FLORIDA TITLE XIX OUTPATIENT HOSPITAL

REIMBURSEMENT PLAN

VERSION XXXV

EFFECTIVE DATE: July 1, 2023

I. Purpose of the Plan

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

II. Standard

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

B. The Agency for Health Care Administration (AHCA) shall implement a methodology for establishing base reimbursement rates for each hospital. The base reimbursement rate is defined in Section III.

C. The list of covered revenue codes is attached as Appendix A. Certain revenue codes are not reimbursed by Florida Medicaid. Service rendered under these codes shall not be billed to Florida Medicaid. Revenue code 510 Clinic/General is reimbursable by Florida Medicaid for health care services, in outpatient clinic facilities where a non-state government owned or operated facility assumed the fiscal and operating responsibilities of one or more primary care centers previously operated by the Florida Department of Health or the local county government. Public hospital providers that have assumed the fiscal and operating responsibilities of one or more primary care centers previously operated by the Florida Department of Health or the local county government must include revenue code 510 to be reimbursed for clinic services using the UB-04 claim form or 837I electronic claim.

III. Enhanced Ambulatory Patient Group (EAPG) Reimbursement

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

A. Applicability

AHCA calculates reimbursement for hospital outpatient visits using an EAPG-based methodology. This methodology applies to all in-state and out-of-state general acute care hospitals, rural hospitals, children's specialty hospitals, teaching hospitals, cancer specialty hospitals, rehabilitation specialty hospitals, long term acute care specialty hospitals, critical access hospitals, and state-owned psychiatric specialty hospitals.

For hospitals reimbursed via the EAPG-based methodology, all outpatient services provided at these facilities and billed on a UB-04 paper claim form or an 837I electronic claim are covered by the EAPG payment with the following exceptions: global transplant services, infant and newborn hearing screening, vagus nerve stimulator devices, and clinic services billed on the CMS 1500 claim form.

B. EAPG Codes and Relative Weights

1. AHCA utilizes EAPGs created by 3M Health Information Systems (HIS) for assigning classifications to services and materials identified on outpatient claims.
2. Services included in the Centers for Medicare and Medicaid Services (CMS) inpatient only (IPO) procedure list are assigned to non-payable EAPG codes.
3. The EAPG relative weights utilized are national EAPG relative weights calculated by 3M HIS

using a database containing millions of hospital outpatient visits. The relative weights are available on the AHCA website at the following link:

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

4. EAPG version 3.18 codes and national relative weights are being used for hospital outpatient pricing in State Fiscal Year (SFY) 2023-2024. The Florida State Fiscal Year is July 1 through June 30.

C. Hospital Base Rates

1. Separate standardized EAPG hospital base rates are calculated for:
   a. Hospitals with signed agreements to participate in the Florida Medicaid program
   b. Hospitals that do not have signed agreements to participate in the Florida Medicaid program.

2. Provider policy adjustors allow for payment adjustments to specific providers. The Rural Hospital Provider Adjustor is 1.5428 and the High Medicaid Outpatient Utilization Hospital Adjustor is 2.1258.
3. Base rates and other EAPG pricing methodology parameters are established by AHCA to achieve neutrality cost projections and to be compliant with federal upper payment limit requirements.
4. EAPG base rates and projected changes in hospital Medicaid outpatient reimbursement are calculated using historical claims data from a period, referred to as the "base period". Claim data from the base period is used to simulate future outpatient Medicaid claim payments for the purpose of setting the new rate year EAPG base rates and other EAPG payment parameters. Baseline payment is calculated by applying rates from the year immediately preceding the upcoming rate year to the claims in the base period dataset. The new rate year EAPG base rate and associated EAPG payment parameters are set to an approximate baseline payment to achieve cost projections. The claim payments from the base period may be adjusted for Medicaid volume, inflation, and legislative direction so that the base period data approximates the upcoming rate year as closely as possible.

