FLORIDA TITLE XIX INPATIENT HOSPITAL

REIMBURSEMENT PLAN

VERSION XL

EFFECTIVE July 1, 2013

I. Cost Finding and Cost Reporting

A. Each hospital participating in the Florida Medicaid Hospital Program shall submit a cost report postmarked no later than five calendar months after the close of its cost-reporting year. A hospital filing a certified cost report that has been audited by the independent auditors of the hospital shall be given a 30-day extension if the Agency for Health Care Administration (AHCA) is notified in writing that a certified report is being filed. The hospital cost reporting year adopted for the purpose of this plan shall be the same as that for Title XVIII or Title V cost reporting, if applicable. A complete legible copy of the cost report shall be submitted to the Medicare intermediary and to AHCA, Bureau of Medicaid Program Finance, Cost Reimbursement.

B. Cost reports available to AHCA as of March 31, 1990, shall be used to initiate this plan.

C. All hospitals are required to detail their costs for their entire reporting year making appropriate adjustments as required by this plan for determination of allowable costs. New hospitals shall adhere to requirements of Section 2414.1, Provider Reimbursement Manual, CMS PUB. 15-1, as incorporated by reference in Rule 59G-6.010, Florida Administrative Code (F.A.C.)

D. The cost report shall be prepared in accordance with generally accepted accounting principles as established by the American Institute of Certified Public Accountants (AICPA) as incorporated by reference in Rule 61H1-20.007, F.A.C., except as modified by the method of reimbursement and cost finding of Title XVIII (Medicare) Principles of Reimbursement described in 42 CFR 413.5 - 413.35 and further interpreted by the Provider Reimbursement Manual CMS PUB. 15-1, as incorporated by reference in Rule 59G-6.010, F.A.C., or as further modified by this plan.

E. If a provider submits a cost report late, after the five month period,

1. If the provider is reimbursed via the DRG method and that cost report would have generated a lower cost-to-charge ratio had it been submitted within 5 months, then any claims from the applicable state fiscal year which were paid an outlier will be retroactively re-priced.
2. If the provider is reimbursed via a per diem method and that cost report would have generated a lower reimbursement rate for a rate semester had it been submitted within 5 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 effected 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 clearly marked "final" cost report in accordance with Section 2414.2, CMS PUB. 15-1, as incorporated by reference in Rule 59G-6.010, F.A.C. For the purposes of this plan, filing a final cost report is not required when:

1. The capital stock of a corporation is sold; or
2. Partnership interest is sold as long as one of the original general partners continues in the partnership or one of the original limited partners becomes a general partner, or control remains unchanged.

Any change of ownership shall be reported to AHCA within 45 days after such change of ownership.

G. All Medicaid participating hospitals are required to maintain the Florida Medicaid Log and financial and statistical records in accordance with 42 CFR 413.24 (a)-(c). In addition for hospitals paid via a per diem method, a separate log shall be maintained to account for concurrent and non-concurrent nursery days. For purposes of this plan, statistical records shall include beneficiaries' medical records. 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). Beneficiaries' medical records shall be released to the above named persons for audit purposes upon proof of a beneficiary's consent to the release of medical records such as the Medicaid Consent Form, AHCA-Med Form 1005.

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 submitted for a period of at least five years following the date of submission of such reports and shall maintain those reports pursuant to the record keeping requirements of 45 CFR 205.60. Access to submitted cost reports shall be in conformity with Chapter 119, Florida Statutes.

J. For cost reports received on or after October 1, 2003, all desk or onsite audits of cost reports shall be final and shall not be reopened past three years of the date that the audit adjustments are noticed through a revised per diem rate completed by the Agency.

Exceptions to the above mentioned time limit:

Effective October 1, 2013, for cost reports received prior to October 1, 2003, all desk or onsite audits of these cost reports shall be final and not subject to reopening.

The aforementioned limitation shall not apply when Medicare audit reopenings result in the issuance of revised Medicaid cost report schedules. A cost report may be reopened for inspection, correction, or referral to a law enforcement agency at any time by the Agency or its contractor if program payments appear to have been obtained by fraud, similar fault, or abuse.

K. Cost reports submitted on or after July 1, 2004, must include the following statement immediately preceding the dated signature of the provider's administrator or chief financial officer: "I certify that I am familiar with the laws and regulations regarding the provision of health care services under the Florida Medicaid program, including the laws and regulations relating to claims for Medicaid reimbursements and payments, and that the services identified in this cost report were provided in compliance with such laws and regulations."

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 s. 409.913(15)(c), F.S., for late cost reports. The amount of the sanctions can be found in 59G-9.070, Florida Administrative Code. A cost report is late if it is not received by AHCA, Bureau of Medicaid Program Finance, on the first cost report cut-off acceptance date after the cost report due date.

N. Effective July 1, 2011, the Agency shall implement a methodology for establishing base reimbursement rates for each hospital based on allowable costs. The base reimbursement rate is defined in section V.A.1.

through 9., V.B., and V.C of the Agency's hospital reimbursement plan. Rates shall be calculated annually and take effect July 1 of each year based on the most recent complete and accurate cost report submitted by each hospital. Adjustments may not be made to the rates after September 30 of the state fiscal year in which the rate takes effect. Errors in cost reporting or calculation of rates discovered after September 30 must be reconciled in a subsequent rate period. Any errors in cost reporting or calculation will be computed after September 30th. The results of the calculation will be retroactively applied on or after July 1 which is the subsequent rate period. Any overpayment or underpayment that resulted from any errors in cost reporting or calculation after September 30 shall be refunded to AHCA or to the provider as appropriated.

O. Effective July 1 2011, the Agency may not make any adjustment to a hospital's reimbursement rate more than 5 years after a hospital is notified of an audited rate established by the agency. The requirement that the agency may not make any adjustment to a hospital's reimbursement rate more than 5 years after a hospital is notified of an audited rate established by the agency is remedial and shall apply to actions by providers involving Medicaid claims for hospital services. Hospital rates shall be subject to such limits or ceilings as may be established in law or described in the Agency's hospital reimbursement plan.

P. Effective July 1, 2012, adjustments may not be made to the rates after October 31of the state fiscal year in which the rate takes effect. Errors in cost reporting or calculation of rates discovered after October 31 must be reconciled in a subsequent rate period. Errors in cost reporting or calculation of rates discovered after October 31 must be reconciled in a subsequent rate period.

Q. Effective July 1, 2013, the Agency shall implement a prospective payment methodology for all hospitals except state-owned psychiatric facilities. State-owned psychiatric facilities will continue to be paid on a per diem basis. The prospective payment methodology will be an acuity-based payment system utilizing Diagnosis Related Groups (DRGs). Rates will be based primarily on annual Medicaid inpatient fee-for-service budget, projected patient case mix (acuity), and payment parameters determined to meet Agency inpatient reimbursement goals. With the DRG payment method, cost reports will continue to be used to calculate hospital-specific cost-to-charge ratios and to help evaluate payment levels within the Medicaid program.

II. Audits

A. Background

Medicaid (Title XIX), Maternal and Child Health and Crippled Children's Services (Title V), and Medicare (Title XVIII) require that inpatient hospital services be reimbursed using rates and methods that promote efficient, economic, and quality care and are sufficient to enlist enough providers so that care and services under the plan are available at least to the extent that such care and services are available to the general population. To assure that payment of reasonable cost is being achieved, a comprehensive hospital audit program has been established to reduce the cost of auditing submitted cost reports under the above three programs, and to avoid duplicate auditing effort. The purpose is to have one audit of a participating hospital that shall serve the needs of all participating programs reimbursing the hospital for services rendered.

B. Common Audit Program

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

C. Other Hospital Audits

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

1. Determine the scope and format for on-site audits;
2. Desk audit all cost reports within 6 months after their submission to AHCA;
3. Ensure all audits are performed in accordance with generally accepted auditing standards of the AICPA, as incorporated by reference in Rule 61H1-20.008, F.A.C;
4. Ensure that only those expense items that the plan has specified as allowable costs under Section III of this plan have been included by the hospital in the computation of the costs of the various services provided under Rule 59G-4.150, F.A.C;

5. Review to determine that the Florida Medicaid Log is properly maintained and current in those hospitals where its maintenance is required;
6. Issue, upon the conclusion of each full scope audit, a report which shall meet generally accepted auditing standards of the AICPA, as incorporated by reference in Rule 61H1-20.008, F.A.C., and shall declare the auditor's opinion as to whether, in all material respects, the cost submitted by a hospital meets the requirements of this plan.

D. Retention

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

E. Overpayments and Underpayments

1. Overpayments for those years or partial years as determined by desk or field audit 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 audits of outpatient hospital services shall be reported separately from audits of inpatient hospital services.
4. Any overpayment or underpayment that resulted from a rate adjustment due to an error in either reporting or calculation of the rate shall be refunded to AHCA or to the provider as appropriate.
5. Any overpayment or underpayment that resulted from a rate based on a budget shall be refunded to AHCA or to the provider as appropriate.
6. The terms of repayments shall be in accordance with Section 414.41, Florida Statutes.
7. All overpayments shall be reported by AHCA to HHS as required.
8. Effective July 1, 2011, any overpayment or underpayment that resulted from a rate adjustment, prior to July 1 of each state fiscal year, will continue to be adjusted after September 30 of each state fiscal year.

9. Effective July 1, 2012, any overpayment or underpayment that resulted from a rate adjustment, prior to July 1 of each state fiscal year, will continue to be adjusted after October 31 of each state fiscal year.

F. Appeals

For audits conducted by AHCA, a concurrence letter that states the results of an audit shall be prepared and sent to the provider, showing all adjustments and changes and the authority for such. Providers shall have the right to a hearing in accordance with Section 28-106, F.A.C, and Section 120.57, Florida Statutes, for any or all adjustments made by AHCA. For cost reports received on or after October 1, 2003, all desk or onsite audits of these cost reports shall be final and shall not be reopened past three years of the date that the audit adjustments are noticed through a revised per diem rate completed by the Agency.

Exceptions to the above mentioned time limit:

Effective October 1, 2013, for cost reports received prior to October 1, 2003, all desk or onsite audits of these cost reports shall be final and not subject to reopening.

The aforementioned limitation shall not apply when Medicare audit reopenings result in the issuance of revised Medicaid cost report schedules. A cost report may be reopened for inspection, correction, or referral to a law enforcement agency at any time by the Agency or its contractor if program payments appear to have been obtained by fraud, similar fault, or abuse.

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 413.5 - 413.35 (excluding the inpatient routine nursing salary cost differential) and the guidelines in the Provider Reimbursement Manual CMS PUB. 15-1, as incorporated by reference in Rule 59G-6.010, F.A.C., and as further modified by Title XIX of the Social Security Act (the Act), this plan, requirements of licensure and certification, and the duration and scope of benefits provided under the Florida Medicaid Program. These include:

A. Costs incurred by a hospital in meeting:

1. The definition of a hospital contained in 42 CFR 440.10 (for the care and treatment of patients with disorders other than mental diseases) and 42 CFR 440.140 (for individuals age 65 or older in institutions for mental diseases), in order to meet the requirements of Sections 1902(a)(13) and (20) of the Social Security Act;
2. The requirements established by the Agency for establishing and maintaining health standards under the authority of 42 CFR 431.610 (b); and
3. Any other requirements for licensing under Chapter 395.003, Florida Statutes, which are necessary for providing inpatient hospital services.

B. Hospital inpatient general routine operating costs shall be the lesser of allowable costs, direct and indirect, incurred or the limits established by HHS under 42 CFR 413.30.

C. Malpractice insurance costs shall be apportioned to Medicaid in the ratio of Medicaid Patient Days to Total Patient Days.

D. Under this plan, hospitals shall be required to accept Medicaid reimbursement as payment in full for services provided during the benefit period and billed to the Medicaid program; therefore, there shall be no payments due from patients. As a result, for Medicaid cost reporting purposes, there shall be no Medicaid bad debts generated by patients. 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 on a random basis to determine if the costs are allowable in accordance with Section III of this plan. All such orders determined by the Utilization and Quality Control Peer Review Organization (PRO) or the hospital's utilization review (UR) committee to be unnecessary or not related to the spell of illness shall require appropriate adjustments to the Florida Medicaid Log.

F. The allowable costs of nursery care for Medicaid eligible infants shall include direct and indirect costs incurred on all days these infants are in the hospital.

G. The revenue assessments, and any fines associated with those assessments, mandated by the Health Care Access Act of 1984, Section 395.7015, Florida Statutes, shall not be considered an allowable Medicaid cost and shall not be allocated as a Medicaid allowable cost for purposes of cost reporting.

H. For purposes of this plan, gains or losses resulting from a change of ownership will not be included in the determination of allowable cost for Medicaid reimbursement.

IV. DRG Reimbursement

This section defines the methods used by the Florida Medicaid Program for DRG-based reimbursement of hospital inpatient stays using a prospective payment system. DRG payments are designed to be a single payment covering a complete hospital stay – from admission to discharge. In addition, DRG payments cover all services and items furnished during the inpatient stay, except newborn hearing screenings, which will be paid in addition to the DRG reimbursement.

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

A. Applicability

Effective with admissions on or after July 1, 2013, the Agency calculates reimbursement for inpatient stays using a DRG-based methodology. This methodology applies to all in-state and out-of-state general acute care hospitals, rural hospitals, children's specialty hospitals, teaching hospitals, cancer specialty hospitals, rehabilitation specialty hospitals, and long term acute care specialty hospitals. State-owned psychiatric specialty hospitals are paid via a per diem both before and after July 1, 2013. (Please see section V for details of the per diem payment method.)

For hospitals reimbursed via the DRG-based methodology, all inpatient services provided at these facilities and billed on a UB-04 paper claim form or 837I electronic claim are covered by the DRG payment with only four exceptions – services covered under the transplant global fee, newborn hearing screening, services for recipients with tuberculosis that is resistant to therapy, and services provided to recipients dually eligible for Medicare and Medicaid.

- Transplants covered under the global fee are reimbursed as described in section VIII.1 of this attachment.
- Newborn hearing screening will be reimbursed in addition to DRG-based payment.

- Services for recipients with tuberculosis that is resistant to therapy are reimbursed as described in section VIII.2 of this attachment.
- Services provided to recipients dually eligible for Medicare and Medicaid are reimbursed as described in section VIII.3 of this attachment.

B. DRG Codes and Relative Weights

1. The Agency utilizes All Patient Refined Diagnosis Related Groups (APR-DRGs) created by 3M Health Information Systems for assigning DRG classifications to claims.
2. The APR-DRG methodology includes a series of DRG codes which are made up of two parts, a base DRG and a level of severity. The base DRG is three characters in length. The level of severity is an additional 1-digit field with values 1 through 4 in which 1 indicates mild, 2 indicates moderate, 3 indicates major and 4 indicates extreme. DRG relative weights and average lengths of stay are assigned to each unique combination of 3-digit DRG code and 1-digit level of severity.
3. The DRG relative weights utilized are national APR-DRG relative weights calculated by 3M using a database containing millions of hospitals stays. For use with Florida Medicaid, the national relative weights are re-centered to the Florida Medicaid population. Re-centering the weights involves dividing each DRG's national relative weight by the average APR-DRG relative weight for a set of Florida Medicaid claims. The result of the re-centering process is a set of weights in which the average relative weight for a Florida Medicaid inpatient hospital stay is 1.0. The average Florida Medicaid relative weight (referred to as "case mix") will be calculated using the same set of historical data used to determine DRG base rate(s).
4. On all claims, two DRG codes are assigned by the MMIS. One DRG code is assigned when including all diagnosis and procedure codes on the claim and the other is assigned when ignoring any diagnosis and/or procedure codes identified to be Health Care Acquired Conditions (HCACs). If a HCAC is identified and the DRG assigned when ignoring the HCAC codes has a lower relative weight, then the lower relative weight (and its associated DRG code) is used to price the claim. Please see section IV.J for more details on payment adjustments related to HCACs.
5. Annual Updates:

a. Effective July 1, 2013:

(1) APR-DRG version 30 DRGs, relative weights and average lengths of stay are being used.

(2) Average Florida Medicaid relative weight (case mix) was calculated using claims from SFY 2010/2011.

C. Hospital Base Rate

1. One standardized base rate is used for all hospitals reimbursed via DRG pricing.
2. Provider policy adjustors are included which allow for payment adjustments to specific providers.
3. Rates and methodology parameters are established by the Agency to achieve budget neutrality, and to be compliant with federal upper payment limit requirements.
4. Base rates are calculated using historical claims data from the most recently completed state fiscal year (referred to as the "base year"). Claim data from the base year is used to simulate future inpatient fee-for-service claim payments for the purpose of setting the DRG base rate and other DRG payment parameters such as cost outlier threshold, marginal cost percentage, and policy adjustors. The claim payments from the base year may be adjusted for Medicaid volume and inflation so that the base year data approximates the upcoming rate year as closely as possible.
5. Annual Updates:

a. Effective July 1, 2013:

(1) Base year historical claims used to calculate the DRG base rate had dates of admission within SFY 2010/2011.

(2) Total inpatient reimbursement amount used to ensure budget neutrality was the sum of per diem claim payments on the base year claims calculated using SFY 2012/2013 per diem rates increased by two percent.

(3) In addition, ten percent of the federal matching funds obtained from self-funded intergovernmental transfers were used to fund an increase in the base rate for all hospitals that do not receive a policy adjustor.

(4) The DRG base rate was calculated with an assumption that overall Florida Medicaid case mix will increase by 5 percent above the case mix measured on claims in the base year (SFY 2010/2011). Case mix was predicted to increase by four percent because of improved documentation and coding on submitted claims and another one percent because of real change in the average acuity of patients seen in an inpatient setting. The result of these assumptions was a reduction of the base rate by about five percent over what would be calculated if case mix was assumed to be unchanged.

