The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.
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-6.010, Florida Administrative Code (F.A.C.) effective July 1, 2014.

D. The cost report shall be prepared in accordance with generally accepted accounting principles and the methods 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-6.010, 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-6.010, F.A.C. For the purposes of this plan, filing a final cost report is not required when:

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

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

G. All Medicaid participating hospitals are required to maintain the Florida Medicaid Log and financial and statistical records in accordance with 42 CFR 413.24 (a)-(c). In addition, for hospitals paid via a per diem method, a separate log shall be maintained to account for concurrent and non-concurrent nursery days. For purposes of this plan, statistical records shall include beneficiaries' medical records. These records shall be available upon demand to representatives, employees or contractors of AHCA, the Auditor General of the State of Florida, the General Accounting Office (GAO) or the United States Department of Health and Human Services (HHS). Beneficiaries' medical records shall be released to the above named persons for audit purposes upon proof of a beneficiary's consent to the release of medical records such as the Medicaid Consent Form, AHCA-Med Form 1005.

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

I. AHCA shall retain all uniform cost reports 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.).

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. Desk review/audit cost reports during the period between cost report receipts.

4. 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.;

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

7. 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), Florida Statutes. 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, Florida Statutes.

4. The exclusive means to challenge a written notice of an audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care for the purpose of correcting or adjusting such rate before, on, or after July 1, 2016, or to challenge the methodologies set forth in the rules of AHCA and in reimbursement plans incorporated by reference therein used to calculate the reimbursement rate for inpatient and outpatient care is through an administrative proceeding pursuant to chapter 120.

5. Any challenge to the methodologies set forth in the rules of AHCA and in reimbursement plans incorporated by reference therein used to calculate the reimbursement rate for inpatient and outpatient care may not result in a correction or an adjustment of a reimbursement rate for a rate period that occurred more than 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, 2016.

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 XLI 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-6.010, F.A.C., and as further modified by Title XIX of the Social Security Act (the Act), this plan, requirements of licensure and certification, and the duration and scope of benefits provided under the Florida Medicaid Program. These include:

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 Chapter 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 Quality Improvement Organization (QIO) 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, Florida Statutes, shall not be considered an allowable Medicaid cost and shall not be allocated as a Medicaid allowable cost for purposes of cost reporting.

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. Services that are paid in addition to the DRG reimbursement can be found in the Inpatient Hospital Services Coverage Policy.

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, services paid for in addition to the DRG reimbursement, services for recipients with tuberculosis that are 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.
- Services that can be reimbursed in addition to DRG-based payment are specified in the Inpatient Hospital Services Coverage Policy.
- Services for recipients with tuberculosis that are 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 hospitals stays. For use with Florida Medicaid, the national relative weights are re-centered to the Florida Medicaid population. Re-centering the weights involves dividing each DRG’s national relative weight by the average APR-DRG relative weight for a set of Florida Medicaid claims. The result of the re-centering process is a set of weights in which the average relative weight for a Florida Medicaid inpatient hospital stay is 1.0. The average Florida Medicaid relative weight (referred to as “case mix”) will be calculated using the same set of historical data used to determine DRG base rate(s).

4. On all claims, two DRG codes are assigned by the 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 33 DRGs, relative weights and average lengths of stay are being used as of July 1, 2016.
   b. Average Florida Medicaid relative weight (case mix) was calculated using fee-for-service and managed care encounter claims from SFY 2013-2014.

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”). Because of Florida Medicaid’s shift to statewide mandatory Medicaid managed care, the base year historical claims dataset included claims from both the fee-for-service and managed care programs. Claim data from the base year is used to simulate future inpatient 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 2016-2017 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 statewide mandatory Medicaid managed care.

5. Annual Updates:
   a. Base year historical claims used to calculate the DRG base rate had dates of admission within SFY 2013-2014.
   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 2015-2016 DRG rates and pricing rules and then adjusted based on Legislative direction for SFY 2016-2017. For SFY 2016-2017, the only adjustment was an increase in DRG payment, which equals the sum of DRG base payment plus outlier payment, by two (2) percent for inflation.
   c. The DRG base rate was calculated with an assumption that overall Florida Medicaid case mix will increase by one (1) percent above the case mix measured on claims in the base year (SFY 2013-2014). Case mix was predicted to increase by 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 one (1) 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 2016 posted in the IPPS Public Use File as of March 31, 2016 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
E. Per Claim Rate Enhancement Payments

1. Two types of per claim rate enhancements payments are made in SFY 2016-2017. One of the rate enhancements is called “automatic rate enhancements” and the other is a called “trauma hospital rate enhancements.”

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 Medicaid inpatient admissions in the base year (SFY 2013-2014) 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 rate enhancement 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 rate enhancement payment is calculated as a percentage of the DRG Base Payment. For SFY 2016-2017, 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: No service adjustors are currently applied.

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, Transplant Pediatric, Neonate, 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:

\[
\text{Claim Payment} = \text{DRG Base Payment} + \text{Outlier Payment} + \text{Automatic Rate Enhancement} + \text{Trauma Hospital Rate Enhancement}
\]

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 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:

\[
\text{Case mix adjusted automatic rate enhancement payment} = \text{average per-discharge automatic rate enhancement payment} \\
\times \left( \frac{\text{claim DRG relative weight}}{\text{provider’s estimated annual case mix}} \right)
\]

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 Rate Enhancement: Hospitals qualifying as one of the following receive a
trauma hospital rate enhancement: Level I trauma, Level II trauma or pediatric trauma. The
payment is performed using the following formula:

\[
\text{Trauma Hospital Rate Enhancement} = \text{DRG Base Payment} \\
\times \text{Trauma Rate Enhancement Percentage}
\]

1. Trauma Rate Enhancement 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:

\[
\text{Transfer Base Payment} = \left( \frac{\text{DRG Base Payment}}{\text{DRG national average length of stay}} \right) \times (\text{actual length of stay} + 1)
\]

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 rate enhancements, including automatic rate enhancement and trauma hospital rate enhancement payments, are unaffected by transfer status. Rate enhancement 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,

\[
\text{Non-covered day adjustment factor} = \frac{\text{Covered days}}{\text{Length of stay}}
\]

c. The non-covered day adjustment factor is applied only to the DRG base payment and outlier payment. Claim rate enhancement including automatic rate enhancement and trauma hospital rate enhancement 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 rate enhancement 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.

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 rate enhancements, including automatic rate enhancement and trauma hospital rate enhancements 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.

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:

\[
\text{Allowable Inpatient Medicaid Variable Costs} = \text{Total Inpatient Medicaid Costs} - \text{Total Medicaid Fixed Costs}
\]
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:

   \[ \text{Total Medicaid Fixed Costs Per Diem} = \frac{\text{Total Medicaid Fixed Costs}}{\text{Total Florida Medicaid Days}} \]

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 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.
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 Chapter 409.911 of the Florida Statutes.

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:

\[ DSHP = \frac{HMD}{TSMD} \times $1 \text{ million} \]

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:

\[ DSHP = \left( \frac{HMD}{TMDMH} \right) \times TAAMH \]

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:

\[ DSHP = \left[ (.82 \times HCCD/TCCD) + (.18 \times HMD/TMD) \right] \times TAAPH \]
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 2016-2017 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 Chapter 408.07 of the Florida Statutes, and family practice teaching hospitals, as defined in Chapter 395.805 of the Florida Statutes 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 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:

\[ TAP = THAF \times A \]

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.

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

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.

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:

\[ TAERH = \frac{(CCD + MDD)}{TPD} \]

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.

\[ PDAER = \frac{(TAERH \times TARH)}{STAERH} \]

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:

\[ SFOER = \text{Maximum value of (1)SFOL - PDAER or (2) 0} \]

Where:

- \( SFOER \) = state funds only payment amount for each rural hospital

41
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:

\[ \text{ATARH} = (\text{TARH} - \text{SSFOER}) \]

Where:

\[ \text{ATARH} = \text{adjusted total amount appropriated or distributed under this section} \]

\[ \text{SSFOER} = \text{Sum of the state funds only payment amount (4)(a) for all rural hospitals.} \]

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

\[ \text{DAERH} = \left( \frac{\text{TAERH} \times \text{ATARH}}{\text{STAERH}} \right) \]

Where:

\[ \text{DAERH} = \text{distribution amount for each rural hospital} \]

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), 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:

\[ TAE = \frac{(MD/TMD)}{TA} \]  

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 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.
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. 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:

   $TAE = DSR \times BMPD \times MD$

   Where:
   
   $TAE = \text{total amount earned by a children’s hospital}$
   
   $DSR = \text{disproportionate share rate}$
   
   $BMPD = \text{base Medicaid per diem}$
   
   $MD = \text{Medicaid Days}$

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

   $TAP = \left[ \frac{(TAE \times TA)}{STAE} \right]$

   Where:

   $TAP = \text{total additional payment for a specialty hospital for children}$
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:

$$DSHP = TAAPSNH \times (IHPSND \times THPSND)$$

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 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. These payments will be made to physicians and facilities that have met specified guidelines and are established as designated transplant centers as appointed by the Secretary of AHCA. 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 are effective for services provided on and after that date July 1, 2016.

   All other transplant rates are published on the Agency’s website at [http://ahca.myflorida.com/medicaid/review/fee_schedules.shtml](http://ahca.myflorida.com/medicaid/review/fee_schedules.shtml).

   Only one provider may bill for the transplant phase.

   Global maximum rates for transplantation surgery are as follows:
## 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.

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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 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. This alternative Medicaid payment applies only to the subset of recipients infected with tuberculosis that have been deemed a threat to public health and admitted for hospitalization through the Department of Health in accordance with s. 392.62, F.S. The Department of Health negotiated an alternate Medicaid payment to be $1,400 per diem. This Medicaid inpatient per diem rate will apply statewide for all hospital providers who contract with the Department of Health to serve recipients admitted under the provisions of 392.62, F.S.

3. Crossover Claims

Crossover claims are claims for services provided to recipients who are dually eligible for Medicare and Medicaid. The term “crossover” is used to identify any claims that have first gone to Medicare for adjudication and then sent to Florida Medicaid, whether an automatic crossover process from Medicare, or submitted on a paper claim with adjudication information from Medicare. For dual eligible persons, 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, Florida Medicaid reimburses Medicare Parts A and C, deductible(s) coinsurance, and copayments for dually eligible recipients, based on the lesser of the amount billed or the Florida Medicaid rate. Florida Medicaid reimbursement for crossover claims is up to the Medicaid rate, less any amount paid by Medicare. If this amount is negative, no Medicaid reimbursement is made. If this
amount is positive, Medicaid reimburses: the deductible plus the coinsurance or copayment; or the Medicaid rate, whichever is less.

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-6.010, F.A.C., except as further modified by the Florida Title XIX Inpatient Hospital Reimbursement Plan.

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

F. APR-DRG – Please see “DRG.”

G. APR-DRG Relative Weight – Please see “DRG Relative Weight.”

H. Automatic 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 buyback 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


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 costs, 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-6.010, 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. QIO- A group of health quality experts, clinicians, and consumers organized to improve the care delivered to recipients.

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 1 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.

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. Substantially Affected Provider – Any hospital seeking compensations under the challenge of
reimbursement rates in accordance 409.908 of the Florida Statues.
UUU. 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.

VVV. 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).

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

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

YYY. 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.

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

AAAA. 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.

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

CCCC. 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.

DDDD. 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.

EEE. 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.

FFF. 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).

GGG. 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.

HHH. 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.

III. 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.

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

KKKK. 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.

LLLL. 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.

MMMM. 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).

NNNN. 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.

OOOO. 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.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>213.0</td>
<td>237.7</td>
<td>250.1</td>
<td>278.1</td>
<td>308.0</td>
</tr>
<tr>
<td>Q2</td>
<td>217.8</td>
<td>234.5</td>
<td>256.5</td>
<td>285.9</td>
<td>314.9</td>
</tr>
<tr>
<td>Q3</td>
<td>222.7</td>
<td>237.9</td>
<td>263.2</td>
<td>294.0</td>
<td>322.0</td>
</tr>
<tr>
<td>Q4</td>
<td>227.7</td>
<td>243.8</td>
<td>270.4</td>
<td>301.2</td>
<td>329.3</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>COMPONENTS</th>
<th>WEIGHTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wages and Salaries</td>
<td>55.57%</td>
</tr>
<tr>
<td>Employee Benefits</td>
<td>7.28%</td>
</tr>
<tr>
<td>All Other Products</td>
<td>3.82%</td>
</tr>
<tr>
<td>Utilities</td>
<td>3.41%</td>
</tr>
<tr>
<td>All Other</td>
<td>29.92%</td>
</tr>
<tr>
<td></td>
<td>100.00%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>QUARTER</th>
<th>INDEX</th>
<th>AVERAGE INDEX</th>
<th>MONTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>213.0</td>
<td>215.4</td>
<td>March 31</td>
</tr>
<tr>
<td>2</td>
<td>217.8</td>
<td>220.3</td>
<td>June 30</td>
</tr>
<tr>
<td>3</td>
<td>222.7</td>
<td>225.2</td>
<td>Sept. 30</td>
</tr>
<tr>
<td>4</td>
<td>227.7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)

= 224.8

Amendment: 2016-029
Effective: July 1, 2016
Supersedes: 2015-007
Approval: April 27, 2017
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 midpoint 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 = \[
\frac{(\text{Total outpatient revenue from Worksheet G-2 Parts I and II, column 2, line 28}) \text{ minus (revenue from non-applicable services such as RHC, FQHC, Hospice, Home Health Agencies, and any other non-hospital services))}}{(\text{Total overall revenue from Worksheet G-2 Parts I and II, column 3, line 28}) \text{ minus (revenue from non-applicable services such as RHC, FQHC, Hospice, Home Health Agencies, and any other non-hospital services))}}
\]

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:

<table>
<thead>
<tr>
<th>Type</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td>1=’1 - Voluntary Nonprofit, Church'</td>
</tr>
<tr>
<td></td>
<td>2=’2 - Voluntary Nonprofit, Other'</td>
</tr>
<tr>
<td></td>
<td>3=’3 - Proprietary, Individual'</td>
</tr>
<tr>
<td></td>
<td>4=’4 - Proprietary, Corporation'</td>
</tr>
<tr>
<td></td>
<td>5=’5 - Proprietary, Partnership'</td>
</tr>
<tr>
<td></td>
<td>6=’6 - Proprietary, Other'</td>
</tr>
<tr>
<td>State owned</td>
<td>10=’10 - Governmental, State'</td>
</tr>
<tr>
<td>Government owned, non-state</td>
<td>7=’7 - Governmental, Federal'</td>
</tr>
<tr>
<td></td>
<td>8=’8 - Governmental, City-County'</td>
</tr>
<tr>
<td></td>
<td>9=’9 - Governmental, County'</td>
</tr>
<tr>
<td></td>
<td>11=’11 - Governmental, Hospital District'</td>
</tr>
<tr>
<td></td>
<td>12=’12 - Governmental, City'</td>
</tr>
<tr>
<td></td>
<td>13=’13 - Governmental, Other'</td>
</tr>
</tbody>
</table>
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 Rate Enhancement
- 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 Rate Enhancement

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 \times (2.1852 / 1.6292)) = $5,070.10.
- Trauma Rate Enhancement percentage is 11% - trauma level II hospital
- Outlier loss threshold is $60,000.
- Outlier marginal cost factor is 60%.

Basic example:

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Filed Charge</td>
<td>$34,000.00</td>
</tr>
<tr>
<td>Provider CCR</td>
<td>38.356%</td>
</tr>
<tr>
<td>DRG Relative Weight</td>
<td>2.1852</td>
</tr>
<tr>
<td>Max Policy Adjustor</td>
<td>1.0</td>
</tr>
<tr>
<td>Provider Base Rate</td>
<td>$3,000.00</td>
</tr>
<tr>
<td>Outlier Threshold</td>
<td>$60,000</td>
</tr>
<tr>
<td>Marginal Cost Percentage</td>
<td>60%</td>
</tr>
<tr>
<td>DRG Base Payment</td>
<td>$6,555.60</td>
</tr>
<tr>
<td>Estimated Hospital Cost</td>
<td>$13,041.04</td>
</tr>
<tr>
<td>Estimated Loss</td>
<td>$6,485.44</td>
</tr>
<tr>
<td>Loss Above Threshold</td>
<td>$0</td>
</tr>
<tr>
<td>Outlier Payment</td>
<td>$0</td>
</tr>
<tr>
<td>Automatic Rate Enhancement</td>
<td>$5,070.10</td>
</tr>
<tr>
<td>Trauma Rate Enhancement</td>
<td>$721.12</td>
</tr>
<tr>
<td>Claim Payment</td>
<td>$12,346.82</td>
</tr>
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</table>
Outlier example:

<table>
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<th>Value</th>
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<tbody>
<tr>
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</tr>
<tr>
<td>Provider CCR</td>
<td>38.356%</td>
</tr>
<tr>
<td>DRG Relative Weight</td>
<td>2.1852</td>
</tr>
<tr>
<td>Max Policy Adjustor</td>
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</tr>
<tr>
<td>Provider Base Rate</td>
<td>$3,000.00</td>
</tr>
<tr>
<td>Outlier Threshold</td>
<td>$60,000</td>
</tr>
<tr>
<td>Marginal Cost Percentage</td>
<td>60%</td>
</tr>
<tr>
<td>DRG Base Payment</td>
<td>$6,555.60</td>
</tr>
<tr>
<td>Estimated Hospital Cost</td>
<td>$92,054.40</td>
</tr>
<tr>
<td>Estimated Loss</td>
<td>$85,498.80</td>
</tr>
<tr>
<td>Loss Above Threshold</td>
<td>$25,498.80</td>
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<td>Outlier Payment</td>
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</tr>
<tr>
<td>Automatic Rate Enhancement</td>
<td>$5,070.10</td>
</tr>
<tr>
<td>Trauma Rate Enhancement</td>
<td>$721.12</td>
</tr>
<tr>
<td>Claim Payment</td>
<td>$27,646.10</td>
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</table>
### Maximum policy adjustor example:

<table>
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<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>Provider CCR</td>
<td>38.356%</td>
</tr>
<tr>
<td>DRG Relative Weight</td>
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<tr>
<td>Service Adjustor</td>
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<tr>
<td>Age Adjustor</td>
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<tr>
<td>Provider Adjustor</td>
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<tr>
<td>Max Policy Adjustor</td>
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<tr>
<td>Provider Base Rate</td>
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</tr>
<tr>
<td>Outlier Threshold</td>
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</tr>
<tr>
<td>Marginal Cost Percentage</td>
<td>60%</td>
</tr>
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<td>Estimated Hospital Cost</td>
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</tr>
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<td>Estimated Loss</td>
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<tr>
<td>Loss Above Threshold</td>
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<tr>
<td>Outlier Payment</td>
<td>$0</td>
</tr>
<tr>
<td>Automatic Rate Enhancement</td>
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<tr>
<td>Trauma Rate Enhancement</td>
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</tr>
<tr>
<td>Claim Payment</td>
<td>$19,820.00</td>
</tr>
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</table>
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 Rate Enhancement | $437.04 |
|Claim Payment | $9,480.23 |
Non-covered day example:

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</thead>
<tbody>
<tr>
<td>Provider CCR</td>
<td>38.356%</td>
</tr>
<tr>
<td>DRG Relative Weight</td>
<td>2.1852</td>
</tr>
<tr>
<td>Length of Stay</td>
<td>5</td>
</tr>
<tr>
<td>Covered Days</td>
<td>2</td>
</tr>
<tr>
<td>Max Policy Adjustor</td>
<td>1.0</td>
</tr>
<tr>
<td>Provider Base Rate</td>
<td>$3,000.00</td>
</tr>
<tr>
<td>Outlier Threshold</td>
<td>$60,000</td>
</tr>
<tr>
<td>Marginal Cost Percentage</td>
<td>60%</td>
</tr>
<tr>
<td>DRG Base</td>
<td>$6,555.60</td>
</tr>
<tr>
<td>Estimated Hospital Cost</td>
<td>$13,041.04</td>
</tr>
<tr>
<td>Estimated Loss</td>
<td>$6,485.44</td>
</tr>
<tr>
<td>Loss Above Threshold</td>
<td>$0</td>
</tr>
<tr>
<td>Outlier Payment</td>
<td>$0</td>
</tr>
</tbody>
</table>

**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 Rate Enhancement          | $721.12 |
| Claim Payment                    | $8,413.46 |
Charge cap example:

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

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

**Description** | **Amount** | **CMS 2552-96**
---|---|---
9. Total Hospital Charges: | $138,000,000 | Line 4 plus Line 8, in this example

### Total Hospital Outpatient Ancillary Costs Example

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
<th>CMS 2552-96</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total Hospital Outpatient Charges:</td>
<td>$48,000,000</td>
<td>See above</td>
</tr>
<tr>
<td>2. Total Hospital Charges:</td>
<td>$138,000,000</td>
<td>See above</td>
</tr>
<tr>
<td>3. Outpatient Charge Ratio:</td>
<td>0.3478</td>
<td>Line 1 / Line 2, in this example</td>
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<tr>
<td>5. Total Hospital O/P Ancillary Costs:</td>
<td>$10,665,440</td>
<td>Line 3 multiplied by Line 4, in this example</td>
</tr>
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### Total Outpatient Allowable Costs Example

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
<th>CMS 2552-96</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total Hospital O/P Ancillary Costs:</td>
<td>$10,665,440</td>
<td>See above</td>
</tr>
<tr>
<td>2. Plus Other Hospital O/P Costs:</td>
<td>$2,804,560</td>
<td>Medicaid W/S C, Pt. I, Sum of Lines 60 through 62.99, Col. 1</td>
</tr>
<tr>
<td>3. Less Medicaid O/P Lab Cost:</td>
<td>$70,000</td>
<td>Medicaid W/S D, Pt. V, Sum of Lines 44 through 44.99, Col. 9</td>
</tr>
<tr>
<td>5. Total Outpatient Allowable Costs:</td>
<td>$13,200,000</td>
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### Florida Medicaid Inpatient Days

<table>
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<tr>
<th>Description</th>
<th>Days</th>
<th>CMS 2552-96</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medicaid Hospital Inpatient Days Excluding Newborn and HMO:</td>
<td>2,000</td>
<td>W/S S-3, Pt. I, Col. 5, Line 12, less Line 11, less Line 2</td>
</tr>
<tr>
<td>3. Florida Medicaid Inpatient Days:</td>
<td>2,200</td>
<td>Sum of Lines 1 and 2, in this example</td>
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### Florida Medicaid Newborn Inpatient Days Example Plan

<table>
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<tr>
<th>Description</th>
<th>Days</th>
<th>CMS 2552-96</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medicaid Non-Concurrent Nursery Days:</td>
<td>2,000</td>
<td>Reported Separately by Hospitals</td>
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</table>

### Total Florida Medicaid Days Example

<table>
<thead>
<tr>
<th>Description</th>
<th>Days</th>
<th>CMS 2552-96</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Florida Medicaid Inpatient Days:</td>
<td>2,200</td>
<td>See section above</td>
</tr>
<tr>
<td>2. Plus Florida Medicaid Newborn Inpatient Days:</td>
<td>2,000</td>
<td>See section above</td>
</tr>
<tr>
<td>3. Total Florida Medicaid Days:</td>
<td>4,200</td>
<td>Sum of Lines 1 and 2, in this example</td>
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</table>

### Newborn Inpatient Days Example

<table>
<thead>
<tr>
<th>Description</th>
<th>Days</th>
<th>CMS 2552-96</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nursery Inpatient Days:</td>
<td>15,000</td>
<td>W/S S-3, Pt. I, Col. 5, Line 11</td>
</tr>
<tr>
<td>2. Plus Neonatal Intensive Care Unit Inpatient Days:</td>
<td>3,000</td>
<td>W/S S-3, Pt. I, Col. 5, Line 9.01</td>
</tr>
<tr>
<td>3. Newborn Inpatient Days</td>
<td>18,000</td>
<td>Sum of Lines 1 and 2, in this example</td>
</tr>
</tbody>
</table>
### Hospital Inpatient Days Example

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Days</th>
<th>CMS 2552-96</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Newborn Inpatient Days:</td>
<td>18,000</td>
<td>See above</td>
</tr>
<tr>
<td>2. Plus Hospital Inpatient Days:</td>
<td>15,600</td>
<td>See above</td>
</tr>
<tr>
<td>3. Total Hospital Days</td>
<td>33,600</td>
<td>Sum of Lines 1 and 2, in this example</td>
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</table>

### Total Inpatient Ancillary Costs Example

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

### Total Routine Costs Example

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
<th>CMS 2552-96</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adults &amp; Pediatrics Routine Costs:</td>
<td>$9,000,000</td>
<td>Medicaid W/S C, Pt. 1, Col. 1, Line 25 or Medicaid D-1, Pt. 1, Col. 1, Line 27 (if swing-bed exists)</td>
</tr>
<tr>
<td>2. Plus Sub-Provider Routine Costs:</td>
<td>$1,000,000</td>
<td>Medicaid W/S C, Pt. 1, Sum of Lines 31 through 31.99, Col. 1</td>
</tr>
<tr>
<td>3. Total Routine Costs:</td>
<td>$10,000,000</td>
<td>Line 1 plus Line 2, in this example</td>
</tr>
</tbody>
</table>
## Total Special Care Costs Example

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

## Total Newborn Routine Costs Example

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

## Total Intern and Resident Costs in Non-Approved Programs Example

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
<th>CMS 2552-96</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I&amp;R Costs in Non-Approved Programs:</td>
<td>$800,000</td>
<td>W/S B, Pt. I, Line 70, Col. 27</td>
</tr>
</tbody>
</table>

89
### Cost Report Inpatient Allowable Costs Example

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

### Total Inpatient Adjustments (Indigent Care Assessment) Example

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

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

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

### Total Inpatient Allowable Costs Example

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cost Report Inpatient Allowable Costs:</td>
<td>$36,800,000</td>
<td>See above</td>
</tr>
<tr>
<td>2. Less Total I/P Adjustments (Indigent Care Assessment):</td>
<td>$ 600,000</td>
<td>See above</td>
</tr>
<tr>
<td>3. Plus Total I/P Malpractice Insurance Costs:</td>
<td>$ 800,000</td>
<td>See above</td>
</tr>
<tr>
<td>4. Total Inpatient Allowable Costs:</td>
<td>$37,000,000</td>
<td>Line 1 Less Line 2 Plus Line 3, in this example</td>
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</tbody>
</table>
## Total Allowable Hospital Fixed Costs Example

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

## Medicaid Inpatient Ancillary Costs Example

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
<th>CMS 2552-96</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medicaid I/P Hospital Ancillary Costs:</td>
<td>$2,000,000</td>
<td>Hospital Medicaid W/S D-1, Part II, Line 48, Col. 1</td>
</tr>
<tr>
<td>2. Plus Medicaid I/P Sub-Provider Ancillary Costs:</td>
<td>$100,000</td>
<td>Sum of Sub-Providers’ Medicaid W/S D-1, Part II, Line 48, Col. 1</td>
</tr>
<tr>
<td>3. Medicaid I/P Ancillary Costs:</td>
<td>$2,100,000</td>
<td>Line 1 Plus Line 2, in this example</td>
</tr>
</tbody>
</table>

## Medicaid Routine Costs Example

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
<th>CMS 2552-96</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medicaid I/P Ancillary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Plus Medicaid I/P Sub-Provider Ancillary Costs:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Medicaid I/P Ancillary</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Medicaid Special Care Costs Example

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

### Medicaid Newborn Routine Costs Example

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

### Medicaid Intern and Resident Costs in Non-Approved Programs Example

Amendment: 2016-029  
Effective: July 1, 2016  
Supersedes: 2015-007  
Approval: April 27, 2017
<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
<th>CMS</th>
<th>2552-96</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I&amp;R Costs in Non-Approved Programs:</td>
<td>$50,000</td>
<td>W/S D-2, Col. 10, Line 9</td>
<td></td>
</tr>
</tbody>
</table>
**Cost Report Inpatient Medicaid Costs Example**

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

**Medicaid Inpatient Adjustments (Indigent Care Assessment) Example**

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

**Medicaid Inpatient Malpractice Insurance Costs Example**

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total Florida Medicaid Inpatient Days:</td>
<td>4,200</td>
<td>See above</td>
</tr>
<tr>
<td>2. Divided by Total Hospital Inpatient Days:</td>
<td>33,600</td>
<td>See above</td>
</tr>
<tr>
<td>3. Multiplied by Total I/P Malpractice Insurance Costs:</td>
<td>$800,000</td>
<td>See above</td>
</tr>
<tr>
<td>4. Medicaid I/P Malpractice Insurance Costs:</td>
<td>$100,000</td>
<td>Line 1 Divided by Line 2 Multiplied by Line 3, in this example</td>
</tr>
</tbody>
</table>
### Total Inpatient Medicaid Costs Example

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

### Total Medicaid Fixed Costs Example

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

**Acronyms / Abbreviations Used**

Col. = Column  
W/S = Worksheet  
I/P = Inpatient  
O/P = Outpatient
METHODS USED IN ESTABLISHING PAYMENT RATES

08/01/93 EMERGENCY SERVICES

Inpatient: Reimbursement to nonparticipating Florida hospitals for inpatient emergency services is the lesser of the amount charged or the average of per diem rates paid to participating Florida hospitals in the same county in effect on the date of service.

Reimbursement to nonparticipating out-of-state hospitals rendering inpatient emergency services, is the lesser of the amount charged or the average of per diems paid to participating Florida hospitals in effect on the date of service.

Reimbursement to nonparticipating out-of-state teaching and specialty hospitals for inpatient emergency services is the lesser of the amount charged or the average of per diems paid to participating Florida teaching and specialty hospitals in effect on the date of service.

Negotiated rates will be employed to reimburse out-of-state hospital providers when: 1) such a rate is requested by the provider; and 2) Florida’s per diem is less than 75 percent of the amount the out-of-state hospital would receive for the same service from the Medicaid program in its state. Any negotiated rate will not exceed 85 percent of the hospital’s usual and customary charges for the procedure to be performed, or cover services for inpatient days in excess of the 45 day limit for adult Florida recipients 21 years of age and older.

Amendment 93-52
Effective 8/1/93
Supersedes NEW

Approval 10/6/94
Reimbursement Methodology

Inpatient psychiatric services for individuals age 65 and older, when provided in a state treatment facility licensed under Chapter 395, Florida Statutes, are reimbursed on a per diem rate. The rate is determined under Medicaid’s per diem rate-setting methodology for inpatient hospital services, based on cost reports submitted in accordance with the Medicaid Title XIX Inpatient Reimbursement Plan.

For the purpose of cost sharing for Qualified Medicare Beneficiaries, Medicaid payments for qualified private freestanding specialty psychiatric hospital inpatient services shall be limited to the Medicare deductible per spell of illness and coinsurance for qualified Medicare beneficiaries. Medicaid payments for these services shall be limited to the Medicaid established qualified Medicare beneficiary rate less any amounts paid by Medicare, but only up to the amount of Medicare coinsurance. The Medicaid rate shall be the rate in effect for the dates of service of the crossover claims and may not be subsequently adjusted due to subsequent per diem adjustments.

Source data is collected from the most recent full calendar year of hospital data reporting. The projected psychiatric Part A crossover per diem is calculated by the following:

1. Psychiatric charges per day are determined by dividing total psychiatric charges by total psychiatric days.
2. Non-psychiatric hospital charges are determined by subtracting the psychiatric hospital charges from all hospital charges, then dividing that number by the remainder of all hospital days, minus psychiatric hospital days.
3. The psychiatric/non-psychiatric charge ratio is determined by dividing hospital psychiatric charges per day by the hospital non-psychiatric charges per day.
4. To determine the projected Medicaid private psychiatric Medicare part A crossover per diem, the determined ratio is multiplied by the projected Medicaid hospital per diem.

Amendment 2008-006
Supersedes New
Effective 7/1/08
Approval MAY 7 2009
CANCER HOSPITALS REIMBURSEMENT METHODOLOGY

**REIMBURSEMENT** - Eligible providers specified below will be reimbursed for Florida Medicaid reimbursable services rendered to Florida Medicaid recipients who are not enrolled in a managed care plan and who are not dually eligible Medicare and Medicaid recipients. Eligible providers shall be reimbursed up to their respective individual UPLs based on the upper payment limits described in 42 CFR 447.272 for inpatient hospital services. Due to the effective date, October 26, 2017, the UPL gap for state fiscal year (SFY) 2017-18 will be prorated by using the ratio of effective days within SFY 2017-18 and multiplying that ratio by the UPL gap for inpatient hospital services. The calculated ratio for SFY 2017-18 is 0.6795. These supplemental payments shall be calculated quarterly and be based on the previous three months’ worth of valid claims. These supplemental payments shall be made by the last day of the following quarter.

**ELIGIBLE PROVIDERS** – Cancer hospitals that meet the criteria under 42 USC s. 1395ww(d)(1)(B)(v) and are members of the Alliance of Dedicated Cancer Centers, including only H. Lee Moffitt Cancer Center and University of Miami Hospital and Clinics d/b/a Sylvester Comprehensive Cancer Center, will receive the enhanced reimbursement for services rendered at these facilities. Eligible providers shall be enrolled Florida Medicaid providers.
## PAYMENT FOR SERVICES

### Table of Contents Pages

1. Contents
1a. Contents (Continued)
2. Emergency Service
3. Rehabilitative Services
3a. Personal Care/Assistive Care Services
3b. Community-Based-Substance Abuse Services
3c. Personal Care Services: Prescribed Pediatric Extended Care (PPEC)
3.1 Early Intervention Services
3.2 School Based Therapy Services
3.3 School Based Psychological Services
3.4 School Based Social Work Services
3.5 School Based Nursing Services
3.6 School Based Nursing Services by County Health Departments
3.7 School Based Behavioral Services by County Health Departments
4. Prescribed Drugs
4a. Prescribed Drugs (Continued)
4b. Preventive Services
4c. Preventive Services for Pregnant Women
5. Rural Health Clinic Services
6. Outpatient Hospital Services
7. Hospice Care Services
7a. Obstetrics/Pediatrics
8. Payment of Pediatric Services
8a. Immunization Injection
8b. Immunization Injection (Continued)
9. Immunization Injection (Continued)
10. Established Patient
11. Adequacy of Access (Pediatrics)
12. Maximum Payment Rates for Listed Obstetrical Services
13. Cesarean Deliver
14. Abortion/Diagnostic Ultrasound
15. Adequacy of Access (Obstetrics)
16. HMO Obstetrical and Pediatric Coverage and Capitation Rates
17. HMO Obstetrical and Pediatric Coverage and Capitation Rates (Continued)
17a. HMO Obstetrical and Pediatric Coverage and Capitation Rates (Continued)
17b. HMO Obstetrical and Pediatric Coverage and Capitation Rates (Continued)
18. Florida’s Medicaid Areas/Counties
19. Maximum Payment Rates for Listed Obstetrical Services for Physicians
20. Maximum Payment Rates for Listed Obstetrical Services for Physicians (Continued)
20a. Maximum Payment Rates for Listed ARNP Obstetrical Services
21. (Reserved)
22. (Reserved)
23. (Reserved)
24. Independent Laboratory and Portable X-Ray Services
25. EPSDT Services
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>Eyeglasses/Contact Lenses</td>
</tr>
<tr>
<td>27</td>
<td>Hearing Aids</td>
</tr>
<tr>
<td>28</td>
<td>Individual Practitioners Services (Physicians, Chiropractors, Dentists, Osteopathy, Optometry)</td>
</tr>
<tr>
<td>28a</td>
<td>Medical School Faculty Reimbursement Methodology</td>
</tr>
<tr>
<td>28b</td>
<td>Reimbursement Template for Physician Services</td>
</tr>
<tr>
<td>28c</td>
<td>Reimbursement Template for Physician Services (Continued)</td>
</tr>
<tr>
<td>28d</td>
<td>Reimbursement Template for Physician Services (Continued)</td>
</tr>
<tr>
<td>29</td>
<td>Other Practitioners (Nurses, Midwives, Physician’s Assistants)</td>
</tr>
<tr>
<td>30</td>
<td>Family Planning Services</td>
</tr>
<tr>
<td>31</td>
<td>Christian Science Sanatoria Services</td>
</tr>
<tr>
<td>32</td>
<td>Home Health Services</td>
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<tr>
<td>32a</td>
<td>Home Health Aides</td>
</tr>
<tr>
<td>33</td>
<td>Clinic Services: Birthing Centers</td>
</tr>
<tr>
<td>33a</td>
<td>Clinic Services: Ambulatory Surgical Centers</td>
</tr>
<tr>
<td>33b</td>
<td>Clinic Services: County Health Units</td>
</tr>
<tr>
<td>33c</td>
<td>Clinic Services: Freestanding Dialysis Center Services</td>
</tr>
<tr>
<td>34</td>
<td>Transportation</td>
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<td>34a-f</td>
<td>Certified Public Expenditure Program for Emergency Transportation</td>
</tr>
<tr>
<td>35</td>
<td>Emergency Services to Aliens</td>
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<tr>
<td>36</td>
<td>Federally Qualified Health Center Services</td>
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<tr>
<td>37</td>
<td>Case Management Services</td>
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<tr>
<td>38</td>
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<td>39</td>
<td>Respiratory Services</td>
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<td>40</td>
<td>Personal Care Services</td>
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<td>41</td>
<td>Private Duty Nursing</td>
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<tr>
<td>42</td>
<td>Therapies</td>
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<tr>
<td>43</td>
<td>Durable Medical Equipment including Prosthetic Devices and Orthotics</td>
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<tr>
<td>44</td>
<td>Inpatient Psychiatric Services for Individuals under 21</td>
</tr>
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<td>45</td>
<td>Transplants</td>
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<td>46</td>
<td>Dental Services</td>
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<tr>
<td>47</td>
<td>1915(j) Self Directions Methodology</td>
</tr>
<tr>
<td>48</td>
<td>Cancer Hospitals Reimbursement Methodology</td>
</tr>
<tr>
<td></td>
<td>Supplement I: Payment of Medicare Parts A, B and C Deductibles and Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Supplement II: FQHC Reimbursement Plan</td>
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<tr>
<td></td>
<td>Supplement III: County Health Department Reimbursement Plan</td>
</tr>
<tr>
<td></td>
<td>Exhibit I: Outpatient Hospital Reimbursement Plan</td>
</tr>
</tbody>
</table>
METHODS USED IN ESTABLISHING PAYMENT RATES

08/01/93  EMERGENCY SERVICES

Outpatient: Reimbursement to nonparticipating Florida hospitals for outpatient emergency services is the lesser of the amount charged or the lowest of outpatient rates paid to participating Florida hospitals in effect on the date of service.

Reimbursement to nonparticipating out-of-state hospitals for outpatient emergency services is the lesser of the amount charged or the average of outpatient rates paid to participating Florida hospitals for covered outpatient revenue center codes in effect on the date of service.

Reimbursement for laboratory and pathology services rendered in emergency situations is the lesser of the amount charged or the technical component on the fee schedule found in the hospital provider handbook in effect on the date of service.
REHABILITATIVE SERVICES

10/1/2011 Except as otherwise noted in the plan, payment for these services is based on state-developed fee schedule rates, which are the same for both governmental and private providers of Rehabilitative Services. The fee schedules are subject to annual/periodic adjustment. All rates, including current and prior rates, are published and maintained on the agency’s fiscal agent website. Specifically, the fee schedules and any annual/periodic adjustments to the fee schedules are published at www.MyMedicaid-Florida.com.
PERSONAL CARE/ASSISTIVE CARE SERVICES

Survey results of prospective service providers indicated that on average one-hour per resident per day would be needed to provide the personal care/assistive care service to residents.

Each component of the personal care/assistive care service is similar to the care provided under personal care in the Medicaid waiver programs.

<table>
<thead>
<tr>
<th>Medicaid Waiver</th>
<th>Service</th>
<th>Ave. Per Hour Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged/Disabled Adult</td>
<td>Personal Care</td>
<td>$12.76</td>
</tr>
<tr>
<td>Project Aids Care</td>
<td>Personal Care</td>
<td>$8.00</td>
</tr>
<tr>
<td>Developmental Services</td>
<td>Personal Care</td>
<td>$9.27</td>
</tr>
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</table>

The average reimbursement rate for the personal care services in Medicaid Waiver programs ranges between $8.00 and 12.76 per hour. Since facility personnel providing the personal care/assistive care service will be required to have similar training, the per unit costs of providing the service will not exceed the current reimbursement rate for personal care services in the Medicaid waiver programs.

Based upon this information, reimbursement of personal care/assistive care services will be based upon a per diem payment that will be the average of the current per hour rate for personal care services included in the above-mentioned waivers. Payment to a provider will be limited to one hour per day. The per diem rate will not exceed the upper limit established through the application of the parameters of 42 CFR 447.304.

Amendment 2000-11
Effective 1/1/2001
Supersedes NEW Approval APR 5 2001

3a
Methods used in Establishing Payment Rates

Community-based-Substance Abuse Services

Substance abuse providers, under contract with the County, are reimbursed costs as represented by the lower of the state’s fee or their charge for the procedure code billed. There is an established fee schedule for the services.

It is normal procedure to seek reimbursement from liable third parties. Medicaid third party information is included on the recipient file and when liable, third parties are automatically billed for services provided and the claim’s cost avoided.

Billable activities include Comprehensive Community Support Services for Substance Abuse; Comprehensive Community Support Services for Substance Abuse, Bachelors Degree Level; and/or Drug Intervention Services.

Except as otherwise noted in the plan, state developed rates are the same for both governmental and private providers of Comprehensive Community Based Substance Abuse Services and Intervention Services and the fee schedule and any annual/periodic adjustments are published in the Medicaid Community Based Substance Abuse Services Handbook that is incorporated in Florida Administrative Code and publicly noticed in the Florida Administrative Weekly.
10/1/2011  Personal Care Services: Prescribed Pediatric Extended Care (PPEC) recipients attend on an hourly basis up to four hours or a daily basis up to 12 hours, depending on the prescribed Plan of Care (POC). PPECs are reimbursed an hourly fixed rate up to four hours, and any stay exceeding four hours is paid a single daily fixed rate, not to exceed 12 hours. The rate does not include room and board costs. The Medicaid rates were originally determined by calculating a fixed rate from fiscal data obtained through 1989-90 cost reports provided by the Florida Department of Health, Children’s Medical Services program which was previously responsible for providing PPEC services. The rate was calculated at no profit and includes basic services such as implementation and monitoring of the POC which is developed in conjunction with the parent or guardian, as defined in 400.902, Florida Statutes, and personal care services such as physical assessment, oral hygiene, bathing and grooming, range of motion and positioning, toileting, tracheostomy care, and medication administration, as defined in 59G-1.010(212) Florida Administrative Code. A 10% increase in the rate was mandated by the Florida Legislature July 1, 2006.

PPEC providers that provide other Medicaid services not covered in the PPEC rates must be enrolled as a Medicaid provider of those services and follow the reimbursement requirements as specified in the Florida Medicaid coverage and limitations handbook for the specific service.

Except as otherwise noted in the plan, payment for these services is based on state-developed fee schedule rates, which are the same for both governmental and private providers of Prescribed Pediatric Extended Care. The agency's rates were set as of July 1, 2006, and are effective for services provided on or after that date. The fee schedule is subject to annual/periodic adjustment. All rates, including current and prior rates, are published and maintained on the agency's fiscal agent website. Specifically, the fee schedule and any annual/periodic adjustments to the fee schedule are published at www.MyMedicaid-Florida.com.
METHODS USED IN ESTABLISHING PAYMENT RATES

Payment rates for behavior analysis services are based on a state developed fee schedule. The Agency for Health Care Administration’s behavior analysis rates are effective for services provided on or after January 1, 2016.

Florida Medicaid behavior analysis fee schedule can be located at:

http://ahca.myflorida.com/medicaid/review/Promulgated.shtml Payments are the lesser of the provider charges or the Medicaid maximum allowable fee schedule, which is the same as both governmental and private providers.
10/1/93 EARLY INTERVENTION SERVICES

Early intervention services are based on a fee schedule determined by the state agency and will not exceed the upper limits established through application of the parameters at 42 CFR 304.
REHABILITATIVE SERVICES:

School-Based Therapy Services

Reimbursement for school district providers, as public agencies, is based on their reasonable cost of providing services, according to the Office of Management and Budget Circular A-87. Local school districts will certify quarterly that they have expended public funds needed to match the federal share of school-based therapy claims (speech, occupational, or physical therapy) provided to eligible recipients during the quarter. Certified expenditures are separately identified and supported in the local school district's accounting system.

Payment of the therapy group fee is based on percentage reductions of the 15-minute individual visit fee based on the average size of groups in each school district. For example, if the average group size in a school district for PT is two children, the district's group fee is 50 percent of the individual visit fee. If the group size is four, the district's individual rate is divided by 4. There is a maximum of 4 children allowed in OT or PT groups. Not all children in the group have to be Medicaid eligible. The group session is in 15-minute time units.

HMO capitation rates do not include fee for service payments to school districts for school-based physical, occupational or speech therapy services. The state provides assurance that, for school districts participating in the certified payment system, HMO capitation rates do not include fee for service payments and that no duplication of payment will occur.

The costs of providing these services will not be duplicated in any other cost allocation plan.
School-Based Psychological Service

Reimbursement will be a state established rate based on 15-minute time units of services, with different rates established depending on the professional level of the individual providing the service and with different rates established for individual or group services.

Reimbursement for school district providers, as public agencies, is based on their reasonable cost of providing services, according to the Office of Management and Budget Circular A-87. In addition, local school districts will certify quarterly that they have expended public funds needed to match the federal share of their claims for services included in the State Plan provided to eligible recipients during the quarter. Certified expenditures are separately identified and supported in the local school districts' accounting systems.

Payment of the group fees are based on percentage reductions of the 15-minute individual visit fee based on the average size of groups for psychological services in each school district. For example, if the average group size for psychological services in a school district is five children, the district's group fee is 20 percent of the individual visit, or the individual rate divided by 5. Not all children in the group have to be Medicaid eligible. The group session is in 15-minute time units.

Managed Care Plans' capitation rates do not include payments to school districts for school-based services. The state provides assurance that, for school districts participating in the certified payment system, Managed Care Plans' capitation rates do not include payments and that no duplication of payment will occur.

The costs of providing these services will not be duplicated in any other cost allocation plan.
School-Based Social Work Service

Reimbursement will be a state established rate based on 15-minute time units of services, with different rates established depending on the professional level of the individual providing the service and with different rates established for individual or group services.

Reimbursement for school district providers, as public agencies, is based on their reasonable cost of providing services, according to the Office of Management and Budget Circular A-87. In addition, local school districts will certify quarterly that they have expended public funds needed to match the federal share of their claims for services included in the State Plan provided to eligible recipients during the quarter. Certified expenditures are separately identified and supported in the local school districts' accounting systems.

Payment of the group fees are based on percentage reductions of the 15-minute individual visit fee based on the average size of groups for social work services in each school district. For example, if the average group size for social work services in a school district is five children, the district's group fee is 20 percent of the individual visit, or the individual rate divided by 5. Not all children in the group have to be Medicaid eligible. The group session is in 15-minute time units.

Managed Care Plans' capitation rates do not include payments to school districts for school-based services. The state provides assurance that, for school districts participating in the certified payment system, Managed Care Plans' capitation rates do not include payments and that no duplication of payment will occur.

The costs of providing these services will not be duplicated in any other cost allocation plan.
REHABILITATIVE SERVICES (Continued)

School-Based Nursing Services

Nursing service reimbursement will be a state established rate based on 15 minute time units with different rates established depending on the professional level of the nurse providing the service.

For medication administration, payment will be based on a reasonable state established cost.

Reimbursement for school district providers, as public agencies, is based on their reasonable cost of providing services, according to the Office of Management and Budget Circular A-87. In addition, local school districts will certify quarterly that they have expended public funds needed to match the federal share of their claims for services included in the State Plan provided to eligible recipients during the quarter. Certified expenditures are separately identified and supported in the local school districts' accounting systems.

Managed Care Plans' capitation rates do not include payments to school districts for school-based services. The state provides assurance that, for school districts participating in the certified payment system, Managed Care Plans' capitation rates do not include service payments and that no duplication of payment will occur.
METHODS USED IN ESTABLISHING PAYMENT RATES

REHABILITATIVE SERVICES (Continued)

School-Based Nursing Services by County Health Departments

The reimbursement will be determined by the state agency and will not exceed the upper limits established through the application of the parameters of 42 CFR 447.304. County Health Departments are reimbursed the lower of the state's fee or their charge for the procedure code billed. There is an established fee schedule for the services. The fee schedule is posted in a prominent location in the school.

The nursing services rate will be based on 15 minute time units. Medication administration will be based on a single dose dispensed. Both nursing services and medication administration will have different rates established depending on the professional level of the nurse providing the services.

County Health Departments will certify quarterly that they have expended public funds needed to match the federal share of their claims for services included in the State Plan provided to eligible recipients during the quarter. Certified expenditures are separately identified and supported in the County Health Departments' accounting systems.

Managed Care Plans' capitation rates do not include payments to County Health Departments for school-based nursing services. The state provides assurance that for County Health Departments participating in the certified payment system, Managed Care Plans' capitation rates do not include service payments and that no duplication of payment will occur.

It is normal procedure to seek reimbursement from liable third parties. Medicaid third party information is included on the recipient file and when liable, third parties are automatically billed for services provided and the claims cost avoided.
METHODS USED IN ESTABLISHING PAYMENT RATES

REHABILITATIVE SERVICES: (Continued)

School-Based Behavioral Services by County Health Departments

The reimbursement will be determined by the state agency and will not exceed the upper limits established through the application of the parameters of 42 CFR 447.304. County Health Departments are reimbursed the lower of the state’s fee or their charge for the procedure code billed. There is an established fee schedule for the services.

The reimbursement rate for behavioral services will be based on 15 minute time units of service, with different rates established for individual or group services. The group rate will be lower than the individual rate to reflect the lower cost of providing the service per student. A maximum group size of six (6) students with a minimum service time of thirty (30) minutes is required for group therapy services.

County Health Departments will certify quarterly that they have expended public funds needed to match the federal share of their claims for services included in the State Plan provided to eligible recipients during the quarter. Certified expenditures are separately identified and supported in the County Health Department’s accounting systems.

Managed Care Plan’ capitation rates do not include payments to County Health Departments for school-based behavioral services. The state provides assurance that for County Health Departments participating in the certified payment system, Managed Care Plans’ capitation rates do not include service payments and that no duplication of payment will occur.

It is normal procedure to seek reimbursement from liable third parties. Medicaid third party information is included on the recipient file and when liable, third parties are automatically billed for services provided and the claims cost avoided.

Billable activities include: Case consultation, evaluation, and testing of the individual, therapy and counseling services with the individual, including face-to-face, collaborative, consultative, and crisis interventions. Behavioral services may be provided in either an individual or group setting.
PRESCRIBED DRUGS

Florida Medicaid reimburses for prescribed drugs in accordance with the provisions of Title 42 Code of Federal Regulations, Section 447 Subpart I.

1. Florida Medicaid reimburses for covered drugs dispensed by an approved Florida Medicaid pharmacy provider, or a provider enrolled as a dispensing practitioner, in an amount not to exceed the lesser of the following four items:
   a. The Actual Acquisition Cost (AAC) plus a professional dispensing fee (PDF) of $10.24. The National Average Drug Acquisition Cost (NADAC) will be used for the AAC when available. If the NADAC is unavailable, the AAC will be equal to wholesaler acquisition cost.
   b. The Wholesaler Acquisition Cost (WAC) plus a PDF of $10.24.
   c. The State Maximum Allowable Cost plus a PDF of $10.24.
   d. The provider’s Usual and Customary Charge (U&C).

Florida Medicaid reimburses for the following utilizing the above payment methodology:
- Covered outpatient drugs dispensed by a retail community pharmacy
- Specialty drugs dispensed primarily through the mail
- Drugs not purchased pursuant to the 340B Program by a covered entity
- Drugs dispensed in an institutional or long term care pharmacy when not included as part of an inpatient stay

Florida Medicaid utilizes the NADAC in the reimbursement methodology, which ensures that the FUL price in the aggregate will not be exceeded.

2. Florida Medicaid utilizes the actual purchased drug price plus a PDF in the reimbursement methodology for drugs acquired via the Federal Supply Schedule (FFS).

3. Florida Medicaid utilizes the actual purchased drug price plus a PDF in the reimbursement methodology for drugs acquired via Nominal price.

4. Florida Medicaid reimburses for drugs purchased under the 340B program at the actual purchased drug price, which cannot exceed the 340B ceiling price, plus a dispensing fee of $10.24. This provision only applies to covered entities, Indian Health Services, tribal organizations, urban Indian pharmacies and federally qualified health centers or the contracted agents that dispense drugs purchased at prices authorized under section 340B of the Public Health Service Act.
5. Florida Medicaid reimburses for clotting factor to the vendors awarded the State’s hemophilia contract at the negotiated price.

6. Florida Medicaid reimburses for covered prescribed drugs administered by a licensed practitioner in an office setting at WAC.

7. Florida Medicaid reimburses for covered prescribed drugs administered in an outpatient facility at WAC.

8. Florida Medicaid reimburses for covered prescribed drugs purchased under the 340B program administered in an outpatient facility at an amount not to exceed the 340B ceiling price.

9. Florida Medicaid does not reimburse for investigational or experimental drugs.
Preventive Services:

10/1/09 Licensed Medicaid providers practicing within their scope of practice will administer the H1N1 influenza vaccine to adult recipients age 21 and over, following recommendations by the Centers for Disease Control and Prevention.

Notwithstanding other pages in this Attachment, individual providers will be paid the amount of current vaccine administration rates. The agency’s rates were set as of 9/1/09. All rates are published on the agency website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.
13c  **Preventive Services for Pregnant Women:**

Licensed Medicaid providers practicing within their scope of practice will administer the influenza vaccine to adult pregnant female recipients age 21 and over. The reimbursement rate will be the same as those vaccines that are covered for Medicaid recipients between the ages of 18-20, and will be effective for dates of service between and including December 19, 2013 through March 31, 2014.