5. Because most Florida Medicaid recipients are enrolled in statewide Medicaid managed care, the base period historical claims dataset includes claims from both the fee-for-service and managed care programs. A Florida Medicaid recipient is any individual whom the Florida Department of Children and Families, or the Social Security Administration on behalf of AHCA, determines is eligible, pursuant to federal and state law, to receive medical or allied care, goods, or services for which the department may make payments under the Florida Medicaid program and is enrolled inthe Florida Medicaid program.
6. For SFY 2023-2024, base historical claims used to calculate the EAPG base rates had a claim first date of service between January 1, 2021, and December 31, 2021.
7. For SFY 2023-2024 rates, standardized EAPG base rates and provider policy adjustors were initially calculated to achieve a simulated budget neutral effect relative to the SFY 2022-2023 EAPG-based payment system for the base historical claims, less the SFY 2022-2023 appropriation for "Hospital Outlier Payments".
8. The hospital EAPG base rates are available on the AHCA website at the following link: http://ahca.myflorida.com/medicaid/Finance/finance/institutional/hoppps.shtml.

D. Children's Hospital Add-On Payments

1. Children's hospital per-service add-on payments are paid to nonprofit hospitals that as of January 1, 2022, are separately licensed by the state as specialty hospitals providing comprehensive acute care services to children and remain so licensed and qualify for the High Medicaid Inpatient Utilization Policy Adjustor. The outpatient EAPG per-service add-on payments were calculated by distributing $139,179,488 to qualifying hospitals proportionately based on each hospital's total of simulated DRG and Trauma hospital rate enhancement payments and simulated EAPG payments from the budget neutral simulations. A hospital's eligibility to receive these add-on payments is contingent on the hospital having full network contracts with each applicable Medicaid managed care plan in the state.

2. For each qualifying hospital, the total appropriated add-on payment amount is translated into an average per-service amount by dividing the total appropriated amount by the number of qualifying services in the base period historical claims dataset.
3. Children's hospital per-service add-on payment amounts are included in the provider rate worksheets available on the AHCA website at the following link: http://ahca.myflorida.com/medicaid/Finance/finance/institutional/hoppps.shtml

E. Policy Adjustors

1. Policy adjustors are numerical multipliers included in the EAPG claim service line payment calculation that allow AHCA to increase or decrease payments to categories of services and/or categories of providers.
2. Only one policy adjustor, a provider policy adjustor, has been built into the EAPG-based payment method and is applied to two categories of hospitals – rural hospitals and hospitals with very high Medicaid outpatient utilization.
    a. The Rural Hospital Provider Adjustor is 1.5428. Rural hospitals are acute care hospitals with 100 or fewer licensed beds, an emergency room, and must meet one of the following criteria:
        i. The sole provider within a county with a population density of up to 100 persons per square mile;
        ii. An acute care hospital, in a county with a population density of up to 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county;
        iii. A hospital supported by a tax district or sub-district whose boundaries encompass a population of up to 100 persons per square mile;
        iv. A hospital classified as a sole community hospital under 42 C.F.R. s. 412.92, regardless of the number of licensed beds;

v. A hospital with a service area that has a population of up to 100 persons per square mile. Service area means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Transparency at the Agency; or

vi. A hospital designated as a critical access hospital.

vii. A hospital that received Medicaid funds for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2024, if the hospital continues to have up to 100 licensed beds and an emergency room. An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this paragraph shall be granted such designation upon application, including supporting documentation, to the Agency. A hospital that was licensed as a rural hospital during the 2010-2011 or 2011-2012 fiscal year shall continue to be a rural hospital from the date of designation through June 30, 2025, if the hospital continues to have up to 100 licensed beds and an emergency room.

b. High Medicaid outpatient utilization hospitals are those that have 50 percent or more of their total annual outpatient charges resulting from care provided to Medicaid recipients. The High Medicaid Outpatient Utilization Hospital Adjustor is 2.1258. Florida Medicaid outpatient charges are the hospital's usual and customary charges for outpatient services rendered to patients excluding charges for laboratory and pathology services.

c. All other hospitals receive a provider policy adjustor of 1.0, which generates no payment adjustment.

