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State/Territory Name: Florida

State Plan Amendment (SPA) #: FL-24-0008

This file contains the following documents in the order listed:

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Financial Management Group

December 18, 2025

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

RE: TN 24-0008

Dear Secretary Meyer:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Florida state plan amendment (SPA) to Attachment 4.19-A FL-24-0008, which was submitted to CMS on September 25, 2024. This plan amendment updates Diagnosis Related Group (DRG) reimbursement rates for hospital inpatient services, specifying calculation of 2024–25 base rates using claims data from the calendar year ending 18 months prior to the rate effective date; updates the amount of DRG per-discharge add-on payment and year for Children's hospital per-discharge add-on payments; adds a service adjustor for services categorized as Obstetrics or Normal Newborn to the three types of policy adjustors built into the DRG-based payment method; and adds an end date to the methodology for certain existing graduate medical education (GME) payments.

We reviewed your SPA submission for compliance with statutory requirements, including sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 of the Social Security Act (the Act) 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 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. Additionally, a companion letter is included with this approval package. CMS identified issues with GME payments that allocate a set dollar amount per full-time equivalent resident. To the extent the payments are not connected to the provision of underlying covered services, the aggregate payments appear inconsistent with economy and efficiency as required under section 1902(a)(30)(A) of the Act. The companion letter requests that the state end these payments, which currently are being made under previously approved state plan authority. More details can be found in the attached companion letter.

If you have any additional questions or need further assistance, please contact James Francis at 617-531-7575 or via email at James.Francis@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

December 18, 2025

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

RE: Payments to Hospitals for Medical Education in SPA FL-24-0008

Dear Secretary Meyer:

This letter is being sent as a companion to our approval of Florida Medicaid state plan amendment (SPA) 24-0008. During our review of this SPA, the Centers for Medicare & Medicaid Services (CMS) identified issues with graduate medical education costs payments. Section 1902(a)(10) of the Social Security Act (the Act) requires that the Medicaid state plan "provide for making medical assistance available" for eligible individuals. Medical assistance is defined at 1905(a) of the Act as "payment of part or all of the cost of the following care and services, or the care and services themselves, or both…." Section 1902(a)(30)(A) of the Act requires that the state plan provide for methods and procedures relating to the payment for care and services under the plan to "assure that payments are consistent with efficiency [and] economy…." Section 1902(a)(2) of the Act requires the state to provide for financial participation by the state, including as permissible from local sources, equal to all of the required non-federal share of Medicaid expenditures.

Florida SPA 24-0008 includes Medicaid state plan payment provisions that appear to not be for care and services furnished to Medicaid beneficiaries, but instead for payments to hospitals for medical education that we are unable to determine, based on the information the state has provided, are related to the provision of medical assistance to eligible Medicaid beneficiaries. The Medicaid statute does not include authority for standalone graduate medical education payments to providers. To the extent payments to providers include payments for care and services they have furnished to Medicaid beneficiaries and also graduate medical education payments under SPA 24-0008 that are not connected to the provision of underlying covered services, the aggregate payments to providers would appear inconsistent with economy and efficiency as required under section 1902(a)(30)(A) of the Act. And, to the extent the state were to receive federal financial participation in the graduate medical education payments, this would appear to have the effect of increasing the federal share of expenditures for the medical assistance expenditures above the level specified in statute. The current methodology that allocates a set dollar amount per full-time equivalent (FTE) resident per provider does not clearly

demonstrate a connection to the provision of Medicaid services. As a result, CMS is issuing this companion letter acknowledging that the state has added to SPA 24-0008 a "sunset date" of June 30, 2027, to end these payments, which currently are being made under previously approved state plan authority. We are taking this approach instead of disapproving SPA 24-0008 to allow the state a limited but sufficient amount of time to wind down the graduate medical education payments that we cannot determine are connected to the provision of Medicaid-covered care and services.

CMS appreciates the state's partnership with addressing the issues identified with this SPA, and we are available to provide any required technical assistance should the state wish to submit any future SPAs to make graduate medical education payments. If you have any questions, please contact James Francis via email at james.francis@cms.hhs.gov.

Sincerely,

Rory Howe
Director
Financial Management Group

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24 — 0008	2. STATE: FL
3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI	
TO: CENTER DIRECTOR CENTERS FOR MEDICAID & CHIP SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2024
5. FEDERAL STATUTE/REGULATION CITATION 42 CFR 447	6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a FFY 2023-24 $ ~~9,150,079~~ 5,431,029 b FFY 2024-25 $ ~~27,450,238~~ 16,293,088
7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19-A Part I	8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)* Attachment 4.19-A Part I

9. SUBJECT OF AMENDMENT
Inpatient Hospital Reimbursement

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL [redacted]	15. RETURN TO Mr. Tom Wallace Deputy Secretary for Health Care Finance and Data 2727 Mahan Drive, Mail Stop #2 Tallahassee, Florida 32301 Attention: Shanise Jackson
12. TYPED NAME ~~Tom Wallace~~ MATT COOPER	
13. TITLE Deputy Secretary for Health Care Finance and Data	
14. DATE SUBMITTED 9-25-24	

FOR CMS USE ONLY

16. DATE RECEIVED September 25, 2024	17. DATE APPROVED December 18, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL July 1, 2024	19. SIGNATURE OF APPROVING OFFICIAL [redacted]
20. TYPED NAME OF APPROVING OFFICIAL Rory Howe	21. TITLE OF APPROVING OFFICIAL Director, Financial Management Group

22. REMARKS

Instructions on Back

FLORIDA TITLE XIX INPATIENT HOSPITAL

REIMBURSEMENT PLAN VERSION XLIII

EFFECTIVE DATE July 1, 2024

I. Cost Finding and Cost Reporting

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

B. Cost reports available to AHCA as of April 15 of each year shall be used to initiate this plan.

C. State mental health hospitals are required to detail their costs for their entire reporting year making appropriate adjustments as required by this plan for determination of allowable costs. State mental health hospitals shall adhere to requirements of section 2414.1, Provider Reimbursement Manual, Centers for Medicare and Medicaid Services (CMS) PUB. 15-1.

D. The cost report shall be prepared in accordance with generally accepted accounting principles and the methods of reimbursement and cost finding of Title XVIII (Medicare) Principles of Reimbursement described in 42 Code of Federal Regulations (CFR) 413.5 - 413.35 and further interpreted by the Provider Reimbursement Manual CMS PUB. 15-1.

E. The following applies if a provider files a cost report late:

1. If the provider is reimbursed via the Diagnosis Related Group (DRG) method and that cost report would have generated a lower cost-to-charge ratio had it been filed within 5 months, then any claims from the applicable state fiscal year which were paid an outlier will be retroactively re-priced; or

2. If the provider is reimbursed via a per diem method and that cost report would have generated a lower

reimbursement rate for a rate semester had it been filed within 5 months, then the provider's rate for that rate semester shall be retroactively calculated using the new cost report, and full payments at the recalculated rate shall be effected retroactively. Medicare granted exceptions to these limits shall be accepted by AHCA.

F. A hospital which voluntarily or involuntarily ceases to participate in the Florida Medicaid Program or experiences a change of ownership shall file a clearly marked "final" cost report in accordance with section 2414.2, CMS PUB. 15-1. For the purposes of this plan, filing a final cost report is not required when:

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

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

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

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

I. AHCA shall retain all uniform cost reports filed for a period of at least five years following the date of submission of such reports and shall maintain those reports pursuant to the record keeping requirements of 45 CFR 205.60.

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

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

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

M. Providers shall be subject to sanctions for late cost reports.

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

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

P. State mental health hospitals are paid on a per diem basis. All other acute care hospitals are paid via a prospective payment methodology using an acuity-based patient categorization system based on DRGs. Rates are based primarily on annual Medicaid inpatient fee-for-service budget, projected patient case mix (acuity), and payment parameters determined to meet AHCA inpatient reimbursement goals. With the DRG payment method, cost reports continue to be used for disproportionate share hospital examinations and to help evaluate payment levels within the Medicaid program.

II. Audits

A. Background

Medicaid (Title XIX), Maternal and Child Health and Crippled Children's Services (Title V), and Medicare (Title XVIII) require that inpatient hospital services be reimbursed using rates and methods

that promote efficient, economic, and quality care and are sufficient to enlist enough providers so that care and services under the plan are available at least to the extent that such care and services are available to the general population. To assure that payment of reasonable cost is being achieved, a comprehensive hospital audit program has been established to reduce overlap of audit procedures filed under the above three programs, and to minimize duplicate auditing effort. The purpose is to use audit results of a participating hospital, where possible, for all participating programs reimbursing the hospital for services rendered.

B. Hospital Audits Desk Procedure Reviews

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

1. Determine the need for on-site full scope audits and determine the scope and format for such audits when selected;
2. Desk audit all cost reports within 12 months after receipt by AHCA's designated contractor. The review may not include the Medicare auditor settlements if they are not available in the CMS Healthcare Cost Report Information System (HCRIS) data;
3. Desk review/audit cost reports during the period between cost report receipts.
4. Ensure all audits are based on AICPA Attestation Standards for examining or reviewing statistical information and other data.
5. Ensure that only those expense items that the plan has specified as allowable costs under section III of this plan have been included by the hospital in the computation of the costs of the various services.
6. Review to determine that the Florida Medicaid Log is properly maintained and current in those hospitals where its maintenance is required;
7. Issue, upon the conclusion of each full scope audit, a report which shall meet the requirements of 42 CFR 447.202 and AICPA Attestation Standards and shall declare the auditor's opinion as to whether, in all material respects, the cost filed by a hospital meets the requirements of this plan.

C. Retention

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

D. Overpayments and Underpayments

1. Overpayments for those years or partial years as determined by desk or field audit using prior approved state plans shall be reimbursable to AHCA as shall overpayments, attributable to unallowable costs only.
2. Overpayments in outpatient hospital services shall not be used to offset underpayments in inpatient hospital services and, conversely, overpayments in inpatient hospital services shall not be used to offset underpayments in outpatient hospital services.
3. The results of audits of outpatient hospital services shall be reported separately from audits of inpatient hospital services.
4. Any overpayment or underpayment that resulted from a rate adjustment due to an error in either reporting or calculation of the rate shall be refunded to AHCA or to the provider as appropriate.
5. Any overpayment or underpayment that resulted from a rate based on a budget shall be refunded to AHCA or to the provider as appropriate.
6. All overpayments shall be reported by AHCA to CMS as required.
7. AHCA or its designated contractor shall furnish to providers written notice of the audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care. The written notice constitutes final agency action.

E. Administrative Hearings

1. A substantially affected provider seeking to correct or adjust the calculation of the audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care, other than a challenge to the methodologies set forth in the rules of AHCA and in reimbursement plans incorporated by reference therein used to calculate the reimbursement rate for inpatient and outpatient care, may request an administrative hearing to challenge the final agency action by filing a petition with AHCA within 180 days after receipt of the written notice by the provider. The petition must include all

documentation supporting the challenge upon which the provider intends to rely at the administrative hearing and may not be amended or supplemented except as authorized under uniform rules adopted. The failure to timely file a petition in compliance with this subparagraph is deemed conclusive acceptance of the audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care established by the agency.

2. A correction or adjustment of an audited hospital cost-based per diem reimbursement rate for inpatient and outpatient care which is required by an administrative order or appellate decision:

   a. Must be reconciled in the first rate period after the order or decision becomes final.

   b. May not be the basis for any challenge to correct or adjust hospital rates required to be paid by any Medicaid managed care provider pursuant to part IV of this chapter.

3. AHCA may not be compelled by an administrative body or a court to pay additional compensation to a hospital relating to the establishment of audited hospital cost-based per diem reimbursement rates by the agency or for remedies relating to such rates, unless an appropriation has been made by law for the exclusive, specific purpose of paying such additional compensation.

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

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

6. This section regarding Administrative Hearings applies to any challenge to final agency action which seeks the correction or adjustment of a provider's audited hospital cost-based per diem

reimbursement rate for inpatient and outpatient care and to any challenge to the methodologies set forth in the rules of the agency and in reimbursement plans incorporated by reference therein used to calculate the reimbursement rate for inpatient and outpatient care, including any right to challenge which arose before July 1, 2016.

7. Any change in this Plan in this Section regarding Administrative Hearings is remedial in nature, confirms and clarifies existing law, and applies to all proceedings pending on or commenced after this Plan Version XLIII takes effect.

III. Allowable Costs

A. General Allowable Cost Principles

Allowable costs shall be determined using generally accepted accounting principles, except as modified by Title XVIII (Medicare) Principles of Reimbursement as described in 42 CFR 413.5 - 413.35 (excluding the inpatient routine nursing salary cost differential) and the guidelines in the Provider Reimbursement Manual CMS PUB. 15-1, and as further modified by Title XIX of the Social Security Act (the Act), this plan, requirements of licensure and certification, and the duration and scope of benefits provided under the Florida Medicaid Program. These include:

1. Costs incurred by a hospital in meeting:
   (a). The definition of a hospital contained in 42 CFR 440.10 (for the care and treatment of patients with disorders other than mental diseases) and 42 CFR 440.140 (for individuals age 65 or older in institutions for mental diseases), in order to meet the requirements of section 1902(a)(13) and (20) of the Social Security Act;
   (b). The requirements established by AHCA for establishing and maintaining health standards under the authority of 42 CFR 431.610 (b); and
   (c). Any other requirements for licensing which are necessary for providing inpatient hospital services.
2. Hospital inpatient general routine operating costs shall be the lesser of allowable costs, direct and indirect, incurred or the limits established by CMS under 42 CFR 413.30.

