FLORIDA TITLE XIX OUTPATIENT HOSPITAL

REIMBURSEMENT PLAN

VERSION XXVII

EFFECTIVE DATE: July 1, 2016

I. Cost Finding and Cost Reporting

A. Each hospital participating in the Florida Medicaid program shall file a cost report postmarked no later than five calendar months after the close of its cost-reporting year. A hospital filing a certified cost report that has been audited by the independent auditors of the hospital shall be given a 30-day extension if the Agency for Health Care Administration (AHCA) is notified in writing that a certified report is being filed. The hospital cost reporting year adopted for the purpose of this plan shall be the same as that for Title XVIII or Title V cost reporting, if applicable. A complete, electronic copy of the cost report shall be filed with the Medicare intermediary and AHCA's designated audit contractor.

B. All hospitals are required to detail their costs for their entire reporting year, making appropriate adjustments as required by this plan for determination of allowable costs. New hospitals shall adhere to requirements of section 2414.1, Provider Reimbursement Manual, Centers for Medicare and Medicaid Services (CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.030, Florida Administrative Code, (F.A.C.). A prospective reimbursement rate shall not be established for a new hospital based on a cost report for a period less than 12 months. For a new hospital or a new provider with no cost history, excluding new providers resulting from a change in ownership where the previous provider participated in the program, the interim rate shall be the lesser of: the county reimbursement ceiling for variable costs (including outpatient fixed costs), or the budgeted rate in compliance with CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.030, F.A.C. and section III of the Outpatient Hospital Reimbursement Plan, as applied to the budget submitted by the provider. Interim rates shall be cost settled for the interim rate period. Interim per diem rates shall not be approved for new providers resulting from a change in ownership. Florida Medicaid reimbursement is hospital specific and is not provider specific.

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C. The cost report shall be prepared in accordance with generally accepted accounting principles as established by the American Institute of Certified Public Accountants except as modified by the method of reimbursement and cost finding of Title XVIII (Medicare) Principles of Reimbursement described in 42 Code of Federal Regulations (CFR) 413.35 - 413.50, further interpreted by the Provider Reimbursement Manual (CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.030, Florida Administrative Code (F.A.C.), and as further modified by this plan.

D. Hospitals shall file an electronic and complete cost report within five months, or six months if a certified report is being filed, after the close of its reporting period. Medicare-granted exceptions to these time limits shall be accepted by AHCA.

E. If a provider files a cost report late, after the five month period, and that cost report would have been used to set a lower reimbursement rate for a rate semester had it been filed within five months, then the provider's rate for that rate semester shall be retroactively calculated using the new cost report, and full payments at the recalculated rate shall be affected retroactively. Medicare granted exceptions to these time limits shall be accepted by AHCA.

F. A hospital which voluntarily (or involuntarily) ceases to participate in the Florida Medicaid program or experiences a change of ownership, shall file a final cost report in accordance with section 2414.2, CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.030, F.A.C. For the purposes of this plan, filing a final cost report is not required when: the capital stock of a corporation is sold, partnership interest is sold as long as one of the original general partners continues in the partnership, one of the original limited partners becomes a general partner, or control remains unchanged. Any change of ownership shall be reported to AHCA within 45 days after such change of ownership.

G. All Florida Medicaid participating hospitals are required to maintain the Florida Medicaid Log and financial and statistical records regarding outpatients in accordance with 42 CFR 413.24(a)-(c). For purposes of this plan, statistical records shall include the medical records of eligible Florida Medicaid recipients. These records shall be available upon demand to representatives, employees or contractors of AHCA, the Auditor General of the State of Florida, the General Accounting Office (GAO) or the United States Department of Health and Human Services (HHS). A Florida

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Medicaid recipient's medical records shall be released to the above named persons for audit purposes upon proof of the recipient's consent.

H. Records of related organizations as defined by 42 CFR 413.17 shall be available upon demand to representatives, employees or contractors of AHCA, the Auditor General, GAO, or HHS.

I. AHCA shall retain all uniform cost reports filed for a period of at least five years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of 45 CFR 205.60. Access to filed cost reports shall conform with Chapter 119, Florida Statue (F.S.).

J. A cost report may be reopened for inspection, correction, or referral to a law enforcement agency at any time by AHCA or its designated contractor if program payments appear to have been obtained by fraud, similar fault, or abuse.

K. Cost reports must include the following statement immediately preceding the dated signature of the provider’s administrator or chief financial officer: “I certify that I am familiar with the laws and regulations regarding the provision of health care services under the Florida Medicaid program, including the laws and regulations relating to claims for Medicaid reimbursements and payments, and that the services identified in this cost report were provided in compliance with such laws and regulations.”

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

M. Providers shall be subject to sanctions pursuant to section 409.913(15)(c), F.S., for late cost reports. The amount of the sanctions can be found in 59G-9.070, F.A.C. A cost report is late if it is not received by AHCA, Bureau of Medicaid Program Finance, Division of Cost Reimbursement, on the first cost report acceptance cut-off date after the cost report due date.

N. AHCA shall implement a methodology for establishing base reimbursement rates for each hospital based on allowable costs. The base reimbursement rate is defined in section V.A. and V.B. of AHCA’s Outpatient Hospital Reimbursement Plan. Rates shall be calculated annually and take

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effect July 1 of each year based on the most recent complete and accurate cost report filed by each hospital.

II. Audits

A. Background

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

B. Hospital Audits

AHCA shall be responsible for performance of desk and field audits. AHCA, or its designated contractor shall:

l. Determine the need for on-site full scope audits and determine the scope and format for such audits when selected.

2. Desk audit all cost reports within 12 months after receipt by AHCA's designated contractor. The review may not include Medicare auditor settlements if they are not available in the CMS Healthcare Cost Report Information System (HCRIS) database.

3. Ensure all audits are performed in accordance with generally accepted auditing standards of the AICPA as incorporated by reference in Rule 61H1-20.008 F.A.C.

4. Ensure that only those expense items that the plan has specified as allowable costs under section III of this plan have been included by the hospital in the computation of the costs of the various services provided under Rule 59G-4.160 F.A.C.

5. Review to determine that the Florida Medicaid Log is properly maintained and current in those hospitals where its maintenance is required.

5. Issue, upon the conclusion of each full scope audit, a report which shall meet generally accepted auditing standards of the AICPA as incorporated by reference in Rule 61H1-20.008, F.A.C. and shall declare the auditor's opinion as to whether, in all material respects, the cost filed by a hospital meets the requirements of this plan.

