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State/Territory Name: Florida

State Plan Amendment (SPA) #: 18-0006

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

November 21, 2018

Ms. Beth Kidder
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

RE: Title XIX State Plan Amendment, FL 18-0006

Dear Ms. Kidder:

We have reviewed the proposed State Plan Amendment, FL 18-0006, which was submitted to the Atlanta Regional Office on September 27, 2018 with the a stated purpose to update the Enhanced Ambulatory Patient Group (EAPG) reimbursement rates for hospital outpatient services to the Title XIX Outpatient Hospital Reimbursement Plan effective July 1, 2018.

Based on the information provided, the Medicaid State Plan Amendment FL 18-0006 was approved on November 21, 2018. The effective date of this amendment is July 1, 2018. We are enclosing the approved HCFA-179 and the plan pages.

If you have any additional questions or need further assistance, please contact Sid Staton at (850) 878-3486 or Sidney.Staton@cms.hhs.gov.

Sincerely,

/s/

Shantrina D. Roberts, MSN
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

| | | | |
|---|--|---|---------------------|
| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION | | 1. TRANSMITTAL NUMBER: 2018-006 | 2. STATE Florida |
| | | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | |
| TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES | | 4. PROPOSED EFFECTIVE DATE July 1, 2018 | |
| 5. TYPE OF PLAN MATERIAL (<i>Check One</i>): | | | |
| <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT | | | |
| COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>) | | | |
| 6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447 | | 7. FEDERAL BUDGET IMPACT: (in thousands) FFY 2017-2018 \$(305) FFY 2018-2019 \$(915) | |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B Exhibit I | | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 4.19-B Exhibit I | |
| 10. SUBJECT OF AMENDMENT: To update the reimbursement rates for services in Outpatient Hospitals. | | | |
| 11. GOVERNOR'S REVIEW (<i>Check One</i>): | | | |
| <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL | | <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Reviewed by the Deputy Secretary for Medicaid who is the Governor's designee. | |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL: /s/ | | 16. RETURN TO: Ms. Beth Kidder Deputy Secretary for Medicaid Agency for Health Care Administration 2727 Mahan Drive, Mail Stop #8 Tallahassee, FL 32308 Attention: Rules Unit | |
| 13. TYPED NAME: Ms. Beth Kidder | | | |
| 14. TITLE: Deputy Secretary for Medicaid | | | |
| 15. DATE SUBMITTED: 09/27/2018 | | | |
| FOR REGIONAL OFFICE USE ONLY | | | |
| 17. DATE RECEIVED: 09/27/2018 | | 18. DATE APPROVED: 11/21/2018 | |
| PLAN APPROVED – ONE COPY ATTACHED | | | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/2018 | | 20. SIGNATURE OF REGIONAL OFFICIAL: /s/ | |
| 21. TYPED NAME: Shantrina D. Roberts | | 22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health Operations | |
| 23. REMARKS: | | | |

**FLORIDA TITLE XIX OUTPATIENT HOSPITAL
REIMBURSEMENT PLAN
VERSION XXIX**

EFFECTIVE DATE: July 1, 2018

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

Amendment: 2018-006
Effective Date: July 1, 2018
Supersedes: 2017-008
Approval Date: November 21, 2018

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

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 State Fiscal Year (SFY) 2018-2019.

C. Hospital Base Rate

1. One standardized EAPG hospital base rate is calculated using historical claims data.
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 rate and projected changes in hospital Medicaid outpatient reimbursement are calculated using historical claims data from a period, referred to as the “baseperiod”. Claim data from the base period is used to simulate future outpatient Medicaid claim payments for the purpose of setting the EAPG base rates and other EAPG payment parameters. The claim payments from the base period may be adjusted for Medicaid volume, inflation, changes in

payment method, and other program changes as applicable so that the base period data approximates the upcoming rate year as closely as possible.