F. EAPG Service Line Payment Adjustments

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

Amendment: 2023-0004
Effective Date: 7/1/2023
Supersedes: 2022-0011
Approval Date: December 19, 2023

2. Other lines may bundle indicating that payment for these lines is included in payment for other lines on the claim. For bundled lines, the Payment Adjustment Factor gets set to zero.
3. Still other service lines on the claim may pay at a discounted rate. For all except bilateral services, the Payment Adjustment Factor gets set to 0.50 on discounting claim lines. For bilateral procedures, the Payment Adjustment Factor gets set to 1.50.

G. Recipient Annual Benefit Limit

1. Reimbursement for hospital outpatient care to adults is annually limited to $1,500 per SFY per recipient.
2. Exempt from this annual limit are Medicaid recipients under the age of 21, renal dialysis services, labor and delivery services, surgical procedures, dialysis services, chemotherapy services which are covered when medically necessary, and services provided under revenue codes noted in Appendix A.
3. The $1,500 annual limit is applied only to services provided to recipients enrolled in the Medicaid fee-for-service program.

H. EAPG Payment Calculation

1. EAPG Payment:

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

      EAPG Payment = Hospital Base Rate * EAPG Relative Weight * Policy Adjustor
      * Payment Adjustment Factor

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

      Line Item Allowed Amount = (EAPG Payment + Children's Hospital Add-On Payment)
      - Reduction for Annual Benefit Limit

      i. If the recipient's annual hospital outpatient reimbursement has exceeded the annual limit and a given service is subject to the benefit limit, then the "Reduction for Annual Benefit Limit" will be set equal to the (EAPG Payment + Children's Hospital Add-On Payment) so that the Medicaid allowed amount is $0.

Amendment: 2023-0004
Effective Date: 7/1/2023
Supersedes: 2022-0011
Approval Date: December 19, 2023

ii. If the sum of (EAPG Payment + Children's Hospital Add-On Payment) on the service line being processed is an amount that will put the recipient over his/her annual benefit limit, then the value for field "Reduction for Annual Benefit Limit" will get set so that the Medicaid allowed amount on the claim service line is enough to set total hospital outpatient reimbursement to the annual limit for the recipient.

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

3. Third party liability: EAPG reimbursement shall be limited to an amount, if any, by which the rate calculation for an allowable claim exceeds the amount of a third-party recovery during the Florida Medicaid benefit period. The Medicaid benefit period is the period of time where medical benefits for services covered by the Florida Medicaid program, with certain specified maximum limitations, are available to the Florida Medicaid beneficiary. For the purposes of determining third party liability, a Florida Medicaid recipient includes an individual formerly determined to be eligible for Florida Medicaid, an individual who has received medical assistance under the Florida Medicaid program, or an individual on whose behalf Florida Medicaid has become obligated.

I. Frequency of EAPG Payment Parameter Updates

1. New versions of EAPGs are released annually and include a new set of relative weights. AHCA will install a new version of EAPGs no more frequently than onceper year and no less frequently than once every two years. Installation of new versions of EAPGs and associated relative weights will occur at the beginning of a SFY and will coincide with a recalculation of hospital base rates and EAPG policy adjustors. When installing new versions of EAPG codes and relative weights, AHCA will install the most current version that is available at the time the annual rate setting process is performed.

2. Hospital EAPG Base Rate:

An EAPG base rate is the reimbursement rate assigned to each hospital that is multiplied by

an EAPG relative weight and policy adjustor in the calculation of the EAPG base payment. A new hospital base rate is calculated annually based on historical claim data and becomes effective at the beginning of each SFY. The base rate is calculated to meet cost projections which get applied to a base year dataset including claims with dates of admission within a minimum of a 6-month and most often a 12-month timeframe (referred to as the "base year").

