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

a. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act:

Service	Type of Charge			Amount and Basis for Determinations
	Deduct.	Coins.	Copay	
Hospital Services: Non-emergency services in the hospital emergency room.		X		Effective July 1, 2003, there is a five (5) percent coinsurance charge to recipients 21 years of age or older on Medicaid payments greater than $0.00 through the first $300 per date of service for non-emergency services rendered in a hospital emergency room. There is 0% coinsurance on Medicaid payments in excess of $300. Providers are responsible for collecting the cost sharing charges from recipients not otherwise exempt. Providers cannot deny services to recipients who are unable to meet their cost sharing obligation. Authority for the maximum charge is 42 CFR 447.54(a)(2). All exemptions to cost sharing noted in 42 CFR 447.53(b)(1)-(5) apply.
Dental Services: Complete dentures, removable partial dentures and all services related to the provision of complete and partial dentures.		X		There is a five (5) percent coinsurance charge to recipients twenty-one years of age or older who are not institutionalized, receiving hospice care or enrolled in an HMO. The 5 percent coinsurance applies to the amount of Medicaid payment made for the services and not the provider's charges for services. Providers are prohibited from denying services to recipients who are unable to meet their cost sharing obligation. Basis for determination was the maximum charge offered at 42 CFR 447.54(a)(2). The exemptions to cost sharing noted in 42 CFR 447.53(b)(1)-(5) apply.

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

a. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act:

Service	Type of Charge			Amount and Basis for Determinations
	Deduct.	Coins.	Copay	
Prescribed Drug Services		X		Effective June 1, 2004, coinsurance will apply to prescribed drug services for recipients 21 years of age and older, who are not in a long term care facility and are not pregnant or receiving Family Planning Services or supplies; are not receiving Emergency Room services or supplies; or are not receiving Hospice services or supplies. Coinsurance amounts are as follows: 2.5% of the Medicaid payment up to $300, 0% of the Medicaid payment in excess of $300 per prescription, and 0% of Medicaid payments after total monthly beneficiary co-payments and coinsurance billed reaches 5% of total monthly family income. Providers are responsible for collecting the coinsurance from recipients and may not deny an initial service because of an individual's inability to pay coinsurance. An individual's inability to pay is based on his or her statement to the provider that they are unable to pay the required cost sharing. Inability to pay does not extinguish the liability of the individual to pay cost sharing. Authority for the maximum charge is 42 CFR 447.54(a)(2).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Florida

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

There is a copayment charge to recipients 21 years of age and older who are not pregnant, in institutions, nursing homes, ICF/DDs, or receiving hospice care or family planning services. Providers are prohibited from denying services to recipients who are unable to pay their copayment. Basis for determination was the maximum allowable charges in 42 CFR 447.54 (a)(3) and 447.55(b).

Effective July 1, 1993, a $2.00 copayment applied to the following services:
Physician Services: New or established patient office/outpatient services, office/outpatient consultations, and general ophthalmological services.

Optometric Services: New or established patient office/outpatient services, and office/outpatient consultations.

Oral Surgeons: New or established patient office/outpatient services, and office/outpatient consultations.

Effective July 1, 1995, a copayment applies to the following services:
Inpatient Hospital: $3.00 copay per admission.

Outpatient Hospital: $3.00 copay per visit.

Rural Health Clinic: $3.00 copay per day per provider per recipient.

Federally Qualified Health Center: $3.00 copay per day per provider per recipient.

Osteopath, Physician, Physician Assistant, Nurse Practitioner, Podiatrist, or Optometrist: $2.00 copay per day per provider per recipient.

Home Health Agency: $2.00 copay per day per provider per recipient.

Community Mental Health: $2.00 copay per day per provider per recipient.

Independent Laboratory: $1.00 copay per day per provider per recipient.

Portable X-Ray Company: $1.00 copay per day per provider per recipient.

Chiropractic Services: $1.00 copay per day per provider per recipient.

Transportation: $1.00 copay per trip.

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

B. The method used to collect cost sharing charges for categorically needy individuals:

/X/ Providers are responsible for collecting the cost sharing charges from individuals.

/_/ The agency reimburses providers the full Medicaid rate for a service and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Providers are required to ask for the copayment and must determine the recipient's ability to pay based on:

a) his response to the request for payment,
b) his past purchasing history with that provider,
c) his recent purchases of non-essential items.

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

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53 (b) are described below:

Due to the nature of the services subject to coinsurance, enforcement of the cost sharing exclusions is accomplished by simple MMIS edits flagging recipients who are:

1. Under 21 years of age,
2. Institutionalized,
3. Pregnant,
4. Receiving family planning drugs/supplies,
5. Receiving trial prescriptions of anti-arthritis drugs or anti-hyperlipidemics when required.

E. Cumulative maximums on charges:

/X/ State policy does not provide for cumulative maximums.

/_/ Cumulative maximums have been established as described below: