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State/Territory Name: FL

State Plan Amendment (SPA) #: 22-0004

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

May 24, 2022

Mr. Thomas Wallace
Deputy Secretary for Medicaid
Agency for Health Care
Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

RE: TN 22-00004

Dear Mr. Wallace,

We have reviewed the proposed Florida State Plan Amendment (SPA) 22-0004, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on March 4, 2022. This plan amendment updates the language regarding the auditing practices utilized within the County Health Department Reimbursement methodology.

Based upon the information provided by the State, we have approved the amendment with an effective date of January 1, 2022. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Moe Wolf at 410-786-9291 or Moshe.Wolf@CMS.HHS.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22-0004

2. STATE: FL

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2022

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447 Subpart F

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 21-22 $ 0
b. FFY 22-23 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Att. 4.19-B Supplement 3

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(if Applicable)*
Att. 4.19-B Supplement 3

9. SUBJECT OF AMENDMENT

County Health Department Reimbursement - Auditing Practice

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Tom Wallace

13. TITLE
Deputy Secretary for Medicaid

14. DATE SUBMITTED

15. RETURN TO
Mr. Tom Wallace
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #8
Tallahassee, FL 32308

Attn: Cole Giering

FOR CMS USE ONLY

16. DATE RECEIVED
March 4, 2022

17. DATE APPROVED
May 24, 2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2022

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, Division of Reimbursement Review

22. REMARKS

Instructions on Back

FLORIDA TITLE XIX COUNTY HEALTH DEPARTMENT

REIMBURSEMENT PLAN

VERSION XIX

EFFECTIVE DATE: January 1, 2022

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, 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.

F. If a CHD provider submits a cost report late, after the five month period, and that cost report would have been used to set a lower reimbursement rate for a rate period had it been submitted within five

months, then the CHD provider's rate for that rate period shall be calculated using the new cost report, and full payments at the recalculated rate shall be effective retroactively.

G. AHCA shall retain all uniform cost reports filed for a period of at least five years following the date of filing of such reports and shall maintain those reports pursuant to the record-keeping requirements of 45 CFR section 205.60. Individual cost reports may be requested from the Medicare Administrative contractors in conformity with the Freedom of Information Act (FOIA).

H. Cost reports 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 Florida 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 section 440.90, Clinic Services.

J. AHCA reserves the right to refer providers found to be out of compliance with any of the policies and procedures regarding cost reporting to the Bureau of Medicaid Program Integrity for investigation.

K. Providers are subject to sanctions for late cost reports. A cost report is late if it is not received by AHCA, Bureau of Medicaid Program Finance, Division of Cost Reimbursement, on the first cost report acceptance cut-off date after the cost report due date.

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 assumed by AHCA. AHCA audit staff may enter into contracts with certified public accountant firms to ensure that the requirements of 42 CFR section 447.202 are met.

2. All audits shall be based on American Institute of Certified Public Accountants (AICPA) Attestation Standards for examining or reviewing statistical information and other data.

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 three years.

B. Retention

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

C. Overpayments and Underpayments

l. 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. All overpayments shall be reported by AHCA to CMS, as required under the authority of 42 CFR 433, Subpart F. All underpayments will be subjected to the time limitations under the authority of 45 CFR 95.7.

5. 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.

III. Allowable Costs

Allowable costs for purposes of computing the encounter rate shall be determined in accordance with the provisions outlined within this reimbursement plan. These include:

A. Costs incurred by a CHD in meeting:

1. The definition of a CHDs are those counties recognized by the Florida Department of Health that have as their purpose the provision and an administration of public health services.

2. The requirements created by AHCA for establishing and maintaining health standards under the authority of 42 CFR section 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 costs and the appropriate indirect overhead, as determined in the cost report, shall not be included in the reimbursement rate.

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

D. Under this plan, a CHD shall be required to accept Florida Medicaid reimbursement as payment in full for covered services provided during the benefit period and billed to the Florida Medicaid program; therefore, there shall be no payments due from Florida Medicaid recipients. As a result, for Florida Medicaid cost reporting purposes, there shall be no Florida Medicaid bad debts generated by Florida 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 1 of each year.

B. All cost reports received by AHCA as of April 15 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 cause a change of one 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.

