemental payments. This method is similar to the method used to distribute hospital inpatient automatic rate enhancements within AHCA's inpatient DRG payment method. For the outpatient payment method, we modeled a supplemental payment on every claim service line that contained a covered revenue code, even if the EAPG payment for that service line was $0 because of bundling. We considered this method of providing a supplemental on every line with a covered revenue code a more accurate way to distribute the funds than including a supplemental payment only on service lines that received a non-zero EAPG payment.

3.7 Calculation of Cost

During the OPPS modeling process, Navigant used comparisons of hospital costs of providing services to the baseline payments under the legacy payment method and to the simulated payments under an EAPG payment methodology as one measure of the impact of the change in payment method. Also, simulated EAPG pay-to-cost ratios for various sub-categories such as service line and provider category were compared to the overall statewide average hospital outpatient pay-to-cost ratio. Results of these comparisons are shown in various summary tables provided in the Appendices. Estimates of provider costs were used only for these comparisons, and for no other purpose, as the recommended payment method does not include outlier payments.[5]

To estimate provider costs, Navigant calculated outpatient ancillary cost-to-charge ratios (CCRs) for in-state hospitals based on Medicare cost report information found in the Healthcare Cost Report Information System (HCRIS). Costs and charges were retrieved from Worksheet C, Part I. Within this worksheet, values were retrieved from cost centers 50 through 76, 90 through 93, and 96 through 99 for inclusion in the CCR calculations. An overall CCR was calculated for most outpatient services provided by hospitals along with separate CCRs calculated for lab, therapy, dialysis, and radiology services. In cases where an outpatient claim was from an out of state hospital, cost-to-charge ratios were assigned to service lines based on the state wide average CCRs for in-state providers. Once the appropriate service line CCR was assigned to a claim service line, cost was calculated as the product of the line's submitted charges times the CCR.

[4] The full allotment of hospital outpatient rate enhancements for SFY 2015/16 is $133,997,697. Our models distribute less than this full amount because some hospitals who receive automatic rate enhancements were removed from our modeling dataset because of a lack of procedure codes.

[5] Outlier payment calculations commonly use estimates of provider cost as part of the formula that determines the outlier payment amount on individual claims.

4 Grouping Algorithms in Outpatient Payment Methods

Most Outpatient Prospective Payment Systems (OPPS) used in the U.S. healthcare industry utilize a grouping algorithm that categorizes services, devices, and supplies for the purpose of calculating reimbursement. The two most common grouping algorithms used are Enhanced Ambulatory Patient Groups (EAPGs) and Ambulatory Patient Classifications (APCs). EAPGs are a proprietary product created and maintained by 3M Health Information Systems. APCs are maintained by a combination of the Centers for Medicare and Medicaid Services (CMS) and 3M Health Information Systems, and are publicly available with less copyright restrictions. APCs are used by the Medicare program, about 10 state Medicaid agencies and several commercial payers. EAPGs are used by six state Medicaid agencies and several commercial payers. In addition, four more state Medicaid agencies, including Florida, are considering implementation of EAPGs. One of the most fundamental payment policy decisions that must be made for the Florida OPPS is which grouping algorithm to use.

4.1 Basics of an Outpatient Prospective Payment System

Outpatient Prospective Payment Systems (OPPS) share financial risk between payers and providers, giving both an incentive to manage overall cost of care. Prospective payment methodologies ensure that payment rates for services do not change based on the overall cost of providing those services. This is in contrast to AHCA's current outpatient payment method, which assigns each hospital its own cost-based rate and cost settles reimbursements retrospectively when audited cost reports are available.

In both the EAPG-based and APC-based OPPS's, each service line on an outpatient claim is assigned an EAPG/APC code. This is in contrast to Inpatient Prospective Payment Systems (IPPS) utilizing Diagnosis Related Groups (DRGs) which assign a single DRG code to a medical claim and a single payment based on that DRG code. The wide variation in locations of service, reasons for outpatient care, and the high cost associated with ancillary services requires outpatient classification systems to closely reflect services provided to a patient. This is done by assigning an EAPG or APC code to each claim service line. However, to promote efficiency and to reduce the likelihood of unnecessary services being performed, not all claim lines are assigned a full payment rate or used in the payment calculation. Both grouping algorithms, EAPGs and APCs, provide ways to bundle payment for some services and supplies in with payment for other services. Payment bundling within the APC payment method is somewhat limited, but is increasing with newer releases of the APC grouping algorithm. The EAPG grouping algorithm, in contrast, has a relatively robust set of logic which bundles payment of service lines in some scenarios and discounts payment in other scenarios based on the procedure codes submitted on the claim.

For purposes of payment, both the EAPG and APC codes are assigned a relative weight. The relative weights estimate the relative amount of resources required by a healthcare provider to perform the service. Base payment is calculated by multiplying the relative weight times a base rate (a base rate in an OPPS is also often referred to as a conversion factor). Using these values,

a payment amount is calculated for each service line on a claim and total payment for the claim equals the sum of the payments on all lines of the claim.

4.2 Ambulatory Patient Classifications (APCs)

4.2.1 Basics of an APC Payment Method

On August 1, 2000 Medicare began using an APC-based OPPS for payment of hospital outpatient services. Under the APC payment method, Medicare assigns procedure to APC codes based on similar clinical characteristics and costs. Under the APC methodology, services may be paid separately or bundled together based on the different information that is present on an outpatient claim. APCs are designed for use by Medicare and are updated annually to assign new payment weights, payment rates, wage and other adjustments to APC groups. This annual review of APCs and their relative weights considers hospital, medical practice, and service and technology changes that may affect payment rates or APC groups. Additional information such as new cost data may also be used to ensure adequate payments are made.[6]

Under an APC-based OPPS, some services are paid separately and not bundled including many surgical procedures, diagnostic procedures, non-surgical therapeutic procedures, blood and blood products, most clinical and emergency department visits, certain preventative services and some drugs, biologicals and radiopharmaceuticals, along with other services and products. Under the same APC method, services typically packaged and combined for APC payment include supplies, ancillary services, anesthesia, operating and recovery room use, add-on procedures, medical device implants, and inexpensive drugs, radiology, imaging and observation services.[7]

In most cases, APC payment rates for separately payable medical and surgical services are calculated by multiplying the APC relative weight by a conversion factor to get a national adjustment payment for each APC. Further adjustments are made to adjust for geographic differences in input prices for labor using a wage index applicable to the location where the service was performed. For Medicare payments additional add-on or outlier payments may be available for specific drugs, high cost services, transitional payments for cancer hospitals, and other adjustments for certain types of hospitals.[8]

A generic APC payment is calculated as:

APC Payment = ([Conversion Factor] x [APC Relative Weight]) x ([60% Labor related Adjustment[9]] + [40% non-labor related Adjustment])[10]

[6] Hospital Outpatient Prospective Payment System – Payment System Fact Sheet Series. Department of Health and Human Services – Centers for Medicare & Medicaid Services, December 2014.
[7] Ibid.
[8] Ibid.
[9] Based on hospital wage index.
[10] Hospital Outpatient Prospective Payment System – Payment System Fact Sheet Series. Department of Health and Human Services – Centers for Medicare & Medicaid Services, December 2014.

Under the Medicare APC-based OPPS, payment exceptions may be applied for high cost cases, resulting in the inclusion of an outlier payment, for Sole Community Hospitals (SCH), and in cases where a cancer or children's hospital is eligible for a transitional outpatient payment.[11] These special calculations are as follows:

1. APC payment with outlier = [APC Payment] + [Outlier Payment]
2. APC Payment of SCH = [APC Payment] x [1.071]
3. Cancer or Children's hospital eligible for transitional outpatient payment
   = [APC Payment] + [Transitional Outpatient Payment]

While many providers may be familiar with the Medicare APC system, the program would need to be modified for use by the Florida Medicaid Agency to ensure that groups and services not served by the Medicare program are included in the APC payment method. This may result in significant variation from the Medicare structured system and increase the need for annual updates to fee-schedules and payment rates.

4.2.2 Services Covered Under APCs

APCs are only designed to categorize some of the services provided in an ambulatory care setting. Many other ambulatory care services are paid for using fee schedules in an APC-based OPPS. Services that are paid via a fee schedule include laboratory, pathology, physical therapy, mammography, non-implantable prosthetics, and durable medical equipment (DME). Thus, maintenance of an APC-based OPPS includes documentation and updates to both APC payment parameters and fee schedules.

4.2.3 Medical Visits in an APC Payment Method

APCs also differ from EAPGs in payment for medical visits, which are outpatient visits in which a patient receives medical treatment but there was no significant procedure performed. An outpatient visit that required only observation services is an example of a medical visit. The APC categorization method includes 15 codes for medical visits and many of those are assigned based on procedure codes that identify the duration of patient contact. The EAPG grouping algorithm has 191 codes for medical visits and bases EAPG assignment on the primary diagnosis (the condition) of the patient.

4.3 Enhanced Ambulatory Patient Groups (EAPGs)

4.3.1 Basics of an EAPG Payment Method

EAPGs are a product of 3M Health Information Systems that is designed to categorize outpatient services and procedures into groups for payment based on clinical information present on an outpatient claim. EAPGs are designed for the categorization of services provided to all patient groups and across multiple ambulatory care settings such as ambulatory clinics,

[11] Hospital Outpatient Prospective Payment System – Payment System Fact Sheet Series. Department of Health and Human Services – Centers for Medicare & Medicaid Services, December 2014.

surgery centers, emergency rooms, physicians' visits and other outpatient facilities. There is no need to maintain fee schedules for some types of care when implementing an EAPG-based OPPS. In addition, like APCs, EAPGs are not designed to pay for all types of care and exclude nursing home care, inpatient care, self-administered pharmaceuticals, and various other services such as transportation. EAPGs are designed to pay for facility time and resources and not for professional services which are billed through other methods.[12]

In the EAPG classification scheme, there are three primary types of procedures – significant, ancillary, and incidental. In an ambulatory setting, a significant procedure is usually the primary reason for the visit. Significant procedures normally require a majority of the time and resources used during the visit. In the EAPG classification scheme, significant tests may also constitute a significant procedure.[13] Ancillary procedures are generally ordered by the primary physician to assist in patient diagnosis or treatment. Ancillary procedures include pathology, laboratory, chemotherapy & pharmacotherapy, durable medical equipment, and other ancillary tests. Ancillary procedures increase the resources used during an outpatient visit, but do not constitute a majority of the time or supplies used during the visit. Incidental procedures are an integral part of a medical visit and are usually associated with professional services. Examples of incidental procedures include range of motion measurements, category II CPT codes for performance measurement, PQRI (Physician Quality Reporting Initiative) codes (HCPCS G-codes), and evaluation and management codes.[14]

4.3.2 Calculating Payment in an EAPG-Based OPPS

4.3.2.1 Visit Type

Based on the primary type of procedure performed, each outpatient visit is categorized as either a significant procedure visit, a medical visit, or an ancillary-only visit. When the visit type is "significant procedure visit," payment is usually applied to the claim lines with significant procedures and services commonly packaged include routine ancillaries, incidental procedures, supplies, many drugs and anesthesia. However, additional payments are permitted for unrelated significant procedures with applicable discounts, non-packaged ancillaries, chemotherapy, and select drugs and biologicals.[15]

The visit type assigned is "medical visit" if a patient received medical treatment but there was no significant procedure performed during the visit. With a medical visit, payment is generally applied to the medical visit EAPG and items generally packaged include routine ancillaries, incidental procedures, supplies and most drugs (excluding chemotherapy and select drugs and biologicals). In this case, additional payment may be available for non-packaged ancillaries, chemotherapy and other select drugs and biologics.[16]

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[12] 3M™ Enhanced Ambulatory Patient Grouping System – Definitions Manual, July, 2015.
[13] Ibid.
[14] Introduction to 3M Enhanced Ambulatory Patient Groups, Presentation from 3M to Ohio Hospital Association, June 2015.
[15] 3M™ Enhanced Ambulatory Patient Grouping System – Definitions Manual, July, 2015.
[16] Ibid.

When the visit type assigned is "ancillary services only," all ancillary items receive separate payment. A summary of this information can be found in Table 3.[17]

Table 3. EAPG payment system overview[18]

Visit Type	Items Included in the Base EAPG Payment	Items for Which Additional Payment is Permitted
Significant Procedure	Routine Ancillaries, Incidental Procedures, Supplies, Drug (except chemo and selected drugs and biologicals), Anesthesia	Significant Unrelated Procedures with any Applicable Discounts, Non-Packaged Ancillaries, Chemo and selected drugs and biologicals
Medical Visit	Packaged Routine Ancillaries, Incidental Procedures, Supplies, Drugs (except chemo and selected drugs and biologicals)	Non-Packaged Ancillaries, Chemo and selected drugs and biologicals
Ancillary Only	None	All "Ancillary Only" Items Are Paid Separately

4.3.2.2 Medical Visits in an EAPG Payment Method

Medical visits are outpatient visits in which a patient received medical treatment but there was no significant procedure performed. In this scenario, patients may require a wide array of different services, making it difficult to estimate the resource needs for these types of services. The EAPG grouping algorithm handles these cases by defining 191 different codes for medical visits (there are 15 different APC codes), and basing EAPG assignment on the diagnoses submitted on the claim instead of on the HCPCS procedure codes. Thus, payment is based on the condition of the patient and not on the duration of patient contact self-reported by providers, as is the case with APCs.

4.3.2.3 Bundling and Discounting

To promote efficiency and to reduce the likelihood of up-coding EAPGs or the provision of unnecessary services, not all claim lines are assigned a full payment rate or used in the payment calculation. This is true in both the APC and EAPG payment methods. Within the EAPG payment methodology, bundling and discounting is more sophisticated, and uses three different techniques, ancillary packaging, significant procedure consolidation, and procedure

[17] 3M™ Enhanced Ambulatory Patient Grouping System – Definitions Manual, July, 2015.
[18] Ibid.

discounting to group different services provided during outpatient visits into a single claim payment.[19]

4.3.2.3.1 Ancillary Packaging

When a significant procedure or medical visit is present on an outpatient claim, ancillary services that are performed at the same visit may be packaged with the significant procedure. Ancillary packaging combines the payment of certain ancillary services into the payment of a significant EAPG procedure. Payments for packaged ancillary procedures become paid through an increased payment associated with the significant procedure or medical EAPG on a claim.[20]

The goal of EAPG packaging is to incent providers to improve quality and reduce cost by either eliminating unnecessary services or replacing more expensive services with lower cost ones. At the same time packaging should not be defined in a way that discourages providers from giving patients expensive tests or procedures when clinically warranted. Because packaging, which results in $0 payment, risks discouraging providers from offering some services, expensive tests and procedures, for example an MRI, are paid separately and not packaged with another procedure. Packaging is reserved for only inexpensive and frequently performed ancillary procedures.[21]

Packaging schedules can be developed using two different methods, using a clinical packaging approach or through designing a list of procedures which are always packaged. Clinical packaging chooses which ancillary services to package on an EAPG specific basis using clinical methodologies to determine which ancillary services are expected as a routine part of an outpatient visit. Creating a list of services which will always be packaged with a significant procedure or medical visit is another way of customizing the EAPG grouping algorithm. By creating a uniform list of services that will always be packaged both payers and providers will be aware of what services will always be packaged allowing for easy tracking of these procedures. Creating a defined list of ancillary procedures that will be packaged can help to prevent providers from trying to use tests or procedures that will not be packaged into a significant procedure or using other coding and billing methods to avoid packaged payments.[22]

4.3.2.3.2 Significant Procedure Consolidation

Procedure consolidation may occur when multiple significant procedures of the same type are present on the same outpatient claim. Procedures of the same type which are provided during the same encounter may be consolidated, which means paid at $0, to provide a single payment for multiple services due to a decrease in the additional time and resources needed to perform the second service.[23]

[19] 3M™ Enhanced Ambulatory Patient Grouping System – Definitions Manual, July, 2015.
[20] Ibid.
[21] Ibid.
[22] Ibid.
[23] Ibid.

4.3.2.3.3 Discounting

Under an EAPG payment methodology, when multiple significant, ancillary, or other procedures are performed multiple times during an outpatient visit, an EAPG payment rate may be reduced through a process known as discounting. Discounting is justified by the fact that the cost of providing an additional service to a patient is less than providing the same procedure by itself, in general because much of the patient preparation that may be necessary for outpatient services has already been performed. In instances where these services are identified and selected for discounting, the reduction of payment through discounting may range from zero to 100 percent of payment.[24] In the Navigant modeling the discounting was set to 50 percent.

4.4 Grouping Algorithm Recommendations

Given the dynamics of the two OPPSs commonly in use in the U.S. healthcare industry, Navigant recommends the use of an EAPG payment method by Florida Medicaid. An EAPG payment method provides a less complex OPPS as it can be used for all services offered in an outpatient setting without the need for maintaining separate fee schedules. In addition, EAPGs bundle services more frequently than the alternative APC system, creating greater incentives for providers to control costs and services offered to Medicaid recipients.

In addition, while many providers may be familiar with the APC-based OPPS method used by Medicare, changes and modifications to this system would be needed for it to work with the Florida Medicaid population. It would need to be customized to support payment of services covered by Florida Medicaid, but not covered by Medicare. In addition, the Florida Legislature may choose to apply adjustors to the standard APC payment rates to meet Florida Medicaid goals. Thus, even if Florida Medicaid implemented an APC-based OPPS, providers would not be able to use software they already have for their Medicare business as a way to predict payment for their Medicaid patients.

5 Payment Policy Option – Included and Excluded Provider Types

An EAPG payment methodology allows for multiple types of facilities to be reimbursed for the outpatient services they provide. EAPG payment is intended to reimburse facility costs including labor for healthcare providers commonly employed by a healthcare facility. Physician services are generally billed separately and are not included in the EAPG reimbursement. Currently, the following types of facilities submit institutional outpatient claims to Florida Medicaid: free-standing dialysis centers, free-standing hospice providers, and hospitals. This makes each group a candidate for reimbursement through an EAPG payment method. In addition, free-standing (independent) laboratories and Ambulatory Surgical

[24] 3M™ Enhanced Ambulatory Patient Grouping System – Definitions Manual, July, 2015.

Centers (ASCs) perform services very similar to those offered in a hospital. As a result both independent laboratories and ASCs are candidates for inclusion in an EAPG-based OPPS.

5.1 Included and Excluded Provider Types – Discussion

From a broad payment policy prospective, a defensible payment method offers consistency and fairness of reimbursement for medical services. The method may include adjustments that account for fundamental differences in cost structures and/or payer mix of certain categories of providers. However, within a single category of providers, a common goal of a payment method is to pay the same amount for the same service independent of where the service was performed.

Specific to Florida Medicaid, free-standing hospice facilities and free-standing dialysis facilities are currently paid using separate methods that are unique to these types of facilities. Free-standing hospice facilities are assigned a facility-and-revenue-specific rate for six specific revenue codes. In addition, there are unique federal requirements related to payment for hospice services which further differentiate free-standing hospice and hospital provided hospice services. Free standing dialysis centers are paid statewide standardized rates for a specific set of revenue code and procedure code combinations. In contrast to these two payment methods, hospital outpatient services are paid using a hospital-specific, cost-based, per-service rate which is applied to each payable revenue code.

In the Florida Medicaid program, independent laboratories are currently paid using the same lab fee schedule that is used for laboratory services provided within an acute care hospital. However, the cost structures of these hospital-based lab services and free-standing labs is not the same, as hospitals have greater overhead to support offering a wide array of services at any time of the day.

Ambulatory Surgical Centers (ASCs) are currently paid using a method similar to that applied by Medicare, which groups a finite set of procedure codes into a set of fourteen categories and assigns a different state-wide rate to each of the fourteen categories. Also, ASCs currently bill using a professional claim form, again consistent with the process utilized by Medicare.

Assuming that the goal of an outpatient prospective payment system is to provide fair and consistent payments for provided medical services, current payment and cost structures must be accounted for when deciding what provider types to include in an EAPG-based OPPS payment methodology.

5.2 Included and Excluded Provider Types – Recommendation

Navigant and the AHCA Governance Committee believed the primary focus of the Florida Legislature in considering an OPPS was to move away from cost-based facility specific payment rates for hospitals. In addition, we believe the EAPG payment method is particularly well-suited for surgical services for which significant, ancillary, and incidental procedures are

generally clearly identified. As a result, we recommend including only hospitals (provider types 01) and Ambulatory Surgical Centers (provider type 06) in the new EAPG-based OPPS.

Assuming a successful transition to the new OPPS, Florida Medicaid might consider converting reimbursement for free-standing dialysis centers, independent laboratories, and free-standing hospice facilities to the OPPS. If included in the future, the varying cost structures of these types of facilities would likely require separate EAPG base rates for each.

