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:

1. 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.

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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

1. 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.