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

IV. Medicare Crossover Pricing

For hospital outpatient Medicare crossover claims, the Medicaid allowed amount will be determined using the EAPG pricing methodology. Florida Medicaid reimbursement for crossover claims is up to the Medicaid rate, less any amount paid by Medicare. If this amount is negative, no Medicaid reimbursement is made. If this amount is positive, Medicaid reimburses: the deductible plus the coinsurance or copayment; or the Medicaid rate, whichever is less.

APPENDIX A TO FLORIDA TITLE XIX OUTPATIENT HOSPITAL REIMBURSEMENT PLAN

OUTPATIENT REVENUE CODES**

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

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Approval Date: December 19, 2023

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

Amendment: 2023-0004
Effective Date: 7/1/2023
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Approval Date: December 19, 2023

469	Other Pulmonary Function
471	Audiology/Diagnostic
472	Audiology/Treatment
480	Cardiology/General
481	Cardiology/Cardiac Cath Laboratory
482	Cardiology/Stress Test
483	Cardiology/Echocardiology
489	Other Cardiology
490	Ambulatory Surgical Care
510	Clinic/General
	Note: Please reference the most recent version of the Medicaid Outpatient Hospital Coverage and Limitations Handbook
513	Psychiatric Clinic
	Note: Use code 513, psychiatric clinic, with code 914, psychiatric individual therapy services, or with 918, psychiatric testing, when either of these codes is appropriate and applicable.
610	MRI Diagnostic/General
611	MRI Diagnostic/Brain
612	MRI Diagnostic/Spine
614	MRI - Other
615	Magnetic Resonance Angiography (MRA) - Head & Neck
616	MRA - Lower Extremities
618	MRA – Other
619	Other MRT
621	Supplies Incident to Radiology
622	Dressings Supplies Incident to Other Diagnostic Services Surgical Dressings
623	Surgical Dressings
634*	Erythropoietin (EPO) less than 10,000 units
635*	Erythropoietin (EPO) 10,000 or more units
636	Pharmacy/Coded Drugs
637	Self-Administered Drugs
	Note: Use code 637 exclusively to bill self-administered drugs not covered by Medicare for dually-eligible Medicare and Medicaid recipients. Code 637 must only be billed with the Total Charge 001 revenue code. Payment will be made for 637 only.
700	Cast Room/General
710	Recovery Room/General
721	Labor - Delivery Room/Labor
722*	Labor - Delivery Room/Delivery
730	EKG - ECG/General
731	EKG - ECG/Holter Monitor
732	Telemetry
739	Other EKG – ECG
740	EEG/General
749	Other EEG
750	Gastro-Intestinal Services/General
759	Other Gastro - Intestinal
761	Treatment Room
762	Observation Room
790*	Lithotripsy/General
820*	OPH-Hemodialysis/General
821*	Hemodialysis Outpatient/Composite
824*	Hemodialysis-Maintenance 100%
829*	OPH-Hemodialysis/Other
830*	Peritoneal Dialysis/General

Amendment: 2023-0004
Effective Date: 7/1/2023
Supersedes: 2022-0011
Approval Date: December 19, 2023

831*	Peritoneal Dialysis Outpatient/Composite Rate
834*	Peritoneal Dialysis-Maintenance 100%
839*	OPH-Peritoneal Dialysis/Other
840*	Continuous Capo General
841*	CAPD Composite or Other Rate
844*	CAPD OP/Home-Maintenance 100%
849*	CAPD/Other
850*	Continuous Cycling Dialysis CCPD General
851*	CCPD Composite or Other Rate
854*	CCPD OP/Home-Maintenance 100%
859*	CCPD/Other
880*	Miscellaneous Dialysis/General
881*	Ultrafiltration
901*	Psychiatric/Psychological - Electroshock Treatment
914	Psychiatric/Psychological - Clinic Visit/Individual Therapy
918	Psychiatric/Testing
	Note: Bill 513, psychiatric clinic, with this service,
920	Other Diagnostic Services/General
921	Other Diagnostic Services/Peripheral Vascular Lab
922	Other Diagnostic Services/Electromyelgram
924	Other Diagnostic Services/Allergy Test
940	General
943	Other Therapeutic Services/Cardiac Rehabilitation
944	Other Therapeutic Services/Drug Rehabilitation
945	Other Therapeutic Services/Alcohol Rehabilitation

*Exempt from $1,500 outpatient cap limit.