C. Retention

All audit reports received from AHCA's designated contractor or issued by AHCA shall be kept in accordance with 45 CFR 205.60.

D. Overpayments and Underpayments

l. Overpayments for those years or partial years as determined by desk or field audits using prior approved state plans shall be reimbursable to AHCA, as shall overpayments attributable to unallowable costs only.

2. Overpayments in outpatient hospital services shall not be used to offset underpayments in inpatient hospital services and, conversely, overpayments in inpatient hospital services shall not be used to offset underpayments in outpatient hospital services.

3. The results of desk or field audits of outpatient hospital services shall be identified separately from the results of desk or field audits of inpatient hospital services.

4. Any overpayment or underpayment that resulted from a rate adjustment due to an error in either reporting or calculation of the rate shall be refunded to AHCA or to the provider as appropriate.

5. Any overpayment or underpayment that resulted from a rate based on a budget shall be refunded to AHCA or to the provider as appropriate.

6. The terms of repayments shall be in accordance with section 414.41, F.S.

7. All overpayments shall be reported by AHCA to CMS as required, under the authority of 42 CFR 433, Subpart F. All underpayments will be subject to the time limitations under the authority of 45 CFR 95.7.

8. Information intentionally misrepresented by a hospital in the cost report shall result in a suspension of the outpatient hospital from the Florida Medicaid program.

9. AHCA or its designated contractor shall furnish to providers written notice of the audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care. The written notice constitutes final agency action.

E. Administrative Hearing

1. A substantially affected provider seeking to correct or adjust the calculation of the audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care,

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other than a challenge to the methodologies set forth in the rules of AHCA and in reimbursement plans incorporated by reference therein used to calculate the reimbursement rate for inpatient and outpatient care, may request an administrative hearing to challenge the final agency action by filing a petition with AHCA within 180 days after receipt of the written notice. The petition must include all documentation supporting the challenge upon which the provider intends to rely at the administrative hearing and may not be amended or supplemented except as authorized under uniform rules adopted pursuant to s. 120.54(5), F.S. Failure to timely file a petition in compliance with this subparagraph is deemed conclusive acceptance of the audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care established by AHCA.

2. A correction or adjustment of an audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care which is required by an administrative order or appellate decision:

    a. Must be reconciled in the first rate period after the order or decision becomes final.

    b. May not be the basis for any challenge to correct or adjust hospital rates required to be paid by any Medicaid managed care provider pursuant to part IV of this chapter.

3. AHCA may not be compelled by an administrative body or a court to pay additional compensation to a hospital relating to the establishment of audited hospital cost-based per diem reimbursement rates by the agency or for remedies relating to such rates, unless an appropriation has been made by law for the exclusive, specific purpose of paying such additional compensation. As used in this subparagraph, the term “appropriation made by law” has the same meaning as provided in s. 11.066, Florida Statutes.

4. The exclusive means to challenge a written notice of an audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care for the purpose of correcting or

adjusting such rate before, on, or after July 1, 2015, or to challenge the methodologies set forth in the rules of AHCA and in reimbursement plans incorporated by reference therein used to calculate the reimbursement rate for inpatient and outpatient care is through an administrative proceeding pursuant to chapter 120.

5. Any challenge to the methodologies set forth in the rules of AHCA and in reimbursement plans incorporated by reference therein used to calculate the reimbursement rate for inpatient and outpatient care may not result in a correction or an adjustment of a reimbursement rate for a rate period that occurred more than five years before the date the petition initiating the proceeding was filed.

6. This section regarding Administrative Hearings applies to any challenge to final agency action which seeks the correction or adjustment of a provider’s audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care and to any challenge to the methodologies set forth in the rules of the agency and in reimbursement plans incorporated by reference therein used to calculate the reimbursement rate for inpatient and outpatient care, including any right to challenge which arose before July 1, 2015.

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

III. Allowable Costs

Allowable costs shall be determined using generally accepted accounting principles, except as modified by Title XVIII (Medicare) Principles of Reimbursement as described in 42 CFR 413.35 - 413.50, the inpatient routine nursing salary cost differential, and the guidelines in the Provider Reimbursement Manual (CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.030, F.A.C.) and as further modified by Title XIX of the Social Security Act (SSA), this plan, requirements of licensure and certification, and the duration and scope of benefits provided under the Florida Medicaid program. These include:

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A. Costs incurred by a hospital in meeting:

1. The definition of a hospital contained in 42 CFR 440.20 and 42 CFR 440.140 in order to meet the requirements of sections 1902(a)(13) and (20) of the Social Security Act (SSA).
2. The requirements established by AHCA found in 42 CFR 431.610.
3. Any other requirements for licensing under the state law which are necessary for providing outpatient hospital services.

B. Florida Medicaid reimbursements shall be limited to an amount, if any, by which the rate calculation for an allowable claim exceeds the amount of a third party recovery during the Florida Medicaid benefit period. In addition, the reimbursement shall not exceed the amount established in 42 CFR 447.321.

C. Malpractice insurance costs shall be apportioned to Florida Medicaid in the ratio of Florida Medicaid outpatient costs to total hospital costs, if not already included in the cost report being used to establish the Medicaid hospital outpatient rates.

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

E. All physician orders and records that result in costs being passed on by the hospital to the Florida Medicaid program through the cost report shall be subject to review by AHCA or AHCA's authorized representative.

F. Certain revenue centers are not reimbursed by Florida Medicaid. Service rendered under these centers shall not be recorded on the Florida Medicaid log and shall not be billed to Florida Medicaid. The list of covered revenue centers is attached as Appendix A. Modifications of this list subsequent to the implementation of this plan shall appear in the most recent version of the Florida Medicaid Outpatient Hospital Services Coverage policy incorporated by reference in Rule

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59G-4.160, F.A.C.. Revenue code 510, Clinic/General is reimbursable by Florida Medicaid, in accordance with the most recent version of the Florida Medicaid Outpatient Hospital Services Coverage policy, for health care services, in outpatient clinic facilities where a non-state government owned or operated facility assumed the fiscal and operating responsibilities of one or more primary care centers previously operated by the Florida Department of Health or the local county government.

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

IV. Standards

A. In accordance with Chapter 120, F.S., Administrative Procedures Act, and 42 CFR 447.205, this plan shall be promulgated as an administrative rule and as such shall be made available for public inspection. A public hearing shall be held so that interested members of the public shall be afforded the opportunity to review and comment on this plan.

