Table of Contents

State/Territory Name: FLORIDA

State Plan Amendment (SPA) #: FL-24-0002

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 15, 2024

Mr. Tom Wallace
Deputy Secretary for health Care Finance and Data
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #8
Tallahassee, FL 32308

RE: **Florida State Plan Amendment (SPA) Transmittal Number SPA # 24-0002**

Dear Deputy Secretary Wallace,

We have reviewed the proposed Florida State Plan Amendment (SPA) to Attachment 4.19-B, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on March 26, 2024. This plan amendment updates the Practitioner reimbursement methodology.

Based upon the information provided by the State, we have approved the amendment with an effective date of January 1, 2024. 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 Ysabel Gavino at maria.gavino@cms.hhs.gov

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

DEPARTMENT OF HEALTH ANDHUMAN 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: 24 — 0002

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, 2024

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447.201.

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023-24 $ 564,239
b. FFY 2024-25 $ 564,239

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B, Exhibit II

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B, Exhibit II

9. SUBJECT OF AMENDMENT
Practitioner Reimbursement Methodology

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 Health Care Finance and Data

14. DATE SUBMITTED
3-26-24

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

Attention: Shanise Jackson

FOR CMS USE ONLY

16. DATE RECEIVED
March 26, 2024

17. DATE APPROVED
April 15, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2024

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

The state authorizes CMS the following pen and ink changes:
Box 5 - Federal Statute/Regulation Citation - to add 42 CFR 447.201 - MYLG 4/12/24

Instructions on Back

FLORIDA TITLE XIX PRACTIOTIONER

REIMBURSEMENT METHODOLOGY

VERSION I

EFFECTIVE DATE: January 1, 2024

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 defined in Rule 59G-4.013, FAC.

B. Anesthesia services as defined in Rule 59G-4.022, FAC.

C. Cardiovascular services as defined in Rule 59G-4.033, FAC.

D. Chiropractic services as defined in Rule 59G-4.040, FAC.

E. Evaluation and Management services as defined in Rule 59G-4.087, FAC.

F. Gastrointestinal services as defined in Rule 59G-4.026, FAC.

G. Genitourinary services as defined in Rule 59G-4.108, FAC.

H. Hearing services as defined in Rule 59G-4.110, FAC.

I. Integumentary services as defined in Rule 59G-4.032, FAC.

J. Laboratory services as defined in Rule 59G-4.190, FAC.

K. Neurology services as defined in Rule 59G-4.201, FAC.

L. Oral and Maxillofacial services as defined in Rule 59G-4.207, FAC.

M. Orthopedic services as defined in Rule 59G-4.211, FAC.

N. Pain Management services as defined in Rule 59G-4.222, FAC.

O. Podiatry services as defined in Rule 59G-4.220, FAC.

P. Radiology and Nuclear Medicine services as defined in Rule 59G-4.240, FAC.

Amendment: 2024-0002
Effective Date: 1/1/2024
Supersedes: 2019-003
Approval Date: April 15, 2024

Q. Reproductive services as defined in Rule 59G-4.030, FAC.

R. Transplant services as defined in Rule 59G-4.360, FAC.

S. Visual Aid services as defined in Rule 59G-4.340, FAC.

T. Visual Care services as defined in Rule 59G-4.210, FAC.

II. Calculations

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

A. Per Section 409.908 (12)(a), Florida Statute, *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. Legislative Rates will be based upon Florida Statute and the General Appropriations Act.

C. 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:

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

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

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

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

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

Non-Facility Rate:

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

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

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

Amendment: 2024-0002
Effective Date: 1/1/2024
Supersedes: 2019-003
Approval Date: April 15, 2024

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

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

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

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

Facility Rate:

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

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

E. Rates for services that are not Legislative Rates and 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 (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):

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

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

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

$$A_2 = A_1 \cdot C$$

$$B_2 = B_1 \cdot C$$

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

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

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

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:

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

Amendment: 2024-0002
Effective Date: 1/1/2024
Supersedes: 2019-003
Approval Date: April 15, 2024

(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 15minute 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

F. Rates for services that are not Florida legislatively appropriated, 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.

G. 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.

H. 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.

I. Pursuant to section 409.905, F.S., 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 Conversion Factor calculation. Updated information is obtained including updated RVUs and utilization data from the most recent and complete twelve-month period. The conversion factor is calculated through an optimization equation. At the end of each calendar year, utilization data from the most recent and complete twelve-month period 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 Legislative Rate Increases to the Methodology

Reimbursement increases noted above do not apply to the following services: supplies, devices and laboratory/pathology services. If there is an appropriation increase in the General Appropriations Act for a specific service, provider, or place of service applicable to the practitioner reimbursement methodology, the Agency will utilize expenditure and unit data from the most recent and complete twelve-month period. This data is then used to ensure that service rate increases are appropriately applied based upon allocation and direction as listed in the General Appropriations Act or Laws of Florida. 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 Legislature appropriated funds to increase the 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 (Sec Ch. 99-223, Laws of Florida). 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 Legislature appropriated funds for a 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, (Sec Ch. 2000-166, Laws of Florida), including all age groups.

(c) Pediatric Services: The Legislature appropriated funds for a separate 4% increase in rates for physician services provided to beneficiaries under age 21, (Sec Ch. 2001-253, Laws of Florida). This is calculated as an added 4% to the FSI in the reimbursement rules in the Agency's FLMMIS.

(d) Pediatric Physician Specialty: Legislature appropriated 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, (Sec Ch. 2004-268, Laws of Florida). 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 Legislature appropriated funds for a pediatric rate increase (Sec Ch. 2014-51, Laws of Florida). 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) Physicians Providing Pediatric Care Increase: The legislature appropriated funds for a 7.3% increase in rates for physicians for services provided to individuals under age 21. The Agency identifies two physician provider types that receive an enhanced fee of 7.3% over the FSI rate for all codes on the Practitioner Fee Schedule as directed in the 2023-24 General Appropriations Act. These provider types are 25 physician and 26 osteopathic physician.

(g) Total increases for Pediatric Specialty Codes: When all criteria are met and the 4%, 24% , 10.2%, and 7.3% 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, then multiply that result by 1.102, and then multiply that result by 1.073. The highest rate following the inclusion of all applicable fee schedule increases is reimbursed.

(h) Critical Pediatric Neonatal Intensive Care (NICU)/Pediatric Intensive Care Unit (PICU) Rate increase: Outlined in 2016-18, from the funds in the Specific Appropriation 218, $1,350,000 from the General Revenue Fund and $2,120,437 from the Medical Care Trust Fund are provided for a rate increase for NICU/PICU services.

(i) Epidural rate increase: For the 2018/19 Fiscal Year, from the Specific Appropriation, $500,000 from the General Revenue Fund and $785,347 from Medical Care Trust Fund are provided for a rate increase for epidural services.

(j) Maternal Fetal Medicine Increase: The legislature appropriated funds for an increase in rates for physicians specializing in maternal fetal medicine. Physicians with physician specialty type 065 receive an enhanced fee over the FSI rate for all codes on the Practitioner Fee Schedule and Radiology Fee Schedule.

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: 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. Legislative Rates -Services for which the Florida Legislature mandates a specific rate or rate methodology.

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

M. Medicaid Fee Schedule (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.

N. 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.

O. 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.

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

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

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

S. 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.

T. 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.

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

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