APPENDIX B TO FLORIDA TITLE XIX OUTPATIENT HOSPITAL REIMBURSEMENT PLAN UPPER PAYMENT LIMIT (UPL) METHODOLOGY

Overview of UPL Analyses

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

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

The claim data used in a UPL analysis is historical data, usually from a twelve (12) month period. The period for which claims are selected is referred to as the "base" year. The UPL analysis is performed for a specific SFY referred to as the "rate" year. Often the rate year is a current or present-day timeframe. In contrast, the base year is a timeframe in the past because the data needed for a UPL analysis, hospital cost reports and billed claims, are only available for services performed in the past. For example, the UPL analysis for SFY2017/2018 (the "rate" year) was performed at the beginning of the fiscal year – September 2017. That UPL analysis could not utilize claim data from SFY 2017/2018 (7/1/2017 – 6/30/2018) because the year was not yet complete. Instead, historical claim data that had been received and processed prior to September 2017 was used for the analysis.

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

Florida Medicaid Hospital Outpatient UPL Analysis Method

Estimated Medicare payments are calculated using hospital outpatient costs as a proxy for the upper payment limit. The costs are calculated by multiplying each hospital's outpatient cost-to-charge ratio times each claim service line's submitted charge and summing the resulting estimated hospital cost for all claims in the base-year dataset. The costs are then inflated to the midpoint of the UPL rate year. This analysis uses the same "base"-year dataset that was used to calculate EAPG base rates and payment system parameters for the state fiscal year for which the UPL analysis is performed (referred to as the "rate" year).

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

Source of Hospital Cost Data

Hospital cost data is retrieved from Medicare cost reports from the CMS Healthcare Cost Report Information System (HCRIS) that align with the base year claims experience. From these cost reports, an outpatient cost-to-charge ratio (CCR) is calculated using the cost and charge information in Worksheet C Part I for included ancillary cost centers. Specifically, costs and charges are retrieved from cost centers in the following ranges:

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

For each of these cost centers, total hospital costs are retrieved from column 5 and total hospital charges are retrieved from column 8. For each hospital, the costs and charges are summed and then an outpatient CCR iscalculated as (total ancillary cost center cost) divided by (total ancillary cost center charges). If, for a given hospital, costs are not reported in Worksheet C Part I, Column 5, the above calculations are performed using costs reported in Worksheet B Part I, Column 26. Cost report experience impacted by the COVID-19 pandemic (i.e. cost reports with fiscal year end dates on or after 3/1/2020) was excluded from the calculation of cost-to-charge ratios.

Source of Medicaid Pricing Parameters and Claim Data

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

Medicaid claims data used in UPL demonstrations is extracted from a data warehouse fed from the Florida MMIS. For each hospital, claims are selected if they contain a first date of service within the base year. The base year is the calendar year ending 18 months prior to the rate effective date.

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

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

Calculation of Upper Payment Limit

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

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

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

To get the percentages of Medicaid and total revenue, data is used from the base year cost reports. The percentage of Medicaid revenue is calculated as Medicaid revenue from Worksheet S-10, Column 1, Lines 2, 5 and 9, divided by Net Patient Revenues from Worksheet G-3, Column 1, Line 3.

Calculation of Medicaid Payment

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

Non-Claim Payments and other Adjustments to Medicaid Payment

The FFS portion of rate year indirect medical education (IME) outpatient supplemental payments are added to this estimate of EAPG claims-based payments for each hospital.

