FLORIDA TITLE XIX INPATIENT HOSPITAL

REIMBURSEMENT PLAN

VERSION XLII

EFFECTIVE DATE July 1, 2015

I. Cost Finding and Cost Reporting

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

B. Cost reports available to AHCA as of April 15 of each year 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, Centers for Medicare and Medicaid Services (CMS) PUB. 15-1, as incorporated by reference in Rule 59G-6.020, Florida Administrative Code (F.A.C.) (http://www.leg.state.fl.us/Statutes/index.cfm?Mode=View%20Statutes&Submenu=1&Tab=Statutes) effective July 1, 2014.

D. The cost report shall be prepared in accordance with generally accepted accounting principles as required 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 Code of Federal Regulations (CFR) 413.5 - 413.35 and further interpreted by the Provider Reimbursement Manual CMS PUB. 15-1, as incorporated by reference in Rule 59G-6.020, F.A.C., or as further modified by this plan.

E. If a provider files a cost report late:

1. If the provider is reimbursed via the Diagnosis Related Group (DRG) method and that cost report would have generated a lower cost-to-charge ratio had it been filed within 5 months, then any claims from the applicable state fiscal year which were paid an outlier will be retroactively re-priced; or
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 filed 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 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-6.020, 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 filed for a period of at least five years following the date of submission of such reports and shall maintain those reports pursuant to the record keeping requirements of 45 CFR 205.60. Access to filed cost reports shall be in conformity with Chapter 119, Florida Statutes (F.S.) (https://www.flrules.org).

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

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

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

M. Providers shall be subject to sanctions pursuant to s. 409.913(15)(c), F.S., for late cost reports. The amount of the sanctions can be found in Rule 59G-9.070, F.A.C.

N. AHCA shall implement a methodology for establishing base reimbursement rates for each hospital that is still being reimbursed via per diem based on allowable costs. The base reimbursement rate is defined in sections V.A., V.B., and V.C. of AHCA's Inpatient Hospital Reimbursement Plan.

O. Rates shall be calculated annually and take effect July 1 of each year based on the most recent complete and accurate cost report filed by each hospital.

P. State-owned psychiatric facilities are paid on a per diem basis. All other acute care hospitals are paid via a prospective payment methodology using an acuity-based patient categorization system based on DRGs. Rates are based primarily on annual Medicaid inpatient fee-for-service budget, projected patient case mix (acuity), and payment parameters determined to meet AHCA inpatient reimbursement goals. With the DRG payment method, cost reports continue to be used for disproportionate share hospital examinations 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 overlap of audit procedures filed under the above three programs, and to minimize duplicate auditing effort. The purpose is to use audit results of a participating hospital, where possible, for all participating programs reimbursing the hospital for services rendered.

B. Hospital Audits Desk Procedure Reviews

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

1. Determine the need for on-site full scope audits and determine the scope and format for such audits when selected;
2. Desk audit all cost reports within 12 months after receipt by AHCA’s designated contractor. The review may not include the Medicare auditor settlements if they are not available in the CMS Healthcare Cost Report Information System (HCRIS) data;
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 filed by a hospital meets the requirements of this plan.

C. Retention

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

D. Overpayments and Underpayments

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, F.S.
7. All overpayments shall be reported by AHCA to CMS as required.
8. AHCA or its designated contractor shall furnish to providers written notice of the audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care. The written notice constitutes final agency action.

E. Administrative Hearings

1. A substantially affected provider seeking to correct or adjust the calculation of the audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care, other than a challenge to the methodologies set forth in the rules of AHCA and in reimbursement plans incorporated by reference therein used to calculate the reimbursement rate for inpatient and outpatient care, may request an administrative hearing to challenge the final agency action by filing a petition with AHCA within 180 days after receipt of the written notice by the provider. The petition must include all documentation supporting the challenge upon which the provider intends to rely at the administrative hearing and may not be amended or supplemented except as authorized under uniform rules adopted pursuant to s. 120.54(5), F.S. The failure to timely file a petition in compliance with this subparagraph is deemed conclusive acceptance of the audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care established by the agency.
2. A correction or adjustment of an audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care which is required by an administrative order or appellate decision:
   a. Must be reconciled in the first rate period after the order or decision becomes final.
   b. May not be the basis for any challenge to correct or adjust hospital rates required to be paid by any Medicaid managed care provider pursuant to part IV of this chapter.
3. AHCA may not be compelled by an administrative body or a court to pay additional compensation to a hospital relating to the establishment of audited hospital cost-based per diem reimbursement rates by the agency or for remedies relating to such rates, unless an appropriation has been made by law for the exclusive, specific purpose of paying such additional compensation. As used in this subparagraph, the term “appropriation made by law” has the same meaning as provided in s. 11.066, F.S.
4. The exclusive means to challenge a written notice of an audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care for the purpose of correcting or adjusting such rate before, on, or after July 1, 2015, or to challenge the methodologies set forth in the rules of AHCA and in reimbursement plans incorporated by reference therein used to calculate the

reimbursement rate for inpatient and outpatient care is through an administrative proceeding pursuant to chapter 120, F.S.

5. Any challenge to the methodologies set forth in the rules of AHCA and in reimbursement plans incorporated by reference therein used to calculate the reimbursement rate for inpatient and outpatient care may not result in a correction or an adjustment of a reimbursement rate for a rate period that occurred more than 5 years before the date the petition initiating the proceeding was filed.
6. This section regarding Administrative Hearings applies to any challenge to final agency action which seeks the correction or adjustment of a provider's audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care and to any challenge to the methodologies set forth in the rules of the agency and in reimbursement plans incorporated by reference therein used to calculate the reimbursement rate for inpatient and outpatient care, including any right to challenge which arose before July 1, 2015.
7. Any change in this Plan in this Section regarding Administrative Hearings is remedial in nature, confirms and clarifies existing law, and applies to all proceedings pending on or commenced after this Plan Version XLII takes effect.

III. Allowable Costs

A. General Allowable Cost Principles

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-6.020, 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:

1. Costs incurred by a hospital in meeting:
   (a). 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 section 1902(a)(13) and (20) of the Social Security Act;

(b) The requirements established by AHCA for establishing and maintaining health standards under the authority of 42 CFR 431.610 (b); and

(c). Any other requirements for licensing under s. 395.003, F.S., which are necessary for providing inpatient hospital services.

2. Hospital inpatient general routine operating costs shall be the lesser of allowable costs, direct and indirect, incurred or the limits established by CMS under 42 CFR 413.30.
3. Malpractice insurance costs shall be apportioned to Medicaid in the ratio of Medicaid Patient Days to Total Patient Days, if not already included in the cost report being used to establish the Medicaid hospital inpatient rates.
4. 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.
5. 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.
6. 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.
7. The revenue assessments, and any fines associated with those assessments, mandated by the Health Care Access Act of 1984, section 395.7015, F.S., shall not be considered an allowable

Medicaid cost and shall not be allocated as a Medicaid allowable cost for purposes of cost reporting.

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

A. Applicability

AHCA calculates reimbursement for 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.

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. AHCA 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 hospital 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 Medicaid Management Information System (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. APR-DRG version 32 DRGs, relative weights and average lengths of stay are being used as of July 1, 2015.
    b. Average Florida Medicaid relative weight (case mix) was calculated using claims from SFY 2012-2013.

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 AHCA 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"). Due to AHCA's implementation of statewide Medicaid managed care (SMMC), the base year historical claims dataset included claims from both the fee-for-service and managed care programs. Claims data from the base year is used to simulate future inpatient Florida Medicaid 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. For SFY 2015-2016 rate setting, the base year historical claims dataset was reduced slightly to approximate anticipated hospital inpatient utilization reduction between the base year and the rate year resulting from the shift to SMMC.
5. Annual Updates:
    a. Base year historical claims used to calculate the DRG base rate had dates of admission within SFY 2012-2013.

b. Total inpatient reimbursement amount used to ensure budget neutrality was the sum of DRG claim payments on the base year claims calculated using SFY 2014-2015 DRG rates and pricing rules and then adjusted based on Legislative direction for SFY 2015-2016. The adjustments included:

(1) DRG payment, which equals the sum of DRG base payment plus outlier payment, was increased by two (2) percent for inflation.

(2) $7,542,036 in non-recurring funds made available for sole community hospitals in the previous state fiscal year were removed from the funding.

(3) $81,641,165 in additional funds (state share plus federal share) were added to the budget for DRG claim payments for the entire Medicaid program – spread across the fee-for-service and managed care programs.

c. The DRG base rate was calculated with an assumption that overall Florida Medicaid case mix will increase by seven (7) percent above the case mix measured on claims in the base year (SFY 2012-2013). Case mix was predicted to increase by six (6) percent because of improved documentation and coding through the implementation of the DRG payment and another one (1) 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 seven (7) percent over what would be calculated if case mix was assumed to be unchanged.

