FLORIDA TITLE XIX COUNTY HEALTH DEPARTMENT

REIMBURSEMENT PLAN

VERSION VI

EFFECTIVE DATE: March 1, 2009

I. Cost Finding and Cost Reporting

A. Each County Health Department (CHD) participating in the Florida Medicaid CHD Program shall submit one complete, legible copy of a cost report to AHCA postmarked or accepted by a common carrier no later than 5 calendar months after the close of its cost reporting year. The services provided at each CHD are in compliance with 42 CFR 440.90.

B. Cost reports available to AHCA pursuant to Section IV, 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, however, 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 42 Code of Federal Regulations (CFR) 413 , and further interpreted

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by the Provider Reimbursement Manual (CMS-Pub. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C.) except as modified by this plan.

E. Each CHD shall file a legible and complete cost report within 5 months, or 6 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 150 day period, and that cost report would have been used to set a lower reimbursement rate for a rate period had it been submitted within 5 months, then the CHD provider's rate for that rate period shall be retroactively calculated using the new cost report, and full payments at the recalculated rate shall be effective retroactively. A CHD which does not file a legible and complete cost report within 6 calendar months after the close of its reporting period shall have its provider agreement cancelled.

G. AHCA shall retain all uniform cost reports submitted for a period of at least 5 years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of 45 CFR 205.60. Access to submitted cost reports shall be in conformity with Chapter 119, Florida Statutes.

H. Cost reports submitted on or after July 1, 2004, 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

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 440.90, Clinic Services.

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 borne by AHCA. AHCA audit staff may enter into contracts with CPA firms to ensure that the requirements of 42 CFR 447.202 are met.

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

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 3 years.

B. Retention

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

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 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. The terms of repayments shall be in accordance with Section 414.41, Florida Statutes.
5. All overpayments shall be reported by AHCA to HHS as required.
6. 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 in

accordance with Section 120.57, Florida Statutes, for any or all adjustments made by AHCA.

III. Allowable Costs

Allowable costs for purposes of computing the encounter rate shall be determined using Title XVIII (Medicare) Principles of Reimbursement as described in 42 CFR 413 , and the guidelines in the Provider Reimbursement Manual (CMS-Pub. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C.), except as modified by Title XIX of The Social Security Act (The Act), this plan, requirements of licensure and certification, and the duration and scope of benefits provided under the Florida Medicaid Program. These include:

A. Costs incurred by a CHD in meeting:

1. The definition of a County Health Department, CHD. Those recognized Health and Rehabilitative Services of Florida, HRS organizations in Florida counties that have as their purpose the provision and administration of public health services as defined in Chapter 154, F.S.
2. The requirements established by the State Agency responsible for establishing and maintaining health standards under the authority of 42 CFR 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 cost and the appropriate indirect overhead, as determined in the cost report, shall not be included in the reimbursement rate.

C. 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 Medicaid benefit period. In addition, the reimbursement shall not exceed the amount according to 42 CFR 447.321 .

D. Under this plan, a CHD 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. As a result, for Medicaid cost reporting purposes, there shall be no Medicaid bad debts generated by 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 1st of each year.

B. All cost reports received by AHCA as of April 15th 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 effect a change of 1 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 in accordance with Section 120.57, Florida Statutes.

E. CHD reimbursable services are defined in the County Public Health Unit Clinic Services Coverage and Limitations Handbook. The Handbook, which is incorporated in Rule 59G-4.055, does define reimbursable services rendered by the clinic:

- physicians

- dentists
- physician assistants
- nurse practitioners
- registered nurses
- services and supplies incidental to physicians, dentists, RNs, ARNPs, and PAs

F. Prescription drugs and immunization costs shall be reimbursed through the Pharmacy Program utilizing current fee schedules established for those 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 pharmacy 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 services and off site clinical laboratory services. However, the health care rendered away from the clinic may be billed under other Medicaid programs, if eligible.

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V. Methods

This section defines the methodologies to be used by the Florida Medicaid Program in establishing individual CHD reimbursement encounter rates on July 1 of each year.

