STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF FLORIDA

PAYMENT FOR SERVICES

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Amendment: 2019-0003
Effective: 12/1/2019
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF FLORIDA

PAYMENT OF SERVICES

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Amendment: 2019-003
Effective: 12/1/19
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METHODS USED IN ESTABLISHING PAYMENT RATES

08/01/93 EMERGENCY SERVICES

Outpatient: Reimbursement to nonparticipating Florida hospitals for outpatient emergency services is the lesser of the amount charged or the lowest of outpatient rates paid to participating Florida hospitals in effect on the date of service.

Reimbursement to nonparticipating out-of-state hospitals for outpatient emergency services is the lesser of the amount charged or the average of outpatient rates paid to participating Florida hospitals for covered outpatient revenue center codes in effect on the date of service.

Reimbursement for laboratory and pathology services rendered in emergency situations is the lesser of the amount charged or the technical component on the fee schedule found in the hospital provider handbook in effect on the date of service.

Amendment 93-32
Effective 8/1/93
Supersedes 93-02

Approval SEP 17 1993

Revised Submission 8/12/93
Revised Submission 9/13/93

REHABILITATIVE SERVICES

10/1/2011 Except as otherwise noted in the plan, payment for these services is based on state-developed fee schedule rates, which are the same for both governmental and private providers of Rehabilitative Services. The fee schedules are subject to annual/periodic adjustment. All rates, including current and prior rates, are published and maintained on the agency's fiscal agent website. Specifically, the fee schedules and any annual/periodic adjustments to the fee schedules are published at www.MyMedicaid-Florida.com.

PERSONAL CARE/ASSISTIVE CARE SERVICES

Survey results of prospective service providers indicated that on average one-hour per resident per day would be needed to provide the personal care/assistive care service to residents

Each component of the personal care/assistive care service is similar to the care provided under personal care in the Medicaid waiver programs.

Medicaid Waiver	Service	Ave. Per Hour Rate
Aged/Disabled Adult	Personal Care	$12.76
Project Aids Care	Personal Care	$8.00
Developmental Services	Personal Care	$9.27

The average reimbursement rate for the personal care services in Medicaid Waiver programs ranges between $8.00 and 12.76 per hour. Since facility personnel providing the personal care/assistive care service will be required to have similar training, the per unit costs of providing the service will not exceed the current reimbursement rate for personal care services in the Medicaid waiver programs.

Based upon this information, reimbursement of personal care/assistive care services will be based upon a per diem payment that will be the average of the current per hour rate for personal care services included in the above-mentioned waivers. Payment to a provider will be limited to one hour per day. The per diem rate will not exceed the upper limit established through the application of the parameters of 42 CFR 447.304

Amendment 2000-11
Effective 1/1/2001
Supersedes NEW
Approval APR 0 5 2001

Methods used in Establishing Payment Rates

Community-based-Substance Abuse Services

Substance abuse providers, under contract with the County, are reimbursed costs as represented by the lower of the state's fee or their charge for the procedure code billed. There is an established fee schedule for the services.

It is normal procedure to seek reimbursement from liable third parities. Medicaid third party information is included on the recipient file and when liable, third parties are automatically billed for services provided and the claim's cost avoided.

Billable activities include Comprehensive Community Support Services for Substance Abuse; Comprehensive Community Support Services for Substance Abuse, Bachelors Degree Level; and/or Drug Intervention Services.

Except as otherwise noted in the plan, state developed rates are the same for both governmental and private providers of Comprehensive Community Based Substance Abuse Services and Intervention Services and the fee schedule and any annual/periodic adjustments are published in the Medicaid Community Based Substance Abuse Services Handbook that is incorporated in Florida Administrative Code and publicly noticed in the Florida Administrative Weekly.

10/1/2011 Personal Care Services: Prescribed Pediatric Extended Care (PPEC) recipients attend on an hourly basis up to four hours or a daily basis up to 12 hours, depending on the prescribed Plan of Care (POC). PPECs are reimbursed an hourly fixed rate up to four hours, and any stay exceeding four hours is paid a single daily fixed rate, not to exceed 12 hours. The rate does not include room and board costs. The Medicaid rates were originally determined by calculating a fixed rate from fiscal data obtained through 1989-90 cost reports provided by the Florida Department of Health, Children's Medical Services program which was previously responsible for providing PPEC services. The rate was calculated at no profit and includes basic services such as implementation and monitoring of the POC which is developed in conjunction with the parent or guardian, as defined in 400.902, Florida Statutes, and personal care services such as physical assessment, oral hygiene, bathing and grooming, range of motion and positioning, toileting, tracheostomy care, and medication administration, as defined in 59G-1.010(212) Florida Administrative Code. A 10% increase in the rate was mandated by the Florida Legislature July 1, 2006.

PPEC providers that provide other Medicaid services not covered in the PPEC rates must be enrolled as a Medicaid provider of those services and follow the reimbursement requirements as specified in the Florida Medicaid coverage and limitations handbook for the specific service.

Except as otherwise noted in the plan, payment for these services is based on state-developed fee schedule rates, which are the same for both governmental and private providers of Prescribed Pediatric Extended Care. The agency's rates were set as of July 1, 2006, and are effective for services provided on or after that date. The fee schedule is subject to annual/periodic adjustment. All rates, including current and prior rates, are published and maintained on the agency's fiscal agent website. Specifically, the fee schedule and any annual/periodic adjustments to the fee schedule are published at www.MyMedicaid-Florida.com.

METHODS USED IN ESTABLISHING PAYMENT RATES

Payment rates for behavior analysis services are based on a state developed fee schedule. The Agency for Health Care Administration's behavior analysis rates are effective for services provided on or after January 1, 2016.

Florida Medicaid behavior analysis fee schedule can be located at:

http://ahca.myflorida.com/medicaid/review/Promulgated.shtml Payments are the lesser of the provider charges or the Medicaid maximum allowable fee schedule, which is the same as both governmental and private providers.

10/1/93 EARLY INTERVENTION SERVICES

Early intervention services are based on a fee schedule determined by the state agency and will not exceed the upper limits established through application of the parameters at 42 CFR 304.

Amendment 93-57
Effective 10/1/93
Supersedes NEW
Approval 7-3-96

3/9/98
(13d)

REHABILITATIVE SERVICES:

School-Based Therapy Services

Reimbursement for school district providers, as public agencies, is based on their reasonable cost of providing services, according to the Office of Management and Budget Circular A-87. Local school districts will certify quarterly that they have expended public funds needed to match the federal share of school-based therapy claims (speech, occupational, or physical therapy) provided to eligible recipients during the quarter. Certified expenditures are separately identified and supported in the local school district's accounting system.

Payment of the therapy group fee is based on percentage reductions of the 15-minute individual visit fee based on the average size of groups in each school district. For example, if the average group size in a school district for PT is two children, the district's group fee is 50 percent of the individual visit fee. If the group size is four, the district's individual rate is divided by 4. There is a maximum of 4 children allowed in OT or PT groups. Not all children in the group have to be Medicaid eligible. The group session is in 15-minute time units.

HMO capitation rates do not include fee for service payments to school districts for school-based physical, occupational or speech therapy services. The state provides assurance that, for school districts participating in the certified payment system, HMO capitation rates do not include fee for service payments and that no duplication of payment will occur.

The costs of providing these services will not be duplicated in any other cost allocation plan.

Amendment 98-08
Effective 3/9/98
Supersedes 98-06
Approved 9/4/98

Revised Submission 8/27/98
Revised Submission 9/1/98

3/9/98
13d)

REHABILITATIVE SERVICES (Continued)

School-Based Psychological Service

Reimbursement will be a state established rate based on 15-minute time units of services, with different rates established depending on the professional level of the individual providing the service and with different rates established for individual or group services.

Reimbursement for school district providers, as public agencies, is based on their reasonable cost of providing services, according to the Office of Management and Budget Circular A-87. In addition, local school districts will certify quarterly that they have expended public funds needed to match the federal share of their claims for services included in the State Plan provided to eligible recipients during the quarter. Certified expenditures are separately identified and supported in the local school districts' accounting systems.

Payment of the group fees are based on percentage reductions of the 15-minute individual visit fee based on the average size of groups for psychological services in each school district. For example, if the average group size for psychological services in a school district is five children, the district's group fee is 20 percent of the individual visit, or the individual rate divided by 5. Not all children in the group have to be Medicaid eligible. The group session is in 15-minute time units.

Managed Care Plans' capitation rates do not include payments to school districts for school-based services. The state provides assurance that, for school districts participating in the certified payment system, Managed Care Plans' capitation rates do not include payments and that no duplication of payment will occur.

The costs of providing these services will not be duplicated in any other cost allocation plan.

Amendment 98-08
Effective 3/9/98
Supersedes 97-12
Approved 9/4/98

Revised Submission 8/27/98
Revised Submission 9/1/98

3/9/98
13d)

REHABILITATIVE SERVICES (Continued)

School-Based Social Work Service

Reimbursement will be a state established rate based on 15-minute time units of services, with different rates established depending on the professional level of the individual providing the service and with different rates established for individual or group services.

Reimbursement for school district providers, as public agencies, is based on their reasonable cost of providing services, according to the Office of Management and Budget Circular A-87. In addition, local school districts will certify quarterly that they have expended public funds needed to match the federal share of their claims for services included in the State Plan provided to eligible recipients during the quarter. Certified expenditures are separately identified and supported in the local school districts' accounting systems.

Payment of the group fees are based on percentage reductions of the 15-minute individual visit fee based on the average size of groups for social work services in each school district. For example, if the average group size for social work services in a school district is five children, the district's group fee is 20 percent of the individual visit, or the individual rate divided by 5. Not all children in the group have to be Medicaid eligible. The group session is in 15-minute time units.

Managed Care Plans' capitation rates do not include payments to school districts for school-based services. The state provides assurance that, for school districts participating in the certified payment system, Managed Care Plans' capitation rates do not include payments and that no duplication of payment will occur.

The costs of providing these services will not be duplicated in any other cost allocation plan.

Amendment 98-08
Effective 3/9/98
Supersedes 98-10
Approved 9/4/98

Revised Submission 8/27/98
Revised Submission 9/1/98

3/9/98 (13d) REHABILITATIVE SERVICES (Continued)

School-Based Nursing Services

Nursing service reimbursement will be a state established rate based on 15 minute time units with different rates established depending on the professional level of the nurse providing the service.

For medication administration, payment will be based on a reaonable state established cost.

Reimbursement for school district providers, as public agencies, is based on their reasonable cost of providing services, according to the Office of Management and Budget Circular A-87. In addition, local school districts will certify quarterly that they have expended public funds needed to match the federal share of their claims for services included in the State Plan provided to eligible recipients during the quarter. Certified expenditures are separately identified and supported in the local school districts' accounting systems.

Managed Care Plans' capitation rates do not include payments to school districts for school-based services. The state provides assurance that, for school districts participating in the certified payment system, Managed Care Plans' capitation rates do not include service payments and that no duplication of payment will occur.

Amendment 98-08
Effective 3/9/98
Supersedes 97-14
Approved 9/4/98

Revised Submission 9/1/98

METHODS USED IN ESTABLISHING PAYMENT RATES

7/1/98 (13d) REHABILITATIVE SERVICES (Continued)

School-Based Nursing Services by County Health Departments

The reimbursement will be determined by the state agency and will not exceed the upper limits established through the application of the parameters of 42 CFR 447.304. County Health Departments are reimbursed the lower of the state's fee or their charge for the procedure code billed. There is an established fee schedule for the services. The fee schedule is posted in a prominent location in the school.

The nursing services rate will be based on 15 minute time units. Medication administration will be based on a single dose dispensed. Both nursing services and medication administration will have different rates established depending on the professional level of the nurse providing the services.

County Health Departments will certify quarterly that they have expended public funds needed to match the federal share of their claims for services included in the State Plan provided to eligible recipients during the quarter. Certified expenditures are separately identified and supported in the County Health Departments' accounting systems.

Managed Care Plans' capitation rates do not include payments to County Health Departments for school-based nursing services. The state provides assurance that for County Health Departments participating in the certified payment system, Managed Care Plans' capitation rates do not include service payments and that no duplication of payment will occur.

It is normal procedure to seek reimbursement from liable third parties. Medicaid third party information is included on the recipient file and when liable, third parties are automatically billed for services provided and the claims cost avoided.

Amendment 98-12
Effective 7/1/98
Supersedes NEW
Approved 9/4/98

Revised Submission 8/27/98
Revised Submission 9/1/98

METHODS USED IN ESTABLISHING PAYMENT RATES

REHABILITATIVE SERVICES: (Continued)

School-Based Behavioral Services by County Health Departments

The reimbursement will be determined by the state agency and will not exceed the upper limits established through the application of the parameters of 42 CFR 447.304. County Health Departments are reimbursed the lower of the state's fee or their charge for the procedure code billed. There is an established fee schedule for the services.

The reimbursement rate for behavioral services will be based on 15 minute time units of service, with different rates established for individual or group services. The group rate will be lower than the individual rate to reflect the lower cost of providing the service per student. A maximum group size of six (6) students with a minimum service time of thirty (30) minutes is required for group therapy services.

County Health Departments will certify quarterly that they have expended public funds needed to match the federal share of their claims for services included in the State Plan provided to eligible recipients during the quarter. Certified expenditures are separately identified and supported in the County Health Department's accounting systems.

Managed Care Plan' capitation rates do not include payments to County Health Departments for school-based behavioral services. The state provides assurance that for County Health Departments participating in the certified payment system, Managed Care Plans' capitation rates do not include service payments and that no duplication of payment will occur.

It is normal procedure to seek reimbursement from liable third parties. Medicaid third party information is included on the recipient file and when liable, third parties are automatically billed for services provided and the claims cost avoided.

Billable activities include: Case consultation, evaluation, and testing of the individual, therapy and counseling services with the individual, including face-to-face, collaborative, consultative, and crisis interventions. Behavioral services may be provided in either an individual or group setting.

Amendment 2002-02
Effective 7/1/02
Supersedes NEW

Approval Date JUN 0 6 2002
Revised Submission May 30, 2002

METHODS USED IN ESTABLISHING PAYMENT RATES
REHABILITATIVE SERVICES: (Continued)

School-Based Services Delivered in Private and Charter Schools

Effective for services on and after January 1, 2020, the Agency for Health Care Administration (AHCA) will reimburse private and charter school providers based upon a state developed fee schedule. Specifically, the fee schedule is published at www.ahca.myflorida.com/medicaid/review/fee_schedules.shtml, which has an effective date as of January 1, 2020. All fee schedule rates are less than or equal to the rates paid for the same services described in the 4.19-B pages of the State Plan.

PRESCRIBED DRUGS

Florida Medicaid reimburses for prescribed drugs in accordance with the provisions of Title 42 Code of Federal Regulations, Section 447 Subpart I.

1. Florida Medicaid reimburses for covered drugs dispensed by an approved Florida Medicaid pharmacy provider, or a provider enrolled as a dispensing practitioner, in an amount not to exceed the lesser of the following four items:

   a. The Actual Acquisition Cost (AAC) plus a professional dispensing fee (PDF) of $10.24. The National Average Drug Acquisition Cost (NADAC) will be used for the AAC when available. If the NADAC is unavailable, the AAC will be equal to wholesaler acquisition cost.
   b. The Wholesaler Acquisition Cost (WAC) plus a PDF of $10.24.
   c. The State Maximum Allowable Cost plus a PDF of $10.24.
   d. The provider's Usual and Customary Charge (U&C).

   Florida Medicaid reimburses for the following utilizing the above payment methodology:
   - Covered outpatient drugs dispensed by a retail community pharmacy
   - Specialty drugs dispensed primarily through the mail
   - Drugs not purchased pursuant to the 340B Program by a covered entity
   - Drugs dispensed in an institutional or long-term care pharmacy when not included as part of an inpatient stay

   Florida Medicaid utilizes the NADAC in the reimbursement methodology, which ensures that the Federal Upper Limit price in the aggregate will not be exceeded.

2. Florida Medicaid utilizes the actual purchased drug price plus a PDF in the reimbursement methodology for drugs acquired via the Federal Supply Schedule.

3. Florida Medicaid utilizes the actual purchased drug price plus a PDF in the reimbursement methodology for drugs acquired via nominal price.

4. Florida Medicaid reimburses for drugs purchased under the 340B program at the actual purchased drug price, which cannot exceed the 340B ceiling price, plus a dispensing fee of $10.24. This provision only applies to covered entities, Indian Health Services, tribal organizations, urban Indian pharmacies and federally qualified health centers or the contracted agents that dispense drugs purchased at prices authorized under section 340B of the Public Health Service Act.

5. Florida Medicaid reimburses for clotting factor to the vendors awarded the State's hemophilia contract at the negotiated price.

6. Florida Medicaid reimburses for covered prescribed drugs administered by a licensed practitioner in an office setting as provided by the Centers for Medicare & Medicaid Services (CMS) quarterly in the format of drug pricing files, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html, or when no ASP rate is available, at WAC.

7. Florida Medicaid reimburses for covered prescribed drugs purchased under the 340B program administered in an outpatient facility at an amount not to exceed the 340B ceiling price.

8. Florida Medicaid does not reimburse for investigational or experimental drugs.

13c **Preventive Services:**

10/1/09 Licensed Medicaid providers practicing within their scope of practice will administer the H1N1 influenza vaccine to adult recipients age 21 and over, following recommendations by the Centers for Disease Control and Prevention.

Notwithstanding other pages in this Attachment, individual providers will be paid the amount of current vaccine administration rates. The agency's rates were set as of 9/1/09. All rates are published on the agency website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

Amendment TN: 2009-025
Effective: 10/1/09
Supersedes: NEW
Approval Date: 02-04-10

13c Preventive Services for Pregnant Women:

Licensed Medicaid providers practicing within their scope of practice will administer the influenza vaccine to adult pregnant female recipients age 21 and over. The reimbursement rate will be the same as those vaccines that are covered for Medicaid recipients between the ages of 18-20, and will be effective for dates of service between and including December 19, 2013 through March 31, 2014.

