**59G-1.056 Copayments and Coinsurance.**

(1) This rule applies to providers rendering Florida Medicaid services to recipients.

(2) Requirement. Recipients are responsible for paying all applicable copayment and coinsurance amounts directly to the provider who furnished Florida Medicaid covered services.

(3) Amounts. The copayment and coinsurance amounts, as specified in Section 409.9081, F.S., are as follows:

| SERVICE | FEE |
|---|---|
| Chiropractor services, per provider or group provider, per day | $1.00 |
| Community behavioral health services, per provider, per day | $2.00 |
| Home health services, per provider, per day | $2.00 |
| Hospital outpatient services, per visit | $3.00 |
| Federally qualified health center visit, per clinic, per day | $3.00 |
| Independent laboratory services, per provider, per day | $1.00 |
| Non-emergency transportation services, per each one-way trip | $1.00 |
| Nurse practitioner services, per provider or group provider, per day | $2.00 |
| Optometrist services, per provider or group provider, per day | $2.00 |
| Physician and physician assistant, per provider or group provider, per day | $2.00 |
| Podiatrist services, per provider or group provider, per day | $2.00 |
| Portable x-ray services, per provider, per day | $1.00 |
| Rural health clinic visit, per clinic, per day | $3.00 |
| Use of the hospital emergency department for non-emergency services | 5% of the first $300.00 of the Florida Medicaid payment (maximum $15.00) |

(4) Exemptions. The following categories of recipients are not required to pay a copayment or coinsurance:

(a) Individuals under the age of 21 years.

(b) Pregnant women – for pregnancy-related services, including services for medical conditions that may complicate the pregnancy. This exemption includes the six week period following the end of the pregnancy.

(c) Individuals receiving services in an inpatient hospital setting, long-term care facility, or other medical institution if, as a condition of receiving services in the institution, that individual is required to spend all of his or her income for medical care costs with the exception of the minimal amount required for personal needs.

(d) Individuals who require emergency services after the sudden onset of a medical condition which, if left untreated, would place their health in serious jeopardy.

(e) Individuals receiving services or supplies related to family planning.

(5) Recipients Unable to Pay. Providers may not deny services to a recipient based solely on the recipient's inability to pay a Florida Medicaid copayment or coinsurance amount. Providers may bill the recipient for the unpaid copayment or coinsurance amount.

(6) Third-Party Coverage. Recipients who have third-party liability coverage (including recipients eligible for Medicare) are required to pay copayment or coinsurance amounts, unless:

(a) The recipient is otherwise exempt.

(b) The Medicare or third-party payment is equal to, or exceeds, the Florida Medicaid fee for the service. Providers must reimburse recipients who have paid a Florida Medicaid copayment when the Medicare or third-party liability payment is equal to or exceeds the Florida Medicaid fee for the service.

*Rulemaking Authority 409.919 FS. Law Implemented 409.9081 FS. History–New 7-17-16.*