3. Malpractice insurance costs shall be apportioned to Medicaid in the ratio of Medicaid Patient Days to Total Patient Days, if not already included in the cost report being used to establish the Medicaid hospital inpatient rates.
4. Under this plan, hospitals shall be required to accept Medicaid reimbursement as payment in full for services provided during the benefit period and billed to the Medicaid program; therefore, there shall be no payments due from patients. As a result, for Medicaid cost reporting purposes, there shall be no Medicaid bad debts generated by patients. Bad debts shall not be considered as an allowable expense.
5. All physician orders and records that result in costs being passed on by the hospital to the Florida Medicaid Program through the cost report shall be subject to review by AHCA on a random basis to determine if the costs are allowable in accordance with section III of this plan. All such orders determined by the Utilization and Quality Control Quality Improvement Organization (QIO) or the hospital's utilization review (UR) committee to be unnecessary or not related to the spell of illness shall require appropriate adjustments to the Florida Medicaid Log.
6. The allowable costs of nursery care for Medicaid eligible infants shall include direct and indirect costs incurred on all days these infants are in the hospital.
7. The revenue assessments, and any fines associated with those assessments, mandated by the Health Care Access Act of 1984, shall not be considered an allowable Medicaid cost and shall not be allocated as a Medicaid allowable cost for purposes of cost reporting.
8. For purposes of this plan, gains or losses resulting from a change of ownership will not be included in the determination of allowable cost for Medicaid reimbursement.

IV. DRG Reimbursement

This section defines the methods used by the Florida Medicaid Program for DRG-based reimbursement of hospital inpatient stays using a prospective payment system. DRG payments are designed to be a single payment covering a complete hospital stay – from admission to discharge. In addition, DRG payments cover all services and items furnished during the inpatient stay.

A. Applicability

AHCA calculates reimbursement for inpatient stays using a DRG-based methodology. This methodology applies to all in-state and out-of-state general acute care hospitals, rural hospitals, children's specialty hospitals, teaching hospitals, cancer specialty hospitals, rehabilitation specialty hospitals, and long term acute care specialty hospitals. State mental health hospitals are paid via a per diem.

For hospitals reimbursed via the DRG-based methodology, all inpatient services provided at these facilities and billed on a UB-04 paper claim form or 837I electronic claim are covered by the DRG payment with only four exceptions – services covered under the transplant global fee, services paid for in addition to the DRG reimbursement, services for recipients with tuberculosis that are resistant to therapy, and services provided to recipients dually eligible for Medicare and Medicaid where Medicare is the primary payer.

- Transplants covered under the global fee are reimbursed as described in section IX.1 of this attachment.
- Services for recipients with tuberculosis that are resistant to therapy are reimbursed as described in section IX.2 of this attachment.
- Services provided to recipients dually eligible for Medicare and Medicaid where Medicare is the primary payer are reimbursed asdescribed in section IX.3 of this attachment.

B. DRG Codes and Relative Weights

1. AHCA utilizes All Patient Refined Diagnosis Related Groups (APR-DRGs) created by 3M Health Information Systems for assigning DRG classifications to claims.
2. The APR-DRG methodology includes a series of DRG codes which are made up of two parts, a base DRG and a level of severity. The base DRG is three characters in length. The level of severity is an additional 1-digit field with values 1 through 4 in which 1 indicates minor, 2 indicates moderate, 3 indicates major, and 4 indicates extreme. DRG relative weights and average lengths of stay are assigned to each unique combination of 3-digit DRG code and 1-digit level of severity.

3. The DRG relative weights utilized are national APR-DRG relative weights calculated by 3M using a database containing millions of hospitals stays. For use with Florida Medicaid, the national relative weights are re-centered to the Florida Medicaid population. Re-centering the weights involves dividing each DRG's national relative weight by the average APR-DRG relative weight for a set of Florida Medicaid claims. The result of the re-centering process is a set of weights in which the average relative weight for a Florida Medicaid inpatient hospital stay is 1.0. The average Florida Medicaid relative weight (referred to as "case mix") will be calculated using the same set of historical data used to determine DRG base rate(s).
4. On all claims, two DRG codes are assigned by the Medicaid Management Information System (MMIS.) One DRG code is assigned when including all diagnosis and procedure codes on the claim and the other is assigned when ignoring any diagnosis and/or procedure codes identified to be Health Care Acquired Conditions (HCACs). If a HCAC is identified and the DRG assigned when ignoring the HCAC codes has a lower relative weight, then the lower relative weight (and its associated DRG code) is used to price the claim. Please see section IV.J for more details on payment adjustments related to HCACs.
5. Annual Updates: AHCA will install a new version of APR-DRGs once per year.

C. Hospital Base Rates

1. Separate standardized base rates are used for:
   (a). Hospitals reimbursed via DRG pricing with signed agreements to participate in the Florida Medicaid program
   (b). Hospitals reimbursed via DRG pricing that do not have signed agreements to participate in the Florida Medicaid program.
2. Provider policy adjustors are included which allow for payment adjustments to specific providers.
3. Rates and methodology parameters are established by AHCA to achieve budget neutrality, and to be compliant with federal upper payment limit requirements.
4. Base rates for SFY 2024-2025 were calculated using historical claims data from the calendar year ending 18 months prior to the rate effective date (referred to as the "base year") including claims from both the fee-for-service and managed care programs. Claim data from the base year is used to simulate future inpatient Medicaid claim payments for the purpose of setting the DRG base rate

and other DRG payment parameters such as cost outlier threshold, marginal cost percentage, and policy adjustors. The claim payments from the base year may be adjusted for Medicaid volume and inflation so that the base year data approximates the upcoming rate year as closely as possible. Baseline payment is calculated by applying rates from the year immediately preceding the upcoming rate year to the claims in the base year dataset. The new rate year DRG base rates and associated DRG payment parameters are initially set to an approximate baseline payment.

5. The new rate year DRG base rates are calculated using an assumption that overall Florida Medicaid hospital inpatient case mix will increase annually by one-third of one percent.
6. The hospital DRG base rates are available on the AHCA website at https://ahca.myflorida.com/medicaid/cost_reim/drg.shtml

D. Cost-to-Charge Ratios

1. Cost-to-charge ratios (CCRs) are used in the calculation of outliers in the DRG reimbursement method. Specifically, they are used to estimate hospital cost on individual claims.
2. One CCR is calculated for each hospital participating in the Florida Medicaid program (including out-of-state providers with signed Medicaid participant agreements). Non-participating hospitals (both in and out of state) are assigned a state-wide average cost-to-charge ratio.
3. For hospitals that have a CCR published in the Medicare Inpatient Prospective Payment System (IPPS) Provider Specific File (PSF), the hospital-specific Medicare IPPS CCR from this file is used. This CCR is calculated as the sum of each hospital's operating and capital cost to charge ratios.
4. For hospitals that do not have a CCR published in the Medicare IPPS PSF, total cost and charge data as reported on Medicare cost reports in the Healthcare Cost Report Information System (HCRIS) are used to calculate hospital-specific CCRs. CCRs are calculated by dividing total reported hospital costs by total reported hospital charges.
5. The combination of IPPS PSF and HCRIS data is used to assign CCRs for all in-state and out-of-

state hospitals with signed agreements to participate in the Florida Medicaid program. All other hospitals, which are primarily out-of-state hospitals, are assigned a statewide average CCR.

E. Rate Enhancement Payments

1. Trauma hospital rate enhancement payments are paid to hospitals that qualify for one of three trauma classifications – Level I Trauma, Level II Trauma, or Pediatric Trauma. The trauma hospital rate enhancement payment is calculated as a percentage of the DRG Base Payment. The percentages are:

    a. Level I Trauma 17%

    b. Level II Trauma 11%

    c. Pediatric Trauma 4%

F. Children's Hospital Add-On Payments

1. Children's hospital per-discharge 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 pursuant to chapter 395.002(28), Florida Statutes and remain so licensed and qualify for the High Medicaid Inpatient Utilization Policy Adjustor. The inpatient DRG per-discharge add-on payments were calculated by distributing $84,886,650 appropriated in the SFY 2024-2025 GAA 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.

G. Policy Adjustors

1. Policy adjustors are numerical multipliers included in the DRG payment calculation that allow AHCA to increase or decrease payments to categories of services and/or categories of providers.
2. Three types of policy adjustors have been built into the DRG-based payment method:
    a. Service adjustors, which are assigned to individual DRGs.
    b. Age adjustors, which are assigned based on a combination of DRG and recipient age. When utilized, age adjustors apply to recipients under the age of 21.

c. Provider adjustors, which are assigned to categories of providers.

In many cases the adjustors are set to 1.0, which indicates no adjustment.

3. The following provider and service categories have policy adjustors greater than 1.0:

a. Service Adjustors: Applied to claims for services categorized as Obstetrics or Normal Newborn.

b. Age adjustors: Applied to claims for recipients under the age of 21 for which severity of illness as defined during the APR-DRG assignment is 2 (moderate), 3 (major), or 4 (extreme), and the service provided is categorized as Pediatric, Transplant Pediatric, Neonate, Mental Health, or Rehabilitation.

c. Provider adjustors: Applied to claims from rural hospitals, free-standing rehabilitation hospitals, long term acute care hospitals, and high Medicaid inpatient utilization hospitals. Hospitals qualify as high Medicaid inpatient utilization if their combined Florida Medicaid fee-for-service and Florida Medicaidmanaged care program utilization is at least 50%.

H. DRG Payment Calculation

1. Standard DRG payment: The basic components which make up DRG payment on an individual claim are shown below. These components are sometimes adjusted because of patient transfers, non-covered days, or the charge cap policy.

2. The primary components of DRG payment are:

Claim Payment = DRG Base Payment + Outlier Payment + Children's Hospital Add-On Payment + Trauma Hospital Rate Enhancement

a. DRG Base Payment:

DRG Base payment = Provider base rate * DRG relative weight * Maximum applicable policy adjustor

(1) Provider base rate is a dollar amount assigned to each hospital. Please see section IV.C for more details regarding provider base rates.

(2) The DRG relative weight is a numerical multiplier used to adjust payment based on the acuity of the patient. In cases involving a Health Care Acquired Condition (HCAC), the

DRG code with the lower relative weight will be used in the pricing calculation. Please see section IV.B.3 for more details regarding DRG relative weights.

(3) Maximum applicable policy adjustor is the highest numerical value of the three policy adjustors that may apply to an individual inpatient stay – service adjustor, age adjustor and provider adjustor. Please see section IV.G for more details regarding policy adjustors.

b. Outlier Payment:

(1) Outlier payments are additional payments made at the claim level for stays that have extraordinarily high costs when compared to other stays within the same DRG.

(2) A stay classifies for an outlier payment if the estimated hospital loss is greater than a loss threshold set by AHCA. Losses exceeding the loss threshold are multiplied by a marginal cost factor to determine the Outlier Payment. The components of outlier calculations are:

(a) Outlier Payment = (Estimated Hospital Loss – Outlier Loss Threshold) * Marginal Cost Factor

(b) Estimated Hospital Loss = (Billed Charges * Provider Cost-to-Charge Ratio) – DRG base payment

c. Children's Hospital Add-On Payment: For each qualifying hospital, the total appropriated add-on payment amount is translated into an average per-discharge amount. On individual inpatient claims, the average per-discharge children's hospital add-on payment for the hospital is case mix adjusted to determine the payment amount for that claim. "Case mix adjusting" the payment is performed using the following formula:

Case mix adjusted children's hospital add-on payment
= average per-discharge children's hospital add-on payment
* (claim DRG relative weight / provider's estimated annual case mix)

(1) A provider's estimated annual case mix is the average of the DRG relative weights on the provider's inpatient claims as calculated using the same

historical claims used for the setting the DRG base rate. If the case mix is assumed to increase between the base year and the rate year when calculating the DRG base rate, then the same trend assumption is applied to the provider's annual case mix used in the children's hospital add-on payment calculation.

(2) Case mix adjusting the average per-discharge children's hospital add-on payment increases the children's hospital add-on payment for claims with higher than average relative weight and decreases the children's hospital add-on payment for claims with lower than average relative weight.

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

Trauma Hospital Rate Enhancement = DRG Base Payment * Trauma Rate Enhancement Percentage

(1) Trauma Rate Enhancement percentages are as follows:

(a) Level I Trauma 17%

(b) Level II Trauma 11%

(c) Pediatric Trauma 4%

(2) The DRG Base Payment used in the formula above is the final DRG Base Payment calculated after application of the transfer policy, non-covered days adjustment, and charge cap adjustment (discussed in the following sections.

3. Transfer Payment Adjustment: Payment adjustments are made when an inpatient hospital stay is shorter than average due to a transfer from one acute care facility to another. This payment adjustment is referred to as a "transfer policy."

a. The transfer payment adjustment only applies when a patient is transferred to another acute care hospital as identified by the following patient discharge status values:

02 – discharged/transferred to a short-term general hospital for inpatient care

05 – discharged/transferred to a designated cancer center or children's hospital

65 – discharged/transferred to a psychiatric hospital or distinct part unit

66 – discharged/transferred to a critical access hospital

82 – discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission

85 – discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission

93 – discharged/transferred to a psychiatric distinct part of a hospital with a planned acute care hospital inpatient readmission

94 – discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission

The transfer policy does not apply in cases where a patient is discharged to a post-acute setting such as a skilled nursing facility.

b. When one of the discharge statuses listed above exists on the claim, a separate Transfer Base Payment amount is calculated using a per diem type of calculation and the lower of Transfer Base Payment and the DRG Base Payment is applied to the claim. The Transfer Base Payment amount is calculated with the following formula:

Transfer Base Payment = (DRG Base Payment / DRG national average length of stay) * (actual length of stay + 1)

c. If the Transfer Base Payment is less than the DRG base payment, then the Transfer Base Payment replaces the DRG Base Payment and is used for the rest of the pricing calculations on the claim. Transfer claims that meet the outlier criteria described above are eligible for an outlier payment.

d. Transfer payment reductions only apply to the transferring hospital. Reimbursement to the receiving hospital is not impacted by the transfer payment adjustment unless the receiving hospital also transfers the patient to another hospital.