(5) Ten percent of the federal matching funds earned through the use of intergovernmental transfers donated for hospital-specific rate adjustments shall be used by the Agency for Health Care Administration to fund an increase in the base rate for all hospitals.

D. Cost-to-Charge Ratios

1. Cost-to-charge ratios (CCRs) are used in the calculation of outliers in the DRG reimbursement method. Specifically, they are used to estimate hospital cost on individual claims.
2. One CCR is calculated for each hospital participating in the Florida Medicaid program (including out-of-state providers with signed Medicaid participant agreements). Non-participating hospitals (both in and out of state) are assigned a state-wide average cost-to-charge ratio.
3. Medicaid cost and charge data as reported on Medicare cost reports (CMS 2552-10) are used to calculate hospital-specific cost-to-charge ratios. Cost-to-charge ratios are calculated by dividing total annual Medicaid costs by total annual Medicaid charges. For hospitals with less than 200 Medicaid stays in a year, total annual costs and charges are used instead of Medicaid-specific costs and charges.
4. Annual Updates:
   a. Effective July 1, 2013, cost reports filed as of April 15, 2013 were used to calculate CCRs.

E. Per Claim IGT Payments

1. Per claim IGT payments are payments made from automatic and self-funded Inter-Governmental Transfer funds.
2. Both automatic and self-funded IGT disbursements are re-calculated each year.

3. Automatic IGT disbursements are identified for each qualifying hospital in the Medicaid Hospital Funding Program Fiscal Year Final Conference Report. Automatic IGT disbursements are currently recommended by the Low Income Pool Council and determined by the Florida Legislature.
4. Self-funded IGT payments are negotiated annually between the Agency and hospitals or non-state governmental agencies acting on the behalf of hospitals.
5. Annual Updates:
    a. Effective July 1, 2013, the following process was used to determine average per-discharge IGT payments for each hospital:
        (1) Full historical per diems were divided into three parts using numerical percentages. The percentages identified the amount of each hospital's per diem funded by the three different funding mechanisms - automatic IGTs, self-funded IGTs, and general revenue plus Public Medical Assistance Trust Fund. For the SFY 2013/2014 rate setting period, SFY 2012/2013 historical per diems increased by two percent (2%) were used.
        (2) Claims in the base year dataset used for rate setting were re-priced using SFY 2012/2013 per diems increased by two percent (2%).
        (3) The percentages calculated in step (1) above were applied to full payment on each claim to determine the portion of payment from automatic IGTs, self-funded IGTs, and general revenue plus Public Medical Assistance Trust Fund.
        (4) For each hospital, automatic IGT payments were summed from all applicable claims and then divided by the hospital's total number of claims in the base year dataset to determine the average per-discharge automatic IGT payment.
        (5) For each hospital, self-funded IGT payments were summed from all applicable claims and then divided by the hospital's total number of claims in the base year dataset to determine the average per-discharge self-funded IGT payment.

F. Policy Adjustors

1. Policy adjustors are numerical multipliers included in the DRG payment calculation that allow the Agency to increase or decrease payments to categories of services and/or categories of providers.
2. Three types of policy adjustors have been built into the DRG-based payment method:
    a. Service adjustors, which are assigned to individual DRGs.
    b. Age adjustors, which are assigned based on a combination of DRG and recipient age. When utilized, age adjustors apply to recipients under the age of 21.
    c. Provider adjustors, which are assigned to categories of providers.

    In many cases the adjustors are set to 1.0, which indicates no adjustment.
3. Annual Updates:
    a. Effective July 1, 2013, the following provider and service categories have policy adjustors greater than 1.0:
        (1) Service adjustors: Claims with neonatal (sick newborn) APR-DRG assignments in which severity of illness as defined during the APR-DRG assignment is 3 (major) or 4 (extreme).
        (2) Age adjustors: Claims for pediatric services in which severity of illness as defined during the APR-DRG assignment is 3 (major) or 4 (extreme). Pediatric services are defined as inpatient care to recipients under the age of 21 for which the APR-DRG assigned to the claim indicates anything other than normal newborn, neonatal and obstetric care.
        (3) Provider adjustors: Rural hospitals (as defined in section 395.602, Florida Statutes), free-standing rehabilitation hospitals, long term acute care hospitals, and high Medicaid utilization and high outlier percentage hospitals. Hospitals qualify as high Medicaid utilization and high outlier percentage if their combined Medicaid fee-for-service and Medicaid managed care utilization is at least 50% and their percentage of outlier payments is at least 30% prior to application of a policy adjustor.

G. DRG Payment Calculation

1. Standard DRG payment: The basic components which make up DRG payment on an individual claim are shown below. These components are sometimes adjusted because of patient transfers, non-covered days or the charge cap policy. The primary components of DRG payment are:

   Claim Payment = DRG Base Payment + Outlier Payment + Automatic IGT Payment + Self-funded IGT Payment

   a. DRG Base payment:

      DRG Base payment = Provider base rate * DRG relative weight * Maximum applicable policy adjustor

      (1) Provider base rate is a dollar amount assigned to each hospital. Please see section IV.C for more details regarding provider base rates.

      (2) The DRG relative weight is a numerical multiplier used to adjust payment based on the acuity of the patient. In cases involving a Health Care Acquired Condition (HCAC), the DRG code with the lower relative weight will be used in the pricing calculation. Please see section IV.B.3 for more details regarding DRG relative weights.

      (3) Maximum applicable policy adjustor is the highest numerical value of the three policy adjustors that may apply to an individual inpatient stay – service adjustor, age adjustor and provider adjustor. Please see section IV.F for more details regarding policy adjustors.

   b. Outlier Payment:

      (1) Outlier payments are additional payments made at the claim level for stays that have extraordinarily high costs when compared to other stays within the same DRG.

      (2) A stay classifies for an outlier payment if the estimated hospital loss is greater than a loss threshold set by the Agency. Losses exceeding the loss threshold are multiplied by a marginal cost factor to determine the Outlier Payment. The components of outlier calculations are:

(a) Outlier Payment = (Estimated Hospital Loss – Outlier Loss Threshold) * Marginal Cost Factor

(b) Estimated Hospital Loss = (Billed Charges * Provider Cost-to-Charge Ratio) – DRG base payment – Automatic IGT payment – Self-funded IGT payment

c. Automatic IGT payment: An Automatic IGT payment is one of two supplemental payments made on each inpatient claim. For each hospital, the annual automatic IGT disbursement is translated into an average per-discharge amount. On individual inpatient claims, the average per-discharge automatic IGT payment for the hospital is case mix adjusted to determine the payment amount for that claim. "Case mix adjusting" the payment is performed using the following formula:

Case mix adjusted automatic IGT payment = average per-discharge automatic IGT payment * (claim DRG relative weight / provider's estimated annual case mix)

(1) A provider's estimated annual case mix is the average of the DRG relative weight on all of the provider's inpatient claims as calculated using the same historical claims used for setting the DRG base rate. If case mix is assumed to increase between the base year and the rate year when calculating the DRG base rate, then the same forward trend is applied to provider annual case mix used in the IGT payment calculation.

(2) Case mix adjusting the average per-discharge automatic IGT payment increases the IGT payment for claims with higher than average relative weight and decreases the IGT payment for claims with lower than average relative weight.

d. Self-Funded IGT Payment: Self-funded IGT payments are the second of two supplemental payments applied to each inpatient claim. Each hospital's negotiated annual self-funded IGT payment is translated into an average per-discharge amount. On individual inpatient claims, the average per-discharge self-funded IGT payment for the hospital is case mix adjusted to

determine the self-funded supplemental payment amount for that claim. "Case mix adjusting" the payment is performed using the following formula:

Case mix adjusted self-funded IGT payment = average per-discharge self-funded IGT payment * (claim DRG relative weight / provider's estimated annual case mix)

(1) A provider's estimated annual case mix is the average of the DRG relative weight on all of the provider's inpatient claims as calculated using the same historical claims used for setting the DRG base rate. If case mix is assumed to increase between the base year and the rate year when calculating the DRG base rate, then the same forward trend is applied to provider annual case mix used in the IGT payment calculation.

(2) Case mix adjusting the average per-discharge self-funded IGT payment increases the IGT payment for claims with higher than average relative weight and decreases the IGT payment for claims with lower than average relative weight.

2. Transfer Payment Adjustment: Payment adjustments are made when an inpatient hospital stay is shorter than average due to a transfer from one acute care facility to another. This payment adjustment is referred to as a "transfer policy."

a. The transfer payment adjustment only applies when a patient is transferred to another acute care hospital as identified by patient discharge status values,

02 – discharged/transferred to a short-term general hospital for inpatient care
05 – discharged/transferred to a designated cancer center or children's hospital
65 – discharged/transferred to a psychiatric hospital or distinct part unit
66 – discharged/transferred to a critical access hospital

The transfer policy does not apply in cases where a patient is discharged to a post-acute setting such as a skilled nursing facility.

b. When one of the four discharge statuses listed above exists on the claim, a separate Transfer Base Payment amount is calculated using a per diem type of calculation and the lower of Transfer Base Payment and the DRG Base Payment is applied to the claim. The Transfer Base Payment amount is calculated with the following formula:

Transfer Base Payment = (DRG Base Payment / DRG national average length of stay)

* (actual length of stay + 1)

c. If the Transfer Base Payment is less than the DRG base payment, then the Transfer Base Payment replaces the DRG Base Payment and is used for the rest of the pricing calculations on the claim. Transfer claims that meet the outlier criteria described above are eligible for an outlier payment.

d. IGT payments are unaffected by transfer status. IGT payments are applied the same for transfer and non-transfer stays.

e. Transfer payment reductions only apply to the transferring hospital. Reimbursement to the receiving hospital is not impacted by the transfer payment adjustment unless the receiving hospital also transfers the patient to another hospital.

3. Non-Covered Day Adjustment: The DRG payment is proportionately reduced in cases where some of the days of the hospital stay are not covered by the Florida Medicaid fee-for-service program.

a. Stays with non-covered days can occur in the following scenarios:

- Recipient is an undocumented non-citizen (for which only emergency services are reimbursed)
- Recipient exhausted his/her 45-day benefit limit prior to admission (in which case only emergency services are reimbursed)
- Recipient is dually eligible for Medicare and Medicaid and exhausts his/her Medicare Part A benefits during an inpatient admission

b. When only a portion of an inpatient admission is reimbursable by Florida Medicaid fee-for-service, payment is prorated downward based on the number of covered days in relation to the full length of stay. Specifically, a proration factor is calculated as,

Non-covered day adjustment factor = (Covered days / Length of stay)

c. For claims with non-covered days, the non-covered day adjustment factor is applied to all four parts of the DRG payment: base payment, outlier payment, automatic IGT payment, and self-funded IGT payment.

4. Charge cap: For claims where the calculated Medicaid allowed amount exceeds submitted charges, the allowed amount is reduced to submitted charges. This is done by reducing all four parts of the allowed amount: DRG base payment, outlier payment, automatic IGT payment, and self-funded IGT payment proportionally. For example, if the submitted charges are 30% less than the Medicaid allowed amount (including IGT payment), then all four parts of the allowed amount get reduced by 30%.
5. Third party liability: DRG reimbursement shall be limited to an amount, if any, by which the DRG payment calculated for an allowable claim exceeds the amount of third party benefits applied to the inpatient admission.
6. Examples: Please see Appendix D for examples of the DRG pricing calculation.

H. Cost Settlement

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

I. Interim Claims and Late Charges

1. Because DRG payment is designed to be payment in full for a complete hospital stay, interim claims (claims for only part of a hospital stay, and submitted with bill type 0112, 0113, and 0114) will not be accepted. If recipient has Medicaid fee-for-service eligibility for only part of a hospital stay, a claim should be submitted for the complete hospital stay and payment will be prorated downward based on a comparison of the eligible days to the actual length of stay.
2. Late charges, submitted with bill type 0115, will not be accepted. Instead, hospitals are instructed to adjust previously submitted claims if appropriate.

J. Payment Adjustment for Provider Preventable Conditions (PPCs)

1. Citation: 42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903.

2. The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions. These requirements apply to inpatient hospitals.
3. No reduction in payment for a provider preventable condition (PPC) is 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.
4. Reductions in provider payment may be limited to the extent that the following apply:
    a. The identified provider-preventable conditions would otherwise result in an increase in payment.
    b. The State can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.
5. Two DRGs are assigned to each claim and are referred to as "pre-HCAC" and "post-HCAC" DRGs. The pre-HCAC DRG is assigned using all the diagnosis and surgical procedure codes on the claim. The post-HCAC DRG is assigned when ignoring any diagnosis and surgical procedure codes identified as HCACs. If the pre-HCAC and post-HCAC DRGs are different, then the DRG code with the lower relative weight is used to price the claim. In all or nearly all cases, the DRG code with the lower relative weight is the post-HCAC DRG.
6. The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19-A.
    a. Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.
7. The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19 –A:
    a. 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.

b. On and after May 1, 2012, Medicaid makes zero payments to providers for Other Provider-Preventable Conditions which includes Never Events (NE) as defined by the National Coverage Determination (NCD). The Never Events (NE) as defined in the NCD includes Inpatient Hospitals, Outpatient Hospitals, Ambulatory Surgical Centers (ASC) and practitioners, and these providers, regardless of the health care setting, are required to report NEs.

K. Frequency of DRG Payment Parameter Updates

1. DRGs and relative weights: New versions of APR-DRGs are released annually and include a new set of relative weights and average lengths of stay. The Agency will install a new version of APR-DRGs no more frequently than once per year and no less frequently than once every two years. Installation of new versions of APR-DRGs and associated relative weights will occur at the beginning of a state fiscal year and will coincide with a recalculation of hospital base rates, DRG policy adjustors, and outlier parameters. When installing new versions of APR-DRG classifications, relative weights and average lengths of stay, the Agency will install the most current version that is available at the time of installation.
2. Hospital Base Rate:
   a. New hospital base rates are calculated annually and become effective at the beginning of each state fiscal year.
   b. During each fiscal year, hospital base rates are recalculated and implemented by the end of October to account for finalized self-funded IGT amounts. Self-funded IGT amounts are reset annually during the first three months of the state fiscal year.
   c. In SFY 2013/2014, the first year of DRG reimbursement, the base rate will also be recalculated effective March 1, 2014, if the actual case mix measured on claims billed in the first six months of the fiscal year differs significantly from the predicted case mix. Predicted case mix is five percent above case mix measured on claims in the base year (2010/2011). Case mix on claims in the base year was 1.00 so predicted case mix in SFY 2013/2014 is 1.05. Adjustment to the base rate, if applied, will be prospective for the remainder of the state

fiscal year and must maintain budget neutrality for the full fiscal year. This base rate adjustment will not affect the supplemental transitional payments made available for the first year of DRG reimbursement. However, the base rate adjustment could affect the reconciliation of transitional payments described in section IV.L.3 which involves comparison of actual DRG payments to estimated per diem payments.

3. Hospital Cost-to-Charge Ratios: New cost-to-charge ratios are calculated at the beginning of each state fiscal year using each hospital's most currently available cost report.
4. Automatic IGT Funds: These payments become effective at the beginning of the state fiscal year.
5. Self-Funded IGT Funds: At the beginning of each state fiscal year, hospitals are assumed to have the same level of self-funded IGTs as they had in the previous year. New values applicable to the current fiscal year are determined by October 1st and DRG payment rates are updated in response to these new values by October 31st.
6. Policy Adjustors
    a. New values for the policy adjustors are calculated annually and become effective at the beginning of each state fiscal year.
    b. During each state fiscal year, the policy adjustors are recalculated and implemented by the end of October to account for finalized self-funded IGT amounts. Self-funded IGT amounts are reset annually during the first three months of the state fiscal year.
    c. During SFY 2013/2014, the first year of implementation of DRG reimbursement, the policy adjustors will be recalculated effective March 1, 2014 in concert with recalculation of the base rate, if the actual case mix measured on claims billed in the first six months of the fiscal year differs significantly from the predicted case mix. Predicted case mix is five percent above case mix measured on claims in the base year (2010/2011). Case mix on claims in the base year was 1.00 so predicted case mix in SFY 2013/2014 if 1.05. Updates to the policy adjustors, if applied, will be prospective for the remainder of the state fiscal year and must maintain budget neutrality for the full fiscal year. The policy adjustor updates will not affect the supplemental transitional payments made available for the first year of DRG

reimbursement. However, the policy adjustor updates may affect the reconciliation of transitional payments described in section IV.L.3 which involve comparison of actual DRG payments to estimated per diem payments.

7. Outlier Loss Threshold: The outlier loss threshold is re-evaluated annually and new values become effective at the start of a state fiscal year.
8. The Outlier Marginal Cost Factor is re-evaluated annually and new values become effective at the start of a state fiscal year.
9. Provider estimated annual case mix: New values for provider estimated annual case mix are calculated annually and become effective at the beginning of each state fiscal year.
10. Provider estimated number of annual Medicaid admissions: New values for provider estimated annual Medicaid admissions are calculated annually and become effective at the beginning of each state fiscal year.

L. Transitional Payments for First Year of DRG Reimbursement

1. During the first year of DRG reimbursement, supplemental quarterly lump-sum payments are being made to any rural hospital estimated to experience a decrease in inpatient reimbursements due to the implementation of the Diagnosis-Related Group reimbursement methodology. In addition, supplemental quarterly lump-sum payments are being made to any non-rural hospital estimated to experience a decrease in inpatient reimbursements in excess of $300,000 due to the implementation of the Diagnosis-Related Group reimbursement methodology. Funding for these supplemental payments is allocated into three tiers:

   Tier 1 – Rural Hospitals - $2,672,283

   Tier 2 – Non-Rural Hospitals with losses equal to or greater than 10%

   Tier 3 – Non-Rural Hospitals with losses less than 10%

2. Initial estimates of transitional payments for individual hospitals were calculated prior to the beginning of SFY 2013/2014 and are listed in Appendix E. These projected amounts were determined by estimating decreases in inpatient reimbursement between simulated DRG payments

and payments calculated using the legacy per diem payment method, when applied to the base year (SFY 2010/2011) paid claims data.

