Table of Contents

State/Territory Name: Florida

State Plan Amendment (SPA) #: 19-0003

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

April 20, 2021

Beth Kidder
Deputy Secretary for Medicaid
Agency for health Care Administration
2727 Mahan Drive MS #8
Tallahassee, FL 32308

RE: Florida State Plan Amendment 19-0003

Dear Ms. Kidder:

We have reviewed the proposed amendment to your state plan submitted on November 13, 2019. The amendment includes the Practitioner Reimbursement Methodology for services outlined within the State Plan.

Based upon the information provided by the State, we have approved the amendment with an effective date of December 1, 2019. We are enclosing the approved CMS-179 (HCFA-179) and a copy of the new table of contents and exhibit 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
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: 2019-003

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
December 1, 2019

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 447.201

7. FEDERAL BUDGET IMPACT: (in thousands)
FFY 2020 $ 0
FFY 2021 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B Exhibit II

Table of contents pages for Attachment 4. 19-B pages 1 and 1a.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
New

Attachment 4. 19-B pages 12, 13, 24, 26, 27, 28, 30, and 45

10. SUBJECT OF AMENDMENT: Practitioner Reimbursement Methodology

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.

[redacted] Y OFFICIAL:

13. TYPED NAME:
Ms. Beth Kidder

14. TITLE:
Deputy Secretary for Medicaid

15. DATE SUBMITTED:
November 13, 2019

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:
November 13, 2019

18. DATE APPROVED:
April 20, 2021

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
December 1, 2019

20. SIGNATURE O[redacted]

21. TYPED NAME: Todd McMillion

22. TITLE: Direct[redacted]eview

23. REMARKS:

Pen & ink changes authorized by state via email:

Box 8: added "Table of contents pages for Attachment 4. 19-B pages 1 and 1a. "

Box 9: added "Attachment 4. 19-B pages 12, 13, 24, 26, 27, 28, 30, and 45 " via technical correction, and "New"

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF FLORIDA

PAYMENT FOR SERVICES

Table of Contents Pages

Amendment: 2019-0003
Effective: 12/1/2019
Supersedes: 2017-013
Approval: 4/20/21

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF FLORIDA

PAYMENT OF SERVICES

Table of Contents Pages (Continued)

Amendment: 2019-003
Effective: 12/1/19
Supersedes: 2017-013
Approval: 4/20/21

FLORIDA TITLE XIX PRACTIOTIONER

REIMBURSEMENT METHODOLOGY

VERSION I

EFFECTIVE DATE: December 1, 2019

I. Practitioner Reimbursement Methodology

This section defines the Agency for Health Care Administration's (Agency's) practitioner reimbursement methodology utilizing a Resource-Based Relative Value Scale (RBRVS). The methodology applies to all practitioners rendering the below services to eligible Florida Medicaid recipients in the fee-for-service delivery system:

A. Allergy services as listed in Attachment 3.1-A coverage pages.

B. Anesthesia services as listed in Attachment 3.1-A coverage pages.

C. Cardiovascular services as listed in Attachment 3.1-A coverage pages.

D. Chiropractic services as listed in Attachment 3.1-A coverage pages.

E. Evaluation and Management services as listed in Attachment 3.1-A coverage pages.

F. Gastrointestinal services as listed in Attachment 3.1-A coverage pages.

G. Genitourinary services as listed in Attachment 3.1-A coverage pages.

H. Hearing services as listed in Attachment 3.1-A coverage pages.

I. Integumentary services as listed in Attachment 3.1-A coverage pages.

J. Laboratory services as listed in Attachment 3.1-A coverage pages.

K. Neurology services as listed in Attachment 3.1-A coverage pages.

L. Oral and Maxillofacial services as listed on Attachment 3.1-A coverage pages.

M. Orthopedic services as listed in Attachment 3.1-A coverage pages.

N. Pain Management services as listed in Attachment 3.1-A coverage pages.

O. Podiatry services as listed on Attachment 3.1-A coverage pages.

P. Radiology and Nuclear Medicine services as listed on Attachment 3.1-A coverage pages.

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Approval Date: 4/20/21

Q. Reproductive services as listed on Attachment 3.1-A coverage pages.

R. Transplant services as listed in Attachment 3.1-A coverage pages.

S. Visual Aid services as listed on Attachment 3.1-A coverage pages.

T. Visual Care services as listed on Attachment 3.1-A coverage pages.

Except as otherwise noted in the plan, State-developed fee schedule rates are the same for both governmental and private providers for Practitioners. The Agency's fee schedule rate was set as of December 1, 2019 and is effective for services provided on or after that date. All rates are published on the Agency's website under "Rule 59G-4.002, Provider Reimbursement Schedules and Billing Codes".