B. Reimbursement ceilings shall be established prospectively for each Florida county. Additional ceilings based on the target rate system shall also be imposed. For purposes of establishing reimbursement ceilings, each hospital within the state shall be classified as general, teaching, specialized, rural, or as a Community Hospital Education Program (CHEP) hospital. Outpatient reimbursement ceilings shall be established for and applied to general hospitals. Rural and specialized psychiatric hospitals shall be excluded from the calculation and application of the outpatient reimbursement ceilings. Teaching, specialized, Community Hospital Education Program (CHEP) hospitals, shall be included in the calculation but are exempt from the application of the outpatient reimbursement ceilings.

C. Effective July 1, 2011, there will be one rate setting period from July 1 through June 30.

D. Changes in individual hospital rates shall be effective from July l through June 30 of each year.

E. For the initial period, the last cost report received from each hospital shall be used to establish the reimbursement ceilings. In the absence of sufficient information from the above source, claims

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payment data from the Florida Medicaid fiscal agent shall be used. Should none of the above sources provide acceptable information, the hospital shall be excluded from the reimbursement ceiling calculations. The hospital shall then have a rate assigned that equals the lowest computed rate in the county in which the hospital is located, or the lowest rate in the AHCA District in which the hospital is located, if there are no other hospitals in the county in question.

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

G. Effective July 1, 2016, all amended cost reports must be filed with AHCA by July 31st to be used for the current rate setting. All amended cost reports filed after July 31st will be reconciled in the subsequent rate setting year.

H. The individual hospital's prospectively determined rate shall be adjusted only under the following circumstances:

1. An error was made by AHCA’s designated contractor or AHCA in the calculation of the hospital's unaudited rate.
2. A hospital files an amended unaudited cost report to supersede the unaudited cost report used to determine the rate in effect. There shall be no change in rate if an amended cost report is filed beyond three years of the effective date the rate was established, or if the change is not material, or if the cost report has been audited. Effective July 1, 2016, a hospital must submit an amended cost report by July 31st of the state fiscal year the rates are effective.
3. Further desk or field audits of cost reports used in the establishment of the prospective rate disclose material changes in these reports.
4. Where the charge structure of a hospital changes and the application of the lower of cost or charges limitations is reconsidered.

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

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J. The reimbursement rates for laboratory and pathology services shall be the lower of the hospital's charges or the Florida Medicaid fee schedule technical component as provided for in Rule 59G-4.160, F.A.C. Payment for Clinic Diagnostic Laboratory (CDL) outpatient hospital rates are based on a state-developed fee schedule, which is the same as both governmental and private outpatient hospitals. The agency's CDL outpatient hospital rates were set as January 1, 2016 effective for services on or after this date. The fee schedules are published at : http://ahca.myflorida.com/medicaid/review/fee_schedules.shtml. Rates do not exceed Medicare rates for the same codes on a per test basis as required by Section 1903(i)(7).

V. Method

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

A. Setting Reimbursement Ceilings.

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

   a. To reflect the results of desk or field audits.

   b. To reduce the Florida Medicaid outpatient costs and charges for laboratory and pathology costs and charges.

2. Reduce a hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.9.

3. Determine Florida Medicaid outpatient variable costs defined in section X.

4. Adjust Florida Medicaid outpatient variable costs for the number of months between the midpoint of the hospital's fiscal year and December 31, the midpoint of the rate semester for which the new rate is being calculated. The adjustment shall be made utilizing the latest available projections at the time of rate setting for the Data Resources Incorporated (DRI) Type Hospital Market Basket Index as detailed in Appendix B.

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5. Divide the inflated Florida Medicaid outpatient variable costs by the latest available Health Care Component of the Florida Price Level Index (FPLI) for the county in which the hospital is located.

6. Divide the results of step five for each hospital by the total Florida Medicaid outpatient occasions of service excluding occasions of service for laboratory and pathology resulting in an occasion of service rate.

7. Array the occasions of service rates in step six from the lowest to the highest rate with the associated occasions of service.

8. Establish the reimbursement ceilings as the lower of:

   a. The cost based ceilings for variable costs per occasion of service at the occasion of service rate associated with the 80th percentile of occasions of service, times the FPLI component utilized in step five for the county in which the hospital is located. Rural and specialized psychiatric hospitals are excluded from the calculation and application of this cost based ceiling.

      The following types of hospitals are included in the calculation, but are exempt from the application of this cost based ceiling except for the limitations described in 9 through 11 below:

      i. Teaching hospitals.

      ii. Specialized hospitals.

      iii. Community Hospital Education Program (CHEP).

      iv. Those mentioned in 9 through 11 below

      v. Hospitals with Level III Neonatal Intensive Care Units that have a minimum of three of the following designated tertiary services as regulated under the certificate of need program: pediatric bone marrow transplantation, pediatric open heart surgery, pediatric cardiac catheterization and pediatric heart transplantation.

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

b. The target ceiling shall be calculated by multiplying the previous rate period's ceiling by the target inflation factor as calculated in the following formula:

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

This target ceiling shall not apply to rural, specialized, teaching, and Community Hospital Education Program (CHEP) hospitals, and those hospitals defined in 9 through 11 below.

This target ceiling shall not apply to the following:

i. Teaching hospitals.

ii. Specialized hospitals.

iii. Community Hospital Education Program (CHEP).

iv. Those mentioned in 9 through 11 below

v. Hospitals with Level III Neonatal Intensive Care Units that have a minimum of three of the following designated tertiary services as regulated under the certificate of need program: pediatric bone marrow transplantation, pediatric open heart surgery, pediatric cardiac catheterization and pediatric heart transplantation.

9. The outpatient hospital reimbursement ceilings will be eliminated for hospitals whose charity care and Medicaid days as a percentage of total adjusted hospital days equals or exceeds 11 percent. For any public hospital or any leased public hospital found to have sovereign immunity or hospital with graduate medical education positions that does not qualify for the elimination of the outpatient ceilings, such hospitals shall be exempt from the outpatient reimbursement ceilings. AHCA shall use the average of the 2007, 2008 and 2009 audited DSH data available as of March 1, 2015. In the event AHCA does not have the prescribed three years of audited DSH data for a hospital, AHCA shall use the

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average of the audited DSH data for 2007, 2008 and 2009 that are available. Any hospital that was exempt from the outpatient reimbursement ceiling in the prior state fiscal year, due to their charity care and Medicaid days as a percentage to total adjusted hospital days equaling or exceeding 11 percent, but no longer meet the 11 percent threshold, because of updated audited DSH data shall remain exempt from the outpatient reimbursement ceilings for a period of two years.