Notwithstanding other pages in this Attachment, individual providers will be paid the amount of current vaccine administration rates. The agency's rates were set as of 12/19/13. All rates are published on the agency website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

Amendment TN: 2013-025
Effective: 12/19/13
Supersedes: NEW
Approval Date: 01-17-14

METHODS USED IN ESTABLISHING PAYMENT RATES

10/1/80 RURAL HEALTH CLINIC SERVICES - Each rural health clinic will be reimbursed the same rate per visit established by the Title XVIII (Medicare) carrier Blue Cross/Blue Shield of Tennessee for Medicare. Medicaid will utilize the annual rate established by the Medicare carriers for reimbursement of Rural Health Clinics. In lieu of retroactive payment to a facility, a percentage allowance will be added to the per encounter rate as of July 1 of each year based on the clinic's last year-end cost report. The percentage allowance will be based on the Consumer Price Index (CPI) estimated for the month of the clinic's fiscal year end divided into the CPI projected for December of the following year. The established rate multiplied by this ratio will determine the clinic's rate per encounter for each subsequent twelve month period. The effective date of each rate change will be July 1 of each year. Other Title XIX ambulatory services will be reimbursed using the same methodology as specified elsewhere in the State Plan for those services.

1/1/01 The payment methodology for RHCs will conform to section 702 of the Medicare, Medicaid & SCHIP Benefits Improvement Act of 2000 (BIPA) legislation. The payment methodology for RHCs will conform to the BIPA 2000 requirements under a prospective payment system. The payment methodology will use the existing interim rate plan and retroactively adjust the payment upon final calculation.

Amendment 2001-02
Effective 1/1/2001
Supersedes 93-02

Approval NOV 01 2001

METHODS USED IN ESTABLISHING PAYMENT RATES

11/1/85 OUTPATIENT HOSPITAL SERVICES - Are reimbursed according to the methodology described in Exhibit I of this attachment.

Amendment 93-02
Effective 1/1/93
Supersedes 91-39
APR 22 1993
Approval _____

METHODS USED IN ESTABLISHING PAYMENT RATES

7/1/90 HOSPICE CARE SERVICES - Medicaid reimbursement to hospice providers is the same as their Medicare established rate for the following four categories of service: 1) routine home care; 2) continuous home care; 3) inpatient respite care; and 4) general inpatient care.

These rates have been established based on a Medicare hospice national rate, adjusted for regional differences in wages, using indices published in the Medicare Hospice Manual.

In addition, Medicaid will reimburse the hospice for physician services such as direct patient care services, furnished to individual patients by hospice employees and for physician services furnished under arrangements made by the hospice. These physician fees are reimbursable at the established Medicaid rate for physician services.

For Medicaid eligible recipients residing in an ICF or SNF facility who have elected to receive hospice services, the hospice provider will be paid the routine or continuous home care rate plus an additional amount for room and board.

For dual eligible recipients residing in an ICF or SNF facility who have elected to receive hospice services and whose hospice services costs are covered by Medicare, Medicaid will make an additional payment to the hospice provider for room and board.

The following is the methodology used in determining the room and board rate for nursing home hospice patients. An amount equal to 95% of what the state payment would have been to the nursing home will be paid to the hospice. It will be based upon the weighted average of days paid to each nursing home that the hospice has made payment to in the previous fiscal year. Those weights will be applied to 95% of the current nursing home rates to develop a weighted average rate that will be paid to the hospice for each of its nursing home clients. In the event the hospice provider has no history, the provider will be paid 95% of the average nursing home rate in the county the hospice resides. This average will be weighted based on Medicaid days.

Amendment 93-02
Effective 1/1/93
Supersedes 89-22

Approval APR 22 1993

./1/97 As required in Section 6402 of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) Florida is providing the following information as a part of this state plan amendment which demonstrates the availability of pediatric and obstetrical services for Medicaid recipients. The Health Care Financing Administration (HCFA) requires that access be exhibited by county or other geographical sub-region.

Florida is organized into 11 area Medicaid offices and 15 Department of Children and Families (DCF) geographical service districts in order to efficiently provide health, social and rehabilitative services. The 11 Medicaid areas incorporate the 15 geographical service districts of the Department of Children and Families. These areas/districts consist of groupings of various counties which are based on data showing natural trade areas for economic and medical services. Each area Medicaid office and DCF district has an administrator who is responsible for ensuring that the administration of all service programs is carried out in conformity with statewide service plans. In addition, each administrator is responsible for coordinating Medicaid and DCF services and also coordinating services with other public and private agencies which provide health, social and rehabilitative services within the district.

This organizational structure is designed to meet the needs of the specific population of each district. Each geographical area/district is the natural trade area for the receipt of medical services (whether delivered by Medicaid or not), and has at least a 50% participation rate by its obstetricians, obstetrician-gynecologists, family practitioners, and pediatric practitioners.

PAYMENT FOR PEDIATRIC SERVICES

The payment schedule is applied uniformly to all reimbursements regardless of geographic location for all practitioner types cited in the statutory definitions of Obstetric/Pediatric services.

For County Public Health Units (CPHUs) and Federally Qualified Health Centers (FQHCs), all office/clinic visits are paid or reimbursed at 100% of reasonable cost. Rural Health Clinics (RHCs) are paid their Medicare determined encounter rate.

Maximum Payment Rates for Listed Pediatric Services

Procedure Code	Procedure Description	Level	Maximum Payments
OFFICE MEDICAL SERVICES			
	New Patient		
99201**	Office/other outpatient services	I	30.00
99202**		II	31.35
99203**		III	43.62
99204		IV	64.98
99205		V	82.02
	Established patient		
99211**	Office/other outpatient services	I	12.00
99212**		II	21.00
99213**		III	25.00
99214		IV	37.26
99215		V	59.07
OFFICE OR OTHER OUTPATIENT CONSULTATIONS			
	New or Established Patient		
99241	Physicians typically spend 15 minutes		26.74
99242	Physicians typically spend 30 minutes		42.27
99243	Physicians typically spend 40 minutes		54.85
99244	Physicians typically spend 60 minutes		77.07
99245	Physicians typically spend 80 minutes		103.80
CONFIRMATORY CONSULTATIONS			
	New or Established Patient		
99271	Usually the presenting problems(s) are self limited or minor		N/A
99272	Usually the presenting problems(s) are of low severity		N/A
99273	Usually the presenting problems(s) are of moderate severity		N/A
99274	Usually the presenting problems(s) are of moderate to high severity		N/A
99275	Usually the presenting problems(s) are of moderate to high severity		N/A
EMERGENCY DEPARTMENT VISITS			
	New or Established Patient		
99281**	Emergency department visits	I	14.00
99282		II	21.81
99283		III	40.21
99284		IV	61.57
99285		V	97.01
HOME SERVICES			
	New Patient		
99341	Usually the presenting problems(s) are of low severity		33.42
99342	Usually the presenting problems(s) are of moderate severity		43.84
99343	Usually the presenting problems(s) are of high severity		57.41
	Established Patient		
99351	Usually the patient is stable, recovering or improving		25.95
99352	Usually the patient is responding inadequately to therapy or has developed a minor complication		33.23
99353	Usually the patient is unstable, or has developed a significant complication or a significant new problem		42.07

** This procedure may also be provided by Advanced Registered Nurse Practitioners and Physician Assistants who are reimbursed at 80% of the stated fee.

N/A These procedures are not reimbursed by Florida Medicaid.

IMMUNIZATION INJECTION Fees:	Physician RHCs	ARNP PA	CPHU FQHC
For recipients age birth through 18 years, the following rates apply:			
90700 immunization, active; diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTAP)	10.00	8.00	5.00
90701 immunization, active; diphtheria and tetanus toxoids and pertussis vaccine (DTP)	10.00	8.00	5.00
90702 diphtheria and tetanus toxoids(DT)	10.00	8.00	5.00
90704 mumps virus vaccine, live	10.00	8.00	5.00
90705 measles virus vaccine, live attenuated	10.00	8.00	5.00
90706 rubella virus vaccine, live	10.00	8.00	5.00
90707 measles, mumps and rubella virus vaccine, live	10.00	8.00	5.00
90708 measles and rubella virus vaccine, live	10.00	8.00	5.00
90709 rubella and mumps virus vaccine, live	10.00	8.00	5.00
90712 polio virus vaccine, live, oral (any type(s))	10.00	8.00	5.00
90713 poliomyelitis vaccine	10.00	8.00	5.00
90714 typhoid vaccine		N/A	
90716 Varicella vaccine	10.00	8.00	5.00
90717 yellow fever vaccine		N/A	
90718 tetanus and diphtheria toxoids absorbed	10.00	8.00	5.00
90719 diphtheria toxoid		N/A	
90720 diphtheria, tetanus, and pertussis (DTP) and hemophilus influenza (HIB) vaccine	10.00	8.00	5.00
90721 DTAP and HIB vaccine	10.00	8.00	5.00
90724 influenza virus vaccine	10.00		
90725 cholera vaccine		N/A	
90726 rabies vaccine		N/A	
90727 plague vaccine		N/A	
90728 BGC vaccine		N/A	
90730 Hepatitis A	66.90	64.90	66.90
90732 pneumococcal vaccine, polyvalent	21.90	19.90	21.90
90733 meningococcal polysaccharide vaccine-any group(s)		N/A	
90737 hemophilus influenza B	10.00	8.00	5.00
90741 immunization, passive; immune serum globulin, human (ISG)		N/A	
90742 specific hyperimmune serum globulin (e.g., hepatitis B, measles, pertussis, rabies, Rho(D), tetanus, vaccinia, varicella-zoster)		N/A	
90744 hepatitis B vaccine, active (0-11 years)	10.00	8.00	5.00
W1949 hepatitis B vaccine, active (12-18 years)	10.00	8.00	5.00

(This rate includes the professional service)
* No payment made.
N/A These procedures are not reimbursed by Florida Medicaid.

IMMUNIZATION INJECTION		Fees: Physician	ARNP PA	CPHU FOHC
For recipients age 19 and 20, the following rates apply:				
W1940	mumps virus vaccine, live	28.78	26.78	28.78
W1941	measles virus vaccine, live attenuated	26.83	24.83	26.83
W1942	rubella virus vaccine, live	27.43	25.43	27.43
W1943	measles, mumps and rubella virus vaccine-live	44.64	42.64	44.64
W1944	measles and rubella virus vaccine, live	34.47	32.47	34.47
W1945	rubella and mumps virus vaccine, live	36.25	34.25	36.25
W1946	tetanus and diphtheria toxoids absorbed	11.32	9.32	11.32
W1947	hepatitis B vaccine	63.54	61.54	63.54
90714	typhoid vaccine	N/A		
90716	varicella, active	10.00	8.00	5.00
90717	yellow fever vaccine	N/A		
90719	diphtheria toxoid	N/A		
90724	influenza virus vaccine	10.00	8.00	5.00
90725	cholera vaccine	N/A		
90726	rabies vaccine	N/A		
90727	plague vaccine	N/A		
90728	BGC vaccine	N/A		
90730	hepatitis A, active	66.90	53.52	
90732	pneumococcal vaccine, polyvalent	21.90	19.90	21.90
90733	meningococcal polysaccharide vaccine-any group(s)	N/A		
90741	immunization, passive; immune serum globulin, human (ISG)	N/A		
90742	specific hyperimmune serum globulin (e.g., hepatitis B, measles, pertussis, rabies, Rho(D), tetanus, vaccinia, varicella-zoster)	N/A		
90749	poliomyelitis vaccine - bill using CPT code and attach report			
W1948	influenza virus vaccine	14.36	12.36	14.36

(This rate includes the cost of the drug plus the administrative fee.)
* No payment made.
N/A These procedures are not reimbursed by Florida Medicaid.

No payment was made for services for the following procedure codes during the period of this amendment.

90703	No payment made
90710	No payment made
90711	No payment made
99358	No payment made
99359	No payment made

The following codes have been replaced by the local code W9881. (Payment of $64.98 - Effective 1/1/97)

99381	EPSDT code W9881
99382	EPSDT code W9881
99383	EPSDT code W9881
99384	EPSDT code W9881
99391	EPSDT code W9881
99392	EPSDT code W9881
99393	EPSDT code W9881
99394	EPSDT code W9881

MUNIZATION INJECTION	Fees:	Physician	ARNP PA	CPHU FQHC
99354	Prolonged physician service	$51.12	$40.90	
99355	Prolonged physician service	$51.12	$40.90	

CASE MANAGEMENT SERVICES

99361	Team Conference - Approximately 30 minutes	N/A
99362	Team Conference - Approximately 60 minutes	N/A
99371	Telephone Calls - Simple or brief	N/A
99372	Telephone Calls - Intermediate	N/A
99373	Telephone Calls - Complex or lengthy	N/A

PREVENTIVE MEDICINE

New Patient

Initial evaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures.

W9881	adolescent (age 12 through 17 years)	$64.98
	late childhood (age 5 through 11 years)	$64.98
	early childhood (age 1 through 4 years)	$64.98
	infant (age under 1 year)	$64.98

)881 CPHUs and FQHCs are paid 100% of reasonable costs for EPSDT.
881 RHCs are paid their Medicare determined encounter rate.

* No payment made.

N/A These procedures are not reimbursed by Florida Medicaid.

Established Patient
Periodic reevaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedure.

94772	Circadian respiratory pattern recording (pediatric pneumogram), 12 to 24 hour continuous recording, infant	17.50
W9881	infant(age under 1 year)	64.98
	early childhood (1 through 4 years)	64.98
	late childhood (5 through 11 years)	64.98
	adolescent (12 through 17 years)	64.98
	Administration and medical interpretation of developmental tests	64.98
	Early Periodic Screening and Diagnostic Treatment	64.98

W9881 CPHUs are paid 100% of reasonable cost for EPSDT.

COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION

New or Established Patient

Preventive Medicine, Individual Counseling

99401	Counseling and/or risk factor reduction intervention(s) provided to a healthy individual; approximately 15 minutes	N/A
99402	approximately 30 minutes	N/A
99403	approximately 45 minutes	N/A
99404	approximately 60 minutes	N/A

Preventive Medicine, Group Counseling

99411	Counseling and/or risk factor reduction intervention(s) provided to healthy individuals in a group setting; approximately 30 minutes	N/A
99412	approximately 60 minutes	N/A

Other Preventive Medicine Services

99420	Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)	N/A
99429	Unlisted preventive medicine services	N/A
99432	Newborn care, in other than hospital setting, including physical examination of baby and conference(s) with parent(s)	52.10
99435	History and examination of the normal newborn infant, including the preparation of medical records.	61.93

(Early Periodic Screening and diagnostic Treatment)

W9881	Infant care to one year of age.	64.98

** Procedures so indicated may also be provided by enrolled Advanced Registered Nurse Practitioners, Physician Assistants and licensed midwives. Reimbursement of these procedures is 80% of the stated fee.

N/A These procedures are not reimbursed by Florida Medicaid.

Adequacy of Access

t least 50% of the Pediatricians or Family Practitioners (as a group) re Medicaid participants.

dditionally, Certified Pediatric Nurse Practitioners and Family Nurse ractitioners are eligible to participate in the Medicaid program.

ll County Public Health Units provide EPSDT services (or have contracts with rivate physicians for EPSDT services) to children under 21. Provider articipation includes all providers of pediatric services excluding nstitutional services.

1995 - 1996
Florida Pediatric
Participation By Area

Area	Total Pediatric Providers	Total Medicaid Participating	Percent Participation
Area 1	161	135	84%
Area 2	241	171	71%
Area 3	403	290	72%
Area 4	498	361	73%
ea 5	358	290	81%
a 6	576	411	71%
a 7	558	455	82%
Area 8	313	239	76%
Area 9	314	236	75%
Area 10	395	298	75%
Area 11	980	739	75%
TOTALS Cumulative	4,797	3,625	76%

Participation means at least one paid claim on file in the fiscal year.

ABORTION

59812	Treatment of spontaneous abortion, any trimester; completed surgically	147.06
59820	Treatment of missed abortion, first trimester; completed surgically	162.20
59821	Treatment of missed abortion, second trimester; completed surgically	149.42
59830	Treatment of septic abortion, completed surgically	216.46
59840	Induced abortion, by dilation and curettage	134.08
59841	Induced abortion, by dilation and evacuation	183.03
59850	Induced abortion, by one or more intra-amniotic injections	202.69
59851	with dilation and curettage and/or evacuation	211.93
59852	with hysterotomy (failed intra-amniotic injections)	284.68
59855	Induced abortion, by one or more vaginal suppositories	214.29
59856	with dilation and curettage and/or evacuation	264.62
59857	with hysterotomy	321.83
59866	Multifetal pregnancy reduction(s) (MPR) (Fee to be determined by RVU value - pending)	

Diagnostic Ultrasound

PELVIS

6805	Echography, pregnant uterus, B-scan and/or real time with image documentation; (complete maternal and fetal evaluation)	71.56
76810	Complete maternal and fetal evaluation, multiple gestation, after the first trimester	142.14
76815	Limited (gestational age, heartbeat, placental location, fetal position or emergency in the delivery room)	47.77
76816	Follow-up or repeat	39.32
76818	Fetal biophysical profile	55.24
76825	Echocardiography, fetal real time with image documentation (2D) with or without M-Mode recording	80.02

Adequacy of Access

At least 50% of the actively participating Obstetricians, Obstetrician-Gynecologists, Family and General Practitioners, Certified Nurse Midwives and Certified Family Nurse Practitioners are Medicaid providers.

All 67 County Public Health Units (CPHUs) either provide maternity care at their clinic or have contracts with the private obstetricians to provide maternity services.

The 11 Regional Perinatal Intensive Care Centers (RPICC) provide obstetrical services for all medically eligible high risk pregnant women regardless of ability to pay. They also provide services to the neonates in these same specialized centers regardless of ability to pay.

Assurance of the eligibility of pregnant women to receive adequate access to care is provided by CPHUs, up to 200% of poverty, under Florida Administrative Code, Chapter 10D-99.002 (13), Eligibility for State Funded Prenatal Care. Another assurance for adequate access to obstetrical care is the Florida Administrative Code, Chapter 10J-7, Regional Perinatal Intensive Care Centers, and section 409.908 (12)(b) F.S. (Medicaid).