II. Calculations

This section defines the methods used by the Florida Medicaid Program for the calculations used in the practitioner reimbursement methodology.

A. A physician shall be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the Agency.

B. Relative Value Units (RVUs) - The Agency adopts Medicare's Relative Value Units (RVUs). There are three components of the RVU, which include (1) Work RVU, (2) Facility Practice Expense (FAC PE RVU) or Non-Facility Practice Expense (NON FAC PE RVU), and (3) Malpractice RVU. Standard calculations include:

$$Non\ Facility\ RVU = Work\ RVU + Non\ Facility\ PE\ RVU + Malpractice\ RVU$$

$$Facility\ RVU = Work\ RVU + Facility\ PE\ RVU + Malpractice\ RVU$$

$$Non\ Facility\ TC\ RVU = Work\ TC\ RVU + Non\ Facility\ PE\ TC\ RVU + Malpractice\ TC\ RVU$$

$$Non\ Facility\ PC\ RVU = Work\ PC\ RVU + Non\ Facility\ PE\ PC\ RVU + Malpractice\ PC\ RVU$$

C. Rates for services that have Medicare defined RVUs, rates are set utilizing the below calculations.

Non-Facility Rate:

$$Fee = Agency\ Geographic\ Practice\ Cost\ Index\ of\ 1 \cdot\ Non\ Facility\ RVU\ \cdot Agency\ Conversion\ Factor$$

$$Fee\ Schedule\ Increase = Fee\ \cdot 1.04$$

Amendment: 2019-003
Effective Date: 12/1/2019
Supersedes: New
Approval Date: 4/20/21

When service is defined by Medicare to include a Technical Component (TC) and Professional Component (PC):

$$TC = Agency\ GPCI\ of\ 1 \cdot Non\ Facility\ TC\ RVU \cdot Agency\ Conversion\ Factor$$

$$Technical\ Component\ Increase = TC \cdot 1.04$$

$$PC = Agency\ GPCI\ of\ 1 \cdot Non\ Facility\ PC\ RVU \cdot Agency\ Conversion\ Factor$$

$$Professional\ Component\ Increase = PC \cdot 1.04$$

Facility Rate:

$$Facility\ Fee = Agency\ GPCI\ of\ 1 \cdot Facility\ RVU \cdot Agency\ Conversion\ Factor$$

$$Facility\ Fee\ Schedule\ Increase = Fee \cdot 1.04$$

D. Rates for services that do not have Medicare defined RVUs rates are set utilizing the below calculations.

(a) Medicare First Coast Services Options (FCSO), Inc. Local Rate Calculations

FCSO rates are reviewed among the three Florida locales: 03, 04 and 99. When applicable, an available rate may correspond to an FS, TC, PC and/or Facility rate determined based on the corresponding modifier. Each available local rate is then calculated based on a weighted average basis. The weighted averages are calculated based on the population of each Florida locale:

$$A = \frac{Locale\ 03\ Population}{Total\ FL\ Population}$$

$$B = \frac{Locale\ 04\ Population}{Total\ FL\ Population}$$

$$C = \frac{Locale\ 99\ Population}{Total\ FL\ Population}$$

Local Rate	Weight
03 Rate = R03	A

04 Rate = R04	B
99 Rate = R99	C

The weighted average rate, when all three locales are available:

$$Medicare\ Fee\ Schedule\ Rate = (R03\ FS\ \cdot A) + (R04\ FS\ \cdot B) + (R99\ FS \cdot C)$$