No adjustments are made to estimate changes in Medicaid utilization between the base year and the UPL rate year. Similarly, no attempt is made to adjust Medicaid payments based on a prediction of future cost settlements resulting from audits of hospital cost reports as there are no cost settlements performed for claims paid via the EAPG-based method.

Comparison of Medicaid Payment to Upper Payment Limit

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

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

REIMBURSEMENT PLAN

Indirect Graduate Medical Education (IME) Payments

IME payments are made directly to eligible teaching hospitals based on the hospital's IME costs for services provided. These payments recognize the increased use of ancillary services associated with the educational process and the higher case-mix intensity of teaching hospitals. The managed care IME payments which are based in part on managed care outpatient payments and utilization shall not be included in the capitation rates paid to Medicaid Managed Care plans. In accordance with provisions under 42 CFR 438.60, states are permitted to make Medicaid GME payments for managed care services as direct payments to providers outside of managed care capitation rates. The state shall use the Enhanced Ambulatory Patient Group (EAPGs) payment plus the Automatic Rate Enhancement payments (AREs), plus the outpatient state directed payment arrangements allowed under 42 (C.F.R.) Section (§) 438.6(c) approved pre-prints and made through managed care plans ("Outpatient EAPG Rate") in calculating the annual IME payments. Annual IME payments will be calculated using the most recently filed and available Medicare Cost Report (CMS Form 2552) extracted from the Healthcare Cost Report Information System (HCRIS). One fourth of the annual computed IME payment will be paid to eligible teaching hospitals on a quarterly basis. The quarterly payments are considered final and shall not be reconciled or amended due to updated or amended Medicare Cost Reports.

1. Eligible Teaching Hospitals

An eligible teaching hospital must meet at least one of the five criteria below and have a resident to bed ratio between 0.1% and 100% as calculated from data reported in the hospital's fiscal year ending (FYE) 2021 Medicare cost report, CMS Form 2552.

A. Statutory teaching hospital with greater than 650 beds per license as recorded in the Agency for Health Care Administration (AHCA) licensure file and greater than 500 FTEs as referenced in in FYE 2019 CMS Form 2552, Worksheet E, Part A, lines 10 and 11, column 1, or Statutory teaching hospitals affiliated with the University of Florida Board of Trustees as specified in Section 1004.41(5)(a) of the Florida Statutes." These eligible teaching hospitals shall be known as Academic Medical Centers Group 1 (AMC 1).

B. Public hospital with residents in approved ACGME training programs and does not meet the eligibility criteria in 1.a. These eligible teaching hospitals shall be known as Public Teaching Hospitals

C. Statutory teaching hospital with greater than 650 beds per license as recorded in the AHCA licensure file and does not meet the eligibility criteria in 1.a. or 1.b. These eligible teaching hospitals shall be known as Academic Medical Centers Group 2 (AMC 2).

D. Children's hospital as indicated as provider type 7, on CMS Form 2552, Worksheet S_2, Part I, Column 4, that are excluded from the Medicare prospective payment system under 42 CFR 412.23, or Regional Perinatal Intensive Care Center, that does not meet the eligibility criteria in 1a, 1b, or 1c. These eligible teaching hospitals shall be known as Children's Teaching Hospitals.

E. Statutory teaching hospital with greater than 200 beds per license as recorded in the AHCA

licensure file that does not qualify as Academic Medical Centers, and does not meet the eligibility criteria in 1a, 1b, 1c or 1d. These eligible teaching hospitals shall beknown as Statutory Teaching Hospitals.

2. Determination of IME Payments

On or before October 1 of each year, AHCA shall calculate IME payments for eligible teaching hospitals by computing each hospital's ratio of residents to beds and Medicaid outpatient payment as described below.