10. The outpatient hospital reimbursement ceilings will be eliminated for hospitals that have a minimum of ten licensed Level II Neonatal Intensive Care Beds and are located in Trauma Services Area 2.

11. The outpatient reimbursement ceilings will be eliminated for hospitals whose Medicaid days, as a percentage of total hospital days, exceed 7.3 percent, and are designated or provisional trauma centers. This provision shall apply to all hospitals that are designated or provisional trauma centers on July 1, 2010 or became a designated or provisional trauma center during Fiscal Year 2010-2011. Included in these funds are the annualized amounts to offset the reductions taken against certified trauma centers as identified in section 13, chapter 2007-326, Laws of Florida. AHCA shall use the average of the 2007, 2008 and 2009 audited DSH data available as of March 1, 2015. In the event AHCA does not have the prescribed three years of audited DSH data for a hospital, AHCA shall use the average of the audited DSH data for 2007, 2008 and 2009 that are available.

B. Setting Individual Hospital Rates.

This section V.B. defines the methodologies and steps to be used by the Florida Medicaid program in establishing individual hospital reimbursement rates. Additions and changes to this section from the preceding year(s) are intended to clarify the rate-setting process, not to make substantive changes to it.

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

   a. To reflect the results of desk and field audits.

b. To reduce the Florida Medicaid outpatient costs and charges for laboratory and pathology costs and charges.

2. Reduce the hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.9.

3. Determine Florida Medicaid outpatient variable costs as defined in section X.

4. Adjust Florida Medicaid outpatient variable costs for the number of months between the midpoint of the hospital's fiscal year and December 31, the midpoint of the following rate semester. The adjustment shall be made utilizing the DRI Regional Hospital Input Price Index as detailed in Appendix B.

5. Establish the variable cost rate as the lower of:

   a. The inflated rate by dividing the inflated allowable Florida Medicaid outpatient variable costs by the total Florida Medicaid outpatient occasions of service for the hospital excluding occasions of service for laboratory and pathology.

   b. The target rate by inflating the variable cost rate in the previous rate period by the target inflation factor calculated in section V.A.8.b. in establishing target ceilings. This target rate shall not apply to rural, specialized, teaching, Community Hospital Education Program (CHEP) hospitals, and those hospitals defined in Section V.A. 9 through 11.

      i. Set the rate for the hospital as the lower of the result of step five, the reimbursement ceiling in section V.A.8 for the county in which the hospital is located, or the result of inflated Florida Medicaid outpatient charges divided by total Florida Medicaid outpatient occasions of service excluding charges and occasions of service for laboratory and pathology.

6. Effective July 1, 2005, a recurring rate reduction shall be established until an aggregate total estimated savings of $16,796,807 is achieved each year. This reduction is the Medicaid trend adjustment (MTA). In reducing hospital outpatient rates, rural hospitals and hospitals with 20,000 or more combined Medicaid managed care and fee-for-service inpatient days shall not

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have their outpatient rates reduced below the final rates that are effective on the prior June 30 of each year. The 2002 Financial Hospital Uniform Reporting System (FHURS) data shall be used to determine the combined inpatient Medicaid days. This recurring rate reduction amount is referred to as MTA number 1. This rate setting methodology step utilizes each hospital's outpatient rate which is calculated without the MTA based on the hospital's current submitted cost report and using Florida Medicaid outpatient occasions of service based on the current cost report. Each hospital's rate without the MTA is proportionally reduced until the saving of $16,796,807 is achieved.

7. Effective January 1, 2008, an additional MTA shall be applied to achieve a recurring annual reduction of $17,211,796. This recurring rate reduction amount is referred to as MTA number 2. This step begins with the rates calculated after MTA number 1 has been established. The resulting MTA number 1 rates are proportionally reduced until the saving of $17,211,796 is achieved using the hospital's Florida Medicaid occasions of service based on the current cost report. After this reduction, a recurring annual buy-back of $4,068,064 is applied to offset a proportion of the MTA number 2 reduction to trauma centers/trauma hospitals only using the hospital's Florida Medicaid outpatient occasions of service.
8. Effective July 1, 2008, an additional MTA shall be applied to achieve a recurring annual reduction of $36,403,451. This recurring rate reduction amount is referred to as MTA number 3. This step begins with the rates calculated after MTA number 2 and after the trauma buy-back has been applied. The resulting rates are then proportionally reduced until the saving of $36,403,451 is achieved using the hospital's Florida Medicaid outpatient occasions of service based on the current cost report.
9. Effective March 1, 2009, AHCA shall implement a recurring methodology to reduce individual outpatient hospital rates proportionately until the required $19,384,437 annual savings is achieved. Hospitals that are licensed as a children's specialty hospital and whose Medicaid days plus charity care days divided by total adjusted patient days equals or exceeds 30 percent are excluded from this reduction. This recurring rate reduction amount is referred to as MTA number 4. This step begins with the rates calculated after MTA number 3 is

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established. The resulting MTA number 3 rates are then proportionally reduced until the saving of $19,384,437 is achieved using the hospital's Florida Medicaid outpatient occasions of service based on the current cost report.

10. Effective July 1, 2009, the recurring rate reduction referred to as MTA number 5 was not necessary based on the established rate setting unit cost being less than the unit cost used in establishing the budget. The rates after MTA number 5 would be the same as the rates after MTA number 4.
11. Effective July 1, 2010, the recurring rate reduction referred to as MTA number 6 was not necessary based on the established rate setting unit cost being less than the unit cost used in establishing the budget. The rates after MTA number 6 would be the same as the rates after MTA number 5.

12. Effective July 1, 2011, AHCA shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs.
13. Effective July 1, 2011, $99,045,233 will be used for a reduction in outpatient hospital reimbursement rates. Hospitals that are licensed as a children's specialty hospital and whose Medicaid days plus charity care days divided by total adjusted patient days equals or exceeds 30 percent and rural hospitals as defined in s. 395.602, are excluded from this reduction. This recurring rate reduction amount is referred to as MTA number 7. This step begins with the rates calculated after MTA number 6 is established. The resulting MTA number 6 rates are then proportionally reduced until the saving of $99,045,233 is achieved using the hospital's Florida Medicaid outpatient budgeted occasions of service (fee-for-service only) which are the same as those used in the July 1, 2015 rate setting calculation .
14. Effective July 1, 2012, AHCA shall implement a recurring methodology in the Title XIX Outpatient Hospital Reimbursement Plan to achieve a $49,078,485 annual reduction. This recurring rate reduction amount is referred to as MTA number 8. This step begins with the rates calculated after MTA number 7 is established. The resulting MTA number 7 rates are then proportionally reduced until the saving of $49,078,485 is achieved using the hospital's

Florida Medicaid outpatient budgeted occasions of service (fee-for-service only) which are the same as those used in the July 1, 2015 rate setting calculation. .