4. Non-Covered Day Adjustment: The DRG payment is proportionately reduced in cases where some of the days of the hospital stay are not covered by the Florida Medicaid fee-for-service program.

a. Stays with non-covered days can occur in the following scenarios:

- Recipient is an undocumented non-citizen (for which only emergency services are reimbursed)
- Recipient exhausted his/her 45-day benefit limit prior to admission (in which case only emergency services are reimbursed)
- Recipient is dually eligible for Medicare and Medicaid and exhausts his/her Medicare Part A benefits during an inpatient admission
- Recipient is in the Medically Needy eligibility category and incurs enough healthcare costs to qualify for Medicaid during an inpatient admission

b. When only a portion of an inpatient admission is reimbursable by Florida Medicaid fee-for-service, payment is prorated downward based on the number of covered days in relation to the full length of stay. Specifically, a proration factor is calculated as,

Non-covered day adjustment factor = (Covered days / Length of stay)

c. The non-covered day adjustment factor is applied to the DRG base payment and outlier payment.

5. Charge cap: The charge cap is applied to the DRG payment, which is the sum of the DRG base payment and outlier payment. If the sum of DRG base payment and outlier payment is greater than filed charges, then the DRG base payment and outlier payment are reduced proportionally so that their new, reduced sum equals filed charges. For example, if the submitted charges are 30% less than the sum of DRG base payment and outlier payment, then the DRG base payment and outlier payment are reduced by 30%.
6. Third party liability: DRG reimbursement shall be limited to an amount, if any, by which the DRG payment calculated for an allowable claim exceeds the amount of third-party benefits applied to the inpatient admission.
7. Examples: Please see Appendix C for examples of the DRG pricing calculation.

I. Cost Settlement

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

J. Interim Claims and Late Charges

1. Because DRG payment is designed to be payment in full for a complete hospital stay, interim claims (claims for only part of a hospital stay, and filed with bill type 0112, 0113, and 0114) will not be accepted. If recipient has Medicaid fee-for-service eligibility for only part of a hospital stay, a claim should be filed for the complete hospital stay and payment will be prorated downward based on a comparison of the eligible days to the actual length of stay.
2. Late charges, filed with bill type 0115, will not be accepted. Instead, hospitals are instructed to adjust previously filed claims if appropriate.

K. Payment Adjustment for Provider Preventable Conditions (PPCs)

1. Citation: 42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903.
2. The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions. These requirements apply to inpatient hospitals.
3. No reduction in payment for a provider preventable condition (PPC) is imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.
4. Reductions in provider payment may be limited to the extent that the following apply:
    a. The identified provider-preventable conditions would otherwise result in an increase in payment.
    b. The State can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.
5. Two DRGs are assigned to each claim and are referred to as “pre-HCAC” and “post-HCAC” DRGs. The pre-HCAC DRG is assigned using all the diagnosis and surgical procedure codes on the claim. The post-HCAC DRG is assigned when ignoring any diagnosis and surgical procedure codes identified as HCACs. If the pre-HCAC and post-HCAC DRGs are different, then the DRG code with the lower relative weight is used to price the claim. In all or nearly all cases, the DRG

code with the lower relative weight is the post-HCAC DRG.

6. The State identifies the following Health Care-Acquired Conditions for non-payment under section 4.19-A.
   a. Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.
7. The State identifies the following Other Provider-Preventable Conditions for non-payment under section(s) 4.19 –A:
   a. Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.
   b. Medicaid makes zero payments to providers for Other Provider-Preventable Conditions which includes Never Events (NE) as defined by the National Coverage Determination (NCD). The Never Events (NE) as defined in the NCD includes Inpatient Hospitals, Outpatient Hospitals, Ambulatory Surgical Centers (ASC) and practitioners, and these providers, regardless of the health care setting, are required to report NEs.

L. Frequency of DRG Payment Parameter Updates

1. DRGs and relative weights: New versions of APR-DRGs are released annually and include a new set of relative weights and average lengths of stay. AHCA will install a new version of APR-DRGs once per year. Installation of new versions of APR-DRGs and associated relative weights will occur at the beginning of a state fiscal year and will coincide with a recalculation of hospital base rates, DRG policy adjustors, and outlier parameters. When applying new versions of APR-DRG classifications, relative weights, and average lengths of stay, AHCA will apply a version of APR-DRGs that has been available from 3M for a minimum of nine months prior to the implementation of new rates to allow ample time for calculation of a new DRG base rate and DRG policy adjustors.

The re-centering factor applied to the new DRG relative weights is calculated using the same claims dataset used to determine the new hospital base rate and other DRG payment parameters.

2. Hospital Base Rates:

   a. The new DRG base rates are calculated annually and become effective at the beginning of each state fiscal year. The base rates are calculated to meet budget goals on a base year dataset that includes claims with dates of discharge within the base year.

3. Hospital Cost-to-Charge Ratios:

   a. CCR values are retrieved from the Medicare Inpatient Prospective Payment System (IPPS) Provider Specific File (PSF) published for hospitals having a CCR in the IPPS PSF. For hospitals that do not have a CCR published in the IPPS PSF, CCR values are calculated using total reported hospital costs and charges retrieved from each hospital's most currently available Medicare cost report found in the Healthcare Cost Report Information System (HCRIS) datasets.

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

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

4. Trauma hospital rate enhancement payments are re-calculated and become effective at the beginning of the state fiscalyear.

5. Policy Adjustors:
    a. New values for the policy adjustors are calculated annually and become effective at the beginning of each state fiscal year.
6. Outlier Loss Threshold: The outlier loss threshold is re-evaluated annually, and new values become effective at the start of a state fiscal year.
7. The Outlier Marginal Cost Factor is re-evaluated annually, and new values become effective at the start of a state fiscal year.
8. Provider estimated annual case mix: New values for provider estimated annual case mix are calculated annually and become effective at the beginning of each state fiscal year.
9. Children's hospital average per-discharge add-on payments: New values for average per-discharge add-on payment are calculated annually and become effective at the beginning of each state fiscal year.

V. Per Diem Reimbursement

This section defines the process used by the Florida Medicaid Program for per diem reimbursement of hospital inpatient stays.

A. Applicability

Per diem reimbursement applies to all inpatient stays for fee-for-service recipients with admissions prior to July 1, 2013, except those covered by the global transplant fee. For admissions on or after July 1, 2013, per diem reimbursement for inpatient stays for fee-for-service recipients will be used only if the care was provided at a state mental health hospital. All other inpatient admissions on or after July 1, 2013 will be reimbursed using a DRG-based inpatient prospective payment system, except those described as exceptions to DRG-based reimbursement in section IV.A.

B. Standards

1. Changes in individual hospital per diem rates shall be effective from July 1 through June 30 of each year. The prospectively determined individual hospital's rate may be adjusted only under the following circumstances:
    a. An error was made by AHCA's designated contractor or AHCA in the calculation of the

hospital's unaudited rate.

b. A hospital files an amended unaudited cost report to supersede the unaudited cost report used to determine the rate in effect. There shall be no change in rate if an amended unaudited cost report is filed beyond 3 years of the effective date that the rate was established, or if the change is not material, or if the cost report has been audited. Effective July 1, 2014, a hospital must submit an amended cost report by July 1 of the state fiscal year the rates are effective.

c. Further desk or on-site audits of cost reports used in the establishment of the prospective rate disclose material changes in these reports.

d. The charge structure of a hospital changes and invalidates the application of the lower of cost or charges limitations.

2. AHCA shall distribute monies as appropriated to hospitals providing a disproportionate share of Medicaid or charity care services by increasing Medicaid payments to hospitals as required by section 1923 of the Act.

3. AHCA shall distribute monies as appropriated to hospitals determined to be disproportionate share providers by allowing for an outlier adjustment in Medicaid payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age as required by section 1923 of the Act.

4. Effective July 1, 2006, in accordance with the approved Medicaid Reform section 1115 Demonstration, Special Terms and Conditions 100(c), a hospital's inpatient reimbursement rate will be limited by allowable Medicaid cost, as defined in section III of this plan, utilizing CMS-2552-96 (or its successor).

5. A prospective reimbursement rate, however, shall not be established for a new hospital based on a cost report for a period less than 12 months. For a new provider with no cost history, excluding new providers resulting from a change in ownership where the previous provider participated in the program, the interim per diem rate shall be the lesser of:

a. The county reimbursement ceiling, if applicable; or

b. The budgeted rate approved by AHCA based on this plan.

7. Interim rates shall be cost settled for the interim rate period. Interim per diem rates shall not be approved for new providers resulting from a change in ownership. Medicaid reimbursement is hospital specific and is not provider specific.

8. Medicaid reimbursement shall be limited to an amount, if any, by which the final prospective per diem rate for an allowable claim exceeds the amount of third-party benefits during the Medicaid benefit period.

9. Effective July 1, 2014, all amended cost reports filed with AHCA after the initial rates have been established for the current rate setting period will be reconciled in the subsequent rate setting year.

C. Methods

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

1. Setting Reimbursement Rates for Inpatient Variable Cost

a. Review and adjust the hospital cost report available to AHCA as of each April 15 as follows:

(1) To reflect the results of desk reviews and full audits

(2) To exclude from the allowable costs, any gains and losses resulting from a change of ownership and included in clearly marked “Final” cost reports.

b. Reduce a hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.30.

c. Determine allowable inpatient Medicaid variable costs: Allowable inpatient Medicaid variable costs are based on the total inpatient Medicaid costs less total Medicaid fixed costs. The formula is as follows:

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

d. Inflated Allowable Inpatient Medicaid Variable Costs: Adjust allowable inpatient Medicaid

variable costs for the number of months between the midpoint of the hospital's fiscal year and December 31 the midpoint of the following rate semester. The adjustment shall be made utilizing the latest available projections at the time the rate is set for the Data Resources Incorporated (DRI) (or its successor) National and Regional Hospital Input Price Indices as detailed in Appendix A.

2. Setting Reimbursement Rates for Fixed Cost

a. Review and adjust the hospital cost report available to AHCA as of each April 15 as follows:

(1) To reflect the results of desk reviews or audits;

(2) To exclude from the allowable cost any gains and losses resulting from a change of ownership and included in clearly marked "Final" cost reports.

b. Compute the total Medicaid fixed costs per diem for each hospital by dividing the total Medicaid fixed costs calculated by the total Florida Medicaid. The formula is as follows:

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

3. Setting Individual Hospital Rates

a. Review and adjust the hospital cost report available to AHCA as of each April 15 as follows:

(1) To reflect the results of desk reviews or audits;

(2) To exclude from the allowable cost any gains and losses resulting from a change of ownership and included in clearly marked "Final" cost reports.

b. Reduce the hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.30.

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

d. Inflated Allowable Inpatient Medicaid Variable Costs: Adjust allowable inpatient Medicaid variable costs for the number of months between the midpoint of the hospital's fiscal year and December 31, the midpoint of the following rate semester. The adjustment shall be made utilizing the latest available projections at the time of rate set for the DRI (or its successor)

National and Regional Hospital Input Price Index as detailed in Appendix A.

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

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

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

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

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

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

k. Effective July 1, 2005, a recurring rate reduction shall be established until an aggregate total estimated savings of $100,537,618 is achieved each year. This reduction is the Medicaid Trend Adjustment. In reducing hospital inpatient rates, rural hospitals and hospitals with twenty thousand (20,000) or more combined Medicaid managed care and fee-for-service inpatient days shall not have their inpatient rates reduced below the final rates that are effective on the prior June 30 of each year. The 2002 Financial Hospital Uniform Reporting System (FHURS) data shall be used to determine the combined inpatient Medicaid days.

(1) The July 1, 2005 and January 1, 2006 reimbursement rates shall be adjusted as follows:

(a) Restore the $69,662,000 inpatient hospital reimbursement rate reduction set forth in section V.C.3.o above to the June 30, 2005 reimbursement rate;

(b) Determine the lower of the June 30, 2005 rate with the restoration of the $69,662,000 reduction referenced in (a) above or the July 1, 2005 or January 1, 2006 rates, as applicable, before the application of the Medicaid Trend Adjustment described in section V.C.3.p above;

(2) Effective July 1, 2006, the reduction implemented during the period July 1, 2005 through June 30, 2006 shall become a recurring annual reduction. This recurring reduction, called the Medicaid Trend Adjustment, shall be applied proportionally to all rates on an annual basis.

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

m. Effective January 1, 2008 and ending June 30, 2008, the Medicaid Trend Adjustment shall be removed for all certified trauma centers and hospitals. The aggregate Medicaid Trend Adjustment found in V.C.3.r above shall be reduced by up to $12,067,473.

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

o. Effective March 1, 2009, AHCA shall implement a recurring methodology to reduce individual hospital rates proportionately until the required $84,675,876 savings is achieved. Hospitals that are licensed as a children's specialty hospital and whose Medicaid days plus charity care days divided by total adjusted patient days equals or exceeds 30 percent are excluded from this reduction. Public hospitals, teaching hospitals which have 70 or more full-time equivalent resident physicians, designated trauma centers and those hospitals whose Medicaid and charity care days divided by total adjusted days exceeds 25 percent may buy back the Medicaid inpatient trend adjustment applied to their individual hospital rates and other Medicaid reductions to their inpatient rates up to actual Medicaid inpatient cost. The Agency shall use the average of 2002, 2003, and 2004 audited DSH data available as of March 1, 2008. In the event the agency does not have the prescribed three years of audited DSH data for a hospital, the agency shall use the average of the audited DSH data for 2002,

2003, and 2004 that are available.

p. Effective January 1, 2010, an additional Medicaid trend adjustment shall be applied to achieve an annual recurring reduction of $9,635,295. In establishing rates through the normal process, prior to including this reduction, if the rate setting unit cost is equal to or less than the legislative unit cost, then no additional reduction in rates is necessary.

q. Effective July 1, 2011, an additional Medicaid Trend Adjustment shall be applied to achieve an annual recurring reduction of $394,928,848 as a result of modifying the reimbursement for inpatient hospital rates.

4. Payment Adjustment for Provider Preventable Conditions (PPCs)

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

b. The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions. These requirements apply to hospitals reimbursed via a per diem (inpatient psychiatric hospitals).