3. The agency shall, by June 30, 2014, perform reconciliation and apply positive or negative adjustments to the transitional payments to any hospital that qualified for a transitional payment. The reconciliation shall compare actual DRG payments to estimated per diem payments on claims with admissions in SFY 2013/2014 to determine qualified hospitals and the applicable transition payment amount on an individual hospital basis. Any unearned transitional funds shall be redistributed to increase hospital inpatient base rates on a statewide basis. Adjustments applied must in total remain within the funds allocated for DRG transitional payments.

V. . Per Diem Reimbursement

This section defines the process used by the Florida Medicaid Program for per diem reimbursement of hospital inpatient stays.

A. Applicability

Per diem reimbursement applies to all inpatient stays for fee-for-service recipients with admissions prior to July 1, 2013, except those covered by the global transplant fee. For admissions on or after July 1, 2013, per diem reimbursement for inpatient stays for fee-for-service recipients will be used only if the care was provided at a state-owned psychiatric specialty facility. All other inpatient admissions on or after July 1, 2013 will be reimbursed using a DRG-based inpatient prospective payment system, except those covered by the global transplant fee or those classified as tuberculosis resistant to therapy.

B. Standards

1. In accordance with Chapter 120, Florida Statutes, 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.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. An

inpatient variable cost county reimbursement ceiling shall be established for and applied to general hospitals. An inpatient county reimbursement ceiling shall not be applied to specialized, statutory teaching, rural, CHEP hospitals, or those hospitals included in Section V. C.1 except as described in V.C.1 of the Plan. An inpatient fixed cost reimbursement ceiling shall be established for all hospitals except rural hospitals and specialized psychiatric hospitals. Out-of-state hospitals shall be considered to be general hospitals under this plan.

2. Reimbursement ceilings shall be established prospectively for each Florida County. Beginning with the July 1, 1991, rate period, additional ceilings based on the target rate system shall be imposed. The target rate ceiling shall be the approved rate of increase in the prospective payment system for the Medicare Inpatient Hospital Reimbursement Program as determined by the Department of HHS. For fiscal year 1991-1992, the allowable rate of increase shall be 3.3 percent. Effective July 1, 1995, the target rate ceiling shall be calculated from an annually adjusted Data Resource Inc. (DRI, or its successor) inflation factor. The DRI (or its successor) inflation factor for this time period is 3.47 percent. With the adjustment of this DRI (or its successor) factor, the allowable rate of increase shall be 2.2 percent. Effective July 1, 1996, and for subsequent state fiscal years, the allowable rate of increase shall be calculated by an amount derived from the DRI (or its successor) inflation index described in appendix A. The allowable rate of increase shall be calculated by dividing the inflation index value for the midpoint of the next state fiscal year by the inflation index value for the midpoint of the current state fiscal year and then multiply this amount by 63.4 percent. The allowable rate of increase shall be recalculated for each July rate setting period and shall be the same during the remainder of the state fiscal year. These target ceilings shall apply to inpatient variable cost per diems (facility specific target ceilings) and county ceilings (county target ceilings) and shall be used to limit per diem increases during state fiscal years. The facility specific target and county target ceilings shall apply to all general hospitals. Rural, specialized, statutory teaching, Community Hospital Education Program (CHEP) hospitals, and those hospitals included in Section V. C.1 of the Plan are exempt from both target ceilings in accordance with Section V.C.1.

3. The initial reimbursement ceilings shall be determined prospectively and shall be effective from July l, 1990, through December 31, 1990. For subsequent periods the reimbursement ceilings shall be effective from January l through June 30 and July l through December 31 of the appropriate years except as provided in 7 below. Inpatient reimbursement ceilings set under the provisions of the Plan for the July 1, 2003 rate setting will be effective October 1, 2003. Effective July 1, 2011, there will be one rate setting period from July 1 through June 30.
4. Changes in individual hospital per diem rates shall be effective from July 1 through June 30 of each year. Inpatient reimbursement rates set under the provisions of the Plan for the July 1, 2003 rate setting will be effective October 1, 2003. Effective July 1, 2011, there will be one rate setting period from July 1 through June 30.
5. For the initial period, the last cost report received from each hospital as of March 31, 1990 shall be used to establish the reimbursement ceilings. For subsequent periods, all cost reports postmarked by March 31 and received by AHCA by April 15 shall be used to establish the reimbursement ceilings. For the initial period within 20 days after publication, a public hearing, if requested, shall be held so that interested members of the public shall be afforded the opportunity to review and comment on the proposed reimbursement ceilings. Subsequent rate periods shall not be automatically subject to public hearing.
6. For subsequent periods, all cost reports received by AHCA as of each April 15 shall be used to establish the reimbursement ceilings.
7. The prospectively determined individual hospital's rate shall be adjusted only under the following circumstances:
    a. An error was made by the fiscal intermediary or AHCA in the calculation of the hospital's rate.
    b. A hospital submits an amended cost report to supersede the cost report used to determine the rate in effect. There shall be no change in rate if an amended cost report is submitted beyond 3 years of the effective date that the rate was established, or if the change is not material. Effective July 1, 2011, a hospital must submit an amended cost report by September 15 of

the state fiscal year the rates are effective to have the amended cost report recognized in the final rates set at September 30.

c. Further desk or on-site audits of cost reports used in the establishment of the prospective rate disclose material changes in these reports.

d. The charge structure of a hospital changes and invalidates the application of the lower of cost or charges limitations.

8. Any rate adjustment or denial of a rate adjustment by AHCA may be appealed by the provider in accordance with Section 120.57, Florida Statutes.

9. Under no circumstances shall any rate adjustment exceed the reimbursement ceiling, except as provided for in Sections V.C.2.a and V.C.2.b.

10. The Agency shall distribute monies as appropriated to hospitals providing a disproportionate share of Medicaid or charity care services by increasing Medicaid payments to hospitals as required by Section 1923 of the Act.

11. The Agency shall distribute monies as appropriated to hospitals determined to be disproportionate share providers by allowing for an outlier adjustment in Medicaid payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age as required by Section 1923 of the Act.

12. Effective July 1, 2006, in accordance with the approved Medicaid Reform Section 1115 Demonstration, Special Terms and Conditions 100(c), a hospital's inpatient reimbursement rate will be limited by allowable Medicaid cost, as defined in Section III of this plan, utilizing Form CMS-2552-96 (or its successor).

13. Effective July 1, 2011, a hospital must submit an amended cost report by September 15 of the state fiscal year the rates are effective to have the amended cost report recognized in the final rates set at September 30.

14. Effective July 1, 2012, a hospital must submit an amended cost report by October 15 of the state fiscal year the rates are effective to have the amended cost report recognized in the final rates set at October 31.

15. A prospective reimbursement rate, however, shall not be established for a new hospital based on a cost report for a period less than 12 months. For a new provider with no cost history, excluding new providers resulting from a change in ownership where the previous provider participated in the program, the interim per diem rate shall be the lesser of:

    a. The county reimbursement ceiling, if applicable; or

    b. The budgeted rate approved by AHCA based on this plan.

    Interim rates shall be cost settled for the interim rate period. Interim per diem rates shall not be approved for new providers resulting from a change in ownership. Medicaid reimbursement is hospital specific and is not provider specific.

16. Medicaid reimbursement shall be limited to an amount, if any, by which the per diem calculation for an allowable claim exceeds the amount of third party benefits during the Medicaid benefit period.

C. Methods

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

1. Setting Reimbursement Ceilings for Inpatient Variable Cost.

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

   (1) To reflect the results of desk audits;

   (2) To exclude from the allowable costs, any gains and losses resulting from a change of ownership and included in clearly marked "Final" cost reports.

b. Reduce a hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.30.

c. Determine allowable Medicaid variable costs defined in Section XIV of this plan.

d. Adjust allowable Medicaid 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 latest available projections as of December 31for the Data Resources Incorporated (DRI) (or its successor) National and Regional Hospital Input Price Indices as detailed in Appendix A.

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

f. Divide the results of Step 5 for each hospital by the sum of its Medicaid regular inpatient days plus Medicaid non-concurrent nursery days resulting in a variable cost per diem rate. Medicaid non-concurrent nursery days are inpatient nursery days for a Medicaid eligible newborn whose mother is not an inpatient in the same hospital at the same time.

g. Array the per diem rates in Step 6 from the lowest to the highest rate for all general hospitals within the State with the associated Medicaid patient days.

h. For general hospitals in a county, set the county ceiling for variable costs at the lower of:

(1) The cost based county ceiling which is the per diem rate associated with the 70th percentile of Medicaid days from Step 7 times the FPLI component utilized in Step 5 for the county;

(2) The target county ceiling that is the prior January rate semester's county ceiling plus an annually adjusted factor using the DRI (or its successor) inflation table. Effective July 1, 1995, the DRI (or its successor) inflation factor is 3.47 percent. With the adjustment of this DRI (or its successor) factor, the allowable rate of increase shall be 2.2 percent. Effective July 1, 1996, and for subsequent state fiscal years, the allowable rate of increase shall be calculated by an amount derived from the DRI (or its successor) inflation index described in appendix A. The allowable rate of increase shall be calculated by dividing the inflation index value for the midpoint of the next state fiscal year by the inflation

index value for the midpoint of the current state fiscal year and then multiply this amount by 63.4 percent. The allowable rate of increase shall be recalculated for each July rate setting period and shall be the same during the remainder of the state fiscal year.

i. Specialized, statutory teaching, and rural hospitals are excluded from the calculation and application of the reimbursement county ceilings in C.1.a through h, above. Community Hospital Education Program (CHEP) hospitals and those hospitals included in 10, 11, 12, and 13 below are included in the calculation of the ceilings in C.1.a through h, above, but are exempt from the application of these ceilings.

j. Effective July 1, 2001, inpatient reimbursement ceilings will be eliminated for hospitals whose sum of charity care and Medicaid days as a percentage of adjusted patient days equals or exceeds fifteen percent. Effective July 1, 2002, the fifteen percent (15%) will be changed to fourteen and one-half percent (14.5%). The Agency shall use the 1997 audited DSH data available as of March 1, 2001, in determining eligibility for these adjustments to ceilings. Effective July 1, 2003, the fourteen and one-half percent (14.5%) will be changed to eleven percent (11%) to eliminate the inpatient ceilings for hospitals whose charity care and Medicaid days, as a percentage of total adjusted hospital days, equals or exceeds 11 percent. The Agency will use the average of the 1997, 1998, and 1999 audited DSH data available as of March 1, 2003. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency will use the average of the audited DSH data for 1997, 1998, and 1999 that is available. For those hospitals with only one year of audited DSH data, the Agency shall eliminate the inpatient reimbursement ceilings for only those hospitals with 1999 audited DSH data. Hospital inpatient rates set under the provisions of the Plan for the July 1, 2003 rate setting will be effective October 1, 2003. Effective July 1, 2004, inpatient reimbursement ceilings will be eliminated for hospitals whose sum of charity care and Medicaid days, as a percentage of adjusted patient days, equals or exceeds eleven (11) percent. The Agency will use the average of the 1998, 1999, and 2000 audited DSH data available as of March 1, 2004. In the event the Agency does not

have the prescribed three years of audited DSH data for a hospital, the Agency will use the average of the audited DSH data for 1998, 1999, and 2000 that is available. Effective July 1, 2005, inpatient reimbursement ceilings will be eliminated for hospitals whose sum of charity care and Medicaid days, as a percentage of adjusted patient days, equals or exceeds 11 percent. The Agency will use the average of the 1999, 2000, and 2001 audited DSH data available as of March 1, 2005. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency will use the average of the audited DSH data for 1999, 2000, and 2001 that are available. If the prescribed three years of audited DSH data is not available for the non-state government owned or operated facility, the Agency shall use the average of the 1999, 2000, and 2001 audited DSH data that is available for the non-state government owned or operated facility. Any hospital that met the 11 percent threshold in the State Fiscal Year 2004-2005 and was also exempt from the inpatient reimbursement ceilings shall remain exempt from the inpatient reimbursement ceilings for State Fiscal Year 2005-2006 subject.

k. Effective July 1, 2001, inpatient reimbursement ceilings will be eliminated for hospitals whose Medicaid days as a percentage of total hospital days exceed 9.6% and are a trauma center. The Agency shall use the 1997 audited DSH data available as of March 1, 2001 in determining eligibility for these adjustments to ceilings. Effective July 1, 2003, the Agency will use the average of the 1997, 1998, and 1999 audited DSH data available as of March 1, 2003. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency will use the average of the audited DSH data for 1997, 1998, and 1999 that is available. Hospital inpatient rates set under the provisions of the Plan for the July 1, 2003 rate setting will be effective October 1, 2003. Effective July 1, 2004, the Agency will use the average of the 1998, 1999, and 2000 audited DSH data available as of March 1, 2004. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency will use the average of the audited DSH data for 1998, 1999, and 2000 that is available. Effective July 1, 2005, inpatient reimbursement ceilings

will be eliminated for hospitals whose Medicaid days as a percentage of total hospital days exceed 7.3%, and are a designated or provisional trauma center. This provision shall apply to all hospitals that are a designated or provisional trauma center on July 1, 2005 and any hospitals that become a designated or provisional trauma center during the State Fiscal year 2005-2006. Effective July 1, 2005, the Agency will use the average of the 1999, 2000, and 2001 audited DSH data available as of March 1, 2005. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency will use the average of the audited DSH data for 1999, 2000, and 2001 that are available.

l. Effective July 1, 2004 an inpatient ceiling shall not be applied to hospitals with a Level III Neonatal Intensive Care Unit that has a minimum of three of the following designated tertiary services regulated under the certificate of need program: pediatric bone marrow transplantation, pediatric open heart surgery, pediatric cardiac catheterization and pediatric heart transplantation.

m. Effective July 1, 2005 an inpatient ceiling shall not be applied to hospitals that have a minimum of ten licensed Level II Neonatal Intensive Care Beds and are located in Trauma Services Area 2.

n. Effective July 1, 2006, the Agency will eliminate the inpatient reimbursement ceilings for hospitals whose charity care and Medicaid days, as a percentage of total adjusted hospital days, equal or exceed 11 percent. For any non-state government owned or operated facility that does not qualify for the elimination of the inpatient ceilings in this Plan, the non-state government owned or operated facility shall be exempt from the inpatient reimbursement ceilings. The Agency shall use the average of the 2000, 2001, and 2002 audited DSH data available as of March 1, 2006. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2000, 2001, and 2002 that are available.

o. Effective July 1, 2006, the Agency will eliminate the inpatient hospital reimbursement ceilings for hospitals whose Medicaid days as a percentage of total hospital days exceed 7.3

percent, and are designated or provisional trauma centers. This provision shall apply to all hospitals that are a designated or provisional trauma centers on July 1, 2006 and any hospitals that become a designated or provisional trauma center during State Fiscal Year 2006-2007. The Agency shall use the average of the 2000, 2001, and 2002 audited DSH data available as of March 1, 2006. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2000, 2001, and 2002 that are available.

p. Effective July 1, 2006, the Agency will eliminate the inpatient reimbursement ceilings for teaching, specialty, Community Hospital Education Program hospitals and 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.

q. Effective July 1, 2007, inpatient reimbursement ceilings will be eliminated for hospitals whose charity care and Medicaid days, as a percentage of total adjusted hospital days, equal or exceed 11 percent. The Agency shall use the average of the 2001, 2002, and 2003 audited DSH data available as of March 1, 2007. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2001, 2002, and 2003 that are available.

r. Effective July 1, 2007, the inpatient reimbursement ceilings for hospitals that have a minimum of ten licensed Level II Neonatal Intensive Care Beds and are located in Trauma Services Area 2 will be eliminated.

s. Effective July 1, 2007, the inpatient hospital reimbursement ceilings for hospitals whose Medicaid days as a percentage of total hospital days exceed 7.3 percent, and are designated or provisional trauma centers will be eliminated. This provision shall apply to all hospitals that are designated or provisional trauma centers on July 1, 2007 and any hospitals that become a designated or provisional trauma center during State Fiscal Year 2007-2008. The

Agency shall use the average of the 2001, 2002, and 2003 audited DSH data available as of March 1, 2007. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2001, 2002, and 2003 that are available.

t. Effective July 1, 2007, the inpatient reimbursement ceilings will be eliminated for teaching, specialty, Community Hospital Education Program hospitals and 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.

u. Effective July 1, 2008 and ending June 30, 2009, any hospital will be exempt from the inpatient targets and ceilings if that hospital was identified by the Agency for Health Care Administration as qualifying for the exemption pursuant to section 409.905(5)(c), Florida Statutes in fiscal year 2007-08 and did not receive funding in the final General Appropriations Act for Fiscal Year 2007-08.

v. Effective July 1, 2008, hospitals will be exempt from the inpatient reimbursement ceilings whose charity care and Medicaid days, as a percentage of total adjusted hospital days, equals or exceeds 11 percent. The Agency shall use the average of the 2002, 2003, and 2004 audited DSH data available as of March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003, and 2004 that are available. Those hospitals qualifying using audited DSH data received between January 30, 2008, and March 1, 2008, and who were excluded from the LIP Council recommendations may be exempt from the inpatient ceilings.

w. Effective July 1, 2008, the inpatient 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.

x. Effective July 1, 2008, the inpatient hospital reimbursement ceilings will be eliminated for hospitals whose Medicaid days as a percentage of total hospital days exceed 7.3 percent, and are designated or provisional trauma centers. This provision shall apply to all hospitals that are designated or provisional trauma centers on July 1, 2008, and any hospitals that become a designated or provisional trauma center during state fiscal year 2008-2009. The Agency shall use the average of the 2002, 2003, and 2004 audited DSH data available as of March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003, and 2004 that are available.

y. Effective July 1, 2008, the inpatient reimbursement ceilings will be eliminated for teaching, specialty, Community Hospital Education Program hospitals and 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.

z. Effective July 1, 2008, a buy back provision will be applied to the Medicaid Trend Adjustment that is being applied against the Medicaid inpatient rates for the following three categories of hospitals.