6 Payment Policy Option – Included and Excluded Services

For the provider types included in the new OPPS, it is worthwhile to review whether or not there are any specific procedures, materials, and/or devices which might be more appropriately reimbursed using a method other than an EAPG-based OPPS. If yes, these services could be excluded from the new payment system and reimbursed through another method.

6.1 Included and Excluded Services – Discussion

Unlike the APC-based OPPS, the EAPG-based OPPS is designed to calculate reimbursement for all services provided in the outpatient setting. The EAPG system incorporates into its design logic on how to pay services differently based on cost, resource use, and clinical guidelines. In addition, the EAPG relative weights are calculated under an assumption that the cost and payment for common ancillary procedures will be covered under reimbursement for the significant procedures. Thus, carving specific outpatient procedures out of the EAPG payment method may counteract some of the logic and weighting built into the EAPG design. For this reason, our general preference is to reimburse all outpatient services from applicable providers under EAPG payment method.

During the payment method design process, the one set of procedures that were given consideration for exclusion were pharmaceuticals. The concern with pharmaceuticals related to the impact the EAPG payment methodology may have on rebates AHCA and 340B qualified hospitals currently receive. There are regulations which state that Medicaid agencies may only apply for rebates on drugs that receive explicit payment. Thus, drugs whose payment is bundled in with payment for a significant procedure under an EAPG payment method would not be eligible for drug rebate. Also, similar restrictions are being considered for hospitals who qualify for the 340B drug payment program and receive rebates from drug manufactures separately from the Medicaid Agency. Please see Chapter 15, "Impact of OPPS on 340B Drug Pricing Program" for a more detailed discussion of this topic.

6.2 Included and Excluded Services – Recommendation

Because of the robust and all-encompassing design of the EAPG payment method, we recommend including all outpatient services from included provider types in the OPPS.

In terms of the drug rebate program, current rules limit AHCA to applying for rebates only for pharmaceuticals on hospital outpatient claims that are billed with a procedure code and a National Drug Code (NDC). These codes are generally only included on relatively expensive drugs which will receive payment through the EAPG-based OPPS. Thus, the number of drugs currently applying for rebate today whose reimbursement will be bundled in the OPPS, thus making them no longer applicable for rebate, is anticipated to be low. In addition, the new requirements under the OPPS to include procedure codes on service lines for reimbursement may increase the number of drug service lines submitted with procedure codes. This may increase the number of drugs billed with necessary information to apply for rebates, thus offsetting the effect of payment bundling on drug rebates.

In terms of hospitals who qualify for the 340B Pharmacy Pricing Program, it is unclear at this time if rebates will be disallowed for drugs provided in an outpatient setting and whose reimbursement is bundled in with reimbursement for another procedure. In addition, if rebates are not allowed for drugs in this scenario, it is our expectation that impact to hospitals will be low as only low-cost drugs receive bundled payment in an EAPG-based OPPS. Of the six state Medicaid agencies who have implemented an EAPG-based OPPS to date, only one, Virginia, carved pharmaceuticals out of the OPPS.

7 Payment Policy Option – Base Rate(s)

The EAPG provider base rate, also referred to as the "conversion factor," is one of the most significant contributors to the reimbursement amount in an OPPS. Thus, selection of provider base rate(s) is a critical step in ensuring fair reimbursement when implementing an OPPS payment method. The simplest approach from the point of view of maintaining budget neutrality would be to assign each healthcare provider its own base rate. However, this would defeat one of the basic goals of an OPPS payment method – that is incenting and rewarding provider efficiency. The opposite approach would be to develop a single base rate to be applied to all providers. Many states have found that a solution somewhere between individual provider base rates and a single state-wide base rate is a more appropriate answer. Most states select a small number of base rates for specific provider categories that address reasonable differences in cost between providers in different categories. In the Florida inpatient DRG payment methodology, one base rate is utilized, but a small number of provider category policy adjustors are incorporated, which have a similar effect as separate base rates.

7.1 Provider Base Rates – Discussion

7.1.1 Base Rates for Different Provider Categories

Separate provider base rates are most often selected to adjust for definable differences in cost structure, to adjust for differences in payer mix, and to ensure access to care. For example, the two types of providers recommended for inclusion in AHCA's OPPS are hospitals and ASCs. ASCs are believed to have lower overall cost structures than hospitals because ASCs offer a smaller range of services, ASCs may turn away patients they deem to be overly costly, and

ASCs do not need to remain open 24 hours a day seven days a week. These factors allow ASCs to maintain lower overall cost structures than hospitals. As a result, separate base rates for hospitals versus ASCs may be warranted. Similarly, if a decision is made to add free-standing dialysis centers and/or independent laboratories to the OPPS, separate base rates should be considered for these types of facilities as well.

In addition, within the hospital category some facilities may have different cost structures based on the services they provide to patients, such as trauma care, and complex pediatric care, or because of services they provide to the healthcare community such as training for interns and residents. Other hospitals, most notably small rural hospitals, have relatively low costs, but also have relatively few patients from which to spread their overhead, and they provide access to care to recipients who would otherwise have to travel long distances to reach larger urban facilities. Also within the hospital category, there is a broad range of payer mix. Some facilities have significantly high Medicaid utilization, and rely heavily on Medicaid reimbursement, which on average is less than hospital cost, to remain in operation. All of these differences between hospitals are worthy of consideration when selecting categories for base rates, and/or provider policy adjustors, as described in Chapter 9.

If separate base rates are selected for some groups of providers, we recommend the criteria used to categorize hospitals within groups be very clear and maintainable. Understandably, hospitals will be motivated to be defined into the peer group offering the most attractive reimbursement. Having clearly defined criteria for each grouping will help maintain the integrity of the payment policy and lessen the administrative burden of categorizing all hospitals.

7.1.2 Base Rate Adjustment for Wage Area Differences

Another option employed by some state Medicaid agencies (and by the Medicare program) to adjust hospital base rates is a geographic wage area index or factor. The wage areas and associated wage indices can be state-defined values or can be linked to the Medicare values. Adjustment by wage area allows for higher payment in geographic regions that have historically reported higher wage rates for healthcare employees.

Wage area indices act as multipliers to common base rate(s) and can be applied either to the entire base rate or to a portion of the base rate. For example, Medicare applies the wage area index only to a percentage of the common base rate where the percentage is a standardized estimate of the percentage of hospital costs attributed to labor. In particular, Medicare applies the wage index to 60 percent of the common base rate and leaves 40 percent unadjusted as is shown in the following formula:

Base rate = ([Common base rate] * [hospital wage index] * 0.60)
+ ([Common base rate] * 0.40)

Medicare wage indices for Florida hospitals for federal fiscal year 2016 range from 0.8325 to 0.9765 and the average is 0.9123.[25] The difference from the lowest wage index to the highest is 0.1440 which is approximately 16 percent of the average. This is a relatively small range from low to high values.

If a wage area adjustment is desired by Florida Medicaid, an alternative to adopting Medicare's wage indices would be to develop Florida-specific wage indices. However, determination of wage areas can be very complicated and would likely require AHCA to take on a significant amount of additional effort. In addition, CMS is currently undergoing a major effort to redesign wage areas that will presumably result in a solution more widely accepted in the hospital community.

7.2 Provider Base Rates - Recommendation

Given the current list of provider types recommended for Florida Medicaid's OPPS, we are recommending two OPPS base rates (referred to as "conversion factors" by Medicare), one for hospitals and another for ASCs. This recommendation is made in concert with our recommendation regarding provider policy adjustors, which is given in Chapter 9. In earlier pricing simulations, we used a single base rate and the result was a shift of approximately $16 million from hospital payments to ASC payments. Without any specific direction from the Legislature to shift funds between these two types of providers, we assumed this shift is not intended to be part of the conversion to a new OPPS. Thus, we are recommending separate base rates for hospitals and ASCs in order to keep each type of provider budget neutral in aggregate.

Also, we are assuming hospital outpatient rate enhancements will be disbursed as supplemental claim payments, separate from the funds distributed through the base rates and standard EAPG pricing. This will allow the rate enhancements to be distributed in specific amounts to specific hospitals, as is done under the legacy outpatient payment method. If automatic rate enhancements are rolled into the base rate instead of being paid as a supplemental payment, then each hospital would need to be given their own base rate in order to distribute specific automatic rate enhancement amounts to specific hospitals.

Lastly, because of varying opinions on the fairness of Medicare wage areas, the limited range of wage indices in Florida, and AHCA's strong preference for a simplified payment method, we are recommending against having a wage area adjustment. This is consistent with Florida Medicaid's inpatient DRG payment method, which does not include wage area adjustment to the DRG base rate.

[25] The wage index values were retrieved from the Table 2 Correction Notice in spreadsheet "CMS-1632-F and CN Tables 2 and 3.xlsx" downloaded from URL https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/FY-2016-Wage-Index-Home-Page.html on November 28, 2015.

8 Payment Policy Option – Distribution of Automatic Rate Enhancements

Hospital outpatient automatic rate enhancements total just under $134 million in state fiscal year (SFY) 2015/16. New in SFY 2015/16, the state share of these funds came from general revenue. In previous years, the state share of these funds came from inter-governmental transfers from individual counties and taxing districts.

8.1 Distribution of Automatic Rate Enhancements – Discussion

Prior to the start of each state fiscal year, the Florida Legislature decides on a distribution of automatic rate enhancements to individual hospitals. A total amount to be paid out over the course of the SFY is assigned to each hospital, with some hospitals allocated more and others allocated less, including many hospitals which receive no supplemental rate enhancements.

Under AHCA's current hospital outpatient per diem payment method, automatic rate enhancement funds are distributed as an increase in the hospitals' outpatient per diems. This is possible because each hospital is assigned its own separate outpatient per diem.

In the EAPG-based OPPS, we are not recommending every hospital be given their own EAPG base rate. Because of this, it will not be possible to allocate specific dollar amounts to individual hospitals and distribute that money through standard EAPG pricing. If the automatic rate enhancement funds are distributed through the EAPG base rate, they will be distributed to all hospitals based on utilization and casemix. If on the other hand, the Florida Legislature wishes to continue to allocate specific amounts to specific hospitals, the automatic rate enhancements can be distributed through per-service-line supplemental payments, similar to the way inpatient automatic rate enhancements are distributed today within AHCA's inpatient DRG payment method.

8.2 Distribution of Automatic Rate Enhancements – Recommendation

We are assuming the Florida Legislature wishes to continue to allocate specific amounts of automatic rate enhancements to specific hospitals. As a result, we recommend including a per-service-line supplemental payment in the OPPS payment method that will be used to distribute automatic rate enhancements.

9 Payment Policy Option – Policy Adjustor(s)

Policy adjustors are an optional feature that can be used to help protect access to care for specific services. Often these are used for services where Medicaid funding can have a significant impact on beneficiary access, such as obstetrics, newborn care, mental health and pediatrics. In addition, policy adjustors may be used to direct additional funds to categories of providers that are particularly dependent on Medicaid reimbursement. The adjustors are above and beyond EAPG relative weights and represent an explicit decision to direct funds to a

particular group of patients who are otherwise clinically similar or to a specific category of providers to promote access to care for Medicaid recipients.

Specifically, policy adjustors are multipliers applied to specific claim lines with the effect of increasing or decreasing payment. Four types of policy adjustors are commonly used:

- Service adjustors
- Age/service adjustors
- Provider/service adjustors
- Provider adjustors

Service policy adjustors are applied to specific services, which would likely be identified by revenue code.

In theory, age/service adjustors can be applied to any age range, but are typically used by Medicaid programs to promote access for pediatric beneficiaries. Age/service adjustors provide a different payment for similar services when provided to a child versus an adult. For example, an age/service adjustor of 1.25 on EAPG 060 (pulmonary test) would increase payment by 25 percent if the patient was a child. In contrast, an adult who was given the same service, EAPG 060 pulmonary test, would receive the EAPG base payment without any adjustment.

Provider/service adjustors can be used to increase (or decrease) payment for specific services when offered by specific groups of providers. For example, a Medicaid agency might choose to increase payment for services provided in an emergency department when offered at a Level I trauma center, which might incur greater costs to support the clinical expertise and equipment needed to treat complex trauma cases. In such a scenario, the provider/service adjustor is used to increase payment for care specifically in an emergency department without increasing payment for other types of care (such as physical therapy) at the same hospital.

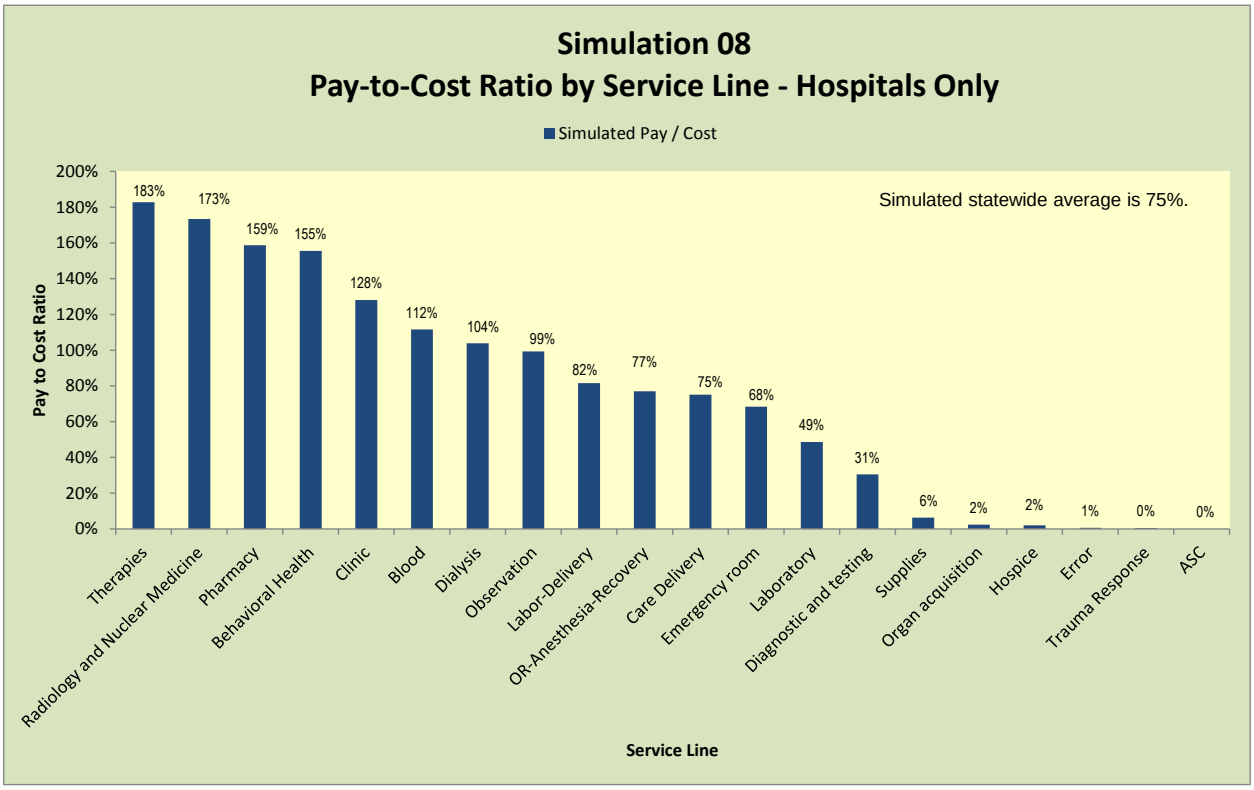
Finally, provider adjustors can be used to increase (or decrease) payments for all services performed by specific individual providers or categories of providers. Provider adjustors differ from provider/service adjustors in that they apply for all services offered by an applicable provider, not just specific types of services.

Assuming a goal of budget neutrality, use of policy adjustors causes provider base rates to be reduced, and has the effect of shifting some money from one area to another. We generally recommend including policy adjustor functionality in an OPPS implementation because it creates an ability to meet current and future Medicaid program goals by adjusting payments without requiring significant software changes within the MMIS. However, policy adjustors do not necessarily need to be a major contributor to overall program reimbursements. They can be used sparingly to meet specific needs.

9.1 Policy Adjustors – Discussion

The EAPG pricing simulations did not highlight any services that were particularly under-paid when compared to AHCA's average hospital outpatient pay-to-cost ratio, as shown in Figure 1.[26] Supplies, laboratory services, and diagnostic and testing services are all paid well below the state-wide average of 75 percent, however, they are all services that are commonly bundled within an EAPG payment methodology. The other service lines showing payment well below the average pay-to-cost ratio, hospice, error (invalid revenue code submitted on claim), and organ acquisition are all services with extremely low volume.

Figure 1. EAPG simulated pay-to-cost by type of service.



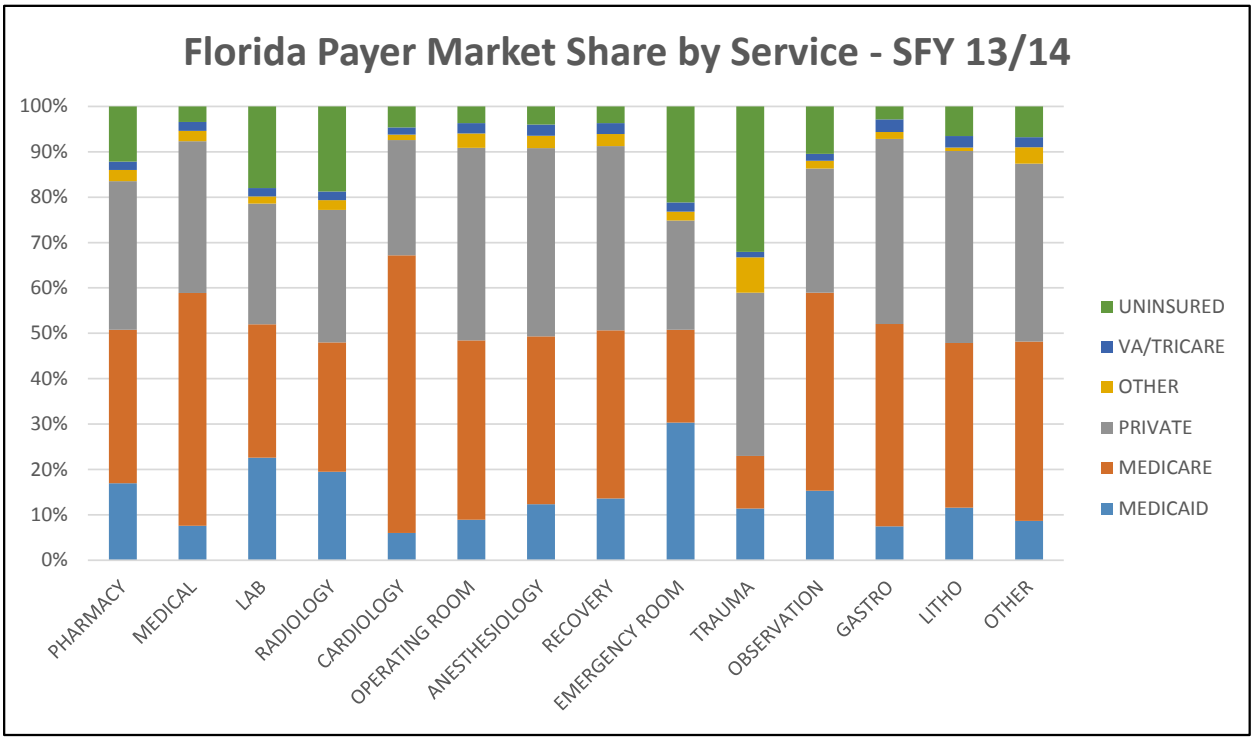
In comparison to the hospital inpatient setting, there are fewer services provided in a hospital outpatient setting for which Medicaid is clearly the primary payer. For example, in a hospital inpatient setting Medicaid is clearly a major payer for maternity and newborn care, as Medicaid pays for more than 50 percent of the deliveries and births in the State of Florida.[27] Medicaid is not as significant a payer for any service in the outpatient setting as shown in Figure 2.

[26] ASCs are not included in this chart because there is currently, no practical way to measure their costs, as they are not required to submit cost Medicare cost reports, as are required of hospitals.

[27] Presentation prepared by Navigant Healthcare for AHCA's second public regarding development of a DRG hospital inpatient payment method, August 29, 2012; Slide 14; Retrieved November 14, 2015 from http://ahca.myflorida.com/medicaid/cost_reim/pdf/DRG_Payment_Implementation_Project_Status_2012-08-29.pdf

Medicaid's greatest impact in the hospital outpatient setting is for Emergency Room (ER) services, where Medicaid pays for 30 percent of the ER services in the State. Thus, a Medicaid service-based OPPS policy adjustor would not necessarily have as much impact on access to care in the outpatient setting as Medicaid service adjustors are likely to generate for certain inpatient services.

Figure 2. Payer mix in Florida for hospital outpatient services.[28]



In addition, our modeling showed relatively little shift in reimbursement from adult to pediatric care as shown in Table 4. Thus, the modeling does not suggest a particular need for a pediatric policy adjustor, as is utilized in Florida Medicaid's inpatient DRG payment method.

