State/Territory: FLORIDA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided: /_/No limitations /X/ With limitations*

2.a. Outpatient hospital services.

Provided: /_/No limitations /X/ With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State Plan).

/X/ Provided: /_/ No limitations /X/With limitations*

/_/ Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Provided: /_/ No limitations /X/With limitations*

3. Other laboratory and x-ray services.

Provided: /_/ No limitations /X/With limitations*

*Description provided on attachment.

State/Territory: FLORIDA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: ___ No Limitations __X__ With limitations*

4. b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

4. c. Family planning services and supplies for individuals of child-bearing age.

Provided: ___No limitations __X___With limitations.*

4. d. Face-to-face tobacco cessation counseling services benefit package for pregnant women

Provided: ____ No limitations __X___ With limitations*

5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: ____No limitations __X___ With limitations.*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5) (B) of the Act).
Provided: ___ No limitations ___X___ With limitations.*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

Provided: _____ No limitations ___X__ with limitations*

* Description provided on attachment.

State/Territory: FLORIDA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

/X/ Provided: /_/ No limitations /X/With limitations*

/_/ Not provided.

c. Chiropractors' services.

/X/ Provided: /_/ No limitations /X/With limitations*

/_/ Not provided.

d. Other practitioners' services.

/X/ Provided: Identified on attached sheet with description of limitations, if any.

/_/ Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: /_/No limitations /X/With limitations*

b. Home health aide services provided by a home health agency.

Provided: /_/No limitations /X/With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: /_/No limitations /X/With limitations*

*Description provided on attachment.

State/Territory: FLORIDA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/X/ Provided: /_/ No limitations /X/With limitations*

/_/ Not provided.

8. Private duty nursing services.

/X/ Provided: /_/ No limitations /X/With limitations*

/_/ Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

X Provided: __ No limitations X With limitations* (7-1-85)

__ Not provided.

10. Dental services.

X Provided: __ No limitations X With limitations*

__ Not provided.

11. Physical therapy and related services.

a. Physical therapy.

X Provided: __ No limitations X With limitations*

__ Not provided.

b. Occupational therapy.

X Provided: __ No limitations X With limitations*

__ Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

X Provided: __ No limitations X With limitations*

__ Not provided.

* Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed Drugs.

X Provided: __ No limitations X With limitations* (6-1-75)

__ Not provided.

b. Dentures.

X Provided: __ No limitations X With limitations* (7-1-80)

__ Not provided.

c. Prosthetic devices.

X Provided: __ No limitations X With limitations* (7-1-80)

__ Not provided.

d. Eyeglasses.

X Provided: __ No limitations X With limitations* (7-1-06)

__ Not provided.

13. Other diagnostic, screening, preventative and rehabilitative services, i.e., other than those provided elsewhere in the plan

a. Diagnostic services.

X Provided: __ No limitations X With limitations*

__ Not provided.

* Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

_X_Provided __No limitations _X_With limitations*

__Not provided

c. Preventive services.

_X_Provided __No limitations _X_With limitations*

__Not provided

d. Rehabilitative services

_X_Provided __No limitations _X_With limitations*

__Not provided

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

_X_Provided __No limitations _X_With limitations*

__Not provided

b. Nursing facility services.

__Provided __No limitations __With limitations*

_X_Not provided

*Description provided on attachment.

Revision: HCFA-PM-86-20 (BERC)
September 1986

State/Territory: Florida

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES
PROVIDED TO THE CATEGORICALLY NEEDY

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

[X] Provided [ ] No limitations [X] With limitations* [ ] Not Provided:

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

[X] Provided [ ] No limitations [X] With limitations* [ ] Not Provided:

16. Inpatient psychiatric facility services for individuals under 22 years of age.

[X] Provided [ ] No limitations [ ] With limitations* [ ] Not Provided:

17. Nurse-midwife services

[X] Provided [ ] No limitations [X] With limitations* [ ] Not Provided:

18. Hospice care (in accordance with section 1905(o) of the Act).

[X] Provided [ ] No limitations

[X] Provided in accordance with section 2302 of the Affordable Care Act

[X] With limitations* [ ] Not Provided:

*Description provided on attachment

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

---

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

___ Provided: ___ With limitations

X Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

___ Provided: ___ With limitations*

X Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

X Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

X Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

State/Territory: FLORIDA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

/_/ Provided: /_/ No limitations /_/ With limitations*

/X/ Not provided.

23. Certified pediatric or family nurse practitioners' services.

Provided: /_/ No limitations /X/ With limitations*

*Description provided on attachment.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.
[X] Provided [ ] No limitations [X] With limitations*
[ ] Not Provided

b. Services of Christian Science nurses.
[ ] Provided [ ] No limitations [ ] With limitations*
[X] Not Provided

c. Care and services provided in Christian Science sanitoria.
[ ] Provided [ ] No limitations [ ] With limitations*
[X] Not Provided

d. Nursing facility services for patients under 21 years of age.
[X] Provided [ ] No limitations [X] With limitations*
[ ] Not Provided

e. Emergency hospital services.
[X] Provided [ ] No limitations [X] With limitations*
[ ] Not Provided

f. Personal care services furnished in recipient's home, and at the state's option, in another location, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.
[X] Provided [ ] No limitations [X] With limitations*
[ ] Not Provided

*Description provided on Attachment.

**State of FLORIDA**
**PACE State Plan Amendment Pre-Print**

Amount, Duration and Scope of Medical and Remedial Care Services Provided to the Categorically Needy

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, and described in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____ provided  X not provided

26. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

X provided  _____ not provided

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

X Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

____ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

**State of Florida**
**1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print**

Amount, Duration, and Scope of Medical and Remedial Care Services Provided To the Categorically Needy

28. _X__ Self-Directed Personal Assistance Services, as described in Supplement _4__ to Attachment 3.1-A.

_X___ Election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects Self-Directed Personal Assistance Services as a State Plan service delivery option.

____ No election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects not to add Self-Directed Personal Assistance Services as a State Plan service delivery option.

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

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED
DESCRIPTION OF LIMITATIONS
PREDETERMINATION OF ELIGIBILITY AND PRIOR AUTHORIZATIONS

Table of Contents Pages


1. Contents
1a. Contents (Continued)
2. EPSDT- General
2a. EPSDT-Diagnostic, Screening and Rehabilitative Services
2a. EPSDT- Early Intervention Services
2a.1 EPSDT- Early Intervention Services (Continued)
2a.2 EPSDT- Early Intervention Services (Continued)
2a.3 EPSDT- Early Intervention Services (Continued)
2a.4 EPSDT- Early Intervention Services (Continued)
2a.5 EPSDT- Early Intervention Services (Continued)
2a.6 EPSDT- Early Intervention Services (Continued)
2a.7 EPSDT- Early Intervention Services (Continued)
2a.8 EPSDT- Early Intervention Services (Continued)
2b. EPSDT- Rehabilitative Services (Mental Health)
2b.1 EPSDT- Mental Health-(Continued)
2b.2 ~~EPSDT- Prescribed Pediatric Extended Care Center (PPEC)~~
2b.3 EPSDT- School-Based Therapy Services
2b.4 EPSDT- School-Based Psychological Services
2b.5 EPSDT-School-Based Social Work Services
2b.6 EPSDT- School-Based Nursing Services
2b.7 EPSDT-School-Based Nursing Services by County Health Departments
2b.8 EPSDT- School Based Behavioral Services by County Health Departments
3. EPSDT- Screening Services
4. EPSDT- Dental Services
5. Rehabilitative Services-Community Mental Health & Substance Abuse
5a. Personal Care Services
5b. Comprehensive Community Support Services for Substance Abuse-Bachelor's Degree Level
6. EPSDT-Optometric Services
7. EPSDT-Eyeglasses
8. EPSDT-Hearing Services
9. EPSDT-Hearing Aids
10. EPSDT-Respiratory Services
11. EPSDT-Home Health Therapies
11a. Telemedicine Services
12. EPSDT-Personal Care Services
12a. EPSDT-Personal Care Services (Continued)
13. EPSDT-Private Duty Nursing
14. EPSDT-Therapy Services
15. EPSDT-Prosthetic Devices
16. EPSDT-Home Health Services-Durable Medical Equipment
17. EPSDT-Chiropractic Services
18. (Reserved)
19. (Reserved)
20. (Reserved)
21. Inpatient Hospital Services
22. Outpatient Hospital Services
23. Emergency Hospital Services




**Amendment 2014-001**
**Effective 01/01/14**
**Supersedes 2013-025**
**Approval 03-21-14**

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

Table of Contents Pages (Continued)


24. Physician Services
25. Advanced Registered Nurse Practitioners
26. Podiatry Services
27. Chiropractic Services
28. Home Health Services
29. Family Planning Services
30. Clinic Services-Birthing Centers
30a. Clinic Services-Ambulatory Surgical Centers
30b. Clinic Services-County Public Health Units
30c. Clinic Services-Freestanding Dialysis Center Services
31. Transportation Services
32. Dental Services
33. Optometric Services
34. Eyeglasses/Contact Lenses
35. Hearing Services
36. Prosthetic Devices-Hearing Aids
37. Hospice Services
38. Nursing Facility Services for Individuals who are Mentally Ill
39. Extended Service to Pregnant Women
39a. Tobacco Cessation Counseling for Pregnant Women
40. Respiratory Services
41. Personal Care Services
42. Private Duty Nursing Services
43. Therapy Service
44. Nurse Midwives
45. Nursing Facility Services
46. Prescribed Drugs
46a. Prescribed Drugs (Continued)
46a.1 Prescribed Drugs (Continued)
46b. Preventive Services
46c. Preventive Services for Pregnant Women
47. ~~Certified Pediatric or Family Nurse Practitioners~~ Intentionally left blank
48. (Reserved)
49. (Reserved)
50. Rural Health Clinic Services
51. Federally Qualified Health Centers (FQHCs)
52. Other Laboratory Services
53. Other X-Ray Services
54. Individuals Age 65 or over in Institutions for Mental Diseases
55. Intermediate Care Facility for the Developmentally Disabled (ICF/DD) Service
56. Ambulatory Prenatal Care
57. Nursing Facilities Services for Patients Under 21
58. Licensed Midwives
59. Physician Assistants
60. Registered Nurse First Assistant
61. Inpatient Psychiatric Services for Individuals under 21

Supplement 1- Case Management Services
Supplement 2- Home and Community Care
Supplement 3- PACE
Supplement 4- 1915(j) Self-Directed Personal Assistance Services
~~Supplement 5- 1915(i) HCBS Redirection Services~~




**Amendment 2014-001**
**Effective 01/01/14**
**Supersedes 2013-025**
**Approval 03-21-14**

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

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED

DESCRIPTION OF LIMITATIONS

PREDETERMINATION OF ELIGIBILITY AND PRIOR AUTHORIZATIONS

1/1/78 The Medicaid program includes the basic concept of predetermination of eligibility of recipients for all services rendered, established by the medical care provider, prior to rendering services, by viewing of the recipient's Medicaid identification card and/or calling on a toll-free telephone line to the fiscal contractor for verification of eligibility. Authorization by the state agency is required for exceptions to limitations as described below.

SPECIFIC LIMITATIONS IN SERVICES

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

4/1/91 All services provided for in Section 1905(a) of the Act which are medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions are provided for EPSDT participants.

Amendment 93-02
Effective 1/1/93
Supersedes 92-43

Approval APR 22 1993

ARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND

10/01/93 REHABILITATIVE SERVICES: Early Intervention Services (13.d)

Rehabilitative services include a range of coordinated rehabilitative or remedial medically necessary services provided to a child in order to identify, evaluate, correct, reduce, or prevent further deterioration of deficits in the child's mental or physical health.

Early intervention services are provided under the Individuals with Disabilities Education Act (IDEA), Part C, and are designed to ameliorate or prevent further developmental disabilities and physical and mental illnesses in children with developmental delays or established conditions that could result in developmental delays at as early an age as possible in order to optimize their functioning capacity. These services are designed to enhance, not duplicate, existing Title XIX mandatory or optional services; to ensure maximum reduction of physical or mental disability and restoration of a beneficiary to his/her best possible functional level.

Developmental delays are defined as a delay in the development in one or more of the following domains: cognitive, physical/motor, sensory (including vision and hearing), communication, social, emotional, or adaptive.

Early intervention services are provided based on the determination of medical need in any of the identified domains.

A developmental delay is a verified delay by use of two or more of the following: appropriate standardized instrument(s); observational assessment; parent report(s); developmental inventory; behavioral checklists; adaptive behavior scales; or professional judgment. When a standardized instrument is used, the following will be used to establish a developmental delay: a score of 1.5 standard deviation below the mean in at least one area of the identified domains, or a 25 percent delay on measures yielding scores in months in at least one of the identified domains.

Amendment 2004-010
Effective 07/01/2004
Supersedes 93-57
Approval 02/03/2005

Revised Submission _____

Early intervention services must be face-to-face encounters, medically necessary, within the scope of practice of the provider, and intended to maximize reduction of identified disabilities or deficits. Suspicious deficits, disabilities or developmental delays are identified and verified through comprehensive screening, assessments and evaluations. Sessions that address the identified delays must be a collaboration of identifying, planning and maintaining a regimen related to the child's functioning. Sessions may be provided in individual or group settings in the following locations: hospital, other clinical settings, home, day care center, or other locations identified as a natural environment for the child.

Provision of services where the family or caregivers are involved must be directed to meeting the identified child's medical treatment needs. Services provided to non-Medicaid eligible family members independent of meeting the identified needs of the child are not covered by Medicaid.

A. Eligible Providers

An eligible provider must enroll as a Medicaid individual provider or group provider that employs or contracts with staff who hold a valid and active license in full force and effect to practice in the state of Florida and have three hours of continuing education per calendar year, or be a non-healing arts certified Infants and Toddler Developmental Specialist (ITDS). The Florida Department of Health, Children's Medical Services Early Steps Program verifies the qualifications, training, experience and certification of the potential Medicaid enrollees, and recommends the provider for Medicaid participation.

In accordance with 42 CFR 431.51, all willing and qualified providers may participate in this program.

Eligible providers must meet the following requirements to enroll as a Medicaid Early Intervention Services provider:

1. Physician - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Physicians and have a minimum of one year experience in early intervention.
2. Physician's assistant - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Physicians and have a minimum of one year experience in early intervention.

3. Nurse practitioner - Be licensed through the Florida Department of Health Medical Quality Assurance Board of Nursing and have a minimum of one year experience in early intervention. Meet requirements contained in 42 CFR 440.166.
4. Registered nurse (RN) - Be licensed through the Florida Department of Health Medical Assurance Board of Nursing and have a minimum of one year experience in early intervention.
5. Practical Nurse (LPN) - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Nursing and have a minimum of one year experience with early intervention.
6. Physical therapist - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Physical Therapy Practice and have a minimum of one year experience in the area of early intervention. Meet requirements contained in 42 CFR 440.110.
7. Occupational therapist - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Occupational Therapy Practice and have a minimum of one year experience in the area of Early Intervention. Meet requirements contained in 42 CFR 440.110.
8. Speech-language pathologist - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Occupational Therapy Practice and have a minimum of one year experience in the area of Early Intervention. Meet requirements contained in 42 CFR 440.110.
9. Audiologist - Be licensed through Florida Department of Health Medical Quality Assurance, Board of Speech-language Pathology and Audiology with a minimum of one year experience in the area of early intervention. Meet the requirements contained in 42 CFR 440.110(c).
10. Respiratory therapist - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Respiratory Care with a minimum of one year experience in the area of early intervention.
11. Clinical psychologist - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Psychology and have a minimum of one year experience in the area of early intervention.
12. School Psychologist - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Psychology and have a minimum of one year experience in the area of early intervention.
13. Clinical social worker - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling. Minimum of one year experience in the area of early intervention.
14. Marriage and family counselor - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Clinical

Social Work, Marriage and Family Therapy, and Mental Health Counseling. Must have a master's level degree or higher and have a minimum of one year experience in the area of early intervention.

15. Mental health counselor - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling. Must have a master's level degree or higher and have a minimum of one year experience in the area of early intervention.
16. Registered dietician - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Dietetics and Nutrition and have a minimum of one year experience in the area of early intervention.
17. Nutrition counselor - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Dietetics and Nutrition and have a minimum of one year experience in the area of early intervention.
18. Infants and Toddlers Developmental Specialist (ITDS) - Have a bachelor's degree or higher from an accredited college or university in early childhood or early childhood/special education, child and family development, family life specialist, communication sciences, psychology or social work or equivalent degree based on transcript review. Must have a minimum of one year experience in early intervention or a minimum of five years documented experience may substitute for an out of field degree. The ITDS provides early intervention services under the direction of a licensed physician or other health care professional acting within their scope of practice. The licensed healing arts professionals on the Family Support Plan Team who provide the evaluation, the service planning assessment, the development of the IFSP and the development of the plan of care follow the child and direct and support the activities of the ITDS through consultation at team meetings or by accompanying the ITDS on visits with the child and family.

Experience requirements are set by the Department of Health, Early Steps Program. Early Steps defines one year of experience in early intervention as equaling 1600 hours of hands-on experience with 0-5 year old children with special needs or their families. A maximum of 400 hours hands-on work with 0 to 5 year old children with special needs or their families obtained as part of the educational requirement to obtain a degree can substitute for 25% of the 1 year experience. Certification of all experience is required upon

enrollment from the Department of Health, Early Steps Program. Certification can consist of letters from former and current employers, letters from professors, or course syllabi describing internship experience and hours with transcripts showing the successful completion of the course.

B. Benefits and Limitations

Early intervention services are medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level. Early intervention services are provided to Medicaid-eligible children for whom all services are medically necessary.

Rehabilitative services include the following range of services, referred to as early intervention services:

1) Screening Services: a screening is a brief assessment of a child that is intended to identify the presence of a high probability of delayed or abnormal development which may require further evaluation and assessment. A screening must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice under state law. The component(s) of the screening performed must be within the scope of practice of the provider. Screenings are performed by one early intervention professional and are limited to three per year per recipient.

Exceptions to the service limitations will be granted based on medical necessity. Authorization to increase the limitation of frequency or time must be requested and approved prior to providing the service. Such authorization is limited to a 3-month period.

Providers retain 100 percent of the payments provided for in Attachment 4.19-B.

2) Interdisciplinary Psychosocial and Developmental Evaluation Services: This is either an initial or follow-up comprehensive, interdisciplinary psychosocial and developmental evaluation to determine a child's level of functioning in each of the following developmental areas: (1) gross motor; (2) fine motor;

(3) communication; (4) self-help and self-care; (5) social and emotional development; and (6) cognitive skills. An evaluation is based on informed clinical opinion through objective testing and includes, at a minimum, a review of pertinent records related to the child's current health status and medical history; an evaluation of the child's level of functioning in each of the developmental areas; an assessment of the unique strengths and needs of the child; and identification of services appropriate to meet the needs of the child.

When used, a standardized test should be thorough, efficient, objectively scored, reliable, valid, culturally fair, and have a broad developmental focus. Tests are to be administered by providers.

The initial evaluation is limited to one per lifetime per recipient. Follow-up evaluations are limited to three per year per recipient. Evaluations must be recommended by a licensed healing arts professional or paraprofessional.

Exceptions to the service limitations will be granted based on medical necessity. Authorization to increase the limitation of frequency or time must be requested and approved prior to providing the service. Such authorization is limited to a 3-month period.

Providers retain 100 percent of the payments provided for in Attachment 4.19-B.

3) Group, Individual, and Home Visiting Sessions: Sessions are face-to-face encounters of at least 30 minutes, not to exceed 60 minutes, with the child or the child's parent, family member or caregiver or both. The purpose of the session is to provide medically necessary services to alleviate or minimize the child's developmental disability, or the condition that could lead to the developmental disability or delay. Sessions must be provided by a Medicaid enrolled professional or paraprofessional early intervention provider within their scope of practice.

An individual session is held with one child or one of the child's parents, family member or caregiver or both.

A group session is held with more than one child, more than one of the child's parents, family member or caregiver; or, more than one child and those children's parents, family members or caregivers. A minimum number of participants in a group is two. The recommended maximum for a group is four.

A home-visit session is an individualized session with one child or that child's parent(s), family member(s) or caregiver(s) or both in the child's home, child care facility or other location conducive to the natural environment of the child, and does not have a center-based or developmental day program.

Billable activities are those identified in the Medicaid Early Intervention Session(s) Plan of Care for the period authorized. Session services cannot duplicate or supplant existing Medicaid services. Services are designed to enhance development in physical/motor, communication, adaptive, cognitive, social or emotional and sensory domains, or to teach compensatory skills for deficits that directly result from medical, developmental, or other health-related conditions.

Providers retain 100 percent of the payments provided for in Attachment 4.19-B.

Providers can be reimbursed for only one type of early intervention session (group, individual, or home-visit) per day, per child. A session cannot be split between providers, nor can more than one type of provider provide a session per day for the same child.

Exceptions to the service limitations will be granted based on medical necessity. Authorization to increase the limitation of frequency or time must be requested and approved prior to providing the service. Such authorization is limited to a 3-month period.

C. Early Intervention Services By Provider Type

Early intervention services are rehabilitative services that include a range of coordinated rehabilitative or remedial medically necessary services provided to a child in order to identify, evaluate, correct, reduce, or prevent further deterioration of deficits in the child's mental or physical health. Early intervention services, which include screening,

evaluations and sessions, are designed to enhance, not duplicate, existing Title XIX mandatory or optional services; to ensure maximum reduction of physical or mental disability and restoration of a recipient to his/her best possible functional level.

The following services are provided by the appropriate provider type within his scope of practice, and when medically necessary, as part of an early intervention screening, evaluation or session. Services include:

1) Developmental - services under the direction of a licensed physician or other health care professional acting within their scope of practice. The licensed healing arts professionals on the Family Support Plan team provide the evaluation, the service planning assessment, the development of the Individualized Family Support Plan (IFSP) and the development of the plan of care, follow the child and direct and support the activities through consultation at team meetings, or by accompanying a provider on visits. These consultative services encompass identifying and rehabilitating a child's medical or other health-related condition and integrating developmental intervention strategies into the daily routines of a child and family to restore or maintain function or reduce dysfunction resulting from a mental or physical disability or developmental delay. Ensuring carryover of medically necessary developmental intervention strategies into all of the child's daily activities to increase the range of normal daily functioning and experience.
2) Medical - services for diagnostic or evaluation purposes, services to determine a child's developmental status and need for early intervention services.
3) Psychological - services are administering psychological and developmental tests, interpreting results, obtaining and integrating information about the child's behavior, child and family conditions related to learning, mental health and development, and planning and managing a program of psychological services, including psychological counseling, family counseling, consultation on child development, parent training and education programs.
4) Occupational Therapy - services to address the functional needs of a child related to adaptive development, adaptive behavior and

play, and sensory, motor, and postural development to improve the child's functional ability to perform tasks, including identification, assessment, intervention, adaptation of the environment, and selection of assistive and orthotic devices.

5) Physical Therapy - services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. It includes evaluation to identify movement dysfunction, obtaining, interpreting and integrating information for program planning and treatment to prevent or compensate for functional problems.
6) Speech/Language - services to identify children with communicative or oropharyngeal disorders and delays in communication skills development, referral for medical or other professional services and the provision of services necessary for their rehabilitation.
7) Nutritional - services that include conducting nutritional assessments, developing and monitoring appropriate plans to address the nutritional needs of the child, based on the findings of the nutritional needs of the child, based on the findings of the nutritional assessment, and making referrals to appropriate community resources to carry out nutritional goals.
8) Audiological - services to identify children with auditory impairment, using at risk criteria and appropriate audiologic evaluation procedures to determine the range, nature, and degree of hearing loss and communication functions. It includes referral for medical and other services necessary for rehabilitation, provision of auditory training and aural rehabilitation, and determination of the child's need for amplification and its selection, use and evaluation.
9) Respiratory Therapy - services to identify, evaluate and provide interventions to children with respiratory disorder which may result in a developmental delay in any of the identified domains.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND: (Continued)

10/1/90 (13d) 15. REHABILITATIVE SERVICES: Exceptions to the service limitations can be granted based on medical necessity.

a. Intensive therapeutic on-site services include the provision of therapeutic services, with the goal of preventing more restrictive, costly placement by teaching problem solving skills, behavior strategies, normalization activities and other treatment modalities as appropriate. On-site is defined as where the child is living, working or receiving schooling. Children residing in a public institution or who are under the control of the juvenile justice system are not eligible for Medicaid.

While it is recognized that involvement of family (including legal guardians) in the treatment of the child is necessary and appropriate, provision of services where the family is involved clearly must be directed to meeting the identified child's treatment needs. Services provided to non-Medicaid eligible family members independent of meeting the identified needs of the child are not covered by Medicaid.

Billable services are face-to-face encounters with the child and/or the child's family. Services must be rendered by a mental health professional with a minimum of a B.A. degree from an accredited university a with emphasis in the areas of psychology, social work, health education or a related human services field.

Intensive therapeutic on-site services include:

o Behavioral assessment of the child in order to define, delineate, evaluate and diagnose treatment needs. Assessment services include; psychosocial evaluation, psychiatric mental status exam, psychological testing, and developmental assessment of the child within the home, community, educational or vocational setting.

o Development of a behavioral management program for the child designed to reduce behavior problems and/or functional deficits stemming from the existence of a mental disorder that interfere with the child's personal, familial, vocational and/or community adjustment.

o Monitoring of the child's compliance with the behavioral management program.

o Individual counseling or psychotherapy between the child and the mental health professional designed to maximize strengths and to reduce behavior problems and or functional deficits stemming from the existence of a mental disorder that interferes with the child's personal, familiar, vocational and/or community adjustment.

o Family counseling or psychotherapy involving the child, his/her family and or significant others and a mental health professional designed to maximize strengths and to reduce behavior problems and or functional deficits stemming from the existence of a mental disorder that interfere with the child's personal, familial, vocational and/or community adjustment.

o Other medically necessary therapeutic services specified by the psychiatrist in the child's plan of care.

Services are limited to one visit per day. Additional visits can be granted based on medical necessity.

Amendment 90-67
Effective 10/1/90
Supersedes 92-26
Approved 5-12-94
Revised Submission 2/20/92
Revised Submission 8/7/92
Revised Submission 2/3/94

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND: (Continued)

4/1/96 15. REHABILITATIVE SERVICES: (Continued)
(13d)

b. Home-based rehabilitative services are designed for the restoration or modification, and/or maintenance of social, personal adjustment, and basic living skills. These services shall be an effective intervention in assuring that a child with a psychiatric disability possesses those physical, emotional, and intellectual skills to live, learn and work in his or her own particular environment. Home-based is defined as the child's official place of residence. Children residing in a public institution, or who are under the control of the juvenile justice system, are not eligible for Medicaid.

While it is recognized that involvement of family (including legal guardians) in the treatment of the child is necessary and appropriate, provision of services where the family is involved clearly must be directed to meeting the identified child's treatment needs. Services provided to non-Medicaid eligible family members independent of meeting the identified needs of the child are not covered by Medicaid.

Billable services are face-to-face encounters with the child and/or the child's family. Services must be rendered by an individual who is experienced in the needs of severely emotionally disturbed children, is capable of implementing services which address the child's needs identified in the care plan, demonstrate skills and abilities to deliver therapeutic services to severely emotionally disturbed children, complete an ADM approved pre-service training program and participate in annual training to improve skills. Providers may not be relatives of the recipient. Services are limited to those provided by or under the recommendation of a physician, psychiatrist or other licensed practitioner of the healing arts acting within the scope of his/her practice under State law.

Home-based rehabilitative services include:

o One to one supervision of the child's therapeutic activities in accordance with his or her behavioral management program.

o Skill training of the child for ~~development and/or~~ HCFA Pix Change 8-12-96 restoration of those basic living and social skills necessary to function in his or her own particular environment.

o Assistance to the child and family in implementing behavioral goals identified through family counseling or treatment planning.

Services are limited to 56 hours per month. Additional hours can be approved based on medical necessity.

Amendment 96-03
Effective 4/1/96
Supersedes 95-16
Approved 8-12-96

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

1/98
(13d) School-Based Therapy Services

**Description**
Florida Medicaid certified school match program allows school districts, charter, and private schools to receive reimbursement under the Florida Medicaid program for therapy services furnished in a school setting. These services are provided in accordance with 42 CFR 440.130(d).

**Who Can Receive**
Florida Medicaid recipients under the age of 21 years requiring medically necessary therapy services in the school setting.

**Who Can Provide**
The following licensed practitioners rendering services through the school district, charter, or private school, and in accordance with 42 Code of Federal Regulations 440.110:

- Occupational therapists or occupational therapy assistants licensed in accordance with Chapter 468, Florida Statutes under the supervision of a licensed occupational therapist.
- Physical therapists or physical therapy assistants who meet the requirements in Chapter 486, Florida Statutes under the supervision of a licensed physical therapist.
- Speech therapists or speech-language pathology assistants licensed in accordance with Chapter 468, Florida Statutes or Certified by the Department of Education under the supervision of a licensed speech therapist.

**Allowable Benefits**
Florida Medicaid covers the following therapy services:

- Evaluations
- Individual and group treatment sessions

In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary.



Amendment 2016-031
Effective 10/28/16
Supersedes 98-06
Approved 10/02/17

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

10/1/01 (13d) School-Based Behavioral Services

**Description**
Florida Medicaid certified school match program allows school districts, charter, and private schools to receive reimbursement under the Florida Medicaid program for behavioral health services furnished in a school setting. These services are provided in accordance with 42 CFR 440.130(d).

**Who Can Receive**
Florida Medicaid recipients under the age of 21 years requiring medically necessary behavioral services in the school setting.

**Who Can Provide**
The following licensed and/or certified practitioners rendering services through the school district, charter, or private school:

- Behavior analysts or assistant behavior analysts certified by the Behavior Analyst Certification Board
- School counselors certified in accordance with Chapter 1012, Florida Statutes.
- Marriage and family therapists licensed in accordance with Chapter 491, Florida Statutes.
- Mental health counselors licensed in accordance with Chapter 491, Florida Statutes.
- Psychologists licensed in accordance with Chapter 490, Florida Statutes.
- Social workers licensed in accordance with Chapter 491, Florida Statutes.

**Allowable Benefits**
Florida Medicaid covers the following school-based behavioral services:

- Assessments
- Behavior analysis, including interpretations of information about the student's behavior and conditions relating to functioning
- Consultation, coordination of services, and follow-up referrals with other health care staff, other entities or agencies, parents, teachers, and family
- Evaluations
- Individual counseling sessions
- Group counseling sessions [minimum of two recipients and a maximum of 10]

In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

**THIS PAGE IS INTENTIONALLY LEFT BLANK**

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

10/01/97 (6d) School-Based Nursing Services

**Description**
Florida Medicaid certified school match program allows school districts, charter, and private schools to receive reimbursement under the Florida Medicaid program for nursing services furnished in a school setting in accordance with 42 CFR 440.60.

**Who Can Receive**
Florida Medicaid recipients under the age of 21 years requiring medically necessary nursing services in the school setting.

**Who Can Provide**
The following licensed and/or certified practitioners rendering services through the school district, charter or private school**:**

- Registered nurses (RN) licensed in accordance with Chapter 464, Florida Statutes
- Licensed practical nurses (LPN) licensed in accordance with Chapter 464, Florida Statutes
- School health aides working under the supervision of an RN, in accordance with Chapter 464, F.S., who have completed the following courses:
    - Cardiopulmonary resuscitation (CPR)
    - First aid
    - Medication administration
    - Patient specific training

In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

7/1/98 (13d) REHABILITATIVE SERVICES (Continued)

School-Based Nursing Services by County Health Departments

County Health Departments will only provide nursing services on the school campus and in the student's home that are not reimbursable under the clinic services program. Nursing services under the rehabilitative services program include the basic nursing care students require while they are in the school or in school home-bound programs.

Medication administration will include the dispensing of the medication and necessary documentation of oral, and/or inhalator medications. A licensed registered nurse (RN) and licensed practical nurse (LPN) may administer the medication within their scope of practice.

Services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice, per 42 CFR 440.130. All requirements of 42 CFR 440.130 will be met.

Services may be rendered by or under the direction of a licensed registered nurse (RN) as allowed by state licensure laws, and must be within the scope of the professional practice act.

Licensed practical nurses (LPN) may render services as allowed by state licensure laws and under the professional practice act, if under the supervision of a registered nurse.

County Health Departments will be the paid-to-provider. All of the treating providers, both RNs and LPNs will be enrolled in the Medicaid program as treating providers.

Amendment 98-12
Effective 7/1/98
Supersedes NEW
Approved 9/4/98

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

REHABILITATIVE SERVICES

School-Based Behavioral Services by County Health Departments

County Health Departments will provide behavioral services that are not reimbursable under the clinic services program, only on the school campus and in the student's home. Behavioral services under the rehabilitative services program include the behavioral health students require while they are in the school or in school home-bound programs.

Behavioral services are diagnostic testing or active treatments to be rendered with the intent to reasonably improve the individual's physical or mental condition or functioning. Services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice, per 42 CFR 440.130. All requirements of 42 CFR 440.130 will be met.

Behavioral services are intervention services that focus on treatment. Behavioral services may include testing and evaluation that apprise cognitive, emotional and social functioning and self-concept; interviews and behavioral evaluations including interpretations of information about the individual's behavior and conditions relating to functioning; therapy, including providing a program of behavioral services for the individual with diagnosed behavioral problems; unscheduled activities for the purpose of resolving an immediate crisis situation; and other medically necessary services within the scope of practice. Behavioral services may be provided in either an individual or group setting.

County Health Departments will be the Medicaid pay to provider of services provided in the school setting with treating providers either employed or individually contracted. Treating providers of behavioral services must have at a minimum a Master's degree in social work from an accredited college, and work under the supervision of a licensed clinical social worker (LCSW) as required by Florida Statutes in order to obtain the work experience necessary for licensure or certification. The state agency will require County Health Departments to verify that school-based treating behavioral services providers meet provider requirements. The state Medicaid agency will require an agreement with each County Health Department to this effect and will monitor this factor. Behavioral services providers should have experience in providing services in school settings to Medicaid eligible children and must establish linkages in order to coordinate and consult with school authorities, as well as families, to assess a child's needs and identify treatment options.

Employees of the Health Department providing behavioral health services in schools will not duplicate services provided by school district employees. Health Department staff will provide services only when the need of the student exceeds the level of staff employed by the school district or is not available from school district staff.

Health Department social workers (MSW and LCSW) will provide services to all Medicaid eligible students in the school setting who are in need of such services.

Amendment 2002-02
Effective 7/1/02
Supersedes NEW
Approval Date JUN 0 6 2002
Revised Submission May 30, 2002
Revised Submission June 3, 2002

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE AND TREATMENT OF CONDITIONS FOUND:

1. Screening examinations are recommended to be scheduled in accordance with the Bright Futures/American Academy of Pediatrics Periodicity Schedule. Additional screening examinations are also available upon referral from a healthcare, developmental or educational professional, when factors suggesting the need for EPSDT are presented, or upon the request of the parent/recipient.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

4/1/91
(10)
(12b)

2. Dental Services. A direct dental referral is required for every child, 3 years of age and older, or earlier as medically indicated to adhere to the recommendation for preventive pediatric health care as recommended by the American Academy of Pediatrics and the Committee on Practice and Ambulatory Medicines. The periodicity schedule meets the requirements of Section 1905(r) of the Act. Following the initial dental referral, subsequent examinations by a dental professional are recommended every six months or more frequently as prescribed by a dentist or other authorized provider. Orthodontic services require prior authorization to be obtained for medical necessity.