(1) Budget authority up to $34,484,976 is provided to the first category of hospitals, which are those hospitals that are part of a system that operates a provider service network in the following manner: $20,000,000 is for Jackson Memorial Hospital; $3,968,662 is for hospitals in Broward Health; $2,376,638 is for hospitals in the Memorial Healthcare System; and $3,428,386 is for Shands Jacksonville and $4,711,290 is for Shands Gainesville. In the event the above amounts exceed the amount of the Medicaid trend adjustment applied to each hospital, the excess funds will be used to buy back other Medicaid reductions in the inpatient rate.

(2) Budget authority up to $18,125,729 shall be used for the second category to buy back the Medicaid trend adjustment that is being applied against the Medicaid inpatient rates for those hospitals that are licensed as a children's specialty hospital and whose Medicaid days plus charity care days divided by total adjusted patient days equals or exceeds 30 percent. In the event that the funds under this category exceed the amount of the Medicaid trend adjustment, then any excess funds will be used to buy back other Medicaid reductions in the inpatient rate for those individual hospitals.

(3) Budget authority up to $3,420,570 shall be used for the third category to buy back the additional Medicaid trend adjustment that is being applied to rural hospitals under Specific Appropriation 206 for fiscal year 2008-2009. In the event the funds under this category exceed the amount of the Medicaid trend adjustment, then any excess funds will be used to buy back other Medicaid reductions in the inpatient rate for those individual hospitals.

aa. For this provision the Agency shall use the 2002, 2003, and 2004 audited DSH data available as of March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003, and 2004 that are available. Effective July 1, 2008, budget authority up to $111,355,553 is provided for a buy back provision for state or local government owned or operated hospitals, teaching hospitals as defined in section 408.07 (45) or 395.805, Florida Statutes, which have 70 or more full-time equivalent resident physicians and those hospitals whose Medicaid and charity care days divided by total adjusted days exceeds 25 percent to buy back the Medicaid inpatient trend adjustment shall be applied to their individual hospital rates and other Medicaid reductions to their inpatient rates up to actual Medicaid inpatient cost. The Agency shall use the average of 2002, 2003, and 2004 audited DSH data available as of March 1, 2008. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency shall use the average of the audited DSH data for 2002, 2003, and 2004 that are available.

bb. Effective July 1, 2009, inpatient hospital reimbursement ceilings will be eliminated for hospitals whose charity care and Medicaid days, as a percentage of total adjusted hospital days, equal or exceed 11 percent. For any non-state government owned or operated hospital or any leased non-state government owned or operated hospital found to have sovereign immunity or hospital with graduate medical education positions that does not qualify for the elimination of the inpatient ceilings under this section, such hospitals shall be exempt from the inpatient reimbursement ceilings contingent on the hospital or local governmental entity providing the required state match. The agency shall use the average of the 2003, 2004 and 2005 audited DSH data available as of March 1, 2009. In the event the agency does not have the prescribed three years of audited DSH data for a hospital, the agency shall use the average of the audited DSH data for 2003, 2004 and 2005 that are available.

cc. Effective July 1, 2009, inpatient 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.

dd. Effective July 1, 2009, inpatient hospital reimbursement ceilings will be eliminated for hospitals whose Medicaid days as a percentage of total hospital days exceed 7.3 percent, and are designated or provisional trauma centers. This provision shall apply to all hospitals that are designated or provisional trauma centers on July 1, 2009 and any hospitals that become a designated or provisional trauma center during Fiscal Year 2009-2010. Included in these funds are the annualized amounts to offset the reductions taken against certified trauma centers as identified in Section 12, chapter 2007-326, Laws of Florida. The Agency shall use the average of the 2003, 2004 and 2005 audited Disproportionate Share Hospital (DSH) data available as of March 1, 2009. In the event the agency does not have the prescribed three years of audited Disproportionate Share Hospital (DSH) data for a hospital, the agency shall use the average of the audited DSH data for 2003, 2004 and 2005 that are available.

ee. Effective July 1, 2009, inpatient hospital reimbursement ceilings will be eliminated for teaching, specialty, Community Hospital Education Program hospitals and 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. Included in these funds are the annualized amounts to offset the reductions taken against hospitals defined in section 408.07 (45), Florida Statutes, that are not certified trauma centers, as identified in Section 12, chapter 2007-326, Laws of Florida.

ff. Effective July 1, 2009, a buy back provision will be applied to the Medicaid trend adjustment that is being applied against the Medicaid inpatient rates for the following three categories of hospitals:

(1) $38,503,310 is provided to the first category of hospitals, which are those hospitals that are part of a system that operates a provider service network in the following manner: $18,152,419 is for Jackson Memorial Hospital; $5,407,484 is for hospitals in Broward Health; $5,457,550 is for hospitals in the Memorial Healthcare System; and $2,748,092 is for Shands Jacksonville and $6,737,765 is for Shands Gainesville. In the event that the above amounts exceed the amount of the Medicaid trend adjustment applied to each hospital, then the excess funds will be used to buy back other Medicaid reductions in the inpatient rate not to exceed the base rate effective July 1, 2009.

(2) $21,365,269 shall be used for the second category to buy back the Medicaid trend adjustment that is being applied against the Medicaid inpatient rates for those hospitals that are licensed as a children's specialty hospital and whose Medicaid days plus charity care days divided by total adjusted patient days equals or exceeds 30 percent. In the event that the funds under this category exceed the amount of the Medicaid trend adjustment, then any excess funds will be used to buy back other

Medicaid reductions in the inpatient rate for those individual hospitals not to exceed the base rate effective July 1, 2009.

(3) $10,031,002 shall be used for the third category to buy back the Medicaid trend adjustment that is being applied against the Medicaid inpatient rates to rural hospitals. In the event that the funds under this category exceed the amount of the Medicaid trend adjustment, then any excess funds will be used to buy back other Medicaid reductions in the inpatient rate for those individual hospitals not to exceed the base rate effective July 1, 2009.

(4) For this section the Agency shall use the 2003, 2004 and 2005 audited DSH data available as of March 1, 2009. In the event the agency does not have the prescribed three years of audited DSH data for a hospital, the agency shall use the average of the audited DSH data for 2003, 2004 and 2005 that are available.

gg. $212,264,180 shall be used for non state government owned or operated hospitals, including any leased non state government owned or operated hospital found to have sovereign immunity, teaching hospitals as defined in section 408.07 (45) or 395.805, Florida Statutes, which have seventy or more full-time equivalent resident physicians and for designated trauma hospitals may buy back the Medicaid inpatient trend adjustment applied to their individual hospital rates and other Medicaid reductions to their inpatient rates up to actual Medicaid inpatient cost not to exceed the base rate effective July 1, 2009.

hh. Effective July 1, 2010, eliminate the inpatient reimbursement ceilings for hospitals whose charity care and Medicaid days, as a percentage of total adjusted hospital days, equal or exceed 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 inpatient ceilings under this section or any other section, such hospitals shall be exempt from the inpatient reimbursement ceilings. The agency shall use the average of the 2003, 2004 and 2005 audited DSH data available as of March 1, 2009. In the event the agency does not have the prescribed three years of audited DSH data

for a hospital, the agency shall use the average of the audited DSH data for 2003, 2004 and 2005 that are available. Any hospital that was exempt from the inpatient 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 meets the 11 percent threshold, because of updated audited DSH data, shall remain exempt from the inpatient reimbursement ceilings for a period of two years.

ii. Effective July 1, 2010, inpatient 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.

jj. Effective July 1, 2010, inpatient hospital reimbursement ceilings will be eliminated for hospitals whose Medicaid days as a percentage of total hospital days exceed 7.3 percent, and are designated or provisional trauma centers. This provision shall apply to all hospitals that are designated or provisional trauma centers on July 1, 2010, and any hospitals that becomes 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 12, chapter 2007-326, Laws of Florida. The agency shall use the average of the 2003, 2004 and 2005 audited Disproportionate Share Hospital (DSH) data available as of March 1, 2009. In the event the agency does not have the prescribed three years of audited Disproportionate Share Hospital (DSH) data for a hospital, the agency shall use the average of the audited DSH data for 2003, 2004 and 2005 that are available.

kk. Effective July 1, 2010, inpatient reimbursement ceilings will be eliminated for teaching, specialty, Community Hospital Education Program hospitals, and 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. Included in these funds are the annualized amounts to offset the

reductions taken against hospitals defined in section 408.07 (45), Florida Statutes, that are not certified trauma centers, as identified in section 12, chapter 2007-326, Laws of Florida.

ll. Effective July 1, 2010, a buy back provision will be applied to the Medicaid trend adjustment that is being applied against the Medicaid inpatient rates for the following three categories of hospitals. Of these funds:

(1) $31,984,943 is provided to the first category of hospitals, which are those hospitals that are part of a system that operates a provider service network in the following manner: $18,773,903 is for Jackson Memorial Hospital; $2,133,277 is for hospitals in Broward Health; $4,906,684 is for hospitals in the Memorial Healthcare System; and $760,226 is for Shands Jacksonville and $5,410,853 is for Shands Gainesville. In the event that the above amounts exceed the amount of the Medicaid trend adjustment applied to each hospital, then the excess funds will be used to buy back other Medicaid reductions in the inpatient rate not to exceed the base rate effective July 1, 2010.

(2) $12,139,819 shall be used for the second category to buy back the Medicaid trend adjustment that is being applied against the Medicaid inpatient rates for those hospitals that are licensed as a children's specialty hospital and whose Medicaid days plus charity care days divided by total adjusted patient days equals or exceeds 30 percent. In the event that the funds under this category exceed the amount of the Medicaid trend adjustment, then any excess funds will be used to buy back other Medicaid reductions in the inpatient rate for those individual hospitals not to exceed the base rate effective July 1, 2010.

(3) $5,475,985 shall be used for the third category to buy back the Medicaid trend adjustment that is being applied against the Medicaid inpatient rates to rural hospitals. In the event that the funds under this category exceed the amount of the Medicaid trend adjustment, then any excess funds will be used to buy back other Medicaid

reductions in the inpatient rate for those individual hospitals not to exceed the base rate effective July 1, 2010.

The agency shall use the 2003, 2004 and 2005 audited DSH data available as of March 1, 2009. In the event the agency does not have the prescribed three years of audited DSH data for a hospital, the agency shall use the average of the audited DSH data for 2003, 2004 and 2005 that are available.

mm. Effective July 1, 2010, non state or local government owned or operated hospitals , including any leased non state or local government owned or operated hospitals found to have sovereign immunity, teaching hospitals as defined in section 408.07 (45) or 395.805, Florida Statutes, which have seventy or more full-time equivalent resident physicians, hospitals with graduate medical education positions that do not otherwise qualify, and for designated trauma hospitals to buy back the Medicaid inpatient trend adjustment applied to their individual hospital rates and other Medicaid reductions to their inpatient rates up to actual Medicaid inpatient cost.

nn. Effective July 1, 2010, hospitals not previously provided this authority, may buy back the Medicaid inpatient trend adjustment applied to their individual hospital rates and other Medicaid reductions to their inpatient rates up to actual Medicaid inpatient cost.

oo. Effective July 1, 2010, any hospital, not elsewhere qualifying for an exemption that has local funds available for intergovernmental transfers may be exempt from inpatient reimbursement limitations.

pp. Effective July, 2010, the Agency will adjust the Medicaid rate for any rural hospital that moved into a replacement facility during calendar year 2009 to reflect Medicaid costs for the period of time from moving into the replacement facility to when the rate would reflect the costs of the replacement facility through the routine rate setting process. To qualify for this adjustment, a hospital must have a combined Medicaid and charity care utilization rate of at least 25 percent based on the most recent information reported to the Agency for Health Care Administration prior to moving into the replacement facility.

qq. Effective July 1, 2011, $543,389,836 is available for non state or local government owned or operated hospitals, including any leased non-state or local government owned or operated hospitals found to have sovereign immunity, teaching hospitals as defined in section 408.07 (45) or 395.805, Florida Statutes, which have seventy or more full-time equivalent resident physicians, hospitals with graduate medical education positions that do not otherwise qualify, and for designated trauma hospitals to buy back the Medicaid inpatient trend adjustment applied to their individual hospital rates and Medicaid inpatient cost.

rr. Effective July 1, 2011, $286,624,908 is available to hospitals that are eligible to buy back the Medicaid inpatient trend adjustment applied to their individual hospital rates and other Medicaid reductions to their inpatient rates up to actual Medicaid inpatient cost.

ss. Effective July 1, 2011, $424,872,347 is available for exemptions from inpatient reimbursement limitations.

tt. Effective July 1, 2011, any provider's base rate adjusted in accordance with Section V.C.3 and identified in Section V.C.1. shall have their rates adjusted not to exceed the base rate determined in accordance with Section V.C.3.

uu. Effective July 1, 2012, $313,585,574 is provided for non-state or local government owned or operated hospitals, including any leased public hospital determined to be covered under the state's sovereign immunity; teaching hospitals, as defined in s. 408.07 or s. 395.805, Florida Statutes, which have 70 or more full-time equivalent resident physicians; hospitals that have graduate medical education positions that do not otherwise qualify; and designated trauma hospitals to buy back the Medicaid inpatient trend adjustment applied to their individual hospital rates and other Medicaid reductions to their inpatient rates not to exceed actual Medicaid inpatient cost, not to exceed the base rate established July 1, 2012.

vv. Effective July 1, 2012, $142,242,439 is provided to buy back the Medicaid inpatient trend adjustment applied to their individual hospital rates and other Medicaid reductions to their

inpatient rates not to exceed actual Medicaid inpatient cost, not to exceed the base rate established July 1, 2012.

ww. Effective July 1, 2012, $260,774,208 is provided for hospitals to be exempt from inpatient reimbursement limitations.

xx. Effective July 1, 2012, $61,382,359 is provided to partially restore the reduction in inpatient hospital reimbursement rates.

yy. Effective July 1, 2012, any hospital that was exempt from the inpatient 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 meets the 11 percent threshold, because of updated audited DSH data, shall remain exempt from the inpatient reimbursement ceilings for a period of two years.

zz. Effective July 1, 2012, in calculating the current reductions, the Agency shall use budgeted Medicaid hospital days in calculating hospital reimbursement rates under the Title XIX Hospital Inpatient Reimbursement Plan.

aaa. Effective July 1, 2012, $396,739 is provided to buy back the Fiscal Year 2011-2012 Inpatient Medicaid Trend Adjustment for Putnam Community Medical Center.

bbb. Effective July 1, 2013, $466,251is provided as a special Medicaid payment for Winter Haven Hospital.

ccc. Effective July 1, 2013, $2,702,029 is provided to allow for exemptions from inpatient reimbursement ceilings for any hospital that is classified as a sole community hospital under 42 C.F.R.412.92 but is not classified as a rural hospital under section 395.602, Florida Statutes.

ddd. Effective July 1, 2013, any hospital that was exempt from the inpatient 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 11percent, but no longer meets the 11 percent threshold, because of updated audited DSH data, shall remain exempt from the inpatient reimbursement ceilings for a period of two years.

eee. Effective July 1, 2013, $360,623,411 is provided for public hospitals, including any leased public hospital determined to be covered under the state's sovereign immunity; teaching hospitals, as defined in s. 408.07 or s. 395.805, Florida Statutes, which have 70 or more full-time equivalent resident physicians; hospitals that have graduate medical education positions that do not otherwise qualify; and designated trauma hospitals to adjust the prior Medicaid inpatient trend adjustment applied to their individual hospital reimbursements and other Medicaid reductions to their inpatient reimbursements.

fff. Effective July 1, 2013, $190,660,237is provided for hospitals to adjust the prior Medicaid inpatient trend adjustment applied to their individual hospital reimbursements and other Medicaid reductions to their inpatient reimbursements.

ggg. Effective July 1, 2013, $325,908,058 is provided for hospitals to allow for adjustments for inpatient reimbursement limitations.

2. Setting Reimbursement Ceilings for Fixed Cost

a. Compute the fixed costs per diem rate for each hospital by dividing the Medicaid depreciation by the total Medicaid days.

b. Calculate the fixed cost ceiling for each hospital by multiplying Step 1 by 80%. This fixed cost ceiling shall not apply to rural hospitals and specialized psychiatric hospitals.

3. Setting Individual Hospital Rates

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

(1) To reflect the results of desk reviews or audits;

(2) To exclude from the allowable cost any gains and losses resulting from a change of ownership and included in clearly marked "Final" cost reports.

b. Reduce the hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.30.

c. Determine allowable Medicaid variable costs as in C.1.c.

d. Adjust allowable Medicaid variable costs for the number of months between the midpoint of the hospital's fiscal year and December 31the midpoint of the following rate semester. The

adjustment shall be made utilizing the latest available projections as of December 31 for the DRI (or its successor) National and Regional Hospital Input Price Index as detailed in Appendix A.

e. The variable cost per diem shall be the lesser of:

(1) The inflated allowable Medicaid variable costs divided by the sum of Medicaid inpatient days plus Medicaid non-concurrent nursery days for the hospital, or

(2) The facility specific target ceiling that is the prior rate semester's variable cost per diem plus an annually adjusted factor using the DRI (or its successor) inflation table. Effective July 1, 1995, the DRI (or its successor) inflation factor is 3.47 percent. With the adjustment of this DRI (or its successor) factor, the allowable rate of increase shall be 2.2 percent. Effective July 1, 1996, and for subsequent state fiscal years, the allowable rate of increase shall be calculated by an amount derived from the DRI (or its successor) inflation index described in appendix A. The allowable rate of increase shall be calculated by dividing the inflation index value for the midpoint of the next state fiscal year by the inflation index value for the midpoint of the current state fiscal year and then multiply this amount by 63.4 percent. The allowable rate of increase shall be recalculated for each July rate setting period and shall be the same during the remainder of the state fiscal year. The facility specific target ceiling shall apply to all hospitals except rural, specialized, statutory teaching, and Community Hospital Education Program (CHEP) hospitals and those hospitals included in Section V.C.1. j, k, and l.

f. Establish the variable costs component of the per diem as the lower of the result of Step 5 or the reimbursement ceiling determined under Section V.C.1.h for the county in which the hospital is located.