1995 - 1996
Florida Obstetrical
Participation By Area

Area	Total Obstetric Services Providers	Total Medicaid Participating	Percent Participation
Area 1	56	45	80%
Area 2	51	39	77%
Area 3	101	78	77%
Area 4	136	91	67%
Area 5	94	71	76%
Area 6	206	163	79%
Area 7	177	145	82%
Area 8	93	74	80%
Area 9	134	96	72%
Area 10	127	95	75%
Area 11	230	175	76%
TOTALS	1,405	1,072	76%

Participation means at least one paid claim on file in the fiscal year.

HMO Obstetrical and Pediatric Coverage and Capitation Rates

All Medicaid health maintenance organizations (HMO) and prepaid health plans are required to provide obstetrical and pediatric care under terms of the standard contract between the plans and the Agency for Health Care Administration (AHCA). No plan is permitted to commence operation until the necessary resources are in place either through a direct employment relationship or under contract. The availability of those services is routinely monitored for each plan (quarterly at a minimum).

Payment to the plans for obstetrics and pediatrics is included in the capitation rate paid to each plan in the physician services category. The plan is paid a contractually fixed amount at the beginning of each month for each enrolled recipient. The total amount of the capitation rate paid to each plan is the sum of the rates for each category of covered services, e.g., inpatient hospital services + physician services + prescribed drug, etc. The final rate for each eligibility category is a percentage less than 100 of the expected fee-for-service experience for the Medicaid population in that area in that eligibility category, by age band, based upon actual experience in the last year for which a full year of claims data is available. The capitation rates are shown to be adequate as all HMO's and prepaid health plans with Medicaid contracts consistently demonstrate fiscal solvency.

HMO: As of February 1997, more than 373,000 Medicaid recipients were enrolled in HMOs and prepaid health plans statewide. The following table shows each HMO/prepaid health plan in operation by county, their enrollment and the obstetrical and pediatric providers under contract with the plans.

Medicaid Prepaid Health Plans
Enrollment, OB, and Pediatrician
As of February 1997

PLAN NAME	COUNTY	ENROLLMENT	OB-GYN	PEDIATRICIANS
CHAMPION HEALTHCARE	CLAY	0	7	12
CHAMPION HEALTHCARE	DUVAL	0	54	68
CHAMPION HEALTHCARE	NASSAU	0	2	1
CHAMPION HEALTHCARE	ST. JOHNS	0	3	0
DISCOVERY HEALTH PLAN	BAY	1940	6	4
DISCOVERY HEALTH PLAN	GADSDEN	1227	0	1
DISCOVERY HEALTH PLAN	JEFFERSON	170	0	0
DISCOVERY HEALTH PLAN	LEON	1490	10	16
DISCOVERY HEALTH PLAN	MADISON	407	0	0
DISCOVERY HEALTH PLAN	WAKULLA	209	0	0
FLORIDA FIRST HEALTH PLAN	HARDEE	0	0	1
FLORIDA FIRST HEALTH PLAN	HIGHLANDS	0	7	6
FLORIDA FIRST HEALTH PLAN	POLK	0	20	17
FOUNDATION HEALTH	BREVARD	411	13	8
FOUNDATION HEALTH	BROWARD	2585	32	59
FOUNDATION HEALTH	CHARLOTTE	42	3	3
FOUNDATION HEALTH	CLAY	242	1	7
FOUNDATION HEALTH	DADE	3478	35	88
FOUNDATION HEALTH	DUVAL	6285	37	22
FOUNDATION HEALTH	LEE	236	26	9
FOUNDATION HEALTH	MARTIN	431	4	8
FOUNDATION HEALTH	PALM BEACH	4206	37	26
FOUNDATION HEALTH	ST. LUCIE	2002	5	4
HEALTHCARE USA	ALACHUA	3703	23	36
HEALTHCARE USA	BAKER	253	0	1
HEALTHCARE USA	BRADFORD	651	0	0
HEALTHCARE USA	CLAY	456	4	11
HEALTHCARE USA	COLUMBIA	1154	0	0
HEALTHCARE USA	DUVAL	6985	0	0
HEALTHCARE USA	FLAGLER	467	0	2
HEALTHCARE USA	MARION	5461	7	4
HEALTHCARE USA	NASSAU	202	2	0
HEALTHCARE USA	PUTNAM	1573	4	5
HEALTHCARE USA	ST. JOHNS	1031	4	3
HEALTHCARE USA	UNION	227	0	1
HEALTHCARE USA	VOLUSIA	1578	6	4
HEALTHEASE	HILLSBOROUGH	3627	40	36
HEALTHEASE	PASCO	13	10	1
HEALTHEASE	PINELLAS	35	14	5
HEALTHEASE	POLK	55	4	2
JMH HEALTH PLAN	DADE	6417	36	89
MEDCHOICE HEALTH PLAN	BROWARD	2202	51	73
MEDCHOICE HEALTH PLAN	PALM BEACH	329	30	19
NEIGHBORHOOD HEALTH	BROWARD	0	0	19
NEIGHBORHOOD HEALTH	DADE	9286	23	138
PCA FAMILY HEALTH PLAN	ALACHUA	2119	15	10
PCA FAMILY HEALTH PLAN	BAKER	164	1	1
PCA FAMILY HEALTH PLAN	BRADFORD	236	0	4
PCA FAMILY HEALTH PLAN	BREVARD	2332	22	24
PCA FAMILY HEALTH PLAN	BROWARD	16527	79	141
PCA FAMILY HEALTH PLAN	CHARLOTTE	451	3	8
PCA FAMILY HEALTH PLAN	CITRUS	544	0	3
PCA FAMILY HEALTH PLAN	CLAY	691	7	28
PCA FAMILY HEALTH PLAN	DADE	31588	147	263
PCA FAMILY HEALTH PLAN	DIXIE	85	15	8
PCA FAMILY HEALTH PLAN	DUVAL	15097	72	162
PCA FAMILY HEALTH PLAN	ESCAMBIA	6236	2	26
PCA FAMILY HEALTH PLAN	GADSDEN	1334	0	2
PCA FAMILY HEALTH PLAN	GILCHRIST	85	15	8
PCA FAMILY HEALTH PLAN	HIGHLANDS	585	4	7

Medicaid Prepaid Health Plans
Enrollment, OB, and Pediatrician
As of February 1997

Attachment 4.19-B
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PLAN NAME	COUNTY	* ENROLLMENT	OB/GYN	PEDIATRICIANS
PCA FAMILY HEALTH PLAN	HILLSBOROUGH	8050	85	84
PCA FAMILY HEALTH PLAN	JEFFERSON	560	0	4
PCA FAMILY HEALTH PLAN	LAKE	1341	10	29
PCA FAMILY HEALTH PLAN	LEE	1591	37	28
PCA FAMILY HEALTH PLAN	LEON	2463	7	5
PCA FAMILY HEALTH PLAN	LEVY	359	0	8
PCA FAMILY HEALTH PLAN	MANATEE	4717	6	13
PCA FAMILY HEALTH PLAN	MARION	1119	1	9
PCA FAMILY HEALTH PLAN	MARTIN	417	4	4
PCA FAMILY HEALTH PLAN	NASSAU	263	0	8
PCA FAMILY HEALTH PLAN	OKEECHOBEE	200	2	2
PCA FAMILY HEALTH PLAN	ORANGE	7256	25	54
PCA FAMILY HEALTH PLAN	OSCEOLA	1595	4	10
PCA FAMILY HEALTH PLAN	PALM BEACH	4203	71	68
PCA FAMILY HEALTH PLAN	PASCO	1778	18	34
PCA FAMILY HEALTH PLAN	PINELLAS	5991	10	72
PCA FAMILY HEALTH PLAN	POLK	4401	19	40
PCA FAMILY HEALTH PLAN	PUTNAM	4	1	9
PCA FAMILY HEALTH PLAN	SANTA ROSA	762	2	12
PCA FAMILY HEALTH PLAN	SARASOTA	667	4	12
PCA FAMILY HEALTH PLAN	SEMINOLE	2257	11	19
PCA FAMILY HEALTH PLAN	ST. JOHNS	334	0	5
PCA FAMILY HEALTH PLAN	VOLUSIA	2416	16	33
PERSONAL HEALTH PLAN	PALM BEACH	3608	10	13
PHYSICIAN CARE PLAN	BROWARD	1028	132	165
PHYSICIAN CARE PLAN	DADE	1314	81	135
PHYSICIAN CARE PLAN	HILLSBOROUGH	14235	33	91
PHYSICIAN CARE PLAN	LEE	5047	28	43
PHYSICIAN CARE PLAN	MANATEE	1	0	1
PHYSICIAN CARE PLAN	ORANGE	5996	105	82
PHYSICIAN CARE PLAN	OSCEOLA	164	14	9
PHYSICIAN CARE PLAN	PALM BEACH	713	36	27
PHYSICIAN CARE PLAN	PASCO	2310	25	21
PHYSICIAN CARE PLAN	PINELLAS	8898	80	50
PHYSICIAN CARE PLAN	POLK	3347	10	6
PHYSICIAN CARE PLAN	SARASOTA	1852	41	24
PHYSICIAN CARE PLAN	SEMINOLE	565	85	21
PREFERRED MEDICAL PLAN	DADE	5385	21	42
ST. AUGUSTINE HEALTH CARE	CHARLOTTE	324	8	5
ST. AUGUSTINE HEALTH CARE	HERNANDO	2473	7	4
ST. AUGUSTINE HEALTH CARE	HILLSBOROUGH	2552	59	37
ST. AUGUSTINE HEALTH CARE	LEE	560	4	5
ST. AUGUSTINE HEALTH CARE	MARION	120	2	1
ST. AUGUSTINE HEALTH CARE	PASCO	595	11	6
ST. AUGUSTINE HEALTH CARE	PINELLAS	449	29	11
ST. AUGUSTINE HEALTH CARE	POLK	9	5	1
ST. AUGUSTINE HEALTH CARE	SUMTER	1138	1	1
STAYWELL	BROWARD	2262	43	57
STAYWELL	DADE	6899	52	92
STAYWELL	HILLSBOROUGH	8371	83	50
STAYWELL	ORANGE	2489	14	13
STAYWELL	OSCEOLA	304	4	4
STAYWELL	PALM BEACH	180	31	30
STAYWELL	PASCO	769	24	16
STAYWELL	PINELLAS	2411	33	31
STAYWELL	POLK	13133	5	15
STAYWELL	SEMINOLE	373	16	2
SUNSHINE HEALTH PLAN	BROWARD	817	8	6
ULTRAMEDIX HEALTH CARE	ALACHUA	706	16	9
ULTRAMEDIX HEALTH CARE	DIXIE	210	0	1
ULTRAMEDIX HEALTH CARE	GILCHRIST	73	0	1

Medicaid Prepaid Health Plans
Enrollment, OB, and Pediatrician
As of February 1997

PLAN NAME	COUNTY	ENROLLMENT	OB/GYN	PEDIATRICIANS
ULTRAMEDIX HEALTH CARE	HERNANDO	1574	4	14
ULTRAMEDIX HEALTH CARE	HILLSBOROUGH	1214	31	12
ULTRAMEDIX HEALTH CARE	LEVY	272	0	1
ULTRAMEDIX HEALTH CARE	MARION	1444	10	2
ULTRAMEDIX HEALTH CARE	PASCO	760	9	12
ULTRAMEDIX HEALTH CARE	PINELLAS	285	16	5
ULTRAMEDIX HEALTH CARE	POLK	984	26	3
UNITED HEALTHCARE PLAN	BREVARD	5499	14	29
UNITED HEALTHCARE PLAN	BROWARD	5318	27	73
UNITED HEALTHCARE PLAN	DADE	24514	53	61
UNITED HEALTHCARE PLAN	HIGHLANDS	910	3	3
UNITED HEALTHCARE PLAN	LAKE	2972	22	8
UNITED HEALTHCARE PLAN	OKEECHOBEE	427	3	3
UNITED HEALTHCARE PLAN	ORANGE	6700	12	10
UNITED HEALTHCARE PLAN	OSCEOLA	2168	5	3
UNITED HEALTHCARE PLAN	PALM BEACH	2967	47	32
UNITED HEALTHCARE PLAN	SEMINOLE	2399	12	10
UNITED HEALTHCARE PLAN	VOLUSIA	2057	18	3
UNITED HEALTHCARE PLAN	BROWARD	266	27	73
UNITED HEALTHCARE PLAN	DADE	2618	53	61
UNITED HEALTHCARE PLAN	PALM BEACH	80	47	32
	Total	373,262	2875	3855

Access to Services: In summary, the Florida Medicaid program provides access to care for all pediatric and obstetric recipients in each county within the district. The Medicaid program provides transportation services to neighboring counties for Medicaid recipients when necessary to obtain services. Additionally, all Florida counties have a county public health unit which provides access to our Medicaid recipients. Services are available to Medicaid recipients within each of the geographical district areas.

FLORIDA'S MEDICAID AREAS/COUNTIES

AREA 1 Pensacola	Escambia Okaloosa Santa Rosa Walton		
AREA 2 Tallahassee	Bay Calhoun Franklin Gadsden	Gulf Holmes Jackson Jefferson Leon	Liberty Madison Taylor Wakulla Washington
AREA 3 Gainesville	Alachua Bradford Citrus Columbia Dixie Gilchrist	Hamilton Hernando Lafayette Lake Levy	Marion Putnam Sumter Suwannee Union
AREA 4 Jacksonville	Baker Clay	Duval Flagler	Nassua St. Johns Volusia
AREA 5 Clearwater/ St. Petersburg	Pasco Pinellas		
AREA 6 Tampa	Hillsborough Manatee	Hardee Highlands	Polk
AREA 7 Orlando/ Winter Park	Brevard Orange Osceola	Seminole	
AREA 8 Ft. Myers	Charlotte Collier	DeSoto Glades	Hendry Lee Sarasota
AREA 9 West Palm Beach/ Ft. Pierce	Indian River Martin Okeechobee	Palm Beach St. Lucie	
AREA 10 Ft. Lauderdale/ Margate	Broward		
AREA 11 Miami	Dade Monroe		

Maximum Payment Rates for Listed Obstetrical Services - Physicians
Average Payment Amount - July 1, 1995 to June 30, 1996
Statewide Averages

PROCEDURE CODE	AVERAGE PAYMENT
59000	$50.92
59012	$126.00
59015	$64.13
59020	$36.63
59025	$26.26
59030	$44.37
59050	N/A
59051	N/A
59100	$114.06
59120	$314.69
59121	$240.73
59130	$128.06
59135	$509.92
59136	$395.28
59140	$190.99
59150	$253.89
59151	$341.63
59160	$120.48
59200	$29.73
59300	$65.77
59320	$94.34
59325	$153.98
59350	$135.18
59400	$800.00
59409	N/A
59410	$835.86
59412	$79.16
59414	$152.54
59425	N/A
59426	N/A
59430	$50.47
59510	N/A
59514	N/A
59515	$722.63
59525	$252.91
59812	$154.65
59820	$172.40
59821	$147.37
59830	$228.78
59840	$180.48
59841	$138.94
59850	$210.14
59851	$248.00
59852	N/A
59855	$188.66
59856	$227.47
59857	N/A
59870	$163.86
59899	$95.39
370.0	$1483.11
370.1	$1617.95
370.2	$1774.51
372.0	$1445.89
372.1	$1579.97
372.2	$1664.20
376.0	$348.43
383.0	$435.04
383.1	$449.61
383.2	$562.08
470.1	$1607.81
470.2	$1981.45
470.3	$1717.09
472.1	$1582.33
472.3	$1632.73
76805	$56.62
76810	$124.91
76815	$33.01
76816	$34.31
76818	$38.70
76825	$54.38
99201	$33.39
99202	$33.72
99203	$42.80
99204	$62.83
99205	$77.68
99211	$17.66
99212	$25.86
99213	$25.39
99214	$36.64
99215	$57.39
99281	$11.72
99282	$19.06
99283	$33.42
99284	$51.21
99285	$80.16
99420	$49.75
W9607	$51.11

N/A These procedures are not reimbursed by Florida Medicaid.

Maximum Payment Rates for Listed Pediatric Services - Physicians
Average Payment Amount - July 1, 1995 to June 30, 1996
Statewide Averages

PROCEDURE CODE	AVERAGE PAID	PROCEDURE CODE	AVERAGE PAID
90700	$10.01	99201	$33.39
90701	$9.94	99202	$33.72
90702	$9.84	99203	$42.80
90703	N/A	99204	$62.83
90704	$9.96	99205	$77.68
90705	$9.99	99211	$17.66
90706	$10.08	99212	$25.86
90707	$10.00	99213	$25.39
90708	$10.00	99214	$36.64
90709	$9.96	99215	$57.39
90710	N/A	99241	$26.30
90711	N/A	99242	$40.72
90712	$9.96	99243	$52.89
90713	$9.98	99244	$73.86
90714	N/A	99245	$99.84
90716	$50.49	99271	N/A
90717	N/A	99272	N/A
90719	N/A	99273	N/A
90720	$10.02	99274	N/A
90721	$10.00	99275	N/A
90724	$9.41	99281	$11.72
90725	N/A	99282	$19.06
90726	N/A	99283	$33.42
90727	N/A	99284	$51.21
90728	N/A	99285	$80.16
90730	$64.30	99341	$33.99
90731	$10.00	99342	$45.19
90732	N/A	99343	$59.67
90733	N/A	99351	$27.26
90737	$9.98	99352	$34.49
90741	N/A	99353	$44.59
90742	N/A	99354	$36.48
90744	$9.95	99355	$16.48
90745	N/A	99358	N/A
90749	$7.73	99359	N/A
		99381	N/A
		99382	N/A
W9878	N/A	99383	N/A
W9879	N/A	99384	N/A
		99391	N/A
		99392	N/A
		99393	N/A
		99394	N/A
		99401	N/A
		99402	N/A
		99403	N/A
		99404	N/A
		99411	N/A
		99412	N/A
		99420	$49.75
		99429	N/A
		99432	$52.36

* Immunization services were reduced to a $10.00 administrative fee effective 10/1/94.

N/A These procedures are not reimbursed by Florida Medicaid.