The Medicaid Fee schedule (Medicaid FS) rate calculation:

$$Medicaid\ FS = Medicare\ Fee\ Schedule\ Rate\ \cdot 0.60$$

The weighted average rate, when two locales are available (i.e. only A and B):

$$Total\ Weight\ (for\ 2\ Locales) = A + B$$

$$A_1 = \frac{A}{Total\ Weight}$$

$$B_1 = \frac{B}{Total\ Weight}$$

$$A_2 = A_1 \cdot C$$

$$B_2 = B_1 \cdot C$$

$$A_{final} = A + A_2$$

$$B_{final} = B + B_2$$

$$Medicare\ Fee\ Schedule\ Rate = \left(R04\ FS\ \cdot A_{final}\right) + (R04\ FS \cdot B_{final})$$

The Medicaid fee schedule calculation:

$$Medicaid\ FS = Medicare\ Fee\ Schedule\ Rate\ \cdot 0.60$$

The rate, when only one rate is available (i.e., only A):

$$Medicare\ FS\ Rate = R03$$

The Medicaid fee schedule calculation:

$$Medicaid\ FS = Medicare\ FS\ Rate\ \cdot 0.60$$

(b) Anesthesia Calculation

Formula:

$$Cost = FSI + (Time\ in\ 15\ \text{min}\ increment\ units\ \cdot 14.50\ Anesthesia\ Time\ Rate)$$

Increments of time not totaling 15 minutes are automatically rounded down to the nearest 15-minute increment. The pediatric rate increase of 4% applies to anesthesia services for children under the age of 21.

(c) Practitioner laboratory services

FCSO is reviewed for laboratory services. If the service is not found on the locales from FCSO, the FCSO clinical lab fee schedule is used on a per test basis. The value included in the FCSO clinical lab fee schedule is the TC component. The Agency cannot pay in excess of established Medicare rates for clinical diagnostic laboratory services performed by a physician/practitioner, independent laboratory or hospital.

$$Practitioner\ Lab\ Fee = Medicare\ TC\ \cdot 0.60$$

$$Practitioner\ Lab\ PC = Practitioner\ Lab\ Fee\ \cdot 0.20$$

$$Practitioner\ Lab\ TC = Practitioner\ Lab\ Fee\ \cdot 0.80$$

Note: The PC and TC are only calculated when the fee includes a PC or TC component.

(d) Independent laboratory services

Rates are 10% less than the practitioner laboratory services. The Agency cannot pay in excess of established Medicare rates for clinical diagnostic laboratory services performed by a physician/practitioner, independent laboratory or hospital.

$$Independent\ Lab\ Fee = Medicare\ TC\ \cdot 0.60\ \cdot 0.90$$

$$Independent\ Lab\ PC = Independent\ Lab\ Fee\ \cdot 0.20$$

$$Independent\ Lab\ TC = Independent\ Lab\ Fee\ \cdot 0.80$$

Note: The PC and TC are only calculated when the fee includes a PC or TC component

E. Rates for services that do not have Medicare RVUs, and do not have locales from FCSO utilize the below calculations.

(a) For services without a FS or TC component from FCSO, Florida Medicaid rates are determined based upon other state's Medicaid rates utilizing Purchasing Power Parities (PPP) and other states' Regional Price Parities.

F. When none of the data in A. – E. is available or the code is unlisted, a like-code coverage for Florida is subject to review for applicability to the new code. If Florida does not cover a similar code, PPP will be used for other state rates coverage of like-codes.

G. When none of the data in A. – F. are available, the code is priced manually. Manual pricing is rare and evaluates codes that are in the same service type subset of the national coding manual. The code is subject to review the next year to determine data availability for A. – F. for an updated rate.

H. Florida Medicaid reimburses physician assistants and advanced practice registered nurses at 80% of the FSI reimbursement of a physician who provides the same services.