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

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

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

    b. The State can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions in the following manner: Hospitals are paid based on a daily per diem rate. It is the responsibility of the hospital to identify any Health Care Acquired Conditions and not seek payment for any additional days that have lengthened a recipient's stay due to a PPC. In reducing the amount of days, the following is required on a claim to identify these non-covered days: Hospitals are to report a value code of '81' on the UB-04

claim form along with any non-covered days and the amount field must be greater than '0'.

e. Hospital records will be retroactively reviewed by Medicaid's contracted Quality Improvement Organization (QIO). If any days are identified that are associated with a lengthened stay due to a PPC then Medicaid will initiate recoupment for the identified overpayment.

f. The State identifies the following Health Care-Acquired Conditions (HCACs) for non-payment under section 4.19-A.

   a. Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

g. The State identifies the following Other Provider-Preventable Conditions for non-payment under section(s) 4.19 –A.

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

   b. On and after May 1, 2012, Medicaid will make zero payments to providers for Other Provider-Preventable Conditions which includes Never Events (NE) as defined by the National Coverage Determination (NCD). The Never Events (NE) as defined in the NCD includes Inpatient Hospitals, Outpatient Hospitals, Ambulatory Surgical Centers (ASC) and practitioners, and these providers, regardless of the health care setting, will be required to report NEs.

VI. Disproportionate Share Hospital (DSH) Reimbursement Methods

A. Determination of Individual Hospital Regular Disproportionate Share Payments for Disproportionate Share Hospitals (DSH).

1. No hospital may be defined or deemed as a disproportionate share hospital unless the hospital has a Medicaid inpatient utilization rate of not less than one percent. In order to

qualify for reimbursement, a hospital shall meet either of the minimum federal requirements specified in section 1923(b) of the Act. The Act specifies that hospitals must meet one of the following requirements:

a. The Medicaid inpatient utilization rate is greater than one standard deviation above the statewide mean, or;

b. The low-income utilization rate is at least 25%.

2. Additionally, the Act specifies that in order for the hospital to qualify for reimbursement, the hospital must have at least two obstetricians or physicians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the State Medicaid Plan. This does not apply to hospitals where:

   a. The inpatients are predominantly individuals under 18 years of age, or

   b. Non-emergency obstetric services were not offered as of December 21, 1987.

3. AHCA shall only distribute regular DSH payments to those hospitals that meet the requirements of section VI.A. 1., above, and to non-state government owned or operated facilities. The following methodology shall be used to distribute disproportionate share payments to hospitals that meet the federal minimum requirements and to non-state government owned or operated facilities.

   a. For hospitals that meet the requirements of section VI.A.1., above, and do not qualify as a non-state government owned or operated facility, the following formula shall be used:

      DSHP = (HMD/TSMD) x $1 million

      Where:

      DSHP = disproportionate share hospital payment

      HMD = hospital Medicaid days

      TSMD = total state Medicaid days

   Any funds not allocated to hospitals qualifying under this section shall be redistributed to the non-state government owned or operated hospitals with greater than 3,100 Medicaid

days.

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

For state mental health hospitals:

DSHP = (HMD/TMDMH) x TAAMH

The total amount available for the state mental health hospitals shall be the difference between the federal cap for Institutions for Mental Diseases and the amounts paid under the mental health disproportionate share program in section VI.C.

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

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

TAAPH = TAA – TAAMH

For non-state government owned or operated hospitals with less than 3,100 Medicaid days, a total of $750,000 shall be distributed equally among these hospitals.

Where:

TAA = total available appropriation

TAAPH = total amount available for public hospitals

TAAMH = total amount available for mental health hospitals

DSHP = disproportionate share hospital payments

HMD = hospital Medicaid days

TMDMH = total state Medicaid days for state mental health hospitals

TMD = total state Medicaid days for public hospitals

HCCD = hospital charity care dollars

TCCD = total state charity care dollars for public non-state hospitals

For funds appropriated for public disproportionate share payments the TAAPH shall be

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

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

4. Payments shall comply with the limits set forth in section 1923(g-j) of the Social Security Act. Overpayments made in the disproportionate share program will be handled in compliance with 42 CFR Part 433, Subpart F. Should a DSH overpayment be determined, the State will redistribute the recouped overpayment to the providers in the same category of DSH based on the proportion of the original distribution.

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

B. Determination of Disproportionate Share Payments for Teaching Hospitals.

1. Disproportionate share payments shall be paid to statutorily defined teaching hospitals, and family practice teaching hospitals for their increased costs associated with medical education programs and for tertiary health care services provided to the indigent. In order to qualify for these payments, a teaching hospital must first qualify for regular disproportionate share hospital payments based on the criteria contained in section VI.A.,above.

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

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

On or before September 15 of each year, AHCA shall calculate an allocation fraction to be used for distributing funds to state statutory teaching hospitals. Subsequent to the end of each quarter of the state fiscal year, AHCA shall distribute to each statutory teaching

hospital, an amount determined by multiplying one-fourth of the funds appropriated for this purpose times such hospital's allocation fraction. The allocation fraction for each such hospital shall be determined by the sum of three primary factors, divided by three. The primary factors are:

a. The number of nationally accredited graduate medical education programs offered by the hospital, including programs accredited by the Accreditation Council for Graduate Medical Education or programs accredited by the Council on Postdoctoral Training of the American Osteopathic Association and the combined Internal Medicine and Pediatrics programs acceptable to both the American Board of Internal Medicine and the American Board of Pediatrics at the beginning of the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of programs, where the total is computed for all state statutory teaching hospitals;

b. The number of full-time equivalent trainees in the hospital, which comprises two components:

(1) The number of trainees enrolled in nationally accredited graduate medical education programs. Full time equivalents are computed using the fraction of the year during which each trainee is primarily assigned to the given institution, over the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of full-time equivalent trainees enrolled in accredited graduate programs, where the total is computed for all state statutory teaching hospitals.

(2) The number of medical students enrolled in accredited colleges of medicine and engaged in clinical activities, including required clinical clerkships and clinical electives. Full-time equivalents are computed

using the fraction of the year during which each trainee is primarily assigned to the given institution, over the course of the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total number of full-time equivalent students enrolled in accredited colleges of medicine, where the total is computed for all state statutory teaching hospitals.

The primary factor for full-time equivalent trainees is computed as the sum of these two components, divided by two.

c. A service index which comprises three components:

(1) AHCA Service Index, computed by applying the standard Service Inventory Scores established by AHCA to services offered by the given hospital, as reported on AHCA Worksheet A-2, located in the Budget Review section of the Division of Health Policy and Cost Control for the last fiscal year reported to AHCA before the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total Agency for Health Care Service Index values where the total is computed for all state statutory teaching hospitals;

(2) Volume-weighted service index, computed by applying the standard Service Inventory Scores established by AHCA to the volume of each service, expressed in terms of the standard units of measure reported on AHCA Worksheet A-2 for the last fiscal year reported to AHCA beforethe date on which the allocation factor is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total volume-weighted service index values, where the total is computed for all state statutory teaching hospitals;

(3) Total Medicaid payments to each hospital for direct inpatient and outpatient services during the fiscal year preceding the date on which the allocation factor is calculated. This includes payments made to each hospital for such services by Medicaid prepaid health plans, whether the plan was administered by the hospital or not. The numerical value of this factor is the fraction that each hospital represents of the total of such Medicaid payments, where the total is computed for all statutory teaching hospitals.

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

4. By October 1 of each year, the following formula shall be utilized by the department to calculate the maximum additional disproportionate share payment for statutorily defined teaching hospitals:

TAP = THAF x A

Where:

TAP = total additional payment.

THAF = teaching hospital allocation factor.

A = amount appropriated for a teaching hospital disproportionate share program.

C. Mental Health Disproportionate Share Payments

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

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

The following formula shall be used by AHCA to calculate the total amount earned for hospitals

that participate in the mental health disproportionate share program:

TAP = (DSH/TDSH) x TA

Where:

TAP = total additional payment for a mental health hospital

DSH = total amount earned by a mental health hospital under s. 409.911

TDSH = sum of total amount earned by each hospital that participates in the mental health hospital disproportionate share program

TA = total appropriation for the mental health disproportionate share program. In order to receive payments under this section, a hospital must participate in the Florida Title XIX program and must:

1. Agree to serve all individuals referred by AHCA who require inpatient psychiatric services, regardless of ability to pay.
2. Be certified or certifiable to be a provider of Title XVIII services.
3. Receive all of its inpatient clients from admissions governed by the Baker Act as specified in chapter 394.

D. Determination of Rural Hospital Disproportionate Share/Financial Assistance Program.

The agency shall make disproportionate share payments to statutory rural hospitals that qualify for such payments and financial assistance payments to statutory rural hospitals that do not qualify for disproportionate share payments. In order to receive payments under this section, a hospital must be a rural hospital and must meet the following additional requirements:

1. Agree to conform to all Agency requirements to ensure high quality in the provision of services, including criteria adopted by Agency rule concerning staffing ratios, medical records, standards of care, equipment, space, and such other standards and criteria as AHCA deems appropriate as specified by rule.
2. Agree to accept all patients, regardless of ability to pay, on a functional space-available

basis.

3. Agree to provide backup and referral services to the county public health units and other low-income providers within the hospital's service area, including the development of written agreements between these organizations and the hospital.
4. For any hospital owned by a county government that is leased to a management company, agree to submit on a quarterly basis a report to AHCA, in a format specified by AHCA, which provides a specific accounting of how all funds dispersed under this act are spent.
    a. The following formula shall be used by AHCA to calculate the total amount earned for hospitals that participate in the rural hospital disproportionate share program or the financial assistance program:

        TAERH = (CCD + MDD)/TPD

        Where:

        CCD = total charity care-other, plus charity care-Hill Burton, minus 50 percent of unrestricted tax revenue from local governments, and restricted funds for indigent care, divided by gross revenue per adjusted patient day; however, if CCD is less than zero, then zero shall be used for CCD

        MDD = Medicaid inpatient days plus Medicaid HMO inpatient days

        TPD = total inpatient days

        TAERH = total amount earned by each rural hospital

    In computing the total amount earned by each rural hospital, AHCA must use the average of the three (3) most recent years of actual data reported. AHCA shall provide a preliminary estimate of the payments under the rural disproportionate share and financial assistance programs to the rural hospitals by August 31 of each state fiscal year for review. Each rural hospital shall have 30 days to review the preliminary estimates of payments and report any errors to AHCA. AHCA shall make any corrections deemed

necessary and compute the rural disproportionate share and financial assistance program payments.

b. AHCA shall first determine a preliminary payment amount for each rural hospital by allocating all available state funds using the following formula.

PDAER= (TAERH x TARH)/STAERH

Where:

PDAER = preliminary distribution amount for each rural hospital

TAERH = total amount earned by each rural hospital

TARH = total amount appropriated or distributed under this section

STAERH = sum of total amount earned by each rural hospital

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

d. The state funds only payment amount is then calculated for each hospital using the formula:

SFOER = Maximum value of (1) SFOL - PDAER or (2) 0

Where:

SFOER = state funds only payment amount for each rural hospital

SFOL = state funds only payment level, which is set at 4% of TARH. In calculating the SFOER, PDAER includes federal matching funds from paragraph (b).

e. The adjusted total amount allocated to the rural disproportionate share program shall then be calculated using the following formula:

ATARH = (TARH - SSFOER)

Where:

ATARH = adjusted total amount appropriated or distributed under this section

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

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

DAERH = ((TAERH x ATARH)/STAERH)

Where:

DAERH = distribution amount for each rural hospital

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

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

5. This section applies only to hospitals that were defined as statutory rural hospitals, or their successor in-interest hospital, prior to January 1, 2001. Any additional hospital that is defined as a statutory rural hospital, or its successor-in-interest hospital, on or after January 1, 2001, is not eligible for programs under this section unless additional funds are appropriated each fiscal year specifically to the rural hospital disproportionate share and financial assistance programs in an amount necessary to prevent any hospital, or its successor-in-interest hospital, eligible for the programs prior to January 1, 2001, from incurring a reduction in payments because of the eligibility of an additional hospital to participate in the programs. A hospital, or its successor-in-interest hospital, which received funds pursuant to this section before January 1,2001, and which qualifies under s. 395.602(2)(e), shall be included in the programs under this section and is not required to seek additional appropriations under this subsection.

E. Determination of Disproportionate Share Payments for Specialty Hospitals

1. The following formula shall be used by AHCA to calculate the total amount available for

hospitals that participate in the specialty hospital disproportionate share program:

TAE = (MD/TMD) x TA

Where:

TAE = total amount earned by a specialty hospital

TA = total appropriation for payments to hospitals that qualify under this program

MD = total Medicaid days for each qualifying hospital

TMD = total Medicaid days for all hospitals that qualify under this program

2. In order to receive payments under this section, a hospital must be licensed in accordance with Part I of Chapter 395 as a specialty hospital which meets all requirements listed in subsection (2), participates in the Florida Title XIX program, and meets the following requirements:

   a. Be certified or certifiable to be a provider of Title XVIII services.

   b. Receives all of its inpatient clients through referrals or admissions from county public health departments.

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

   d. Retains a contract with the Department of Health to accept clients for admission and inpatient treatment.

F. Disproportionate Share Program for Specialty Hospitals for Children

1. Specialty hospitals for children must be licensed by the state and designated by January 1, 2000, as specialty hospitals for children. The agency may make disproportionate share payments to specialty hospitals for children as provided in the General Appropriations Act. Unless specified in the General Appropriations Act, AHCA shall use the following formula to calculate the total amount earned for hospitals that participate in the children'shospital disproportionate share program:

TAE = DSR x BMPD x MD

Where:

TAE = total amount earned by a children's hospital

DSR = disproportionate share rate

BMPD = base Medicaid per diem

MD = Medicaid Days

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

TAP = [(TAE x TA)/STAE]

Where:

TAP = total additional payment for a specialty hospital for children

TAE = total amount earned by a specialty hospital for children

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

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

3. A hospital may not receive any payments under this section until it achieves full compliance with the applicable rules of AHCA. A hospital that is not in compliance fortwo or more consecutive quarters may not receive its share of the funds. Any forfeited funds must be distributed to the remaining participating hospitals for children that are incompliance.