Maximum Payment Rates for Listed ARNP Obstetrical Services
Average Payment Amount - July 1, 1995 to June 30, 1996
Statewide Averages

PROCEDURE CODE	AVERAGE PAID
59025	$20.92
59400	N/A
59410	$627.47
59420	N/A
59430	$54.49
99201	$47.91
99202	$46.64
99203	$36.08
99211	$39.82
99212	$46.31
99213	$37.35
99281	$ 9.55
99420	$45.58

N/A These procedures are not reimbursed by Florida Medicaid.

METHODS USED IN ESTABLISHING PAYMENT RATES

4/1/91 EARLY AND PERIODIC SCREENING DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

All services provided for in Section 1905(a) of the Act which are medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions are provided for EPSDT participants.

Institutional services (inpatient/outpatient hospital services, nursing home services and ICF/MR services), Federally Qualified Health Centers and Rural Health Services are reimbursed as described within Attachment 4.19-B.

All other services are reimbursed on a fee-for-service basis in accordance with established fee schedules as described within Attachment 4.19-B.

PHYSICIAN SUPPLEMENTAL PAYMENT METHODOLOGY

REIMBURSEMENT - Eligible providers specified below will be reimbursed for services rendered to Florida Medicaid recipients who are not enrolled in a managed care plan. This excludes dually eligible Medicare and Medicaid recipients. The supplemental payments, which reflect the alternative fee schedule, will be made monthly based on the calculation of the differential amount between the base Medicaid payment and supplemental payment for allowable Current Procedural Terminology codes. Each Florida Medicaid covered medical (excluding vaccines for children, and the technical component (TC) for radiology services), dental, and behavioral health billable code listed on the applicable Florida Medicaid fee schedule, will be reimbursed in accordance with the following payment methodology:

(a) An average of the payments from the top five (5) commercial payers for each CPT code was provided to generate the Average Commercial Rate (ACR).

(b) Both the Medicare rate and the ACR were multiplied by the Florida Medicaid fee-for-service (FFS) volume of services reimbursed for eligible CPT codes.

(c) The statewide Medicare equivalent of the ACR was calculated by dividing the product of ACR and FFS volume by the product of the Medicare and FFS volume.

(d) The calculated ACR for physicians employed by or contracted with a Florida public hospital was established based on the 2022-2023 ACR.

(e) The calculated ACR for physicians employed by or contracted by a Florida private, non-profit, accredited medical, dental, or optometry school was established based on the 2019-2020 ACR.

(f) The calculated ACR for physicians employed by or contracted with a Florida public hospital pays at one-hundred thirty-four point one percent of the Medicare rate for eligible Florida Medicaid Services, with Clinical Diagnostic Laboratory (CDL) CPT codes limited to the Medicare Rate. If the service does not have a Medicare rate, the calculated ACR for physicians employed by or contracted with a Florida public hospital pays at one-hundred thirty-four point one percent of the Florida Medicaid rate.

(g) The calculated ACR for physicians employed or contracted by a Florida private, non-profit, accredited medical, dental, or optometry school pays at one hundred ninety-four point five percent of the Medicare rate for eligible Florida Medicaid Services, with Clinical Diagnostic Laboratory (CDL) CPT codes limited to the Medicare Rate. If the service is not covered by Medicare, the calculated ACR for physicians employed by or contracted by a Florida private, non-profit, accredited medical, dental, or optometry school pays at two-hundred three percent of the Florida Medicaid rate.

(h) For physicians employed by a public hospital who are contracted by a Florida private, non-profit, accredited medical, dental, or optometry school will be paid at the calculated ACR for physicians employed by or contracted by a Florida private, non-profit, accredited medical, dental, or optometry school.

(i) The ACR and Medicare percentages will be recalculated every three years.

ELIGIBLE PROVIDERS – Practitioners as defined under the Merit-based Incentive Payment System (MIPS), who are enrolled in Florida Medicaid, and are either:

- employed by or contracted with a Florida public or private, non-profit, accredited medical, dental, or optometry school, including: University of Florida, University of Florida – Jacksonville, University of Miami, University of South Florida, Florida Atlantic University, Florida International University, Florida State University, and University of Central Florida, and Mount Sinai Teaching Faculty Practice, to provide supervision and teaching of medical, dental, or optometric students, residents, or fellows through application of the parameters of 42 CFR 447.304. or,
- employed by or contracted with a Florida public hospital.

Eligible practitioners include qualifying faculty physicians and all allied health personnel under their supervision pursuant to the Physician Quality Reporting System (PQRS), who are eligible Florida Medicaid providers, and furnish Florida Medicaid reimbursable services.

Reimbursement Template -Physician Services

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

☐ The rates reflect all Medicare site of service and locality adjustments.

☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

☒ The rates reflect all Medicare geographic/locality adjustments.

☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code: _____

Method of Payment

☒ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

☐ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ monthly ☐ quarterly

Primary Care Services Affected by this Payment Methodology

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

99288, 99316, 99358, 99359, 99363, 99364, 99366, 99367, 99368, 99374, 99375, 99377, 99378, 99379, 99380, 99404, 99408, 99409, 99411, 99412, 99420, 99429, 99441, 99442, 99443, 99444, 99450, 99455, 99456, 99466, 99467, 99485, 99486, 99487, 99488, 99489, 99495, 99496, 99499.

(Primary Care Services Affected by this Payment Methodology – continued)

☒ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

The state will make payment for 99224, 99225, and 99226. All three codes were added January 1, 2011.

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☐ Medicare Physician Fee Schedule rate

☒ State regional maximum administration fee set by the Vaccines for Children program

☐ Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☐ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: _____.

☒ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: $10.00.

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:_____
_____

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

Florida Medicaid will be using the Deloitte fee schedule (which was based on the November 2012 Medicare release and the 2009 conversion factor). The state will not adjust the fee schedule to account for changes in Medicare rates throughout the year.

Effective Date of Payment

E & M Services
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014, but not prior to December 31, 2014. All rates are published at:

The Florida Medicaid fiscal agent's Web site at www.mymedicaid-florida.com.

Vaccine Administration
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014, but not prior to December 31, 2014. All rates are published at

The Florida Medicaid fiscal agent's Web site at www.mymedicaid-florida.com.

METHODS USED IN ESTABLISHING PAYMENT RATES

OTHER PRACTITIONER SERVICES
Advanced Registered Nurse Practitioner, Licensed Midwife, Physician Assistant, and Registered Nurse First Assistant Services:

Except at otherwise noted in the plan, payment for these services is based on state-developed fee schedule rates which are the same for both governmental and private providers of advanced registered nurse practitioner, licensed midwife, physician assistant and registered nursed first assistant services. The fee schedule rate is in effect for Licensed Midwife services provided on or after January 1, 2016. The fee schedule rate for Advanced Registered Nurse Practitioner, Physician Assistant, and Registered Nurse First Assistant services is included in the Practitioner fee schedule and is in effect on or after January 1, 2016. All rates, including current and prior rates, are published and maintained on the agency's website. Specifically, the fee schedule is published at http://ahca.myflorida.com/medicaid/review/fee_schedules.shtml

METHODS USED IN ESTABLISHING PAYMENT RATES

CHRISTIAN SCIENCE SANATORIA SERVICES

2/15/79 Effective 10/1/77, Christian Science SANATORIA Services are reimbursed as a general intermediate care facility under methods and standards described in Attachment 4.19-D.

Amendment 93-02
Effective 1/1/93
Supersedes NEW

Approval APR 22 1993

HOME HEALTH VISITS -

Payment for home health visits are based on a State-developed fee schedule which is the same for both governmental and private providers. The Agency's home health visits rates were set as of 1/01/2015, effective for services on or after this date. The fee schedules are published at: http://ahca.myflorida.com/medicaid/review/fee_schedules.shtml

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METHODS USED IN ESTABLISHING PAYMENT RATES

7/1/2011 Freestanding Birth Center Services

Freestanding Birth Centers are reimbursed a facility fee.

Except as otherwise noted in the plan, payment for these services is based on state-developed fee schedule rates, which are the same for both governmental and private providers of Freestanding Birth Center Services (FBCS). The Agency's FBCS rates were set as of May 21, 2014, and are effective for facility services provided on or after that date. The FBCS practitioners, (licensed physicians, certified nurse midwives and licensed midwives) bill their services separately from the FBCS. The FBCS practitioners' fee schedules are referenced in the state plan under physician services (licensed physicians) and Other Practitioner Services (licensed midwife and nurse midwife). All rates, including current and prior rates, are published and maintained on the Agency's fiscal agent website. Specifically, the fee schedules are published at www.mymedicaid-florida.com. Rates for practitioners and physicians were last updated as described in Physician Services and Other Practitioner Services of the plan.

METHODS USED IN ESTABLISHING PAYMENT RATES

7/1/2017

CLINIC SERVICES: Ambulatory Surgical Centers

Ambulatory surgical centers are reimbursed using the Enhanced Ambulatory Patient Grouping (EAPG) reimbursement methodology for hospital outpatient services as directed in section 409.905(6)(b), Florida Statutes. In addition, the defined methods are outlined in Attachment 4.19-B, Exhibit I (Florida Title XIX Outpatient Hospital Reimbursement Plan).

1/1/93 CLINIC SERVICES: County Public Health Units

Clinic services are reimbursed for medically necessary primary care services in addition to preventive health care services provided in the clinic or satellite clinic locations. This includes all services and supplies provided in the course of diagnosis and treatment of an illness or injury or to assess health status in order to detect and prevent disease, disability, and other health conditions or their progression. Reimbursement is on the basis of an all inclusive rate per visit which is reasonable and related to the cost of furnishing services. The rate is calculated based on a cost report which must be submitted to Medicaid. Cost reports will be subject to audits to determine reasonableness of costs. The rate per visit reimbursement is determined by dividing reasonable costs reported by the number of visits. If there has been a payment that is less or exceeds the payment determined as reasonable cost, Medicaid will make an adjustment at the end of the fiscal year. The reimbursement is subject to the upper limits in accordance with 42 CFR 447.321.

Amendment 93-61
Effective 10/1/93
Supersedes: NEW
Approval FEB 18 1994

METHODS USED IN ESTABLISHING PAYMENT RATES

CLINIC SERVICES: Freestanding Dialysis Center Services

Freestanding Dialysis Centers are reimbursed for in-center hemodialysis dialysis treatments using a single composite rate established by the Florida Legislature. The rate is less than Medicare's composite rates for the same service.

Freestanding Dialysis Centers are reimbursed for peritoneal dialysis treatments using a single composite rate based on State- established fee schedule rates.

Please refer to Attachment 3.1A and 3.1B for Freestanding Dialysis Center covered treatment services.

The Agency's dialysis rates were set as of January 1, 2016, effective for services on or after this date. The rates are the same for both governmental and private providers. The fee schedules are published at: http://ahca.myflorida.com/medicaid/review/fee_schedules.shtml

The Agency's rate is calculated at 54.25% of the Medicare rate.

Medicaid Rate	Medicare
$125 (Hemodialysis)	$230. 39 (End Stage Renal Dialysis)
$53.57 (Peritoneal)	

*The percent of the State's End Stage Renal Dialysis rate is 54.25% ($125 / $230.39) of Medicare's rate.

METHODS USED IN ESTABLISHING PAYMENT RATES

TRANSPORTATION

7/1/97 Payment is as follows: 1) For ambulance service, all inclusive rates for basic life support, advanced life support, and air ambulance, including base rate, mileage and oxygen, the lesser of the rates determined by the State Agency not to exceed usual and customary charges; 2) the lesser of the usual and customary rates or the negotiated rates for specialized non-emergency transportation; 3) established mileage rate for private transportation and 4) the lesser of the usual and customary rates or negotiated rates for public transportation.

School districts will be reimbursed transportation for students based on costs developed by the Department of Education using cost data from each individual county. Each school district will be reimbursed a unique rate. These costs will reflect only the non-federal funds used for transportation. The costs will be adjusted yearly, if necessary. School districts will certify quarterly the state's share and receive only the federal share for reimbursement.

Amendment 97-10
Effective 7/1/97
Supersedes 93-02

Approval 9/18/97

SUPPLEMENTAL PAYMENT FOR PUBLICLY OWNED OR OPERATED EMERGENCY MEDICAL TRANSPORTATION PROVIDERS

This program provides supplemental payments for eligible Public Emergency Medical Transportation (PEMT) entities that meet specified requirements and provide emergency medical transportation services to Medicaid beneficiaries.

Supplemental payments provided by this program are available only for allowable costs that are in excess of other Medicaid revenue that the eligible PEMT entities receive for emergency medical transportation services to Medicaid eligible recipients. Eligible PEMT entities must provide to the Agency for Health Care Administration (AHCA) certification for the total expenditure of funds and certification of federal financial participation (FFP) eligibility for the amount claimed.

Providers must submit as-filed cost reports for the previous State fiscal year (SFY) by November 30 of the current SFY. Following the cost report submission, the corresponding lump-sum payments will be disbursed annually prior to the certified forward period of the current SFY (September 30). For example, cost reports with data covering SFY 2014-15 must be submitted by November 30, 2015. AHCA will then review the SFY 2014-15 submission and process a payment prior to September 30, 2016.

Payments will not be disbursed as supplemental increases to current reimbursement rates for specific services. Costs will be identified through the Centers for Medicare and Medicaid Services (CMS) approved cost report.

Costs covered will include the following applicable Medicaid emergency services: Ambulance Services: both Basic Life Support and Advanced Life Support, Advanced Life Support Level 2, and Specialty Care Transport (SCT). Services must be provided by fire rescue or ambulance services.

This supplemental payment program will be in effect beginning October 1, 2015.

A. Definitions

1. "Direct costs" means all costs that can be identified specifically with a particular final cost objective in order to meet medical transportation mandates.

2. "Indirect costs" means costs for a common or joint purpose benefitting more than one cost objective that are allocated to each benefiting objective using AHCA approved indirect rate or an allocation methodology. Indirect costs rate or allocation methodology must comply with OMB Circular A-87 and CMS non-institutional reimbursement policy.

3. "PEMT entity" is determined to be eligible if it is a county, city, healthcare district, or public university in Florida and provides emergency medical transportation services for Medicaid beneficiaries.

Amendment: 2015-014
Effective: 10/01/15
Supersedes: New
Approved: 10-20-16

4. "PEMT services" means both the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient, as well as the advanced life support, advanced life support II, basic life support, and specialty care transport services provided to an individual by PEMT providers before or during the act of transportation.

   a. "Advanced life support" means the assessment or treatment through the use of techniques described in the Emergency Medical Technician (EMT)-Paramedic: National Standard Curriculum or the National Emergency Medical Services (EMS) Education Standards, provided by an emergency medical technician-intermediate or EMT-Paramedic. These are special services designed to provide definitive prehospital emergency medical care, including but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration with drugs and other medicinal preparations, and other specified techniques and procedures.

   b. "Advanced life support level 2" means transportation by ground ambulance vehicle and the provision of medically necessary supplies and services, including one of the following:
      - At least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids).
      - Provision of manual defibrillation/cardioversion, endotracheal intubation, central venous line, cardiac pacing, chest decompression, surgical airway, or intraosseous line.

   c. "Basic life support" means the assessment or treatment through the use of techniques described in the EMT-Basic National Standard Curriculum or the National EMS Education Standards. It includes emergency first aid and cardiopulmonary resuscitation procedures to maintain life without invasive techniques.

   d. "Specialty care transport" means the inter-facility transportation of a critically injured or ill recipient by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic that must be furnished by one or more health professionals in an appropriate specialty area.

5. "Shared direct costs" are direct costs that can be allocated to two or more departmental functions on the basis of shared benefits.

Amendment: 2015-014
Effective: 10/01/15
Supersedes: New
Approved: 10-20-16

SUPPLEMENTAL PAYMENT FOR PUBLICLY OWNED OR OPERATED EMERGENCY MEDICAL TRANSPORTATION PROVIDERS

B. Supplemental Payment Methodology

Supplemental payments provided by this program to an eligible PEMT entity will consist of FFP for Medicaid uncompensated emergency medical transportation costs based on the difference between the Medicaid reimbursement amount and the providers actual cost for providing emergency medical transportation services to eligible Medicaid beneficiaries. The supplemental payment methodology is as follows:

1. As described in Section D, the expenditures certified by the eligible PEMT entity to AHCA will represent the payment eligible for FFP. Allowable certified public expenditures will determine the amount of FFP claimed.

2. In no instance will the amount certified pursuant to Paragraph D.1, when combined with the amount received for emergency medical transportation services pursuant to any other provision of this State Plan or any Medicaid waiver granted by CMS, exceed 100 percent of the allowable costs for such emergency medical transportation services.

3. Pursuant to Paragraph D.1, the eligible PEMT entity will annually certify to AHCA the total costs for providing emergency medical transportation services for Medicaid beneficiaries offset by the received Medicaid payments for the previous state fiscal year. The supplemental Medicaid reimbursement received pursuant to this segment of the State Plan will be distributed in one annual lump-sum payment after submission of such annual certification.

4. For the subject year, the emergency medical transportation service costs that are certified pursuant to Paragraph D.1 will be computed in a manner consistent with Medicaid cost principles regarding allowable costs, and will only include costs that satisfy applicable Medicaid requirements.

5. Computation of allowable costs and their allocation methodology must be determined in accordance with the CMS Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, and OMB Circular A-87, which establish principles and standards for determining allowable costs and the methodology for allocating and apportioning those expenses to the Medicaid program, except as expressly modified below.

6. Medicaid base payments to the PEMT providers for providing PEMT services are derived from the Medical Transportation fee-schedule established for reimbursements payable by the Medicaid program by procedure code. The base payments for these eligible PEMT providers are fee-for-service (FFS) payments. The primary source of paid claims data and other Medicaid reimbursements is the Florida Medicaid Management Information System (FLMMIS). The number of paid

Medicaid FFS PEMT transports is derived from and supported by the FLMMIS reports for services during the applicable service period.

7. For each eligible PEMT provider in this supplemental program, the total uncompensated care costs available for reimbursement will be no greater than the shortfall resulting from the allowable costs calculated using the Cost Determination Protocols (Section C.). Each eligible PEMT provider must provide PEMT services to Medicaid beneficiaries in excess of payments made from the Medicaid program and all other sources of reimbursement for such PEMT services provided to Medicaid beneficiaries. Eligible PEMT providers that do not have any uncompensated care costs will not receive a supplemental payment under this supplemental reimbursement program.

