

## **Table of Contents**

**State/Territory Name: FLORIDA**

**State Plan Amendment (SPA) #: FL-24-0007**

This file contains the following documents in the order listed:

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

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Centers for Medicare & Medicaid Services  
Center for Medicaid & CHIP Services  
230 South Dearborn  
Chicago, Illinois 60604



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**Financial Management Group**

April 23, 2026

Mr. Brian Meyer  
Deputy Secretary for Medicaid  
Agency for Health Care Administration  
2727 Mahan Drive, Mail Stop #8  
Tallahassee, FL 32308

ATTENTION: Shanise Jackson

RE: **TN FL-24-0007**

Dear Deputy Secretary Meyer,

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Florida state plan amendment (SPA) to Attachment 4.19-B FL-24-0007, which was submitted to CMS on September 25, 2024. This plan amendment updates the Outpatient Hospital reimbursement.

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 1, 2024. 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 Ysabel Gavino via email at [maria.gavino@cms.hhs.gov](mailto:maria.gavino@cms.hhs.gov).

Sincerely,

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

Todd McMillion  
Director  
Division of Reimbursement Review

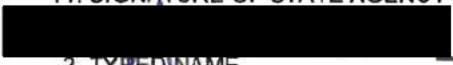
Enclosures

<p><b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> <b>FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b></p>	1. TRANSMITTAL NUMBER <u>2 4 - 0 0 0 7</u>	2. STATE <u>FL</u>
	3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT <input checked="" type="radio"/> XIX <input type="radio"/> XXI	
TO: CENTER DIRECTOR CENTERS FOR MEDICAID & CHIP SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE <p style="text-align: center;">July 1, 2024</p>	
5. FEDERAL STATUTE/REGULATION CITATION <u>42 CFR 447</u>	6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a FFY <u>2023-24</u> \$ <u>(1,075,757)</u> b FFY <u>2024-25</u> \$ <u>(3,227,270)</u>	
7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT <u>Attachment 4.19-B Exhibit I pages 13,4,5,6,15</u>	8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) <u>Attachment 4.19-B Exhibit I pages 13,4,5,6,15</u>	

9. SUBJECT OF AMENDMENT  
Outpatient Reimbursement Methodology

10. GOVERNOR'S REVIEW (Check One)

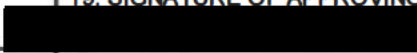
GOVERNOR'S OFFICE REPORTED NO COMMENT  OTHER, AS SPECIFIED:  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

11. SIGNATURE OF STATE AGENCY OFFICIAL 	15. RETURN TO Mr. Tom Wallace Deputy Secretary for Health Care Finance and Data Agency for Health Care Administration 2727 Mahan Drive, Mail Stop #2 Tallahassee, Florida 32308 Attention: Shanise Jackson
12. TYPED NAME <u>MATT COOPER</u>	
13. TITLE Deputy Secretary for Health Care Finance and Data	
14. DATE SUBMITTED <u>9-25-24</u>	

**FOR CMS USE ONLY**

16. DATE RECEIVED <u>September 25, 2024</u>	17. DATE APPROVED
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**PLAN APPROVED - ONE COPY ATTACHED**

18. EFFECTIVE DATE OF APPROVED MATERIAL <u>July 1, 2024</u>	19. SIGNATURE OF APPROVING OFFICIAL 
20. TYPED NAME OF APPROVING OFFICIAL <u>Todd McMillion</u>	21. TITLE OF APPROVING OFFICIAL <u>Director, Division of Reimbursement Review</u>

22. REMARKS

**The State of Florida authorizes CMS to perform the following pen and ink change:**

**Box 7 and 8: To add pages 13,4,5,6,15 MYLG 10/22/2025**

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

**EFFECTIVE DATE: July 1, 2024**

**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.

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/hopppts.shtml>.

4. Effective July 1, 2024, EAPG version 3.18 codes and national relative weights are being used for hospital outpatient pricing in State Fiscal Year (SFY) 2024-2025. The Florida State Fiscal Year is July 1 through June 30.

### **C. Hospital Base Rates**

1. Separate standardized EAPG hospital base rates are calculated for:
  - a. Hospitals with signed agreements to participate in the Florida Medicaid program
  - b. Hospitals that do not have signed agreements to participate in the Florida Medicaid program.
2. Provider policy adjustors allow for payment adjustments to specific providers. The Rural Hospital Provider Adjustor is 1.5328 and the High Medicaid Outpatient Utilization Hospital Adjustor is 2.0930.
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 rates 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 2024-2025, base historical claims used to calculate the EAPG base rates had a claim first date of service between January 1, 2022, and December 31, 2022.
7. For SFY 2024-2025 rates, standardized EAPG base rates and provider policy adjustors were initially calculated to achieve a simulated budget neutral effect relative to the SFY 2023-2024 EAPG-based payment system.
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>. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient services. The Agency's fee schedule rate was set as of July 1, 2024, and is effective for services provided on or after that date. All rates are published on the Agency's website.

#### **D. Children's Hospital Add-On Payments**

1. Children's hospital per-service add-on payments are paid to nonprofit hospitals that as of January 1, 2022, are separately licensed by the state as specialty hospitals providing comprehensive acute care services to children and remain so licensed and qualify for the High Medicaid Inpatient Utilization Policy Adjustor. The outpatient EAPG per-service add-on payments were calculated by distributing \$84,886,650 to qualifying hospitals proportionately based on each hospital's total of simulated DRG and Trauma hospital rate enhancement payments and simulated EAPG payments from the budget neutral simulations. A hospital's eligibility to receive these add-on payments is contingent on the hospital having full network contracts with each applicable Medicaid managed care plan in the state.

2. For each qualifying hospital, the total appropriated add-on payment amount is translated into an average per-service amount by dividing the total appropriated amount by the number of qualifying services in the base period historical claims dataset.
3. Children's hospital per-service add-on payment amounts are available on the AHCA website at the following link:  
<http://ahca.myflorida.com/medicaid/Finance/finance/institutional/hoppps.shtml>. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient services. The Agency's fee schedule rate was set as of July 1, 2024, and is effective for services provided on or after that date. All rates are published on the Agency's website.

## **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 1.5328. Rural hospitals are acute care hospitals with 100 or fewer licensed beds, an emergency room, and which is:
    - 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, as defined in section [1861\(mm\)\(1\)](#) and [1820\(e\)](#) of the Social Security Act.
  - vii. 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, 2031, if the hospital continues to have up to 100 licensed beds and an emergency room.
- b. High Medicaid outpatient utilization hospitals are those that 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 2.0930. 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.

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 are excluded from 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 S&P Global 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 trend adjustment to the claim payments.