Table 4. Estimated change in payment from move to OPPS for pediatric versus adult recipients.

Description	Claim Lines	Billed Amount	Baseline Payment	Simulated EAPG Payment	Payment Change (Dollars)	Payment Change (Percent)
Pediatric Recipients	7,367,877	$4,115,419,120	$568,333,943	$567,733,334	-$600,609	-0.1%
Adult Recipients	12,104,227	$7,697,531,147	$688,763,380	$689,362,472	$599,093	0.1%
Total	**19,472,104**	**$11,812,950,267**	**$1,257,097,323**	**$1,257,095,806**	**-$1,517**	**0%**

[28] Data for this graph was provided by the Florida Data Center.

In contrast, when considering specific categories of providers, there are some providers who may be justified in receiving a policy adjustor because a relatively high percentage of their patients are enrolled in Medicaid. A ranking of the top 15 hospitals when looking at outpatient Medicaid utilization is shown in Table 5.

Table 5. Ranking of hospital outpatient Medicaid utilization – top 15 hospitals.

Provider Medicaid ID	Provider Name	Outpatient Charges - Medicaid Recipients	Outpatient Charges - Non-Medicaid Recipients	Outpatient Charges - Total	Percent of Outpatient Utilization from Medicaid Recipients
010060900	Nicklaus Children's Hospital	$175,459,357	$86,883,316	$262,342,673	67%
004087600	Nemours Children's Hospital	$50,493,593	$29,664,040	$80,157,633	63%
002576600	Shriners Hospital for Children-Tampa	$3,301,513	$2,262,642	$5,564,155	59%
010151600	All Children's Hospital	$122,034,787	$89,389,720	$211,424,507	58%
012000600	Plantation General Hospital	$135,928,256	$203,348,796	$339,277,052	40%
010033100	Shands Lake Shore Rgnl Med Cntr	$34,615,737	$53,627,998	$88,243,735	39%
010049800	North Shore Medical Center	$101,669,083	$167,867,576	$269,536,659	38%
010133800	Orlando Health	$115,349,667	$196,710,977	$312,060,644	37%
010260100	Florida Hospital Wauchula	$13,543,077	$23,198,666	$36,741,743	37%
011980600	Capital Regional Medical Center	$13,594,172	$23,424,311	$37,018,483	37%
009268300	Poinciana Medical Center	$86,461,749	$149,191,565	$235,653,314	37%
010111700	Lehigh Regional Medical Center	$56,793,421	$98,360,066	$155,153,487	37%
010144300	Lakeside Medical Center	$16,611,281	$31,960,571	$48,571,852	34%
010086200	Hendry Regional Medical Center	$8,915,067	$17,216,536	$26,131,603	34%
010087100	Bayfront Health Brooksville	$79,766,762	$156,517,725	$236,284,487	34%

Note(s):
1) Data in this table was provided by the Florida Data Center.
2) The data is a sum of the hospital ambulatory care and emergency department categories from state fiscal year 2013/14 – July 1, 2013 through June 30, 2014.

9.2 Policy Adjustors – Recommendation

We do not see any particular value in adding any service policy adjustors, and thus recommend initial implementation of the OPPS with all service, service/age, or provider/service policy adjustors set to 1 (no adjustment). However, we do recommend including a provider policy adjustor for hospitals that have high Medicaid utilization for outpatient services. Hospitals with a high percentage of Medicaid patients have less ability to cover costs with payments from patients with Medicare and commercial insurance. Because of this, Navigant is recommending a provider policy adjustor that keeps the pay-to-cost ratio at 90 percent for any hospital with greater than 50 percent of their outpatient utilization coming from Medicaid recipients. Given the numbers in Table 5 above, this would apply to Nicklaus Children's, Nemours Children's, Shriners Hospital for Children, and All Children's hospitals. Also, the pay-to-cost ratio goal of 90 percent would be measured including both EAPG payment and supplemental automatic rate

enhancements. Currently, these four hospitals are paid 92 percent of cost under the legacy payment method.

10 Payment Policy Option – Outlier Payments

OPPS payment methods may include outlier provisions to adjust payment for patients that are unpredictably expensive. The EAPG grouping algorithm and associated EAPG relative weights are designed to predict hospital resource use so that the relative weight and therefore the EAPG base payment may be set accordingly. However, the EAPG grouper is limited to using only the information on medical insurance claims including procedure codes and diagnosis codes. Given the wide range of cases seen in an outpatient setting, EAPG grouping does not always accurately predict hospital resource use. In those cases, where the prediction differs significantly from reality, outlier payments may be used to generate a more reasonable reimbursement.

10.1 Outlier Payments – Discussion

If implemented, the outlier calculation would likely be cost-based and the formula would be,

[Outlier pymt adjstmnt] = {[Hospital cost] – [EAPG payment] – [Outlier threshold]} * [Marginal cost %]

In theory, this formula could be applied at the claim line level or at the claim header level. Arguably, the calculation will be more meaningful and accurate if calculated at the claim header level so that it is based on full cost of the outpatient visit, including some services that might get bundled under EAPG payment. However, EAPG pricing is performed at the line level, and performing pricing operations at both the header and line levels on the same claim adds significant complexity to the payment method. To reduce complexity, this calculation could be performed at the claim line level for line items that are not paid at $0 because of bundling. Unfortunately, this would result in the outlier calculation including only the cost of services on each non-bundled line item individually, and would never consider costs from lines whose payment was bundled in with another line.

In general, there is less need for outlier payments under an outpatient EAPG payment method versus an inpatient DRG payment method. This is because outpatient EAPG payment amounts are calculated individually for each service at the claim line level, whereas inpatient DRG payments are calculated as a single payment for an entire hospital admission based on a categorization of the patient's condition. In the outpatient EAPG pricing method, each additional service added as an additional claim detail line will be considered for additional payment. Some lines will get bundled, thus paying at $0, and others may pay at a discounted rate. Even so, EAPG payment is far more tied to the services performed than the DRG inpatient payment method, and, thus, is more capable of adjusting for unusually costly cases, which, presumably, result in more procedures being performed.

Of the six state Medicaid agencies that have implemented EAPG payment for their OPPS, none have chosen to include outlier payments. In contrast, Medicare's OPPS, does include an outlier payment calculation. In calendar year 2015, Medicare pays an outlier if the hospital's cost of furnishing a service exceeds the APC payment by 1.75 times and the hospital's costs exceeds the sum of the APC payment and a fixed loss threshold equal to $2,775. When this occurs, Medicare calculates an outlier payment for the service that is equal to 50 percent of the amount by which the cost to the hospital exceeds 1.75 times the APC payment rate. In calendar year 2016, Medicare plans to increase the fixed loss threshold to $3,250. Medicare states that the fixed loss threshold is set with a goal of distributing one percent of total reimbursements in the form of outlier payments.

Navigant estimated the amount of payment that might be paid out through outpatient outliers in the Florida Medicaid program by using a slightly less complex method that utilizes a mixture of the Medicare outpatient outlier calculation and the Florida Medicaid inpatient outlier calculation. We estimated the total outlier payment for Florida Medicaid for a year under EAPG pricing using a fixed loss threshold equal to $2,775 (Medicare's calendar year 2015 value), a marginal cost percentage of 80 percent, and the outlier payment formula described above (which is the same formula Florida Medicaid uses when calculating inpatient DRG outlier payments). In our model, the outlier calculation was performed at the claim service line level, for lines that received an EAPG payment greater than $0 (thus, were not bundled). Also, the outlier calculation was made without consideration of the supplemental automatic rate enhancements. Excluding supplemental automatic rate enhancements is consistent with Florida Medicaid's inpatient DRG outlier calculation, and results in more claims receiving outlier payments, for the same fixed loss threshold. Even with a marginal cost percentage of 80 percent, which is higher than the 60 percent value used in Florida Medicaid's inpatient DRG payment method, only $9,056,906 was paid out as outlier payments in our model. This is less than one percent of total payments.

10.2 Outlier Payments – Recommendation

Given the added complexity of including outlier payments in the OPPS, the reduced need for outlier payments in an OPPS, and the very small amount of money estimated to be distributed through outlier payments, (less than one percent of total EAPG payments), Navigant recommends implementing the OPPS without outlier payments.

11 Payment Policy Option – Transitional Period

Making a change in payment method from hospital-specific cost-based outpatient rates to an OPPS with relatively standardized rates will likely result in redistribution of some Medicaid outpatient reimbursements. Even if implemented with budget neutrality, we expect some providers will receive higher payments under the new OPPS method (when compared to legacy outpatient payments) and some providers will receive lower payments. A transitional period is a pre-set timeframe in which one or more strategies are implemented to limit individual providers' changes in Medicaid outpatient reimbursement for a period of time. The period of

time commonly used by payers who have chosen to include a transitional period when updating a payment method is between one and three years.

11.1 Transitional Period – Discussion

There are some advantages to utilizing transitional strategies. Phase-in or transitional periods provide time for providers to internally respond to anticipated changes in Medicaid reimbursement. A transitional period allows time for providers to take the steps necessary to improve documentation and coding practices, and potentially to implement improvements to operating performance relative to efficient delivery of services. In addition, a transitional period gives providers time to make modifications to the complement of service lines offered in future periods – to the extent that Medicaid payments affect such decisions.

On the other hand, there are disadvantages to utilizing transitional strategies. From a payer perspective, transitional periods tend to increase program administrative complexity for both policy and system implementation. A transitional period requires payers to either maintain two payment systems simultaneously (which would be required to blend payments between the legacy per diem method and the new EAPG model), or alternatively, to determine provider-specific base rates that would limit reimbursement changes during the transitional period. AHCA's Managed Medical Assistance program exacerbates the complexity further as the managed care plans tend to base their contracting rates on the Medicaid fee-for-service rates. From the providers' perspective, facilities that stand to see increased payments under the new payment model will not realize the full benefit of the change in payment model until after the transitional period has run its course.

A less complex, but more costly method to lessen the impact of a change in payment method includes making available additional funds distributed as supplemental payments separate from claim payments to individual providers who experience a reduction in Medicaid reimbursement. This was the method selected by the Florida Legislature when Florida Medicaid converted from hospital-specific cost-based per diem payments to DRG payments for inpatient services. $65 million, including state and federal share, in non-recurring funds was made available in the first year of DRG implementation to offset reductions in Medicaid inpatient reimbursement to specific hospitals. Distribution of that $65 million to individual hospitals was determined before the start of state fiscal year 2013/14 and then was reconciled near the end of 2013/14 based on partial year actual results.

Unfortunately, some hospitals have so far been excluded from EAPG payment modeling because their data was not sufficiently complete to include in the modeling (please see Chapter 3 for details of this issue). As a result, at the time of writing this report, we are unable to estimate changes in outpatient reimbursement for all hospitals in Florida, and, thus, could not calculate a defensible disbursement of transitional funds if they were made available. Data from specific individual hospitals will need to be collected and merged with existing historical claim data if we are to include all hospitals in the OPPS payment modeling. This limitation did

not exist in the claim data from the Ambulatory Surgical Centers, so we are able to model changes in reimbursement for all the ASCs.

11.2 Transition Period – Recommendation

We recommend Florida Medicaid implement its new OPPS fully from the start, without a transitional period due to the increased complexity resulting from transitional strategies, particularly in an environment with significant managed care. Furthermore, the level of reimbursement for outpatient services is significantly below that of inpatient services. As a result, the impact to hospitals from a change in outpatient payment methodology will be significantly less than the change in inpatient payment method.

12 Payment Policy Option – Adjustment for Anticipated Improvement in Documentation and Coding

When developing a new payment method, historical claims data is commonly used to model the new payment method and to set payment rates. This is done under the assumption that the historical claims data accurately represents that which will be billed and paid under the new method. For the most part, this assumption is accurate, as the medical services rendered and the medical providers rendering those services do not change significantly from year to year. However, the change in payment method itself may have an effect on billing practices and that change may influence overall reimbursements. When this is the case, the payment rates need to be adjusted in anticipation of the new billing practices so that overall reimbursements remain budget neutral, as is the direction of the Florida Legislature.

12.1 Adjustment for Anticipated Improvement in Documentation and Coding – Discussion

There is one notable difference between the current legacy outpatient payment method and the proposed new EAPG-based OPPS that we believe will result in a change in billing practices. That is the inclusion of HCPCS procedure codes on individual claim service lines. The legacy outpatient payment method only requires HCPCS procedure codes for laboratory services. Other than laboratory services, payment is calculated without consideration of the procedure performed. In contrast, under an EAPG-based OPPS, the procedure code is the most fundamental data element used in determining payment for all outpatient visits except those determined to be medical visits. (Please see section "Medical Visits in an EAPG Payment Method" for a description of medical visits in the EAPG grouping algorithm.)

The inclusion of procedure codes on more service lines in the future will not necessarily increase casemix as was the concern when moving from a per diem to a DRG payment methodology for hospital inpatient services. However, the presence of more service lines with procedure codes will result in more lines receiving payment when the OPPS is implemented than received payment in the OPPS modeling performed on claim data from state fiscal year

2013/14. To remain budget neutral, EAPG rates will need to be adjusted to account for additional service lines receiving reimbursement.

The expectation of improved documentation and coding is anticipated for hospitals only, not for ASCs. ASCs bill on a professional claim form (CMS-1500) for which a procedure code is already required on all service lines. Thus, there is no expectation of change in billing practices of ASCs.

12.2 Adjustment for Anticipated Improvement in Documentation and Coding – Recommendation

Even if all claim service lines currently billed without a procedure code are billed with a procedure code in the future, it is difficult to predict the exact effect on overall reimbursement because some of those service lines will receive bundled payment. In addition, there is surprisingly little industry documentation describing the experiences of other Medicaid agencies who have implemented an EAPG-based OPPS.

We are recommending a 5 percent reduction in EAPG base rate for hospitals to account for anticipated improvements in documentation and coding. This amount is consistent with the adjustment made during the first year of APR-DRG pricing for inpatient services by Florida Medicaid. For ASCs we do not recommend any documentation and coding improvement (DCI) adjustment as we do not anticipate any changes in their billing practices.

Because of the uncertainty regarding the effect of DCI on overall reimbursement, we also recommend a mid-year or end-of-year reconciliation. However, because Florida Medicaid has converted most of its program into the Managed Medical Assistance program, a DCI reconciliation for the OPPS may need to be designed differently than the DCI reconciliation used in the first two years of inpatient DRG pricing. In the first two years of inpatient DRG pricing, the DCI reconciliation, when needed, was executed through prospective adjustment to the DRG rates applied to the Medicaid fee-for-service population. Today, the Medicaid fee-for-service population is so small, changes in rates for these recipients may not be sufficient to effect necessary adjustments. Instead, it may be more practical to set aside funds that may be distributed through supplemental payments directly from the Medicaid agencies to hospitals if actual billing does not change as much as anticipated. Unfortunately, if actual billing changes more than anticipated it will be difficult for the Agency to recoup money from hospitals. If needed, credit balances could be defined for individual hospitals that would hold back payment for care to fee-for-service in both the hospital inpatient and outpatient settings until the outpatient overpayments have been recouped.

13 Payment Policy Option – Hospital Outpatient Benefit Limit

Florida Medicaid currently imposes a $1,500 annual benefit limit on hospital outpatient services. This limit is applied in the fee-for-service (FFS) program, and is optional for the managed care

plans in the Managed Medical Assistance program. According to the Agency, some managed care plans have chosen to implement the $1,500 annual benefit limit, others have included a limit but increased the dollar threshold, and still others have chosen to do away with the limit.

13.1 Hospital Outpatient Benefit Limit – Discussion

In the FFS program, there are a variety of services for which the benefit limit does not apply, including emergency services, maternity services, and most surgeries. In addition, the benefit limit does not apply to Medicaid recipients under the age of 21.

It is Navigant's understanding that the outpatient benefit limit was installed to help control Medicaid spending, and is unrelated to the method used to calculate individual claim payments. Modeling of the new EAPG-based OPPS has applied the existing $1,500 benefit limit rules under the assumption that the limit will continue in its current form. Modeling with the benefit limit removed is possible, but the payment rates calculated without the limit will only be accurate to the extent that hospitals bill Medicaid for all services provided, even in cases in which they know the recipient has already exhausted his/her annual benefit.

13.2 Hospital Outpatient Benefit Limit – Recommendation

Given the specific Legislative direction to develop an OPPS that maintains budget neutrality, Navigant and the AHCA Governance Committee are working under the assumption that the $1,500 hospital outpatient annual benefit limit will continue to be in place when the OPPS is implemented.

14 Payment Policy Option – Charge Cap

Medicaid programs, like most payers traditionally have a charge cap in place which ensures payment on individual claims equals the lesser of the Medicaid allowable payment and the provider's submitted charges. Florida Medicaid currently has a charge cap in place on hospital outpatient claims that limits the allowed amount on individual service lines to be the lesser of the outpatient per diem and the submitted charges on the line.

14.1 Charge Cap – Discussion

The general strategy with EAPG payments is that payments will average out over time to hit Medicaid's desired pay-to-cost ratio even though payments on individual claims may be above or below this ratio. On individual claim service lines payment is calculated using the provider EAPG base rate, the EAPG relative weight, and any applicable policy adjustors. And the EAPG relative weight is based off the average provider resource usage to perform the services grouped within that EAPG category. Given these factors, the EAPG payment on an individual service line may be above or below actual hospital costs, and in rare cases may even be above hospital charges.

Instituting a charge cap on claims paid via EAPGs has the advantage of avoiding large overpayments for individual services. It also has potential to negatively impact providers who are doing a good job of aligning charges with costs. Charge caps have the effect of rewarding hospitals who inflate charges well above costs, which is not necessarily a behavior worthy of reward.

In addition, EAPG payment on an individual service line is often calculated with the intent of covering costs of that line plus other related ancillary services whose payment is bundled in with the payment for the primary service. As a result, a charge cap would more accurately be applied by comparing the EAPG payment to the cost of the service line on which the payment is made plus the cost on all lines whose payment is bundled in with the primary service. Unfortunately, it is not particularly easy to identify which service lines were bundled in with other service lines. Thus, another option would be to apply the charge cap at the claim header level. But applying the charge cap at the claim header level would result in a mixture of payment calculations occurring at both the header and line levels, which adds a significant amount of complexity to a payment method.

In Navigant's EAPG pricing modeling there are some individual service lines with EAPG payment exceeding submitted charges on claims from both hospitals and ASCs. Total payment above submitted charges at the individual claim service line level is shown in Table 6[29].

Table 6. EAPG payment above charges on individual service lines.

Provider Type	Number of Claim Lines	EAPG Payment Above Service Line Charge
Hospital	736,474	$ 85,316,393
ASC	2,256	$ 207,983
Total	**738,730**	**$ 85,524,376**

When applying a charge cap at the claim header, there are still occurrences of payments exceeding charges, but, as expected the total payments above charges is lower. Results of the analysis at the claim header level is shown in Table 7.

[29] Payment above charges was calculated when considering only the EAPG payment. Supplemental automatic rate enhancements were not included in the payment values. This is consistent with the charge cap policy implemented by AHCA for inpatient DRG pricing. Supplemental automatic rate enhancements are excluded so that we may increase the likelihood of accurately distributing all rate enhancements allocated to individual hospitals over the course of the fiscal year.

Table 7. EAPG payment above charges when calculated at the claim header level.

Provider Type	Number of Claims	EAPG Payment Above Claim Header Level Charge
Hospital	246,707	$ 38,335,406
ASC	1,504	$ 137,840
Total	**248,211**	**$ 38,473,246**

If a charge cap policy is implemented, it does not result in savings to the State. Instead, it results in a slightly higher EAPG base rate, thus redistributing the overpayments across other claims in which EAPG payment is less than submitted charges.

14.2 Charge Cap – Recommendation

Although there are some instances in which EAPG payment is greater than provider submitted charges, Navigant does not recommend implementing a charge cap within the OPPS. We feel that a charge cap policy applied at the claim service line level is inaccurate because it would not consider provider cost from all the lines whose payment was bundled in with payment for the primary procedure. Application of a charge cap policy at the claim header level would be more accurate and fair. However, a charge cap at the claim header level would create a mixture of payment calculations at the header and line levels, which adds significant complexity to a payment method. We feel this added complexity is unnecessary when the net result would simply be redistribution of approximately $38 million, which is approximately 3 percent of total EAPG payments.

15 Impact of OPPS on 340B Drug Pricing Program

15.1 Background

Section 340B of the Public Health Service Act (PHSA), which is referred to as the "340B Drug Pricing Program" or the "340B Program" is a program that allows Medicaid agencies and certain qualified healthcare providers, referred to as "covered entities" to purchase drugs at reduced prices for distribution to their patients. Covered entities are defined in section 340B(a)(4) of the PHSA, and only include healthcare organizations that have certain Federal designations or receive funding from specific Federal programs. These include Federally Qualified Health Centers, Ryan White HIV/AIDS Program grantees, and certain types of hospitals and specialized clinics. The intent of the 340B Program is to permit covered entities "to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services."[30]

[30] H.R. Rep. No. 102-384 (Part 2), at 12 (1992) (Conf. Rep.).