Notwithstanding other pages in this Attachment, individual providers will be paid the amount of current vaccine administration rates. The agency’s rates were set as of 12/19/13. All rates are published on the agency website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.
METHODS USED IN ESTABLISHING PAYMENT RATES

10/1/80 RURAL HEALTH CLINIC SERVICES - Each rural health clinic will be reimbursed the same rate per visit established by the Title XVIII (Medicare) carrier Blue Cross/Blue Shield of Tennessee for Medicare. Medicaid will utilize the annual rate established by the Medicare carriers for reimbursement of Rural Health Clinics. In lieu of retroactive payment to a facility, a percentage allowance will be added to the per encounter rate as of July 1 of each year based on the clinic's last year-end cost report. The percentage allowance will be based on the Consumer Price Index (CPI) estimated for the month of the clinic's fiscal year end divided into the CPI projected for December of the following year. The established rate multiplied by this ratio will determine the clinic's rate per encounter for each subsequent twelve month period. The effective date of each rate change will be July 1 of each year. Other Title XIX ambulatory services will be reimbursed using the same methodology as specified elsewhere in the State Plan for those services.

1/1/01 The payment methodology for RHCs will conform to section 702 of the Medicare, Medicaid & SCHIP Benefits Improvement Act of 2000 (BIPA) legislation. The payment methodology for RHCs will conform to the BIPA 2000 requirements under a prospective payment system. The payment methodology will use the existing interim rate plan and retroactively adjust the payment upon final calculation.

Amendment 2001-02
Effective 1/1/2001
Supersedes 93-02

Approval NOV 01 2001
METHODS USED IN ESTABLISHING PAYMENT RATES

11/1/85  OUTPATIENT HOSPITAL SERVICES - Are reimbursed according to the methodology described in Exhibit I of this attachment.
HOSPICE CARE SERVICES - Medicaid reimbursement to hospice providers is the same as their Medicare established rate for the following four categories of service: 1) routine home care; 2) continuous home care; 3) inpatient respite care; and 4) general inpatient care.

These rates have been established based on a Medicare hospice national rate, adjusted for regional differences in wages, using indices published in the Medicare Hospice Manual.

In addition, Medicaid will reimburse the hospice for physician services such as direct patient care services, furnished to individual patients by hospice employees and for physician services furnished under arrangements made by the hospice. These physician fees are reimbursable at the established Medicaid rate for physician services.

For Medicaid eligible recipients residing in an ICF or SNF facility who have elected to receive hospice services, the hospice provider will be paid the routine or continuous home care rate plus an additional amount for room and board.

For dual eligible recipients residing in an ICF or SNF facility who have elected to receive hospice services and whose hospice services costs are covered by Medicare, Medicaid will make an additional payment to the hospice provider for room and board.

The following is the methodology used in determining the room and board rate for nursing home hospice patients. An amount equal to 95% of what the state payment would have been to the nursing home will be paid to the hospice. It will be based upon the weighted average of days paid to each nursing home that the hospice has made payment to in the previous fiscal year. Those weights will be applied to 95% of the current nursing home rates to develop a weighted average rate that will be paid to the hospice for each of its nursing home clients. In the event the hospice provider has no history, the provider will be paid 95% of the average nursing home rate in the county the hospice resides. This average will be weighted based on Medicaid days.
As required in Section 6402 of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) Florida is providing the following information as a part of this state plan amendment which demonstrates the availability of pediatric and obstetrical services for Medicaid recipients. The Health Care Financing Administration (HCFA) requires that access be exhibited by county or other geographical sub-region.

Florida is organized into 11 area Medicaid offices and 15 Department of Children and Families (DCF) geographical service districts in order to efficiently provide health, social and rehabilitative services. The 11 Medicaid areas incorporate the 15 geographical service districts of the Department of Children and Families. These areas/districts consist of groupings of various counties which are based on data showing natural trade areas for economic and medical services. Each area Medicaid office and DCF district has an administrator who is responsible for ensuring that the administration of all service programs is carried out in conformity with statewide service plans. In addition, each administrator is responsible for coordinating Medicaid and DCF services and also coordinating services with other public and private agencies which provide health, social and rehabilitative services within the district.

This organizational structure is designed to meet the needs of the specific population of each district. Each geographical area/district is the natural trade area for the receipt of medical services (whether delivered by Medicaid or not), and has at least a 50% participation rate by its obstetricians, obstetrician-gynecologists, family practitioners, and pediatric practitioners.
PAYMENT FOR PEDIATRIC SERVICES

The payment schedule is applied uniformly to all reimbursements regardless of geographic location for all practitioner types cited in the statutory definitions of Obstetric/Pediatric services.

For County Public Health Units (CPHUs) and Federally Qualified Health Centers (FQHCs), all office/clinic visits are paid or reimbursed at 100% of reasonable cost. Rural Health Clinics (RHCs) are paid their Medicare determined encounter rate.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Procedure Description</th>
<th>Level</th>
<th>Maximum Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201**</td>
<td>Office/other outpatient services</td>
<td>I</td>
<td>30.00</td>
</tr>
<tr>
<td>99202**</td>
<td>Office/other outpatient services</td>
<td>II</td>
<td>31.35</td>
</tr>
<tr>
<td>99203**</td>
<td>Office/other outpatient services</td>
<td>III</td>
<td>43.62</td>
</tr>
<tr>
<td>99204</td>
<td>Office/other outpatient services</td>
<td>IV</td>
<td>64.98</td>
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<tr>
<td>99205</td>
<td>Office/other outpatient services</td>
<td>V</td>
<td>82.02</td>
</tr>
<tr>
<td>99211**</td>
<td>Office/other outpatient services</td>
<td>I</td>
<td>22.00</td>
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<tr>
<td>99212**</td>
<td>Office/other outpatient services</td>
<td>II</td>
<td>21.00</td>
</tr>
<tr>
<td>99213**</td>
<td>Office/other outpatient services</td>
<td>III</td>
<td>25.00</td>
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<tr>
<td>99214</td>
<td>Office/other outpatient services</td>
<td>IV</td>
<td>37.26</td>
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<tr>
<td>99215</td>
<td>Office/other outpatient services</td>
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<td>59.07</td>
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<tr>
<td>99241</td>
<td>Physicians typically spend 15 minutes</td>
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<td>Physicians typically spend 80 minutes</td>
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<tr>
<td>99272</td>
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<td>99273</td>
<td>Usually the presenting problems(s) are of high severity</td>
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</tr>
<tr>
<td>99274</td>
<td>Usually the presenting problems(s) are of very high severity</td>
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<td></td>
</tr>
<tr>
<td>99275</td>
<td>Usually the patient is unstable, or has developed a significant complication or a significant new problem</td>
<td>N/A</td>
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EMERGENCY DEPARTMENT VISITS

<table>
<thead>
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<th>Procedure Code</th>
<th>Procedure Description</th>
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<td>Emergency department visits</td>
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<td>99282</td>
<td>Emergency department visits</td>
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<td>99283</td>
<td>Emergency department visits</td>
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<td>99284</td>
<td>Emergency department visits</td>
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<tr>
<td>99285</td>
<td>Emergency department visits</td>
<td>V</td>
<td>97.01</td>
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HOME SERVICES

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<th>Procedure Code</th>
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<th>Level</th>
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<td>99342</td>
<td>Usually the presenting problems(s) are of moderate severity</td>
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<td>43.84</td>
</tr>
<tr>
<td>99343</td>
<td>Usually the presenting problems(s) are of high severity</td>
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<td>57.41</td>
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<tr>
<td>99351</td>
<td>Usually the patient is stable, recovering or improving</td>
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<td>25.95</td>
</tr>
<tr>
<td>99352</td>
<td>Usually the patient is responding inadequately to therapy or has developed a new complication</td>
<td></td>
<td>33.25</td>
</tr>
<tr>
<td>99353</td>
<td>Usually the patient is unstable, or has developed a significant complication or a significant new problem</td>
<td></td>
<td>42.07</td>
</tr>
</tbody>
</table>

** This procedure may also be provided by Advanced Registered Nurse Practitioners and Physician Assistants who are reimbursed at 80% of the stated fee.

N/A These procedures are not reimbursed by Florida Medicaid.

Attachment 4.19-B
Page 8

Supersedes
TN No. 26-01 Approval 5/1/97 Effective 7/1/97

TN No. 27-02

Supersedes

N/A These procedures are not reimbursed by Florida Medicaid.
For recipients age birth through 18 years, the following rates apply:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>90700</td>
<td>Immunization, active; diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTAP)</td>
<td>$10.00</td>
</tr>
<tr>
<td>90701</td>
<td>Immunization, active; diphtheria and tetanus toxoids and pertussis vaccine (DTP)</td>
<td>$10.00</td>
</tr>
<tr>
<td>90702</td>
<td>Diphtheria and tetanus toxoids (DT)</td>
<td>$10.00</td>
</tr>
<tr>
<td>90704</td>
<td>Mumps virus vaccine, live</td>
<td>$10.00</td>
</tr>
<tr>
<td>90705</td>
<td>Measles virus vaccine, live attenuated</td>
<td>$10.00</td>
</tr>
<tr>
<td>90706</td>
<td>Rubella virus vaccine, live</td>
<td>$10.00</td>
</tr>
<tr>
<td>90707</td>
<td>Measles, mumps and rubella virus vaccine, live</td>
<td>$10.00</td>
</tr>
<tr>
<td>90708</td>
<td>Measles and rubella virus vaccine, live</td>
<td>$10.00</td>
</tr>
<tr>
<td>90709</td>
<td>Rubella and mumps virus vaccine, live</td>
<td>$10.00</td>
</tr>
<tr>
<td>90712</td>
<td>Polio virus vaccine, live, oral (any type(s))</td>
<td>$10.00</td>
</tr>
<tr>
<td>90713</td>
<td>Poliomyelitis vaccine</td>
<td>$10.00</td>
</tr>
<tr>
<td>90714</td>
<td>Typhoid vaccine</td>
<td>N/A</td>
</tr>
<tr>
<td>90716</td>
<td>Varicella vaccine</td>
<td>$10.00</td>
</tr>
<tr>
<td>90717</td>
<td>Yellow fever vaccine</td>
<td>N/A</td>
</tr>
<tr>
<td>90718</td>
<td>Tetanus and diphtheria toxoids absorbed</td>
<td>$10.00</td>
</tr>
<tr>
<td>90719</td>
<td>Diphtheria toxoid</td>
<td>N/A</td>
</tr>
<tr>
<td>90720</td>
<td>Diphtheria, tetanus, and pertussis (DTP) and hemophilus influenza (HIB) vaccine</td>
<td>$10.00</td>
</tr>
<tr>
<td>90721</td>
<td>DTAP and HIB vaccine</td>
<td>$10.00</td>
</tr>
<tr>
<td>90724</td>
<td>Influenza virus vaccine</td>
<td>$10.00</td>
</tr>
<tr>
<td>90725</td>
<td>Cholera vaccine</td>
<td>N/A</td>
</tr>
<tr>
<td>90726</td>
<td>Rabies vaccine</td>
<td>N/A</td>
</tr>
<tr>
<td>90727</td>
<td>Plague vaccine</td>
<td>N/A</td>
</tr>
<tr>
<td>90728</td>
<td>BCG vaccine</td>
<td>N/A</td>
</tr>
<tr>
<td>90730</td>
<td>Hepatitis A</td>
<td>$66.90</td>
</tr>
<tr>
<td>90732</td>
<td>Pneumococcal vaccine, polyvalent</td>
<td>$21.90</td>
</tr>
<tr>
<td>90733</td>
<td>Meningococcal polysaccharide vaccine—any group(s)</td>
<td>N/A</td>
</tr>
<tr>
<td>90737</td>
<td>Hemophilus influenza B</td>
<td>$10.00</td>
</tr>
<tr>
<td>90741</td>
<td>Immunization, passive; immune serum globulin, human (ISG)</td>
<td>N/A</td>
</tr>
<tr>
<td>90742</td>
<td>Specific hyperimmune serum globulin</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>(e.g., hepatitis B, measles, pertussis, rabies, Rho(D), tetanus, vaccinia, varicella-zoster)</td>
<td></td>
</tr>
<tr>
<td>90744</td>
<td>Hepatitis B vaccine, active (0-11 years)</td>
<td>$10.00</td>
</tr>
<tr>
<td>W1949</td>
<td>Hepatitis B vaccine, active (12-18 years)</td>
<td>$10.00</td>
</tr>
</tbody>
</table>

(This rate includes the professional service)
* No payment made.
N/A These procedures are not reimbursed by Florida Medicaid.

TN No. 97-02 Supersedes Approval 5/7/97 Effective 7/1/97
IMMUNIZATION INJECTION Fees: Physician ARNP CPHU PA FQHC

For recipients age 19 and 20, the following rates apply:

- W1940 mumps virus vaccine, live $28.78 $26.78 $28.78
- W1941 measles virus vaccine, live attenuated $26.83 $24.83 $26.83
- W1942 rubella virus vaccine, live $27.43 $25.43 $27.43
- W1943 measles, mumps and rubella virus vaccine-live $44.64 $42.64 $44.64
- W1944 measles and rubella virus vaccine, live $34.47 $32.47 $34.47
- W1945 rubella and mumps virus vaccine, live $36.25 $34.25 $36.25
- W1946 tetanus and diphtheria toxoids absorbed $11.32 $9.32 $11.32
- W1947 hepatitis B vaccine $63.54 $61.54 $63.54

- 90714 typhoid vaccine N/A
- 90716 varicella, active 10.00 $8.00 5.00
- 90717 yellow fever vaccine N/A
- 90719 diphtheria toxoid N/A
- 90724 influenza virus vaccine 10.00 $8.00 5.00
- 90725 cholera vaccine N/A
- 90726 rabies vaccine N/A
- 90727 plague vaccine N/A
- 90728 BCG vaccine N/A
- 90730 hepatitis A, active 66.90 52.52
- 90732 pneumococcal vaccine, polyvalent 21.90 $19.90 21.90
- 90733 meningococcal polysaccharide vaccine-any group(s) N/A
- 90741 immunization, passive; immune serum globulin, N/A
- human (ISG)
- 90742 specific hyperimmune serum globulin (e.g., hepatitis B, N/A
- measles, pertussis, rabies, Rho(D), tetanus,
- vaccinia, varicella-zoster)
- 90749 poliomyelitis vaccine - bill using CPT code and attach report

(This rate includes the cost of the drug plus the administrative fee.)

* No payment made.
N/A These procedures are not reimbursed by Florida Medicaid.

No payment was made for services for the following procedure codes during the period of this amendment:

- 90703 No payment made
- 90710 No payment made
- 90711 No payment made
- 99358 No payment made
- 99359 No payment made

The following codes have been replaced by the local code W9881.
(Payment of $64.98 - Effective 1/1/97)

- 99381 EPSDT code W9881
- 99382 EPSDT code W9881
- 99383 EPSDT code W9881
- 99384 EPSDT code W9881
- 99385 EPSDT code W9881
- 99386 EPSDT code W9881
- 99387 EPSDT code W9881
- 99388 EPSDT code W9881
- 99389 EPSDT code W9881
- 99390 EPSDT code W9881

TN No. 97-02
Supersedes
TN No. 96-01
Approval 5/1/97
Effective 1/1/97
UNIVERSAL INJECTION

**CASE MANAGEMENT SERVICES**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>ARNP</th>
<th>PA</th>
<th>CPHU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99354</td>
<td>Prolonged physician service</td>
<td>$51.12</td>
<td>$40.90</td>
<td></td>
</tr>
<tr>
<td>99355</td>
<td>Prolonged physician service</td>
<td>$51.12</td>
<td>$40.90</td>
<td></td>
</tr>
</tbody>
</table>

**PREVENTIVE MEDICINE**

**New Patient**

Initial evaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures.

- W9881 adolescent (age 12 through 17 years) $64.98
- W9882 late childhood (age 5 through 11 years) $64.98
- W9883 early childhood (age 1 through 4 years) $64.98
- W9884 infant (age under 1 year) $64.98

- CPHUs and FQHCs are paid 100% of reasonable costs for EPSDT.
- RHCs are paid their Medicare determined encounter rate.

* No payment made.

N/A These procedures are not reimbursed by Florida Medicaid.

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TN No. 97-02

Supersedes

TN No. 96-01

Approval 5/1/97

Effective 4/1/97
Established Patient
Periodic reevaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedure.

94772 Circadian respiratory pattern recording (pediatric pneumogram), 12 to 24 hour continuous recording, infant

W9881 infant (age under 1 year) early childhood (1 through 4 years) late childhood (5 through 11 years) adolescent (12 through 17 years)

Administration and medical interpretation of developmental tests

Early Periodic Screening and Diagnostic Treatment

W9881 CPHUs are paid 100% of reasonable cost for EPSDT.

COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION
New or Established Patient

Preventive Medicine, Individual Counseling
99401 Counseling and/or risk factor reduction intervention(s) provided to a healthy individual; approximately 15 minutes
99402 approximately 30 minutes
99403 approximately 45 minutes
99404 approximately 60 minutes

Preventive Medicine, Group Counseling
99411 Counseling and/or risk factor reduction intervention(s) provided to healthy individuals in a group setting; approximately 30 minutes
99412 approximately 60 minutes

Other Preventive Medicine Services
99420 Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)
99429 Unlisted preventive medicine services
99432 Newborn care, in other than hospital setting, including physical examination of baby and conference(s) with parent(s)
99435 History and examination of the normal newborn infant, including the preparation of medical records.

(Early Periodic Screening and diagnostic Treatment)

W9881 Infant care to one year of age.

** Procedures so indicated may also be provided by enrolled Advanced Registered Nurse Practitioners, Physician Assistants and licensed midwives. Reimbursement of these procedures is 80% of the stated fee.

N/A These procedures are not reimbursed by Florida Medicaid.

Attachment 4.19-B
Page 10

TN No. 97-02
Supersedes TN No. 96-01
Approval 5/17/97
Effective 7/1/97
Adequacy of Access

At least 50% of the Pediatricians or Family Practitioners (as a group) are Medicaid participants.

Additionally, Certified Pediatric Nurse Practitioners and Family Nurse Practitioners are eligible to participate in the Medicaid program.

All County Public Health Units provide EPSDT services (or have contracts with private physicians for EPSDT services) to children under 21. Provider participation includes all providers of pediatric services excluding institutional services.

1995 - 1996
Florida Pediatric Participation By Area

<table>
<thead>
<tr>
<th>Area</th>
<th>Total Pediatric Providers</th>
<th>Total Medicaid Participating</th>
<th>Percent Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area 1</td>
<td>161</td>
<td>135</td>
<td>84%</td>
</tr>
<tr>
<td>Area 2</td>
<td>241</td>
<td>171</td>
<td>71%</td>
</tr>
<tr>
<td>Area 3</td>
<td>403</td>
<td>290</td>
<td>72%</td>
</tr>
<tr>
<td>Area 4</td>
<td>498</td>
<td>361</td>
<td>73%</td>
</tr>
<tr>
<td>Area 5</td>
<td>358</td>
<td>290</td>
<td>81%</td>
</tr>
<tr>
<td>Area 6</td>
<td>576</td>
<td>411</td>
<td>71%</td>
</tr>
<tr>
<td>Area 7</td>
<td>558</td>
<td>455</td>
<td>82%</td>
</tr>
<tr>
<td>Area 8</td>
<td>313</td>
<td>239</td>
<td>76%</td>
</tr>
<tr>
<td>Area 9</td>
<td>314</td>
<td>236</td>
<td>75%</td>
</tr>
<tr>
<td>Area 10</td>
<td>395</td>
<td>298</td>
<td>75%</td>
</tr>
<tr>
<td>Area 11</td>
<td>980</td>
<td>739</td>
<td>75%</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>Cumulative</strong></td>
<td><strong>3,625</strong></td>
<td><strong>76%</strong></td>
</tr>
</tbody>
</table>

Participation means at least one paid claim on file in the fiscal year.

Supersedes TN No. 96-01

Approval Date 5/7/97
## Maximum Payment Rates for Listed Obstetrical Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Procedure Description</th>
<th>Maximum Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INCISION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>59000</td>
<td>Amniocentesis, any method</td>
<td>48.17</td>
</tr>
<tr>
<td>59012</td>
<td>Cordocentesis (intrauterine), any method</td>
<td>125.43</td>
</tr>
<tr>
<td>59015</td>
<td>Chorionic villus sampling, any method</td>
<td>68.81</td>
</tr>
<tr>
<td>59020</td>
<td>Fetal Contraction stress test</td>
<td>45.22</td>
</tr>
<tr>
<td>59025**</td>
<td>Fetal non-stress test</td>
<td>24.77</td>
</tr>
<tr>
<td>59030</td>
<td>Fetal scalp blood sampling;</td>
<td></td>
</tr>
<tr>
<td>59050</td>
<td>Initiation and/or supervision of internal fetal monitoring during labor by consultant included in delivery fee.</td>
<td>N/A</td>
</tr>
<tr>
<td>59051***</td>
<td>Fetal monitoring interpretation</td>
<td></td>
</tr>
<tr>
<td>59100</td>
<td>Hysterotomy-abdominal (hydatidiform mole-abortion)</td>
<td>327.14</td>
</tr>
<tr>
<td><strong>EXCISION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>59120</td>
<td>Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach</td>
<td>393.99</td>
</tr>
<tr>
<td>59121</td>
<td>tubal or ovarian, without salpingectomy and/or oophorectomy</td>
<td>342.87</td>
</tr>
<tr>
<td>59130</td>
<td>abdominal pregnancy</td>
<td>396.15</td>
</tr>
<tr>
<td>59135</td>
<td>interstitial, uterine pregnancy</td>
<td>472.84</td>
</tr>
<tr>
<td>59136</td>
<td>interstitial, uterine pregnancy with partial resection of uterus</td>
<td>396.35</td>
</tr>
<tr>
<td>59140</td>
<td>Cervical, with evacuation</td>
<td>197.39</td>
</tr>
<tr>
<td>59150</td>
<td>Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy</td>
<td>234.35</td>
</tr>
<tr>
<td>59151</td>
<td>with salpingectomy and/or oophorectomy</td>
<td>324.19</td>
</tr>
<tr>
<td>59160</td>
<td>Curettage, postpartum (separate procedure)</td>
<td>120.12</td>
</tr>
<tr>
<td><strong>INTRODUCTION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>59200</td>
<td>Insertion of cervical dilator</td>
<td>28.31</td>
</tr>
<tr>
<td><strong>REPAIR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>59300</td>
<td>Episiotomy or vaginal repair only, by other than attending physician;</td>
<td>68.81</td>
</tr>
<tr>
<td>59320</td>
<td>Cerclage or cervix, during pregnancy; vaginal hysterorrhaphy or ruptured uterus</td>
<td>91.81</td>
</tr>
<tr>
<td>59325</td>
<td>abdominal</td>
<td>91.81</td>
</tr>
<tr>
<td>59350</td>
<td>Hysterectomy or ruptured uterus</td>
<td>183.03</td>
</tr>
<tr>
<td><strong>VAGINAL DELIVERY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>59400**</td>
<td>Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care</td>
<td>N/A</td>
</tr>
<tr>
<td>59409***</td>
<td>Vaginal Delivery</td>
<td>N/A</td>
</tr>
<tr>
<td>59410**</td>
<td>Vaginal Delivery only (with or without episiotomy, and/or forceps) including postpartum care</td>
<td>800.00 1100.00</td>
</tr>
<tr>
<td>59412</td>
<td>External Cephalic version, with or without tocolysis (in addition to delivery codes)</td>
<td>83.00 83.00</td>
</tr>
<tr>
<td>59414</td>
<td>Delivery of placenta (separate procedure)</td>
<td>168.00 168.00</td>
</tr>
<tr>
<td>59425***</td>
<td>Antepartum care only (4 to 6 visits)</td>
<td>N/A</td>
</tr>
<tr>
<td>59426***</td>
<td>Antepartum care only (7 or more visits)</td>
<td>N/A</td>
</tr>
<tr>
<td>59614</td>
<td>Vaginal delivery, after previous cesarean</td>
<td>800.00 1100.00</td>
</tr>
<tr>
<td><strong>ANTEPARTUM AND POSTPARTUM CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>59430**</td>
<td>Postpartum Care only (paid per visit)</td>
<td>50.00 50.00</td>
</tr>
<tr>
<td>W1990**</td>
<td>Antepartum Care Only (paid per visit)</td>
<td>50.00 50.00</td>
</tr>
<tr>
<td>CPHUs and FQHCs are paid 100% of reasonable costs. RHCs are paid their Medicare determined encounter rate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>W1991**</td>
<td>Antepartum visit plus Healthy Start prenatal risk screening</td>
<td>100.00 100.00</td>
</tr>
<tr>
<td>W1992**</td>
<td>Antepartum visit plus Healthy Start prenatal risk screening performed in 1st trimester.</td>
<td>150.00 150.00</td>
</tr>
</tbody>
</table>

Either W1991 or W1992 may be reimbursed once per pregnancy.

** This procedure may also be provided to low risk patients by ARNP's and licensed midwives, who are reimbursed at 80% of the stated fee.

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TN No. 97-02
Supersedes
TN No. 96-01
Approval 5/17/97
Effective 7/1/97
CESAREAN DELIVERY

59510 Routine obstetric care including antepartum care, cesarean section, delivery, and postpartum care

Payment is not made under a global delivery procedure code, but on the individual components.

59514*** Cesarean delivery only

Low High
Risk Risk

59515 Cesarean section, delivery only including postpartum care

59524 Sub-total hysterectomy after cesarean delivery

59622 Cesarean delivery, following attempted vaginal delivery after previous cesarean delivery, including postpartum care

59870 Uterine evacuation & curettage (hydatidiform mole) N/A

N/A

The antepartum, vaginal delivery, cesarean section and postpartum care are paid according to a low or high risk diagnosis. The differences should be noted in the payment column.

Additionally, a set of procedures is identified for a prospective payment methodology for services of the same type done in all Regional Perinatal Intensive Care Centers (RPICC) in Florida.

RPICC procedure codes are listed below:

370A C-Section, no complications 1450.00
370B C-Section, 1 complication 1550.00
370C C-Section, 2+ complications 1650.00
372A Vaginal Delivery, no complications 1450.00
372B Vaginal Delivery, 1 complication 1550.00
372C Vaginal Delivery with 2+ complication 1650.00
376A Postpartum Hospitalization 330.00
383A Antepartum Hospitalization, no complications 450.00
383B Antepartum Hospitalization, 1 complication 540.00
383C Antepartum Hospitalization, 2+ complications 670.00
470A C-Section with Tubal Ligation 1550.00
470B C-Section with Hysterectomy 1650.00
470C C-Section with Tubal Ligation and 1 other complication 1650.00
472A Vaginal Delivery with Tubal Ligation and 1+ complication 1550.00
472B Vaginal Delivery with Hysterectomy and 1+ other complication 1650.00
472C Vaginal Delivery with Tubal Ligation and 1+ other complication 1650.00
476A Postpartum Hospitalization with Hysterectomy 1150.00

** This procedure may also be provided to low risk patients by Advanced Registered Nurse Practitioners, Physician Assistants and licensed midwives, who are reimbursed at 100% of the stated fee.

*** These procedures are included in the global fees.

TN No. 97-02
Supercedes
TN No. 96-01

Attachment 4.19-B
Page 13

Effective 1/1/97

Approval 5/7/97
ABORTION

9812 Treatment of spontaneous abortion, any trimester; completed surgically 147.06
59820 Treatment of missed abortion, first trimester; completed surgically 162.20
59821 Treatment of missed abortion, second trimester; completed surgically 149.42
59830 Treatment of septic abortion, completed surgically 216.46
59840 Induced abortion, by dilation and curettage 134.08
59841 Induced abortion, by dilation and evacuation 183.03
59850 Induced abortion, by one or more intra-amniotic injections 202.69
59851 with dilation and curettage and/or evacuation 211.93
59852 with hysterotomy 284.68
(failed intra-amniotic injections)
59855 Induced abortion, by one or more vaginal suppositories 214.29
59856 with dilation and curettage and/or evacuation 264.62
59857 with hysterotomy 321.83
59866 Multifetal pregnancy reduction(s) (MPR) (Fee to be determined by RVU value - pending)

Diagnostic Ultrasound
PELVIS

6805 Echography, pregnant uterus, B-scan and/or real time with image documentation; (complete maternal and fetal evaluation) 71.56
76810 Complete maternal and fetal evaluation, multiple gestation, after the first trimester 142.14
76815 Limited (gestational age, heartbeat, placental location, fetal position or emergency in the delivery room) 47.77
76816 Follow-up or repeat 39.32
76818 Fetal biophysical profile 55.24
76825 Echocardiography, fetal real time with image documentation (2D) with or without M-Mode recording 80.02

Supersedes No. 96-01
TN No. Effective 5/7/97
Approval 7/1/97
Adequacy of Access

At least 50% of the actively participating Obstetricians, Obstetrician-Gynecologists, Family and General Practitioners, Certified Nurse Midwives and Certified Family Nurse Practitioners are Medicaid providers.

All 67 County Public Health Units (CPHUs) either provide maternity care at their clinic or have contracts with the private obstetricians to provide maternity services.

The 11 Regional Perinatal Intensive Care Centers (RPICCC) provide obstetrical services for all medically eligible high risk pregnant women regardless of ability to pay. They also provide services to the neonates in these same specialized centers regardless of ability to pay.

Assurance of the eligibility of pregnant women to receive adequate access to care is provided by CPHUs, up to 200% of poverty, under Florida Administrative Code, Chapter 10D-99.002 (13), Eligibility for State Funded Prenatal Care. Another assurance for adequate access to obstetrical care is the Florida Administrative Code, Chapter 10J-7, Regional Perinatal Intensive Care Centers, and section 409.908 (12)(b) F.S. (Medicaid).

1995 - 1996
Florida Obstetrical Participation By Area

<table>
<thead>
<tr>
<th>Area</th>
<th>Total Obstetric Services Providers</th>
<th>Total Medicaid Participating</th>
<th>Percent Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area 1</td>
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Participation means at least one paid claim on file in the fiscal year.

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TN No. 97-02
Supersedes
TN No. 96-01
Approval Date 5/7/97
Effective 7/1/97
HMO Obstetrical and Pediatric Coverage and Capitation Rates

All Medicaid health maintenance organizations (HMO) and prepaid health plans are required to provide obstetrical and pediatric care under terms of the standard contract between the plans and the Agency for Health Care Administration (AHCA). No plan is permitted to commence operation until the necessary resources are in place either through a direct employment relationship or under contract. The availability of those services is routinely monitored for each plan (quarterly at a minimum).

Payment to the plans for obstetrics and pediatrics is included in the capitation rate paid to each plan in the physician services category. The plan is paid a contractually fixed amount at the beginning of each month for each enrolled recipient. The total amount of the capitation rate paid to each plan is the sum of the rates for each category of covered services, e.g., inpatient hospital services + physician services + prescribed drug, etc. The final rate for each eligibility category is a percentage less than 100 of the expected fee-for-service experience for the Medicaid population in that area in that eligibility category, by age band, based upon actual experience in the last year for which a full year of claims data is available. The capitation rates are shown to be adequate as all HMO's and prepaid health plans with Medicaid contracts consistently demonstrate fiscal solvency.

HMO: As of February 1997, more than 373,000 Medicaid recipients were enrolled in HMOs and prepaid health plans statewide. The following table shows each HMO/prepaid health plan in operation by county, their enrollment and the obstetrical and pediatric providers under contract with the plans.
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Effective 7/1/97

Attachment 4.19-B

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**Total** | **373,262** | **2875** | **3855**

**Access to Services:** In summary, the Florida Medicaid program provides access to care for all pediatric and obstetric recipients in each county within the district. The Medicaid program provides transportation services to neighboring counties for Medicaid recipients when necessary to obtain services. Additionally, all Florida counties have a county public health unit which provides access to our Medicaid recipients. Services are available to Medicaid recipients within each of the geographical district areas.
# Florida's Medicaid Areas/Counties

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**TN No. 97-02** Supersedes **TN No. 96-01**

Approval **5/1/97** Effective **7/1/97**
Maximum Payment Rates for Listed Obstetrical Services - Physicians
Average Payment Amount - July 1, 1995 to June 30, 1996
Statewide Averages

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N/A: These procedures are not reimbursed by Florida Medicaid.

TN No. 97-02
Supersedes
TN No. 96-01

Attachment 4.11-3
Page 15

Approval 7/1/97
Effective 7/1/97
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* Immunization services were reduced to a $10.00 administrative fee effective 10/1/94.

N/A These procedures are not reimbursed by Florida Medicaid.
Maximum Payment Rates for Listed ARNP Obstetrical Services

Average Payment Amount - July 1, 1995 to June 30, 1996

Statewide Averages

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N/A These procedures are not reimbursed by Florida Medicaid.

TN No. 97-02
Supersedes
TN No. 96-01

Approval 5/7/97

Effective 7/1/97
METHODS USED IN ESTABLISHING PAYMENT RATES

INDEPENDENT LABORATORY AND PORTABLE X-RAY SERVICES - Payments are the lesser of the provider charges or the Medicaid maximum allowable fee schedule, which is the same as both governmental and private providers. The agency’s laboratory rates were set as of 1/01/16, effective for services on or after this date. The fee schedules are published at: http://portal.fimmis.com/FLPublic/. Select Provider Services, then under Provider Support, select Provider Fee Schedules. Rates do not exceed Medicare rates for the same codes on a per test basis as required by section 1903(i)(7).
METHODS USED IN ESTABLISHING PAYMENT RATES

4/1/91  EARLY AND PERIODIC SCREENING DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

All services provided for in Section 1905(a) of the Act which are medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions are provided for EPSDT participants.

Institutional services (inpatient/outpatient hospital services, nursing home services and ICF/MR services), Federally Qualified Health Centers and Rural Health Services are reimbursed as described within Attachment 4.19-B.

All other services are reimbursed on a fee-for-service basis in accordance with established fee schedules as described within Attachment 4.19-B.
VISUAL SERVICES

Payment for visual aid services are based on a state developed fee schedule, which is the same for both governmental and private providers. The agency's visual aid services rates were set as of 1/01/16, and are effective for services on or after this date. The fee schedules are published at [http://portal.flmmis.com/FLPublic/Provider_ProviderServices/Provider_ProviderSupport/Provider_ProviderSupport_FeeSchedules/](http://portal.flmmis.com/FLPublic/Provider_ProviderServices/Provider_ProviderSupport/Provider_ProviderSupport_FeeSchedules/).
HEARING SERVICES

Payment for hearing services are based on a state developed fee schedule, which is the same for both governmental and private providers. The agency's hearing services rates were set as of 1/01/16, and are effective for services on or after this date. The fee schedules are published at: http://ahca.myflorida.com/medicaid/review/fee_schedules.shtml

Amendment: 2016-006
Supersedes: 06-005
Effective Date: 5/05/16
Approved: 04/06/17
METHODS USED IN ESTABLISHING PAYMENT RATES

1/1/14

INDIVIDUAL PRACTITIONERS SERVICES - (Doctors of Medicine, Chiropractic, Osteopathy, Dentistry, Optometry and other individual Practitioners services) -

Except as otherwise noted in the plan, payment for these services is based on state-developed fee schedule rates, which are the same for both governmental and private providers of physician, chiropractic, osteopathic, dental, optometric, and podiatric services. The agency’s fee schedule rate is in effect for services provided on or after January 1, 2014. All rates, including current and prior rates, are published and maintained on the agency’s website. Specifically, the fee schedule and any annual/periodic adjustments to the fee schedule including the Primary Care Rate Increase referenced in section 1902 (a) (13) (C) of the Social Security Act are published at www.MyMedicaid-Florida.com.

1/1/01

Medicaid will only reimburse doctors of medicine, osteopathy, and other individual practitioner services for mobile services under contractual agreement with a Federally Qualified Health Center or a County Health Department. Medicaid will only reimburse those practitioners whose mobile Rural Health Clinic (RHC) units are certified by Medicare as mobile RHCs in accordance with Title 42 Code of Federal Regulations.

Medicaid will only reimburse doctors of optometry for mobile services under contractual agreement with a Federally Qualified Health Center. Medicaid will only reimburse those practitioners whose mobile Rural Health Clinic (RHC) units are certified by Medicare as mobile RHCs in accordance with Title 42 Code of Federal Regulations.

7/1/01

Medicaid will only reimburse doctors of dentistry for mobile services under contractual arrangement with a Federally Qualified Health Center, County Health Department, state approved dental educational institution, or for services rendered to recipients age 21 and over at nursing home facilities.

Reimbursement for mobile services is made directly to the CHD, FQHC or RHC on a cost-based reimbursement method. Reimbursement to the individual practitioners contracting with these entities is made directly by the CHD, FQHC or RHC with whom they contract the services provided.

Medicaid will not reimburse for mobile services for radiology procedures or interpretations if the service was provided by a mobile provider.

Amendment 2014-001
Effective 01/01/2014
Supersedes 2013-002
Approval 03-21-14
MEDICAL SCHOOL FACULTY REIMBURSEMENT METHODOLOGY

REIMBURSEMENT - Eligible providers specified below will be reimbursed for services rendered to Florida Medicaid recipients who are not enrolled in a managed care plan. This excludes dually eligible Medicare and Medicaid recipients. The supplemental payments, which reflect the alternative fee schedule, will be made monthly based on the calculation of the differential amount between the base Medicaid payment and supplemental payment for allowable Current Procedural Terminology codes. Each Florida Medicaid covered medical (excluding vaccines, laboratory and radiology services), dental, and behavioral health billable code listed on the applicable Florida Medicaid fee schedule, will be reimbursed in accordance with the following payment methodology:

(a) An average of the payments from the top five (5) commercial payers for each CPT code were provided to generate the Average Commercial Rate (ACR).
(b) Both the Medicare rate and the ACR were multiplied by the Florida Medicaid fee-for-service (FFS) volume of services reimbursed for eligible CPT codes.
(c) The statewide Medicare equivalent of the ACR was calculated by dividing the product of ACR and FFS volume by the product of the Medicare and FFS volume.
(d) The calculated ACR pays at one-hundred-ninety percent of the 2015 Medicare Rate for eligible Florida Medicaid services.
(e) The calculated ACR pays at one-hundred-ninety percent of the Florida Medicaid rate if the service is not covered by Medicare.
(f) The ACR and Medicare percentages will be recalculated every three years.

ELIGIBLE PROVIDERS – Practitioners as defined under the Physician Quality Reporting Systems (PQRS), who are enrolled in Florida Medicaid, and employed by or contracted with a Florida public or private, non-profit, accredited medical, dental, or optometry school to provide supervision and teaching of medical, dental, or optometric students, residents, or fellows through application of the parameters of 42 CFR 447.304. The following medical school faculty physicians will receive the enhanced reimbursement: University of Florida, University of Florida – Jacksonville, University of Miami, University of South Florida, Florida International University, Florida State University, and University of Central Florida. Eligible practitioners include qualifying faculty physicians and all allied health personnel under their supervision pursuant to the PQRS, who are eligible Florida Medicaid providers, and furnish Florida Medicaid reimbursable services.
Reimbursement Template - Physician Services

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

- The rates reflect all Medicare site of service and locality adjustments.
- The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.
- The rates reflect all Medicare geographic/locality adjustments.
- The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code:

Method of Payment

- The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.
- The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: □ monthly □ quarterly

Primary Care Services Affected by this Payment Methodology

- This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.
- The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

99288, 99316, 99358, 99359, 99363, 99364, 99366, 99367, 99368, 99374, 99375, 99377, 99378, 99379, 99380, 99404, 99408, 99409, 99411, 99412, 99420, 99429, 99441, 99442, 99443, 99444, 99450, 99455, 99456, 99466, 99467, 99485, 99486, 99487, 99488, 99489, 99495, 99496, 99499.

TN No. 2014-001

Supersedes Page: 2013-002 Approval Date: 03-21-14 Effective Date: 01-01-14
(Primary Care Services Affected by this Payment Methodology – continued)

☑ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

The state will make payment for 99224, 99225, and 99226. All three codes were added January 1, 2011.

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☐ Medicare Physician Fee Schedule rate

☑ State regional maximum administration fee set by the Vaccines for Children program

☐ Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☐ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: __________.

☑ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: $10.00.

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:_______________________________

________________________________________________________________________

Note: This section contains a description of the state’s methodology and specifies the affected billing codes.

Florida Medicaid will be using the Deloitte fee schedule (which was based on the November 2012 Medicare release and the 2009 conversion factor). The state will not adjust the fee schedule to account for changes in Medicare rates throughout the year.
Effective Date of Payment

E & M Services
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014, but not prior to December 31, 2014. All rates are published at:


Vaccine Administration
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014, but not prior to December 31, 2014. All rates are published at


PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 48 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

TN No. 2013-002
Supersedes Page: New Approval Date: 04-01-13 Effective Date: 01-01-13
METHODS USED IN ESTABLISHING PAYMENT RATES

OTHER PRACTITIONER SERVICES
Advanced Registered Nurse Practitioner, Licensed Midwife, Physician Assistant, and Registered Nurse First Assistant Services:

Except at otherwise noted in the plan, payment for these services is based on state-developed fee schedule rates which are the same for both governmental and private providers of advanced registered nurse practitioner, licensed midwife, physician assistant and registered nurse first assistant services. The fee schedule rate is in effect for Licensed Midwife services provided on or after January 1, 2016. The fee schedule rate for Advanced Registered Nurse Practitioner, Physician Assistant, and Registered Nurse First Assistant services is included in the Practitioner fee schedule and is in effect on or after January 1, 2016. All rates, including current and prior rates, are published and maintained on the agency’s website. Specifically, the fee schedule is published at http://ahca.myflorida.com/medicaid/review/fee_schedules.shtml
METHODS USED IN ESTABLISHING PAYMENT RATES

4/1/87  FAMILY PLANNING SERVICE - Individual payments are based on a fee schedule determined by the state agency and will not exceed the upper limits established through application of the parameters at 42 CFR 447.104.

Amendment 93-02
Effective 1/1/93
Supersedes NEW

Approval APR 22 1993
METHODS USED IN ESTABLISHING PAYMENT RATES

CHRISTIAN SCIENCE SANATORIA SERVICES

2/15/79 Effective 10/1/77, Christian Science SANATORIA Services are reimbursed as a general intermediate care facility under methods and standards described in Attachment 4.19-D.
HOME HEALTH VISITS -

Payment for home health visits are based on a State-developed fee schedule which is the same for both governmental and private providers. The Agency’s home health visits rates were set as of 1/01/2015, effective for services on or after this date. The fee schedules are published at:
http://ahca.myflorida.com/medicaid/review/fee_schedules.shtml
METHODS USED IN ESTABLISHING PAYMENT RATES

7/1/2011 Freestanding Birth Center Services

Freestanding Birth Centers are reimbursed a facility fee.

Except as otherwise noted in the plan, payment for these services is based on state-developed fee schedule rates, which are the same for both governmental and private providers of Freestanding Birth Center Services (FBCS). The Agency's FBCS rates were set as of May 21, 2014, and are effective for facility services provided on or after that date. The FBCS practitioners, (licensed physicians, certified nurse midwives and licensed midwives) bill their services separately from the FBCS. The FBCS practitioners’ fee schedules are referenced in the state plan under physician services (licensed physicians) and Other Practitioner Services (licensed midwife and nurse midwife). All rates, including current and prior rates, are published and maintained on the Agency's fiscal agent website. Specifically, the fee schedules are published at www.mymedicaid-florida.com. Rates for practitioners and physicians were last updated as described in Physician Services and Other Practitioner Services of the plan.

SPA TN: 2011-005
Effective: 07/01/11
Superseded by: 93-61
Approval: 08-22-14
METHODS USED IN ESTABLISHING PAYMENT RATES

7/1/2017 CLINIC SERVICES: Ambulatory Surgical Centers

Ambulatory surgical centers are reimbursed using the Enhanced Ambulatory Patient Grouping (EAPG) reimbursement methodology for hospital outpatient services as directed in section 409.905(6)(b), Florida Statutes. In addition, the defined methods are outlined in Attachment 4.19-B, Exhibit I (Florida Title XIX Outpatient Hospital Reimbursement Plan).
Clinic services are reimbursed for medically necessary primary care services in addition to preventive health care services provided in the clinic or satellite clinic locations. This includes all services and supplies provided in the course of diagnosis and treatment of an illness or injury or to assess health status in order to detect and prevent disease, disability, and other health conditions or their progression. Reimbursement is on the basis of an all inclusive rate per visit which is reasonable and related to the cost of furnishing services. The rate is calculated based on a cost report which must be submitted to Medicaid. Cost reports will be subject to audits to determine reasonableness of costs. The rate per visit reimbursement is determined by dividing reasonable costs reported by the number of visits. If there has been a payment that is less or exceeds the payment determined as reasonable cost, Medicaid will make an adjustment at the end of the fiscal year. The reimbursement is subject to the upper limits in accordance with 42 CFR 447.321.
METHODS USED IN ESTABLISHING PAYMENT RATES

CLINIC SERVICES: Freestanding Dialysis Center Services

Freestanding Dialysis Centers are reimbursed for in-center hemodialysis dialysis treatments using a single composite rate established by the Florida Legislature. The rate is less than Medicare's composite rates for the same service.

Freestanding Dialysis Centers are reimbursed for peritoneal dialysis treatments using a single composite rate based on State-established fee schedule rates.

Please refer to Attachment 3.1A and 3.1B for Freestanding Dialysis Center covered treatment services.

The Agency's dialysis rates were set as of January 1, 2016, effective for services on or after this date. The rates are the same for both governmental and private providers. The fee schedules are published at: http://ahca.myflorida.com/medicaid/review/fee_schedules.shtml

The Agency's rate is calculated at 54.25% of the Medicare rate.

<table>
<thead>
<tr>
<th>Medicaid Rate</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>$125 (Hemodialysis)</td>
<td>$230.39 (End Stage Renal Dialysis)</td>
</tr>
<tr>
<td>$53.57 (Peritoneal)</td>
<td></td>
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</tbody>
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*The percent of the State's End Stage Renal Dialysis rate is 54.25% ($125 / $230.39) of Medicare's rate.
METHODS USED IN ESTABLISHING PAYMENT RATES

TRANSPORTATION

7/1/97

Payment is as follows: 1) For ambulance service, all inclusive rates for basic life support, advanced life support, and air ambulance, including base rate, mileage and oxygen, the lesser of the rates determined by the State Agency not to exceed usual and customary charges; 2) the lesser of the usual and customary rates or the negotiated rates for specialized non-emergency transportation; 3) established mileage rate for private transportation and 4) the lesser of the usual and customary rates or negotiated rates for public transportation.

School districts will be reimbursed transportation for students based on costs developed by the Department of Education using cost data from each individual county. Each school district will be reimbursed a unique rate. These costs will reflect only the non-federal funds used for transportation. The costs will be adjusted yearly, if necessary. School districts will certify quarterly the state's share and receive only the federal share for reimbursement.
SUPPLEMENTAL PAYMENT FOR PUBLICLY OWNED OR OPERATED EMERGENCY MEDICAL TRANSPORTATION PROVIDERS

This program provides supplemental payments for eligible Public Emergency Medical Transportation (PEMT) entities that meet specified requirements and provide emergency medical transportation services to Medicaid beneficiaries.

Supplemental payments provided by this program are available only for allowable costs that are in excess of other Medicaid revenue that the eligible PEMT entities receive for emergency medical transportation services to Medicaid eligible recipients. Eligible PEMT entities must provide to the Agency for Health Care Administration (AHCA) certification for the total expenditure of funds and certification of federal financial participation (FFP) eligibility for the amount claimed.

Providers must submit as-filed cost reports for the previous State fiscal year (SFY) by November 30 of the current SFY. Following the cost report submission, the corresponding lump-sum payments will be disbursed annually prior to the certified forward period of the current SFY (September 30). For example, cost reports with data covering SFY 2014-15 must be submitted by November 30, 2015. AHCA will then review the SFY 2014-15 submission and process a payment prior to September 30, 2016.

Payments will not be disbursed as supplemental increases to current reimbursement rates for specific services. Costs will be identified through the Centers for Medicare and Medicaid Services (CMS) approved cost report.

Costs covered will include the following applicable Medicaid emergency services: Ambulance Services: both Basic Life Support and Advanced Life Support, Advanced Life Support Level 2, and Specialty Care Transport (SCT). Services must be provided by fire rescue or ambulance services.

This supplemental payment program will be in effect beginning October 1, 2015.

A. Definitions

1. “Direct costs” means all costs that can be identified specifically with a particular final cost objective in order to meet medical transportation mandates.

2. “Indirect costs” means costs for a common or joint purpose benefitting more than one cost objective that are allocated to each benefiting objective using AHCA approved indirect rate or an allocation methodology. Indirect costs rate or allocation methodology must comply with OMB Circular A-87 and CMS non-institutional reimbursement policy.

3. “PEMT entity” is determined to be eligible if it is a county, city, healthcare district, or public university in Florida and provides emergency medical transportation services for Medicaid beneficiaries.
4. “PEMT services” means both the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient, as well as the advanced life support, advanced life support II, basic life support, and specialty care transport services provided to an individual by PEMT providers before or during the act of transportation.

a. “Advanced life support” means the assessment or treatment through the use of techniques described in the Emergency Medical Technician (EMT)-Paramedic: National Standard Curriculum or the National Emergency Medical Services (EMS) Education Standards, provided by an emergency medical technician-intermediate or EMT-Paramedic. These are special services designed to provide definitive prehospital emergency medical care, including but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration with drugs and other medicinal preparations, and other specified techniques and procedures.

b. “Advanced life support level 2” means transportation by ground ambulance vehicle and the provision of medically necessary supplies and services, including one of the following:
   • At least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids).
   • Provision of manual defibrillation/cardioversion, endotracheal intubation, central venous line, cardiac pacing, chest decompression, surgical airway, or intraosseous line.

c. “Basic life support” means the assessment or treatment through the use of techniques described in the EMT-Basic National Standard Curriculum or the National EMS Education Standards. It includes emergency first aid and cardiopulmonary resuscitation procedures to maintain life without invasive techniques.

d. “Specialty care transport” means the inter-facility transportation of a critically injured or ill recipient by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic that must be furnished by one or more health professionals in an appropriate specialty area.

5. “Shared direct costs” are direct costs that can be allocated to two or more departmental functions on the basis of shared benefits.
B. Supplemental Payment Methodology

Supplemental payments provided by this program to an eligible PEMT entity will consist of FFP for Medicaid uncompensated emergency medical transportation costs based on the difference between the Medicaid reimbursement amount and the providers actual cost for providing emergency medical transportation services to eligible Medicaid beneficiaries. The supplemental payment methodology is as follows:

1. As described in Section D, the expenditures certified by the eligible PEMT entity to AHCA will represent the payment eligible for FFP. Allowable certified public expenditures will determine the amount of FFP claimed.

2. In no instance will the amount certified pursuant to Paragraph D.1, when combined with the amount received for emergency medical transportation services pursuant to any other provision of this State Plan or any Medicaid waiver granted by CMS, exceed 100 percent of the allowable costs for such emergency medical transportation services.

3. Pursuant to Paragraph D.1, the eligible PEMT entity will annually certify to AHCA the total costs for providing emergency medical transportation services for Medicaid beneficiaries offset by the received Medicaid payments for the previous state fiscal year. The supplemental Medicaid reimbursement received pursuant to this segment of the State Plan will be distributed in one annual lump-sum payment after submission of such annual certification.

4. For the subject year, the emergency medical transportation service costs that are certified pursuant to Paragraph D.1 will be computed in a manner consistent with Medicaid cost principles regarding allowable costs, and will only include costs that satisfy applicable Medicaid requirements.

5. Computation of allowable costs and their allocation methodology must be determined in accordance with the CMS Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, and OMB Circular A-87, which establish principles and standards for determining allowable costs and the methodology for allocating and apportioning those expenses to the Medicaid program, except as expressly modified below.

6. Medicaid base payments to the PEMT providers for providing PEMT services are derived from the Medical Transportation fee-schedule established for reimbursements payable by the Medicaid program by procedure code. The base payments for these eligible PEMT providers are fee-for-service (FFS) payments. The primary source of paid claims data and other Medicaid reimbursements is the Florida Medicaid Management Information System (FLMMIS). The number of paid claims is determined by the Florida Medicaid Management Information System (FLMMIS).
Medicaid FFS PEMT transports is derived from and supported by the FLMMIS reports for services during the applicable service period.

7. For each eligible PEMT provider in this supplemental program, the total uncompensated care costs available for reimbursement will be no greater than the shortfall resulting from the allowable costs calculated using the Cost Determination Protocols (Section C.). Each eligible PEMT provider must provide PEMT services to Medicaid beneficiaries in excess of payments made from the Medicaid program and all other sources of reimbursement for such PEMT services provided to Medicaid beneficiaries. Eligible PEMT providers that do not have any uncompensated care costs will not receive a supplemental payment under this supplemental reimbursement program.

C. Cost Determination Protocols

1. An eligible PEMT provider’s specific allowable cost per-medical transport rate will be calculated based on the provider’s audited financial data reported on the CMS-approved cost report. The per-medical transport cost rate will be the sum of actual allowable direct and indirect costs of providing medical transport services divided by the actual number of medical transports provided for the applicable service period.

   a. Direct costs for providing medical transport services include only the unallocated payroll costs and fringe benefits for the shifts in which personnel dedicate 100 percent of their time to providing medical transport services, medical equipment and supplies, and other costs directly related to the delivery of covered services, such as first-line supervision, materials and supplies, professional and contracted services, capital outlay, travel, and training. These costs must be in compliance with Medicaid non-institutional reimbursement policy and are directly attributable to the provision of the medical transport services.

   b. Shared direct costs for emergency medical transport services, as defined by Paragraph A.5., must be allocated for salaries and benefits and capital outlay. The salaries and benefits will be allocated based on the percentage of total hours logged performing EMT activities versus other activities. The capital related costs will be allocated based on the percentage of total square footage.

   c. Indirect costs are determined by applying the cognizant agency specific approved indirect cost rate to its total direct costs (Paragraph A.1.) or derived from provider’s approved cost allocation plan. For eligible PEMT providers that do not have a cognizant agency approved indirect cost rate or approved cost allocation plan, the costs and related basis used to determine the allocated indirect costs must be in compliance with OMB Circular A-87,
SUPPLEMENTAL PAYMENT FOR PUBLICLY OWNED OR OPERATED EMERGENCY MEDICAL TRANSPORTATION PROVIDERS


d. The PEMT provider specific per-medical transport cost rate is calculated by dividing the total net medical transport allowable costs (Paragraphs A.1. and A.2.) of the specific provider by the total number of medical transports as reported in the transportation daily logs provided by the PEMT provider for the applicable service period.

2. Medicaid’s portion of the total allowable cost for providing PEMT services by each eligible PEMT provider is calculated by multiplying the total number of Medicaid FFS PEMT transports provided by the PEMT provider’s specific per-medical transport cost rate (Paragraph C.1.d.) for the applicable service period.

