

Table of Contents

State/Territory Name: Florida

State Plan Amendment (SPA) #: 21-0005

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601



Financial Management Group

November 15, 2021

Mr. Tom Wallace
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive MS #8
Tallahassee, FL 32301

RE: Florida State Plan Amendment 21-0005

Dear Mr. Wallace:

We have reviewed the proposed State Plan Amendment (SPA) 21-0005, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on September 24, 2021. This plan amendment updates outpatient hospital reimbursement.

Based upon the information provided by the State, we have approved the amendment with an effective date of July 1, 2021. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Moe Wolf at 410-786-9291 or Moshe.Wolf@CMS.HHS.gov.

Sincerely,

A solid black rectangular box redacting the signature of Todd McMillion.

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER 2 1 — 0 0 5	2. STATE FL
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	

TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2021
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5. TYPE OF PLAN MATERIAL (Check One)

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)


6. FEDERAL STATUTE/REGULATION CITATION 42 CFR 447	7. FEDERAL BUDGET IMPACT a. FFY ²⁰⁻²¹ \$ 0 b. FFY ²¹⁻²² \$ 0
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8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Att. 4.19-B Exhibit I	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Att. 4.19-B Exhibit I
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10. SUBJECT OF AMENDMENT
Outpatient Hospital Reimbursement

11. GOVERNOR'S REVIEW (Check One)


GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL 	16. RETURN TO Mr. Tom Wallace Deputy Secretary for Medicaid Agency for Health Care Administration 2727 Mahan Drive, Mail Stop #8 Tallahassee, FL 32301 Attention: Cole Giering
13. TYPED NAME Tom Wallace	
14. TITLE Deputy Secretary for Medicaid	
15. DATE SUBMITTED September 24, 2021	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED September 24, 2021	18. DATE APPROVED November 15, 2021
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL July 1, 2021	20. SIGNATURE OF REGIONAL OFFICIAL 
21. TYPED NAME Todd McMillion	22. TITLE Director, Division of Reimbursement Review

23. REMARKS

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

EFFECTIVE DATE: July 1, 2021

I. Purpose of the Plan

This Title XIX Outpatient Hospital Reimbursement Plan establishes the methodology for calculating the reimbursement rates for covered Florida Medicaid outpatient hospital services. Title XIX provides grants to states for Medicaid medical assistance programs as specified in the Social Security Act, certified in 42 U.S.C. 1396-1396(p).

II. Standard

- A. Each hospital participating in the Florida Medicaid program shall be paid based on a prospective payment system for outpatient services.
- B. The Agency for Health Care Administration (AHCA) shall implement a methodology for establishing base reimbursement rates for each hospital. The base reimbursement rate is defined in Section III.
- C. The list of covered revenue codes is attached as Appendix A. Certain revenue codes are not reimbursed by Florida Medicaid. Service rendered under these codes shall not be billed to Florida Medicaid. Revenue code 510 Clinic/General is reimbursable by Florida Medicaid 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. Public hospital providers that have 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 must include revenue code 510 to be reimbursed for clinic services using the UB-04 claim form or 837I electronic claim.

Amendment: 2021-0005
Effective Date: July 1, 2021
Supersedes: 2020-006
Approval Date: 11/15/2021

III. Enhanced Ambulatory Patient Group (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 EAPGs. 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 a hospital outpatient visit, unless otherwise specified in 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: global transplant services, infant and newborn hearing screening, vagus nerve stimulator devices, and clinic services billed on the CMS 1500 claim form.

B. EAPG Codes and Relative Weights

1. AHCA utilizes 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 the following link:

<http://ahca.myflorida.com/medicaid/Finance/finance/institutional/hoppps.shtml>

3. EAPG version 3.16 codes and national relative weights are being used for hospital outpatient pricing in State Fiscal Year (SFY) 2021-22. The Florida State Fiscal Year is July 1 through June 30.

C. Hospital Base Rate

1. One standardized EAPG hospital base rate is calculated using historical claims data. The Provider EAPG Rate Worksheet can be found at the following link:
http://ahca.myflorida.com/medicaid/cost_reim/xls/Provider_EAPG_Rate_Worksheet_Effective_July_1_2020.xlsx.
2. Provider policy adjustors allow for payment adjustments to specific providers. The Rural Hospital Provider Adjustor is 1.5636 and the High Medicaid Outpatient Utilization Hospital Adjustor is 2.1358.
3. Base rates and other EAPG pricing methodology parameters are established by AHCA to achieve neutrality cost projections and to be compliant with federal upper payment limit requirements.
4. EAPG base rate and projected changes in hospital Medicaid outpatient reimbursement are calculated using historical claims data from a period, referred to as the “base period”. Claim data from the base period is used to simulate future outpatient Medicaid claim payments for the purpose of setting the new rate year EAPG base rates and other EAPG payment parameters. Baseline payment is calculated by applying rates from the year immediately preceding the upcoming rate year to the claims in the base period dataset. The new rate year EAPG base rate and associated EAPG payment parameters are set to an approximate baseline payment to achieve cost projections. The claim payments from the base period may be adjusted for Medicaid volume, inflation, and legislative direction so that the base period data approximates the upcoming rate year as closely as possible.
5. 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. A Florida Medicaid recipient is any individual whom the Florida Department of

Children and Families, or the Social Security Administration 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.