(1) A temporary exemption from the county ceiling for a period not to exceed 12 months shall be granted to an in-state general hospital by AHCA if all of the following criteria are met:

a. The hospital has been voluntarily disenrolled for a period of not less than 180 days in the 365 days immediately prior to the date of application for this exemption. The hospital shall have been a fully participating Medicaid provider prior to their last disenrollment;

b. During the 6-month period prior to the last voluntary disenrollment, the hospital provided the largest proportionate share of Medicaid services of all hospitals in the county, as measured by total Medicaid costs for the period;

c. On the date of the last voluntary disenrollment, less than 51 percent of the private, non-governmental hospitals in the county were participating in the Medicaid Program;

d. During the 6-month period prior to the last voluntary disenrollment, the hospital treated over 50 percent of the indigent patients in the county who required hospital services during that time period. Indigent patients are those eligible for Medicaid or classified as indigent by a county-approved social services or welfare program.

If an exemption is granted to a hospital, the hospital shall agree to remain in the Medicaid Program and accept Medicaid eligible patients for a period of not less than 3 years from the date of re-enrollment. The exemption shall be granted to a hospital only once since original construction, regardless of changes in ownership or control. If a hospital disenrolls prior to the fulfillment of its 3-year enrollment agreement, AHCA shall recoup funds paid to the hospital in excess of the amount that would have been paid if the county ceiling had been imposed during the first 12 months which shall be defined as excess amount, according to the following schedule. If a hospital is re-enrolled under the ceiling exemption provision for less than 12 months, the Agency shall recoup 100 percent of the excess amount. For each month of enrollment subsequent to the first year of re-enrollment under the ceiling exemption provision, 1/24 of the excess amount shall be no longer owed so that after 36 months of re enrollment AHCA shall recoup none of the excess amount.

Example 1: Hospital reenrolls under the ceiling exemption provision on July 1, 1984, and disenrolls on November 30, 1984. During this 5-month period the hospital receives an excess amount of $10,000. Recoupment would be calculated as:

$10,000 - ((0 months x l/24) x (10,000)) = $10,000

Example 2: Hospital re-enrolls under the ceiling exemption provision on July l, 1984, and disenrolls on December 31, 1986. During the first 12 months the hospital receives an excess amount of $20,000. Recoupment would be calculated as:

$20,000 - ((18 months x l/24) x (20,000)) = $ 5,000

g. Compute the fixed costs component of the per diem by dividing the Medicaid depreciation by the total Medicaid days.

h. Established the fixed costs component of the per diem as the lower of Step 7 or the reimbursement ceiling determined under V.B.2.

i. Calculate the overall per diem by adding the results of Steps 6 and 8.

j. Set the per diem rate for the hospital as the lower of the result of Step 9 or the result of inflated Medicaid charges divided by total Medicaid days.

k. For hospitals with less than 200 total Medicaid patient days, or less than 20 Medicaid patient admissions, the per diem rate shall be computed using the principles outlined in Steps 1 through 10 above, but total costs, charges, and days shall be utilized, instead of the Medicaid apportioned costs, charges and days.

l. Effective July 1, 2001, the Medicaid inpatient per diem rate will be adjusted for Lake Wales Hospital, Winter Haven Hospital, Health Central Hospital and Larkin Community Hospital in accordance with section 409.905(5)(c), Florida Statutes. The Agency for Health Care Administration shall adjust a hospital's current inpatient per diem rate to reflect the cost of serving the Medicaid population at that institution if:

(1) The hospital experiences an increase in Medicaid caseload by more than 25 percent in any year, primarily resulting from the closure of a hospital in the same service area occurring after July 1, 1995;

(2) The hospital's Medicaid per diem rate is at least 25 percent below the Medicaid per patient cost for that year; or

(3) The hospital is located in a county that has five or fewer hospitals, began offering obstetrical services on or after September 1999, and has submitted a request in writing to the Agency for a rate adjustment after July 1, 2000, but before September 30, 2000, in which case such hospital's Medicaid inpatient per diem rate shall be adjusted to cost, effective July 1, 2002.

m. No later than October 1 of each year the Agency must provide estimated costs for any adjustment in a hospital inpatient per diem pursuant to this paragraph to the Executive Office of the Governor, the House of Representatives General Appropriations Committee, and the Senate Budget Committee.

n. Effective July 1, 2002, the Medicaid inpatient per diem rate will be adjusted for New Port Richey hospital in accordance with section 409.905(5)(c), Florida Statutes. Hospital inpatient rates set under the provisions of the Plan for the July 1, 2003 rate setting will be effective October 1, 2003.

o. Effective July 1, 2004 and ending June 30, 2005, each inpatient rate shall be reduced proportionately until an aggregate total estimated savings of $69,662,000 is achieved. In reducing hospital inpatient rates, rural hospitals and hospitals with twenty thousand (20,000) or more combined Medicaid managed care and fee-for-service inpatient days shall not have their inpatient rates reduced below the final rates that are effective on June 30, 2004. The 2002 Financial Hospital Uniform Reporting System (FHURS) data shall be used to determine the combined inpatient Medicaid days.

p. Effective July 1, 2005, a recurring rate reduction shall be established until an aggregate total estimated savings of $100,537,618 is achieved each year. This reduction is the Medicaid Trend Adjustment. In reducing hospital inpatient rates, rural hospitals and hospitals with twenty thousand (20,000) or more combined Medicaid managed care and fee-for-service inpatient days shall not have their inpatient 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.

(1) The July 1, 2005 and January 1, 2006 reimbursement rates shall be adjusted as follows:

(a) Restore the $69,662,000 inpatient hospital reimbursement rate reduction set forth in Section V.C.3.o above to the June 30, 2005 reimbursement rate;

(b) Determine the lower of the June 30, 2005 rate with the restoration of the $69,662,000 reduction referenced in (a) above or the July 1, 2005 or January 1, 2006 rates, as applicable, before the application of the Medicaid Trend Adjustment described inp above;

(2) Effective July 1, 2006, the reduction implemented during the period July 1, 2005 through June 30, 2006 shall become a recurring annual reduction. This recurring reduction, called the Medicaid Trend Adjustment, shall be applied proportionally to all rates on an annual basis.

q. Effective July 1, 2007 and ending June 30, 2008, the Medicaid Trend Adjustment shall be removed for all hospitals whose Medicaid and charity care days as a percentage to total adjusted days equals or exceeds 30 percent and have more than 10,000 Medicaid days, or a hospital or hospital system that established a provider service network during the prior state fiscal year. The aggregate Medicaid Trend Adjustment found in V.C.16 above shall be reduced by up to $25,352,420. The Agency shall use the average of the 2001, 2002 and 2003 audited DSH data available as of March 1, 2007.

r. Effective January 1, 2008, an additional Medicaid Trend Adjustment shall be applied to achieve a recurring annual reduction of $68,640,064.

s. Effective January 1, 2008 and ending June 30, 2008, the Medicaid Trend Adjustment shall be removed for all certified trauma centers and hospitals defined in section 408.07(45), Florida Statutes. The aggregate Medicaid Trend Adjustment found in V.C.18 above shall be reduced by up to$12,067,473.

t. Effective July 1, 2008, an additional Medicaid Trend Adjustment shall be applied to achieve a recurring annual reduction of $154,333,435. In establishing rates through the normal process, prior to including this reduction, if the rate setting unit cost is equal to or less than the legislative unit cost, no additional reduction in rates is necessary. In establishing rates through the normal process, prior to including this reduction, if the rate setting unit cost is greater than the legislative unit cost , then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the legislative unit cost.

u. The Agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs for two fiscal years effective July 1, 2009.

v. Effective March 1, 2009, the Agency for Health Care Administration shall implement a recurring methodology to reduce individual hospital rates proportionately until the required $84,675,876 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. Public hospitals, teaching hospitals as defined in section 408.07 (45) or section 395.805, Florida Statutes, which have seventy or more full-time equivalent resident physicians, designated trauma centers and those hospitals whose Medicaid and charity care days divided by total adjusted days exceeds 25 percent may buy back the Medicaid inpatient trend adjustment applied to their individual hospital rates and other Medicaid reductions to their inpatient rates up to actual Medicaid inpatient cost. The Agency shall use the average of 2002, 2003 and 2004 audited DSH data available as of March 1, 2008. In the event the agency does not have the prescribed three years of audited DSH data for a hospital, the agency shall use the average of the audited DSH data for 2002, 2003 and 2004 that are available.

w. Effective January 1, 2010, an additional Medicaid trend adjustment shall be applied to achieve an annual recurring reduction of $9,635,295. In establishing rates through the normal process, prior to including this reduction, if the rate setting unit cost is equal to or less than the legislative unit cost, then no additional reduction in rates is necessary. In establishing rates

through the normal process, prior to including this reduction, if the rate setting unit cost is greater than the legislative unit cost, then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the legislative unit cost.

x. Effective July 1, 2011, an additional Medicaid Trend Adjustment shall be applied to achieve an annual recurring reduction of $394,928,848 as a result of modifying the reimbursement for inpatient hospital rates. In establishing rates through the normal process, prior to including this reduction, if the rate setting unit cost is equal to or less than the legislative unit cost, then no additional reduction in rates is necessary. In establishing rates through the normal process, prior to including this reduction, if the rate setting unit cost is greater than the legislative unit cost, then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the legislative unit cost. Hospitals that are licensed as a children's specialty hospital and whose Medicaid days plus charity care days divided by total adjusted patient days equals or exceeds 30 percent and rural hospitals as defined in s. 395.602, are excluded from this reduction.

y. Effective July 1, 2011, a rate reduction in the amount of $12,608,937 shall be applied as a result of modifying the reimbursement for inpatient hospital rates for hospitals that are licensed as a children's specialty hospital and whose Medicaid days plus charity care days divided by total adjusted patient days equals or exceeds 30 percent and rural hospitals as defined in section 395.602, Florida Statutes. In establishing rates through the normal process, prior to including this reduction, if the rate setting unit cost is equal to or less than the legislative unit cost, then no additional reduction in rates is necessary. In establishing rates through the normal process, prior to including this reduction, if the rate setting unit cost is greater than the legislative unit cost, then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the legislative unit cost.

z. Effective July 1, 2011, the Agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs.

aa. For a period of five years from the opening of Nemours' hospital, the reimbursement rate will be based on the average of the current Medicaid payment rates accepted by the two Class II children's hospitals (All Children's Hospital and Miami Children's Hospital).

bb. Effective July 1, 2012, an additional Medicaid Trend Adjustment shall be applied to achieve an annual recurring reduction of $247,581,463 as a result of modifying the reimbursement for inpatient hospital rates. In establishing rates through the normal process, prior to including this reduction, if the rate setting unit cost is equal to or less than the legislative unit cost, then no additional reduction in rates is necessary. In establishing rates through the normal process, prior to including this reduction, if the rate setting unit cost is greater than the legislative unit cost, then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the legislative unit cost. Hospitals that are licensed as a children's specialty hospital and whose Medicaid days plus charity care days divided by total adjusted patient days equals or exceeds 30 percent, and rural hospitals as defined in section 395.602, Florida Statutes, are excluded from this reduction.

4. Payment Adjustment for Provider Preventable Conditions (PPCs)

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

b. The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions. These requirements apply to hospitals reimbursed via a per diem (inpatient psychiatric hospitals).

c. No reduction in payment for a provider preventable condition (PPC) 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.

d. 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 non-payment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions in the following manner: Hospitals are paid based on a daily per diem rate. It is the responsibility of the hospital to identify any Health Care Acquired Conditions and not seek payment for any additional days that have lengthened a recipient's stay due to a PPC. In reducing the amount of days the following is required on a claim to identify these non-covered days: Hospitals are to report a value code of '81' on the UB-04 claim form along with any non-covered days and the amount field must be greater than '0'.

e. Hospital records will be retroactively reviewed by Medicaid's contracted Quality Improvement Organization (QIO). If any days are identified that are associated with a lengthened stay due to a PPC then Medicaid will initiate recoupment for the identified overpayment.

f. The State identifies the following Health Care-Acquired Conditions (HCACs) for non-payment under Section 4.19-A.

(1) Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

g. The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19 –A.

(1) 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.

(2) On and after May 1, 2012, Medicaid will make zero payments to providers for Other Provider-Preventable Conditions which includes Never Events (NE) as defined by the National Coverage Determination (NCD). The Never Events (NE) as defined in the NCD includes Inpatient Hospitals, Outpatient Hospitals, Ambulatory Surgical Centers

(ASC) and practitioners, and these providers, regardless of the health care setting, will be required to report NEs.

VI. Disproportionate Share Hospital (DSH) Reimbursement Methods

A. Determination of Individual Hospital Regular Disproportionate Share Payments for Disproportionate Share Hospitals (DSH).

1. No hospital may be defined or deemed as a disproportionate share hospital unless the hospital has a Medicaid inpatient utilization rate of not less than one percent. In order to qualify for reimbursement, a hospital shall meet either of the minimum federal requirements specified in Section 1923(b) of the Act. The Act specifies that hospitals must meet one of the following requirements:

   a. The Medicaid inpatient utilization rate is greater than one standard deviation above the statewide mean, or;

   b. The low-income utilization rate is at least 25%.

2. Additionally, the Act specifies that in order for the hospital to qualify for reimbursement, the hospital must have at least two obstetricians or physicians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the State Medicaid Plan. This does not apply to hospitals where:

   a. The inpatients are predominantly individuals under 18 years of age, or

   b. Non-emergency obstetric services were not offered as of December 21, 1987.

3. a. The hospital Medicaid inpatient utilization rate in 1.a. above shall be calculated once a year based on cost reports used for the July 1 rate setting.

   b. The low-income utilization rate in 1.b. above shall also be calculated once a year every July 1.

4. Effective July 1, 2003, the Agency shall use the following methodology to distribute payments under the Regular DSH program for state fiscal year 2003-2004 and forward.

The Agency shall only distribute regular DSH payments to those hospitals that meet the requirements of Section VI.A. 1., above, and to non-state government owned or operated facility. The following methodology shall be used to distribute disproportionate share payments to hospitals that meet the federal minimum requirements and to non-state government owned or operated facilities.

a. For hospitals that meet the requirements of Section VI.A.1., above, and do not qualify as a non-state government owned or operated facility, the following formula shall be used:

DSHP = (HMD/TSMD) * $1 million

Where:

DSHP = disproportionate share hospital payment

HMD = hospital Medicaid days

TSMD = total state Medicaid days

Any funds not allocated to hospitals qualifying under this section shall be redistributed to the non-state government owned operated hospitals
with greater than 3,100 Medicaid days.

b. The following formulas shall be used to pay disproportionate share dollars to non-state government owned or operated facilities:

For state mental health hospitals:

DSHP = (HMD/TMDMH) * TAAMH

The total amount available for the state mental health hospitals shall be the difference between the federal cap for Institutions for Mental Diseases and the amounts paid under the mental health disproportionate share program in Section VI.D.

For non-state government owned or operated hospitals with 3,100 or more Medicaid days:

DSHP = [(.82 * HCCD/TCCD) + (.18 * HMD/TMD)] * TAAPH

TAAPH = TAA – TAAMH

For non-state government owned or operated hospitals with less than 3,100 Medicaid days, a total of $750,000 shall be distributed equally among these hospitals.

Where:

TAA = total available appropriation (as found in Appendix B)

TAAPH = total amount available for non-state government owned or operated facility

TAAMH = total amount available for mental health hospitals

DSHP = disproportionate share hospital payments

HMD = hospital Medicaid days

TMDMH = total state Medicaid days for mental health hospitals

TMD = total state Medicaid days for public non-state hospitals

HCCD = hospital charity care dollars

TCCD = total state charity care dollars for public non-state hospitals

For funds appropriated for public disproportionate share payments for state fiscal years beginning July 1, 2004 and later, the TAAPH shall be reduced by $6,365,257 before computing the DSHP for each non-state government owned or operated facility. The $6,365,257 shall be distributed equally between the non-state government owned or operated facilities that are also designated statutory teaching hospitals.

In computing the above amounts for non-state government owned or operated facilities and hospitals that qualify under Section VI.A.2., above, the average of the 2004, 2005, and 2006 audited disproportionate share data will be used to determine each hospital's Medicaid days and charity care for the 2011-2012 state fiscal year. For the 2011-12 State Fiscal Year, the Agency shall use the average of 2004, 2005, and 2006 audited DSH data available as of March 1, 2010.

5. The total of all disproportionate share payments shall not exceed the amount appropriated, or the federal government's upper payment limits. Payments shall comply with the limits set forth in Section 1923(g-j) of the Social Security Act. Overpayments made in the disproportionate share program will be handled in compliance with 42 CFR Part 433, Subpart F. Should a DSH overpayment be determined, the State will redistribute the recouped overpayment to the providers in the same category of DSH based on the proportion of the original distribution defined in the General Appropriations Act and Florida Statutes.

6. In no case shall total payments to a hospital under this section, with the exception of public non-state facilities or state facilities, exceed the total amount of uncompensated charity care of the hospital, as determined by the Agency according to the most recent calendar year audited data available at the beginning of each state fiscal year.