D. Responsibilities and Reporting Requirements of the Eligible PEMT Entity

An eligible PEMT entity must do all of the following:

1. Certify that the claimed expenditures for emergency medical transportation services made by the eligible PEMT entity are eligible for FFP.

2. Provide evidence supporting the certification as specified by AHCA.

3. Submit data as specified by AHCA to determine the appropriate amounts to claim as qualifying expenditures for FFP through the CMS approved cost report and cost identification methodology.

4. Keep, maintain, and have readily retrievable any records required by AHCA or CMS.

E. AHCA’s Responsibilities

1. AHCA will submit claims for FFP for the expenditures for services that are allowable expenditures under federal law.

2. AHCA will, on an annual basis, submit to the federal government any necessary materials, including but not limited to the CMS approved cost report, in order to provide assurances that FFP will include only those expenditures that are allowable under federal law.

F. Interim Supplemental Payment

1. AHCA will make annual interim Medicaid supplemental payments to eligible PEMT providers. The interim supplemental payments for each provider are based on the

Amendment: 2015-014
Effective: 10/01/15
Supersedes: New
Approved: 10-20-16
provider's completed annual cost report in the format prescribed by AHCA and approved by CMS for the applicable cost reporting year. AHCA will make adjustments to the as-filed cost report based on the results of the most recently retrieved FLMMIS report.

2. Each eligible PEMT provider must compute the annual cost in accordance with the Cost Determination Protocols (Section C.) and must submit the completed annual as-filed cost report to AHCA five months after the close of the SFY.

3. The interim supplemental payment is calculated by subtracting the total Medicaid base payments (Paragraph B.6.) and other payments, such as Medicaid co-payments, received by the providers for PEMT services to Medicaid beneficiaries from the Medicaid portion of the total PEMT allowable costs (Paragraph C.2.) reported in the as-filed cost report or the as-filed cost report adjusted by AHCA (Paragraph F.1.).

G. Final Reconciliation

1. Providers must submit auditable documentation to AHCA within two years following the end of the state fiscal year in which payments have been received. AHCA will perform a final reconciliation where it will settle the provider's annual cost report as audited, three years following the State fiscal year end. AHCA will compute the net Medicaid PEMT allowable cost using audited per-medical transport cost, and the number of Medicaid FFS PEMT transports data from the updated FLMMIS reports. Actual net Medicaid allowable cost will be compared to the total base and interim supplemental payments and settlement payments made, and any other source of reimbursement received by the provider for the period.

2. If at the end of the final reconciliation it is determined that the PEMT provider has been overpaid, the provider will return the overpayment to AHCA, and AHCA will return the overpayment to the federal government pursuant to 42 CFR 433.316. If at the end of the final reconciliation it is determined that the PEMT provider has been underpaid, the PEMT provider will receive a final supplemental payment in the amount of the underpayment.

3. All cost report information for which Medicaid payments are calculated and reconciled are subject to CMS review and must be furnished upon request.
METHODS USED IN ESTABLISHING PAYMENT RATES

4/1/87

EMERGENCY SERVICES TO ALIENS

Claims for treatment of an emergency medical condition, as defined in the Social Security Act, will be paid for any alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Claims for inpatient emergency services will be reimbursed as indicated in Attachment 4.19-A, for outpatient emergency services as indicated in Attachment 4.19-B Exhibit I, for pharmacy and emergency ambulance as indicated in this Attachment 4.19-B, for those specific services. Claims for physician, dental and non-institutional services, will be reimbursed as indicated in this attachment, however, unlike other recipient claims, will be pended for aliens and manually reviewed to determine that the service was provided as an emergency. All other claims which are not emergency in nature will be denied.
METHODS USED IN ESTABLISHING PAYMENT RATES

7/1/91  FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES

Providers enrolled in Medicaid’s Federally Qualified Health Center (FQHC) Services program will be reimbursed at an all inclusive rate per visit that includes all services and supplies provided in the course of diagnosis and treatment of an illness or injury or to assess health status in order to detect and prevent disease, disability, and other health conditions or their progression and integral thereto.

1/1/01  The payment methodology for FQHCs will conform to section 702 of Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 (BIPA) legislation. The payment methodology for FQHCs will conform to the BIPA 2000 requirements under a prospective payment system.
Methods used in Establishing Payment Rates

Case Management Services

Reimbursement to providers of case management services will be on a fee for services basis, not to exceed the actual cost of the service when rendered by a state agency. Payment to private providers will be the lesser of the fee for service established by the state agency or the amount billed. The detailed description of the cost finding methodology is on file at the state agency.

The reimbursement rate for Targeted Case Management (TCM) for At Risk Children is established based on historical cost data of actual expenditures for this same type of service by providers who meet the qualifications as described the state plan amendment, adjusted to include only TCM allowable activities. This data is derived through a time study of case managers, all of whom meet the minimum qualifications stipulated in the Section E, Paragraph E of the state plan amendment.

An analysis of the results of the time study is used to derive a percentage of staff time spent on allowable case management activities. This percentage is then applied to the cost pool to arrive at the portion of salary and program costs that are allocable to the delivery of case management services.

The cost of a unit of service is derived by dividing the allowable cost pool by the number of children served times twelve months. A unit of service is one month in which all required services, per the state plan amendment requirements, is delivered.

The time study will be repeated annually with adjustments to the rate as indicated.
METHODS USED IN ESTABLISHING PAYMENT RATES

Reimbursement for respiratory therapy providers under the EPSDT program is based on a fee schedule determined by the state agency and will not exceed the upper limits established through the application of the parameters of 42 CFR 447.304.

Amendment 96-06
Effective 7/1/96
Supersedes 93-02

Approval 3/10/97
Revised Submission 2/10/97
METHODS USED IN ESTABLISHING PAYMENT RATES

PERSONAL CARE SERVICES:

Payment for personal care services is based on a state-developed fee schedule, which is the same for both governmental and private providers. The agency’s personal care services rates were set as of 1/01/2015, effective for services on or after this date. The fee schedules are published at: http://ahca.myflorida.com/medicaid/review/fee_schedules.shtml
Private Duty Nursing

Payments for private duty nursing rates are based on a state developed fee schedule, which is the same for both governmental and private providers. The agency’s Private Duty Nursing rates were set as of 7/1/2016, effective for services on or after this date. The fee schedules are published at: http://ahca.myflorida.com/medicaid/review/Promulgated.shtml
THERAPIES:

Reimbursement for Occupational, Physical, Respiratory, and Speech-Language Pathology Therapy rates are based on a state developed fee schedule, which is the same for both governmental and private providers.

The Agency’s Occupational, Physical, and Speech-Language Pathology Therapy rates were set as of January 1, 2016, effective for services on or after this date.

The Agency’s Respiratory Therapy rates were set as of January 1, 2015, effective for services on or after this date.

The fee schedules are published at http://ahca.myflorida.com/medicaid/review/Promulgated.shtml.
METHODS USED IN ESTABLISHING PAYMENT RATES

8/1/2012

**DURABLE MEDICAL EQUIPMENT INCLUDING PROSTHETIC DEVICES AND ORTHOTICS:**
Reimbursement is based on state-developed fee schedule rates for providers of durable medical equipment services which are the same for government and non-government providers. The agency's rates for durable medical equipment are in effect as of August 1, 2012 and are effective for services provided on or after that date. The fee schedule is subject to annual/periodic adjustment. All rates, including current and prior rates, are published and maintained on the agency's fiscal agent website. Specifically, the fee schedule and any annual/periodic adjustments to the fee schedule are published at www.MyMedicaid-Florida.com.

Amendment 2012-013
Effective 8/1/12
Supersedes 1/1/93
Approval: 11-30-12
Reimbursement Methodology

Inpatient Psychiatric Services for Individuals under 21, when provided in a psychiatric Residential Treatment Facility, licensed under Chapter 394, F.S., or in a hospital licensed under Chapter 395, F.S., are reimbursed on a per diem rate. The rate is determined under Medicare’s per diem rate-setting methodology (42 CFR 413) for psychiatric inpatient hospital services, based on cost reports submitted in accordance with Medicare’s Provider Reimbursement Manual.

Inpatient Psychiatric Services for Individuals under 21, when provided to individuals 18 through 20 years of age, in acute care settings in psychiatric units of general hospitals will be reimbursed, on a per diem basis in accordance with Florida Medicaid’s current Inpatient Hospital Reimbursement Plan.
METHODS USED IN ESTABLISHING PAYMENT RATES

Reimbursement rates for globally paid transplants include adult (age 21 and over) heart, liver, lung and intestine/multivisceral and pediatric (age 20 and under) lung and intestine multivisceral transplant services, which are paid the actual billed charges up to a global maximum rate established by the Agency. (See global rates below) These payments will be made to physicians and facilities that have met specified guidelines and are established as Medicaid-designated transplant centers. The global maximum reimbursement for transplant surgery services is an all-inclusive payment that encompasses the date of transplantation and extends through 365 days post facility discharge of transplant related care.

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

All other transplant rates are published on the Agency’s website at http://portal.flmmis.com/flpublic.

Only one provider may bill for the transplant phase.

Global maximum rates for transplantation surgery are as follows:

<table>
<thead>
<tr>
<th>Service</th>
<th>Facility</th>
<th>Physician</th>
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</thead>
<tbody>
<tr>
<td>Adult Heart</td>
<td>$135,000</td>
<td>$27,000</td>
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<tr>
<td>Adult Liver</td>
<td>$95,600</td>
<td>$27,000</td>
</tr>
<tr>
<td>Adult Lung</td>
<td>$205,000</td>
<td>$33,000</td>
</tr>
<tr>
<td>Pediatric Lung</td>
<td>$280,000</td>
<td>$40,800</td>
</tr>
<tr>
<td>Adult and Pediatric Intestinal/Multi-visceral</td>
<td>$450,000</td>
<td>$50,000</td>
</tr>
</tbody>
</table>
METHODS USED IN ESTABLISHING PAYMENT RATES

DENTAL SERVICES

Individual payments are based on a fee schedule determined by the state agency. State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published on Medicaid's fiscal agent website at http://floridamedicaid.acs-inc.com.

For adults over 21 years of age, services are limited to emergency procedures and partial and complete dentures.

Refer to Attachment 4.19-B, CLINIC SERVICES, page 33b for reimbursement in County Health Departments (CHDs).

Refer to Attachment 4.19-B, FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs), page 36 for reimbursement in FQHCs.

TN No.: 06-004
Supersedes
TN No.: New
Approval Date: 09/05/06
Effective Date: 07/01/06
1915(j) SELF-DIRECTION METHODOLOGY

DEVELOPMENTAL DISABLED WHO HAVE THE OPTION TO REMAIN IN THE STATE PLAN SELF-DIRECTION METHODOLOGY

Florida’s methodology for determining the consumer’s budget is based on the assessment of needs and the development of the service plan. The cost of providing the services included in the service plan is calculated based on the expected reimbursement for services listed on page 2 of Supplement 4 to Attachment 3.1-A under the 1915(c) waiver and the expected reimbursement for the cost of State Plan personal care services. It is adjusted to account for the self-directed service delivery model. Based on historical utilization patterns and differences in set-up and oversight, the State will use an adjustment factor of 87.25% of the expected waiver/State Plan service reimbursement to calculate the consumer’s service budget for self-directed personal assistance services.
CANCER HOSPITALS REIMBURSEMENT METHODOLOGY

REIMBURSEMENT - Eligible providers specified below will be reimbursed for Florida Medicaid reimbursable services rendered to Florida Medicaid recipients who are not enrolled in a managed care plan and who are not dually eligible Medicare and Medicaid recipients. Eligible providers shall be reimbursed up to their respective individual UPLs based on the upper payment limits described in 42 CFR 447.321 for outpatient services. Due to the effective date, October 26, 2017, the UPL gap for state fiscal year (SFY) 2017-18 will be prorated by using the ratio of effective days within SFY 2017-18 and multiplying that ratio by the UPL gap for outpatient hospital services. The calculated ratio for SFY 2017-18 is 0.6795. These supplemental payments shall be calculated quarterly and be based on the previous three months’ worth of valid claims. These supplemental payments shall be made by the last day of the following quarter.

ELIGIBLE PROVIDERS – Cancer hospitals that meet the criteria under 42 USC s. 1395ww(d)(1)(B)(v) and are members of the Alliance of Dedicated Cancer Centers, including only H. Lee Moffitt Cancer Center and University of Miami Hospital and Clinics d/b/a Sylvester Comprehensive Cancer Center, will receive the enhanced reimbursement for services rendered at these facilities. Eligible providers shall be enrolled Florida Medicaid providers.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ______________ FLORIDA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance, and Payment of Medicare Part C Deductible/Coinsurance/Copayment

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State Plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters “SP”.

For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on page 4, in item 7 of this attachment.

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, as set out on page 4 in items _7 and 8_ of this attachment.

3. Payments are up to the amount of a special rate, or according to a special method, described on pages 3 and 4, in items _4, 5, 6, 9, and 10_ of this attachment.

4. Any exceptions to the general methods used for a particular group or payment are specified on__, in item __ of this attachment.

TN No: 10-003
Supersedes Approval Date: 06-21-10 Effective Date: January 1, 2010
TN No: 08-011 HCFA ID: 7982E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance, and Payment of Medicare Part C Deductible/Coinsurance/Copayment

<table>
<thead>
<tr>
<th>QMBs:</th>
<th>Part A</th>
<th>SP Deductibles</th>
<th>SP Coinsurance</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Part B</td>
<td>SP Deductibles</td>
<td>SP Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Part C</td>
<td>SP Deductibles</td>
<td>SP Coinsurance</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Medicaid Recipients</th>
<th>Part A</th>
<th>SP Deductibles</th>
<th>SP Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Part B</td>
<td>SP Deductibles</td>
<td>SP Coinsurance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dual Eligible (QMB Plus)</th>
<th>Part A</th>
<th>SP Deductibles</th>
<th>SP Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Part B</td>
<td>SP Deductibles</td>
<td>SP Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Part C</td>
<td>SP Deductibles</td>
<td>SP Coinsurance</td>
</tr>
</tbody>
</table>
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: FLORIDA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
- OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible /Coinsurance, and Payment of Medicare Part C Deductible/Coinsurance/Copayment

01/01/10 MEDICARE PREMIUMS, DEDUCTIBLES, COINSURANCE, AND COPAYMENTS

1. Florida Medicaid shares Medicare costs in the manner described below for persons eligible under both Medicaid and Medicare, including Qualified Medicare Beneficiaries (QMB) and QMB Plus.

2. Medicare Part A Premium
Florida Medicaid covers the Part A premium for QMBs and QMB Plus. Florida Medicaid does not cover the Part A premium for the QI1, SLMB, and the Medically Needy without QMB.

3. Medicare Part B Premium
Florida Medicaid covers the Part B premium for QMBs, QMB Plus, SLMBs and QI1. Florida Medicaid does not cover the Part B premium for the Medically Needy without QMB.

4. Medicare Part A Deductible and Coinsurance
For hospitals, Medicaid payment for general and specialty hospital inpatient services are limited to the Medicare deductible and coinsurance per spell of illness. Medicaid payments for hospital Medicare Part A coinsurance are limited to the Medicaid hospital per diem rate less any amounts paid by Medicare, but only up to the amount of Medicare coinsurance. Medicaid payment for coinsurance is tied to the Medicaid per diem rate in effect for the dates of service of the crossover claims, and may not be subsequently adjusted due to subsequent per diem adjustments.

Florida Medicaid covers the Part A deductible and coinsurance for QMBs and QMB Plus. Medicaid does not cover Medicare Part A deductible and coinsurance for the QI1 or SLMB.

5. For nursing facilities, Medicaid will pay no portion of the Medicare Part A coinsurance when payment that Medicare has made for the services equals or exceeds what Medicaid would have paid if it had been the sole payer.
6. Medicare Part B Deductible and Coinsurance

Florida Medicaid covers the Medicare Part B deductible and coinsurance up to the Medicaid fee, less any amounts paid by Medicare. If this amount is negative, no Medicaid payment is made. If this amount is positive, Medicaid pays the coinsurance and deductible up to the billed or allowed amount, whichever is less. This covers all dual eligible categories including SLMB Plus. Florida Medicaid does not cover Medicare Part B deductible and coinsurance for QI1 and SLMB.

7. For freestanding end-stage dialysis centers, emergency transportation, and portable x-ray services, Medicaid reimburses 100 percent of the deductible and coinsurance.

8. Florida Medicaid covers the Medicare Part B deductible and coinsurance for Medicaid non-covered services up to 50 percent of the Medicare allowed amount, less amounts paid by Medicare. Total payments from all sources will not be less than the Medicaid established rate of payment.

Florida Medicaid covers the Part B deductible and coinsurance for non-covered Medicaid Services only for QMB and QMB Plus.

9. Medicare Part C Deductible, Coinsurance, and Copayment

Florida Medicaid covers the Medicare Part C deductible and coinsurance up to the Medicaid fee, less any amounts paid by Medicare. If this amount is negative, no Medicaid payment is made. If this amount is positive, Medicaid pays the coinsurance and deductible up to the billed or allowed amount, whichever is less.

Florida Medicaid covers the Medicare Part C copayment up to the Medicaid copayment, less any amounts paid by Medicare. If this amount is negative, no Medicaid payment is made. If this amount is positive, Medicaid pays the coinsurance and deductible up to the billed or allowed amount, whichever is less.

10. The financial obligations of Medicaid for services is based upon Medicare’s allowable, not the provider’s charge. Except for provider types noted in number seven (7) above, Medicaid will pay no portion of Medicare deductibles and coinsurance when payment that Medicare has made for the service equals or exceeds what Medicaid would have paid had it been the sole payer. The combined payment from Medicare and Medicaid shall not exceed the amount Medicaid would have paid had it been the sole payer.
I. Medicaid Method of Payment

A. Each federally qualified health center (FQHC) and rural health clinic (RHC) in the Florida Medicaid program is subject to the Medicaid Prospective Payment System (PPS) under the authority of 1902(bb) of the Social Security Act (SSA) and Title 42, Code of Federal Regulation (CFR), section 405.2401 (b).

B. Reimbursement authority for FQHC or RHCs as follows:

1. The definition of an FQHC and RHC as contained in section 4161(a)(2) of the Omnibus Budget Reconciliation Act of 1990 as described in section 1861(aa)(1)(A)-(C) of the Social Security Act (SSA).

2. The requirements created by the Agency for Health Care Administration (AHCA) for establishing and maintaining health standards under the authority of Title 42, CFR, section 431.610(c) and further interpreted by the Centers for Medicare and Medicaid Services (CMS) Pub. 15-1.

3. Any other requirements for licensing under the state law which are necessary for providing FQHC or RHC services, in accordance with Chapter 59 g-6.080, Florida Administrative Code, Florida FQHC/RHC Clinic Services Coverage and Limitations Handbook and the Florida Medicaid Provider Reimbursement Handbook.
II. Audits

All documents submitted by the provider are subject to field or desk audits at the discretion of AHCA.

A. Description of AHCA’s Procedures for Audits - General.
   1. Primary responsibility for the audit of providers shall be assumed by AHCA. AHCA audit staff may enter into contracts with certified public accountants firms to ensure that the requirements of 42 CFR section 447.202 are met.
   2. All audits shall be performed in accordance with generally accepted auditing standards of the American Institute of Certified Public Accountants as incorporated by reference in Rule 61H1-20.008 Florida Administrative Code (F.A.C.) .
   3. The auditor shall issue an opinion as to whether, in all material respects, the financial and statistical report submitted complies with all federal and state regulations pertaining to the reimbursement program for FQHC's and RHC’s.

B. Retention

All reports shall be retained by AHCA for 10 years in accordance with 42 CFR 413.

C. Overpayments and Underpayments

1. Any overpayments or underpayments for those years or partial years as determined by desk or field audits, using approved state plans, shall be reimbursable to the provider or to AHCA, as appropriate.
2. Any overpayment or underpayment that resulted from an encounter rate adjustment due to an error in either reporting or calculation of the encounter rate shall be refunded to AHCA or to the provider, as appropriate.

3. The terms of repayments shall be in accordance with section 414.41, Florida Statutes (F.S.) under the authority of 42 CFR 433, Subpart F. All underpayments will be subject to the time limitations under the authority of 45 CFR 957.7.

4. All overpayments shall be reported by AHCA to CMS, as required.

5. Information intentionally misrepresented by an FQHC or RHC shall result in a suspension of the FQHC or RHC from the Florida Medicaid program.

D. Appeals
For audits conducted by AHCA, a concurrence letter stating the results of an audit shall be prepared and sent to the provider, showing all adjustments and changes and the authority for such. Providers shall have the right to a hearing in accordance with section 120.57, F.S., for any or all adjustments made by AHCA.

III. Allowable Medicaid Reimbursement
A. Medicaid reimbursements shall be limited to an amount, if any, by which the encounter rate for any allowable claim exceeds the amount of third party benefit during the Medicaid benefit period.

B. Under this plan, an FQHC or RHC shall be required to accept Medicaid reimbursement as payment in full for covered services provided during the benefit period and billed to the Medicaid program; therefore, there shall be no payments due from Medicaid recipients.
C. There shall be no Medicaid bad debts generated by Medicaid recipients. Bad debts shall not be considered as an allowable expense.

IV. Standards

A. Effective October 1 of each year, an FQHC’s and RHC’s individual encounter rate will be increased by the percentage increase in the Medicare Economic Index (MEI) for applicable primary and preventative care services for that fiscal year.

B. For new providers entering the program, the initial encounter rate shall be established based on provider type (see section V.).

C. The individual FQHC’s and RHC’s encounter rate shall be adjusted only under the following circumstances:

1. An error was made by AHCA in the calculation of the encounter rate.

2. An increase or decrease in the scope of service(s). Only the incremental increase or decrease in the scope of service(s) will be applied to the provider’s encounter rate.

3. A. Example

   WTJ Family Clinic
   Medicaid PPS rate – October 2014 $123.54
   Increase in Scope $ 2.80
   Decrease in Scope $ 0.75
   Revised Medicaid PPS Rate $125.12

D. For purposes of this plan, a change in scope of service(s) for an FQHC and RHC is defined as:

1. The addition of a new service not previously provided by the FQHC or RHC.
2. The elimination of an existing service provided by the FQHC or RHC.

E. A change in the cost of a service such as an addition or reduction of staff members to or from an existing service is not considered a change in scope of service(s).

F. It is the responsibility of the FQHC and RHC to notify the Division of Medicaid of any change in scope of service(s) and provide proper documentation.

G. FQHC’s requesting an encounter rate adjustment as a result of an increase or decrease in their scope of service(s) shall meet the following criteria:

1. The provider must demonstrate the change in cost caused by the scope of service(s) change as defined above in Section IV. D.

2. The effective date for scope of service(s) increases will be the latter of the date the service was implemented or 75 days prior to the date the request was received. The effective date for scope of service(s) decreases will be the date the service was terminated.

3. The providers’ fiscal year end (FYE) audit shall be submitted before the scope of service(s) increase can be approved.

4. The financial data submitted for the scope of service(s) increase or decrease shall contain at least six months of actual cost information.

5. If all requested financial data for a scope of service-related encounter rate adjustment request(s) has not been received within 12 months after the FQHC’s FYE in which costs were first affected, the encounter rate adjustment request shall be granted only when all documentation has been satisfied, and any rate adjustment will be effective as of the beginning of the month in which all information was received by the Agency.
H. RHC’s that experience an increase or decrease in their scope of service(s) of greater than one percent and request an adjustment to their encounter rate shall meet the following criteria:

1. The effective date for scope of service(s) increases will be the latter of the date the service was implemented or 75 days prior to the date the request was received. The effective date for scope of service(s) decreases will be the date the service was terminated.

2. A copy of the most recent audited Medicare cost report shall be filed with the request.

3. If all requested financial data for a scope of service related encounter adjustment request has not been received within 12 months after the RHC’s FYE in which the costs were first affected, the encounter rate adjustment request shall be granted only when all documentation has been satisfied, and any rate adjustment will be effective as of the beginning of the month in which the information was received by the Agency.

4. A budgeted cost report shall be submitted (RHC Form 222-Medicare), which contains the increase or decrease costs associated with the scope of service(s).

   a. Allowable cost relates to services defined by section 1861(aa) (1) (A)-(C) of the SSA as:
      1. Physician services.
      2. Services and supplies incident to physician services (including drugs and biologicals that cannot be self administered).
3. Pneumococcal vaccine and its administration and influenza vaccine and its administration.

4. Physician assistant services.

5. Nurse practitioner services.

6. Clinical psychologist services.

7. Clinical social work services.

Also included in allowable costs are costs associated with case management, transportation, on-site lab, and on-site X-ray services.

b. Pharmacy and immunization costs shall be reimbursed through the Title XIX pharmacy program utilizing current fee schedules established for those services. Costs relating to contracted pharmacy services shall be reported under non-allowable services and adjusted out in full.

c. Costs relating to the following services are excluded from the encounter rate:

1. Ambulance services

2. Home health services

3. WIC certifications and recertifications

4. Any health care services rendered away from the center, at a hospital, or a nursing home. (These services include off-site radiology services and off-site clinical laboratory services. However, the health care rendered away from the center may be billed under other Florida Medicaid programs, if eligible.)

I. Under no circumstances shall the initial encounter rate exceed the reimbursement ceiling established (described in section V.).

Amendment: 2014-012
Effective: 07/01/14
Supersedes: 2003-014
Approved: 04-02-15
J. The approved FQHC or RHC scope of service(s) encounter rate adjustment will be added to their encounter rates.

K. Any encounter rate adjustment or denial of a encounter rate adjustment by AHCA may be appealed by the provider in accordance with section 120.57, F.S.

L. In a change in ownership, the new owner will adopt the previous owner’s Medicaid PPS encounter rate.

V. Method

This section defines the methodologies used by the Florida Medicaid program in establishing reimbursement ceilings and individual FQHC and RHC reimbursement encounter rates.

A. Setting Reimbursement Ceilings

The reimbursement ceiling shall be established and applied to all new FQHC and RHC providers entering the Florida Medicaid program.

1. The FQHC reimbursement ceiling shall be calculated by taking the sum of all the encounter rates divided by the number of providers in the Florida Medicaid program.

2. The RHC reimbursement ceiling shall be calculated by taking the sum of all the encounter rates divided by the number of providers in the Florida Medicaid program.

B. Florida Medicaid PPS

For the Florida Medicaid PPS, January 1, 2001 through September 30, 2001, Medicaid will compute a base rate for current FQHCs and RHC's by taking the average of their Florida Medicaid rates set by the center’s fiscal year 1999 and 2000 cost reports. Effective October 1, 2001 and every October 1 thereafter, the
rate will be increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services for that fiscal year.

C. Setting Individual Center Encounter Rates - FQHC

1. For new providers entering the program, the initial encounter rate shall be established by taking an average of the encounter rates for centers in the same county.

2. In the absence of centers in the same county, encounter rate shall be established by taking an average of the encounter rates for centers in the same area (AHCA geographic area).

3. In the absence of centers in the same county and area, the facility encounter rate will be the reimbursement ceiling as defined in Section V.A.1.

4. All subsequent encounter rates shall be determined every October 1 by multiplying the encounter rate by the MEI for primary care services for the fiscal year.

D. Setting Individual Center Encounter Rates - RHC

1. For new providers entering the program, the initial encounter rate is determined by using the lower of the current Medicare encounter rate established by the Title XVIII Medicare carrier or the ceiling established in section V(A.).

2. All subsequent encounter rates shall be determined every October 1 by multiplying the encounter rate by the MEI for primary care services for the fiscal year.
VI. Supplemental Payments

In accordance with section 1902(bb)(5) of the SSA, Florida Medicaid is required to make supplemental payments (at least quarterly) to FQHC’s (provider type 68) and RHC’s (provider type 66) that contract with Medicaid managed care plans representing the difference, if any, between the Medicaid managed care plans’ payment to the contracting FQHC/RHC and the payment to which the FQHC/RHC would be entitled for the services under the SSA. In order for this supplemental payment to apply, the FQHC/RHC shall have a contract with the Medicaid managed care plans providing services under the Statewide Medicaid Managed Care program. Physicians (provider type 25) are not eligible to receive supplemental payments. Only claims filed with the Medicaid managed care plans using provider type 68 or 66 are eligible to receive Florida Medicaid supplemental payments. FQHC requests for supplemental payments shall be submitted to Florida Medicaid no later than 30 days from the end of the quarter being reported. RHC requests for supplemental payments may be submitted monthly, to be received no later than 15 days from the end of the month being reported. Supplemental payment instructions and electronic submission forms can be located on the Florida Medicaid Web site. The methodology for calculating the Florida Medicaid supplemental payments for FQHCs and RHCs includes a reconciliation of the payments and at least a quarterly payment schedule, which ensures that the payments are in accordance with section 1902(bb)(5) of the SSA.

VII. Payment Assurance

The state shall pay each FQHC and RHC for services provided in accordance with the requirements of the Florida Title XIX Federally Qualified Health Center and Rural Health Clinic Reimbursement Plan, in accordance with Title 42, CFR, section 405.2401 and
Chapter 59G-6.080, Florida Administrative Code, Florida FQHC/RHC Clinic Services Coverage and Limitations Handbook and the Florida Medicaid Provider Reimbursement Handbook. The payment amount shall be determined for each FQHC and RHC according to the standards and methods set forth in the Florida Title XIX Federally Qualified Health Center and Rural Health Clinic Reimbursement Plan.

VIII. Provider Participation

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

IX. Revisions

The plan shall be revised as operating experience data are developed and as changes are necessary in accordance with modifications in the CFR.

X. Payment in Full

Participation in the program shall be limited to FQHC’s and RHC’s which accept as payment in full for covered services the amount paid in accordance with the Florida Title XIX Federally Qualified Health Center and Rural Health Clinic Reimbursement Plan.

XI. Glossary

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

B. AHCA - Agency for Health Care Administration.

C. CMS - Centers for Medicare and Medicaid Services.

D. CMS-Pub. 15-1 - Also known as the Provider Reimbursement Manual, published by the Department of Health and Human Services, the Centers for Medicare and

Amendment: 2014-012
Effective: 07/01/14
Supersedes: 2003-014
Approved: 04-02-15
Medicaid Services. This manual details cost finding principles for institutional providers for Medicare and Medicaid reimbursement and is incorporated by reference in Rule 59G-6.010, F.A.C.

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

F. Encounter - A face-to-face contact between a recipient and a health care professional who exercises independent judgment in the provision of health services to the individual recipient. For a health service to be defined as an encounter, the provision of the health service shall be recorded in the recipient's record and completed on site. Categorically, encounters are:

1. Physician. An encounter between a physician and a recipient during which medical services are provided for the prevention, diagnosis, treatment, and rehabilitation of illness or injury.

2. Midlevel practitioner. An encounter between a advanced registered nurse practitioner (ARNP) or a physician’s assistant (PA) and a recipient when the ARNP or PA exercises independent judgement in providing health services.
3. Dental. An encounter between a dentist and a recipient for the purpose of prevention, assessment, or treatment of a dental problem, including restoration.

4. Mental Health. An encounter between a licensed psychologist or licensed clinical social worker and recipient for the diagnosis and treatment of mental illness.

G. Encounter rate - The approved Medicaid reimbursement rate based on the Medicaid PPS system.

H. Medicaid prospective payment system - is a method of reimbursement in which Medicaid payment is made based on a predetermined, fixed amount.

I. Rate period - October 1 of a calendar year through September 30 of the next calendar year.

J. Title XVIII - The sections of the federal SSA, certified in Title 42 of the United States Code (U.S.C.) 1395 et seq., and regulations there under that authorize the Medicare program.

K. Title XIX - The sections of the federal SSA, certified in Title 42 of the U.S.C. 1396 et seq., and regulations there under that authorize the Medicaid program.
FLORIDA TITLE XIX COUNTY HEALTH DEPARTMENT

REIMBURSEMENT PLAN

VERSION XV

EFFECTIVE DATE: July 1, 2017

I. Cost Finding and Cost Reporting

A. Each county health department (CHD) participating in the Florida Medicaid program shall submit one complete, legible copy of a cost report to the Agency for Health Care Administration (AHCA), Bureau of Medicaid Program Finance, Division of Cost Reimbursement, postmarked or accepted by a common carrier no later than five calendar months after the close of its cost reporting year.

B. Cost reports available to AHCA pursuant to section IV of this plan, shall be used to initiate this plan.

C. Each CHD is required to detail costs for its entire reporting year, making appropriate adjustments as required by this plan for determination of allowable costs. A prospective reimbursement rate shall not be established for a CHD based on a cost report for a period less than 12 months. Interim rates shall be cost settled for the interim rate period.

D. The cost report shall be prepared in accordance with the method of reimbursement and cost finding of Title XVIII (Medicare) Principles of Reimbursement described in Title 42, Code of Federal Regulations (CFR), Chapter 413, and further interpreted by the Provider Reimbursement Manual, Centers for Medicare and Medicaid Services (CMS) Pub. 15-1, as incorporated by reference in Rule 59G-6.040, Florida Administrative Code (F.A.C.), except as modified by Title XIX of the Social Security Act (SSA), this plan, requirements of licensure and certification, and the duration and scope of benefits provided under the Florida Medicaid program.

E. Each CHD shall file a legible and complete cost report within five months, or six months (if a certified report is being filed), after the close of its reporting period.
F. If a CHD provider submits a cost report late, after the five month period, and that cost report would have been used to set a lower reimbursement rate for a rate period had it been submitted within five months, then the CHD provider's rate for that rate period shall be calculated using the new cost report, and full payments at the recalculated rate shall be effective retroactively.

G. AHCA shall retain all uniform cost reports filed for a period of at least five years following the date of filing of such reports and shall maintain those reports pursuant to the record-keeping requirements of 45 CFR section 205.60. Access to filed cost reports shall be in conformity with Chapter 119, Florida Statutes (F.S.).

H. 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 Florida Medicaid reimbursements and payments, and that the services identified in this cost report were provided in compliance with such laws and regulations.”

I. The services provided at each CHD are in compliance with 42 CFR section 440.90, Clinic Services.

J. AHCA reserves the right to refer providers found to be out of compliance with any of the policies and procedures regarding cost reporting to the Bureau of Medicaid Program Integrity for investigation.

K. Providers are subject to sanctions pursuant to section 409.913(15)(c) and 409.913(16)(c), F.S., for late cost reports. The amount of the sanctions can be found in Rule 59G-9.070, F.A.C. A cost report is late if it is not received by AHCA, Bureau of Medicaid Program Finance, Division of Cost Reimbursement, on the first cost report acceptance cut-off date after the cost report due date.

II. Audits

All cost reports and related documents submitted by the providers shall be either field or desk audited at the discretion of AHCA.

A. Description of AHCA’s Procedures for Audits - General.
1. Primary responsibility for the audit of providers shall be assumed by AHCA. AHCA audit staff may enter into contracts with certified public accountant firms to ensure that the requirements of 42 CFR section 447.202 are met.

2. All audits shall be performed in accordance with generally accepted auditing standards as incorporated by reference in Rule 61H1-20.008, F.A.C., of the American Institute of Certified Public Accountants.

3. The auditor shall issue an opinion as to whether, in all material respects, the financial and statistical report submitted complies with all federal and state regulations pertaining to the reimbursement program for CHDs. All reports shall be retained by AHCA for three years.

B. Retention

All audit reports issued by AHCA shall be kept in accordance with 45 CFR section 205.60.

C. Overpayments and Underpayments

1. Any overpayments or underpayments for those years or partial years as determined by desk or field audits, using approved state plans, shall be reimbursable to the provider or to AHCA as appropriate.

2. 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.

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

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

5. All overpayments shall be reported by AHCA to CMS, as required under the authority of 42 CFR 433, Subpart F. All underpayments will be subjected to the time limitations under the authority of 45 CFR 95.7.
6. Information intentionally misrepresented by a CHD in the cost report shall result in a suspension from the Florida Medicaid program.

D. Appeals

For audits conducted by AHCA, a concurrence letter that states the results of an audit shall be prepared and sent to the provider, showing all adjustments and changes and the authority for such. Providers shall have the right to a hearing in accordance with section 120.57, F.S., for all adjustments made by AHCA.

III. Allowable Costs

Allowable costs for purposes of computing the encounter rate shall be determined in accordance with the provisions outlined within this reimbursement plan. These include:

A. Costs incurred by a CHD in meeting:
   1. The definition of a CHD. Those counties recognized by the Florida Department of Health that have as their purpose the provision and an administration of public health services as defined in Chapter 154, F.S.
   2. The requirements created by AHCA for establishing and maintaining health standards under the authority of 42 CFR section 431.610(c).
   3. Any other requirements for licensing under the state law which are necessary for providing county health department services.

B. A CHD shall report its total cost in the cost report. However, only allowable health care services costs and the appropriate indirect overhead cost, as determined in the cost report, shall be included in the reimbursement rate. Non-allowable services costs and the appropriate indirect overhead, as determined in the cost report, shall not be included in the reimbursement rate.

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

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

E. Allowable costs of contracts for physician services shall be limited to the prior year's contract amount, or a similar prior year's contract amount, increased by an inflation factor based on the consumer price index (CPI) for services rendered in the contract.

IV. Standards

A. Changes in individual CHD rates shall be effective July 1 of each year.

B. All cost reports received by AHCA as of April 15 of each year shall be used to establish the encounter rates for the following rate period.

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

1. An error was made by AHCA in the calculation of the CHD's rate.

2. A provider submits an amended cost report used to determine the rates in effect. An amended cost report may be submitted in the event that it would cause a change of one percent or more in the total reimbursement rate. The amended cost report must be filed by the filing date of the subsequent cost report. An audited cost report may not be amended. A cost report shall be deemed audited 30 days after the exit conference between field audit staff and the provider has been completed.
3. Further desk or on-site audits of cost reports used in the establishment of the prospective rates, disclose a change in allowable costs in those reports.

D. Any rate adjustment or denial of a rate adjustment by AHCA may be appealed by the provider in accordance with section 120.57, F.S.

E. CHD services are reimbursed as defined in Rule 59G-4.055, F.A.C.

F. Prescription drugs and immunization costs shall be reimbursed through Florida Medicaid’s prescribed drug services. These costs shall be reported in the cost report as non-allowable services and product cost shall be adjusted out. Costs relating to contracted prescribed drug services shall be reported under non-allowable services and adjusted out in total.

G. Costs relating to the following services are excluded from the encounter rate and shall be reported in the cost report under non-allowable service:
   1. Ambulance services.
   2. Home health services.
   3. WIC certifications and recertifications.
   4. Any health care services rendered away from the clinic, at a hospital, or a nursing home. (These services include off-site radiology and clinical laboratory services. However, services rendered away from the clinic may be billed under the appropriate Florida Medicaid service-specific coverage policy, if eligible).

V. Methods

This section defines the methodologies used by the Florida Medicaid program in establishing individual CHD reimbursement encounter rates on July 1 of each year. The services provided at each CHD are in compliance with 42 CFR section 440.90.

A. Setting Individual CHD Rates.
1. Review and adjust each CHD's cost report available to AHCA as of April 15 to reflect the results of desk and field audits.

2. Determine each CHD's encounter rate by dividing total allowable cost by total allowable encounters.

3. Adjust each CHD's encounter rate with an inflation factor based on the CPI of the midpoint of the CHD's cost reporting period divided into the CPI projected for December 31 of each year. The adjustment shall be made utilizing the latest available projections from the Data Resource Incorporation (DRI) CPI (Appendix A).

B. Method of Establishing Historical Rate Reductions

1. AHCA shall apply a recurring methodology to establish rates taking into consideration the reductions imposed in the following manner:
   a. AHCA shall divide the total amount of each recurring reduction imposed by the number of visits originally used in the rate calculation for each rate setting period which will yield a rate reduction per diem for each rate period.
   b. AHCA shall multiply the resulting rate reduction per diem for each rate setting period by the projected number of visits used in establishing the current budget estimate, which will yield the total current reduction amount to be applied to current rates.
   c. In the event the total current reduction amount is greater than the historical reduction amount, AHCA shall hold the rate reduction to the historical reduction amount.

2. The recurring methodology includes an efficiency calculation where the reduction amount is subtracted from the CHD prospective rate to calculate the final prospective rate which cannot exceed the $180 ceiling rate or be lower than the $100 floor rate. If the floor rate...
is higher than the CHD prospective rate then use the CHD prospective rate which cannot exceed cost.

C. Applying Historical Reductions to Rates

1. Apply the first rate reduction based on the steps outlined in section V.A. The rates shall be proportionately reduced until the required savings is achieved.

2. Apply the first, and all subsequent rate reductions based on the steps outlined in section V.A. The rates shall be proportionately reduced until the required savings is achieved.

3. The unit cost for the current rate setting is compared to the budgeted unit cost for state fiscal year (SFY) 2010-2011 ($163.10). If the unit cost for the current rate setting is less than the budgeted unit cost for SFY 2010-2011, no further rate reduction is required.

4. Buy-back clinic services are provided $8,925,168 for rate reductions that were effective on or after July 1, 2008.

5. The total Buy-back amount cannot exceed the total rate reduction as listed in Appendix B.

VI. Payment Assurance

AHCA shall pay each CHD for services provided in accordance with the requirements of the Florida Title XIX County Health Department Reimbursement Plan and applicable state and federal rules and regulations. The payment amount shall be determined for each CHD according to the standards and methods set forth in the Florida Title XIX County Health Department Reimbursement Plan.

VII. Provider Participation

This plan is designed to assure adequate participation of CHD's in the Florida Medicaid program, the availability of CHD services of high quality to recipients, and services which are comparable to those available to the general public in accordance with 42 CFR section 447.204.
VIII. Revisions

The plan shall be revised as operating experience data are developed and the need for changes are necessary in accordance with modifications in the CFR.

IX. Payment in Full

Participation in the Florida Medicaid program shall be limited to CHD’s which accept as payment in full for covered services the amount paid in accordance with the Florida Title XIX County Health Department Reimbursement Plan.

X. Glossary

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

B. AHCA - Agency for Health Care Administration.

C. Base rate - A CHD’s per diem reimbursement rate before a Medicaid trend adjustment or a buy-back is applied.

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

E. Buy-back - A provision that allows a CHD to decrease the Medicaid trend adjustment from the established percent down to zero percent.

F. CMS-Pub. 15-1 - Manual detailing cost finding principles for institutional providers for Medicare and Medicaid reimbursement (also known as the Provider Reimbursement Manual published by the Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services) which is incorporated by reference in Rule 59G-6.010.

G. County health department clinic services - Medicaid CHD clinic services consist of primary and preventive health care, related diagnostic services, and dental services.
H. Cost reporting year - A 12-month period of operation based upon the provider's accounting year.

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

J. Encounter - An encounter is a single day, face-to-face visit between a recipient and health care professional(s). Two encounters cannot be reimbursed on the same day even if the visits are for different types of services such as a Child Health Check-Up screening and a dental service.

Categorically, encounters are:

1. Physician. An encounter between a physician and a recipient during which medical services are provided for the prevention, diagnosis, treatment, and rehabilitation of illness or injury.

2. Midlevel practitioner. An encounter between an advanced registered nurse practitioner (ARNP) or a physician assistant (PA) and a recipient when the ARNP or PA acts as an independent provider.

3. Nurse. An encounter between a registered nurse and a recipient in which the nurse acts as an independent provider of medical services. The service may be provided under standing protocols of a physician, under specific instructions from a previous visit, or under the general supervision of a physician or midlevel practitioner who has no direct contact with the recipient during a visit.

4. Dental. An encounter between a dentist and a recipient for the purpose of prevention, assessment, or treatment of a dental problem, including restoration.
K. Filing due date - No later than five calendar months after the close of the CHD cost-reporting year.

L. HHS - Department of Health and Human Services.

M. Interim rate - A reimbursement rate that is calculated from budgeted cost data and is subject to cost settlement.

N. 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.

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

P. Medicaid trend adjustment (MTA) - A proportional percentage rate reduction that is uniformly applied to all Florida Medicaid providers’ rate semester which equals all recurring and nonrecurring budget reductions on an annualized basis. The MTA is applied to all components of the prospective per diem.

Q. Rate period - July 1 of a calendar year through June 30 of the next calendar year.

R. Rate setting due date - All cost reports received by AHCA by April 15 of each year.

S. Rate setting unit cost - The weighted average per diem after all rate reductions but prior to any buybacks based on submitted cost reports.

T. Title XVIII - The sections of the federal SSA, as certified by Title 42, United States Code (U.S.C.) 1395 et seq., and regulations thereunder that authorize the Medicare program.

U. Title XIX - The sections of the federal SSA, as certified by 42 U.S.C. 1396 et seq., and regulations thereunder that authorize the Florida Medicaid program.
CALCULATION OF INFLATION INDEX

1. An inflation index used in adjusting each county health department’s (CHD) encounter rate for inflation, developed from the DRI CPI All Urban (All Items) inflation indices. An example of the technique is detailed below. Assume the following DRI quarterly indices for the South Atlantic Region:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>1.504</td>
<td>1.542</td>
<td>1.574</td>
<td>1.621</td>
<td>1.647</td>
</tr>
<tr>
<td>Q2</td>
<td>1.514</td>
<td>1.539</td>
<td>1.596</td>
<td>1.626</td>
<td>1.649</td>
</tr>
<tr>
<td>Q3</td>
<td>1.526</td>
<td>1.544</td>
<td>1.606</td>
<td>1.633</td>
<td>1.660</td>
</tr>
<tr>
<td>Q4</td>
<td>1.540</td>
<td>1.558</td>
<td>1.613</td>
<td>1.639</td>
<td>1.665</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Index</th>
<th>Average Index</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1.504</td>
<td>1.509</td>
<td>MARCH 31</td>
</tr>
<tr>
<td>2</td>
<td>1.514</td>
<td>1.520</td>
<td>JUNE 30</td>
</tr>
<tr>
<td>3</td>
<td>1.526</td>
<td>1.533</td>
<td>SEPTEMBER 30</td>
</tr>
<tr>
<td>4</td>
<td>1.540</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
April 30 Index = (June 30 Index/March 31 Index)$^{1/3}$ (March 31 Index)

= $(1.520/1.509)^{1/3} (1.509)$

= 1.512

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

= $(1.520/1.509)^{2/3} (1.509)$

= 1.516

All other monthly indices can be calculated in a similar fashion. To determine the applicable inflation factor for a given CHD for the rate period July 1, 2014, the index for December 31, 2014, the midpoint of the rate period, is divided by the index for the midpoint of the provider's fiscal year. For example, if a CHD has a fiscal year end of June 30, 2013, then its midpoint is December 31, and the applicable inflation is:

December 2014 Index/December 2012 Index$(1.706/1.643)$

= 1.03834

Therefore, the CHD's Florida Medicaid encounter rate as established by the cost report is multiplied by 1.03834 to obtain the prospectively determined rate for the rate period July 1, 2014 through June 30, 2015.
# APPENDIX B

**FLORIDA TITLE XIX COUNTY HEALTH DEPARTMENT**

**REIMBURSEMENT PLAN**

## Medicaid Trend Adjustment (MTA) Percentages

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Percentages</th>
<th>Reduction Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 1, 2008</td>
<td>5.9781%</td>
<td>$7,426,780</td>
</tr>
<tr>
<td>2. March 1, 2009</td>
<td>5.7808%</td>
<td>$1,907,971</td>
</tr>
<tr>
<td>3. July 1, 2009</td>
<td>First Cut</td>
<td>5.1307% $5,601,154</td>
</tr>
<tr>
<td></td>
<td>Second Cut</td>
<td>5.5267% $5,723,913</td>
</tr>
<tr>
<td></td>
<td>Third Cut</td>
<td>.123013% $120,361</td>
</tr>
<tr>
<td>4. July 1, 2010</td>
<td>First Cut</td>
<td>4.16308% $5,601,154</td>
</tr>
<tr>
<td></td>
<td>Second Cut</td>
<td>4.43912% $5,723,913</td>
</tr>
<tr>
<td></td>
<td>Third Cut</td>
<td>.097681% $120,361</td>
</tr>
<tr>
<td></td>
<td>Fourth Cut</td>
<td>27.7950% $36,984,286</td>
</tr>
<tr>
<td>5. July 1, 2011</td>
<td>First Cut</td>
<td>3.5186% $5,601,154</td>
</tr>
<tr>
<td></td>
<td>Second Cut</td>
<td>3.7269% $5,723,913</td>
</tr>
<tr>
<td></td>
<td>Third Cut</td>
<td>0.0814% $120,361</td>
</tr>
<tr>
<td></td>
<td>Fourth Cut</td>
<td>25.0332% $36,984,286</td>
</tr>
<tr>
<td></td>
<td>Second Cut</td>
<td>3.762456% $5,723,913</td>
</tr>
<tr>
<td></td>
<td>Third Cut</td>
<td>.082209% $120,361</td>
</tr>
<tr>
<td></td>
<td>Fourth Cut</td>
<td>25.281816% $36,984,286</td>
</tr>
<tr>
<td></td>
<td>Fifth Cut</td>
<td>13.087637% $14,305,285</td>
</tr>
<tr>
<td>7. July 1, 2013</td>
<td>First Cut</td>
<td>4.06110% $5,601,154</td>
</tr>
<tr>
<td></td>
<td>Second Cut</td>
<td>4.432578% $5,723,913</td>
</tr>
<tr>
<td></td>
<td>Third Cut</td>
<td>.09507% $120,361</td>
</tr>
<tr>
<td></td>
<td>Fourth Cut</td>
<td>28.03615% $35,459,164</td>
</tr>
<tr>
<td></td>
<td>Fifth Cut</td>
<td>12.42594% $11,309,767</td>
</tr>
</tbody>
</table>

Amendment 2016-027  
Effective July 1, 2016  
Supersedes 2015-010  
Approval Date:01/20/17
<table>
<thead>
<tr>
<th>Date</th>
<th>First Cut</th>
<th>Second Cut</th>
<th>Third Cut</th>
<th>Fourth Cut</th>
<th>Fifth Cut</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 1, 2014</td>
<td>5.348313%</td>
<td>$3,490,065</td>
<td>5.774361%</td>
<td>$3,566,556</td>
<td>.127385%</td>
</tr>
<tr>
<td></td>
<td>30.663694%</td>
<td>$17,823,174</td>
<td></td>
<td></td>
<td>14.105514%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>July 1, 2015</td>
<td>4.82554%</td>
<td>$799,883</td>
<td>5.181325%</td>
<td>$817,414</td>
<td>.111358%</td>
</tr>
<tr>
<td></td>
<td>27.33862%</td>
<td>$4,084,869</td>
<td></td>
<td></td>
<td>12.0047%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>July 1, 2016</td>
<td>4.853741%</td>
<td>$506,286</td>
<td>4.857250%</td>
<td>$517,382</td>
<td>.106120%</td>
</tr>
<tr>
<td></td>
<td>25.53950%</td>
<td>$2,285,518</td>
<td></td>
<td></td>
<td>10.93986%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>July 1, 2017</td>
<td>4.30639%</td>
<td>$557,405</td>
<td>4.59882%</td>
<td>$569,622</td>
<td>.100210%</td>
</tr>
<tr>
<td></td>
<td>24.11371%</td>
<td>$2,846,574</td>
<td></td>
<td></td>
<td>10.13505%</td>
</tr>
</tbody>
</table>
I. Purpose of the Plan

This Outpatient Hospital Reimbursement Plan establishes the methodology for calculating the line item reimbursement rates for covered Florida Medicaid outpatient hospital services. Other rates established for non-line item payments are referenced in the coverage policy. In addition, policy for coverage of Florida Medicaid outpatient hospital services is established in the Florida Medicaid Outpatient Hospital Services Coverage policy incorporated by reference in Rule 59G-4.160, F.A.C.

II. Standard

A. Each hospital participating in the Florida Medicaid program shall be paid based on a prospective payment system for outpatient services.

B. AHCA reserves the right to submit any provider found to be out of compliance with any of the policies and procedures regarding reimbursement to the Bureau of Medicaid Program Integrity for investigation.

C. AHCA shall implement a methodology for establishing base reimbursement rates for each hospital. The base reimbursement rate is defined in Section III of AHCA’s Outpatient Hospital Reimbursement Plan. Rates shall be calculated annually and take effect July 1 of each year.

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

E. Certain revenue codes are not reimbursed by Florida Medicaid. Service rendered under these codes shall not be recorded on the Florida Medicaid log and shall not be billed to Florida Medicaid. The list of covered revenue codes is attached as Appendix A. Modifications of this list subsequent to the implementation of this plan shall appear in the most recent version of the Florida Medicaid Outpatient Hospital Reimbursement Plan.
Medicaid Outpatient Hospital Services Coverage policy incorporated by reference in Rule 59G-4.160, F.A.C. Revenue code 510, Clinic/General is reimbursable by Florida Medicaid, in accordance with the most recent version of the Florida Medicaid Outpatient Hospital Services Coverage policy, for health care services, in outpatient clinic facilities where a non-state government owned or operated facility assumed the fiscal and operating responsibilities of one or more primary care centers previously operated by the Florida Department of Health or the local county government.

### III. EAPG Reimbursement

This section defines the methods used by the Florida Medicaid Program for reimbursement of hospital outpatient visits using a prospective payment system based on Enhanced Ambulatory Patient Groups (EAPGs), effective July 1, 2017. The EAPG payment methodology categorizes for purposes of calculating reimbursement the amount and type of outpatient services used in ambulatory visits by grouping together procedures, medications and materials that share similar characteristics and resource utilization. Each category is assigned an EAPG code and each EAPG code is assigned a relative weight used in calculating payment. EAPG grouping and payment is used for all services and items furnished during an outpatient visit, unless otherwise specified in this plan.

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 hospital outpatient visits using an EAPG-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

ment: 2017-008
Effective Date: July 1, 2017
Supersedes: 2016-034
Approval Date: 3/22/18
hospitals, long term acute care specialty hospitals, critical access hospitals, and state-owned psychiatric
specialty hospitals.

For hospitals reimbursed via the EAPG-based methodology, all outpatient services provided at these
facilities and billed on a UB-04 paper claim form or an 837I electronic claim are covered by the EAPG
payment with the following exceptions – services covered under the transplant global fee are
reimbursed as described in section VIII.1 of Attachment 4.19-A and vagus nerve stimulators are
reimbursed as described in Attachment 4.19-B.

B. EAPG Codes and Relative Weights

1. AHCA utilizes Enhanced Ambulatory Patient Groups (EAPGs) created by 3M Health Information
   Systems (HIS) for assigning classifications to services and materials identified on outpatient
   claims.

2. The EAPG relative weights utilized are national EAPG relative weights calculated by 3M HIS
   using a database containing millions of hospital outpatient visits. The relative weights are
   available on the AHCA website at,

   http://ahca.myflorida.com/medicaid/cost_reim/hospital_rates.shtml

3. EAPG version 3.12 codes and national relative weights are being used for hospital outpatient
   pricing in SFY 2017-2018.