Medicaid agencies are allowed to apply for rebates from drug manufacturers for drugs paid for by the Medicaid program that were not purchased at a discounted rate by a covered entity. Drug rebates may be claimed for drugs provided to Medicaid recipients in both fee-for-service and Medicaid managed care programs. However, paying a rebate to a Medicaid agency for a drug that was purchased at a 340B discounted rate by a covered entity is considered duplicate discounting and is prohibited by law.

Also, according to Section 1927(k)(3) (Definitions) of the Social Security Act, Medicaid agencies may not apply for a rebate for drugs, biological products, or insulin if "provided as part of, or as incident to and in the same setting as, any of the following (and for which payment may be made under this title as part of payment for the following and not as direct reimbursement for the drug)."

(A) Inpatient hospital services;
(B) Hospice services;
(C) Dental services, except that drugs for which the State plan authorizes direct reimbursement to the dispensing dentist are covered outpatient drugs;
(D) Physicians' services;
(E) Outpatient hospital services;
(F) Nursing facility services and services provided by an intermediate care facility for the mentally retarded;
(G) Other laboratory and x-ray services; and
(H) Renal dialysis.[31]

HHS published additional guidance on May 13, 1994, which further clarified that, in the settings identified in the limiting definition, "if a covered drug is included in the *per diem* rate (i.e., bundled with other payments in an all-inclusive, a per visit, or an encounter rate), it will not be included in the 340B discount program. However, if a covered drug is billed and paid for instead as a separate line item as an outpatient drug in a cost basis billing system, this drug will be included in the program."[32]

Guidance published in the Federal Register on August 28, 2015 says the following:

> "Further, the limiting definition in section 1927(k)(3) to exclude covered outpatient drugs for purposes of the 340B Program only applies when the drug is bundled for payment under Medicaid as part of a service in the settings described in the limiting definition. In contrast, a drug provided as part of a hospital outpatient service which is billed to any other third party or directly billed to Medicaid would still qualify as a covered outpatient drug."

[31] The Social Security Act, Section 1927(k)(3).
[32] Federal Register, Volume 59, Issue 92, released May 13, 1994.

We find this language to be rather confusing because a drug provided to a recipient in a hospital outpatient setting can be both billed directly to Medicaid and bundled for payment by Medicaid.

15.2 Impact of OPPS on 340B Drug Pricing Program

If drugs are included in the EAPG-based OPPS, many drugs that currently receive specific payment by Florida Medicaid will receive zero payment as their payment will be bundled in with another service deemed more significant by the EAPG categorization scheme. Given the regulations described in the previous section, there is risk that HRSA will consider drugs with EAPG bundled payments to be excluded from the 340B Drug Pricing Program.

For Medicaid drug rebates, we estimated approximately 790,000 drug claim lines annually that were eligible for the rebate in the past, will no longer be eligible for rebate.[33]

For hospitals who are covered entities within the 340B Drug Pricing Program, we do not have any way to estimate the impact to their drug purchasing costs if Medicaid implements an EAPG payment method.

16 Timing of Implementation

Development of an EAPG-based OPPS within the Florida Medicaid Management Information System (FMMIS) will require a significant amount of time and utilization of software development resources. In addition, each managed care plan that decides to mimic the Medicaid fee-for-service payment method will need to perform their own conversion to an EAPG-based OPPS. Even if the Florida Legislature decides during the 2016 session to move forward with a change in the outpatient payment method, any payer who waits until completion of the 2016 Legislative session to begin development of an EAPG-based OPPS will almost certainly be unable to implement on July 1, 2016 and will have difficulty implementing by September 1, 2016. (September 1 is the date that annual Medicaid managed care capitation rates are currently updated.) AHCA and the Florida Medicaid Fiscal Agent are currently moving forward with development of an EAPG-based OPPS under the assumption that the Florida Legislature does decide to move forward with this change. Even so, they are estimating an implementation in the fall of 2016 to be the earliest possible timeframe. Assuming this timeframe holds true, AHCA would retroactively adjust outpatient claims with dates of service between July 1, 2016 and the date the OPPS is implemented in FMMIS.

[33] At the time this report was submitted, AHCA and Navigant were still gathering the information needed to estimate the amount of drug rebate AHCA would have collected for these claim lines.

Appendices[34]

17 Appendix A – Summary of OPPS Payment Method Options

The following table summarizes the payment method options described in this document.

Table 8. Summary of OPPS payment method policy options and recommendations.

Payment Policy Option	Recommendation
Model dataset	• SFY 2013/14 data • Including FFS and managed care encounter data • Remove hospitals with more than 33% of their claim lines submitted with blank procedure codes, excluding specific service lines
Outpatient grouping algorithm	• Enhanced Ambulatory Patient Groups (EAPGs)
Provider types included and excluded from new OPPS	• Include hospitals and Ambulatory Surgical Centers (ASCs) • Exclude free-standing labs and free-standing dialysis centers
Services included and excluded from new OPPS	• Include all outpatient services from the included providers • Include pharmaceuticals in the OPPS
Hospital base rate categories	• Two, one for hospitals and one for ASCs • No wage area adjustment of base rates
Application of automatic rate enhancements	• Distributed as per claim supplemental payments

[34] Some information provided in the Appendices was obtained through use of proprietary computer software and data created, owned and licensed by the 3M Company. All copyrights in and to the 3M™ Software are owned by 3M. All rights reserved.

Payment Policy Option	Recommendation
Policy adjustors	• Provider policy adjustor for hospitals with 35% or more of their outpatient utilization coming from Medicaid recipients
Outlier payments	• No outlier payments
Transition period	• None
Documentation and coding improvement adjustment	• 5% for hospitals • 0% for ASCs
Charge cap	• None
Billing rule changes	• Require a procedure code on all outpatient line items effective 7/1/2016, with exceptions if appropriate

18 Appendix B – Hospital Specific Payment Estimates from EAPG Pricing Simulations

The table in this section shows historical (baseline) and simulated outpatient payments for each in-state hospital. Both payment types in this table include distribution of State general revenue, PMATF, and automatic rate enhancements. As mentioned previously, the numbers presented in this table are from SFY 2013/14 FFS and Medicaid managed care claim data re-priced using SFY 2015/16 FFS rates to determine the baseline amounts.

Table 9. Comparison of legacy payment to OPPS payment by hospital - in-state hospitals only.

Provider Medicaid ID	Provider Name	Case Mix	Claim Lines	Cost	Charges	Baseline Payment	Simulated EAPG Payment	Change in Payment	Percent Payment Change	Baseline Pay to Cost Ratio	Simulated Pay to Cost Ratio
010151600	All Children's Hospital	0.656	385,233	$63,980,754	$211,187,687	$64,773,333	$65,644,674	$871,341	1%	101%	103%
011648300	Anne Bates Leach Eye Hospital	1.411	41,676	$12,512,090	$48,666,419	$7,571,750	$7,899,762	$328,012	4%	61%	63%
012037500	Aventura Hospital and Medical Center	0.790	76,327	$3,911,907	$49,739,030	$1,673,489	$3,189,578	$1,516,088	91%	43%	82%
010074900	Baptist Hospital Inc	0.532	170,718	$10,125,111	$82,391,470	$7,891,101	$9,142,168	$1,251,067	16%	78%	90%
010035800	Baptist Hospital of Miami	0.502	237,267	$20,276,506	$117,335,182	$15,655,837	$12,606,648	$3,049,189	-19%	77%	62%
010232600	Baptist Medical Center - Beaches	0.594	52,388	$2,942,140	$18,022,463	$2,126,047	$1,849,738	-$276,308	-13%	72%	63%
010123100	Baptist Medical Center - Nassau	0.514	43,880	$2,314,698	$13,869,558	$2,511,987	$1,667,743	-$844,244	-34%	109%	72%
010064100	Baptist Medical Center Jacksonville	0.739	536,198	$39,806,019	$220,262,515	$30,506,206	$31,324,514	$818,308	3%	77%	79%
012041300	Bartow Regional Medical Center	0.622	73,001	$4,715,928	$47,085,130	$1,490,722	$3,638,496	$2,147,775	144%	32%	77%
010006400	Bay Med Cntr Sacred Heart Hlth Sys	0.713	125,485	$8,257,187	$51,823,043	$6,720,112	$7,120,456	$400,344	6%	81%	86%
010156700	Bayfront Health - St Petersburg	0.587	142,114	$7,335,967	$70,697,070	$4,120,284	$6,209,795	$2,089,511	51%	56%	85%
010087100	Bayfront Health Brooksville	0.716	161,238	$8,468,454	$149,767,622	$4,838,633	$7,999,892	$3,161,259	65%	57%	94%
010959200	Bayfront Health Dade City	0.567	49,810	$3,300,668	$42,208,541	$2,138,718	$2,471,722	$333,004	16%	65%	75%
010028500	Bayfront Health Port Charlotte	0.598	76,766	$4,035,752	$54,712,016	$2,901,587	$3,451,758	$550,171	19%	72%	86%
010027700	Bayfront Health Punta Gorda	0.633	25,329	$1,652,646	$17,889,855	$863,339	$1,094,629	$231,290	27%	52%	66%
010183400	Bert Fish Medical Center	0.592	52,354	$4,007,142	$14,628,049	$2,622,554	$2,313,504	-$309,051	-12%	65%	58%
010140100	Bethesda Hospital East	0.693	159,975	$11,545,097	$89,726,400	$7,652,979	$9,666,851	$2,013,872	26%	66%	84%
011021300	Blake Medical Center	0.571	46,661	$4,053,149	$34,278,893	$2,295,377	$3,176,782	$881,405	38%	57%	78%
010141900	Boca Raton Regional Hospital	0.720	29,551	$1,946,688	$11,614,522	$1,296,405	$1,562,706	$266,302	21%	67%	80%
011807900	Brandon Regional Hospital	0.502	229,309	$14,893,446	$234,244,434	$10,830,503	$9,459,398	-$1,371,104	-13%	73%	64%
010271700	Brooks Rehab Hosp	0.636	55,435	$2,549,588	$7,698,368	$2,500,467	$6,964,408	$4,463,941	179%	98%	273%
012040500	Broward Health Coral Springs	0.899	161,664	$10,737,143	$62,287,205	$9,057,230	$11,702,277	$2,645,047	29%	84%	109%

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010821900	Broward Health Imperial Point	1.061	42,913	$3,539,006	$18,000,843	$2,429,389	$3,103,446	$674,057	28%	69%	88%
010012900	Broward Health Medical Center	0.767	374,964	$26,583,376	$144,161,741	$22,250,760	$27,911,079	$5,660,319	25%	84%	105%
010021800	Broward Health North	1.115	120,353	$8,353,464	$49,430,212	$6,902,109	$10,067,240	$3,165,131	46%	83%	121%
010026900	Calhoun Liberty Hospital	0.327	24,814	$894,260	$3,330,376	$680,526	$715,594	$35,068	5%	76%	80%
010194000	Campbellton-Graceville Hospital	0.287	4,186	$247,785	$538,226	$265,021	$147,811	-$117,209	-44%	107%	60%
010009900	Cape Canaveral Hospital	0.610	37,592	$2,675,101	$17,920,237	$1,983,655	$1,728,898	-$254,757	-13%	74%	65%
011971700	Cape Coral Hospital	0.549	143,610	$7,434,488	$52,512,473	$4,816,075	$5,910,817	$1,094,742	23%	65%	80%
011980600	Capital Regional Medical Center	0.559	152,070	$9,944,907	$95,414,701	$7,832,024	$7,345,548	-$486,476	-6%	79%	74%
010178800	Central Florida Regional Hospital	0.467	108,035	$8,224,164	$91,059,150	$4,891,919	$3,769,951	-$1,121,968	-23%	59%	46%
010219900	Citrus Memorial Hospital	0.513	111,121	$3,590,961	$26,368,758	$4,045,110	$3,755,325	-$289,785	-7%	113%	105%
010220200	Cleveland Clinic Hospital	0.686	16,524	$797,348	$4,935,362	$664,579	$552,182	-$112,397	-17%	83%	69%
010960600	Coral Gables Hospital	1.029	38,489	$3,530,600	$31,977,326	$2,699,304	$1,849,133	-$850,171	-31%	76%	52%
012009000	Delray Medical Center	0.826	24,525	$2,264,193	$21,370,421	$1,539,068	$1,130,098	-$408,970	-27%	68%	50%
010192300	Desoto Memorial Hospital	0.510	43,036	$3,099,693	$11,730,625	$3,980,263	$2,276,595	-$1,703,668	-43%	128%	73%
010354300	Doctors Hospital	0.874	13,120	$1,749,109	$9,410,673	$1,085,227	$742,996	-$342,231	-32%	62%	42%
011995400	Doctors Hospital of Sarasota	0.478	15,404	$1,301,688	$12,365,073	$781,080	$673,662	-$107,418	-14%	60%	52%
010103600	Doctors Memorial Hospital	0.450	20,635	$1,651,325	$3,653,797	$1,526,764	$909,329	-$617,435	-40%	92%	55%
010180000	Doctors' Memorial Hospital	0.562	33,703	$1,914,688	$6,684,838	$2,103,564	$1,738,437	-$365,127	-17%	110%	91%
010004800	Ed Fraser Memorial Hospital	0.500	25,332	$1,751,758	$6,988,939	$1,691,775	$768,488	-$923,287	-55%	97%	44%
010259800	Edward White Hospital	0.626	14,559	$1,572,575	$16,179,898	$922,677	$619,637	-$303,039	-33%	59%	39%
010253900	Englewood Community Hospital	0.481	12,913	$1,062,148	$13,478,588	$413,854	$546,860	$133,006	32%	39%	51%
011746300	Fawcett Memorial Hospital	0.629	28,757	$2,384,379	$34,264,360	$1,395,542	$1,257,430	-$138,112	-10%	59%	53%
010120600	Fishermen's Hospital	0.560	11,246	$951,615	$3,497,210	$609,551	$408,108	-$201,443	-33%	64%	43%
010171100	Flagler Hospital	0.555	102,744	$7,144,724	$38,726,385	$4,213,849	$3,705,312	-$508,537	-12%	59%	52%
010129000	Florida Hospital	0.714	1,194,184	$90,266,298	$630,589,339	$78,510,524	$66,208,484	-$12,302,039	-16%	87%	73%
010187700	Florida Hospital DeLand	0.479	119,622	$9,321,014	$46,231,383	$4,937,502	$4,877,434	-$60,068	-1%	53%	52%
010182600	Florida Hospital Fish Memorial	0.569	110,381	$7,944,834	$45,030,334	$5,067,864	$4,847,793	-$220,071	-4%	64%	61%
010189300	Florida Hospital Flagler	0.564	80,644	$4,734,544	$28,989,227	$3,815,006	$4,768,351	$953,346	25%	81%	101%
010186900	Florida Hospital Memorial Med Cntr	0.580	91,034	$6,737,046	$37,067,727	$4,568,344	$4,392,173	-$176,171	-4%	68%	65%
010357800	Fort Lauderdale Hospital	0.594	46	$3,417	$17,665	$0	$622	$622		0%	18%
011132500	Fort Walton Beach Medical Center	0.537	94,457	$5,990,057	$97,094,032	$2,700,316	$4,161,413	$1,461,098	54%	45%	69%

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010080300	George E. Weems Memorial Hospital	0.443	9,337	$773,061	$1,484,382	$673,212	$430,931	-$242,281	-36%	87%	56%
010152400	Good Samaritan Medical Center	0.810	83,594	$7,185,613	$54,142,233	$5,110,083	$4,525,871	-$584,212	-11%	71%	63%
011134100	Gulf Coast Medical Center Lee Memorial Health System	0.801	101,489	$7,986,365	$51,073,567	$5,192,068	$4,698,706	-$493,363	-10%	65%	59%
011761700	Gulf Coast Regional Medical Center	0.612	117,563	$7,429,334	$92,858,997	$5,412,873	$6,800,947	$1,388,074	26%	73%	92%
012032400	H Lee Moffitt Cancer Center & Research Institute Hospital	1.601	126,693	$27,723,863	$118,798,860	$14,565,359	$19,316,748	$4,751,388	33%	53%	70%
010184200	Halifax Health Medical Center	0.664	196,163	$18,072,178	$76,191,958	$10,118,884	$12,037,692	$1,918,808	19%	56%	67%
010135400	Health Central	0.664	111,473	$7,775,437	$54,712,155	$5,989,931	$5,836,822	-$153,110	-3%	77%	75%
010188500	Healthmark Regional Medical Center	0.406	29,209	$1,284,855	$5,072,890	$1,146,431	$984,585	-$161,846	-14%	89%	77%
010275000	HealthSouth Emerald Coast Rehab Hosp	0.847	6	$361	$846	$222	$986	$763	343%	62%	273%
010355100	HealthSouth Rehab Hosp of Spring Hill	1.119	125	$3,455	$10,376	$3,768	$7,267	$3,499	93%	109%	210%
012033200	HealthSouth Rehab Hosp of Tallahassee	0.736	231	$26,404	$68,275	$14,577	$35,431	$20,854	143%	55%	134%
012042100	HealthSouth Sea Pines Rehab Hosp	0.775	29	$1,868	$3,960	$933	$3,845	$2,912	312%	50%	206%
012027800	HealthSouth Sunrise Rehab Hosp	1.336	221	$10,209	$25,522	$6,287	$29,740	$23,453	373%	62%	291%
010228800	Heart of Florida Regional Medical Center	0.729	143,660	$8,743,314	$131,991,098	$5,599,854	$6,913,251	$1,313,398	23%	64%	79%
010086200	Hendry Regional Medical Center	0.575	47,669	$4,751,887	$13,263,749	$3,082,496	$2,301,094	-$781,402	-25%	65%	48%
010041200	Hialeah Hospital	0.923	107,309	$7,021,726	$76,493,159	$4,409,765	$5,502,865	$1,093,100	25%	63%	78%
010089700	Highlands Regional Medical Center	0.628	56,409	$3,909,623	$36,122,676	$2,427,020	$2,371,759	-$55,261	-2%	62%	61%
010008100	Holmes Regional Medical Center	0.545	136,900	$10,806,622	$64,418,998	$6,661,533	$6,118,181	-$543,352	-8%	62%	57%
010018800	Holy Cross Hospital	0.644	65,253	$4,380,342	$28,930,665	$3,410,314	$2,823,351	-$586,962	-17%	78%	64%
010226100	Homestead Hospital	0.483	245,707	$23,964,722	$122,049,561	$20,396,849	$9,589,376	-$10,807,473	-53%	85%	40%
010104400	Indian River Medical Center	0.507	102,345	$5,817,195	$20,928,039	$5,357,025	$4,417,089	-$939,935	-18%	92%	76%
010106100	Jackson Hospital	0.502	65,890	$3,600,036	$15,226,380	$3,234,593	$3,392,457	$157,864	5%	90%	94%
010042100	Jackson Memorial Hospital	0.659	690,811	$83,925,927	$297,267,789	$77,087,845	$53,221,994	-$23,865,851	-31%	92%	63%
010173700	Jay Hospital	0.329	13,716	$616,217	$4,096,073	$776,553	$515,692	-$260,860	-34%	126%	84%
010146000	JFK Medical Center	0.936	119,379	$10,977,733	$129,166,252	$8,257,126	$6,738,283	-$1,518,843	-18%	75%	61%
012029400	Jupiter Medical Center	0.866	27,225	$2,550,808	$13,442,408	$1,270,873	$1,497,656	$226,783	18%	50%	59%
012013800	Kendall Regional Medical Center	0.699	151,419	$10,943,266	$159,772,510	$7,174,631	$8,445,901	$1,271,270	18%	66%	77%
010822700	Lake Butler Hospital	0.409	13,496	$1,183,982	$3,734,463	$1,091,184	$547,516	-$543,669	-50%	92%	46%
011976800	Lake City Medical Center	0.593	37,512	$2,624,769	$28,049,791	$1,935,503	$1,806,275	-$129,228	-7%	74%	69%