7. The total amount calculated to be distributed shall be made in quarterly payments subsequent to each quarter during the fiscal year.

8. Payments to each disproportionate share hospital shall result in payments of at least the minimum payment adjustment specified in the Act. The Act specifies that the payment adjustment must at a minimum provide either:

   a. An additional payment amount equal to the product of the hospital's Medicaid operating cost payment times the hospital's disproportionate share adjustment percentage in accordance with Section 1886(d)(5)(F)(iv) of the Social Security Act, or

   b. A minimum specified additional payment amount (or increased percentage amount) and for an increase in such payment amount in proportion to the percentage by which the hospital's Medicaid utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate for hospital's receiving Medicaid payments in the state.

B. Determination of Disproportionate Share Payments for Teaching Hospitals.

1. Disproportionate share payments shall be paid to statutorily defined teaching hospitals for their increased costs associated with medical education programs and for tertiary health care services provided to the indigent. In order to qualify for these payments, a teaching hospital must first qualify for regular disproportionate share hospital payments based on the criteria contained in Section VI.A., above. For state fiscal year 2002-2003 forward, only hospitals that qualified as a statutory teaching hospital and received a payment under this Section in state fiscal year 2001-2002, shall qualify to receive payments in state fiscal year 2002-2003 forward.

2. On or before September 15 of each year, the Agency for Health Care Administration shall calculate an allocation fraction to be used for distributing funds to state statutory teaching hospitals. Subsequent to the end of each quarter of the state fiscal year, the Agency shall distribute to each statutory teaching hospital, an amount determined by multiplying one-fourth of the funds appropriated for this purpose times such hospital's allocation fraction. The allocation fraction for each such hospital shall be determined by the sum of three primary factors, divided by three. The primary factors are:

   a. The number of nationally accredited graduate medical education programs offered by the hospital, including programs accredited by the Accreditation Council for Graduate Medical Education and the combined Internal Medicine and Pediatrics programs acceptable to both the American Board of Internal Medicine and the American Board of Pediatrics at the beginning of the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of programs, where the total is computed for all state statutory teaching hospitals;

   b. The number of full-time equivalent trainees in the hospital, which comprises two components:

(1) The number of trainees enrolled in nationally accredited graduate medical education programs. Full time equivalents are computed using the fraction of the year during which each trainee is primarily assigned to the given institution, over the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of full-time equivalent trainees enrolled in accredited graduate programs, where the total is computed for all state statutory teaching hospitals.

(2) The number of medical students enrolled in accredited colleges of medicine and engaged in clinical activities, including required clinical clerkships and clinical electives. Full-time equivalents are computed using the fraction of the year during which each trainee is primarily assigned to the given institution, over the course of the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total number of full-time equivalent students enrolled in accredited colleges of medicine, where the total is computed for all state statutory teaching hospitals.

The primary factor for full-time equivalent trainees is computed as the sum of these two components, divided by two.

c. A service index which comprises three components:

(1) The Agency for Health Care Administration Service Index, computed by applying the standard Service Inventory Scores established by the Agency for Health Care Administration to services offered by the given hospital, as reported on the Agency for Health Care Administration Worksheet A-2, located in the Budget Review Section of the Division of Health Policy and Cost Control for the last fiscal year reported to the

Agency before the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total Agency for Health Care Service Index values where the total is computed for all state statutory teaching hospitals;

(2) Volume-weighted service index, computed by applying the standard Service Inventory Scores established by AHCA under 409.9113 F.S., to the volume of each service, expressed in terms of the standard units of measure reported on the Agency for Health Care Administration Worksheet A-2 for the last fiscal year reported to the Agency before the date on which the allocation factor is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total volume-weighted service index values, where the total is computed for all state statutory teaching hospitals;

(3) Total Medicaid payments to each hospital for direct inpatient and outpatient services during the fiscal year preceding the date on which the allocation factor is calculated. This includes payments made to each hospital for such services by Medicaid prepaid health plans, whether the plan was administered by the hospital or not. The numerical value of this factor is the fraction that each hospital represents of the total of such Medicaid payments, where the total is computed for all statutory teaching hospitals.

3. The following formula shall be utilized by the department to calculate the maximum additional disproportionate share payment for statutorily defined teaching hospitals:

TAP = THAF x A

Where:

TAP = total additional payment.

THAF = teaching hospital allocation factor.

A = amount appropriated for a teaching hospital disproportionate share program. (as found in Appendix B)

4. Effective July 1, 2011, the funds for statutory teaching hospitals are allocated based on a formula using the 2009 accepted FHURS data for medical programs, students, residents, service values and Medicaid payments.

D. Mental Health Disproportionate Share Payments

The following formula shall be used by the Agency to calculate the total amount earned for hospitals that participate in the mental health disproportionate share program:

$$TAP = \left(\frac{DSH}{TDSH}\right) X\ TA$$

Where:

TAP = total additional payment for a mental health hospital

DSH = total amount earned by a mental health hospital under s. 409.911

TDSH = sum of total amount earned by each hospital that participates in the mental health hospital disproportionate share program

TA = total appropriation for the mental health disproportionate share program (as found in Appendix B). Includes additional disproportionate share amounts provided by the Medicare Prescription Drug, Improvement and Modernization Act of 2003,

In order to receive payments under this section, a hospital must participate in the Florida Title XIX program and must:

1. Agree to serve all individuals referred by the Agency who require inpatient psychiatric services, regardless of ability to pay.
2. Be certified or certifiable to be a provider of Title XVIII services.
3. Receive all of its inpatient clients from admissions governed by the Baker Act as specified in chapter 394.

All state-owned psychiatric hospitals will not be reimbursed more than their unreimbursed cost to provide service to Medicaid recipients and uninsured patients.

E. Determination of Rural Hospital Disproportionate Share/financial assistance program. In order to receive payments under this section, a hospital must be a rural hospital as defined in s. 395.602, Florida Statutes, and must meet the following additional requirements:

1. Agree to conform to all Agency requirements to ensure high quality in the provision of services, including criteria adopted by Agency rule concerning staffing ratios, medical records, standards of care, equipment, space, and such other standards and criteria as the Agency deems appropriate as specified by rule.

2. Agree to accept all patients, regardless of ability to pay, on a functional space-available basis.

3. Agree to provide backup and referral services to the county public health units and other low-income providers within the hospital's service area, including the development of written agreements between these organizations and the hospital.

4. For any hospital owned by a county government that is leased to a management company, agree to submit on a quarterly basis a report to the Agency, in a format specified by the Agency, which provides a specific accounting of how all funds dispersed under this act are spent.

   a. The following formula shall be used by the Agency to calculate the total amount earned for hospitals that participate in the rural hospital disproportionate share program or the financial assistance program:

      TAERH = (CCD + MDD)/TPD

      Where:

      CCD = total charity care-other, plus charity care-Hill Burton, minus 50 percent of unrestricted tax revenue from local governments, and restricted funds for

indigent care, divided by gross revenue per adjusted patient day; however, if CCD is less than zero, then zero shall be used for CCD

MDD = Medicaid inpatient days plus Medicaid HMO inpatient days.

TPD = total inpatient days.

TAERH = total amount earned by each rural hospital

In computing the total amount earned by each rural hospital, the Agency must use the average of the three (3) most recent years of actual data reported in accordance with s.408.061 (4), Florida Statutes. The Agency shall provide a preliminary estimate of the payments under the rural disproportionate share and financial assistance programs to the rural hospitals by August 31 of each state fiscal year for review. Each rural hospital shall have 30 days to review the preliminary estimates of payments and report any errors to the Agency. The Agency shall make any corrections deemed necessary and compute the rural disproportionate share and financial assistance program payments.

b. In determining the payment amount for each rural hospital under this section, the Agency shall first allocate all available state funds by the following formula:

DAER = (TAERH x TARH)/STAERH

Where:

DAER = distribution amount for each rural hospital.

STAERH = sum of total amount earned by each rural hospital.

TAERH = total amount earned by each rural hospital.

TARH = total amount appropriated or distributed under this section. (as found in Appendix B)

Federal matching funds for the disproportionate share program shall then be calculated for those hospitals that qualify for disproportionate share payments under this section.

5. For state fiscal year 1996-97 and subsequent years, the following steps shall be used to determine the rural disproportionate share payment amount for each hospital.

a. The Agency shall first determine a preliminary payment amount for each rural hospital by allocating all available state funds using the following formula.

PDAER=(TAERH x TARH)/STAERH

Where:

PDAER = preliminary distribution amount for each rural hospital.

TAERH = total amount earned by each rural hospital.

TARH = total amount appropriated or distributed under this section.

STAERH = sum of total amount earned by each rural hospital.

b. Federal matching funds for the disproportionate share program shall then be calculated for those hospitals that qualify for disproportionate share in section (E)(1) above.

c. The state funds only payment amount is then calculated for each hospital using the formula:

SFOER = Maximum value of (1)SFOL - PDAER or (2) 0

Where:

SFOER = state funds only payment amount for each rural hospital

SFOL = state funds only payment level, which is set at 4% of TARH.

d. The adjusted total amount allocated to the rural disproportionate share program shall then be calculated using the following formula:

ATARH = (TARH - SSFOER)

Where:

ATARH = adjusted total amount appropriated or distributed under this section (as found in Appendix B)

SSFOER = Sum of the state funds only payment amount (5)(a) for all rural hospitals.

e. The determination of the amount of rural DSH funds is calculated by the following formula:

TDAERH = ((TAERH x ATARH)/STAERH)

Where:

TDAERH = total distribution amount for each rural hospital.

f. Federal matching funds for the disproportionate share program shall then be calculated for those hospitals that qualify for disproportionate share in section (5)(e) above.

g. State funds only payment amounts (5)(c)are then added to the results of (5)(f) to determine the total distribution amount for each rural hospital.

TDAERH = (TDAERH + SFOER)

F. Determination of Disproportionate Share Payments for Specialty Hospitals

1. The following formula shall be used by the Agency to calculate the total amount available for hospitals that participate in the specialty hospital disproportionate share program:

TAE = (MD/TMD) x TA

Where:

TAE = total amount earned by a specialty hospital.

TA = total appropriation for payments to hospitals that qualify under this program (as found in Appendix B)

MD = total Medicaid days for each qualifying hospital.

TMD = total Medicaid days for all hospitals that qualify under this program.

2. In order to receive payments under this section, a hospital must be licensed in accordance with part I of chapter 395, participate in the Florida Title XIX program, and meet the following requirements:

   a. Be certified or certifiable to be a provider of Title XVIII services.

   b. Receive all of its inpatient clients through referrals or admissions from county public health departments, as defined in chapter 154.

   c. Require a diagnosis for the control of a communicable disease for all admissions for inpatient treatment.

G. Disproportionate Share Program for Specialty Hospitals for Children

1. Specialty hospitals for children must be licensed by the state and designated by January 1, 2000, as specialty hospitals for children. The Agency for Health Care Administration shall use the following formula to calculate the total amount earned for hospitals that participate in the children's hospital disproportionate share program:

   TAE = DSR x TIMAC

   Where:

   For Per Diem Hospitals: TIMAC = BMPD * MD

   For DRG Hospitals: TIMAC = Sum of all Medicaid Allowed Charges for all DRG Payments

   TAE = total amount earned by a children's hospital

   TIMAC = Total Inpatient Medicaid Allowed Charges

   DSR = disproportionate share rate

   BMPD = base Medicaid per diem

   MD = Medicaid Days

2. The Agency shall calculate the total additional payment for hospitals that participate in the children's hospital disproportionate share program as follows:

$$TAP = \frac{(TAE \times TA)}{STAE}$$

Where:

TAP = total additional payment for a children's hospital.

TAE = total amount earned by a children's hospital

TA = total appropriation for the children's hospital disproportionate share program. (as found in Appendix B)

STAE = sum of total amount earned by each hospital that participates in the children's hospital disproportionate share program.

3. A hospital may not receive any payments under this section until it achieves full compliance with the applicable rules of the Agency. A hospital that is not in compliance for two or more consecutive quarters may not receive its share of the funds. Any forfeited funds must be distributed to the remaining participating children's hospitals that are in compliance.

H. Disproportionate Share Payments for Provider Service Network (PSN) Hospitals

1. The following formula shall be used to pay disproportionate share dollars to provider service network (PSN) hospitals:

DSHP = TAAPSNH X (IHPSND X THPSND)

Where:

DSHP = Disproportionate share hospital payments.

TAAPSNH = Total amount available for PSN hospitals.

IHPSND = Individual hospital PSN days.

THPSND = Total of all hospital PSN days.

2. Distributions are made to qualifying Provider Service Network hospitals or systems proportionally based on Fiscal Year 2006-2007 Provider Service Network patient days from qualifying Provider Service Network hospitals or systems. The Provider Service Network inpatient days used in distributing these funds shall be based on the utilization for the following individual hospitals or hospital systems only: Jackson Memorial Hospital - 15,464 days; Broward Health - 18,109 days; Memorial Healthcare System - 12,047 days; Shands Teaching - Gainesville - 1,581 days; and Shands Teaching - Jacksonville - 13,227 days.

VII. Statewide Medicaid Residency Program

A. The Statewide Medicaid Residency Program is established to improve the quality of care and access to care for Medicaid recipients, expand graduate medical education on an equitable basis, and increase the supply of highly trained physicians statewide. The agency shall make payments to hospitals licensed under part I of chapter 395 for graduate medical education associated with the Medicaid program. This system of payments is designed to generate federal matching funds under Medicaid and distribute the resulting funds to participating hospitals on a quarterly basis in each fiscal year for which an appropriation is made.

B. On or before September 15 of each year, the agency shall calculate an allocation fraction to be used for distributing funds to participating hospitals. On or before the final business day of each quarter of a state fiscal year, the agency shall distribute to each participating hospital one fourth of that hospital's annual allocation calculated under subsection (D). The allocation fraction for each participating hospital is based on the hospital's number of full-time equivalent residents and the amount of its Medicaid payments. As used in this section, the term:

1. "Full-time equivalent," or "FTE," means a resident who is in his or her initial residency period, which is defined as the minimum number of years of training required before the resident may become eligible for board certification by the American Osteopathic Association Bureau of

Osteopathic Specialists or the American Board of Medical Specialties in the specialty in which he or she first began training, not to exceed 5 years. A resident training beyond the initial residency period is counted as 0.5 FTE, unless his or her chosen specialty is in general surgery or primary care, in which case the resident is counted as 1.0 FTE. For the purposes of this section, primary care specialties include:

- Family medicine;
- General internal medicine;
- General pediatrics;
- Preventive medicine;
- Geriatric medicine;
- Osteopathic general practice;
- Obstetrics and gynecology; and
- Emergency medicine.

2. "Medicaid payments" means the estimated total payments for reimbursing a hospital for direct inpatient services for the fiscal year in which the allocation fraction is calculated based on the hospital inpatient appropriation and the parameters for the inpatient diagnosis-related group base rate, including applicable intergovernmental transfers, specified in the General Appropriations Act, as determined by the agency.
3. "Resident" means a medical intern, fellow, or resident enrolled in a program accredited by the Accreditation Council for Graduate Medical Education, the American Association of Colleges of Osteopathic Medicine, or the American Osteopathic Association at the beginning of the state fiscal year during which the allocation fraction is calculated, as reported by the hospital to the agency.

C. The agency shall use the following formula to calculate a participating hospital's allocation fraction:

HAF = [0.9 x (HFTE/TFTE)] + [0.1 x (HMP/TMP)]

Where:

HAF = A hospital's allocation fraction.

HFTE = A hospital's total number of FTE residents.

TFTE = The total FTE residents for all participating hospitals.

HMP = A hospital's Medicaid payments.

TMP = The total Medicaid payments for all participating hospitals.

D. A hospital's annual allocation shall be calculated by multiplying the funds appropriated for the Statewide Medicaid Residency Program in the General Appropriations Act by that hospital's allocation fraction. If the calculation results in an annual allocation that exceeds $50,000 per FTE resident, hospital's annual allocation shall be reduced to a sum equaling no more than $50,000 per FTE resident. The funds calculated for that hospital in excess of $50,000 per FTE resident shall be redistributed to participating hospitals whose annual allocation does not exceed $50,000 per FTE resident, using the same methodology and payment schedule specified in this section.

VIII. Alternative Reimbursement Methods

1. Transplant Global Fee

A. Methods Used in Establishing Payment Rates

Reimbursement for adult (age 21 and over) heart, liver, lung, intestinal/multivisceral and pediatric (age 20 and under) lung and intestinal/multivisceral transplant surgery services will be paid the actual billed charges up to a global maximum rate established by the Agency. These payments will be made to physicians and facilities that have met specified guidelines and are established as designated transplant centers as appointed by the Secretary of the Agency. The global maximum reimbursement for transplant surgery services is an all-inclusive payment and encompasses 365 days of transplant related care. Only one provider may bill for the transplant phase.

Effective July 1, 2010, global maximum rates for transplantation surgery are as follows:

Adult Heart	
Facility	Physician
$135,000	$27,000

Adult Liver	
Facility	Physician

$95,600	$27,000

Adult Lung	
Facility	Physician
$205,000	$33,000

Pediatric Lung	
Facility	Physician
$280,000	$40,800

Adult and Pediatric Intestinal/Multi-visceral	
Facility	Physician
$450,000	$50,000

B. Effective July 1, 2005, approved lung transplant facilities will be reimbursed a global fee for providing lung transplant services to Medicaid recipients.

C. Effective July 1, 2009, Florida Medicaid will make payments for multi-visceral transplant and intestine transplants in Florida. The agency shall establish a reasonable global fee for these transplant procedures and the payments shall be used to pay approved multi-visceral transplant and intestine transplant facilities a global fee for providing transplant services to Medicaid beneficiaries.

D. Effective July 1, 2010, approved intestinal/multivisceral transplant centers will be reimbursed with a global fee for providing intestinal/multivisceral transplants to Medicaid recipients.