4. Because most Florida Medicaid recipients are enrolled in statewide Medicaid managed care, the base period historical claims dataset includes claims from both the fee-for-service and managed care programs.
5. For SFY 2018-2019, base historical claims used to calculate the EAPG base rate had a claim header level first date of service between July 1, 2017 and February 1, 2018 and included only claims reimbursed through the EAPG payment methodology. Use of this dataset with less than 12-month volume removed the need to make adjustments for changes in billing practices from the pre-EAPG payment method to the EAPG payment method.
6. For SFY 2018-2019 rates, budget neutrality is determined by applying average Medicaid fee-for-service payment per hospital outpatient visit in SFY 2016-2017 to the claims in the base period dataset.
7. The SFY 2018-2019 EAPG hospital base rate is calculated to maintain this average Medicaid payment per hospital outpatient visit.
8. The hospital EAPG base rates are available on the AHCA website at http://ahca.myflorida.com/medicaid/cost_reim/hospital_rates.shtml.

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 outpatient automatic rate enhancements, a per-payable-service-line payment amount is calculated by dividing the full, annual allotment by the annualized number of Medicaid outpatient payable service lines in the base period for both the fee-for-service and managed care programs. Because the base dataset for SFY 2018-2019 claims contains less than 12-months of volume, each hospital's SFY 2018-2019 allotment was reduced proportionately to the size of the base dataset before calculating the per-service-line amount.
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 SFY 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:

$$\text{EAPG Payment} = \text{Hospital Base Rate} * \text{EAPG Relative Weight} * \text{Policy Adjustor} \\ * \text{Payment Adjustment Factor}$$

- 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 SFY and will coincide with a recalculation of hospital base rates and EAPG policy adjusters. 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. A new hospital base rate is calculated annually based on the most currently available historical claim data and becomes effective at the beginning of each SFY. If required by the State Legislature, a reconciliation will be performed based on actual experience to establish new base rates effective on April 1 of the rate SFY to achieve budget neutrality
3. The annual allocation of automatic rate enhancements is reset each year and becomes effective at the beginning of each SFY.
4. Per-payable-service automatic rate enhancement amounts are re-calculated and become effective at the beginning of the SFY. 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 adjusters are calculated annually and become effective at the beginning of each SFY.

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
 - $[\text{Medicaid allowed amount}] \text{ minus } [\text{Medicare payment amount}]$.

- 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**

| <u>CODE</u> | <u>DESCRIPTION</u> |
|-------------|---|
| 250 | Pharmacy/General |
| 251 | Pharmacy/Generic |
| 252 | Pharmacy/NonGeneric |
| 254 | Drugs Incident to Other Diagnostic Services |
| 255 | Drugs Incident to Radiology |
| 258 | Pharmacy/IV Solutions |
| 259 | Other Pharmacy |
| 260 | IV Therapy |
| 261 | Infusion Pump |
| 262* | IV Therapy/Pharmacy Services |
| 264* | IV Therapy/Supplies |
| 269* | Other IV Therapy |
| 270 | General Classification |
| 271 | Medical Surgical- Nonsterile supplies |
| 272 | Medical/Surgical - Sterile Supplies |
| 273* | Burn Pressure Garment |
| 275 | Pacemaker |
| 276* | Intraocular Lens |
| 278 | Subdermal Contraceptive Implant |
| 279* | Burn Pressure Garment Fitting |
| 300 | Laboratory/General |
| 301 | Laboratory/Chemistry |
| 302 | Laboratory/Immunology |
| 304 | Laboratory/Non-Routine Dialysis |
| 305 | Laboratory/Hematology |
| 306 | Laboratory/Bacteriology and Microbiology |
| 307 | Laboratory/Urology |
| 310 | Pathological Laboratory/General |
| 311 | Pathological Laboratory/Cytology |
| 312 | Pathological Laboratory/Histology |
| 314 | Pathological Laboratory/Biopsy |
| 320 | Diagnostic Radiology/General |
| 321 | Diagnostic Radiology/Angiocardiology |
| 322 | Diagnostic Radiology/Arthrography |
| 323 | Diagnostic Radiology/Arteriography |
| 324 | Diagnostic Radiology/Chest |
| 329 | Other Radiology Diagnostic |
| 330* | Therapeutic Radiology/General |
| 331* | Therapeutic Radiology/Injected |
| 332* | Therapeutic Radiology/Oral |
| 333* | Therapeutic Radiology/Radiation Therapy |
| 335* | Therapeutic Radiology/Chemotherapy - IV |
| 339* | Other Radiology Therapeutic |