E. CHD services are reimbursed at one encounter rate per day, per recipient, per provider.

F. Prescription drugs and immunization costs shall be reimbursed through Florida Medicaid's prescribed drug 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 prescribed drug 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 and clinical laboratory services. However, services rendered away from the clinic may be billed under the appropriate Florida Medicaid service-specific coverage policy, if eligible).

V. Methods

This section defines the methodologies used by the Florida Medicaid program in establishing individual CHD reimbursement encounter rates on July 1 of each year. The services provided at each CHD are in compliance with 42 CFR section 440.90.

A. Setting Individual CHD Rates.

1. Review and adjust each CHD's cost report available to AHCA as of April 15 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.
3. Adjust each CHD's encounter rate with an inflation factor based on the 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) CPI (Appendix A).

B. Method of Establishing Historical Rate Reductions

1. AHCA shall apply a recurring methodology to establish rates taking into consideration the reductions imposed in the following manner:

a. AHCA shall divide the total amount of each recurring reduction imposed by the number of visits originally used in the rate calculation for each rate setting period which will yield a rate reduction per diem for each rate period.

b. AHCA shall multiply the resulting rate reduction per diem for each rate setting period by the projected number of visits used in establishing the current budget estimate, which will yield the total current reduction amount to be applied to current rates.

c. In the event the total current reduction amount is greater than the historical reduction amount, AHCA shall hold the rate reduction to the historical reduction amount.

2. The recurring methodology includes an efficiency calculation where the reduction amount is subtracted from the CHD prospective rate to calculate the final prospective rate which cannot exceed the $180 ceiling rate or be lower than the $100 floor rate. If the floor rate 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. Effective July 1, 2021 buy-back clinic services rate reductions funding of $1,078, 588. This reimbursement methodology follows the annual General Appropriation Act for buy-back clinic services rate reductions that were effective on or after July 1, 2008.

5. The total Buy-back amount cannot exceed the total rate reduction as calculate in Section V.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 public in accordance with 42 CFR section 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 CFR.

IX. Payment in Full

Participation in the Florida Medicaid 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. Glossary

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.

C. Base rate - A CHD's per diem reimbursement rate before a Medicaid trend adjustment or a buy-back is applied.

D. Benefit period - The period of time where medical benefits for services covered by the Florida Medicaid program, with certain specified maximum limitations, are available to the Florida Medicaid beneficiary.

E. Buy-back - A provision that allows a CHD to decrease the Medicaid trend adjustment from the established percent down to zero percent.

F. CMS-Pub. 15-1 - Manual detailing cost finding principles for institutional providers for Medicare and Medicaid reimbursement (also known as the Provider Reimbursement Manual published by the Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services).

G. County health department clinic services - Medicaid CHD clinic services consist of primary and preventive health care, related diagnostic services, and dental services.

H. Cost reporting year - A 12-month period of operation based upon the provider's accounting year.

I. Eligible Florida Medicaid recipient - Any individual whom the Florida Department of Children and Families, or the 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 the Florida Medicaid program, or an individual on whose behalf Florida Medicaid has become obligated.

J. Encounter - An encounter is a single day, face-to-face visit between a recipient and health care professional(s). Two encounters cannot be reimbursed on the same day even if the visits are for different types of services such as a Child Health Check-Up screening and a dental service. 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 an advanced registered nurse practitioner (ARNP) or a physician assistant (PA) 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.

K. Filing due date - No later than five calendar months after the close of the CHD cost-reporting year.

L. HHS - Department of Health and Human Services.

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

N. Late cost report - A cost report is late when it is filed with AHCA, Bureau of Medicaid Program Finance after the filing due date and after the rate setting due date.

O. Legislative unit cost - The weighted average per diem of the state anticipated expenditure after all rate reductions but prior to any buy back.

P. Medicaid trend adjustment (MTA) - A proportional percentage rate reduction that is uniformly applied to all Florida Medicaid providers' rate semester which equals all recurring and nonrecurring budget reductions on an annualized basis. The MTA is applied to all components of the prospective per diem.

Q. Rate period - July 1 of a calendar year through June 30 of the next calendar year.

R. Rate setting due date - All cost reports received by AHCA by April 15 of each year.

S. Rate setting unit cost - The weighted average per diem after all rate reductions but prior to any buy-backs based on submitted cost reports.