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. For hospitals reimbursed by Medicare through the Medicare Inpatient Prospective Payment System (IPPS), the hospital-specific Medicare IPPS CCR is used. This CCR is calculated as the sum of each hospital's operating and capital cost to charge ratios.

4. For hospitals not reimbursed by Medicare through the IPPS, total inpatient 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 inpatient costs by total hospital inpatient charges.
5. The combination of IPPS Public Use File and HCRIS data is used to assign CCRs for all in-state and out-of-state hospitals with signed agreements to participate in the Florida Medicaid program. All other hospitals, which are primarily out-of-state hospitals, are assigned a statewide average CCR.
6. Annual Updates:

   Medicare IPPS CCRs for FFY 2015 posted in the IPPS Public Use File as of March 31, 2015 were used for hospitals reimbursed by Medicare through the IPPS. For hospitals not reimbursed by Medicare through the IPPS, cost and charge data were retrieved from the most current hospital cost reports available in the Healthcare Cost Report Information System (HCRIS) datasets published as of March 31, 2015.

E. Per Claim Supplemental Payments

1. Two types of per claim supplemental payments are made in SFY 2015-2016. One of the supplemental payments is called “automatic rate enhancements” and the other supplemental payment is a called “trauma hospital supplemental payment.”
2. Automatic rate enhancement payments are identified for each qualifying hospital in the Medicaid Hospital Funding Program Fiscal Year Final Conference Report. Automatic rate enhancement annual allocations per hospital are determined by the Florida Legislature.
3. For each hospital receiving automatic rate enhancements, an average per discharge payment amount was calculated by dividing the full, annual allotment by the number of Florida Medicaid inpatient admissions in the base year (SFY 2012-2013) for both the fee-for-service and managed care programs after adjustments for differences in billing rules for per diem reimbursement versus DRG reimbursement and for anticipated utilization reduction.

4. Trauma hospital supplemental payments are paid to hospitals that qualify for one of three trauma classifications – Level I Trauma, Level II Trauma, or Pediatric Trauma (as defined in sections 395.4001 and 395.4025 (14), F.S.). The trauma hospital supplemental payment is calculated as a percentage of the DRG Base Payment. For SFY 2015-2016, the percentages are:
   a. Level I Trauma 17%
   b. Level II Trauma 11%
   c. Pediatric Trauma 4%

F. Policy Adjustors

1. Policy adjustors are numerical multipliers included in the DRG payment calculation that allow AHCA 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. The following provider and service categories have policy adjustors greater than 1.0:
   a. 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).
   b. Age adjustors: Claims for recipients under the age of 21 for which severity of illness as defined during the APR-DRG assignment is 3 (major) or 4 (extreme), and the service provided is categorized as Pediatric, Mental Health, or Rehabilitation.
   c. Provider adjustors: Claims from rural hospitals (as defined in section 395.602, F.S.), 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

program 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.
2. The primary components of DRG payment are:

   Claim Payment = DRG Base Payment + Outlier Payment + Automatic Rate Enhancement
   + Trauma Hospital Supplemental 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 AHCA. 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

c. Automatic Rate Enhancement Supplemental Payment: For each hospital, the annual automatic rate enhancement is translated into an average per-discharge amount. On individual inpatient claims, the average per-discharge automatic rate enhancement 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 rate enhancement payment
= average per-discharge automatic rate enhancement 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 automatic rate enhancement payment calculation.

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

d. Trauma Hospital Supplemental Payment: Hospitals qualifying as one of the following receive a trauma hospital supplemental payment: Level I trauma, Level II trauma or pediatric trauma. The payment is performed using the following formula:

Trauma Hospital Supplemental Payment = DRG Base Payment
* Trauma Supplemental Payment Percentage

(1) Trauma supplemental payment percentages are determined by the Florida Legislature.

(2) The DRG Base Payment used in the formula above is the final DRG Base Payment calculated after application of the transfer policy (discussed in the following section).

3. 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 the following 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
82 – discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission
85 – discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission
93 – discharged/transferred to a psychiatric distinct part of a hospital with a planned acute care hospital inpatient readmission
94 – discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission

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 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. Claim supplemental payments, including automatic rate enhancement and trauma hospital supplemental payments, are unaffected by transfer status. Supplemental 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.

4. 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
- Recipient is in the Medically Needy eligibility category and incurs enough healthcare costs to qualify for Medicaid 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. The non-covered day adjustment factor is applied only to the DRG base payment and outlier payment. Claim supplemental payments including automatic rate enhancement and trauma hospital supplemental payments, are not adjusted based on non-covered days.

5. Charge cap: The charge cap is applied only to the DRG payment, which is the sum of the DRG base payment and outlier payment, and is not applied to supplemental claim payments. If the sum of DRG base payment and outlier payment is greater than filed charges, then the DRG base payment and outlier payment are reduced proportionally so that their new, reduced sum equals filed charges. For example, if the submitted charges are 30% less than the sum of DRG base payment and outlier payment, then the DRG base payment and outlier payment get reduced by 30%.
6. 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.
7. Examples: Please see Appendix C 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 filed 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 filed 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, filed with bill type 0115, will not be accepted. Instead, hospitals are instructed to adjust previously filed 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. 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. AHCA 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, AHCA 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. In SFY 2015-2016, the third year of DRG reimbursement, the base rate will also be recalculated effective March 1, 2016, if the actual case mix in aggregate for the Medicaid fee-for-service and managed care programs differs significantly from predicted case mix. Predicted case mix is seven (7) percent above case mix measured on claims in the base year

(2012-2013). Case mix on claims in the base year was 1.00 so predicted case mix in SFY 2015-2016 is 1.07. Actual case mix will be measured using admissions between April 1, 2014 and March 31, 2015. Actual case mix in state fiscal year 2015-2016will be assumed to be higher than measured case mix by between one (1) and three (3) percent based on case mix trending. 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. The adjustment will only be applied to hospital inpatient claims in the fee-for-service program.

3. Hospital Cost-to-Charge Ratios:

   a. New cost-to-charge ratios are calculated at the beginning of each state fiscal year. CCR values are retrieved from the Medicare IPPS Public Use File published as of March 31st for hospitals reimbursed by Medicare using the IPPS. For hospitals not reimbursed by Medicare through the IPPS, CCR values are calculated using total inpatient cost and charges retrieved from each hospital's most currently available cost report found in the Healthcare Cost Report Information System (HCRIS) datasets published as of March 31.

   b. The combination of IPPS PUF and HCRIS data is used to assign CCRs for all in-state and out-of-state hospitals with signed agreements to participate in the Florida Medicaid program. All other hospitals, which are primarily out-of-state hospitals, are assigned a statewide average CCR.

   c. Mid fiscal year changes to an individual hospital's cost-to-charge ratio are permitted in cases where a hospital adjusts its entire charge master for inpatient services. This type of change to a hospital's CCR would require Agency review and approval. In addition, the Agency would validate the charge master change through review of claim data and reserves the right to reverse the CCR change if adjustments in charges cannot be validated. If approved, a CCR adjustment shall apply from the effective date of the hospital's charge master change until new cost reports reflect the hospital's change or until the hospital applies another all-encompassing charge master change.

4. Claim supplemental payments, including automatic rate enhancement and trauma hospital supplemental payments, are re-calculated and become effective at the beginning of the state fiscal year.
5. Policy Adjustors:
    a. New values for the policy adjustors are calculated annually and become effective at the beginning of each state fiscal year.
    b. In SFY 2015-2016, the third year of DRG reimbursement, the policy adjustors will be recalculated effective March 1, 2016, in concert with recalculation of the base rate, if the actual case mix differs significantly from predicted case mix. Predicted case mix is seven (7) percent above case mix measured on claims in the base year (2012-2013). Case mix on claims in the base year was 1.00 so predicted case mix in SFY 2015-2016is 1.07. Actual case mix will be measured using admissions between April 1, 2014 and March 31, 2015. Actual case mix in state fiscal year 2015-2016 will be assumed to be higher than measured case mix by between one (1) and three (3) percent based on case mix trending. 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. Updates to policy adjustors will only be applied to hospital inpatient claims in the fee-for-service program.
6. Outlier Loss Threshold: The outlier loss threshold is re-evaluated annually and new values become effective at the start of a state fiscal year.
7. The Outlier Marginal Cost Factor is re-evaluated annually and new values become effective at the start of a state fiscal year.
8. 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.
9. 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.

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, F.S., Administrative Procedures Act, and 42 CFR 447.205, this plan shall be promulgated as an Administrative Rule and as such shall be made available for public inspection. A public hearing shall be held so that interested members of the public shall be afforded the opportunity to review and comment on this plan.
2. Changes in individual hospital per diem rates shall be effective from July 1 through June 30 of each year. The prospectively determined individual hospital's rate may be adjusted only under the following circumstances:
    a. An error was made by AHCA’s designated contractor or AHCA in the calculation of the hospital's unaudited rate.
    b. A hospital files an amended unaudited cost report to supersede the unaudited cost report used to determine the rate in effect. There shall be no change in rate if an amended unaudited cost report is filed beyond 3 years of the effective date that the rate was established, or if the change is not material, or if the cost report has been audited. Effective July 1, 2014, a hospital must submit an amended cost report by July 1 of the state fiscal year the rates are effective.