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010166400	Lake Wales Medical Center	0.581	51,270	$3,324,967	$37,396,582	$2,275,527	$2,660,840	$385,314	17%	68%	80%
010164800	Lakeland Regional Medical Center	0.752	550,188	$37,547,161	$287,662,558	$23,586,245	$26,469,628	$2,883,382	12%	63%	70%
010144300	Lakeside Medical Center	0.492	80,576	$4,858,191	$20,621,583	$4,368,671	$2,887,568	-$1,481,104	-34%	90%	59%
010342000	Lakewood Ranch Medical Center	0.552	33,519	$2,293,331	$20,786,868	$1,879,988	$1,494,758	-$385,230	-20%	82%	65%
011974100	Largo Medical Center	0.645	58,104	$4,846,912	$53,341,071	$2,807,661	$2,611,393	-$196,268	-7%	58%	54%
012005700	Larkin Community Hospital	0.733	17,713	$2,144,668	$10,971,292	$1,082,373	$1,265,867	$183,494	17%	50%	59%
011969500	Lawnwood Regional Medical Center & Heart Institute	0.781	148,737	$8,167,870	$123,110,815	$7,097,433	$8,194,400	$1,096,967	15%	87%	100%
010110900	Lee Memorial Hospital	0.725	305,782	$25,561,067	$162,888,187	$16,395,917	$25,199,588	$8,803,671	54%	64%	99%
010107900	Leesburg Regional Medical Center	0.599	95,570	$6,234,478	$37,604,971	$4,930,200	$4,095,238	-$834,962	-17%	79%	66%
010111700	Lehigh Regional Medical Center	0.521	88,158	$4,834,969	$59,697,810	$2,389,802	$3,799,437	$1,409,635	59%	49%	79%
010119200	Lower Keys Medical Center	0.622	33,579	$2,134,786	$17,018,125	$1,228,427	$1,671,628	$443,201	36%	58%	78%
010115000	Madison County Memorial Hospital	0.365	18,656	$705,476	$2,154,411	$452,071	$645,238	$193,167	43%	64%	91%
010116800	Manatee Memorial Hospital	0.583	151,117	$9,072,012	$84,965,235	$6,668,298	$7,286,800	$618,502	9%	74%	80%
010121400	Mariners Hospital	0.411	11,466	$1,548,240	$5,746,212	$1,427,406	$461,701	-$965,705	-68%	92%	30%
010118400	Martin Medical Center	0.655	188,251	$13,379,507	$94,712,747	$10,990,774	$10,341,725	-$649,049	-6%	82%	77%
010072200	Mayo Clinic	1.305	10,821	$1,035,828	$4,562,925	$667,860	$745,130	$77,270	12%	64%	72%
012008100	Mease Countryside Hospital	0.682	87,315	$6,014,945	$42,197,544	$3,767,560	$3,942,043	$174,483	5%	63%	66%
010154100	Mease Dunedin Hospital	0.537	39,029	$2,450,426	$17,835,558	$1,806,068	$1,421,042	-$385,027	-21%	74%	58%
010552000	Medical Center of Trinity	0.535	89,649	$6,561,912	$96,470,041	$2,260,066	$3,642,721	$1,382,655	61%	34%	56%
010193100	Memorial Hospital Jacksonville	0.529	135,966	$11,341,495	$150,842,214	$7,313,761	$6,639,530	-$674,231	-9%	64%	59%
011279800	Memorial Hospital of Tampa	1.151	9,657	$1,042,141	$9,268,365	$817,764	$788,557	-$29,207	-4%	78%	76%
010043900	Mercy Hospital	1.432	1,766	$387,770	$1,970,434	$145,006	$174,267	$29,261	20%	37%	45%
010054400	Metropolitan Hospital Miami	1.155	28,191	$1,456,960	$10,461,528	$1,156,446	$1,182,191	$25,745	2%	79%	81%
010158300	Morton Plant Hospital	0.626	163,034	$10,803,280	$69,713,789	$7,663,448	$8,270,786	$607,338	8%	71%	77%
010150800	Morton Plant North Bay Hospital	0.608	73,562	$4,923,278	$37,650,293	$3,584,987	$2,891,407	-$693,580	-19%	73%	59%
010046300	Mount Sinai Medical Center	0.907	103,874	$9,406,128	$66,353,028	$8,354,008	$6,858,785	-$1,495,223	-18%	89%	73%
010117600	Munroe Regional Medical Center	0.566	192,534	$11,393,279	$86,819,142	$9,110,059	$12,131,799	$3,021,740	33%	80%	106%
010031500	Naples Community Hospital	0.615	136,526	$9,991,530	$58,538,427	$6,570,521	$8,795,165	$2,224,644	34%	66%	88%
004087600	Nemours Children's Hospital	0.719	92,551	$42,281,494	$70,808,913	$14,960,329	$11,895,244	-$3,065,086	-20%	35%	28%
010060900	Nicklaus Children's Hospital	0.648	592,011	$78,423,750	$351,278,606	$88,823,353	$88,299,410	-$523,943	-1%	113%	113%
010862600	North Florida Regional Medical Center	0.988	107,612	$9,744,190	$126,349,511	$6,319,650	$5,382,199	-$937,451	-15%	65%	55%

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010126500	North Okaloosa Medical Center	1.001	76,548	$4,548,029	$76,821,425	$4,047,548	$5,780,527	$1,732,980	43%	89%	127%
010049800	North Shore Medical Center	0.619	233,030	$16,712,762	$162,142,388	$7,203,490	$9,619,618	$2,416,128	34%	43%	58%
011519300	Northside Hospital	0.520	39,984	$3,368,510	$47,099,054	$1,770,694	$1,484,985	-$285,709	-16%	53%	44%
010459100	Northwest Medical Center	0.693	101,728	$5,449,400	$70,933,584	$3,413,834	$4,396,853	$983,019	29%	63%	81%
012007300	Oak Hill Hospital	0.605	70,761	$4,513,819	$71,570,185	$2,687,042	$2,718,704	$31,662	1%	60%	60%
010828800	Ocala Behavioral Health, LLC	0.598	1	$73	$375	$0	$0	$0		0%	0%
010988600	Ocala Regional Medical Center	0.666	116,463	$8,015,464	$89,335,733	$3,553,401	$5,533,213	$1,979,812	56%	44%	69%
011174100	Orange Park Medical Center	0.555	100,709	$8,179,012	$123,157,408	$5,678,737	$5,266,186	-$412,551	-7%	69%	64%
010133800	Orlando Health	0.968	602,415	$55,168,533	$404,007,866	$48,154,393	$60,389,460	$12,235,066	25%	87%	109%
010138900	Osceola Regional Medical Center	0.525	171,274	$14,215,557	$215,632,657	$9,149,541	$7,389,484	-$1,760,056	-19%	64%	52%
003297500	Palm Bay Hospital	0.519	76,045	$5,321,389	$36,056,939	$3,205,891	$3,071,064	-$134,827	-4%	60%	58%
010210500	Palm Beach Gardens Medical Center	0.892	31,620	$2,339,980	$17,449,170	$1,636,808	$1,247,699	-$389,109	-24%	70%	53%
010053600	Palm Springs General Hospital	1.048	35,600	$1,755,964	$11,066,610	$818,363	$1,316,350	$497,987	61%	47%	75%
010460400	Palmetto General Hospital	0.690	162,706	$13,212,058	$108,007,430	$8,339,323	$8,522,570	$183,247	2%	63%	65%
012011100	Palms of Pasadena Hospital	0.741	8,253	$632,868	$7,513,410	$488,550	$355,727	-$132,823	-27%	77%	56%
012026000	Palms West Hospital	0.730	98,927	$8,227,147	$83,847,693	$5,257,927	$7,490,155	$2,232,228	42%	64%	91%
010010200	Parrish Medical Center	0.527	95,060	$8,589,228	$41,177,978	$5,217,271	$4,774,746	-$442,525	-8%	61%	56%
010314400	Physicians Regional Medical Center - Pine Ridge	0.667	71,419	$5,589,096	$55,062,176	$2,862,019	$3,576,135	$714,116	25%	51%	64%
012000600	Plantation General Hospital	0.937	255,972	$17,950,796	$211,364,196	$11,557,311	$16,630,581	$5,073,270	44%	64%	93%
009268300	Poinciana Medical Center	0.410	61,361	$6,039,772	$71,440,784	$5,635,219	$1,988,646	-$3,646,573	-65%	93%	33%
004805200	Port St Lucie Hosp, Inc	0.730	5	$404	$2,090	$0	$232	$232		0%	57%
011351400	Putnam Community Medical Center	0.606	86,413	$5,525,245	$36,230,843	$5,744,403	$5,728,779	-$15,623	0%	104%	104%
011975000	Raulerson Hospital	0.722	67,560	$4,017,575	$42,330,341	$4,069,839	$3,867,417	-$202,422	-5%	101%	96%
010114100	Regional General Hospital Williston	0.469	16,494	$495,051	$2,493,555	$459,147	$503,239	$44,091	10%	93%	102%
011988100	Regional Med Cntr Bayonet Point	0.566	60,018	$4,756,482	$63,966,018	$2,831,153	$2,350,369	-$480,784	-17%	60%	49%
010076500	Sacred Heart Hospital	0.606	338,038	$36,980,211	$131,150,317	$25,618,778	$18,394,291	-$7,224,486	-28%	69%	50%
010323300	Sacred Heart Hosp on the Emerald Coast	0.632	44,009	$3,706,914	$24,508,655	$3,625,691	$2,799,766	-$825,925	-23%	98%	76%
002012700	Sacred Heart Hospital on the Gulf	0.457	11,065	$2,060,514	$4,418,789	$1,793,376	$544,440	-$1,248,936	-70%	87%	26%
010174500	Santa Rosa Medical Center	0.607	88,219	$5,009,940	$53,568,733	$4,018,887	$3,929,812	-$89,075	-2%	80%	78%
010176100	Sarasota Memorial Hospital	0.683	165,995	$14,797,366	$85,054,209	$9,499,462	$10,135,459	$635,997	7%	64%	68%

Provider Medicaid ID	Provider Name	Case Mix	Claim Lines	Cost	Charges	Baseline Payment	Simulated EAPG Payment	Change in Payment	Percent Payment Change	Baseline Pay to Cost Ratio	Simulated Pay to Cost Ratio
012001400	Sebastian River Medical Center	0.569	26,725	$2,398,342	$27,528,135	$1,041,866	$1,269,459	$227,592	22%	43%	53%
011998900	Seven Rivers Regional Med Cntr	0.585	49,689	$3,088,505	$35,548,477	$2,016,386	$2,059,120	$42,735	2%	65%	67%
010033100	Shands Lake Shore Rgnl Med Cntr	0.550	110,740	$5,438,391	$39,314,660	$6,455,985	$4,782,293	-$1,673,691	-26%	119%	88%
010179600	Shands Live Oak Rgnl Med Cntr	0.461	63,146	$2,726,914	$18,443,004	$2,694,304	$2,339,364	-$354,940	-13%	99%	86%
010007200	Shands Starke Rgnl Med Cntr	0.496	59,157	$3,196,070	$17,753,886	$3,042,196	$2,405,430	-$636,767	-21%	95%	75%
002576600	Shriners Hospital for Children-Tampa	0.482	7,759	$883,093	$4,250,378	$2,610,092	$1,174,955	-$1,435,137	-55%	296%	133%
011994600	South Bay Hospital	0.493	26,460	$1,709,450	$25,008,948	$1,270,600	$1,039,951	-$230,648	-18%	74%	61%
010098600	South Florida Baptist Hospital	0.639	92,741	$7,121,048	$48,231,254	$4,007,684	$5,847,633	$1,839,949	46%	56%	82%
010108700	South Lake Hospital	0.839	86,327	$5,198,025	$42,154,898	$4,042,547	$5,538,317	$1,495,770	37%	78%	107%
010058700	South Miami Hospital	0.603	81,517	$10,568,032	$49,323,926	$4,789,320	$5,945,715	$1,156,395	24%	45%	56%
004819100	Springbrook Hosp, Inc	0.763	4	$1,298	$6,710	$0	$0	$0		0%	0%
012022700	St Anthonys Hospital	0.901	83,453	$6,081,622	$45,698,812	$5,023,110	$5,444,137	$421,027	8%	83%	90%
010346200	St Cloud Regional Medical Center	0.606	59,187	$4,089,373	$31,609,583	$2,482,757	$2,301,739	-$181,019	-7%	61%	56%
010148600	St Mary's Medical Center	0.616	194,398	$16,912,143	$120,576,900	$10,873,864	$11,828,684	$954,820	9%	64%	70%
010240700	St. Anthony's Rehab Hosp	0.726	44	$2,140	$5,103	$407	$2,063	$1,656	407%	19%	96%
010097800	St. Josephs Hospital	0.632	508,632	$45,545,624	$266,844,627	$35,248,028	$30,524,508	-$4,723,520	-13%	77%	67%
012010300	St. Petersburg General Hospital	0.650	60,391	$5,882,152	$84,267,441	$3,618,671	$3,280,264	-$338,407	-9%	62%	56%
009701300	St. Vincent's Hosp - Clay County	0.542	16,187	$1,789,661	$9,074,437	$1,098,264	$743,766	-$354,498	-32%	61%	42%
010073100	St. Vincent's Medical Center Riverside	0.657	120,130	$9,595,241	$66,756,206	$4,591,875	$6,675,327	$2,083,452	45%	48%	70%
010373000	St. Vincent's Med Cntr Southside	0.991	43,568	$3,688,874	$27,079,286	$1,807,532	$2,767,554	$960,022	53%	49%	75%
012002200	St.Catherine's Rehab Hosp	0.726	32	$1,524	$2,889	$465	$2,345	$1,880	404%	31%	154%
011997100	St.Lucie Medical Center	0.694	54,926	$3,287,394	$44,230,277	$2,735,945	$2,683,308	-$52,637	-2%	83%	82%
010113300	Tallahassee Memorial Hospital	0.860	148,280	$15,980,764	$76,407,688	$10,476,678	$10,979,857	$503,179	5%	66%	69%
011984900	Tampa Community Hospital	0.494	28,942	$2,440,785	$24,200,913	$1,426,494	$1,259,213	-$167,281	-12%	58%	52%
010099400	Tampa General Hospital	1.045	325,492	$27,568,528	$237,746,528	$27,545,430	$24,859,408	-$2,686,022	-10%	100%	90%
010317900	The Villages Regional Hospital	0.700	30,612	$2,049,516	$13,887,686	$1,119,434	$1,501,254	$381,821	34%	55%	73%
010125700	Twin Cities Hospital	0.574	22,129	$1,581,546	$19,903,237	$1,031,707	$847,536	-$184,171	-18%	65%	54%
011280100	University Hospital and Med Cntr	0.614	45,008	$2,676,046	$35,698,938	$1,718,086	$1,736,029	$17,944	1%	64%	65%
010036600	University of Miami Hospital	1.486	64,126	$7,738,833	$61,483,746	$5,535,678	$7,865,965	$2,330,286	42%	72%	102%
010047100	Univ of Miami Hospital and Clinics	1.427	161,519	$30,631,101	$166,267,927	$18,314,781	$19,935,141	$1,620,360	9%	60%	65%
011973300	Venice Regional Bayfront Health	0.607	22,560	$1,632,656	$16,985,922	$830,950	$1,151,311	$320,360	39%	51%	71%

Provider Medicaid ID	Provider Name	Case Mix	Claim Lines	Cost	Charges	Baseline Payment	Simulated EAPG Payment	Change in Payment	Percent Payment Change	Baseline Pay to Cost Ratio	Simulated Pay to Cost Ratio
003158800	Viera Hospital	0.663	14,041	$1,589,828	$7,857,049	$1,038,480	$742,471	-$296,008	-29%	65%	47%
008589300	Wekiva Springs Center LLC	0.598	43	$4,928	$25,475	$0	$0	$0		0%	0%
010213000	Wellington Regional Medical Center	0.649	77,549	$4,396,628	$40,362,092	$4,255,029	$3,645,079	-$609,950	-14%	97%	83%
012024300	West Boca Medical Center	0.715	69,372	$5,468,575	$30,555,401	$4,282,386	$3,962,803	-$319,582	-7%	78%	72%
011321200	West Florida Hospital	0.671	71,787	$5,252,325	$52,779,807	$2,827,182	$3,748,348	$921,166	33%	54%	71%
010170200	West Gables Rehab Hosp	0.985	62	$4,350	$8,013	$901	$2,294	$1,394	155%	21%	53%
003226500	West Kendall Baptist Hospital	0.587	98,689	$9,966,612	$53,360,047	$8,282,330	$3,908,718	-$4,373,612	-53%	83%	39%
012030800	West Palm Hospital	0.862	29,533	$2,928,551	$32,108,955	$1,022,608	$1,807,835	$785,227	77%	35%	62%
010062500	Westchester General Hospital	1.376	21,827	$1,367,479	$7,740,980	$1,463,960	$1,059,672	-$404,287	-28%	107%	77%
011230500	Westside Regional Medical Center	0.682	42,444	$2,383,503	$29,088,452	$1,210,036	$1,778,719	$568,683	47%	51%	75%
010169900	Winter Haven Hospital	0.583	142,257	$11,576,396	$76,888,387	$6,361,737	$5,748,257	-$613,481	-10%	55%	50%
010320900	Wuesthoff Medical Center-Melbourne	0.878	57,193	$4,313,495	$51,090,764	$2,367,321	$3,207,069	$839,747	35%	55%	74%
010011100	Wuesthoff Medical Center-Rockledge	0.615	130,478	$8,134,972	$92,698,261	$4,725,023	$5,534,466	$809,443	17%	58%	68%
Total		**0.706**	**19,277,857**	**$1,625,103,346**	**$11,546,618,523**	**$1,216,297,592**	**$1,217,850,024**	**$1,552,432**	**0%**	**75%**	**75%**

19 Appendix C – ASC Specific Payment Estimates from EAPG Pricing Simulations

The table in this section shows historical and simulated outpatient payments for each Ambulatory Surgical Center, both in and out of state. As mentioned previously, the numbers presented in this table are from SFY 2013/14 FFS and Medicaid managed care claim data re-priced using SFY 2015/16 FFS rates to determine the baseline amounts.

Table 10. Comparison of legacy payment to OPPS payment for each Ambulatory Surgical Center.

Provider Medicaid ID	Provider Name	Provider Type	Case Mix	Claim Lines	Charges	Baseline Payment	Simulated EAPG Payment	Change in Payment	Percent Payment Change
001768100	Advanced Surgery Center of Palm Beach	06	1.358	248	$857,818	$64,519	$72,332	$7,813	12%
075718700	Aesculapian Surgery Center LLC	06	2.759	195	$178,640	$114,024	$92,322	-$21,702	-19%
075317300	Aker Kasten Vision & Laser Center	06	2.816	1	$1,435	$995	$785	-$210	-21%
009386900	Alamarcon Holdings LLC	06	5.303	6	$23,857	$3,864	$4,437	$573	15%
014293800	Alliance Surgical Center LLC	06	1.139	2	$12,705	$666	$635	-$31	-5%
079080000	Alpha Ambulatory Surgery	06	1.901	6	$2,650	$1,095	$1,060	-$35	-3%
079077000	Ambulatory Ankle & Foot Ctr of FL.	06	3.754	277	$966,768	$144,990	$162,285	$17,295	12%
062927800	Ambulatory Surgery Center Group	06	1.699	318	$1,487,780	$119,924	$126,967	$7,043	6%
079072900	Ambulatory Surgical Care	06	2.286	43	$38,746	$13,583	$16,575	$2,992	22%
062936700	American Surgery Center	06	2.962	26	$53,647	$20,700	$18,996	-$1,704	-8%
079048600	Andre J. Golino, MD & Associates,PA	06	2.816	1	$3,200	$995	$785	-$210	-21%
076921500	Andrews Institute ASC, LLC	06	3.930	39	$206,560	$24,341	$21,917	-$2,423	-10%
009285500	Apollo Anesthesia, PA	06	0.075	34	$29,165	$0	$688	$688	
000934600	Apollo Surgery Center	06	5.065	9	$27,176	$4,664	$5,650	$986	21%
000875400	Apollo Surgery Center LLC	06	4.946	31	$74,599	$18,883	$23,451	$4,568	24%
001680900	Armenia Ambulatory Surgery Center, LLC	06	1.906	225	$469,191	$51,534	$79,179	$27,645	54%
006574700	Atlantic Surgery Center Inc	06	4.176	12	$9,190	$8,630	$12,809	$4,179	48%
070620500	Baptist Medical Park Surgery Cntr	06	2.200	127	$312,519	$48,927	$48,476	-$450	-1%
079217900	Baptist Medical Services Corp	06	3.967	136	$702,024	$118,496	$125,010	$6,514	5%
000788200	Baptist Surgery and Endoscopy Centers LLC	06	1.208	60	$182,788	$18,981	$18,534	-$447	-2%
003879600	Baptist Surgery and Endoscopy Centers LLC	06	1.777	4	$8,039	$1,188	$1,486	$299	25%
076159100	Baptist Surgery and Endoscopy Centers, LLC	06	3.714	261	$1,046,691	$191,007	$194,711	$3,704	2%
009512000	Bardmoor Surgery Center, LLC	06	2.258	7	$15,467	$2,043	$2,519	$476	23%