1/02
3d)

REHABILITATIVE SERVICES:

Rehabilitative services are limited to mental health and substance abuse services that are provided for the maximum reduction of the recipient's mental health and substance abuse disability and restoration to the best possible functional level. Services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

Services are limited to those which are medically necessary and are recommended by a licensed practitioner of the healing arts, psychiatrist, or other physician and included in a treatment plan. Exceptions to the service limitations can be granted based on medical necessity. Service limitations for EPSDT recipients are listed in the EPSDT section.

In keeping with the 2001-2002 General Appropriations Act, certain high cost mental health procedure codes are subject to prior authorization.

To be eligible to participate in this program, providers must:

- Have a current contract pursuant to the provision of Chapter 394, Florida Statutes, for the provision of community mental health or substance abuse services from the district or regional Department of Children and Families, Alcohol, Drug Abuse and Mental Health (ADM) program office; and

- Employ or have under contract a Medicaid-enrolled psychiatrist or other physician.

In addition to the above requirements:

- Alcohol prevention, treatment, or drug abuse treatment and prevention programs must hold a regular (i.e., not probationary or interim) license as defined in Chapter 397, F.S.

- Individuals seeking enrollment as providers of comprehensive behavioral health assessments must be reviewed and certified as meeting specific provider qualifications.

- Agencies seeking enrollment as providers of comprehensive behavioral health assessments or specialized therapeutic foster care services (Level I, Level II, and Crisis Intervention) must be reviewed and certified as meeting specific provider qualifications.

Amendment 2002-04
Effective 1/1/02
Supersedes 90-67
Approval MAY 21 2002

# PERSONAL CARE/ASSISTIVE CARE SERVICES

Personal Care/Assistive Care Services are provided to Medicaid eligible recipients requiring an integrated set of services on a 24-hour basis. Recipients must have health assessments establishing the medical necessity of at least two components of the integrated personal/assistive care services. The medical necessity must be determined by a physician or other licensed practitioner of the healing arts acting within the scope of their practice under state law. All requirements of 42 CFR 440.167 will be met.

Eligible providers must be able to provide the integrated set of personal care/assistive care services on a 24-hour basis and maintain a standard license under Chapters 400.407, 400.468 or 394.875, F.S. Only trained personnel employed by the service provider will be able to provide care under this service.

The personal care/assistive care services are: health support, assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) and assistance with self-administration of medication.

Health support is defined as requiring the provider to observe the resident's whereabouts and well being, to remind the resident of any important tasks, and to record and report any significant changes in the resident's appearance, behavior, or state of health to the resident's health care provider, designated representative or case manager.

Assistance with activities of daily living is defined as individual assiatance with ambulating, transferring, bathing, dressing eating grooming and toileting. Assistance with instrumental activities of daily living is defined as individual assistance with shopping for personal items, making telephone calls and managing money.

Assistance with self-medication administration of medication is defined as assistance with or supervision of self-administration to the extent permitted by state law.

Personal Care/Assistive Care Services will be provided based upon individual care plans developed from health assessments. The personal care/assistive care service provider is responsible for developing the recipient's care plan. Care plans will be reviewed by the Agency for Health Care Administration (AHCA) annually.

Amendment 2000-11
Effective 1/1/2001
Supersedes NEW
Approval 4/5/2001

Rehabilitative Services:

Community-based Substance Abuse Services

Community-based substance abuse rehabilitative services will be available to all Medicaid eligible individuals with substance abuse disorders who are medically determined to need rehabilitative services. These services must be delivered by an agency licensed by the state to deliver substance abuse services and under contract with a county to receive county tax dollars that are certified as the state share of reimbursement for these services. These services must be recommended by a physician or other practitioner of the healing arts within the scope of his/her practice under state regulation and furnished by or under the direction of a physician or other practitioner operating within the scope of applicable state regulations, to promote the maximum reduction of symptoms of substance abuse and/or restoration of a recipient to his/her best possible functional level. The services are as follows:

Comprehensive Community Support Services for Substance Abuse

These services are designed to assist clients to strengthen and/or regain skills, to develop the environmental support necessary to help clients thrive in the community, and to aide clients in meeting life goals the promote recovery and resiliency. Services include substance abuse education, family/parenting guidance, life skills, anger/stress management, and support counseling. Services do not include meetings of Narcotics Anonymous, Alcoholics Anonymous, or other twelve-step programs.

Comprehensive Community Support Services for Substance Abuse-Bachelors Degree Level

Comprehensive community support services are medically necessary clinical aftercare services that are directed toward individuals who have received and successfully completed substance abuse treatment within a correctional or other institutional setting or a community-based program, and need continued therapeutic services to maintain their recovery as they re-enter the community. The purpose of comprehensive community support services is to provide integrative therapeutic supports and aftercare in collaboration with available and relevant ancillary medical and behavioral support services in the community to promote the receipt and effectiveness of those services. These services are based on a recovery support services model that addresses interpersonal and coping skills in home, work, and school situations and facilitates medication monitoring and symptom monitoring through therapeutic service provision. Identifying barriers that impede the development of skills necessary for independent functioning in the community will also be an integral part of these services. These out patient services may be provided in a variety of community-based settings that are licensed by the state to provide substance abuse services. Effective after care services are comprised of the following activities: supportive and psycho-educational counseling about substance abuse disorders; specific recovery support services such as guidance in locating housing, counseling to support employment; monitoring recipient progress toward meeting goals of the aftercare plan; coordinating any necessary services with other sources and subsequently making any referrals for medically necessary services. Services must be provided by a substance abuse counselor who has knowledge of existing support services within the community. Services shall be supervised by a licensed practitioner of the healing arts or a master's level C.A.P. Reimbursement for this service is limited to 60 units per state fiscal year per recipient. Each unit must be 30 minutes in duration.

Alcohol and/or Drug Intervention Service

Alcohol and/or Drug Intervention Service is provided for the purpose of early identification of substance abuse problems and rapid linkage to needed services. This service is used to detect alcohol or other drug problems and to provide a brief intervention to arrest the progression of such problems, thereby avoiding the need for more costly and intensive levels of treatment. The intervention service is delivered on an outpatient basis in community-based settings such as licensed substance abuse providers, schools, work sites, community centers, and homes. The goal is to provide the medically necessary clinical services to minimize and ameliorate substance abuse risk factors and behaviors early in the process as an alternative to a more restrictive level of treatment. The following activities are included under this service: clinical screening and evaluation; identification and provision of medically necessary treatment needs; referral to other clinically indicated services; and ensuring referral appointments are met. Services must be delivered by a substance abuse counselor under the supervision of a licensed practitioner of the healing arts or a master's level C.A.P. Reimbursement for this service is limited to 24 units of at least 30 minutes each, per state fiscal year per recipient.

# BEHAVIOR ANALYSIS SERVICES

Description

Behavior analysis (BA) services are highly structured interventions, strategies, and approaches provided to restore appropriate behaviors by decreasing maladaptive behaviors.

Who Can Receive

Behavior analysis services are available for recipients under the age of 21 years for whom BA services are recommended by a licensed physician in accordance with 42 CFR 440.130(d) and are medically necessary for the restoration of the recipient to the best possible functional level.

Who Can Provide

Services must be performed by a practitioner who meets one of the following:

- Lead Analyst
  - Licensed in accordance with Chapter 490 or 491, Florida Statutes, with training and expertise in the field of behavior analysis; or
  - Certified behavior analysts who meet the following:
    - Are credentialed by the Behavior Analyst Certification Board®
    - Has a master's degree from an accedited university or college in a related human services field
    - Possesses a minimum of 250 hours of classroom graduate level instruction, 1500 hours of supervised independent field work, 1,000 hours of practicum, or 750 hours of intensive practicum in behavior analysis

- Registered behavior technicians who meet the following:
  - Are credentialed by the Behavior Analyst Certification Board®
  - Are 18 years or older with a high school diploma or equivalent
  - Complete a 40 hour training relevant for behavior techicians
  - Work under the supervision of a lead analyst

- Behavior assistants who meet one of the following and work under the supervision of a lead analyst:
  - Are 18 years or older with a high school diploma or equivalent with at least:
    - Two years of experience providing direct services to recipients with mental health disorders, developmental or intellectual disabilities
    - Complete 20 hours of documented in-service trainings in the treatment of mental health, developmental or intellectual disabilities, recipient rights, crisis management strategies, and confidentiality
  - Has a bachelor's degree from an accedited university or college in a related human services field.

Allowable Benefits

- One behavioral assessments per recipient, per fiscal year.
  - The behavior assessment is used to identify specific factors associated with the occurrence of maladaptive behaviors, functional capacity, strengths and service needs used in the development of a behavior plan.
- Up to three behavior reassessments per recipient, per fiscal year.
- Up to 40 hours of behavior analysis services, per week.
  - The implementation of BA interventions and ongoing monitoring of the recepient's progress towards goals in the behavior plan
  - Behavior analysis interventions may include but are not limited to discrete trial teaching, chaining, prompting, fading, and shaping

Behavior analysis services require prior authorization from the Agency for Health Care Administration (Agency) or the Agency's designee.

In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary.

Exclusions

- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provision of the Individuals with Disabilities Education Act.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

10/1/95 (6b) 3. Optometric Services: A specific periodicity schedule has been established as mandated by OBRA 1989 for vision screenings in accordance with the recommendations of the appropriate medical consultants. The schedule for screenings adhere to the Recommendation for Preventative Pediatric Health Care as recommended by the American Academy of Pediatrics and the Committee on Practice and Ambulatory Medicines. The periodicity schedule meets the requirements of Section 1905(r) of the Act.

Amendment 95-20
Effective 10/1/95
Supersedes 93-02

Approval 1-23-96

Early and Periodic Screening and Diagnosis of recipients under the age of 21 years, and Treatment of conditions found:

4. Description

Visual aid services provide visual aids to recipients to alleviate visual impairments.

Who Can Receive

Visual aid services are available to Florida Medicaid recipients under the age of 21 years who require medically necessary visual aid services.

Who Can Provide

Practitioners certified or licensed within their scope of practice.

Allowable Benefits

- Eyeglasses
  Up to two pairs per 365 days

- Contact Lenses
  For limited conditions and requires prior authorization by the Agency for Health Care Administration or its designee

- In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary. The provider is required to obtain prior authorization from the Agency or its designee.

Early and Periodic Screening and Diagnosis of recipients under the age of 21 years, and Treatment of conditions found:

5. 11c. Description

Hearing services are designed to provide screening, assessment, testing, or corrective services to recipients in order to detect and mitigate the impact of hearing loss in accordance with Title 42, Code of Federal Regulations, section 440.110 (c).

Who Can Receive

Hearing services are available to Florida Medicaid recipients under the age of 21 years who require medically necessary hearing services.

Who Can Provide

Practitioners certified or licensed within their scope of practice:

- Audiologists licensed in accordance with Chapter 468, F.S.
- Physicians licensed in accordance with Chapter 458 or 459, F.S., with a specialty in otolaryngology or otology
- Audiology assistants or provisionally licensed individuals directly supervised by a federally qualified and Florida-licensed audiologist

Allowable Benefits

- The periodicity schedule for hearing services screening adheres to the Recommendations by the American Academy of Pediatrics and the Committee on Screening and Ambulatory Medicine. The periodicity schedule also meets the requirements of Section 1905(r) of the Act. Benefits include:
    - Diagnostic audiological tests
    - Corrective services, when clinical improvement can be reasonably expected.
    - One routine hearing assessment or reassessment every three years. This limit can be exceeded based upon medical necessity.
    - Newborn and infant hearing screening up to one screening for recipients under the age of 12 months
- In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary. The provider is required to obtain prior authorization from the Agency for Health Care Administration or its designee.

Early and Periodic Screening and Diagnosis of recipients under the age of 21 years, and Treatment of conditions found:

6. 12c. Description

Hearing devices are provided to recipients in order to mitigate the impact of hearing loss.

Who Can Receive

Hearing device services are available to Florida Medicaid recipients under the age of 21 years who require medically necessary hearing services.

Who Can Provide

In accordance with section 440.120, prosthetic devices must be prescribed by a physician or other licensed practitioner of the healing arts. Practitioners certified or licensed within their scope of practice include:

- Audiologists licensed in accordance with Chapter 468, F.S.
- Hearing aid specialists licensed in accordance with Chapter 484, F.S.
- Physicians licensed in accordance with Chapter 458 or 459, F.S., with a specialty in otolaryngology or otology
- Audiology assistants or provisionally licensed individuals directly supervised by a federally qualified and Florida-licensed audiologist

Allowable Benefits

Hearing aid devices are available for recipients under the age of 21 years as determined medically necessary by a licensed otolaryngologist, otologist or general physician. Benefits include:

  - BAHA up to one per ear with prior authorization by the Agency for Health Care Administration (AHCA) or its designee
  - Cochlear implants up to one per ear with prior authorization by the AHCA or its designee
  - Repairs and replacements of implant external parts after the one year warranty period has expired

- In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary. The provider is required to obtain prior authorization from the AHCA or its designee.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

7/1/98 (6d) Respiratory Services

Medicaid recipients under the age of 21 may receive medically necessary respiratory therapy services which are reimbursable to Medicaid enrolled providers. Services must be prescribed in writing by the recipient's primary care physician (or designated physician assistant or advanced registered nurse practitioner) or a designated MD specialist. Services must be provided by a registered respiratory therapist who is licensed by the state of Florida, has met the requirements of 42 CFR 440.60 and has been enrolled as a Medicaid provider. The registered respiratory therapist must administer treatment according to the primary care provider's specific approved written plan of care and written prescription. Florida allows all eligible licensed registered respiratory therapists to enroll as providers to ensure freedom of choice of providers in accordance with 42 CFR 440.70.

Reimbursement for one evaluation or re-evaluation per recipient is allowed every six months. Respiratory therapy visits must be a minimum of fifteen (15) minutes in duration with reimbursement available for a maximum of two individual treatment sessions per day. Exceptions to these limitations may be made based on medical necessity.

Therapy treatments are subject to prior authorization.

Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found

Home Health Nursing Visits

(7a) Description

Home health nursing services provide care to recipients whose medical conditions, illness, or injury require the care to be delivered in the recipient's place of residence or other community setting. Home health nursing services are provided in accordance with Title 42, Code of Federal Regulations 440.70.

Who Can Receive

Home health nursing services are available to recipients under the age of 21 years who require medically necessary home health visit services.

Who Can Provide

- Home health agencies licensed in accordance with section 408.810, Florida Statutes (F.S.), and Rule Chapter 59A-8, Florida Administrative Code.
- Licensed practical nurses licensed in accordance with Chapter 464, F.S.
- Registered nurses licensed in accordance with Chapter 464, F.S.

Allowable Benefits

Florida Medicaid reimburses for up to four intermittent home health visits, per day, when prior authorized by the Agency for Health Care Administration (Agency) or its designee.

The four visit limit is a combined limited for both home health nursing and home health aide services.

In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary when prior authorized by the Agency or its designee.

Exclusions

Florida Medicaid does not reimburse for the following:

- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services furnished by relatives as defined in section 429.02, F.S., household members, or any person with custodial or legal responsibility for the recipient
- Services provided in any of the following locations:
  - Hospitals
  - Intermediate care facility for individuals with intellectual disabilities
  - Nursing facilities
  - Prescribed pediatric extended care centers
  - Residential facilities or assisted living facilities when the services duplicate those provided by the facility

TELEMEDICINE SERVICES

Telemedicine services under Florida Medicaid are subject to the specifications, conditions, and limitations set by the State. Telemedicine is defined as the practice of health care delivery by a practitioner who is located at a site other than the site where the patient is located for the purposes of evaluation, diagnosis, or recommendation of treatment.

Providers rendering telemedicine within their scope of practice must involve the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time, interactive communication between the recipient and the practitioner to provide and support care when distance separates participants who are in different geographical locations. Telephone conversations, chart review, electronic mail messages, or facsimile transmissions are not considered telemedicine.

All equipment required to provide telemedicine services is the responsibility of the providers.

Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found

Home Health Aide Visits

(7b) Description

Home health aide services provide care to recipients whose medical conditions, illness, or injury require the care to be delivered in the recipient's place of residence or other community setting. Home health aide services are provided in accordance with Title 42, Code of Federal Regulations 440.70.

Who Can Receive

Home health aide services are available to recipients under the age of 21 years who require medically necessary home health visit services.

Who Can Provide

- Home health agencies licensed in accordance with section 408.810, Florida Statutes (F.S.), and Rule Chapter 59A-8, Florida Administrative Code.
- Licensed practical nurses licensed in accordance with Chapter 464, F.S.
- Registered nurses licensed in accordance with Chapter 464, F.S.

Allowable Benefits

Florida Medicaid reimburses for up to four intermittent home health aide visits, per day, when prior authorized by the Agency for Health Care Administration (Agency) or its designee.

The four visit limit is a combined limited for both home health nursing and home health aide services.

In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary when prior authorized by the Agency or its designee.

Exclusions

Florida Medicaid does not reimburse for the following:

- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services furnished by relatives as defined in section 429.02, F.S., household members, or any person with custodial or legal responsibility for the recipient
- Services provided in any of the following locations:
  - Hospitals
  - Intermediate care facility for individuals with intellectual disabilities
  - Nursing facilities
  - Prescribed pediatric extended care centers
  - Residential facilities or assisted living facilities when the services duplicate those provided by the facility

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

(24f) Description

9 Personal care services provide medically necessary assistance, in the home or the community, with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) to enable recipients to accomplish tasks they would normally be able to do for themselves if they did not have a medical condition or disability. Personal care services are provided in accordance with 42 Code of Federal Regulations 440.167.

Who Can Receive

Personal care services are available to recipients under the age of 21 years who require medically necessary personal care services.

Who Can Provide

- Home health agencies licensed in accordance with section 408.810, Florida Statutes (F.S.), and Rule Chapter 59A-8, Florida Administrative Code.
- Independent personal care providers who:
  - Are 18 years or older.
  - Are trained in the areas of cardiopulmonary resuscitation, HIV/AIDS, and infection control.
  - Have at least one year of experience working in a medical, psychiatric, nursing or child care setting or working with recipients who have an intellectual disability. College, vocational, or technical training in medical, psychiatric, nursing, child care, or intellectual disabilities equal to 30 semester hours, 45 quarter hours, or 720 classroom hours can be substituted for the required experience.

Allowable Benefits

Personal care services are reimbursed for up to 24 hours per day, per recipient, in order to provide assistance with ADLs and age appropriate IADLS when the recipient meets the following criteria:

- Is under the care of a physician and has a physician's order for personal care services
- Requires more extensive and continual care than can be provided through a home health visit
- Requires services that can be safely provided in their home or the community
- Has a medical condition or disability that substantially limits their ability to perform ADLs or IADLs and does not have a parent or legal guardian able to provide the required care

In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary. The provider is required to obtain prior authorization from the Agency or its designee.

Exclusions

Florida Medicaid does not reimburse for the following:

- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services furnished by relatives as defined in section 429.02(18), F.S., household members, or any person with custodial or legal responsibility for the recipient. (Except when a recipient is enrolled in the Consumer-Directed Care Plus program)
- Services provided in any of the following locations:
  - Hospitals
  - Institutions for Mental Disease (IMDs)
  - Intermediate care facility for individuals with intellectual disabilities
  - Nursing facilities
  - Prescribed pediatric extended care centers
  - Residential facilities or assisted living facilities when the services duplicate those provided by the facility

PPECs are licensed by the State, and must meet all State licensure laws and regulations based on established criteria and policies in 59A-13 FAC. Staffing includes the following, at a minimum:

1. Medical Director: National Board Certified Pediatrician
2. Director of Nursing: Licensed Registered Nurse (RN) with current certification in cardio pulmonary resuscitation (CPR) and a minimum of 2 years pediatric nursing experience and 6 months caring for medically fragile infants or children in a pediatric intensive care, neo-natal intensive care, PPEC or similar care setting during the last 5 years.
3. Registered Nursing Staff: Licensed RNs with 2 or more years of pediatric experience, 6 months caring for medically dependent or technologically dependent children, and current certification in CPR.
4. Licensed Practical Nurses: 2 years of experience in pediatrics and current certification in CPR. All LPNs must be supervised by an RN.
5. Direct Care Personnel: 1 year experience in care of infants and toddlers with employment references and current CPR certification. Must be supervised by an RN.

Physicians, Registered Nursing staff and Licensed Practical Nurses are also provided and described elsewhere in the plan, pursuant to 42 CFR 440.

All willing and qualified providers will be permitted to participate in accordance with 42 CFR 431.51. All medically necessary services will be provided to individuals qualifying under the EPSDT mandate.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

## PRIVATE DUTY NURSING SERVICES

Description

Private duty nursing services provide care to recipients whose medical condition, illness, or injury requires the care to be delivered in the home or community setting. Private duty nursing services are provided in accordance with 42 Code of Federal Regulations 440.80.

Who Can Receive

Private duty nursing services are available to recipients under the age of 21 years who require medically necessary private duty nursing services.

Who Can Provide

- Home health agencies licensed in accordance with section 408.810, Florida Statutes (F.S.), and Rule Chapter 59A-8, Florida Administrative Code.
- Independent licensed practical nurses licensed in accordance with Chapter 464, F.S.
- Independent registered nurses licensed in accordance with Chapter 464, F.S.

Allowable Benefits

Private duty nursing services are authorized for up to 24 hours per recipient, per day and must be prior authorized by the Agency for Health Care Administration or its designee.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

1/1/98 (11) Therapy Services

Services must be prescribed in writing by the recipient's primary care provider (or designated physician assistant or advanced registered nurse practitioner) or a designated MD specialist. One evaluation or re-evaluation per recipient is allowed every six months. Exceptions to the service limitations can be granted based on medical necessity. All therapists must meet the requirements of 42 CFR 440.110.

Medically necessary occupational, physical and speech therapy services may be provided for recipients under 21 years of age. Therapy sessions administered to recipients on an individual basis must be a minimum of 15 minutes in duration with reimbursement available for a maximum of two individual treatment sessions per day. Speech therapy may also be administered in group sessions, provided that the group contains a maximum of six children, for a minimum of thirty (30) minutes per group. Therapy sessions are subject to prior authorization.

Evaluations for Augmentative and Alternative Communication (AAC) systems must be conducted and documented by the speech therapist. An initial evaluation as well as a follow-up evaluation upon delivery of the system are required to ensure appropriateness of the unit. Re-evaluation of both the unit and the user is required every six months. One initial AAC evaluation is allowed every three (3) calendar years. The follow-up/re-evaluations are limited to two (2) per calendar year. Exceptions to these limitations may be made based on medical necessity.

Fitting/adjustment/training sessions for AAC systems are limited to eight (8) 30 minute sessions per year, per device. Exceptions to these limitations may be made based on medical necessity.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

1/1/93 (12c) 12. Services for prosthetic and orthotic devices must be service authorized by the state agency and approved based on medical necessity. Prosthetic eyes are limited to one initial prosthetic eye for each eye per individual. Exceptions are granted based on medical necessity. Examples of medically necessary replacements are that the prosthetic eye is no longer the appropriate size or the eye has been inadvertently damaged, destroyed or stolen.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

Home Health Services

3/1/97 (7c) Medical supplies and durable medical equipment must be prescribed in writing by the recipient's primary care provider or a designated MD specialist and are limited to the items listed in the agency's provider handbook. Exceptions can be granted based on medical necessity.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

1/1/94 14. Chiropractic Services: Chiropractic services are limited to twenty-four visits within a calendar year. Exceptions to the service limitations can be granted based on medical necessity.

Amendment 94-01
Effective 1/1/94
Supersedes 93-02

Approval JUN 17 1994

## 1. INPATIENT HOSPITAL SERVICES OTHER THAN THOSE PROVIDED IN AN INSTITUTION FOR MENTAL DISEASE:

Description

Inpatient hospital services may be provided in accordance with 42, Code of Federal Regulations 440.10. Inpatient hospital services for all ages require authorization from the Agency or the Agency's designee, with the exception of emergency services.

Who Can Receive

Recipients enrolled on the date of service and requiring medically necessary inpatient hospital services.

Who Can Provide

Services must be performed by a facility that meets state requirements for licensure as an inpatient hospital.

Allowable Benefits

- Up to 365/6 days per fiscal year for recipients under the age of 21 years
- Up to 45 days per fiscal year for recipients age 21 years of age or older

Inpatient hospital services beyond the 45 day limit can be reimbursed with prior authorization when medically necessary, for emergency services, or for the treatment of tuberculosis.

Sterilization and abortion procedures, which meet federal requirements, can be reimbursed.

OUTPATIENT HOSPITAL SERVICES: Pursuant to Florida Statutes, services are limited to a maximum of $1,500 for non-EPSDT recipients 21 years of age and over per fiscal year. There is no limitation for EPSDT recipients. To best serve the needs of Florida's Medicaid population, the Agency has exempted the following services from the $1500 limitation: emergencies, outpatient surgeries, and life sustaining treatments such as chemotherapy and dialysis.

7/1/92 EMERGENCY HOSPITAL SERVICES: Same limitations as for Outpatient or Inpatient Hospital Services.

Amendment 93-02
Effective 1/1/93
Supersedes NEW

Approval APR 22 1993

# PHYSICIAN SERVICES

Description
Physician services are provided to maintain the recipient's health, prevent disease, and treat illness, in accordance with 42 CFR 440.

Who Can Receive
An eligible recipient enrolled on the date of service, and requiring a medically necessary physician service.

Who Can Provide
Physicians licensed within their scope of practice to perform this service.

Allowable Benefits

- Health screenings for recipients under the age of 21 years in accordance with the American Academy of Pediatrics periodicity schedule.
- Office visits as medically necessary for recipients under the age of 21 years and pregnant recipients age 21 years and older.
- Up to two primary care office visits per month for recipients age 21 years and older.
- Up to one evaluation and management visit per month, per recipient in a custodial care or nursing care facility.
- Up to one adult health screening every 365 days for recipients age 21 years and older.

*Exceptions to the limits will be authorized on a case by case basis and will be evaluated based on medical necessity.

Amendment 2016-010
Effective 4/01/16
Supersedes 2012-014
Approval 05-24-16

ADVANCED REGISTERED NURSE PRACTITIONER SERVICES

(6d) Description

Advanced registered nurse practitioner services are provided to maintain the recipient's health, prevent disease, and treat illness, in accordance with 42 CFR 440.60.

Who Can Receive

An eligible recipient enrolled on the date of service, and requiring a medically necessary medical service.

Who Can Provide

Advanced registered nurse practitioners licensed within their scope of practice to perform this service.

Allowable Benefits

- Health screenings for recipients under the age of 21 years in accordance with the American Academy of Pediatrics periodicity schedule.
- Primary care visits as medically necessary for recipients under the age of 21 years and pregnant recipients age 21 years and older.
- Up to two primary care office visits per month for recipients age 21 years and older.
- Up to one evaluation and management visit per month, per recipient in a custodial care or nursing care facility.
- Up to one adult health screening every 365 days for recipients age 21 years and older.

Exceptions to the limits will be authorized on a case by case basis and will be evaluated based on medical necessity.

1/1/91 (6a) PODIATRISTS: Limits visits outside the hospital to not more than one per recipient per day per podiatrist not to exceed two visits per month (except for emergencies) and one per recipient per month per podiatrist upon referral from the recipient's attending physician in long term care facilities (except for emergencies). One hospital visit per day per recipient per provider is allowed. A visit is not allowed on the same day as a surgical procedure unless it is indicated by an asterisk in the provider handbook. All elective surgical procedures require prior authorization or an EPSDT referral to determine medical necessity. Excludes routine foot care unless medically indicated (ex., allowed for diabetics), also excludes experimental and clinically unproven surgical procedures.

1/1/95
(6c)

CHIROPRACTIC SERVICES: Visits to a chiropractor are limited to twenty-four visits within a calendar year. Nursing home and ICF/DD residents require a referral from a physician (M.D. or D.O.). Service limitations for EPSDT recipients are listed in the EPSDT section.

Amendment 95-05
Effective 1/1/95
Supersedes 94-01

Approval 4/26/95

Home Health Nursing Visits

(7a) Description

Home health nursing services provide care to recipients whose medical conditions, illness, or injury require the care to be delivered in the recipient's place of residence or other community setting. Home health nursing services are provided in accordance with Title 42, Code of Federal Regulations 440.70.

Who Can Receive

Home health nursing services are available to recipients age 21 years and older who require medically necessary home health visit services.

Who Can Provide

- Home health agencies licensed in accordance with section 408.810, Florida Statutes (F.S.), and Rule Chapter 59A-8, Florida Administrative Code.
- Licensed practical nurses licensed in accordance with Chapter 464, F.S.
- Registered nurses licensed in accordance with Chapter 464, F.S.

Allowable Benefits

Florida Medicaid reimburses for the following when prior authorized by the Agency for Health Care Administration or its designee:

- Up to four intermittent home health visits, per day, for pregnant recipients
- Up to three intermittent home health visits, per day, for non-pregnant recipients,

The three and four visit limits are a combined limit for both home health nursing and home health aide services.

Service limitations for Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions (EPSDT) recipients are listed in the EPSDT section.

Exclusions

Florida Medicaid does not reimburse for the following:

- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services furnished by relatives as defined in section 429.02, F.S., household members, or any person with custodial or legal responsibility for the recipient
- Services provided in any of the following locations:
  - Hospitals
  - Intermediate care facility for individuals with intellectual disabilities
  - Nursing facilities
  - Prescribed pediatric extended care centers
  - Residential facilities or assisted living facilities when the services duplicate those provided by the facility

Home Health Aide Visits

(7b) Description

Home health aide services provide care to recipients whose medical conditions, illness, or injury require the care to be delivered in the recipient's place of residence or other community setting. Home health aide services are provided in accordance with Title 42, Code of Federal Regulations 440.70.

Who Can Receive

Home health aide services are available to recipients age 21 years and older who require medically necessary home health visit services.

Who Can Provide

- Home health agencies licensed in accordance with section 408.810, Florida Statutes (F.S.), and Rule Chapter 59A-8, Florida Administrative Code.
- Licensed practical nurses licensed in accordance with Chapter 464, F.S.
- Registered nurses licensed in accordance with Chapter 464, F.S.

Allowable Benefits

Florida Medicaid reimburses for the following when prior authorized by the Agency for Health Care Administration or its designee:

- Up to four intermittent home health visits, per day, for pregnant recipients
- Up to three intermittent home health visits, per day, for non-pregnant recipients,

The three and four visit limits are a combined limit for both home health nursing and home health aide services.

Service limitations for Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions (EPSDT) recipients are listed in the EPSDT section.

Exclusions

Florida Medicaid does not reimburse for the following:

- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services furnished by relatives as defined in section 429.02, F.S., household members, or any person with custodial or legal responsibility for the recipient
- Services provided in any of the following locations:
  - Hospitals
  - Intermediate care facility for individuals with intellectual disabilities
  - Nursing facilities
  - Prescribed pediatric extended care centers
  - Residential facilities or assisted living facilities when the services duplicate those provided by the facility

FAMILY PLANNING

4/1/2001 (4c) An initial/annual family planning visit is limited to one per year and a supply visit is limited to one every month. Sterilizations are limited to recipients who meet the requirements of 42 CFR 441.253.

HIV testing and counseling are limited to four per year for recipients acknowledging HIV risks.

HIV testing and counseling are limited to two per lifetime for preventive measures.

Amendment 2001-05
Effective 4/1/2001
Supersedes 98-26

Approval JUN 2 7 2001

## Coverage Template for Freestanding Birth Center Services

**Attachment 3.1A: Freestanding Birth Center Services**

**28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers**

Provided: ☒ **No limitations** With limitations None licensed or approved

Florida Medicaid birth centers provide prenatal and delivery services for recipients expected to experience a medically low risk pregnancy and delivery.

**28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center**

Provided: No limitations ☒ **With limitations (please describe below)**

Please describe any limitations: Florida Medicaid limits prenatal visits to a maximum of 10 visits provided in a licensed birth center to a recipient expected to experience a low-risk pregnancy and delivery, however, additional visits may be provided based on medical necessity in a medically appropriate setting.

Please check all that apply:

☒ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

☒ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

(c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services: Florida Licensed Midwives

10/1/93 CLINIC SERVICES: Ambulatory Surgical Centers

For ambulatory surgical centers, services are limited to those procedures which can be safely done outside of the inpatient hospital setting as determined by Medicare and the state agency policy.

Amendment 93-61
Effective 10/1/93
Supersedes NEW

Approval FEB 18 1994

1/1/93 CLINIC SERVICES: County Public Health Units

For county public health units, services are limited to one clinic encounter per recipient, per day, per provider for preventive or primary care.

Amendment 93-61
Effective 10/1/93
Supersedes NEW

Approval FEB 18 1994

7/1/98 CLINIC SERVICES: Freestanding Dialysis Center Services

Services are limited to one hemodialysis treatment per recipient, per day, up to three times per week provided by a freestanding dialysis center.

Peritoneal dialysis treatments occur as medically indicated and all care is coordinated by the freestanding dialysis center.

All dialysis treatments include: supervision, management, and training of the dialysis treatment routine, durable and disposable medical supplies, equipment, laboratory tests, support services, parenteral drugs and applicable drug categories (including substitutions) provided by and at the freestanding dialysis center.

7/1/97 TRANSPORTATION: Excludes the provision of transportation by ambulance for ambulatory patients; ambulance services to a physician's private office; transportation to pharmacies; and transportation of nursing home patients to a physician's private office to fulfill utilization control requirements.

Transportation to and from school is allowed for students who are eligible under the provisions of Parts B and H of the Individuals with Disabilities Education Act (I.D.E.A.) and receive Medicaid reimbursable services listed in their Individual Education Plans (IEP) or Family Support Plans (FSP) at the school site on the date transportation is provided. Transportation service must be listed as a required service in the IEP or FSP.

Amendment 97-10
Effective 7/1/97
Supersedes 93-02

Approval 9/18/97

(10)
(12.b)

DENTAL SERVICES: For non-EPSDT recipients twenty-one years of age and older, services that are provided in accordance with 42 CFR 440.100 and 440.120(b) are limited to:

a. Dentures. The dental services provided are limited to procedures related to dentures and those procedures necessary to seat the dentures. The recipient is limited to either a complete upper denture, a complete lower denture, or one complete set of dentures per lifetime. Replacement of broken or lost dentures is excluded from coverage. Repairs of dentures are covered services. Adjustments and relines are covered after three months for immediate dentures and six months for non-immediate dentures from the date of service.

b. Partial Dentures. The dental services provided are limited to the fabrication, repair, reline and adjustment of a removable partial denture. The recipient is limited to either an upper partial, a lower partial, or one set of partials per lifetime. Replacement of a broken or lost partial is excluded from coverage. Adjustments and relines are covered up to six months after original seating of partial. Repairs of partial dentures are covered.

c. Oral and maxillofacial surgery for injury or disease when provided by a qualified oral surgeon (dentist).

d. Emergency dental services are medically necessary emergency procedures to relieve pain or infection. The services are limited to emergency oral examinations, necessary radiographs, extractions, and the incision and drainage of an abscess.