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.

3. AHCA 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.

4. AHCA 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.

5. 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 CMS-2552-96 (or its successor).

6. 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.

7. 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.

8. Medicaid reimbursement shall be limited to an amount, if any, by which the final prospective per diem rate for an allowable claim exceeds the amount of third party benefits during the Medicaid benefit period.
9. Effective July 1, 2014, all amended cost reports filed with AHCA after the initial rates have been established for the current rate setting period will be reconciled in the subsequent rate setting year.

C. Methods

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

1. Setting Reimbursement Rates 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 reviews and full 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 inpatient Medicaid variable costs: Allowable inpatient Medicaid variable costs are based on the total inpatient Medicaid costs less total Medicaid fixed costs. The formula is as follows:

   Allowable Inpatient Medicaid Variable Costs = *Total Inpatient Medicaid Costs – Total Medicaid Fixed Costs*

d. Inflated Allowable Inpatient Medicaid Variable Costs: Adjust allowable inpatient 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 at the time the rate is set for the Data Resources Incorporated (DRI) (or its successor) National and Regional Hospital Input Price Indices as detailed in Appendix A.

2. Setting Reimbursement Rates for Fixed 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 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. Compute the total Medicaid fixed costs per diem for each hospital by dividing the total Medicaid fixed costs calculated by the total Florida Medicaid. The formula is as follows:

Total Medicaid Fixed Costs Per Diem *= Total Medicaid Fixed Costs / Total Florida Medicaid Days*

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 inpatient Medicaid variable costs as in section V.C.1.c of this plan.

d. Inflated Allowable Inpatient Medicaid Variable Costs: Adjust allowable inpatient 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 at the time of rate set for the DRI (or its successor) National and Regional Hospital Input Price Index as detailed in Appendix A.

e. Establish the inpatient variable costs component of the inpatient Medicaid per diem as: The inflated allowable inpatient Medicaid variable costs divided by Total Florida Medicaid days.

f. Establish the total Medicaid fixed costs component of the inpatient Medicaid per diem.

g. Calculate the overall inpatient Medicaid per diem by adding the results of the amounts calculated in sections V.C.3.f (variable costs component) and V.C.2 (total Medicaid fixed costs component) of this plan.

h. Calculate inflated inpatient Medicaid charges based on the charges in the CMS 2552 cost report. Inflated inpatient Medicaid charges equals total hospital inpatient Medicaid charges multiplied by the same inflation factor used for variable costs in section V.C.3.e of this plan.

i. Set the inpatient Medicaid per diem rate for the hospital; as result of inflated inpatient Medicaid charges divided by total Florida Medicaid days.

j. For hospitals with less than 200 total Medicaid patient days, the inpatient Medicaid per diem rate shall be computed using the principles outlined in above, but total inpatient costs, charges, and days (total hospital days) shall be utilized, instead of the inpatient Medicaid costs, charges, and days.

k. 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 in section V.C.3.p 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.

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

m. 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), F.S. The aggregate Medicaid Trend Adjustment found in V.C.3.r above shall be reduced by up to $12,067,473.

n. Effective July 1, 2008, an additional Medicaid Trend Adjustment shall be applied to achieve a recurring annual reduction of $154,333,435.

o. Effective March 1, 2009, AHCA 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, F.S., which have 70 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.

p. 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.

q. 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.

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:

    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 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.

   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.

g. 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 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. AHCA 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 facilities. 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 using data sources outlined in section 409.911, F.S.

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) x $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 or operated hospitals

with greater than 3,100 Medicaid days.

b. The following formulas shall be used to pay disproportionate share dollars to public hospitals:

For state mental health hospitals:

DSHP = (HMD/TMDMH) x 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.C.

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

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

TAAPH = total amount available for public hospitals

TAAMH = total amount available for mental health hospitals

DSHP = disproportionate share hospital payments

HMD = hospital Medicaid days

TMDMH = total state Medicaid days for state mental health hospitals

TMD = total state Medicaid days for public 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 the TAAPH shall be reduced by $6,365,257 before computing the DSHP for each public hospital. The $6,365,257 shall be distributed equally between the public hospitals that are also designated statutory teaching hospitals.

Any nonstate government owned or operated hospital eligible for payments under this section as of July 1, 2011, remains eligible for payments during the 2015-2016 state fiscal year.

4. 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.

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

B. Determination of Disproportionate Share Payments for Teaching Hospitals.

1. Disproportionate share payments shall be paid to statutorily defined teaching hospitals, as defined in s. 408.07, F.S., and family practice teaching hospitals, as defined in s. 395.805, F.S. 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.

2. The funds provided in the General Appropriations Act for family practice teaching hospitals shall be distributed equally among the family practice teaching hospitals.

3. The funds provided for in the General Appropriations Act for statutorily defined teaching hospitals shall be distributed based the General Appropriations Act with any remaining funds allocated using the following methodology:

On or before September 15 of each year, AHCA 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, AHCA 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 or programs accredited by the Council on Postdoctoral Training of the American Osteopathic Association 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) AHCA Service Index, computed by applying the standard Service Inventory Scores established by AHCA to services offered by the given hospital, as reported on AHCA 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 AHCA 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 section 409.9113 F.S., to the volume of each service, expressed in terms of the standard units of measure reported on AHCA Worksheet A-2 for the last fiscal year reported to AHCA 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.

The primary factor for the service index is computed as the sum of these three components, divided by three.

4. By October 1 of each year, 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.

C. Mental Health Disproportionate Share Payments

Funding generated through the mental health disproportionate share program shall be expended in accordance with legislatively authorized appropriations. If such funding is not addressed in legislatively authorized appropriations, AHCA shall prepare a plan and submit a request for spending authority in accordance with the provisions of chapter 216, F.S.

The Agency will make mental health disproportionate share payments to hospitals that first qualify for regular disproportionate share hospital payments based on the criteria contained in section VI.A

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

TAP = (DSH/TDSH) 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, F.S.

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. 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 AHCA 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, F.S.

.

D. Determination of Rural Hospital Disproportionate Share/financial assistance program. The agency shall make disproportionate share payments to statutory rural hospitals that qualify for such payments and financial assistance payments to statutory rural hospitals that do not qualify for disproportionate share payments. In order to receive payments under this section, a hospital must be a rural hospital as defined in s. 395.602, F.S., 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 AHCA 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 AHCA, in a format specified by AHCA, which provides a specific accounting of how all funds dispersed under this act are spent.
    a. The following formula shall be used by AHCA 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, AHCA must use the average of the three (3) most recent years of actual data reported in accordance with section 408.061 (4), F.S. AHCA 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 AHCA. AHCA shall make any corrections deemed necessary and compute the rural disproportionate share and financial assistance program payments.

b. AHCA 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

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

d. 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. In calculating the SFOER, PDAER includes federal matching funds from paragraph (b).

e 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

SSFOER = Sum of the state funds only payment amount (4)(a) for all rural hospitals.

f. The distribution of the adjusted total amount of rural disproportionate share hospital funds shall then be calculated using the following formula:

DAERH = ((TAERH x ATARH)/STAERH)

Where:

DAERH = distribution amount for each rural hospital

g. Federal matching funds for the disproportionate share program shall then be calculated for those hospitals that qualify for disproportionate share in section (4)(e) above.

h. State funds only payment amounts (4)(c) are then added to the results of (4)(f) to determine the total distribution amount for each rural hospital.

5. This section applies only to hospitals that were defined as statutory rural hospitals, or their successor in-interest hospital, prior to January 1, 2001. Any additional hospital that is defined as a statutory rural hospital, or its successor-in-interest hospital, on or after January 1, 2001, is not eligible for programs under this section unless additional funds are appropriated each fiscal year specifically to the rural hospital disproportionate share and

financial assistance programs in an amount necessary to prevent any hospital, or its successor-in-interest hospital, eligible for the programs prior to January 1, 2001, from incurring a reduction in payments because of the eligibility of an additional hospital to participate in the programs. A hospital, or its successor-in-interest hospital, which received funds pursuant to this section before January 1, 2001, and which qualifies under s. 395.602(2)(e), F.S, shall be included in the programs under this section and is not required to seek additional appropriations under this subsection.

E. Determination of Disproportionate Share Payments for Specialty Hospitals

1. The following formula shall be used by AHCA 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

   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, F.S as a specialty hospital which meet all requirements listed in subsection (2), 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, F.S.

c. Require a diagnosis for the control of active tuberculosis or a history of noncompliance with prescribed drug regimens for the treatment of tuberculosis for admissions for inpatient treatment.

d. Retain a contract with the Department of Health to accept clients for admission and inpatient treatment pursuant to s. 392.62, F.S.