C. Cost Determination Protocols

1. An eligible PEMT provider's specific allowable cost per-medical transport rate will be calculated based on the provider's audited financial data reported on the CMS-approved cost report. The per-medical transport cost rate will be the sum of actual allowable direct and indirect costs of providing medical transport services divided by the actual number of medical transports provided for the applicable service period.

    a. Direct costs for providing medical transport services include only the unallocated payroll costs and fringe benefits for the shifts in which personnel dedicate 100 percent of their time to providing medical transport services, medical equipment and supplies, and other costs directly related to the delivery of covered services, such as first-line supervision, materials and supplies, professional and contracted services, capital outlay, travel, and training. These costs must be in compliance with Medicaid non-institutional reimbursement policy and are directly attributable to the provision of the medical transport services.

    b. Shared direct costs for emergency medical transport services, as defined by Paragraph A.5., must be allocated for salaries and benefits and capital outlay. The salaries and benefits will be allocated based on the percentage of total hours logged performing EMT activities versus other activities. The capital related costs will be allocated based on the percentage of total square footage.

    c. Indirect costs are determined by applying the cognizant agency specific approved indirect cost rate to its total direct costs (Paragraph A.1.) or derived from provider's approved cost allocation plan. For eligible PEMT providers that do not have a cognizant agency approved indirect cost rate or approved cost allocation plan, the costs and related basis used to determine the allocated indirect costs must be in compliance with OMB Circular A-87,

Medicare Cost Principle (42 CFR 413 and Medicare Provider Reimbursement Manual Part 1 and Part 2), and Medicaid non-institutional reimbursement policy.

d. The PEMT provider specific per-medical transport cost rate is calculated by dividing the total net medical transport allowable costs (Paragraphs A.1. and A.2.) of the specific provider by the total number of medical transports as reported in the transportation daily logs provided by the PEMT provider for the applicable service period.

2. Medicaid's portion of the total allowable cost for providing PEMT services by each eligible PEMT provider is calculated by multiplying the total number of Medicaid FFS PEMT transports provided by the PEMT provider's specific per-medical transport cost rate (Paragraph C.1.d.) for the applicable service period.

D. Responsibilities and Reporting Requirements of the Eligible PEMT Entity

An eligible PEMT entity must do all of the following:

1. Certify that the claimed expenditures for emergency medical transportation services made by the eligible PEMT entity are eligible for FFP.

2. Provide evidence supporting the certification as specified by AHCA.

3. Submit data as specified by AHCA to determine the appropriate amounts to claim as qualifying expenditures for FFP through the CMS approved cost report and cost identification methodology.

4. Keep, maintain, and have readily retrievable any records required by AHCA or CMS.

E. AHCA's Responsibilities

1. AHCA will submit claims for FFP for the expenditures for services that are allowable expenditures under federal law.

2. AHCA will, on an annual basis, submit to the federal government any necessary materials, including but not limited to the CMS approved cost report, in order to provide assurances that FFP will include only those expenditures that are allowable under federal law.

F. Interim Supplemental Payment

1. AHCA will make annual interim Medicaid supplemental payments to eligible PEMT providers. The interim supplemental payments for each provider are based on the

provider's completed annual cost report in the format prescribed by AHCA and approved by CMS for the applicable cost reporting year. AHCA will make adjustments to the as-filed cost report based on the results of the most recently retrieved FLMMIS report.

2. Each eligible PEMT provider must compute the annual cost in accordance with the Cost Determination Protocols (Section C.) and must submit the completed annual as-filed cost report to AHCA five months after the close of the SFY.

3. The interim supplemental payment is calculated by subtracting the total Medicaid base payments (Paragraph B.6.) and other payments, such as Medicaid co-payments, received by the providers for PEMT services to Medicaid beneficiaries from the Medicaid portion of the total PEMT allowable costs (Paragraph C.2.) reported in the as-filed cost report or the as-filed cost report adjusted by AHCA (Paragraph F.1.).

G. Final Reconciliation

1. Providers must submit auditable documentation to AHCA within two years following the end of the state fiscal year in which payments have been received. AHCA will perform a final reconciliation where it will settle the provider's annual cost report as audited, three years following the State fiscal year end. AHCA will compute the net Medicaid PEMT allowable cost using audited per-medical transport cost, and the number of Medicaid FFS PEMT transports data from the updated FLMMIS reports. Actual net Medicaid allowable cost will be compared to the total base and interim supplemental payments and settlement payments made, and any other source of reimbursement received by the provider for the period.

2. If at the end of the final reconciliation it is determined that the PEMT provider has been overpaid, the provider will return the overpayment to AHCA, and AHCA will return the overpayment to the federal government pursuant to 42 CFR 433.316. If at the end of the final reconciliation it is determined that the PEMT provider has been underpaid, the PEMT provider will receive a final supplemental payment in the amount of the underpayment.

3. All cost report information for which Medicaid payments are calculated and reconciled are subject to CMS review and must be furnished upon request.

Amendment: 2015-014
Effective: 10/01/15
Supersedes: New
Approved: 10-20-16

METHODS USED IN ESTABLISHING PAYMENT RATES

4/1/87 EMERGENCY SERVICES TO ALIENS

Claims for treatment of an emergency medical condition, as defined in the Social Security Act, will be paid for any alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Claims for inpatient emergency services will be reimbursed as indicated in Attachment 4.19-A, for outpatient emergency services as indicated in Attachment 4.19-B Exhibit I, for pharmacy and emergency ambulance as indicated in this Attachment 4.19-B, for those specific services. Claims for physician, dental and non-institutional services, will be reimbursed as indicated in this attachment, however, unlike other recipient claims, will be pended for aliens and manually reviewed to determine that the service was provided as an emergency. All other claims which are not emergency in nature will be denied.

METHODS USED IN ESTABLISHING PAYMENT RATES

7/1/91 FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES

Providers enrolled in Medicaid's Federally Qualified Health Center (FQHC) Services program will be reimbursed at an all inclusive rate per visit that includes all services and supplies provided in the course of diagnosis and treatment of an illness or injury or to assess health status in order to detect and prevent disease, disability, and other health conditions or their progression and integral thereto.

1/1/01 The payment methodology for FQHCs will conform to section 702 of Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 (BIPA) legislation. The payment methodology for FQHCs will conform to the BIPA 2000 requirements under a prospective payment system.

Methods used in Establishing Payment Rates

4/1/2003 **Case Management Services**

Reimbursement to providers of case management services will be on a fee for services basis, not to exceed the actual cost of the service when rendered by a state agency. Payment to private providers will be the lesser of the fee for service established by the state agency or the amount billed. The detailed description of the cost finding methodology is on file at the state agency.

The reimbursement rate for Targeted Case Management (TCM) for At Risk Children is established based on historical cost data of actual expenditures for this same type of service by providers who meet the qualifications as described the state plan amendment, adjusted to include only TCM allowable activities. This data is derived through a time study of case managers, all of whom meet the minimum qualifications stipulated in the Section E, Paragraph E of the state plan amendment.

An analysis of the results of the time study is used to derive a percentage of staff time spent on allowable case management activities. This percentage is then applied to the cost pool to arrive at the portion of salary and program costs that are allocable to the delivery of case management services.

The cost of a unit of service is derived by dividing the allowable cost pool by the number of children served times twelve months. A unit of service is one month in which all required services, per the state plan amendment requirements, is delivered.

The time study will be repeated annually with adjustments to the rate as indicated.

Amendment 2003-06
Effective 4/1/03
Supersedes 93-02
Approved DEC 23 2003

METHODS USED IN ESTABLISHING PAYMENT RATES

/1/96 Reimbursement for respiratory therapy providers under the EPSDT program is based on a fee schedule determined by the state agency and will not exceed the upper limits established through the application of the parameters of 42 CFR 447.304.

Amendment 96-06
Effective 7/1/96
Supersedes 93-02

Approval 3/10/97
Revised Submission 2/10/97

METHODS USED IN ESTABLISHING PAYMENT RATES

PERSONAL CARE SERVICES:

Payment for personal care services is based on a state-developed fee schedule, which is the same for both governmental and private providers. The agency's personal care services rates were set as of 1/01/2015, effective for services on or after this date. The fee schedules are published at:
http://ahca.myflorida.com/medicaid/review/fee_schedules.shtml

Private Duty Nursing

Payments for private duty nursing rates are based on a state developed fee schedule, which is the same for both governmental and private providers. The agency's Private Duty Nursing rates were set as of 7/1/2016, effective for services on or after this date. The fee schedules are published at: http://ahca.myflorida.com/medicaid/review/Promulgated.shtml

THERAPIES:

Reimbursement for Occupational, Physical, Respiratory, and Speech-Language Pathology Therapy rates are based on a state developed fee schedule, which is the same for both governmental and private providers.

The Agency's Occupational, Physical, and Speech-Language Pathology Therapy rates were set as of January 1, 2016, effective for services on or after this date.

The Agency's Respiratory Therapy rates were set as of January 1, 2015, effective for services on or after this date.

The fee schedules are published at http://ahca.myflorida.com/medicaid/review/Promulgated.shtml.

METHODS USED IN ESTABLISHING PAYMENT RATES

8/1/2012 **DURABLE MEDICAL EQUIPMENT INCLUDING PROSTHETIC DEVICES AND ORTHOTICS**: Reimbursement is based on state-developed fee schedule rates for providers of durable medical equipment services which are the same for government and non- government providers. The agency's rates for durable medical equipment are in effect as of August 1, 2012 and are effective for services provided on or after that date. The fee schedule is subject to annual/periodic adjustment. All rates, including current and prior rates, are published and maintained on the agency's fiscal agent website. Specifically, the fee schedule and any annual/periodic adjustments to the fee schedule are published at www.MyMedicaid-Florida.com.

Reimbursement Methodology

Inpatient Psychiatric Services for Individuals under 21, when provided in a psychiatric Residential Treatment Facility, licensed under Chapter 394, F.S., or in a hospital licensed under Chapter 395, F.S., are reimbursed on a per diem rate. The rate is determined under Medicare's per diem rate-setting methodology (42 CFR 413) for psychiatric inpatient hospital services, based on cost reports submitted in accordance with Medicare's Provider Reimbursement Manual.

Inpatient Psychiatric Services for Individuals under 21, when provided to individuals 18 through 20 years of age, in acute care settings in psychiatric units of general hospitals will be reimbursed, on a per diem basis in accordance with Florida Medicaid's current Inpatient Hospital Reimbursement Plan.

METHODS USED IN ESTABLISHING PAYMENT RATES

Reimbursement rates for globally paid transplants include adult (age 21 and over) heart, liver, lung and intestine/multivisceral and pediatric (age 20 and under) lung and intestine multivisceral transplant services, which are paid the actual billed charges up to a global maximum rate established by the Agency. (See global rates below) These payments will be made to physicians and facilities that have met specified guidelines and are established as Medicaid-designated transplant centers. The global maximum reimbursement for transplant surgery services is an all- inclusive payment that encompasses the date of transplantation and extends through 365 days post facility discharge of transplant related care. The Agency's global reimbursement rates are effective for services provided on or after July 4, 2023.
All other transplant rates are published on the Agency's website at http://portal.flmmis.com/flpublic.

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

METHODS USED IN ESTABLISHING PAYMENT RATES

DENTAL SERVICES

Individual payments are based on a fee schedule determined by the state agency. State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published on Medicaid's fiscal agent website at http://floridamedicaid.acs-inc.com.

For adults over 21 years of age, services are limited to emergency procedures and partial and complete dentures.

Refer to Attachment 4.19-B, CLINIC SERVICES, page 33b for reimbursement in County Health Departments (CHDs).

Refer to Attachment 4.19-B, FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs), page 36 for reimbursement in FQHCs.

1915(j) SELF-DIRECTION METHODOLOGY

DEVELOPMENTAL DISABLED WHO HAVE THE OPTION TO REMAIN IN THE STATE PLAN SELF-DIRECTION METHODOLOGY

Florida's methodology for determining the consumer's budget is based on the assessment of needs and the development of the service plan. The cost of providing the services included in the service plan is calculated based on the expected reimbursement for services listed on page 2 of Supplement 4 to Attachment 3.1-A under the 1915(c) waiver and the expected reimbursement for the cost of State Plan personal care services. It is adjusted to account for the self-directed service delivery model. Based on historical utilization patterns and differences in set-up and oversight, the State will use an adjustment factor of 87.25% of the expected waiver/State Plan service reimbursement to calculate the consumer's service budget for self-directed personal assistance services.

CANCER HOSPITALS REIMBURSEMENT METHODOLOGY

REIMBURSEMENT - Eligible providers specified below will be reimbursed for Florida Medicaid reimbursable services rendered to Florida Medicaid recipients who are not enrolled in a managed care plan and who are not dually eligible Medicare and Medicaid recipients. Eligible providers shall be reimbursed up to their respective individual UPLs based on the upper payment limits described in 42 CFR 447.321 for outpatient services. These supplemental payments shall be made by the last day of the following quarter.

An additional one-time payment will be made to University of Miami Hospital and Clinics d/b/a Sylvester Comprehensive Cancer Center in the amount of $1,590,974 during the quarter ending on 6/30/2019 and will be paid by 9/30/2019.

ELIGIBLE PROVIDERS - Cancer hospitals that meet the criteria under 42 USC s. 1395ww(d)(1)(B)(v), including only H. Lee Moffitt Cancer Center and University of Miami Hospital and Clinics d/b/a Sylvester Comprehensive Cancer Center, will receive the enhanced reimbursement for services rendered at these facilities. Eligible providers shall be enrolled Florida Medicaid providers.

Medication-Assisted Treatment (MAT) Pursuant to section 1905(a)(29) of the Social Security Act

MAT Behavioral Health Services

MAT Behavioral Health Services are reimbursed in accordance with Attachment 4.19-B Page 3, Rehabilitation Services, and Attachment 4.19-B Page 3b, Community-Based-Substance Abuse Services.

MAT Prescribed Drugs

The state covers all formulations of MAT drugs and biologicals for OUD that are approved under section 505 of the Federal Food,-Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

Unbundled MAT Prescribed Drugs and biologicals that are dispensed or administered to treat opioid use disorder are reimbursed using the same methodology as described for prescribed drugs in Attachment 4.19-B page 4 and 4a, Prescribed Drugs.

Clinical Trial Coverage Reimbursement Pursuant to section 1905(a)(30) and 1905(gg)(1) of the Social Security Act

The State attests to reimbursement for routine patient costs for a beneficiary participating in a qualifying clinical trial including any item or service provided to the individual under the qualifying clinical trial to prevent, diagnose, monitor, or treat complications resulting from participation in the qualifying clinical trial, to the extent that the provision of such items or services to the beneficiary would otherwise be covered outside the course of participation in the qualifying clinical trial.

Services otherwise covered outside the course of participation in the qualifying clinical trial are paid based on state developed fee schedule rates which are the same for both governmental and private providers. All rates, including current and prior rates, are published and maintained on the agency's website. Specifically, the fee schedule is published at http://ahca.myflorida.com/medicaid/review/fee_schedules.shtml

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance, and Payment of Medicare Part C Deductible/Coinsurance/Copayment

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Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State Plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on page 4, in item 7 of this attachment.

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, as set out on page 4 in items 7 and 8 of this attachment.

3. Payments are up to the amount of a special rate, or according to a special method, described on pages 3 and 4, in items 4, 5, 6, 9, and 10 of this attachment.

4. Any exceptions to the general methods used for a particular group or payment are specified on__, in item __ of this attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance, and Payment of Medicare Part C Deductible/Coinsurance/Copayment

QMBs:	Part A SP Deductibles	SP Coinsurance	
	Part B SP Deductibles	SP Coinsurance	
	Part C SP Deductibles	SP Coinsurance	SP Copayments
Other Medicaid Recipients	Part A SP Deductibles	SP Coinsurance	
	Part B SP Deductibles	SP Coinsurance	
Dual Eligible (QMB Plus)	Part A SP Deductibles	SP Coinsurance	
	Part B SP Deductibles	SP Coinsurance	
	Part C SP Deductibles	SP Coinsurance	SP Copayments

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: FLORIDA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
- OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible /Coinsurance, and Payment of Medicare Part C Deductible/Coinsurance/Copayment

01/01/10 MEDICARE PREMIUMS, DEDUCTIBLES, COINSURANCE, AND COPAYMENTS

1. Florida Medicaid shares Medicare costs in the manner described below for persons eligible under both Medicaid and Medicare, including Qualified Medicare Beneficiaries (QMB) and QMB Plus.

2. Medicare Part A Premium
Florida Medicaid covers the Part A premium for QMBs and QMB Plus. Florida Medicaid does not cover the Part A premium for the QI1, SLMB, and the Medically Needy without QMB.

3. Medicare Part B Premium
Florida Medicaid covers the Part B premium for QMBs, QMB Plus, SLMBs and QI1. Florida Medicaid does not cover the Part B premium for the Medically Needy without QMB.

4. Medicare Part A Deductible and Coinsurance
For hospitals, Medicaid payment for general and specialty hospital inpatient services are limited to the Medicare deductible and coinsurance per spell of illness. Medicaid payments for hospital Medicare Part A coinsurance are limited to the Medicaid hospital per diem rate less any amounts paid by Medicare, but only up to the amount of Medicare coinsurance. Medicaid payment for coinsurance is tied to the Medicaid per diem rate in effect for the dates of service of the crossover claims, and may not be subsequently adjusted due to subsequent per diem adjustments.

   Florida Medicaid covers the Part A deductible and coinsurance for QMBs and QMB Plus. Medicaid does not cover Medicare Part A deductible and coinsurance for the QI1 or SLMB.

5. For nursing facilities, Medicaid will pay no portion of the Medicare Part A coinsurance when payment that Medicare has made for the services equals or exceeds what Medicaid would have paid if it had been the sole payer.

6. Medicare Part B Deductible and Coinsurance

   Florida Medicaid covers the Medicare Part B deductible and coinsurance up to the Medicaid fee, less any amounts paid by Medicare. If this amount is negative, no Medicaid payment is made. If this amount is positive, Medicaid pays the coinsurance and deductible up to the billed or allowed amount, whichever is less. This covers all dual eligible categories including SLMB Plus. Florida Medicaid does not cover Medicare Part B deductible and coinsurance for QI1 and SLMB.