15. Effective July 1, 2012, $10,656,238 is provided to partially restore the July 1, 2012 reduction in outpatient hospitals. This step begins with the rates calculated after MTA number 8. A recurring annual buy-back of $10,656,238 is applied to offset a portion of the MTA number 8 reduction except for hospitals that are licensed as a children's specialty hospital and the Medicaid days plus charity care days divided by total adjusted patient days equals or exceeds 30 percent and rural hospitals as defined in s. 395.602 F.S., as they are excluded from this buy-back.

16. As required by paragraph number 12 above, the rate setting unit cost as of June 30, 2011, which was $141.51, is compared to the current rate setting unit cost. The rate setting unit cost calculation is determined as following; Rate Setting Unit Cost = (Total Estimated XIX Payment / (Total Florida Medicaid Outpatient Budgeted Occasions of Service – Children's & Rural Occasions of Service)). If the current rate setting unit cost is less than the June 30, 2011 unit cost, no additional rate reduction is necessary. If the rate setting unit cost is greater than the June 30, 2011unit cost, the rates shall be proportionally reduced by the reduction percentage. The reduction percentage is calculated by the following formula; 1-(rate setting unit cost / $141.51).

17. The next step is referred to as the Tier Cap Calculation. The Tier Cap Calculation is determined based on a hospital's classification and allowable percent of exemption. The hospitals in the classification exemption category for the Tier Cap Calculation are those hospitals who qualified under the parameters for ceiling and target limitations for hospital reimbursement. The qualifying hospitals are allowed to receive a specific percentage of the exemption based on the hospital's classification 88.76826% - Specialty Children's; 70.76825% - Public/Statutory Teaching; 66.18086% - Designated Trauma, Specialty Hospitals, Specialty Legislative, Medicaid and Charity Utilization, Community Hospital Education Program; 1.50% - Trauma Add-on; and explicit dollar amount – Pediatric Add-on.

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18. $26,131,167 is provided for qualifying hospitals to allow for exemptions from outpatient reimbursement limitations. The rates from the Tier Cap Calculation step are allowed a buy-back of $26,131,167 which is applied to offset all reductions for hospitals. The total buy-back amount for each hospital is added to the hospital's estimated Medicaid payment after the results from the Tier Cap Calculation. This calculation produces a new estimated Medicaid payment. Based on the new estimated Medicaid payment, a new outpatient rate is calculated by dividing the new estimated Medicaid payment by the Florida Medicaid outpatient budgeted occasions of service. The new outpatient rate is compared to the Tier Rate calculated in the Tier Cap Calculation step and the difference is the maximum buy-back amount. The lessor of maximum buy-back amount and the allowable buy-back amount calculated in the Tier Cap Calculation step is added to the Tier Rate and becomes the final rate.
19. Effective July 1, 2014, the outpatient rates will not include any self-funded IGT rate enhancements for exemptions and buybacks.

VI. Payment Assurance

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

VII. Provider Participation

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

VIII. Revisions

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

IX. Payment in Full

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

X. Glossary

A. Acceptable cost report - A completed, legible cost report that contains all relevant schedules, worksheets and supporting documents.

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

C. AHCA - Agency for Health Care Administration.

D. Allowable costs - An item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with generally accepted accounting principles except as modified by the Principles of Reimbursement for Provider Costs, as defined in CMS PUB. 15-1 as incorporated by reference in 59G-6.030 F.A.C., and as further defined in the most recent version of the Florida Title XIX Outpatient Hospital Reimbursement Plan.

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

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

G. Buy-back - The buy back provision potentially allows a hospital to decrease their Florida Medicaid trend adjustment from the established percent down to zero percent.

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H. Community Hospital Education Program (CHEP) hospitals – Hospitals that participate in a program that offers continuing medical education programs for interns and residents established on a statewide basis.

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

J. Eligible Florida Medicaid recipient - "Recipient" or "Florida Medicaid recipient" means any individual whom the Florida Department of Children and Families, or the SSA on behalf of AHCA, determines is eligible, pursuant to federal and state law, to receive medical or allied care, goods, or services for which the department may make payments under the Florida Medicaid program and is enrolled in the Florida Medicaid program. For the purposes of determining third party liability, the term includes an individual formerly determined to be eligible for Florida Medicaid, an individual who has received medical assistance under the Florida Medicaid program, or an individual on whose behalf Florida Medicaid has become obligated.

K. Filing due date - No later than five calendar months after the close of the hospital's cost-reporting year.

L. Florida Medicaid log - A schedule to be maintained by a hospital listing each Florida Medicaid patient's recipient number, dates of admission and discharge, and the charges and payments for services and goods received from the hospital's revenue centers.

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

N. Florida Medicaid outpatient costs – Allowable operating costs as apportioned to Florida Medicaid by cost finding methods in the CMS 2552 cost report.

O. Florida Medicaid outpatient occasions of service – Based on the fiscal year end of the hospital's cost report, the number of distinct revenue center code line items listed on a valid claim that a hospital has filed with the fiscal agent, excluding laboratory and pathology revenue center code line items, and that have been paid by the fiscal agent, which represent covered Florida Medicaid outpatient services.

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P. Florida Medicaid outpatient variable costs - Allowable operating costs excluding laboratory and pathology costs less return on equity as apportioned to Florida Medicaid by cost finding methods in the CMS 2552 cost report.

Q. Florida price level index - A spatial index which measures differences from county to county in the cost of purchasing a specified market basket of items at a particular point in time. The items in the market basket range from various food products to hospital lab fees, and are grouped into the components of food, housing, apparel, transportation, and health, recreation and personal services. A county index for each of the five components is developed bi-annually by the Florida Executive Office of the Governor. County indices are population weighted to average 100 percent. An index of 1.1265 for a given county means that the basket of goods in that county costs 12.65 percent more than the State average. Changes to the methodology utilized in the development of the FPLI will constitute changes in this plan and will require a formal plan amendment.

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

S. HHS - Department of Health and Human Services.

T. Late cost report - A cost report is late when it is filed with AHCA's designated audit contractor, after the Filing Due Date, and after the Rate Setting Due Date.

U. Legislative unit cost - The average weighted per diem of the State anticipated expenditure after all rate reductions but prior to any buy back.