F. 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 may make disproportionate share payments to specialty hospitals for children as provided in the General Appropriations Act. Unless specified in the General Appropriations Act, AHCA 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 BMPD x MD

Where:

TAE = total amount earned by a children's hospital

DSR = disproportionate share rate

BMPD = base Medicaid per diem

MD = Medicaid Days

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

TAP = [(TAE x TA)/STAE]

Where:

TAP = total additional payment for a specialty hospital for children

TAE = total amount earned by a specialty hospital for children

TA = total appropriation for the specialty hospital for children disproportionate share program.

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

3. A hospital may not receive any payments under this section until it achieves full compliance with the applicable rules of AHCA. 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 hospitals for children that are in compliance.

G. 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

The PSN inpatient days shall be provided in the General Appropriations Act.

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. AHCA shall make payments to hospitals licensed under part I of chapter 395, F.S. 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.

VIII. Alternative Reimbursement Methods

1. Transplant Global Fee

A. Methods Used in Establishing Payment Rates

Reimbursement for globally paid transplants include 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 AHCA. (See global rates below) These payments will be made to physicians and facilities that have met specified guidelines and are established as designated transplant centers. The global maximum reimbursement for transplant surgery services is an all-inclusive payment and encompasses 365 days of transplant related care.

The Agency's global reimbursement rates were updated on February 22, 2010, and are effective for services provided on and after that date.

Only one provider may bill for the transplant phase.

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. Approved lung transplant facilities will be reimbursed a global fee for providing lung transplant services to Medicaid recipients.

C. Florida Medicaid will make payments for multi-visceral transplant and intestine transplants in Florida. AHCA 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. Approved intestinal/multivisceral transplant centers will be reimbursed with a global fee for providing intestinal/multivisceral transplants to Medicaid recipients.

E. Effective July 1, 2014, AHCA may establish a global fee for bone marrow transplants and the global fee payment shall be paid to approved bone marrow transplant providers that provide bone marrow transplants to Medicaid beneficiaries.

2. Tuberculosis Claims

In accordance with s. 409.908(1)(a) 2. F.S., AHCA has established 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, F.S. 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 s. 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. 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. 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. 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, F.S., Administrative Procedures Act, and 42 CFR 447.205, this plan shall be promulgated as an Administrative Rule and as such shall be made available for public inspection. A public hearing shall be held so that interested members of the public shall be afforded the opportunity to review and comment on this plan.

XII. 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. Definitions

A. Actual audited data or actual audited experience - Data reported to AHCA 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 AHCA or representatives under contract with AHCA.

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

C. AHCA - Agency for Health Care Administration.

D. Allowable costs - An item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with Generally Accepted Accounting Principles (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-6.020, 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 Rate Enhancement– 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 Reimbursement 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 eligibility changes.

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 AHCA 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, F.S., 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 Report Inpatient Medicaid Costs – the sum of Medicaid Inpatient Ancillary Costs + Medicaid Routine Costs + Medicaid Special Care Costs + Medicaid Newborn Routine Costs + Medicaid Intern and Resident in Non-Approved Program Costs.

U. 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.

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 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 inpatient days – The Florida Medicaid inpatient days only include covered Florida Medicaid hospital inpatient days (excluding any non-concurrent nursery days) as obtained from Medicaid fee-for-service paid claims data for the cost reporting period. The Florida Medicaid inpatient days exclude Medicaid managed care days, and concurrent nursery days, and non-concurrent nursery days.

CC. Florida Medicaid newborn inpatient days – The Florida Medicaid newborn inpatient days only include non-concurrent nursery days as obtained from Medicaid fee-for-service paid claims data for the cost reporting period.

DD. 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.

EE. 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.

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

GG. HHS - Department of Health and Human Services

HH. 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.

II. Cost report inpatient allowable costs – Total inpatient ancillary costs + total routine costs + total special care costs + newborn routine costs + total intern and resident costs in non-approved programs.

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

KK. Hospital inpatient days – Hospital inpatient days (excluding newborn inpatient days) + total sub-provider inpatient days.

LL. 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.

MM. 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.

NN. 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.

OO. 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.

PP. Marginal cost factor – used in calculation of outlier payments for inpatient claims priced via DRG method. Marginal cost factor is a percentage set by AHCA.

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

RR. Medicaid days - The number of actual days attributable to Medicaid patients as determined by AHCA.

SS. Medicaid Inpatient Adjustments (Indigent Care Assessment) – The inpatient adjustments (indigent care assessment) are zero if all indigent care assessment costs have already been excluded in the CMS 2552 cost report being used to calculate costs. If hospital indigent care assessment cost is included in the CMS 2552 cost report allowable cost, the Medicaid inpatient portion of the hospital indigent care assessment will be calculated based on the ratio of cost report inpatient Medicaid costs to cost report inpatient allowable costs.

TT. Medicaid inpatient ancillary costs – the allowable inpatient hospital ancillary costs apportioned to Medicaid on the CMS 2552 cost report; the sum of Medicaid Allowable Inpatient Hospital Ancillary Costs + Medicaid Allowable Sub-provider Inpatient Ancillary Costs.

UU. 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.

VV. Medicaid Inpatient Malpractice Insurance Costs – The Medicaid inpatient malpractice insurance cost is zero if all allowable malpractice insurance costs have already been included in the CMS 2552 cost report being used to calculate cost. If there is additional allowable hospital malpractice insurance costs not included in the CMS 2552 cost report allowable cots, the allowable hospital malpractice insurance costs will be apportioned to Medicaid in the ratio of Total Florida Medicaid Days to Total Hospital Days.

WW. Medicaid Intern and Resident Cost in Non- Approved Programs – Medicaid allowable hospital intern and resident cost related to non-approved programs.

XX. Medicaid Newborn Routine Costs – The sum of allowable nursery, newborn intensive care unit, and other newborn special care unit costs apportioned to Medicaid on the CMS 2552 cost report.

YY. Medicaid routine costs – the allowable hospital routine costs apportioned to Medicaid on the CMS 2552 cost report; the sum of Medicaid allowable Adults and Pediatrics Routine Costs + Medicaid Allowable Sub-provider Routine Costs.

ZZ. Medicaid Special Care Costs – The sum of allowable hospital intensive care unit, coronary care unit, burn intensive care unit, surgical intensive care unit, pediatric intensive care unit, and other pediatric special care unit costs apportioned to Medicaid on the CMS 2552 cost report.

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

BBB. Newborn inpatient days – Total nursery and neonatal intensive care unit days.

CCC. 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.

DDD. 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-6.020, F.A.C.

EEE. 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.

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

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

HHH. Provider Service Network (PSN) – is defined in section 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.

III. Rate Enhancement – 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.

JJJ. Rate semester - a rate semester will be from July 1 to June 30 of each year.

KKK. 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.

LLL. Rate Setting Unit Cost - The weighted average per diem after all rate reductions but prior to any buy backs based on filed 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.

MMM. 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.

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

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

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

1. The sole provider within a county with a population density of no greater than 100 persons per square mile; 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.

QQQ. Self-Funded Rate Enhancement- Transfer funds used to cover the difference between each hospital's CMS Upper Payment Limit (UPL) and Medicaid fee-for-service claim payments. Effective July 1, 2014, self-funded IGTs are no longer distributed with claim payments. They are distributed as part of the Low Income Pool (LIP) program.

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

SSS. 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.

TTT. 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.

UUU. 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).

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

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

XXX. Total allowable hospital fixed costs – Total allowable hospital fixed costs are based on the costs related to building, fixtures, and movable equipment as allocated to the hospital in the Medicaid version of the CMS 2552 cost report. Non-hospital fixed costs include but are not limited to skilled nursing facilities (SNF), nursing facilities (NF), home health agencies (HHA), community health centers (CMHC), rural health clinics (RHC), and hospice.

YYY. Total Florida Medicaid days – Florida Medicaid inpatient days + Florida Medicaid newborn inpatient days.

ZZZ. Total hospital charges – Total hospital charges include outpatient and inpatient charges and are based on the CMS 2552 cost report totals excluding non-hospital charges.

AAAA. Total hospital days – newborn inpatient days + hospital inpatient days.

BBBB. Total hospital outpatient ancillary costs – The total outpatient allowable costs are based on the ratio of total hospital outpatient charges to total hospital charges multiplied by total hospital ancillary costs, including applicable general service cost allocation, on the CMS 2552 cost report. The ratio is rounded to four decimal places.

CCCC. Total inpatient adjustments (Indigent Care Assessment) – The inpatient adjustments (indigent care assessment) are zero, if all indigent care assessment cost have already been excluded in the CMS 2552 cost report being used to calculate costs. The formula is as follows: Total inpatient adjustments (Indigent Care Assessment) = Cost report inpatient allowable costs/total hospital allowable costs x total indigent care assessment.

DDDD. Total inpatient allowable costs – Total inpatient allowable costs are based on the costs allocated to the hospital in the Medicaid version of the CMS 2552 cost report with adjustments for adding in malpractice (if not included in the CMS 2552) and removing the indigent tax assessment (if included in the CMS 2552). The formula is as follows: Total inpatient allowable costs = Cost report inpatient allowable costs – inpatient indigent care assessment cost adjustment + inpatient malpractice insurance costs.

