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**State/Territory Name: Florida**

**State Plan Amendment (SPA) #:17-0010**

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**

November 21, 2017

Ms. Beth Kidder
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

RE: Title XIX State Plan Amendment, FL 17-0010

Dear Ms. Kidder:

We have reviewed the proposed Medicaid State Plan Amendment (SPA), submitted under transmittal number FL 17-0010. This SPA was initially submitted on September 7, 2017 with the a stated purpose to update reimbursement rates for county health departments (CHD) and includes technical and editorial changes, and provides CHDs to buy-back any rate reduction not to exceed cost.

Based on the information provided, this amendment was approved on November 21, 2017. The effective date is July 1, 2017. We are enclosing the approved HCFA-179 and the plan pages. If you have any additional questions or need further assistance, please contact Sid Staton at (850) 878-3486 or Sidney.Staton@cms.hhs.gov.

Sincerely,

//s//

Shantrina Roberts
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: 2017-010

2. STATE: Florida

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: July 1, 2017

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447

7. FEDERAL BUDGET IMPACT: (in thousands)
FFY 2016-2017 $63
FFY 2017-2018 $189

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B Supplement 3, pgs. 1,8,15

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B Supplement 3, pgs. 1,8,15

10. SUBJECT OF AMENDMENT:
Update the buy-back provisions for county health department reimbursement.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Reviewed by the Deputy Secretary for Medicaid who is the Governor's designee.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
//s//

13. TYPED NAME:
Ms. Beth Kidder

14. TITLE:
Deputy Secretary for Medicaid

15. DATE SUBMITTED: 9/7/17

16. RETURN TO:
Ms. Beth Kidder
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #8
Tallahassee, FL 32308

Attention: Abigail Moudy

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: 09/07/17

18. DATE APPROVED: 11/21/17

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/17

20. SIGNATURE OF REGIONAL OFFICIAL: //s//

21. TYPED NAME: Shantrina Roberts

22. TITLE: Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

23. REMARKS: Approved with the following changes to block # 7 as authorization by state agency: Block # 7 changed to read FFY2016-2017 $7,385 and FFY2017-2018 $22,154.

FORM HCFA-179 (07-92)

**FLORIDA TITLE XIX COUNTY HEALTH DEPARTMENT**

**REIMBURSEMENT PLAN**

**VERSION XV**

**EFFECTIVE DATE: July 1, 2017**

# 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, as incorporated by reference in Rule 59G-6.040, Florida Administrative Code (F.A.C.), 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.

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. Buy-back clinic services are provided $8,925,168 for rate reductions that were effective on or after July 1, 2008.
5. The total Buy-back amount cannot exceed the total rate reduction as listed in Appendix 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 general public in accordance with 42 CFR section 447.204.

8. **July 1, 2014**

| | | |
|---|---|---|
| First Cut | 5.348313% | $3,490,065 |
| Second Cut | 5.774361% | $3,566,556 |
| 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 |



Amendment 2017-010
Effective July 1, 2017
Supersedes 2016-027
Approval Date:11/21/17