C. Hospital Base Rate

1. One standardized EAPG hospital base rate is calculated using historical claims data.

   For State Fiscal Year (SFY) 2017-2018, some hospitals receive the standardized base rate and
   other hospitals receive a base rate that is higher or lower than the standardized base rate. Each
   hospital’s base rate is determined so that their modeled change in annual Medicaid reimbursement
   resulting from the shift from cost-based per-service rates to EAPG rates is no greater than five
   percent (changes in automatic rate enhancement distributions in SFY 2017-2018 are unrelated to
   the shift to EAPG pricing and are not included in the EAPG base rate adjustments). A hospital is
given an EAPG base rate for SFY 2017-2018 that is less than the standardized base rate if the
hospital’s Medicaid outpatient reimbursement estimated when using the standardized EAPG base rate is more than five percent above reimbursement estimated using SFY 2016-2017 cost-based per-service rates. The reduced base rate limits the hospital’s projected gains from the shift to EAPG payment. Similarly, a hospital is given an EAPG base rate for SFY 2017-2018 that is greater than the standardized base rate if the hospital’s Medicaid outpatient reimbursement estimated when using the standardized EAPG base rate is more than five percent below reimbursement estimated using SFY 2016-2017 cost-based per-service rates. The increased base rate limits the hospital’s projected losses from the shift to EAPG payment. The estimates of hospital-specific change in Medicaid outpatient reimbursement used in setting SFY 2017-2018 EAPG base rates exclude automatic rate enhancements. Because of this exclusion, a hospital’s overall estimated decrease in Medicaid outpatient reimbursement may be greater than five percent. The hospital EAPG base rates are available on the AHCA website at http://ahca.myflorida.com/medicaid/cost_reim/hospital_rates.shtml.

2. Base rates and other EAPG pricing methodology parameters are established by AHCA to achieve budget neutrality, and to be compliant with federal upper payment limit requirements.

3. EAPG base rates and projected changes in hospital Medicaid outpatient reimbursement are calculated using historical claims data from a twelve-month period, referred to as the “base year”. Because of Florida Medicaid’s implementation of statewide mandatory Medicaid managed care, the base year historical claims dataset includes claims from both the fee-for-service and managed care programs. In general, claim data from the base year is used to simulate future outpatient Medicaid claim payments for the purpose of setting the EAPG base rates and other EAPG provider policy adjustors. The claim payments from the base year may be adjusted for Medicaid volume, inflation, changes in payment method, and other program changes as applicable so that the base year data approximates the upcoming rate year as closely as possible. For SFY 2017-2018 rate setting, some procedure codes and EAPG codes were added to claim service lines in the base year historical claims dataset to approximate anticipated changes in hospital billing practices
once EAPG payment is implemented. Under the EAPG payment method, service line procedure code is the primary data element used in determining the EAPG code and relative weight. However, procedure code is not required for most types of services under the cost-based payment method used in SFY 2016-2017.

4. Annual Updates:

a. Base year historical claims used to calculate the EAPG base rate had a claim header level first date of service between April 1, 2015 and March 31, 2016.

b. Total outpatient reimbursement amount used to ensure budget neutrality was the sum of per-service and laboratory fee schedule payments applied to the base year claims using SFY 2016-2017 Florida Medicaid rates and pricing rules and then adjusted based on Legislative direction for SFY 2017-2018. The only budgetary adjustment applied for SFY 2017-2018 that had an affect on the EAPG base rate was a shift of $17.3 million out of hospital outpatient claim payments and into supplemental graduate medical education payments.

c. The EAPG base rate was calculated with an assumption that overall Florida Medicaid outpatient case mix will increase by two (2) percent above the case mix measured on claims in the base year. Case mix was predicted to increase by two (2) percent because of appropriate changes in hospital billing practices necessary to achieve appropriate reimbursement under the EAPG payment method. The result of these assumptions was a reduction of the standardized EAPG base rate by about two (2) percent over what would be calculated if case mix was assumed to be unchanged.

D. Per Service Rate Enhancement Payments

1. A per-payable-service rate enhancement called an “automatic rate enhancement” is applied to each payable claim line for hospital outpatient services.

2. An annual allocation of automatic rate enhancement payments are identified for each qualifying hospital in the Medicaid Hospital Funding Program Fiscal Year Final Conference Report, which is part of the General Appropriations Act determined by the Florida Legislature. Separate
allocations are made for hospital inpatient and hospital outpatient services. These allocations are included in the provider rate worksheets available on the AHCA website at http://ahca.myflorida.com/medicaid/cost_reim/hospital_rates.shtml.

3. For each hospital receiving automatic rate enhancements, a per-payable-service-line payment amount is calculated by dividing the full, annual allotment by the number of Medicaid outpatient payable service lines in the base year for both the fee-for-service and managed care programs.

4. Only a portion of the annual allotment is distributed through fee-for-service claims. The rest is included in managed care capitation rates and is to be distributed by managed care plans through their claim payments.

5. Claim service lines that receive a bundled EAPG payment will still receive an automatic rate enhancement payment.

6. Claim service lines adjudicated after a recipient reaches his/her annual hospital outpatient benefit limit will have the automatic rate enhancement payment set to $0.

7. Claim service lines that receive a status of “Denied” will have the automatic rate enhancement payment set to $0.

**E. Policy Adjustors**

1. Policy adjustors are numerical multipliers included in the EAPG claim service line payment calculation that allow AHCA to increase or decrease payments to categories of services and/or categories of providers.

2. Only one policy adjustor, a provider policy adjustor, has been built into the EAPG-based payment method and is applied to two categories of hospitals – rural hospitals and hospitals with very high Medicaid outpatient utilization.
   a. Rural hospitals are identified in section 395.602, F.S.
   b. High Medicaid outpatient utilization hospitals are those who have 55 percent or more of their total annual outpatient charges resulting from care provided to Medicaid recipients.
c. All other hospitals receive a provider policy adjustor of 1.0, which generates no payment adjustment.

F. EAPG Service Line Payment Adjustments

1. Under the EAPG payment methodology some claim service lines will pay in full, in which case the Payment Adjustment Factor gets set to 1.0.

2. Other lines may bundle indicating that payment for these lines is included in payment for other lines on the claim. For bundled lines, the Payment Adjustment Factor gets set to zero.

3. Still other service lines on the claim may pay at a discounted rate. For all except bilateral services, the Payment Adjustment Factor gets set to 0.50 on discounting claim lines. For bilateral procedures, the Payment Adjustment Factor gets set to 1.50.

G. Recipient Annual Benefit Limit

1. Reimbursement for hospital outpatient care to adults is limited to $1,500 per state fiscal year per recipient.

2. Exempt from this annual limit are Medicaid recipients under the age of 21, renal dialysis services, and any other services identified by the Agency.

3. The $1,500 annual benefit limit is applied only to services provided to recipients enrolled in the Medicaid fee-for-service program.

H. EAPG Payment Calculation

1. **EAPG Payment:**

   a. EAPG Base Payment is calculated with the following formula:

   \[
   \text{EAPG Payment} = \text{Hospital Base Rate} \times \text{EAPG Relative Weight} \times \text{Policy Adjustor} \times \text{Payment Adjustment Factor}
   \]

   b. Claim service line allowed amount is calculated with the following formula:

   \[
   \text{Line Item Allowed Amount} = (\text{EAPG Payment} + \text{Automatic Rate Enhancement}) - \text{Reduction for Annual Benefit Limit}
   \]
i. If the recipient’s annual hospital outpatient reimbursement has exceeded the limit then the “Reduction for Annual Benefit Limit” will be set equal to (EAPG Payment + Automatic Rate Enhancement) so that the Medicaid allowed amount is $0.

ii. If the sum of (EAPG Payment + Automatic Rate Enhancement) on the service line being processed is an amount that will put the recipient over his/her annual benefit limit, then the value for field “Reduction for Annual Benefit Limit” will get set so that the Medicaid allowed amount on the claim service line is enough to set total hospital outpatient reimbursement to the limit for the recipient.

2. **Charge cap:** No charge cap will be applied under the EAPG payment method. Thus, the full EAPG payment will be applied even if the Medicaid allowed amount is greater than the submitted charges on an individual service line or overall for the outpatient claim.

3. **Third party liability:** EAPG reimbursement shall be limited to an amount, if any, by which the rate calculation for an allowable claim exceeds the amount of a third party recovery during the Florida Medicaid benefit period.

### I. Cost Settlement

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

### J. Frequency of EAPG Payment Parameter Updates

1. New versions of EAPGs are released annually and include a new set of relative weights and average lengths of stay. AHCA will install a new version of EAPGs no more frequently than once per year and no less frequently than once every two years. Installation of new versions of EAPGs and associated relative weights will occur at the beginning of a state fiscal year and will coincide with a recalculation of hospital base rates and EAPG policy adjustors. When installing new versions of EAPG codes and relative weights, AHCA will install the most current version that is available at the time the annual rate setting process is performed.
2. New hospital base rates are calculated annually based on the most currently available historical claim data and become effective at the beginning of each state fiscal year.

3. The annual allocation of automatic rate enhancements is reset each year and becomes effective at the beginning of each state fiscal year.

4. Per-payable-service automatic rate enhancement amounts are re-calculated and become effective at the beginning of the state fiscal year. The volume of payable Medicaid outpatient service lines used in the calculation of the per-service amount is determined using the same historical claim dataset used for calculation of hospital base rates.

5. New values for the policy adjustors are calculated annually and become effective at the beginning of each state fiscal year.

IV. Medicare Crossover Pricing

A. 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 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 submitted to Medicaid for consideration of additional payment.

B. Medicaid’s financial obligation for reimbursement on the Medicare crossover claims is based on the Medicare allowable amount, not on the provider’s billed charges.

C. Medicaid pays the lower of:
   - A calculated coinsurance equal to \([\text{Medicare Paid Amount} / 0.78] * 20\%
   - The Medicare coinsurance plus deductible as reported on the claim, versus
   - \([\text{Medicaid allowed amount}] - \text{[Medicare payment amount]}\)

D. If the Medicare payment amount is equal to or greater than the Medicaid allowed amount, then Medicaid reimbursement will be zero.
E. For hospital outpatient Medicare crossover claims, the Medicaid allowed amount will be determined using the EAPG pricing methodology.

V. Payment Assurance

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

VI. Provider Participation

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

VII. 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.

VIII. Payment in Full

Participation in the Program shall be limited to hospitals of service which accept as payment in full for covered services the amount paid in accordance with the most recent version of the state plan.

IX. Glossary

A. 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

B. AHCA - Agency for Health Care Administration.
C. Automatic Rate Enhancement – A per-payable service rate enhancement applied to each payable claim line.

D. Base rate - A hospital’s reimbursement rate assigned to each hospital that is multiplied by an EAPG relative weight and policy adjustor in the calculation of the EAPG base payment.

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

F. EAPGs - Enhanced Ambulatory Patient Groups

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

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

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

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

K. HHS - Department of Health and Human Services.

L. CMS PUB. 15-1 - Health Insurance Manual No. 15, also known as the Provider Reimbursement
Manual, as incorporated by reference in Rule 59G-6.031, F.A.C.

M. Non-covered services - Those goods and services which are not medically necessary for the care and treatment of outpatients.

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

O. Rate semester - The rate semester begins on July 1 and runs through June 30.

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

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

2. An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county.

3. A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or less per square mile.

4. A hospital in a constitutional charter county with a population of over 1 million persons that has imposed a local option health service tax pursuant to law and in an area that was directly impacted by a catastrophic event on August 24, 1992, for which the Governor of Florida declared a state of emergency pursuant to chapter 125, and has 120 beds or less that serves an agricultural community with an emergency room utilization of no less than 20,000 visits and a Florida Medicaid inpatient utilization rate greater than 15 percent.

5. A hospital with a service area that has a population of 100 persons or fewer per square mile. As used in this subparagraph, the term "service area" means the fewest number of zip codes...
that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Transparency at AHCA.

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

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

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

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

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

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

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

U. Total Outpatient Charges - Total patient revenues assessed for all outpatient services excluding charges for laboratory and pathology.
### APPENDIX A TO FLORIDA TITLE XIX OUTPATIENT HOSPITAL REIMBURSEMENT PLAN

**OUTPATIENT REVENUE CODES**

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
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<td>Pharmacy/General</td>
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<tr>
<td>251</td>
<td>Pharmacy/Generic</td>
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<td>252</td>
<td>Pharmacy/NonGeneric</td>
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<td>Drugs Incident to Other Diagnostic Services</td>
</tr>
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<td>255</td>
<td>Drugs Incident to Radiology</td>
</tr>
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<td>258</td>
<td>Pharmacy/IV Solutions</td>
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<td>Other Pharmacy</td>
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<td>IV Therapy</td>
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<td>IV Therapy/Supplies</td>
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<td>Other IV Therapy</td>
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<td>General Classification</td>
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<td>Medical Surgical- Nonsterile supplies</td>
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<td>Medical/Surgical - Sterile Supplies</td>
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<td>Pacemaker</td>
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<td>Intraocular Lens</td>
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<td>Subdermal Contraceptive Implant</td>
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<td>Burn Pressure Garment Fitting</td>
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<td>300</td>
<td>Laboratory/General</td>
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<td>301</td>
<td>Laboratory/Chemistry</td>
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<td>304</td>
<td>Laboratory/Non-Routine Dialysis</td>
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<td>Laboratory/Hematology</td>
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<td>Laboratory/Bacteriology and Microbiology</td>
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<td>Diagnostic Radiology/Angiocardiology</td>
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<td>Physical Therapy/Evaluation or Re-evaluation (All Ages)</td>
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<td>Speech-Language Pathology/Visit Charge (Under 21 only)</td>
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<td>Audiology/Treatment</td>
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480  Cardiology/General
481  Cardiology/Cardiac Cath Laboratory
482  Cardiology/Stress Test
483  Cardiology/Echocardiology
489  Other Cardiology
490  Ambulatory Surgical Care
510  Clinic/General

• Note: Please reference the most recent version of the Medicaid Outpatient Hospital Coverage and Limitations Handbook

513  Psychiatric Clinic

Note: Use code 513, psychiatric clinic, with code 914, psychiatric individual therapy services, or with 918, psychiatric testing, when either of these codes is appropriate and applicable.

610  MRI Diagnostic/General
611  MRI Diagnostic/Brain
612  MRI Diagnostic/Spine
614  MRI - Other
615  Magnetic Resonance Angiography (MRA) - Head & Neck
616  MRA - Lower Extremities
618  MRA – Other
619  Other MRT

621  Supplies Incident to Radiology
622  Dressings Supplies Incident to Other Diagnostic Services

Surgical Dressings
634*  Erythropoietin (EPO) less than 10,000 units
635*  Erythropoietin (EPO) 10,000 or more units
636  Pharmacy/Coded Drugs
637  Self-Administered Drugs

Note: Use code 637 exclusively to bill self-administered drugs not covered by Medicare for dually-eligible Medicare and Medicaid recipients. Code 637 must only be billed with the Total Charge 001 revenue code. Payment will be made for 637 only.

700  Cast Room/General
710  Recovery Room/General
721  Labor - Delivery Room/Labor
722*  Labor - Delivery Room/Delivery
730  EKG - ECG/General
731  EKG - ECG/Holter Monitor
732  Telemetry
739  Other EKG – ECG
740  EEG/General
749  Other EEG
750  Gastro-Intestinal Services/General
759  Other Gastro - Intestinal
761  Treatment Room
762  Observation Room
790*  Lithotripsy/General
820*  OPH-Hemodialysis/General
821*  Hemodialysis Outpatient/Composite
824*  Hemodialysis-Maintenance 100%
829*  OPH-Hemodialysis/Other
831*  Peritoneal Dialysis Outpatient/Composite Rate
834*  Peritoneal Dialysis-Maintenance 100%
839*  OPH-Peritoneal Dialysis/Other
840*  Continuous Capo General
841*  CAPD Composite or Other Rate
844*  CAPD OP/Home-Maintenance 100%
849*  CAPD/Other
850*  Continuous Cycling Dialysis CCPD General
851*  CCPD Composite or Other Rate
854*  CCPD OP/Home-Maintenance 100%
859*  CCPD/Other
880*  Miscellaneous Dialysis/General
881*  Ultrafiltration
901*  Psychiatric/Psychological - Electroshock Treatment
914  Psychiatric/Psychological - Clinic Visit/Individual Therapy
918  Psychiatric/Testing
  *Note: Bill 513, psychiatric clinic, with this service,
920  Other Diagnostic Services/General
921  Other Diagnostic Services/Peripheral Vascular Lab
922  Other Diagnostic Services/Electromyelgram
924  Other Diagnostic Services/Allergy Test
943  Other Therapeutic Services/Cardiac Rehabilitation
944  Other Therapeutic Services/Drug Rehabilitation
945  Other Therapeutic Services/Alcohol Rehabilitation

*Exempt from $1500 outpatient cap limit.
APPENDIX B TO FLORIDA TITLE XIX OUTPATIENT HOSPITAL
REIMBURSEMENT PLAN

PAYMENT ADJUSTMENT FOR PROVIDER PREVENTABLE CONDITIONS

**Citation**

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

**Payment Adjustment for Provider Preventable Conditions**

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

**Other Provider-Preventable Conditions**

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

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

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

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

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

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

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

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

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

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

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

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

D. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.
APPENDIX C TO FLORIDA TITLE XIX OUTPATIENT HOSPITAL
REIMBURSEMENT PLAN

UPPER PAYMENT LIMIT (UPL) METHODOLOGY

Overview of UPL Analyses

This document describes the methodology used by the Florida Agency for Health Care Administration (AHCA) for calculating the outpatient hospital upper payment limit (UPL) demonstration for Florida Medicaid services. AHCA develops UPL demonstrations in accordance with UPL guidance set forth by the Centers for Medicare and Medicaid Services (CMS). Effective AHCA’s SFY 2017-2018 conversion to hospital outpatient payment based on Enhanced Ambulatory Patient Groupings (EAPGs), the hospital outpatient UPL includes all services billed on hospital outpatient claims, including clinical diagnostic lab services.

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

The claim data used in a UPL analysis is historical data, usually from a twelve (12) month period. The period for which claims are selected is referred to as the “base” year. The UPL analysis is performed for a specific state fiscal year referred to as the “rate” year. Often the rate year is a current or present-day timeframe. In contrast, the base year is a timeframe in the past because the data needed for a UPL analysis, hospital cost reports and billed claims, are only available for services performed in the past. For example, the UPL analysis for state fiscal year 2017/2018 (the “rate” year) was performed at the beginning of the fiscal year – September 2017. That UPL analysis could not utilize claim data from state fiscal year 2017/2018 (7/1/2017 – 6/30/2018) because the year was not yet complete. Instead, historical claim data that had been received and processed prior to September 2017 was used for the analysis.

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

Florida Medicaid Hospital Outpatient UPL Analysis Method

Estimated Medicare payments are calculated using hospital outpatient costs as a proxy for the upper payment limit. The costs are calculated by multiplying each hospital’s outpatient cost-to-charge ratio times each claim service line’s submitted charge, and summing the resulting estimated hospital cost for all claims in the base-year dataset. The costs are then inflated to the midpoint of the UPL rate year. Historical claim data used for this modelling contain dates of service that were within the cost report timeframes of the most recently available Medicare cost report for each hospital.

Medicaid payments are calculated by applying EAPG pricing using UPL rate year payment rules and parameters to the same twelve (12) months of historical claim data as used for the cost calculations.

Source of Hospital Cost Data

Hospital cost data is retrieved from the most currently available hospital Medicare cost report in the Healthcare Cost Report Information System (HCRIS) at the time the UPL analysis is performed. From these cost reports, an
outpatient cost-to-charge ratio (CCR) is calculated using the cost and charge information in Worksheet C Part I for all ancillary cost centers. Specifically, costs and charges are retrieved from cost centers in the following ranges:

'05000' through '07699'
'09000' through '09399'
'09600' through '09999'

For each of these cost centers, total hospital costs are retrieved from column 5 and total hospital charges are retrieved from column 8. For each hospital, the costs and charges are summed and then an outpatient CCR is calculated as (total ancillary cost center cost) divided by (total ancillary cost center charges).

Source of Medicaid Pricing Parameters and Claim Data

EAPG pricing parameters for the UPL rate year are retrieved from the “EAPG Calculator” published by AHCA for the rate year. EAPG rates are updated annually and become effective on the first day of each state fiscal year.

Medicaid claims data used in UPL demonstrations is extracted from a data warehouse fed from the Florida MMIS. For each hospital, claims are selected if they contain a first date of service within the base year. The base year is the timeframe on the most currently available Medicare cost report filed by each hospital.

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

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

Calculation of Upper Payment Limit

The upper payment limits for each of the three UPL categories are calculated using an estimate of hospital cost. Hospital cost is calculated by multiplying a hospital-specific cost-to-charge ratio times the billed charges on each claim line. The costs on each line are then summed to get total Medicaid outpatient costs per hospital. And the costs from each hospital are summed to get the total cost for each UPL category.

The costs are inflated forward from the mid-point of the base year (the hospital’s cost report year) to the mid-point of the UPL rate year.

Calculation of Medicaid Payment

Medicaid payment is calculated using the UPL rate year EAPG-based payment rules and payment parameters. Claims in the dataset are re-priced using these parameters. Because these parameters are applicable to the UPL rate year, there is no need to apply a forward trending to the claim payments.
Non-Claim Payments and other Adjustments to Medicaid Payment

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

Comparison of Medicaid Payment to Upper Payment Limit

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

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Private</td>
<td>1='1 - Voluntary Nonprofit, Church'</td>
</tr>
<tr>
<td></td>
<td>2='2 - Voluntary Nonprofit, Other'</td>
</tr>
<tr>
<td></td>
<td>3='3 - Proprietary, Individual'</td>
</tr>
<tr>
<td></td>
<td>4='4 - Proprietary, Corporation'</td>
</tr>
<tr>
<td></td>
<td>5='5 - Proprietary, Partnership'</td>
</tr>
<tr>
<td></td>
<td>6='6 - Proprietary, Other'</td>
</tr>
<tr>
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</tr>
<tr>
<td>Government owned, non-</td>
<td>7='7 - Governmental, Federal'</td>
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<td>state</td>
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</tr>
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<td>9='9 - Governmental, County'</td>
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<tr>
<td></td>
<td>11='11 - Governmental, Hospital District'</td>
</tr>
<tr>
<td></td>
<td>12='12 - Governmental, City'</td>
</tr>
<tr>
<td></td>
<td>13='13 - Governmental, Other'</td>
</tr>
</tbody>
</table>

All out-of-state hospitals get mapped to the “private hospital” UPL category independent of their provider category listed in the HCRIS data.
PAID BED RESERVATION POLICY

Medicaid reimbursable absences from a long-term care institution are described below. All leave must be documented in a resident’s plan of care and approved by a physician.

A. **INPATIENT HOSPITALIZATION**  Up to eight days per hospitalization for each nursing facility resident approved for the institutional care program (ICP). Up to eight days per hospitalization for each hospice enrolled nursing home resident approved for the institutional care program (ICP). Up to 15 days per hospitalization for each state mental health hospital (age 65 years and older) resident. There is no annual maximum. One day is described as an overnight stay from the facility.

B. **THERAPEUTIC LEAVE DAYS**  Therapeutic leave means a resident leaves the facility to go to a family-type setting and not to another facility. Family type settings include a private home, boarding home or assisted living facility. One day of therapeutic leave is described as an overnight stay from the facility.

   (1) Nursing Facility Residents: Up to 16 days per state fiscal year (July 1 through June 30).

   (2) State Mental Health Hospital Residents (age 65 years and older): Up to 30 days per state fiscal year (July 1 and June 30). Each visit over three consecutive days must be prior authorized.

   (3) Nursing Facility Residents Enrolled in Hospice: Up to 16 days per state fiscal year (July 1 through June 30).

Amendment: 15-013  
Supersedes: 04-016  
Effective: 12/31/15  
Approved: 3/21/16
PAID BED RESERVATION POLICY

INTERMEDIATE CARE FACILITY SERVICES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

Medicaid reimburses for leave days for Intermediate Care Facility services for Individuals with Intellectual Disabilities (ICF/IID) as described below.

A. HOSPITALIZATION Up to 15 days per hospitalization for each recipient. There is no annual maximum. Recipients are not entitled to an additional 15 days of hospitalization immediately following an infirmary stay.

B. THERAPEUTIC LEAVE Up to 45 days per state fiscal year. Therapeutic leave means a resident leaves the facility to go to a family-type setting and not to another facility.

One day is described as an overnight stay away from the facility.

All leave days must be documented in a recipient’s plan of care and approved by a physician.
I. Cost Finding and Cost Reporting

A. Each provider participating in the Florida Medicaid program shall submit a uniform cost report and related documents required by this Plan. The electronic cost report and revised instructions must be used. To be considered a complete submission, the electronic version of the cost report, one hard copy of the cost report, the certification page, supplemental schedules and attachments, and the accountant’s compilation letter must all be received by the Agency for Healthcare Administration (AHCA), Bureau of Medicaid Program Finance, Audit Services, 2727 Mahan Drive, Mailstop 23, Tallahassee, FL 32308. Cost reports are due to AHCA, Bureau of Medicaid Program Finance, Audit Services, five months after the close of the provider’s cost reporting year. Extensions will not be granted.

B. All providers are required to detail all of their costs for their entire reporting period, making appropriate adjustments as required by this Plan for determination of allowable costs. For a new provider with no cost history in a newly constructed facility, an existing provider entering the program, an existing provider in a newly constructed replacement facility, or a new provider with no cost history resulting from a change of ownership or operator with the prior provider having participated in the Florida Medicaid program, the interim operating, direct care, and indirect care cost per diems shall be the lesser of: the effective class reimbursement ceiling based on section V.B.13, the budgeted operating, direct care, and indirect care cost per diems approved by AHCA based on section III, or the new provider target limitation. The new provider target limitation for a new provider with no cost history in a newly constructed facility or an existing provider entering the program shall be the average operating and indirect care per diems excluding the Medicaid Adjustment Rate (MAR) in the region in which the facility is located plus 50 percent of the difference between the average region per diem (excluding MAR) and the facility’s effective class.
Long-term Care Reimbursement Plan
Attachment 4.19-D
Part I

ceiling. The new provider target limitation for existing providers in a newly constructed replacement facility shall be the greater of the above new provider target limitation or their current operating and indirect care cost per diems that are in effect prior to the operation of their replacement facility, not to exceed the facility’s effective class ceilings. The average region per diem is calculated by taking the sum of all operating, direct care, and indirect care per diems within the region divided by the number of facilities within the region. The new provider target limitation for a new provider with no cost history resulting from a change of ownership or operator with the prior provider having participated in the Florida Medicaid program shall be the previous provider’s operating and indirect care cost per diem (excluding MAR), plus 50 percent of the difference between the previous provider’s per diem (excluding MAR) and the effective class ceiling. The above new provider target limitation, whether based on the region average per diem or the previous provider’s per diem, shall apply to all new providers with a Florida Medicaid certification. The new provider target limitation above, whether based on the region average per diem or the previous providers' per diem, which affects providers already in the Florida Medicaid program, shall not apply to these same providers beginning with the rate period in which the target reimbursement provision in section V.B.14 does not apply. The new provider target limitation shall apply to new providers entering the Florida Medicaid program, even if the new provider enters the program during a rate period in which section V.B.14 does not apply. New provider target limitations applicable to the first rate period a new provider enters the program shall be the basis for calculating subsequent rate period new provider target limitations for that same provider through the following calculation:

Establish the target reimbursement for operating and indirect care cost per diems for each provider by multiplying each provider's target reimbursement rate for operating and indirect care cost in section I.B from the previous rate period, excluding the MAR with the quantity:
In the above calculation, the 2.0 shall be referred to as the provider specific inflation multiplier. The direct care component shall not be limited to the new provider target limitation described above. The new provider target limitation shall not fall below 75 percent of the cost-based class ceiling for each rate setting as calculated in section V.B.12.

For new providers who enter the program operating a facility that had been previously operated by a Florida Medicaid provider, the property reimbursement rate shall be established per sections V.D.3 and 4. The property cost per diem for a provider with a newly constructed facility or replacement facility shall be the lesser of the budgeted fair rental value rate approved by AHCA based on section V.D, or the applicable fair rental value based upon the cost per bed standard that was in effect six months prior to the date the facility was first put in service as a nursing facility but not prior to January 1, 1972. Return on equity (ROE) or use allowance per diems shall be the budgeted rate approved by AHCA per section III. Prospective reimbursement rates shall only be set on cost reports for periods of 6 months or more but not more than 18 months. Cost reporting periods shall be for periods of 6 months or more but not more than 18 months. Interim rates shall be cost settled for the interim rate period, and the cost settlement is subject to the above new provider reimbursement limitations. For changes of ownership or licensed operator, the provider is required to file an initial cost report.

C. The cost report shall be prepared using the electronic cost report described in section I.A, and on the accrual basis of accounting in accordance with generally accepted accounting principles as established by the American Institute of Certified Public Accountants (AICPA). The methods of
reimbursement are in accordance with Title XVIII of the Social Security Act (SSA) and Center for Medicare and Medicaid Services (CMS) Publication 15-1 (CMS-PUB.15-1) incorporated herein by reference except as modified by the Florida Title XIX Long-term Care Reimbursement Plan and state of Florida Administrative Rules. For governmental facilities operating on a cash method of accounting, data based on such a method of accounting shall be acceptable. The certified public accountant (CPA) preparing the cost report shall sign the cost report as the preparer, or, in a separate letter, state the scope of his work and opinion in conformity with generally accepted auditing standards and AICPA statements on auditing standards. Cost reports that are not signed by a certified public accountant or not accompanied by a separate letter signed by a CPA shall not be accepted.

D. Providers may elect, with prior approval from AHCA, Bureau of Medicaid Program Finance, Audit Services, to change their current fiscal year end and file a new cost report for a period of not less than 6 months and not greater than 18 months. Should a provider elect to change their current fiscal year end and file a new cost report, then cost reports filed for the next two years must have the same fiscal year end. All prior year cost reports must be submitted to and accepted by AHCA before the current year cost report may be submitted and accepted for rate setting by AHCA.

E. Cost reports submitted after the due date and after the rate setting acceptance cutoff date for the first rate setting for which the cost report could have been used if it had been received on the cost report due date shall be late tested. The late test shall consist of recalculating the per diem rates for the first rate setting after the due date for the cost report for which the cost report could have been used if the cost report had been received on the cost report due date and all subsequent rate periods. If the new cost report sets a lower per diem rate for a rate period as compared to the rate previously set, then the providers' rate for that rate period shall be calculated using the new cost report, and full payments at the recalculated rate shall be effective retroactively. If the new cost report sets a higher per diem rate for a rate period as compared to the rate previously set, then the
late tested cost report shall not be used for that rate period. If a provider submits more than one late cost report at the same time, the cost reports shall be late tested in fiscal year end date order. The lower rate shall not be paid retroactively if the provider adequately demonstrates, through documentation, that emergency circumstances prevented the provider from submitting the cost report within the prescribed deadline. Similarly, if a provider submits a cost report late because of emergency circumstances, and the use of that cost report would have resulted in higher reimbursement for a rate period had it been submitted timely, then the provider's rate for that rate period shall be calculated using the new cost report, and full payment at the recalculated rate shall be effective retroactively. Emergency circumstances are limited to loss of records from fire, flood, theft, or wind.

F. A provider that has been receiving an interim reimbursement rate, which voluntarily or involuntarily ceases to participate in the Florida Medicaid program or experiences a change of ownership or operator, shall file a final cost report in accordance with section 2414.2, CMS-PUB.15-1. The cost report is to be based on financial and statistical records maintained by the provider as required in Title 42 Code of Federal Regulations (CFR), 413.24 (a), (b), (c), and (e). Cost information shall be current, accurate, and in sufficient detail to support costs set forth in the report. This includes all ledgers, books, records, original evidence of costs and other records in accordance with CMS-PUB.15-1, which pertain to the determination of reasonable costs and shall be capable of and available for auditing by state and federal authorities. All accounting and other records shall be brought up to date at the end of each fiscal quarter. These records shall be retained by the provider for a minimum of five years following the date of submission of the cost report to AHCA.

G. Records of related organizations as identified by 42 CFR 413.17 shall be available upon demand to representatives, employees, or contractors of AHCA, the Auditor General, General Accounting Office (GAO), or Department of Health and Human Services (HHS).
H. AHCA shall retain all uniform cost reports submitted for a period of at least three years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of 42 CFR 431.17. Access to submitted cost reports shall be in conformity with Chapter 119, Florida Statutes (F.S.).

I. Chart of Accounts: All providers must use the most recent version of the standard chart of accounts to govern the content and manner of the presentation of financial information to be submitted by Florida Medicaid long-term care providers in their cost reports. The standard chart of accounts includes specific accounts for each component of direct care staff organized by type of personnel and may not be revised without the written consent of the Auditor General.

J. 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 Florida Medicaid reimbursements and payments, and that the services identified in this cost report were provided in compliance with such laws and regulations.”

K. AHCA reserves the right to refer providers found to be out of compliance with any of the policies and procedures regarding cost reporting to the Bureau of Medicaid Program Integrity for investigation.

L. Providers are subject to sanctions pursuant to sections 409.913(15)(c), F.S., and 409.913(16)(c), F.S., for late cost reports. The amount of the sanctions can be found in Rule 59G-9.070, F.A.C. A cost report is late if it is not received by AHCA, Bureau of Medicaid Program Finance, Audit Services on the cost report due date. Sanctions shall commence 60 days after the cost report due date. If a provider submits a cost report late because of emergency circumstances, then the provider shall not be subject to the sanctions. Emergency circumstances are limited to loss of records from fire, flood, theft, or wind.
II. Audits and Desk Reviews

Cost reports submitted by providers of nursing facility care, in accordance with this Plan, are subject to an audit or desk review on a random basis or at any time AHCA has been informed or has reason to believe that a provider has claimed or is claiming reimbursement for unallowable costs. The performance of a desk review does not preclude the performance of an audit at a later date.

A. General Description of AHCA’s Procedures for Audits

1. Primary responsibility for the audit of provider cost reports shall be borne by AHCA. The efforts of AHCA audit staff may be augmented by contracts with CPA firms to ensure that the requirements of 42 CFR 447.202 will be met.

2. All audits shall be based on generally accepted auditing standards of the AICPA.

3. Upon completion of each audit, the auditors shall issue a report that meets the requirements of 42 CFR 447.202 and generally accepted auditing standards. The auditor shall declare an opinion as to whether, in all material respects, the financial and statistical report submitted complies with all federal and state regulations pertaining to reimbursement for long-term care facilities. All reports shall be retained by AHCA for three years.

4. The provider’s copy of the audit report shall include all audit adjustments and changes, the authority for each, and all audit findings. The audit report shall be accompanied by such other documentation as is necessary to clarify such adjustments or findings.

B. Field Audit and Desk Review Procedures

Upon receipt of a cost report from the provider, prepared in accordance with instructions furnished by AHCA, AHCA will determine whether an audit or desk review is to be performed. Providers selected for audit or desk review will be notified in writing by the AHCA audit office or CPA firm assigned to perform the audit or desk review.
1. Upon completion of an audit or desk review and before publication of the audit or desk review report, the provider shall be given an exit conference at which all findings will be discussed and explained. A copy of the proposed audit or desk review adjustments will be given to the provider at least 10 days before the exit conference. If the provider fails to schedule an exit conference within 20 calendar days of receipt of the adjustments, the audit or desk review report will be issued without an exit conference. Desk review exit conferences will be conducted through the mail or in AHCA’s office in Tallahassee.

2. Following the exit conference, the provider has 60 calendar days to submit documentation or other evidence to contest any disallowed expenditures or other adjustments. Any documentation received after the 60 day period shall not be considered when revising adjustments made due to lack of adequate documentation or lack of support. However, the 60 day limitation shall not apply if the provider can adequately demonstrate, through documentation, that emergency circumstances prevented the provider from submitting additional documentation within the prescribed deadline. Emergency circumstances are limited to loss of records from fire, wind, flood, or theft.

3. All audit or desk review reports shall be issued by certified mail, return receipt requested to the address of the nursing facility and to the attention of the administrator. The provider shall have 21 calendar days from the date of receipt of the audit report to challenge any audit or desk review adjustments or findings contained in the report by requesting an administrative hearing in accordance with section 120.57, F.S., and Chapter 28.106, F.A.C. The audit or desk review report shall constitute prima facie evidence of the propriety of the adjustments contained therein. The burden of proof is upon the provider to affirmatively demonstrate the entitlement to the Florida Medicaid reimbursement. Except as otherwise provided in this Plan, Chapter 28-106, F.A.C. shall be applicable to any administrative proceeding under this Plan.
4. Collection of overpayments will be in accordance with section 414.41, F.S. and Rule 59G-6.010, F.A.C.

III. Allowable Costs

A. All items of expense shall be included on the cost report, which providers must incur in meeting:
   1. The definition of nursing facilities contained in sections 1919(a), (b), (c), and (d) of the Social Security Act (SSA).
   2. The standards prescribed by the Secretary of Health and Human Services (HHS) for nursing facilities in regulations under the SSA in 42 CFR 483, Subpart B.
   3. The requirements established by AHCA which is responsible for establishing and maintaining health standards, under the authority of 42 CFR 431.610.

B. All therapy required by 42 CFR 409.33 and Medicare or Medicaid certification standards and prescribed by the physician of record shall be considered as covered services and all costs, direct or indirect, shall be included in the cost report. These include physical, audiology, speech pathology, and occupational therapies.

C. Implicit in any definition of allowable costs is that those costs shall not exceed what a prudent and cost-conscious buyer pays for a given service or item. If costs are determined by AHCA, utilizing the Title XVIII Principles of Reimbursement, CMS-PUB.15-1 and this Plan, to exceed the level that a prudent buyer would incur, then the excess costs shall not be reimbursable under this Plan.

D. All items of expense, which providers incur in the provision of routine services, such as the regular room, dietary and nursing services, minor medical and surgical supplies, and the use of equipment and facilities, are allowable. A comprehensive listing of these items includes laundry services, nutritional services, personal care services, personal care supplies, incontinence supplies, rehabilitative and restorative care services, durable medical equipment, stock medical supplies, analgesics, antacids, laxatives, vitamins, and wound care supplies. Physician Services, dialysis services, community mental health services, dental services, podiatry services, flu and pneumonia services.
injections, visual services, and transportation services are not included in the per diem rate as the rendering provider bills Medicaid directly.

E. Bad debts other than Title XIX of the SSA, charity, and courtesy allowances shall not be included in allowable costs. Bad debts for Title XIX of the SSA shall be limited to Title XIX of the SSA uncollectible deductible and copayments and the uncollectible portion of eligible Florida Medicaid recipients' responsibilities. Example- Daily rate is $210.00; state pays $190.00 and recipient is to pay $20.00. If Florida Medicaid recipient pays only $15.00, then $5.00 would be an allowable bad debt. All Florida Medicaid Title XIX of the SSA bad debts shown on a cost report shall be supported by proof of collection efforts, such as copies of two collection letters.

F. Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to a provider by common ownership or control shall be governed by Title XVIII of the SSA and Chapter 10, CMS-PUB.15-1. Providers shall identify such related organizations and costs in their cost reports.

G. Costs, which are otherwise allowable, shall be limited by the following provisions:

1. The owner-administrator and owner-assistant administrator compensation shall be limited to reasonable levels determined in accordance with CMS-PUB.15-1 or determined by surveyed ranges of compensation conducted by AHCA. The survey shall be of all administrators and assistant administrators of Florida long-term care facilities, and shall, to the extent feasible with the survey data collected, recognize differences in organization, size, experience, length of service, services administered, and other distinguishing characteristics. Results of surveys and salary limitations shall be furnished to providers when the survey results are completed, and shall be updated each year by the wage and salary component of the Plan's inflation index. A new salary survey may be conducted at the discretion of AHCA.

2. Limitation of rents:
a. For the purposes of this provision, allowable ownership costs of leased property shall be defined as:

(1) Cost of depreciable assets, property taxes on personal and real property, and property insurance.

(2) Sales tax on lease payments except in cases of related parties.

(3) ROE that would be paid to the owner if he were the provider, as per section III.J.

b. Lease costs allowed for lease contracts existing as of August 31, 1984, shall remain unchanged except for increases specified in the contract entered into by the lessee and lessor before September 1, 1984. If, prior to October 1, 1985, the lessee exercises an option to renew the lease that existed as of August 31, 1984, increases in lease cost for each year of the renewal period shall be limited to the increase in the Florida Construction Cost Inflation Index during the last 12 months. See Appendix B for the computation of this index. Lease cost increases shall be further limited to a maximum of 20 percent over five years. When the lease contract in effect on September 30, 1985 expires, including only options to renew which were exercised prior to October 1, 1985, the provider’s reimbursement for lease costs and other property costs shall be based on a fair rental value system (FRVS) for the facility per section V.D.1.

c. Facilities not leased on October 1, 1985:

(1) For facilities that were not leased as of August 31, 1984 and that are operating under a lease agreement commencing on or after September 1, 1984 and before October 1, 1985, the Florida Medicaid rent reimbursement shall be based on the lesser of actual rent paid or the
allowable ownership costs of the leased property per sections III.G.3 through 5.

(2) Annual increases in lease costs for providers in (1) above shall be limited to the increase in the Florida Construction Cost Inflation Index during the last 12 months. See Appendix B for the computation of this index. Lease cost increases shall be further limited to a maximum of 20 percent over five years. When the lease contract in effect on September 30, 1985 expires, including only options to renew which were exercised prior to October 1, 1985, the provider’s reimbursement for lease costs and other property costs shall be based on a FRVS for the facility per section V.D.1.

d.

Facilities leased on or after October 1, 1985:

(1) Providers that leased facilities on or after October 1, 1985, shall be reimbursed for lease costs and other property costs based on the FRVS per section V.D.1. Allowable ownership costs shall be documented to AHCA for purposes of computing the fair rental value. Facilities not currently reimbursed based on the FRVS per section V.D.1 shall not become reimbursed based on the FRVS per section V.D.1, solely due to the execution of a lease agreement between related organizations under section III.F.

(2) In no case shall Florida Medicaid reimburse property costs of a provider who is subject to b, c, d. (1) and e, if ownership costs are not properly documented per the provisions. Providers shall not be reimbursed for property costs if proper documentation of the owner’s costs, capable of being verified by an auditor, is not submitted to
AHCA. The owner shall be required to sign a letter to AHCA that states that the documentation submitted presents to the best of his knowledge true and correct information. The letter signed by the owner shall also state that the owner agrees to make his books and records of original entry related to the nursing facility properties available to auditors or official representatives of AHCA.

(3) Approval shall not be given for proof of financial ability for a provider if the provider is leasing the facility and does not submit the documentation of the owner's costs with the letter signed by the owner as per (2).

e. A lease agreement may be assigned and transferred (assumed) for Florida Medicaid reimbursement purposes if all of the following criteria are met:

(1) The lease agreement was executed prior to September 1, 1984 (when the "limitations of rents" provisions were implemented).

(2) The lease cost is allowable for Florida Medicaid reimbursement purposes.

(3) The lease agreement includes provisions that allow for the assignment.

(4) All provisions (terms, payment rates, etc.) of the lease agreement remained unchanged (only the lessee changes).

When the assumed lease contract in effect on September 30, 1985 expires, including only options to renew which were exercised prior to October 1, 1985, the provider’s reimbursement for lease costs and other property costs shall be based on a FRVS for the facility per section V.D.1.

3. Basis for depreciation and calculation:
a. Cost - Historical cost of long-term care facilities shall be the basis for calculating depreciation as an allowable cost, except as provided by 3.b and 6. All provisions of the Title XVIII of the SSA and CMS-PUB.15-1 regarding asset cost finding shall be followed.

b. Change in ownership of depreciable assets - For purposes of this Plan, a change in ownership of assets occurs when unrelated parties purchase the depreciable assets of the facility, or purchase 100 percent of the stock of the facility and within one year merge the purchased facility into an existing corporate structure or liquidate the purchased corporation and create a new corporation to operate as the provider. In a case in which a change in ownership of a provider's or the lessor's depreciable assets occur, and if a bona fide sale is established, the provider's basis for depreciation shall be the lesser of the following:

1. The fair market value of the depreciable facility as defined by 42 CFR 413.134 and determined by an appraiser who meets the requirements of Chapters 61J1-4 and 61J1-6, F.A.C.

2. The allowable acquisition cost of the assets to the owner of record on July 18, 1984, for facilities operating on that date, or the first owner of record for facilities that began operation after July 18, 1984.

3. The acquisition cost of such assets to the new owner.

4. Example 1 - An entity, who is the owner of record on July 18, 1984, has a facility with a historical depreciable basis of $5,000,000. A new owner purchases the facility for $10,000,000. The new owner's basis for depreciation is the lesser of the two, or $5,000,000.

Example 2 - An entity, who is the owner of record on July 18, 1984, has a facility with a historical depreciable basis of $5,000,000. A new
owner purchases the facility for $3,000,000. The new owner's basis for depreciation is the lesser of the two, or $3,000,000.

4. Limitation on Interest Expense for Property-Related Debt and ROE or Use Allowance

At a change of ownership on or after July 18, 1984, the interest cost and ROE or use allowance to the new owner shall be limited by the allowable basis for depreciation as defined per 3.b. The new owner shall be allowed the lesser of actual costs or interest cost and ROE cost or use allowance in amounts that would have occurred based on the allowable depreciable basis of the assets. These limited amounts shall be determined as follows:

a. The portion of the equity balance that represents the owner's investment in the capital assets shall be limited for purposes of calculating a ROE or use allowance to the total amount allowed as depreciable basis for those assets as per 3.b.

b. The amount of interest cost due to debt financing of the capital assets shall be limited to the amount calculated on the remainder of the allowable depreciable basis after reducing that allowable basis by the amount allowed for equity in a. The new owner’s current terms of financing shall be used for purposes of this provision.

Example 1 - The first owner of record after July 18, 1984 has an acquisition cost of $6,000,000. The new owner pays $10,000,000 for the facility, makes a down payment of $2,000,000 and finances $8,000,000 at 5 percent for 25 years. The basis for depreciation to the new owner is $6,000,000, and the disallowed portion of the depreciable basis is $4,000,000. Therefore, the allowable equity attributable to investment in the capital assets is $2,000,000, and interest cost
allowed shall be computed on $4,000,000 ($6,000,000 minus $2,000,000) at 5 percent over 25 years.

Example 2 - If the new owner above had made a down payment of $7,000,000 and financed $3,000,000, the allowable equity would be $6,000,000, and no interest cost would be allowed.

5. Costs attributable to the negotiation or settlement of a sale or purchase of a facility occurring on or after July 18, 1984 shall not be considered allowable costs for the provider’s Florida Medicaid reimbursement purposes, to the extent that such costs were previously reimbursed for that facility under a former owner. Such costs include legal fees, accounting fees, administrative costs, travel costs, and costs of feasibility studies, but do not include costs of tangible assets, financing costs, or other soft costs.

6. Capital costs which require certificate of need (CON) approval shall be allowed for reimbursement purposes only if the capital expenditure receives approval from the CON office. All cost overruns which require CON approval must also be approved in order to qualify for reimbursement. This section will apply to all providers with Florida Medicaid certification effective on or after July 1, 1991. Total capital expenditures which are greater than the total amount approved by CON shall not be recognized for reimbursement purposes. In the example below, the reimbursable cost which is considered in rate calculations is the lower of the new facility cost, CON approval, or the Florida Medicaid allowable cost.
Example 1 | Example 2
---|---
New Facility Cost | $10.0 Million | $9.0 Million
CON Approval | $7.0 Million | $6.0 Million
Medicaid Allowable Cost | $6.5 Million | $7.5 Million
Reimbursable Cost | $6.5 Million | $6.0 Million

H. Recapture of depreciation resulting from sale of assets:

1. The sale of depreciable assets, or substantial portion thereof, at a price in excess of the cost of the property as reduced by accumulated depreciation, resulting in a gain on sale, and calculated in accordance with Title XVIII of the SSA, indicates the fact that depreciation used for the purpose of computing allowable costs was greater than the actual economic depreciation. The amount of the recapture applicable to payments made to a provider prior to reimbursement under the FRVS shall be determined as follows:

a. The gross recapture amount shall be the lesser of the actual gain on the sale allocated to the periods during which depreciation was paid or the accumulated depreciation after the effective date of January 1, 1972 and prior to the implementation of payments based on FRVS to the facility. The gross recapture shall be reduced by 1 percent for each month in excess of 48 months participation in the Florida Medicaid program. Additional beds and other related depreciable assets put into service after April 1, 1983 shall be subject to the same 12 ⅜ year depreciation recapture phase-out schedule beginning at the time the additional beds are put into service. The gross recapture amount related to the additional beds shall be reduced by 1 percent for each month in excess of 48 months of participation in the Florida Medicaid program subsequent to the date the additional beds were put into service. To determine the amount of gain associated with additional beds, the portion of the sale price associated with all
depreciable assets shall be allocated to the older and new portions of a facility as follows:

(1) For each part of the facility, determine the proportion of beds to the facility's total number of beds.

(2) Multiply the proportion of beds in that part of the facility by the sales price.

(3) The result is the portion of the sales price allocable to that part of the facility.

<table>
<thead>
<tr>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sales Price</td>
</tr>
<tr>
<td>Older Portion of Facility</td>
</tr>
<tr>
<td>Newer Portion of Facility</td>
</tr>
<tr>
<td>Allocation to older portion</td>
</tr>
<tr>
<td>Allocation to newer portion</td>
</tr>
<tr>
<td>Total Sales Price</td>
</tr>
</tbody>
</table>

b. The adjusted gross recapture amounts as determined in section a shall be allocated for fiscal periods from January 1, 1972 through the earlier of the date of sale, or the implementation of payments based on the FRVS for the facility. The adjusted gross recapture amounts shall be allocated to each fiscal period in the same ratio as depreciation amounts claimed for the respective portions of the facility. Allowable costs shall be computed for each period after depreciation recapture. The recomputed allowable costs shall be used to determine if there should be an adjustment to the payment rate, and any resulting overpayment shall be recovered.
c. The net recapture overpayment amount, if any, so determined in b, shall be paid by the former owners to the state. If the net recapture amount is not paid by the former owner, in total or in part, the amount not paid shall be deducted from future payments by AHCA to the buyer until net recapture has been received. AHCA shall grant terms of extended payment when the facts and circumstances of the unrecovered recapture from the seller justify the extension.

2. Depreciation Recapture Resulting from Leasing a Facility or Withdrawing from the Florida Medicaid Program

In cases where an owner-operator withdraws from the Florida Medicaid program as the provider, but does not sell the facility, the depreciation paid by Florida Medicaid to the owner during the time he was the Florida Medicaid provider shall be subject to the depreciation recapture provisions of this Plan when the owner sells the facility. This includes cases where an owner-provider leases a facility to another unrelated, licensed operator after having operated the facility as a licensed Florida Medicaid provider. All owner-providers that withdraw from the Florida Medicaid program shall be required to sign a contract with AHCA creating an equitable lien on the owner's nursing facility assets. This lien shall be filed by AHCA with the clerk of the circuit court in the judicial circuit within which the nursing facility is located. The contract shall specify the method for computing depreciation recapture, in accordance with the provisions of this Plan, and the contract shall state that such recapture so determined shall be due to AHCA upon sale of the facility. In the event that an owner-provider withdraws from the Florida Medicaid program, the reduction in the gross depreciation recapture amount calculated in section III.H.1.a shall be computed using only the number of consecutive months that the facility is used to serve Florida Medicaid recipients.
Example - An owner-operator participates in Florida Medicaid for 60 months. He then withdraws from the Florida Medicaid program and leases the facility to a new operator, who enters the Florida Medicaid program as a new provider and participates for 24 months. At the end of the 24 months, the lessee withdraws from the Florida Medicaid program and operates the facility for another 60 months, after which the owner sells the facility. The gross recapture amount owed by the owner shall be computed using the amount of depreciation claimed by the owner and allowed by Florida Medicaid during the 60 months that he was the provider. The reduction in the gross recapture amount will be \((60 + 24 - 48) = 36\) months times 1 percent. If a provider fails to sign and return the contract to AHCA, the new license for the prospective operator of the facility shall not be approved.

I. Recapture of property cost indexing above the FRVS base paid under the fair rental value method:

1. Reimbursement due to indexing paid under the FRVS shall be defined as the accumulated reimbursement paid due to the difference between the FRVS rates paid and the initial FRVS rate established for the provider.

2. Upon sale of assets, recapture of reimbursement due to indexing under FRVS shall be determined as follows:

   a. The total amount of indexing shall be recaptured if the facility is sold during the first 60 months that the provider has been reimbursed under FRVS.

   b. For months 61 and subsequent months, 1 percent of the recapture amount shall be forgiven per month. Two percent of the recapture amount shall be forgiven per month if the provider had Florida Medicaid utilization greater than 55 percent for a majority of the months that the provider was reimbursed under FRVS.
Long-term Care Reimbursement Plan
Attachment 4.19-D
Part I

21

Amendment 2017-011
Effective 07/01/2017
Supersedes 2016-021
Approval 12/12/2017

J. Return on Equity

An allowance of a reasonable ROE for capital invested and used in providing patient care is includable as an element of the reasonable cost of covered services furnished to the beneficiaries by proprietary providers. The rate of return shall be equal to the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the provider’s reporting period or portion thereof covered under the Florida Medicaid program. ROE shall be limited to those providers who are organized and operated with the expectation of earning a profit for the owners, as distinguished from providers organized and operated on a non-profit basis. ROE shall exclude positive net working capital (an amount greater than zero). For facilities being reimbursed under FRVS for property, positive equity in capital assets shall be removed from the owners' equity balance in computing ROE. A full ROE payment shall be calculated on 20 percent of the FRVS asset valuation per section V.D.1.e and included in the FRVS rate.