G. Disproportionate Share Payments for Provider Service Network (PSN) Hospitals

1. The following formula shall be used to pay disproportionate share dollars to provider service network (PSN) hospitals:

DSHP = TAAPSNH x (IHPSND x THPSND)

Where:

DSHP = Disproportionate share hospital payments

TAAPSNH = Total amount available for PSN hospitals

IHPSND = Individual hospital PSN days

THPSND = Total of all hospital PSN days

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

VII. Skilled Nursing Unit (SNU) Reimbursement

Medicaid reimburses Medicaid participating hospitals for the provision of skilled nursing services. These rates are made on the basis of the average nursing home payment for those services in the county in which the hospital is located. If a hospital is located in a county that does not have a nursing home, the payment to the hospital will be the average nursing home service payment for the surrounding counties. Skilled nursing unit services are limited to 30 days for each Medicaid recipient unless prior authorization has been granted by AHCA. Rates published are effective as of the first day of the rate semester.

VIII. Graduate Medical Education

The Graduate Medical Education program (Sections A – G below) is established to improve the quality of care and access to care for Medicaid recipients by supporting graduate medical education activities that are directly linked to the Medicaid program and intended to strengthen the availability of providers serving Medicaid beneficiaries. Payments shall be made to hospitals and qualifying institutions for graduate medical education activities that support Medicaid's objectives of improving quality of care and access for Medicaid beneficiaries and will be administered in compliance with the aggregate UPL requirement. This system of payments is designed to generate federal matching funds under Medicaid and distribute the resulting funds to participating providers on a quarterly basis in each fiscal year for which an appropriation is made.

A. The Statewide Medicaid Residency Program is established to improve the quality of care and access to care for Medicaid recipients, expand graduate medical education on an equitable basis, and increase the supply of highly trained physicians statewide. AHCA shall make payments to hospitals and qualifying institutions for graduate medical education associated with the Medicaid program. This

system of payments is designed to generate federal matching funds under Medicaid and distribute the resulting funds to participating providers on a quarterly basis in each fiscal year for which an appropriation is made.

1. The following formula is used to calculate a participating hospital's allocation fraction:

   HAF= [0.9 x (HFTE/TFTE)] + [0.1 x (HMP/TMP)]

   Where:

   HAF=A hospital's allocation fraction.

   HFTE=A hospital's total number of FTE residents.

   TFTE=The total FTE residents for all participating hospitals.

   HMP=A hospital's Medicaid payments.

   TMP=The total Medicaid payments for all participating hospitals

   The annual allocation shall be calculated by multiplying the funds appropriated in the amount of $191,080,850 for SFY 2024-25 to the Statewide Medicaid Residency Program in the General Appropriations Act by that hospital's allocation fraction. If the calculation results in an annual allocation that exceeds two times the average perFTE resident amount for all hospitals, the hospital's annual allocation shall be reduced to a sumequaling no more than two times the average per FTE resident. The funds calculated for that hospital in excess of two times the average per FTE resident amount for all hospitals shall be redistributed to participating hospitals whose annual allocation does not exceed two times the average per FTE resident amount for all hospitals, using the same methodology and payment schedule specified in this section.

B. Graduate Medical Education Startup Bonus

1. The Graduate Medical Education Startup Bonus Program is established to provide resources for the education and training of physicians in specialties which are in a statewide supply-and-demand deficit. A $100,000 startup bonus is provided for each newly created resident position that is authorized by the Accreditation Council for Graduate Medical Education or Osteopathic Postdoctoral Training Institution in an initial or established accredited training program that is in a

physician specialty in statewide supply-and-demand deficit. In any year in which funding is not sufficient to provide $100,000 for each newly created resident position, funding shall be reduced pro rata across all newly created resident positions in physician specialties in statewide supply-and-demand deficit. This payment methodology ends as of June 30, 2027.

2. Hospitals must submit to the agency by March 1 their Accreditation Council for Graduate Medical Education or Osteopathic Postdoctoral Training Institution approval validating the new resident positions approved on or after March 2 of the prior fiscal year through March 1 of the current fiscal year for the physician specialties identified in a statewide supply-and-demand deficit as provided in the current fiscal year's General Appropriations Act. An applicant hospital may validate a change in the number of residents by comparing the number in the prior period Accreditation Council for Graduate Medical Education or Osteopathic Postdoctoral Training Institution approval to the number in the current year.

3. Any unobligated startup bonus funds on April 15 of each fiscal year shall be proportionally allocated to hospitals for existing FTE residents in the physician specialties in statewide supply-and-demand deficit. The allocation under this subsection may not exceed $100,000 per FTE resident.

4. Physician specialties and subspecialties, both adult and pediatric, in statewide supply-and-demand deficit are those identified below:

    i. allergy or immunology; anesthesiology; cardiology; colon and rectal surgery; emergency medicine; endocrinology; family medicine; gastroenterology; general internal medicine; geriatric medicine; hematology; oncology; infectious diseases; neonatology; nephrology; neurological surgery; obstetrics/gynecology; ophthalmology; orthopedic surgery; pediatrics; physical medicine and rehabilitation; plastic surgery/reconstructive surgery; psychiatry; pulmonary/critical care; radiation oncology; rheumatology; thoracic surgery; urology; and vascular surgery .

C. Primary Care Graduate Medical Education

Payments are made for Full Time Employees (FTE)s in primary care and training in Medicaid regions with

primary care demand greater than supply by 85 percent or more as documented in the IHS Markit Florida Statewide and Regional Physician Workforce Analysis: 2019 to 2035, 2021 Update to Projections of Supply and Demand: Exhibit 23 Physician Gap divided by Supply by Specialty and Medicaid Region, 2035. Of these funds $3,600,000 are provided to fund $100,000 per newly approved internal medicine residency slot effective as of September 2021. The second distribution of these funds in the amount of $4,500,000 shall be distributed proportionally per-FTE to hospitals with greater than or equal to 14 percent Medicaid utilization, based on the 2020 Florida Hospital Uniform Reporting System data as of December 1, 2022. The remaining funds shall be distributed proportionally per the filled State Fiscal Year 2022-2023 Medicaid approved Graduate Medical Education FTEs. This payment methodology ends as of June 30, 2027.

1. Payments are made to fund $150,000 per-FTE in primary care and training in Medicaid Region 1 and 2. Payments are distributed proportionally per the filled State Fiscal Year 2022-2023 Medicaid approved Graduate Medical Education FTEs. This payment methodology ends as of June 30, 2027.

D. High Tertiary Statutory Teaching Graduate Medical Education

Payments are made to statutory teaching hospitals that provide charity care greater than $15 million in charity costs as calculated by the Florida Medicaid Low Income Pool Program and also provide highly specialized tertiary care including: comprehensive stroke and Level 2 adult cardiovascular services; NICU II and III; and adult open heart; shall be designated as a High Tertiary Statutory Teaching Hospital and eligible for funding calculated on a per GME resident-FTE proportional allocation that shall be in addition to any other GME funding. Of these funds, 27,000,000 shall be first distributed to hospitals with greater than 500 unweighted 2021-2022 fiscal year FTEs. The remaining funds shall be distributed proportionally based on the total unweighted 2021-2022 fiscal year FTEs. This payment methodology ends as of June 30, 2027.

E. Mental Health Graduate Medical Education

Payments are made to fund $200,000 per FTE per filled Fiscal Year 2022-2023 unweighted FTE resident, fellow or intern position in an accredited program who rotates through mental health and behavioral health facilities licensed under section 394, Florida Statutes, to address the severe deficit of physicians trained in these specialties. This payment methodology ends as of June 30, 2027.

F. Adult and Child Psychiatry for Federally Qualified Health Centers

Payments are made to fund Psychiatry Residents slots for Federally Qualified Health Centers that hold continued institutional accreditation from the Accreditation Council for Graduate Medical Education in adult and child psychiatry. This payment methodology ends as of June 30, 2027.

G. Indirect Graduate Medical Education

Indirect graduate medical education (IME) payments shall be made to eligible teaching hospitals. These payments recognize the increased use of ancillary services associated with the educational process and the higher case-mix intensity of teaching hospitals. The state shall use the total Diagnosis Related Group (DRG) payment as published in the Medicaid Hospital Funding Programs each state fiscal year to calculate the IME payments.

IX. Alternative Reimbursement Methods

1. Transplant Global Fee

A. Methods Used in Establishing Payment Rates

Reimbursement for globally paid transplants include adult (age 21 and over) heart, liver, lung, intestinal/multi-visceral, and pediatric (age 20 and under) lung and intestinal/multi-visceral transplant surgery services will be paid the actual billed charges up to a global maximum rate established by AHCA. These payments will be made to physicians and facilities that have met specified guidelines and are established as designated transplant centers as appointed by the Secretary of AHCA. The global maximum reimbursement for transplant surgery services is an all-

inclusive payment and encompasses 365 days of transplant related care.

All other transplant rates are published on the Agency's website at

http://ahca.myflorida.com/medicaid/review/fee_schedules.shtml

Only one provider may bill for the transplant phase.

Global maximum rates for transplantation surgery are as follows:

Adult Heart	
Facility	Physician
$207,406	$41,406

Adult Liver	
Facility	Physician
$146,606	$41,406

Adult Lung	
Facility	Physician
$314,375	$50,607

Pediatric Lung	
Facility	Physician
$429,391	$62,569

Adult and Pediatric Intestinal/Multi-visceral	
Facility	Physician
$690,092	$76,677

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

C. Florida Medicaid will make payments for multi-visceral transplant and intestine transplants in Florida. AHCA shall establish a reasonable global fee for these transplant procedures and the payments shall be used to pay approved multi-visceral transplant and intestine transplant facilities a global fee for providing transplant services to Medicaid beneficiaries.

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

2. Tuberculosis Claims

AHCA has established an alternative methodology to the DRG-based prospective payment system to set reimbursement rates for recipients who have tuberculosis that is resistant to therapy who are in need of long-term, hospital-based treatment pursuant to s. 392.62.

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

3. Crossover Claims

Crossover claims are claims for services provided to recipients who are dually eligible for Medicare and Medicaid. The term "crossover" is used to identify any claims that have first gone to Medicare for adjudication and then sent to Florida Medicaid, whether an automatic crossover process from Medicare, or submitted on a paper claim with adjudication information from Medicare. For dual eligible persons, Medicaid is always the payer of last resort. If Medicare considered the claim payable and reduced payment because of coinsurance or patient deductible, then a crossover claim may be sent to Medicaid for consideration of additional payment.

On inpatient crossover claims, Florida Medicaid reimburses Medicare Parts A and C, deductible(s) coinsurance, and copayments for dually eligible recipients, based on the lesser of the amount billed or the Florida Medicaid rate. Florida Medicaid reimbursement for crossover claims is up to the Medicaid rate, less any amount paid by Medicare. If this amount is negative, no Medicaid reimbursement is made. If this amount is positive, Medicaid reimburses: the deductible plus the coinsurance or copayment; or the Medicaid rate, whichever is less.

IX. Payment Assurance

The State shall pay each hospital for services provided in accordance with the requirements of the Florida Title XIX State Plan and applicable State and Federal rules and regulations. The payment amount shall be determined for each hospital according to the standards and methods set forth in the Florida Title XIX

Inpatient Hospital Reimbursement Plan.

X. Provider Participation

This plan is designed to assure adequate participation of hospitals in the Medicaid Program, the availability of hospital services of high quality to recipients, and services that are comparable to those available to the general public.

XI. Revisions

The plan shall be revised as operating experience data are developed and the need for changes is necessary in accordance with modifications in the Code of Federal Regulations.

XII. Payment in Full

Participation in the Medicaid Program shall be limited to hospitals that accept, as payment in full for covered services, the amount paid in accordance with the Florida Title XIX Inpatient Hospital Reimbursement Plan.

XIII. Definitions

A. Actual audited data or actual audited experience - Data reported to AHCA which has been audited in accordance with generally accepted auditing standards of the AICPA by AHCA or representatives under contract with AHCA.

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

C. AHCA - Agency for Health Care Administration.

D. Allowable costs - An item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with Generally Accepted Accounting Principles (GAAP), except as modified by the Principles of Reimbursement for Provider Costs, as defined in CMS PUB. 15-1, except as further modified by the Florida Title XIX Inpatient Hospital Reimbursement Plan.

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

F. APR-DRG – Please see “DRG.”

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

H. Base Reimbursement Rate – For hospitals reimbursed on a per diem basis, a hospital's per diem reimbursement rate before a Medicaid trend adjustment or a buy back is applied. For Hospitals reimbursed by DRG, the Base Rate is a dollar amount assigned to each hospital that gets multiplied by the DRG relative weight and policy adjustor in the calculation of DRG Base Payment.

I. Base Year – State fiscal year of historical claims extracted for pricing simulations used to set rates for an upcoming year.

J. Budget Neutrality – Expenditures in the first year of DRG payment are intended to equal the total expenditures from the previous year, except for standard adjustments made for inflation and fee for service eligibility changes.

K. Buy Back - The buyback provision potentially allows a hospital to decrease their Medicaid Trend Adjustment from the established percent down to zero percent.

L. Case mix – average DRG relative weight

M. CCR – Please see "Cost to Charge Ratio"

N. Charity care or uncompensated charity care - That portion of hospital charges reported to AHCA for which there is no compensation, other than restricted or unrestricted revenues provided to a hospital by local governments or tax districts regardless of the method of payment, for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 200 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds four times the federal poverty level for a family of four be considered charity. Each hospital will determine which patients are charity care patients by a verifiable process subject to the above provisions. In addition, each hospital must provide appropriate documentation of amounts reported as charity care.
For all patients claimed as charity care, appropriate documentation shall include one of the following forms:

1. W-2 withholding forms

2. Paycheck stubs
3. Income tax returns
4. Forms approving or denying unemployment compensation or workers' compensation.
5. Written verification of wages from employer.
6. Written verification from public welfare agencies or any governmental Agency which can attest to the patient's income status for the past twelve (12) months.
7. A witnessed statement signed by the patient or responsible party, as provided for in Public Law 70-725, as amended, known as the Hill-Burton Act, except that such statement need not be obtained within 48 hours of the patient's admission to the hospital, as required by the Hill-Burton Act. The statement shall include an acknowledgment that providing false information to defraud a hospital for the purposes of obtaining goods or services is a misdemeanor in the second (2nd) degree.
8. A Medicaid remittance voucher which reflects that the patient's Medicaid benefits for that Medicaid fiscal year have been exhausted.

