disenrolls prior to the fulfillment of its 3-year enrollment agreement, AHCA shall recoup funds paid to the hospital in excess of the amount that would have been paid if the county ceiling had been imposed during the first 12 months which shall be defined as excess amount, according to the following schedule. If a hospital is re-enrolled under the ceiling exemption provision for less than 12 months, the Agency shall recoup 100 percent of the excess amount. For each month of enrollment subsequent to the first year of re-enrollment under the ceiling exemption provision, 1/24 of the excess amount shall be no longer owed so that after 36 months of re enrollment AHCA shall recoup none of the excess amount. Example 1: Hospital reenrolls under the ceiling exemption provision on July 1, 1984, and disenrolls on November 30, 1984. During this 5-month period the hospital receives an excess amount of $10,000. Recoupment would be calculated as:

$10,000 - ((0 months x 1/24) x (10,000)) = $10,000

Example 2: Hospital re-enrolls under the ceiling exemption provision on July 1, 1984, and disenrolls on December 31, 1986. During the first 12 months the hospital receives an excess amount of $20,000. Recoupment would be calculated as:

$20,000 - ((18 months x 1/24) x (20,000)) = $ 5,000

7. Compute the fixed costs component of the per diem by dividing the Medicaid depreciation by the total Medicaid days.

8. Established the fixed costs component of the per diem as the lower of Step 7 or the reimbursement ceiling determined under V.B.2.

9. Calculate the overall per diem by adding the results of Steps 6 and 8.

10. Set the per diem rate for the hospital as the lower of the result of Step 9 or the result of inflated Medicaid charges divided by total Medicaid days.

11. For hospitals with less than 200 total Medicaid patient days, or less than 20 Medicaid patient admissions, the per diem rate shall be computed using the principles outlined in Steps 1 through 10 above, but total costs, charges, and days shall be utilized, instead of the Medicaid apportioned costs, charges and days.

12. Effective July 1, 2001, the Medicaid inpatient per diem rate will be adjusted for Lake Wales Hospital, Winter Haven Hospital, Health Central Hospital and Larkin Community Hospital in accordance with section 409.905(5)(c), Florida Statutes:

    The Agency for Health Care Administration shall adjust a hospital's current inpatient per diem rate to reflect the cost of serving the Medicaid population at that institution if:

    a. The hospital experiences an increase in Medicaid caseload by more than 25 percent in any year, primarily resulting from the closure of a hospital in the same service area occurring after July 1, 1995;

    b. The hospital's Medicaid per diem rate is at least 25 percent below the Medicaid per patient cost for that year; or

    c. The hospital is located in a county that has five or fewer hospitals, began offering obstetrical services on or after September 1999, and has submitted a request in writing to the Agency for a rate adjustment after July 1, 2000, but before September 30, 2000, in

which case such hospital's Medicaid inpatient per diem rate shall be adjusted to cost, effective July 1, 2002.

13. No later than October 1 of each year the agency must provide estimated costs for any adjustment in a hospital inpatient per diem pursuant to this paragraph to the Executive Office of the Governor, the House of Representatives General Appropriations Committee, and the Senate Budget Committee.

14. Effective July 1, 2002, the Medicaid inpatient per diem rate will be adjusted for New Port Richey hospital in accordance with section 409.905(5)(c), Florida Statutes. Hospital inpatient rates set under the provisions of the Plan for the July 1, 2003 rate setting will be effective October 1, 2003.

VI. Disproportionate Share Hospital (DSH) Reimbursement Methods

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

1. 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%.

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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. a. The hospital Medicaid inpatient utilization rate in 1.a. above shall be calculated once a year based on cost reports used for the July 1 rate setting.

b. The low-income utilization rate in 1.b. above shall also be calculated once a year every July 1.

4. .Effective July 1, 2003, the Agency shall use the following methodology to distribute payments under the Regular DSH program for state fiscal year 2003-2004 and forward.

The Agency shall only distribute regular DSH payments to those hospitals that meet the requirements of Section VI.A. 1., above, and to public hospitals. The following methodology shall be used to distribute disproportionate share payments to hospitals that meet the federal minimum requirements and to public hospitals.

a. For hospitals that meet the requirements of Section VI.A.1., above, and do not qualify as a public hospital, the following

formula shall be used:

DSHP = (HMD/TSMD) * $1 million

Where:

DSHP = disproportionate share hospital payment

HMD = hospital Medicaid days

TSMD = total state 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) * 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.D.

For non-state government owned or operated hospitals with 3,300 or more Medicaid days:

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

TAAPH = TAA – TAAMH

For non-state government owned or operated hospitals with less than 3,300 Medicaid days, a total of $400,000 shall be distributed equally among these hospitals.

Where:

TAA = total available appropriation (as found in Appendix B)

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 mental health hospitals

TMD = total state Medicaid days for public non-state hospitals

HCCD = hospital charity care dollars

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

In computing the above amounts for public hospitals and hospitals that qualify under Section VI.A.2., above, the Agency shall use the average of the 1997, 1998 and 1999 audited data to determine each hospital's Medicaid days and charity care. The Agency will use the average of the audited disproportionate share data for the years available if the Agency does not have the prescribed three years of audited disproportionate share data for a hospital.