Dental services limitations for EPSDT recipients, provided in accordance with 42 CFR 441.56, are listed in the EPSDT section.

10/1/97 (6b) Optometric Services

For non-EPSDT recipients twenty-one years of age and older, visual examinations are limited to two per year per recipient for the purpose of determining the refractive powers of the eyes. Exception authorization for any service limitation may be made by the state agency based on medical necessity. Service limitations for EPSDT recipients are listed in the EPSDT section.

Amendment 97-17
Effective 10/1/97
Supersedes 93-02

Approval 1/20/98

For non-Early and Periodic Screening and Diagnosis recipients 21 years of age and older:

12d. Description - Eyeglasses
Visual aid services provide visual aids to recipients to alleviate visual impairments.

Who Can Receive
Visual aid services are available to Florida Medicaid recipients 21 years of age or older who require medically necessary visual aid services.

Who Can Provide
Practitioners certified or licensed within their scope of practice:

- Optometrist and certified optometrist licensed in accordance with Chapter 463, F.S.
- Ophthalmologist licensed in accordance with Chapter 458, F.S.
- Optician licensed in accordance with Chapter 484, F.S.

Allowable Benefits

- Eyeglasses
  Up to one frame every two years
  Up to two lenses every 365 days

- Additional eyeglass frames, lenses, pairs of glasses, and special order frames may be provided with prior authorization by the Agency for Health Care Administration or its designee

- Contact lenses
  For limited conditions and requires prior authorization by the Agency for Health Care Administration or its designee

- Prosthetic eyes and services related to measuring, fitting, and dispensing

Service limitations for EPSDT recipients are listed in the EPSDT section.

For non-Early and Periodic Screening and Diagnosis recipients 21 years of age and older:

11c. Description

Hearing services are designed to provide screening, assessment, testing, or corrective services to recipients in order to detect and mitigate the impact of hearing loss in accordance with Title 42, Code of Federal Regulations, section 440.110 (c).

Who Can Receive

Hearing services are available to Florida Medicaid recipients 21 years of age or older who require medically necessary hearing services.

Who Can Provide

Practitioners certified or licensed within their scope of practice:

- Audiologists licensed in accordance with Chapter 468, F.S.
- Physicians licensed in accordance with Chapter 458 or 459, F.S., with a specialty in otolaryngology or otology
- Audiology assistants or provisionally licensed individuals directly supervised by a federally qualified and Florida-licensed audiologist

Allowable Benefits

- Diagnostic audiological tests
- Corrective services, when clinical improvement can be reasonably expected.
- One routine hearing assessment or reassessment every three years. This limit can be exceeded when medically necessary.

Service limitations for recipients under the age of 21 years are listed in the Early and Periodic Screening Diagnosis and Treatment section.

For non-Early and Periodic Screening and Diagnosis recipients 21 years of age and older:

12c. Description

Hearing devices are provided to recipients in order to mitigate the impact of hearing loss.

Who Can Receive

Hearing device services are available to Florida Medicaid recipients 21 years of age or older who require medically necessary hearing services.

Who Can Provide

In accordance with section 440.120, prosthetic devices must be prescribed by a physician or other licensed practitioner of the healing arts. Practitioners certified or licensed within their scope of practice include:

- Audiologists licensed in accordance with Chapter 468, F.S.
- Hearing aid specialists licensed in accordance with Chapter 484, F.S.
- Physicians licensed in accordance with Chapter 458 or 459, F.S., with a specialty in otolaryngology or otology
- Audiology assistants or provisionally licensed individuals directly supervised by a federally qualified and Florida-licensed audiologist

Allowable Benefits

- BAHA up to one per ear with prior authorization by the Agency for Health Care Administration (AHCA) or its designee
- Cochlear implant up to one per ear with prior authorization by the AHCA or its designee
- Repairs and replacements of implant external parts after the one year warranty period has expired.

Service limitations for recipients under 21 years are listed in the Early and Periodic Screening Diagnosis and Treatment section.

HOSPICE SERVICES

10/1/89 Benefit periods are the same as those established by Medicare.

Amendment 93-02
Effective 1/1/93
Supersedes NEW

Approval APR 22 1993

NURSING FACILITY SERVICES

1/1/91 Individuals who are mentally ill or mentally retarded can only receive nursing services in accordance with the preadmission screening and annual resident review requirements of section 1919(b)(3)(F) and (e)(7) of the Act.

EXTENDED SERVICES FOR PREGNANT WOMEN

4/1/93 The same services that are offered to any categorically needy recipient, as described in Attachment 3.1-A, are available to women for 60 days after the pregnancy ends. No additional coverage beyond what is provided to the general categorically needy recipient is provided and the group receiving services under this provision are subject to the same service limitations as the general categorically needy recipients as outlined in Attachment 3.1-A.

Ten prenatal obstetrical visits to low risk pregnant women and fourteen visits to high risk pregnant women are provided. Additional visits can be authorized if the Medicaid program medical consultant finds the additional visits medically necessary.

## Tobacco Cessation Counseling Services for Pregnant Women

4. d **1) Face-to-Face Tobacco Cessation Counseling Services provided:**

1-1-14 (i) By or under supervision of a physician; and

(ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; or*

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.)

*describe if there are any limits on who can provide these counseling services

**2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women**

Provided: No limitations X With limitations*

Please describe any limitations:

*Pregnant women are allowed up to two (2) quit attempts per 12 month period and as many as four (4) counseling sessions per quit attempt.

Amendment 2014-001
Effective 01/01/14
Supersedes New
Approval 03-21-14

7/1/98 OTHER PRACTITIONERS SERVICES

(6d) RESPIRATORY THERAPY: Services are available for non-EPSDT recipients 21 years of age and older in the outpatient and inpatient hospital settings and in nursing facilities. Refer to the EPSDT section for EPSDT limitations.

Amendment 98-14
Effective 7/1/98
Supersedes NEW
Approval 10/12/98

PERSONAL CARE SERVICES

(23f) Description

Personal care services are not available for non-EPSDT recipients 21 years of age and older. Service limitations for EPSDT recipients are listed in the EPSDT section.

PRIVATE DUTY NURSING SERVICES

10/1/90 (8) No services are available for non-EPSDT recipients 21 years of age and older. Refer to the EPSDT section for EPSDT limitations.

Amendment 93-02
Effective 1/1/93
Supersedes NEW

Approval APR 22 1993

1/01/2003 THERAPIES

(11a) Physical Therapy: Services are available for non-EPSDT recipients 21 years of age and older in the outpatient and inpatient hospital settings and in nursing facilities, and in community settings for the provision of wheelchair evaluations, re-evaluations, and fittings. Refer to the EPSDT section for EPSDT limitations.

(11b) Occupational Therapy: Services are available in nursing facilities for non-EPSDT recipients 21 years of age and older, and in community settings for the provision of wheelchair evaluations, re-evaluations, and fittings. Refer to the EPSDT section for EPSDT limitations.

(11c) Speech Therapy: Services are available in nursing facilities for non-EPSDT recipients 21 years of age and older. In addition, for non-EPSDT recipients 21 years of age and older, one initial evaluation for Augmentative and Alternative Communication (AAC) systems and eight (8) 30-minute fitting/adjustment/training sessions for AAC systems are available per person, per device, per year. Refer to the EPSDT section for EPSDT limitations.

Amendment 2003-03
Effective 1/01/2003
Supercedes 98-14
Approved 05/30/03

Nurse Midwives

7/1/2011 Nurse Midwives provide services to recipients with medically low risk pregnancies for prenatal, delivery and postpartum care, within their scope of practice under State law.

The following is a list of items and services furnished in nursing facilities that are reimbursed under the NF per diem rate. The recipient can not be charged for these items or services.

1. Room and board including all of the items necessary to furnish a resident's room;
2. Dietary, rehabilitative and nursing services including the professional handling and personal care of the resident;
3. Medical supplies provided for a resident when medically necessary, including:
   - Catheters, catheter irrigation trays, and related supplies.
   - Bandages, adhesive strips, dressings and sterile gauze.
   - Linen savers, diapers, waterproof pads, rubber pants, and sanitary napkins.
   - Needles and syringes.
   - Air matresses, neoprene plastic pads, bed pads, heel protectors, and sheepskins.
   - Laxatives - at least one product of each of the following categories: bulk, fecal softner, irritant, saline, emollient, enema.
   - Non-legend analgesics - at least one product of each of the following categories: asprin, acetaminophen, ibuprofen.
   - Non-legend antacid - at least one product of each of the following categories: Magnesium hydroxide and aluminum hydroxide with or without Simethicone, Aluminum hydroxide.
   - Non-legend vitamins - at least one product of each of the following categories: oil and water soluble multiple vitamins without minerals, oil and water soluble multiple vitamins with minerals, ferrous sulfate, ferrous gluconate and ferrous fumarate products, therapeutic multivitamin mineral combination, B-complex with vitamin C, stress formula.
   - Dietary supplements, salt and sugar substitutes, and tube feedings.
   - Medicinal alcohol, hydrogen peroxide, astringents, tinture benzoin, bulk epsom salts for soaking, and providone-iodine ointment and solution.
   - Cotton balls, tissue, applicators, body oil or body lotion, powder, lemon glycerin swabs, and cotton swabs.
   - Colostomy bags and related supplies and ileostomy supplies.
   - Non-legend cough preparation - at least one product of each of the following categories: expectorant, combination of expectorant and cough suppressant.
   - Blood glucose strips.
   - Topical anti-bacterial preparation.
   - Bland ointment.
   - Ophthalmic lubricant.
   - Oxygen and the equipment and supplies needed to dispense the oxygen.
   - First aid supplies.
   - Anti-diarrheal preparation.
   - Moisturizing spray and ointment for treatment of pressure sores.
   - Absorbent bladder control garments and external catheters.
   - Sterile saline solution for wound dressing.
4. Medical equipment to be available for use by the resident on a short-term basis but not for the exclusive use of the resident on a long-term ongoing basis which shall include at a minimum, the following: wheelchairs, geri-chairs, walkers, crutches and canes, bedside commodes.
5. Medical equipment for use by or on a resident when determined medically necessary: traction equipment, blood pressure equipment, oral and rectal thermometers, protective restraints, suction equipment.
6. Routine personal hygiene items and services including but not limited to: hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razors, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, hair and nail hygiene services, bathing supplies, basic personal laundry, incontinence care, water pitcher and drinking glass, wash pan, emesis basin, bedpan and urinal, and straws.

Amendment 93-58
Supersedes 93-02
Effective 10/1/93
Approval 2-18-94

**Covered Legend Drugs:**

Covered outpatient drugs are those produced by any manufacturer that has entered into and complies with an agreement under Section 1927(a) of the Act, and which are prescribed for a medically accepted indication. Drugs must be prescribed and dispensed in accordance with medically accepted indications for uses and dosages.

Coverage for immunizations is limited to the following recipients who are not covered by Medicare Part D:

- Influenza and pneumococcal vaccine for institutionalized recipients age 21 through 64 ; and
- Herpes Zoster (Shingles) vaccine for institutionalized recipients age 60 through 64

Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B as provided by Section 1935 (d)(1) of the Act.

The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D.

As provided by Section 1927(d)(2) of the Act, certain outpatient drugs may be excluded from coverage. Those excluded are DESI drugs; experimental drugs; anorectics (unless prescribed for an indication other than obesity); non-legend drugs (except as specified below), aspirin, aluminum and calcium products used as phosphate binders, sodium chloride for specific medical indications; and any drugs for which the manufacturer has not entered into rebate agreements with the Department of Health and Human Services, the Veteran's Administration and the Public Health Service.

As provided by Section 1935(d)(2) of the ACT:

☑ **The following excluded drugs are covered:**

☐ (a) agents when used for anorexia, weight loss, weight gain
☑ *None of the drugs under this drug class are covered*

☐ (b) agents when used to promote fertility
☑ *None of the drugs under this drug class are covered*

☐ (c) agents when used for cosmetic purposes or hair growth
☑ *None of the drugs under this drug class are covered*

☑ (d) agents when used for the symptomatic relief cough and colds
☑ *Some drugs categories covered under the drug class*

- Legend cough and cold preparations, including antitussives, decongestants, and expectorants are covered for recipients under the age of 21 years.
- Legend or OTC single entity guaifenesin products are covered for all recipients.

☑ (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride.

☑ *Some drug categories covered under the drug class*

- Legend vitamin and mineral products are covered for dialysis patients.

☑ (f) nonprescription drugs

☑ *Some drug categories covered under the drug class*

- Aspirin; 650mg acetaminophen tablets; aluminum and calcium products used as phosphate binders; sodium chloride for specific medical indications for all recipients

When prescribed the following OTC medications that have previously been legend drugs are covered:

- Topical antiparasitics
- Vaginal antifungals
- OTC single-entity antihistamines (Loratidine and Cetirizine with age restrictions on liquids) and antihistamine-decongestant combinations (Loratidine D and Cetirizine D with age restrictions on liquids).

☐ (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee

☑ *None of the drugs under this drug class are covered*

Drug Rebate Agreement: The state is in compliance with Section 1927 of the Act. Based on the requirements for Section 1927 of the Act, the state has the following policies for drug rebate agreements:

- The drug file permits coverage of participating manufacturers' drugs.
- Compliance with the reporting requirements for state utilization information and restrictions to coverage.

- A supplemental rebate agreement, Version 05/20/2013, between the state and a drug manufacturer that is separate from the drug rebate agreements of Section 1927 is authorized by the Centers for Medicare and Medicaid Services. The agreement to be used between the State of Florida and drug manufacturers for supplemental rebates for drugs provided to the Medicaid population has been reviewed and authorized by the Centers for Medicare and Medicaid Services. The state reports rebates from separate agreements to the Secretary for Health and Human Services. The state will remit the federal portion of any cash state supplemental rebates collected.

- Manufacturers are allowed to audit utilization data.

- The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification.

- Prior authorization programs provide for a 24-hour turn-around on prior authorization from receipt of a completed request, and at least a 72-hour supply in emergency situations.

**13c** **Preventive Services:**

10/1/09 Licensed Medicaid providers practicing within their scope of practice will administer the H1N1 influenza vaccine to adult recipients age 21 and over, following recommendations by the Centers for Disease Control and Prevention.



Amendment TN: 2009-025
Effective: 10/1/09
Supersedes: NEW
Approval Date: 02-04-10

## 13c Preventive Services for Pregnant Women:

Licensed Medicaid providers practicing within their scope of practice will administer the influenza vaccine to adult pregnant female recipients age 21 and over. The reimbursement rate will be the same as those vaccines that are covered for Medicaid recipients between the ages of 18-20, and will be effective for dates of service between and including December 19, 2013 through March 31, 2014.

THIS PAGE INTENTIONALLY LEFT BLANK

Rural Health Clinic Services

Services are limited to one visit per day in a rural health clinic. Exceptions will be granted based on medical necessity. For example, a recipient seen at a rural health clinic who subsequently experiences an accident or his condition worsens, may seek the necessary additional medical care from the rural health clinic on the same day.

Federally Qualified Health Center Services

Services provided in a federally qualified health center are limited to one medical, one dental, and one mental health visit per day, per recipient. Exceptions will be granted based on medical necessity. For example, a recipient seen at a federally qualified health center who subsequently experiences an accident or his condition worsens, may seek the necessary additional medical care from the federally qualified health center on the same day.

Other Laboratory Services

The recipient must be referred by a physician or other practitioner of the healing arts and the services must be performed in a Clinical Laboratory Improvement Amendment of 1988 (CLIA) certified independent laboratory.

Other X-Ray Services

The service must be ordered by a physician or other practitioner of the healing arts and must be provided in either:
(1) a physician's office, including an independent, private, diagnostic x-ray facility; or
(2) if the recipient is homebound, at the recipients' residence, including an ICF/MR or nursing home.

Inpatient psychiatric services for individuals in institutions for mental diseases

Inpatient psychiatric services are provided to high-risk recipients who have experienced multiple admissions into psychiatric units in acute care hospital settings or have longer than the state's average length of stay in these settings. For individuals age 65 and older, Medicaid will provide extended inpatient psychiatric treatment in state treatment facilities licensed under Chapter 395, Florida Statutes.

For the purpose of cost sharing for Qualified Medicare Beneficiaries, Medicaid payments for qualified private freestanding specialty psychiatric hospital inpatient services shall be limited to the Medicare deductible per spell of illness and coinsurance for qualified Medicare beneficiaries. Medicaid payments for these services shall be limited to the Medicaid established qualified Medicare beneficiary rate less any amounts paid by Medicare, but only up to the amount of Medicare coinsurance. The Medicaid rate shall be the rate in effect for the dates of service of the crossover claims and may not be subsequently adjusted due to subsequent per diem adjustments.

Admissions and continued stays may be subject to utilization review. Medical necessity criteria include: a reasonable course of acute inpatient treatment has failed to bring about adequate resolution of symptoms; the recipient's condition requires services on an inpatient basis under the direction of a physician; services can be expected to improve the recipient's condition or prevent regression; and ambulatory care resources available in the community do not meet treatment needs. Recipients who meet level of care criteria must receive active treatment in accordance with an individual plan of care. Service components include psychiatric, medical, psychological assessment and diagnosis; psychiatric and routine medical treatment; clinical and therapy services; family or other caregiver involvement; peer support groups; recreational and vocational services, when appropriate; and comprehensive discharge, after care and follow-up services.

Intermediate Care Facility Services

Intermediate Care Facility services for individuals with Intellectual Disabilities (ICF/IID) may be provided in accordance with 42, CFR 440.150 and 442, Subpart C, by facilities licensed in accordance with Chapter 400, Part VIII, F.S. for recipients with an intellectual disability, or other related condition.

Limitation:

1) The recipient's need for ICF/IID services must be determined by the agency's designee based on medical necessity.

Ambulatory Prenatal Care

All prenatal services are provided except for inpatient hospital services.

Nursing Facility Services for Patients under 21 years of Age

Recipient's need must be determined by the agency based on medical necessity.

Licensed Midwives

7/1/2011 Licensed Midwives provide services to recipients with medically low risk pregnancies for prenatal, delivery and postpartum care, within their scope of practice under State law.

# PHYSICIAN ASSISTANT SERVICES

(6d) Description

Physician assistant services are provided to maintain the recipient's health, prevent disease, and treat illness, in accordance with 42 CFR 440.60.

Who Can Receive

An eligible recipient enrolled on the date of service, and requiring a medically necessary medical service.

Who Can Provide

Physician assistants licensed within their scope of practice to perform this service.

Allowable Benefits

- Health screenings for recipients under the age of 21 years in accordance with the American Academy of Pediatrics periodicity schedule.
- Office visits as medically necessary for recipients under the age of 21 years and pregnant recipients age 21 years and older.
- Up to two primary care office visits per month for recipients age 21 years and older.
- Up to one evaluation and management visit per month, per recipient in a custodial care or nursing care facility.
- Up to one adult health screening every 365 days for recipients age 21 years and older.

Exceptions to the limits will be authorized on a case by case basis and will be evaluated based on medical necessity.

Amendment 2016-022
Effective 8/15/16
Supersedes 2012-014
Approval 10-12-16

7/1/97 (6d) REGISTERED NURSE FIRST ASSISTANT:

Assistant at surgery fees are limited to surgical codes that allow an assistant surgeon.

Amendment 97-08
Effective 7/1/97
Supersedes NEW
Approval 8/25/97

Inpatient Psychiatric Services for Individuals under 21

Inpatient Psychiatric Services for Individuals under 21 are provided to high-risk recipients who have experienced multiple admissions into psychiatric units in acute care hospital settings or who have longer than the state's average length of stay in these settings.

For individuals under age 18, this service will provide extended inpatient psychiatric treatment in Residential Treatment Centers licensed under Chapter 394, Florida Statutes, or in a hospital licensed under Chapter 395, Florida Statutes. Providers must be accredited by the Joint Commission on Accreditation of Health Care Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children or a comparable nationally recognized accrediting organization.

Admissions and continued stays are subject to certification of need for this level of care. These criteria include: a reasonable course of acute inpatient treatment has failed to bring about adequate resolution of symptoms; the recipient's condition requires services on an inpatient basis under the direction of a physician; services can be expected to improve the recipient's condition or prevent regression; and ambulatory care resources available in the community do not meet treatment needs. Recipients who meet level-of-care criteria must receive active treatment in accordance with an individual plan of care. Service components include psychiatric, medical, psychological assessment and diagnosis; psychiatric and routine medical treatment; clinical and therapy services; mandatory family or other caregiver involvement; peer support groups; recreational and vocational services, when appropriate; a certified education program; and comprehensive discharge, after care and follow-up services.

Comparable services for individuals 18 to 21 years of age are provided through extended stays in acute care psychiatric care settings until symptoms are resolved to permit admission into intensive treatment services in the community. Florida Assertive Community Treatment Programs for persons with severe and persistent mental illnesses are available statewide to individuals 18 and over. These services provide intensive, psychiatric, rehabilitation, and support services for persons with severe and persistent mental illnesses. The program is designed to reduce the frequency and duration of hospitalization, increase functioning and improve quality of life in the community. Additionally, this age group has access to residential treatment services and state mental hospitals, funded through the Florida Department of Children and Families, if longer-term inpatient services are deemed necessary.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

CASE MANAGEMENT SERVICES

A. **Target Group:** By invoking the exception to comparability allowed by 1915 (g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are: (see page 2)

B. **Areas of State in which services will be provided:**

/x/ Entire State.

/ / Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

/ / Services are provided in accordance with section 1902(a)(10)(B) of the Act.

/x/ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. **Definition of Services:** Case management is defined as those activities which assist eligible individuals in gaining access to needed medical, social, educational and other support services. Consistent with the requirements of Section 1902 a (23) of the Act, the providers will insure that clients receive services to which they are referred. These activities may include but are not limited to: (see page 2)

E. **Qualification of Providers:**

Case management providers must be certified by the department as meeting the following criteria:

1. Demonstrate capacity to provide all core elements of case management services including:

   a. Comprehensive client assessment
   b. Comprehensive care/service plan development (see page 2)

State/Territory: FLORIDA

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

A. continued from page 1

1. Aged 0-21 and meet the medical eligibility criteria of Children's Medical Services (CMS), the states Title V Crippled Children's Agency,
2. SSI-Disabled Children's Program Clients age 0-16, or
3. Aged 21 and over with a handicapping condition and who had received services from Children's Medical Services before their 21st birthday.
4. Not receiving case management services under an approved 1915(c) waiver program.

D. continued from page 1

1. assessment of clients' medical, social and functional status and identification of client service needs,
2. arranging for service delivery from the clients chosen provider to insure access to required services,
3. periodic review and reassessment of client functional status and service needs,
4. insure access to needed services by explaining the need and importance of services in relation to the clients condition,
5. insure access, quality and delivery of necessary services and,
6. preparation and maintenance of case record documentation to include service plans, forms, reports and narratives, as appropriate.

E. continued from page 1

c. Linking/coordination of services
d. Monitoring and follow-up of services
e. Reassessment of the client's status and needs

2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population.

3. Demonstrated experience with the target population. (See page 3)

E. Continued from page 2

4. An administrative capacity to insure quality of services in accordance with State and federal requirements.

5. A financial management capacity and system that provides documentation of services and costs.

6. Capacity to document and maintain individual case records in accordance with State and federal requirements.

7. Consistent with Section 1902 a (23), demonstrate a capacity for referral to acute care facilities for patients with special health needs. Such facilities should have and average daily census of fifteen children, excluding normal newborn and neonatal intensive care patients. The facilities must also have defined pediatric units and preferably have pediatric intensive care centers and neonatal intensive care centers. The facilities must accept Medicaid patients.

Qualifications of Case Managers:

1. Licensed to practice as a registered professional nurse in the State of Florida and be employed as a community health nurse at the entry level or above, or

2. Hold a bachelors degree from an accredited university with emphasis in the areas of psychology, social work, health education or interdisciplinary sociology or

3. Able to demonstrate to the department that comparable qualifications are met.

4. The staff must have received approved departmental training appropriate to their area of speciality.

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

CASE MANAGEMENT SERVICES

A. Target Group: By invoking the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who:

1. Are aged 0 to 18 and are Medicaid eligible.

2. Have a serious emotional disturbance as indicated by:

   a. A defined mental disorder diagnosable under DSM III-R or current edition.

   b. A level of functioning of disability which requires two or more coordinated and integrated mental health services to enable the person to live in a home in the community and be successful in school.

   c. The duration of the disability which will, in professional judgement, last for at least one year.

B. Areas of State in which services will be provided:

/X/ Entire State.

/_/ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

/_/ Services are provided in accordance with section 1902 (a)(10)(B) of the Act.

State/Territory: FLORIDA

/X/ Services are not comparable in amount, duration and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services: Case management is defined as those activities which assist eligible individuals in gaining access to needed medical, social, mental, substance abuse, educational and other support services. These activities may include but are not limited to:

1. Assisting the eligible individual and his or her mental health professionals in obtaining the necessary assessment to adequately develop a plan of care;

2. Developing and reviewing the plan of care;

3. Assuring access to the needed services documented in the plan of care;

4. Monitoring and reviewing the plan of care with other mental health professionals;

5. Advocating for the eligible individual at service planning meeting;

6. Referring to service providers and establishing a linkage between providers for eligible individuals;

7. Assessing and reassessing the need for services;

8. Monitoring the quality of care;

9. Preparing and maintaining case record documentation to include service plans, forms reports and narratives as appropriate; and

10. Ensuring access to needed services by explaining the need and importance of the services in relation to the individual's condition.

State/Territory: FLORIDA

E. Qualifications of Providers:

1. Case management providers must be under contract with and certified annually by the Office of Alcohol, Drug Abuse and Mental Health as meeting the following criteria:

   a. Have adequate administrative capacity to assure availability and accessibility of qualified case managers;

   b. Have the ability to recruit qualified case management staff to serve the target group;

   c. Have administrative capacity to insure quality of services in accordance with state and federal requirements;

   d. Is community based and has established linkages with residential and non residential treatment services;

   e. Have adequate in-service training capability to assure the competent case management knowledge, skills and abilities of all case managers;

   f. Maintain programmatic records which show that the agency is able to develop and maintain assessment and services documentation; and

   g. Have financial management capacity and systems that provide documentation of costs.

2. Individual case managers must be employed by an agency certified to provide case management services and who meet the following qualifications:

   a. Must have a minimum of a baccalaureate degree from an accredited university, with emphasis in the areas of psychology, social work, health education or a related human services field;

   b. Must have a minimum of one year of experience working with children who have serious emotional disturbances; or

State/Territory: FLORIDA

c. Must be able to demonstrate that comparable degree and experience are met.

d. Must be knowledgeable of the residential and nonresidential resources available in the geographic area served.

f. Must demonstrate capacity to provide case management services.

g. Must be knowledgeable of, and comply with, the statutes, rules and policies which affect the target population.

h. Must have completed or complete within one year of enrollment as a case manager, Health and Rehabilitative Services approved case management training and complete periodic retraining as required by the Alcohol, Drug Abuse, and Mental Health Program Office.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payment made to public agencies or private entities under other program authorities for this same purpose.

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

CASE MANAGEMENT SERVICES

A. Target Group: By invoking the exception to comparability allowed by 1915 (g) (1) of the Social Security Act, this service will be reimbursed when provided to persons who:

1. Are aged 18 or older that are Medicaid eligible.

2. Are in need of case management services as evidenced by a physician's order.

3. Have a serious emotional disturbance as indicated by a defined mental disorder diagnosable under DSM III-R or current edition.

4. Are defined as a priority client in active status under sections 10E-15.031 and 10E-15.041, Florida Administrative Code.

5. Have been approved for case management services by the district Alcohol, Drug Abuse and Mental Health Program Office.

B. Areas of State in which services will be provided:

/X/ Entire State.

/_/ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

/_/ Services are provided in accordance with section 1902 (a)(10)(B) of the Act.

/X/ Services are not comparable in amount, duration and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

State/Territory: FLORIDA

D. **Definition of Services:** Case management is defined as those activities which assist eligible individuals in gaining access to needed medical, social, mental, educational and other support services. These activities may include but are not limited to:

1. The completion of an overall assessment of the individual's living situation, strengths and weaknesses, needs and resources and the strengths and weaknesses of the individual's support system;

2. The development of the individual's plan of care which comprehensively addresses his or her needs;

3. Linking the client with specified services and resources as identified in the service plan to the extent appropriate;

4. Advocating for the acquisition of services and resources as necessary to implement the service plan;

5. Coordinating the delivery of services as specified in the service plan;

6. Working with the clients, families and natural support system, as appropriate;

7. Monitoring service delivery to continually evaluate recipient status and the quality of service provided;

8. Periodic reviewing and updating of service plans and records, and documenting case management activities according to state standards and recipient needs.

E. **Qualifications of Providers:**

1. Case management providers must have a contract with the department to provide community mental health services and be certified by the district Alcohol, Drug Abuse and Mental Health Program Office as meeting the following criteria:

   a. Adequate administrative ability to provide case management services to the target population.

State/Territory: FLORIDA

b. Have the ability to recruit qualified case management staff to serve the target group and assure availability and accessibility of case managers;

PEI 5-5-92 HCFA

c. Have knowledge~~able~~ of and comply with the statutes, rules and policies which affect the target population;

d. Have administrative capacity to insure quality of services in accordance with state and federal requirements;

e. Have established linkages with the resources available in the geographical area served;

f. Have adequate inservice training capability to assure competent case management knowledge, skills and abilities of all case managers;

g. Maintain individual and programmatic records which comply with state and federal documentation requirements, including the registration of case management clients;

h. Maintain a financial management capacity and systems that provide documentation of costs; and

i. Involve district Alcohol, Drug Abuse and Mental Health office staff in case management services related activities and be responsive to corrective action plans.

2. Individual case managers must be employed by an agency certified to provide case management services and meet the following qualifications:

a. Must have a minimum of a baccalaureate degree from an accredited university, with major course work in the areas of psychology, social work, health education or a related human services field, or

State/Territory: FLORIDA

b. Must have two years of undergraduate course work or Associates degree related to the field and year for year experience in mental health equivalent to the educational requirements in a.

c. Must have completed or complete within one year of enrollment, Health and Rehabilitative Services approved case management training and complete periodic retraining as required by the Alcohol, Drug Abuse, and Mental Health Program Office.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payment made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Florida

CASE MANAGEMENT SERVICES

**A. Target Group:**

By invoking the exception to comparability allowed by 1915 (g) (1) of the Social Security Act, this service will be reimbursed when provided to:

All Medicaid eligible children, ages 0-21, who have been placed under protective supervision by a protective investigator based on a determination of either some indication of maltreatment or verified maltreatment, or have been court ordered into shelter or foster care. (See Chapters 415 and 39, F.S.)

**B. Areas of the State in which services will be provided:**

The authority of section 1915 (g) (1) of the Act is invoked to provide services on a less than statewide basis. Services shall be provided in Sarasota, Manatee, Pasco and Pinellas Counties.

**C. Comparability of Services:**

Services are not comparable in amount, duration and scope. Authority of section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of section 1902 (a) (10) (B) of the Act.

**D. Definition of Services:**

Case management is defined as those activities which will assist individuals eligible under the Plan in gaining access to needed medical, social, educational, and other services. The case manager, in partnership with the child, family, significant others, or identified caregivers, facilitates access to and coordinates the services, treatments and supports necessary to achieve the goals and objectives stated in the service plan.

Case management activities include:

1. Completion of a comprehensive needs assessment which identifies the service needs of the child. The process of completing the needs assessment includes assisting the eligible child in obtaining access to providers who will perform the full range of assessments necessary to identify the biological, psychological, social, developmental and environmental aspects of the child's needs.

2. Assuring access to the needed services and supports which have been identified in the assessment of the eligible child and are reflected in the child's service plan.

3. Ongoing monitoring and follow-up of the services and supports being provided as indicated in the service plan. This includes determining the degree to which the plan is being followed, progress is being achieved on plan objectives, and ensuring that services are coordinated with the active participants in the child's life. Monitoring is accomplished through face-to-face, telephone, or written contact with the child or others on behalf of the child (physicians, therapists, teachers, other service providers, etc.), as appropriate.

4. Development of a service plan that identifies services, assistance, and activities which are needed to address the child's needs that are represented in the comprehensive needs assessment. Service planning includes participating in meetings with the child, family members and appropriate others (physicians, therapists, teachers, other service providers) to develop goals, objectives and tasks directed toward addressing the child's needs in all areas. The case manager is responsible for activities that will assure that the unique needs of the child are being addressed, and for promoting integration and continuity of services.

5. Developing referral review packets.

6. Referring the child to service providers and establishing a linkage between providers for the child .

7. Activities to assist the child in accessing needed services and service providers so that the objectives and goals identified in the service planning documents can be achieved. The case manager is responsible for coordinating and ensuring continuity of services (social, medical, educational, etc.) for the child by multiple providers, involving and updating them on developments in the child's situation and advocating on behalf of the child for needed community resources.

8. Communicating and collaborating with the biological parents or other family members as appropriate regarding the child's care, needs and progress if the child is in foster/out of home care.

9. Making home visits and phone calls for the purpose of assessing, arranging, integrating and coordinating the services and supports which have been identified as necessary to achieve the child's stability.

10. Encouraging and supporting the child and family's participation in the services offered as part of the case plan.

Activities that are not included are:

1. Title IV-E eligibility determination and redetermination.

2. Initial and annual adoption subsidy development, review, and processing.

3. Transportation.

4. Consultation with child welfare legal services, preparing legal documents, court preparation and appearances, staff travel related to court preparation and appearances.

5. Performing adoption pre-placement and placement activities, arranging termination of parental rights.

6. Placement services including locating initial out-of-home care, managing the disruption of a placement and re-placement if necessary. Working with the foster family to avoid disruptions and coordination of placement visits.

7. Relative Caregiver Program oversight.

**E. Qualifications of Providers:**

Providers will be approved and certified by either the designated public entity or the eligible lead community based privatization provider. (Chapter 409.1671, F.S.) Payment for services will be made to the case management provider. The public or community based provider will accept applications for provider enrollment from any provider meeting the following requirements:

1. Agency providers must meet all of the following criteria:

   a. Be knowledgeable of and comply with state and federal statutes, rules and policies that pertain to this service and target population.

   b. Have the ability to administer case management services to the target population as evidenced by sufficient numbers of managerial staff, targeted case management supervisors and certified case managers.

   c. Be a community based provider agency with at least five years of prior professional experience with this target population.

d. Have the financial management capacity and system to provide documentation of costs.

e. Have established linkages with the local network of human services providers, schools and other resources in the service area.

f. Have a Quality Improvement Program with written policies and procedures, which include an active case management peer review process and ongoing recipient and family satisfaction surveys.

g. Have established pre-service and in-service training programs that promote the knowledge, skills, and competency of all case managers.

h. Have an established credentialing process which will assess and validate the qualifications of all case managers and supervisors of case managers.

i. Have the capacity to provide supervision by a person who has a Masters degree in a human services field and three years of professional case management experience or other professional experience serving this target population. In addition, the individual must have completed the state approved child welfare and case management training and any other training, including periodic retraining, which is required and offered by the Department of Children and Families.

j. Maintain for a period of five years after the delivery of service, programmatic records that include clearly identified targeted case management certifications for eligibility, assessments, services plans and service documentation.

k. Cooperate with and participate in monitoring conducted by the Agency for Health Care Administration and the Department of Children and Families, Office of Family Safety and Preservation.