   Charges applicable to Hill-Burton and contractual adjustments should not be claimed as charity care.

O. Charity care days - The sum of the deductions from revenues for charity care minus 50 percent of restricted and unrestricted revenues provided to a hospital by local governments or tax districts, divided by gross revenues per adjusted patient day.

P. Community Hospital Education Program (CHEP) hospitals – Hospitals that are administered by the Department of Health. CHEP hospitals offer continuing medical education programs for interns and residents established on a statewide basis. CHEP hospitals provide financial support for interns and residents based on policies recommended and approved by the Department of Health.

Q. Concurrent nursery days - Inpatient nursery days for a Medicaid-eligible newborn whose mother is also an inpatient in the same hospital at the same time. The concept of concurrent nursery days

exists in the per diem payment method (costs are included, days are not), but is not used in the DRG payment method (mother and newborn hospital stays are billed and paid separately).

R. Cost reporting year - A 12-month period of operations based upon the provider's accounting year.

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

T. Cost to Charge Ratio - Used in outlier calculation for claims priced via DRGs. The calculation of hospital-specific cost to charge ratios is described in section IV.D.

U. DOH – Florida Department of Health

V. DRG - Diagnosis-related group (DRG) is a classification system that reflects clinically similar groupings of services that can be expected to consume similar amounts of hospital resources. Florida Medicaid uses the APR-DRGs developed and maintained by 3M. APR-DRGs classify each case based on information contained on the inpatient Medicaid claim such as diagnoses, procedures performed, patient age, patient sex, and discharge status.

W. DRG Payment Parameters – numerical values that are used to determine DRG reimbursement amount on individual claims. The parameters include hospital base rate, DRG relative weight, policy adjustors, outlier loss threshold, outlier marginal cost percentage, hospital cost-to-charge ratios, hospital annual case mix, and children’s hospital average per-discharge add-on payment.

X. DRG Relative Weight - For each DRG a relative weight factor is assigned. These weights are intended to reflect the relative resource consumption of each inpatient stay. The weights are adapted from a national database containing millions of inpatient stays and are then “re-centered”so that the average Florida Medicaid stay in a base year has a weight of 1.00. The DRG relative weight is a weight assigned that reflects the typical hospital resources consumed in care of a patient. For example, the average hospitalization with a DRG weight of 1.5 would consume 50percent more resources than the average hospitalization with a weight of 1.0, while a hospital stay that is assigned a DRG with a weight of 0.5 would require half the resources.

Y. Eligible Medicaid recipient - An individual who meets certain eligibility criteria for the Title XIX

Medical Assistance Program as established by the State of Florida.

AA. Filing Due Date - No later than five (5) calendar months after the close of the hospital's cost-reporting year.

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

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

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

EE. Florida Price Level Index - A spatial index that measures the differences from county to county in the cost of purchasing a specified market basket of items at a particular point in time. The items in the market basket range from various food products to hospital lab fees, and are grouped into the components of food, housing, apparel, transportation, and health, recreation and personal services. A county index for each of the five components is developed bi-annually by the Florida Executive Office of the Governor. County indices are population weighted to average 100 percent. For example, an index of 1.1265 for a given county means that the basket of goods in that county costs 12.65 percent more than the state average. Changes to the methodology utilized in the development of the FPLI will constitute changes in this plan and will require a formal plan amendment.

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

GG. HHS - Department of Health and Human Services

HH. CMS PUB. 15-1 - Health Insurance Manual No. 15, herein incorporated by reference, also

known as the Provider Reimbursement Manual available from The Centers for Medicare and Medicaid Services.

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

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

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

LL. Inpatient general routine operating costs - Costs incurred for the provision of general routine services including the regular room, dietary and nursing services, and minor medical and surgical supplies.

MM. Inpatient hospital services - Services that are ordinarily furnished in a hospital for the care and treatment of an inpatient under the direction of a physician, dentist, or other recognized member of the medical staff and are furnished in an institution that:

1. Is maintained primarily for the care and treatment of patients with disorders other than tuberculosis or mental diseases;
2. Is licensed as a hospital by AHCA;
3. Meets the requirements for participation in Medicare; and
4. Has in effect a utilization review plan, approved by the PRO pursuant to 42 CFR 456.100 (1998), applicable to all Medicaid patients.

NN. Late Cost Report - A cost report is late when it is filed with AHCA, Bureau of Medicaid Program Finance after the Filing Due Date and after the Rate Setting Due Date.

OO. Legislative Unit Cost - The weighted average per diem of the State anticipated expenditure after all rate reductions but prior to any buy back. The concept of Legislative Unit Cost exists in the per diem payment method but is not used in the DRG payment method.

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

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

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

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

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

UU. Medicaid inpatient charges - Usual and customary charges made for inpatient services rendered to Medicaid patients. These charges shall be the allowable charges as reconciled with the hospital Medicaid log and found on the Medicaid paid claims report.

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

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

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

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

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

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

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

CCC. Non-concurrent nursery days - Inpatient nursery days for a Medicaid-eligible newborn whose mother is not an inpatient in the same hospital at the same time. Under the per diem payment method, concurrent and non-concurrent days are treated differently for billing purposes. Under the DRG payment method, all newborn nursery days are considered non-concurrent and are billed separately from services provided to the mother.

DDD. Non-covered services - Those goods and services which are not medically necessary for the care and treatment of inpatients as defined in CMS PUB. 15-1.

EEE. Outlier payment – An extra payment added to some claims priced via the DRG pricing methodology. Outlier payments are made when the estimated hospital cost for an admission far exceeds normal reimbursement for the DRG assigned to the claim.

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

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

HHH. Provider Service Network (PSN) – is defined as a network established or organized and operated by a health care provider, or group of affiliated health care providers, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers.

III. Rate year - A rate year will be from July 1 to June 30 of each year.

JJJ. Rate Setting Due Date - All cost reports postmarked by March 31 and received by AHCA by April 15 shall be used to establish the reimbursement rates.

KKK. Rate Setting Unit Cost - The weighted average per diem after all rate reductions but prior to any buy backs based on filed cost reports. The concept of Rate Setting Unit Cost exists in the per diem payment method but is not used in the DRG payment method.

LLL. Reasonable cost - The reimbursable portion of all allowable costs. Implicit in the meaning of reasonable cost is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs will not be included under the program. The determination of reasonable cost is made on a specific item of cost basis as well as a per diem of overall cost basis.

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

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

OOO. Rural hospital - An acute care hospital with 100 licensed beds or less, which has an emergency room, 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 classified as a sole community hospital under 42 C.F.R. s. 412.92, regardless of the number of licensed beds;

5. 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

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

Population densities used in this paragraph must be based upon the most recently completed United States census. 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.

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

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

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

SSS. Substantially Affected Provider –Any hospital seeking compensations under the challenge of reimbursement rates.

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

UUU. Title V - Maternal and Child Health and Crippled Children's Services as provided for in the

Social Security Act (42 U.S.C. 1396-1396p).

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

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

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

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

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

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

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

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

DDDD. Total inpatient allowable costs – Total inpatient allowable costs are based on the costs allocated to the hospital in the Medicaid version of the CMS 2552 cost report with adjustments for adding in malpractice (if not included in the CMS 2552) and removing the indigent tax assessment (if

included in the CMS 2552). The formula is as follows: Total inpatient allowable costs = Cost report inpatient allowable costs – inpatient indigent care assessment cost adjustment + inpatient malpractice insurance costs.

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

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

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

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

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

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

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

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

MMMM. Total special care costs – the sum of total allowable intensive care unit, coronary care unit, burn intensive care unit, surgical intensive care unit, pediatric intensive care unit, other pediatric special care unit, and ambulance costs, including the applicable general service cost allocation, as reported on the CMS 2552 cost report. Total allowable organ acquisition costs are also included in special care costs to the extent the organ acquisitions are related to organs not included under the global fee.

NNNN. UR Committee - Utilization review committee

APPENDIX A TO FLORIDA TITLE XIX INPATIENT HOSPITAL

REIMBURSEMENT PLAN

ADJUSTMENTS TO ALLOWABLE MEDICAID VARIABLE COSTS

The technique to be utilized to adjust allowable Medicaid variable costs for inflation in the process of computing the reimbursement limits is detailed below. Assume the following DRI (or its successor) Quarterly Indices.

	1996	1997	1998	1999	2000
Q1	213.0	237.7	250.1	278.1	308.0
Q2	217.8	234.5	256.5	285.9	314.9
Q3	222.7	237.9	263.2	294.0	322.0
Q4	227.7	243.8	270.4	301.2	329.3

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

COMPONENTS	WEIGHTS
Wages and Salaries	55.57%
Employee Benefits	7.28%
All Other Products	3.82%
Utilities	3.41%
All Other	29.92%
	100.00%

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

QUARTER	INDEX	AVERAGE INDEX	MONTH
1	213.0		
		215.4	March 31
2	217.8		
		220.3	June 30
3	222.7		
		225.2	Sept. 30
4	227.7		

April 30 Index = (June 30 Index/March 31 Index)$^{1/3}$ (March 31 Index)
= (220.3/215.4)$^{1/3}$ (215.4)
= 217.0
May 31 Index = (June 30 Index/March 31 Index)$^{2/3}$ (March 31 Index)
= (220.3/215.4)$^{2/3}$ (215.4)

= 218.7

All other monthly indices can be calculated in a similar fashion. To determine the applicable inflation factor for a given hospital for the first semester of 1999-2000 the index for September 30, 1999, the midpoint of the rate semester, is divided by the index for the midpoint of the Provider's Fiscal Year. For example, if a hospital has a fiscal year end of November 30, 1996then its midpoint is May 31, and the applicable inflation is:

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

Therefore, the hospital's reported variable cost Medicaid per diem is multiplied by 1.3607 to obtain the estimated average variable Medicaid per diem for the first rate semester of FY1999-2000. Similar calculations utilizing March 31 and the midpoint yield adjustments for the second semester of FY1999-2000.

APPENDIX B TO FLORIDA TITLE XIX INPATIENT HOSPITAL REIMBURSEMENT PLAN

Upper Payment Limit (UPL) Methodology

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

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

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

Florida Medicaid Hospital Inpatient UPL Analysis Method

The analysis generally uses hospital cost as the proxy for the upper payment limit and compares Medicaid payment to hospital cost. This analysis uses the same "base"-year dataset that was used to calculate DRG base rates and payment system parameters for the state fiscal year for which the UPL analysis is performed (referred to as the "rate" year).

For state mental health hospital program providers, the UPL demonstrations are based on information reported in the rate year state mental health hospital program rate calculation worksheets posted on the Agency website. These per diem rate worksheets are derived from the cost reports received by AHCA by April 15th, two and a half months prior to the start of the state fiscal year (which is also the UPL rate year). Because the UPLs for the state mental health hospital program providers are based on the information reported in the rate calculation worksheets, the base year for these hospitals may be different.

The calculations for Medicaid payment and hospital cost are performed differently for the state mental health hospital program and statewide inpatient psychiatric program hospitals than for all other hospitals. Medicaid payment is calculated differently for these hospitals because they are paid via a per diem while all other inpatient facilities are paid via a DRG methodology. Hospital cost is calculated using a cost per-diem for the state mental health hospital program providers. For statewide inpatient psychiatric program hospitals, the UPL is calculated as the estimated Medicare payments based on the Medicare Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS) per diem rate.

DRG Hospitals

SFY 2013/2014 is the first year of DRG pricing of inpatient claims by Florida Medicaid. Thus, starting

with the UPL analysis for SFY 2013/2014, Medicaid payment is calculated by re-pricing historical claims using the rates and DRG pricing rules defined for the UPL rate year. The FFS portion of rate year graduate medical education (GME) and indirect medical education (IME) inpatient supplemental payments are then added to this estimate of DRG claims-based payments for each hospital.

Hospital cost is calculated by first determining a Florida Medicaid cost-to-charge ratio for each hospital for the base year. The applicable cost-to-charge ratio is then multiplied by base year charges to get hospital cost for each claim for the base year. An inflation factor is then applied to estimate hospital cost in the rate year. The Medicaid FFS portion of projected rate year inpatient hospital assessments are then added to this estimate of hospital cost for each hospital.

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

Non-DRG Hospitals (State Mental Health Hospital Program and Statewide Inpatient Psychiatric Program Hospitals)

For state mental health hospital program providers, the UPL demonstrations are based on information reported in the most recent available state mental health hospital program rate calculation worksheets posted on the Agency website. Medicaid payments are calculated as the Medicaid days reported in the rate calculation worksheets multiplied by each hospital's rate year Medicaid per diem rate.

For statewide inpatient psychiatric program hospitals, the UPL demonstrations are based on base year claims data. Medicaid payments are calculated as the covered days reported in the base year claims multiplied by the statewide inpatient psychiatric program Medicaid per diem rate effective as of the beginning of the rate year.

The FFS portion of rate year graduate medical education (GME) and indirect medical education (IME) inpatient supplemental payments are added to the estimate of claims-based payments for all non-DRG hospitals.

Hospital cost is calculated using a cost per-diem for state mental health hospital program providers. For statewide inpatient psychiatric program hospitals, the UPL is calculated as the estimated Medicare payments according to the Medicare Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS) per diem rate.