5. The total of all disproportionate share payments shall not exceed the amount appropriated, or the federal government's upper payment limits. Payments shall comply with the limits set forth in Section 1923(g) of the Social Security Act.

6. In no case shall total payments to a hospital under this section, with the exception of public non-state facilities or state facilities, exceed the total amount of uncompensated charity care of the hospital, as determined by the agency according to the most recent calendar year audited data available at the beginning of each state fiscal year.

7. The total amount calculated to be distributed shall be made in quarterly payments subsequent to each quarter during the fiscal year.
8. Payments to each disproportionate share hospital shall result in payments of at least the minimum payment adjustment specified in the Act. The Act specifies that the payment adjustment must at a minimum provide either:
   a. An additional payment amount equal to the product of the hospital's Medicaid operating cost payment times the hospital's disproportionate share adjustment percentage in accordance with Section 1886(d)(5)(F)(iv) of the Social Security Act, or
   b. A minimum specified additional payment amount (or increased percentage amount) and for an increase in such payment amount in proportion to the percentage by which the hospital's Medicaid utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate for hospital's receiving Medicaid payments in the state.

B. Determination of an outlier adjustment in Medicaid payment amounts for Disproportionate Share Hospitals for medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age in Regional Perinatal Intensive Care Centers (RPICC). Exceptionally high costs are costs attributable to critically ill and/or extremely small (low birth weight) individuals who receive services in Neonatal Intensive Care Units (NICU) of hospitals that qualify for outlier payment adjustments. Exceptionally long lengths of stay are stays in excess of forty-five days.

1. Disproportionate Share Hospitals that qualify under VI.A., above, for regular disproportionate share hospital payments and meet all of the following requirements shall qualify for an outlier adjustment in payment amounts. For state fiscal year 2002-2003, and 2003-2004 forward, payments under this Section will be limited to the hospitals that received a payment under this Section in state fiscal year 2001-2002.

   a. Agree to conform to all agency requirements to assure high quality in the provision of service, including criteria adopted by Department of Health rule 64C-6.003, F.A.C., concerning staffing ratios, medical records, standards of care, equipment, space and such other standards and criteria as specified by this rule, as well as meeting the RPICC designation pursuant to 383.15 – 383.21, F.S.

   b. Agree to provide information to the agency, in a form and manner to be prescribed by rule 64C-6.002, F.A.C., of the Department of Health, concerning the care provided to all patients in neonatal intensive care centers and high-risk maternity care.

   c. Agree to accept all patients for neonatal intensive care and high-risk maternity care, regardless of ability to pay, on a functional space-available basis.

   d. Agree to develop arrangements with other maternity and neonatal care providers in the hospital's region for the appropriate receipt and transfer of patients in need of specialized maternity and neonatal intensive care services.

   e. Agree to establish and provide a developmental evaluation and services program for certain high-risk neonates, as prescribed and defined by rule of the department.

f. Agree to sponsor a program of continuing education in perinatal care for health care professionals within the region of the hospital, as specified by rule.

g. Agree to provide backup and referral services to the department's county public health units and other low income perinatal providers within the hospital's region, including the development of written agreements between these organizations and the hospital.

h. Agree to arrange for transportation for high-risk obstetrical patients and neonates in need of transfer from the community to the hospital or from the hospital to another more appropriate facility.

2. Hospitals that fail to comply with any of the above conditions, or the rules of the department under Chapter 64C-6.001, F.A.C., shall not receive any payment under this subsection until full compliance is achieved. A hospital that is non-compliant in two or more consecutive quarters, shall not receive its share of the funds. Any forfeited funds shall be distributed by the remaining participating program hospitals.

3. Outlier payment amounts earned by disproportionate share hospitals that meet all of the qualifications in 1.a. through 1.h., above, shall be in addition to each hospital Medicaid per diem rate.

4.. For state fiscal year 2002-2003and 2003-2004 forward, the outlier payments will be made only to those hospitals that received an outlier payment in state fiscal year 2001-2002. The individual hospital payments in 2002-2003 and 2003-2004 forward shall be made in the same proportion as the individual hospital payments were made in state fiscal year 2001-2002. The total outlier payments may not exceed the total amount appropriated as found in Appendix B.

5. Effective for state fiscal year 2003-2004 forward, the following formula shall be used by the agency to calculate the total amount earned for hospitals that qualify to participate in the RPICC program:

TAE = HDSP/THDSP

Where:

TAE = total amount earned by a RPICC.

HDSP = the prior state fiscal year RPICC disproportionate share payment to the individual hospital.

THDSP = the prior state year total RPICC disproportionate share payment to all hospitals

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6. Effective for state fiscal year 2003-2004 forward, the total additional payment for hospitals that participate in the RPICC program shall be calculated by the agency as follows:

TAP = TAE x TA

Where:

TAP = total additional payment for a RPICC.

TAE = total amount earned by a RPICC.

TA = total appropriation for the RPICC disproportionate share program . (as found in Appendix B)

7. Distribute the outlier payments in four equal installments during the state fiscal year.

C. Determination of Disproportionate Share Payments for Teaching Hospitals.

1. Disproportionate share payments shall be paid to statutorily defined teaching hospitals for their increased costs associated with medical education programs and for tertiary health care services provided to the