EEEE. Total inpatient Medicaid costs – Total inpatient Medicaid costs are based on the costs apportioned to Medicaid in the Medicaid version of the CMS 2552 cost report with adjustments for adding in Medicaid's portion of total inpatient malpractice costs (if not reported in the CMS 2552) and removing Medicaid's portion of the total inpatient adjustments for the indigent care assessment (if reported in the CMS 2552).

FFFF. Total Inpatient Medicaid Costs – the sum of Cost Report Inpatient Medicaid Costs – Medicaid Inpatient Adjustments (Indigent Care Assessments) + Medicaid Inpatient Malpractice Insurance Costs. Total inpatient charges - Total patient revenues assessed for all inpatient services.

GGGG. Total intern and resident costs in non-approved programs – Total allowable hospital intern and resident cost related to non-approved programs, including applicable general service cost allocation, as reported on the CMS 2552 cost report.

HHHH. Total inpatient malpractice insurance costs – The total inpatient malpractice insurance cost is zero if all allowable malpractice insurance cost has already been included in the CMS 2552 cost report being used to calculate cost. If there is additional allowable hospital malpractice insurance costs not included in the CMS 2552 cost report allowable cost, the inpatient portion of the allowable hospital malpractice insurance cost will be calculated using a ratio of hospital inpatient allowable costs to total hospital allowable costs. The formula is as follows: Total inpatient malpractice insurance costs = -cost report inpatient allowable costs/total hospital allowable costs x total additional allowable malpractice insurance costs.

IIII. Total Medicaid Fixed Costs –the sum of Total Hospital Medicaid Charges/Total Hospital Inpatient Charges x Total Allowable Hospital Fixed Costs.

JJJJ. Total newborn routine costs – the sum of total allowable nursery, newborn intensive care unit, and other newborn special care unit costs, including applicable general service cost allocation, as reported on the CMS 2552 cost report.

KKKK. Total outpatient allowable costs – total outpatient allowable costs are based on outpatient costs, including applicable general service cost allocation, on the CMS 2552 cost report. The outpatient allowable costs exclude Medicaid outpatient lab cost and observation costs.

LLLL. Total routine costs – the sum of Total allowable adults and pediatrics routine costs (net of swing-bed costs) + total allowable sub-provider routine costs (psychiatric and rehab).

MMMM. Total special care costs – the sum of total allowable intensive care unit, coronary care unit, burn intensive care unit, surgical intensive care unit, pediatric intensive care unit, other pediatric special care unit, and ambulance costs, including the applicable general service cost allocation, as

reported on the CMS 2552 cost report. Total allowable organ acquisition costs are also included in special care costs to the extent the organ acquisitions are related to organs not included under the global fee.

NNNN. 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, 1996 then its midpoint is May 31, and the applicable inflation is:

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

Therefore, the 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

Upper Payment Limit (UPL) Methodology

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

In general, the UPL analysis involves estimating Medicare payment for a set of Medicaid claims and comparing those payments to actual payments made by Medicaid. The claim data and hospital Medicare cost data are aligned so that they are from the same time frame. In addition, inflation factors are applied as appropriate to make payment and cost amounts comparable under the same time frame. Also if appropriate, other adjustments may be made to the baseline claim data to align with Medicaid program changes that have occurred between the timeframe of the baseline claim data and the UPL rate year.

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

Florida Medicaid Hospital Inpatient UPL Analysis Method

The analysis uses hospital cost as the proxy for the upper payment limit and compares Medicaid payment to hospital cost. Historical claims with admission dates that align to each hospital's fiscal year as reported in the hospital's cost report are used for the analysis. The timeframe for the extract claims is referred to as the "base" year and varies by hospital depending on the hospital's fiscal year. In contrast, the "rate" year, is the state fiscal year for which the UPL analysis is performed.

The calculations for Medicaid payment and hospital cost are performed differently for the state-owned psychiatric hospitals than for all other hospitals. Medicaid payment is calculated differently for the state-owned psychiatric facilities because they are paid via a per diem while all other inpatient facilities are paid via a DRG methodology. Also, hospital cost is calculated differently for the state-owned psychiatric facilities because their filed charges generally equal the payment amount, so an application of cost-to-charge ratio to filed charges does not generate an accurate picture of hospital cost.

DRG Hospitals

SFY 2013/2014 is the first year of DRG pricing of inpatient claims by Florida Medicaid. Thus, starting with the UPL analysis for SFY 2013/2014, Medicaid payment is calculated by re-pricing historical claims using the rates and DRG pricing rules defined for the UPL rate year.

Hospital cost is calculated by first determining a Florida Medicaid cost-to-charge ratio for each hospital for the base year. The applicable cost-to-charge ratio is then multiplied by filed charges to get hospital cost for each claim for the base year. An inflation factor is then applied to estimate hospital cost in the rate year.

Medicaid payment and hospital cost determined for each claim is summed by category of provider to get the UPL amount for the three UPL categories, state-owned, non-state government owned, and privately owned (all others).

Non-DRG Hospitals (State-Owned Psychiatric Facilities)

For the state-owned psychiatric facilities, Medicaid payment is calculated by multiplying each hospital's rate year per diem times the number of Medicaid covered days in the base year claims.

Hospital cost is calculated by multiplying each hospital's rate year full cost per diem times the number of Medicaid covered days in the base year claims.

Source of Hospital Cost Data

The cost-to-charge ratios and full cost per diems used for the calculation of the upper payment limit are retrieved from AHCA per diem rate worksheets. These per diem rate worksheets are derived from the cost reports received by AHCA by April 15th, two and a half months prior to the start of the state fiscal year (which is also the UPL rate year).

From the per diem rate worksheets, the specific cells used to calculate a hospital's cost-to-charge ratio depend on the number of Medicaid covered days identified in the hospital's cost report. If the number of Medicaid inpatient days is greater than or equal to two hundred (200), then Medicaid inpatient cost and charges are used. Medicaid inpatient cost is retrieved from cell C9 and Medicaid inpatient charges are retrieved from cell C10. If on the other hand, the number of Medicaid inpatient days is less than two hundred (200), then total hospital inpatient cost and charges are used. Total hospital inpatient cost is retrieved from cell A9 and total hospital inpatient charges are retrieved from cell A10.

From the per diem rate worksheets, the specific cell used to retrieve the inpatient full cost per diems is in the inpatient column on row AP, which is labeled "Total Rate Based On Medicaid Cost Data (AP=AM+AN)."

Full hospital inpatient cost is retrieved from the cost report using the following process:

1. All costs are summed from Worksheet C, Part I Column 1, lines 30 – 46 (Inpatient Routine Service Cost Centers). It provides for the apportionment of total inpatient operating costs, including routine, special care, newborn routine and less non-allowable services, i.e. SNF, RHC, FQHC

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

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

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

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

5. Cost from steps 1 and 4 are summed.

Medicaid hospital inpatient cost is retrieved from the cost report using the following process:

1 All Medicaid costs are summed from Worksheet D-1, Part II, line 41, column 5, line 42 – 47, and line 48. It provides for the apportionment of total Medicaid inpatient operating costs, including routine, special care, newborn routine and ancillary.

2. The Hospital Assessment imposed by section 154.35 Florida Statutes is a non-allowable cost for Medicaid reimbursement. The portion that is applied to inpatient is removed from the Total Medicaid Cost

3. Allowable Medicaid cost equals cost identified in step 1 minus cost identified in step 2.

Full hospital charges are retrieved from the cost report using the following process:

1. Total inpatient charges are taken from Worksheet G-2, Part I & II, Column 1, line 28 (charges from non-applicable services are excluded; i.e. RHC, FQHC, Hospice HHA and any other non-hospital services)

Medicaid hospital charges are retrieved from the cost report using the following process:

1. Medicaid inpatient charges are taken from Worksheet E-3, Part VII, Title XIX, Column 1, line 12.

Medicaid inpatient days are retrieved from the cost report using the following process:

1. Medicaid inpatient days are taken from Worksheet S-3, Part I, Column 7, line 12, less nursery days (line 13), plus Sub-providers, if applicable.

Source of Medicaid Claim Data

Medicaid claims data used in UPL demonstrations is extracted from a data warehouse fed from the Florida MMIS. For each hospital, claims are selected if they contain a date of service within the base year. The claim date of service used is admission date for all claims paid via DRG. First date of service is used instead of admission date for claims from the state psychiatric facilities because many of the stays span fiscal years.

The base year is the timeframe of the most current hospital cost report received by AHCA by April 15th of each year, two and a half months prior to the start of the state fiscal year. The timeframes of the cost reports align with hospital fiscal years. Different hospitals may have different fiscal years, so the timeframe of claims selected for a UPL may vary by hospital.

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

In addition, only Medicaid fee-for-service claims are included in the claims extract. Medicare crossover claims and Medicaid managed care encounter claims are excluded. Also, all recipients are included, independent of place of residence. However, only services payable by Florida Medicaid are included, as only paid claims are included.