The IME payment amount for eligible teaching hospitals in accordance with section 1.a) Academic Medical Centers Group 1 (AMC 1), is calculated using the hospital's ratio of residents to beds and Medicaid outpatient payments as follows:

A. Calculate each hospital's IME Percentage:

$$(2.27 \times ((1 + (\text{Residents}/\text{Beds}))^{0.405} - 1)) \times 1.35$$

Residents – The number of full-time equivalent (FTE) interns and residents in approved training programs for an eligible teaching hospital as reported on the most recent CMS Form 2552, Worksheet E, Part A, Line 10, Column 1 plus Worksheet E, Part A, Line 11, Column 1

Beds - The total number of bed days available as reported on the most recent CMS Form 2552, Worksheet E, Part A, Line 4, Column 1

B. Calculate the IME adjustment amount for each hospital in 2.A. Multiply the IME percentage computed in 2.A. for each hospital, by the hospital's Medicaid outpatient payments. Medicaid outpatient payments are the total simulated outpatient payments less GME/IME payments. The Medicaid outpatient payments are based on the hospital outpatient appropriation and the parameters for the Outpatient EAPG Rate, specified in the General Appropriations Act, as determined by the agency.

The IME payment amount for eligible teaching hospitals in accordance with section 1.b) Public Teaching Hospitals above, is calculated using the hospital's ratio of residents to beds and Medicaid outpatient payments as follows:

C. Calculate each hospital's IME Percentage:

$$(2.27 \times ((1 + (\text{Residents}/\text{Beds}))^{0.405} - 1)) \times 1.35$$

Residents - The number of full-time equivalent (FTE) interns and residents in approved training programs for an eligible teaching hospital as reported on the most recent CMS Form 2552, Worksheet E, Part A, Line 10, Column 1 plus Worksheet E, Part A, Line 11, Column 1. For hospitals with FTE counts from Worksheet E, Part A, Lines 10 and 11 that equal 0, use FTEs as reported in Worksheet E, Part A, Line 16.

Beds - The total number of bed days available as reported on the most recent CMS Form 2552, Worksheet E, Part A, Line 4, Column 1.

D. Calculate the IME adjustment amount for each hospital in 2.C. Multiply the IME percentage computed in 2.C. for each hospital, by the hospital's Medicaid outpatient payments. Medicaid outpatient payments are the total simulated outpatient payments less GME/IME payments. The Medicaid outpatient payments are based on the hospital outpatient appropriation and the parameters for the Outpatient EAPG Rate, specified in the General Appropriations Act, as determined by the agency.

The IME payment amount for eligible teaching hospitals in accordance with section 1.c) Academic Medical Centers group 2 (AMC 2) above, is limited to $13,482,658. Each AMC 2 hospital will receive a pro rata share of the total annual payment limit. The pro rata allocation will be calculated using the hospital's ratio of residents to beds and Medicaid outpatient payments as follows:

E. Calculate each hospital's IME Percentage:

$$(2.27 \times ((1 + (\text{Residents}/\text{Beds}))^{0.405} - 1)) \times 0.3$$

Residents - The number of full-time equivalent (FTE) interns and residents in approved training programs for an eligible teaching hospital as reported on the most recent CMS Form 2552, Worksheet E, Part A, Line 10, Column 1 plus Worksheet E, Part A, Line 11, Column 1.

Beds - The total number of bed days available as reported on the most recent CMS Form 2552, Worksheet E, Part A, Line 4, Column 1.

F. Calculate the IME adjustment amount and pro rata payment for each hospital in 2.E. Multiply the IME percentage computed in 2.E. for each hospital, by the hospital's Medicaid outpatient payments. Medicaid outpatient payments are the total simulated outpatient payments less GME/IME payments. The Medicaid outpatient payments are based on the hospital outpatient appropriation and the parameters for the Outpatient EAPG Rate, specified in the General Appropriations Act, as determined by the agency. Each hospital's pro rata annualized IME payments is the product of the following factors:
    a. The AMC 2 Hospital payment limit based on SFY 23/24 ($13,482,658)
    b. A quotient of:
        i. The numerator of which is the hospital's IME adjusted amount.
        ii. The denominator of which is the total AMC 2 IME adjusted amounts.