III. Resource Based Relative Value Scale Annual Rebalancing

This section defines the method of determining the Resource Based Relative Value Scale and the Agency Conversion Factor calculation. Updated information is obtained including updated RVUs and prior complete state fiscal year (July – June) utilization data. The conversion factor is calculated through an optimization equation. At the end of each calendar year, utilization data from the previous state fiscal year is collected for all procedure codes on relevant fee schedules. For codes with utilization, the updated RVUs will also be utilized for that code, if available. The conversion factor is calculated through the below equations:

1. Total Expenditures

   1.1. Total Expenditures is calculated by taking the FS for each code and multiplying it by its utilization:

$$Total\ Expenditures = FS_{current} \cdot Utilization$$

2. Total Adjusted Expenditures

   2.1. Total Adjusted Expenditures is calculated by calculating new rates based on new RVU's and multiplying the rate by its utilization. The formula for FS $_{adjusted}$ (the estimated new fee schedule rate) is conditional:
   If $FS_{current} \cdot 0.9 < RVU \cdot CF < FS_{current} \cdot 1.1$, then $FS_{adjusted} = RVU \cdot CF$
   If $RVU \cdot CF < FS_{current} \cdot 0.9$, then $FS_{adjusted} = FS_{current} \cdot 0.9$
   If $RVU \cdot CF > FS_{current} \cdot 1.1$, then $FS_{adjusted} = FS_{current} \cdot 1.1$
   These conditions ensure that the rate does not increase or decrease by more than 10%. Once the adjusted rates are calculated, Total Adjusted Expenditures can be calculated,

$$Total\ Adjusted\ Expenditures = FS_{adjusted} \cdot Utilization$$

The conversion factor is calculated through the below equation:

$$\text{Min} \sum Total\ Expenditures - \sum Total\ Adjusted\ Expenditures$$

$$\ni \sum Total\ Expenditures - \sum Total\ Adjusted\ Expenditures \geq 0.$$

A. Exclusions

(a) Facility fees for services have the flexibility to increase by more than 10% to align with Medicare's implementation of the facility fee.

(b) Fee calculations based upon Medicare's RVU definitions have the flexibility to increase by more than 10% to align with Medicare RVUs.

(c) Rate increases or decreases may exceed 10% in order to correct an error made by the Agency.

(d) Laboratory services rates may decrease by more than 10% to align with Medicare's RVUs. The Agency cannot reimburse more than Medicare for laboratory services.

IV. Recurring Rate Increases to the Methodology

Reimbursement increases noted above do not apply to the following services: supplies, devices and laboratory/pathology services.. The Agency ensures recurring rate increases are included for each service and service increase throughout future years.

(a) Pediatric Primary Care (Primary Care Evaluation and Management Rate Increase) The increase of fees for the three most common utilized office visit procedure codes for beneficiaries ages 0-19, for evaluation and management service codes 99212, 99213 and 99214. These three CPT codes continue to receive set rates as detailed below:

CPT Code	Rate
99212	26.45
99213	32.56

99214	48.27

(b) Physician Services Fee: The 4% increase in physician service rates, known as the FSI rate in Florida Medicaid Managed Information System (FLMMIS). The following provider types were included in this increase in physician services per the line item budget: 25 physician; 26 osteopathic physician; 27 podiatrist; 28 chiropractor; 29 physician assistant; 30 advanced registered nurse practitioner; 35 dentist and 62 optometrist, including all age groups.

(c) Pediatric Services: The separate 4% increase in rates for physician services provided to beneficiaries under age 21. This is calculated as an added 4% to the FSI in the reimbursement rules in the Agency's FLMMIS.

(d) Pediatric Physician Specialty: Funds to increase reimbursement rates to physicians for services provided to individuals under age 21 with emphasis on pediatric specialty care for those services deemed by the Agency to be the most difficult to secure under the reimbursement methodology. There are 29 specialty types that receive an enhanced fee of 24% over the base fee to other physician providers for the same services. These specialty types are: 002, 003, 004, 005, 008, 010, 014, 015, 017, 020, 021, 022, 023, 029, 030, 031, 036, 037, 038, 039, 043, 046, 051, 053, 055, 057, 058, 060, and 062.

(e) Pediatric Rate Increase: The Agency identifies the CPT code range of 99201-99496 and 13 physician specialty types that receive an enhanced fee of 10.2% over the FSI rate. They are 01, 19, 23, 35, 36, 37, 38, 39, 43, 49, 59, 101, and 102.

(f) Total increases for Pediatric Specialty Codes: When all criteria are met and the 4%, 24% and 10.2% increases are applicable, to calculate the specialty fee for those certain pediatrician specialty codes, multiply the base fee by 1.04, then multiply that result by 1.24, and then multiply that result by 1.102. The highest rate following the inclusion of all applicable fee schedule increases is reimbursed.