Source of Medicaid Per Diem Data

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

Calculation of Upper Payment Limit

Hospital cost is used as the proxy for the upper payment limit. As described below, hospital cost is calculated differently for DRG reimbursed hospitals and for the state-owned psychiatric hospitals. Hospital cost is calculated differently for the state-owned psychiatric facilities because of their practice of setting filed charges equal to the payment amount. With this billing practice, an application of cost-to-charge ratio to filed charges does not generate an accurate picture of hospital cost.

DRG Reimbursed Hospitals

For DRG reimbursed hospitals, the upper payment limits for each of the three UPL categories are calculated using an estimate of hospital cost. Hospital cost is calculated on a claim by claim basis by multiplying filed charges times the hospital's applicable cost-to-charge ratio. Costs are then summed by hospital, inflated from the base year to the rate year, and then summed by UPL category.

Cost-to-charge ratios are calculated based on data from each hospital's most recently filed cost report. The timeframes of the cost reports determine which claims are selected for each hospital. This ensures the cost-to-charge ratio is applicable for the claims used in the UPL analysis. To calculate hospital cost on each claim, the filed charges are multiplied by the cost-to-charge ratio.

As a final step, hospital costs are inflated from the midpoint of each hospital's fiscal year (i.e. the base year) to the midpoint of the rate year. The inflation multiplier is calculated as a ratio of the IHS Global Insight Hospital Market Basket inflation factor from the midpoint of rate year divided by the inflation factor for the midpoint of base year.

Non-DRG Hospitals (State-Owned Psychiatric Facilities)

For the state-owned psychiatric facilities, hospital cost is calculated by multiplying each hospital's rate year full cost per diem times the number of Medicaid covered days in the base year claims. Full cost per

diems are calculated by AHCA annually as part of the inpatient per diem rate setting process, and are based on data included in Medicare cost reports, or in some cases, in Medicaid-specific cost reports, filed by hospitals to AHCA. Final Medicaid inpatient per diems differ from the full cost per diems because of a variety of rate cuts and rate ceilings which reduce the per diems along with rate-cut buy-backs made by some hospitals which increase per diems. Each hospital's final Medicaid inpatient per diem is never more than the hospital's full cost per diem.

Because rate year per diems are used, costs calculated for the state-owned psychiatric facilities are not inflated forward.

Calculation of Medicaid Payment

DRG Reimbursed Hospitals

Medicaid payment for DRG reimbursed hospitals is calculated by re-pricing the base year claims using rate year rates and pricing rules. Because rate year DRG rates are used, Medicaid payments are not inflated forward.

Non-DRG Hospitals (State-Owned Psychiatric Facilities)

For the state-owned psychiatric facilities, Medicaid payment is calculated by multiplying each hospital's rate year per diem times the number of Medicaid covered days in the base year claims. Because rate year per diem rates are used, Medicaid payments are not inflated forward.

Comparison of Medicaid Payment to Upper Payment Limit

Final comparison of Florida Medicaid payments to the upper payment limits is performed by grouping each provider into one of the three UPL categories and summing the dollar amounts for each provider within a UPL category. In-state hospitals are assigned to a UPL category based on a mapping of the thirteen provider categories included in the HCRIS data to the three UPL categories. This mapping is shown below:

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

	11='11 - Governmental, Hospital District'
	12='12 - Governmental, City'
	13='13 - Governmental, Other'

APPENDIX C 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.

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

- Claim Payment = DRG Base Payment + Outlier Payment + Automatic Rate Enhancement
  + Trauma Supplemental 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
- For transfer claims, Transfer Base Payment = (DRG Base Payment / ALOS) * (1 + Covered Days)
- For non-covered days and charge cap, Adjusted Payment = (DRG Base Payment * Proration Factor)
  + (Outlier Payment * Proration Factor)
  + Automatic Rate Enhancement Payment
  + Trauma Supplemental Payment

In all the examples below the following parameters are used:

- Provider base rate = $3,000.
- APR-DRG 302-2 (knee joint replace), which has a Florida Medicaid re-centered relative weight of 2.1852 and average length of stay (ALOS) equal to 3.30.
- Hospital-specific cost-to-charge ratio is 38.356%.
- Hospital case mix is 1.6292.

- Hospital average per discharge automatic rate enhancement add on payment is $3,780.07. Case mix adjusted, this value is ($3,780.07 * (2.1852 / 1.6292)) = $5,070.10.
- Trauma Supplemental Payment percentage is 11% - trauma level II hospital
- Outlier loss threshold is $60,000.
- Outlier marginal cost factor is 60%.

Basic example:

Filed Charge	$34,000.00
Provider CCR	38.356%
DRG Relative Weight	2.1852
Max Policy Adjustor	1.0
Provider Base Rate	$3,000.00
Outlier Threshold	$60,000
Marginal Cost Percentage	60%
DRG Base Payment	$6,555.60
Estimated Hospital Cost	$13,041.04
Estimated Loss	$6,485.44
Loss Above Threshold	$0
Outlier Payment	$0
Automatic Rate Enhancement	$5,070.10
Trauma Supplemental	$721.12
Claim Payment	$12,346.82

Outlier example:

Filed Charge	$240,000.00
Provider CCR	38.356%
DRG Relative Weight	2.1852
Max Policy Adjustor	1.0
Provider Base Rate	$3,000.00
Outlier Threshold	$60,000
Marginal Cost Percentage	60%
DRG Base Payment	$6,555.60
Estimated Hospital Cost	$92,054.40
Estimated Loss	$85,498.80
Loss Above Threshold	$25,498.80
Outlier Payment	$15,299.28
Automatic Rate Enhancement	$5,070.10
Trauma Supplemental	$721.12
Claim Payment	$27,646.10

Maximum policy adjustor example:

Filed Charge	$40,000.00
Provider CCR	38.356%
DRG Relative Weight	2.1852
Service Adjustor	1.30
Age Adjustor	1.00
Provider Adjustor	2.027
Max Policy Adjustor	2.027
Provider Base Rate	$3,000.00
Outlier Threshold	$60,000
Marginal Cost Percentage	60%
DRG Base Payment	$13,288.20
Estimated Hospital Cost	$15,342.40
Estimated Loss	$2,054.20
Loss Above Threshold	$0
Outlier Payment	$0
Automatic Rate Enhancement	$5,070.10
Trauma Supplemental	$1,461.70
Claim Payment	$19,820.00

Transfer example:

Filed Charge	$34,000.00
Provider CCR	38.356%
Length of Stay	1
Discharge status	02
DRG Relative Weight	2.1852
DRG Avg Length of Stay	3.30
Max Policy Adjustor	1.0
Provider Base Rate	$3,000.00
Outlier Threshold	$60,000
Marginal Cost Percentage	60%
DRG Base Payment	$6,555.60
Transfer Base Payment	$3,973.09
Lessor of DRG and Transfer	$3,973.09
Estimated Hospital Cost	$13,041.04
Estimated Loss	$9,067.95
Loss Above Threshold	$0
Outlier Payment	$0
Automatic Rate Enhancement	$5,070.10
Trauma Supplemental	$437.04
Claim Payment	$9,480.23

Non-covered day example:

Filed Charge	$34,000.00
Provider CCR	38.356%
DRG Relative Weight	2.1852
Length of Stay	5
Covered Days	2
Max Policy Adjustor	1.0
Provider Base Rate	$3,000.00
Outlier Threshold	$60,000
Marginal Cost Percentage	60%
DRG Base	$6,555.60
Estimated Hospital Cost	$13,041.04
Estimated Loss	$6,485.44
Loss Above Threshold	$0
Outlier Payment	$0
Adjusted DRG Payment:	
Non-covered Day Proration Factor	0.4000
DRG Base	$2,622.24
Outlier Payment	$0.00
Automatic Rate Enhancement	$5,070.10
Trauma Supplemental	$721.12
Claim Payment	$8,413.46

Charge cap example:

Filed Charge	$5,000.00
Provider CCR	38.356%
DRG Relative Weight	2.1852
Max Policy Adjustor	1.0
Provider Base Rate	$3,000.00
Outlier Threshold	$60,000
Marginal Cost Percentage	60%
DRG Base	$6,555.60
Estimated Hospital Cost	$1,917.80
Estimated Loss	$0
Loss Above Threshold	$0
Outlier Payment	$0
Adjusted DRG Payment:	
Charge Cap Proration Factor	0.762707
DRG Base	$5,000.00
Outlier Payment	$0.00
Automatic Rate Enhancement	$5,070.10
Trauma Supplemental	$721.12
Claim Payment	$10,791.22

APPENDIX D TO FLORIDA TITLE XIX INPATIENT HOSPITAL REIMBURSEMENT PLAN

Certified Public Expenditures (CPE) Protocol Methodology

The Florida Medicaid Agency uses the CMS 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 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. AHCA will use the protocol below.

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.