A. Setting Individual CHD Rates.

1. Review and adjust each CHD's cost report available to AHCA as of April 15th 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. (See Section X for definition of allowable encounters).
3. Adjust each CHD's encounter rate with an inflation factor based on the Consumer Price Index (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) Consumer Price Index. (Appendix A)
4. Effective July 1, 2008, as a result of modifying the reimbursement for county health department rates, the Agency shall implement a recurring methodology to achieve a $7,426,780 recurring rate reduction. In establishing rates through the normal process, prior to including this reduction, if the unit cost is equal to or less than the unit cost used in establishing the budget, no additional reduction in rates is necessary. In

establishing rates through the normal process, prior to including this reduction, if the unit cost is greater than the unit cost used in establishing the budget, then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the unit cost used in establishing the budget.

5. The Agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs for two fiscal years effective July 1, 2009.
6. Effective March 1, 2009, the Agency for Health Care Administration shall implement a recurring methodology in the Title XIX County Health Department Reimbursement Plan to reduce individual County Health Department reimbursement rates proportionately until the required savings of $1, 907,971 is achieved.

VI. Payment Assurance

The State shall pay each CHD for services provided in accordance with the requirements of the Florida Title XIX State 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 Medicaid Program, the availability of CHD 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 .

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 Code of Federal Regulations.

IX. Payment in Full

Participation in the 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. Definitions

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, also known as the Agency.

C. County Health Department Clinic Services - Those medically necessary procedures, services, and supplies provided at the health clinic or a satellite clinic, in the course of diagnosis and treatment of an illness, injury, or to assess health status in order to detect and prevent disease, disability and/or health conditions

and their progression to individuals who are outpatients of the county health department. These services may be preventive, diagnostic, therapeutic, rehabilitative, or palliative.

D. Cost Reporting Year - A 12-month period of operation based upon the provider's accounting year.

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

F. Encounter - A face-to-face contact between a clinic patient and a provider of health care services who exercises independent judgement in the provision of health services to the individual recipient at the county public health unit or its satellite unit. 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 ARNP or a Physician Assistant 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.

G. CMS-Pub. 15-1 - also known as the Provider Reimbursement Manual published by the Department of Health and Human Services, 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.

H. DOH - The Florida Department of Health.

I. HHS - Department of Health and Human Services.

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

K. Rate Period - July 1st of a calendar year through June 30th of the next calendar year.

L. Satellite clinic - A facility that functions collaboratively as a surrogate to a county health department for the purpose of providing and administrating public health services as defined in Chapter 154, F.S.

M. Title XVIII - The sections of the federal Social Security Act, 42 U.S.C.s 1395 et seq., and regulations thereunder, that authorize the Medicare program.

N. Title XIX - The sections of the federal Social Security Act, 42 U.S.C.s 1396 et seq., and regulations thereunder, that authorize the Medicaid program.

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APPENDIX A

FLORIDA TITLE XIX COUNTY HEALTH DEPARTMENT (CHD)

REIMBURSEMENT PLAN

CALCULATION OF INFLATION INDEX

1. An inflation index for CHD's to be utilized in adjusting each CHD's encounter rate for inflation is developed from the Data Resources, Inc.(DRI) Consumer Price Index (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:

	1989	1990	1991	1992	1993
Q1	1.071	1.129	1.188	1.230	1.272
Q2	1.087	1.140	1.199	1.239	1.282
Q3	1.098	1.161	1.208	1.250	1.291
Q4	1.109	1.180	1.219	1.261	1.302

2. Based on the quarterly indices, monthly indices are calculated by averaging pairs of quarterly indices and interpolating between these averages as follows:

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QUARTER	INDEX	AVERAGE INDEX	MONTH
1	1.071		
		1.079	MARCH 31
2	1.087		
		1.0925	JUNE 30
3	1.098		
		1.1035	SEPT. 30
4	1.109		

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

= (1.0925/1.079)$^{1/3}$ (1.079)

= 1.084

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

= (1.0925/1.079)$^{2/3}$ (1.079)

= 1.088

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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, 1991, the index for December 31, 1991, 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 November 30, 1990 then its midpoint is May 31, and the applicable inflation is:

December 1991 Index/May 1990 Index(1.2245/1.20016)

= 1.02028

Therefore, the CHD's Medicaid encounter rate as established by the cost report is multiplied by 1.02028 to obtain the prospectively determined rate for the rate period July 1, 1991 through June 30, 1992.

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APPENDIX B TO 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

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