

59G-6.031 Enhanced Ambulatory Patient Grouping Reimbursement Methodology for Hospital Outpatient Services and Ambulatory Surgical Centers.

(1) This rule applies to all hospitals and ambulatory surgical centers (ASC) rendering Florida Medicaid outpatient hospital services to recipients, in accordance with rules 59G-4.160 and 59G-4.020, Florida Administrative Code, (F.A.C.), respectively.

(2) Definitions.

(a) Annual Appropriation – The funding provided in the General Appropriations Act and the incorporated Medicaid Hospital Funding Programs document.

(b) Automatic Rate Enhancement – An additional fee applied to each payable claim line.

(c) Base Rate – An amount calculated using 12 months of historical claims data.

(d) Base Year – A period of historical claims extracted for a pricing simulation.

(e) Bundled EAPG Payment – A single payment applied to one claim line that includes reimbursement for services reported on multiple claim lines.

(f) Charge Cap – A limitation that ensures the Medicaid-allowed amount does not exceed the submitted charges on either individual service line(s), or overall for the entire outpatient claim.

(g) Crossover Claim – Provider claim for services provided to recipients who are eligible for Medicare and Medicaid services, or who have other third-party insurance.

(h) Discounting Claim Line – A service line on a claim where the payment is adjusted.

(i) Enhanced Ambulatory Patient Groups (EAPG) – A product of 3M Health Information Systems (HIS) that categorizes outpatient services and procedures into groups for payment based on clinical information present on an outpatient claim.

(j) EAPG Code – Proprietary number developed by 3M HIS to indicate a specific grouping of services.

(k) EAPG Methodology – Reimbursement system that provides an all-inclusive rate for all services and items furnished during an outpatient visit, unless otherwise specified. The methodology categorizes the amount and type of services provided during an outpatient visit and groups together procedures, medications, materials, and patient factors that share similar characteristics and resource utilization. Each category is assigned an EAPG code. Each EAPG code is assigned a relative weight (which may equal zero) that is used to calculate payment.

(l) Florida Medicaid Outpatient Charges – The billed charges for outpatient services covered by the Florida Medicaid program for a hospital or an ASC.

(m) General Hospital – As defined in section 395.002(10), Florida Statutes (F.S.).

(n) High Medicaid Outpatient Utilization Hospital – A hospital that renders 55 percent or more of its total annual outpatient services to Florida Medicaid recipients.

(o) Payment Adjustment Factor – A multiplier used to package and consolidate payment for similar services; or, to discount services if the services are determined to be clinically similar to other services on the claim.

(p) Policy Adjustor – Numerical multipliers included in the EAPG claim service line payment calculation that increase or decrease payments to categories of services, categories of providers, or both.

(q) Provider Rate Worksheets – A list of the EAPG base rates and automatic rate enhancements for each hospital and ASC.

(r) Relative Weights – National average values calculated by 3M HIS which identify the relative amount of resources utilized to perform the services mapped to the EAPG code.

(s) Rural Hospital – As defined in section 395.602(2), F.S.

(t) Service Line Payment – A calculation used to determine individual claim line reimbursement.

(u) Service Line Procedure Code – The assigned Common Procedure Terminology[®] (CPT) Code and Health Procedural Code System (HCPCS) included on a claim line.

(3) Reimbursement. Effective July 1, 2017, the Agency for Health Care Administration (AHCA) will reimburse for Florida Medicaid outpatient hospital services rendered by hospital and ASC providers using the EAPG payment methodology in accordance with section 409.905, F.S.

(4) Reimbursement Methodology.

(a) EAPG Payment Calculation. The calculation is as follows:

[(Base Rate * EAPG Relative Weight * Policy Adjustor * Payment Adjustment Factor) (up to the \$1,500 recipient annual benefit limit, when applicable)] + Automatic Rate Enhancement.