APPENDIX E TO FLORIDA TITLE XIX INPATIENT HOSPITAL REIMBURSEMENT PLAN

Calculation Examples of Allowable Cost for Per Diem Rate-Setting

The examples included in this appendix relate to the allowable cost used in the hospital inpatient per-diem rate-setting as described in sections III and V of this plan. These examples do not apply to inpatient services paid under the DRG-based methodology described in section IV of this plan.

Please note, the examples shown in this appendix are for illustrative purposes only and do not necessarily indicate every worksheet, line, or column on the CMS 2552 cost report to be used in a given calculation. The example lines are based on one version of the 2552-96 CMS cost report and do not attempt to cover every scenario of cost reporting that could occur. Equivalent worksheets, lines, and columns will be used in other versions of the CMS 2552 cost report.

Total Hospital Charges Example

	Description	Amount	CMS 2552-96
1.	Total Outpatient Charges:	$50,000,000	W/S G-2, Pt. I, Line 25, Col. 2
2.	Less Skilled Nursing Facility:	$1,000,000	W/S G-2, Pt. I, Line 6, Col. 2
3.	Less Home Health Agency:	$1,000,000	W/S G-2, Pt. 1, Line 19, Col. 2
4.	Total Hospital Outpatient Charges:	$48,000,000	Line 1 less Lines 2 and 3, in this example
5.	Total Inpatient Charges:	$100,000,000	W/S G-2, Pt. I, Line 25, Col. 1
6.	Less Skilled Nursing Facility:	$5,000,000	W/S G-2, Pt. I, Line 6, Col. 1
7.	Less Home Health Agency:	$5,000,000	W/S G-2, Pt. 1, Line 19, Col. 1
8.	Total Hospital Inpatient Charges:	$90,000,000	Line 5 less Lines 6 and 7, in this example
9.	Total Hospital Charges:	$138,000,000	Line 4 plus Line 8, in this example

Total Hospital Outpatient Ancillary Costs Example

	Description	Amount	CMS 2552-96
1.	Total Hospital Outpatient Charges:	$48,000,000	See above
2.	Total Hospital Charges:	$138,000,000	See above
3.	Outpatient Charge Ratio:	0.3478	Line 1 / Line 2, in this example
4.	Multiplied by Total Hospital Ancillary Costs:	$30,665,440	Medicaid W/S C, Pt. I, Sum of Lines 37 through 59.99, Col. 1
5.	Total Hospital O/P Ancillary Costs:	$10,665,440	Line 3 multiplied by Line 4, in this example

Total Outpatient Allowable Costs Example

	Description	Amount	CMS 2552-96
1.	Total Hospital O/P Ancillary Costs:	$10,665,440	See above
2.	Plus Other Hospital O/P Costs:	$2,804,560	Medicaid W/S C, Pt. I, Sum of Lines 60 through 62.99, Col. 1
3.	Less Medicaid O/P Lab Cost:	$70,000	Medicaid W/S D, Pt. V, Sum of Lines 44 through 44.99, Col. 9
4.	Less Observation Costs:	$200,000	Medicaid W/S C, Pt. I, Sum of Lines 62 through 62.99, Col. 1
5.	Total Outpatient Allowable Costs:	$13,200,000	Line 1 Plus Line 2 Less Lines 3 and 4, in this example

Florida Medicaid Inpatient Days

	Description	Days	CMS 2552-96
1.	Medicaid Hospital Inpatient Days Excluding Newborn and HMO:	2,000	W/S S-3, Pt. I, Col. 5, Line 12, less Line 11, less Line 2
2.	Plus Medicaid Sub-Provider Inpatient Days:	200	W/S S-3, Pt. I, Col. 5, Line 14 + Line 14.01
3.	Florida Medicaid Inpatient Days:	2,200	Sum of Lines 1 and 2, in this example

Florida Medicaid Newborn Inpatient Days Example Plan

	Description	Days	CMS 2552-96
1.	Medicaid Non-Concurrent Nursery Days:	2,000	Reported Separately by Hospitals

Total Florida Medicaid Days Example

	Description	Days	CMS 2552-96
1.	Florida Medicaid Inpatient Days:	2.200	See section above
2.	Plus Florida Medicaid Newborn Inpatient Days:	2,000	See section above
3.	Total Florida Medicaid Days:	4,200	Sum of Lines 1 and 2, in this example

Newborn Inpatient Days Example

	Description	Days	CMS 2552-96
1.	Nursery Inpatient Days:	15,000	W/S S-3, Pt. I, Col. 5, Line 11
2.	Plus Neonatal Intensive Care Unit Inpatient Days:	3,000	W/S S-3, Pt. I, Col. 5, Line 9.01
3.	Newborn Inpatient Days	18,000	Sum of Lines 1 and 2, in this example

Hospital Inpatient Days Example

	Description	Days	CMS 2552-96
1.	Total Hospital Inpatient Days excluding Newborn:	15,000	W/S S-3, Pt. I, Col. 5, Line 12, less Lines 2, 9.01, and 11
2.	Plus Total Sub-Provider Inpatient Days:	600	W/S S-3, Pt. I, Col. 5, Line 14 + Line 14.01
3.	Hospital Inpatient Days:	15,600	Sum of Lines 1 and 2, in this example

Total Hospital Days Example

	Description	Days	CMS 2552-96
1.	Newborn Inpatient Days:	18,000	See above
2.	Plus Hospital Inpatient Days:	15,600	See above
3.	Total Hospital Days	33,600	Sum of Lines 1 and 2, in this example

Total Inpatient Ancillary Costs Example

	Description	Amount	CMS 2552-96
1.	Total Hospital Ancillary Costs:	$30,665,440	Medicaid W/S C, Pt. I, Sum of Lines 37 through 59.99, Col. 1
2.	Less Total Hospital O/P Ancillary Costs:	$10,665,440	See above
3.	Total Inpatient Ancillary Costs:	$20,000,000	Line 1 less Line 2, in this example

Total Routine Costs Example

	Description	Amount	CMS 2552-96
1.	Adults & Pediatrics Routine Costs:	$9,000,000	Medicaid W/S C, Pt. I, Col. 1, Line 25 or Medicaid D-1, Pt. I, Col. 1, Line 27 (if swing-bed exists)
2.	Plus Sub-Provider Routine Costs:	$1,000,000	Medicaid W/S C, Pt. I, Sum of Lines 31 through 31.99, Col. 1
3.	Total Routine Costs:	$10,000,000	Line 1 plus Line 2, in this example

Total Special Care Costs Example

	Description	Amount	CMS 2552-96
1.	Intensive Care Unit Routine Costs:	$1,100,000	Medicaid W/S C, Pt. I, Sum of Lines 26 through 26.99, Col. 1
2.	Plus Coronary Care Unit Routine Costs:	$700,000	Medicaid W/S C, Pt. I, Sum of Lines 27 through 27.99, Col. 1
3.	Plus Burn ICU Routine Costs:	$200,000	Medicaid W/S C, Pt. I, Sum of Lines 28 through 28.99, Col. 1
4.	Plus Surgical ICU Routine Costs:	$500,000	Medicaid W/S C, Pt. I, Sum of Lines 29 through 29.99, Col. 1
5.	Plus Pediatric ICU Routine Costs:	$300,000	Medicaid W/S C, Pt. I, Line 30.00, Col. 1
6.	Plus Pediatric Surgical ICU Routine Costs:	$200,000	Medicaid W/S C, Pt. I, Line 30.01, Col. 1
7.	Plus Ambulance Costs:	$500,000	Medicaid W/S C, Pt. I, Line 65, Col. 1
8.	Total Special Care Costs:	$ 3,500,000	Sum of Lines 1 through 7, in this example

Total Newborn Routine Costs Example

	Description	Amount	CMS 2552-96
1.	Nursery Routine Costs:	$500,000	Medicaid W/S C, Pt. I, Line 33, Col. 1
2.	Plus Newborn ICU Routine Costs:	$1,200,000	Medicaid W/S C, Pt. I, Line 30.02, Col. 1
3.	Plus Newborn SCU Routine Costs:	$800,000	Medicaid W/S C, Pt. I, Line 30.03, Col. 1
4.	Total Newborn Routine Costs:	$2,500,000	Sum of Lines 1 through 3, in this example

Total Intern and Resident Costs in Non-Approved Programs Example

	Description	Amount	CMS 2552-96
1.	I&R Costs in Non-Approved Programs:	$800,000	W/S B, Pt. I, Line 70, Col. 27

Cost Report Inpatient Allowable Costs Example

	Description	Amount	Source
1.	Total I/P Ancillary Costs:	$20,000,000	See above
2.	Plus Total Routine Costs:	$10,000,000	See above
3.	Plus Total Special Care Costs:	$3,500,000	See above
4.	Plus Total Newborn Routine Costs:	$2,500,000	See above
5.	Plus Total I&R In Non-Approved Program Costs:	$800,000	See above
6.	Cost Report Inpatient Allowable Costs:	$36,800,000	Sum of Lines 1 through 5, in this example

Total Inpatient Adjustments (Indigent Care Assessment) Example

	Description	Amount	Source
1.	Cost Report Inpatient Allowable Costs:	$36,800,000	See above
2.	Plus Outpatient Allowable Costs	$13,200,000	See above
3.	Total Hospital Allowable Costs:	$50,000,000	Sum of Lines 1 and 2, in this example
4.	Inpatient Allowable Cost Ratio:	0.7360	Line 1 Divided by Line 3, in this example
5.	Multiplied by Total Indigent Care Assessment:	$815,217	Reported Separately by Hospital
6.	Total Inpatient Adjustments:	$600,000	Line 4 Multiplied by Line 5, in this example

Total Inpatient Malpractice Insurance Costs Example

Note: Example calculation only applies to malpractice insurance cost excluded from the CMS 2552 cost report.