K. Use Allowance

A use allowance on equity capital invested and used in providing patient care, excluding positive net working capital (an amount greater than zero), shall be defined for purposes of the Plan as an allowable cost. The use allowance shall be allowed for non-profit providers except those that are owned or operated by government agencies. This use allowance shall use the principles stated in section J, but shall be limited to one-third of the rate given to profit-making providers. For facilities being reimbursed under the FRVS method for property costs, including government owned or operated facilities, all provisions of J, including the full rate of return, shall be used in computing the use allowance for the property-related equity and included in the FRVS rate.
L. **Legal Fees and Related Costs**

In order to be considered an allowable cost of a provider in the Florida Medicaid program, attorneys' fees, accountants' fees, consultants' fees, experts' fees and all other fees or costs incurred related to litigation, must have been incurred by a provider who was the successful party in the case on all claims, issues, rights, and causes of action in a judicial or administrative proceeding. If a provider prevails on some but less than all claims, issues, rights, and causes of action, the provider shall not be considered the successful party and all costs of the case shall be unallowable. All costs incurred on appellate review are governed in the same manner as costs in the lower tribunal. If on appeal, a provider prevails on all claims, issues, rights and causes of action, the provider is entitled to its litigation costs, in both the lower tribunal and the reviewing court, related to those claims issues, rights and causes of action in which a provider is the successful party on appeal as determined by a final non-appealable disposition of the case in a provider's favor. This provision applies to litigation between a provider and AHCA as it relates to Florida Medicaid audits and Florida Medicaid cost reimbursement cases, including administrative rules, and certificate of need cases. This provision pertains only to allowable costs for the recalculation of reimbursement rates and does not create an independent right to recovery of litigation costs and fees.

M. The direct care component shall include salaries and benefits of direct care staff providing nursing services including registered nurses, licensed practical nurses, and certified nursing assistants (CNA) who deliver care directly to residents in the nursing facility. Direct care staff does not include nursing administration, Minimum Data Set (MDS) and care plan coordinators, staff development, and staffing coordinators. There shall be no costs directly or indirectly allocated to the direct care component from a home office or management company for staff who do not deliver care directly to residents in the nursing facility.

N. All other patient care costs shall be included in the indirect care cost per diem rate.
Effective April 1, 2009, the Nursing Facility Quality Assessment (NFQA) fee is an allowable cost and shall be included in the cost report with required adjustments. Refer to section V.F of this Plan for specific details of this fee. Nursing facilities may not create a separate line-item charge for the purpose of passing through the assessment to residents.

IV. Standards

A. In accordance with Chapter 120, F.S., Administrative Procedure Act, this Plan shall be made available for public inspection, and a public hearing, if requested, shall also be held so that interested members of the public shall be afforded the opportunity to review and comment on the Plan.

B. For purposes of establishing reimbursement ceilings, each nursing facility within the state shall be classified into one of six reimbursement classes as defined in sections V.A.2 and 3. Separate operating, direct care, and indirect care reimbursement ceilings shall be established for each class, but the property cost component shall be subject to a statewide reimbursement ceiling of $13.6500 for facilities still being reimbursed depreciation and interest per sections III.G.3 through 5 except as noted in section V.B.6.b.

C. The ceilings shall be determined prospectively and shall be effective the first day of the rate period, as described in section V.A. Ceilings shall be set at a level which the State determines to be adequate to reimburse a provider for the allowable and reasonable costs of an economically and efficiently operated facility. The statewide property ceilings shall be set as described in section V.A and V.B. The operating, direct care, and indirect care class ceilings shall be the maximum amount paid to any provider in that class as reimbursement for operating, direct care, and indirect care costs. Establishment of prospective class ceilings and an individual provider's reimbursement rate will reasonably take into account economic conditions and trends during the time periods covered by the payment rates.

D. Supplemental Payments for Special Care
In order to receive a supplemental payment in excess of the class ceilings, a provider must
demonstrate to AHCA that unique medical care requirements exist which require extraordinary
outlays of funds. Circumstances which shall require such an outlay of funds in order to receive a
supplemental payment shall be limited to patients under age 21 with complex medical needs based
upon a level of care established by the Agency’s designee. The period of reimbursement in excess
of the class ceiling shall not exceed 12 months. Effective September 1, 2017, the period of
reimbursement in excess of the class ceiling shall not exceed 13 months. A flat rate shall be paid
for the specific patients identified, in addition to the per diem paid to the provider. The flat rate
supplemental payment shall be trended forward each rate period using the IHS Healthcare Cost
Review indices used to compute the operating and patient care ceilings. These incremental costs
shall be included in the cost reports submitted to AHCA, but shall not be included in the
calculation of future prospective rates. The cost of the patients shall be adjusted out based upon
the flat rate payments made to the provider, in lieu of separately identifying actual costs. Special
billing procedures shall be obtained by the provider from the Bureau of Medicaid Policy. The
class ceilings may also be exceeded in cases where Florida Medicaid patients are placed by AHCA
in hospitals or in non-Florida Medicaid participating institutions on a temporary basis pending
relocation to participating nursing facilities, for example, upon closure of a participating nursing
facility. The CMS Regional Office shall be notified in writing at least 10 days in advance in all
situations to which this exception is to be applied, and shall be advised of the rationale for the
decision, the financial impact, including the proposed rates, and the number of facilities and
patients involved. AHCA shall extend the class ceiling exception for subsequent allowable
periods upon making a determination that a need for the exception still exists and upon providing
the CMS Regional Office with another advance written notification as stated above.

E. FRVS shall be used to reimburse facilities for property. To prevent any provider from receiving
lower reimbursement under FRVS than under the former method where depreciation plus interest
costs were used to calculate payments, there shall be a transition period in which some facilities shall continue to be paid depreciation plus interest until such time as FRVS payments exceed depreciation and interest payments as specified in section V.D.1.h. At that time, a provider shall begin reimbursement under the FRVS. Providers entering the program after October 1, 1985 that had entered into an arm’s length (not between related parties) legally enforceable agreement for construction or purchase loans prior to October 1, 1985 shall be eligible for the hold harmless clause per section V.D.1.h.

F. The prospectively determined individual nursing facility's rate will be adjusted retroactively to the effective date of the affected rate under the following circumstances:

1. An error was made by AHCA in the calculation of the provider's rate.
2. A provider submits an amended cost report used to determine the rate in effect. An adjustment due to the submission of an amended cost report shall not be granted unless the amended cost report shall cause a change of one or more percent in the total reimbursement rate. The provider shall submit documentation supporting that the one percent requirement is satisfied. This documentation shall include a rate calculation using the same methodology and in a similar format as used by AHCA in calculating rates. The amended cost report shall be filed by the filing date of the subsequent cost report, the date of the first field audit exit conference for the period being amended, or the date a desk audit letter is received by the provider for the period being amended, whichever is earlier.

3. Further desk or on-site audits of cost reports disclose a change in allowable costs.

G. The Florida Medicaid program shall pay a single level of payment rate for all levels of nursing care. This single per diem shall be based upon each provider's allowable Florida Medicaid costs divided by the Florida Medicaid patient days from the most recent cost report subject to the rate setting methodology in section V.
H. Reimbursement of operating, direct care, and indirect care costs are subject to class ceilings. Property costs are subject to statewide ceilings of $13,650 for facilities being reimbursed under sections III.G.3 through 5 except as noted in section V.B.6.b. For facilities being reimbursed under FRVS, the cost per bed ceiling shall be per section V.D.1.g. ROE and use allowance are passed through and are not subject to a ceiling.

I. A MAR shall be calculated pursuant to section V.E.

J. The following provisions apply to interim changes in component reimbursement rates, other than through the routine rate setting process:

1. Requests for rate adjustments to account for increases in property-related costs due to capital additions, expansions, replacements, or repairs, or for allowable lease cost increases shall not be considered in the interim between cost report submissions, except for the addition of new beds or if the cost of the specified expansion, addition, replacement, allowable lease cost increase or repair would cause a change of one percent or more in the provider's total per diem reimbursement rate. For providers being reimbursed under FRVS, property-related costs shall not be considered in any interim rate request. Adjustments to FRVS rates for property-related costs shall be made only on the first day of the rate period per section V.D.1.i.

2. Interim rate changes reflecting increased costs occurring as a result of patient care or operating changes shall be considered only if such changes were made to comply with existing state or federal rules, laws, or standards, and if the change in cost to the provider is at least $5,000 and would cause a change of one percent or more in the provider's current total per diem rate.

   a. If new state or federal laws, rules, regulations, licensure and certification requirements, or new interpretations of existing laws, rules, regulations, or licensure and certification requirements require providers to make changes that...
result in increased or decreased patient care, operating, or capital costs, requests for component interim rates shall be considered for each provider based on the budget submitted by the provider. All providers' budgets submitted shall be reviewed by AHCA and shall be the basis for establishing reasonable cost parameters.

b. In cases where new state or federal requirements are imposed that affect all providers, appropriate adjustments shall be made to the class ceilings to account for changes in costs caused by the new requirements effective as of the date of the new requirements or implementation of the new requirements, whichever is later.

c. Interim rate adjustments shall be granted to reflect increases in the cost of general or professional liability insurance for nursing facilities if the change in cost to the provider is at least $5,000 and would cause a change of one percent or more in the provider's current total per diem rate.

d. Interim rates shall not be granted for fiscal periods that have ended, such as after the close of the provider's reporting year in which the additional costs were incurred.

e. Interim rates for the staffing requirements shall not be granted.

3. Interim rate requests must be submitted within 60 days after the costs are incurred, and shall be accompanied by a 12 month budget that reflects changes in services and costs. These interim rate requests shall be submitted to AHCA, Bureau of Medicaid Program Finance, Cost Reimbursement – Nursing Homes, 2727 Mahan Drive, Mailstop 23, Tallahassee, FL 32308. An interim reimbursement rate, if approved, shall be established for estimated additional costs retroactive to the time of the change in services or the time the costs are incurred, but not to exceed 60 days before the date AHCA receives the
interim rate request. The interim per diem rate shall reflect only the estimated additional costs, and the total reimbursement rate paid to the provider shall be the sum of the previously established prospective rates plus the interim rate as limited by the effective ceiling. A discontinued service would offset the appropriate components of the prospective per diem rates currently in effect for the provider. Upon receipt of a valid interim rate request, AHCA, Bureau of Medicaid Program Finance, shall determine whether additional information is needed from the provider and request such information within 30 days. Upon receipt of the complete, legible additional information as requested, AHCA, Bureau of Medicaid Program Finance, shall approve or disapprove the interim rate request within 60 days. If AHCA, Bureau of Medicaid Program Finance, does not make such determination within the 60 days, the interim rate request shall be deemed approved.

4. Interim Rate Settlement

The interim rate settlement will adjust targets from the interim effective date going forward so the new interim cost, that otherwise would not have been reimbursed, can now flow through provider specific targets per section V.B.14. The settlement will adjust the actual Florida Medicaid cost against estimated cost from the effective interim date until the cost report containing the interim cost is used to set rates. The interim adjustment, line 5a of the rate sheet, is settled by the following calculation:

\[
\text{Schedule S, line 6 of the cost report} \div \frac{\text{Total patient days from interim date until cost report fiscal year end}}{}
\]

The provider specific target adjustment, line 7a of the rate sheet, is settled by the following calculation:
Overpayment as a result of the difference between the approved budgeted interim rate and the revised rate using the actual costs of the item shall be refunded to AHCA.

Underpayment as a result of the difference between the budgeted interim rate and the revised rate using the actual costs shall be paid to the provider.

K. Aggregate Test Comparing Florida Medicaid to Medicare

42 CFR 447.272 provides that states must ensure CMS that AHCA’s estimated average proposed payment rate pay no more in the aggregate by category for long-term care facility services than the amount that would be paid for the services under the Medicare principles of reimbursement. At any rate period if the aggregate reimbursement to be paid is higher than would be paid under Medicare reimbursement principles the following steps shall be taken in order to meet the aggregate test:

1. The increase in property reimbursement due to indexing for FRVS shall be reduced until the upper limit test is met for that rate period. The amount of the property reimbursement rate paid under FRVS shall be reduced, but not below the initial per diem the provider received under FRVS. This per diem is inclusive of all components of FRVS, including property, ROE, taxes, insurance, and home office.

2. Any incentive payments or other payments that exceed the projected cost rate shall be reduced on a pro rata basis until Florida Medicaid aggregate payments are equal to or less than the amount that would be paid for services under the Medicare reimbursement principles.
3. If provisions 1 and 2 above are implemented in order to meet the upper limit test, for a period of one year, this Plan shall be reanalyzed and formally amended to conform to the necessary program cost limits.

L. Payments made under this Plan are subject to retroactive adjustment if approval of this Plan or any part of this Plan is not received from CMS. The retroactive adjustments made shall reflect only the federal financial participation portions of payments due to elements of this Plan not authorized by CMS.

V. Method

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

A. Ceilings

1. Ceilings shall be determined prospectively and shall be effective on the first day of the rate period. The most current acceptable cost reports received by AHCA, Bureau of Medicaid Program Finance, Audit Services by the close of the business day on April 30 of each year, or by the close of the next business day if April 30 fall on a weekend, and the provider’s most recent reimbursement rates shall be used to establish the operating, direct care, and indirect care ceilings. The statewide property ceiling for facilities being reimbursed per sections III.G.3 through 5, pending transition to payments based on the FRVS, shall be $13.6500 except as noted in section V.B.6.b. For those facilities being reimbursed under FRVS, the cost per bed ceiling per section V.D.1.g shall be used.

2. For the purpose of establishing reimbursement limits for operating, direct care, and indirect care costs, four classes based on geographic location and facility size were developed. These classes are as follows:

a. Class 1 Small Size 1 - 100 beds - Northern Florida Counties

b. Class 2 Large Size 101 - 500 beds - Northern Florida Counties
c. Class 3 Small Size 1 - 100 beds - Southern Florida Counties

d. Class 4 Large Size 101 - 500 beds - Southern Florida Counties

For purposes of defining the four reimbursement classes, the "Southern Florida Counties"
shall be comprised of:

<table>
<thead>
<tr>
<th>Broward</th>
<th>Hardee</th>
<th>Monroe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charlotte</td>
<td>Hendry</td>
<td>Okeechobee</td>
</tr>
<tr>
<td>Collier</td>
<td>Highlands</td>
<td>Palm Beach</td>
</tr>
<tr>
<td>Dade</td>
<td>Indian River</td>
<td>Polk</td>
</tr>
<tr>
<td>Desoto</td>
<td>Lee</td>
<td>St. Lucie</td>
</tr>
<tr>
<td>Glades</td>
<td>Martin</td>
<td>Sarasota</td>
</tr>
</tbody>
</table>

All remaining Florida counties shall be "Northern Florida Counties."

3. As of July 1, 1994, two additional reimbursement classes shall be defined as follows:

a. Class 5 Small Size 1 - 100 beds - Central Florida Counties

b. Class 6 Large Size 101 - 500 beds - Central Florida Counties

The "Central Florida Counties" shall be comprised of:

<table>
<thead>
<tr>
<th>Brevard</th>
<th>Manatee</th>
<th>Pinellas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hardee</td>
<td>Orange</td>
<td>Polk</td>
</tr>
<tr>
<td>Highlands</td>
<td>Osceola</td>
<td>Seminole</td>
</tr>
<tr>
<td>Hillsborough</td>
<td>Pasco</td>
<td></td>
</tr>
</tbody>
</table>

The "Northern Florida Counties" and "Southern Florida Counties" shall be comprised of the counties enumerated in section V.A.2 less the "Central Florida Counties" as defined above.

B. Setting Prospective Reimbursement Per Diems and Ceilings

In determining the class ceilings, all calculations for sections V.B.1 through 14 shall be made using the four classes, and "Northern Florida Counties" and "Southern Florida Counties"
Long-term Care Reimbursement Plan
Attachment 4.19-D
Part I

definitions of section V.A.2. All calculations for sections V.B.15 and 16 shall be made using the six classes and "Central Florida Counties" definition of section V.A.3. AHCA shall:

1. Review and adjust each provider's cost report referred to in section V.A.1 to reflect the result of desk or on-site audits, if available.

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

3. Determine total allowable Florida Medicaid cost:
   a. Determine allowable Florida Medicaid property costs, operating costs, direct care costs, indirect care costs, and ROE or use allowance. Direct and indirect care costs include those costs directly attributable to nursing services, dietary costs, activity costs, social services costs, and all medically ordered therapies. All other costs, except for property costs and ROE or use allowance costs, are considered operating costs. For providers receiving FRVS payments, the ROE cost or use allowance cost shall be reduced by the amount attributable to property assets, and the FRVS rate shall reflect a ROE for property assets as per sections III.J and K. Beginning with the January 1, 2007 rate period, providers that do not meet the CNA staffing requirements of a minimum 2.7 hours per patient day with a 2.9 hours per patient day weekly average effective January 1, 2007 (hereinafter referred to as the 2007 CNA staffing requirements), based upon the provider's most recent cost report with a fiscal year beginning prior to January 1, 2007, each prospective provider's direct care subcomponent shall be adjusted or grossed up in compliance with the revised staffing requirements. This adjustment will be based on the information provided by each provider in the most recent cost report used to establish the Florida Medicaid per diem rate for the current rate period. The total reported productive hours for CNAs will be
Long-term Care Reimbursement Plan
Attachment 4.19-D
Part I

33

divided by the number of total patient days reported. Total reported productive
hours include hours for employees of the facility and hours for leased staff. The
result will represent the hours per patient day for CNA nursing service. Gross
up factors will be calculated for CNA hours by dividing the greater of hours per
patient day or the weighted minimum requirement for the cost reporting period
(weighted by month) into the 2007 CNA staffing requirements. The nursing
CNA weighted minimum requirement shall be weighted by days and the 2007
CNA staffing requirements after January 1, 2007, using the time period defined
in the cost report used to set the respective rate. Facility direct care CNA costs
will be multiplied by the CNA gross up factor if the factor is greater than 1.0,
and by 1.0 if the factor is less than or equal to 1.0. The adjusted direct care costs
will be used for the purpose of computing ceilings and the prospective per diem
rate.

b. Effective July 1, 2010 a minimum weekly average of CNA and licensed nursing
staffing combined of 3.9 hours of direct care per resident per day is required. As
used in this sub-subparagraph, a week is defined as Sunday through Saturday. A
minimum CNA staffing of 2.7 hours of direct care per resident per day is
required. A facility may not staff below 1 CNA per 20 residents. A minimum
licensed nursing staffing of 1.0 hour of direct care per resident per day is
required. A facility may not staff below 1 licensed nurse per 40 residents. No
gross up adjustment will be generated due to the July 1, 2010 staffing revisions
because the revisions do not increase the minimum staffing requirements.

c. Effective July 1, 2011 a minimum weekly average of CNA and licensed nursing
staffing combined of 3.6 hours of direct care per resident per day is required. As
used in this sub-subparagraph, a week is defined as Sunday through Saturday. A
minimum CNA staffing of 2.5 hours of direct care per resident per day is required. A facility may not staff below 1 CNA per 20 residents. A minimum licensed nursing staffing of 1.0 hour of direct care per resident per day is required. A facility may not staff below 1 licensed nurse per 40 residents. No gross up adjustment will be generated due to the July 1, 2011 staffing revisions because the revisions do not increase the minimum staffing requirements.

4. Calculate per diems for each of these five cost components listed in section 3.a by dividing the components' costs by the total number of Florida Medicaid patient days from the latest cost report. For providers receiving FRVS cost reimbursement, substitute the appropriate FRVS per diem as per section V.D.

5. Adjust a provider's operating, direct care, and indirect care per diem costs that resulted from section 4 for the effects of inflation by multiplying these per diem costs by the fraction:

\[
\frac{\text{Florida Nursing Facility Cost Inflation Index at midpoint of prospective rate period}}{\text{Florida Nursing Facility Cost Inflation Index at midpoint of provider’s cost report period}}
\]

The calculation of the Florida Nursing Facility Cost Inflation Index is displayed in Appendix A.

6. The statewide property ceiling for facilities being reimbursed per sections III.G.3 through 5 pending transition to payments based on the FRVS, shall be:
   a. The statewide property cost per diem ceiling is $13.6500.
   b. A provider is subject to a weighted average property ceiling at the addition of beds at 50 percent or more of the existing bed capacity, or the addition of 60 beds or more. A weighted average rate shall be computed, equal to the sum of:
Long-term Care Reimbursement Plan
Attachment 4.19-D
Part I

Amendment 2017-011
Effective 07/01/2017
Supersedes 2016-021
Approval 12/12/2017

(1) Actual per diem costs to the provider of the original facility, limited by the property ceiling $13,650.00, multiplied by the ratio of its current beds to total facility beds; and

(2) Actual per diem costs to the provider of the facility addition, limited by the property ceiling $18,623.00, multiplied by the ratio of its new beds to total facility beds.

This weighted average rate shall be effective for 18 months from the date the additional beds were put into service.

7. Determine the median inflated operating, direct care, and indirect care costs per diems for each of the four classes and for the entire state. For each of the per diems, calculate the ratios for each of the four class medians to the state medians.

8. Divide individual provider operating, direct care, and indirect care cost per diems that resulted from section 4 by the ratio calculated for the provider’s facility class in section 7.

9. Determine the statewide median for the per diems obtained in section 8.

10. For each of the operating, direct care, and indirect care per diems, exclude the lower and upper 10 percent of the per diems of section 8 and calculate the standard deviation for the remaining 80 percent.

11. Establish the statewide cost-based reimbursement ceiling for the operating cost per diem as the sum of the median plus one standard deviation and for the direct care and indirect care cost per diems as the sum of the median plus 1.75 standard deviations that resulted from sections 9 and 10.

12. Establish the cost-based class reimbursement ceilings for:
   a. The operating, direct care, and indirect care costs per diems for classes one through four as defined in section V.A.2 by multiplying the statewide ceilings in section 11 by the ratios calculated for that class in section 7.
b. The operating, direct care, and indirect care cost per diems for classes five through six as defined in section V.A.3 as the arithmetic average of the reimbursement ceilings determined in section a.

13. Establish the effective class reimbursement ceilings for operating, direct care, and indirect care cost per diems for each class as the lesser of:

a. The cost-based class reimbursement ceiling determined in section 12.

b. The target rate class reimbursement ceiling as calculated in 13.b, from the previous rate period, inflated forward with 1.4 (the class target inflation multiplier) times the rate of increase in the Florida Nursing Facility Cost Inflation Index through a calculation similar to that given in section 14. No reimbursement ceiling can increase in excess of 15 percent annually. The direct care component shall not be limited to the target rate class reimbursement ceiling. The target rate class reimbursement ceiling shall not fall below 90 percent of the cost-based class ceiling for each rate period as calculated in section 12.

14. Establish the provider target reimbursement rate for operating and indirect care cost per diems for each provider by multiplying each provider's target reimbursement rate for operating and indirect care cost in section 14 from the previous rate period, excluding the MAR, with the quantity:

\[
1 + 2.0 \times \left[ \frac{\text{Florida Nursing Facility Cost Inflation Index at the midpoint of the prospective rate period}}{\text{Florida Nursing Facility Cost Inflation Index at the midpoint of the current rate period}} - 1 \right]
\]

In the above calculation the 2.0 shall be referred to as the provider specific target reimbursement rate inflation multiplier. The provider target reimbursement rate limitation shall not fall below 75 percent of the cost-based class reimbursement ceiling.
for each rate setting as calculated in section 12. The direct care component shall not be limited to the target reimbursement rate.

15. Compute the total cost-related per diem for a provider as the sum of:
   a. The lesser of the operating cost per diem obtained in section 5, the provider’s operating provider target rate in section 14, the effective operating class ceiling obtained in section 13, or the provider’s operating new provider target limitation per diem obtained in section I.B.
   b. The lesser of the direct care cost per diem obtained in section 5 or the direct care cost-based class ceiling obtained in section 12.
   c. The lesser of the indirect care cost per diem obtained in section 5, the provider’s indirect care provider target rate in section 14, the indirect care effective class ceiling obtained in section 13, or the provider’s indirect care new provider target limitation per diem obtained in section I.
   d. The lesser of the property cost per diem obtained in section 5 or the applicable statewide property cost per diem ceiling in section 6 for facilities not reimbursed under FRVS. For those reimbursed under FRVS, substitute the FRVS rate calculated per section D, which shall be the sum of the property tax (which excludes sales tax on lease payments), insurance, and home office pass through per diems plus the per diem calculated based on the indexed 80 percent asset value plus the ROE or use allowance per diem calculated on the indexed 20 percent asset value.
   e. ROE per diem obtained in section 4.
   f. The MAR as described in section E.

16. Establish the prospective per diem for a provider as the result of section V.B.

C. Medicaid Trend Adjustment (MTA)

The MTA is a percentage cut that is uniformly applied to all Florida Medicaid providers each rate period which equals all recurring and nonrecurring budget reductions on an annualized basis. The
MTA is applied to all components after targets and ceilings. Below are all the recurring and nonrecurring cuts that are included in the MTA. Please reference Appendix C for each MTA percentage by rate period.

1. Effective July 1, 2005 a recurring annual reduction of $25,853,709 shall be applied proportionally to all rates.

2. Effective January 1, 2008 an additional MTA shall be applied to achieve a recurring annual reduction of $75,182,326.

3. Effective January 1, 2009 AHCA shall implement a recurring methodology to reduce nursing facility rates to achieve a reimbursement rate reduction of $83,847,252. In establishing rates through the normal process, prior to including this reduction, if the unit cost is equal to or less than the unit cost used in establishing the budget, then no additional reduction in rates is necessary. In establishing rates through the normal process, prior to including this reduction, if the unit cost is greater than the unit cost used in establishing the budget, then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the unit cost used in establishing the budget.

4. AHCA shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs for two fiscal years effective July 1, 2009. Reimbursement rates for the two fiscal years shall be as provided in the General Appropriations Act.

5. Effective March 1, 2009 AHCA shall implement a recurring methodology to reduce individual nursing facility rates proportionately until the $231,362,589 required savings is achieved.

6. Effective July 1, 2009 AHCA shall implement a recurring methodology to reduce nursing facility rates to achieve an $81,333,369 rate reduction. In establishing rates through the normal process, prior to including this reduction, if the unit cost is equal to or less than the unit cost used in establishing the budget, then no additional reduction in rates is
necessary. In establishing rates through the normal process, prior to including this reduction, if the unit cost is greater than the unit cost used in establishing the budget, then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the unit cost used in establishing the budget.

7. Effective July 1, 2009 AHCA shall implement a recurring methodology to reduce nursing facility rates to maximize the Nursing Facility Quality Assessment (NFQA) fee which will vary based on legislative authority for the assessment, Federal Medical Assistance Percentage (FMAP), and other reductions that have priority. This reduction will only occur if there are sufficient funds collected through the NFQA fee to restore the reduction. Refer to section V.F for a complete description of the methodology used in establishing the NFQA.

8. Effective July 1, 2011 budget authority up to $187,751,660 is provided for modifying the reimbursement for nursing facility rates. In establishing rates through the normal process, prior to including this reduction, if the unit cost is equal to or less than the unit cost used in establishing the budget, then no additional reduction in rates is necessary. In establishing rates through the normal process, prior to including this reduction, if the unit cost is greater than the unit cost used in establishing the budget, then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the unit cost used in establishing the budget.

9. Effective July 1, 2011 AHCA shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs. Reimbursement rates shall be as provided in the General Appropriations Act.

10. Effective July 1, 2012 AHCA shall implement a recurring methodology in the Title XIX Long-term Care Reimbursement Plan to reduce nursing facility rates to achieve a $35,160,584 rate reduction. In establishing rates through the normal process, prior to including this reduction, if the rate setting unit cost is equal to or less than the legislative unit cost, then no additional reduction in rates is necessary. In establishing rates through
the normal process, prior to including this reduction, if the rate setting unit cost is greater
than the legislative unit cost, then rates shall be reduced by an amount required to achieve
this reduction, but shall not be reduced below the legislative unit cost.

D. Fair Rental Value System (FRVS):

1. FRVS for providers in existing facilities at October 1, 1985:
   a. Each provider in an existing facility at October 1, 1985 shall have an FRVS rate
      established for capitalized tangible assets based upon the assets' acquisition costs
      at the last dates of acquisition prior to July 18, 1984. Facilities purchased after
      July 18, 1984 and not enrolled in the Florida Medicaid program prior to the
      purchase or facilities constructed after July 18, 1984 and enrolled in the
      program, shall have an FRVS rate established on the basis of the last acquisition
      costs prior to enrolling in the Florida Medicaid program. The acquisition costs
      shall be determined from the most current depreciation schedule which shall be
      submitted by each provider. These acquisition costs, including the cost of
      capital improvements and additions subsequent to acquisition, shall be indexed
      forward to October 1, 1985 by a portion of the rate of increase in the Florida
      Construction Cost Inflation (FCCI) Index based on the Dodge Construction
      Index. The change in the FCCI Index from September 1984 to March 1985,
      shall be used to project the FCCI Index for October 1, 1985, with no subsequent
      retroactive adjustment. The costs of land, buildings, equipment, and other
      capital items allowable for Florida Medicaid reimbursement per CMS-PUB.15-1,
      such as construction loan interest expense capitalized, financing points paid,
      attorneys’ fees, and other amortized soft costs associated with financing or
      acquisition shall be included in determining allowable acquisition costs subject
      to indexing. Property taxes (which exclude sales tax on lease payments) and
      property insurance expenses shall not be included in the calculation of the FRVS
      rate, but shall be reimbursed prospectively, based on actual costs incurred and
included in the total property rate. For FRVS rates calculated after October 1, 1985, but prior to July 1, 1991, the six month change in the FCCI Index based on the Dodge Construction Index shall be determined for adjusting FRVS rates. For rates effective on or after July 1, 1991, the FCCI Index based on the IHS Healthcare Cost Review quarterly forecast publication, Regional Prices and Wages table, Consumer Price Index All Items section, South Region subsection shall be used. FRVS rates shall be adjusted for inflation on each rate period, using the change in the FCCI Index for the most recent rate period published prior to the rate period. FRVS rates shall be adjusted per subsections f and i for changes in interest rates on capital debt instruments and for capital additions or improvements on each rate period. See Appendix B for the computation of this index.

b. A single FCCI Index, based upon the average of the Dodge Construction indices for the six cities in Florida for which an index is published, shall be used through June 30, 1991. The most recently published IHS Healthcare Cost Review, Regional Prices and Wages table, Consumer Price Index All Items section, South Region subsection quarterly indices shall be used for July 1, 1991 and thereafter. The rate of increase in the FCCI Index, for purposes of indexing FRVS rates, shall be limited to a three percent semiannual increase and a six percent annual increase. During rate periods when the increase in the index is greater than the maximum percentage, a credit shall be calculated as the actual increase minus the maximum percentage. This credit shall be carried forward for future periods and added to the increase in the index, up to the maximum percentage, when the actual future increases in the index are less than the maximum percentage. For example, if the increase in the index is four percent in a six-month period, three percent shall be used and a credit of one percent shall be carried forward; then, if the increase in the index is two percent in the
next six-month period, a three percent rate of indexing shall be used, by adding
the one percent credit to the actual two percent increase. If more than two
percent credits were available, a maximum of three percent rate of indexing
would be used, and the remaining credits would again be carried forward to
future periods. The credits shall carry forward indefinitely until they are
reduced by applying them to periods during which the rate of increase in the
FCCI Index is less than the maximum percentage. The credits shall accrue by
individual facility, so that any facility entering the program in a period where the
increase in the FCCI Index is less than the maximum percentage shall not
benefit from credits accrued during prior periods by other facilities.

c. The portion of the FCCI Index increase used to index asset valuation each year
shall vary with the number of years the facility participated in the program since
January 1, 1972. For the first 10 years of participation, a straight-line increasing
portion of the allowable increase in the index shall be used: one-tenth in year
one, two-tenths in year two, three-tenths in year three, up to ten-tenths in year
10. The total percent increase allowed for any six-month rate period shall not
exceed three percent, shall not exceed four percent for any eight-month period,
shall not exceed six percent for any 12-month rate period, and shall not exceed
six and a half percent for any 13-month rate period. For the second 10 years, the
unadjusted index increase shall be used, subject to a three percent semi-annual
limitation and six percent annual limitation. For years 20 through 40, a straight-
line decreasing portion of the allowable increase in the index shall be used
subject to the three percent limit per six-month rate period, four percent per
eight-month period, six percent per 12-month rate period, and six and a half
percent per 13-month period: 95 percent in year 21, 90 percent in year 22, 85
percent in year 23, down to 0 percent in year 40. Thus, after 39 years of
participation in the program, no further indexing shall be given to a facility.
d. For rate periods beginning on or after January 1, 1986 an adjustment shall be made in indexing for failure of a licensure re-inspection and for low Florida Medicaid utilization.

(1) Any facility which receives a conditional licensure rating and upon reinspection has not corrected deficiencies as required by AHCA, Bureau of Long Term Care Services, shall receive no indexing in the FRVS rate for the rate period subsequent to the reinspection.

(2) Florida Medicaid utilization shall be calculated as Florida Medicaid patient days divided by total patient days, for fiscal years ending in 1980 or after. The utilization will be calculated from the cost report or budget used to set the rates for the respective rate period. For the initial FRVS rates established on October 1, 1985, cost reports received by AHCA by September 1, 1985, will be used. Years earlier than 1980 shall have no adjustment made for utilization, but rather shall receive full credit for Florida Medicaid utilization. The adjustment for fiscal years ending in 1980 or after shall be computed as follows:

(a) If the provider's cost report or budget shows less than 25 percent average Florida Medicaid utilization for the cost reporting period, then no indexing of asset valuation shall be given.

(b) If 25 percent to 55 percent Florida Medicaid utilization is computed, then the portion of the FCCI Index increase calculated in subsection 1.c shall be multiplied by the fraction equal to the actual utilization percent divided by 55 percent.

(c) If 55 percent or greater Florida Medicaid utilization is computed, then full indexing using the portion of the FCCI Index increase calculated in subsection 1.c shall be given.
e. The asset valuation of the facility shall be indexed, according to sections a through d, from the date of entry into the Florida Medicaid program but not prior to January 1, 1972. That asset valuation, subject to the cost per bed ceiling in g., shall be used to initiate the provider’s FRVS property reimbursement at October 1, 1985. The change in the FCCI Index from September 1984 to March 1985 shall be used to project the FCCI Index for October 1, 1985, with no subsequent retroactive adjustment. The total asset valuation shall be divided into two components:

(1) 80 percent of the total asset valuation, which shall be amortized over 20 years at the interest rate specified in section 6 to determine an amount which would pay principal and interest on an installment mortgage for that 80 percent of the asset valuation, and

(2) 20 percent of the asset valuation, which shall be used to calculate a ROE for property-related equity per sections III.J and K. The second component, representing 20 percent of the asset valuation and used as a ROE, will be converted to a per diem by dividing by 90 percent of the maximum annual bed days of the facility or by 75 percent of the maximum annual bed days for providers with newly constructed facilities.

Both components shall be used to calculate per diems which shall be included in the FRVS rate. When calculating the first component, if the provider begins FRVS with a total initial principal balance of all current mortgages less than 60 percent of the indexed asset value, only the interest portion of the calculated installment mortgage on the 80 percent of the asset valuation is used in calculating the provider’s FRVS rate. The calculated first component, based on
either interest plus principal or interest-only expense, will be converted to a per
diem by dividing by 90 percent of the maximum annual bed days of the facility.
However, for providers with newly constructed facilities, the provider’s per
diem calculated for that facility's first year of operation shall be the result of the
principal and interest or interest-only expense divided by 75 percent of the
maximum possible annual bed days. For those providers with facilities that
have put into service new beds for the first 12 months, the provider’s per diem
shall be the result of the principal and interest or interest-only expense divided
by a weighted average occupancy percentage greater than 75 percent but less
than 90 percent of the maximum annual bed days if the addition of beds was 50
percent or more of the existing bed capacity, or the addition of 60 beds or more.
A weighted average occupancy rate shall be computed, equal to the sum of:

\[
\frac{\text{New Beds}}{\text{Total Facility Beds}} \times 75\% + \frac{\text{Existing Beds prior to the Addition}}{\text{Total Facility Beds}} \times 90\%
\]

For those providers with facilities that have put into service new beds for the
first 12 months, and the addition of beds was 50 percent or more of the existing
bed capacity, or the addition of 60 beds or more, the 20 percent will be
converted to a per diem by dividing by a weighted average occupancy
percentage greater than 75 percent but less than 90 percent of the maximum
annual bed days as outlined in the formulas above.

Property taxes excluding sales tax on lease payments, insurance, and home
office costs shall have a per diem calculated based upon actual historic cost and
patient days as shown in the latest applicable cost report.

f. Mortgages and Interest Rates:
The interest rate used to amortize the 80 percent component of the asset valuation shall be the lower of:

(a) The owner's actual mortgage rate;

(b) The Chase Manhattan Bank's prime rate, hereinafter referenced as Chase prime, as of the date of the provider's loan commitment plus two percent for a variable rate mortgage or plus three percent for a fixed rate mortgage; or

(c) 15 percent.

If an owner has more than one outstanding debt instrument, the owner's actual rate used for this section shall be an average of the rates for all of the outstanding debt, weighted by the amount of the original principal of each debt instrument.

No changes subsequent to establishment of the initial FRVS rate shall be made to the interest rate used to calculate the FRVS rate for providers with fixed rate mortgages except as allowed per (5). For variable rate mortgages, no changes shall be made unless the owner's interest rate changes according to (3).

For the initial FRVS rates at October 1, 1985 the July 1, 1984 Chase prime shall be used for the lesser of comparison with the provider's actual rate. For those providers that received the July 1, 1984 Chase prime (13 percent) at June 30, 1996 beginning with the July 1, 1996 rate period, shall have 12.5 percent used for the lesser of comparison on and after July 1, 1996. For rate periods prior to July 1, 1996, 13 percent shall be used. Providers shall be required to notify AHCA of their mortgage rate and any changes in their mortgage rate. For rate periods prior to September 1, 2015 providers with variable mortgage rates shall submit current changes in their mortgage rates by October 15.
and April 15 of each year to qualify for an adjustment to their FRVS rate on the following January 1 or July 1, respectively. For rate periods beginning on or after September 1, 2015, providers with variable mortgage rates shall submit current changes in their mortgage rates by April 15 of each year to qualify for an adjustment to their FRVS rate on the following September 1. At that time, the FRVS rate to be used for the next rate period shall be determined using the most current mortgage rate, but not to exceed the rate at October 15 or April 15, respectively, Chase prime plus two percent, or 15 percent.

(4) For facilities beginning the FRVS with a total initial principal balance of the mortgages less than 60 percent of their indexed asset value, the interest rate used to amortize the 80 percent component shall be the applicable Chase prime per section (3), but not to exceed 15 percent. The amortization of prime over 20 years shall be used to determine an amount which would pay interest on an installment mortgage for that 80 percent valuation. The prime rate used to initiate FRVS for providers with an initial principal balance of the mortgage less than 60 percent of their indexed asset value shall remain fixed for that provider in calculating future FRVS payments. However, if at some point in the future a provider finances capital assets such that the total original principal of debt instruments equals or exceeds 60 percent of the FRVS asset valuation, then the FRVS rate at the next rate period shall be calculated using the interest rate per section (1).

(5) An increase in the interest rate shall be allowed only if refinancing was necessary in order to finance the addition of new beds, to meet the final payments of the former debt instrument, or to consolidate existing debt excluding debt to owners; for example, in cases where balloon
payments are due. If a new mortgage is secured at the addition of new beds and a prior mortgage is still in effect for the original facility, a weighted average mortgage rate shall be used in section (1) based upon mortgage amounts and interest rates of the various mortgages.

g. The standard, or ceiling, per bed cost shall be established at $28,500 at October 1, 1985. Each existing facility at October 1, 1985 shall have its total capital assets valuation limited to the lesser of that standard or the facility's computed asset valuation, whichever is less. The standard of $28,500 shall be indexed forward every rate period based upon the most recently published increase in the FCCI Index and shall be used to limit new construction costs in the future. New facilities shall be limited to the standard in effect the rate period prior to the date the facility was first put into service as a nursing facility. A facility shall not receive an adjustment to account for increases in the standard at later dates.

h. A hold harmless provision shall be implemented to ensure that facilities existing and enrolled in the Florida Medicaid program at October 1, 1985 do not receive reimbursement for property and ROE or use allowance under the FRVS method less than the property cost reimbursement plus ROE or use allowance given at September 30, 1985. If the FRVS rate would be lower than depreciation plus interest costs under sections III.G.3 through 5, a provider in the facility shall continue to be reimbursed depreciation plus interest according to sections III.G.3 through 5 until such time as the net difference in total payments between sections III.G.3 through 5 and FRVS is zero. Providers who wish to begin FRVS reimbursement that would result in payments less than the depreciation plus interest payments must notify AHCA in writing by December 2, 1985. Providers in facilities with existing leases at October 1, 1985 shall be paid at the September 30, 1985 rate subject to section III.G.2 until the current lease expires, at which time reimbursement shall begin under FRVS based on the owner's
acquisition costs. Providers shall supply AHCA with the appropriate lessor's ownership costs to receive property reimbursement after the current lease expires. No reimbursement for property-related costs shall be given to a provider in a leased facility subsequent to the expiration of the lease existing at October 1, 1985 if the lessor's ownership costs are not adequately documented per section III.G.4.

i. No adjustments to asset valuation shall be made for replacement of existing equipment. Adjustments at cost shall be allowed for capital improvements and additions. Capital additions of beds shall be subject to the per bed standard as computed in section g that is in effect the rate period prior to the date the facility addition was first put in service as a nursing facility. An adjustment to the FRVS rate may be requested if expenditures for capital additions and improvements totaling $0.40 per available bed day accrue in the cost reporting period utilized in establishing the per diem rate for the upcoming rate period.

Costs incurred during a cost reporting period that do not total $0.40 per available bed day shall not be included in the next cost reporting total. Thus, a provider in a 120 bed facility purchasing new equipment which does not replace any old equipment, and making capital improvements at a total unamortized purchase cost less than $17,520 during a twelve-month cost reporting period shall not receive an adjustment to the FRVS rate in the coming rate period or in any rate period for those improvements or equipment. The cost of capital additions or improvements shall be established on the date new beds are put into service, the date of completion for capital improvements, and date of acquisition for equipment or other purchased assets and recognized for FRVS purposes so long as the total indexed asset valuation does not exceed the current per bed standard except as provided below:
(1) In no circumstances, other than (2) and (3) below, shall a provider’s total asset value under FRVS exceed the current per bed standard.

(2) Effective July 1, 1996 providers whose indexed asset valuation exceeds the per bed standard at June 30, 1996 shall be limited to their June 30, 1996 indexed value until the rate period in which their total asset value is less than the current per bed standard.

(3) Providers that entered into a legally enforceable arm’s length agreement prior to July 1, 1996 for the construction or purchase loans of additions (excluding bed additions) or improvements which were not previously reported in a cost report shall have those additions or improvements included in their indexed asset value when the cost report that includes those additions or improvements is used to establish the reimbursement rate. When the above mentioned additions or improvements cause the providers indexed asset value to exceed the current per bed standard, the provider shall be limited to that indexed asset value until the rate period in which that indexed asset value is less than the current per bed standard. Documentation of the legally enforceable, arm’s length agreement must be submitted with the cost report in which the additions or improvements are reported.

(4) Any cost associated with capital additions or improvements, which are not recognized in the FRVS rate due to the per bed standard limitation, shall not be allowed in any future FRVS rate. Adjustments made to FRVS rates due to capital additions or improvements shall be subject to retroactive adjustment based on audit findings made by AHCA.

2. FRVS for providers in facilities entering the Florida Medicaid program subsequent to October 1, 1985:
a. The FRVS rate for providers in facilities constructed subsequent to October 1, 1985 or existing facilities which enter the Florida Medicaid program subsequent to October 1, 1985 shall be calculated as in sections V.D.1.a through g. These facilities shall not be subject to any phase-in to the FRVS rate, and shall not have the option to elect reimbursement under sections III.G.2 through 5.

b. The ceiling that shall apply to facilities entering the program subsequent to October 1, 1985 shall be the ceiling in effect the rate period prior to the date the facility was first put into service as a nursing facility. For facilities built prior to October 1, 1985 which enter the program subsequent to October 1, 1985, the ceiling at October 1, 1985 shall be deflated, using the FCCI Index, back to the rate period prior to the date the facility was first put into service as a nursing facility but not prior to January 1, 1972.

3. Facilities that are currently participating in the Florida Medicaid program but subsequently withdraw:
   a. Facilities that participate in the Florida Medicaid program on or after October 1, 1985, but subsequently withdraw shall be subject to the same cost per bed ceiling that they were previously subject to should they decide to re-enter the program.
   b. At re-entry into the program, the indexing of asset valuation shall resume at the point where the facility was in the 40 year indexing curve per section D.1.c when it withdrew from the program.

4. Property reimbursement for facilities upon change of ownership:
   a. Facilities that undergo a change of ownership on or after October 1, 1985 shall be reimbursed for property based upon the provisions contained in this section. It is AHCA's intent that, to the extent possible, the new provider shall receive essentially the same reimbursement for property costs as the previous provider.
Therefore, unless stated otherwise in b through f, the new provider's reimbursement shall be based on sections D.1.a through c.

b. If the previous owner of a facility was being paid depreciation plus interest under the hold harmless provision of section D.1.h, the new owner shall also receive depreciation plus interest per section III.G unless the new owner requests AHCA, in writing, to begin FRVS payments instead. The FRVS depreciable basis shall remain the same as that of the previous owner; interest expense allowed, subject to the limitations in section D.1.f.

c. If the previous owner was being reimbursed under FRVS, the new owner shall also receive FRVS payment, entering at the point of phase-in and asset value indexing that the previous owner had reached. If the new owner's principal balance of all current mortgages is less than 60 percent of the indexed asset value, only the interest portion, at a rate determined in section D.1.f, will be used in calculating the new owner's FRVS rate. If the new owner's principal balance of all current mortgages is equal to or greater than 60 percent of the indexed asset value, then the new owner shall be paid principal and interest on 80 percent of the total asset valuation amortized over 20 years at the interest rate specified in section D.1.f. In addition, the new owner's interest rate shall be used in lieu of the original owner's interest rate in accordance with the limitations described at section D.1.f. Any credits accrued by the previous owner for indexing as described in section D.1.b shall be applied to the new owner.

d. The ROE or use allowance shall be calculated as per section D.1.e. A per diem shall be calculated for property taxes, insurance, and home office costs based upon actual historic cost and patient days shown in the latest applicable cost report, as per section D.1.e.
Long-term Care Reimbursement Plan  
Attachment 4.19-D  
Part I

Amendment 2017-011  
Effective 07/01/2017  
Supersedes 2016-021  
Approval 12/12/2017

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e. The new provider shall be subject to the recapture provisions in section III.H. The new provider's cost basis shall be computed per section III.G.3.
f. Reimbursement to a new provider for costs of replacement equipment shall be governed by the same provisions affecting the previous provider.

5. Capital costs which require Certificate of Need (CON) approval shall be allowed for reimbursement purposes only if the capital expenditure receives approval from the CON office. All cost overruns which require CON approval must also be approved in order to qualify for reimbursement. This section will apply to all providers with Florida Medicaid certification effective on or after July 1, 1991.

<table>
<thead>
<tr>
<th>Example 1</th>
<th>Example 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Facility Cost</td>
<td>$10.0 Million</td>
</tr>
<tr>
<td>CON Approval</td>
<td>$7.0 Million</td>
</tr>
<tr>
<td>Medicaid Allowable Cost</td>
<td>$6.5 Million</td>
</tr>
<tr>
<td>Reimbursable Cost</td>
<td>$6.5 Million</td>
</tr>
<tr>
<td></td>
<td>$6.0 Million</td>
</tr>
</tbody>
</table>

Total capital expenditures which are greater than the total amount approved by CON shall not be recognized for reimbursement purposes. In the example above, the reimbursable cost, which is considered in rate calculations, is the lower of the new facility cost, CON approval, or the Florida Medicaid allowable cost.

E. Medicaid Adjustment Rate (MAR)

The MAR for direct care and indirect care shall be calculated as follows:

1. Facilities with 90 percent or greater Florida Medicaid utilization shall have their MAR equal their WBR as determined in section E.3.

2. Facilities with 50 percent or less Medicaid utilization shall receive no MAR.

3. Facilities between 50 percent and 90 percent Medicaid utilization shall have their MAR as determined by the following formula:
Long-term Care Reimbursement Plan
Attachment 4.19-D
Part I

MAR = WBR X MA

WBR = (BR x MAW) X
      (Superior + Standard)
      All

MA = (Medicaid Utilization % - MIN) ÷ (MAX – MIN)

Definitions:

MAR - Medicaid Adjustment Rate

WBR - Weighted Base Rate

MA - Medicaid Adjustment

BR - Base Rate, which is set as the result of sections V.B.15.b and c.

MAW - Medicaid Adjustment Weight, which is set at .045

Superior - Number of Superior Days as described in 4.

Standard - Number of Standard Days as described in 4.

All - All superior, standard, and conditional days

MIN - Minimum Medicaid utilization amount which is set at 50 percent

MAX - Maximum Florida Medicaid utilization amount which is set at 90 percent

4. Determine the number of days one year prior to the rate period for which the facility held each of the three possible licensure ratings: superior, standard, and conditional.

Example - For the rate period January 1, 2014 through June 30, 2014, the period one year prior is January 1, 2013 to June 30, 2013. During that prior period, the provider's licensure ratings were:
The result of these calculations will represent the MAR to which the provider is entitled. This rate is to be included in the direct care and indirect care component of the provider's total reimbursement rate.

5. Only providers being paid a prospective rate under section V.B.6 shall be eligible for the MAR.

F. Nursing Facility Quality Assessment (NFQA)

Effective April 1, 2009, AHCA, in accordance with section 409.9082, F.S., shall implement methodologies revising reimbursement to nursing facilities that will create a pass-through of the Florida Medicaid share of the assessment, restore prior reductions as allowed, and provide for an operating add-on as a phase-in to a pricing model. The funding for reimbursement improvements is provided through the NFQA fee. The funds shall exclusively be for the following purposes and in the following order of priority:

1. To reimburse the Florida Medicaid share of the NFQA fee as a pass through. The per diem Florida Medicaid share of the NFQA is calculated as follows:
   a. Total patient days minus Medicare days is equal to total non-Medicare days.
   b. The product of total non-Medicare days, NFQA rate and Florida Medicaid utilization to is equal to the total NFQA Florida Medicaid share.
   c. Total NFQA Florida Medicaid share divided by Florida Medicaid days is equal to the per diem Florida Medicaid Share of the NFQA.
2. To increase each nursing facility’s Florida Medicaid rate, an amount that restores the rate reductions effective on or after January 1, 2008. These reductions are listed in sections V.C.2 through 10.

3. To increase each nursing facility’s Florida Medicaid rate that accounts for the remainder of the total assessment not included in sections V.F.1 through 2. The rate increase is a pass through which is calculated by taking total funds remaining after sections V.F.1 through 2. Then, subtract budgeted administrative cost and funds required for Hospice rate cut restoration to equal total quality assessment funds remaining. Next, divide total quality assessment funds remaining by annualized Florida Medicaid days to determine the increase available for nursing facilities’ Florida Medicaid rates.

Each facility shall report monthly to AHCA its total number of resident days, exclusive of Medicare resident days, and remit an amount equal to the assessment rate times the reported number of days. Facilities are required to submit their assessment by the 20th day of the next succeeding calendar month.

VI. Prospective Payment System

Effective October 1, 2018 a prospective payment methodology shall be implemented for rate setting purposes. The following outlines the requirements to transition to a prospective payment system.

A. Exempt Facilities

1. Pediatric, Florida Department of Veterans Affairs, and government-operated facilities are exempt from reimbursement under the prospective payment methodology. These providers shall be reimbursed on a cost-based prospective payment system.

   a. Facilities that have both licensed pediatric beds and community or sheltered beds must file two separate cost reports in accordance with Sections I and III in order to separate the cost of care associated with the Pediatric population. The cost reports must use cost allocation methodologies in accordance with CMS-PUB.15-1.

B. Quality Incentive Component
The prospective payment system will include a quality incentive add-on component consisting of process, outcome, structural, and credentialing measures.

1. Process Measures

For each process measure, each provider will be ranked and points will be awarded based on the percentile in which the provider scores in relation to other Florida Medicaid providers included in the prospective payment methodology. For each rate period, the process measures will be calculated using the most recent one-year average from the Minimum Data Set (MDS) Quality Measures from the Nursing Home Compare datasets provided by the Centers for Medicare and Medicaid Services as of May 31 of the year in which the rate period begins.

a. Percentage of long-stay residents assessed and appropriately given the seasonal influenza vaccine
b. Percentage of long-stay residents who received an antipsychotic medication
c. Percentage of long-stay residents who were physically restrained

2. Outcome Measures

For each outcome measure, each provider will be ranked and points will be awarded based on the percentile in which the provider scores in relation to other Florida Medicaid providers included in the prospective payment methodology. For each rate period, the outcome measures will be calculated using the most recent one-year average from the MDS Quality Measures from the Nursing Home Compare datasets provided by the Centers for Medicare and Medicaid Services as of May 31 of the year in which the rate period begins.

a. Percentage of long-stay residents with a urinary tract infection
b. Percentage of high-risk long-stay residents with pressure ulcers
c. Percentage of long-stay residents experiencing one or more falls with major injury
d. Percentage of low-risk long-stay residents who lose control of their bowels or bladder

e. Percentage of long-stay residents whose need for help with daily activities has increased

3. Structural Measures

For each structural measure, each provider will be ranked and points will be awarded based on the percentile in which the provider scores in relation to other Florida Medicaid providers included in the prospective payment methodology.

a. Hours of licensed nursing (RN, LPN) and CNA staffing

The licensed nursing and CNA staffing measure will be calculated using the total combined RN, LPN, and CNA productive hours per patient day as reported in the Medicaid cost report submitted prior to the cost report cutoff date. For a new provider with no cost history resulting from a change of ownership or operator, the measure will be calculated using the prior provider’s cost report submitted prior to the cost report cutoff date.

b. Social work and activities staffing

The social work and activities staffing measure will be calculated using the total number of qualified activities professionals and qualified social workers employed by the facility on a full-time basis, part-time basis, or under contract to a facility per resident day. For each rate period, the data will be collected from the CMS-671 and CMS-672 reports as of May 31 of the year in which the rate period begins.

4. Credential Measures

a. CMS 5 Star Rating

For each rate period, the CMS 5 Star Rating Measure will be calculated using the most recent overall rating from the Star Ratings dataset from the Nursing
Home Compare datasets provided by the Centers for Medicare and Medicaid Services as of May 31 of the year in which the rate period begins.

b. Nursing Home Gold Seal Award

For each rate period, the Nursing Home Gold Seal Award measure will be calculated using the licensees with the Gold Seal designation as of May 31 of the year in which the rate period begins.

c. Joint Commission Accreditation

For each rate period, the Joint Commission Accreditation measure will be calculated using the providers with accreditation as of May 31 of the year in which the rate period begins.

d. AHCA National Quality Award

For each rate period, the AHCA National Quality Award measure will be calculated using the gold or silver level award recipients as of May 31 of the year in which the rate period begins.