V. CMS PUB. 15-1 - Health Insurance Manual No. 15, also known as the Provider Reimbursement Manual, as incorporated by reference in Rule 59G-6.030, F.A.C.

W. Non-covered services - Those goods and services which are not medically necessary for the care and treatment of outpatients as defined in CMS PUB 15.1 as incorporated by reference in Rule 59G-6.030, F.A.C.

X. Provider service network (PSN) – is defined in s. 409.912, F.S., as a network established or organized and operated by a health care provider, or group of affiliated health care providers, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers.

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Y. Rate semester - January 1 through June 30 of a given year, or July 1 through December 31 of a given year. Effective July 1, 2011, the rate semester begins on July 1 and runs through June 30.

Z. Rate setting due date - All cost reports postmarked by March 3~~2~~1 and received by AHCA by April 15 shall be used to establish the reimbursement rates.

AA. Rate setting unit cost - The weighted average per diem after all rate reductions but prior to any buy backs based on filed cost reports.

BB. Reimbursement ceiling - The upper limit for Florida Medicaid Outpatient Variable Cost rate reimbursement for an individual hospital.

CC. Reimbursement ceiling period - January 1 through June 30 of a given year or July 1 through December 31, of a given year.

DD. Rural hospital - An acute care hospital licensed under Chapter 395, F.S., with 100 licensed beds or less, which has an emergency room and is located in an area defined as rural by the United States Census, and which is:

1. The sole provider within a county with a population density of no greater than 100 persons per square mile.
2. An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county.
3. A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or less per square mile.
4. A hospital in a constitutional charter county with a population of over 1 million persons that has imposed a local option health service tax pursuant to law and in an area that was directly impacted by a catastrophic event on August 24, 1992, for which the Governor of Florida declared a state of emergency pursuant to chapter 125, and has 120 beds or less that serves an agricultural community with an emergency room utilization of no less than 20,000 visits and a Florida Medicaid inpatient utilization rate greater than 15 percent.
5. A hospital with a service area that has a population of 100 persons or fewer per square mile. As used in this subparagraph, the term "service area" means the fewest number of zip codes

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

6. A hospital designated as a critical access hospital, as defined in s. 408.07 F.S.

   Population densities used in this paragraph must be based upon the most recently completed United States census. A hospital that received funds under s. 409.9116 F.S. for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2021, if the hospital continues to have up to 100 licensed beds and an emergency room. An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this paragraph shall be granted such designation upon application, including supporting documentation to AHCA.

7. A hospital that was licensed to continue to be a rural hospital during fiscal year 2010-2011 or 2011-2012 shall continue to be a rural hospital from the date of designation through June 30, 2021, if the hospital continues to have up to 100 licensed beds and an emergency room.

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

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

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

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

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

XI. Purpose of the Plan

This Outpatient Hospital Reimbursement Plan establishes the methodology for calculating the line item reimbursement rates for covered Florida Medicaid outpatient hospital services. Other rates established for non-line item payments, such as but not limited to, lab and pathology services, are referenced in the handbook. In addition, policy for coverage of Florida Medicaid outpatient hospital services is established in the Florida Medicaid Outpatient Hospital Services Coverage policy incorporated by reference in Rule 59G-4.160, F.A.C.

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APPENDIX A TO FLORIDA TITLE XIX OUTPATIENT HOSPITAL
REIMBURSEMENT PLAN

OUTPATIENT REVENUE CENTER CODES**

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

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344 Therapeutic Radiopharmaceuticals
349 Other Nuclear Medicine
350 Computed Tomographic (CT) Scan/General
351 Computed Tomographic (CT) Scan/Head
352 Computed Tomographic (CT) Scan/Body
359 Other CT Scans
360* Operating Room Services/General
361* Operating Room Services/Minor Surgery
362* Operating Room Services/Bone Marrow Transplant
369* Other Operating Room Services
370 Anesthesia/General
371 Anesthesia Incident to Radiology
372 Anesthesia Incident to Other Diagnostic Services
379 Other Anesthesia
380 Blood/General
381 Blood/Packed Red Cells
382 Blood/Whole
383 Blood/Plasma
384 Blood/Platelets
385 Blood/Leucocytes
386 Blood/Other Components
387 Blood/Other Derivatives
389 Other Blood
390 Blood Storage and Processing/General
391 Blood Storage and Processing/Administration
399 Other Processing and Storage
400 Imaging Services/General
401 Imaging Services/Mammography
402 Imaging Services/Ultrasound
403 Screening Mammography
404 Positron Emission Tomography
409 Other Imaging Services

410 Respiratory Services/General (All Ages)
412 Respiratory Services/Inhalation (All Ages)
413 Respiratory Services/Hyperbaric Oxygen Therapy (All Ages)
419 Other Respiratory Services
421 Physical Therapy/Visit Charge (All Ages)
424 Physical Therapy/Evaluation or Re-evaluation (All Ages)
Note: Effective 1/1/99
431 Occupational Therapy/Visit Charge (Under 21 only)
434 Occupation Therapy/Evaluation or Re-evaluation (Under 21)
Note: Effective 1/1/99
441 Speech-Language Pathology/Visit Charge (Under 21 only)
444 Speech-Language Pathology/Evaluation or Re-evaluation Under 21) Note: Effective 1/1/99
450* Emergency Room/General
451 EMTALA Emergency Medical Screening Services
460 Pulmonary Function/General
469 Other Pulmonary Function
471 Audiology/Diagnostic
472 Audiology/Treatment
480 Cardiology/General
481 Cardiology/Cardiac Cath Laboratory
482 .... Cardiology/Stress Test
483 .... Cardiology/Echocardiology

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489 .... Other Cardiology
490 .... Ambulatory Surgical Care
510 .... Clinic/General
- Note: Please reference the most recent version of the Medicaid Outpatient Hospital Coverage and Limitations Handbook

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

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944 .... Other Therapeutic Services/Drug Rehabilitation
945 .... Other Therapeutic Services/Alcohol Rehabilitation

*Exempt from $1500 outpatient cap limit.
** Note: For current listing of covered outpatient revenue center codes, see the most recent version of the Florida Medicaid Outpatient Hospital Services Coverage Policy incorporated by reference in Rule 59G-4.160, F.A.C.