	Description	Amount	Source
1.	Cost Report Inpatient Allowable Costs:	$36,800,000	See above
2.	Plus Outpatient Allowable Costs	$13,200,000	See above
3.	Total Hospital Allowable Costs:	$50,000,000	Sum of Lines 1 and 2, in this example
4.	Inpatient Allowable Cost Ratio:	0.7360	Line 1 Divided by Line 3, in this example
5.	Multiplied by Total Additional Malpractice Insurance Costs:	$1,086,957	Reported Separately by Hospital
6.	Total Inpatient Malpractice Insurance Costs:	$800,000	Line 4 Multiplied by Line 5, in this example

Total Inpatient Allowable Costs Example

	Description	Amount	Source
1.	Cost Report Inpatient Allowable Costs:	$36,800,000	See above
2.	Less Total I/P Adjustments (Indigent Care Assessment):	$ 600,000	See above
3.	Plus Total I/P Malpractice Insurance Costs:	$ 800,000	See above
4.	Total Inpatient Allowable Costs:	$37,000,000	Line 1 Less Line 2 Plus Line 3, in this example

Total Allowable Hospital Fixed Costs Example

	Description	Amount	CMS 2552-96
1.	Total Old Capital Costs:	$1,315,000	W/S B, Pt. II, Line 95, Col. 4a
2.	Less SNF Capital Costs:	$10,000	W/S B, Pt. II, Line 34, Col. 4a
3.	Less HHA Capital Costs:	$5,000	W/S B, Pt. II, Sum of Lines 71 through 71.99, Col. 4a
4.	Total Allowable Old Capital Costs:	$1,300,000	Line 1 Less Lines 2 and 3, in this example
5.	Total New Capital Costs:	$4,220,000	W/S B, Pt. III, Line 95, Col. 4a
6.	Less SNF New Capital Costs:	$10,000	W/S B, Pt. III, Line 34, Col. 4a
7.	Less HHA New Capital Costs:	$10,000	W/S B, Pt. III, Sum of Lines 71 through 71.99, Col. 4a
8.	Total Allowable New Capital Costs:	$4,200,000	Line 5 Less Lines 6 and 7, in this example
9.	Total Allowable Hospital Fixed Costs:	$5,500,000	Line 4 Plus Line 8, in this example

Medicaid Inpatient Ancillary Costs Example

	Description	Amount	CMS 2552-96
1.	Medicaid I/P Hospital Ancillary Costs:	$2,000,000	Hospital Medicaid W/S D-1, Part II, Line 48 , Col. 1
2.	Plus Medicaid I/P Sub-Provider Ancillary Costs:	$100,000	Sum of Sub-Providers' Medicaid W/S D-1, Part II, Line 48 , Col. 1
3.	Medicaid I/P Ancillary Costs:	$2,100,000	Line 1 Plus Line 2, in this example

Medicaid Routine Costs Example

	Description	Amount	CMS 2552-96
1.	Medicaid Adults & Pediatrics Routine Costs:	$1,000,000	Hospital Medicaid W/S D-1, Part II, Line 41, Col. 1
2.	Plus Medicaid Sub-Provider Routine Costs:	$200,000	Sum of Sub-Providers' Medicaid W/S D-1, Part II, Line 41, Col. 1
3.	Medicaid Routine Costs:	$1,200,000	Line 1 Plus Line 2, in this example

Medicaid Special Care Costs Example

	Description	Amount	CMS 2552-96
1.	Medicaid ICU Routine Costs:	$100,000	Medicaid W/S D-1, Part II, Line 43, Col. 5
2.	Plus Medicaid CCU Routine Costs:	$100,000	Medicaid W/S D-1, Part II, Line 44, Col. 5
3.	Plus Medicaid Burn ICU Routine Costs:	$25,000	Medicaid W/S D-1, Part II, Line 45, Col. 5
4.	Plus Medicaid Surgical ICU Routine Costs:	$35,000	Medicaid W/S D-1, Part II, Line 46, Col. 5
5.	Plus Medicaid Pediatric ICU Routine Costs:	$75,000	Medicaid W/S D-1, Part II, Line 47, Col. 5
6.	Plus Medicaid Pediatric Surgical ICU Routine Costs:	$65,000	Medicaid W/S D-1, Part II, Line 47.01, Col. 5
7.	Medicaid Special Care Costs:	$ 400,000	Sum of Lines 1 through 6, in this example

Medicaid Newborn Routine Costs Example

	Description	Amount	CMS 2552-96
1.	Medicaid Nursery Routine Costs:	$200,000	Medicaid W/S D-1, Part II, Line 42, Col. 5
2.	Plus Medicaid Newborn ICU Routine Costs:	$300,000	Medicaid W/S D-1, Part II, Line 47.02, Col. 5
3.	Plus Medicaid Newborn SCU Routine Costs:	$200,000	Medicaid W/S D-1, Part II, Line 47.03, Col. 5
4.	Medicaid Newborn Routine Costs:	$700,000	Sum of Lines 1 through 3, in this example

Medicaid Intern and Resident Costs in Non-Approved Programs Example

	Description	Amount	CMS 2552-96
1.	I&R Costs in Non-Approved Programs:	$50,000	W/S D-2, Col. 10, Line 9

Cost Report Inpatient Medicaid Costs Example

	Description	Amount	Source
1.	Medicaid I/P Ancillary Costs:	$2,100,000	See above
2.	Plus Medicaid Routine Costs:	$1,200,000	See above
3.	Plus Medicaid Special Care Costs:	$400,000	See above
4.	Plus Medicaid Newborn Routine Costs:	$700,000	See above
5.	Plus Medicaid I&R In Non-Approved Program Costs:	$50,000	See above
6.	Cost Report Inpatient Medicaid Costs:	$4,450,000	Sum of Lines 1 through 5, in this example

Medicaid Inpatient Adjustments (Indigent Care Assessment) Example

	Description	Amount	Source
1.	Cost Report I/P Medicaid Costs:	$4,450,000	See above
2.	Divided by Cost Report I/P Allowable Costs:	$36,800,000	See above
3.	Multiplied by Total Inpatient Adjustments:	$600,000	See above
4.	Medicaid Inpatient Adjustments:	$72,554	Line 1 Divided by Line 2 Multiplied by Line 3, in this example

Medicaid Inpatient Malpractice Insurance Costs Example

Note: Example calculation only applies to malpractice insurance cost excluded from the CMS 2552 cost report.

	Description	Amount	Source
1.	Total Florida Medicaid Inpatient Days:	4,200	See above
2.	Divided by Total Hospital Inpatient Days:	33,600	See above
3.	Multiplied by Total I/P Malpractice Insurance Costs:	$800,000	See above
4.	Medicaid I/P Malpractice Insurance Costs:	$100,000	Line 1 Divided by Line 2 Multiplied by Line 3, in this example

Total Inpatient Medicaid Costs Example

	Description	Amount	Source
1.	Cost Report Inpatient Medicaid Costs:	$4,450,000	See above
2.	Less Medicaid I/P Adjustments (Indigent Care Assessment):	$ 72,554	See above
3.	Plus Medicaid I/P Malpractice Insurance Costs:	$ 100,000	See above
4.	Total Inpatient Medicaid Costs:	$4,477,446	Line 1 Less Line 2 Plus Line 3, in this example

Total Medicaid Fixed Costs Example

	Description	Amount	CMS 2552-96
1.	Total Hospital Medicaid Charges:	$15,000,000	W/S E-3, Pt. III, Line 16 Col. 1 (Hospital and Sub-Providers)
2	Less Total Hospital O/P Medicaid Ancillary Charges:	$2,500,000	Medicaid W/S D, Pt. V, Line 104, Col. 5
3.	Total Hospital Inpatient Medicaid Charges:	$12,500,000	Line 1 Less Line 2, in this example
4.	Divided by Total Hospital Inpatient Charges:	$ 90,000,000	See above
5.	Multiplied by Total Allowable Hospital Fixed Costs:	$5,500,000	See above
6.	Total Medicaid Fixed Costs:	$763,889	Line 3Divided by Line 4 Multiplied by Line 5, in this example

Acronyms / Abbreviations Used

Col. = Column
W/S = Worksheet
I/P = Inpatient
O/P = Outpatient

FTLDOCS 6926811 2