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**State/Territory Name: Florida**

**State Plan Amendment (SPA) #:16-0019**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Atlanta Regional Office  
61 Forsyth Street, Suite 4T20  
Atlanta, Georgia 30303



**DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS**

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August 29, 2016

Justin M. Senior  
Deputy Secretary for Medicaid  
Agency for Health Care Administration  
2727 Mahan Drive, Mailstop #20  
Tallahassee, FL 32308

ATTN: April Cook

RE: Title XIX State Plan Amendment 16-0019

Dear Mr. Senior:

We have reviewed the proposed amendment to the Florida State Plan, submitted under transmittal number FL 16-0019. This amendment is requesting an exception to the federal mandate that directs the state to establish a Medicaid RAC to audit providers furnishing services through the fee-for-service delivery system.

Based on the information provided, this amendment was approved on August 29, 2016. The effective date is June 30, 2016. We are enclosing the approved form HCFA 179 and plan pages. If you have any questions, please contact Cheryl L. Brimage at 404-562-7116 or by email at [cheryl.brimage@cms.hhs.gov](mailto:cheryl.brimage@cms.hhs.gov).

Sincerely,

//s//

Jackie Glaze  
Associate Regional Administrator  
Division of Medicaid & Children's Health Operations

Enclosure

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: 2016-019	2. STATE Florida
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE June 30, 2016	
5. TYPE OF PLAN MATERIAL <i>(Check One)</i> :  <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT <i>(Separate Transmittal for each amendment)</i>			
6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a)(42)(B)(i) of the Act		7. FEDERAL BUDGET IMPACT: (in thousands) FFY 2015-2016 \$0 FFY 2016-2017 \$0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Section 4.5b		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT <i>(If Applicable)</i> : Section 4.5b	
10. SUBJECT OF AMENDMENT: Medicaid Recovery Audit Contractor Program Exception			
11. GOVERNOR'S REVIEW <i>(Check One)</i> : <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED                      Reviewed by the Deputy Secretary for Medicaid <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL                      who is the Governor's designee.			
12. SIGNATURE OF STATE AGENCY OFFICIAL: //s//		16. RETURN TO: Mr. Justin M. Senior Agency Secretary for Medicaid 2727 Mahan Drive, Mail Stop #8 Tallahassee, FL 32308  Attention: April Cook	
13. TYPED NAME: Mr. Justin M. Senior			
14. TITLE: Deputy Secretary for Medicaid			
15. DATE SUBMITTED: 06/30/16			
17. DATE RECEIVED: 06/30/16		18. DATE APPROVED: 08/29/16	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 06/30/16		20. SIGNATURE OF REGIONAL OFFICIAL: //s//	
21. TYPED NAME: Jackie Glaze		22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Opns	
23. REMARKS:			



<p>Section 1902 (a)(42)(B)(ii)(II)(aa) of the Act</p>	<p>_____ The State will make payments to the RAC(s) on a contingent Basis for collecting overpayments.</p> <p>The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee):</p> <p>_____ The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register.</p> <p>_____ The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RAC as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate.</p> <p>_____ The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.</p>
<p>Section 1902 (a)(42)(B)(ii)(II)(bb) of the Act</p>	<p>_____ The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee):</p>
<p>Section 1902 (a)(42)(B)(ii)(III) of the Act</p>	<p>_____ The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).</p>
<p>Section 1902 (a)(42)(B)(ii)(IV)(aa) of the Act</p>	<p>_____ The State assures that the amounts expended by the State to Carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.</p>
<p>Section 1902(a)(42)(B)(ii)(IV)(bb) of the Act</p>	<p>_____ The State assures that the recovered amounts will be subject to a State’s quarterly expenditure estimates and funding of the State’s share.</p>
<p>Section 1902 (a)(42)(B)(ii)(IV)(cc) of the Act</p>	<p>_____ Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.</p>