2. Agency providers agree that the services identified below shall constitute the minimum amount of service to be provided by the targeted case manager to the child on a monthly basis.

a. A home visit which shall include a face-to-face meeting with the child. The home visit shall be for the purpose of assessing the child and family's progress toward the achievement of the goals and objectives which specifically pertain to the child's needs and stability in the living environment and are stated in the service plan.

b. The case manager shall have verbal (i.e., telephonic or face-to-face) or written contact with a minimum of two separate providers who are rendering services

to the child or the child's family as related to assisting the child toward achievement of identified needs. This contact shall be for the purpose of determining whether the child, and family as appropriately related to meeting the child's needs, are responding to services and if said services are appropriate and rendered at the correct level of intensity.

c. A second face-to-face visit with the child, which may occur in the home or in the setting in which the child spends most of his or her time. The case manager shall observe the child and assess whether or not his or her level of functioning has remained unchanged, improved, deteriorated or stabilized.

d. The case manager shall complete or obtain at least one of the following:
   1. A client satisfaction survey
   2. A Current Status Summary that includes descriptions of functional issues, behavior problems, or developmental concerns. The summary is developed by gathering information from various service providers, teachers, family members or caretakers, and other significant individuals involved in the child's life.

   or

   3. A comprehensive summary statement which depicts the child's progress toward the achievement of established goals and objectives and addresses the status of the child's stability within the identified living environment.

3. Individual case manager providers must meet all of the following criteria:

   a. Be employed by or under contract with an agency that has been certified by the Agency for Health Care Administration as qualified to provide case management services to the target population.

   b. Have a minimum of a baccalaureate degree from an accredited university, with major course work in the areas of psychology, social work, child development or a related human services field and have a minimum of one year of professional experience working with children who have been abused, neglected or abandoned, or are at risk of abuse, neglect or abandonment.

   c. Have successfully completed the state mandated child welfare and case management training and any other training, including periodic retraining, which is required and approved by the Department of Children and Families.

   d. Be certified by the Department of Children and Families district office as meeting the requirements to be a Children's Protection Group targeted case manager.

e. Be enrolled as a Medicaid approved individual treating provider, Provider Type 32.

f. Specific to the identified service area, have knowledge of the resources that are available for children who are abused, neglected or abandoned or at risk for abuse, neglect or abandonment.

g. Be knowledgeable of, and comply with, the state and federal statutes and rules and policies that pertain to this service and target population.

**F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902 (a) (23) of the Act.**

1. Eligible recipients will have free choice of the individual case management providers.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

**G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.**

1. Providers shall bill a monthly rate of $450.00 per child. In order for reimbursement to occur, the clinical record must contain documentation, which indicates that the services identified above in section E-2a-d, were provided.

REQUIREMENTS AND LIMITS
12-91 APPLICABLE TO SPECIFIC SERVICES 4302.3(Cont.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

**State/Territory:** Florida

## CASE MANAGEMENT SERVICES

**A. Target Group:**

Medicaid eligible children, whose parents request services, who are not receiving Targeted Case Management under another target group or waiver; and who, based on the results of a formal assessment to be delivered to children who voluntarily take part in case management services, must meet one of the following criteria:

1. Is or has been determined to present at least two of the following seven risk factors:

    a) Is the child of a parent who is unable to meet his or her basic needs (access to food, clothing, transportation);
    b) is the child of a parent who has inadequate income and/or housing;
    c) is the child of a parent who is socially isolated/has limited natural supports
    d) is or has been a witness to domestic violence;
    e) is the child of a parent with a history of mental illness requiring treatment or hospitalization;
    f) is the child of a mother who, upon knowledge of pregnancy, used tobacco, alcohol, and/or drugs;
    g) is the child of a mother who received little to no pre-natal care (less than five visits)

2. Is the child of a parent who is or has been a victim of domestic violence.
3. Is the child of a parent suffering from mental health, post-partum depression or substance abuse problems.
4. Is the subject of a report of abuse and neglect made to the Department of Children and Families and/or Community Based Care Lead Agency that did not result in a court order into foster care/shelter care or Protective Supervision.



Amendment 2003-06
Effective 4/1/2003
Supercedes NEW
Approved DEC 23 2003

**B. Areas of State in Which Services Will Be Provided:**

☐ Entire State

☑ Only in the following geographic areas (authority of §1915(g)(1) of the Act is invoked to provide services less than statewide):

Services will be provided in Florida counties where a Children's Services Council (CSC) or local government entity (LGE) exists that funds programs to support children and families in need, currently including Duval County; Palm Beach County; Hillsborough County; Pinellas County; Broward County; Miami-Dade County; and, Martin County.

**C. Comparability of Services:**

☐ Services are provided in accordance with §1902(a)(10)(B) of the Act.

☑ Services are not comparable in amount, duration and scope. Authority of §1915(g)(1) of the Act is invoked to provide services without regard to the requirements of §1902(a)(10)(B).

**D. Definition of Services:**

Targeted Case Management is a set of interrelated activities under which the responsibility for locating, coordinating, and monitoring appropriate services for an recipient rests with a specific person (case manager). The purpose of case management is to assist recipients in the target group to gain access to medical, social, educational, and other services. Targeted Case Management includes:

A. Collecting all assessment data.

B. Developing an individualized plan of care;
C. Coordinating needed services and providers;
D. Making home visits and collateral contacts as needed;
E. Maintaining client case records; and,
F. Monitoring and evaluating client progress and service effectiveness.

Activities that are not included are:

1. All Title IV-E eligibility determination and redetermination;



Amendment 2003-06
Effective 4/1/2003
Supercedes NEW
Approved DEC 23 2003

2. Medicaid eligibility determination and redetermination;
3. Medicaid Outreach;
4. Individual or Group therapy;
5. Transportation; and
6. Title IV.b. and Title XX activities.

**E. Qualifications of Providers:**

Providers will be approved and certified by either the designated public entity or the Children's Services Council. The Children's Services Council will accept applications for provider enrollment for any provider meeting the following requirements:

1. Agency providers must meet all of the following criteria:

a. Be receiving funding from the Children's Services Council/Local Government Entity
b. Be knowledgeable of and comply with state and Federal statutes, rules and policies that pertain to this service and target population.
c. Have the ability to administer case management services to the target population as evidenced by sufficient numbers of managerial staff, targeted case management supervisors and case managers.
d. Be a community based provider agency with a demonstrated capability with this target population.
e. Have the financial management capacity and system to provide documentation of costs.
f. Have established linkages with the local network of human services providers, schools and other resources in the service area.
g. Have a Quality Improvement Program with written policies and procedures, which include an active case management peer review process and ongoing recipient and family satisfaction surveys.
h. Have established pre-service and in-service training programs that promote the knowledge, skills, and competency of all case managers.
i. Have an established credentialing process which will assess and validate the qualifications of all case managers and supervisors or case managers.
j. Have the capacity to provide supervision by a person who has a Bachelor's degree in a human services field and two years of professional case management experience or 3 years of other professional experience serving this target population or any combination thereof.
k. Maintain documentation/programmatic records that include clearly identified targeted case management certifications for eligibility, assessments, service plans and service documentation.
l. Cooperate with and participate in monitoring conducted by the Agency for Health Care Administration and the Children's Services Council.

2. Individual case managers must meet all of the following criteria:

   a. Be employed by or under contract with an agency that has been certified by the Children's Services Council as qualified to provide case management services to the target population
   b. Have a minimum of high school equivalent with a minimum of one year of experience working with children who have been abused, neglected or abandoned, or are at risk of abuse, neglect or abandonment.
   c. Have successfully completed the CSC approved training and any other training including periodic retraining.
   d. Have completed mandated reporter training that addresses abuse and neglect.
   e. Be enrolled as a Medicaid approved individual training provider, Provider Type 32.
   f. Specific to the identified service area, have knowledge of the resources that are available for children who are abused, neglected or abandoned or at risk for abuse, neglect or abandonment.
   g. Be knowledgeable of, and comply with, the state and federal statues and rules and policies that pertain to this service and target population.
   h. Be certified by the certified agency as meeting these requirements.

**F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of §1902(a)(23) of the Act.**

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

**G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.**

A monthly rate will reflect the reasonable and necessary costs for required staff including salaries, taxes, benefits and the associated overhead In order for reimbursement to occur, the clinical record must maintain documentation that the case manager provided all of the following minimum monthly service requirements:

   a. A home visit that shall include a face-to-face meeting with the child. The home visit shall be for the purpose of assessing the child and family's progress toward the achievement of the goals and objectives, which



Amendment 2003-06
Effective 4/1/2003
Supercedes NEW
Approved DEC 23 2003

specifically pertain to the child's needs and stability in the living environment and are stated in the service plan.

b. The case manager shall have verbal (i.e. telephonic or face-to-face) or written contact with at least one provider who is rendering services to the child or the child's family as related to assisting the child toward achievement of identified needs. This contact shall be for the purpose of determining whether the child, and family are responding to services and if said services are appropriate and rendered at the correct level of intensity.

c. A second face-to-face visit with the child which may occur in the home or in the setting in which the child spends most of his or her time. The case manager shall observe the child and assess whether or not his or her level of functioning has remained unchanged, improved, deteriorated or stabilized.

d. The case manager shall complete or obtain at least <u>one</u> of the following:
   i. A client satisfaction survey
   ii. A current status summary that includes descriptions of functional issues, behavior problems, or developmental concerns. The summary is developed by gathering information from various service providers, teachers, family members or caretakers, and other significant involved in the child's life.
   iii. A comprehensive summary statement which depicts the child's progress toward the achievement of established goals and objectives and addresses the status of the child's stability within the identified living environment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES FOR THE CATEGORICALLY NEEDY

1. The State of _____ provides home and community care to functionally disabled elderly individuals to the extent described and defined in this Supplement (and Appendices) in accordance with section 1929 of the Social Security Act.

2. Home and community care services are available Statewide.

   _____ Yes _____ No

   If no, these services will be available to individuals only in the following geographic areas or political subdivisions of the State (specify): _____

3. The home and community care services specified in this Supplement will be limited to the following target groups of recipients (specify all restrictions that will apply):

   a. _____ aged (age 65 and older, or greater than age 65 as limited in Appendix B)

   b. _____ In accordance with §1929(b)(2)(A) of the Act, individuals age 65 or older who were served under a waiver granted pursuant to section 1915(c) of the Act on the date on which that waiver was terminated. Financial eligibility standards for these individuals are specified in Appendix A. Minimum disability standards for these individuals are specified in Appendix B.

   c. _____ In accordance with §1929(b)(2)(A) of the Act, individuals who were served under a waiver granted pursuant to section 1915(d) of the Act on the date on which that waiver was terminated. Financial eligibility standards for these individuals are specified in Appendix A. Minimum disability standards for these individuals are specified in Appendix B.

   d. _____ In accordance with §1929(b)(2)(B) of the Act, individuals who meet the test of disability under the State's §1115 waiver which provides personal care services under the State plan for functionally disabled individuals, and which was in effect on December 31, 1990. Financial eligibility standards for these individuals are specified in Appendix A. Functional disability standards for these individuals are specified in Appendix B.

4. Additional targeting restrictions (specify):

   a. _____ Eligibility is limited to the following age groups (specify): _____

State: FLORIDA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES FOR THE CATEGORICALLY NEEDY

b. _____ Eligibility is limited by the severity of disease or condition, as specified in Appendix B.

c. _____ Eligibility is limited to individuals who have been shown to have a need for one or more of the services elected by the State under this benefit.

5. Standards for financial eligibility are set forth in Appendix A. Each individual served shall meet applicable standards for financial eligibility.

6. Each individual served will meet the test of functional disability set forth in Appendix B.

7. The State will provide for a comprehensive functional assessment for a financially eligible individual who meets the targeting requirements set forth in item 3 of this Supplement. This assessment will be provided at the request of the individual or another person acting on such individual's behalf. The individual will not be charged a fee for this assessment.

8. The comprehensive functional assessment will be used to determine whether the individual is functionally disabled, as defined in Appendix B. Procedures to ensure the performance of this assessment are specified in Appendix D.

9. The comprehensive functional assessment is based on the uniform minimum data set specified by the Secretary. Check one:

a. _____ The State will use the assessment instrument designed by HCFA.

b. _____ The State will use an assessment instrument of its own designation. The assessment instrument to be used is consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by HCFA. A copy of the assessment instrument can be found at Appendix D.

10. The comprehensive functional assessment will be reviewed and revised not less often than every 12 months. Procedures to ensure this review and revision are specified in Appendix D.

11. The comprehensive functional assessment and review will be conducted by an interdisciplinary team designated by the State. Qualifications of the interdisciplinary team are specified in Appendix D.

12. Based on the comprehensive functional assessment or review, the interdisciplinary team will:

a. identify in each such assessment or review each individual's functional disabilities and need for home and community care, including information about the individual's health status, home and community environment, and informal support system; and

State: FLORIDA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES FOR THE CATEGORICALLY NEEDY

b. based on such assessment or review, determine whether the individual is (or continues to be) functionally disabled.

13. The results of the comprehensive functional assessment or review will be used in establishing, reviewing and revising the person's individual community care plan (ICCP).

14. An ICCP will be developed by a qualified community care case manager for each individual who has been determined, on the basis of a comprehensive functional assessment, to be a functionally disabled elderly individual.

15. All services will be furnished in accordance with a written ICCP which:

    a. is established, and periodically reviewed and revised, by a qualified community care case manager after a face-to-face interview with the individual or primary care giver;

    b. is based upon the most recent comprehensive functional assessment of the individual;

    c. specifies, within the amount, duration and scope of service limitations specified in Appendix C, the home and community care to be provided under the plan. The ICCP will specify the community care services to be provided, their frequency, and the type of provider to furnish each service;

    d. indicates the individual's preferences for the types and providers of services and documents the individual's free choice of providers and services to be furnished; and

    e. may specify other services required by the individual.

    A copy of the ICCP format to be used in implementing this benefit is included in Appendix E.

16. Each individual's ICCP will be established and periodically reviewed and revised by a qualified community care case manager, as provided in Appendix E.

17. A qualified community care case manager is a nonprofit or public agency or organization which meets the conditions and performs the duties specified in Appendix E.

18. The State will provide the following home and community care services, as defined, described and limited in Appendix C to the groups specified in items 3, 4, 5 and 6 of this Supplement.

    a. _____ Homemaker services

    b. _____ Home health aide services

    c. _____ Chore services

State: FLORIDA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES FOR THE CATEGORICALLY NEEDY

d. _____ Personal care services

e. _____ Nursing care services provided by, or under the supervision of, a registered nurse

f. _____ Respite care

g. _____ Training for family members in managing the individual

h. _____ Adult day care

i. _____ The following services will be provided to individuals with chronic mental illness:

1. _____ Day treatment/Partial hospitalization

2. _____ Psychosocial rehabilitation services

3. _____ Clinic services (whether or not furnished in a facility)

j. _____ Other home and community-based services (other than room and board) as the Secretary may approve. The following other services will be provided:

1. _____ Habilitation

A. _____ Residential Habilitation

B. _____ Day Habilitation

2. _____ Environmental modifications

3. _____ Transportation

4. _____ Specialized medical equipment and supplies

5. _____ Personal Emergency Response Systems

6. _____ Adult companion services

7. _____ Attendant Care Services

8. _____ Private Duty Nursing Services

9. _____ Extended State plan services (check all that apply):

A. _____ Physician Services

B. _____ Home health care services

State: FLORIDA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES FOR THE CATEGORICALLY NEEDY

C. _____ Physical therapy services

D. _____ Occupational therapy services

E. _____ Speech, hearing and language services

F. _____ Prescribed drugs

G. _____ Other State plan services (specify): _____

10. _____ Other home and community based services (specify): _____

19. The State assures that adequate standards for each provider of services exist and will be met. These provider standards are found at Appendix C-2.

20. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to individuals who are adversely affected by the determinations of the interdisciplinary team, or who are denied the service(s) of their choice, or the provider(s) of their choice, or who disagree with the ICCP which has been established.

21. FFP will not be claimed for the home and community care services specified in item 18 of this Supplement prior to the development of the ICCP. FFP will not be claimed for home and community care services which are not included in the ICCP.

22. The State provides the following assurances to HCFA:

a. Home and community care services will not be furnished to recipients while they are inpatients of a hospital, NF, or ICF/MR.

b. FFP will not be claimed in expenditures for the cost of room and board, except when provided as part of respite care furnished in a facility which is (1) approved by the State, and (2) not a private residence. Meals furnished under any community care service (or combination of services) will not constitute a "full nutritional regimen" (3 meals a day).

c. FFP will not be claimed in expenditures for the cost of room and board furnished to a provider of services.

d. The agency will provide HCFA annually with information on the amount of funds obligated by the State with respect to the provision of home and community care to the functionally disabled elderly in that fiscal year. These reports will begin with information relative to FFY 1990 and will be provided in the manner prescribed by HCFA. The State assures that it will provide data on its maintenance of effort, as required by section 1929(e) of the Social Security Act, in such format and at such times as are specified by HCFA.

State: FLORIDA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES FOR THE CATEGORICALLY NEEDY

e. The home and community care provided in accordance with this Supplement and Appendices will meet all requirements for individual's rights and quality of care as are published or developed by HCFA.

1. All individuals providing care are competent to provide such care; and

2. Each provider of services under this benefit will meet the requirements applicable to the provision of home and community care as set forth in Appendix C.

3. Each individual receiving home and community care will be accorded the rights specified in Appendix F.

4. Case managers will comply with all standards and procedures set forth in Appendix E.

23. FFP will not be claimed for the home and community care services specified in item 18 of this Supplement in any quarter to the extent that cost of such care in the quarter exceeds 50 percent of the product of:

a. the average number of individuals in the quarter receiving home and community care;

b. the average per diem rate of Medicare payment for extended care services (without regard to coinsurance) furnished in the State during such quarter; and

c. the number of days in such quarter.

24. Community care settings in which home and community care is provided will meet the requirements set forth in section 1929(g) and (h) of the Act, as applicable to the specific setting. The State assures that the requirements of Appendix G will be met for each setting in which home and community care is provided under this section.

25. The State will refuse to provide home and community care in settings which have been found not to meet the requirements of sections 1929(g) and (h) of the Act.

26. The State will comply with the requirements of section 1929(i), of the Act, regarding survey and certification of community care settings, as set forth in Appendix G.

27. The State will comply with the requirements of section 1929(i) of the Act, regarding the compliance of providers of home and community care and reviews of this compliance, as set forth in Appendix C.

28. The State will provide for an enforcement process for providers of community care, as required by section 1929(j) of the Act. This process is described in Appendix C.

State: FLORIDA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES FOR THE CATEGORICALLY NEEDY

29. The State assures that payment for home and community care services will be made through rates which are reasonable and adequate to meet the costs of providing care efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

30. Payment will not be made for home and community care to reimburse (or otherwise compensate) a provider of such care for payment of a civil money penalty imposed under title XIX or title XI of the Social Security Act or for legal expenses in defense of an exclusion or civil money penalty under title XIX or title XI of the Social Security Act if there is no reasonable legal ground for the provider's case.

31. The State will begin provision of services under section 1905(a)(23) of the Social Security Act effective (specify date):

_____

These services will be provided to eligible individuals for a minimum of four calendar quarters, beginning on this date.

32. Services will be provided to eligible recipients for the duration of the period specified in item 31, above, without regard to the amount of Federal financial participation available to the State.

33. The State assures that it will monitor the appropriateness and accuracy of the assessments and reviews. Through its monitoring, the State assures the appropriateness and accuracy of the assessments and periodic reviews. The State assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the nature and severity of any deficiencies noted.

PACE Services

_____ The State of Florida has not entered into any valid program agreements with a PACE provider and the Secretary of the Department of Health and Human Services.

__X__ The State of Florida has entered into a valid program agreement(s) with a PACE provider(s) and the Secretary, as follows: Florida PACE Centers, Inc.

Name and address of State Administering Agency, if different from the State Medicaid Agency:

_____

_____

I. Eligibility

The State determines eligibility for PACE enrollees only under rules applying to institutional groups, and applies post-eligibility treatment of income to those individuals as specified below. Note that post –eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waivers. Certain individuals who receive services that Florida is authorized to provide under PACE are eligible for Medicaid via Florida's 1115 MEDS-AD Demonstration waiver. These individuals include dual and non-dual aged and disabled participants with income levels up to 88% of the federal poverty level. The MEDS-AD program covers individuals with assets up to $5,000 as opposed to the PACE program which covers individuals with assets up to $2,000.

**Regular Post Eligibility**

1. __X__ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a). *Sec. 435.726--States which do not use more restrictive eligibility requirements than* SSI.

1. Allowances for the needs of the:
   (A.) Individual (check one)
   1.____The following standard included under the State plan (check one):
   (a) _____SSI
   (b) _____Medically Needy
   (c) _____The special income level for the institutionalized
   (d) _____Percent of the Federal Poverty Level: ____%
   (e) _____Other (specify):_____
   2._____The following dollar amount: $_____
   Note: If this amount changes, this item will be revised.
   3.__X__The following formula is used to determine the needs allowance:

For individuals residing in the community (not in an ALF), the personal needs allowance shall be equal to 300% of the SSI Federal benefit rate (FBR).

For individuals placed in an assisted living facility (ALF), the personal needs allowance shall be calculated according to the following formula:

Three meals per day and a Semi-private room (ALF Basic Monthly Charge)

+ 20% of Federal Poverty Level

= Personal Needs Allowance

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):

1.____ SSI Standard
2.____ Optional State Supplement Standard
3.____ Medically Needy Income Standard
4.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
5 .____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
6.____ The amount is determined using the following formula:
_____
_____
7.____ Not applicable (N/A)

(C.) Family (check one):

1. X AFDC need standard
2.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

4.____ The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.

5.____ The amount is determined using the following formula:

_____

_____

6.____ Other

7.____ Not applicable (N/A)

(2). Medical and remedial care expenses in 42 CFR 435.726.

**Regular Post Eligibility**

2. _____209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) 42 CFR 435.735--States using more restrictive requirements than SSI.

1. Allowances for the needs of the:

(A.) Individual (check one)

1.___The following standard included under the State plan (check one):

(a) _____SSI

(b) _____Medically Needy

(c) _____The special income level for the institutionalized

(d) _____Percent of the Federal Poverty Level: _____%

(e) _____Other (specify):_____

2.___The following dollar amount: $_____

Note: If this amount changes, this item will be revised.

3___The following formula is used to determine the needs allowance:

_____

_____

Note: If the amount protected for PACE enrollees in item 1 is **equal to, or greater than** the maximum amount of income a PACE enrollee may have and be eligible under PACE, **enter N/A in items 2 and 3.**

(B.) Spouse only (check one):

1._____The following standard under 42 CFR 435.121:

_____

2._____The Medically needy income standard

_____

3.____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

4.____The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.

5._____The amount is determined using the following formula:

_____

_____

6._____Not applicable (N/A)

(C.) Family (check one):
1.____AFDC need standard
2_____Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

4.____The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.

5.____ The amount is determined using the following formula:

_____

_____

6.____ Other

7.____ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

**Spousal Post Eligibility**

3._X__ State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:
1. Individual (check one)
(A).____The following standard included under the State plan (check one):

1. _____SSI
2. _____Medically Needy
3. _____The special income level for the institutionalized
4. _____Percent of the Federal Poverty Level: _____%
5. _____Other (specify):_____

(B)._____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

(C)_X_ The following formula is used to determine the needs allowance:

For individuals residing in the community (not an ALF) the personal needs allowance shall be equal to 300% of the SSI Federal Rate (FBR).

For individuals placed in an assisted living facility (ALF), the personal needs allowance shall be calculated according to the following formula:

Three meals per Day and Semi-private room (ALF BASIC Monthly Charge)
+ 20 % of Federal Poverty Level

_____
= Personal Needs Allowance

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

_____

_____

II. Program Agreement: For State Medicaid Agencies also serving as PACE State Administering Agencies, the State assures that it is willing to enter into a program agreement with the applicant entity covering the required PACE services listed in 42 CFR, Part 460.92

III. Compliance and State Monitoring of the PACE Program

For State Medicaid Agencies also serving as PACE State Administering Agencies, the State further assures all requirements of section 1934 of the Social Security Act will be met. All relevant provisions are included in the contract with the PACE entities, either as contractor or State responsibility. Both scheduled and unscheduled on-site reviews will be conducted by State staff.

A. Readiness Review: The State will perform a Readiness Review of the applicant entity that assures the entity has fully developed its policies and procedures, obtained commitments from key staff, developed its solvency plan and has a facility that meets State and Federal requirements at the time of the application, in accordance with Section 460.12(b)(1).

B. Monitoring During Trial Period: During the trial period, the State, in cooperation with CMS, will conduct comprehensive reviews of a PACE organization to ensure compliance with State and federal requirements.

At the conclusion of the trial period, the State, in cooperation with CMS, will continue to conduct reviews of a PACE organization, as appropriate, taking into account the quality of care furnished and the organization's compliance with State and federal requirements.

C. Annual Monitoring: The State assures that at least annually it will reevaluate whether a participant meets the level of care required under the State Medicaid plan for coverage of nursing facility services. The State understands that this determination may be waived if there is no reasonable expectation of improvement or significant change in the participant's conditions because of the severity of a chronic condition or the degree of impairment of functional capacity.

D. Monitoring of Corrective Action Plans: The State assures it will monitor the effectiveness of corrective actions required to be taken by the PACE organization.

IV. Rates and Payments

A. Calculation of Medicaid Capitation Rate

The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

1.___ Rates are set at a percent of fee-for-service costs
2. X Experience-based (contractors/State's cost experience or encounter date)(please describe)
3.___ Adjusted Community Rate (please Describe)
4.___ Other (please describe)

The Medicaid capitation rates are based upon the most recent claims data for a similar population in Florida's Aged/Disabled Adult Services and Assisted Living for the Elderly waiver populations who would be eligible for the PACE program and who spent at least 50% of their waiver claims experience in the community. Only Dual eligible, Medicare Part B only eligible,

and Medicaid only eligible experience is included for those recipients with 50% of their total monthly eligibility months occurring in the community (versus being a nursing home resident). Although the waivers used for comparable populations do not require Medicare coverage, the presence of Medicare coverage would reduce Medicaid coverage for that individual.

Step One

The data for the most recent waiver claims are summarized by service category for all covered services and trended forward using the same inflation factors approved by the Florida Legislature for use in projecting social service program budgets.

PACE UPPER PAYMENT LIMIT METHODOLOGY – STEPS

i. Summarize the most recent fee-for-service data by service category for all covered service categories by eligibility category (SSI without Medicare, Medicare B Only and Medicare A & B). Include separately both a community and an institutional population using Medicaid fee-for-service data for individuals ages 55 and over who are nursing home eligible.
ii. Trend the data to the contract period using inflation factors approved by the Florida Legislature for the covered services for both populations.
iii. Summarize the trended data from previous step by service category for all covered service categories by eligibility category and calculate a PMPM amount separately for both the community and institutional populations.
iv. Blend together the results obtained for the community and institutional populations using their respective case months.
v. Adjust for incurred but not reported (IBNR) claims and third party liability (TPL) recoveries.
vi. Add non-emergency transportation cost to reflect a capitation arrangement. The capitation amount was adjusted to reflect fee-for-service utilization differences between the base population underlying the capitation and the waiver population used for the PACE capitation rates.
vii. Rate development in this Upper Payment Limit method is compared with program rates developed through the program rate process period. The Upper Payment Limit rates and program rates are compared to verify that the Upper Payment Limit rates are higher than the actual program rates.

Step Two

Home and community based services for the PACE capitation rates are adjusted because a capitation rate based fully on the Assisted Living for the Elderly waiver and Aged/Disabled Adult waiver experience does not fully represent the same service mix as found in the PACE population. The rates are adjusted based on encounter data collected for a comparable population (see step 8). The following service categories are affected by the adjustment:

- Adult Congregate Living
- Assistive Care Services
- Home and Community Based – Aging
- Home Health Services

Step Three

Statewide Assessment Rating Factor (ARF)

A statewide assessment rating factor (ARF) was developed to address health status differences between different areas of the state. Recipients were given functional screens that gauged health status. Measurements were made of recipient's required level of assistance in activities of daily living (i.e. ADLs), instrumental activities of daily living (IADLs), presence of specific chronic conditions (diabetes, etc.) and level of cognitive impairment. Statistical techniques were employed to model the relationship of medical costs as they vary in the presence and severity of impaired health as measured by the assessments. After the model was validated, an average ARF was determined. The average represents the magnitude of the payment PMPM attributable to health status compared to a similar but healthy population.

Step Four

This step adjusts trended historical costs for health status by dividing the statewide ARF into the service categories. This step establishes the average statewide service costs for the PACE program population.

Step Five

The claims data is adjusted for incurred but not reported (IBNR) claims and third party recoveries (TPL) using the same factors used in all other Florida managed care programs for the same rate period.

Step Six

Capitated ARF Factor

For Florida's existing PACE providers, the capitated assessment rating factor (ARF) was calculated using the enrolled provider's population. For prospective PACE providers, a blending schedule was used to determine the extent the plan/county specific ARF is credible. The blending schedule was developed after reviewing the standard deviation of the ARF by provider service area (PSA) and plan. This step adjusts the PACE plan's costs to reflect the greater or lesser assessment rating factor of its beneficiaries.

Step Seven

Nursing Home Add-on Factor

The trended claims data from the Aged/Disabled Adult and Assisted Living for the Elderly waivers was limited to individuals living in the community for at least 50% of their waiver experience. Since this assumption understates the risk for nursing home placement for a PACE provider, a nursing home add-on factor was developed. The actuary conducted research on nursing home admission rates, and month to month nursing home continuance rates once a recipient enters a nursing home. The research was conducted on the Aged/Disabled Adult and Assisted Living for the Elderly waiver populations. The cost of nursing home services on a per diem basis was included to estimate per enrollee per month cost if recipients were allowed to stay in the nursing home for an unlimited amount of time.

Step Eight

Encounter Data Adjustment

The fee-for-service based capitation rates are adjusted to reflect the impact that encounter data would have. Since PACE encounter data or PACE specific financial reports are not available, the Nursing Home Diversion experience data is used instead. PACE serves a population very similar to the Nursing Home Diversion program with a very similar set of services. The fee-for-service data is adjusted in the same manner as the Nursing Home Diversion rates are adjusted for Nursing Home Diversion encounter data.

i. Develop the encounter data adjustment by dividing the Statewide Nursing Home Diversion blended rate by the Nursing Home Diversion Statewide FFS based capitation rate.
ii. Apply the encounter data adjustment factor to the FFS based PACE capitation rate.

Step Nine

Final Rate Determination

For purposes of the calculation of the UPL the capitation rate is compared to the previous year's rate. The final PACE capitation rate is the higher of the two rates so that the capitation payment does not decrease from year to year.

PACE program rates will be revised annually based upon the rate methodology set out in the previous steps.

B. The rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

C. X The State will submit all capitated rates to the CMS Regional Office for prior approval.

Calculation of PACE Upper Payment Limit

The PACE Upper Payment Limit is based on the most recent claims data for a population similar to Florida's Aged / Disabled Adult Services and Assisted Living for the Elderly Waiver populations and nursing home residents who would be eligible for the PACE program. Only Dual eligible, Medicare Part B only eligible, and Medicaid only eligible experience is included and recipients are separated by their care setting in any given month: living in the community or in a nursing home. Without the PACE program, the current PACE enrollees would be living in one of settings of care and the UPL needs to reflect the cost of the enrollees in the appropriate proportion to evaluate savings from the PACE program.

V. Enrollment and Disenrollment: For both State Medicaid Agencies and State Administering Agencies, the State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month. In cases where the State Medicaid Agency is separate from the State Administering Agency, the State Medicaid Agency assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the two agencies.

A. Enrollment Process (Please describe):

For Medicare only Applicants:

1. The PACE contractor will interview the applicant to determine if the applicant is eligible for and enrolled in Medicare Part A and/or Part B.
2. If the enrolled Medicare applicant is 55 or older, and a resident of the PACE contractor's catchment area, the applicant will be referred to the local Department of Elder Affair's (DOEA) Comprehensive Assessment and Review for Long Term Care Services (CARES) office for determination of level of care.
3. If the CARES unit determines the applicant meets level of care criteria for nursing home placement, the PACE contractor will be sent a notification of the determination. When the PACE contractor receives the level of care determination from the CARES office, the PACE contractor will schedule another interview with the applicant for assessment by the multidisciplinary team and review of the PACE Enrollment Agreement.
4. After the multidisciplinary team's assessment and determination that the applicant is appropriate for care in the community setting, the PACE contractor will review the PACE Enrollment Agreement with the applicant.

   The PACE Enrollment Agreement will disclose to the applicant:

   a. Applicant's name, sex, date of birth and Medicare Numbers as applicable.
   b. Description of PACE program benefits including all Medicaid and Medicare covered services and how services can be obtained.
   c. Explanation of participant premiums and procedures for payment, if applicable.

d. Effective date of enrollment,
e. Explanation of participant rights, grievance procedures, conditions for enrollment and disenrollment and Medicaid and Medicare contacts in appeal situations,
f. Notification of participant's obligation to notify PACE provider of a move or absence from the provider's service area,
g. Explanation of the lock-in requirement and an acknowledgment by the participant that he or she understands that all services must be received through the PACE provider,
h. Explanation of procedures for obtaining emergency services and urgent care,
i. Explanation of requirement to maintain their own Medicare eligibility including Medicare Part B eligibility through the payment of required premiums,
j. Statement that private premiums can only be raised once a year,
k. Explanation that PACE provider has a contract with CMS, AHCA, and DOEA which is subject to renewal on a periodic basis and failure of the PACE provider to renew the contract will result in termination of enrollment in the program,
l. Explanation that a Medicare member may not disenroll from PACE at a local Social Security Administration Office,
m. Explanation that enrollment in PACE will result in automatic disenrollment from any other Medicare prepayment health plan,
n. Applicant's authorization for the disclosure and exchange of information between CMS, its agent, AHCA, DOEA, and the PACE provider,
o. Applicant's signature and date,
p. Notification of Medicaid recipients that liability may exist for any applicable spenddown and any amounts due under the post-eligibility treatment of income process,
q. Explanation of the consequences of subsequent enrollment in other optional Medicare and Medicaid programs following disenrollment from PACE, and
r. Explanation that any changes in the enrollment agreement must be provided to the participant in writing at least sixty (60) days before any change and fully discussed with the participant and his or her representative or caregiver.

5. After the PACE Enrollment Handbook review, the applicant can sign the Handbook's enrollment agreement and enroll in the program.