Provider Medicaid ID	Provider Name	Provider Type	Case Mix	Claim Lines	Charges	Baseline Payment	Simulated EAPG Payment	Change in Payment	Percent Payment Change
079135100	Barkley Surgicenter	06	1.613	2,528	$1,536,113	$327,330	$371,216	$43,886	13%
079148200	Bay Area Endoscopy Center	06	1.196	549	$331,052	$97,319	$96,400	-$919	-1%
076889800	Bay Area Physicians Surgery Center	06	2.115	58	$146,982	$22,613	$20,640	-$1,973	-9%
010795400	Bay Area Physicians Surgery Center	06	2.503	22	$63,382	$11,554	$9,772	-$1,782	-15%
062935900	Bay Eye & Surgical Cntr.	06	2.118	50	$43,216	$29,769	$28,942	-$827	-3%
075404800	Bayfront Same Day Surgery Ctr, LLC	06	2.264	456	$2,451,444	$199,074	$191,977	-$7,096	-4%
075882500	Bayonet Point Surgery Center Ltd	06	2.496	282	$1,567,245	$151,504	$151,059	-$445	0%
004613100	Bayside Ambulatory Center, LLC	06	2.278	444	$2,189,207	$198,931	$207,772	$8,841	4%
079061300	Belleair Surgi-Center	06	2.249	175	$864,721	$71,711	$75,903	$4,192	6%
079208000	Beraja Healthcare Corporation	06	2.600	420	$593,157	$292,207	$263,904	-$28,302	-10%
002327900	Bethesda Outpatient Surgery Center, LLC	06	3.153	558	$2,575,368	$372,520	$328,881	-$43,638	-12%
079215200	Bethesda Outpatient Surgery Ctr LLC	06	3.322	20	$93,399	$14,719	$12,970	-$1,749	-12%
079097400	Boca Raton Out Pt. Surg & Laser Ctr	06	1.923	45	$164,746	$21,467	$18,773	-$2,694	-13%
075967800	Bonita Community Health Center, Inc	06	2.222	3	$12,144	$1,793	$1,239	-$553	-31%
075890600	Boynton Beach ASC LLC	06	2.354	47	$104,841	$34,545	$29,546	-$4,999	-14%
079233100	Bradenton Endoscopy Center	06	1.156	3	$895	$333	$322	-$11	-3%
009605300	Brandon Ambulatory Surgery Center	06	2.610	47	$174,745	$38,146	$30,567	-$7,579	-20%
076015300	Brandon Ambulatory Surgery Center	06	2.899	36	$126,374	$27,069	$23,443	-$3,626	-13%
076908800	Brandon Ambulatory Surgery Center	06	2.900	30	$127,070	$28,604	$24,266	-$4,337	-15%
010667300	Brandon Ambulatory Surgery Center	06	2.667	27	$105,045	$22,131	$17,108	-$5,023	-23%
079085100	Brandon Surgi Center	06	1.992	608	$3,127,787	$273,980	$282,751	$8,772	3%
010300500	Brevard Surgery Center	06	2.062	8	$7,543	$3,529	$4,026	$497	14%
079180600	Brevard Surgery Center	06	2.847	7	$9,735	$6,414	$5,557	-$857	-13%
009012800	BVL Pediatrics	06	0.217	6,256	$787,462	$0	$237,233	$237,233	
076184200	Cape Coral Ambulatory Surgery, LLC	06	3.912	47	$290,268	$36,714	$29,454	-$7,260	-20%
079051600	Cape Coral Eye Center, Pa	06	2.512	40	$50,015	$29,533	$23,822	-$5,710	-19%
076826000	Capital City Surgical Center LLC	06	1.352	231	$537,000	$63,609	$62,580	-$1,029	-2%
010857300	Capital Surgical Associates	06	0.352	1	$83	$0	$98	$98	
001037300	Carillon Surgery Center LLC	06	3.064	33	$92,489	$25,306	$21,365	-$3,941	-16%
014069600	Center For Endoscopy Inc	06	1.765	7	$4,416	$833	$984	$152	18%
076109500	Central FL Endo & Surg Inst of Ocal	06	1.844	1,419	$1,572,989	$315,404	$418,663	$103,259	33%

Provider Medicaid ID	Provider Name	Provider Type	Case Mix	Claim Lines	Charges	Baseline Payment	Simulated EAPG Payment	Change in Payment	Percent Payment Change
079143100	Central FL. Eye Assoc Asc	06	2.783	270	$1,247,247	$172,550	$163,761	-$8,789	-5%
008676300	Central Florida Heart Care	06	0.299	66	$11,087	$0	$4,670	$4,670	
009238100	Central Florida Internal, Occupational & Environme	06	0.240	17	$2,056	$0	$1,136	$1,136	
075366100	Charlotte Endoscopic Surgery Ctr	06	1.328	41	$71,313	$12,850	$12,957	$107	1%
002965700	Childrens Surgery Center LLC	06	3.055	1,381	$3,497,570	$782,879	$684,913	-$97,966	-13%
079140700	Citrus Regional Surgery Center, LP	06	3.519	266	$1,305,872	$184,750	$174,704	-$10,046	-5%
079242000	Citrus Urology Center, Inc	06	2.414	31	$30,175	$12,071	$15,486	$3,415	28%
003516500	Clermont Ambulatory Surgical Center	06	2.590	63	$128,689	$30,068	$26,001	-$4,068	-14%
010060700	C-Med Ambulatory Surgery Center	06	1.747	34	$46,166	$4,388	$6,822	$2,434	55%
075218500	Coastal Medical Center LLC	06	2.134	3	$1,000	$717	$595	-$122	-17%
062949900	Columbia Eye & Spec Surg Ctr, Ltd	06	2.814	48	$278,068	$47,760	$37,666	-$10,094	-21%
079045100	Columbia Same Day Surgicenter-Orlan	06	3.256	413	$4,191,946	$318,429	$315,989	-$2,440	-1%
075439100	Coral Gables Surgery Center	06	2.814	145	$737,421	$120,457	$97,298	-$23,158	-19%
070313300	Coral Springs Ambulatory Surgery Ct	06	1.811	110	$345,064	$43,332	$50,501	$7,169	17%
079087700	Coral View Surgery Center	06	1.873	867	$792,655	$372,870	$388,159	$15,289	4%
079046000	Cordova Ambulatory Surgical Center	06	2.412	284	$253,180	$56,646	$100,885	$44,240	78%
079131800	Countryside Surgery Center, Ltd	06	4.362	64	$480,833	$53,782	$55,963	$2,181	4%
002230900	David W Nussear	06	0.074	1	$1,050	$0	$21	$21	
076096000	Delray Ambulatory Surgical & Laser	06	2.816	1	$12,000	$995	$785	-$210	-21%
001746600	Delray Anesthesia Services, LLC	06	0.074	43	$31,968	$0	$883	$883	
075230400	Destin Surgery Center Ltd	06	2.215	14	$73,516	$8,963	$7,412	-$1,551	-17%
075356400	Digestive & Liver Ctr of Melbourne	06	1.266	30	$66,700	$8,875	$8,829	-$45	-1%
010062100	Doctors Choice Medical Center	06	0.232	669	$91	$0	$40,612	$40,612	
075479000	Doctors Gi Partnership, Ltd	06	1.484	34	$109,083	$9,740	$10,347	$607	6%
070793700	Doctors Outpatient Surg. Cntr/Jupit	06	4.324	462	$942,190	$298,295	$267,698	-$30,597	-10%
076033100	Doctors Outpatient Surgery Center	06	2.223	7	$14,881	$4,810	$4,339	-$471	-10%
011908000	Doctors Outpatiert Surgery Center of Jupiter, LLC	06	3.040	30	$58,600	$23,846	$21,194	-$2,652	-11%
079212800	Doctors Same Day Surgery Center,Ltd	06	3.106	97	$498,759	$58,234	$58,044	-$190	0%
079108300	Doctors Surgery Center	06	1.975	414	$355,267	$200,726	$205,974	$5,248	3%
070375300	Doctor's Surgical Partnership	06	3.450	283	$692,732	$177,940	$179,899	$1,959	1%
079044300	Dothan Surgery Center, LLC	06	2.951	3	$3,800	$2,320	$2,469	$149	6%

Provider Medicaid ID	Provider Name	Provider Type	Case Mix	Claim Lines	Charges	Baseline Payment	Simulated EAPG Payment	Change in Payment	Percent Payment Change
002689600	E Street Endoscopy,LLC	06	1.408	159	$388,253	$46,447	$47,103	$656	1%
079142300	Emerald Coast Surgery Center, LP	06	3.032	163	$855,436	$115,195	$103,149	-$12,046	-10%
000564100	Endoscopy Center of Ocala, Inc	06	1.437	3	$1,650	$833	$801	-$31	-4%
070908500	Endosurg Outpatient Center	06	1.688	147	$90,727	$42,980	$48,488	$5,508	13%
005791600	Endosurg Outpatient Center	06	1.480	32	$21,426	$10,650	$10,733	$83	1%
004843600	Endo-Surgical Center of Florida, LLC	06	1.224	782	$873,230	$243,440	$242,011	-$1,429	-1%
004226100	Eye Care and Surgery Center of Ft Lauderdale, LLC	06	2.705	41	$94,575	$36,670	$30,179	-$6,491	-18%
070413000	Eye Center of North Florida, Pa	06	2.908	48	$63,798	$43,923	$37,298	-$6,624	-15%
004801300	Eye Physicians of Pinellas, Ph	06	2.950	179	$252,516	$137,243	$128,354	-$8,889	-6%
003297700	Eye Specialists Laser & Surgery Center Inc.	06	2.600	44	$95,840	$38,209	$31,908	-$6,301	-16%
001031700	Eye Surgery Center of North Florida, LLC	06	4.217	2	$3,450	$1,408	$1,176	-$232	-16%
001865700	Feinerman Anesthesia, PA	06	0.081	118	$94,450	$0	$2,632	$2,632	
079119900	Filutowski Eye Institute	06	0.751	163	$73,385	$25,701	$25,965	$264	1%
076860000	Filutowski Eye Institute Pa	06	2.792	18	$32,622	$17,545	$14,017	-$3,528	-20%
009287400	First Priority Anesthesia LLC	06	0.074	12	$2,088	$0	$246	$246	
076646100	Fleming Island Surgery Center, LLC	06	2.513	161	$368,321	$100,836	$99,518	-$1,318	-1%
009588500	Florida Endoscopy & Surgery Center LLC	06	0.074	9	$4,275	$0	$185	$185	
070553500	Florida Endoscopy/Surgery Center,Ll	06	1.588	104	$145,300	$32,106	$32,775	$669	2%
062926000	Florida Eye Clinic	06	0.986	2	$2,000	$0	$550	$550	
079122900	Florida Eye Institute Surgicenter	06	1.352	5	$3,080	$995	$1,885	$890	89%
075623700	Florida Medical Clinic-Ambulatory	06	2.816	1	$1,716	$995	$785	-$210	-21%
075261400	Florida Ortho Inst. Surgery Ctr,LLC	06	2.686	16	$78,498	$8,512	$5,993	-$2,519	-30%
009622700	Florida Outpatient Surgery Center Ltd	06	1.749	90	$412,152	$33,239	$37,067	$3,828	12%
079084200	Florida Outpatient Surgery Ctr, Ltd	06	1.139	2	$7,219	$666	$635	-$31	-5%
372900101	FMC Special Proc.	06	1.709	18	$13,883	$5,727	$4,767	-$959	-17%
002383900	Ft Myers Endoscopy Center, LLC	06	1.507	142	$179,390	$39,099	$43,277	$4,179	11%
075183900	Ft. Myers Digestive Health and Pain	06	1.251	1	$1,300	$333	$349	$16	5%
005493800	Gables Surgical Center	06	3.665	25	$64,192	$6,921	$7,154	$233	3%
075474900	Grove Place Surgery Center LLC	06	2.151	62	$78,300	$20,455	$30,600	$10,145	50%
070712100	Gulf Coast Endoscopy Center South	06	1.837	53	$82,935	$13,139	$14,858	$1,719	13%
075825600	Gulf Coast Surgery Center Inc	06	7.515	4	$29,924	$826	$4,192	$3,366	407%

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003213900	Hernando Hma, LLC	06	1.465	181	$250,584	$58,100	$58,028	-$72	0%
003342200	Hillmoor Eye Surgery Center, LLC	06	2.212	88	$137,269	$57,658	$51,806	-$5,851	-10%
076705100	Hospital Corporation of America	06	3.525	648	$3,746,257	$428,024	$480,733	$52,709	12%
004259500	Hsc Gamma Partners	06	3.258	17	$56,242	$5,727	$5,452	-$275	-5%
009288500	Independent Anesthesia Services PA	06	0.074	5	$3,990	$0	$103	$103	
079172500	Indian River Surgery Center, Ltd	06	2.133	51	$128,352	$25,194	$27,959	$2,765	11%
076124900	Interventional Therapeutics Institu	06	1.849	115	$288,127	$17,588	$31,457	$13,869	79%
076593700	Jacksonville Ctr for Endoscopy	06	1.329	281	$220,508	$84,059	$85,591	$1,532	2%
076592900	Jacksonville Ctr for Endoscopy	06	1.296	277	$218,365	$84,435	$85,655	$1,220	1%
079187300	Jacksonville Surgery Center	06	3.691	51	$357,024	$49,780	$48,384	-$1,396	-3%
010092500	James D Davenport MD PA	06	15.910	9	$4,072	$655	$4,437	$3,782	577%
075208800	Jupiter Outpatient Surg.Ctr.LLC	06	2.971	11	$37,460	$7,169	$8,286	$1,117	16%
003191300	Key Biscayne Surgery Center	06	2.801	45	$131,400	$21,585	$24,219	$2,634	12%
079060500	Kissimmee Surgicare, Ltd	06	2.090	271	$1,751,956	$130,016	$133,481	$3,466	3%
000268900	KZMss Again, LLLP	06	2.853	39	$138,990	$34,980	$30,237	-$4,743	-14%
010931500	KZMSS Again, LLLP	06	3.313	5	$28,865	$4,775	$4,620	-$155	-3%
000852900	Lake City Surgery Center	06	1.488	136	$118,816	$49,151	$48,136	-$1,015	-2%
076874000	Lake Mary Surgery Center LLC	06	2.992	58	$185,155	$29,158	$35,879	$6,722	23%
005495600	Lake Mary Surgical Center	06	2.418	23	$30,217	$18,410	$15,508	-$2,902	-16%
079209800	Lake Surgery & Endoscopy Ctr	06	1.003	171	$85,306	$38,651	$43,341	$4,690	12%
079223300	Lakeland Surgical Diagnostic Ctr	06	4.686	20	$75,050	$13,966	$16,989	$3,024	22%
076650000	Laser and Outpatient Surgery Center	06	3.044	46	$134,524	$24,923	$21,225	-$3,698	-15%
062967700	Lee Island Coast Surgery Center	06	3.451	9	$39,661	$6,982	$7,700	$718	10%
075390400	Live Oak Endoscopy Center, LLC	06	1.156	4	$4,250	$1,137	$967	-$169	-15%
076167200	Manatee Surgical Center Inc	06	0.534	151	$366,800	$69,087	$22,498	-$46,589	-67%
062953700	Manatee Surgicare, Ltd.	06	2.776	42	$223,182	$34,866	$27,872	-$6,994	-20%
009238200	Marinas Medical Center, LLC	06	0.230	1,504	$179,240	$0	$56,734	$56,734	
002028900	Mayo Clinic	06	0.484	73	$53,273	$1,998	$5,801	$3,803	190%
079081800	Med Cntr Surgery Assoc., LP	06	5.272	1,150	$2,039,395	$721,784	$676,336	-$45,448	-6%
079214400	Melbourne Surgery Center LP	06	3.504	165	$832,676	$109,190	$97,731	-$11,459	-10%
062943000	Memorial Same-Day Surgery	06	2.415	331	$796,821	$172,179	$167,000	-$5,178	-3%

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076464700	Merritt Island ASC, LLC	06	2.946	26	$56,430	$15,363	$12,323	-$3,040	-20%
079042700	Miami Eye Center, Inc	06	1.578	3	$49	$350	$440	$90	26%
079247100	Miami Hand Center, Inc	06	3.225	4	$11,900	$2,576	$2,698	$122	5%
003044100	Miami Kendall FL Endoscopy ASC,LLC	06	2.373	2	$3,040	$500	$662	$162	33%
076476100	Miami Lakes Surgery Center, Ltd	06	3.058	165	$1,077,124	$106,367	$107,463	$1,096	1%
005505000	Miami Lakes Surgery Ctr	06	2.151	122	$634,499	$33,763	$38,987	$5,224	15%
002837600	Mid Florida Endoscopy and Surgery Center	06	1.267	69	$41,400	$22,145	$22,256	$111	1%
009131900	Mid-Florida Endoscopy & Surgery Center LLC	06	1.366	70	$44,100	$23,798	$23,239	-$558	-2%
076884700	Millenia Park Surgery Center LLC	06	1.380	599	$1,466,486	$194,690	$189,307	-$5,382	-3%
001147200	Mnh Gi Surgical Center, LLC	06	1.257	1,054	$1,574,213	$325,042	$333,615	$8,573	3%
070519500	Morton Plant Health Services Inc	06	3.535	9	$30,476	$4,998	$6,902	$1,904	38%
076523600	Murdock Ambulatory Surgery Center	06	3.611	70	$220,500	$57,966	$62,443	$4,477	8%
005464000	Murdock Ambulatory Surgical Center	06	1.156	2	$6,400	$666	$645	-$21	-3%
075173100	N Miami Beach Surgical Center Ltd	06	3.426	88	$709,106	$71,354	$64,967	-$6,387	-9%
079105900	N.Palm Bch Cty Surgery Ctr, Ltd	06	1.831	281	$1,426,974	$86,795	$100,106	$13,311	15%
070844500	Naples Day Surgery, LLC	06	3.567	433	$1,567,347	$286,326	$263,622	-$22,703	-8%
070994800	Naples Day Surgery, LLC	06	3.449	44	$173,289	$33,098	$32,703	-$395	-1%
079039700	New Port Richey Surgery Center	06	2.936	155	$927,570	$105,242	$104,795	-$447	0%
076773500	New Tampa Surgery Center Ltd	06	3.192	144	$402,431	$72,313	$70,334	-$1,979	-3%
070711200	North Broward Hospital Distric	06	2.338	515	$1,760,442	$278,191	$247,724	-$30,467	-11%
079139300	North FL Surgery Center	06	3.609	298	$918,650	$199,543	$199,305	-$238	0%
070571300	North Florida Endoscopy Center	06	1.619	169	$387,072	$43,241	$46,056	$2,815	7%
079210100	North Florida Surgery Center	06	1.262	276	$265,580	$99,437	$95,405	-$4,032	-4%
079112100	North Florida Surgical Pavillion	06	3.323	431	$3,625,771	$326,415	$276,181	-$50,234	-15%
006979900	North Miami Beach Surgery	06	3.541	8	$69,440	$8,319	$6,913	-$1,406	-17%
075258400	North Pinellas Surgery Ctr LLC	06	1.522	12	$18,197	$3,330	$3,396	$66	2%
079136900	Northwest Florida ASC, LP	06	1.599	315	$428,593	$84,133	$90,962	$6,829	8%
079169500	Northwest Florida Surgery Center	06	2.360	1,194	$4,661,194	$326,451	$379,082	$52,630	16%
008438800	Nostrum Medical Center Homestead LLC	06	0.227	31	$4,175	$0	$1,962	$1,962	
002373900	Novamed Surgery Center of Orlando,LLC	06	3.053	388	$1,924,922	$249,476	$236,715	-$12,761	-5%
075862100	Novamed Surgery Center of Palm Bch	06	1.291	20	$44,478	$3,685	$6,478	$2,793	76%