2. Tuberculosis Claims

Effective July 1, 2013, in accordance with 409.908(1)(a)2., Florida Statutes, the agency may establish an alternative methodology to the DRG-based prospective payment system to set reimbursement rates for recipients who have tuberculosis that is resistant to therapy who are in need of long-term, hospital-based treatment pursuant to s. 392.62.

This alternative Medicaid payment applies only to the subset of recipients infected with tuberculosis that have been deemed a threat to public health and admitted for hospitalization through the Department of

Health in accordance with s. 392.62, F.S. The Department of Health negotiated an alternate Medicaid payment to be $1,400 per diem. This Medicaid inpatient per diem rate will apply statewide for all hospital providers who contract with the Department of Health to serve recipients admitted under the provisions of 392.62, F.S.

3. Crossover Claims

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

On inpatient crossover claims for Medicare Part A eligible recipients, Florida Medicaid payment is set to the Medicare coinsurance amount.

On inpatient crossover claims for Medicare Part C eligible recipients, Florida Medicaid payment is set to the sum of the Medicare coinsurance and deductible amounts.

IX. ~~VIII.~~ Payment Assurance

The State shall pay each hospital for services provided in accordance with the requirements of the Florida Title XIX State Plan and applicable State and Federal rules and regulations. The payment amount shall be determined for each hospital according to the standards and methods set forth in the Florida Title XIX Inpatient Hospital Reimbursement Plan.

X. ~~IX.~~ Provider Participation

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

XI. ~~X.~~ 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.

In accordance with Chapter 120, Florida Statutes, 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.

XII.~~XI.~~ Payment in Full

Participation in the Medicaid Program shall be limited to hospitals that accept, as payment in full for covered services, the amount paid in accordance with the Florida Title XIX Inpatient Hospital Reimbursement Plan.

XIII. ~~XII.~~ Definitions

A. Actual audited data or actual audited experience - Data reported to the Agency for Health Care Administration which has been audited in accordance with generally accepted auditing standards of the AICPA as incorporated by reference in Rule 61H1-20.008, F.A.C. by the Agency or representatives under contract with the Agency.

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

C. AHCA - Agency for Health Care Administration, also known as the Agency.

D. Allowable costs - An item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with Generally Accepted Accounting Principles (GAAP), except as modified by the Principles of Reimbursement for Provider Costs, as defined in CMS PUB. 15-1

as incorporated by reference in Rule 59G-6.010, F.A.C., except as further modified by the Florida Title XIX Inpatient Hospital Reimbursement Plan.

E. ALOS – The average length of stay for the DRG.

F. APR-DRG – Please see "DRG."

G. APR-DRG Relative Weight – Please see "DRG Relative Weight."

H. Automatic Intergovernmental Transfer (IGT) – Rate enhancement for which the hospital provider automatically qualifies based on special designation (such as Trauma Center), regardless of their ability to provide state share of funding.

I. Base Rate – For hospitals reimbursed on a per diem basis, a hospital's per diem reimbursement rate before a Medicaid trend adjustment or a buy back is applied For Hospitals reimbursed by DRG, the Base Rate is a dollar amount assigned to each hospital that gets multiplied by the DRG relative weight and policy adjustor in the calculation of DRG Base Payment.

J. Base Year – State fiscal year of historical claims extracted for pricing simulations used to set rates for an upcoming year.

K. Budget Neutrality – Expenditures in the first year of DRG payment are intended to equal the total expenditures from the previous year, except for standard adjustments made for inflation and fee for service eligibilitychanges.

L. Buy Back - The buy back provision potentially allows a hospital to decrease their Medicaid Trend Adjustment from the established percent down to zero percent.

M. Case mix – average DRG relative weight

N. CCR – Please see "Cost to Charge Ratio"

O. Charity care or uncompensated charity care - That portion of hospital charges reported to the Agency for which there is no compensation, other than restricted or unrestricted revenues provided to a hospital by local governments or tax districts regardless of the method of payment, for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 200 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income.

However, in no case shall the hospital charges for a patient whose family income exceeds four times the federal poverty level for a family of four be considered charity. Each hospital will determine which patients are charity care patients by a verifiable process subject to the above provisions. In addition, each hospital must provide appropriate documentation of amounts reported as charity care.

For all patients claimed as charity care, appropriate documentation shall include one of the following forms:

1. W-2 withholding forms.
2. Paycheck stubs.
3. Income tax returns.
4. Forms approving or denying unemployment compensation or workers' compensation.
5. Written verification of wages from employer.
6. Written verification from public welfare agencies or any governmental Agency which can attest to the patient's income status for the past twelve (12) months.
7. A witnessed statement signed by the patient or responsible party, as provided for in Public Law 70-725, as amended, known as the Hill-Burton Act, except that such statement need not be obtained within 48 hours of the patient's admission to the hospital, as required by the Hill-Burton Act. The statement shall include an acknowledgment that, in accordance with Section 817.50, Florida Statutes, providing false information to defraud a hospital for the purposes of obtaining goods or services is a misdemeanor in the second (2nd) degree.
8. A Medicaid remittance voucher which reflects that the patient's Medicaid benefits for that Medicaid fiscal year have been exhausted.

   Charges applicable to Hill-Burton and contractual adjustments should not be claimed as charity care.

P. Charity care days - The sum of the deductions from revenues for charity care minus 50 percent of restricted and unrestricted revenues provided to a hospital by local governments or tax districts, divided by gross revenues per adjusted patient day.

Q. Community Hospital Education Program (CHEP) hospitals – Hospitals that are administered by the Department of Health. CHEP hospitals offer continuing medical education programs for interns and residents established on a statewide basis. CHEP hospitals provide financial support for interns and residents based on policies recommended and approved by the Department of Health.

R. Concurrent nursery days - Inpatient nursery days for a Medicaid-eligible newborn whose mother is also an inpatient in the same hospital at the same time. The concept of concurrent nursery days exists in the per diem payment method (costs are included, days are not), but is not used in the DRG payment method (mother and newborn hospital stays are billed and paid separately).

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

T. Cost to Charge Ratio - Used in outlier calculation for claims priced via DRGs. Equals total Medicaid costs divided by total Medicaid charges as reported in a Medicare cost report. If the hospital has less than 200 Medicaid days, total hospital charges and cost are used instead of Medicaid-specific values.

U. Depreciation - Fixed costs related to buildings, fixtures, and movable equipment as apportioned to Medicaid by cost finding methods used in the CMS 2552 cost report.

V. DOH – Florida Department of Health.

W. DRG - Diagnosis-related group (DRG) is a classification system that reflects clinically similar groupings of services that can be expected to consume similar amounts of hospital resources. Florida Medicaid uses the All Patient Refined Diagnosis Related Groups (APR-DRGs) developed and maintained by 3M. APR-DRGs classify each case based on information contained on the inpatient Medicaid claim such as diagnoses, procedures performed, patient age, patient sex, and discharge status.

X. DRG Payment Parameters – numerical values that are used to determine DRG reimbursement amount on individual claims. The parameters include hospital base rate, DRG relative weight, policy adjustors, outlier loss threshold, outlier marginal cost percentage, hospital cost-to-charge ratios, hospital annual case mix values, and hospital annual Medicaid admission estimates.

Y. DRG Relative Weight - For each DRG a relative weight factor is assigned. These weights are intended to reflect the relative resource consumption of each inpatient stay. The weights are adapted from a national database containing millions of inpatient stays and are then "re-centered" so that the average Florida Medicaid stay in a base year has a weight of 1.00. The DRG relative weight is a weight assigned that reflects the typical hospital resources consumed in care of a patient. For example, the average hospitalization with a DRG weight of 1.5 would consume 50 percent more resources than the average hospitalization with a weight of 1.0, while a hospital stay assigned a DRG with a weight of 0.5 would require half the resources.

Z. Eligible Medicaid recipient - An individual who meets certain eligibility criteria for the Title XIX Medical Assistance Program as established by the State of Florida.

AA. Filing Due Date - No later than five (5) calendar months after the close of the hospital's cost-reporting year.

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

CC. Florida Price Level Index - A spatial index that measures the 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. For example, 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.

DD. General hospital - A hospital in this state which is not classified as a specialized hospital.

EE. HHS - Department of Health and Human Services

FF. CMS PUB. 15-1 - Health Insurance Manual No. 15, herein incorporated by reference, also known as the Provider Reimbursement Manual available from The Centers for Medicare and Medicaid Services.

GG. Hospital - means a health care institution licensed as a hospital pursuant to Chapter 395, but does not include ambulatory surgical centers.

HH. IGT – Inter Governmental Transfer – these are funds subject to federal matching that are transferred from non-state governmental agencies to the Agency for Health Care Administration to help fund Florida Medicaid hospital reimbursements.

II. Inpatient general routine operating costs - Costs incurred for the provision of general routine services including the regular room, dietary and nursing services, and minor medical and surgical supplies.

JJ. Inpatient hospital services - Services that are ordinarily furnished in a hospital for the care and treatment of an inpatient under the direction of a physician, dentist, or other recognized member of the medical staff and are furnished in an institution that:

1. Is maintained primarily for the care and treatment of patients with disorders other than tuberculosis or mental diseases;
2. Is licensed as a hospital by AHCA;
3. Meets the requirements for participation in Medicare; and
4. Has in effect a utilization review plan, approved by the PRO pursuant to 42 CFR 456.100 (1998), applicable to all Medicaid patients.

KK. Late Cost Report - A cost report is late when it is filed with AHCA, Bureau of Medicaid Program

Finance after the Filing Due Date and after the Rate Setting Due Date.

LL. Legislative Unit Cost - The weighted average per diem of the State anticipated expenditure after all rate reductions but prior to any buy back. The concept of Legislative Unit Cost exists in the per diem payment method, but is not used in the DRG payment method.

MM. Marginal cost factor – used in calculation of outlier payments for inpatient claims priced via DRG method. Marginal cost factor is a percentage set by the Agency for Health Care Administration.

NN. Medicaid allowable variable costs - Allowable operating costs less depreciation as apportioned to Medicaid by cost-finding methods in the CMS 2552 cost report.

OO. Medicaid days - The number of actual days attributable to Medicaid patients as determined by the Agency for Health Care Administration.

PP. Medicaid inpatient charges - Usual and customary charges made for inpatient services rendered to Medicaid patients. These charges shall be the allowable charges as reconciled with the hospital Medicaid log and found on the Medicaid paid claims report.

QQ. Medicaid covered nursery days - Days of nursery care for a Medicaid eligible infant.

RR. Medicaid depreciation - Depreciation times the ratio of Medicaid charges to total charges divided by Medicaid inpatient days.

SS. MMIS – Medicaid Management Information System – the computer application used to adjudicate medical claims and determine reimbursement amounts.

TT. Non-concurrent nursery days - Inpatient nursery days for a Medicaid-eligible newborn whose mother is not an inpatient in the same hospital at the same time. Under the per diem payment method, concurrent and non-concurrent days are treated differently for billing purposes. Under the DRG payment method, all newborn nursery days are considered non-concurrent and are billed separately from services provided to the mother.

UU. Non-covered services - Those goods and services which are not medically necessary for the care and treatment of inpatients as defined in CMS PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C.

VV. Outlier payment – An extra payment added to some claims priced via the DRG pricing methodology. Outlier payments are made when the estimated hospital cost for an admission far exceeds normal reimbursement for the DRG assigned to the claim.

WW. Patient's physician - The physician of record responsible for the care of the patient in the hospital.

XX. PRO - Utilization and quality control peer review organization.

YY. 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.

ZZ. Rate semester - January l through June 30, of a given year or July l through December 31, of a given year. Effective July 1, 2011, a rate semester will be from July 1 to June 30 of each year.

AAA. Rate Setting Due Date - All cost reports postmarked by March 31 and received by AHCA by April 15 shall be used to establish the reimbursement rates

BBB. Rate Setting Unit Cost - The weighted average per diem after all rate reductions but prior to any buy backs based on submitted cost reports. The concept of Rate Setting Unit Cost exists in the per diem payment method, but is not used in the DRG payment method.

CCC. Reasonable cost - The reimbursable portion of all allowable costs. Implicit in the meaning of reasonable cost is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs will not be included under the program. The determination of reasonable cost is made on a specific item of cost basis as well as a per diem of overall cost basis.

DDD. Reimbursement ceiling - The upper limit for Medicaid variable cost per diem reimbursement for an individual hospital.

EEE. Reimbursement ceiling period - July l through June 30 , of a given year.

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

1. The sole provider within a county with a population density of no greater than 100 persons per square mile; or
2. An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county; or
3. A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or less per square mile.

GGG. Self-Funded Intergovernmental Transfer (IGT) - the hospital provider receives the enhanced reimbursement rate only if they can find a source of qualified state share.

HHH. SFY – state fiscal year – begins on July 1st and ends of June 30th of the following year.

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

JJJ. Teaching Hospital - Means 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.

KKK. Title V - Maternal and Child Health and Crippled Children's Services as provided for in the Social Security Act (42 U.S.C. 1396-1396p).

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

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

NNN. Total inpatient charges - Total patient revenues assessed for all inpatient services.

OOO. UR Committee - Utilization review committee.

APPENDIX A TO FLORIDA TITLE XIX INPATIENT HOSPITAL

REIMBURSEMENT PLAN

ADJUSTMENTS TO ALLOWABLE MEDICAID VARIABLE COSTS

The technique to be utilized to adjust allowable Medicaid variable costs for inflation in the process of computing the reimbursement limits is detailed below. Assume the following DRI (or its successor) Quarterly Indices.

	1996	1997	1998	1999	2000
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
Wages and Salaries	55.57
Employee Benefits	7.28%
All Other Products	3.82%
Utilities	3.41%
All 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
l	213.0		
		215.4	March 31
2	217.8		
		220.3	June 30
3	222.7		
		225.2	Sept. 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

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

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

Therefore, the hospital's reported variable cost Medicaid per diem is multiplied by 1.3607 to obtain the estimated average variable Medicaid per diem for the first rate semester of FY1999-2000. Similar calculations utilizing March 31 and the mid point yield adjustments for the second semester of FY1999-2000.

APPENDIX B TO FLORIDA TITLE XIX INPATIENT HOSPITAL REIMBURSEMENT PLAN

Medicaid Trend Adjustment Percentages

	Effective Date	Percentages	Reduction Amount
1.	July 1, 2008		
	First Cut	5.467597%	$100,537,618
	Second Cut	3.071006%	$68,641,064
	Third Cut	5.45000%	$154,333,435
2.	**January 1, 2009**		
	First Cut	4.434310%	$100,537,618
	Second Cut	2.999492%	$68,641,064
	Third Cut	6.877860%	$154,333,435
3.	**March 1, 2009**		
	First Cut	4.434067%	$100,537,618
	Second Cut	2.999356%	$68,641,064
	Third Cut	6.877541%	$154,333,435
	Fourth Cut	4.033571%	$84,675,186
4.	**July 1, 2009**		
	First Cut	5.148770%	$100,537,618
	Second Cut	2.955273%	$68,641,064
	Third Cut	6.774483%	$154,333,435
	Fourth Cut	3.866916%	$84,675,186
	Fifth Cut	.0%	$35,478,571
5.	**January 1, 2010**		
	First Cut	5.067599%	$100,537,618
	Second Cut	2.874361%	$68,641,064
	Third Cut	6.585483%	$154,333,435
	Fourth Cut	3.742465%	$76,712,855
	Fifth Cut	.456110%	$35,478,571
6.	**July 1, 2011**		
	First Cut	4.127263%	$100,537,618
	Second Cut	2.413944%	$68,674,064
	Third Cut	5.513843%	$154,333,435
	Fourth Cut	3.091489%	$76,712,855
	Fifth Cut	0.375210%	$35,478,571
	Sixth Cut	0.000000%	$232,221,607

Seventh Cut	12.528817%	$394,928,848
7.1 Cut	0.000000%	$12,608,937

7. July 1, 2012

First Cut	4.614997%	$100,537,618
Second Cut	2.362229%	$68,674,064
Third Cut	5.393882%	$154,333,435
Fourth Cut	3.045251%	$76,712,855
Fifth Cut	0.366330%	$35,478,571
Sixth Cut	0.000000%	$232,221,607
Seventh Cut	12.6267267%	$394,928,848
7.1 Cut	0.0000000%	$12,608,937
Eighth Cut	4.343881%	$247,581,463

APPENDIX C TO FLORIDA TITLE XIX INPATIENT HOSPITAL REIMBURSEMENT PLAN

Upper Payment Limit (UPL) Methodology

APPENDIX D TO FLORIDA TITLE XIX INPATIENT HOSPITAL

REIMBURSEMENT PLAN

DRG Pricing Examples

Please note, the examples in this appendix are for illustrative purposes only and do not necessarily match the exact rounding of calculations performed within the MMIS. In addition, the base rate and policy adjustors used in these examples do not exactly match the values being used for inpatient claim reimbursement.

These are the calculations used to determine the claim payment for Inpatient DRG stays:

- Claim Payment = DRG Base Payment + Outlier Payment + Automatic IGT + Self-funded IGT Payment
- DRG Base Payment = Provider base rate * DRG relative weight * Maximum policy adjustor
- Outlier Payment = (Estimated Loss – Outlier Loss Threshold) * Marginal Cost Factor
- Estimated Hospital Loss = (Billed Charges * Provider Cost to Charge Ratio) – DRG Base Payment – Automatic IGT Payment – Self-Funded IGT Payment
- For transfer claims, Transfer Base Payment = (DRG Base Payment / ALOS) * (1 + Covered Days)
- For non-covered days and charge cap, Adjusted Payment = Full Payment * Proration Factor

In all the examples below the following parameters are used:

- Provider base rate = $2,900.
- APR-DRG 302-2 (knee joint replace), which has a relative weight 1.6921 and average length of stay equal to ALOS of 3.35.
- Hospital-specific cost-to-charge ratio is 40.34%.
- Hospital case mix is 1.4432.
- Hospital average per discharge automatic IGT add on payment is $3,447.88. Case mix adjusted, this value is ($3,447.88 * (1.6921 / 1.4432)) = $4,042.52.