C. Fair Rental Value System (FRVS)

1. A FRVS will be implemented to reimburse providers for their facility-related property and capital costs. Each provider participating in the Florida Medicaid program shall submit a fair rental value survey using the electronic form and instructions on the Florida Nursing Home: Fair Rental Value Survey web page. The most recent FRVS survey received by April 30 of the year in which the rate period begins will be used to calculate the FRVS rate. Extensions will not be granted.

2. If a facility fails to submit an FRVS survey by April 30, 2018, no building additions, replacements, renovation, or major improvement data will be used in the FRVS calculation for the October 1, 2018 rate semester. In addition, for a provider who has never submitted an FRVS survey to the Agency, the FRVS calculation will use the minimum square footage as the facility square footage.
3. The Agency may perform desk reviews on the provider-submitted survey data and amend the survey data based on the desk review results.

D. Transition

Beginning October 1, 2018, the Agency shall reimburse providers the greater of their cost-based rate effective September 1, 2016, hereinafter referred to as “hold harmless rate”, or their prospective payment rate.

1. The hold harmless rate will be the most current rate published to the Agency’s web page with a September 1, 2016 effective date on May 31, 2018.

2. For providers with no published rate effective September 1, 2016, the hold harmless rate will be the prior provider’s most current rate published to the Agency’s web page with a September 1, 2016 effective date on May 31, 2018.

3. New facilities that began operation after September 1, 2016 will not qualify for the transition payment and will receive their prospective payment rate.

VII. Payment Assurance

The State shall pay each nursing facility for services provided in accordance with the requirements of the Florida Title XIX State Plan, Rule 59G-6.010, F.A.C., 42 CFR, and section 1902 of the SSA. The payment amount shall be determined for each nursing facility according to the standards and methods set forth in the Florida Title XIX Long-Term Care Reimbursement Plan.

VIII. Provider Participation

This Plan is designed to assure adequate participation of nursing facilities in the Florida Medicaid program and the availability of high quality nursing facility services for recipients which are comparable to those available to the general public.

IX. Payment in Full

Any provider participating in the Florida Medicaid program who knowingly and willfully charges money or other consideration, for any service provided to the patient under the state plan in excess of the rates established by the State Plan, or charges, solicits, accepts, or receives, in addition to any amount otherwise
required to be paid under the State Plan approved under this title, any gift, money, donation or other
consideration other than a charitable, religious or philanthropic contribution from an organization or from a
person unrelated to the patient as a condition of admitting a patient to a nursing facility, or as a requirement
for the patient's continued stay in such a facility, when the cost of the services provided therein is paid for
in whole or in part under the State Plan, shall be construed to be soliciting supplementation of the State's
payment for services. Payments made as a condition of admitting a patient or as a requirement for
continued stay in a facility shall be deemed to be payments to meet the cost of care of the Florida Medicaid
patient and shall be deemed to be out of compliance with 42 CFR 447.15.

X. Glossary

A. Acceptable cost report - A completed, legible cost report that contains all relevant schedules,
worksheets and supporting documents in accordance with cost reporting instructions.

B. AHCA - Agency for Health Care Administration.

C. Audit - A direct examination of the books, records, and accounts supporting amounts reported in
the cost report to determine correctness and propriety.

D. Audit adjustment - Any adjustment within the Florida Medicaid audit report or Florida Medicaid
desk review report on Attachment A.

E. Audit finding - Any adjustment within the Florida Medicaid audit report or Florida Medicaid desk
review report not listed on Attachment A.

F. Bed - A licensed Skilled Nursing Facility (SNF) bed.

G. CMS-PUB.15-1 - Health Insurance Manual No. 15, also known as the Provider Reimbursement
Manual, published by the Department of Health and Human Services, Centers for Medicare and
Medicaid Services.

H. Rate setting acceptance cut-off date - The rate setting acceptance cut-off date is April 30 or the
next business day if April 30 falls on a weekend.

I. Cost report due date - A provider’s cost report is due five calendar months after the close of the
provider’s cost reporting year. Initial cost reports are due 23 months after the Florida Medicaid
provider’s effective date.
J. Desk review - An examination of the amounts reported in the cost report to determine correctness and propriety. This examination is conducted from AHCA reviewer’s office and is focused on documentation solicited from the provider or documents otherwise available to the reviewer.

K. Facility - The physical grounds and buildings where a provider operates a licensed nursing facility.

L. Government-operated facility – A nursing facility operated by a city, county, state, or federal government entity, including hospital districts owned by city or county government entities.

M. Late cost report - A cost report that is not received by AHCA on the cost report due date.

N. Legislative unit cost - The weighted average per diem of the state anticipated expenditure after all rate reductions.

O. Medicaid Adjustment Rate (MAR) - An add-on to the direct care and indirect care cost components of providers with greater than 50 percent Florida Medicaid utilization to encourage high quality care while containing costs. The MAR per diem calculation is detailed in section V.E of this Plan.

P. Medicaid interim reimbursement rate - A component of an overall reimbursement rate that is calculated from budgeted cost data. Any overpayments or under payments resulting from the difference between budgeted cost rates and actual cost rates (limited by provider specific targets and class or statewide ceilings), as determined through an audit of the same reporting period, will be either refunded to AHCA or paid to the provider as appropriate.

Q. Medicaid nursing facility direct and indirect patient care costs - Those costs directly attributed to nursing services, dietary costs, and other costs directly related to patient care, such as activity costs, social services, and all medically-ordered therapies.

R. Medicaid nursing facility operating costs - Those costs not directly related to patient care or property costs, such as administrative, plant operation, laundry and housekeeping costs. ROE or use allowance costs are not included in operating costs.

S. Medicaid nursing facility property costs - Those costs related to the ownership or leasing of a nursing facility. Such costs may include property taxes, insurance, interest and depreciation, or rent.
T. Provider - A person or entity licensed and/or certified under state law to deliver health care or related services, which services are reimbursable under the Florida Medicaid program.

U. Rate period - September 1 - August 31 between September 1, 2015 and August 31, 2017.

V. Rate setting unit cost - The weighted average per diem after all rate reductions based on submitted cost reports.

W. Region - AHCA shall plan and administer its programs of health, social, and rehabilitative services through 11 service areas composed of the following counties:

1. Region 1 - Escambia, Okaloosa, Santa Rosa, and Walton counties
2. Region 2 - Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington counties
3. Region 3 - Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwanee, and Union counties
4. Region 4 - Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia counties
5. Region 5 - Pasco and Pinellas counties
6. Region 6 - Hardee, Highlands, Hillsborough, Manatee, and Polk counties
7. Region 7 - Brevard, Orange, Osceola, and Seminole counties
8. Region 8 - Charlotte, Collier, Desoto, Glades, Hendry, Lee, and Sarasota counties
9. Region 9 - Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie counties
10. Region 10 - Broward county
11. Region 11 - Dade and Monroe counties

X. Reimbursement ceilings - The upper rate limits for a Florida Medicaid nursing facility’s operating and patient care reimbursement for nursing facilities in a specified reimbursement class or the upper limit for a nursing facility’s property cost reimbursement for all nursing facilities statewide.

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

AA. Title XIX - Grants to States for Medical Assistance Programs (Medicaid, as provided for in the SSA, as certified by 42, U.S.C. 1396-1396i).
Appendix A: Calculation of Florida Nursing Facility Cost Inflation Index

The following example uses data from the September 1, 2015 rate period. For this rate period the percentage weights for the cost components are:

<table>
<thead>
<tr>
<th>Component</th>
<th>Direct Patient Care</th>
<th>Indirect Patient Care</th>
<th>Operating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and Benefits</td>
<td>100.0%</td>
<td>55.75%</td>
<td>55.75%</td>
</tr>
<tr>
<td>Dietary</td>
<td>0.0%</td>
<td>6.23%</td>
<td>6.23%</td>
</tr>
<tr>
<td>Others</td>
<td>0.0%</td>
<td>38.02%</td>
<td>38.02%</td>
</tr>
</tbody>
</table>

An inflation index for each of these components is developed from IHS Healthcare Cost Review quarterly index, Skilled Nursing Facility without Capital Market Basket table, using the following routine services costs inflation indices:

<table>
<thead>
<tr>
<th>Component</th>
<th>IHS Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and Benefits</td>
<td>Wage &amp; Salary combined with Employee Benefits</td>
</tr>
<tr>
<td>Dietary</td>
<td>Food</td>
</tr>
<tr>
<td>All Others</td>
<td>Utilities combined with All Other Expenses</td>
</tr>
</tbody>
</table>

The IHS indices are combined by summing the products of each index times the ratio of the respective Global Insight budget share to total budget share represented by the combined indices.

The following example uses data from the first quarter of 2015 Healthcare Cost Review publication to calculate the first quarter of 2014 Salaries and Benefits component. The All Others Index is calculated in the same manner.
The Weighted Salaries and Benefits index is calculated using the following formula:

\[(1.220 \times 0.519/(0.519+0.118)) + (1.245 \times 0.118/(0.519+0.118)) = 1.225\]

A Combined Quarterly Index is then constructed by summing the products of the weights and quarterly component indices.

The Combined Quarterly Index is calculated using the following formula:

\[(\text{Weighted Salaries & Benefits Index} \times \text{percentage weight}) + (\text{Dietary Index} \times \text{percentage weight}) + (\text{Weighted All Others Index} \times \text{percentage weight})\]

\[(1.225 \times 55.75\%) + (1.360 \times 6.23\%) + (1.483 \times 38.02\%) = 1.33149863\]

The Weighted Salaries and Benefits Index and the Combined Quarterly Index is utilized to obtain monthly indices called the Florida Nursing Facility Cost Inflation Index by averaging pairs of quarterly indices and interpolating between these averages as follows:

The Average Weighted Salaries & Benefits Index for months with end dates that correspond with the end date of a quarter is calculated using the following formula. The Average Combined Quarterly Index is calculated in the same manner for these months.

Average Weighted Salaries & Benefits Index = [(Weighted Salary & Benefits Index for current quarter + Weighted Salary & Benefits Index for following quarter) / 2]

The Average Weighted Salaries & Benefits Index and Average Combined Quarterly Index for months that do not end on the end date of a quarter are calculated as follows:

April 2014 Average Weighted Salaries & Benefits Index

\[= \left( \frac{\text{June 30 Index}}{\text{March 31 Index}} \right)^{1/3} \times (\text{March 31 Index}) \]

\[= \left( \frac{1.229}{1.226} \right)^{1/3} \times 1.226 = 1.227 \]

May 2014 Direct Care Inflation Index

\[= \left( \frac{\text{June 30 Index}}{\text{March 31 Index}} \right)^{2/3} \times (\text{March 31 Index}) \]

\[= \left( \frac{1.342}{1.334} \right)^{2/3} \times 1.334 = 1.339 \]

These indices will be updated prior to each rate setting.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Average Weighted Salaries &amp; Benefits Index</th>
<th>Average Combined Quarterly Index</th>
<th>Corresponding Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014:1</td>
<td>1.226</td>
<td>1.334</td>
<td>March 31</td>
</tr>
<tr>
<td>2014:2</td>
<td>1.229</td>
<td>1.342</td>
<td>June 30</td>
</tr>
<tr>
<td>2014:3</td>
<td>1.235</td>
<td>1.350</td>
<td>September 30</td>
</tr>
<tr>
<td>2014:4</td>
<td>1.244</td>
<td>1.361</td>
<td>December 31</td>
</tr>
</tbody>
</table>
Appendix B: Calculation of the Florida Construction Cost Inflation Index

For Rates Effective on and after 7/1/1991

The Florida Construction Cost Inflation Index is calculated from IHS Healthcare Cost Review quarterly forecast publication, Regional Prices and Wages table, Consumer Price Index All Items section, South Region subsection. The Florida Index is calculated by the following steps:

1. Using the most recent publication, locate the tables containing the Consumer Price Index All Items.

2. Using the South Region, divide the index corresponding to the midpoint of the current rate period by the index of the midpoint of the previous rate period. The results shall be the inflation multiplier for the rate period.

Example - Rate Period – July 2014

Publication - IHS Healthcare Cost Review, First Quarter 2014, Table 7.

<table>
<thead>
<tr>
<th>Corresponding Quarter</th>
<th>Index</th>
<th>Average Index</th>
<th>Corresponding Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014:4</td>
<td>233.6</td>
<td>233.000</td>
<td>September 30</td>
</tr>
<tr>
<td>2014:3</td>
<td>232.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014:2</td>
<td>230.8</td>
<td>230.150</td>
<td>March 31</td>
</tr>
<tr>
<td>2014:1</td>
<td>229.5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The six month inflation multiplier is calculated by:

\[
\frac{233.000}{230.150} = 1.012383 \text{ or } 1.2383 \text{ percent increase over 6 months}
\]

These indices will be updated prior to each rate period using the current data.
## Appendix C: Florida Medicaid Trend Adjustment (MTA) Percentages

The following are the uniform percentage cuts for the effective rate period listed.

<table>
<thead>
<tr>
<th>Rate Period</th>
<th>Uniform Medicaid Trend Adjustment</th>
<th>Annualized Reduction Amount</th>
<th>Uniform Medicaid Trend Adjustment with NFQA effect</th>
<th>Annualized Reduction Amount with NFQA effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/05</td>
<td>0.40%</td>
<td>$25,853,709</td>
<td>0.40%</td>
<td>$25,853,709</td>
</tr>
<tr>
<td>1/06</td>
<td>1.48%</td>
<td>$25,853,709</td>
<td>1.48%</td>
<td>$25,853,709</td>
</tr>
<tr>
<td>7/06</td>
<td>0.96%</td>
<td>$25,853,709</td>
<td>0.96%</td>
<td>$25,853,709</td>
</tr>
<tr>
<td>1/07</td>
<td>0.93%</td>
<td>$25,853,709</td>
<td>0.93%</td>
<td>$25,853,709</td>
</tr>
<tr>
<td>7/07</td>
<td>0.91%</td>
<td>$25,853,709</td>
<td>0.91%</td>
<td>$25,853,709</td>
</tr>
<tr>
<td>1/08</td>
<td>3.52%</td>
<td>$101,036,035</td>
<td>3.52%</td>
<td>$101,036,035</td>
</tr>
<tr>
<td>7/08</td>
<td>3.52%</td>
<td>$101,036,035</td>
<td>3.52%</td>
<td>$101,036,035</td>
</tr>
<tr>
<td>1/09</td>
<td>6.28%</td>
<td>$184,883,287</td>
<td>6.28%</td>
<td>$184,883,287</td>
</tr>
<tr>
<td>4/09</td>
<td>14.13%</td>
<td>$416,245,876</td>
<td>0.88%</td>
<td>$25,853,709</td>
</tr>
<tr>
<td>7/09</td>
<td>21.42%</td>
<td>$621,282,257</td>
<td>0.89%</td>
<td>$25,853,709</td>
</tr>
<tr>
<td>1/10</td>
<td>21.36%</td>
<td>$621,282,257</td>
<td>0.89%</td>
<td>$25,853,709</td>
</tr>
<tr>
<td>7/10</td>
<td>23.52%</td>
<td>$644,823,648</td>
<td>0.87%</td>
<td>$25,853,709</td>
</tr>
<tr>
<td>1/11</td>
<td>23.52%</td>
<td>$644,823,648</td>
<td>0.87%</td>
<td>$25,853,709</td>
</tr>
<tr>
<td>7/11</td>
<td>22.75%</td>
<td>$685,330,905</td>
<td>7.30%</td>
<td>$220,042,943</td>
</tr>
<tr>
<td>1/12</td>
<td>22.63%</td>
<td>$685,330,905</td>
<td>7.25%</td>
<td>$219,612,898</td>
</tr>
<tr>
<td>7/12</td>
<td>23.58%</td>
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Note: Effective April 1, 2009 the Nursing Facility Quality Assessment (NFQA) fee, as referenced in section V.F of this Plan, was implemented for the purpose of restoring the annualized recurring reductions implemented on or after January 1, 2008. Effective September 1, 2015 a cut to reduce the unit cost was required in accordance with section V.C.9.
Appendix D: Upper Payment Limit (UPL) Methodology

A. Pursuant to 42 CFR 447.272, AHCA shall use a cost-based demonstration to ensure Florida Medicaid expenditures do not exceed the Upper Payment Limit (UPL), a reasonable estimate of the amount that would be paid for the services furnished under Medicare payment principles. The UPL shall be determined separately for state government, non-state government, and privately owned or operated nursing facilities. The UPL calculation requires the compilation of Medicare and Florida Medicaid data for all nursing facilities that participate in the Florida Medicaid program. Medicare data shall be acquired from the most recently available, filed Medicare cost report, Form #CMS 2540, from a reporting period no more than two years prior to the current rate year. The following fields from the Medicare cost report are used in the UPL calculation:

1. Total Medicare Routine Cost found on Worksheet B or Worksheet D.
2. Ancillary Medicare Charges, Ancillary Medicare Cost, Drug Charges, and Drug Cost found on Worksheet C.
3. Medicare Days found on Worksheet D or Worksheet S.

B. Florida Medicaid charges and days reported in the Florida Medicaid cost reports, which are used for the September 1, 2017 rate setting, shall be used for the fiscal year 2017-2018 UPL calculation. The state shall only include Florida Medicaid charges from in-state Florida Medicaid residents and shall exclude crossover claims, physician service charges, and other professional service charges. Estimated Florida Medicaid expenditures for the applicable fiscal year shall be calculated based on the nursing facility per diem rates effective September 1, 2016 and September 1, 2017. The average of the rates will be multiplied by annualized Florida Medicaid days to determine total estimated Florida Medicaid expenditures. The Florida Medicaid expenditures shall be the net actual total expenditures excluding patient responsibility. The Florida Medicaid expenditures include base payments through Florida Medicaid reimbursement to the provider. Payments shall be identified separately as private, state government, and non-state government. The dollar amount of payments for the UPL base period shall equal the claimed amounts on the CMS-64, a quarterly expense report.
C. The total UPL for each provider shall be trended from the midpoint of the corresponding Medicare cost report to the midpoint of the state fiscal year. The data shall be trended to inflate historical Medicare costs to reflect current period expenses. The trending factors shall come from the IHS Healthcare Cost Review, the Skilled Nursing Facility Total Market Basket Index, and the %MOVAVG line.

D. The Total Trended Upper Payment Limit shall be calculated for each facility as follows:

\[
\text{Total Trended Upper Payment Limit} = \text{Total Upper Payment Limit} \times \text{Trend Factor}
\]

\[
\text{Total Upper Payment Limit} = \text{Routine UPL Cost} + \text{Ancillary UPL Cost}
\]

\[
\text{Routine UPL Cost} = \frac{\text{Total Medicare Routine Cost}}{\text{Medicare Days}} \times \text{Annualized Florida Medicaid Days}
\]

\[
\text{Ancillary UPL Cost} = \frac{(\text{Ancillary Medicare Cost} - \text{Medicare Drug Cost})}{(\text{Ancillary Medicare Charges} - \text{Medicare Drug Charges})} \times \text{Ancillary Florida Medicaid Charges}
\]

Note: The Ancillary UPL Cost shall be calculated by removing costs and charges for drugs to account for differences in Medicare and Florida Medicaid costs and charges.
FLORIDA TITLE XIX INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED AND DEVELOPMENTALLY DISABLED REIMBURSEMENT PLAN FOR PUBLICLY OWNED AND PUBLICLY OPERATED FACILITIES
VERSION VIII
EFFECTIVE DATE: July 1, 2004

I. Cost Finding and Cost Reporting

A. Each intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR-DD) provider participating in the Florida Medicaid program shall submit a cost report to the Florida Agency for Health Care Administration (AHCA) postmarked or accepted by a common carrier no later than 3 calendar months after the close of its cost reporting year. Upon written request, AHCA shall grant an extension of time up to six months from fiscal year end for filing cost reports. An extension for filing a cost report is not an exception to the February 1, and August 1 dates in determining which cost reports are used to establish rates effective April 1 and October 1 of each year. The cost reporting year adopted for the purpose of this plan shall be the same as that for Title XVIII cost reporting, if applicable. Four complete, legible copies of the cost report shall be submitted to the Agency for Health Care Administration.

B. Cost reports used to establish rates effective April 1, 1991 shall be used to establish rates effective July 1, 1991 for all providers enrolled in the Medicaid program as of April 1, 1991.

C. All providers are required to detail all of their costs for their entire reporting period, making appropriate adjustments as required by this plan for determination of allowable costs. The cost report must be prepared using the accrual basis of...
accounting in accordance with generally accepted accounting principles, as incorporated by reference in Rule 61H1-20.007 F.A.C., the methods of reimbursement in accordance with Medicare (Title XVIII) Principles of Reimbursement, the Provider Reimbursement Manual CMS PUB.15-1, incorporated by reference in Rule 59G-6.010, F.A.C., except as modified by the Florida Title XIX ICF/MR-DD Reimbursement Plan for Publicly Owned and Publicly Operated Facilities, and State of Florida Administrative Rules. The CMS PUB:15-1 Manual may be obtained from the regional Health Care Financing Administration office in Atlanta. For government-owned and operated facilities operating on a cash method of accounting, data based on such a method of accounting will be acceptable. The person preparing the cost report must sign the cost report as the preparer. Cost reports which are not signed shall not be accepted.

D. If a provider submits a cost report late, after the 90 day period, and that cost report would have been used to set a lower reimbursement rate for a rate semester had it been submitted within 90 days, 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. A provider who does not file within 180 days of the end of his cost reporting period shall have his contract canceled.

E. A provider which voluntarily or involuntarily ceases to participate in the Florida Medicaid Program or experiences a change of ownership must file a final cost report within 90 days of withdrawal from the program when that provider has been receiving an interim reimbursement rate.

F. All providers are required to maintain financial and statistical records in accordance with Title 42 Code of Federal Regulations (CFR), Sections 413.24 (a),(b),(c) and (e). The cost report is to be based on financial and statistical records maintained by the provider. Cost information must be current, accurate, and in sufficient detail to support costs set forth in the report. This includes all
ledgers, books, records, original evidence of cost and other records in accordance with CMS PUB.15-1 which pertain to the determination of allowable costs, and must be capable of being audited and available within the State of Florida for auditing by state and federal agencies and their representatives within 20 days of the request. All accounting and other records must be brought up to date within 30 days of the end of each fiscal quarter. These records shall be retained by the provider for a minimum of 3 years following the date of submission of the cost report form to AHCA.

G. Records of organizations determined by AHCA to be related as defined by 42 CFR 413.17 must be available upon demand within the State of Florida to representatives, employees, or contractors of AHCA, the Florida Auditor General, U.S. General Accounting Office (GAO), or U.S. Department of Health and Human Services (HHS).

H. AHCA shall retain all uniform cost reports submitted for a period of at least 3 years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of 42 CFR 431.17. Access to submitted cost reports shall be in conformity with Chapter 119, Florida Statutes.

I. New providers entering the program must submit a cost report for a period of not less than 12 months for purposes of setting prospective rates. A partial-year cost report may be submitted initially, but may be used only to adjust the interim budgeted rate in effect.

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

All cost reports submitted by the providers shall be either field or desk audited at the discretion of AHCA.

A. Description of AHCA's Procedures for Audits - General

1. Primary responsibility for the audit of providers shall be borne by AHCA. The efforts of AHCA audit staff may be augmented by contracts with CPA firms to ensure that the requirements of 42 CFR 447.202 are met. AHCA shall determine the scope and format for on-site audits and desk audits of cost reports and financial records of providers.

2. All audits shall be based on generally accepted auditing standards of the AICPA, as incorporated by reference in Rule 61H1-20.008, F.A.C.

3. Upon completion of each field audit, the auditors shall issue a report which meets the requirements of 42 CFR 447.202 and generally accepted auditing standards. The auditor must express an opinion as to whether, in all material respects, the financial and statistical report submitted complies with all federal and state regulations pertaining to the reimbursement program for long-term care facilities. All reports shall be retained by AHCA for 3 years.

4. Providers shall have the right to petition for an administrative hearing in accordance with Chapter 120, Florida Statutes.

B. Desk Audit Procedures

1. Cost reports shall be reviewed for completeness, accuracy, consistency, and compliance with Medicaid regulations. Necessary adjustments shall be made. All findings and adjustments shall be summarized in writing.

2. A concurrence letter will be prepared and sent to the provider, showing all adjustments and changes and the authority for such.

III. Allowable Costs
A. The cost report must include all items of expense which a provider must incur in meeting:

1. The definition of intermediate care facility set forth in Section 42 CFR 440.150;
2. The standards prescribed by the Secretary of HHS for intermediate care facilities in regulations under the Social Security Act in 42 CFR 442, Subpart C;
3. The requirements established by the state agency responsible for establishing and maintaining health standards, under the authority of 42 CFR 431.610; and
4. Any other requirements for licensing under laws in the state which are necessary for providing long-term care facility services, as applicable.

B. All therapy required by Medicare or Medicaid certification standards and prescribed by the physician of record shall be considered as covered services and all costs, direct or indirect, shall be included in the cost report. These therapeutic opportunities shall include habilitative, rehabilitative or other professional treatments which shall be composed of, for example, medical, dental, nutritional, nursing, pharmacy, physical therapy, occupational therapy, psychological, recreational, social work, speech therapy or other mental retardation specialized services as appropriate.

C. Implicit in any definition of allowable costs is that those costs do not exceed what a prudent and cost-conscious buyer pays for a given service or item. If costs are determined by AHCA, utilizing the Title XVIII principles of reimbursement, CMS PUB.15-1 (1993), and this plan, to exceed what a prudent buyer would pay, then the excess costs shall not be reimbursable under this plan.

D. All items of expense which providers incur in the provision of routine services, such as the regular room, dietary and nursing services, medical supplies, and the use of equipment and facilities, are allowable. Expenses for services covered by Florida Medicaid programs other than the ICF/MR-DD Program are not allowable.
under this plan and should not be included in the ICF/MR-DD cost report for Medicaid. These include expenses associated with prescription drugs, physicians' fees, etc. Refer to the services covered by the Medicaid ICF/MR-DD vendor payment in the Florida Medicaid ICF/MR-DD Services Coverage and Limitations Handbook. Refer to Chapter 59G-4.170, F.A.C., for further clarification of allowable and non-allowable costs.

E. Bad debts other than Title XIX, charity, and courtesy allowances shall not be included in allowable costs. Bad debts for Title XIX shall be limited to Title XIX uncollectible deductible and co-payments and the uncollectible portion of eligible Medicaid recipients' responsibilities. Example: Daily Medicaid reimbursement rate is $50.00; State pays $40.00 and resident is to pay $10.00. If Medicaid resident pays only $8.00, then $2.00 would be an allowable bad debt. Medicaid bad debts are allowable if revenue was earned in the prior year and two collection letters were sent to the appropriate party responsible for the debt within 12 months of revenue recognition.

F. Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to a provider will be governed by 42 CFR 413.17 Medicare (Title XVIII) Principles of Reimbursement, and Chapter 10, CMS PUB.15-1. Providers must identify such related organizations and costs in their cost reports.

G. Other costs which are allowable shall be limited by the following provisions:

1. The owner administrator and owner assistant administrator compensation shall be limited to reasonable levels determined in accordance with CMS PUB.15-1 (1993) or as may be determined by surveys conducted by AHCA.

2. Limitation of rents:
   
a. It is the intent of the Medicaid program to limit lease cost reimbursement, that is, rent, to the allowable ownership costs associated with the leased land, building, and equipment. For the
purposes of this provision, allowable ownership costs of the leased property shall be defined as the sum of:

(1) Depreciation, property-related interest, property taxes including personal and real property, property insurance, and other property-related costs as allowed under the provisions of this plan;

(2) Sales tax on lease payments, if applicable; and

(3) Return on equity that would be paid to the owner if he were the provider, as per Section H. below.

b. Implementation of this provision shall be in accordance with the following:

(1) Reimbursable lease costs of existing providers as of July 18, 1984 will remain unchanged until such time as the provider documents that ownership costs, as defined above, exceed the Medicaid rent costs allowed. No other upward adjustments shall be made to allowable lease costs, that is, increased rent associated with negotiated or renewed leases of existing providers shall not be allowed, except for those legally binding agreements entered into by the lessee and lessor before July 18, 1984.

(2a) For currently participating non-leased facilities that subsequently are operated under a lease agreement commencing on or after July 18, 1984 with no change in ownership, the Medicaid rent costs allowed for reimbursement will be the lesser of actual rent paid or the allowable ownership costs of the leased property immediately prior to the commencement of the lease arrangement, adjusted subsequently only for cost increases that would have been allowable for the owner, for example, increases in
property taxes. This provision does not apply to lease costs for equipment that is not being leased from the owner of the facility.

(2b) For leased facilities that subsequently undergo a change of ownership, the lease costs shall be limited to the ownership costs of the original owner of record as of July 18, 1984 or the rent, whichever is lower.

(3) For new providers entering the Medicaid program on or after July 18, 1984, lease payments shall be the lesser of actual rent paid or allowable ownership costs as determined by the provisions of this plan. Allowable ownership costs must be adequately documented by the provider. This provision does not apply to lease costs for equipment that is not being leased from the owner of the facility.

(4) In no case shall Medicaid reimburse a provider for costs not properly documented per the provisions of this plan. Providers showing rent costs, with the exception of providers who have entered into legally binding lease agreements prior to July 18, 1984, shall not be reimbursed for such costs if proper documentation of the owner's costs are not submitted to AHCA. The owner shall be required to sign a letter to AHCA which states that the documentation submitted presents to the best of his knowledge true and correct information. The letter signed by the owner must also state that the owner agrees to make his books and records of original entry related to the ICF/MR-DD properties available to auditors or official representatives of AHCA, and that he agrees to abide by the depreciation recapture provisions of this plan set forth in Section III.G.3. below.
(5) AHCA shall not make a determination that a provider has shown adequate proof of financial ability to operate if the provider is leasing the facility and does not submit the documentation of the owner's costs with the letter signed by the owner as per (4) above.

3. Basis for depreciation and calculation:

a. Cost.

Historical cost of long-term care facilities shall be the basis for calculating depreciation as an allowable cost subject to the provisions of b. below. All other provisions of the Medicare (Title XVIII) Principles of Reimbursement and CMS PUB.15-1 (1993) will be followed.

b. Change in ownership of depreciable assets. For purposes of this plan, a change in ownership of assets occurs when unrelated parties: purchase the depreciable assets of the facility; or purchase 100 percent of the stock of the facility and within one year merge the purchased facility into an existing corporate structure or liquidate the purchased corporation and create a new corporation to operate as the provider. In compliance with Section 1902(a)(13)(c) of the Social Security Act, in a case in which a change in ownership of a provider's or lessor's depreciable assets occurs, and if a bona fide sale is established, the valuation of capital assets for determining payment rates for intermediate care facilities for the mentally retarded and developmentally disabled shall be increased (as measured from the date of acquisition by the seller to the date of the change of ownership), solely as a result of a change of ownership, by the lesser of:

(1) One-half of the percentage increase (as measured over the same period of time, or, if necessary, as extrapolated
retrospectively by the Secretary of H.H.S.) in the current Dodge Construction Systems Cost for Nursing Homes, applied in the aggregate with respect to those facilities which have undergone a change of ownership during the fiscal year, or

(2) One-half of the percentage increase (as measured over the same period of time) in the current consumer price index for all urban consumers (United States city average).

In any change in ownership, the total valuation of capital assets allowed for determining payment rates shall not exceed the lessor of:

(1) The acquisition cost of the facility to the new owner; or
(2) The fair market value of the facility at the time of purchase.

This valuation shall be used to calculate depreciation, interest on capital indebtedness, and, if applicable, return on equity.

Example 1: The allowable acquisition cost of the facility to the seller in 1985 was $500,000. A new owner purchases the facility in 1990 for $700,000. The increase in the Dodge Construction Index and the Consumer Price Index from the date of acquisition by the seller to the date of change in ownership is 25% and 20% respectively. The new owner's allowable depreciable basis is $550,000.

Example 2: The allowable acquisition cost of the facility to the seller in 1985 was $1,500,000. A new owner purchases the facility in 1990 for $1,250,000. The new owner's allowable depreciable basis is $1,250,000.

c. Recapture of depreciation resulting from sale of assets. The sale of depreciable assets, or a substantial portion thereof, at a price in excess of the cost of the property as reduced by accumulated depreciation, resulting in, a gain on sale, and calculated in accordance with Medicare (Title XVIII) Principles of
Reimbursement indicates the fact that depreciation used for the purpose of computing allowable costs was greater than the actual economic depreciation. The amount of the recapture shall be determined as follows:

(I) The gross recapture amount shall be the lesser of the actual gain on the sale or the Medicaid portion of accumulated depreciation after the effective date of January 1, 1972.

The gross recapture amount shall be reduced by .877193 percent for each month in excess of forty-eight (48) months participation in the Medicaid program. Additional beds and other related depreciable assets put into service after July 1, 1990 shall be subject to the same thirteen and one-half (13 1/2) year depreciation recapture phase out schedule beginning at the time the additional beds are put into service.

The gross recapture amount related to the additional beds shall be reduced by .877193 percent for each month in excess of forty-eight (48) months' participation in the Medicaid program subsequent to the date the additional beds were put into service. To determine the amount of gain associated with additional beds, the portion of the sale price associated with all depreciable assets shall be allocated to the older and new portions of a facility as follows: For each part of the facility, determine the proportion of beds to the facility's total number of beds. Multiply the proportion of beds in that part of the facility by the sale price. The result is the portion of the sales price allocable to that part of the facility.

Example:
Sales Price: $6,000,000

Older Portion of Facility:
Number of beds = 60

Newer portion of facility:
Number of beds = 120

Allocation to older portion: \((\frac{60}{180}) \times 6,000,000 = $2,000,000\)

Allocation to new portion: \((\frac{120}{180}) \times 6,000,000 = $4,000,000\)

Sale Price \(= 6,000,000\)

(2) The adjusted gross recapture amounts as determined in (1) above shall be allocated for fiscal periods from January 1, 1972, through the date of sale. The adjusted gross recapture amounts shall be allocated to each fiscal period in the same ratio as depreciation amounts claimed for the respective portions of the facility. Allowable costs shall be computed for each period after depreciation recapture. The recomputed allowable costs shall be used to determine if there should be an adjustment to the payment rate, and any resulting overpayment shall be recovered.

(3) The net recapture amount, if any, so determined in (2) above shall be paid by the former owners, to the State. If the net recapture amount is not paid by the former owner, in total or in part, the amount not paid shall be deducted from the future payments by AHCA to the buyer until the net recapture has been received. AHCA shall grant terms of extended payment when the facts and circumstances of the unrecovered recapture from the seller justify the extension.

d. Depreciation recapture resulting from leasing the facility or withdrawing from Medicaid program.
(1) In cases where an owner-operator withdraws from the Medicaid program as the provider, but does not sell the facility, the depreciation paid by Medicaid to the owner during the same time he was the Medicaid provider shall be subject to the depreciation recapture provisions of this plan when the owner sells the facility. This includes cases where an owner-provider leases a facility to another, unrelated, licensed operator after having operated the facility as the licensed Medicaid provider. In addition, if an owner-operator elects to withdraw from the Medicaid program and lease the facility to an operator who continues to participate in the Medicaid program, the portion of the reimbursable rent payment that represents depreciation expenses shall be subject to the depreciation recapture provisions of this plan, Section III.G.3.c, at the time the facility is sold. On or after July 1, 1984, all owner-providers that withdraw from the Medicaid program shall be required to sign a contract with the department creating an equitable lien on the owner's capital assets. This lien shall be filed by the department with the clerk of the circuit court in the judicial circuit within which the facility is located. The contract shall specify that the method for computing depreciation recapture shall be in accordance with the provisions of this plan, and the contract shall state that such recapture so determined shall be due to the agency upon sale of the facility. In the event that a provider fails to sign and return the contract to the department, the Proof of Financial Ability which is required for the prospective operator of the facility to be licensed shall not be approved.
(2) For lessees entering the Medicaid program after July 1, 1984 and for existing Medicaid providers who are granted an upward adjustment to their allowable lease costs after July 1, 1984, the portion of the Medicaid reimbursement rent payment that represents depreciation expense shall be subject to the depreciation recapture provisions of the plan at the time the facility is sold. The recapture amount owed by the owner shall be computed using the amount of depreciation claimed by the owner and allowed by Medicaid during the months that he was the Medicaid provider or a lessor to a Medicaid provider, or both.

4. Limitations on interest. For reimbursement purposes, the amount of interest allowed to a new provider in a change of ownership is limited by the allowed basis for depreciation. If the new owner's equity in the facility is less than the allowed basis for depreciation, the owner shall be allowed interest expense on the difference between the allowed basis and the equity. If the new owner's equity in the facility is more than the allowed basis for depreciation, no interest shall be allowed.

Example 1: The original owner's acquisition cost is $1,000,000. A new owner purchases the facility in 1985 for $2,000,000, putting $500,000 down and financing $1,500,000 at 15 percent. The new owner's allowable depreciation basis is $1,000,000, and he can be reimbursed interest on $500,000 at 15 percent, that is, $1,000,000 - $500,000 = $500,000 at current rate of 15 percent.

Example 2: The original owner's acquisition cost is $1,000,000. A new owner purchases the facility in 1985 for $2,000,000, putting $1,250,000 down and financing $750,000 at 15 percent. The new owner's
allowable depreciation basis is $1,000,000 which is less than the equity, so he receives no interest reimbursement.

5. Limitations on return on equity ROE. Return on equity is also limited by the new owner's allowed acquisition cost. The new owner can receive a return on equity based upon his actual equity, up to the allowed acquisition cost.

Example 1:
The original owner's acquisition cost is $1,000,000.
A new owner purchases the facility in 1985 for $2,000,000, putting down $750,000. The new owner's allowable depreciation basis is $1,000,000, and he can receive ROE reimbursement on the $750,000.

Example 2:
The original owner's acquisition cost is $1,000,000.
A new owner purchases the facility in 1985 for $2,000,000, putting down $1,250,000. His equity amount for reimbursement purposes shall be limited to $1,000,000.

6. Property-related costs allowed for reimbursement purposes shall be limited by the following provisions.

a. Costs that are capitalized as per CMS PUB.15-1 (1993) provisions other than land, buildings, construction loan costs, and equipment shall not exceed what a prudent and cost-conscious buyer would pay for the given service or item. If such costs are determined by AHCA, utilizing the Title XVIII Principles of Reimbursement, CMS PUB.15-1 (1993), and this Plan to exceed the level that a prudent buyer would incur, then the excess costs shall not be reimbursed under the plan. Examples of such costs include but are not limited to legal fees, developers' fees, underwriters' fees, bond discount, loan points, trustee fees, interest cost on debt reserve requirements, and costs of feasibility studies.
7. After June 30, 1984, additional costs incurred after enrollment in the program that are due to capital additions or expansion must have prior approval by the DCF Office of Developmental Services if such costs exceed 1 percent of the provider's current total reimbursement rate, with the exception of the addition of new beds which are approved through the state's Certificate of Need process. Costs for specific expansion or additions that exceed the 1 percent limit shall not be reimbursable if not previously approved. Further, financing costs for approved expansions or additions shall be limited by the prudent buyer limits established in Section III.G.4. above.

8. Depreciable basis as a result of capital improvements. If capital improvements are made to a facility after July 18, 1984, the actual cost of the improvements shall be added to the owner's basis, allowing the owner reimbursement of interest, return on equity, or both as specified in Section III of this plan.

9. Retirement and replacement of outdated equipment. Upon a change of ownership of a facility, the new provider must maintain the original owner's records of capital assets. If the new owner subsequently retires outdated equipment, the original owner's cost minus any depreciation shall be an allowable write-off. Replacement equipment costs shall be allowed according to capital improvement rules as specified above.

H. Use Allowance

A use allowance shall not be paid for publicly owned and publicly operated facilities.

IV. Standards

A. In accordance with Chapter 120, Florida Statutes, Administrative Procedures Act, this plan shall be made available for public inspection, and a public hearing, if
requested, shall be held so that interested members of the public shall be afforded
the opportunity to review and comment on the plan.

B. Reimbursement rates shall be established prospectively for each individual
provider based on the most recent historic costs. If certain costs are determined by
the AHCA Office of Medicaid or the AHCA Office of Audit Services, utilizing the
Title XVIII Principles of Reimbursement, CMS PUB.15-1 (1993) and this Plan, to
exceed the level that a prudent buyer would incur, then the excess costs shall not
be reimbursable under the plan.

C. Prospective payment rates shall be established semi-annually on April 1 and
October 1. The most current acceptable cost report received by the agency by
February 1 and August 1 shall be used in the rate-setting process to set rates
effective on April 1 and October 1, respectively. The rate-setting process is
detailed in Section V of this plan. The same cost reports used for the April 1,
1991 rate semester shall be used to establish rates effective July 1, 1991 through
March 31, 1992. There shall not be a rate semester for October 1, 1991.

D. Reimbursement rates shall be calculated separately for two classes. The classes
shall be based on the four levels of ICF/MR-DD care as defined in Chapter 59G-
4.170 of the Florida Administrative Code. The four levels of care, listed in
ascending order of handicap severity, are Developmental Residential,
Developmental Institutional, Developmental Non-ambulatory, and Developmental
Medical. Developmental Residential and Developmental Institutional shall
constitute one class for reimbursement purposes, while Developmental Non-
ambulatory and Developmental Medical shall constitute the other. All providers
must allocate costs by the four levels of care in their cost reports. The agency
shall monitor placements of clients to determine whether discrimination against
clients with higher cost or more complex service needs is occurring. If the agency
determines that such placement discrimination is occurring, this plan may be
amended to provide for payments based on four levels of care.
E. For the two classes described in D. above, three components of the total reimbursement rate shall be calculated separately. These three components are operating costs, resident care costs, property costs. Inflation allowances used in the rate-setting process shall be applied to the operating and resident care cost components independently for the two reimbursement classes.

F. The prospectively-determined individual provider’s rates shall be adjusted retroactively to the effective date of the affected rates under the following circumstances:

1. An error was made by AHCA in the calculation of the provider’s rates.
2. A provider submits an amended cost report used to determine the rates in effect. An amended cost report may be submitted in the event that it would effect a change of 1 percent or more in the total reimbursement rate. The amended cost report must be filed by the filing date of the subsequent cost report. An audited cost report may not be amended. A cost report shall be deemed audited 30 days after the exit conference between field audit staff and the provider has been completed.
3. Further desk or on-site audits of cost reports used in the establishment of the prospective rates disclose a change in allowable costs in those reports.

G. The following provisions apply to interim changes in component reimbursement rates, other than through the routine semi-annual rate setting process described in Section V, as well as to changes in a provider’s allowable cost basis. These provisions are not applicable to new providers’ first year interim rates, which are addressed in sections H. and I. below.

1. Requests for rate adjustments for increases in property-related costs due to capital additions, expansion, replacements, or repairs shall not be considered in the interim between cost report submissions, except for the addition of new beds or if the cost of the specific expansion, addition, repair, or replacement would cause a change of 1 percent or more in the provider’s total per diem reimbursement rate.
2. Requests for interim rate changes reflecting increased costs occurring as a result of resident care or administration changes or capital replacement other than that specified in (1) above shall be considered only if such changes were made to comply with existing state or federal rules, laws, or standards, and if the change in cost to the provider is at least $5000 and would cause a change of 1.0 percent or more in the provider's current total per diem rate. The provider must submit documentation showing that the changes made were necessary to meet existing state or federal requirements.

3. In the event that new state or federal laws, rules, regulations, licensure and certification requirements, or new interpretations of existing laws, rules, regulations, or licensure and certification requirements require all affected providers to make changes that result in increased or decreased resident care, operating, or capital costs, requests for component interim rates shall be considered for each provider based on the budget submitted by the provider. All affected providers' budgets submitted shall be reviewed by the agency and shall be the basis for establishing reasonable cost parameters.

4. Interim rate requests resulting from (1), (2), and (3) above must be submitted within 60 days after the costs are incurred, and must be accompanied by a 12-month budget which reflects changes in services and costs. An interim reimbursement rate, if approved, shall be established for estimated additional costs retroactive to the time of the change in services or the time the costs are incurred, but not to exceed 60 days before the date AHCA receives the interim rate request. The interim per diem rate shall reflect only the estimated additional costs, and the total reimbursement rate paid to the provider shall be the sum of the previously-established prospective rates plus the interim rate. A discontinued service would offset the appropriate components of the prospective per diem rates currently in
effect for the provider. Upon receipt of a valid interim rate request subsequent to June 30, 1984, the AHCA Office of Medicaid must determine whether additional information is needed from the provider and request such information within 30 days. Upon receipt of the complete, legible additional information as requested, the AHCA Office of Medicaid must approve or disapprove the interim rate within 60 days. If the Office of Medicaid does not make such determination within the 60 days, the interim rate request shall be deemed approved.

5. Interim Rate Settlement.

Overpayment as a result of the difference between the approved budgeted interim rate and actual costs of the budgeted item shall be refunded to AHCA. Under-payment as a result of the difference between the budgeted interim rate and actual allowable costs shall be refunded to the provider.

After the interim rate is settled, a provider’s cost basis shall be restricted to the same limits as those of a new provider per Section I. below.

6. The right to request interim rates shall not be granted for fiscal periods that have ended.

H. For a new provider in a facility with greater than six beds, the interim cost per diems for each reimbursement class shall be the budgeted component cost rates approved by AHCA. These initial cost estimates shall be limited as follows:

A. Property Costs:

Must be approved by the AHCA Office of Medicaid and shall not be in excess of the limitations established in Section III. of this plan.

B. Operating Costs:

Shall not exceed the 90th percentile of per resident day costs of all currently participating ICF/MR-DD providers that currently have prospective rates.

C. Resident Care Costs:
Shall not exceed the highest per resident day cost for the respective reimbursement class of any other currently participating provider having a prospective rate.

I. For a new provider in a facility with greater than six beds, AHCA shall establish the cost basis for calculation of prospective rates using the first acceptable historical cost report covering at least a 12-month period submitted by the provider. Overpayment as a result of the difference between the approved budgeted interim rate and actual allowable costs of the budgeted item shall be refunded to AHCA. Underpayment as a result of the difference between the budgeted interim rate and actual allowable costs shall be refunded to the provider. The basis for calculating prospective rates shall be the first year settled cost report. Basis shall be set at 100 percent of the total allowable costs as determined by Medicaid and the Developmental Services Program Office.

J. Base Costs:
The initial base costs for each provider shall be allowable costs documented by the cost report used to establish the rate being set. For new providers entering the Medicaid program the initial base costs shall be established in accordance with Section IV.I. of this plan. Prospective rates calculated using unadited costs shall be retroactively adjusted when audit results become available.

K. Aggregate test comparing Medicaid to Medicare according to 42 CFR 447.253(6), the Medicaid agency's estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for long-term care facility services than the amount that would be paid for the services under the Medicare principles of reimbursement.
At any rate-setting period, if the aggregate reimbursement to be paid is higher than would be paid under Medicare principles, property cost shall be reduced or eliminated as necessary to meet the aggregate test.

V. Methodology

A. Prospective rate-setting method for rate semesters beginning on or after July 1, 1991.

1. For rate semesters beginning on April 1 of a given year, the prospective rates shall be set using the most current acceptable cost report on file with AHCA as of February 1 of that year. For rate semesters beginning on October 1 of a given year, the prospective rates will be set using the most current acceptable cost report on file with AHCA as of August 1 of that year. For the rate semester July 1, 1991 through March 31, 1992, the same cost reports used in setting April 1, 1991, rates shall be used. There shall not be a rate semester for October 1, 1991.

2. Review and adjust the provider's current cost report on file to reflect the results of desk or on-site audits, if available.

3. Determine total allowable cost by reimbursement class for property cost, resident care cost, and operating cost. See the Definitions section of this plan for the definitions of allowable costs for each of the cost components. Costs shall be allocated to each reimbursement class by the methodology shown in Appendix A.

4. Calculate per diems for each of the three cost components for the two reimbursement classes by dividing the component's cost by the appropriate number of resident days.

5. The new base per diem for property shall be the per diem established in step 4 above.
6. Using the appropriate current per diem for resident care and operating costs from Step 4 above, calculate the prospective operating and resident care per diems for the new rate semester by multiplying each of the base per diems by the fraction:

Simple average of the Florida ICF/MR-DD monthly cost inflation indices for the prospective rate semester divided by the simple average of the Florida ICF/MR-DD monthly cost inflation indices for the cost report period used to calculate current base per diems. For rates effective July 1, 1991, the prospective rate semester used in calculating the above fraction shall be the period July 1, 1991 through March 31, 1992.

7. Establish the total prospective per diem for each reimbursement class as the sum of the appropriate operating and resident care per diems resulting from Step 6 plus the current approved per diem for property, from Step 5.

VI. Payment Assurance

The state shall pay each provider for services provided in accordance with the requirements of the Florida Title XIX state plan and applicable state or federal rules and regulations. The payment amount shall be determined for each provider according to the standards and methods set forth in this Florida Title XIX ICF/MR-DD Reimbursement Plan for Publicly Owned and Publicly Operated Facilities

VII. Provider Participation

This plan is designed to assure adequate participation of Publicly Owned and Publicly Operated ICF/MR-DD providers in the Medicaid program, the availability of high-quality services for recipients, and for services which are comparable to those available to the general public.

VIII. Payment in Full

Payments made to any provider participating in the Florida Medicaid program who knowingly and willfully charges, for any service provided to the resident under the state plan, money or other consideration in excess of the rates established by the state plan, or
charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under the State plan approved under this title, any gift, money, donation or other consideration, other than a charitable, religious or philanthropic contribution from an organization or from a person unrelated to the resident: as a condition of admitting a resident to a Publicly Owned and Publicly Operated ICF/MR-DD facility; or as a requirement for the resident's continued stay in such a facility, when the cost of the services provided therein is paid for, in whole or in part, under the state plan, shall be construed to be supplementation of the state's payment for services. Payments made as a condition of admitting a resident or as a requirement for continued stay in a facility shall be deemed to be payments to meet the cost of care of the Medicaid resident and shall be deemed to be out of compliance with 42 CFR 447.15.

IX. Definitions

Acceptable Cost Report: A completed, legible cost report that contains all relevant schedules, worksheets and supporting documents in accordance with cost reporting instructions.

AHCA: Agency for Health Care Administration, also known as the agency.

CMS PUB.15-1: also known as the Provider Reimbursement Manual, published by the Department of Health and Human Services, Centers for Medicare and Medicaid Services.

DCF: Department of Children and Family Services

ICF/MR-DD Operating Costs: Those costs not directly related to resident care or property costs. Operating costs include administrative, plant operation, laundry and housekeeping costs. ICF/MR-DD Resident Care Costs: Those costs directly attributed to nursing services, dietary costs, and other costs directly related to resident care such as activity costs, social services, and all medically-ordered therapies.

ICF/MR-DD Property Costs: Those costs related to the ownership or leasing of an ICF/MR-DD. Such costs may include property taxes, insurance, interest and depreciation, or rent.

Title XVIII: Health Insurance for the Aged, Blind or Disabled (Medicare) as provided for in the Social Security Act (42 U.S.C. 1395-1395pp).

Title XIX: Grants to States for Medical Assistance Programs (Medicaid) as provided for in the Social Security Act (42 U.S.C. 1396-1396i)

Medicaid Interim Reimbursement Rate: A reimbursement rate or a portion of an overall reimbursement rate that is calculated from budgeted cost data.
## APPENDIX A

<table>
<thead>
<tr>
<th>COL C</th>
<th>COL A</th>
<th>COL B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resid./Inst.</td>
<td>Non-amb./Medical</td>
<td>TOTAL</td>
</tr>
</tbody>
</table>

### A. Alloc of Exp (Excl B&C)

1. **Resident Days**
   - COL A: 02461
   - COL B: 8325
   - TOTAL: 10786

2. **OPER. EXPENSE COMP**
   a. **Administration**
   - COL A: -
   - COL B: -
   - TOTAL: 120482
   b. **Plant Operation**
   - COL A: -
   - COL B: -
   - TOTAL: 45060
   c. **Laundry**
   - COL A: -
   - COL B: -
   - TOTAL: 15265
   d. **Housekeeping**
   - COL A: -
   - COL B: -
   - TOTAL: 29090
   e. **Oper. Exp. Comp and Per Diem**
   - COL A: 19.460
   - COL B: 19.460
   - TOTAL: 209897

3. **Resident Care Expense**
   a. **Dietary**
   - COL A: -
   - COL B: -
   - TOTAL: 74861
   b. **Other**
   - COL A: -
   - COL B: 34188
   c. **Nursing**
   - COL A: -
   - COL B: -
   - TOTAL: 86018
   d. **Res. Care Exp. and Per Diem**
   - COL A: 18.0852
   - COL B: 18.0852
   - TOTAL: 19.5067

4. **PROP. EXP. COMP. AND PER DIEM**
   - COL A: 8.605
   - COL B: 8.605
   - TOTAL: 92812

5. **ROE/UA COMP & PER DIEM**
   - COL A: 6.604
   - COL B: 6.604
   - TOTAL: 71236

### B. DIRECT CARE EXPENSE

1. **Staffing**
   - COL A: 1230.5
   - COL B: 8325
   - TOTAL: 95555

2. **Total Staffing Required**
   - COL A: 12.877%
   - COL B: 87.123
   - TOTAL: 100%

3. **Alloc. of Direct Care**
   - COL A: 39263.97
   - COL B: 26542.03
   - TOTAL: 304906

4. **Dir. Care Exp. Per Diem**
   - COL A: 15.945
   - COL B: 31.9090

### C. ADDITIONAL SERVICES EXPENSE

1. **Medicaid Patient Days**
   - COL A: 2461
   - COL B: 8275
   - TOTAL: 10736

2. **Add. Ser. (Sch.AM-6)**
   - COL A: 36780
   - COL B: 69380
   - TOTAL: 106160

3. **Add. Ser. Exp. Per Diem**
   - COL A: 14.951
   - COL B: 8.3839

### D. MEDICAID PER DIEM COST

1. **Operating Component**
   - COL A: 19.460
   - COL B: 19.460
   - TOTAL: 209897

2. **Resident Care Component**
   - COL A: 48.985
   - COL B: 58.378
   - TOTAL: 606133

3. **Property Cost Component**
   - COL A: 8.605
   - COL B: 8.605
   - TOTAL: 92812

4. **Subtotal (Schedule BM)**
   - COL A: -
   - COL B: -
   - TOTAL: -

5. **ROE/USE ALLOW Comp.**
   - COL A: 6.604
   - COL B: 6.604
   - TOTAL: 71236

6. **TOTAL PER DIEM COST**
   - COL A: 83.654
   - COL B: 93.047
   - TOTAL: 980078
APPENDIX B
CALCULATION OF THE
FLORIDA ICF/MR-DD COST INFLATION INDEX

1. Weights.

Percentage weights for cost components shall be based on cost reports filed for fiscal years ending in 1983. These percentage weights are:

<table>
<thead>
<tr>
<th>Component</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and Benefits</td>
<td>65.66%</td>
</tr>
<tr>
<td>Dietary</td>
<td>4.94%</td>
</tr>
<tr>
<td>All Other</td>
<td>29.40%</td>
</tr>
</tbody>
</table>

2. Inflation index for each component

An inflation index for each of these components is developed from the Data Resources, Inc. (DRI) Skilled Nursing Facility Market Basket of Routine Services Costs inflation indices as follows:

<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>DRI INDEX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and Benefits with Employee Benefits</td>
<td>Wages and Salaries, combined</td>
</tr>
<tr>
<td>Dietary</td>
<td>Food</td>
</tr>
<tr>
<td>All Others with other expenses</td>
<td>Fuel and Utilities, combined</td>
</tr>
</tbody>
</table>

The DRI indices that are combined are merged by summing the products of each index times the ratio of the respective DRI budget share to the total share represented by the combined indices.