(g) Critical Pediatric Neonatal Intensive Care (NICU)/Pediatric Intensive Care Unit (PICU) Rate increase: $3,470,437 are provided for a rate increase for NICU/PICU services.

(h) Epidural rate increase: For the 2018/19 Fiscal Year, $1,285,347 are provided for a rate increase for epidural services.

V. Glossary

This section details a glossary of terms, alongside acronyms, used throughout the practitioner methodology.

A. Agency - In Florida, the Agency for Health Care Administration is responsible for Medicaid. Medicaid is the medical assistance program that provides access to health care for low-income families and individuals. Medicaid also assists the elderly and people with disabilities with the costs of nursing facility care and other medical and long-term care expenses.

B. Anesthesia Time Rate - Anesthesia is reported in total minutes and reimbursed through the anesthesia rate calculation. Qualified non-physician providers, within their scope of practice, are reimbursed at 80%.

C. Base Fee (FS) - Fee set by the Agency prior to the application of legislatively mandated increases, on which all reimbursement is based.

D. Existing Covered Service – Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes that are included on a current Agency fee schedule.

E. Newly Covered Service – CPT and HCPCS codes that are added to an Agency fee schedule that were not on the previous fee schedule.

F. Facility Fee - Fee paid to the practitioner when the service is performed in the following places of service: 19 (outpatient hospital off-campus), 21 (inpatient hospital), 22 (outpatient hospital), 23 (emergency room hospital), and 24 (ambulatory surgical center).

G. Fee Schedule Increase (FSI) - Base fee plus an additional four percent for services to Medicaid recipients of all ages, based upon provider type.

H. Medicare First Coast Services Options (FCSO), Inc. -the current Medicare Administrative Contractor (MAC) for Jurisdiction N (JN), which includes Florida, Puerto Rico and the U.S. Virgin Islands.

I. Florida Medicaid Management Information System (FLMMIS) - The information system currently utilized to enroll providers, reimburse providers, and maintain eligibility and provider enrollment data.

J. Agency's Conversion Factor (CF) - Defined annually based upon Florida Medicaid service utilization, rebalancing, and available budget. Florida's CF is a value used in this reimbursement methodology to turn Relative Value Units into payable rate (i.e., actual fees).

K. Like-Code Coverage - Code that is similar in nature, scope, and direction to an existing covered code in Florida Medicaid.

L. Medicaid Fee Schedule (Medicaid FS) – A fee schedule is a complete listing of fees used by Medicaid to pay doctors or other providers and suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis.

M. Medicare Physician Fee Schedule - Florida Medicaid utilizes the most current Medicare Physician Fee Schedule available, along with cost RVUs to set rates as detailed in this exhibit.

N. Medicare Geographic Practice Index (GPCI) for Florida - Florida Medicaid utilizes the Geographic Practice Cost Index along with Medicare Relative Value Units to determine allowable payment amounts for medical procedures. The Agency utilizes a standard GPCI of 1 across all locales for all RVU components for Medicare's reported geographic variances.

O. Professional Component (PC, modifier 26) - Used for reimbursement for the interpretation and report of a procedure.

P. Professional Component Increase (PCI) - Base PC fee plus an additional four percent.

Q. Purchasing Power Parodies (PPP) - Ratio of other state service-level coverage set by the United States Department of Commerce Bureau of Economic Analysis.

R. Relative Value Units (RVUs) - The Agency adopts Medicare's RVUs. There are three components of the RVU, which include (1) Work RVU, (2) Facility Practice Expense (FAC PE RVU) or Non-Facility Practice Expense (NON FAC PE RVU), and (3) Malpractice RVU.

S. Resource-Based Relative Value Scale (RBRVS) Methodology - the Agency's methodology to assign practitioner procedures a relative value which is multiplied by an annual fixed conversion factor to determine each procedure's rate.

T. Technical Component (TC) - The increase for the technical portion (i.e., staff and equipment costs) of a test.

U. Technical Component Increase (TCI) - Base TC fee plus an additional four percent.