- Hospital average per discharge self-funded IGT add on payment is $1,304.49. Case mix adjusted, this value is ($1,304.49 * (1.6921 / 1.4432)) = $1,529.47.
- Outlier loss threshold is $31,000.
- Outlier marginal cost factor is 80%.

Basic example:

Submitted Charge	$34,000.00
Provider CCR	40.34%
DRG Relative Weight	1.6921
Max Policy Adjustor	1.0
Provider Base Rate	$2,900.00
Outlier Threshold	$31,000
Marginal Cost Percentage	80%
DRG Base Payment	$4,907.09
Automatic IGT	$4,042.52
Self-Funded IGT	$1,529.47
Estimated Hospital Cost	$13,715.60
Estimated Loss	$3,236.52
Loss Above Threshold	$0
Outlier Payment	$0
Claim Payment	$10,479.08

Outlier example:

Submitted Charge	$110,000.00
Provider CCR	40.34%
DRG Relative Weight	1.6921
Max Policy Adjustor	1.0
Provider Base Rate	$2,900.00
Outlier Threshold	$31,000
Marginal Cost Percentage	80%
DRG Base Payment	$4,907.09
Automatic IGT	$4,042.52
Self-Funded IGT	$1,529.47

Estimated Hospital Cost	$44,374.00
Estimated Loss	$33,894.92
Loss Above Threshold	$2,894.92
Outlier Payment	$2,315.94
Claim Payment	$12,795.02

Maximum policy adjustor example:

Submitted Charge	$34,000.00
Provider CCR	40.34%
DRG Relative Weight	1.6921
Service adjustor	1.30
Age adjustor	1.00
Provider adjustor	2.027
Max Policy Adjustor	2.027
Provider Base Rate	$2,900.00
Outlier Threshold	$31,000
Marginal Cost Percentage	80%
DRG Base Payment	$9,946.67
Automatic IGT	$4,042.52
Self-Funded IGT	$1,529.47
Estimated Hospital Cost	$13,715.60
Estimated Loss	$3,236.52
Loss Above Threshold	$0
Outlier Payment	$0
Claim Payment	$15,518.66

Transfer example:

Submitted Charge	$34,000.00
Provider CCR	40.34%
Length of Stay	1
Discharge status	02
DRG Relative Weight	1.6921
DRG Avg Length of Stay	3.35

Max Policy Adjustor	1.0
Provider Base Rate	$2,900.00
Outlier Threshold	$31,000
Marginal Cost Percentage	80%
DRG Base Payment	$4,907.09
Transfer Base Payment	$2,929.61
Lessor of DRG and Transfer	$2,929.61
Automatic IGT	$4,042.52
Self-Funded IGT	$1,529.47
Estimated Hospital Cost	$13,715.60
Estimated Loss	$3,236.52
Loss Above Threshold	$0
Outlier Payment	$0
Claim Payment	$8,501.60

Non-covered day example:

Submitted Charge	$34,000.00
Provider CCR	40.34%
DRG Relative Weight	1.6921
Length of Stay	5
Covered Days	2
Max Policy Adjustor	1.0
Provider Base Rate	$2,900.00
Outlier Threshold	$31,000
Marginal Cost Percentage	80%
DRG Base	$4,907.09
Automatic IGT	$4,042.52
Self-Funded IGT	$1,529.47
Estimated Hospital Cost	$13,715.60
Estimated Loss	$3,236.52
Loss Above Threshold	$0
Outlier Payment	$0
Adjusted DRG Payment:	
Non-covered day proration factor	0.4000
DRG Base	$1,962.84

Automatic IGT	$1,617.01
Self-Funded IGT	$611.79
Outlier Payment	$0.00
Claim Payment	$4,191.64

Charge cap example:

Submitted Charge	$8,000.00
Provider CCR	40.34%
DRG Relative Weight	1.6921
Max Policy Adjustor	1.0
Provider Base Rate	$2,900.00
Outlier Threshold	$31,000
Marginal Cost Percentage	80%
DRG Base	$4,907.09
Automatic IGT	$4,042.52
Self-Funded IGT	$1,529.47
Estimated Hospital Cost	$3,227.20
Estimated Loss	$0
Loss Above Threshold	$0
Outlier Payment	$0
Adjusted DRG Payment:	
Charge cap proration factor	0.76343
DRG Base	$3,746.20
Automatic IGT	$3,086.16
Self-Funded IGT	$1,167.64
Outlier Payment	$0.00
Claim Payment	$8,000.00

APPENDIX E TO FLORIDA TITLE XIX INPATIENT HOSPITAL REIMBURSEMENT PLAN

Transitional Payments

Provider Medicaid ID	Provider Name	Payment Change	Percent Payment Change	Rural	Three Tiered Percent of Loss	Tier	Percentage of Loss Covered through Transition	Quarterly Payments
010260100	Florida Hospital Wauchula	$(98,204)	-56%	Y	$98,204	1	100%	$24,551
010121400	Mariners Hospital	$(413,358)	-55%	Y	$413,358	1	100%	$103,340
002012700	Sacred Heart Hosp. - Gulf	$(324,813)	-42%	Y	$324,813	1	100%	$81,203
010194000	Campbellton-Graceville Hospital	$(29,319)	-38%	Y	$29,319	1	100%	$7,330
010080300	George E. Weems Memorial Hosp	$(22,907)	-24%	Y	$22,907	1	100%	$5,727
010123100	Baptist Medical Center - Nassau	$(546,664)	-21%	Y	$546,664	1	100%	$136,666
010026900	Calhoun Liberty Hospital	$(53,549)	-19%	Y	$53,549	1	100%	$13,387
010120600	Fishermen's Hospital	$(48,210)	-17%	Y	$48,210	1	100%	$12,053
010106100	Jackson Hospital	$(682,766)	-12%	Y	$682,766	1	100%	$170,692
010115000	Madison County Memorial Hospital	$(5,092)	-7%	Y	$5,092	1	100%	$1,273
010323300	Sacred Heart Hosp - Emerald Coast	$(288,396)	-6%	Y	$288,396	1	100%	$72,099
010192300	Desoto Memorial Hospital	$(158,237)	-4%	Y	$158,237	1	100%	$39,559
010033100	Shands At Lake Shore	$(768)	0%	Y	$768	1	100%	$192
010047100	University of Miami Hospital	$(658,173)	-57%	N	$335,688	2	51.003%	$83,922
010552000	Columbia New Port Richey Hospital	$(1,919,904)	-36%	N	$979,209	2	51.003%	$244,802
010036600	Cedars Medical Center, Inc.	$(6,913,017)	-28%	N	$3,525,846	2	51.003%	$881,462
010011100	Wuesthoff Memorial Hospital	$(592,550)	-15%	N	$302,218	2	51.003%	$75,555
010042100	Jackson Memorial Hospital	$(45,716,377)	-14%	N	$23,316,724	2	51.003%	$5,829,181
010003000	Shands Teaching Hospital	$(23,517,098)	-14%	N	$11,994,425	2	51.003%	$2,998,606
012029400	Jupiter Hospital	$(385,815)	-14%	N	$196,777	2	51.003%	$49,194
010140100	Bethesda Mem. Hosp.	$(3,613,520)	-13%	N	$1,843,004	2	51.003%	$460,751
012000600	Columbia Plantation General Hosp	$(2,126,887)	-12%	N	$1,084,776	2	51.003%	$271,194
012032400	H L Moffitt Cancer Center	$(1,864,158)	-12%	N	$950,777	2	51.003%	$237,694
010148600	St. Mary's Hospital	$(6,752,849)	-12%	N	$3,444,156	2	51.003%	$861,039
010222900	Pembroke Pines Hospital	$(727,400)	-12%	N	$370,996	2	51.003%	$92,749
010031500	Naples Community Hospital	$(2,494,276)	-11%	N	$1,272,156	2	51.003%	$318,039
010169900	Winter Haven Hospital	$(1,692,368)	-11%	N	$863,159	2	51.003%	$215,790
010314400	Cleveland Clinic FL Hospital - Naples	$(690,746)	-10%	N	$352,301	2	51.003%	$88,075
010067600	Shands Jacksonville Med Cntr	$(7,924,028)	-9%	N	$2,456,621	3	31.00217563%	$614,155
010226100	Homestead Hospital	$(1,383,677)	-9%	N	$428,970	3	31.00217563%	$107,243
012040500	Coral Springs Medical Center	$(1,276,298)	-8%	N	$395,680	3	31.00217563%	$98,920
012026000	Columbia Palms West Hospital	$(1,159,675)	-7%	N	$359,524	3	31.00217563%	$89,881
010046300	Mt. Sinai Medical Center	$(1,395,990)	-6%	N	$432,787	3	31.00217563%	$108,197
010010200	Parrish Medical Center	$(368,042)	-6%	N	$114,101	3	31.00217563%	$28,525
011971700	Cape Coral Hospital	$(700,045)	-6%	N	$217,029	3	31.00217563%	$54,257
010099400	Tampa General Hospital	$(7,045,238)	-5%	N	$2,184,177	3	31.00217563%	$546,044
010164800	Lakeland Regional Medical Center	$(1,410,169)	-4%	N	$437,183	3	31.00217563%	$109,296
011134100	Southwest Florida Regional Medical	$(714,137)	-3%	N	$221,398	3	31.00217563%	$55,350
010133800	Orlando Regional Medical Center	$(3,943,218)	-3%	N	$1,222,483	3	31.00217563%	$305,621
010020000	Memorial Hospital	$(2,446,216)	-3%	N	$758,380	3	31.00217563%	$189,595
010110900	Lee Memorial Hospital	$(1,960,769)	-3%	N	$607,881	3	31.00217563%	$151,970
010012900	Broward General Hospital	$(2,794,921)	-3%	N	$866,486	3	31.00217563%	$216,622
010008100	Holmes Regional Medical Center	$(357,623)	-2%	N	$110,871	3	31.00217563%	$27,718
010129000	Florida Hospital	$(2,239,616)	-2%	N	$694,330	3	31.00217563%	$173,583
					$ 65,012,397			

APPENDIX F TO FLORIDA TITLE XIX INPATIENT HOSPITAL REIMBURSEMENT PLAN

Certified Public Expenditures (CPE) Protocol Methodology

The Florida Medicaid Agency uses the CMS Form 2552-10 cost report, which was prepared based on Medicare cost reporting principles, as the basis for ensuring proper cost allocation and apportionment for services provided to Medicaid eligible beneficiaries and individuals with no source of third party insurance. Worksheets from the CMS Form 2552-10 cost report will be identified as appropriate in this appendix to ensure proper calculation of cost to be certified as public expenditures (CPE) for Mental Health Hospitals. The Agency will use the protocol below.

Note: For the purposes of this appendix, the term "per diem" is used to represent the per diem costs incurred by a hospital, and is in no way tied to a per diem reimbursement methodology. The methodology outlined in the appendix is not tied to or dependent upon a per diem reimbursement methodology, and would remain the same if the program reimbursed through a Diagnosis Related Group, or DRG methodology.

I. Protocol for Determining CPE:

To the extent that there are expenditures a hospital provider wants to make against the cost limit, and the methodology for capturing such expenditures is not stated in this protocol, the expenditures will need to be approved by CMS and the State prior to the submission of the reconciliation for the applicable period for the expenditures. The protocol will be prospectively modified to include such prior approval, and the claiming protocol will be prospectively incorporated into the protocol when the protocol is next updated.

A per diem is calculated by dividing total costs by total days. In this attachment, a per diem is referencing a calculation found in the *CMS Medicare 2552-10 Cost Report* and is not referring to hospital reimbursement calculations.

A. Hospital's Cost Limit

1. Hospital's Medicaid Fee-For-Service (FFS)

   For the State payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are to be determined using the hospital's Medicare cost report (CMS-2552-10) on file with Florida Medicaid for the annual rate setting. The per diems and cost-to-charge ratios are calculated as follows:

   Step 1

   Total hospital costs for the payment year are identified from Worksheet B Part I Column 24; Line 116 (excludes no reimbursable cost centers). These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series. These costs should match Line 116 on Worksheet C.

   Step 2

The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 8 (Total All Patients), Lines 14 plus Line 28 (Observation Beds). The hospital's total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8 Lines 50-116 (Ancillary Cost Centers).

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552-10 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing hospital costs and non-medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid FFS inpatient routine cost center costs for the payment year, the hospital's actual inpatient Medicaid days by cost center, as obtained from FMMIS for the period covered by the as-filed (most recent base year) cost report, will be used. The covered days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing hospital, skilled nursing hospital, and long term care services are excluded.

Step 5

To determine Medicaid FFS ancillary costs for the payment year, the hospital's actual Medicaid FFS allowable charges, as obtained from FMMIS for the period covered by the most recent base year cost report, will be used. Medicaid FFS allowable charges for ancillary observation beds must be included in line 62. These Medicaid FFS allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid FFS allowable costs for each cost center. The Medicaid FFS allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.

Step 6

The Medicaid allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-4 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-4 Part III under the Part A cost column line 61. For this calculation, a usable organ is defined as the number of organs excised and furnished to an organ procurement organization. Medicaid "usable organs" are counted as the number of

Medicaid patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid days and charges in Steps 4 and 5 above, or any Medicaid managed care or uninsured days and charges in Steps 4 and 5 of those portions of this protocol.

Step 7

The Medicaid FFS allowable costs are determined by adding the Medicaid routine costs from Step 4, the Medicaid ancillary costs from Step 5 and the Medicaid organ acquisition costs from Step 6.

2. Hospital's Medicaid Managed Care

For the State payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's Medicare cost report(s) (CMS-2552-10) covering the payment year, as filed with Florida Medicaid. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified from Worksheet B Part I Column 24 line 116 (excludes no reimbursable cost centers). These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series. These costs should match up to the same lines as charges on Worksheet C.

Step 2

The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 8. The hospital's total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8 Lines 50-116 (Ancillary Cost Centers).

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552-10 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing hospital costs and non-medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid managed care inpatient routine costs for the payment year, the hospital's actual Medicaid managed care inpatient days by cost center, as obtained from FMMIS for the period covered by the as-filed (most recent base year) cost report, will be used. The covered days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid managed care allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing hospital, skilled nursing hospital, and long term care services are excluded.

Step 5

To determine the Medicaid managed care ancillary costs for the payment year, the hospital's actual Medicaid managed care charges, as obtained from FMMIS for the period covered by the most recent base year cost report will be used. Medicaid managed care allowable charges for ancillary observation beds must be included in line 62. These Medicaid managed care allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid managed care allowable costs for each cost center. The Medicaid managed care allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.

Step 6

The Medicaid managed care allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid managed care usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-4 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-4 Part III under the Part A cost column line 61. "Medicaid managed care usable organs" are counted as the number of Medicaid managed care patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid managed care days and charges in Steps 4 and 5 above (or any Medicaid days or uninsured days in Steps 4 and 5 of those portions of this protocol).

Step 7

The Medicaid managed care allowable costs are determined by adding the Medicaid managed care routine costs from Step 4, the Medicaid managed care ancillary costs from Step 5 and the Medicaid managed care organ acquisition costs from Step 6.

3. Hospital's Uninsured/Underinsured

For the payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's most recent as filed Medicare cost report (CMS-2552-10), as filed with Florida Medicaid. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified from Worksheet B Part I Column 26 line 116 (excludes no reimbursable cost centers). These are the costs that have already been

reclassified, adjusted, and stepped down through the A and B worksheet series. These costs should match up to the same lines as charges on Worksheet C.

Step 2

The hospital's total actual days by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total actual charges by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total actual costs from Step 1 by total actual days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total actual costs from Step 1 by the total actual charges from Step 2. The A&P routine per diem, in accordance with CMS-2552-10 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing hospital costs and private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's actual costs for the payment year. The data sources utilized to determine eligible costs under this section must be derived from the hospitals FMMIS pull. The hospital costs for care provided to those with no source of third party coverage (i.e., uninsured cost) for the payment year are determined as follows:

Step 4

To determine the uninsured routine cost center costs for the payment year, the hospital's actual inpatient days by cost center for individuals with no source of third party coverage are used. The actual uninsured days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the low income uncompensated care inpatient costs for each cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing hospital, skilled nursing hospital, and long term care services are excluded.

Step 5

To determine the uninsured ancillary cost center actual costs for the payment year, the hospital's inpatient and outpatient actual charges by cost center for individuals with no source of third party coverage are used. These allowable uninsured charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the uninsured allowable costs for each cost center. The uninsured care charges for the payment year should only pertain to inpatient and outpatient hospital services and should exclude charges pertaining to any professional services or non-hospital component services such as hospital-based providers.

Step 6

The uninsured care share of organ acquisition costs is determined by first finding the ratio of uninsured care usable organs to total usable organs. This is determined by dividing the number of uninsured usable organs as identified from provider records by the hospital's total usable organs

from Worksheet D-4 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-4 Part III under the Part A cost column line 53. "Uninsured usable organs" are counted as the number of patients who received an organ transplant and had no insurance. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid or uninsured days and charges in Steps 4 and 5 above or Steps 4 and 5 of the Medicaid (or Medicaid managed care) portion of this protocol.

Step 7

The eligible uninsured care costs are determined by adding the uninsured care routine costs from Step 4, uninsured ancillary costs from Step 5 and uninsured organ acquisition costs from Step 6.

Actual uninsured data for services furnished during the payment year are used to the extent such data can be verified to be complete and accurate. The data sources utilized to determine eligible costs under this section must be derived from hospitals' audited financial statements and other auditable documentation.