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079207100	Ocala Eye Surgery Center Inc	06	2.816	2	$2,399	$1,990	$1,570	-$420	-21%
013677600	Ocala Specialty Surgery Center LLC	06	5.196	4	$6,987	$2,599	$2,898	$299	12%
079199700	Ocalasurg, Inc.	06	3.392	86	$380,061	$70,122	$62,438	-$7,684	-11%
004200000	Orange City Surgery Center, LLC	06	2.195	985	$1,512,105	$428,129	$418,628	-$9,501	-2%
000133500	Orange City Surgical, LLC	06	3.415	81	$493,031	$69,333	$64,762	-$4,571	-7%
079109100	Orlando Center For Outpatient Surge	06	1.871	104	$364,113	$42,407	$43,316	$909	2%
076152400	Orlando FL Endoscopy Acs, LLC	06	1.148	13	$20,085	$4,329	$4,161	-$168	-4%
000562600	Orlando Mills FL Endoscopy ASC, LLC	06	1.497	30	$45,000	$8,159	$8,350	$191	2%
075381500	Orlando Ophthalmology Surgery Ctr	06	4.198	7	$41,650	$7,576	$7,024	-$552	-7%
076188500	Outpatient Surgery Ctr of St August	06	3.972	3	$11,640	$1,386	$2,215	$829	60%
006804700	Outpatient Surgical Service	06	1.749	77	$350,241	$29,997	$31,220	$1,223	4%
079161000	Outpatient Surgical Services, Ltd	06	1.899	276	$1,333,928	$115,628	$113,307	-$2,320	-2%
009238000	Palermo MD PA	06	0.376	354	$55,359	$5,638	$30,925	$25,287	449%
010210000	Palm Beach Broward Medical Inc	06	0.544	4	$950	$0	$304	$304	
075618100	Palm Beach Surgery Center, LLC	06	1.542	1,049	$2,562,395	$317,605	$356,000	$38,395	12%
076116800	Palms West Surgery Center, Ltd.	06	2.444	985	$4,324,228	$480,163	$464,860	-$15,303	-3%
075701200	Panama City Surgery Center LLC	06	3.234	1,214	$5,078,334	$402,275	$450,051	$47,776	12%
007839700	Paramount Surgery Center, LLC	06	3.341	30	$365,773	$19,210	$14,906	-$4,303	-22%
004540200	Park Center For Procedures	06	3.308	44	$64,063	$11,496	$20,296	$8,800	77%
076718200	Park Creek Surgery Center, LLLP	06	3.529	501	$1,377,574	$103,850	$169,253	$65,403	63%
076106100	Park Place Surgery Center	06	3.164	81	$234,956	$24,164	$38,829	$14,665	61%
001394100	Pasadena Surgery Center, LLC	06	2.943	8	$13,599	$3,839	$4,104	$265	7%
007254600	Pediatric Surgery Center-Odessa, LLC	06	2.920	3,178	$7,905,775	$1,793,645	$1,593,475	-$200,169	-11%
000486000	Pediatric Surgery Center-Odessa, LLC	06	2.699	1,046	$2,625,400	$597,044	$560,839	-$36,205	-6%
007250300	Pediatric Surgery Centers LLC	06	2.983	4,827	$12,107,425	$2,819,949	$2,569,826	-$250,123	-9%
079155500	Physicians Ambulatory Surgery Ctr	06	1.563	331	$690,050	$95,969	$105,478	$9,509	10%
070466100	Physicians Day Surgery Center	06	4.273	165	$541,715	$163,363	$138,228	-$25,135	-15%
076177000	Physicians of Winter Haven LLC	06	4.090	6	$17,758	$3,233	$4,563	$1,330	41%
011143500	Physicians Outpatient Surgery Center, LLC	06	3.321	2	$9,568	$973	$926	-$47	-5%
079205500	Pinellas Surgery Ctr, Ltd	06	2.683	80	$410,176	$42,729	$46,397	$3,668	9%
000577800	Premier Endoscopy Center, LLC	06	1.614	59	$76,300	$15,789	$16,657	$869	6%

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003985800	Premier Surgical Center, LLC	06	1.571	107	$344,805	$33,977	$38,988	$5,011	15%
079229200	Presidential Surgicenter, Inc	06	2.803	2	$2,400	$1,260	$1,563	$303	24%
079231400	Prgfl Xiv, Inc	06	2.875	54	$174,221	$47,035	$41,687	-$5,348	-11%
070572100	Pshs Alpha Parteners, Ltd.	06	3.164	65	$163,934	$39,074	$31,766	-$7,307	-19%
076877400	Pshs Beta Partners Ltd	06	2.424	18	$39,294	$4,508	$5,407	$900	20%
004012900	Red Hills Surgical Center, LLC	06	3.325	415	$1,443,947	$313,621	$287,493	-$26,128	-8%
079102400	Riverside Park Surgi Center	06	3.071	53	$139,199	$51,100	$43,678	-$7,422	-15%
001577500	Riverside Surgery Center	06	2.572	15	$18,685	$13,035	$10,758	-$2,277	-17%
005502800	Riverside Surgical Center	06	1.480	119	$86,198	$7,109	$16,097	$8,988	126%
008139800	Riverwalk Ambulatory Surgery Center	06	1.536	34	$26,975	$6,635	$8,140	$1,505	23%
076074900	Riverwalk Endoscopy and Surgery Center, LLC	06	1.537	15	$12,774	$3,830	$4,285	$456	12%
079225000	Riverwalk Surgery Center	06	3.718	33	$119,773	$23,251	$17,628	-$5,623	-24%
004779700	Sacred Heart Health System, Inc	06	3.133	229	$573,360	$160,612	$140,652	-$19,960	-12%
003825500	Safety Harbor Surgery Center	06	1.869	133	$148,549	$19,428	$35,972	$16,544	85%
026267200	Same Day Surgery Centers of Florida LLC	06	2.280	5	$3,629	$3,032	$2,543	-$489	-16%
000064900	Sand Lake Surgery Center	06	3.944	193	$1,101,075	$122,298	$125,385	$3,087	3%
007688800	Sand Lake Surgery Center, LP	06	3.723	37	$201,578	$20,417	$17,650	-$2,767	-14%
004126600	Santa Fe Surgery Center, LLC	06	3.706	7	$46,933	$6,110	$6,201	$91	1%
007257900	Santa Lucia Surgical Center, LLC	06	2.604	335	$454,114	$269,305	$228,027	-$41,277	-15%
009289900	Sarasota Physicians Surgical Center LLC	06	3.700	15	$56,600	$9,169	$12,383	$3,214	35%
070933600	Sarc/Jacksonville	06	3.719	6	$38,791	$4,472	$4,148	-$324	-7%
076139700	Seven Hills Surgery Center	06	2.801	15	$22,308	$9,911	$9,372	-$539	-5%
079086900	Seven Springs Surgery	06	2.716	44	$42,273	$35,404	$31,809	-$3,595	-10%
076062500	South Broward Endoscopy, LLC	06	1.176	3	$2,161	$999	$984	-$15	-1%
075660100	South FL Ctr For Endoscopy	06	1.500	101	$186,445	$27,806	$29,276	$1,470	5%
075962700	South Fla Ambulatory Surgical Cntr	06	2.852	125	$761,143	$68,812	$57,264	-$11,548	-17%
070310900	Southeastern Urological Partners	06	3.113	117	$241,012	$84,208	$89,408	$5,200	6%
003464500	Southpoint Surgery Center, LLC	06	2.202	38	$113,318	$25,695	$22,104	-$3,592	-14%
079154700	Space Coast Surgical Center, Ltd.	06	3.350	42	$335,643	$35,473	$34,564	-$909	-3%
008646400	Specialists In Urology Surgery Center	06	2.502	11	$17,810	$4,295	$5,583	$1,288	30%
076522800	Specialists In Urology Surgery Cntr	06	3.143	17	$29,585	$9,190	$11,394	$2,205	24%

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075586900	Specialists In Urology Surgery Ctr	06	3.294	28	$83,975	$21,659	$21,131	-$528	-2%
076181800	St Anthony's Physicians Surgery Ctr	06	2.253	325	$796,222	$131,526	$128,828	-$2,697	-2%
076283100	St Augustine Surgery Ctr LLC	06	1.746	39	$217,849	$11,447	$10,710	-$737	-6%
070735000	St Lucie Surgical Center, Pa	06	1.222	72	$156,960	$23,477	$23,515	$38	0%
070826700	St Michaels Eye & Laser Institute	06	2.711	6	$10,519	$4,589	$4,537	-$52	-1%
079055900	St. Augustine Endoscopy	06	1.436	145	$94,425	$41,515	$43,259	$1,744	4%
079194600	St. Johns Surgery Center, Inc	06	2.816	14	$16,800	$13,930	$10,993	-$2,937	-21%
079224100	St. Lucie Surgery Center	06	1.619	366	$1,430,287	$173,241	$151,726	-$21,515	-12%
079068100	St. Lucy's Outpatient Surg. Cntr	06	2.388	32	$25,408	$12,284	$9,991	-$2,293	-19%
062925100	St. Lukes's Surgical Ctr	06	2.217	186	$187,012	$126,393	$107,597	-$18,796	-15%
076934700	St. Marks Surgical Center, LLC	06	1.629	33	$33,930	$12,848	$12,721	-$127	-1%
076202400	St. Petersburg Endoscopy Center	06	1.470	107	$107,000	$30,386	$32,389	$2,002	7%
010310700	Stuart Outpatient Surgery Ctr-Hca	06	1.155	10	$17,495	$3,330	$3,220	-$110	-3%
070785600	Summerlin Bend Surgery Center, LLP	06	2.933	725	$4,612,123	$391,792	$321,484	-$70,308	-18%
079053200	Suncoast Eye Center	06	2.525	32	$31,850	$23,773	$20,422	-$3,351	-14%
079192000	Suncoast Medical Clinic, LLC	06	0.048	2	$25	$0	$27	$27	
006679700	Suncoast Specialty Surgery Center, LLLP	06	5.578	6,919	$21,010,289	$2,635,683	$2,517,114	-$118,569	-4%
000012700	Suncoast Specialty Surgery Center, LLLP	06	4.664	1,133	$3,390,837	$572,304	$518,969	-$53,335	-9%
070762700	Suncoast Surgery Center, LLC	06	2.204	9	$17,900	$6,270	$5,532	-$738	-12%
009290200	Sunrise Anesthesia Assoc	06	0.708	183	$82,051	$16,025	$32,996	$16,971	106%
010840700	Surgcenter Northeast LLC	06	2.062	2	$12,206	$1,076	$575	-$501	-47%
009742700	Surgcenter Pinellas, LLC	06	1.677	11	$42,040	$3,150	$2,339	-$811	-26%
079171700	Surgery Center at St. Andrews	06	3.009	9	$54,195	$7,278	$6,713	-$565	-8%
010410300	Surgery Center at University Park, LLC	06	1.496	193	$1,136,485	$71,917	$68,832	-$3,085	-4%
000957400	Surgery Center at University Park, LLC	06	1.416	164	$974,447	$57,416	$57,244	-$172	0%
076770100	Surgery Center of Atlantis, LLC	06	1.440	89	$324,526	$24,290	$26,509	$2,220	9%
006878100	Surgery Center of Aventura	06	1.320	40	$149,401	$11,665	$11,039	-$626	-5%
076169900	Surgery Center of Aventura Ltd	06	1.828	146	$604,215	$51,791	$53,010	$1,219	2%
000899000	Surgery Center of Key West, LLC	06	5.997	1	$18,243	$1,500	$1,673	$173	12%
009446700	Surgery Center of Okeechobee, LLC	06	2.527	125	$298,352	$47,979	$47,217	-$762	-2%
007957500	Surgery Center of Pembroke Pines, LLC	06	2.528	20	$134,535	$12,310	$10,575	-$1,735	-14%

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002184900	Surgery Center of Pembroke Pines,LLC	06	4.178	2	$18,330	$1,460	$1,165	-$294	-20%
076113300	Surgery Center of Port Charlotte	06	2.960	238	$1,069,308	$95,555	$111,431	$15,876	17%
075319000	Surgery Center of Southwest Florida	06	3.296	79	$179,068	$46,322	$53,306	$6,983	15%
002854500	Surgery Center of Volusia, LLC	06	2.157	27	$112,150	$14,330	$12,635	-$1,694	-12%
079149100	Surgery Ctr at Coral Springs	06	2.672	409	$2,452,292	$221,260	$220,538	-$722	0%
079246200	Surgery Ctr of Okeechobee, Inc	06	1.680	20	$41,135	$5,846	$6,089	$243	4%
075971600	Surgical Center For Excellence	06	2.408	2,374	$3,618,040	$593,004	$857,507	$264,503	45%
007109600	Surgical License Ward	06	3.709	64	$201,902	$30,453	$34,129	$3,676	12%
079168700	Surgical Licensed Ward	06	3.381	267	$652,780	$105,251	$117,861	$12,610	12%
079107500	Surgical Park Center	06	3.387	251	$2,235,560	$185,072	$171,897	-$13,176	-7%
006826900	Surgical Park Center Ltd	06	3.019	118	$944,309	$64,639	$55,571	-$9,067	-14%
000164800	Surgical Specialists ASC	06	2.673	49	$97,600	$22,725	$22,367	-$358	-2%
006594000	Surgical Specialists of St. Lucie County, LLC	06	2.752	179	$1,192,280	$84,654	$79,059	-$5,596	-7%
062937500	Surgicare Center	06	0.496	8,959	$2,106,247	$513,689	$640,097	$126,408	25%
007954800	Surgicare of Miramar, LLC	06	2.062	2	$15,653	$1,076	$575	-$501	-47%
079096600	Surgicare of Orange Park	06	2.334	131	$668,815	$75,392	$75,520	$128	0%
079069900	Tallahassee Endoscopy Center	06	1.478	193	$188,460	$55,445	$58,933	$3,488	6%
076111700	Tallahassee Neurosurgery Pain Mgmt	06	1.578	82	$131,200	$14,325	$25,087	$10,762	75%
079092300	Tallahassee Orthopedic Surgery Cntr	06	4.650	170	$1,350,745	$149,284	$160,813	$11,530	8%
076855300	Tallahassee Orthopedic Surgery Part	06	2.898	31	$177,815	$24,811	$22,630	-$2,181	-9%
002307300	Tamarac Surgery Center	06	1.460	265	$1,173,050	$76,025	$79,405	$3,380	4%
001191700	Tamarac Surgery Center	06	1.717	2	$7,634	$500	$479	-$21	-4%
009290400	Tampa Bay Regional Surgery Center	06	1.156	1	$1,100	$333	$322	-$11	-3%
075539700	Tampa Bay Specialty Surgery Center	06	1.603	12	$30,797	$3,247	$3,577	$330	10%
075986400	Tampa Bay Surgery Center	06	3.335	1,993	$7,005,088	$1,364,768	$1,246,426	-$118,342	-9%
079156300	Tampa Bay Surgery Center	06	2.750	1,448	$3,273,780	$314,832	$417,193	$102,361	33%
007071100	Tampa Bay Surgery Center Assoc DBA Tampa	06	0.074	555	$580,271	$0	$11,354	$11,354	
004622700	Tampa Outpatient Surgical Facility	06	1.858	7	$18,200	$3,076	$2,591	-$485	-16%
002380700	Tampa Surgery Center LLC	06	2.204	35	$102,000	$20,450	$19,665	-$785	-4%
009001500	Tavares Surgery, LLC	06	1.310	9	$12,150	$2,581	$2,558	-$23	-1%
076885500	The Altamonte Springs Fl Endoscopy	06	1.156	1	$1,340	$333	$322	-$11	-3%

Provider Medicaid ID	Provider Name	Provider Type	Case Mix	Claim Lines	Charges	Baseline Payment	Simulated EAPG Payment	Change in Payment	Percent Payment Change
001569600	The Brevard Speciality Surgery Center, LLC	06	3.088	328	$2,279,025	$184,839	$160,186	-$24,653	-13%
079167900	The Crystal River Endoscopy ASC, LP	06	1.248	152	$114,661	$46,254	$45,929	-$325	-1%
079204700	The Endoscopy Group, LLC	06	1.472	942	$604,800	$256,511	$264,365	$7,855	3%
079038900	The Eye Associates Surgery Center	06	2.437	19	$18,064	$12,083	$9,513	-$2,570	-21%
075954600	The Eye Institute Surgery Center	06	2.816	1	$2,500	$995	$785	-$210	-21%
003931300	The Ft Myers FL Ophthalmology ASC LLC	06	2.089	36	$77,012	$23,553	$19,812	-$3,741	-16%
079066400	The Gastroentrology Cntr of Hialeah	06	1.245	540	$420,675	$169,930	$167,749	-$2,181	-1%
076847200	The Kissimmee FL Endoscopy ASC, LLC	06	1.199	1,054	$1,580,600	$337,995	$330,607	-$7,388	-2%
075976700	The Lakeland FL Endoscopy ASC LLC	06	1.261	750	$1,053,620	$232,240	$230,602	-$1,638	-1%
079230600	The Melbourne Asc, L.P.	06	1.480	84	$92,168	$23,477	$24,345	$869	4%
006830200	The Miami ASC LP DBA	06	1.524	396	$557,586	$108,825	$114,734	$5,909	5%
004356600	The Miami ASC, L.P.	06	1.600	1,413	$2,012,753	$376,057	$403,023	$26,966	7%
079101600	The Mount Dora Ophtalmolgy ASC, LLC	06	2.002	27	$33,745	$15,725	$15,076	-$649	-4%
079113000	The Ocala Endoscopy ASC, L.P.	06	1.409	63	$29,342	$17,899	$18,467	$569	3%
079091500	The Opthalmology Ctr of Brevard	06	2.746	32	$52,850	$27,346	$23,742	-$3,604	-13%
076151600	The Orlando FL Endoscopy Acs LLC	06	1.269	167	$251,835	$48,368	$48,144	-$225	0%
079186500	The Outpatient Center of Boynton Bc	06	1.723	284	$442,011	$74,892	$85,544	$10,652	14%
079232200	The Palmetto Asc LP	06	1.201	1,353	$1,955,245	$435,466	$428,441	-$7,024	-2%
075984800	The Rockledge Fl Endoscopy ASC LLC	06	1.369	50	$57,054	$14,402	$14,894	$491	3%
070806200	The Sarasota Endoscopy ASC, LLC	06	1.748	3	$4,338	$833	$975	$142	17%
070950600	The Suncoast Endoscopy ASC, LP	06	1.254	75	$51,613	$22,894	$23,072	$178	1%
075162600	The Sunrise Ophthalmology, ASC,LLC	06	2.363	30	$60,707	$20,693	$17,789	-$2,903	-14%
070948400	The Surg. Cntr of Coral Gables,LLC	06	3.036	153	$262,805	$137,777	$121,933	-$15,844	-11%
075682200	The Surgery & Endoscopy Center	06	1.320	21	$63,063	$6,044	$5,888	-$156	-3%
009461900	The Surgery Center At Jensen Beach, LLC	06	2.907	9	$16,000	$4,983	$4,053	-$929	-19%
075675000	The Surgery Center At Sacred Heart	06	1.939	37	$57,650	$8,285	$13,516	$5,231	63%
076888000	The Surgery Center of Jacksonville	06	3.081	1	$6,994	$995	$859	-$136	-14%
000620900	The Surgery Center of The Villages, LLC	06	2.894	33	$55,936	$29,643	$25,828	-$3,815	-13%
000625000	The Surgical Center at Sun N Lake, LLC	06	1.875	260	$1,249,649	$112,428	$113,474	$1,046	1%
075922800	The Tampa FL Endoscopy ASC LLC	06	1.224	883	$1,091,398	$274,485	$270,286	-$4,198	-2%
075918000	The Winter Haven/Sebring FL Ophthal	06	2.573	36	$67,195	$30,143	$25,833	-$4,310	-14%

Provider Medicaid ID	Provider Name	Provider Type	Case Mix	Claim Lines	Charges	Baseline Payment	Simulated EAPG Payment	Change in Payment	Percent Payment Change
075483800	The Winter Haven/Sebring FL Opthalm	06	2.807	29	$56,989	$25,566	$22,701	-$2,865	-11%
076525200	Tomoka Surgery Center, LLC	06	2.129	8	$17,240	$5,075	$4,751	-$324	-6%
079222500	Treasure Coast Surgery Center LLC	06	2.315	19	$57,575	$9,374	$9,685	$311	3%
000895400	Treasure Coast Surgical Center Inc	06	1.237	310	$759,502	$97,278	$97,310	$32	0%
075510900	Trinity Surgery Center, LLC	06	2.760	166	$512,868	$66,705	$78,509	$11,805	18%
076653400	Umdc Dept of Ophthalmology	06	3.994	65	$217,715	$50,760	$50,125	-$636	-1%
000168500	University Medical Service Association Inc	06	3.420	160	$326,971	$98,301	$96,341	-$1,960	-2%
079153900	University Surgical Center, Inc	06	3.058	446	$2,427,818	$339,095	$314,638	-$24,457	-7%
009290700	Unlimited Medical Services of FL PL	06	0.221	412	$42,165	$0	$21,966	$21,966	
000641000	Venture Ambulatory Surgery Center, LLC	06	1.377	238	$817,550	$68,681	$69,487	$805	1%
079123700	Vesc Inc	06	1.769	16	$15,873	$7,080	$7,402	$322	5%
000563400	Villages Endoscopy & Surgical Center, LLC	06	1.566	32	$41,791	$8,492	$9,608	$1,117	13%
075141300	Visual Hlt @ Jupiter Eye Ctr, LLC	06	2.696	49	$222,800	$43,085	$34,589	-$8,496	-20%
079106700	Waterside Ambulatory Surg Ctr, Inc	06	1.365	29	$33,669	$8,325	$9,136	$811	10%
075409900	Webster Surgical Ctr of Tall., LLC	06	1.210	61	$66,300	$19,148	$18,555	-$592	-3%
079184900	West FL Med Cntr Clinic Pa	06	3.901	128	$265,950	$110,849	$93,559	-$17,290	-16%
076643700	West Florida Surgery Center	06	1.415	27	$14,155	$7,326	$7,892	$566	8%
076072200	West Palm Beach FL Endoscopy ASC,LI	06	1.175	5	$9,175	$1,665	$1,638	-$27	-2%
079220900	West Palm Beach Outpt Surg & Laser	06	2.107	115	$598,859	$55,145	$52,885	-$2,260	-4%
075941400	West Park Surgery Center	06	1.574	745	$862,280	$89,738	$168,126	$78,388	87%
004259900	Westchase Surery Center	06	3.970	4	$17,051	$2,121	$2,214	$93	4%
070645100	Weston Outpatient Surgical Ctr, Ltd	06	3.510	231	$1,710,420	$138,897	$148,781	$9,884	7%
075145600	Westside Outpatient Center LLC	06	1.764	33	$54,848	$2,413	$6,886	$4,473	185%
079185700	Westside Surgery Center, Ltd.	06	3.191	51	$310,510	$42,887	$41,828	-$1,059	-2%
007987800	Winter Haven Ambulatory Surgical Center, LLC	06	2.799	422	$1,223,938	$274,436	$274,003	-$433	0%
079145800	Winter Park Surgery LP	06	2.768	283	$867,552	$159,948	$164,437	$4,490	3%
Total			**2.045**	**98,786**	**$226,180,498**	**$35,657,540**	**$35,657,877**	**$337**	**0%**

20 Appendix D – Budget Calculations

The table in this section shows the budget or total payment goals for the EAPG pricing simulation. The payment goals were set in order to reach budget neutrality – that is the total payment under the EAPG pricing simulations is intended to be as close as possible to the total historical payment for the claims in the dataset. The budget goal for hospitals in the "High Medicaid Outpatient Utilization" category was set to 90 percent of cost, which is slightly lower than what they receive under the legacy payment method. The reduction in payment to these hospitals was shifted to the hospitals in the "All Other" category.