7. For freestanding end-stage dialysis centers, emergency transportation, and portable x-ray services, Medicaid reimburses 100 percent of the deductible and coinsurance.

8. Florida Medicaid covers the Medicare Part B deductible and coinsurance for Medicaid non-covered services up to 50 percent of the Medicare allowed amount, less amounts paid by Medicare. Total payments from all sources will not be less than the Medicaid established rate of payment.

   Florida Medicaid covers the Part B deductible and coinsurance for non-covered Medicaid Services only for QMB and QMB Plus.

9. Medicare Part C Deductible, Coinsurance, and Copayment

   Florida Medicaid covers the Medicare Part C deductible and coinsurance up to the Medicaid fee, less any amounts paid by Medicare. If this amount is negative, no Medicaid payment is made. If this amount is positive, Medicaid pays the coinsurance and deductible up to the billed or allowed amount, whichever is less.

   Florida Medicaid covers the Medicare Part C copayment up to the Medicaid copayment, less any amounts paid by Medicare. If this amount is negative, no Medicaid payment is made. If this amount is positive, Medicaid pays the coinsurance and deductible up to the billed or allowed amount, whichever is less.

10. The financial obligations of Medicaid for services is based upon Medicare's allowable, not the provider's charge. Except for provider types noted in number seven (7) above, Medicaid will pay no portion of Medicare deductibles and coinsurance when payment that Medicare has made for the service equals or exceeds what Medicaid would have paid had it been the sole payer. The combined payment from Medicare and Medicaid shall not exceed the amount Medicaid would have paid had it been the sole payer

FLORIDA TITLE XIX FEDERALLY QUALIFIED HEALTH CENTER AND RURAL HEALTH CLINIC REIMBURSEMENT PLAN

VERSION V

EFFECTIVE DATE: July 1, 2014

I. Medicaid Method of Payment

A. Each federally qualified health center (FQHC) and rural health clinic (RHC) in the Florida Medicaid program is subject to the Medicaid Prospective Payment System (PPS) under the authority of 1902(bb) of the Social Security Act (SSA) and Title 42, Code of Federal Regulation (CFR), section 405.2401 (b).

B. Reimbursement authority for FQHC or RHCis as follows:

l. The definition of an FQHC and RHC as contained in section 4161(a)(2) of the Omnibus Budget Reconciliation Act of 1990 as described in section 1861(aa)(1)(A)-(C) of the Social Security Act (SSA).

2. The requirements created by the Agency for Health Care Administration (AHCA) for establishing and maintaining health standards under the authority of Title 42, CFR, section 431.610(c) and further interpreted by the Centers for Medicare and Medicaid Services (CMS) Pub. 15-1.

3. Any other requirements for licensing under the state law which are necessary for providing FQHC or RHC services, in accordance with Chapter 59 g-6.080, Florida Administrative Code, Florida FQHC/RHC Clinic Services Coverange and Limitations Handbook and the Florida Medicaid Provider Reimbursement Handbook.

Amendment: 2014-012
Effective: 07/01/14
Supersedes: 2003-014
Approved: 04-02-15

II. Audits

All documents submitted by the provider are subject to field or desk audits at the discretion of AHCA.

A. Description of AHCA's Procedures for Audits - General.

1. Primary responsibility for the audit of providers shall be assumed by AHCA. AHCA audit staff may enter into contracts with certified public accountants firms to ensure that the requirements of 42 CFR section 447.202 are met.

2. All audits shall be performed in accordance with generally accepted auditing standards of the American Institute of Certified Public Accountants as incorporated by reference in Rule 61H1-20.008 Florida Administrative Code (F.A.C.) .

3. The auditor shall issue an opinion as to whether, in all material respects, the financial and statistical report submitted complies with all federal and state regulations pertaining to the reimbursement program for FQHC's and RHC’s.

B. Retention

All reports shall be retained by AHCA for 10 years in accordance with 42 CFR 413.

C. Overpayments and Underpayments

l. Any overpayments or underpayments for those years or partial years as determined by desk or field audits, using approved state plans, shall be reimbursable to the provider or to AHCA, as appropriate.

2. Any overpayment or underpayment that resulted from an encounter rate adjustment due to an error in either reporting or calculation of the encounter rate shall be refunded to AHCA or to the provider, as appropriate.

3. The terms of repayments shall be in accordance with section 414.41, Florida Statutes (F.S.) under the authority of 42 CFR 433, Subpart F. All underpayments will be subject to the time limitations under the authority of 45 CFR 957.7.

4. All overpayments shall be reported by AHCA to CMS, as required.

5. Information intentionally misrepresented by an FQHC or RHC shall result in a suspension of the FQHC or RHC from the Florida Medicaid program.

D. Appeals

For audits conducted by AHCA, a concurrence letter stating the results of an audit shall be prepared and sent to the provider, showing all adjustments and changes and the authority for such. Providers shall have the right to a hearing in accordance with section 120.57, F.S., for any or all adjustments made by AHCA.

III. Allowable Medicaid Reimbursement

A. Medicaid reimbursements shall be limited to an amount, if any, by which the encounter rate for any allowable claim exceeds the amount of third party benefit during the Medicaid benefit period.

B. Under this plan, an FQHC or RHC shall be required to accept Medicaid reimbursement as payment in full for covered services provided during the benefit period and billed to the Medicaid program; therefore, there shall be no payments due from Medicaid recipients.

C. There shall be no Medicaid bad debts generated by Medicaid recipients. Bad debts shall not be considered as an allowable expense.

IV. Standards

A. Effective October 1 of each year, an FQHC's and RHC's individual encounter rate will be increased by the percentage increase in the Medicare Economic Index (MEI) for applicable primary and preventative care services for that fiscal year.

B. For new providers entering the program, the initial encounter rate shall be established based on provider type (see section V.).

C. The individual FQHC's and RHC's encounter rate shall be adjusted only under the following circumstances:

1. An error was made by AHCA in the calculation of the encounter rate.

2. An increase or decrease in the scope of service(s). Only the incremental increase or decrease in the scope of service(s) will be applied to the provider's encounter rate.

3. A. Example

WTJ Family Clinic

Medicaid PPS rate – October 2014	$123.54
Increase in Scope	$ 2.80
Decrease in Scope	$ 0.75
Revised Medicaid PPS Rate	$125.12

D. For purposes of this plan, a change in scope of service(s) for an FQHC and RHC is defined as:

1. The addition of a new service not previously provided by the FQHC or RHC.

2. The elimination of an existing service provided by the FQHC or RHC.

E. A change in the cost of a service such as an addition or reduction of staff members to or from an existing service is not considered a change in scope of service(s).

F. It is the responsibility of the FQHC and RHC to notify the Division of Medicaid of any change in scope of service(s) and provide proper documentation.

G. FQHC's requesting an encounter rate adjustment as a result of an increase or decrease in their scope of service(s) shall meet the following criteria:

1. The provider must demonstrate the change in cost caused by the scope of service(s) change as defined above in Section IV. D.
2. The effective date for scope of service(s) increases will be the latter of the date the service was implemented or 75 days prior to the date the request was received. The effective date for scope of service(s) decreases will be the date the service was terminated.
3. The providers' fiscal year end (FYE) audit shall be submitted before the scope of service(s) increase can be approved.
4. The financial data submitted for the scope of service(s) increase or decrease shall contain at least six months of actual cost information.
5. If all requested financial data for a scope of service-related encounter rate adjustment request(s) has not been received within 12 months after the FQHC's FYE in which costs were first affected, the encounter rate adjustment request shall be granted only when all documentation has been satisfied, and any rate adjustment will be effective as of the beginning of the month in which all information was received by the Agency.

H. RHC's that experience an increase or decrease in their scope of service(s) of greater than one percent and request an adjustment to their encounter rate shall meet the following criteria:

1. The effective date for scope of service(s) increases will be the latter of the date the service was implemented or 75 days prior to the date the request was received. The effective date date for scope of service(s) decreases will be the date the service was terminated.
2. A copy of the most recent audited Medicare cost report shall be filed with the request.
3. If all requested financial data for a scope of service related encounter adjustment request has not been received within 12 months after the RHC's FYE in which the costs were first affected, the encounter rate adjustment request shall be granted only when all documentation has been satisfied, and any rate adjustment will be effective as of the beginning of the month in which the information was received by the Agency.
4. A budgeted cost report shall be submitted (RHC Form 222-Medicare), which contains the increase or decrease costs associated with the scope of service(s).

a. Allowable cost relates to services defined by section 1861(aa) (1) (A)-(C) of the SSA as:

   1. Physician services.
   2. Services and supplies incident to physician services (including drugs and biologicals that cannot be self administered).

3. Pneumococcal vaccine and its administration and influenza vaccine and its administration.
4. Physician assistant services.
5. Nurse practitioner services.
6. Clinical psychologist services.
7. Clinical social work services.

Also included in allowable costs are costs associated with case management, transportation, on-site lab, and on-site X-ray services.

b. Pharmacy and immunization costs shall be reimbursed through the Title XIX pharmacy program utilizing current fee schedules established for those services. Costs relating to contracted pharmacy services shall be reported under non-allowable services and adjusted out in full.

c. Costs relating to the following services are excluded from the encounter rate:

1. Ambulance services
2. Home health services
3. WIC certifications and recertifications
4. Any health care services rendered away from the center, at a hospital, or a nursing home. (These services include off- site radiology services and off- site clinical laboratory services. However, the health care rendered away from the center may be billed under other Florida Medicaid programs, if eligible.)

I. Under no circumstances shall the initial encounter rate exceed the reimbursement ceiling established (described in section V.).

J. The approved FQHC or RHC scope of service(s) encounter rate adjustment will be added to their encounter rates.

K. Any encounter rate adjustment or denial of a encounter rate adjustment by AHCA may be appealed by the provider in accordance with section 120.57, F.S.

L. In a change in ownership, the new owner will adopt the previous owner's Medicaid PPS encounter rate.

V. Method

This section defines the methodologies used by the Florida Medicaid program in establishing reimbursement ceilings and individual FQHC and RHC reimbursement encounter rates.

A. Setting Reimbursement Ceilings

The reimbursement ceiling shall be established and applied to all new FQHC and RHC providers entering the Florida Medicaid program.

1. The FQHC reimbursement ceiling shall be calculated by taking the sum of all the encounter rates divided by the number of providers in the Florida Medicaid program.
2. The RHC reimbursement ceiling shall be calculated by taking the sum of all the encounter rates divided by the number of providers in the Florida Medicaid program.

B. Florida Medicaid PPS

For the Florida Medicaid PPS, January 1, 2001 through September 30, 2001, Medicaid will compute a base rate for current FQHCs and RHC's by taking the average of their Florida Medicaid rates set by the center's fiscal year 1999 and 2000 cost reports. Effective October 1, 2001 and every October 1 thereafter, the

rate will be increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services for that fiscal year.

C. Setting Individual Center Encounter Rates - FQHC

1. For new providers entering the program, the initial encounter rate shall be established by taking an average of the encounter rates for centers in the same county.
2. In the absence of centers in the same county, encounter rate shall be established by taking an average of the encounter rates for centers in the same area (AHCA geographic area).
3. In the absence of centers in the same county and area, the facility encounter rate will be the reimbursement ceiling as defined in Section V.A.1.
4. All subsequent encounter rates shall be determined every October 1 by multiplying the encounter rate by the MEI for primary care services for the fiscal year.

D. Setting Individual Center Encounter Rates - RHC

1. For new providers entering the program, the initial encounter rate is determined by using the lower of the current Medicare encounter rate established by the Title XVIII Medicare carrier or the ceiling established in section V(A.).
2. All subsequent encounter rates shall be determined every October 1 by multiplying the encounter rate by the MEI for primary care services for the fiscal year.

VI. Supplemental Payments

In accordance with section 1902(bb)(5of the SSA, Florida Medicaid is required to make supplemental payments (at least quarterly) to FQHC's (provider type 68) and RHC's (provider type 66) that contract with Medicaid managed care plans representing the difference, if any, between the Medicaid managed care plans's payment to the contracting FQHC/RHC and the payment to which the FQHC/RHC would be entitled for the services under the SSA. In order for this supplemental payment to apply, the FQHC/RHC shall have a contract with the Medicaid managed care plans providing services under the Statewide Medicaid Managed Care program. Physicians (provider type 25) are not eligible to receive supplemental payments. Only claims filed with the Medicaid managed care plans using provider type 68 or 66 are eligible to receive Florida Medicaid supplemental payments. FQHC requests for supplemental payments shall be submitted to Florida Medicaid no later than 30 days from the end of the quarter being reported. RHC requests for supplemental payments may be submitted monthly, to be received no later than 15 days from the end of the month being reported. Supplemental payment instructions and electronic submission forms can be located on the Florida Medicaid Web site. The methodology for calculating the Florida Medicaid supplemental payments for FQHCs and RHCs includes a reconciliation of the payments and at least a quarterly payment schedule, which ensures that the payments are in accordance with section 1902(bb)(5) of the SSA.

VII. Payment Assurance

The state shall pay each FQHC and RHC for services provided in accordance with the requirements of the Florida Title XIX Federally Qualified Health Center and Rural Health Clinic Reimbursement Plan, in accordance with Title 42, CFR, section 405.2401 and

Chapter 59G-6.080, Florida Administrative Code, Florida FQHC/RHC Clinic Services Coverage and Limitations Handbook and the Florida Medicaid Provider Reimbursement Handbook. The payment amount shall be determined for each FQHC and RHC according to the standards and methods set forth in the Florida Title XIX Federally Qualified Health Center and Rural Health Clinic Reimbursement Plan.

VIII. Provider Participation

This plan is designed to assure adequate participation of FQHC's and RHC's in the Florida Medicaid program, the availability of FQHC and RHC services of high quality to recipients, and services which are comparable to those available to the general public. This is in accordance with 42 CFR 447.204.

IX. Revisions

The plan shall be revised as operating experience data are developed and as changes are necessary in accordance with modifications in the CFR.

X. Payment in Full

Participation in the program shall be limited to FQHC's and RHC's which accept as payment in full for covered services the amount paid in accordance with the Florida Title XIX Federally Qualified Health Center and Rural Health Clinic Reimbursement Plan.

XI. Glossary

A. Acceptable budgeted cost report - A completed, legible cost report that contains all relevant schedules, worksheets and supporting documents.

B. AHCA - Agency for Health Care Administration.

C. CMS - Centers for Medicare and Medicaid Services.

D. CMS-Pub. 15-1 - Also known as the Provider Reimbursement Manual, published by the Department of Health and Human Services, the Centers for Medicare and

Medicaid Services. This manual details cost finding principles for institutional providers for Medicare and Medicaid reimbursement and is incorporated by reference in Rule 59G-6.010, F.A.C.

E. Eligible Medicaid recipient - Any individual whom the Florida Department of Children and Families, AHCA, or SSA on behalf of AHCA, determines is eligible, pursuant to federal and state law, to receive medical or allied care, goods, or services for which AHCA may make payments under the Florida Medicaid program and is enrolled in the Florida Medicaid program. For the purposes of determining third party liability, the term includes an individual formerly determined to be eligible for Florida Medicaid, an individual who has received medical assistance under Florida Medicaid or an individual on whose behalf Florida Medicaid has become obligated.

F. Encounter - A face-to-face contact between a recipient and a health care professional who exercises independent judgment in the provision of health services to the individual recipient. For a health service to be defined as an encounter, the provision of the health service shall be recorded in the recipient's record and completed on site. Categorically, encounters are:

1. Physician. An encounter between a physician and a recipient during which medical services are provided for the prevention, diagnosis, treatment, and rehabilitation of illness or injury.
2. Midlevel practitioner. An encounter between a advanced registered nurse practicioner (ARNP) or a physician’s assistamt (PA) and a recipient when the ARNP or PA exercises independent judgement in providing health services.

3. Dental. An encounter between a dentist and a recipient for the purpose of prevention, assessment, or treatment of a dental problem, including restoration.

4. Mental Health. An encounter between a licensed psychologist or licensed clinical social worker and recipient for the diagnosis and treatment of mental illness.

G. Encounter rate - The approved Medicaid reimbursement rate based on the Medicaid PPS system.

H. Medicaid prospective payment system - is a method of reimbursement in which Medicaid payment is made based on a predetermined, fixed amount.

I. Rate period - October 1 of a calendar year through September 30 of the next calendar year.

J. Title XVIII - The sections of the federal SSA, certified in Title 42 of the United States Code (U.S.C.) 1395 et seq., and regulations there under that authorize the Medicare program.

K. Title XIX - The sections of the federal SSA, certified in Title 42 of the U.S.C. 1396 et seq., and regulations there under that authorize the Medicaid program.

FLORIDA TITLE XIX COUNTY HEALTH DEPARTMENT

REIMBURSEMENT PLAN

VERSION XXI

EFFECTIVE DATE: July 1, 2023

I. Cost Finding and Cost Reporting

A. Each county health department (CHD) participating in the Florida Medicaid program shall submit one complete, legible copy of a cost report to the Agency for Health Care Administration (AHCA), Bureau of Medicaid Program Finance, Division of Cost Reimbursement, postmarked or accepted by a common carrier no later than five calendar months after the close of its cost reporting year.

B. Cost reports available to AHCA pursuant to section IV of this plan, shall be used to initiate this plan.

C. Each CHD is required to detail costs for its entire reporting year, making appropriate adjustments as required by this plan for determination of allowable costs. A prospective reimbursement rate shall not be established for a CHD based on a cost report for a period less than 12 months. Interim rates shall be cost settled for the interim rate period.

D. The cost report shall be prepared in accordance with the method of reimbursement and cost finding of Title XVIII (Medicare) Principles of Reimbursement described in Title 42, Code of Federal Regulations (CFR), Chapter 413, and further interpreted by the Provider Reimbursement Manual, Centers for Medicare and Medicaid Services (CMS) Pub. 15-1, except as modified by Title XIX of the Social Security Act (SSA), this plan, requirements of licensure and certification, and the duration and scope of benefits provided under the Florida Medicaid program.

E. Each CHD shall file a legible and complete cost report within five months, or six months (if a certified report is being filed), after the close of its reporting period.