(b) Base Rate. AHCA will establish base rates. The base rates for dates of service beginning July 1, 2017 through March 31,

2018 are found on the Provider EAPG Rate Worksheet FY 2017-2018, incorporated by reference and available on the AHCA website at http://ahca.myflorida.com/medicaid/cost_reim/archive/hospital_rates_archive.shtml#rates and at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10093>. The base rates for dates of service beginning April 1, 2018 through June 30, 2018 are found on the Provider EAPG Rate Worksheet Reconciliation, incorporated by reference and available on the AHCA website at http://ahca.myflorida.com/medicaid/cost_reim/hospital_rates.shtml and at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10094>.

The base rates for dates of service beginning July 1, 2018 are found in Provider EAPG Rate Worksheet FY 2018-2019, incorporated by reference and available on the AHCA website at http://ahca.myflorida.com/medicaid/cost_reim/hospital_rates.shtml and at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10095>.

(c) EAPG Relative Weight. AHCA will use 3M HIS relative weights as found on the EAPG Rate Worksheet FY 2018-19, incorporated by reference and available on the AHCA website at http://ahca.myflorida.com/medicaid/cost_reim/hospital_rates.shtml and at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10096>.

AHCA will use the service line procedure code to determine the EAPG code and relative weight, except in claims for evaluation and management services without another significant procedure, wherein AHCA will use the recipient's primary diagnosis to determine the EAPG code and relative weight.

(d) Policy Adjustor. AHCA will only include a provider policy adjustor in the EAPG payment for rural hospitals and high Florida Medicaid outpatient utilization hospitals.

(e) Payment Adjustment Factor. AHCA will establish the Payment Adjustment Factor(s) as follows:

1. The Payment Adjustment Factor will be 1.0 for claim service lines that pay in full.
2. The Payment Adjustment Factor will be zero for bundled lines.
3. The Payment Adjustment Factor will be 0.50 on discounting claim lines, except for bilateral procedures.
4. The Payment Adjustment Factor will be 1.50 for bilateral procedures.

(f) Automatic Rate Enhancements. AHCA will apply an automatic rate enhancement to payable claim lines for outpatient hospitals for dates of service beginning July 1, 2017 as found on the Provider EAPG Rate Worksheet FY 2017-2018, incorporated by reference and available on the AHCA website at: http://ahca.myflorida.com/medicaid/cost_reim/archive/hospital_rates_archive.shtml and at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10093>. AHCA will apply an automatic rate enhancement to payable claim lines for outpatient hospitals for dates of service beginning July 1, 2018 as found on the Provider EAPG Rate Worksheet FY 2018-19, incorporated by reference and available on the AHCA website at: http://ahca.myflorida.com/medicaid/cost_reim/hospital_rates.shtml and at <http://www.flrules.org/Gateway/reference.asp?No=Ref-10095>.

1. For each hospital receiving automatic rate enhancements, AHCA will calculate a per-payable-service-line payment amount by dividing the annual appropriation by the number of Florida Medicaid outpatient payable service lines in the base year.

2. AHCA will apply an automatic rate enhancement payment as follows:

a. To claim service lines that receive a bundled EAPG payment.

b. When adjudicated after a recipient reaches his or her annual hospital outpatient benefit limit with claim service lines that are paid \$0.00 and have a status of paid.

3. AHCA will apply an automatic rate enhancement payment of \$0.00 to claim service lines when claim service lines are denied.

(g) Budget Neutrality. AHCA will reconcile the EAPG parameters to comply with budget neutrality requirements.

(h) Terminated Procedures. AHCA will reimburse providers for procedures that are terminated prior to the administration of anesthesia at 50% of the rate.

(i) Charge Cap. AHCA will not apply a charge cap to services reimbursed under the EAPG payment methodology.

(5) Exclusion. AHCA will not apply the EAPG reimbursement methodology to reimburse the following:

1. Services covered under the transplant global fee in accordance with rule 59G-4.150, F.A.C.
2. Vagus nerve stimulator device payments.
3. Newborn hearing screening.

(6) Cost Settlement. AHCA will not subject hospitals and ASCs reimbursed using the EAPG payment methodology to retrospective cost settlement.

(7) Crossover Pricing. For hospital outpatient crossover claims, AHCA will determine the Medicaid-allowed amount using the EAPG pricing methodology.

Rulemaking Authority 409.919 FS. Law Implemented 409.905, 409.908, 409.913 FS. History—New 12-25-18.