6. Any denial of enrollment by the PACE contractor must be promptly reported to the Centers for Medicare and Medicaid Services (CMS), the Agency for Health Care Administration (AHCA), and the Department of Elder Affairs (DOEA).

For Dually Eligible (Medicare and Medicaid) Applicants:

1) The Department of Elder Affairs' CARES unit will be the initial entry point in the PACE program for potential participants. CARES will accept referrals from both the PACE provider and the community. When the PACE provider receives inquiries about the PACE program, the PACE provider will make a referral to the local CARES Unit and may conduct a home visit and an evaluation of the potential PACE participant.

2) When the CARES unit determines a consumer is clinically eligible and the consumer indicates an interest in the PACE option during Choice Counseling, the consumer will be referred to the PACE provider.

3) The PACE provider will introduce the consumer to the PACE facility and staff. After the introduction, the consumer will be visited at home by the PACE provider's staff and evaluated by the PACE multidisciplinary team. After the introduction and evaluation if the consumer decides to select the PACE option, the consumer will need to contact the CARES unit to complete Choice Counseling process. When the consumer selects the PACE option, CARES will refer the consumer to the Department of Children and Family Services' eligibility unit to complete the Medicaid financial eligibility process, if necessary. When the consumer has completed the Medicaid eligibility process, the CARES unit will complete enrollment in the PACE program and refer the participant to the PACE provider.

4) The PACE provider will provide the PACE enrollee with the PACE Handbook containing the following information:

   a. Applicant's name, sex, date of birth, and Medicare numbers as applicable,
   b. Description of PACE program benefits including all Medicaid and Medicare covered services, and how services can be obtained,
   c. Explanation of participant premiums and procedures for payment, if applicable,
   d. Effective date of enrollment,
   e. Explanation of participant rights, grievance procedures, conditions for enrollment and disenrollment and Medicaid and Medicare contacts in appeal situations,
   f. Notification of participant's obligation to notify PACE provider of a move or absence from the provider's service area,
   g. Explanation of the lock-in requirement and an acknowledgment by the participant that he or she understands that all services must be received through the PACE provider,
   h. Explanation of procedures for obtaining emergency services and urgent care,
   i. Explanation of requirement to maintain their own Medicare eligibility including Medicare Part B eligibility through the payment of required premiums,
   j. Statement that private premiums can only be raised once a year,
   k. Explanation that the PACE provider has a contract with CMS, AHCA, and DOEA which is subject to renewal on a periodic basis and failure of the PACE provider to renew the contract will result in termination of enrollment in the program,
   l. Explanation that a Medicare member may not disenroll from PACE at a local Social Security Administration Office,
   m. Explanation that enrollment in PACE will result in automatic disenrollment from any other Medicare prepayment health plan,
   n. Applicant's authorization for the disclosure and exchange of information between CMS, its agent, AHCA, DOEA, and the PACE provider,
   o. Applicant's signature and date,
   p. Notification of Medicaid recipients that liability may exist for any applicable spenddown and any amounts due under the post-eligibility treatment of income process,

n. Applicant's authorization for the disclosure and exchange of information between CMS, its agent, AHCA, DOEA, and the PACE provider,
o. Applicant's signature and date,
p. Notification of Medicaid recipients that liability may exist for any applicable spenddown and any amounts due under the post-eligibility treatment of income process,
q. Explanation of the consequences of subsequent enrollment in other optional Medicare and Medicaid programs following disenrollment from PACE, and
r. Explanation that any changes in the enrollment agreement must be provided to the participant in writing at least sixty (60) days before any change and fully discussed with the participant and his or her representative or caregiver.

1) The PACE contractor will not be allowed to deny enrollment to anyone that is enrolled by CARES except as provided in the dispute resolution process as established by the Department of Elder Affairs (DOEA) in consultation with the Agency for Health Care Administration (AHCA). This excludes matters brought forth by enrollees. All DOEA enrollment dispute decisions will be issued in writing and given to the contractor. DOEA's and AHCA's enrollment dispute decisions will be final and conclusive.

2) If the PACE applicant or participant is Medicaid eligible or is applying for Medicaid coverage and receives an adverse action on the application or is denied services, the applicant or participant has a right to a Fair Hearing on the adverse action.

   A) If the PACE applicant is determined to be ineligible for clinical or financial eligibility reasons, the applicant with the assistance of the PACE provider or the CARES Unit may request a fair hearing with the Department of Children and Family Services (DCF), Office of Hearings Appeals (OSIH), 1317 Winewood Blvd, Building 1, Room 309, Tallahassee, Florida, 32399-0700. The telephone number is (850) 488-1429.

   B) If the PACE participant is Medicaid eligible and denied services by the PACE provider, the PACE provider must assist the participant with preparation of the request for a Fair Hearing. The contact information is listed in Section 6 A of these Pace enrollment procedures.

B. Enrollee Information (Please describe the information to be provided to enrollees):

   1. Prior to or upon enrollment, the PACE contractor must provide each new enrollee with a copy of the written enrollment agreement containing the effective date of enrollment, emergency care access information to be posted in the enrollee's home, a PACE Program ID card which includes the contractor's name, address and the member services telephone number and stickers for enrollees' Medicare and Medicaid cards, if applicable.

   2. The PACE contractor must notify, within 5 working days from the effective date of enrollment, all new enrollees or their representatives of a time and place for a face-to-face PACE orientation. Orientation must occur within two weeks of the effective date of enrollment.

3. The PACE contractor must ensure that orientation information is communicated effectively, provided in the enrollee's language if that language is spoken by more than 5 per cent of the county's total population, and is available in alternative formats for enrollees who have communication-affecting conditions.
4. The contractor must provide each new enrollee with an enrollee handbook or agreement prior to or at the time of orientation. The enrollee handbook or agreement must be written so it can be read and understood by the PACE enrollees or their representatives and must include the following items:

   a. Applicant's name, sex, date of birth, Medicaid and Medicare numbers as applicable,
   b. Description of PACE program benefits including all Medicaid and Medicare covered services, and how services can be obtained,
   c. Explanation of participant premiums and procedures for payment, if applicable,
   d. Effective date of enrollment,
   e. Explanation of participant rights, grievance procedures, conditions for enrollment and disenrollment and Medicaid and Medicare contacts in appeal situations,
   f. Notification of participant's obligation to notify the PACE provider of a move or absence from the provider's service area,
   g. Explanation of the lock-in requirement and an acknowledgment by the participant that he or she understands that all services must be received through the PACE provider
   h. Explanation of procedures for obtaining emergency services and urgent care,
   i. Explanation of the requirement to maintain their own Medicare and Medicaid eligibility including Medicare Part B eligibility through the payment of required premiums,
   j. Statement that private premiums can only be raised once a year,
   k. Explanation that the PACE provider has a contract with CMS, AHCA, and DOEA which is subject to renewal on a periodic basis and failure of the PACE provider to renew the contract will result in termination of enrollment in the program,
   l. Explanation that a Medicare member may not disenroll from PACE at a local Social Security Administrative Office,
   m. Explanation that enrollment in PACE will result in automatic disenrollment from any other Medicare or Medicaid prepayment health plan,
   n. Applicant's authorization for the disclosure and exchange of information between CMS, its agent, AHCA, DOEA, and the PACE provider,
   o. Applicant's signature and date,
   p. Notification of Medicaid recipients and dually eligible Medicaid and Medicare participants that no liability exists for any PACE premiums,
   q. Notification of Medicaid recipients and dually eligible Medicaid and Medicare participants that liability may exist for any applicable spenddown and any amounts due under the post-eligibility treatment of income process,
   r. Explanation of the consequences of subsequent enrollment in other optional Medicare and Medicaid programs following disenrollment from PACE, and
   s. Explanation that any changes in the enrollment agreement must be provided to the participant in writing at least sixty (60) days before any change and fully discussed with the participant and his or her representative or caregiver.

C. Disenrollment Process (Please describe - voluntary and involuntary):

1. Voluntary Disenrollment

   a. PACE program enrollees are allowed to voluntarily disenroll at any time.
   b. The PACE contractor will ensure that it does not restrict the enrollee's right to voluntarily disenroll in any way, and that the enrollee's contact with the state is not deterred.
   c. Immediately upon receiving a voluntary request for disenrollment, the PACE contractor must inform the enrollee of disenrollment procedures, provide the enrollee with AHCA's toll-free disenrollment telephone number and notify the Area Agency on Aging.
   d. The PACE contractor must make disenrollment assistance available during business hours. This assistance must be available through a toll-free telephone number and face-to-face contact. The PACE contractor's written disenrollment procedure must list the staff responsible for this type of assistance.
   e. The PACE contractor must keep a daily log of all verbal and written disenrollment requests and the disposition of such requests. The PACE contractor must ensure that disenrollment request logs are maintained in an identifiable manner, involuntary disenrollment documents are maintained in an identifiable enrollee record, and enrollees who wish to file a grievance are afforded appropriate notice and opportunity to do so.
   f. The PACE contractor must ensure that instructions for disenrollment are available to enrollees in their own language when the population speaking that language is greater than 5 per cent of the county's total population.

2. Involuntary Disenrollment

   a. Involuntary Disenrollments are limited to the following reasons:
      Participant's death;
      Participant fails to pay or to make satisfactory arrangements to pay any premium due the PACE organization after a 30 day grace period;
      Participant moves outside the PACE program's service area or is absent from the service area for more than 30 days unless the PACE organization agrees to a longer absence due to extenuating circumstances;
      PACE organization is unable to offer health care services due to the loss of State licenses or contracts with outside providers;
      PACE agreement between CMS and AHCA is not renewed;
      Participant's disruptive or threatening behavior where the behavior jeopardizes the participant's health or safety or the health or safety of others; and
      Mentally competent participants who consistently and repeatedly fail to comply with his/her plan of care or the terms of the enrollment agreement.

b. After providing at least one verbal and at least one written warning of the full implications of failure to follow a recommended plan of care, the PACE contractor may submit an involuntary disenrollment request to the DOEA PACE Contract Manager and the Agency for Health Care Administration (AHCA) PACE Program Analyst for an enrollee who continues not to comply. DOEA in consultation with AHCA may approve such a request provided that a written explanation of the reason(s) for disenrollment is given to the enrollee prior to the effective date and provided that the enrollee's actions are not related to the enrollee's medical or mental condition.

Enrollees who are disenrolled through this section are not eligible for re-enrollment without the permission of the contractor.

c. The PACE contractor may also submit an involuntary disenrollment request for an enrollee whose behavior is disruptive, unruly, abusive or uncooperative to the extent that his or her enrollment with the contractor seriously impairs the contractor's ability to furnish services to either the enrollee or other enrollees. The PACE contractor must provide at least one verbal and one written warning to the enrollee regarding the implications of his or her actions. A written explanation of the reason(s) for disenrollment must be given to the enrollee prior to submitting the disenrollment request. DOEA in consultation with AHCA may approve such requests provided the PACE contractor has documented the actions described above and the enrollee's actions are not related to the enrollee's medical or mental condition. Enrollees who are disenrolled through this action are not eligible for re-enrollment without the permission of the PACE contractor.

d. Disenrollment request forms, whether completed by the PACE contractor, enrollee, or DOEA in consultation with AHCA , must contain the following information: name, address, telephone number, reason for disenrollment, with brief explanation, a signature by the enrollee (for voluntary requests submitted by the enrollee), date, signatures by the PACE contractor's staff (for involuntary disenrollments submitted by the contractor), and an indication as to whether or not the enrollee wishes to file a grievance.

e. All disenrollments, including those subject to prior approval, must be completed through the submission of a disenrollment report to Medicaid fiscal agent in the enrollment, disenrollment and cancellation report for payment.

f. The PACE contractor must provide the disenrollment data via the disenrollment report on the first available transmission after the date of receipt of the disenrollment request. In no event will the PACE contractor submit a disenrollment report with an effective date later than 49 calendar days after the PACE contractor's receipt of a voluntary disenrollment request.

D. The State assures that before an involuntary disenrollment is effective, it will review and determine in a timely manner that the PACE organization has adequately documented grounds for disenrollment.

E. In the event a PACE participant disenrolls or is disenrolled from a PACE program, the State will work with the PACE organization to assure the participant has access to care during the transitional period.

F. The State assures it will facilitate reinstatement in other Medicaid/Medicare programs after a participant disenrolls.

G. The State assures that the State PACE requirements and State procedures will specify the process for how the PACE organization must submit participant information to the State.

VI. Marketing: For State Medicaid Agencies also acting as PACE State Administering Agencies, the State assures that a process is in place to review PACE marketing materials in compliance with Section 460.82(b)(ii).

VII. Services: The following items are the medical and remedial services provided to the categorically needy and medically needy. All required PACE services are listed in 42 CFR, Part 460.92.

The State assures that the state agency that administers the PACE program will regularly consult with the State Agency on Aging in overseeing the operation of the PACE program in order to avoid services duplication in the PACE service area and to assure the delivery and quality of services to the PACE participants.

VIII. Decisions that require joint CMS/State Authority

A. For State Medicaid Agencies also acting as PACE State Administering Agencies, waivers will not be granted without joint CMS/State agreement:
   1. The State will consult with CMS to determine the feasibility of granting any waivers related to conflicts of interest of PACE organization governing board members.
   2. The State will consult with CMS to determine the feasibility of granting any waivers related to the requirements that: members of the multidisciplinary team are employees of the PACE organization; and that members of the multi- disciplinary team must serve primarily PACE participants.

B. Service Area Designations: The State will consult with CMS on changes proposed by the PACE organization related to service area designation.

C. Organizational Structure: The State will consult with CMS on changes proposed by the PACE organization related to organizational structure.

D. Sanctions and Terminations: The State will consult with CMS on termination and sanctions of the PACE organization.

IX. State Licensure Requirements

For State Medicaid Agencies also acting as PACE State Administering Agencies, the State assures that Life Safety Code requirements are met for facilities in which the PACE organization furnishes services to PACE participants in accordance with Section 460.72(b), unless CMS determines that a fire and safety code imposed by State law adequately protects participants and staff

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation.

**State of __Florida__**
**1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print**

i. Eligibility

The State determines eligibility for Self-Directed Personal Assistance Services:

A. __X_ In the same manner as eligibility is determined for traditional State Plan personal care services, described in Item 24 of the Medicaid State Plan.

B. __X_ In the same manner as eligibility is determined for services provided through a 1915(c) Home and Community-Based Services Waiver.

ii. Service Package

The State elects to have the following included as Self-Directed Personal Assistance Services:

A. __X__State Plan Personal Care and Related Services, to be self-directed by individuals eligible under the State Plan.

Only children under 21 years of age, enrolled in the Developmental Disabilities waiver(s) will be self-directing their State Plan personal care services.

B. __X___Services included in the following section 1915(c) Home and Community-Based Services waiver(s) to be self-directed by individuals eligible under the waiver(s). The State assures that all services in the impacted waiver(s) will continue to be provided regardless of service delivery model. Please list waiver names and services to be included.

Service providers will be enrolled with the authorized state agency Fiscal Employer Agent (FEA) designated on behalf of the Consumer Directed Care Plus (CDC+). Providers must attest to the provision of services in order to receive payment for services. All providers must be at least 16 years of age and must satisfy the qualifications, requirements and applicable licensure for the service that is provided. Providers must also comply with the background screening requirements and provisions of the applicable Florida Statutes.

Individual Budgeting (iBudget) Waiver: Life Skills Development, Adult Dental Services, Behavior Analysis Services, Behavior Assistant Services, Personal Supports, Specialized Medical Equipment and Supplies, Dietitian Services, Environmental Accessibility Adaptations, Private Duty Nursing, Occupational Therapy, Personal Emergency Response System, Physical Therapy, Residential Habilitation, Respiratory Therapy, Respite, Skilled Nursing, Special Medical Home Care, Specialized Mental Health Counseling, Speech Therapy, Supported Living Coaching, Transportation, Family and Guardian Training, and Person-Centered Planning.

iii. Payment Methodology

A. __X__ The State will use the same payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services. The State uses the same payment methodology for individuals self-directing their State plan personal care services.

B. __X__ The State will use a different payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services. Amended Attachment 4.19-B page(s) are attached. The State uses a different payment methodology for individuals self-directing their section 1915(c) Home and Community-Based waiver services.

iv. Use of Cash

A. _____ The State elects to disburse cash prospectively to participants self-directing personal assistance services. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.

B. __X___ The State elects not to disburse cash prospectively to participants self-directing personal assistance services.

v. Voluntary Disenrollment

The State will provide the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

A program consumer may elect to discontinue participation in the Consumer-Directed Care Plus (CDC+) program at any time.

In the event disenrollment is requested, the consumer's consultant completes a CDC+ Change Form to disenroll the consumer and forwards the form to program staff. All disenrollments are effective the first day of the month following receipt of the disenrollment form.

Program staff notifies the Agency for Health Care Administration about all disenrollments. Upon disenrollment from CDC+ the consumer may access waiver services through traditional means.

The consumer's consultant is responsible for ensuring the consumer has traditional waiver services in place to begin the first day of the month. Therefore, there will be no lapse in services.

vi. Involuntary Disenrollment

A. The circumstances under which a participant may be involuntarily disenrolled from self-directing personal assistance services, and returned to the traditional service delivery model are noted below. Consumers may be disenrolled by consultants and CDC+ program directors.

Reasons for involuntary disenrollment include:

- Consumer moved out of state;
- Temporary or permanent long-term care facility admission;
- Hospitalization for more than 30 consecutive days;
- Loss of Medicaid eligibility;
- Loss of waiver eligibility;
- Representative not available if necessary for participation;
- Death of consumer;
- Mismanagement of budget;
- Consumer health or safety at risk;
- Consumer can no longer be served safely in the community.
- Admission to a licensed facility (group home, ALF, etc.)

B. The State will provide the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

In the event disenrollment is required, the consumer's consultant completes a Consumer-Directed Care Plus (CDC+) Change Form to disenroll the consumer and forwards the form to program staff. All disenrollments are effective the first day of the month following receipt of the disenrollment form.
Program staff notifies the Agency for Health Care Administration about all disenrollment. Upon disenrollment from CDC+ the consumer may access waiver services through traditional means.

The consultant is responsible for ensuring the consumer has traditional waiver services in place to begin effective the first day of the month. Therefore, there will be no lapse in services.

vii. Participant Living Arrangement

Any additional restrictions on participant living arrangements, other than homes or property owned, operated, or controlled by a provider of services, not related by blood or marriage to the participant are noted below.

The 1915(c) iBudget waiver allows individuals to live in licensed facilities. Those individuals will not be allowed to participate in the CDC+ program based on this requirement.

viii. Geographic Limitations and Comparability

A. __X__ The State elects to provide self-directed personal assistance services on a statewide basis.

B. _____ The State elects to provide self-directed personal assistance services on a targeted geographic basis. Please describe:_____

C. _____ The State elects to provide self-directed personal assistance services to all eligible populations.

D. __X__ The State elects to provide self-directed personal assistance services to targeted populations. Please describe: Eligibility for the program is limited to individuals under 21 years of age enrolled in the iBudget Waiver.

E. __X__ The State elects to provide self-directed personal assistance services to an unlimited number of participants.

F. _____ The State elects to provide self-directed personal assistance services to _____ (insert number of) participants, at any given time.

ix. Assurances

A. The State assures that there are traditional services, comparable in amount, duration, and scope, to self-directed personal assistance services.

B. The State assures that there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan Option, and to assure financial accountability for funds expended for self-directed personal assistance services.

C. The State assures that an evaluation will be performed of participants' need for personal assistance services for individuals who meet the following requirements:

i. Are entitled to medical assistance for personal care services under the Medicaid State Plan; or
ii. Are entitled to and are receiving home and community-based services under a section 1915(c) waiver; or
iii. May require self-directed personal assistance services; or
iv. May be eligible for self-directed personal assistance services

D. The State assures that individuals are informed of all options for receiving self-Directed and/or traditional State Plan personal care services or personal assistance services provided under a section 1915(c) waiver, including information about self-direction opportunities that is sufficient to inform decision-making about the election of self-direction and provided on a timely basis to individuals or their representatives.

E. The State assures that individuals will be provided with a support system meeting the following criteria:
   i. Appropriately assesses and counsels individuals prior to enrollment:
   ii. Provides appropriate counseling, information, training, or assistance to ensure that participants are able to manage their services and budgets:
   iii. Offers additional counseling, information, training, or assistance, including financial management services:
      1. At the request of the participant for any reason; or
      2. When the State has determined the participant is not Effectively managing their services identified in their service plans or budgets.

F. The State assures that an annual report will be provided to CMS on the number of individuals served through this State Plan option and total expenditures on their behalf, in the aggregate.

G. The State assures that an evaluation will be provided to CMS every 3 years, describing the overall impact of this State Plan option on the health and welfare of participating individuals, compared to individuals not self-directing their personal assistance services.

H. The State assures that the provisions of section 1902(a)(27) of the Social Security Act, and Federal Regulations 42 CFR 431.107, governing provider agreements, are met.

I. The State assures that a service plan and service budget will be developed for each individual receiving self-directed PAS. These are developed based on the assessment of needs.

J. The State assures that the methodology used to establish service budgets will meet the following criteria:
   i. Objective and evidence based, utilizing valid, reliable cost data
   ii. Applied consistently to participants
   iii. Open for public inspection

iv. Includes a calculation of the expected cost of the self-directed PAS and supports if those services and supports were not self-directed.
v. Includes a process for any limits placed on self-directed services and supports and the basis/bases for the limits.
vi. Includes any adjustments that will be allowed and the basis/bases for the adjustments.
vii. Includes procedures to safeguard participants when the amount of the limit on services is insufficient to meet a participant's needs.
viii. Includes a method of notifying participants of the amount of any limit that applies to a participant's self-directed PAS and supports.
ix. Does not restrict access to other medically necessary care and services furnished under the plan and approved by the State but not included in the budget.
x. Service Plan

The State has the following safeguards in place, to permit entities providing other Medicaid State Plan services to be responsible for developing the self-directed personal assistance services service plan, to assure that the service provider's influence on the planning process is fully disclosed to the participant and that procedures are in place to mitigate that influence.

Not applicable.

xi. Quality Assurance and Improvement Plan

The State's quality assurance and improvement plan is described below, including

i. How it will conduct activities of discovery, remediation, and quality improvement in order to ascertain whether the program meets assurances, corrects shortcomings, and pursues opportunities for improvement; and

The State will conduct activities of discovery, remediation and quality improvement by using tools to collect data, take action and continuously improve the program. The tools developed for CDC+ fit into a complete quality management plan. These tools include: consumer satisfaction surveys, toll-free helpline, Person Centered Planning process (PCP) and the same follow-up instrument for each group, data reports, a Quality Advisory Committee, and monitoring of consultants and consumers.

I. The Consumer Satisfaction Surveys will be distributed on a yearly basis. The surveys will be accompanied by a letter from the program director explaining its importance and that feedback is necessary for continuous program improvement. Confidentiality will be kept on the surveys, however there is an option to include the responders name and appropriate information if the responder feels necessary or would like to be contacted.

*Discovery*: The survey requests basic information regarding the consumer and respondent such as: the person filling out the survey (consumer or representative) and the city where the consumer resides. Location allows the program office to see how each area rates.

*Remediation*: Areas with low survey ratings or low submission to program offices will alert the program office to do necessary outreach or training in those particular areas. The performance indicators are listed in the survey. Performance indicators are goals that each program office found important for their particular consumer population. Performance Indicators are questions such as: 1) The training provided by my consultant included a complete user-friendly consumer notebook. 2) I am able to find qualified employees and/or vendors to provide my services. Consideration will be given to those answers in which the majority or a large portion of the consumer population is unhappy with a particular item. For example, if one consumer indicated that he/she is unhappy with the consumer notebook. However, the rest of the consumers were very happy with their notebooks. The program office might decide that changing the notebook in that situation would be unnecessary. The survey asks whether or not each performance indicator is important to the respondent as well as the respondent to rate how they feel about the answer to each question. The rating is a 5-point Likert scale ranging from 1-(Strongly Disagree) to 5-(Strongly Agree). There is also a box labeled "Not applicable" for those respondents who feel that question does not apply to them. Every performance indicator includes a comments/suggestion section. Respondents are asked to explain a rating of 3-(Neither Agree or Disagree) or less.

*Quality Improvement*: The surveys are compiled into a data system (such as excel) for reporting. The surveys are evolving documents, meaning if a significant percentage of the responders indicate a performance indicator is not appropriate or relevant, then the performance indicator may be removed or changed in the survey document. Also the program office will review performance indicators with a 3 or less that are not being met by 80% or more of the respondents for relevance and appropriateness. The State assures all CMS' assurances listed in this application regarding consumer services, options and support system will be addressed in the survey.

II. The toll-free helpline is provided at the main program office for the Agency for Persons with Disabilities (APD). In addition, APD provides their consumers an e-mail address for questions; the e-mail is answered daily during normal business hours Monday through Friday from 8:00 A.M. until 5:00 P.M. Eastern Standard Time (EST) excluding holidays.

*Discovery*: The helpline enables consumers, representatives, consultants, members of the general public, etc. to call about anything from requesting general information, payment problem trouble-shooting, or making complaints. The e-mail addresses assists consumers with budget plan issues as well as timesheet and vendor invoice questions.

*Remediation*: Calls and emails into the helpline and e-mail addresses will be logged, researched and responded to within 48 business hours (Monday through Friday from 8:00 A.M. until 5:00 P.M. Eastern Standard Time [EST] excluding holidays). Resolution does not guarantee that the caller is satisfied with the response of the call but was given an answer to their question or issue.

*Quality Improvement*: Helpline and e-mail logs will be reviewed on a quarterly basis as part of ongoing quality assurance. The logs will describe the type of caller (consumers or consultants) and how quickly the call was answered or resolved. The logs will aid the program office in quality assurance enabling them to see what issues are facing the callers. For example, prospective consumers may call with reports of false information being distributed concerning the program. This type of information will allow the program office to provide outreach to the public, identify and refute misinformation as well as distribute correct information about the program. Consumers use the helpline and the consumer e-mail addresses to resolve payment issues, questions about budget/purchasing plans, and general program questions. The operating agency also has a current web-site with current information and forms for consumers. The operating agency tracks consumer issues by a "Notes" section on its database and records any issue regarding the consumer. That way any staff member can access a consumer file for current consumer information.

III. The Person Centered Planning (PCP) process will provide waiver support coordinators/consultants with information gathering tools and techniques that are critical to identifying the strengths, abilities, interests and personal goals of individuals with developmental disabilities on the iBudget waiver.

*Discovery*: The PCP process for the iBudget waiver allows consumers to list their needs and goals and define what services and supports will help them to satisfy their needs and reach their goals. For example a personal goal might be to spend more time with family and friends. The service they can use to reach that goal may include a certain frequency of homemaker hours once a week so the consumer can feel comfortable having visitors.

*Remediation*: These tools help the consumer decide what services and supports should be listed on their purchasing plan. The PCP process for the iBudget waiver is implemented when the consumer begins the program and at their yearly assessment. A follow-up instrument is completed at the semi-annual visit.

*Quality Improvement*: The follow-up instrument asks the consumers if their goals have been reached. Questions include: 1) Have you met Goal #1 listed on the PCP Tool? 2) Do you want to change any of your current goals? From this point, the consumer might decide their goals have changed. The follow-up instrument will be conducted no less than once a

year at the consumer's annual reassessment. The follow-up instrument also incorporates a "mini-survey" from consumers concerning health, safety, and welfare, their service needs, and their feelings regarding the program. From the follow-up instrument, the program office can glean pertinent consumer issues for the annual consumer survey.

IV. Consultant services for individuals with developmental disabilities will be provided by certified support coordinators trained to assume the consultant's role and responsibilities. These certification and training requirements will help assure effective and competent consultants and preserve waiver consumers' choice of consultant. Consultants are trained by Consumer-Directed Care Plus (CDC+) program staff in the overall philosophy of self-direction and specifically in the operations of the CDC+ program. To provide services to CDC+ consumers, consultants are required to be Medicaid waiver service providers for consultant services only. Consultants cannot serve as the consumer's representative. Consultants who are not certified case managers/support coordinators will be considered for enrollment on a case-by-case basis and the Agency for Health Care Administration (AHCA) has the final approval authority. Approval will be granted to those individuals who have a valid provider agreement with the Medicaid agency and who must meet the same training and certification provider requirements as those on the iBudget 1915(c) Home and Community-Based Services (HCBS) waiver.

*Discovery*: Consultant monitoring will include desk reviews and individual participant interviews. Desk reviews will be conducted on a quarterly basis to a random sampling of no less than 10% of all consultants. For consultants serving five or more CDC+ consumers, the desk reviews will include monitoring the consultant file for at least five randomly selected consumers. For consultants serving less than five CDC+ consumers, two files shall be reviewed. The file must include all necessary documentation for that consumer.

Documentation includes items such as: annual Medicaid eligibility determination and a completed and signed Person Centered Planning (PCP) process for the iBudget waiver. The consultant must have monthly contact with the consumer and visit the consumer in their home or community activity no less than once per six-month period. Monthly contact may be in the form of phone calls or in person, whichever is the preferred method of the consumer. Documentation of home visits and monthly contact must be in the consultant files for each consumer.

There is a Monthly Contact Review Form that must be completed by the consultant and includes topics such as: 1) Reviewed Monthly Budget Statement with the consumer and services are purchased along with purchasing plan. 2) Change in service needs due to change in circumstances.

*Remediation*: The consultant receives a copy of the consumer's Monthly Budget Net Worth Statement from APD for the iBudget consumers. If the consumer is not making purchases in accordance with his/her approved budget/purchasing plan, the consultant must complete a Corrective Action Plan (CAP) with the consumer. Consumers must sign that they

understand the implications of the CAP as well following the required action. The CAP must be implemented immediately and all purchases should reflect the CAP by the next monthly consultant review. If the consumer's purchases are still outside the guidelines of CDC+ and/or the budget/ purchasing plan after 60 days, then the consumer will be disenrolled from the program and returned to the traditional 1915(c) HCBS waiver.

*Quality Improvement*: At the semi-annual home visit, the consultant must look for indicators of fraud, abuse, neglect or exploitation and must report any findings to the proper authorities within 24 hours of the visit. Failure of the consultant to perform the monitoring duties will terminate the consultant from providing services on the CDC+ program. The program office will immediately assist the consumer in locating a new, local consultant. The operating program office (APD) has a contingency plan for consultant deficiencies. The State assures that all of Centers for Medicare and Medicaid Services (CMS) assurances listed in this application regarding participant safeguards, participant eligibility and budget development will be addressed in the monitoring of consultants.

V. The Quality Advisory Committee (QAC) is comprised of key program stakeholders. . The QAC will serve in an advisory capacity on behalf of APD.

*Discovery*: All reporting data is shared with the QAC. Along with reviewing data, the QAC will also look at other ways to improve the program and make suggestions to the program offices. The QAC meets on a quarterly basis. The QAC may include consumers, program staff, consultants, consumer-representatives, care-givers, Area Office staff, (AHCA) external reviewers (if applicable), and community advocates. APD will recommend members to the QAC as appropriate, and AHCA will serve as the approval authority.

*Remediation*: The QAC will consist of a maximum of six members. All members are trained in expectations, roles and responsibilities, federal and state laws and program policies and procedures.

*Quality Improvement*: The QAC also reviews the Program Self-Assessment (PSA). The QAC will identify and advise the program office of the areas in which the program should improve itself and will aid in setting the priorities for improvement. The QAC reviews all program policies, consultant and consumer brochures and training materials.

VI. The program office is also charged in completing a PSA that assesses the program structure and policies to see if the program is meeting the performance indicators. The PSA is developed using the guidelines created by SCRIPPS' in the Guide to Quality in Consumer Directed Services.

*Discovery*: The PSA is developed by the program office in assistance with the QAC. The final document must be approved by AHCA. The PSA asks the program office to evaluate itself with statements such as:

1) Consumers, family members and advocates help design, develop, operate and evaluate the program.
2) Can consumers determine which services to use and can they select, hire and dismiss their workers? The main purpose of the PSA is to assist the program office in identifying program goals, having a plan to meet the goals, ensuring the goals are met and aiding the program office in re-assessing itself in an ongoing capacity. The PSA also alerts the program office of unmet goals or issues that the program office might need to address so the program office continues to excel in its efforts.

*Remediation*: The APD Program Office will work with the QAC on identifying performance indicators to list in the PSA. Performance Indicators will be identified from areas that are listed by the consumer in the satisfaction surveys and areas to be improved upon in consultant training gathered from the monitoring reports, etc.

*Quality Improvement*: The QAC reviews the PSA and helps the program office to determine what areas the program office is lacking and the priorities for correcting any deficiencies. The QAC also aids the program office in identifying program improvements needed by the program offices. During the QAC meeting, the program office is responsible for updating the QAC on steps taken to meet requirements of the PSA and any future activities related to program improvement.

VII. APD requires monthly bank reconciliation reports from its subagent to balance consumer accounts. The requirement for the monthly bank reconciliation is listed in the contract between APD and its subagent.

*Discovery*: APD submits Monthly Budget Reports to the consumer, consultant, and program office and keeps a helpline log for calls to their helpline. APD will review Monthly Budget Statements before they are sent out.

*Remediation*: APD requires copies of all state and federal filing completed by the subagent.

*Quality Improvement*: The State assures that all of Centers for Medicare and Medicaid Services (CMS) assurances listed in this application regarding provider agreements will be met by the subagent for APD.

i. The system performance measures, outcome measures, and satisfaction measures that the State will monitor and evaluate.

Below is a list of the system performance measures, outcome measures and satisfaction measures of all aspects of the Consumer-Directed Care Plus (CDC+) program. Please note that the measures are evolving as they are based on performance indicators for the program.

System Performance Measures: All of the following reports/measures will be compiled from the program office database.

- The program office will submit an annual report to Agency for Health Care Administration (AHCA), which will demonstrate: client demographic data and a statement of future goals and activities. It will include detailed financial data, reports on performance measures and relevant facts about program operations. Among the data reporting is enrollment and disenrollment information and per member cost expenditures.
  - This report will help the program office to establish a baseline for performance indicators and to enhance or modify those indicators as necessary.
- The program office will submit a quarterly evidence report to AHCA with monitoring efforts and results. Also included will be actions taken/proposed to address deficiencies. All monitoring must address CMS assurances.
  - This report will allow AHCA to monitor program office performance and activities and to provide feedback to the program office.
- The yearly Program Self-Assessment (PSA) will be delivered to the Quality Advisory Committee (QAC) and the program office must be in compliance with the performance indicators for the program. If the program office is not in compliance, they must work on program improvement activities with the QAC.
  - This will allow the program office with the assistance of the QAC to monitor program progress as well as modify performance indicators as necessary.
- All consultants must use an incident reporting system as specified in the traditional 1915(c) Home and Community-Based Services (HCBS) waiver and all incident information must be reported to the program office. The incident information will be compiled and included with the annual report to Agency for Health Care Administration (AHCA). The incidents will be logged by type of incident and must include appropriate action taken to remedy the situation.
  - This will aid in monitoring of incident reporting and follow-up as well as possible discovery of abuse or neglect.
- The subagent for APD will maintain a current Medicaid Provider Agreement.
  - This is required in the assurances.
- APD maintains a Government Policies and Procedures Manual which reflects all requirements described in the subagent's Medicaid Provider Agreement and contract. The manual includes policies, procedures and internal controls for all operations tasks. The manual also includes a policy and procedure for staying up-to-date with all federal and state requirements and for updating the manual at least annually and as needed.
  - The manual acts as the "blueprint" for government FEA operations, is a training tool for new government FEA staff and is a key component of a quality management system.