F. If a CHD provider submits a cost report late, after the five month period, and that cost report would have been used to set a lower reimbursement rate for a rate period had it been submitted within five

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months, then the CHD provider's rate for that rate period shall be calculated using the new cost report, and full payments at the recalculated rate shall be effective retroactively.

G. AHCA shall retain all uniform cost reports filed for a period of at least five years following the date of filing of such reports and shall maintain those reports pursuant to the record-keeping requirements of 45 CFR section 205.60. Individual cost reports may be requested from the Medicare Administrative contractors in conformity with the Freedom of Information Act (FOIA).

H. 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 Florida Medicaid reimbursements and payments, and that the services identified in this cost report were provided in compliance with such laws and regulations."

I. The services provided at each CHD are in compliance with 42 CFR section 440.90, Clinic Services.

J. AHCA reserves the right to refer providers found to be out of compliance with any of the policies and procedures regarding cost reporting to the Bureau of Medicaid Program Integrity for investigation.

K. Providers are subject to sanctions for late cost reports. A cost report is late if it is not received by AHCA, Bureau of Medicaid Program Finance, Division of Cost Reimbursement, on the first cost report acceptance cut-off date after the cost report due date.

II. Audits

All cost reports and related documents submitted by the providers shall be either field or desk audited at the discretion of AHCA.

A. Description of AHCA's Procedures for Audits - General.

1. Primary responsibility for the audit of providers shall be assumed by AHCA. AHCA audit staff may enter into contracts with certified public accountant firms to ensure that the requirements of 42 CFR section 447.202 are met.

2. All audits shall be based on American Institute of Certified Public Accountants (AICPA) Attestation Standards for examining or reviewing statistical information and other data.

3. The auditor shall issue an opinion as to whether, in all material respects, the financial and statistical report submitted complies with all federal and state regulations pertaining to the reimbursement program for CHDs. All reports shall be retained by AHCA for three years.

B. Retention

All audit reports issued by AHCA shall be kept in accordance with 45 CFR section 205.60.

C. Overpayments and Underpayments

l. Any overpayments or underpayments for those years or partial years as determined by desk or field audits, using approved state plans, shall be reimbursable to the provider or to AHCA as appropriate.

2. 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.

3. Any overpayment or underpayment that resulted from a rate based on a budget shall be refunded to AHCA or to the provider as appropriate.

4. All overpayments shall be reported by AHCA to CMS, as required under the authority of 42 CFR 433, Subpart F. All underpayments will be subjected to the time limitations under the authority of 45 CFR 95.7.

5. Information intentionally misrepresented by a CHD in the cost report shall result in a suspension from the Florida Medicaid program.

D. Appeals

For audits conducted by AHCA, a concurrence letter that states the results of an audit shall be prepared and sent to the provider, showing all adjustments and changes and the authority for such. Providers shall have the right to a hearing.

III. Allowable Costs

Allowable costs for purposes of computing the encounter rate shall be determined in accordance with the provisions outlined within this reimbursement plan. These include:

A. Costs incurred by a CHD in meeting:

1. The definition of a CHDs are those counties recognized by the Florida Department of Health that have as their purpose the provision and an administration of public health services.

2. The requirements created by AHCA for establishing and maintaining health standards under the authority of 42 CFR section 431.610(c).

3. Any other requirements for licensing under the state law which are necessary for providing county health department services.

B. A CHD shall report its total cost in the cost report. However, only allowable health care services costs and the appropriate indirect overhead cost, as determined in the cost report, shall be included in the reimbursement rate. Non-allowable services costs and the appropriate indirect overhead, as determined in the cost report, shall not be included in the reimbursement rate.

C. Florida Medicaid reimbursements 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. In addition, the reimbursement shall not exceed the amount according to 42 CFR section 447.321.

D. Under this plan, a CHD shall be required to accept Florida Medicaid reimbursement as payment in full for covered services provided during the benefit period and billed to the Florida Medicaid program; therefore, there shall be no payments due from Florida Medicaid recipients. As a result, for Florida Medicaid cost reporting purposes, there shall be no Florida Medicaid bad debts generated by Florida Medicaid recipients. Bad debts shall not be considered as an allowable expense.

E. Allowable costs of contracts for physician services shall be limited to the prior year's contract amount, or a similar prior year's contract amount, increased by an inflation factor based on the consumer price index (CPI) for services rendered in the contract.

IV. Standards

A. Changes in individual CHD rates shall be effective July 1 of each year.

B. All cost reports received by AHCA as of April 15 of each year shall be used to establish the encounter rates for the following rate period.

C. The individual CHD's prospectively determined rate shall be adjusted only under the following circumstances:

1. An error was made by AHCA in the calculation of the CHD's rate.
2. A provider submits an amended cost report used to determine the rates in effect. An amended cost report may be submitted in the event that it would cause a change of one percent or more in the total reimbursement rate. The amended cost report must be filed by the filing date of the subsequent cost report. An audited cost report may not be amended. A cost report shall be deemed audited 30 days after the exit conference between field audit staff and the provider has been completed.
3. Further desk or on-site audits of cost reports used in the establishment of the prospective rates, disclose a change in allowable costs in those reports.

D. Any rate adjustment or denial of a rate adjustment by AHCA may be appealed by the provider.

E. CHD services are reimbursed at one encounter rate per day, per recipient, per provider.

F. Prescription drugs and immunization costs shall be reimbursed through Florida Medicaid's prescribed drug services. These costs shall be reported in the cost report as non-allowable services and product cost shall be adjusted out. Costs relating to contracted prescribed drug services shall be reported under non-allowable services and adjusted out in total.

G. Costs relating to the following services are excluded from the encounter rate and shall be reported in the cost report under non-allowable service:

1. Ambulance services.
2. Home health services.
3. WIC certifications and recertifications.
4. Any health care services rendered away from the clinic, at a hospital, or a nursing home. (These services include off-site radiology and clinical laboratory services. However, services rendered away from the clinic may be billed under the appropriate Florida Medicaid service-specific coverage policy, if eligible).

V. Methods

This section defines the methodologies used by the Florida Medicaid program in establishing individual CHD reimbursement encounter rates on July 1 of each year. The services provided at each CHD are in compliance with 42 CFR section 440.90.

A. Setting Individual CHD Rates.

1. Review and adjust each CHD's cost report available to AHCA as of April 15 to reflect the results of desk and field audits.
2. Determine each CHD's encounter rate by dividing total allowable cost by total allowable encounters.
3. Adjust each CHD's encounter rate with an inflation factor based on the CPI of the midpoint of the CHD's cost reporting period divided into the CPI projected for December 31 of each year. The adjustment shall be made utilizing the latest available projections from the Data Resource Incorporation (DRI) CPI (Appendix A).

B. Method of Establishing Historical Rate Reductions

1. AHCA shall apply a recurring methodology to establish rates taking into consideration the reductions imposed in the following manner:

a. AHCA shall divide the total amount of each recurring reduction imposed by the number of visits originally used in the rate calculation for each rate setting period which will yield a rate reduction per diem for each rate period.

b. AHCA shall multiply the resulting rate reduction per diem for each rate setting period by the projected number of visits used in establishing the current budget estimate, which will yield the total current reduction amount to be applied to current rates.

c. In the event the total current reduction amount is greater than the historical reduction amount, AHCA shall hold the rate reduction to the historical reduction amount.

2. The recurring methodology includes an efficiency calculation where the reduction amount is subtracted from the CHD prospective rate to calculate the final prospective rate which cannot exceed the $180 ceiling rate or be lower than the $100 floor rate. If the floor rate is higher than the CHD prospective rate then use the CHD prospective rate which cannot exceed cost.

C. Applying Historical Reductions to Rates

1. Apply the first rate reduction based on the steps outlined in section V.A. The rates shall be proportionately reduced until the required savings is achieved.

2. Apply the first, and all subsequent rate reductions based on the steps outlined in section V.A. The rates shall be proportionately reduced until the required savings is achieved.

3. The unit cost for the current rate setting is compared to the budgeted unit cost for state fiscal year (SFY) 2010-2011 ($163.10). If the unit cost for the current rate setting is less than the budgeted unit cost for SFY 2010-2011, no further rate reduction is required.

4. Effective July 1, 2022 buy-back clinic services rate reductions funding of $987,167. This reimbursement methodology follows the annual General Appropriation Act for buy-back clinic services rate reductions that were effective on or after July 1, 2008.

5. The total Buy-back amount cannot exceed the total rate reduction as calculate in Section V.B.

VI. Payment Assurance

AHCA shall pay each CHD for services provided in accordance with the requirements of the Florida Title XIX County Health Department Reimbursement Plan and applicable state and federal rules and regulations. The payment amount shall be determined for each CHD according to the standards and methods set forth in the Florida Title XIX County Health Department Reimbursement Plan.

VII. Provider Participation

This plan is designed to assure adequate participation of CHD's in the Florida Medicaid program, the availability of CHD services of high quality to recipients, and services which are comparable to those available to the public in accordance with 42 CFR section 447.204.

VIII. Revisions

The plan shall be revised as operating experience data are developed and the need for changes are necessary in accordance with modifications in the CFR.

IX. Payment in Full

Participation in the Florida Medicaid program shall be limited to CHD's which accept as payment in full for covered services the amount paid in accordance with the Florida Title XIX County Health Department Reimbursement Plan.

X. Glossary

A. Acceptable cost report - A completed, legible cost report that contains all relevant schedules, worksheets, and supporting documents.

B. AHCA - Agency for Health Care Administration.

C. Base rate - A CHD's per diem reimbursement rate before a Medicaid trend adjustment or a buy-back is applied.

D. Benefit period - 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.

E. Buy-back - A provision that allows a CHD to decrease the Medicaid trend adjustment from the established percent down to zero percent.

F. CMS-Pub. 15-1 - Manual detailing cost finding principles for institutional providers for Medicare and Medicaid reimbursement (also known as the Provider Reimbursement Manual published by the Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services).

G. County health department clinic services - Medicaid CHD clinic services consist of primary and preventive health care, related diagnostic services, and dental services.

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

I. Eligible Florida Medicaid recipient - Any individual whom the Florida Department of Children and Families, or the SSA on behalf of AHCA, determines is eligible, pursuant to federal and state law, to receive medical or allied care, goods, or services for which AHCA may make payments under the Florida Medicaid program and is enrolled in the Florida Medicaid program. For the purposes of determining third party liability, the term 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.

J. Encounter - An encounter is a single day, face-to-face visit between a recipient and health care professional(s). Two encounters cannot be reimbursed on the same day even if the visits are for different types of services such as a Child Health Check-Up screening and a dental service. Categorically, encounters are:

1. Physician. An encounter between a physician and a recipient during which medical services are provided for the prevention, diagnosis, treatment, and rehabilitation of illness or injury.

2. Midlevel practitioner. An encounter between an advanced registered nurse practitioner (ARNP) or a physician assistant (PA) and a recipient when the ARNP or PA acts as an independent provider.

3. Nurse. An encounter between a registered nurse and a recipient in which the nurse acts as an independent provider of medical services. The service may be provided under standing protocols of a physician, under specific instructions from a previous visit, or under the general supervision of a physician or midlevel practitioner who has no direct contact with the recipient during a visit.

4. Dental. An encounter between a dentist and a recipient for the purpose of prevention, assessment, or treatment of a dental problem, including restoration.

K. Filing due date - No later than five calendar months after the close of the CHD cost-reporting year.

L. HHS - Department of Health and Human Services.

M. Interim rate - A reimbursement rate that is calculated from budgeted cost data and is subject to cost settlement.

N. 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.

O. Legislative unit cost - The weighted average per diem of the state anticipated expenditure after all rate reductions but prior to any buy back.

P. Medicaid trend adjustment (MTA) - A proportional percentage rate reduction that is uniformly applied to all Florida Medicaid providers' rate semester which equals all recurring and nonrecurring budget reductions on an annualized basis. The MTA is applied to all components of the prospective per diem.

Q. Rate period - July 1 of a calendar year through June 30 of the next calendar year.

R. Rate setting due date - All cost reports received by AHCA by April 15 of each year.

S. Rate setting unit cost - The weighted average per diem after all rate reductions but prior to any buy-backs based on submitted cost reports.

T. Title XVIII - The sections of the federal SSA, as certified by Title 42, United States Code (U.S.C.) 1395 et seq., and regulations thereunder that authorize the Medicare program.

U. Title XIX - The sections of the federal SSA, as certified by 42 U.S.C. 1396 et seq., and regulations thereunder that authorize the Florida Medicaid program.

APPENDIX A
FLORIDA TITLE XIX COUNTY HEALTH DEPARTMENT REIMBURSEMENT PLAN

Calculation of Inflation Index

1. An inflation index used in adjusting each county health department's (CHD) encounter rate for inflation, developed from the DRI CPI All Urban (All Items) inflation indices. An example of the technique is detailed below. Assume the following DRI quarterly indices for the South Atlantic Region:

	2009	2010	2011	2012	2013
Q1	1.504	1.542	1.574	1.621	1.647
Q2	1.514	1.539	1.596	1.626	1.649
Q3	1.526	1.544	1.606	1.633	1.660
Q4	1.540	1.558	1.613	1.639	1.665

2. 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	1.504	1.509	MARCH 31
2	1.514	1.520	JUNE 30
3	1.526	1.533	SEPTEMBER 30
4	1.540	N/A	N/A

April 30 Index = (June 30 Index/March 31 Index)$^{1/3}$ (March 31 Index)

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$= (1.520/1.509)^{1/3} (1.509)$

$= 1.512$

May 31 Index = (June 30 Index/March 31 Index)$^{2/3}$ (March 31 Index)

$= (1.520/1.509)^{2/3} (1.509)$

$= 1.516$

All other monthly indices can be calculated in a similar fashion. To determine the applicable inflation factor for a given CHD for the rate period July 1, 2014, the index for December 31, 2014, the midpoint of the rate period, is divided by the index for the midpoint of the provider's fiscal year. For example, if a CHD has a fiscal year end of June 30, 2013, then its midpoint is December 31, and the applicable inflation is:

December 2014 Index/December 2012 Index (1.706/1.643)

$= 1.03834$

Therefore, the CHD's Florida Medicaid encounter rate as established by the cost report is multiplied by 1.03834 to obtain the prospectively determined rate for the rate period July 1, 2014 through June 30, 2015.

APPENDIX B
FLORIDA TITLE XIX COUNTY HEALTH DEPARTMENT
REIMBURSEMENT PLAN

Medicaid Trend Adjustment (MTA) Percentages

	Effective Date	Percentages	Reduction Amount
1.	**July 1, 2008**	5.9781%	$7,426,780
2.	**March 1, 2009**	5.7808%	$1,907,971
3.	**July 1, 2009**		
	First Cut	5.1307%	$5,601,154
	Second Cut	5.5267%	$5,723,913
	Third Cut	.123013%	$120,361
4.	**July 1, 2010**		
	First Cut	4.16308%	$5,601,154
	Second Cut	4.43912%	$5,723,913
	Third Cut	.097681%	$120,361
	Fourth Cut	27.7950%	$36,984,286
5.	**July 1, 2011**		
	First Cut	3.5186%	$5,601,154
	Second Cut	3.7269%	$5,723,913
	Third Cut	0.0814%	$120,361
	Fourth Cut	25.0332%	$36,984,286
6.	**July 1, 2012**		
	First Cut	3.551023%	$5,601,154
	Second Cut	3.762456%	$5,723,913
	Third Cut	.082209%	$120,361
	Fourth Cut	25.281816%	$36,984,286
	Fifth Cut	13.087637%	$14,305,285
7.	**July 1, 2013**		
	First Cut	4.06110%	$5,601,154
	Second Cut	4.432578%	$5,723,913
	Third Cut	.09507%	$120,361
	Fourth Cut	28.03615%	$35,459,164
	Fifth Cut	12.42594%	$11,309,767
8.	**July 1, 2014**		
	First Cut	5.348313%	$3,490,065
	Second Cut	5.774361%	$3,566,556

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	Third Cut	.127385%	$41,137
	Fourth Cut	30.663694%	$17,823,174
	Fifth Cut	14.105514%	$5,684,735
9.	**July 1, 2015**		
	First Cut	4.82554%	$799,883
	Second Cut	5.181325%	$817,414
	Third Cut	.111358%	$16,991
	Fourth Cut	27.33862%	$4,084,869
	Fifth Cut	12.0047%	$1,302,877
10.	**July 1, 2016**		
	First Cut	4.853741%	$506,286
	Second Cut	4.857250%	$517,382
	Third Cut	.106120%	$10,755
	Fourth Cut	25.53950%	$2,285,518
	Fifth Cut	10.93986%	$824,656
11.	**July 1, 2017**		
	First Cut	4.30639%	$557,405
	Second Cut	4.59882%	$569,622
	Third Cut	.100210%	$11,841
	Fourth Cut	24.11371%	$2,846,574
	Fifth Cut	10.13505%	$907,920
12.	**July 1, 2018**		
	First Cut	3.99593%	$486,427
	Second Cut	4.25347%	$497,088
	Third Cut	.092340%	$10,333
	Fourth Cut	22.22069%	$2,484,101
	Fifth Cut	9.112110%	$792,309
13.	**July 1, 2019**		
	First Cut	3.58130%	$427,340
	Second Cut	3.79573%	$436,706
	Third Cut	.08202%	$9,078
	Fourth Cut	19.732991%	$2,182,353
	Fifth Cut	7.84118%	$696,066
14.	**July 1, 2020**		
	First Cut	3.465570%	$386,773
	Second Cut	3.66866%	$495,240
	Third Cut	.07917%	$8,216
	Fourth Cut	19.046731%	$1,975,136
	Fifth Cut	7.50431%	$629,973

15.	**July 1, 2021**		
	First Cut	3.23600%	$368,743
	Second Cut	3.41750%	$376,825
	Third Cut	.073600%	$7,833
	Fourth Cut	17.69600%	$1,883,109
	Fifth Cut	6.85760%	$600,621
16.	**July 1, 2022**		
	First Cut	2.91396%	$207,173
	Second Cut	3.0672%	$211,713
	Third Cut	.06578%	$4,401
	Fourth Cut	15.82315%	$1,057,997
	Fifth Cut	5.9955%	$337,450
17.	**July 1, 2023**		
	First Cut	2.87476%	$263,299
	Second Cut	3.02472%	$269,070
	Third Cut	.064830%	$5,593
	Fourth Cut	15.59703%	$1,344,625
	Fifth Cut	5.89399%	$428,871

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.