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

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

	2009	2010	2011	2012	2013
Q1	213.0	237.7	250.1	278.1	308.0
Q2	217.8	234.5	256.5	285.9	314.9
Q3	222.7	237.9	263.2	294.0	322.0
Q4	227.7	243.8	270.4	301.2	329.3

The elements in the above table represent a weighted composite index based on the following weights and the components:

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

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

QUARTER	INDEX	AVERAGE INDEX	MONTH
1	213.0		
		215.4	MARCH 31
2	217.8		
		220.3	JUNE 30
3	222.7		
		225.2	SEPTEMBER 30
4	227.7		

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

= $(220.3/215.4)^{1/3}$ (215.4)
= 217.0

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

= $(220.3/215.4)^{2/3}$ (215.4)
= 218.7

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All other monthly indices can be calculated in a similar fashion. To determine the applicable inflation factor for a given hospital for the first semester of 2013-2014 the index for September 30, 2013, the midpoint of the rate semester, is divided by the index for the midpoint of the Provider's Fiscal Year. For example, if a hospital has a fiscal year end of November 30, 2013 then its midpoint is May 31, and the applicable inflation is:

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

Therefore, the hospitals reported variable cost Medicaid rate is multiplied by 1.3607 to obtain the estimated average variable Medicaid rate for the first rate semester of FY 2013-2014. Similar calculations utilizing March 31, as the midpoint yield adjustments for the second semester of FY 2013-2014.

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APPENDIX C TO FLORIDA TITLE XIX OUTPATIENT HOSPITAL REIMBURSEMENT PLAN

Medicaid Trend Adjustment Percentages

	Effective Date	Percentages	Reduction Amount
1.	**July 1, 2008**		
	First MTA	3.141039%	$16,796,807
	Second MTA	3.255973%	$17,211,796
	Third MTA	7.05107%	$36,403,451
2.	**January 1, 2009**		
	First MTA	3.096567%	$16,796,807
	Second MTA	3.112936%	$17,211,796
	Third MTA	6.744282%	$36,403,451
3.	**March 1, 2009**		
	First MTA	3.096567%	$16,796,807
	Second MTA	3.112936%	$17,211,796
	Third MTA	6.744282%	$36,403,451
	Fourth MTA	4.321883%	$20,952,069
4.	**July 1, 2009**		
	First MTA	4.00442%	$16,796,807
	Second MTA	3.190547%	$17,211,796
	Third MTA	6.916628%	$36,403,451
	Fourth MTA	4.347763%	$19,384,437
	Fifth MTA	.0%	$10,403,322
5.	**July 1, 2010**		
	First MTA	2.858132%	$16,796,807
	Second MTA	2.656316%	$17,211,796
	Third MTA	5.734510%	$36,403,451
	Fourth MTA	3.548996%	$19,384,437
	Fifth MTA	.0%	$10,403,322
	Sixth MTA	.0%	$54,791,389
6.	**July 1, 2011**		
	First MTA	2.239302%	$16,796,807
	Second MTA	2.145548%	$17,211,796
	Third MTA	4.613485%	$36,403,451
	Fourth MTA	2.817804%	$19,384,437
	Fifth MTA	0.000000%	$10,403,322

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Sixth MTA	0.000000%	$54,791,389
Seventh MTA	12.519441%	$99,864,555
7.1 MTA	0.000000%	$3,886,602

7. **July 1, 2012**

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

8. **July 1, 2013**

First MTA	2.0397268%	$16,796,807
Second MTA	1.8877559%	$17,211,796
Third MTA	4.0510583%	$36,403,451
Fourth MTA	2.5076317%	$19,384,437
Fifth MTA	0.00000%	$10,403,322
Sixth MTA	0.000000%	$54,791,389
Seventh MTA	11.9044469%	$99,864,555
7.1 MTA	0.0000000%	$3,886,602
Eighth MTA	6.6413194%	49,078,485

9. **July 1, 2014**

First MTA	2.279809%	$16,796,807
Second MTA	1.755465%	$17,211,796
Third MTA	3.763308%	$36,403,451
Fourth MTA	2.342623%	$19,384,437
Fifth MTA	0.0000000%	$10,403,322
Sixth MTA	0.0000000%	$54,791,389
Seventh MTA	12.065717%	$99,864,555
7.1 MTA	0.0000000%	$3,886,602
Eighth MTA	6.4743749%	$49,078,485

10. **July 1, 2015**

First MTA	2.279809%	$16,796,807
Second MTA	1.755465%	$17,211,796
Third MTAt	3.763308%	$36,403,451
Fourth MTA	2.342623%	$19,384,437
Fifth MTA	0.0000000%	$10,403,322

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Sixth MTA	0.0000000%	$54,791,389
Seventh MTA	12.065717%	$99,864,555
7.1 MTA	0.0000000%	$3,886,602
Eighth MTA	6.4743749%	$49,078,485

11. **July 1, 2016**

First MTA	3.4379462%	$16,796,807
SecondMTA	3.5473447%	$17,211,796
ThirdMTA	7.7116275%	$36,403,451
FourthMTA	5.0192650%	$19,384,437
FifthMTA	0.0000000%	$10,403,322
SixthMTA	0.0000000%	$54,791,389
SeventhMTA	14.0205105%	$99,864,555
7.1MTA	0.0000000%	$3,886,602
EighthMTA	8.0139898%	$49,078,485

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APPENDIX D TO FLORIDA TITLE XIX OUTPATIENT HOSPITAL
REIMBURSEMENT PLAN

PAYMENT ADJUSTMENT FOR PROVIDER PREVENTABLE CONDITIONS

Citation

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

Payment Adjustment for Provider Preventable Conditions

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

Other Provider-Preventable Conditions

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

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

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

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

A. Dates of service beginning on or after May 1, 2012:

    1. The claims identified with a Present on Admission (POA) indicator of "Y" or "U" and provider-preventable conditions through the claims payment system will be reviewed.

    2. When the review of claims indicates an increase of payment to the provider for an identified provider-preventable condition, the amount for the provider-preventable condition will be excluded from the providers' payment.

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

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

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

    2. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

    3. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

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D. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

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APPENDIX E TO FLORIDA TITLE XIX OUTPATIENT HOSPITAL
REIMBURSEMENT PLAN

UPPER PAYMENT LIMIT (UPL) METHODOLOGY

Overview of UPL Analyses

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

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

The claim data used in a UPL analysis is historical data, usually from a twelve (12) month period. The period for which claims are selected is referred to as the "base" year. The UPL analysis is performed for a specific state fiscal year referred to as the "rate" year. Often the rate year is a current or present-day timeframe. In contrast, the base year is a timeframe in the past because the data needed for a UPL analysis, hospital cost reports and billed claims, are only available for services performed in the past. For example, the UPL analysis for state fiscal year 2013/2014 (the "rate" year) was performed at the beginning of the fiscal year – in December 2013. That UPL analysis could not utilize claim data from state fiscal year 2013/2014 (7/1/2013 – 6/30/2014) because the year was not yet complete. Instead, historical claim data that had been received and processed prior to December 2013 was used for the analysis.