6. For SFY 2021-22, base historical claims used to calculate the EAPG base rate had a claim first date of service between January 1, 2019, and December 31, 2019.
7. For SFY 2021-22 rates, standardized EAPG base rates and provider policy adjustors were calculated to achieve a simulated budget neutral effect relative to the SFY 2020-2021 EAPG-based payment system for the base historical claims. .
8. The hospital EAPG base rates are available on the AHCA website at the following link:
<http://ahca.myflorida.com/medicaid/Finance/finance/institutional/hoppps.shtml>.

D. Rate Enhancement Payments

1. An annual allocation of automatic rate enhancement (ARE) payments is allocated for hospital inpatient and hospital outpatient services. These allocations are included in the provider rate worksheets available on the AHCA website at the following link:
http://ahca.myflorida.com/medicaid/cost_reim/hospital_rates.shtml.
2. ARE funds will be separated into fee-for-service and managed care portions. The fee-for-service portion of the annual allocated amount is determined using the fee-for-service percentage calculated by comparing the number of fee-for-service lines to total lines in the base year data set.
3. The fee-for-service portion will be distributed as supplemental payments to the providers.

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. The Rural Hospital Provider Adjustor is 1.5636. Rural hospitals are acute care hospitals with 100 or fewer licensed beds, an emergency room and, must meet one of the following criteria:
 - i. The sole provider within a county with a population density of up to 100 persons per square mile;
 - ii. An acute care hospital, in a county with a population density of up to 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;
 - iii. A hospital supported by a tax district or sub-district whose boundaries encompass a population of up to 100 persons per square mile;
 - iv. A hospital classified as a sole community hospital under 42 C.F.R. s. 412.92, regardless of the number of licensed beds;
 - v. A hospital with a service area that has a population of up to 100 persons per square mile. 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 the Agency; or
 - vi. A hospital designated as a critical access hospital.
 - vii. A hospital that received Medicaid funds 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, 2022, 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 the Agency. A

hospital that was licensed as a rural hospital during the 2010-2011 or 2011-2012 fiscal year shall continue to be a rural hospital from the date of designation through June 30, 2022, if the hospital continues to have up to 100 licensed beds and an emergency room.

- b. High Medicaid outpatient utilization hospitals are those who have 50 percent or more of their total annual outpatient charges resulting from care provided to Medicaid recipients. The High Medicaid Outpatient Utilization Hospital Adjustor is 2.1358. Florida Medicaid outpatient charges are the hospital's usual and customary charges for outpatient services rendered to patients excluding charges for laboratory and pathology services.
- 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 annually 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, labor and delivery services, surgical procedures, dialysis services, chemotherapy services which are covered when medically necessary, and services provided under revenue codes noted in Appendix A.

3. The \$1,500 annual 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:

$$\text{Line Item Allowed Amount} = \text{EAPG Payment} \\ - \text{Reduction for Annual Benefit Limit}$$

- i. If the recipient's annual hospital outpatient reimbursement has exceeded the annual limit and a given service is subject to the benefit limit, then the "Reduction for Annual Benefit Limit" will be set equal to the EAPG Payment so that the Medicaid allowed amount is \$0.
 - ii. If the EAPG Payment 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 annual 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. The Medicaid benefit period is 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. For the purposes of determining third party

liability, a Florida Medicaid recipient 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.

I. Frequency of EAPG Payment Parameter Updates

1. New versions of EAPGs are released annually and include a new set of relative weights. 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 an SFY 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. Hospital EAPG Base Rate:

An EAPG base rate is the 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. 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. The base rate is calculated to meet cost projections which get applied to a base year dataset including claims with dates of admission within a minimum of a 6-month and most often a 12-month timeframe (referred to as the “base year”).

3. New values for the policy adjustors are calculated annually and become effective at the beginning of each SFY.

IV. Medicare Crossover Pricing

For hospital outpatient Medicare crossover claims, the Medicaid allowed amount will be determined using the EAPG pricing methodology. 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.

**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/Non-Generic
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
	<u>Note:</u> 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 \$1,500 outpatient cap limit.

**APPENDIX B 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 claims with first date of service in the calendar year ending 18 months prior to the rate effective date—referred to as the "base" year—are used for the analysis.

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 Medicare cost reports from the CMS Healthcare Cost Report Information System (HCRIS) that align with the base year claims experience. 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 included 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). If, for a given hospital, costs are not reported in Worksheet C Part I, Column 5, the above calculations are performed using costs reported in Worksheet B Part I, Column 26.

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 calendar year ending 18 months prior to the rate effective date.

Initially, all in-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.

The costs are inflated forward from the mid-point of the base year to the mid-point of the UPL rate year. The inflation multiplier is calculated as a ratio of the IHS Markit Hospital Market Basket inflation factor from the midpoint of rate year divided by the inflation factor for the midpoint of base year.

As a final step, the Medicaid FFS portion of the outpatient hospital assessment is added, which is the total outpatient assessment multiplied by the percentage of Medicaid revenue relative to total revenue, and then multiplied by the percentage of base year FFS Medicaid outpatient charges relative to total Medicaid outpatient charges.

To get the percentages of Medicaid and total revenue, data is used from the base year cost reports. The percentage of

Medicaid revenue is calculated as Medicaid revenue from Worksheet S-10, Column 1, Lines 2, 5 and 9, divided by Net Patient Revenues from Worksheet G-3, Column 1, Line 3.

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

The FFS portion of rate year automatic rate enhancement (ARE) supplemental payments are then added to this estimate of EAPG claims-based payments for each hospital.

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'