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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.

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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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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

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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

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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.

FLORIDA TITLE XIX PRACTIOTIONER

REIMBURSEMENT METHODOLOGY

VERSION I

EFFECTIVE DATE: December 1, 2019

I. Practitioner Reimbursement Methodology

This section defines the Agency for Health Care Administration's (Agency's) practitioner reimbursement methodology utilizing a Resource-Based Relative Value Scale (RBRVS). The methodology applies to all practitioners rendering the below services to eligible Florida Medicaid recipients in the fee-for-service delivery system:

A. Allergy services as listed in Attachment 3.1-A coverage pages.

B. Anesthesia services as listed in Attachment 3.1-A coverage pages.

C. Cardiovascular services as listed in Attachment 3.1-A coverage pages.

D. Chiropractic services as listed in Attachment 3.1-A coverage pages.

E. Evaluation and Management services as listed in Attachment 3.1-A coverage pages.

F. Gastrointestinal services as listed in Attachment 3.1-A coverage pages.

G. Genitourinary services as listed in Attachment 3.1-A coverage pages.

H. Hearing services as listed in Attachment 3.1-A coverage pages.

I. Integumentary services as listed in Attachment 3.1-A coverage pages.

J. Laboratory services as listed in Attachment 3.1-A coverage pages.

K. Neurology services as listed in Attachment 3.1-A coverage pages.

L. Oral and Maxillofacial services as listed on Attachment 3.1-A coverage pages.

M. Orthopedic services as listed in Attachment 3.1-A coverage pages.

N. Pain Management services as listed in Attachment 3.1-A coverage pages.

O. Podiatry services as listed on Attachment 3.1-A coverage pages.

P. Radiology and Nuclear Medicine services as listed on Attachment 3.1-A coverage pages.

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Q. Reproductive services as listed on Attachment 3.1-A coverage pages.

R. Transplant services as listed in Attachment 3.1-A coverage pages.

S. Visual Aid services as listed on Attachment 3.1-A coverage pages.

T. Visual Care services as listed on Attachment 3.1-A coverage pages.

Except as otherwise noted in the plan, State-developed fee schedule rates are the same for both governmental and private providers for Practitioners. The Agency's fee schedule rate was set as of December 1, 2019 and is effective for services provided on or after that date. All rates are published on the Agency's website under "Rule 59G-4.002, Provider Reimbursement Schedules and Billing Codes".

II. Calculations

This section defines the methods used by the Florida Medicaid Program for the calculations used in the practitioner reimbursement methodology.

A. A physician shall be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the Agency.

B. Relative Value Units (RVUs) - The Agency adopts Medicare's Relative Value Units (RVUs). There are three components of the RVU, which include (1) Work RVU, (2) Facility Practice Expense (FAC PE RVU) or Non-Facility Practice Expense (NON FAC PE RVU), and (3) Malpractice RVU. Standard calculations include:

$$Non\ Facility\ RVU = Work\ RVU + Non\ Facility\ PE\ RVU + Malpractice\ RVU$$

$$Facility\ RVU = Work\ RVU + Facility\ PE\ RVU + Malpractice\ RVU$$

$$Non\ Facility\ TC\ RVU = Work\ TC\ RVU + Non\ Facility\ PE\ TC\ RVU + Malpractice\ TC\ RVU$$

$$Non\ Facility\ PC\ RVU = Work\ PC\ RVU + Non\ Facility\ PE\ PC\ RVU + Malpractice\ PC\ RVU$$

C. Rates for services that have Medicare defined RVUs, rates are set utilizing the below calculations.

Non-Facility Rate:

$$Fee = Agency\ Geographic\ Practice\ Cost\ Index\ of\ 1 \cdot\ Non\ Facility\ RVU\ \cdot Agency\ Conversion\ Factor$$

$$Fee\ Schedule\ Increase = Fee\ \cdot 1.04$$

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When service is defined by Medicare to include a Technical Component (TC) and Professional Component (PC):

$$TC = Agency\ GPCI\ of\ 1 \cdot Non\ Facility\ TC\ RVU \cdot Agency\ Conversion\ Factor$$

$$Technical\ Component\ Increase = TC \cdot 1.04$$

$$PC = Agency\ GPCI\ of\ 1 \cdot Non\ Facility\ PC\ RVU \cdot Agency\ Conversion\ Factor$$

$$Professional\ Component\ Increase = PC \cdot 1.04$$

Facility Rate:

$$Facility\ Fee = Agency\ GPCI\ of\ 1 \cdot Facility\ RVU \cdot Agency\ Conversion\ Factor$$

$$Facility\ Fee\ Schedule\ Increase = Fee \cdot 1.04$$

D. Rates for services that do not have Medicare defined RVUs rates are set utilizing the below calculations.

(a) Medicare First Coast Services Options (FCSO), Inc. Local Rate Calculations

FCSO rates are reviewed among the three Florida locales: 03, 04 and 99. When applicable, an available rate may correspond to an FS, TC, PC and/or Facility rate determined based on the corresponding modifier. Each available local rate is then calculated based on a weighted average basis. The weighted averages are calculated based on the population of each Florida locale:

$$A = \frac{Locale\ 03\ Population}{Total\ FL\ Population}$$

$$B = \frac{Locale\ 04\ Population}{Total\ FL\ Population}$$

$$C = \frac{Locale\ 99\ Population}{Total\ FL\ Population}$$

Local Rate	Weight
03 Rate = R03	A

04 Rate = R04	B
99 Rate = R99	C

The weighted average rate, when all three locales are available:

$$Medicare\ Fee\ Schedule\ Rate = (R03\ FS\ \cdot A) + (R04\ FS\ \cdot B) + (R99\ FS \cdot C)$$

The Medicaid Fee schedule (Medicaid FS) rate calculation:

$$Medicaid\ FS = Medicare\ Fee\ Schedule\ Rate\ \cdot 0.60$$

The weighted average rate, when two locales are available (i.e. only A and B):

$$Total\ Weight\ (for\ 2\ Locales) = A + B$$

$$A_1 = \frac{A}{Total\ Weight}$$

$$B_1 = \frac{B}{Total\ Weight}$$

$$A_2 = A_1 \cdot C$$

$$B_2 = B_1 \cdot C$$

$$A_{final} = A + A_2$$

$$B_{final} = B + B_2$$

$$Medicare\ Fee\ Schedule\ Rate = \left(R04\ FS\ \cdot A_{final}\right) + (R04\ FS \cdot B_{final})$$

The Medicaid fee schedule calculation:

$$Medicaid\ FS = Medicare\ Fee\ Schedule\ Rate\ \cdot 0.60$$

The rate, when only one rate is available (i.e., only A):

$$Medicare\ FS\ Rate = R03$$

The Medicaid fee schedule calculation:

$$Medicaid\ FS = Medicare\ FS\ Rate\ \cdot 0.60$$

(b) Anesthesia Calculation

Formula:

$$Cost = FSI + (Time\ in\ 15\ \text{min}\ increment\ units\ \cdot 14.50\ Anesthesia\ Time\ Rate)$$

Increments of time not totaling 15 minutes are automatically rounded down to the nearest 15-minute increment. The pediatric rate increase of 4% applies to anesthesia services for children under the age of 21.

(c) Practitioner laboratory services

FCSO is reviewed for laboratory services. If the service is not found on the locales from FCSO, the FCSO clinical lab fee schedule is used on a per test basis. The value included in the FCSO clinical lab fee schedule is the TC component. The Agency cannot pay in excess of established Medicare rates for clinical diagnostic laboratory services performed by a physician/practitioner, independent laboratory or hospital.

$$Practitioner\ Lab\ Fee = Medicare\ TC\ \cdot 0.60$$

$$Practitioner\ Lab\ PC = Practitioner\ Lab\ Fee\ \cdot 0.20$$

$$Practitioner\ Lab\ TC = Practitioner\ Lab\ Fee\ \cdot 0.80$$

Note: The PC and TC are only calculated when the fee includes a PC or TC component.

(d) Independent laboratory services

Rates are 10% less than the practitioner laboratory services. The Agency cannot pay in excess of established Medicare rates for clinical diagnostic laboratory services performed by a physician/practitioner, independent laboratory or hospital.

$$Independent\ Lab\ Fee = Medicare\ TC\ \cdot 0.60\ \cdot 0.90$$

$$Independent\ Lab\ PC = Independent\ Lab\ Fee\ \cdot 0.20$$

$$Independent\ Lab\ TC = Independent\ Lab\ Fee\ \cdot 0.80$$

Note: The PC and TC are only calculated when the fee includes a PC or TC component

E. Rates for services that do not have Medicare RVUs, and do not have locales from FCSO utilize the below calculations.

(a) For services without a FS or TC component from FCSO, Florida Medicaid rates are determined based upon other state's Medicaid rates utilizing Purchasing Power Parities (PPP) and other states' Regional Price Parities.

F. When none of the data in A. – E. is available or the code is unlisted, a like-code coverage for Florida is subject to review for applicability to the new code. If Florida does not cover a similar code, PPP will be used for other state rates coverage of like-codes.

G. When none of the data in A. – F. are available, the code is priced manually. Manual pricing is rare and evaluates codes that are in the same service type subset of the national coding manual. The code is subject to review the next year to determine data availability for A. – F. for an updated rate.

H. Florida Medicaid reimburses physician assistants and advanced practice registered nurses at 80% of the FSI reimbursement of a physician who provides the same services.

III. Resource Based Relative Value Scale Annual Rebalancing

This section defines the method of determining the Resource Based Relative Value Scale and the Agency Conversion Factor calculation. Updated information is obtained including updated RVUs and prior complete state fiscal year (July – June) utilization data. The conversion factor is calculated through an optimization equation. At the end of each calendar year, utilization data from the previous state fiscal year is collected for all procedure codes on relevant fee schedules. For codes with utilization, the updated RVUs will also be utilized for that code, if available. The conversion factor is calculated through the below equations:

1. Total Expenditures

   1.1. Total Expenditures is calculated by taking the FS for each code and multiplying it by its utilization:

$$Total\ Expenditures = FS_{current} \cdot Utilization$$

2. Total Adjusted Expenditures

   2.1. Total Adjusted Expenditures is calculated by calculating new rates based on new RVU's and multiplying the rate by its utilization. The formula for FS $_{adjusted}$ (the estimated new fee schedule rate) is conditional:
   If $FS_{current} \cdot 0.9 < RVU \cdot CF < FS_{current} \cdot 1.1$, then $FS_{adjusted} = RVU \cdot CF$
   If $RVU \cdot CF < FS_{current} \cdot 0.9$, then $FS_{adjusted} = FS_{current} \cdot 0.9$
   If $RVU \cdot CF > FS_{current} \cdot 1.1$, then $FS_{adjusted} = FS_{current} \cdot 1.1$
   These conditions ensure that the rate does not increase or decrease by more than 10%. Once the adjusted rates are calculated, Total Adjusted Expenditures can be calculated,

$$Total\ Adjusted\ Expenditures = FS_{adjusted} \cdot Utilization$$

The conversion factor is calculated through the below equation:

$$\text{Min} \sum Total\ Expenditures - \sum Total\ Adjusted\ Expenditures$$

$$\ni \sum Total\ Expenditures - \sum Total\ Adjusted\ Expenditures \geq 0.$$

A. Exclusions

(a) Facility fees for services have the flexibility to increase by more than 10% to align with Medicare's implementation of the facility fee.

(b) Fee calculations based upon Medicare's RVU definitions have the flexibility to increase by more than 10% to align with Medicare RVUs.

(c) Rate increases or decreases may exceed 10% in order to correct an error made by the Agency.

(d) Laboratory services rates may decrease by more than 10% to align with Medicare's RVUs. The Agency cannot reimburse more than Medicare for laboratory services.

IV. Recurring Rate Increases to the Methodology

Reimbursement increases noted above do not apply to the following services: supplies, devices and laboratory/pathology services.. The Agency ensures recurring rate increases are included for each service and service increase throughout future years.

(a) Pediatric Primary Care (Primary Care Evaluation and Management Rate Increase) The increase of fees for the three most common utilized office visit procedure codes for beneficiaries ages 0-19, for evaluation and management service codes 99212, 99213 and 99214. These three CPT codes continue to receive set rates as detailed below:

CPT Code	Rate
99212	26.45
99213	32.56

99214	48.27

(b) Physician Services Fee: The 4% increase in physician service rates, known as the FSI rate in Florida Medicaid Managed Information System (FLMMIS). The following provider types were included in this increase in physician services per the line item budget: 25 physician; 26 osteopathic physician; 27 podiatrist; 28 chiropractor; 29 physician assistant; 30 advanced registered nurse practitioner; 35 dentist and 62 optometrist, including all age groups.

(c) Pediatric Services: The separate 4% increase in rates for physician services provided to beneficiaries under age 21. This is calculated as an added 4% to the FSI in the reimbursement rules in the Agency's FLMMIS.

(d) Pediatric Physician Specialty: Funds to increase reimbursement rates to physicians for services provided to individuals under age 21 with emphasis on pediatric specialty care for those services deemed by the Agency to be the most difficult to secure under the reimbursement methodology. There are 29 specialty types that receive an enhanced fee of 24% over the base fee to other physician providers for the same services. These specialty types are: 002, 003, 004, 005, 008, 010, 014, 015, 017, 020, 021, 022, 023, 029, 030, 031, 036, 037, 038, 039, 043, 046, 051, 053, 055, 057, 058, 060, and 062.

(e) Pediatric Rate Increase: The Agency identifies the CPT code range of 99201-99496 and 13 physician specialty types that receive an enhanced fee of 10.2% over the FSI rate. They are 01, 19, 23, 35, 36, 37, 38, 39, 43, 49, 59, 101, and 102.

(f) Total increases for Pediatric Specialty Codes: When all criteria are met and the 4%, 24% and 10.2% increases are applicable, to calculate the specialty fee for those certain pediatrician specialty codes, multiply the base fee by 1.04, then multiply that result by 1.24, and then multiply that result by 1.102. The highest rate following the inclusion of all applicable fee schedule increases is reimbursed.

(g) Critical Pediatric Neonatal Intensive Care (NICU)/Pediatric Intensive Care Unit (PICU) Rate increase: $3,470,437 are provided for a rate increase for NICU/PICU services.

(h) Epidural rate increase: For the 2018/19 Fiscal Year, $1,285,347 are provided for a rate increase for epidural services.

V. Glossary

This section details a glossary of terms, alongside acronyms, used throughout the practitioner methodology.

A. Agency - In Florida, the Agency for Health Care Administration is responsible for Medicaid. Medicaid is the medical assistance program that provides access to health care for low-income families and individuals. Medicaid also assists the elderly and people with disabilities with the costs of nursing facility care and other medical and long-term care expenses.

B. Anesthesia Time Rate - Anesthesia is reported in total minutes and reimbursed through the anesthesia rate calculation. Qualified non-physician providers, within their scope of practice, are reimbursed at 80%.

C. Base Fee (FS) - Fee set by the Agency prior to the application of legislatively mandated increases, on which all reimbursement is based.

D. Existing Covered Service – Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes that are included on a current Agency fee schedule.

E. Newly Covered Service – CPT and HCPCS codes that are added to an Agency fee schedule that were not on the previous fee schedule.

F. Facility Fee - Fee paid to the practitioner when the service is performed in the following places of service: 19 (outpatient hospital off-campus), 21 (inpatient hospital), 22 (outpatient hospital), 23 (emergency room hospital), and 24 (ambulatory surgical center).

G. Fee Schedule Increase (FSI) - Base fee plus an additional four percent for services to Medicaid recipients of all ages, based upon provider type.

H. Medicare First Coast Services Options (FCSO), Inc. -the current Medicare Administrative Contractor (MAC) for Jurisdiction N (JN), which includes Florida, Puerto Rico and the U.S. Virgin Islands.

I. Florida Medicaid Management Information System (FLMMIS) - The information system currently utilized to enroll providers, reimburse providers, and maintain eligibility and provider enrollment data.

J. Agency's Conversion Factor (CF) - Defined annually based upon Florida Medicaid service utilization, rebalancing, and available budget. Florida's CF is a value used in this reimbursement methodology to turn Relative Value Units into payable rate (i.e., actual fees).

K. Like-Code Coverage - Code that is similar in nature, scope, and direction to an existing covered code in Florida Medicaid.

L. Medicaid Fee Schedule (Medicaid FS) – A fee schedule is a complete listing of fees used by Medicaid to pay doctors or other providers and suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis.

M. Medicare Physician Fee Schedule - Florida Medicaid utilizes the most current Medicare Physician Fee Schedule available, along with cost RVUs to set rates as detailed in this exhibit.

N. Medicare Geographic Practice Index (GPCI) for Florida - Florida Medicaid utilizes the Geographic Practice Cost Index along with Medicare Relative Value Units to determine allowable payment amounts for medical procedures. The Agency utilizes a standard GPCI of 1 across all locales for all RVU components for Medicare's reported geographic variances.

O. Professional Component (PC, modifier 26) - Used for reimbursement for the interpretation and report of a procedure.

P. Professional Component Increase (PCI) - Base PC fee plus an additional four percent.

Q. Purchasing Power Parodies (PPP) - Ratio of other state service-level coverage set by the United States Department of Commerce Bureau of Economic Analysis.

R. Relative Value Units (RVUs) - The Agency adopts Medicare's RVUs. There are three components of the RVU, which include (1) Work RVU, (2) Facility Practice Expense (FAC PE RVU) or Non-Facility Practice Expense (NON FAC PE RVU), and (3) Malpractice RVU.

S. Resource-Based Relative Value Scale (RBRVS) Methodology - the Agency's methodology to assign practitioner procedures a relative value which is multiplied by an annual fixed conversion factor to determine each procedure's rate.

T. Technical Component (TC) - The increase for the technical portion (i.e., staff and equipment costs) of a test.

U. Technical Component Increase (TCI) - Base TC fee plus an additional four percent.