Source of Hospital Cost Data

Non-DRG Hospitals (State Mental Health Hospital Program and Statewide Inpatient Psychiatric Program Hospitals)

For state mental health hospital program providers, the UPL demonstrations are based on information reported in the most recent available state mental health hospital program rate calculation worksheets posted on the Agency website. A Medicare cost per-diem is calculated as the all-payer costs (cell A9) divided by all-payer days (cell E2), as reported in the rate calculation worksheets.

For statewide inpatient psychiatric program hospitals, the Medicare Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS) per diem rate effective as of the beginning of the rate year is used to estimate Medicare payments.

DRG Hospitals

Full hospital inpatient cost is retrieved from the Medicare cost reports from the CMS Healthcare Cost Report Information System (HCRIS) that align with the base year claims experience using the following process:

1. Routine costs are summed from Worksheet C Part I, Column 5, Lines '03000' through '04699' (Inpatient Routine Service Cost Centers).

2. Total ancillary costs are summed from Worksheet C Part I, Column 5, Lines '05000' through '07699', '09000' through '09399', and '09600' through '09999' ("Included Ancillary Services Cost Centers").

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

   Percentage of ancillary costs from inpatient services = [(Total inpatient charges for Included Ancillary Service Cost Centers from Worksheet C Part I, Column 6) divided by (Total inpatient and outpatient charges for Included Ancillary Service Cost Centers from Worksheet C Part I, Columns 6 and 7)]

4. Total ancillary costs calculated in step 2 are multiplied by the percentage of ancillary costs from inpatient services calculated in step 3 to get inpatient ancillary costs.

5. Graduate medical education costs are summed from Worksheet B Part I, Columns 21 and 22, Lines '03000' through '11700'.

6. Inpatient routine, inpatient ancillary, and graduate medical education costs from steps 1, 4, and 5 are summed. 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.

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

1. Total inpatient charges are taken from Worksheet C Part I, Column 6, Lines '03000' through '07699', '09000' through '09399', and '09600' through '09999'.

Source of Medicaid Claim Data

Medicaid claims data used in UPL demonstrations is extracted from a data warehouse fed from the Florida MMIS. For each hospital, claims are selected if they contain a date of discharge within the base year. For state mental health hospital program providers, the UPL demonstrations are based on information reported in the most recent available state mental health hospital program rate calculation worksheets posted on the Agency website.

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

Medicaid inpatient claims with date of service in the UPL base year.

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

Source of Medicaid Per Diem Data

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

For statewide inpatient psychiatric program hospitals, the actual per diem paid by Florida Medicaid as of the beginning of the rate year is retrieved from the Agency's hospital rates website.

Calculation of Upper Payment Limit

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

DRG Reimbursed Hospitals

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

Cost-to-charge ratios are calculated based on data from each hospital's cost reports aligning with the base year. This ensures that the cost-to-charge ratio is applicable for the claims used in the UPL analysis. To calculate hospital cost on each claim, the base year claim charges are multiplied by the cost-to-charge ratio.

Hospital costs are inflated from the midpoint of the base year to the midpoint of the 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 inpatient hospital assessment is added, which is the total inpatient assessment multiplied by the percentage of Medicaid revenue relative to total revenue, and then multiplied by the percentage of base year FFS Medicaid inpatient charges relative to total Medicaid inpatient 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.

Non-DRG Hospitals (State Mental Health Hospital Program and Statewide Inpatient Psychiatric Program Hospitals)

For state mental health hospital program providers, hospital cost is calculated by multiplying each hospital's base year full cost per diem times the number of Medicaid covered days reported for the base year. Full cost per diems are calculated by AHCA annually as part of the inpatient per diem rate setting process and are based on data included in Medicare cost reports, or in some cases, in Medicaid-specific cost reports, filed by hospitals to AHCA. Final Medicaid inpatient per diems differ from the full cost per diems because of a variety of rate cuts and rate ceilings which reduce the per diems along with rate-cut buybacks made by some hospitals which increase per diems. Each hospital's final Medicaid inpatient per diem is never more than the hospital's full cost per diem. Hospital costs are inflated from the midpoint of the base year to the midpoint of the 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.

For statewide inpatient psychiatric program hospitals, estimated Medicare FFS payments are calculated by multiplying the Medicare Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS) per diem rate effective as of the beginning of the rate year by the number of Medicaid covered days in the base year claims.

Calculation of Medicaid Payment

DRG Reimbursed Hospitals

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

Non-DRG Hospitals (State Mental Health Hospital Program and Statewide Inpatient Psychiatric Program Hospitals)

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

Comparison of Medicaid Payment to Upper Payment Limit

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

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

APPENDIX C TO FLORIDA TITLE XIX INPATIENT HOSPITAL

REIMBURSEMENT PLAN

DRG Pricing Examples

Please note, the examples in this appendix are for illustrative purposes only and do not necessarily match the exact rounding of calculations performed within the MMIS. In addition, the base rate and policy adjustors used in these examples do not exactly match the values being used for inpatient claim reimbursement.

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

- Claim Payment = DRG Base Payment + Outlier Payment + Children's Hospital Add-On Payments + Trauma Rate Enhancement
- DRG Base Payment = Provider base rate * DRG relative weight * Maximum policy adjustor
- Outlier Payment = (Estimated Loss – Outlier Loss Threshold) * Marginal Cost Factor
- Estimated Hospital Loss = (Billed Charges * Provider Cost to Charge Ratio) – DRG Base Payment
- For transfer claims, Transfer Base Payment = (DRG Base Payment / ALOS) * (1 + Actual Length of Stay)
- For non-covered days and charge cap, Adjusted Payment = (DRG Base Payment * Proration Factor) + (Outlier Payment * Proration Factor) + Children's Hospital Add-On Payment + Trauma Rate Enhancement

In all the examples below the following parameters are used:

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

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

Basic example:

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

Outlier example:

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

Maximum policy adjustor example:

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

Transfer example:

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

Non-covered day example:

Filed Charge	$34,000.00
Provider CCR	38.356%
DRG Relative Weight	2.1852
Length of Stay	5
Covered Days	2
Max Policy Adjustor	1.0
Provider Base Rate	$3,000.00
Outlier Threshold	$60,000
Marginal Cost Percentage	60%
DRG Base	$6,555.60
Estimated Hospital Cost	$13,041.04
Estimated Loss	$6,485.44
Loss Above Threshold	$0
Outlier Payment	$0
Adjusted DRG Payment:	
Non-covered Day ProrationFactor	0.4000
DRG Base	$2,622.24
Outlier Payment	$0.00
Children's Hospital Add-On Payment	$5,070.10
Trauma Rate Enhancement	$288.45
Claim Payment	$7,980.79

Charge cap example:

Filed Charge	$5,000.00
Provider CCR	38.356%
DRG Relative Weight	2.1852
Max Policy Adjustor	1.0
Provider Base Rate	$3,000.00
Outlier Threshold	$60,000
Marginal Cost Percentage	60%
DRG Base	$6,555.60
Estimated Hospital Cost	$1,917.80
Estimated Loss	$0
Loss Above Threshold	$0
Outlier Payment	$0
Adjusted DRG Payment:	
Charge Cap Proration Factor	0.762707
DRG Base	$5,000.00
Outlier Payment	$0.00
Children's Hospital Add-On Payment	$5,070.10
Trauma Rate Enhancement	$550.00
Claim Payment	$10,620.10

APPENDIX D TO FLORIDA TITLE XIX INPATIENT HOSPITAL REIMBURSEMENT PLAN

Certified Public Expenditures (CPE) Protocol Methodology

The Florida Medicaid Agency uses the CMS 2552-10 cost report, which was prepared based on Medicare cost reporting principles, as the basis for ensuring proper cost allocation and apportionment for services provided to Medicaid eligible beneficiaries and individuals with no source of third-party insurance. Worksheets from the CMS 2552-10 cost report will be identified as appropriate in this appendix to ensure proper calculation of cost to be certified as public expenditures (CPE) for Mental Health Hospitals. AHCA will use the protocol below.

Protocol for Determining CPE:

To the extent that there are expenditures a hospital provider wants to make against the cost limit, and the methodology for capturing such expenditures is not stated in this protocol, the expenditures will need to be approved by CMS and the State prior to the submission of the reconciliation for the applicable period for the expenditures. The protocol will be prospectively modified to include such prior approval, and the claiming protocol will be prospectively incorporated into the protocol when the protocol is next updated.

A per diem is calculated by dividing total costs by total days. In this attachment, a per diem is referencing a calculation found in the *CMS Medicare 2552-10 Cost Report* and is not referring to hospital reimbursement calculations.

A. Hospital's Cost Limit

1. Hospital's Medicaid Fee-For-Service (FFS)

   For the State payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are to be determined using the hospital's Medicare cost report (CMS-2552-10) on file with Florida Medicaid for the annual rate setting. The per diems and cost-to-charge ratios are calculated as follows:

   Step 1

   Total hospital costs for the payment year are identified from Worksheet B Part I Column 24; Line 118 (excludes non-reimbursable cost centers). These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series. These costs should match Line 202 on Worksheet C.

   Step 2

   The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 8 (Total All Patients), Lines 14 plus Line 28 (Observation Beds). The hospital's

total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8 Lines 50-116 (Ancillary Cost Centers).

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552-10 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing hospital costs and non-medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid FFS inpatient routine cost center costs for the payment year, the hospital's actual inpatient Medicaid days by cost center, as obtained from FMMIS for the period covered by the as-filed (most recent base year) cost report, will be used. The covered days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing hospital, skilled nursing hospital, and long term care services are excluded.

Step 5

To determine Medicaid FFS ancillary costs for the payment year, the hospital's actual Medicaid FFS allowable charges, as obtained from FMMIS for the period covered by the most recent base year cost report, will be used. Medicaid FFS allowable charges for ancillary observation beds must be included in line 92. These Medicaid FFS allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid FFS allowable costs for each cost center. The Medicaid FFS allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.

Step 6

The Medicaid allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-4 Part III under the Part B cost column line 62. This ratio is then multiplied by total organ acquisition costs from Worksheet D-4 Part III under the Part A cost column line 61. For this calculation, a usable organ is defined as the number of organs excised and furnished to anorgan procurement organization. Medicaid "usable organs" are counted as the number of Medicaidpatients (recipients) who received an organ transplant. A donor's routine days and ancillary chargesshall not be duplicative of any Medicaid days and charges in Steps 4 and 5 above, or any Medicaidmanaged care or uninsured days and charges in Steps 4 and 5 of those portions of this protocol.

Step 7

The Medicaid FFS allowable costs are determined by adding the Medicaid routine costs from Step 4, the Medicaid ancillary costs from Step 5 and the Medicaid organ acquisition costs from Step 6.

2. Hospital's Medicaid Managed Care

For the State payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's Medicare cost report(s) (CMS-2552-10) covering the payment year, as filed with Florida Medicaid. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified from Worksheet B Part I Column 24 line 118 (excludes non-reimbursable cost centers). These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series. These costs should match up to the same lines as charges on Worksheet C.

Step 2

The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 8. The hospital's total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8 Lines 50-116 (Ancillary Cost Centers).

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552-10 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing hospital costs and non-medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid managed care for the payment year are determined as follows:

Step 4

To determine the Medicaid managed care inpatient routine costs for the payment year, the hospital's actual Medicaid managed care inpatient days by cost center, as obtained from FMMIS for the period covered by the as-filed (most recent base year) cost report, will be used. The covered days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid managed care allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing hospital, skilled nursing hospital, and long term care services are excluded.

Step 5

To determine the Medicaid managed care ancillary costs for the payment year, the hospital's actual Medicaid managed care charges, as obtained from FMMIS for the period covered by the most recent base year cost report will be used. Medicaid managed care allowable charges for ancillary observation beds must be included in line 92. These Medicaid managed care allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid managed care allowable costs for each cost center. The Medicaid managed care allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.

Step 6

The Medicaid managed care allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid managed care usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-4 Part III under the Part B cost column line 62. This ratio is then multiplied by total organ acquisition costs from Worksheet D-4 Part III under the Part A cost column line 61. "Medicaid managed care usable organs" are counted as the number of Medicaid managed care patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid managed care days and charges in Steps 4 and 5 above (or any Medicaid days or uninsured days in Steps 4 and 5 of those portions of this protocol).

Step 7

The Medicaid managed care allowable costs are determined by adding the Medicaid managed care routine costs from Step 4, the Medicaid managed care ancillary costs from Step 5 and the Medicaid managed care organ acquisition costs from Step 6.

3. Hospital's Uninsured/Underinsured

For the payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's most recent as filed Medicare cost report (CMS-2552-10), as filed with Florida Medicaid. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified from Worksheet B Part I Column 26 line 118 (excludes non-reimbursable cost centers). These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series. These costs should match up to the same lines as charges on Worksheet C.

Step 2

The hospital's total actual days by routine cost center are identified from Worksheet S-3 Part 1 Column 8. The hospital's total actual charges by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total actual costs from Step 1 by total actual days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total actual costs from Step 1 by the total actual charges from Step 2. The A&P routine per diem, in accordance with CMS-2552-10 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing hospital costs and private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's actual costs for the payment year. The data sources utilized to determine eligible costs under this section must be derived from the hospitals FMMIS pull. The hospital costs for care provided to those with no source of third-party coverage (i.e., uninsured cost) for the payment year are determined as follows:

Step 4

To determine the uninsured routine cost center costs for the payment year, the hospital's actual inpatient days by cost center for individuals with no source of third-party coverage are used. The actual uninsured days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the low-income uncompensated care inpatient costs for each cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing hospital, skilled nursing hospital, and long term care services are excluded.

Step 5

To determine the uninsured ancillary cost center actual costs for the payment year, the hospital's inpatient and outpatient actual charges by cost center for individuals with no source of third-party coverage are used. These allowable uninsured charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the uninsured allowable costs for each cost center. The uninsured care charges for the payment year should only pertain to inpatient and outpatient hospital services and should exclude charges pertaining to any professional services or non-hospital component services such as hospital-based providers.