T. Title XVIII - The sections of the federal SSA, as certified by Title 42, United States Code (U.S.C.) 1395 et seq., and regulations thereunder that authorize the Medicare program.

U. Title XIX - The sections of the federal SSA, as certified by 42 U.S.C. 1396 et seq., and regulations thereunder that authorize the Florida Medicaid program.

APPENDIX A
FLORIDA TITLE XIX COUNTY HEALTH DEPARTMENT REIMBURSEMENT PLAN

Calculation of Inflation Index

1. An inflation index used in adjusting each county health department's (CHD) encounter rate for inflation, developed from the DRI 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:

	2009	2010	2011	2012	2013
Q1	1.504	1.542	1.574	1.621	1.647
Q2	1.514	1.539	1.596	1.626	1.649
Q3	1.526	1.544	1.606	1.633	1.660
Q4	1.540	1.558	1.613	1.639	1.665

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

QUARTER	INDEX	AVERAGE INDEX	MONTH
1	1.504	1.509	MARCH 31
2	1.514	1.520	JUNE 30
3	1.526	1.533	SEPTEMBER 30
4	1.540	N/A	N/A

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

$= (1.520/1.509)^{1/3} (1.509)$

$= 1.512$

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

$= (1.520/1.509)^{2/3} (1.509)$

$= 1.516$

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, 2014, the index for December 31, 2014, 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 June 30, 2013, then its midpoint is December 31, and the applicable inflation is:

December 2014 Index/December 2012 Index(1.706/1.643)

$= 1.03834$

Therefore, the CHD's Florida Medicaid encounter rate as established by the cost report is multiplied by 1.03834 to obtain the prospectively determined rate for the rate period July 1, 2014 through June 30, 2015.

APPENDIX B
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
3.	**July 1, 2009**		
	First Cut	5.1307%	$5,601,154
	Second Cut	5.5267%	$5,723,913
	Third Cut	.123013%	$120,361
4.	**July 1, 2010**		
	First Cut	4.16308%	$5,601,154
	Second Cut	4.43912%	$5,723,913
	Third Cut	.097681%	$120,361
	Fourth Cut	27.7950%	$36,984,286
5.	**July 1, 2011**		
	First Cut	3.5186%	$5,601,154
	Second Cut	3.7269%	$5,723,913
	Third Cut	0.0814%	$120,361
	Fourth Cut	25.0332%	$36,984,286
6.	**July 1, 2012**		
	First Cut	3.551023%	$5,601,154
	Second Cut	3.762456%	$5,723,913
	Third Cut	.082209%	$120,361
	Fourth Cut	25.281816%	$36,984,286
	Fifth Cut	13.087637%	$14,305,285
7.	**July 1, 2013**		
	First Cut	4.06110%	$5,601,154
	Second Cut	4.432578%	$5,723,913
	Third Cut	.09507%	$120,361
	Fourth Cut	28.03615%	$35,459,164
	Fifth Cut	12.42594%	$11,309,767
8.	**July 1, 2014**		
	First Cut	5.348313%	$3,490,065
	Second Cut	5.774361%	$3,566,556

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Effective: January 1, 2022
Supersedes: 2021-0007
Approval Date: May 24, 2022

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

12. **July 1, 2018**

First Cut	3.99593%	$486,427
Second Cut	4.25347%	$497,088
Third Cut	.092340%	$10,333
Fourth Cut	22.22069%	$2,484,101
Fifth Cut	9.112110%	$792,309

13. July 1, 2019

First Cut	3.58130%	$427,340
Second Cut	3.79573%	$436,706
Third Cut	.08202%	$9,078
Fourth Cut	19.732991%	$2,182,353
Fifth Cut	7.84118%	$696,066

14. July 1, 2020

First Cut	3.465570%	$386,773
Second Cut	3.66866%	$495,240
Third Cut	.07917%	$8,216
Fourth Cut	19.046731%	$1,975,136
Fifth Cut	7.50431%	$629,973

15. July 1, 2021

First Cut	3.23600%	$368,743
Second Cut	3.41750%	$376,825
Third Cut	.073600%	$7,833
Fourth Cut	17.69600%	$1,883,109
Fifth Cut	6.85760%	$600,621