The IME payment amount for eligible teaching hospitals in accordance with section 1.d) Children's Teaching Hospitals above, is limited to $9,548,434. Each Children's Teaching Hospital will receive a pro rata share of the total annual payment limit. The pro rata allocation will be calculated using the hospital's ratio of residents to beds and Medicaid outpatient payments as follows:

G. Calculate each hospital's IME Percentage:

$$(2.27 \times ((1 + (\text{Residents}/\text{Beds}))^{0.405} - 1)) \times 0.1$$

Residents – The number of full-time equivalent (FTE) interns and residents in approved training programs as reported on the most recent CMS Form 2552, Worksheet E-4, line 6 for children's hospital as indicated as provider type 7 or Worksheet E, Part A, Line 10, Column 1 plus Worksheet E, Part A, Line 11, Column 1 for a Regional Perinatal Intensive Care Center.

Beds – The total number of bed days available is determined by dividing the number of bed days available from CMS Form 2552 Worksheet S-3, Part I, Column 3, Line 14 by the numberof days in the cost reporting period for children's hospital as indicated as provider type 7 or Worksheet E, Part A, Line 4, Column 1 for a Regional Perinatal Intensive Care Center.

H. Calculate the IME adjustment amount and pro rata payment for each hospital in 2.G. Multiply the IME percentage computed in 2.G. for each hospital, by the hospital's Medicaid outpatient payments. Medicaid outpatient payments are the total simulated outpatient payments less GME/IME payments. The Medicaid outpatient payments are based on the hospital outpatient appropriation and the parameters for the Outpatient EAPG Rate, specified in the General Appropriations Act, as determined by the agency. Each hospital's pro rata annualized IME payment is the product of the following factors:
    a. The Children's Teaching Hospital payment limit based on SFY 23/24 ($9,548,434)
    b. A quotient of:
        i. The numerator of which is the hospital's IME adjusted amount.
        ii. The denominator of which is the total Children's Teaching Hospitals IME adjusted amounts.

The IME payment amount for eligible teaching hospitals in accordance with section 1.e) Statutory Teaching Hospitals above, is limited to $7,695,462. Each Statutory Teaching Hospital will receive a pro rata share of the total annual payment limit. The pro rata allocation will be calculated using the hospital's ratio of residents to beds and Medicaid inpatient payments as follows:

I. Calculate each hospital's IME Percentage:

$$(2.27 \times ((1 + (\text{Residents}/\text{Beds}))^{0.405} - 1)) \times 0.2$$

Residents - The number of full-time equivalent (FTE) interns and residents in approved training programs for an eligible teaching hospital as reported on the most recent CMS Form 2552, Worksheet E, Part A, Line 10, Column 1 plus Worksheet E, Part A, Line 11, Column 1. For hospitals with FTE counts from Worksheet E, Part A, Lines 10 and 11 that equal 0, use FTEs as reported in Worksheet E, Part A, Line 16.

Beds - The total number of bed days available as reported on the most recent CMS Form 2552, Worksheet E, Part A, Line 4, Column 1.

J. Calculate the IME adjusted amount and pro rata payment for each hospital in 2.I. Multiply the IME percentage computed in 2.I. for each hospital, by the hospital's Medicaid outpatient payments. Medicaid outpatient payments are the total simulated outpatient payments less GME/IME payments. The Medicaid outpatient payments are based on the hospital outpatient appropriation and the parameters for the Outpatient EAPG Rate, specified in General Appropriations Act, as determined by the agency. Each hospital's pro rata annualized IME payment is the product of the following factors:

a. The Statutory Teaching Hospital payment limit based on SFY 23/24 ($7,695,462)
b. A quotient of:
    i. The numerator of which is the hospital's IME adjusted amount.
    ii. The denominator of which is the total Statutory Teaching Hospital IME adjusted amounts.