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

Florida Medicaid Hospital Outpatient UPL Analysis Method

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

Non-Lab Services

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

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

Lab Services

For lab services, the upper payment limit is calculated as an estimate of what Medicare would pay for these services. The Medicare lab fee schedule from the federal fiscal year which most closely aligns with the rate year is used to estimate Medicare payment.

Medicaid payment for lab services is taken from the payment amounts on the claim lines as long as the lab rates used on the claims are the same as the AHCA's lab rates for the UPL rate year. If the rates differ on any of the claim lines, then the claim lines are re-priced using the applicable AHCA lab rates for the UPL rate year.

Source of Hospital Cost Data

Full cost per diems used for the calculation of the upper payment limit are retrieved from AHCA per diem rate worksheets. The specific rate worksheets used are those that identify the outpatient payment rates for the UPL rate year. Hospital cost reports used to set these rates are those received by AHCA by April 15th, two and a half months prior to the start of the state fiscal year (which is also the UPL rate year).

From the per diem rate worksheets, the specific cell used to retrieve the outpatient full cost per diems is in the outpatient column on row AG, which is labeled "Variable Cost Rate: Cost Divided by Medicaid Paid Claims (OP)."

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

1. All costs are summed from Worksheet C, Part I, column 1, lines 90 and 91(Outpatient Services Cost Centers).

2. The percentage of the hospital's business coming from outpatient services (versus inpatient services) is calculated using the following formula:

   Percentage of hospital's business from outpatient services = [(Total outpatient revenue from Worksheet G-2 Parts I and II, column 2, line 28) minus (revenue from non-applicable services such as RHC, FQHC, Hospice, Home Health Agencies, and any other non-hospital services)] divided by [(Total overall revenue from Worksheet G-2 Parts I and II, column 3, line 28) minus (revenue from non-applicable services such as RHC, FQHC, Hospice, Home Health Agencies, and any other non-hospital services)]

3. All costs are summed from Worksheet C, Part I, column 1, lines 50 through 76 (Ancillary Services Cost Centers).

4. Costs identified in step 3 are multiplied by the outpatient percentage identified in step 2 to get the portion of these costs applicable to outpatient services.

5. Costs from steps 1 and 4 are summed.

6. Final outpatient costs are calculated as costs from step five minus Medicaid lab costs retrieved from the Title 19 version of Worksheet D, Part five, column 6, lines 60 (Laboratory) and 61 (PBP Clinic Laboratory Services Prgm. Only).

7. The total number of non-lab claim lines per hospital is obtained from an extract of data out of the MMIS.

8. The non-lab full cost per diem is calculated as total non-lab costs, as determined in Step 6, divided by the total number of non-lab claim lines, as determined in Step 7.

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Source of Medicaid Per Diem and Claim Data

The actual per diems paid by Florida Medicaid, which are determined after applying rate ceilings, rate cuts, and rate buybacks to the full cost per diems, are retrieved from AHCA's per diem rate worksheets, specifically in the outpatient column on row AY, which is labeled "Final Prospective Rates."

Medicaid claims data used in UPL demonstrations is extracted from a data warehouse fed from the Florida MMIS. For each hospital, claims are selected if they contain a first date of service within the base year. The base year is the most recent twelve (12) month period for which AHCA has received and processed claims for all services provided to Medicaid recipients. Generally, the base year ends no less than six months prior to the time in which the UPL analysis is performed. This allows sufficient time for services to be provided and claims to be billed and processed.

Initially, all in-state and out-of-state Florida hospitals with signed agreements to participate in the Florida Medicaid fee-for-service program, including Critical Access Hospitals (CAHs), are included in the demonstration. However, a small number of hospitals drop out of the analysis because they did not bill any Medicaid outpatient claims with date of service in the UPL base year.

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

Calculation of Upper Payment Limit

Non-Lab Services
For non-lab services, the upper payment limits for each of the three UPL categories are calculated using an estimate of hospital outpatient covered cost. Hospital outpatient covered cost is calculated by applying the full cost per diem from the Medicaid rate worksheets to each non-lab claim line. The costs on each line are then summed to get total Medicaid outpatient non-lab costs per hospital. And the costs from each hospital are summed to get the total cost for each UPL category.

The full cost per diems retrieved from AHCA's per diem rate worksheets come from costs that have already been trended forward from the hospital's fiscal year, as reported on the hospital's cost report, to the midpoint of the UPL rate year. Thus, no further inflation factor is applied.

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

The Medicare lab rate is retrieved from the fee schedule for the federal fiscal year that most overlaps the UPL rate period. As a result, no inflation or other trending is needed.

Calculation of Medicaid Payment

Non-Lab Services
For non-lab services, Medicaid payment is calculated by applying the hospital's UPL rate year Medicaid outpatient per diem to each claim line. The per diems are not multiplied times units. Medicaid payment on each claim line equals the per diem. The Medicaid payments on all claim lines are summed to get total Medicaid outpatient non-lab payments per hospital. And the Medicaid payments from each hospital are summed to get the total non-lab Medicaid payments for each UPL category.

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The Medicaid per diems retrieved from AHCA's per diem rate worksheets are based on costs that have already been trended forward from the hospital's fiscal year, as reported on the hospital's cost report, to the midpoint of the UPL rate year. Thus, no further inflation factor is applied.

Lab Services

Medicaid payments for lab services are calculated as the sum of the Medicaid payment amounts on the claim lines identified as lab services. Medicaid payment amount equals the number of covered units times the Medicaid lab fee schedule amount applicable for the UPL rate year. As mentioned previously, claim lines are identified as lab services if the revenue code is between "0300" and "0319," inclusive, and the procedure code is found in the applicable Medicare lab fee schedule. All other claim lines are considered to be non-lab services. Medicaid lab payments are NOT trended forward because lab fee schedule rates from the UPL rate year are used in calculating Medicaid payment.

Non-Claim Payments and other Adjustments to Medicaid Payment

There are no supplemental payments made outside the claim data applicable for hospital outpatient services, so Medicaid payment is determined using only payments on claims. Also, no adjustments are made to estimate changes in Medicaid utilization between the base year and the UPL rate year. Similarly, no attempt is made to adjust Medicaid payments based on a prediction of future cost settlements resulting from audits of hospital cost reports.

Comparison of Medicaid Payment to Upper Payment Limit

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

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

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

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

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

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

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