| | |
|------|--|
| 340 | Nuclear Medicine/General |
| 341 | Nuclear Medicine/Diagnostic |
| 342 | Nuclear Medicine/Therapeutic |
| 343 | Diagnostic Radiopharmaceuticals |
| 344 | Therapeutic Radiopharmaceuticals |
| 349 | Other Nuclear Medicine |
| 350 | Computed Tomographic (CT) Scan/General |
| 351 | Computed Tomographic (CT) Scan/Head |
| 352 | Computed Tomographic (CT) Scan/Body |
| 359 | Other CT Scans |
| 360* | Operating Room Services/General |
| 361* | Operating Room Services/Minor Surgery |
| 362* | Operating Room Services/Bone Marrow Transplant |
| 369* | Other Operating Room Services |
| 370 | Anesthesia/General |
| 371 | Anesthesia Incident to Radiology |
| 372 | Anesthesia Incident to Other Diagnostic Services |
| 379 | Other Anesthesia |
| 380 | Blood/General |
| 381 | Blood/Packed Red Cells |
| 382 | Blood/Whole |
| 383 | Blood/Plasma |
| 384 | Blood/Platelets |
| 385 | Blood/Leucocytes |
| 386 | Blood/Other Components |
| 387 | Blood/Other Derivatives |
| 389 | Other Blood |
| 390 | Blood Storage and Processing/General |
| 391 | Blood Storage and Processing/Administration |
| 399 | Other Processing and Storage |
| 400 | Imaging Services/General |
| 401 | Imaging Services/Mammography |
| 402 | Imaging Services/Ultrasound |
| 403 | Screening Mammography |
| 404 | Positron Emission Tomography |
| 409 | Other Imaging Services |
| 410 | Respiratory Services/General (All Ages) |
| 412 | Respiratory Services/Inhalation (All Ages) |
| 413 | Respiratory Services/Hyperbaric Oxygen Therapy (All Ages) |
| 419 | Other Respiratory Services |
| 421 | Physical Therapy/Visit Charge (All Ages) |
| 424 | Physical Therapy/Evaluation or Re-evaluation (All Ages) |
| 431 | Occupational Therapy/Visit Charge (Under 21 only) |
| 434 | Occupation Therapy/Evaluation or Re-evaluation (Under 21) |
| 441 | Speech-Language Pathology/Visit Charge (Under 21 only) |
| 444 | Speech-Language Pathology/Evaluation or Re-evaluation (Under 21) |
| 450* | Emergency Room/General |
| 451 | EMTALA Emergency Medical Screening Services |
| 460 | Pulmonary Function/General |
| 469 | Other Pulmonary Function |
| 471 | Audiology/Diagnostic |
| 472 | Audiology/Treatment |

| | |
|------|---|
| 480 | Cardiology/General |
| 481 | Cardiology/Cardiac Cath Laboratory |
| 482 | Cardiology/Stress Test |
| 483 | Cardiology/Echocardiology |
| 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 |
| | <u>Note:</u> 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 |
| | <u>Note:</u> 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 Capd 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 |
| | <u>Note:</u> 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 SFY 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 SFY2017/2018 (the "rate" year) was performed at the beginning of the fiscal year – September 2017. That UPL analysis could not utilize claim data from SFY 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 SFY.

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:

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

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