Table 11. Calculation of budget goals for determination of EAPG base rates and provider policy adjustors.

	Simulation 08									
	A	B	C	D	E	F	G	H	I	J
	Provider Classification	Outpatient Claim Lines	Baseline Payment From GR and PMATF	Automatic Rate Enhancements	Total Baseline Payment	Estimated Cost (Mcr CCRs)	Ninety Percent of Cost	Adjustment to Funds for Base Rate	Funds Available for EAPG Rates	Funds Available for EAPG Rates
1	All Other Hospitals	18,295,764	$ 974,785,660	$ 75,485,288	$ 1,050,270,947	$ 1,447,139,290	n/a	$ 4,154,927	$ 978,940,586	$ 1,054,425,874
2	Hi Mcaid OP Util Hosps	1,077,554	$ 150,759,934	$ 20,407,173	$ 171,167,108	$ 185,569,090	$ 167,012,181	$ (4,154,927)	$ 146,605,008	$ 167,012,181
3	ASCs	98,786	$ 35,657,540	$ -	$ 35,657,540	n/a	n/a	$ -	$ 35,657,540	$ 35,657,540
4										
5	**Totals:**	19,472,104	$ 1,161,203,134	$ 95,892,461	$ 1,257,095,595	$ 1,632,708,380	$ 167,012,181	$ -	$ 1,161,203,134	$ 1,257,095,595
6										
7								Total Budgeted EAPG Claim Payments:		$ 1,257,095,595

Notes:

1) Stays in dataset are FFS and managed care outpatient claims from state fiscal year (SFY) 2013/2014 with 19 hospitals removed.

2) Baseline Payment from GR and PMATF was calculated by applying SFY 2015/2016 legacy pricing rates and rules to claims in the dataset.

3) Automatic Rate Enhancements are the annual amounts allocated for SFY 2015/16 to the hospitals included in the modeling dataset.

4) Outpatient payment goal for hospitals in the "High Medicaid Outpatient Utilization" category is 90% of cost.

21 Appendix E – OPPS Payment Simulation Parameter Summary

The following table shows historical and simulated payments by the categories of providers given their own base rate or provider policy adjustor. EAPG base rate and policy adjustors are also listed.

Table 12. Summary of OPPS simulated payments and payment parameters.

OPPS Payment Simulation					
Simulation 08					
Simulation Parameters	**Overall**	**All Other Hospitals**	**High Medicaid Outpatient Utilization Hospitals**	**ASCs**	**Comment**
Baseline payment - GR/PMATF	$1,161,203,134	$974,785,660	$150,759,934	$35,657,540	Equals sum of allowed amounts on FFS claims and re-priced MC claims
Baseline payment automatic rate enhancements	$95,892,461	$75,671,878	$20,220,583	$0	
Baseline payment - Total	$1,257,095,595	$1,050,457,538	$170,980,518	$35,657,540	
Simulation payment goal - GR/PMATF	$1,161,203,134	$978,940,586	$146,605,008	$35,657,540	Intention is budget neutrality in aggregate, with small shift of funds from High Medicaid OP Utilization hospitals to All Other hospitals.
Simulation payment goal - automatic rate enhancements	$95,892,461	$75,485,288	$20,407,173	$0	Intention is budget neutrality
Simulation payment goal - Total	$1,257,095,595	$1,054,425,874	$167,012,181	$35,657,540	
Simulation payment result - GR and PMATF	$1,161,201,617	$978,938,145	$146,605,595	$35,657,877	
Difference	-$1,517	-$2,441	$587	$337	
Simulation payment result - automatic rate enhancements	$95,894,189	$75,485,502	$20,408,687	$0	
Difference	$1,728	$214	$1,514	$0	
Simulation payment result - total	$1,257,095,806	$1,054,423,647	$167,014,282	$35,657,877	
Difference	$211	-$2,227	$2,101	$337	
EAPG Base Rate	N/A	$388.07	$388.07	$278.88	
Claim Lines in Simulation	19,472,104	18,295,764	1,077,554	98,786	
Wage index adjustment of base price	None				
Cost outlier parameters	None				
Policy adjustor - Provider	N/A	None	1.4182	None	
Policy adjustor - EAPG (service)	None				
Policy adjustor - Age	None				
Documentation & coding adjustment	None				
Relative weights	EAPG v3.10 national				

Notes:

1) Simulation 08 includes two base rates, one for hospitals and another for ASCs.

2) Simulation 08 has a policy adjustor for High Medicaid Outpatient Utilization Hospitals. These are the four free-standing children's hospitals in Florida - All Childrens Hospital, Nemours Childrens Hospital, Nicklaus Childrens Hospital, and Shriners Hospital for Children.

3) Simulation 08 spreads the nearly $96 million in automatic rate enhancements as per-claim supplemental payments to specific hospitals. This total is less than the $133 million overall budget because some hospitals that receive automatic rate enhancements are not included in the EAPG claims dataset.

22 Appendix F – Payment to Cost Comparisons by Service Line

The table on the following page summarizes estimates of outpatient reimbursement change by service line. Although the payment change is budget neutral overall, changes in payment are expected for individual types of services because the legacy payment method and the new OPPS payment method are significantly different. Outside of laboratory services, the legacy payment method makes no attempt to adjust payment for individual services based on the level of effort or resource requirements needed to perform the service. The EAPG-based OPPS, in contrast, uses relative weights to increase payments for higher cost services and decrease payments for lower cost services. In addition, the legacy payment method provides a reimbursement on nearly every service line, whereas the EAPG-based OPPS bundles payment for some services in with payment for other services.

Also in the table below, services provided by ASCs are grouped into their own category, and estimated cost for these services is intentionally left blank because we have no practical way to measure cost at ASCs. ASCs are not required to submit Medicare cost reports as are hospitals.

Table 13. Comparison of legacy payment to simulated OPPS payment by service line.

Simulation 08 Summary of Simulation by Service Line						
Service Line	Claim Lines	Charges	Baseline Payment - GR/PMATF	Simulated EAPG Payment - GR/PMATF	Payment Change	Percent Payment Change
Laboratory	7,451,195	$1,716,475,458	$46,681,778	$27,368,644	-$19,313,134	-41%
Pharmacy	3,858,775	$956,506,336	$342,189,398	$229,784,026	-$112,405,372	-33%
Emergency room	2,888,826	$2,864,797,433	$244,704,498	$259,808,611	$15,104,113	6%
Diagnostic and testing	2,121,946	$3,044,343,274	$191,778,031	$121,761,466	-$70,016,565	-37%
Therapies	922,465	$263,334,379	$97,805,021	$160,854,466	$63,049,444	64%
Supplies	725,066	$368,524,841	$63,410,371	$0	-$63,410,371	-100%
OR-Anesthesia-Recovery	381,264	$1,352,901,266	$40,546,096	$160,329,991	$119,783,895	295%
Observation	343,666	$283,800,580	$27,928,305	$42,061,861	$14,133,556	51%
Care Delivery	217,178	$344,788,596	$22,133,414	$38,035,068	$15,901,653	72%
Radiology and Nuclear Medicine	210,583	$259,380,462	$20,485,301	$58,994,421	$38,509,120	188%
Clinic	135,158	$41,951,570	$17,369,785	$10,968,658	-$6,401,127	-37%
ASC	98,786	$226,180,498	$35,657,540	$35,657,877	$337	0%
Labor-Delivery	59,055	$43,749,432	$5,113,243	$5,475,689	$362,446	7%
Blood	42,247	$25,178,995	$4,195,771	$5,377,485	$1,181,714	28%
Dialysis	10,043	$13,015,812	$996,699	$4,430,899	$3,434,199	345%
Behavioral Health	1,905	$1,099,637	$159,369	$291,562	$132,193	83%
Error	1,651	$425,146	$14,028	$0	-$14,028	-100%
Non-Payable	926	$32,497	$0	$0	$0	
Trauma Response	545	$5,650,451	$28,942	$892	-$28,051	-97%
Professional Fees	467	$131,529	$0	$0	$0	
DME	104	$10,429	$0	$0	$0	
Transportation	101	$170,137	$0	$0	$0	
Organ acquisition	80	$351,780	$5,474	$0	-$5,474	-100%
Room and board	45	$140,719	$0	$0	$0	
Nursing	9	$1,119	$0	$0	$0	
Telemedicine	7	$3,691	$0	$0	$0	
Oncology	7	$3,074	$0	$0	$0	
Hospice	2	$829	$67	$0	-$67	-100%
Home Health	2	$297	$0	$0	$0	
Total	**19,472,104**	**$ 11,812,950,267**	**$ 1,161,203,134**	**$ 1,161,201,617**	**$ (1,517)**	**0%**

Note(s):
1) Service lines assigned based on the revenue codes.
2) Baseline and simulated payments in this table include only distribution of GR and PMATF funds. Automatic rate enhancements are not included.

23 Appendix G – Payment to Cost Comparisons by Provider Category

The table on the following page summarizes estimates of outpatient reimbursement change by category of provider. In this table, providers may be included in more than one category.

Also in the table below, estimated cost for services provided by ASCs is intentionally left blank because we have no practical way to measure cost at ASCs. ASCs are not required to submit Medicare cost reports as are hospitals.

Table 14. Comparison of legacy payment to simulated OPPS payment by provider category.

Simulation 08										
Summary of Simulation by Provider Category										
Provider Category	Claim Lines	Case Mix	Estimated Cost	Charges	Baseline Payment	Simulated Payment	Change in Payment	Percent Change	Baseline Pay / Cost	Simulated Pay / Cost
Hospital	19,373,318	0.686	$ 1,632,708,380	$ 11,586,769,769	$ 1,221,438,055	$ 1,221,437,929	$ (126)	0%	75%	75%
General Acute	7,259,653	0.652	$ 533,908,978	$ 4,508,505,345	$ 355,874,460	$ 364,472,740	$ 8,598,281	2%	67%	68%
Trauma	7,163,913	0.711	$ 672,172,067	$ 4,143,148,442	$ 554,803,171	$ 559,085,611	$ 4,282,440	1%	83%	83%
Safety Net	6,995,709	0.722	$ 620,469,546	$ 3,684,926,231	$ 528,539,224	$ 512,053,115	$ (16,486,109)	-3%	85%	83%
For Profit	6,438,884	0.677	$ 470,331,076	$ 5,089,596,461	$ 309,451,555	$ 330,882,452	$ 21,430,897	7%	66%	70%
High Charity	4,199,035	0.670	$ 321,558,801	$ 2,866,569,242	$ 223,631,094	$ 235,003,012	$ 11,371,918	5%	70%	73%
Statutory Teaching	3,273,913	0.850	$ 330,573,118	$ 1,978,935,333	$ 276,007,861	$ 254,146,542	$ (21,861,319)	-8%	83%	77%
Public	2,759,233	0.705	$ 201,416,231	$ 1,213,877,176	$ 142,567,308	$ 170,351,160	$ 27,783,852	19%	71%	85%
Children	1,077,554	0.655	$ 185,569,090	$ 637,525,583	$ 171,167,108	$ 167,014,282	$ (4,152,825)	-2%	92%	90%
Rural	1,036,075	0.529	$ 64,048,983	$ 336,176,671	$ 61,322,012	$ 48,537,965	$ (12,784,048)	-21%	96%	76%
ASC	98,786	2.045	$ -	$ 226,180,498	$ 35,657,540	$ 35,657,877	$ 337	0%	0%	0%
Out of state	95,461	0.523	$ 7,605,034	$ 40,151,246	$ 5,140,463	$ 3,587,905	$ (1,552,558)	-30%	68%	47%
Rehabilitation	56,185	0.640	$ 2,599,899	$ 7,823,352	$ 2,528,027	$ 7,048,379	$ 4,520,352	179%	97%	271%
Note(s):										
1) Hospitals may be included in more than one category.										
2) Costs using Medicare cost-to-charge ratios are unavailable for the Ambulatory Surgical Centers.										

24 Appendix H – Manual Adjustments to Improve EAPG Assignment

As mentioned in Section 3.4, manual adjustments were made to specific types of services to enable assignment of an EAPG on claim lines submitted without a procedure code. This was done only for specific revenue codes that are generally billed with one of a small number of procedure codes that map to a small number of EAPG codes. In these scenarios, manual manipulation could be performed for the purpose of assigning EAPG codes, with a reasonable level of accuracy. For some revenue codes, the manual manipulation involved assigning a procedure code to claim service lines with blank procedure codes. This was done prior to processing through the EAPG grouping software so that EAPG codes and discounting logic could be applied based on these procedure codes. A summary of the procedure code assignments is shown in Table 15. In other cases, the manual adjustment involved assignment of an EAPG code directly to the claim line without populating the procedure code. Details of when manual assignment of an EAPG code was performed is included in Table 16.

Table 15. Manual assignment of procedure codes on select lines with blank procedure codes.

Type of Service	Revenue Code	Manually Assigned Procedure Code	Resulting EAPG Code	EAPG Rel Wt
Physical Therapy	0420, 0421, 0424	97110, 97001, 97035, 97112, 97116, 97002, 97140, 97530	271 - Physical Therapy	0.7257
Occupational Therapy	0430, 0431, 0434	97532, 97003, 97535	270 - Occupational Therapy	0.9767
Speech Therapy	0440, 0441, 0444	92507, 92506, 92522	272 - Speech Therapy and Evaluation	0.3224
Dialysis	0800 – 0809 0820, 0822 – 0829 0880 - 0889	90935	168 - Hemodialysis	1.5279
	0821	Assign procedure code 90935 to 1 in every 3 lines with this revenue code	168 - Hemodialysis	1.5279
	0830 - 0859	90945	169 - Peritoneal Dialysis	1.6323
Radiology	0330	96521; Chrgs < $1,000	489 - Level II Other Miscellaneous Ancillary Procedures	0.1828
		77293; Chrgs >= $1,000	481 - Therapeutic Radiology Simulation Field Setting	0.9624
	0331, 0335	96413; Chrgs < $1,275	111 - Pharmacotherapy Except by Extended Infusion	0.7535
		96415; Chrgs >= $1,275	110 - Pharmacotherapy by Extended Infusion	1.4448
	0333	77417; Chrgs < $350	471 - Plain Film	0.1106
		77300; Chrgs Btwn $350 and $590	480 - Teletherapy/Brachytherapy Calculation	0.1703
		77014; Chrgs Btwn $590 and $638	473 - CT Guidance	0.1859

Type of Service	Revenue Code	Manually Assigned Procedure Code	Resulting EAPG Code	EAPG Rel Wt
		77336; Chrgs Btwn $638 and $860	478 - Medical Radiation Physics	0.2149
		77334; Chrgs Btwn $860 and $1,085	479 - Treatment Device Design and Construction	0.3547
		77421; Chrgs Btwn $1,085 and $1,615	474 - Radiological Guidance for Therapeutic or Diagnostic Procedures	0.5431
		77315; Chrgs Btwn $1,615 and $1,671	484 - Therapeutic Radiology Treatment Planning	0.6564
		77290; Chrgs Btwn $1,671 and $1,680	481 - Therapeutic Radiology Simulation Field Setting	0.9624
		77418; Chrgs >= $1,680	343 - Radiation Treatment Delivery	2.0324
Nuclear Medicine	0340, 0341	A9503; Chrgs < $500	490 - Incidental to Medical, Significant Procedure or Therapy Visit	0.0000
		78306; Chrgs Btwn $500 and $1,990	330 - Level I Diagnostic Nuclear Medicine	0.6347
		78582; Chrgs Btwn $1,990 and $3,550	331 - Level II Diagnostic Nuclear Medicine	0.7456
		78452; Chrgs >= $3,550	332 - Level III Diagnostic Nuclear Medicine	1.7284
	0342	79005	340 - Therapeutic Nuclear Medicine	0.9025

Table 16. Manual assignment of EAPG codes to select claims billed with blank procedure codes.

Type of Service	Revenue Code	Submitted Charges	Manually Assigned EAPG Code	EAPG Rel Wt	Packing Indicator
Pharmacy	0250 – 0259 0630 – 0639 0343 - 0344	Charges < $10	496 - Minor Pharmacotherapy	0.0000	Y
		Charges between $10 and $63	435 - Class I Pharmacotherapy	0.0271	Y
		Charges between $63 and $124	436 - Class II Pharmacotherapy	0.2492	N
		Charges between $124 and $212	437 - Class III Pharmacotherapy	0.4632	N
		Charges between $212 and $350	438 - Class IV Pharmacotherapy	0.4741	N
		Charges between $350 and $558	439 - Class V Pharmacotherapy	1.1952	N
		Charges between $558 and $855	440 - Class VI Pharmacotherapy	1.2863	N
		Charges between $855 and $1,260	444 - Class VII Pharmacotherapy	1.6068	N
		Charges between $1,260 and $1,782	460 - Class VIII Combined Chemotherapy and Pharmacotherapy	2.1573	N
		Charges between $1,782 and $2,415	461 - Class IX Combined Chemotherapy and Pharmacotherapy	3.8809	N
		Charges between $2,415 and $4,251	462 - Class X Combined Chemotherapy and Pharmacotherapy	4.4917	N
		Charges between $4,251 and $6,501	463 - Class XI Combined Chemotherapy and Pharmacotherapy	7.4539	N
		Charges between $6,501 and $10,001	464 - Class XII Combined Chemotherapy and Pharmacotherapy	14.2305	N
		Charges >= $10,001	465 - Class XIII Combined Chemotherapy and Pharmacotherapy	30.5443	N
Supplies	0264 0170 – 0279 0621 - 0624	n/a	490 - Incidental to Medical, Significant Procedure, or Therapy Visit	0.0000	Y

The final manual data manipulation involved claims for observation. Claims for observation services only is a unique scenario within the EAPG grouping/pricing algorithm, in that the algorithm looks for the occurrence of two different procedure codes from two different service lines before assigning an EAPG code to each line. One line item affecting another line item's payment amount is very common in an EAPG-based OPPS. However, one line item affecting the assignment of an EAPG code on another line item is rare and occurs when a claim is submitted for observation services only. Specifically, when procedure code G0378 – hospital observation per hour – is included on a claim and there is no significant procedure included on the claim, the EAPG grouping logic looks for a second line item with a procedure code in one of two small lists. One of those lists includes evaluation and management codes, 99201 – 99205; 99211 – 99214, 99281 – 99285, and G0463, and the other list includes observation codes, 99217 – 99220, 99224 –

99226, 99234 – 99236, and G0379. If a procedure code from the evaluation and management list is present on the claim, then a medical visit EAPG gets assigned. If a procedure code from the observation list is present on the claim, then an observation EAPG gets assigned. But if procedure code G0378 is present on the claim, no significant procedure is present on the claim, and no procedure from either of these two small lists is present on the claim, then the observation services receive an error EAPG and no payment.

This somewhat complex billing requirement does not exist in the current legacy payment method, so some claims for observation services only were billed without a combination of codes required by EAPG grouping. For these claims, Navigant added a new claim service line with an evaluation and management procedure code equal to 99281, so that a valid EAPG and a non-zero payment could be determined for the observation services.