- APD will implement a helpline call log.

  - This aids in monitoring so the program office is made aware of what types of complaints or questions are called in to the APD.

The Outcome Measures listed below are taken from the PCP process for the iBudget waiver and follow-up instrument; there are also quarterly monitoring items:

- The PCP process for the iBudget waiver must be completed before a consumer completes their first budget/purchasing plan.
  - This aids the consumer in identifying their goals and needs in order to input the services and supplies which will help them to complete their goals.
- Each consumer will need to list their personal goals and identify which services or supports will help them to reach those goals.
  - This will help the consumer to identify and achieve their goals. For example: Goal #1 might be to live in their own home and remain as independent as possible. In order to reach that goal, the consumer might need to hire someone during the week days to provide personal assistance.
- The follow-up instrument will be conducted at least every six months.
  - This will aid the consumer in determining if their goals are being met.
- The consumer will also be able to identify if they need to modify their goals at their bi-annual follow-up. All consumers must be able to request a change to their service plan based on a change in needs or health status. Service plans must be reviewed annually, or whenever necessary due to a change in a consumer's needs or health status.
  - This will allow the consumer to identify new goals or change current goals and identify the services and supports that will meet the new goals and include them on their purchasing plan, removing any services or supports that are no longer necessary.
- The consultant file must include the annual Medicaid eligibility document for each consumer. This helps to assure the State that there are not ongoing issues with consumers being ineligible for Medicaid because of a missed meeting or other situation that could have been taken care of by completing a document or attending a meeting.
  - This will aid the program office in ensuring all consumers retain their Medicaid eligibility and all consultants are tracking annual Medicaid meetings for their consumers.

- Every consultant must maintain a signed consent form. The form must be either signed by the consumer or representative, if applicable. The consent form will serve as verification that the consumer is responsible for directing their own care and fully understands the program.

- This will aid the State to ensure all consumers understand and consent to participate in this program.

The following Satisfaction Measures are taken from the Consumer Satisfaction Survey:

- The Budget/Purchasing Plan had clear instructions on how to complete.
  - The program office will verify information and instructions distributed to consumers are user-friendly. At least 80% of the consumers must agree that program materials are user-friendly. All results from the Satisfaction Survey will be given to the Quality Advisory Committee (QAC). The QAC will help determine the priorities for the performance indicators in which the State will need to meet. If the State is falling behind expectations on the performance indicators, the QAC will help determine how to correct or improve the processes.

- Payments for consumers' invoices and timesheets must be made in a timely manner.
  - This will inform the program office if the subagent is performing its duties and in a timely manner. If not, the program office will need to discuss a corrective action plan with the subagent.

- Payment issues were responded to within 48 business hours.
  - While a response is expected within 48 business hours (a response could include situations in which the issue is still being researched), 90% of issues should be resolved within 72 business hours.

- The consumer's net worth/monthly statement must be received every month.
  - This will aid the program office in determining if consumers are indeed receiving their statements. Statements must be received in order for the consumers to reconcile their balances monthly. Also consumers use their statements to ensure their purchases are accurately reflected.

Risk Management

A. The risk assessment methods used to identify potential risks to participants are described below.

Potential risks to the consumer are assessed during the service development process. Strategies to mitigate risk are incorporated into the budget/purchasing plan, subject to consumer needs and preferences. The budget/purchasing plan development process addresses emergency backup plans. Each consumer is screened for capacity to direct their own care and required to identify a representative if indicated.

B. The tools or instruments used to mitigate identified risks are described below.

I. Criminal Background Checks are mandatory for all employees, even family members. Criminal Background Checks are mandated by state law. The Criminal Background Checks are performed at no cost to the consumer but are to be paid by the employee. All individuals who will be rendering care to a consumer enrolled in this program must either:

- Be a Medicaid enrolled provider who received background screening at the time of their enrollment into the Medicaid program ( and who remains in good standing with the Medicaid program); or
- Pass a background screening; or
- Provide proof of a State of Florida and/or a Federal background screening completed within six-months prior to employment, the outcome of which was a finding of no disqualifying offenses.

II. Each Consumer-Directed Care Plus (CDC+) consumer is required to develop an emergency back-up plan before starting to manage a budget on CDC+. The emergency backup plan should describe the alternative services delivery methods that will be used under any of the following circumstances: 1) if the primary employees fail to report to work or otherwise cannot perform the job at the time and place required, 2)if the consumer experiences a personal emergency, or 3) if there is a community-wide emergency(e.g., requiring evacuation). The personal emergency portion of the emergency back-up plan will allow the participant to identify circumstances that would cause an emergency for him/her based upon his/her unique needs. The emergency back-up plan must also address ways to assure that the needs of the individual are met should an unexpected shortage of funds occur.

III. The Consumer/Representative Agreement is a written agreement between a consumer and the consumer's representative that sets forth the CDC+ responsibilities of the representative. All consumers have the option of choosing one individual to act as a representative (friend, caregiver, family member or other person, etc.) to assume budget and care management responsibilities. Representatives may not work for the consumer

or be paid by the consumer. Consumers may also receive assistance with their CDC+ responsibilities without appointing a representative; however these individuals cannot sign documents, speak for or otherwise act on behalf of the consumer.

IV. The monthly monitoring of consumers by consultants will be used to assess for risks to the consumer. The consultant will monitor both the consumer's monthly budget to assess the consumer's spending and service utilization in comparison with the purchasing plan and the consultant will also assess the consumer's risk for abuse, neglect or exploitation at the semi-annual home visits.

C. The State's process for ensuring that each service plan reflects the risks that an individual is willing and able to assume, and the plan for how identified risks will be mitigated, is described below.

Prior to enrollment in the CDC+ program, each consumer will receive a Home and Community-Based Waiver care/support plan based on an assessment of need that includes an identification of risks and potential mitigation strategies. All consumers in CDC+ must take part in an initial training prior to the development of the budget/purchasing plan. In this training, the consumer is given lists of roles and responsibilities, which provides a detailed description of the roles and responsibilities of the consumer in the program including a detailed description of the roles, responsibilities and support functions of the consultant, and APD staff. This document will be thoroughly reviewed with the consumer and/or the representative to ensure that there is a clear understanding of the responsibilities related to the health and safety and mitigation risks to be assumed by the consumer. The consumer will list all identified risks in the emergency back-up plan including the plan that each individual consumer will use in the case of an emergency. The consumer/representative will develop a purchasing plan to specify how the monthly budget will be used to meet the consumer's care needs, and how other identified needs might be met through generic, community supports, and Medicaid State plan services. Risks will be documented and updated at the consumer's semi-annual home visit or more frequently if needed.

D. The State's process for ensuring that the risk management plan is the result of discussion and negotiation among the persons designated by the State to develop the service plan, the participant, the participant's representative, if any, and others from whom the participant may seek guidance, is described below.

The consumer/representative is responsible for developing their own budget/purchasing plan to show how their budget will be spent each month. In that plan, the consumer will identify the risks that were discussed with the consultant during their initial and semi-annual monitoring assessment.

The consumer must identify and manage their personal emergency back-up plan/risk mitigation strategy in their PGS tool. Consultants will provide support and technical assistance in order to facilitate the development of the budget/purchasing plan by the consumer/representative.

Consultants will not assume responsibility for developing the budget/purchasing plan, but will review and approve the plan to ensure that proposed services are adequate, purchases are cost-effective and related to the consumer's needs, and that an emergency back-up plan is in place. The consultant reviews the proposed budget/purchasing plan with the consumer/representative and others identified by the consumer as a method to assess the consumer/representative's ability to assume service management responsibilities and to further generate discussion around risk management.

ii. Qualifications of Providers of Personal Assistance

E. __X__ The State elects to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

F. _____ The State elects not to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

iii. Use of a Representative

G. __X__ The State elects to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

i._____ The State elects to include, as a type of representative, a State mandated representative. Please indicate the criteria to be applied.

H. _____ The State elects not to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

iv. Permissible Purchases

I. __X__ The State elects to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

J. The State elects not to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

xvi. Financial Management Services

A. _____The State elects to employ a Financial Management Entity to provide financial management services to participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.

i. __X_ The State elects to provide financial management services through a reporting or subagent through its fiscal intermediary in accordance with section 3504 of the IRS Code and Revenue Procedure 80-4 and Notice 2003-70; or

ii. ____The State elects to provide financial management services through vendor organizations that have the capabilities to perform the required tasks in accordance with section 3504 of the IRS Code and Revenue Procedure 70-6. (When private entities furnish financial management services, the procurement method must meet the requirements set forth Federal regulations in 45 CFR section 74.40 – section 74.48.)

iii. ____The State elects to provide financial management services using "agency with choice" organizations that have the capabilities to perform the required tasks in accordance with the principles of self-direction and with Federal and State Medicaid rules.

B. __X__ The State elects to directly perform financial management services on behalf of participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.

State: FLORIDA

MEDICAID ELIGIBILITY GROUPS SERVED

a. Home and community care services will be made available to individuals age 65 or older, when the individuals have been determined to be functionally disabled as specified in Appendix B.

b. Individuals served under this provision must meet the following Medicaid eligibility criteria (check all that apply):

1. _____ Age 65 or older who have been determined to be functionally disabled (as determined under the SSI program) as specified in Appendix B.

A. _____ The agency uses the same methodologies for treatment of income and resources as used in the SSI program (or the optional State supplement program which meets the requirements of 42 CFR 435.230, as appropriate). Individuals must be receiving SSI/SSP benefits to be eligible under this provision.

B. _____ The agency uses methodologies for treatment of income and resources that differ from those of the SSI program. These differences result from restrictions applied under section 1902(f) of the Act. The methodologies are described in Supplement 5 to Attachment 2.6-A. Individuals must be eligible for Medicaid under the State's plan to be eligible under this provision.

2. _____ Medically needy, age 65 or older who have been determined to be functionally disabled as specified in Appendix B. In determining the individual's eligibility, the State may, at its option, provide for the determination of the individual's anticipated medical expenses (to be deducted from income). (Check one):

A. _____ The State does not consider anticipated medical expenses.

B. _____ The State considers anticipated medical expenses over a period of _____ months (not to exceed 6 months).

State: FLORIDA

INDIVIDUALS PREVIOUSLY COVERED UNDER A WAIVER

a. _____ The State used a health insuring organization before January 1, 1986, and had in effect a waiver under §1115 of the Act, which provides personal care services under the State plan for functionally disabled individuals, and which was in effect on December 31, 1990. In accordance with §1929(b)(2)(B) of the Act, the following individuals will be eligible to receive home and community care services. (Check all that apply):

1. _____ Age 65 or older.

2. _____ Disabled, receiving SSI.

These individuals meet the resource requirement and income standards that apply in the State to individuals described in §1902(a)(10)(A)(ii)(V) of the Act.

b. _____ In accordance with §1929(b)(2)(A) the Act, individuals age 65 or older who were served under a waiver granted pursuant to section 1915(c) of the Act on the date on which that waiver was terminated. This waiver was terminated during the period in which the State furnished home and community care to functionally disabled elderly individuals under its State plan. Financial eligibility standards for these individuals (which are the same as those in effect on the date on which the waiver was terminated) are attached to this Appendix.

c. _____ In accordance with §1929(b)(2)(A) the Act, individuals age 65 or older, who were served under a waiver granted pursuant to section 1915(d) of the Act on the date on which that waiver was terminated. This waiver was terminated during the period in which the State furnished home and community care to functionally disabled elderly individuals under its State plan. Financial eligibility standards for these individuals (which are the same as those in effect on the date on which the waiver was terminated) are attached to this Appendix.

State: FLORIDA

FUNCTIONAL DISABILITY

Home and community care services, as defined in this Supplement, are provided to the following classifications of individuals who have been found on the basis of an assessment to be functionally disabled. Services will be limited to individuals who meet the following targeting criteria.

Check all that apply:

a. _____ Services are provided to individuals, who have been determined, on the basis of an assessment, to require substantial human assistance with at least two of the following activities of daily living: toileting, transferring, eating.

b. _____ Services are provided to individuals, who have been determined, on the basis of an assessment, to require substantial human assistance with each of the following activities of daily living: toileting, transferring, eating.

c. _____ Services are provided to individuals who have been determined, on the basis of an assessment, to have a primary or secondary diagnosis of Alzheimer's Disease, and are unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision, at least 2 of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.

d. _____ Services are provided to individuals, who have been determined, on the basis of an assessment, to have a primary or secondary diagnosis of Alzheimer's Disease, and are unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision, (check one):

1. _____ at least 3 of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.

2. _____ at least 4 of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.

3. _____ all of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.

e. _____ Services are provided to individuals who have been determined, on the basis of an assessment, to have a primary or secondary diagnosis of Alzheimer's Disease, and are sufficiently cognitively impaired so as to require substantial supervision from another individual because they engage in inappropriate behaviors that pose serious health or safety hazards to themselves or others.

State: FLORIDA

AGE

Check all that apply:

a. _____ Services are provided to individuals age 65 and older.

b. _____ Services are provided to individuals who have reached at least the following age, greater than 65 (specify): _____

c. _____ Services are provided to individuals who meet the criteria set forth in item 3.b. of Supplement 2, as set forth in Appendix B-3, who were 65 years of age or older on the date of the waiver's discontinuance.

d. _____ Services are provided to individuals who meet the criteria set forth in item 3.c. of Supplement 2, as set forth in Appendix B-3, who were served under the waiver on the date of its discontinuance.

e. _____ Services are provided to individuals who meet the criteria in item 3.d. of Supplement 2, who fall within the following age categories (check all that apply):

1. _____ Age 65 and older

2. _____ Age greater than 65. Services are limited to those who have attained at least the age of (specify): _____

3. _____ Age less than 65. Services will be provided to those in the following age category (specify): _____

4. _____ The State will impose no age limit.

State: FLORIDA

INDIVIDUALS PREVIOUSLY SERVED UNDER WAIVER AUTHORITY

a. _____ In accordance with §1929(b)(2)(A) of the Act, the State will discontinue the following home and community-based services waiver(s), approved under the authority of §1915(c) or §1915(d) of the Act. (Specify the waiver numbers):

| Waiver Number | Last date of waiver operation |
|---|---|
| | |
| | |
| | |
| | |

b. For each waiver specified in Appendix B-3-a, above, the State will furnish at least 30 days notice of service discontinuance to those individuals under 65 years of age, and to those individuals age 65 or older who do not meet the test of functional disability specified in Appendix B-1 (except those individuals who will continue to receive home and community-based services under a different waiver program).

c. Individuals age 65 years of age or older, who were eligible for benefits under a waiver specified in Appendix B-3-a on the last date of waiver operation, who would, but for income or resources, be eligible for home and community care under the State plan, shall be deemed functionally disabled elderly individuals for so long as they would have remained eligible for services under the waiver.

d. The financial eligibility standards which were in effect on the last date of waiver operation are attached to this Appendix.

e. The following are the schedules, in effect on the last date of waiver operation, under which individuals served under a waiver identified in Appendix B-3-a were reevaluated for financial eligibility (specify):

| Waiver Number | Reevaluation schedule |
|---|---|
| | |
| | |
| | |
| | |

State: FLORIDA

DEFINITION OF SERVICES

The State requests that the following services, as described and defined herein, be provided as home and community care services to functionally disabled elderly individuals under this program:

a. _____ Homemaker Services. (Check one.)

_____ Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities. This service does not include medical care of the client. Hands-on care is limited to such activities as assistance with dressing, uncomplicated feeding, and pushing a wheelchair from one room to another. Direct care furnished to the client is incidental to care of the home. These standards are included in Appendix C-2.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

b. _____ Home Health Aide Services. (Check one.)

_____ Services defined in 42 CFR 440.70 with the exception that limitations on the amount, duration and scope of such services shall instead be governed by the limitations imposed below.

_____ Other Service Definition: _____

State: FLORIDA

DEFINITION OF SERVICES (con't)

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

c. _____ Chore Services. (Check one.)

_____ Services identified in the ICCP which are needed to maintain the individual's home in a clean, sanitary and safe environment. For purposes of this section, the term "home" means the abode of the individual, whether owned or rented by the client, and does not include the residence of a paid caregiver with whom the client resides (such as a foster care provider), or a small or large community care facility.

Covered elements of this service include heavy household chores such as washing floors, windows and walls, removal of trash, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access inside the home for the recipient, and shoveling snow to provide access and egress.

Chore services will be provided only in cases where neither the client, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

State: FLORIDA

DEFINITION OF SERVICES (con't)

Provider qualifications are specified in Appendix C-2.

d. _____ Personal Care Services. (Check one.)

_____ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This service includes meal preparation, when required by the individual community care plan (ICCP), but does not include the cost of the meals. When specified in the ICCP, this service also includes such housekeeping chores as bedmaking, cleaning, shopping, or escort services which are appropriate to maintain the health and welfare of the recipient. Providers of personal care services must meet State standards for this service. These standards are included in Appendix C-2.

_____ Other Service Definition: _____

1. Services provided by family members. Check one:

_____ Payment will not be made for personal care services furnished by a member of the recipient's family or by a person who is legally or financially responsible for that recipient.

_____ Personal care providers may be members of the recipient's family. Payment will not be made for services furnished to a minor by the recipient's parent (or stepparent), or to a recipient by the recipient's spouse. Payment will not be made for services furnished to a recipient by a person who is legally or financially responsible for that recipient.

Check one:

_____ Family members who provide personal care services must meet the same standards as other personal care providers who are unrelated to the recipient. These standards are found in Appendix C-2.

_____ Standards for family members who provide personal care services differ from those for other providers of this service. The standards for personal care services provided by family members are found in Appendix C-2.

2. Personal care providers will be supervised by:

_____ a registered nurse, licensed to practice nursing in the State

_____ case managers

_____ other (specify): _____

State: FLORIDA

DEFINITION OF SERVICES (con't)

3. Minimum frequency or intensity of supervision:

_____ as indicated in the client's ICCP

_____ other (specify): _____

4. Personal care services are limited to those furnished in a recipient's home.

_____ Yes _____ No

5. Limitations (check one):

_____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

_____ The State will impose the following limitations on the provision of this service (specify): _____

e. _____ Nursing Care Services Provided By or Under The Supervision of a Registered Nurse.

_____ Nursing services listed in the ICCP which are within the scope of State law, and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Standards for the provision of this service are included in Appendix C-2.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

State: FLORIDA

DEFINITION OF SERVICES (con't)

f. _____ Respite care. (Check one.)

_____ Services given to individuals unable to care for themselves; provided on a short-term basis because of the absence or need for relief of those persons normally providing the care. FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

_____ Other Service Definition: _____

1. Respite care will be provided in the following location(s):

   _____ Recipient's home or place of residence

   _____ Foster home

   _____ Facility approved by the State which is not a private residence

2. The State will apply the following limits to respite care provided in a facility.

   _____ Hours per recipient per year

   _____ Days per recipient per year

   _____ Respite care will be provided in accordance with the ICCP. There are no set limits on the amount of facility-based respite care which may be utilized by a recipient.

   _____ Not applicable. The State does not provide facility-based respite care.

3. Respite care will be provided in the following type(s) of facilities.

   _____ Hospital

   _____ NF

   _____ ICF/MR

   _____ Group home

   _____ Licensed respite care facility

State: FLORIDA

DEFINITION OF SERVICES (con't)

_____ Other (specify): _____

_____ Not applicable. The State does not provide facility-based respite care.

4. The State will apply the following limits to respite care provided in a community setting which is not a facility (including respite care provided in the recipient's home).

_____ Hours per recipient per year
_____ Days per recipient per year

_____ Respite care will be provided in accordance with the ICCP. There are no set limits on the amount of community-based respite care which may be utilized by a recipient.

_____ Not applicable. The State does not provide respite care outside a facility-based setting.

Qualifications of the providers of respite care services are included in Appendix C-2. Applicable Keys amendment (section 1616(e) of the Social Security Act) standards are cited in Appendix F-2.

g. _____ Training for Family Members in Managing the Individual. (Check one.)

_____ Training and counseling services for the families of functionally disabled elderly individuals. For purposes of this service, "family" is defined as the persons who live with or provide care to a disabled individual, and may include a spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the functionally disabled individual. Training includes instruction about treatment regimens and use of equipment specified in the ICCP and shall include updates as may be necessary to safely maintain the individual at home. This service is provided for the purpose of increasing the ability of a primary caregiver or a member of the recipient's family to maintain and care for the individual at home. All training for family members must be included in the client's ICCP.

_____ Other Service Definition: _____

State: FLORIDA

DEFINITION OF SERVICES (con't)

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Provider qualifications are specified in Appendix C-2.

h. _____ Adult Day Care. (Check one.)

_____ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the client. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

_____ Other Service Definition: _____

Check all that apply:

1. _____ Physical therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of physical therapy will be included in the rate paid to providers of adult day care services.

2. _____ Occupational therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of occupational therapy will be included in the rate paid to providers of adult day care services.

3. _____ Speech therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of speech therapy will be included in the rate paid to providers of adult day care services.

State: FLORIDA

DEFINITION OF SERVICES (con't)

4. _____ Nursing care furnished by or under the supervision of a registered nurse, and indicated in the individual's ICCP, will be provided by the facility as a component part of this service.

5. _____ Transportation between the recipient's place of residence and the adult day care center will be provided as a component part of this service. The cost of this transportation is included in the rate paid to providers of adult day care services.

6. _____ Other therapeutic activities which will be provided by the facility as component parts of this service. (Specify): _____

Limitations. Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Qualifications of the providers of this service are found in Appendix C-2.

i. _____ Services for individuals with chronic mental illness, consisting of (Check all that apply):

1. _____ Day Treatment or other Partial Hospitalization Services. (Check one.)

_____ Services that are necessary for the diagnosis or active treatment of the individual's mental illness. These services consist of the following elements:

a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

State: FLORIDA

DEFINITION OF SERVICES (con't)

b. occupational therapy, requiring the skills of a qualified occupational therapist,

c. services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients,

d. drugs and biologicals furnished for therapeutic purposes,

e. individual activity therapies that are not primarily recreational or diversionary,

f. family counseling (the primary purpose of which is treatment of the individual's condition),

g. patient training and education (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and

h. diagnostic services.

Meals and transportation are excluded from reimbursement under this benefit. The purpose of this benefit is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

_____ Other Service Definition: _____

Limitations. Check one:

a. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

b. _____ The State will impose the following limitations on the provision of this service (specify): _____

Qualifications of the providers of this service are found in Appendix C-2.

2. _____ Psychosocial Rehabilitation Services. (Check one.)

State: FLORIDA

DEFINITION OF SERVICES (con't)

_____ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

- o Restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);
- o Social skills training in appropriate use of community services;
- o Development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and
- o Telephone monitoring and counseling services.

The following services are specifically excluded from Medicaid payment:

Vocational services,
Prevocational services,
Supported employment services,
Educational services, and
Room and board.

_____ Other Service Definition: _____

Psychosocial rehabilitation services are furnished in the following locations (check all that apply):

a. _____ Individual's home or place of residence

b. _____ Facility in which the individual does not reside

c. _____ Other (Specify): _____

State: FLORIDA

DEFINITION OF SERVICES (con't)

Limitations. Check one:

a. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

b. _____ The State will impose the following limitations on the provision of this service (specify): _____

Qualifications of the providers of this service are found in Appendix C-2.

3. _____ Clinic Services (Whether or Not Furnished in a Facility) are services defined in 42 CFR 440.90.

Check one:

a. _____ This benefit is limited to those services furnished on the premises of a clinic.

b. _____ Clinic services may be furnished outside the clinic facility. Services may be furnished in the following locations (specify): _____

Check one:

a. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

b. _____ The State will impose the following limitations on the provision of this service (specify): _____

State: FLORIDA

DEFINITION OF SERVICES (con't)

Qualifications of the providers of this service are found in Appendix C-2.

j. _____ Habilitation. (Check one.)

_____ Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully at home or in the community. This service includes:

1. _____ Residential habilitation: assistance with acquisition, retention or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a home or community setting. Payments for residential habilitation are not made for room and board, or the costs of facility maintenance, upkeep, and improvement. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the recipient's immediate family. Payments will not be made for routine care and supervision, or for activities or supervision for which a payment is available from a source other than Medicaid. The methodology by which payments are calculated and made is described in Attachment 4.19-B.

2. _____ Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the recipient resides. Services shall normally be furnished 4 or more hours per day, on a regularly scheduled basis, for 1 or more days per week, unless provided as an adjunct to other day activities included in the recipient's ICCP. Day habilitation services shall focus on enabling the individual to attain or retain his or her maximum functional level.

_____ Other Service Definition: _____

State: FLORIDA

DEFINITION OF SERVICES (con't)

Check all that apply:

A. _____ Physical therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of physical therapy will be included in the rate paid to providers of habilitation services.

B. _____ Occupational therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of occupational therapy will be included in the rate paid to providers of habilitation services.

C. _____ Speech therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of speech therapy will be included in the rate paid to providers of habilitation services.

D. _____ Nursing care furnished by or under the supervision of a registered nurse, and indicated in the individual's ICCP, will be provided by the facility as a component part of this service.

E. _____ Transportation between the recipient's place of residence and the habilitation center will be provided as a component part of this service. The cost of this transportation is included in the rate paid to providers of habilitation services.

F. _____ Other therapeutic activities which will be provided by the facility as component parts of this service. (Specify): _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

State: FLORIDA

DEFINITION OF SERVICES (con't)

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Payment will not be made for the following:

Vocational Services;
Prevocational services;
Educational services; or
Supported employment services.

Qualifications of the providers of this service are specified in Appendix C-2.

k. _____ Environmental Modifications. (Check one.)

_____ Those physical adaptations to the home, required by the individual's ICCP, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home.

Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies the need for which is identified in the client's ICCP.

Adaptations or improvements to the home which are of general utility, or which are not of direct medical or remedial benefit to the client, such as carpeting, roof repair, central air conditioning, etc., are specifically excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

State: FLORIDA

DEFINITION OF SERVICES (con't)

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

1. _____ Transportation. (Check one.)

_____ Service offered in order to enable individuals receiving home and community care under this section to gain access to services identified in the ICCP. Transportation services under this section shall be offered in accordance with the recipient's ICCP, and shall be used only when the service is not available without charge from family members, neighbors, friends, or community agencies, and when the appropriate type of transportation is not otherwise provided under the State plan. In no case will family members be reimbursed for the provision of transportation services under this section.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Provider qualifications are specified in Appendix C-2.

m. _____ Specialized Medical Equipment and Supplies. (Check one.)

_____ Specialized medical equipment and supplies which include devices, controls, or appliances, specified in the ICCP, which enable clients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This

State: FLORIDA

DEFINITION OF SERVICES (con't)

service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and supplies not otherwise available under the State plan. Items which are not of direct medical or remedial benefit to the recipient are excluded from this service. All specialized medical equipment and supplies provided under this benefit shall meet applicable standards of manufacture, design and installation.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

n. _____ Personal Emergency Response Systems (PERS). (Check one.)

_____ PERS is an electronic device which enables certain high-risk clients to secure help in the event of an emergency. The client may also wear a portable "help" button to allow for mobility. The system is connected to the client's phone and programmed to signal a response center once the "help" button is activated. The response center is staffed by individuals with the qualifications specified in Appendix C-2.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

State: FLORIDA

DEFINITION OF SERVICES (con't)

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

o. _____ Adult Companion Services. (Check one.)

_____ Non-medical care, supervision and socialization provided to a functionally disabled adult. Companions may assist the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on medical care. Companion services may include non-medical care of the client, such as assistance with bathing, dressing and uncomplicated feeding. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the client. This service is provided in accordance with a therapeutic goal in the ICCP, and is not merely diversionary in nature.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Provider qualifications are specified in Appendix C-2.

3. Services provided by family members. Check one:

A. _____ Payment will not be made for adult companion services furnished by a member of the recipient's family or by a person who is legally or financially responsible for that recipient.

State: FLORIDA

DEFINITION OF SERVICES (con't)

B. _____ Adult companion service providers may be members of the recipient's family. Payment will not be made for services furnished to a minor by the recipient's parent (or stepparent), or to a recipient by the recipient's spouse. Payment will not be made for services furnished to a recipient by a person who is legally or financially responsible for that recipient.

Check one:

1. _____ Family members who provide adult companion services must meet the same standards as other adult companion providers who re unrelated to the recipient. These standards are found in Appendix C-2.

2. _____ Standards for family members who provide adult companion services differ from those for other providers of this service. The standards for adult companion services provided by family members are found in Appendix C-2.

p. _____ Attendant Care. (Check one.)

_____ Hands-on care, of both a medical and non-medical supportive nature, specific to the needs of a medically stable, physically handicapped individual. This service may include skilled medical care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of the client-based care may also be furnished as part of this activity.

_____ Other Service Definition: _____

Check all that apply:

1. _____ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the ICCP.

State: FLORIDA

DEFINITION OF SERVICES (con't)

2. _____ Supervision may be furnished directly by the client, when the client has been trained to perform this function, and when the safety and efficacy of client-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on observation of the client and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained with the client's ICCP.

3. _____ Other supervisory arrangements: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Provider qualifications are specified in Appendix C-2.

q. _____ Private Duty Nursing. (Check one.)

_____ Private Duty Nursing services consist of individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within their scope of practice under State law.

_____ Other Service Definition: _____

Check one:

1. _____ Private duty nursing services are limited to services provided in the individual's home or place of residence.

State: FLORIDA

DEFINITION OF SERVICES (con't)

2. _____ Private duty nursing services are not limited to services provided in the individual's home or place of residence.

Check one:

A. _____ Services may also be provided in the following locations (Specify):

_____
_____
_____

B. _____ The State will not place limits on the site of private duty nursing services.

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

_____
_____
_____
_____
_____

r. _____ Extended State Plan Services. The following services are available under the State plan, but with limitations. Under this benefit, these services will be provided in excess of the limitations otherwise specified in the plan. Provider standards will remain unchanged from those otherwise indicated in the State plan. When these services are provided as home and community care, the limitations on each service will be as specified in this section.

1. _____ Physician services.

Check one:

A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

B. _____ The State will impose the following limitations on the provision of this service (specify): _____

_____
_____
_____

State: FLORIDA

DEFINITION OF SERVICES (con't)

2. _____ Home Health Care Services

Check one:

A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

B. _____ The State will impose the following limitations on the provision of this service (specify): _____

3. _____ Physical Therapy Services

Check one:

A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

B. _____ The State will impose the following limitations on the provision of this service (specify): _____

4. _____ Occupational Therapy Services

Check one:

A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

B. _____ The State will impose the following limitations on the provision of this service (specify): _____

5. _____ Speech, Hearing and Language Services

Check one:

A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

State: FLORIDA

DEFINITION OF SERVICES (con't)

B. _____ The State will impose the following limitations on the provision of this service (specify): _____

6. _____ Prescribed Drugs

Check one:

A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

B. _____ The State will impose the following limitations on the provision of this service (specify): _____

8. _____ Other services (specify): _____

Provider standards for each "other" services identified are found in Appendix C-2.

State: FLORIDA

PROVIDER QUALIFICATIONS

a. The following are the minimum qualifications for the provision of each home and community care service under the plan.

LICENSURE AND CERTIFICATION CHART

Cite relevant portions of State licensure and certification rules as they apply to each service to be provided.

| SERVICE | PROVIDER TYPE | LICENSURE | CERTIFICATION |
|---|---|---|---|
| HOMEMAKER | | | |
| HOME HEALTH AIDE | | | |
| CHORE SERVICES | | | |
| PERSONAL CARE | | | |
| NURSING CARE | | | |
| RESPITE CARE | | | |
| IN HOME | | | |
| FACILITY BASED | | | |
| FAMILY TRAINING | | | |
| ADULT DAY CARE | | | |
| DAY TREATMENT/ PARTIAL HOSPITALIZATION | | | |
| PSYCHOSOCIAL REHABILITATION | | | |
| CLINIC SERVICES | | | |

State: FLORIDA

PROVIDER QUALIFICATIONS (con't)

| SERVICE | PROVIDER TYPE | LICENSURE | CERTIFICATION |
|---|---|---|---|
| HABILITATION | | | |
| RESIDENTIAL | | | |
| DAY | | | |
| ENVIRONMENTAL MODIFICATIONS | | | |
| TRANSPORTATION | | | |
| MEDICAL EQUIPMENT AND SUPPLIES | | | |
| PERSONAL EMERGENCY RESPONSE SYSTEMS | | | |
| ADULT COMPANION | | | |
| ATTENDANT CARE | | | |
| PVT DUTY NURSING | | | |

Identify any licensure and certification standards applicable to the providers of "other" services defined in Appendix C-1 on a separate sheet of paper. Attach the paper to this Appendix.

Identify any additional standards applicable to each service on a separate sheet of paper. Attach the paper to this Appendix.

b. ASSURANCE THAT REQUIREMENTS ARE MET

1. The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under this section.

2. The State will require each provider furnishing services under this section to furnish proof that all applicable requirements for service provision, specified in this Appendix, are met prior to the provision of services for which FFP is claimed.

3. The State assures that it will review each provider at least once a year, to ensure that provider requirements continue to be met.

c. PROVIDER REQUIREMENTS APPLICABLE TO ALL SERVICES

In addition to standards of licensure and certification, each individual furnishing services under this section must demonstrate the following to the satisfaction of the State:

1. Familiarity with the needs of elderly individuals. The degree of familiarity must be commensurate with the type of service to be provided.

State: FLORIDA

PROVIDER QUALIFICATIONS (con't)

2. If the provider is to furnish services to individuals with Alzheimer's Disease or to recipients with other mental impairments, familiarity with the course and management of this disease, commensurate with the type of service to be provided.

3. The provider must furnish proof of sufficient ability to communicate with the client or primary caregiver. To be considered sufficient, this ability must be commensurate with the type of service to be provided.

4. Each provider must have received training, appropriate to the demands of the service to be provided, in proper response to emergency situations. This training must include instruction in how to contact the client's case manager.

5. Each provider must be qualified by education, training, experience and/or examination in the skills necessary for the performance of the service.

6. Providers may meet these standards by the following methods:

   A. Education, including formal degree requirements specified in the provider qualifications for the service to be furnished.

   B. Specific course(s), identified in the provider qualifications for the service to be furnished.

   C. Documentation that the provider has completed the equivalent of the course(s) identified in item c.6.B, above.

   D. Training provided by the Medicaid agency or its designee.

      The Medicaid agency or its designee will also make this training available to unpaid providers of service.

      _____ Yes _____ No

   E. Appropriate experience (specified in the provider qualifications for the applicable service) which may substitute for the education and training requirements otherwise applicable.

   F. The provider may demonstrate competence through satisfactory performance of the duties attendant upon the specified service. With regard to particular providers, and particular services, the State may also choose to require satisfactory completion of a written or oral test. Test requirements are included in the provider requirements applicable to the specific service.