Example: Calculation of the Salaries and Benefits combined index for the third quarter of 1984 using Health Care Costs, Third Quarter 1983 Series, p. 15:

DRI Wages and Salaries index = 1.043; Budget Share = .602
DRI Employee Benefits index = 1.073; Budget share = .084

Weighted Combination (Salaries and Benefits) =

\[(1.043 \times \frac{.602}{(.602 + .084)}) + (1.073 \times \frac{.084}{(.602 + .084)}) = 1.047\]
3. Quarterly and monthly indices.

A weighted quarterly index is then constructed by summing the products of the weights and quarterly component indices. This quarterly composite index is used to obtain monthly indices called the Florida ICF/MR-DD Cost Inflation Index by averaging pairs of quarterly indices and interpolating between these averages as follows:

<table>
<thead>
<tr>
<th>Quarter Midpoint</th>
<th>Index</th>
<th>Average Index</th>
<th>Corresponding Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>1984:1</td>
<td>1.029</td>
<td>1.032</td>
<td>March 31</td>
</tr>
<tr>
<td>1984:2</td>
<td>1.035</td>
<td>1.042</td>
<td>June 30</td>
</tr>
<tr>
<td>1984:3</td>
<td>1.048</td>
<td>1.054</td>
<td>September 30</td>
</tr>
<tr>
<td>1984:4</td>
<td>1.059</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

April 30 Index = (June 30 Index/March 31 Index)$^{1/3}$ x (March 31 Index)
= (1.042/1.032)$^{1/3}$ x 1.032
= 1.035

May 30 Index = (June 30 Index/March 31 Index)$^{2/3}$ x (March 31 Index)
= (1.042/1.032)$^{2/3}$ x 1.032
= 1.039

All other monthly indices can be calculated in a similar fashion.

4. Inflation Factors

The inflation factors used to set both target rates of inflation and prospective payment rates utilize 13 indices in order to recognize full inflation for a 12-month period. This is necessary because each index represents the relative level of costs at the end of the month, so that a complete 12-month inflation trend must start with the index as of the last day of the month prior to the 12-month period.

Example: Calculation of target rate of inflation factor for provider with a June 30 fiscal year end.
average of inflation indices from
1984 Target factor = June 1983 through June 1984
average of inflation indices from
June 1982 through June 1983

\[(0.994 + 0.999 + 1.004 + 1.009 + 1.014 + 1.018 + 1.023 + 1.026 + 1.029 + 1.032 + 1.035 + 1.039 + 1.042)/13\]

\[(0.950 + 0.954 + 0.958 + 0.962 + 0.966 + 0.971 + 0.975 + 0.979 + 0.982 + 0.986 + 0.989 + 0.992 + 0.994)/13\]

\[= 1.020\]
\[= 0.974\]
\[= 1.047\]

In the example above, the indices for June 30, 1982, 0.994, and June 30, 1983, 0.950 are taken to represent the relative level of costs on July 1, the beginning of the fiscal year, and the end of the fiscal year, respectively. Hence, in order to measure the change in the relative level of costs for a fiscal year ending June 30, the 13 indices are used to capture a complete 12-month period.
I. Cost Finding and Cost Reporting

A. Each intermediate care facility for individuals with intellectual disabilities (ICF/IID) that is not publicly owned and not publicly operated participating in the Florida Medicaid program and being reimbursed under the provisions of this reimbursement plan shall submit a cost report to the Florida Agency for Health Care Administration (AHCA) postmarked, or accepted by a common carrier, no later than five calendar months after the close of its cost reporting year. No exceptions will be granted to the filing time limits. Two complete, legible, copies of the cost report shall be submitted to AHCA, Bureau of Medicaid Program Finance, Division of Cost Reimbursement, 2727 Mahan Drive, Mailstop 23, Tallahassee, FL 32308. The cost reporting forms and instructions shall be the same as used for facilities reimbursed in accordance with Rule 59G-6.040, Florida Administrative Code (F.A.C.).

B. The most current cost report received by AHCA on or before February 1st each year shall be used to establish rates effective July 1 for all facilities that were being reimbursed in accordance with Rule 59G-6.040, F.A.C.

C. All providers are required to detail all of their costs for their entire reporting period, making appropriate adjustments as required by this plan for determination of allowable costs. The cost report shall be prepared using the accrual basis of accounting in accordance with generally accepted accounting principles and the methods of reimbursement in accordance with Medicare (Title XVIII) Principles of Reimbursement, the Provider Reimbursement Manual Centers for Medicare and Medicaid Services (CMS) PUB.15-1, incorporated by reference in Rule 59G-6.010, F.A.C., except as modified by the Florida Title XIX Reimbursement Plan for Services in Facilities Not Publicly Owned and Not Publicly Operated, and State of Florida administrative rules. The CMS PUB.15-1 Manual may be obtained from the regional CMS office in Atlanta.
The person preparing the cost report shall sign the cost report as the preparer and include contact information. Cost reports not signed will not be accepted.

D. If a provider files a cost report late, after the five month period, and that cost report would have been used to set a lower reimbursement rate for a rate period had it been filed within five months, then the provider's rate for that rate period shall be retroactively calculated using the new cost report, and full payments at the recalculated rate shall be effected retroactively.

E. A provider who voluntarily (or involuntarily) ceases to participate in the Florida Medicaid program or experiences a change of ownership (CHOW) shall file a final cost report within 90 days of withdrawal from the program when that provider has been receiving an interim reimbursement rate.

F. All providers are required to maintain financial and statistical records in accordance with 42 Code of Federal Regulations (CFR), sections 413.24 (a), (b), (c) and (e). The cost report is to be based on financial and statistical records maintained by the provider. Cost information shall be current, accurate, and in sufficient detail to support costs set forth in the report. This includes all ledgers, books, records, original evidence of cost and other records in accordance with CMS PUB.15-1 which pertain to the determination of allowable costs, and shall be capable of being audited and available within the State of Florida for auditing by state and federal agencies and their representatives within 20 days of the request. All accounting and other records shall be brought up to date within 30 days of the end of each fiscal quarter. These records shall be retained by the provider for a minimum of three years following the date the cost report was filed with AHCA.

G. Records of organizations determined by AHCA to be related as defined by 42 CFR 413.17 shall be available upon demand within the State of Florida to representatives, employees, or contractors of AHCA, the Florida Auditor General, U.S. General Accounting Office (GAO), or U.S. Department of Health and Human Services (HHS).

H. AHCA shall retain all uniform cost reports submitted for a period of at least three years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of 42 CFR 431.17. Access to filed cost reports shall be in accordance with Chapter 119, Florida Statutes (F.S.).
I. New providers entering the program shall submit a cost report for a period of not less than 12 months and not greater than 18 months for purposes of setting prospective rates. Initial cost report must be filed not than 5 calendar months after the cost of the provider’s fiscal year end and are due not later than 23 months after the provider’s CHOW effective date. A partial-year cost report may be filed initially, but may only be used to adjust the interim budgeted rate in effect.

J. The provisions of this reimbursement plan shall apply to all ICF/IID facilities not publicly owned and not publicly operated. These facilities shall include ICF/IID facilities that are publicly owned and the State of Florida is the Medicaid provider of record, but are operated or managed by a not-for-profit or for-profit organization.

K. Unless specifically noted, the terms facility and provider shall have the same meaning for all sections of this reimbursement plan.

L. Cost reports shall 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.”

M. AHCA reserves the right to refer providers found to be out of compliance with any of the policies and procedures regarding cost reporting to the Bureau of Medicaid Program Integrity for investigation.

N. Providers are subject to sanctions pursuant to sections 409.913(15)(c) and 409.913(16)(c), F.S., for late cost reports. The amount of sanctions can be found in Rule 59G-9.070, F.A.C. A cost report is late if it is not received by AHCA on the first cost report acceptance cut-off date after the cost report due date.

II. Audits

All cost reports filed by the providers shall be either field or desk audited at the discretion of AHCA.

A. Description of AHCA's Procedures for Audits - General
1. Primary responsibility for the audit of providers shall be assumed by AHCA. The efforts of AHCA audit staff may be augmented by contracts with certified public accountant (CPA) firms to ensure that the requirements of 42 CFR 447.202 are met. AHCA shall determine the scope and format for on-site audits, desk audits of cost reports, and financial records of providers.

2. All audits shall be based on generally accepted auditing standards of the American Institute of Certified Public Accountants.

3. Upon completion of each field audit, the auditors shall issue a report which meets the requirements of 42 CFR 447.202 and generally accepted auditing standards. The auditor shall express an opinion as to whether, in all material respects, the financial and statistical report submitted complies with all federal and state regulations pertaining to the reimbursement program for long-term care facilities. All reports shall be retained by AHCA for three years.

4. Providers shall have the right to petition for an administrative hearing in accordance with Chapter 120, F.S.

B. Desk Audit Procedures

1. Cost reports shall be reviewed for completeness, accuracy, consistency, and compliance with Florida Medicaid regulations. Necessary adjustments shall be made. All findings and adjustments shall be summarized in writing.

2. A concurrence letter will be prepared and sent to the provider, showing all adjustments and changes and the authority for each.

III. Allowable Costs

A. The cost report shall include all items of expense which a provider shall incur in meeting:

1. The definition of intermediate care facility set forth in 42 CFR 440.150.

2. The standards prescribed by the Secretary of HHS for intermediate care facilities in regulations under the Social Security Act (SSA) in 42 CFR 442, Subpart C.
3. The requirements established by AHCA under the authority of 42 CFR 431.610.

B. All therapy required by Medicare or Medicaid certification standards and prescribed by the physician of record shall be considered as covered services and all costs, direct or indirect, shall be included in the cost report. These therapeutic opportunities shall include habilitative, rehabilitative, or other professional treatments which shall be composed of medical, dental, nutritional, nursing, pharmacy, physical therapy, occupational therapy, psychological, recreational, social work, speech therapy, or other intellectual disability specialized services as appropriate.

C. Implicit in any definition of allowable costs is that those costs do not exceed what a prudent and cost-conscious buyer pays for a given service or item. If costs are determined by AHCA, utilizing the Title XVIII Principles of Reimbursement, CMS PUB.15-1, and this plan, to exceed what a prudent buyer would pay, then the excess costs shall not be reimbursable under this plan.

D. All items of expense that providers incur in the provision of routine services, such as the regular room, dietary and nursing services, medical supplies, and the use of equipment and facilities, are allowable. Expenses excluded from the cost report and reimbursable outside the per diem rate include:

- Practitioner services for acute events, including one visit per month for chronic care management
- Dialysis services rendered in the outpatient hospital or freestanding dialysis center setting
- Podiatry services
- Flu and pneumonia vaccines

E. Bad debts other than Title XIX, charity, and courtesy allowances shall not be included in allowable costs. Bad debts for Title XIX shall be limited to Title XIX uncollectible deductible and co-payments and the uncollectible portion of eligible Medicaid recipients' responsibilities.

Example: Daily Medicaid reimbursement rate is $50.00; State pays $40.00 and resident is to pay $10.00. If the Medicaid resident pays only $8.00, then $2.00 would be an allowable bad debt.

Medicaid bad debts are allowable if revenue was earned in the prior year and two collection letters...
were sent to the appropriate party responsible for the debt within 12 months of revenue recognition.

F. Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to a provider will be governed by 42 CFR 413.17, Medicare (Title XVIII) Principles of Reimbursement, and Chapter 10, CMS PUB.15-1. Providers shall identify such related organizations and costs in their cost reports.

G. Other allowable costs shall be limited by the following provisions:

1. The owner administrator and owner assistant administrator compensation shall be limited to reasonable levels determined in accordance with CMS PUB.15-1 or as may be determined by surveys conducted by AHCA.

2. Limitation of rents:
   a. It is the intent of the Medicaid program to limit lease cost reimbursement (rent) to the allowable ownership costs associated with the leased land, building, and equipment. For the purposes of this provision, allowable ownership costs of the leased property shall be defined as the sum of:
      (1) Depreciation, property-related interest, property taxes including personal and real property, property insurance, and other property-related costs as allowed under the provisions of this plan;
      (2) Sales tax on lease payments, if applicable; and
      (3) Return on equity (ROE) that would be paid to the owner if he were the provider, as per section H. below.
   b. Implementation of this provision shall be in accordance with the following:
      (1) Reimbursable lease costs of existing providers will remain unchanged until such time as the provider documents that ownership costs, as defined above, exceed the Medicaid rent costs allowed. No other upward adjustments shall be made to allowable lease costs, that is,
increased rent associated with negotiated or renewed leases of existing
providers shall not be allowed, except for those legally binding
agreements entered into by the lessee and lessor before July 18, 1984.

(2a) For currently participating non-leased facilities that subsequently are
operated under a lease agreement with no change in ownership, the
Medicaid rent costs allowed for reimbursement will be the lesser of
actual rent paid or the allowable ownership costs of the leased property
immediately prior to the commencement of the lease arrangement,
adjusted subsequently only for cost increases that would have been
allowable for the owner, for example, increases in property taxes. This
provision does not apply to lease costs for equipment that is not being
leased from the owner of the facility.

(2b) For leased facilities that subsequently undergo a change of ownership,
the lease costs shall be limited to the ownership costs of the original
owner of record or the rent, whichever is lower.

(3) For new providers entering the Medicaid program, lease payments
shall be the lesser of actual rent paid or allowable ownership costs as
determined by the provisions of this plan. Allowable ownership costs
shall be adequately documented by the provider. This provision does
not apply to lease costs for equipment that is not being leased from the
owner of the facility.

(4) In no case shall Florida Medicaid reimburse a provider for costs not
properly documented per the provisions of this plan. Providers
showing rent costs, with the exception of providers who have entered
into legally binding lease agreements prior to July 18, 1984, shall not
be reimbursed for such costs if proper documentation of the owner's
costs are not submitted to AHCA. The owner shall be required to sign a letter to AHCA which states that the documentation submitted presents to the best of his knowledge true and correct information. The letter signed by the owner shall also state that the owner agrees to make his books and records of original entry related to the ICF/IID properties available to auditors or official representatives of AHCA, and that he agrees to abide by the depreciation recapture provisions of this plan set forth in section III.G.(3).

(5) AHCA shall not make a determination that a provider has shown adequate proof of financial ability to operate if the provider is leasing the facility and does not submit the documentation of the owner's costs with the letter signed by the owner as per four above.

3. Basis for depreciation and calculation:
   a. Cost.

   Historical cost of long-term care facilities shall be the basis for calculating depreciation as an allowable cost subject to the provisions of subsection b. All other provisions of the Medicare (Title XVIII) Principles of Reimbursement and CMS PUB.15-1 shall be followed.

   b. Change in ownership of depreciable assets. For purposes of this plan, a change in ownership of assets occurs when unrelated parties purchase the depreciable assets of the facility, or purchase 100 percent of the stock of the facility, and within one year, merge the purchased facility into an existing corporate structure or liquidate the purchased corporation and create a new corporation to operate as the provider. In compliance with section 1902(a)(13)(c) of the SSA, in a case in which a change in ownership of a provider's or lessor's depreciable assets occurs, and if a bona fide sale is established, the valuation of capital assets for
determining payment rates for intermediate care facilities for individuals with intellectual disabilities for facilities not publicly owned and publicly operated shall be increased (as measured from the date of acquisition by the seller to the date of the change of ownership), solely as a result of a change of ownership, by the lesser of:

1. One-half of the percentage increase (as measured over the same period of time, or, if necessary, as extrapolated retrospectively by the Secretary of HHS.) in the current Dodge Construction Systems Cost for Nursing Homes, applied in the aggregate with respect to those facilities which have undergone a change of ownership during the fiscal year; or

2. One-half of the percentage increase (as measured over the same period of time) in the current consumer price index for all urban consumers (United States city average).

In any change in ownership, the total valuation of capital assets allowed for determining payment rates shall not exceed the lessor of:

1. The acquisition cost of the facility to the new owner; or

2. The fair market value of the facility at the time of purchase.

This valuation shall be used to calculate depreciation, interest on capital indebtedness, and, if applicable, ROE.

Example 1: The allowable acquisition cost of the facility to the seller in 1985 was $500,000. A new owner purchases the facility in 1990 for $700,000. The increase in the Dodge Construction Index and the Consumer Price Index from the date of acquisition by the seller to the date of change in ownership is 25% and 20% respectively. The new owner's allowable depreciable basis is $550,000.
Example 2: The allowable acquisition cost of the facility to the seller in 1985 was $1,500,000. A new owner purchases the facility in 1990 for $1,250,000. The new owner's allowable depreciable basis is $1,250,000.

c. Recapture of depreciation resulting from sale of assets. The sale of depreciable assets, or a substantial portion thereof, at a price in excess of the cost of the property as reduced by accumulated depreciation, resulting in a gain on sale, and calculated in accordance with Medicare (Title XVIII) Principles of Reimbursement indicates the fact that depreciation used for the purpose of computing allowable costs was greater than the actual economic depreciation. The amount of the recapture shall be determined as follows:

(1) The gross recapture amount shall be the lesser of the actual gain on the sale or the Florida Medicaid portion of accumulated depreciation. The gross recapture amount shall be reduced by .877193 percent for each month in excess of 48 months participation in the Florida Medicaid program. Additional beds and other related depreciable assets put into service shall be subject to the same thirteen and one-half year depreciation recapture phase out schedule beginning at the time the additional beds are put into service. The gross recapture amount related to the additional beds shall be reduced by .877193 percent for each month in excess of 48 months participation in the Florida Medicaid program subsequent to the date the additional beds were put into service. To determine the amount of gain associated with additional beds, the portion of the sale price associated with all depreciable assets shall be allocated to the older and new portions of a facility as follows: For each part of the facility, determine the proportion of beds to the facility's total number of beds. Multiply the
proportion of beds in that part of the facility by the sale price. The result is the portion of the sales price allocable to that part of the facility.

Example:

Sales Price: $6,000,000

Older Portion of Facility:
Number of beds = 60

Newer portion of facility:
Number of beds = 120

Allocation to older portion: \((60/180) \times 6,000,000 = $2,000,000\)

Allocation to new portion: \((120/180) \times 6,000,000 = $4,000,000\)

Sale Price = $6,000,000

(2) The adjusted gross recapture amounts as determined in one above shall be allocated for fiscal periods from January 1, 1972, through the date of sale. The adjusted gross recapture amounts shall be allocated to each fiscal period in the same ratio as depreciation amounts claimed for the respective portions of the facility. Allowable costs shall be computed for each period after depreciation recapture. The recomputed allowable costs shall be used to determine if there should be an adjustment to the payment rate, and any resulting overpayment shall be recovered.

(3) The net recapture amount, if any, so determined in two above shall be paid by the former owners, to AHCA. If the net recapture amount is not paid by the former owner, in total or in part, the amount not paid shall be deducted from the future payments by AHCA to the buyer until the net recapture has been received. AHCA shall grant terms of
extended payment when the facts and circumstances of the unrecovered recapture from the seller justify the extension.

d. Depreciation recapture resulting from leasing the facility or withdrawing from Florida Medicaid program.

(1) In cases where an owner-operator withdraws from the Florida Medicaid program as the provider, but does not sell the facility, the depreciation paid by Florida Medicaid to the owner during the same time he was the Florida Medicaid provider shall be subject to the depreciation recapture provisions of this plan when the owner sells the facility. This includes cases where an owner-provider leases a facility to another unrelated licensed operator after having operated the facility as the licensed Florida Medicaid provider. In addition, if an owner-operator elects to withdraw from the Florida Medicaid program and lease the facility to an operator who continues to participate in the Florida Medicaid program, the portion of the reimbursable rent payment that represents depreciation expenses shall be subject to the depreciation recapture provisions of this plan, section III.G.3.c, at the time the facility is sold.

All owner-providers that withdraw from the Florida Medicaid program shall be required to sign a contract with the Agency for Persons with Disabilities (APD) creating an equitable lien on the owner's capital assets. This lien shall be filed by APD with the clerk of the circuit court in the judicial circuit within which the facility is located. The contract shall specify that the method for computing depreciation recapture shall be in accordance with the provisions of this plan, and the contract shall state that such recapture so determined shall be due to AHCA upon sale of the facility. In the event that a provider fails to
sign and return the contract to APD, the Proof of Financial Ability, which is required for the prospective operator of the facility to be licensed, shall not be approved.

(2) For lessees entering the Florida Medicaid program and for existing Florida Medicaid providers who are granted an upward adjustment to their allowable lease costs, the portion of the Florida Medicaid reimbursement rent payment that represents depreciation expense shall be subject to the depreciation recapture provisions of the plan at the time the facility is sold.

The recapture amount owed by the owner shall be computed using the amount of depreciation claimed by the owner and allowed by Florida Medicaid during the months that he was the Florida Medicaid provider or a lessor to a Florida Medicaid provider, or both.

4. Limitations on interest. For reimbursement purposes, the amount of interest allowed to a new provider in a change of ownership is limited by the allowed basis for depreciation. If the new owner's equity in the facility is less than the allowed basis for depreciation, the owner shall be allowed interest expense on the difference between the allowed basis and the equity. If the new owner's equity in the facility is more than the allowed basis for depreciation, no interest shall be allowed.

Example 1: The original owner's acquisition cost is $1,000,000. A new owner purchases the facility in 1985 for $2,000,000, putting $500,000 down and financing $1,500,000 at 15 percent. The new owner's allowable depreciation basis is $1,000,000, and he can be reimbursed interest on $500,000 at 15 percent, that is, $1,000,000 - $500,000 = $500,000 at current rate of 15 percent.

Example 2: The original owner's acquisition cost is $1,000,000.
A new owner purchases the facility in 1985 for $2,000,000, putting $1,250,000 down and financing $750,000 at 15 percent. The new owner's allowable depreciation basis is $1,000,000 which is less than the equity, so he receives no interest reimbursement.

5. Limitations on ROE. ROE is also limited by the new owner's allowed acquisition cost. The new owner can receive an ROE upon his actual equity, up to the allowed acquisition cost.

Example 1: The original owner's acquisition cost is $1,000,000.

A new owner purchases the facility in 1985 for $2,000,000, putting down $750,000. The new owner's allowable depreciation basis is $1,000,000, and he can receive an ROE reimbursement on the $750,000.

Example 2: The original owner's acquisition cost is $1,000,000.

A new owner purchases the facility in 1985 for $2,000,000, putting down $1,250,000. His equity amount for reimbursement purposes shall be limited to $1,000,000.

6. Property-related costs allowed for reimbursement purposes shall be limited by the following provisions.

a. Costs that are capitalized as per CMS PUB.15-1 provisions other than land, buildings, construction loan costs, and equipment shall not exceed what a prudent and cost-conscious buyer would pay for the given service or item. If such costs are determined by AHCA, utilizing the Title XVIII Principles of Reimbursement, CMS PUB.15-1, and this Plan to exceed the level that a prudent buyer would incur, then the excess costs shall not be reimbursed under the plan. Examples of such costs include but are not limited to legal fees, developers' fees, underwriters' fees, bond discount, loan points, trustee fees, interest cost on debt reserve requirements, and costs of feasibility studies.

b. All allowable capitalized costs included in (a) above plus all interest costs incurred as a result of financing the land, building, and equipment, including...
building equipment, major movable equipment, and minor equipment as described in CMS PUB.15-1, shall be limited in total to the amount of interest cost that would be incurred if the land, building, and equipment had been financed through a "conventional financing" debt instrument over a 25-year period, with a ten percent cash down payment, at an interest rate equal to the lesser of 15 percent or the prime rate plus two percent. In cases where the provider obtained greater than 90 percent financing, the difference between the actual down payment and a ten percent cash down payment in this financing limit method shall be included with the balance sheet average equity for the period for purposes of computing an incremental change in ROE or use allowance that would have occurred had a full ten percent down payment actually been made. If the total ROE payment would increase from zero to a positive dollar amount, then the financing cost limitation on interest expense shall increase by that positive dollar amount. If the total ROE payment would increase from a positive payment to a greater amount, then the financing cost limitation on interest expense shall increase by the difference between the two amounts. For purposes of this provision, the "conventional financing" amortization schedule used shall provide for equal installments, that is, payments, with amortization of the principal beginning in the first year, that is, a 25-year payoff schedule. The prime rate used shall be the prime rate as stated by the Chase Manhattan Bank in New York as of the date the provider received a loan commitment from the lending institution, or the date AHCA received the provider's acceptable budgeted cost proposal if no commitment date can be documented. Providers with variable rate debt instruments that are initially approved within these cost limitations shall be granted cost increases due to an
increase in their interest rate, but not to exceed that cost which would be incurred at an interest rate of 15 percent per annum.

c. Additional costs due to refinancing shall not be allowed if refinancing was not necessary in order to meet the final payments of the former debt instrument, that is, in cases where balloon payments are due, or to finance the addition of new beds.

d. AHCA shall make exceptions to the financing limitations set forth in (a) and (b) above when, in consultation with the Agency for Persons with Disabilities (APD), it is in the best interest of the State. Exceptions to the financing limitations shall be considered when it has been demonstrated through the Certificate of Need (CON) or Request for Proposal (RFP) process that financing within the limitations of this plan is not available. Should that decision be made, the APD shall issue a new RFP allowing other financing options. APD shall reject any or all proposals which are made in response to a new RFP if APD determines that the rejection is in the best interest of the State.

7. Additional costs incurred after enrollment in the program that are due to capital additions or expansion shall have prior approval by the APD Office of Developmental Services if such costs exceed one percent of the provider's current total reimbursement rate, with the exception of the addition of new beds which are approved through the state's CON process. Costs for specific expansions or additions that exceed the one percent limit shall not be reimbursable if not previously approved. Further, financing costs for approved expansions or additions shall be limited by the prudent buyer limits established in section III.G(4).

8. Depreciable basis as a result of capital improvements. If capital improvements are made to a facility, the actual cost of the improvements shall be added to the owner's basis,
allowing the owner reimbursement of interest, ROE, or both as specified in section III of this plan.

9. Retirement and replacement of outdated equipment. Upon a change of ownership of a facility, the new provider shall maintain the original owner's records of capital assets. If the new owner subsequently retires outdated equipment, the original owner's cost minus any depreciation shall be an allowable write-off. Replacement equipment costs shall be allowed according to capital improvement rules as specified above.

H. Return on Equity

A reasonable ROE invested and used in providing resident care shall be defined for purposes of this plan as an allowable cost. This ROE shall use the principles stated in Chapter 12, CMS PUB.15-1, except that the rate of return shall be equal to the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the provider's reporting period or portion thereof covered under the Florida Medicaid program. ROE shall be limited to those providers who are organized and operated with the expectation of earning a profit for the owners, as distinguished from providers organized and operated on a non-profit basis.

I. Use Allowance

A use allowance on equity capital invested and used in providing resident care shall be defined for purposes of the plan as an allowable cost. The use allowance shall be allowed only for non-profit providers, except for those facilities which are government-owned. This use allowance shall use the principles established in section H. above.

IV. Standards

A. In accordance with Chapter l20, F.S., Administrative Procedures Act (APA), this plan shall be made available for public inspection, and a public hearing, if requested, shall be held so that interested members of the public shall be afforded the opportunity to review and comment on the plan.
B. Reimbursement rates shall be established prospectively for each individual provider based on the most recent historic costs, but historic costs shall be limited to allowable percentage increases from period to period, as described in section IV.L. of this plan. Further, if certain costs are determined by the Florida Medicaid program or the Florida Medicaid Division of Audit Services, utilizing the Title XVIII Principles of Reimbursement, CMS PUB.15-1 and this plan, to exceed the level that a prudent buyer would incur, then the excess costs shall not be reimbursable under the plan.

C. Prospective payment rates shall be established annually on July 1. The most current acceptable cost report received by AHCA by February 1 shall be used in the rate setting process to set rates effective on July 1.

D. Reimbursement rates shall be calculated separately for the following two levels of reimbursement:

1. Intermediate Care Facility Level of Reimbursement One - A reimbursement level for recipients who are ambulatory or self-mobile using mechanical devices and are able to transfer themselves without human assistance, but may require assistance and oversight to ensure safe evacuation.

2. Intermediate Care Facility Level of Reimbursement Two - A reimbursement level for recipients who are capable of mobility only with human assistance or require human assistance to transfer to or from a mobility device or require continuous medical and nursing supervision.

Developmental Residential and Developmental Institutional shall constitute one class for reimbursement purposes, while Developmental Non-ambulatory and Developmental Medical shall constitute the other. All providers shall allocate costs by the two levels of care in their cost reports. AHCA shall monitor placements of clients to determine whether discrimination against clients with higher cost or more complex service needs is occurring. If AHCA determines that such placement discrimination is occurring, this plan may be amended to provide for payments based on four types of care.
E. For the two classes described in section D. above, four components of the total reimbursement rate shall be calculated separately. These four components are operating costs, resident care costs, property costs, and ROE costs or use allowance, if applicable. Inflation allowances used in the rate-setting process shall be applied to the operating and resident care cost components independently for the two reimbursement classes.

F. The prospectively-determined individual provider's rates shall be adjusted retroactively to the effective date of the affected rates under the following circumstances:

1. An error was made by AHCA in the calculation of the provider's rates.

2. A provider files an amended cost report used to determine the rates in effect. An amended cost report may be filed in the event that it would effect a change of one percent or more in the total reimbursement rate. The amended cost report shall be filed by the filing date of the subsequent cost report. An audited cost report may not be amended. A cost report shall be deemed audited 60 days after the exit conference between field audit staff and the provider has been completed.

3. Further desk or on-site audits of cost reports used in the establishment of the prospective rates disclose a change in allowable costs in those reports.

G. The following provisions apply to interim changes in component reimbursement rates, other than through the routine annual rate setting process described in section V, as well as to changes in a provider's allowable cost basis. These provisions are not applicable to new providers' first year interim rates, which are addressed in sections IV.H. and IV. I.

1. Requests for rate adjustments for increases in property-related costs due to capital additions, expansion, replacements, or repairs shall not be considered in the interim between cost report submissions, except for the addition of new beds or if the cost of the specific expansion, addition, repair, or replacement would cause a change of one percent or more in the provider's total per diem reimbursement rate.
2. Requests for interim rate changes reflecting increased costs occurring as a result of resident care or administration changes or capital replacement other than that specified in (1) above shall be considered only if such changes were made to comply with existing state or federal rules, laws, or standards, and if the change in cost to the provider is at least $5000 and would cause a change of ten percent or more in the provider's current total per diem rate. The provider shall submit documentation showing that the changes made were necessary to meet existing state or federal requirements.

3. In the event that new state or federal laws, rules, regulations, licensure and certification requirements, or new interpretations of existing laws, rules, regulations, or licensure and certification requirements require all affected providers to make changes that result in increased or decreased resident care, operating, or capital costs, requests for component interim rates shall be considered for each provider based on the budget submitted by the provider. All affected providers' budgets submitted shall be reviewed by AHCA and shall be the basis for establishing reasonable cost parameters.

   Interim rate requests resulting from (1), (2), and (3) above shall be filed within 60 days after the costs are incurred, and shall be accompanied by a 12-month budget which reflects changes in services and costs. An interim reimbursement rate, if approved, shall be established for estimated additional costs retroactive to the time of the change in services or the time the costs are incurred, but not to exceed 60 days before the date AHCA receives the interim rate request. The interim per diem rate shall reflect only the estimated additional costs, and the total reimbursement rate paid to the provider shall be the sum of the previously established prospective rates plus the interim rate. A discontinued service would offset the appropriate components of the prospective per diem rates currently in effect for the provider. Upon receipt of a valid interim rate request, Florida Medicaid, Bureau of Medicaid Program Finance, shall determine whether additional information is needed from the provider and request such information.
within 30 days. Upon receipt of the complete, legible additional information requested, the Bureau of Medicaid Program Finance shall approve or disapprove the interim rate within 60 days. If Florida Medicaid does not make such determination within the 60 days, the interim rate request shall be deemed approved.

4. Interim Rate Settlement.

Overpayment as a result of the difference between the approved budgeted interim rate and actual costs of the budgeted item shall be refunded to AHCA. Underpayment as a result of the difference between the budgeted interim rate and actual allowable costs shall be refunded to the provider.

After the interim rate is settled, a provider's cost basis shall be restricted to the same limits as those of a new provider per section I.

5. The right to request interim rates shall not be granted for fiscal periods that have ended.

H.1. For a new provider in a facility with greater than six beds, the interim cost per diems for each reimbursement class shall be the budgeted component cost rates approved by AHCA. These initial cost estimates shall be limited as follows:

1. Property Costs:
   Shall be approved by Florida Medicaid and shall not be in excess of the limitations established in section III. of this plan.

2. Operating Costs:
   Shall not exceed the 90th percentile of per resident day costs of all currently participating ICF/IID providers that currently have prospective rates.

3. Resident Care Costs:
   Shall not exceed the highest per resident day cost for the respective reimbursement class of any other currently participating provider having a prospective rate.
H.2. For a new provider in a facility with six beds or less, the interim cost per diems for each reimbursement class shall be the budgeted component cost rates approved by AHCA. These initial cost estimates shall be limited by ceilings as follows:

1. **Property Costs Ceiling:**
   Shall be approved by the Florida Medicaid and shall not be in excess of the limitations established in section III. of this plan.

2. **Operating Costs Ceiling:**
   Shall not exceed the 90th percentile of per resident day costs of all currently participating ICF/IID providers that currently have prospective rates.

3. **Resident Care Costs Ceiling:**
   Shall not exceed the highest per resident day cost for the respective reimbursement class of any other currently participating provider having a prospective rate.

4. **Total costs per diem ceiling (including ROE):**
   Shall not exceed $239.09 for the Developmental Residential/Developmental Institutional classes and shall not exceed $267.02 for the Developmental Non-Ambulatory classes.

These ceiling amounts shall be inflated forward based on one times the ICF/IID inflation index utilizing the same inflation methodology as used in calculating prospective rates.

When a provider's interim cost is limited to the total cost ceiling, the ceiling shall be allocated to each component based on the percentage that each component's interim cost is to the total of all components' interim costs, including ROE.

<table>
<thead>
<tr>
<th>Example</th>
<th>Interim Cost</th>
<th>Percent to Total</th>
<th>Ceiling</th>
</tr>
</thead>
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</tbody>
</table>
I.1. For a new provider in a facility with greater than six beds, AHCA shall establish the cost basis for calculation of prospective rates using the first acceptable historical cost report covering at least a 12-month period filed by the provider. Overpayment as a result of the difference between the approved budgeted interim rate and actual allowable costs of the budgeted item shall be refunded to AHCA. Underpayment as a result of the difference between the budgeted interim rate and actual allowable costs shall be refunded to the provider. The basis for calculating prospective rates shall be the first year settled cost report. Basis shall be set at 100 percent of the total allowable costs as determined by Florida Medicaid.

I.2. For a new provider in a facility with six beds or less, AHCA shall establish the cost basis for calculation of prospective rates using the first acceptable historical cost report covering at least a 12-month period filed by the provider. Overpayment as a result of the difference between the approved budgeted interim rate and actual allowable costs of the budgeted item subject to base year ceilings in section V.B. of this plan shall be refunded to AHCA. Underpayment as a result of the difference between the budgeted interim rate and actual allowable costs subject to base year ceilings in section V.B. of this plan shall be refunded to the provider. The basis for calculating prospective rates shall be the first year settled cost report. Basis shall be set at the lesser of 100 percent of the total allowable costs or the ceilings as determined by Florida Medicaid.

J. Incentives for rates paid on and after October 1, 1998, shall be paid to providers whose annual rates of cost increase for operating costs or resident care costs from one cost reporting period to the next are less than 1.4 times the average cost increase for the applicable period documented by the ICF/IID Cost Inflation Index used in this plan. Calculation of incentives shall be as detailed in section V.A.(7) of this plan.
K. To encourage high-quality care while containing costs, incentive payments shall be paid to those facilities which are not out of compliance with any condition of participation. Cost containment operating and resident care incentives shall be prorated for the percentage of days that a provider is out of compliance with any condition of participation during the rate period in effect one year prior to the rate period being set.

L. A provider's reimbursement for service provided under the Florida Medicaid program shall be the lower of: the provider's usual and customary charges to the general public for such services, except for public facilities rendering such services free of charge or at a nominal charge, that is, less than or equal to 50 percent of costs; or the rates established for the provider under this reimbursement plan.

M. The use of a target rate of inflation for cost increases shall be used as a measure of efficient operation for purposes of this reimbursement plan. The target rate of inflation principle is that a provider's operating and resident care per diems by reimbursement class should not increase from one fiscal period, that is, year, to the next by a percentage amount which exceeds 1.4 times the average percentage of increase in the Florida ICF/IID Cost Inflation Index for the same period. If a provider's per diem costs for either reimbursement class for operating or resident care exceeds the target rate of inflation, then the allowable per diem costs of the period in which the excessive costs occurred shall be limited to a level equal to the prior period's allowable per diem costs inflated by the target rate percentage. Only allowable per diem costs shall be used for prospective rate setting purposes and for future target rate comparisons.

N. Aggregate test comparing Florida Medicaid to Medicare according to 42 CFR section 447.253(c)(2), Florida Medicaid estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for long-term care facility services than the amount that would be paid for the services under the Medicare principles of reimbursement. At any rate-setting period, if the aggregate reimbursement to be paid is higher than would be paid under Medicare principles, incentives shall be reduced or eliminated as necessary to meet the aggregate test.
O. Base Costs:
The initial base costs for each provider shall be the allowable costs documented by the cost report used to establish the rate being set. For new providers entering the Florida Medicaid program the initial base costs shall be established in accordance with section IV.I. of this plan. Prospective rates calculated using unaudited costs shall be retroactively adjusted when audit results become available.

P. Effective July 1, 2011 through June 30, 2015, the Agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs.

V. Methodology

A. Rate-setting method for rate periods beginning on or after July 1, 2014.

1. For rate periods beginning on July 1 of a given year, the prospective rates shall be set using the most current acceptable cost report on file with AHCA as of February 1 of that year.

2. Review and adjust each provider’s cost report referred to in section IV.N. to reflect the results of desk or on-site audits, if available.

3. Determine total allowable cost by reimbursement class for property cost, resident care cost, operating cost, and ROE or use allowance if applicable. See the glossary section of this plan for the definitions of allowable costs for each of the cost components. Costs shall be allocated to each reimbursement class by the methodology shown in Appendix A. Costs for providers with six beds or less shall be allocated to each reimbursement class by the methodology shown in Appendix A-1.

4. Calculate per diems for each of the four cost components for the two reimbursement classes by dividing the component's cost by the appropriate number of resident days.

5. Calculate the target rate of inflation factor representing the allowable increase in operating and resident care costs from the prior cost reporting period. The target rate of inflation factor is calculated by multiplying 1.4 times the simple average of the monthly...
Florida ICF/IID Cost Inflation Indices associated with the more recent cost reporting period divided by the simple average of the monthly indices associated with the prior cost reporting period.

6. This step presumes that the cost components of the cost reporting period immediately prior to the current cost report have been adjusted for base year ceiling limitations, inflation target rate limits and incentives, and that they now represent the allowable base costs against which the current costs are to be evaluated. If the current year cost report includes new costs that were incurred in order to meet state or federal rules, laws, regulations, or licensure and certification standards, and the provider did not request an interim rate adjustment for those costs during that cost reporting period or if the costs did not meet the $5,000 and one percent threshold under the interim rate provisions in section IV.G., then an adjustment shall be made to the current base year costs such that the calculation of the target cost appropriately accounts for cost incurred in meeting laws, rules, or regulations. For such an adjustment to be made, the provider shall furnish adequate supporting documentation with the cost report. Multiply the adjusted base cost components for operating and resident care costs for each reimbursement class by the target rate factor computed in step five above to reflect the allowable change in costs.

7. Compare the operating and resident care cost per diems resulting from step six with the respective per diems from step four for each reimbursement class.

a. If the operating per diem for either reimbursement class from step four is less than the respective operating per diem from step six, then establish the new operating base per diem as the per diem from step four plus an incentive of one-half of the difference between the two per diems, not to exceed 10 percent of the step four per diem. The operating incentive shall be prorated for the percentage of days that the provider is out of compliance with any Condition of Participation during the rate period in effect one year prior to the rate period.
being set. For example, a provider not out of compliance with a Condition of Participation shall receive 100% of the incentive amount. A provider that is out of compliance for 60 days of a 365-day rate period shall receive 83.61% of the incentive amount based on 305 days divided by 365 days. If the operating per diem from step four is greater than the step six per diem, then establish the new operating base per diem as the step four per diem, not to exceed the base cost per diem from step six inflated by the target rate factor.

b. If the resident care per diem for either reimbursement class from step four is less than the respective resident care per diem from step six then establish the new resident care base per diem as the per diem from step four plus an incentive calculated as 50 percent of the difference between the step four per diem and the step six per diem, not to exceed three percent of the step four per diem. The resident care incentive shall be prorated for the percentage of days that the provider is out of compliance with any condition of participation during the rate period in effect one year prior to the rate period being set. For example, a provider not out of compliance with a condition of participation shall receive 100% of the incentive amount. A provider that is out of compliance for 60 days of a 365-day rate period shall receive 83.61% of the incentive amount based on 305 days divided by 365 days. If the resident care per diem from step four is greater than the step six per diem, then establish the new resident care base per diem as the step four per diem, not to exceed the base cost per diem from step six inflated by the target rate factor.

c. If different operating cost rate components are produced in this rate setting methodology, the total operating rate cost component incentive that is determined shall be allocated to both classes by weighting with patient days of
each class. This shall equalize the operating rate cost components and allow for more meaningful trend comparison between cost reporting periods.

8. The new base per diems for property and ROE or use allowance shall be the per diems established in step four above.

9. Using the appropriate current base per diem for resident care and operating costs from step seven above, calculate the prospective operating and resident care per diems for the new rate period by multiplying each of the base per diems by the fraction:

Simple average of the Florida ICF/IID monthly cost inflation indices for the prospective rate period divided by the simple average of the Florida ICF/IID monthly cost inflation indices for the cost report period used to calculate current base per diems.

10. Establish the total prospective per diem for each reimbursement class as the sum of the appropriate operating and resident care per diems resulting from step nine plus the current approved per diems for property and ROE or use allowance, if applicable, from step eight.

B. Florida Medicaid Trend Adjustment (MTA) – For Rate Periods on or After July 1, 2014

1. Effective July 1, 2014, reimbursement rates for intermediate care facilities will be set July 1 of each year. Between July 1, 2014 and April 30, 2016, providers may elect to change their fiscal year end and file a new cost report for a period of not less than 6 months and not greater than 18 months due to the transition to an annual rate setting. Cost report fiscal year end changes for this purpose are allowed even if a recent change has occurred and cost reports have not been filed with the same fiscal year end for two years.

2. Effective July 1, 2015, $39,127,138 is provided to buy-back intermediate care facilities rate reductions, effective on or after October 1, 2008.
3. The recurring methodology to establish rates taking into consideration the cuts imposed on or after October 1, 2008, shall be to compare the legislative unit cost with the rate setting unit cost as follows:

1) The legislative unit cost shall be determined by dividing the total appropriation for intermediate care facilities by the total bed days for the past fiscal year;

2) The total actual cost as generated based on the July 1 rate settings shall be divided by the total bed days for the past fiscal year to determine the rate setting unit cost;

3) The rate setting unit cost shall be reduced to a “reduced rate setting unit cost” by the same percentage used to calculate the legislative unit cost to account for client participation contributions;

4) No negative adjustment to the rates paid to providers shall occur so long as the reduced rate setting unit cost is equal to or less than the legislative unit cost; and

5) In the event the reduced rate setting unit cost is greater than the legislative unit cost, a prorated reduction shall be imposed on all rates after all quality assessment fee funds have been exhausted to cover the rate reductions.

C. Base year ceilings for new providers in facilities with six beds or less

1. Property costs per diems shall not be in excess of the ceiling limitations established in section III.

2. Operating costs per diems shall not be in excess of the 90th percentile of per resident day costs of all currently participating ICF/IID providers that have prospective rates. This ceiling shall be recalculated for every rate period beginning July 1- of each year.

3. Resident care costs per diems shall not exceed the highest per resident day cost for the respective reimbursement class of any other currently participating provider having a prospective rate. The ceiling shall be recalculated for every rate period beginning July 1 of each year.

4. Total costs per diem ceilings (including ROE):
Shall not exceed the total costs per diem ceilings for interim cost per diems in section IV.H.(2)(D.) multiplied times 1.04. When a provider is limited to the total ceiling in the base year, the total ceiling shall be allocated to each component to cost settle interim rates and to calculate prospective rates based on the percentage that each component's actual allowable cost is to the total actual allowable cost for all components, including ROE, in the base year.

<table>
<thead>
<tr>
<th>Example</th>
<th>Interim Cost</th>
<th>Percent to Total</th>
<th>Ceiling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating</td>
<td>58.15</td>
<td>23.26</td>
<td>55.82</td>
</tr>
<tr>
<td>Resident Care</td>
<td>158.89</td>
<td>63.56</td>
<td>152.54</td>
</tr>
<tr>
<td>Property</td>
<td>25.70</td>
<td>10.28</td>
<td>24.67</td>
</tr>
<tr>
<td>ROE</td>
<td>7.26</td>
<td>2.9</td>
<td>6.97</td>
</tr>
<tr>
<td>Total</td>
<td>250</td>
<td>100%</td>
<td>240</td>
</tr>
</tbody>
</table>

**VI. Payment Assurance**

AHCA shall pay each provider for services provided in accordance with the Florida Title XIX Reimbursement Plan for Services in Facilities Not Publicly Owned and Not Publicly Operated and applicable state or federal rules and regulations. The payment amount shall be determined for each provider according to the standards and methods set forth in this Florida Title XIX Reimbursement Plan for IID Services in Facilities Not Publicly Owned and Not Publicly Operated.

**VII. Provider Participation**

This plan is designed to assure adequate participation of ICF/IID providers in the Florida Medicaid program, the availability of high-quality services for recipients, and for services which are comparable to those available to the general public.
VIII. Payment in Full

Payments made to any provider participating in the Florida Medicaid program who knowingly and willfully charges, for any service provided to the resident under the state plan, money or other consideration in excess of the rates established by the state plan, or charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under the state plan approved under this title, any gift, money, donation or other consideration, other than a charitable, religious or philanthropic contribution from an organization or from a person unrelated to the resident; as a condition of admitting a resident to an ICF/IID facility; or as a requirement for the resident's continued stay in such a facility, when the cost of the services provided therein is paid for, in whole or in part, under the state plan, shall be construed to be supplementation of the state's payment for services. Payments made as a condition of admitting a resident or as a requirement for continued stay in a facility shall be deemed to be payments to meet the cost of care of the Florida Medicaid resident and shall be deemed to be out of compliance with 42 CFR section 447.15.

IX. Intermediate Care Facility Quality Assessment Fee (ICFQAF)

A. In accordance with section 409.9083, F.S., there is imposed upon each ICF/IID, a quality assessment. The aggregated amount of assessments for all ICF/IID’s in a given year shall be an amount not exceeding the maximum percentage allowed under federal law of the total aggregate net patient service revenue of assessed facilities. AHCA shall calculate the quality assessment rate annually on a per resident-day basis as reported by the facilities. The per-resident per day assessment rate shall be uniform. Each facility shall report monthly to AHCA its total number of resident days and shall remit an amount equal to the assessment rate times the reported number of days. AHCA shall collect, and each facility shall pay, the quality assessment each month. AHCA shall collect the assessment from facility providers no later than the 15th of the next succeeding calendar month. AHCA shall notify providers of the quality assessment rate and provide a standardized form to complete and submit with payments. The collection of the quality assessment shall commence no sooner than 15 days after the agency’s initial payment to the facilities that implement the increased Florida Medicaid rates containing the elements prescribed in section B below and monthly thereafter.
facilities for individuals with intellectual disabilities may increase their rates to incorporate the assessment but may not create a separate line-item charge for the purpose of passing through the assessment to residents.

B. The purpose of the facility quality assessment is to ensure continued quality of care. Collected assessment funds shall be used to obtain federal financial participation through the Florida Medicaid program to make Florida Medicaid payments for ICF/IID services up to the amount of the Florida Medicaid rates for such facilities as calculated in accordance with the approved state Florida Medicaid plan in effect on April 1, 2008. The quality assessment and federal matching funds shall be used exclusively for the following purposes and in the following order of priority to:

(a) Reimburse the Florida Medicaid share of the quality assessment as a pass through, Florida Medicaid-allowable cost.

(b) Increase each privately operated ICF/IID Florida Medicaid rate, as needed, by an amount that restores the rate reductions implemented on October 1, 2008.

(c) Increase each ICF/IID Florida Medicaid rate, as needed, by an amount that restores any rate reductions for the 2008-2009 fiscal year and the 2009-2010 fiscal year.

(d) Increase payments to such facilities to fund covered services to Florida Medicaid beneficiaries.

C. Upon termination of the quality assessment, all collected assessment revenues, less any amounts expended by AHCA, shall be returned on a pro rata basis to the facilities that paid such assessments.

X. Glossary

A. Acceptable cost report - A completed, accurate and legible cost report that contains all relevant schedules, worksheets and supporting documents in accordance with cost reporting instructions.

B. APD - Agency for Persons with Disabilities.

C. AHCA - Agency for Health Care Administration.

D. Client participation contributions - See (M) Patient Responsibility.

E. CMS PUB.15-1- also known as the Provider Reimbursement Manual, published by the Department of Health and Human Services, Centers for Medicare and Florida Medicaid Services.

F. Filing due date (Cost Report) - No later than five calendar months after the close of the ICF’s cost-
reporting year.

G. ICF/IID operating costs - Those costs not directly related to resident care or property costs. Operating costs include administrative, plant operation, laundry and housekeeping costs. Return on equity or use allowance costs are not included in operating costs.

H. ICF/IID resident care costs - Those costs directly attributed to nursing services, dietary costs, and other costs directly related to resident care such as activity costs, social services, and all medically-ordered therapies.

I. ICF/IID property costs - Those costs related to the ownership or leasing of an ICF/IID. Such costs may include property taxes, insurance, interest and depreciation, or rent.

J. ICF/IID return on equity or use allowance costs - See sections III.H. and III.I. of this plan.

K. Initial cost report – The ICF/IID first filed cost report containing actual costs following the budget interim period associated with their fiscal year end.

L. Late cost report - A cost report is late when it is filed with AHCA, Bureau of Medicaid Program. Analysis after the filing due date and after the rate setting due date.

M. Legislative unit cost - The weighted average per diem of the state anticipated expenditure.

N. Medicaid interim reimbursement rate – A reimbursement rate or a portion of an overall reimbursement rate that is calculated from budgeted cost data.

O. Patient Responsibility- Florida Medicaid deducts the portion of a recipient’s monthly income, as determined by the Department of Children and Families (DCF), that the recipient is required to pay.

P. Quality assessment fee - Pursuant to section 409.9083, F.S., a per-resident-day basis assessment is imposed upon each intermediate care facility.

Q. Medicaid interim reimbursement rate - A reimbursement rate or a portion of an overall reimbursement rate that is calculated from budgeted cost data.

R. Rate setting due date - All cost reports received by AHCA by February 1 shall be used to establish the reimbursement rates. If the due date falls on the weekend, the rate setting due date is the first business day following February 1.

S. Rate setting unit cost - The weighted average per diem based on filed cost reports.
T. Reduced rate setting unit cost - The rate setting unit cost after it is reduced by the same percentage that was used to calculate the legislative unit cost in order to account for the client participation contributions.

U. Title XVIII - Health Insurance for the Aged, Blind or Disabled (Medicare) as provided for in the SSA (42 U.S.C. 1395-1395pp).

V. Title XIX - Grants to States for Medical Assistance Programs (Medicaid) as provided for in the SSA (42 U.S.C. 1396-1396i).
APPENDIX A
CALCULATION OF PROVIDER COST ALLOCATION

<table>
<thead>
<tr>
<th>Provider Number</th>
<th>FY: 09/30/84</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name</td>
<td>Audit Status Unaudited</td>
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<tr>
<td>Address</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>COL A</th>
<th>COL B</th>
<th>COL C</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Resid./</td>
<td>Non-amb./</td>
<td>TOTAL</td>
</tr>
<tr>
<td>Inst.</td>
<td>Medical</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A. Alloc of Exp (Excl B&C)

1. Resident Days 02461 8325 10786

2. OPER. EXPENSE COMP
   a. Administration - - 120482
   b. Plant Operation - - 45060
   c. Laundry - - 15265
   d. Housekeeping - - 29090
   e. Oper. Exp. Comp and Per Diem 19.460 19.460 209897

3. Resident Care Expense
   a. Dietary - - 74861
   b. Other - - 34188
   c. Nursing - - 86018
   d. Res. Care Exp. and Per Diem 18.0852 18.0852 19.5067

4. PROP. EXP. COMP. AND PER DIEM 8.605 8.605 92812

5. ROE/UA COMP & PER DIEM 6.604 6.604 71236

B. DIRECT CARE EXPENSE

1. Staffing .5 1. - 95555

2. Total Staffing Required 1230.5 8325 95555

3. Staffing Percent 12.877% 87.123 100%

4. Alloc. of Direct Care 39263.97 26542.03 304906

5. Dir. Care Exp. Per Diem 15.945 31.9090

C. ADDITIONAL SERVICES EXPENSE

1. Medicaid Patient Days 2461 8275 10736

2. Add. Ser. (Sch.AM-6) 36780 69380 106160


D. MEDICAID PER DIEM COST

Amendment: 2016-028
Supersedes: 2015-011
Approval Date: 3/24/2017
Effective Date: July 1, 2016
<table>
<thead>
<tr>
<th></th>
<th>Operating Component</th>
<th>19.460</th>
<th>19.460</th>
<th>209897</th>
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<tr>
<td>2.</td>
<td>Resident Care Component</td>
<td>48.985</td>
<td>58.378</td>
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<tr>
<td>3.</td>
<td>Property Cost Component</td>
<td>8.605</td>
<td>8.605</td>
<td>92812</td>
</tr>
<tr>
<td></td>
<td>Subtotal (Schedule BM)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4.</td>
<td>ROE/USE ALLOW Comp.</td>
<td>6.604</td>
<td>6.604</td>
<td>71236</td>
</tr>
<tr>
<td>5.</td>
<td>TOTAL PER DIEM COST</td>
<td>83.654</td>
<td>93.047</td>
<td>980078</td>
</tr>
</tbody>
</table>
## APPENDIX A-1

### CALCULATION OF PROVIDER COST ALLOCATION

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<th>Provider Number</th>
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</thead>
<tbody>
<tr>
<td>Provider Name</td>
<td>Audit Status</td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A. Alloc of Exp (Excl B&amp;C)</th>
<th>COL A</th>
<th>COL B</th>
<th>COL C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Days</td>
<td>2461</td>
<td>8325</td>
<td>10786</td>
</tr>
</tbody>
</table>

| 2. OPER. EXPENSE COMP       |       |       |       |
| a. Administration           | -     | -     | 120482|
| b. Plant Operation          | -     | -     | 45060 |
| c. Laundry                  | -     | -     | 15265 |
| d. Housekeeping             | -     | -     | 29090 |
| e. Oper. Exp. Comp and Per Diem | 19.460 | 19.460 | 209897|

| 3. Resident Care Expense    |       |       |       |
| a. Dietary                  | -     | -     | 74861 |
| b. Other                    | -     | -     | 34188 |
| c. Nursing                  | -     | -     | 86018 |
| d. Res. Care Exp. and Per Diem | 18.0852 | 18.0852 | 195067|

<table>
<thead>
<tr>
<th>4. PROP. EXP. COMP. AND PER DIEM</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8.605</td>
<td>8.605</td>
<td>92812</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. ROE/UA COMP &amp; PER DIEM</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6.604</td>
<td>6.604</td>
<td>71236</td>
</tr>
</tbody>
</table>

### B. DIRECT CARE EXPENSE

| 1. Staffing .75               | 1. | - |
| 2. Total Staffing Required    | 1845.75| 8325 | 10,171 |
| 3. Staffing Percent           | 18.148%| 81.852%| 100% |
| 4. Alloc. of Direct Care      | 55,334.34| 249,571.66 | 304906 |
| 5. Dir. Care Exp. Per Diem    | 22.484 | 29.979 | |

### C. ADDITIONAL SERVICES EXPENSE

| 1. Medicaid Patient Days      | 2461  | 8275  | 10736 |
| 2. Add. Ser. (Sch.AM-6)       | 36780 | 69380 | 106160 |

### D. MEDICAID PER DIEM COST

| 1. Operating Component        | 19.460| 19.460| 209897|

Amendment: 2016-028  
Supersedes: 2015-011  
Approval Date: 3/24/2017  
Effective Date: July 1, 2016
## Attachment 4.19-D
### Part III

<table>
<thead>
<tr>
<th></th>
<th>Component</th>
<th>2016-028</th>
<th>2015-011</th>
<th>Subtotal (Schedule BM)</th>
</tr>
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<tbody>
<tr>
<td>2</td>
<td>Resident Care Component</td>
<td>55.520</td>
<td>56.448</td>
<td>606133</td>
</tr>
<tr>
<td>3</td>
<td>Property Cost Component</td>
<td>8.605</td>
<td>8.605</td>
<td>92812</td>
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<tr>
<td></td>
<td>Subtotal (Schedule BM)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>ROE/USE ALLOW Comp.</td>
<td>6.604</td>
<td>6.604</td>
<td>71236</td>
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<tr>
<td>5</td>
<td>TOTAL PER DIEM COST</td>
<td>90.189</td>
<td>91.117</td>
<td>980078</td>
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</table>

Amendment: 2016-028  
Supersedes: 2015-011  
Approval Date: 3/24/2017  
Effective Date: July 1, 2016
APPENDIX B

CALCULATION OF THE
FLORIDA ICF/IID COST INFLATION INDEX

1. Weights.

Percentage weights for cost components shall be based on cost reports filed for fiscal years ending in 1983. These percentage weights are:

<table>
<thead>
<tr>
<th>Cost Component</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and Benefits</td>
<td>65.66%</td>
</tr>
<tr>
<td>Dietary</td>
<td>4.94%</td>
</tr>
<tr>
<td>All Other</td>
<td>29.40%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.00%</strong></td>
</tr>
</tbody>
</table>

2. Inflation index for each component

An inflation index for each of these components is developed from the Data Resources, Inc. (DRI) Skilled Nursing Facility Market Basket of Routine Services Costs inflation indices as follows:

<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>DRI INDEX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and Benefits</td>
<td>Wages and Salaries, combined with Employee Benefits</td>
</tr>
<tr>
<td>Dietary</td>
<td>Food</td>
</tr>
<tr>
<td>All Others with other expenses</td>
<td>Fuel and Utilities, combined</td>
</tr>
</tbody>
</table>

The DRI indices that are combined are merged by summing the products of each index times the ratio of the respective DRI budget share to the total share represented by the combined indices.

Example: Calculation of the Salaries and Benefits combined index for the third quarter of 1984 using Health Care Costs, Third Quarter 1983 Series, p. 15:

\[
\text{DRI Wages and Salaries index} = 1.043; \quad \text{Budget Share} = .602 \\
\text{DRI Employee Benefits index} = 1.073; \quad \text{Budget share} = .084 \\
\]

\[
\text{Weighted Combination (Salaries and Benefits)} = (1.043 \times (.602/(.602 + .084))) + (1.073 \times (.084/(.602 + .084))) = 1.047
\]
3. Quarterly and monthly indices.

A weighted quarterly index is then constructed by summing the products of the weights and quarterly component indices. This quarterly composite index is used to obtain monthly indices called the Florida ICF/IIDIID Cost Inflation Index by averaging pairs of quarterly indices and interpolating between these averages as follows:

<table>
<thead>
<tr>
<th>Quarter Midpoint</th>
<th>Quarter Index</th>
<th>Average Index</th>
<th>Corresponding Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>1984:1</td>
<td>1.029</td>
<td>1.032</td>
<td>March 31</td>
</tr>
<tr>
<td>1984:2</td>
<td>1.035</td>
<td>1.042</td>
<td>June 30</td>
</tr>
<tr>
<td>1984:3</td>
<td>1.048</td>
<td>1.054</td>
<td>September 30</td>
</tr>
<tr>
<td>1984:4</td>
<td>1.059</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

April 30 Index = \[(\text{June 30 Index}/\text{March 31 Index})^{1/3} \times (\text{March 31 Index})\]

= \[(1.042/1.032)^{1/3} \times 1.032\]

= 1.035

May 30 Index = \[(\text{June 30 Index}/\text{March 31 Index})^{2/3} \times (\text{March 31 Index})\]

= \[(1.042/1.032)^{2/3} \times 1.032\]

= 1.039

All other monthly indices can be calculated in a similar fashion.

4. Inflation Factors

The inflation factors used to set both target rates of inflation and prospective payment rates utilize 13 indices in order to recognize full inflation for a 12-month period. This is necessary because each index represents the relative level of costs at the end of the month, so that a complete 12-month inflation trend shall start with the index as of the last day of the month prior to the 12-month period.

Example: Calculation of target rate of inflation factor for provider with a June 30 fiscal year end.
average of inflation indices from
1984 Target factor = June 1983 through June 1984
average of inflation indices from
June 1982 through June 1983

\[
\frac{(0.994 + 0.999 + 1.004 + 1.009 + 1.014 + 1.018 + 1.023 + 1.026 + 1.029 + 1.032 + 1.035 + 1.039 + 1.042)}{13}
\frac{(0.950 + 0.954 + 0.958 + 0.962 + 0.966 + 0.971 + 0.975 + 0.979 + 0.982 + 0.986 + 0.989 + 0.992 + 0.994)}{13}
\]

= 1.035
= 1.047

In the example above, the indices for June 30, 1982, 0.994, and June 30, 1983, 0.950 are taken to represent the relative level of costs on July 1, the beginning of the fiscal year, and the end of the fiscal year, respectively. Hence, in order to measure the change in the relative level of costs for a fiscal year ending June 30, the 13 indices are used to capture a complete 12-month period.
## APPENDIX C

### Florida Medicaid Trend Adjustment Percentages

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Percentages</th>
<th>Reduction Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. October 1, 2008</td>
<td>0.8200%</td>
<td>$1,524,597</td>
</tr>
<tr>
<td>2. October 1, 2009</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Cut</td>
<td>0.7577%</td>
<td>$1,524,597</td>
</tr>
<tr>
<td>Second Cut</td>
<td>8.7004%</td>
<td>$17,373,303</td>
</tr>
<tr>
<td>3. April 1, 2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Cut</td>
<td>0.8145%</td>
<td>$1,524,597</td>
</tr>
<tr>
<td>Second Cut</td>
<td>9.3580%</td>
<td>$17,373,303</td>
</tr>
<tr>
<td>4. October 1, 2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Cut</td>
<td>0.7878%</td>
<td>$1,524,597</td>
</tr>
<tr>
<td>Second Cut</td>
<td>9.0489%</td>
<td>$17,373,303</td>
</tr>
<tr>
<td>5. April 1, 2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Cut</td>
<td>0.8539%</td>
<td>$1,524,597</td>
</tr>
<tr>
<td>Second Cut</td>
<td>9.8141%</td>
<td>$17,373,303</td>
</tr>
<tr>
<td>6. October 1, 2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Cut</td>
<td>0.8555%</td>
<td>$1,524,597</td>
</tr>
<tr>
<td>Second Cut</td>
<td>9.8325%</td>
<td>$17,373,303</td>
</tr>
<tr>
<td>Third Cut</td>
<td>3.9527%</td>
<td>$6,297,463</td>
</tr>
<tr>
<td>7. April 1, 2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Cut</td>
<td>0.4245%</td>
<td>$762,299</td>
</tr>
<tr>
<td>Second Cut</td>
<td>9.7180%</td>
<td>$17,373,303</td>
</tr>
<tr>
<td>Third Cut</td>
<td>3.0000%</td>
<td>$3,590,754</td>
</tr>
<tr>
<td>8. October 1, 2012</td>
<td></td>
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APPENDIX D

Upper Payment Limit Methodology

ICF/IID Upper Payment Limit (UPL) Methodology

The UPL is an estimation of the amount that would be paid under Medicare payment principles (the Medicare UPL) which is basis for the following UPL methodology:

Determine Medicare Cost Per Day

1. Utilizing cost and utilization data from ICF/IID cost reports for fiscal year 2013-2014 (the Medicare UPL base year)
2. Compute 112% of the weighted mean cost per patient day (the 112% amount).
3. The Weighted Mean Cost Per Day will be trended forward to state fiscal year 2013-2014 by applying a rate change equal to the CMS Nursing Home Price Index (Fourth Quarter Moving Average). The result is the estimated Medicare reimbursement cost per day for state fiscal year 2013-2014.
4. The Weighted Mean Cost Per Day will be trended forward to state fiscal year 2013-2014 by applying a rate change equal to the CMS Nursing Home Price Index (Fourth Quarter Moving Average). The result is the estimated Medicare reimbursement cost per day for state fiscal year 2013-2014.
5. Calculations for future fiscal years – 1) By trending the Weighted Mean Cost Per Day forward by the CMS Nursing Home Price Index or 2) A new Medicare UPL base year will be designated and a new Weighted Mean Cost Per Day will be trended forward.

Determine Medicare UPL Payment

1. To determine the Medicare UPL for each state fiscal year beginning with the base year. For this UPL demonstration, State Fiscal Year 2013-2014 is the base. A 2012 Weighted Mean Cost Per Day is calculated and trended. This figure is multiplied by the 2012 Medicaid days.

Determine Medicaid Payment
1. To determine the Florida Medicaid payment for each state fiscal year beginning with state fiscal year 2012-14, take the total actual paid amount from the Florida Medicaid Management Information System (FMMIS) for each ICF/IID Florida Medicaid provider.

**Determine UPL Difference in Payments**

1. The difference is determined by subtracting the Medicare UPL payment from the Florida Medicaid payment for each year.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF FLORIDA

DEFINITIONS OF A CLAIM

General

CLAIM means (1) a bill for services, (2) a line item of service, or (3) all services for one recipient within a bill.

CLEAN CLAIM means one that can be processed without obtaining additional information from the provider of service or from a third party.

INSTITUTIONAL CLAIM means a request for payment on a form or computer magnetic tape approved by the Department, received from an eligible institutional provider for approved services rendered to an eligible recipient for a procedure, a set of procedures or other approved services rendered for a given diagnosis or a set of related diagnoses. Institutional providers are those classified as nursing homes, ICF/MR's, inpatient hospitals, mental health (psychiatric) hospitals, and TB hospitals.

NONINSTITUTIONAL CLAIM means a request for payment, on a form or computer magnetic tape approved by the Department, received from an eligible noninstitutional provider for services rendered to an eligible recipient for a procedure, a set of procedures or other approved services rendered for a given diagnosis or set of related diagnoses. More than one claim may appear on certain ledger-type input forms; in this case, entries on the claim form represent separate claims, rather than line items. Reimbursement of the claim will be based upon the procedures utilized in rendering of the services by the provider. Noninstitutional providers are those who are physicians, dentists, optometrists, and/or opticians; or who provide hearing, home health care, independent laboratory and x-ray, transportation, medical supplies, screening (EPSDT), family planning services, and/or prescribed drugs.

Specific by Service

The definition of a claim for each service in Florida Medicaid is as follows:

INPATIENT HOSPITAL - A request for payment, on a form or computer magnetic tape approved by the Department, received from an eligible hospital provider for approved services rendered to an eligible recipient for procedure, a set of procedures or other approved
services rendered for a given diagnosis or a set of related diagnoses. All services for one recipient on a claim form. Each claim form is considered as one claim.

OUTPATIENT HOSPITAL - A request for payment, on a form or computer magnetic tape approved by the Department, received from an eligible hospital provider for approved services, rendered to an eligible recipient for a procedure, a set of procedures or other approved services rendered for a given diagnosis or a set related diagnoses. A line item of service for one recipient. Each line item on the claim form is considered a claim, except for those hospitals with an all inclusive, per-visitation rate wherein all services provided a recipient during the same visit will be considered one claim.

RURAL HEALTH CLINIC - A request for payment, on a form or computer magnetic tape approved by the Department, received from an eligible provider for furnishing primary care outpatient health services to an eligible recipient as an all-inclusive visit for a given diagnosis or set of related diagnoses. All services provided a recipient on the same day, at the same location, for the same diagnosis will be considered one claim. More than one request for payment showing different dates of service for the same individual may appear on the claim form and each entry on the claim form represents a separate claim. A line item of service for one recipient. Each line item on the claim form is considered a claim.

Other Ambulatory Services (if the clinic chooses to provide such services) - A request for payment, on a form or computer magnetic tape approved by the Department, received from an eligible provider for furnishing Family Planning, EPSDT, Drug or Transportation services. Claims submission will be in accordance with requirements for each individual program.

OTHER LABORATORY AND X-RAY - A request for payment, on a form or computer magnetic tape approved by the Department, received from an eligible independent laboratory or portable x-ray provider, for Department approved services rendered to an eligible recipient for a given diagnosis or set of related diagnoses. A line item of service for one recipient. Each line item on the claim form is considered a claim.

NURSING HOME - A request for payment on a form or computer magnetic tape approved by the Department, received from an eligible nursing home provider for approved services rendered to an eligible recipient for a specific level of care at the approved rate less recipient responsibility. A line item of service for one recipient. Each line item on the claim form is considered a claim.

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT SCREENING - A screening claim is a request for payment on a form or computer magnetic tape approved by the Department, received from an eligible screening provider for screening services rendered to an eligible recipient for Procedure Code 99300. Requests for payment can be
made for only one individual per claim form. All services for one recipient on a single claim form. All services listed on the claim form are considered one claim.

FAMILY PLANNING - A request for payment, on a form or computer magnetic tape approved by the Department, received from an eligible Family Planning provider, for approved services rendered to an eligible recipient. A line item of service(s) for each date of service. Because the reimbursement is all inclusive the description may include a notation of one or more services. A line item of service for a single recipient. Each line item on the claim form is considered a claim.

PHYSICIAN - A request for payment, on a form or computer magnetic tape approved by the Department, received from an eligible physician provider for approved services rendered to an eligible recipient for a procedure, a set of procedures or other approved services rendered for a given diagnosis or a set of related diagnoses. A line item of service for one recipient. Each item on the claim form is considered a claim.

OTHER PRACTITIONER - NURSE PRACTITIONER - A request for payment, on a form or computer magnetic tape approved by the Department, received from an eligible nurse practitioner provider for providing primary care health services to an eligible recipient. Each individual service is considered a claim even though several procedures may appear on a single claim form. Reimbursement of the claim will be based upon the procedures utilized in rendering the service. A line item of service for one recipient. Each item on the claim form is considered a claim.

HOME HEALTH - A request for payment on a form or computer magnetic tape approved by the Department, received from an eligible home health provider for approved services rendered to an eligible recipient rendered for a given diagnosis or set diagnoses. A line item of service for each date of service. A line item of service for a single recipient. Each line item on the claim form is considered a separate claim.

PRESCRIBED DRUGS - (Pharmaceutical Claim) - A request for payment, on a form or computer magnetic tape approved by the Department, received from an eligible prescribed drug services provider for dispensing a prescription to an eligible recipient. Each individual prescription is considered a claim even though several prescriptions may be included on a single claim form.

TUBERCULOSIS HOSPITAL AND INSTITUTIONS FOR MENTAL DISEASES - A request for payment on a form or computer magnetic tape approved by the Department, received from an eligible State Mental Health or State Tuberculosis Hospital provider, for approved services rendered to an eligible recipient for a specific level of care at the approved rate less recipient responsibility. A line item of service for one recipient. Each line item on the claim form is considered a claim.
ANSPORTATION - A request for payment, on a form or computer magnetic tape approved by the Department, received from an eligible provider for transportation services provided to an eligible recipient receiving a Medicaid-compensable service. Each individual trip is considered a claim, and when public transportation claim forms are used, several trips are included on a single claim form. All service for one recipient on a claim form. Each claim form is considered as one claim. Taxi - a line item of service. Each line on the claim form is considered a separate claim even though more than one recipient and/or different trips for the same recipient may be included on a single claim form.

INTERMEDIATE CARE FACILITY SERVICES FOR THE MENTALLY RETARDED (ICF/MR) - A request for payment on a form or computer magnetic tape approved by the Department, received from an eligible ICF/MR provider for approved services rendered to an eligible recipient for a specific level of care at the approved rate less recipient responsibility. A line item of service for one recipient. Each line item on the claim form is considered a claim.

DENTAL SERVICES - A request for payment, on a form or computer magnetic tape approved by the Department, received from an eligible dental provider for approved dental services rendered to an eligible recipient for a procedure. More than one claim may appear on certain ledger-type input forms; in this case entries on the claim form represent separate claims, rather than line items. Reimbursement of the claim will be based on the procedure code utilization rendering of the service by the provider. A line item of service for one recipient. Each line item on the claim form is considered a separate claim.

VISUAL SERVICES - A request for payment, on a form or computer magnetic tape approved by the Department, received from an eligible visual provider for approved visual services rendered to an eligible recipient for a procedure. More than one claim may appear on certain ledger-type input forms; in this case, entries on the claim form represent separate claims, rather than line items. Reimbursement of the claims will be based upon the procedures utilized in rendering of the services by the provider. A line item of service for one recipient. Each line item on the claim form is considered a separate claim.

HEARING SERVICES - A request for payment, on a form or computer magnetic tape approved by the Department, received from an eligible audiological provider for approved audiological services rendered to an eligible recipient for a procedure. More than one claim may appear on certain ledger-type input forms; in this case, entries on the claim form represent separate claims rather than line items. Reimbursement of the claim will be based upon the procedures utilized in rendering of the services by the provider. A line item of service for one recipient. Each line item on the claim form is considered a separate claim.
CROSSOVER (PART 3) - A line item of Medicare-covered service for one recipient. Each line item on the Medicare request for payment claim form is considered a separate claim.

CROSSOVER (PART A) - All Medicare covered services for one recipient on a claim form. All services on the Medicare request for payment claim form are considered one claim.
Conditions for Direct Payment for Physicians' and Dentists' Services

NOT APPLICABLE IN FLORIDA

July 19, 1978
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Florida

Requirements for Third Party Liability-
Identifying Liable Resources

Citation

433.138(f) 52 FR 5967

Those exchanges required by CFR 433.138(d)(1), (d)(3), and (d)(4) are conducted in the following manner:

433.138(d)(1)

State Wage Information Collection Agency (SWICA) data exchanges are conducted on all active beneficiaries, employed absent parents, and custodial parents after the initial benefit determination interview and on a quarterly basis thereafter. As a result, when Third Party Liability (TPL) is identified, the data is returned to the state during the following nightly cycle. The exchange is conducted by the Florida On-Line Recipient Data Access ("FLORIDA") system and reported to the Florida Medicaid Management Information System (FMMIS).

At the time an individual applies for benefits, the state requests wage and benefit data from the Social Security Administration. A response is received by the state in 3 to 5 days. Additionally, the Social Security Administration sends updates of wage and benefit data to the state, in daily transmissions, whenever changes occur to a beneficiary’s status.

The state targets cases which result in a discrepancy of $75 or more per quarter. A change in income indicates a potential change in employers which could lead to new sources of third party liability. Responses are posted in data exchange and reviews are scheduled for workers whenever the difference between the wage response and the budgeted amount is greater than $75 in a given quarter. Responses that are below the $75 threshold are targeted out (no review is scheduled). Only those targeted cases are posted for district worker action.

433.138(d)(3)

State eligibility workers are required to verify any additional income, resources or other third party resource information (IEVS) available from employers at the time of the initial benefit determination. Follow up data exchanges with the state IV-A agency are conducted on a quarterly basis.

TN No. 93-46
Supersedes
TN No. 91-17

Approval 5-12-94
Effective 7/1/93
Revised Submission 4/1/94
The Medicaid agency has entered into agreements with the Florida Department of Labor and Employment Security and the Department of Highway Safety and Motor Vehicles with respect to 42 CFR 433.138(d)(4).

Pursuant to the Interagency Agreement, the Medicaid agency conducts data matches at least annually with the Department of Highway Safety and Motor Vehicles to identify Medicaid recipients who received medical services as the result of a motor vehicle accident.

In addition, the Medicaid agency conducts data matches at least annually with the Department of Labor and Employment Security to identify Medicaid recipients who are injured in work related accidents.

The Medicaid agency's fiscal agent identifies claims paid with a diagnosis code 800.00 to 999.99 (ICD-9-CM Series) (except those identified by waiver), and reports the claims to the Third Party Liability office for follow up. The system checks for a "trauma diagnosis code" edit every time a provider claim is entered into the FMMIS. All claims meeting the selected criteria are reported weekly to the TPL office.

Information received as a result of data matches with SWICA and SSA wage and earnings files are followed up by IV-A eligibility workers within 45 days of the match when discrepancies with current information are identified.

Health insurance information received during initial application or redetermination processes for Medicaid eligibility is followed up on within 60 days of receipt of such information. Resulting third party resource information is incorporated into the eligibility case file and into the third party data base. As the information is received in the third party data base an insurance verification request is sent to the insurance company asking for policy information verification. Other insurance information is used immediately to cost avoid claims for companies that have chosen not to answer the policy information verification requests.
Information received as a result of data matches with the state's workers compensation records is followed up within 60 days of the match. Resulting hits are followed up by sending a notice and questionnaire to the appropriate insurance carrier.

**433.138(g)(3)(i) and (iii)**

52 FR 5967

Potential leads identified during the data match with the Department of Highway Safety and Motor Vehicles are followed up on within 60 days of receiving the information.

All recipient third party resource information is entered into the recipient's third party data file, along with the recipient's coverage information, within 30 days of discovery.

**433.138(g)(4)(i)-(iii)**

52 FR 5967

The Florida Medicaid Management Information System (FMMIS) produces a Trauma Leads Report on a weekly basis which identifies those recipients who have claims paid for all trauma diagnosis codes (except those identified by waiver). The agency sends each injured recipient identified a questionnaire when paid claims are in excess of $249.99. This is the threshold amount the agency uses in determining the cost effectiveness of seeking recovery from potentially liable third parties. These questionnaires are returned to third party staff who determine the existence of a liable third party. Cases are then opened and liable third parties or their legal representatives are notified of the State's rights in the matter.

The agency does not identify and follow up on certain trauma codes to the exclusion of other codes nor does it give priority to certain trauma codes over others. All trauma leads are investigated and followed up in the same manner as described above.

The recipient's third party resources are entered into the recipient's third party data file, along with the recipient's coverage information, within 30 days of discovery.

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TN No. 93-46  
Supersedes  
TN No. 91-17  

Approval 5-12-94  
Effective 7/1/93

 Revised Submission 4/1/94
Requirements for Third Party Liability—Payment for Claims

433.139(b)(3) (ii)(C) 55 FR 1423

Recipient third party liability information is sent to the Medicaid agency by IV-A and IV-D district workers. As a result of the information obtained, a claims cost avoidance system as outlined in 42 CFR 433.139 is utilized to determine provider compliance with billing instructions. An insurance coverage specific matrix determines the claims various categories of service which are or might be covered by the available third party resource.

All claim types pass through the TPL cost avoidance subsystem. However, in the following circumstances, post payment recovery is instituted rather than cost avoidance:

- Medical services provided for prenatal, labor and delivery, or post partum care, except for inpatient hospital claims;
- Medical services provided for preventive pediatric care, including early and periodic screening, diagnosis and treatment (EPSDT) examinations;
- Pharmacy services provided to recipients who are covered by any health insurance policy except a health maintenance organizations (HMO) coverage or a separate pharmacy card. Pharmacy services provided to these recipients are cost avoided.

Providers are instructed to bill third parties for medical services rendered to Medicaid recipients with coverage maintained by an absent parent whose obligation to pay support is being enforced by the state title IV-D agency. If the insurance carrier denies the claim, the provider must attach the denial to the claim before submitting to medicaid. If the insurer refuses or fails to respond to the claim within 30 days of the date of service, providers may submit bills to Medicaid provided the claim includes a certification statement from the provider that the provider waited 30 days and no response was received from the third party. The TPL office then pays the provider and chases the claim.

TN No. 93-46 Supersedes Approval 5-12-94 Effective 7/1/93
TN No. 92-19 Revised Submission 4/1/94
If a provider claim is received by the system without this documentation, the system rejects the claim, returns it to the provider and instructs the provider to bill the third party. Claims received which have an insurance carrier attachment, or the provider's certification that he has billed the third party, waited thirty days from the date of service and has not received a response from the insurance carrier, are reviewed by the Insurance Resource Section staff. That staff reviews the claim and attached provider certification or carrier Explanation of Benefits (EOB). Claims with carrier denials are processed and the provider's claim is paid. Claims with certification letters are "paid and chased" by the Insurance Resource Section staff.

433.139(f)(2) 50 FR 46652
The agency bills on a monthly basis all claims to insurance carriers regardless of the amount of the claim payment. No threshold amount or other guidelines are used in determining whether to seek reimbursement from a liable third party.

433.139(f)(3) 50 FR 46652
The agency does not accumulate billings with respect to a particular liable third party prior to billing. All bills, regardless of the amount of the claim are billed each month.

42 CFR 447.20 55 FR 1423
In the case of an individual who is eligible for medical assistance under the plan for services for which a third party is liable for payment, if the total amount of the established liability of the third party for the service is:

(a) equal to or greater than the amount payable under the state plan, the provider furnishing the service to the individual may not collect from the individual or any financially responsible relative or representative of that individual the payment amount for that service; or

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TN No. 93-46
Supersedes
TN No. 92-19

Approval 5-12-94
Effective 7/1/93
Revised Submission 4/1/94
(b) less than the amount payable under the state plan, including share of payments, the provider furnishing the service to the individual may collect from the individual or any financially responsible relative or representative of the individual an amount which is the lesser of:

(i) any cost sharing payment amount imposed upon the individual by the Medicaid agency; or

(ii) an amount which represents the difference between the amount payable under the state plan and the total of the established third party liability for the service.

Providers may not refuse to furnish services covered under the plan to an individual who is eligible to medical assistance under the plan on account of a third party's potential liability for the service.

433.145-.148

The requirements for assignment of rights and cooperation in establishing paternity and obtaining support under 433.146 through 433.148 are met.

As a condition of eligibility, each legally able applicant and recipient must assign their rights to medical support or other third party payments to the Medicaid agency and cooperate with the agency in obtaining medical support or payments.

In addition, Florida law provides that the recipient is deemed to have assigned their rights to third party payments to the Medicaid agency.

433.151-.154

Pursuant to Medicaid Program Issuance Transmittal Notice MCD-67-92, July 8, 1992, the Medicaid agency has chosen the option to terminate the cooperative agreement with the IV-D agency.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: FLORIDA

Requirements for Enrollment in 
Employer Based Group Health Insurance

Enrollment in employer-sponsored health care coverage, if available and cost effective is a condition of eligibility for the recipient.

A. Cost Effectiveness

1. Enrollment in employer-sponsored health care coverage shall be considered cost effective when the amount of financial assistance provided for the recipient to pay the employee share of the employer-sponsored health care coverage does not exceed the amount of the Medicaid premium that would have been paid to a managed care plan for the recipient.

2. When determining cost effectiveness of employer-sponsored health care coverage, the Agency shall consider the following:

   a. The cost of the Medicaid premium that would have been paid to a managed care plan for the recipient.

   b. The employee share of the employer-sponsored health care coverage, including copayments and deductibles that the State may reimburse.

3. The employer-sponsored health care coverage shall be treated as a third party resource in accordance with federal third party liability requirements. When recipients are enrolled in employer-sponsored health care coverage, this coverage shall become the first source of health care benefits up to the limits of such coverage, prior to the availability of Title XIX benefits.

SPA TN: 2011-004
Effective: July 1, 2011
Supersedes: NEW
Approval Date: 9/30/11
4. If Medicaid services covered under the State plan are not part of the services covered by a recipient’s employer-sponsored health care coverage, the recipient may obtain those services from participating Medicaid providers. These services are reimbursed at the State Medicaid rate.

5. The Agency shall pay all premiums, deductibles, coinsurance and other cost sharing obligations for items and Medicaid services covered under the State plan up to Medicaid’s rate for recipients in employer-sponsored health care coverage, except for the cost sharing amounts permitted under the State plan which are the recipient’s responsibility.

B. Cost Effectiveness Review

1. The Agency shall complete a cost effectiveness review at least once every six (6) months.

2. The Agency shall perform a cost effectiveness redetermination if:

   a. The employee share of the employer-sponsored health care coverage changes;

   b. Any of the individuals covered under the employer-sponsored health care coverage lose Medicaid eligibility; or

   c. There is loss of employment.

C. Coverage of Non-Medicaid Family Members

The Agency shall pay the employee share of the employer-sponsored health care coverage when cost-effective regardless of whether all family members are Medicaid eligible. The Agency shall not pay a deductible, coinsurance, or other cost-sharing obligation, or provide for payment of services covered under the State Plan but not covered by the plan on behalf of a participating family member who is not Medicaid eligible.

SPA TN: 2011-004
Effective: July 1, 2011
Supersedes: NEW
Approval Date: 9/20/11
### Sanctions for Psychiatric Hospitals

<table>
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<th>Citation</th>
<th>Sanctions</th>
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<td>1902(y)(1), 1902(y)(2)(A), and Section 1902(y)(3) of the Act (P.L. 101-508, Section 4755(a)(2))</td>
<td>(a) The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.</td>
</tr>
<tr>
<td>1902(y)(1)(A) of the Act</td>
<td>(b) The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.</td>
</tr>
<tr>
<td>1902(y)(1)(B) of the Act</td>
<td>(c) When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may:</td>
</tr>
<tr>
<td>1902(y)(2)(A) of the Act</td>
<td>(d) When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.</td>
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**Approval Date:** JAN 06 1993  
**Effective Date:** 10/1/92
Sanctions for MCOs and PCCMs

(a) The State will maintain a monitoring plan and will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below:

For each executed state Medicaid HMO contract with an MCO, the actions of the MCO will be monitored as specified in the State Monitoring Plan through on-site surveys, state desk reviews, enrollee and other complaints, financial status reports, and other sources as required by the state and at time intervals as specified in the contract. In accordance with the contract and the monitoring plan, monthly, quarterly, annual and biannual monitoring will be conducted to ensure that the contract is performed according to contract terms.

(b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management: Temporary management is imposed only if the state finds (through on-site survey, enrollee complaints, financial audits, or any other means) the following:

There is continuous egregious behavior by the MCO, including but not limited to behavior that is described in 42 CFR 438.700, or that is contrary to any requirements of sections 1903(m) or 1932 of the Social Security Act; or

There is substantial risk to the enrollee’s health; or

The sanction is necessary to ensure the health of the MCO’s enrollees while improvements are made to remedy violations under 42 CFR 438.700; or until there is an orderly termination and reorganization of the MCO.

(c) The State’s contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e).

Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.
STATE PLAN UNDER TITLE XII OF THE SOCIAL SECURITY ACT

State: FLORIDA

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
REQUESTS TO OTHER STATE AGENCIES

The following matches of information will be made with the agencies shown for applicants/recipient utilizing the Income and Eligibility Verification System:

(1) Wage data from the State Wage and Income Collection Agency:
   (a) Applicant: Required to submit SSN at time of application.
   (b) Recipient: Required to submit SSN quarterly.

(2) Unemployment Compensation Benefits (UCB) from Department of Labor and Employment Security (DLES).
   (a) Applicant: IEVS requires that the applicant matches against UCB continue for an additional three months if there is no match with the UCB recipient file.
   (b) Recipient: Requires SSN for recipients reporting a loss of employment to be submitted for three months if there is no match on the UCB recipient file. UCB recipients would continue to be submitted monthly until UCB is exhausted.

(3) Beneficiary and Earning Data Exchange System (BENDEX) from the SSA.
   (a) Applicant: Requires submission of SSN at time of application.
   (b) Recipient: Requires submission of any recipient's SSN that has not been added previously.

(4) Beneficiary and Earnings Exchange Record (BEERS) from the Social Security Administration. Any recipient who was added to the BENDEX file with income has wage information on the BEERS file. Any income to BEERS updates will be reported to the state for recipients of the Economic Services programs. This would provide wage data on recipients working in other states.
   (a) Applicant: Requires submission of SSN at time of application.
   (b) Recipient: Requires submission of any recipient's SSN that has not been added previously.
(5) Number Identification Database (NUMIDENT) from the Social Security Administration.

(a) Applicant: Must submit SSN for validation.

(b) Recipient: Must submit SSN for validation if not previously submitted. Any multiple SSN's discovered from the match will be processed through wage match and any discrepancies will be resolved. Validated SSN's will be identified in our current eligibility system to prevent resubmission at a later date.

(6) Unearned income data from the Internal Revenue Service 1099 data files.

(a) Applicant: Required to submit at time of application.

(b) Recipient: Required to submit annually after July IRS update. Information received from the above matches are required to be reviewed and case action taken within 30 days of receipt.
METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS TO HOMELESS INDIVIDUALS

Medicaid identification cards will be sent to a mailing address provided by the recipient or to a United States post office for general delivery purposes if the recipient does not provide a mailing address.

Florida is a 1634 state. The mailing address provided by the Social Security Administration through the SDX will be used to determine where the Medicaid identification card for Supplemental Security Income recipients will be mailed.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: FLORIDA

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives. If applicable, States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

The Life Prolonging Procedure Act, Chapter 765, Florida Statutes (F.S.) recognizes the right of a competent adult to make an oral or written declaration instructing his physician to provide, withhold, or withdraw life-prolonging procedures; or to designate another to make the treatment decision for him if he is suffering from a terminal condition. A written declaration must be signed by the declarant in the presence of two subscribing witnesses, one of whom is neither a spouse or blood relative. If the declarant is physically unable to sign the written declaration, his declaration may be given orally, in which event one of the witnesses must subscribe the declarant's signature in the declarant's presence and at the declarant's direction. It is the responsibility of the declarant to provide for notification to his attending physician that the declaration has been made. If the declarant is mentally or physically incapable, any other person may notify the physician of the existence of the declaration. A declaration may be revoked at any time by the declarant.

The Health Care Surrogate Act, Chapter 745, F.S., provides that any competent adult may designate a person to serve as a health care surrogate to make health care decisions for him and to provide informed consent if he is incapable. A person designated a health care surrogate shall be notified of such designation and shall indicate his consent by providing a signed statement accepting the designation. The designation must be in writing and signed by the person in the presence of two attesting witnesses, one of whom must not be his spouse, a blood relative, an heir to his estate, or responsible for paying his health care costs. An individual may not serve as a health care surrogate if he is (1) the treating health care provider or an employee or relative of the treating health care provider; (2) the operator or an employee of the health care facility in which the patient resides or a relative of such operator or employee; (3) the guardian of the property of the person, but not the guardian of the person. The health care facility must ascertain at the time of admission if the individual has designated a health care surrogate.
REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE (Continued)

Durable Power of Attorney, Chapter 709.08 F.S., provides that an individual may create a durable power of attorney designating a person as his attorney in fact by executing a power of attorney. The power of attorney may include the authority of the attorney to arrange for and consent to medical, therapeutic, and surgical procedures. Such power of attorney shall be in writing, shall state the relationship of the parties, and shall include the words, "This durable power of attorney shall not be affected by disability of the principal except as provided by statute," or similar words clearly showing the intent of the principal that the power conferred on the attorney shall be exercisable from the date specified in the instrument, notwithstanding a later disability or incapacity of the principal, unless otherwise provided by statute.

Court Appointed Guardianship, Chapter 744, F.S., establishes a system that permits incapacitated persons to participate as fully as possible in all decisions affecting them. It assists such person in meeting the essential requirement for their physical health and safety, in protecting their rights, in managing their financial resources, and in developing or regaining their abilities to the maximum extent possible. It accomplishes these objectives through providing, in each case, the form of assistance that least interferes with the legal capacity of a person to act in his own behalf.

Constitutional Right of Privacy -- In Re: Guardianship of Estelle Browning, Florida Supreme Court, 1990 upheld an individual's right to privacy to decide to accept or reject medical care, whether designated in writing or orally.

The State requires providers to provide the attached "Statement of Advance Directive or Living Wills" to adults who are being admitted to health care facilities. Providers may also provide the attached "Additional Information on Advance Directives."

State law does not allow for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.
STATEMENT OF ADVANCED DIRECTIVE OR LIVING WILLS

The following is provided to inform you about Florida law regarding "advanced directives" or "living wills."

Under Florida law (see note below), every adult has the right to make certain decisions concerning his or her medical treatment. The law also allows for your rights and personal wishes to be respected even if you are too sick to make decisions yourself.

You have the right, under certain conditions, to decide whether to accept or reject medical treatment, including whether to continue medical treatment and other procedures that would prolong your life artificially.

These rights may be spelled out by you in a "living will," containing your personal directions about life-prolonging treatment in the case of serious illness that could cause death.

You may also designate another person, or surrogate, who may make decisions for you if you become mentally or physically unable to do so. This surrogate may function on your behalf for a brief time or longer, for a life-threatening or a non-life-threatening illness.

Any limits to the power of the surrogate in making decisions for you should be clearly expressed.

Your health care provider will furnish you written information about its policy regarding advanced directives.

NOTE: The legal basis for these rights can be found in the Florida Statutes: Life-Prolonging Procedure Act, Chapter 765; Health Care Surrogate Act, Chapter 745; Durable Power of-Attorney Section 709.08; and Court Appointed Guardianship, Chapter 744; and in the Florida Supreme Court decision on the constitutional right of privacy, Guardianship of Estelle Browning, 1990.

TN No. 91-48 Supersedes Approval Date 1-28-92 Effective 12/1/91
ADDITIONAL INFORMATION ON ADVANCE DIRECTIVES

Accident or illness can take away a person’s ability to make health care decisions. But decisions still have to be made. If you cannot do so, someone else will; and sometimes this causes the burden, delay and expense of court proceedings. You should consider whether you want to take steps now to control these decisions so that they will reflect your own wishes.

LIVING WILLS

A Living Will (or Declaration) is a statement of your wishes regarding the use of life-prolonging treatment if you are in a terminal condition. (A “Living Will” is different from the Will which disposes of your property after your death.)

Generally, a “Living Will” is a statement that you desire to be allowed to die and not be kept alive by medical treatment when your doctors conclude that you are no longer able to decide matters for yourself and that your condition is terminal. If you would not want to be kept alive by use of a feeding tube or other artificial means of providing food and water, specifically state this.

SURROGATE DESIGNATION

If you are too sick to make decisions, close family members or a close friend usually will decide with the doctor and nurses what is best for you. And most of the time that works. But sometimes everyone doesn’t agree about what to do, even if you have made a Living Will. One way to help ensure that your wishes will be honored is to name someone you trust who will make medical decisions for you. You may name this person in a Living Will (or Declaration), in which case such person makes only those medical decisions related to serious illness that could cause death.

If you want to name someone you trust to make all other medical decisions for you when you are too sick to do so yourself, you may wish to put this in writing. Remember, if you want this person to also make decisions about the use of machines and medical treatment that might delay your death when you are hopelessly ill, name the same person in your Living Will.

It is advisable to name a replacement in case the person you have chosen to make decisions for you becomes unable or unwilling to do so.

If you decide to make a Living Will or other advance directive, it is recommended that you give a copy to your doctor, your closest relative or friend and any hospital, nursing home or other facility where you are receiving treatment or care. If you change your mind, make sure that you so advise all those to whom you have given copies.

A Living Will in no way affects life insurance. Also, it cannot be required as a condition for being insured for, or receiving, health care services. Any medical treatment that is used for the purpose of providing comfort care or to alleviate pain will be continued.

A summary like this cannot answer all of your questions or cover every circumstance. If you have questions about your particular legal situation, please talk to a lawyer. Also talk to your health care provider about the medical issues. Let those who will be caring for you know what you have decided.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: FLORIDA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at Section 488.404(b)(1):

CRITERIA FOR THE APPLICATION OF SPECIFIED REMEDIES FOR NURSING FACILITIES (When and how each remedy is applied, the amounts of any fines, and the severity of the remedies)

Denial of Payment for New Admissions - An immediate moratorium on admissions is imposed by the agency when it is determined that any condition in the facility presents a threat to the health, safety, or welfare of the residents in the facility.

Closure/Transfer - State law allows the department to deny or revoke a state license when a licensee:

o Intentionally or negligently acts to affect resident safety.
o Misappropriates a resident's property.
 o Violates any standards, rules or regulations.
 o Commits an act that constitutes grounds for license denial.

TN No. 95-10
Supersedes
TN No. 90-16

Approval Date 7-30-96
Effective 7/1/95

Revised Submission 4/24/96
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: FLORIDA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Supersedes
Approval Date: 7-30-96
Effective Date: 7/1/95
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at Section 1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

TN No. 95-10 Supersedes . Approval Date 7-30-96 Effective 7/1/95
TN No. NEW Revised Submission 4/24/96
Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at Section 1919(h)(2)(A)) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

ALTERNATIVE REMEDY: Moratorium on Admissions:

The Medicaid agency established a Moratorium on Admissions in place of Denial of Payment for New Admissions. Description: A moratorium on admissions is a ban placed by the Agency prohibiting the facility from admitting any new residents, regardless of the source of payment.

General Requirements/Assurances:

- The Medicaid agency will use the timing and notice requirements specified in the regulation for Denial of Payment for New Admissions.
- The alternative remedy satisfies the statutory intent of the specified remedy. By placing a ban on new admissions, the facility is prevented from obtaining reimbursement for new admissions.
- The alternative remedy will be applied whenever Denial of Payment is the specified remedy.
- The alternative remedy is as effective as the specified remedy because the outcome is the same, i.e., the facility receives no reimbursement for new admissions.
- Factors considered in selecting the remedy are those specified in the regulation for Denial of Payment for New Admissions.
- The remedy is established in State law at s.400.121(4)(a) and (b), Florida Statutes.
- The State's categorization of deficiencies results in the same scope and harm assignment.

TN No. 95-10 Supersedes Approval Date 7-30-96 Effective 7/1/95
TN No. NEW
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

Supersedes Approval Date: 7-30-96 Effective Date: 7/1/95
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

_____ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

TH No. 95-10
Supersedes
TH No. NEW

Approval Date: 7-30-96
Effective Date: 7/1/95
Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy:

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

TN No. 95-10
Supersedes Approval Date: 7-30-96
TN No. NEW Effective Date: 7/1/95
Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

DISCLOSURE OR ADDITIONAL REGISTRY INFORMATION

To comply with OBRA 87 requirements the following procedure is followed:

Beginning October 1, 1990, all nursing homes must screen applicants for certified nursing assistant employment with the district screening unit of the Florida Protective Services System and the Nurse Aide Registry at the Department of Education. Nurse aides hired between October 1, 1990 and the present must be screened through the abuse registry.

Nursing homes which hire CNAs from other agencies or registries which are licensed under Chapter 400, Part III, F.S., (Home Health Agencies), must verify that the CNA was screened and cleared pursuant to Chapter 10D-68, F.A.C., before employing the CNA.

Upon completion of the abuse registry check, the district screening unit will forward the results of the screening to the nursing home.

For applicants who are "cleared", the nursing home will be advised by letter from the district screening coordinator. For applicants who have a confirmed report of abuse, neglect or exploitation, the district screening coordinator will advise both the nursing home and the Office of Licensure and Certification liaison.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

COLLECTION OF ADDITIONAL REGISTRY INFORMATION

TN No. 92-02  
Supersedes TN No. NEW

Approval Date 6/9/92  
Effective Date 1/1/92

HCFA ID:
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

DEFINITION OF SPECIALIZED SERVICES

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TN No. 93-14
Supersedes Approval Date JUN 2 3 1993 Effective Date 1/1/93
TN No. NEW
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State FLORIDA

CATEGORICAL DETERMINATIONS

The following are advance determinations by category which recognize that certain diagnoses, levels of severity of illness, or need for a particular service clearly indicate that admission to or residence in a nursing facility services are normally needed. One of the following advance determinations may be applied to individuals following the Level I only when existing data on the person are current, accurate, and sufficient to easily determine that the person fits into the category:

1. The individual is not a danger to self or others and is certified by a physician to be terminally ill (the prognosis of life expectancy is six months or less), requires continuous nursing care and/or medical supervision and treatment, or

2. The individual is not a danger to self or others and is comatose or ventilator dependent, functions at the brain stem level, has a diagnosis of chronic obstructive pulmonary disease, Huntington’s disease, severe Parkinson’s disease, amyotrophic lateral sclerosis, congestive heart failure, or any other diagnosis that results in a level of impairment so severe that the individual can no longer be expected to benefit from specialized services, or

3. The individual is not a danger to self or others and is admitted from home within 5 days following a hospitalization resulting from an acute illness for which continued convalescent care is required. The attending physician must certify, prior to the nursing facility admission, that the impending stay is likely to be less than 30 days.

An individualized Level II for specialized services is required for all categories except the following time-limited provisional categories:

4. The individual is not a danger to self or others, and needs a provisional admission of up to seven days pending further assessment in the case of delirium where an accurate diagnosis cannot be made until the delirium clears, or

5. The individual is not a danger to self or others, and needs a provisional admission of up to seven days pending further assessment in an emergency situation requiring protective services, with placement in a nursing facility not to exceed seven days, or

6. The individual is not a danger to self or others and needs a very brief and finite stay up to 14 days twice a year to provide respite care to in-home caregivers to whom the individual with mental illness or mental retardation is expected to return.

TN No. 2001-19
Supersedes TN No. 93-14 Approval 8-9-03
Effective 10/1/01
The State has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

The state agency participates with the major provider associations in conducting workshops and information sessions at several locations (usually 6) around the state. These sessions offer the providers, resident representatives, and advocates the opportunity to receive up to date information on regulations, survey criteria, and policies. The participation by providers and resident representatives produces a valuable exchange of ideas and perspectives.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: FLORIDA
ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review, and investigation of allegations of neglect, abuse, and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the nursing facility to provide services to residents.

Complaints may originate from a variety of sources, including anonymous telephone calls and letters from complainants that are received at the Central Complaint Unit under the Office of External Affairs, Consumer Services; referrals from the Division of Health Quality Assurance Area Offices; referrals from other governmental agencies; referrals from HCFA. Complaints are reviewed, logged, and tracked through the centralized complaint unit. Complaints, including misappropriation of residents property, are assigned to the respective Division of Health Quality Assurance Area Office for investigation. Upon the Area Office receipt of a complaint from the Central Complaint Unit, a surveyor is assigned to conduct an unannounced investigation of the complaint. An investigative report of findings is completed and forwarded to the Central Complaint Unit. The Central Complaint Unit staff review the report for compliance with state and federal reporting requirements. Data for certified facilities are entered into the federal data system. In the event a facility is cited for a violation of regulations, a follow-up visit will be conducted to ascertain that the signed plan of correction is carried out.

As required under Chapter 415, Florida Statutes, Adult Protective Services Act, allegations that allege abuse, neglect, or exploitation are referred to the Florida Protective Services System. Protective Services staff respond to allegations of abuse and neglect within 24 hours of receipt of the complaint. However, staff respond immediately, e. g., to allegations of severe physical abuse of a life threatening manner, sexual abuse that occurred within the last 72 hours, or if the perpetrator of sexual abuse is still at the facility. The investigative process provides ample time for the alleged person to respond to allegations or protest findings through an administrative hearing.

TN No. 92-51
Supersedes
TN No. NEW

Effective Date 10/1/92
Approval Date JUN 2 4 1993
Revised Submission 6/2/93
When a report is closed as proposed confirmed, the alleged perpetrator is sent a certified letter informing him of this classification and explaining his rights of appeal and review. If the alleged perpetrator believes that an error has been made, or he feels that he is not responsible for the abuse, neglect, or exploitation described in the report, he may:

* submit a statement or rebuttal letter explaining the incident and why he believes the report is in error. This statement or rebuttal letter is not the same as a request to amend or expunge the report but will be placed in the file to become part of the record; or

* request, within 60 days of receipt of the notification letter, that the department amend or expunge the report.

The department has 30 days from receipt of the request to conduct a review of the investigation and act on the alleged perpetrator’s request to amend or expunge the report. The alleged perpetrator is notified by mail of the department’s decision.

If the department fails to act within the 30 days allowed, or denies the request for amendment or expunction, the alleged perpetrator then has 30 days to request an administrative hearing. The request for an administrative hearing is accomplished by filing a petition.

The hearing officer recommends that the department either amend or expunge the report or reclassify the report as confirmed. A final order informing the alleged perpetrator of any changes made to the report as a result of the hearing is then issued.

If the alleged perpetrator receives the classification letter and then does nothing, his right to appeal the classification of the report is barred and the report is automatically classified as confirmed. This means that the alleged perpetrator does not contest the department’s right to maintain the report findings as stated, including the alleged perpetrator’s identification as a perpetrator. A perpetrator in a confirmed report of abuse, neglect, or exploitation may be disqualified from working in certain positions of trust, including working with children, disabled adults, or aged persons.
In accordance with the provisions of Chapter 415, Florida Statutes, if the certificate of a nurse aide is suspended as a result of abused, neglected, or misappropriation of the property of a resident, the aide is notified in writing and the name of that individual is submitted to the Department of Education for appropriate action. Pursuant to section 400.211, Florida Statutes, the Department of Education notes that on the nurse aide registry. The names of other individuals whose licenses have been suspended as a result of abused, neglected, or misappropriation of a resident's property are submitted to the appropriate licensure authority such as the Department of Professional Regulation.
The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

Area offices establish schedules for surveys which will permit the team to conduct the review within the 9 to 15 month window (with a 12 month statewide average) established by the Health Care Financing Administration for such surveys. Survey staff in the area offices are instructed that schedule information is not to be provided to facility staff and additionally are advised that a 5 day suspension will be imposed on any employee who is found to have disclosed schedule information.

TN No. 92-51
Supersedes
TN No. NEW

Effective Date 10/1/92
Approval Date JUL 24 1993
Revised Submission 6/2/93
The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

The survey results are entered into the federal data system which permits a data recapitulation for the purpose of identifying areas in which major discrepancies occur. Results from this analysis may be incorporated into the curriculum for the area office inservice training. Area survey staff also receive HCFA transmittal letters, state agency policy clarifications related to issues raised in the field, federal regional training based on OBRA requirements, and training based on the federal Surveyor Minimum Qualifications Test (SMQT). All of these inservice training activities build on the Basic Surveyor Training by HCFA which is attended by all survey staff to insure that basic information and approaches to the survey task are consistent. Statewide surveyor training emphasizes consistency in the identification and description of survey issues.
The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

In the event that a facility is investigated for a complaint and found to have a situation that warrants on-site monitoring, the area office of the Office of Licensure and Certification (Agency for Health Care Administration) is assigned responsibility for monitoring. This monitoring is done in a coordinated effort with assistance from other state agencies and ombudsman councils.
Employee Education About False Claims Recovery

Initial Compliance

The State will provide notification of the requirements of the Act to entities identified to have met the stated threshold via Certified US Mail no later than April 30, 2007, which will include notice that the State will incorporate compliance assessments into routine and targeted random onsite visits beginning June 1, 2007.

Ongoing Compliance

The State will incorporate reference to the Act in the provider enrollment agreement of new applicants approved to become Medicaid providers and upon reenrollment of entities currently active in the Medicaid Program who meet the stated threshold, which occurs every two years. Additionally, reference to the Act will be incorporated into managed care contracts via amendment no later than June 1, 2007.

Ongoing compliance assessments will occur through routine random onsite visits and/or surveys.

TN No. 07-004
Supersedes
TN No. NEW

Approval Date: 04/30/07
Effective Date: 01/01/07
NONDISCRIMINATION

METHODS OF ADMINISTRATION

Current methods of administration under civil rights requirements are on file in the Department of Health, Education, and Welfare Civil Rights Regional office.