Step 6

The uninsured care share of organ acquisition costs is determined by first finding the ratio of uninsured care usable organs to total usable organs. This is determined by dividing the number of uninsured usable organs as identified from provider records by the hospital's total usable organs from Worksheet D-4 Part III under the Part B cost column line 62. This ratio is then multiplied by total organ acquisition costs from Worksheet D-4 Part III under the Part A cost column line 61. "Uninsured usable organs" are counted as the number of patients who received an organ transplant and had no insurance. A donor's routine days and ancillary charges shall not be duplicative of any

Medicaid or uninsured days and charges in Steps 4 and 5 above or Steps 4 and 5 of the Medicaid (or Medicaid managed care) portion of this protocol.

Step 7

The eligible uninsured care costs are determined by adding the uninsured care routine costs from Step 4, uninsured ancillary costs from Step 5 and uninsured organ acquisition costs from Step 6.

Actual uninsured data for services furnished during the payment year are used to the extent such data can be verified to be complete and accurate. The data sources utilized to determine eligible costs under this section must be derived from hospitals' audited financial statements and other auditable documentation.

APPENDIX E TO FLORIDA TITLE XIX INPATIENT HOSPITAL REIMBURSEMENT PLAN

Calculation Examples of Allowable Cost for Per Diem Rate-Setting

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

Please note, the examples shown in this appendix are for illustrative purposes only and do not necessarily indicate every worksheet, line, or column on the CMS 2552-10 cost report to be used in a given calculation. The example lines are based on one version of the 2552-10 CMS cost report and do not attempt to cover every scenario of cost reporting that could occur. Equivalent worksheets, lines, and columns will be used in other versions of the CMS 2552 cost report.

Total Hospital Charges Example

	Description	Amount	CMS 2552-10
1.	Total Outpatient Charges:	$50,000,000	W/S G-2, Pt. I, Line 28, Col. 2
2.	Less Skilled Nursing Facility:	$1,000,000	W/S G-2, Pt. I, Line 7, Col. 2
3.	Less Home Health Agency:	$1,000,000	W/S G-2, Pt. 1, Line 22, Col. 2
4.	Total Hospital Outpatient Charges:	$48,000,000	Line 1 less Lines 2 and 3, in this example
5.	Total Inpatient Charges:	$100,000,000	W/S G-2, Pt. I, Line 28, Col. 1
6.	Less Skilled Nursing Facility:	$5,000,000	W/S G-2, Pt. I, Line 7, Col. 1
7.	Less Home Health Agency:	$5,000,000	W/S G-2, Pt. 1, Line 22, Col. 1
8.	Total Hospital Inpatient Charges:	$90,000,000	Line 5 less Lines 6 and 7, in this example
9.	Total Hospital Charges:	$138,000,000	Line 4 plus Line 8, in this example

Total Hospital Outpatient Ancillary Costs Example

	Description	Amount	CMS 2552-10
1.	Total Hospital Outpatient Charges:	$48,000,000	See above
2.	Total Hospital Charges:	$138,000,000	See above
3.	Outpatient Charge Ratio:	0.3478	Line 1 / Line 2, in this example
4.	Multiplied by Total Hospital Ancillary Costs:	$30,665,440	Medicaid W/S C, Pt. I, Sum of Lines 50 through 76.99, Col. 1
5.	Total Hospital O/P Ancillary Costs:	$10,665,440	Line 3 multiplied by Line 4, in this example

Total Outpatient Allowable Costs Example

	Description	Amount	CMS 2552-10
1.	Total Hospital O/P Ancillary Costs:	$10,665,440	See above
2.	Plus Other Hospital O/P Costs:	$2,804,560	Medicaid W/S C, Pt. I, Sum of Lines 90 through 92.99, Col. 1
3.	Less Medicaid O/P Lab Cost:	$70,000	Medicaid W/S D, Pt. V, Sum of Lines 60 through 60.99, Col. 6
4.	Less Observation Costs:	$200,000	Medicaid W/S C, Pt. I, Sum of Lines 92 through 92.99, Col. 1
5.	Total Outpatient Allowable Costs:	$13,200,000	Line 1 Plus Line 2 Less Lines 3 and 4, in this example

Florida Medicaid Inpatient Days

	Description	Days	CMS 2552-10
1.	Medicaid Hospital Inpatient Days Excluding Newborn and HMO:	2,000	W/S S-3, Pt. I, Col. 7, Line 14, less Line 13
2.	Plus Medicaid Sub-Provider Inpatient Days:	200	W/S S-3, Pt. I, Col. 7, Line 16 + Line 17
3.	Florida Medicaid Inpatient Days:	2,200	Sum of Lines 1 and 2, in this example

Florida Medicaid Newborn Inpatient Days Example

	Description	Days	CMS 2552-10
1.	Medicaid Non-Concurrent Nursery Days:	2,000	Reported Separately by Hospitals

Total Florida Medicaid Days Example

	Description	Days	CMS 2552-10
1.	Florida Medicaid Inpatient Days:	2.200	See section above
2.	Plus Florida Medicaid Newborn Inpatient Days:	2,000	See section above
3.	Total Florida Medicaid Days:	4,200	Sum of Lines 1 and 2, in this example

Newborn Inpatient Days Example

	Description	Days	CMS 2552-10
1.	Nursery Inpatient Days:	15,000	W/S S-3, Pt. I, Col. 8, Line 13
2.	Plus Neonatal Intensive Care Unit Inpatient Days:	3,000	W/S S-3, Pt. I, Col. 8, Line 12
3.	Newborn Inpatient Days	18,000	Sum of Lines 1 and 2, in this example

Hospital Inpatient Days Example

	Description	Days	CMS 2552-10
1.	Total Hospital Inpatient Days excluding Newborn:	15,000	W/S S-3, Pt. I, Col. 8, Line 14, less Lines 12 and 13
2.	Plus Total Sub-Provider Inpatient Days:	600	W/S S-3, Pt. I, Col. 8, Line 16 + Line 17
3.	Hospital Inpatient Days:	15,600	Sum of Lines 1 and 2, in this example

Total Hospital Days Example

	Description	Days	CMS 2552-10
1.	Newborn Inpatient Days:	18,000	See above
2.	Plus Hospital Inpatient Days:	15,600	See above
3.	Total Hospital Days	33,600	Sum of Lines 1 and 2, in this example

Total Inpatient Ancillary Costs Example

	Description	Amount	CMS 2552-10
1.	Total Hospital Ancillary Costs:	$30,665,440	Medicaid W/S C, Pt. I, Sum of Lines 50 through 76.99, Col. 1
2.	Less Total Hospital O/P Ancillary Costs:	$10,665,440	See above
3.	Total Inpatient Ancillary Costs:	$20,000,000	Line 1 less Line 2, in this example

Total Routine Costs Example

	Description	Amount	CMS 2552-10
1.	Adults & Pediatrics Routine Costs:	$9,000,000	Medicaid W/S C, Pt. I, Col. 1, Line 30 or Medicaid D-1, Pt. I, Col. 1, Line 27 (if swing-bed exists)
2.	Plus Sub-Provider Routine Costs:	$1,000,000	Medicaid W/S C, Pt. I, Sum of Lines 40 through 41.99, Col. 1
3.	Total Routine Costs:	$10,000,000	Line 1 plus Line 2, in this example

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Total Special Care Costs Example

	Description	Amount	CMS 2552-10
1.	Intensive Care Unit Routine Costs:	$1,100,000	Medicaid W/S C, Pt. I, Sum of Lines 31 through 31.99, Col. 1
2.	Plus Coronary Care Unit Routine Costs:	$700,000	Medicaid W/S C, Pt. I, Sum of Lines 32 through 32.99, Col. 1
3.	Plus Burn ICU Routine Costs:	$200,000	Medicaid W/S C, Pt. I, Sum of Lines 33 through 33.99, Col. 1
4.	Plus Surgical ICU Routine Costs:	$500,000	Medicaid W/S C, Pt. I, Sum of Lines 34 through 34.99, Col. 1
5.	Plus Pediatric ICU Routine Costs:	$300,000	Medicaid W/S C, Pt. I, Line 35.00, Col. 1
6.	Plus Pediatric Surgical ICU Routine Costs:	$200,000	Medicaid W/S C, Pt. I, Line 35.01, Col. 1
7.	Plus Ambulance Costs:	$500,000	Medicaid W/S C, Pt. I, Line 95, Col. 1
8.	Total Special Care Costs:	$ 3,500,000	Sum of Lines 1 through 7, in this example

Total Newborn Routine Costs Example

	Description	Amount	CMS 2552-10
1.	Nursery Routine Costs:	$500,000	Medicaid W/S C, Pt. I, Line 43, Col. 1
2.	Plus Newborn ICU Routine Costs:	$1,200,000	Medicaid W/S C, Pt. I, Line 35.02, Col. 1
2.	Plus Newborn SCU Routine Costs:	$8000,000	Medicaid W/S C, Pt. I, Line 35.03, Col. 1
3.	Total Newborn Routine Costs:	$2,500,000	Sum of Lines 1 through 3, in this example

Total Intern and Resident Costs in Non-Approved Programs Example

	Description	Amount	CMS 2552-10
1.	I&R Costs in Non-Approved Programs:	$800,000	W/S B, Pt. I, Line 100, Col. 24

Cost Report Inpatient Allowable Costs Example

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

Total Inpatient Adjustments (Indigent Care Assessment) Example

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

Total Inpatient Malpractice Insurance Costs Example

Note: Example calculation only applies to malpractice insurance cost excluded from the CMS 2552-10 cost report.

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

Total Inpatient Allowable Costs Example

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

Total Allowable Hospital Fixed Costs Example

	Description	Amount	CMS 2552-10
1.	Total Capital Costs:	$5,700,000	W/S B, Pt. II, Line 118, Col. 2a
2.	Less SNF Capital Costs:	$150,000	W/S B, Pt. II, Line 44, Col. 2a
3.	Less HHA Capital Costs:	$50,000	W/S B, Pt. II, Sum of Lines 101 through 101.99, Col. 2a
4.	Total Allowable Capital Costs:	$5,500,000	Line 1 Less Lines 2 and 3, in this example

Medicaid Inpatient Ancillary Costs Example

	Description	Amount	CMS 2552-10
1.	Medicaid I/P Hospital Ancillary Costs:	$2,000,000	Hospital Medicaid W/S D-1, Part II, Line 48, Col. 1
2.	Plus Medicaid I/P Sub-Provider Ancillary Costs:	$100,000	Sum of Sub-Providers' Medicaid W/S D-1, Part II, Line 48, Col. 1
3.	Medicaid I/P Ancillary Costs:	$2,100,000	Line 1 Plus Line 2, in this example

Medicaid Routine Costs Example

	Description	Amount	CMS 2552-10
1.	Medicaid Adults & Pediatrics Routine Costs:	$1,000,000	Hospital Medicaid W/S D-1, Part II, Line 41, Col. 1
2.	Plus Medicaid Sub-Provider Routine Costs:	$200,000	Sum of Sub-Providers' Medicaid W/S D-1, Part II, Line 41, Col. 1
3.	Medicaid Routine Costs:	$1,200,000	Line 1 Plus Line 2, in this example

Medicaid Special Care Costs Example

	Description	Amount	CMS 2552-10
1.	Medicaid ICU Routine Costs:	$100,000	Medicaid W/S D-1, Part II, Line 43, Col. 5
2.	Plus Medicaid CCU Routine Costs:	$100,000	Medicaid W/S D-1, Part II, Line 44, Col. 5
3.	Plus Medicaid Burn ICU Routine Costs:	$25,000	Medicaid W/S D-1, Part II, Line 45, Col. 5
4.	Plus Medicaid Surgical ICU Routine Costs:	$35,000	Medicaid W/S D-1, Part II, Line 46, Col. 5
5.	Plus Medicaid Pediatric ICU Routine Costs:	$75,000	Medicaid W/S D-1, Part II, Line 47, Col. 5
6.	Plus Medicaid Pediatric Surgical ICU Routine Costs:	$65,000	Medicaid W/S D-1, Part II, Line 47.01, Col. 5
7.	Medicaid Special Care Costs:	$ 400,000	Sum of Lines 1 through 6, in this example

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Medicaid Newborn Routine Costs Example

	Description	Amount	CMS 2552-10
1.	Medicaid Nursery Routine Costs:	$200,000	Medicaid W/S D-1, Part II, Line 42, Col. 5
2.	Plus Medicaid Newborn ICU Routine Costs:	$300,000	Medicaid W/S D-1, Part II, Line 47.02, Col. 5
3.	Plus Medicaid Newborn SCU Routine Costs:	$200,000	Medicaid W/S D-1, Part II, Line 47.03, Col. 5
4.	Medicaid Newborn Routine Costs:	$700,000	Sum of Lines 1 through 3, in this example

Medicaid Intern and Resident Costs in Non-Approved Programs Example

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

Cost Report Inpatient Medicaid Costs Example

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

Medicaid Inpatient Adjustments (Indigent Care Assessment) Example

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

Medicaid Inpatient Malpractice Insurance Costs Example

Note: Example calculation only applies to malpractice insurance cost excluded from the CMS 2552-10 cost report.

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

Total Inpatient Medicaid Costs Example

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

Total Medicaid Fixed Costs Example

	Description	Amount	CMS 2552-10
1.	Total Hospital Medicaid Charges:	$15,000,000	W/S E-3, Pt. VII, Line 12 Col. 1 and 2 (Hospital and Sub-Providers)
2	Less Total Hospital O/P Medicaid Ancillary Charges:	$2,500,000	Medicaid W/S D, Pt. V, Line 202, Col. 3
3.	Total Hospital Inpatient Medicaid Charges:	$12,500,000	Line 1 Less Line 2, in this example
4.	Divided by Total Hospital Inpatient Charges:	$90,000,000	See above
5.	Multiplied by Total Allowable Hospital Fixed Costs:	$5,500,000	See above
6.	Total Medicaid Fixed Costs:	$763,889	Line 3Divided by Line 4 Multiplied by Line 5, in this example

Acronyms / Abbreviations Used

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

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