Specific standards of education, training, experience, and/or demonstration of competence applicable to each service provided are attached to this Appendix.

d. PROVIDER REQUIREMENTS SPECIFIC TO EACH SERVICE

State: FLORIDA

PROVIDER QUALIFICATIONS (con't)

In addition to the licensure and certification standards cited in Appendix, the State will impose the following qualifications for the providers of each service.

| SERVICE | MINIMUM QUALIFICATIONS OF PROVIDERS |
|---|---|
| HOMEMAKER | |
| HOME HEALTH AIDE | Providers of Home Health Aide services meet the qualifications set forth at 42 CFR Part 484 for the provision of this service under the Medicare program. Additional qualifications: |
| CHORE SERVICES | |
| PERSONAL CARE | |
| NURSING CARE | |
| RESPITE CARE<br>IN HOME | |
| FACILITY BASED | |
| FAMILY TRAINING | |
| ADULT DAY CARE | |
| DAY TREATMENT/PARTIAL HOSPITALIZATION | Day treatment/partial hospitalization services are furnished by a hospital to its outpatients, or by a community mental health center. They are furnished by a distinct and organized ambulatory treatment center which offers care less than 24 hours a day. |
| PSYCHOSOCIAL REHABILITATION | |
| CLINIC SERVICES | |
| HABILITATION GENERAL STANDARDS | |
| RESIDENTIAL HABILITATION | |
| DAY HABILITATION | |

State: FLORIDA

PROVIDER QUALIFICATIONS (con't)

| SERVICE | MINIMUM QUALIFICATIONS OF PROVIDERS |
|---|---|
| ENVIRONMENTAL MODIFICATIONS | |
| TRANSPORTATION | |
| MEDICAL EQUIPMENT AND SUPPLIES | |
| PERSONAL EMERGENCY RESPONSE SYSTEMS | |
| ADULT COMPANION | |
| ATTENDANT CARE | |
| PVT DUTY NURSING | |

Identify the provider requirements applicable to the providers of each "other" service specified in Appendix C-1 on a separate sheet of paper. Attach the paper to this Appendix.

State: FLORIDA

ASSESSMENT

a. The State will provide for a comprehensive functional assessment for a financially eligible individual who meets the targeting requirements set forth in items 3 and 4 of Supplement 2.

b. This assessment will be provided at the request of the individual, or another person acting on the individual's behalf.

c. The individual will not be charged a fee for this assessment.

d. Attached to this Appendix is an explanation of the procedures by which the State will ensure the performance of the assessment.

e. The assessment will be reviewed and revised not less often than (check one):

1. _____ Every 12 months

2. _____ Every 6 months

3. _____ Other period not to exceed 12 months (Specify): _____

f. Check one:

1. _____ The State will use an assessment instrument specified by HCFA.

2. _____ The State will use an assessment instrument of its own specification. A copy of this instrument is attached to this Appendix. The State certifies that this instrument will measure functional disability as specified in section 1929(b) and (c) of the Act. The State requests that HCFA approve the use of this instrument, and certifies that at such time as HCFA may publish a minimum data set (consistent with section 1929(c)(2) of the Act), the assessment instrument will be revised, as determined necessary by HCFA, to conform to the core elements, common definitions, and uniform guidelines which are contained in the minimum data set.

g. In conducting the assessment (or the periodic review of the assessment), the interdisciplinary team must:

1. Identify in each such assessment or review each individual's functional disabilities; and

2. Identify in each such assessment or review each individual's need for home and community care. This identification shall include:

A. Information about the individual's health status;

B. Information about the individual's home and community environment; and

C. Information about the individual's informal support system.

State: FLORIDA

ASSESSMENT (con't)

3. Determine whether the individual is, or continues to be, functionally disabled. This determination will be made on the basis of the assessment or review.

h. The interdisciplinary team conducting the assessment shall furnish the results to the Medicaid agency and to the qualified community care case manager designated by the Medicaid agency (as specified in Appendix E) to establish, review and revise the individual's ICCP.

i. The Medicaid agency will monitor the appropriateness and accuracy of the assessments and periodic reviews on an ongoing basis, and whenever it is informed by a qualified community care case manager that inaccuracies appear to exist in the assessment of an individual. All problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the nature and severity of any deficiencies noted.

State: FLORIDA

INTERDISCIPLINARY TEAM

a. Initial assessments will be performed by interdisciplinary teams designated by the State. The agency will designate interdisciplinary teams that meet the following criteria (check all that apply):

1. _____ The interdisciplinary teams will be employed directly by the Medicaid agency.

2. _____ The interdisciplinary teams will be employed directly by other agencies of State government, under contract with the Medicaid agency.

3. _____ The interdisciplinary teams will be employed directly by agencies of local government under contract with the Medicaid agency.

4. _____ The interdisciplinary teams will be employed directly by nonpublic organizations which do not provide home and community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides community care or nursing facility services.

Interdisciplinary teams may utilize data gathered by other professionals, and may consult with service providers in conducting comprehensive functional assessments.

When assessments are provided under contract with an agency or organization which is not part of the Medicaid agency, the Medicaid agency will specify, as part of the contract, that the contracting agency or organization may not subcontract with another entity for the performance of the assessments without the prior written approval of the Medicaid agency.

b. Periodic reviews of assessments will be performed by interdisciplinary teams designated by the State. The agency will designate interdisciplinary teams that meet the following criteria (check all that apply):

1. _____ The interdisciplinary teams will be employed directly by the Medicaid agency.

2. _____ The interdisciplinary teams will be employed directly by other agencies of State government, under contract with the Medicaid agency.

3. _____ The interdisciplinary teams will be employed directly by agencies of local government under contract with the Medicaid agency.

4. _____ The interdisciplinary teams will be employed directly by nonpublic organizations which do not provide home and community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides community care or nursing facility services.

State: FLORIDA

INTERDISCIPLINARY TEAM (con't)

Interdisciplinary teams may utilize data gathered by other professionals, and may consult with service providers in conducting periodic reviews of the individuals' comprehensive functional assessments.

When periodic reviews of assessments are provided under contract with an agency or organization which is not part of the Medicaid agency, the Medicaid agency will specify, as part of the contract, that the contracting agency or organization may not subcontract with another entity for the performance of the periodic reviews without the prior written approval of the Medicaid agency.

c. The interdisciplinary teams conducting initial assessments shall consist, at a minimum, of (check all that apply, but at least 2):

1. _____ Registered nurse, licensed to practice in the State
2. _____ Licensed Practical or Vocational nurse, acting within the scope of practice under State law
3. _____ Physician (M.D. or D.O.), licensed to practice in the State
4. _____ Social Worker (qualifications attached to this Appendix)
5. _____ Case manager
6. _____ Other (specify): _____

d. The interdisciplinary teams conducting periodic reviews of assessments shall consist, at a minimum, of (check all that apply, but at least 2):

1. _____ Registered nurse, licensed to practice in the State
2. _____ Licensed Practical or Vocational nurse, acting within the scope of practice under State law
3. _____ Physician (M.D. or D.O.), licensed to practice in the State
4. _____ Social Worker (qualifications attached to this Appendix)
5. _____ Case manager
6. _____ Other (specify): _____

State: FLORIDA

INDIVIDUAL COMMUNITY CARE PLAN (ICCP)

a. A written individual community care plan (ICCP) will be developed for each individual who has been determined, on the basis of a comprehensive functional assessment performed in accordance with Appendix D, to be a functionally disabled elderly individual, according to the criteria set forth in Appendices A and B.

b. The ICCP will be established, and periodically reviewed and revised, by a Qualified Community Care Case Manager after a face to face interview with the individual or primary caregiver.

c. The ICCP will be based on the most recent comprehensive functional assessment of the individual conducted according to Appendix D.

d. The ICCP will specify, within the amount, duration and scope of service limitations set forth in Appendix C, the home and community care to be provided to such individual under the plan.

e. The ICCP will indicate the individual's preferences for the types and providers of services.

f. The ICCP will specify home and community care and other services required by such individual. (Check one):

1. _____ Yes 2. _____ No

g. The ICCP will designate the specific providers (who meet the qualifications specified in Appendix C-2) which will provide the home and community care. (Check one):

1. _____ Yes 2. _____ No

h. Neither the ICCP, nor the State, shall restrict the specific persons or individuals (who meet the requirements of Appendix C-2) who will provide the home and community care specified in the ICCP.

State: FLORIDA

QUALIFIED COMMUNITY CARE CASE MANAGERS

a. A "Qualified Community Care Case Manager" will meet each of the following qualifications for the provision of community care case management.

1. Be a nonprofit or public agency or organization;

2. Have experience or have been trained in:

A. Establishing and periodically reviewing and revising ICCPs; and

B. The provision of case management services to the elderly.

The minimum standards of experience and training which will be employed by the State are attached to this Appendix;

3. Have procedures for assuring the quality of case management services. These procedures will include a peer review process.

4. The State will assure that community care case managers are competent to perform case management functions, by requiring the following educational or professional qualifications be met. (Check all that apply):

A. _____ Registered nurse, licensed to practice in the State

B. _____ Physician (M.D. or D.O.), licensed to practice in the State

C. _____ Social Worker (qualifications attached to this Appendix)

D. _____ Other (specify): _____

b. When community care case management is provided by a nonprofit, nonpublic agency, the agency providing the community case management will not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides home and community care or nursing facility services and will not furnish home and community care or nursing facility services itself. (Check one):

1. _____ Yes

2. _____ Not applicable. The State will not use nonprofit, nonpublic agencies to provide community care case management.

c. The State will employ procedures to assure that individuals whose home and community care is managed by qualified community care case managers are not at risk of financial exploitation due to such managers. An explanation of these procedures is attached to this Appendix.

State: FLORIDA

QUALIFIED COMMUNITY CARE CASE MANAGERS (con't)

d. The State requests that the requirements of item E-2-b be waived in the case of a nonprofit agency located in a rural area. The State's definition of "rural area" is attached to this Appendix. (Check one):

1. _____ Yes 2. _____ No

3. _____ Not applicable. The State will not use nonprofit, nonpublic agencies to provide community care case management.

State: FLORIDA

COMMUNITY CARE CASE MANAGEMENT FUNCTIONS

a. A qualified community care case manager is responsible for:

1. Assuring that home and community care covered under the State plan and specified in the ICCP is being provided;

2. Visiting each individual's home or community care setting where care is being provided not less often than once every 90 days;

3. Informing the elderly individual or primary caregiver how to contact the case manager if service providers fail to properly provide services or other similar problems occur. This information will be provided verbally and in writing.

4. Completes the ICCP in a timely manner; and

5. Reviews and discusses new and revised ICCPs with elderly individuals or primary caregivers.

b. Whenever a qualified community care case manager has reason to believe that an individual's assessment or periodic review (conducted under Appendix D) appears to contain inaccuracies, the community care case manager will bring these apparent discrepancies to the attention of the agency which has performed the assessment or review. If the assessors and the community care case manager are unable to resolve the apparent conflict, the case manager shall report the situation to the component of the Medicaid agency which is responsible for monitoring the program.

1. _____ Yes 2. _____ No

c. Whenever a qualified community care case manager is informed by an elderly individual or primary caregiver that provider(s) have failed to provide services, or that other similar problems have occurred, the community care case manager shall take whatever steps are necessary to verify or disprove the complaint. If a problem is confirmed by this monitoring, the community care case manager shall address the problem in an appropriate and timely manner, consistent with the nature and severity of any deficiencies noted. This may include reporting the situation to the component of the Medicaid agency which is responsible for monitoring the program.

1. _____ Yes 2. _____ No

d. Whenever a qualified community care case manager is informed by a provider of service (whether paid or unpaid) that there has been a change in the individual's condition, or that a problem may have arisen which is not currently being addressed, the community care case manager shall take whatever steps are necessary to verify or disprove the information. If a problem is confirmed by this monitoring, the community care case manager shall address it in an appropriate and timely manner, consistent with the nature and severity of the situation.

1. _____ Yes 2. _____ No

State: FLORIDA

COMMUNITY CARE CASE MANAGEMENT FUNCTIONS (con't)

e. Community care case managers shall verify the qualifications of each individual or agency providing home and community care services prior to the initiation of services, and at such intervals as are specified in Appendix C, thereafter. (Check one):

1. _____ Yes 2. _____ No

f. Where the provision of services in an individual's ICCP is not governed by State licensure or certification requirements, the community care case manager shall verify the qualifications of the individual or entity furnishing the services, and as necessary, provide or arrange for the training specified in Appendix C-2. (Check one):

1. _____ Yes 2. _____ No

3. _____ Not applicable. All services are governed by State licensure or certification requirements.

g. Community care case managers shall inform each elderly individual for whom an ICCP is established of the person's right to a fair hearing should the individual disagree with the contents of the ICCP.

State: FLORIDA

RIGHTS SPECIFIED IN THE STATUTE

The State assures that home and community care provided under the State plan will meet the following requirements:

a. Individuals providing care are competent to provide such care. The State will maintain documentation to show that each provider of care meets or exceeds the applicable minimum qualifications specified in Appendix C-2.

b. Individuals receiving home and community care shall be assured the following rights:

1. The right to be fully informed in advance, orally and in writing, of the following:

   a. the care to be provided,

   b. any changes in the care to be provided; and

   c. except with respect to an individual determined incompetent, the right to participate in planning care or changes in care.

2. The right to voice grievances with respect to services that are (or fail to be) furnished without discrimination or reprisal for voicing grievances, and to be told how to complain to State and local authorities. A description of the procedures which the State will utilize to ensure this right is attached to this Appendix.

3. The right to confidentiality of personal and clinical records.

4. The right to privacy and to have one's property treated with respect.

5. The right to refuse all or part of any care and to be informed of the likely consequences of such refusal.

6. The right to education or training for oneself and for members of one's family or household on the management of care.

7. The right to be free from physical or mental abuse, corporal punishment, and any physical or chemical restraints imposed for purposes of discipline or convenience and not included in the individual's ICCP.

8. The right to be fully informed orally and in writing of the individual's rights.

State: FLORIDA

ADDITIONAL RIGHTS

The State assures that home and community care provided under the State plan will meet the following additional requirements:

a. The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community care services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities. Copies of these standards are maintained at the Medicaid agency.

b. In the case of an individual who has been adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the individual are exercised by the person appointed under State law to act on the individual's behalf.

c. In the case of an individual who resides in his or her own home, or in the home of a relative, when the individual has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the individual's rights to the extent provided by State law. In addition, all rights to be informed of the care to be provided, and to have input into the development of the ICCP specified in Appendix F-1-b shall be extended to the principal caregiver.

d. In the case of an individual who resides in a community care setting, and who has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the individual's rights to the extent provided by State law.

State: FLORIDA

GUIDELINES FOR PROVIDER COMPENSATION

a. The following advisory guidelines are provided for such minimum compensation for individuals providing home and community care. These guidelines will be used to assure the availability and continuity of competent individuals to provide such care for functionally disabled individuals who have functional disabilities of varying levels of severity.

1. For services which are the same as, or similar (in content, complexity and provider qualifications) to those provided under the approved Medicaid State plan, the State will compensate the providers on the same basis as that which is approved as part of the plan.

A. _____ Yes B. _____ No

2. For services which are the same as, or similar (in content, complexity and provider qualifications) to those provided under another program funded and operated by the State, the State will compensate the providers on a basis which is equivalent to that used by the other publicly funded program.

A. _____ Yes B. _____ No

3. For services which are dissimilar to those provided under the plan or another program funded and operated by the State, the State will develop methods of compensation which are sufficient to enlist an adequate number of providers, taking into account the number of individuals receiving the service and their geographic location.

A. _____ Yes B. _____ No

b. The State assures that it will comply with these guidelines.

1. _____ Yes 2. _____ No

c. The methods by which the State will reimburse providers are described in attachment 4.19-B.

State: FLORIDA

COMMUNITY CARE SETTINGS-GENERAL

a. Definitions.

1. Small residential community care setting. A small residential community care setting is defined as a facility in which between 3 and 8 unrelated adults reside, and in which personal services (other than merely board) are provided in conjunction with residing in the setting. To qualify as a small residential community care setting, at least one resident must receive home and community care under this benefit.

2. Small nonresidential community care setting. A small nonresidential community care setting is defined as a facility in which an organized program is operated (by the facility or on the premises of the facility) which serves between 3 and 8 individuals, at least one of which receives home and community care under this benefit at the setting.

3. Large residential community care setting. A large residential community care setting is a facility in which more than 8 unrelated adults reside, and in which personal services are provided in conjunction with residing in the setting. To qualify as a large residential community care setting, at least one resident must receive home and community care under this benefit.

4. Large nonresidential community care setting. A large nonresidential community care setting is defined as a facility in which an organized program is operated (by the facility or on the premises of the facility) which serves more than 8 individuals, at least one of which receives home and community care under this benefit at the setting.

5. Unrelated adults. Unless defined differently under State law, for purposes of this benefit, unrelated adults are individuals who are 18 years of age or older, and who do not have any of the following relationships to other adults resident in the facility: spouses, parent (including stepparent) or child (including stepchild), or siblings.

6. Personal services. Personal services are those services provided to the individual by the setting, which are intended to compensate for the absence, loss, or diminution of a physical or cognitive function. Personal services, as defined here, are not equated with personal care services available under either 42 CFR 440.170, or personal care services provided under the home and community care benefit.

b. The State will provide home and community care to individuals in the following settings:

1. _____ Nonresidential settings that serve 3 to 8 people.

2. _____ Residential settings that serve 3 to 8 people, and in which personal services (other than merely board) are provided in conjunction with residing in the setting.

3. _____ Nonresidential settings that serve more than 8 people.

State: FLORIDA

COMMUNITY CARE SETTINGS-GENERAL

4. _____ Residential settings that serve more than 8 people, and in which personal services (other than merely board) are provided in conjunction with residing in the setting.

5. _____ Not applicable. The State will not provide services in these types of community care settings.

c. The State assures that the requirements of sections 1929(g) and (h) of the Act (as applicable to the specific setting) will be met for each setting in which home and community care is provided under this section.

d. FFP will not be claimed for home and community care which is provided in settings which have been found not to meet the requirements of sections 1929(g) and (h) of the Act.

State: FLORIDA

SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS

The requirements of this Appendix shall apply to small nonresidential community care settings.

The State will require that small nonresidential community care settings meet requirements specified in this Appendix.

a. The setting shall protect and promote the rights of each client, including each of the following rights:

1. The setting shall extend to each client the right to choose a personal attending physician.

2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.

3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have been adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.

4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.

5. Restraints may only be imposed -

A. to ensure the physical safety of the individual or other clients served in the setting, and

B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, or other clients until such an order can reasonably be obtained).

6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups.

7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the health or safety of the individual or other clients would be endangered.

State: FLORIDA

SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.

10. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.

11. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.

12. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting and any plan of remedial action in effect with respect to the setting.

b. In the case of an individual adjudged incompetent under the laws of the State, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.

c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.

d. A small nonresidential community care setting must extend to each individual served the following access and visitation rights.

1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the client's individual physician or case manager.

2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.

3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.

4. Permit reasonable access to a client by any entity or individual that provides health, social, legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.

5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(iii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.

State: FLORIDA

SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

e. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.

1. The setting may not require clients to deposit their personal funds with the setting, and

2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.

3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.

4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

f. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:

1. The setting must deposit any amount of personal funds in excess of $50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.

2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) of the Social Security Act and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal finds (and a final accounting of such funds) to the individual administering the client's estate.

State: FLORIDA

SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

g. Each small nonresidential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.

h. Each small nonresidential community care setting must meet any applicable State and local certification or license, zoning, building and housing codes, and State and local fire and safety regulations.

i. Each small nonresidential community care setting shall be designed, constructed, equipped and maintained in a manner to protect the health and safety of clients.

j. Nothing in this section shall be construed to require a small nonresidential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the facility.

k. Except to the extent dictated otherwise by State law, a small nonresidential community care setting shall not be held responsible for the actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.

State: FLORIDA

SMALL RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

The requirements of this Appendix shall apply to small nonresidential community care settings.

The State will require that small nonresidential community care settings meet requirements specified in this Appendix.

a. The setting shall protect and promote the rights of each client, including each of the following rights:

1. The setting shall extend to each client the right to choose a personal attending physician.

2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.

3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have been adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.

4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.

5. Restraints may only be imposed -

A. to ensure the physical safety of the individual or other clients served in the setting, and

B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, or other clients until such an order can reasonably be obtained).

6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups. This shall not be construed to require the setting to furnish a private bedroom for the individual.

7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the health or safety of the individual or other clients would be endangered.

SMALL RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.

10. The setting shall extend to the client the right to receive notice before the room or the roommate of the resident in the setting is changed.

11. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.

12. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.

13. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting and any plan of remedial action in effect with respect to the setting.

b. In the case of an individual adjudged incompetent under the laws of the State, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.

c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.

d. A small residential community care setting must extend to each individual served the following access and visitation rights.

1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the clients individual physician or case manager.

2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.

3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.

4. Permit reasonable access to a client by any entity or individual that provides health, social, legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.

SMALL RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(iii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.

e. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.

1. The setting may not require clients to deposit their personal funds with the setting, and

2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.

3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.

4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

f. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:

1. The setting must deposit any amount of personal funds in excess of $50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.

2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) of the Social Security Act and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal finds (and a final accounting of such funds) to the individual administering the client's estate.

State: FLORIDA

SMALL RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

g. Each small residential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.

h. Each small residential community care setting must meet any applicable State and local, certification, licensure, zoning, building and housing codes, and State and local fire and safety regulations.

i. Each small residential community care setting shall be designed, constructed, equipped and maintained in a manner to protect the health and safety of residents.

j. Nothing in this section shall be construed to require a small residential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the setting.

k. Except to the extent dictated otherwise by State law, a small residential community care setting shall not be held responsible for the actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.

LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS

The requirements of this Appendix shall apply to large nonresidential community care settings.

The State will require that large nonresidential community care settings meet requirements specified in this Appendix.

a. The setting shall protect and promote the rights of each client, including each of the following rights:

1. The setting shall extend to each client the right to choose a personal attending physician.

2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.

3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have been adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.

4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.

5. Restraints may only be imposed -

A. to ensure the physical safety of the individual or other clients served in the setting, and

B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, or other clients until such an order can reasonably be obtained).

6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups.

7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the

health or safety of the individual or other clients would be endangered.

9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.

10. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.

11. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.

12. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting and any plans of remedial action in effect with respect to the facility.

b. In the case of an individual adjudged incompetent under the laws of the State, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.

c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.

d. A large nonresidential community care setting must extend to each individual served the following access and visitation rights.

1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the clients individual physician or case manager.

2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.

3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.

4. Permit reasonable access to a client by any entity or individual that provides health, social, legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.

LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(iii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.

c. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.

1. The setting may not require clients to deposit their personal funds with the setting, and

2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.

3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.

4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

d. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:

1. The setting must deposit any amount of personal funds in excess of $50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.

2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) of the Social Security Act and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal finds (and a final accounting of such funds) to the individual administering the client's estate.

State: FLORIDA

LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

e. Each large nonresidential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.

f. Each large nonresidential community care setting must be designed, constructed, equipped and maintained in a manner to protect the health and safety of clients, personnel and the general public.

g. Nothing in this section shall be construed to require a large nonresidential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the facility.

h. Except to the extent dictated otherwise by State law, a large nonresidential community care setting shall not be held responsible for the actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.

i. A large nonresidential community care setting must be licensed or certified under applicable State and local law.

j. A large nonresidential community care setting must meet such provisions of the most recent edition of the Life Safety Code of the National Fire Protection Association as are applicable to the type of setting.

1. The State requests that HCFA waive certain provisions of this Code, which if rigidly applied would result in unreasonable hardship upon a setting. The State certifies that such a waiver would not adversely affect the health and safety of clients or personnel. The specific request for waiver and supporting documentation are attached.

_____ Yes _____ No

2. The State certifies to HCFA that there is in effect a fire and safety code, imposed by State law, which adequately protects clients and personnel in certain types of nonresidential community care settings. The specific types of settings are identified in attached documentation. The State requests that the provisions of the State code be substituted for those of the Life Safety Code of the National fire Protection Association for those particular settings.

_____ Yes _____ No

k. Each large nonresidential community care setting must disclose persons with an ownership or control interest (including such persons as defined in section 1124(a)(3) of the Social Security Act) in the setting.

State: FLORIDA

LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

1. A large nonresidential community care setting may not have, as a person with an ownership or control interest in the setting, any individual or person who has been excluded from participation in the program under Medicaid or who has had such an ownership or control interest in one or more community care settings which have been found repeatedly to be substandard, or to have failed to meet the requirements of this Appendix.

State: FLORIDA

LARGE RESIDENTIAL COMMUNITY CARE SETTINGS

The requirements of this Appendix shall apply to large residential community care settings.

The State will require that large residential community care settings meet requirements specified in this Appendix.

a. The setting shall protect and promote the rights of each client, including each of the following rights:

1. The setting shall extend to each client the right to choose a personal attending physician.

2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.

3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have been adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.

4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.

5. Restraints may only be imposed -

A. to ensure the physical safety of the individual or other clients served in the setting, and

B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, or other clients) until such an order can reasonably be obtained.

6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups. This shall not be construed to require the setting to furnish a private bedroom for the individual.

7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

State: FLORIDA

LARGE RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the health or safety of the individual or other clients would be endangered.

9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.

10. The setting shall extend to the client the right to receive notice before the room or the roommate of the resident in the setting is changed.

11. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.

12. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.

13. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting.

b. In the case of an individual adjudged incompetent under the laws of the State, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.

c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.

d. A large residential community care setting must extend to each individual served the following access and visitation rights.

1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the clients individual physician or case manager.

2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.

3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.

4. Permit reasonable access to a client by any entity or individual that provides health, social, legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.

5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(ii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.

e. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.

1. The setting may not require clients to deposit their personal funds with the setting, and

2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.

3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.

4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

f. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:

1. The setting must deposit any amount of personal funds in excess of $50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.

2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

State: FLORIDA

LARGE RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal finds (and a final accounting of such funds) to the individual administering the client's estate.

g. Each large residential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.

h. Each large residential community care setting shall be designed, constructed, equipped and maintained in a manner to protect the health and safety of clients, personnel and the general public.

i. Nothing in this section shall be construed to require a large residential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the setting.

j. Except to the extent dictated otherwise by State law, a large residential community care setting shall not be held responsible for the actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.

k. A large residential community care setting must be licensed or certified under applicable State and local law.

l. A large residential community care setting must meet such provisions of the most recent edition of the Life Safety Code of the National Fire Protection Association as are applicable to the type of setting.

1. The State requests that HCFA waive certain provisions of this Code, which if rigidly applied would result in unreasonable hardship upon a setting. The State certifies that such a waiver would not adversely affect the health and safety of clients or personnel. The specific request for waiver and supporting documentation are attached.

_____ Yes _____ No

2. The State certifies to HCFA that there is in effect a fire and safety code, imposed by State law, which adequately protects clients and personnel in certain types of residential community care settings. The specific types of settings are identified in attached documentation. The State requests that the provisions of the State code be substituted for those of the Life Safety Code of the National fire Protection Association.

_____ Yes _____ No

LARGE RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

m. Each large residential community care setting must disclose persons with an ownership or control interest (including such persons as defined in section 1124(a)(3) of the Social Security Act) in the setting.

n. A large residential community care setting may not have, as a person with an ownership or control interest in the setting, any individual or person who has been excluded from participation in the program under Medicaid or who has had such an ownership or control interest in one or more community care settings which have been found repeatedly to be substandard, or to have failed to meet the requirements of this Appendix.

State/Territory: FLORIDA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

---

The following ambulatory services are provided:

1. Inpatient hospital services other than those provided in an institution for mental diseases
2. Outpatient hospital services
3. Rural health clinic services and other ambulatory services furnished by a rural health clinic
4. Laboratory and X-ray services
5. Early and periodic screening diagnosis of individuals under 21 years of age, and treatment of conditions found
6. Family planning services
7. Physician services
8. Podiatry services
9. Optometric services
10. Advanced Registered Nurse Practitioners services
11. Home Health services
12. Clinic services
13. Dental services
14. Hearing services
15. Prescribed drugs
16. Dentures
17. Prosthetic devices
18. Eyeglasses
19. Rehabilitative services
20. Emergency hospital services
21. Nurse-midwife services (Included in ARNP program)
22. Transportation services
23. Hospice care services
24. Case management
25. Chiropractor services
26. Federally qualified health center services
27. Respiratory therapy
28. Personal care
29. Private duty nursing
30. Therapies

* Description provided on attachment.

---

State/Territory: FLORIDA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

1. Inpatient hospital services other than those provided in an institution for mental diseases.

/X/Provided: /_/No limitations /X/With limitations*

2.a.Outpatient hospital services.

/X/Provided: /_/No limitations /X/With limitations*

b.Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State Plan).

/X/Provided: /_/No limitations /X/With limitations*

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

/X/Provided: /_/No limitations /X/With limitations*

3. Other laboratory and X-ray services.

/X/ Provided: /_/ No limitations /X/With limitations*

4.a.Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Not Provided

/_/Provided: /_/No limitations /_/With limitations*

b.Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found. *

c.Family planning services and supplies for individuals of childbearing age.

/X/Provided: /_/No limitations /X/With limitations*

*Description provided on attachment.

State/Territory: FLORIDA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(s): _____

---

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

Provided: ___ No limitations X With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: ___ No limitations X With limitations:

*Description provided on attachment.

State/Territory: FLORIDA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' Services

/X/ Provided: /_/ No limitations /X/ With limitations*

b. Optometrists' Services

/X/ Provided: /_/ No limitations /X/ With limitations*

c. Chiropractors' Services

/X/ Provided: /_/ No limitations /X/ With limitations*

d. Other Practitioners' Services (Includes ARNP, Nurse-midwife)

/X/ Provided: /_/ No limitations /X/ With limitations*

7. Home Health Services

a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

/X/ Provided: /_/ No limitations /X/ With limitations*

b. Home health aide services provided by a home health agency.

/X/ Provided: /_/ No limitations /X/ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

/X/ Provided: /_/ No limitations /X/ With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/X/ Provided: /_/ No limitations /X/ With limitations*

*Description provided on attachment.

State/Territory: FLORIDA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

---

8. Private duty nursing services.

X Provided: _ No Limitations X With limitations*

9. Clinic services.

X Provided: _ No Limitations X With limitations*

10. Dental services.

X Provided: _ No Limitations X With limitations*

11. Physical therapy and related services.

a. Physical therapy.

X Provided: _ No Limitations X With limitations*

b. Occupational therapy

X Provided: _ No Limitations X With limitations*

c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.

X Provided: _ No Limitations X With limitations*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in disease of the eye or by an optometrist.

a. Prescribed drugs.

X Provided: _ No Limitations X With limitations*

b. Dentures.

X Provided: _ No Limitations X With limitations*

*Description provided on attachment.

State/Territory: FLORIDA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

---

c. Prosthetic devices.

X Provided: __ No Limitations X With limitations*

d. Eyeglasses. __ Not provided

X Provided: __ No Limitations X With limitations*

13. Other diagnostic, screening, preventative and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic Services

X Provided: __ No Limitations X With limitations*

b. Screening services.

X Provided: __ No Limitations X With limitations*

c. Preventative services. X Not provided

__ Provided: __ No Limitations __ With limitations*

d. Rehabilitative services.

X Provided: __ No Limitations X With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services. X Not provided

__ Provided: __ No Limitations __ With limitations*

b. Nursing facility services. X Not provided

__ Provided: __ No Limitations __ With limitations*

*Description provided on attachment.

Revision: HCFA-PM-86-20 (BERC)
September 1986

State/Territory: Florida

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED
TO THE MEDICALLY NEEDY

c. Intermediate care facility services.

[ ] Provided [ ] No limitation [ ]With limitations* [X] Not Provided

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

[ ] Provided [ ] No limitation [ ] With limitations* [X] Not Provided:

b. Including such services in a public institution (or district part thereof) for the mentally retarded or persons with related conditions.

[ ] Provided [ ] No limitation [ ] With limitations* [X] Not Provided

16. Inpatient psychiatric facility services for individuals under 22 years of age.

[ ] Provided [ ] No limitation [ ] With limitations* [X] Not Provided:

17. Nurse-midwife services.

[X] Provided [ ] No limitation [X] With limitations*

18. Hospice care (in accordance with section 1905(o) of the Act).

[X] Provided [ ] No limitation

[X] Provided in accordance with section 2302 of the Affordable Care Act

[X] With limitations*

*Description provided on attachment-

State/Territory: FLORIDA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

___ Provided: ___ With limitations*

X Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

___ Provided: ___ With limitations*

X Not provided.

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

X Provided:+ ___ Additional coverage++

b. Services for any other medical conditions that may complicate pregnancy.

X Provided:+ ___ Additional coverage++ ___ Not provided.

21. Certified pediatric or family nurse practitioners' services.

X Provided: ___ No limitations ___ With limitations*

___ Not provided.

\+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

22. Respiratory care services (in accordance with section 1902 (e)(9)(A) through C of the Act).
[ ] Provided [ ] No Limitations [ ] With Limitations
[X] Not Provided

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.
[X] Provided [ ] No limitations [X] With limitations
[ ] Not Provided

b. Services of Christian Science nurses.
[ ] Provided [ ] No limitations [ ] With limitations
[X] Not Provided

c. Care and services provided in Christian Science sanitoria.
[ ] Provided [ ] No limitations [ ] With limitations
[X] Not Provided

d. Nursing facility services for patients under 21 years of age.
[ ] Provided [ ] No limitations [ ] With limitations
[X] Not Provided

e. Emergency hospital services.
[X] Provided [ ] No limitations [X] With limitations
[ ] Not Provided

f. Personal care services furnished in recipient's home, and at the state's option, in another location, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.
[X] Provided [ ] No limitations [X] With limitations
[ ] Not Provided

**State of FLORIDA**
**PACE State Plan Amendment Pre-Print**

Amount, Duration and Scope of Medical and Remedial Care Services Provided to the Medically Needy

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____ provided  X not provided

26. Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

____ provided  X not provided

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

_____ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

X No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

**State of Florida**
**1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print**

Amount, Duration, and Scope of Medical and Remedial Care Services Provided To the Medically Needy

28. ___ Self-Directed Personal Assistance Services, as described in Supplement __4_ to Attachment 3.1-A.

____ Election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects Self-Directed Personal Assistance Services as a State Plan service delivery option.

_X___ No election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects not to add Self-Directed Personal Assistance Services as a State Plan service delivery option.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF FLORIDA
AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED

DESCRIPTION OF LIMITATIONS
FOR MEDICALLY NEEDY: ALL GROUPS

Table of Contents Pages


1. Contents
1a. Contents (Continued)
2. EPSDT- General
2a. EPSDT-Diagnostic, Screening and Rehabilitative Services
2a. EPSDT- Early Intervention Services
2a.1 EPSDT- Early Intervention Services (Continued)
2a.2 EPSDT- Early Intervention Services (Continued)
2a.3 EPSDT- Early Intervention Services (Continued)
2a.4 EPSDT- Early Intervention Services (Continued)
2a.5 EPSDT- Early Intervention Services (Continued)
2a.6 EPSDT- Early Intervention Services (Continued)
2a.7 EPSDT- Early Intervention Services (Continued)
2a.8 EPSDT- Early Intervention Services (Continued)
2b. EPSDT- Rehabilitative Services (Mental Health)
2b.1 EPSDT- Mental Health-(Continued)
2b.2 EPSDT- Prescribed Pediatric Extended Care Center (PPEC)
2b.3 EPSDT- School-Based Therapy Services
2b.4 EPSDT- School-Based Psychological Services
2b.5 EPSDT-School-Based Social Work Services
2b.6 EPSDT- School-Based Nursing Services
2b.7 EPSDT-School-Based Nursing Services by County Health Departments
2b.8 EPSDT- School Based Behavioral Services by County Health Departments
3. EPSDT- Screening Services
4. EPSDT- Dental Services
5. EPSDT-Optometric Services
6. Rehabilitative Services
6a. Rehabilitative Services Community Based Substance Abuse
6a.1 Comprehensive Community Support Services for Substance Abuse-Bachelor's Degree Level
7. EPSDT-Eyeglasses
8. EPSDT-Hearing Services
9. EPSDT-Hearing Aids
10. EPSDT-Respiratory Services
11. EPSDT-Home Health Therapies
12. EPSDT-Personal Care Services
12a. EPSDT-Personal Care Services (Continued)
13. EPSDT-Private Duty Nursing
14. EPSDT-Therapy Services
15. EPSDT-Prosthetic Devices
16. EPSDT-Home Health Services-Durable Medical Equipment
17. EPSDT-Chiropractic Services
18. (Reserved for EPSDT-Rehabilitative Services)
19. (Reserved)
20. Inpatient Hospital Services
21. Outpatient Hospital Services
22. Emergency Hospital Services




**Amendment 2013-006**
**Effective 4/1/2013**
**Supersedes 93-57**
**Approval 05-08-13**

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

Table of Contents Pages (Continued)

23. Family Planning Services
24. Physician Services
25. Podiatry Services
26. Optometric Services
27. Chiropractic Services
28. Advanced Registered Nurse Practitioners Services
29. Home Health Services
30. Clinic Services-Birthing Centers
30a. Clinic Services-Ambulatory Surgical Centers
30b. Clinic Services-County Public Health Units
30c. Clinic Services-Freestanding Dialysis Center Services
31. Dental Services
32. Hearing Services
33. Prosthetic Devices-Hearing Aids
34. Eyeglasses/Contact Lenses
35. Transportation Services
36. Hospice Services
37. Respiratory Services
38. Personal Care Services
39. Private Duty Nursing Services
40. Therapy Services
41. Nurse Midwives
42. Extended Service to Pregnant Women
43. ~~Certified Pediatric or Family Nurse Practitioners~~ Intentionally left blank
44. (Reserved for Rehabilitative Services)
45. Prescribed Drugs
45a. Prescribed Drugs (Continued)
45a.1. Prescribed Drugs (Continued)
45b. Preventive Services
46. (Reserved)
47. Rural Health Clinic Services
48. Federally Qualified Health Centers (FQHCs)
49. Other Laboratory Services
50. X-Ray Services
51. Licensed Midwives
52. Physician Assistants
53. Registered Nurse First Assistant



**Amendment 2013-006**
**Effective 4/1/2013**
**Supersedes 93-57**
**Approval 05-08-13**

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

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED

DESCRIPTION OF SERVICE LIMITATIONS
FOR MEDICALLY NEEDY: ALL GROUPS

The following service limitations apply to all medically needy recipients. Authorization by the state agency is required for exceptions to limitations described below.

4/1/91 EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

All services provided for in Section 1905(a) of the Act which are medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions are provided for EPSDT participants.

'RLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS AGE, AND TREATMENT OF CONDITIONS FOUND

10/01/93 REHABILITATIVE SERVICES: Early Intervention Services (13.d)

Rehabilitative services include a range of coordinated rehabilitative or remedial medically necessary services provided to a child in order to identify, evaluate, correct, reduce, or prevent further deterioration of deficits in the child's mental or physical health.

Early intervention services are provided under the Individuals with Disabilities Education Act (IDEA), Part C, and are designed to ameliorate or prevent further developmental disabilities and physical and mental illnesses in children with developmental delays or established conditions that could result in developmental delays at as early an age as possible in order to optimize their functioning capacity. These services are designed to enhance, not duplicate, existing Title XIX mandatory or optional services; to ensure maximum reduction of physical or mental disability and restoration of a beneficiary to his/her best possible functional level.

Developmental delays are defined as a delay in the development in one or re of the following domains: cognitive, physical/motor, sensory (including vision and hearing), communication, social, emotional, or adaptive.

Early intervention services are provided based on the determination of medical need in any of the identified domains.

A developmental delay is a verified delay by use of two or more of the following: appropriate standardized instrument(s); observational assessment; parent report(s); developmental inventory; behavioral checklists; adaptive behavior scales; or professional judgment. When a standardized instrument is used, the following will be used to establish a developmental delay: a score of 1.5 standard deviation below the mean in at least one area of the identified domains, or a 25 percent delay on measures yielding scores in months in at least one of the identified domains.

Amendment 2004-010
Effective 07/01/2004
Supersedes 93-67
Approval 02/03/2005

Revised Submission _____

Early intervention services must be face-to-face encounters, medically necessary, within the scope of practice of the provider, and intended to maximize reduction of identified disabilities or deficits. Suspicious deficits, disabilities or developmental delays are identified and verified through comprehensive screening, assessments and evaluations. Sessions that address the identified delays must be a collaboration of identifying, planning and maintaining a regimen related to the child's functioning. Sessions may be provided in individual or group settings in the following locations: hospital, other clinical settings, home, day care center, or other locations identified as a natural environment for the child.

Provision of services where the family or caregivers are involved must be directed to meeting the identified child's medical treatment needs. Services provided to non-Medicaid eligible family members independent of meeting the identified needs of the child are not covered by Medicaid.

D. Eligible Providers

An eligible provider must enroll as a Medicaid individual provider or group provider that employs or contracts with staff who hold a valid and active license in full force and effect to practice in the state of Florida and have three hours of continuing education per calendar year, or be a non-healing arts certified Infants and Toddler Developmental Specialist (ITDS). The Florida Department of Health, Children's Medical Services Early Steps Program verifies the qualifications, training, experience and certification of the potential Medicaid enrollees, and recommends the provider for Medicaid participation.

In accordance with 42 CFR 431.51, all willing and qualified providers may participate in this program.

Eligible providers must meet the following requirements to enroll as a Medicaid Early Intervention Services provider:

19. Physician - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Physicians and have a minimum of one year experience in early intervention.
20. Physician's assistant - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Physicians and have a minimum of one year experience in early intervention.

Social Work, Marriage and Family Therapy, and Mental Health Counseling. Must have a master's level degree or higher and have a minimum of one year experience in the area of early intervention.

33. Mental health counselor - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling. Must have a master's level degree or higher and have a minimum of one year experience in the area of early intervention.
34. Registered dietician - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Dietetics and Nutrition and have a minimum of one year experience in the area of early intervention.
35. Nutrition counselor - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Dietetics and Nutrition and have a minimum of one year experience in the area of early intervention.
36. Infants and Toddlers Developmental Specialist (ITDS) - Have a bachelor's degree or higher from an accredited college or university in early childhood or early childhood/special education, child and family development, family life specialist, communication sciences, psychology or social work or equivalent degree based on transcript review. Must have a minimum of one year experience in early intervention or a minimum of five years documented experience may substitute for an out of field degree. The ITDS provides early intervention services under the direction of a licensed physician or other health care professional acting within their scope of practice. The licensed healing arts professionals on the Family Support Plan Team who provide the evaluation, the service planning assessment, the development of the IFSP and the development of the plan of care follow the child and direct and support the activities of the ITDS through consultation at team meetings or by accompanying the ITDS on visits with the child and family.

Experience requirements are set by the Department of Health, Early Steps Program. Early Steps defines one year of experience in early intervention as equaling 1600 hours of hands-on experience with 0-5 year old children with special needs or their families. A maximum of 400 hours hands-on work with 0 to 5 year old children with special needs or their families obtained as part of the educational requirement to obtain a degree can substitute for 25% of the 1 year experience. Certification of all experience is required upon

enrollment from the Department of Health, Early Steps Program. Certification can consist of letters from former and current employers, letters from professors, or course syllabi describing internship experience and hours with transcripts showing the successful completion of the course.

E. Benefits and Limitations

Early intervention services are medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level. Early intervention services are provided to Medicaid-eligible children for whom all services are medically necessary.

Rehabilitative services include the following range of services, referred to as early intervention services:

1) Screening Services: a screening is a brief assessment of a child that is intended to identify the presence of a high probability of delayed or abnormal development which may require further evaluation and assessment. A screening must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice under state law. The component(s) of the screening performed must be within the scope of practice of the provider. Screenings are performed by one early intervention professional and are limited to three per year per recipient.

Exceptions to the service limitations will be granted based on medical necessity. Authorization to increase the limitation of frequency or time must be requested and approved prior to providing the service. Such authorization is limited to a 3-month period.

Providers retain 100 percent of the payments provided for in Attachment 4.19-B.

2) Interdisciplinary Psychosocial and Developmental Evaluation Services: This is either an initial or follow-up comprehensive, interdisciplinary psychosocial and developmental evaluation to determine a child's level of functioning in each of the following developmental areas: (1) gross motor; (2) fine motor;

(3) communication; (4) self-help and self-care; (5) social and emotional development; and (6) cognitive skills. An evaluation is based on informed clinical opinion through objective testing and includes, at a minimum, a review of pertinent records related to the child's current health status and medical history; an evaluation of the child's level of functioning in each of the developmental areas; an assessment of the unique strengths and needs of the child; and identification of services appropriate to meet the needs of the child.

When used, a standardized test should be thorough, efficient, objectively scored, reliable, valid, culturally fair, and have a broad developmental focus. Tests are to be administered by providers.

The initial evaluation is limited to one per lifetime per recipient. Follow-up evaluations are limited to three per year per recipient. Evaluations must be recommended by a licensed healing arts professional or paraprofessional.

Exceptions to the service limitations will be granted based on medical necessity. Authorization to increase the limitation of frequency or time must be requested and approved prior to providing the service. Such authorization is limited to a 3-month period.

Providers retain 100 percent of the payments provided for in Attachment 4.19-B.

4) Group, Individual, and Home Visiting Sessions: Sessions are face-to-face encounters of at least 30 minutes, not to exceed 60 minutes, with the child or the child's parent, family member or caregiver or both. The purpose of the session is to provide medically necessary services to alleviate or minimize the child's developmental disability, or the condition that could lead to the developmental disability or delay. Sessions must be provided by a Medicaid enrolled professional or paraprofessional early intervention provider within their scope of practice.

An individual session is held with one child or one of the child's parents, family member or caregiver or both.

A group session is held with more than one child, more than one of the child's parents, family member or caregiver; or, more than one child and those children's parents, family members or caregivers. A minimum number of participants in a group is two. The recommended maximum for a group is four.

A home-visit session is an individualized session with one child or that child's parent(s), family member(s) or caregiver(s) or both in the child's home, child care facility or other location conducive to the natural environment of the child, and does not have a center-based or developmental day program.

Billable activities are those identified in the Medicaid Early Intervention Session(s) Plan of Care for the period authorized. Session services cannot duplicate or supplant existing Medicaid services. Services are designed to enhance development in physical/motor, communication, adaptive, cognitive, social or emotional and sensory domains, or to teach compensatory skills for deficits that directly result from medical, developmental, or other health-related conditions.

Providers retain 100 percent of the payments provided for in Attachment 4.19-B.

Providers can be reimbursed for only one type of early intervention session (group, individual, or home-visit) per day, per child. A session cannot be split between providers, nor can more than one type of provider provide a session per day for the same child.

Exceptions to the service limitations will be granted based on medical necessity. Authorization to increase the limitation of frequency or time must be requested and approved prior to providing the service. Such authorization is limited to a 3-month period.

F. Early Intervention Services By Provider Type

Early intervention services are rehabilitative services that include a range of coordinated rehabilitative or remedial medically necessary services provided to a child in order to identify, evaluate, correct, reduce, or prevent further deterioration of deficits in the child's mental or physical health. Early intervention services, which include screening,

evaluations and sessions, are designed to enhance, not duplicate, existing tle XIX mandatory or optional services; to ensure maximum reduction of physical or mental disability and restoration of a recipient to his/her best possible functional level.

The following services are provided by the appropriate provider type within his scope of practice, and when medically necessary, as part of an early intervention screening, evaluation or session. Services include:

10) Developmental - services under the direction of a licensed physician or other health care professional acting within their scope of practice. The licensed healing arts professionals on the Family Support Plan team provide the evaluation, the service planning assessment, the development of the Individualized Family Support Plan (IFSP) and the development of the plan of care, follow the child and direct and support the activities through consultation at team meetings, or by accompanying a provider on visits. These consultative services encompass identifying and rehabilitating a child's medical or other health-related condition and integrating developmental intervention strategies into the daily routines of a child and family to restore or maintain function or reduce dysfunction resulting from a mental or physical disability or developmental delay. Ensuring carryover of medically necessary developmental intervention strategies into all of the child's daily activities to increase the range of normal daily functioning and experience.
11) Medical - services for diagnostic or evaluation purposes, services to determine a child's developmental status and need for early intervention services.
12) Psychological - services are administering psychological and developmental tests, interpreting results, obtaining and integrating information about the child's behavior, child and family conditions related to learning, mental health and development, and planning and managing a program of psychological services, including psychological counseling, family counseling, consultation on child development, parent training and education programs.
13) Occupational Therapy - services to address the functional needs of a child related to adaptive development, adaptive behavior and

play, and sensory, motor, and postural development to improve the child's functional ability to perform tasks, including identification, assessment, intervention, adaptation of the environment, and selection of assistive and orthotic devices.

14) Physical Therapy - services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. It includes evaluation to identify movement dysfunction, obtaining, interpreting and integrating information for program planning and treatment to prevent or compensate for functional problems.

15) Speech/Language - services to identify children with communicative or oropharyngeal disorders and delays in communication skills development, referral for medical or other professional services and the provision of services necessary for their rehabilitation.

16) Nutritional - services that include conducting nutritional assessments, developing and monitoring appropriate plans to address the nutritional needs of the child, based on the findings of the nutritional needs of the child, based on the findings of the nutritional assessment, and making referrals to appropriate community resources to carry out nutritional goals.

17) Audiological - services to identify children with auditory impairment, using at risk criteria and appropriate audiologic evaluation procedures to determine the range, nature, and degree of hearing loss and communication functions. It includes referral for medical and other services necessary for rehabilitation, provision of auditory training and aural rehabilitation, and determination of the child's need for amplification and its selection, use and evaluation.

18) Respiratory Therapy - services to identify, evaluate and provide interventions to children with respiratory disorder which may result in a developmental delay in any of the identified domains.

Amendment 2004-010
Effective 07/01/2004
Supersedes 93-67
Approval 02/03/2005

Revised Submission _____

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND: (Continued)

10/1/90 (13d) 15. REHABILITATIVE SERVICES: Exceptions to the service limitations can be granted based on medical necessity.

a. Intensive therapeutic on-site services include the provision of therapeutic services, with the goal of preventing more restrictive, costly placement by teaching problem solving skills, behavior strategies, normalization activities and other treatment modalities as appropriate. On-site is defined as where the child is living, working or receiving schooling. Children residing in a public institution or who are under the control of the juvenile justice system are not eligible for Medicaid.

While it is recognized that involvement of family (including legal guardians) in the treatment of the child is necessary and appropriate, provision of services where the family is involved clearly must be directed to meeting the identified child's treatment needs. Services provided to non-Medicaid eligible family members independent of meeting the identified needs of the child are not covered by Medicaid.

Billable services are face-to-face encounters with the child and/or the child's family. Services must be rendered by a mental health professional with a minimum of a B.A. degree from an accredited university a with emphasis in the areas of psychology, social work, health education or a related human services field.

Intensive therapeutic on-site services include:

o Behavioral assessment of the child in order to define, delineate, evaluate and diagnose treatment needs. Assessment services include; psychosocial evaluation, psychiatric mental status exam, psychological testing, and developmental assessment of the child within the home, community, educational or vocational setting.

o Development of a behavioral management program for the child designed to reduce behavior problems and/or functional deficits stemming from the existence of a mental disorder that interfere with the child's personal, familial, vocational and/or community adjustment.

o Monitoring of the child's compliance with the behavioral management program.

o Individual counseling or psychotherapy between the child and the mental health professional designed to maximize strengths and to reduce behavior problems and or functional deficits stemming from the existence of a mental disorder that interferes with the child's personal, familiar, vocational and/or community adjustment.

o Family counseling or psychotherapy involving the child, his/her family and or significant others and a mental health professional designed to maximize strengths and to reduce behavior problems and or functional deficits stemming from the existence of a mental disorder that interfere with the child's personal, familial, vocational and/or community adjustment.

o Other medically necessary therapeutic services specified by the psychiatrist in the child's plan of care.

Services are limited to one visit per day. Additional visits can be granted based on medical necessity.

Amendment 90-67
Effective 10/1/90
Supersedes 92-26
Approved 5-12-94
Revised Submission 2/20/92
Revised Submission 8/7/92
Revised Submission 2/3/94

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND: (Continued)

4/1/96 15. REHABILITATIVE SERVICES: (Continued)
(13d)

b. Home-based rehabilitative services are designed for the restoration or modification, and/or maintenance of social, personal adjustment, and basic living skills. These services shall be an effective intervention in assuring that a child with a psychiatric disability possesses those physical, emotional, and intellectual skills to live, learn and work in his or her own particular environment. Home-based is defined as the child's official place of residence. Children residing in a public institution, or who are under the control of the juvenile justice system, are not eligible for Medicaid.

While it is recognized that involvement of family (including legal guardians) in the treatment of the child is necessary and appropriate, provision of services where the family is involved clearly must be directed to meeting the identified child's treatment needs. Services provided to non-Medicaid eligible family members independent of meeting the identified needs of the child are not covered by Medicaid.

Billable services are face-to-face encounters with the child and/or the child's family. Services must be rendered by an individual who is experienced in the needs of severely emotionally disturbed children, is capable of implementing services which address the child's needs identified in the care plan, demonstrate skills and abilities to deliver therapeutic services to severely emotionally disturbed children, complete an ADM approved pre-service training program and participate in annual training to improve skills. Providers may not be relatives of the recipient. Services are limited to those provided by or under the recommendation of a physician, psychiatrist or other licensed practitioner of the healing arts acting within the scope of his/her practice under State law.

Home-based rehabilitative services include:

o One to one supervision of the child's therapeutic activities in accordance with his or her behavioral management program.

HCFA PI Change 8-12-96

o Skill training of the child for ~~development and/or~~ restoration of those basic living and social skills necessary to function in his or her own particular environment.

o Assistance to the child and family in implementing behavioral goals identified through family counseling or treatment planning.

Services are limited to 56 hours per month. Additional hours can be approved based on medical necessity.

Amendment 96-03
Effective 4/1/96
Supersedes 95-16
Approved 8-12-96

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

1/98 REHABILITATIVE SERVICES: (Continued)
(13d) School-Based Therapy Services

**Description**
Florida Medicaid certified school match program allows school districts, charter, and private schools to receive reimbursement under the Florida Medicaid program for therapy services furnished in a school setting. These services are provided in accordance with 42 CFR 440.130(d).

**Who Can Receive**
Florida Medicaid recipients under the age of 21 years requiring medically necessary therapy services in the school setting.

**Who Can Provide**
The following licensed practitioners rendering services through the school district, charter or private school, and in accordance with 42 Code of Federal Regulations 440.110:

- Occupational therapists or occupational therapy assistants licensed in accordance with Chapter 468, Florida Statutes under the supervision of a licensed occupational therapist.
- Physical therapists or physical therapy assistants who meet the requirements in Chapter 486, Florida Statutes under the supervision of a licensed physical therapist.
- Speech therapists or speech-language pathology assistants licensed in accordance with Chapter 468, Florida Statutes or Certified by the Department of Education under the supervision of a licensed speech therapist.

**Allowable Benefits**
Florida Medicaid covers the following school-based therapy services:

- Evaluations
- Individual and group treatment sessions

In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary.



Amendment 2016-031
Effective 10/28/16
Supersedes 98-06
Approved 10/02/17

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

10/1/99 REHABILITATIVE SERVICES (Continued)
(13d) School-Based Behavioral Services

**Description**
Florida Medicaid certified school match program allows school districts, charter, and private schools to receive reimbursement under the Florida Medicaid program for behavioral health services furnished in a school setting. These services are provided in accordance with 42 CFR 440.130(d).

**Who Can Receive**
Florida Medicaid recipients under the age of 21 years requiring medically necessary behavioral services in the school setting.

**Who Can Provide**
The following licensed and/or certified practitioners rendering services through the school district, charter or private school:

- Behavior analysts or assistant behavior analysts certified by the Behavior Analyst Certification Board
- School counselors certified in accordance with Chapter 1012, Florida Statutes.
- Marriage and family therapists licensed in accordance with Chapter 491, Florida Statutes.
- Mental health counselors licensed in accordance with Chapter 491, Florida Statutes.
- Psychologists licensed in accordance with Chapter 490, Florida Statutes.
- Social workers licensed in accordance with Chapter 491, Florida Statutes.

**Allowable Benefits**
Florida Medicaid covers the following school-based behavioral services:

- Assessments
- Behavior analysis, including interpretations of information about the student behavior and conditions relating to functioning.
- Consultation, coordination of services, and follow-up referrals with other health care staff, other entities or agencies, parents, teachers, and family.
- Evaluations
- Individual counseling sessions
- Group counseling sessions [minimum of two recipients and a maximum of 10]

In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

**THIS PAGE IS INTENTIONALLY LEFT BLANK**

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

10/01/97 (6d) School-Based Nursing Services

**Description**
Florida Medicaid certified school match program allows school districts, charter, and private schools to receive reimbursement under the Florida Medicaid program for nursing services furnished in a school setting in accordance with 42 CFR 440.60.

**Who Can Receive**
Florida Medicaid recipients under the age of 21 years requiring medically necessary nursing services in the school setting.

**Who Can Provide**
The following licensed and/or certified practitioners rendering services through the school district, charter or private school**:**

- Registered nurses (RN) licensed in accordance with Chapter 464, Florida Statutes.
- Licensed practical nurses (LPN) licensed in accordance with Chapter 464, Florida Statutes.
- School health aides working under the supervision of an RN, in accordance with Chapter 464, F.S., who have completed the following courses:
    - Cardiopulmonary resuscitation (CPR)
    - First aid
    - Medication administration
    - Patient specific training

In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary.

.



Amendment 2016-031
Effective 10/28/2016
Supersedes 97-22
Approved 10/02/17

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

7/1/98 (13d) REHABILITATIVE SERVICES (Continued)

School-Based Nursing Services by County Health Departments

County Health Departments will only provide nursing services on the school campus and in the student's home that are not reimbursable under the clinic services program. Nursing services under the rehabilitative services program include the basic nursing care students require while they are in the school or in school home-bound programs.

Medication administration will include the dispensing of the medication and necessary documentation of oral, and/or inhalator medications. A licensed registered nurse (RN) and licensed practical nurse (LPN) may administer the medication within their scope of practice.

Services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice, per 42 CFR 440.130. All requirements of 42 CFR 440.130 will be met.

Services may be rendered by or under the direction of a licensed registered nurse (RN) as allowed by state licensure laws, and must be within the scope of the professional practice act.

Licensed practical nurses (LPN) may render services as allowed by state licensure laws and under the professional practice act, if under the supervision of a registered nurse.

County Health Departments will be the paid-to-provider. All of the treating providers, both RNs and LPNs will be enrolled in the Medicaid program as treating providers.

Amendment 98-12
Effective 7/1/98
Supersedes NEW
Approved 9/4/98

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

REHABILITATIVE SERVICES

School-Based Behavioral Services by County Health Departments

County Health Departments will provide behavioral services that are not reimbursable under the clinic services program, only on the school campus and in the student's home. Behavioral services under the rehabilitative services program include the behavioral health students require while they are in the school or in school home-bound programs.

Behavioral services are diagnostic testing or active treatments to be rendered with the intent to reasonably improve the individual's physical or mental condition or functioning. Services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice, per 42 CFR 440.130. All requirements of 42 CFR 440.130 will be met.

Behavioral services are intervention services that focus on treatment. Behavioral services may include testing and evaluation that apprise cognitive, emotional and social functioning and self-concept; interviews and behavioral evaluations including interpretations of information about the individual's behavior and conditions relating to functioning; therapy, including providing a program of behavioral services for the individual with diagnosed behavioral problems; unscheduled activities for the purpose of resolving an immediate crisis situation; and other medically necessary services within the scope of practice. Behavioral services may be provided in either an individual or group setting.

County Health Departments will be the Medicaid pay to provider of services provided in the school setting with treating providers either employed or individually contracted. Treating providers of behavioral services must have at a minimum a Master's degree in social work from an accredited college, and work under the supervision of a licensed clinical social worker (LCSW) as required by Florida Statutes in order to obtain the work experience necessary for licensure or certification. The state agency will require County Health Departments to verify that school-based treating behavioral services providers meet provider requirements. The state Medicaid agency will require an agreement with each County Health Department to this effect and will monitor this factor. Behavioral services providers should have experience in providing services in school settings to Medicaid eligible children and must establish linkages in order to coordinate and consult with school authorities, as well as families, to assess a child's needs and identify treatment options.

Employees of the Health Department providing behavioral health services in schools will not duplicate services provided by school district employees. Health Department staff will provide services only when the need of the student exceeds the level of staff employed by the school district or is not available from school district staff.

Health Department social workers (MSW and LCSW) will provide services to all Medicaid eligible students in the school setting who are in need of such services.

Amendment 2002-02
Effective 7/1/02
Supersedes NEW
Approval Date JUN 06 2002
Revised Submission May 30, 2002
Revised Submission June 3, 2002

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE AND TREATMENT OF CONDITIONS FOUND:

1. Screening examinations are recommended to be scheduled in accordance with the Bright Futures/American Academy of Pediatrics Periodicity Schedule. Additional screening examinations are also available upon referral from a healthcare, developmental or educational professional, when factors suggesting the need for EPSDT are presented, or upon the request of the parent/recipient.

21. Nurse practitioner - Be licensed through the Florida Department of Health Medical Quality Assurance Board of Nursing and have a minimum of one year experience in early intervention. Meet requirements contained in 42 CFR 440.166.
22. Registered nurse (RN) - Be licensed through the Florida Department of Health Medical Assurance Board of Nursing and have a minimum of one year experience in early intervention.
23. Practical Nurse (LPN) - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Nursing and have a minimum of one year experience with early intervention.
24. Physical therapist - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Physical Therapy Practice and have a minimum of one year experience in the area of early intervention. Meet requirements contained in 42 CFR 440.110.
25. Occupational therapist - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Occupational Therapy Practice and have a minimum of one year experience in the area of Early Intervention. Meet requirements contained in 42 CFR 440.110.
26. Speech-language pathologist - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Occupational Therapy Practice and have a minimum of one year experience in the area of Early Intervention. Meet requirements contained in 42 CFR 440.110.
27. Audiologist - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Speech-language Pathology and Audiology with a minimum of one year experience in the area of early intervention. Meet the requirements contained in 42 CFR 440.110(c).
28. Respiratory therapist - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Respiratory Care with a minimum of one year experience in the area of early intervention.
29. Clinical psychologist - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Psychology and have a minimum of one year experience in the area of early intervention.
30. School Psychologist - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Psychology and have a minimum of one year experience in the area of early intervention.
31. Clinical social worker - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling. Minimum of one year experience in the area of early intervention.
32. Marriage and family counselor - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Clinical

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

4/1/91
(10)
(12b)

2. Dental Services. A direct dental referral is required for every child, 3 years of age and older, or earlier as medically indicated to adhere to the recommendation for preventive pediatric health care as recommended by the American Academy of Pediatrics and the Committee on Practice and Ambulatory Medicines. The periodicity schedule meets the requirements of Section 1905(r) of the Act. Following the initial dental referral, subsequent examinations by a dental professional are recommended every six months or more frequently as prescribed by a dentist or other authorized provider. Orthodontic services require prior authorization to be obtained for medical necessity.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

10/1/95 (6b) 3. Optometric Services: A specific periodicity schedule has been established as mandated by OBRA 1989 for vision screenings in accordance with the recommendations of the appropriate medical consultants. The schedule for screenings adhere to the Recommendation for Preventative Pediatric Health Care as recommended by the American Academy of Pediatrics and the Committee on Practice and Ambulatory Medicines. The periodicity schedule meets the requirements of Section 1905(r) of the Act.

Amendment 95-20
Effective 10/1/95
Supersedes 93-02

Approval 1-23-96

'02
d)

REHABILITATIVE SERVICES:

Rehabilitative services are limited to mental health and substance abuse services that are provided for the maximum reduction of the recipient's mental health and substance abuse disability and restoration to the best possible functional level. Services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

Services are limited to those which are medically necessary and are recommended by a licensed practitioner of the healing arts, psychiatrist, or other physician and included in a treatment plan. Exceptions to the service limitations can be granted based on medical necessity. Service limitations for EPSDT recipients are listed in the EPSDT section.

In keeping with the 2001-2002 General Appropriations Act, certain high cost mental health procedure codes are subject to prior authorization.

To be eligible to participate in this program, providers must:

- Have a current contract pursuant to the provision of Chapter 394, Florida Statutes, for the provision of community mental health or substance abuse services from the district or regional Department of Children and Families, Alcohol, Drug Abuse and Mental Health (ADM) program office; and

- Employ or have under contract a Medicaid-enrolled psychiatrist or other physician.

In addition to the above requirements:

- Alcohol prevention, treatment, or drug abuse treatment and prevention programs must hold a regular (i.e., not probationary or interim) license as defined in Chapter 397, F.S.

- Individuals seeking enrollment as providers of comprehensive behavioral health assessments must be reviewed and certified as meeting specific provider qualifications.

- Agencies seeking enrollment as providers of comprehensive behavioral health assessments or specialized therapeutic foster care services (Level I, Level II, and Crisis Intervention) must be reviewed and certified as meeting specific provider qualifications.

Amendment 2002-04
Effective 1/1/02
Supersedes 90-67
Approval MAY 21 2002

Rehabilitative Services:

Community-based Substance Abuse Services

Community-based substance abuse rehabilitative services will be available to all Medicaid eligible individuals with substance abuse disorders who are medically determined to need rehabilitative services. These services must be delivered by an agency licensed by the state to deliver substance abuse services and under contract with a county to receive county tax dollars that are certified as the state share of reimbursement for these services. These services must be recommended by a physician or other practitioner of the healing arts within the scope of his/her practice under state regulation and furnished by or under the direction of a physician or other practitioner operating within the scope of applicable state regulations, to promote the maximum reduction of symptoms of substance abuse and/or restoration of a recipient to his/her best possible functional level. The services are as follows:

Comprehensive Community Support Services for Substance Abuse

These services are designed to assist clients to strengthen and/or regain skills, to develop the environmental support necessary to help clients thrive in the community, and to aide clients in meeting life goals the promote recovery and resiliency. Services include substance abuse education, family/parenting guidance, life skills, anger/stress management, and support counseling. Services do not include meetings of Narcotics Anonymous, Alcoholics Anonymous, or other twelve-step programs.

Comprehensive Community Support Services for Substance Abuse-Bachelors Degree Level

Comprehensive community support services are medically necessary clinical aftercare services that are directed toward individuals who have received and successfully completed substance abuse treatment within a correctional or other institutional setting or a community-based program, and need continued therapeutic services to maintain their recovery as they re-enter the community. The purpose of comprehensive community support services is to provide integrative therapeutic supports and aftercare in collaboration with available and relevant ancillary medical and behavioral support services in the community to promote the receipt and effectiveness of those services. These services are based on a recovery support services model that addresses interpersonal and coping skills in home, work, and school situations and facilitates medication monitoring and symptom monitoring through therapeutic service provision. Identifying barriers that impede the development of skills necessary for independent functioning in the community will also be an integral part of these services. These out-patient services may be provided in a variety of community-based settings that are licensed by the state to provide substance abuse services. Effective after care services are comprised of the following activities: supportive and psycho-educational counseling about substance abuse disorders; specific recovery support services such as guidance in locating housing, counseling to support employment; monitoring recipient progress toward meeting goals of the aftercare plan; coordinating any necessary services with other sources and subsequently making any referrals for medically necessary services. Services must be provided by a substance abuse counselor who has knowledge of existing support services within the community. Services shall be supervised by a licensed practitioner of the healing arts or a master's level C.A.P. Reimbursement for this service is limited to 60 units per state fiscal year per recipient. Each unit must be 30 minutes in duration.

Alcohol and/or Drug Intervention Service

Alcohol and/or Drug Intervention Service is provided for the purpose of early identification of substance abuse problems and rapid linkage to needed services. This service is used to detect alcohol or other drug problems and to provide a brief intervention to arrest the progression of such problems, thereby avoiding the need for more costly and intensive levels of treatment. The intervention service is delivered on an outpatient basis in community-based settings such as licensed substance abuse providers, schools, work sites, community centers, and homes. The goal is to provide the medically necessary clinical services to minimize and ameliorate substance abuse risk factors and behaviors early in the process as an alternative to a more restrictive level of treatment. The following activities are included under this service: clinical screening and evaluation; identification and provision of medically necessary treatment needs; referral to other clinically indicated services; and ensuring referral appointments are met. Services must be delivered by a substance abuse counselor under the supervision of a licensed practitioner of the healing arts or a master's level C.A.P. Reimbursement for this service is limited to 24 units of at least 30 minutes each, per state fiscal year per recipient.

# BEHAVIOR ANALYSIS SERVICES

Description

Behavior analysis (BA) services are highly structured interventions, strategies, and approaches provided to restore appropriate behaviors by decreasing maladaptive behaviors.

Who Can Receive

Behavior analysis services are available for recipients under the age of 21 years for whom BA services are recommended by a licensed physician in accordance with 42 CFR 440.130(d) and are medically necessary for the restoration of the recipient to the best possible functional level.

Who Can Provide

Services must be performed by a practitioner who meets one of the following:

- Lead Analyst
  - Licensed in accordance with Chapter 490 or 491, Florida Statutes, with training and expertise in the field of behavior analysis; or
  - Certified behavior analysts who meet the following:
    - Are credentialed by the Behavior Analyst Certification Board®
    - Has a master's degree from an accedited university or college in a related human services field
    - Possesses a minimum of 250 hours of classroom graduate level instruction, 1500 hours of supervised independent field work, 1,000 hours of practicum, or 750 hours of intensive practicum in behavior analysis

- Registered behavior technicians who meet the following:
  - Are credentialed by the Behavior Analyst Certification Board®
  - Are 18 years or older with a high school diploma or equivalent
  - Complete a 40 hour training relevant for behavior techicians
  - Work under the supervision of a lead analyst

- Behavior assistants who meet one of the following and work under the supervision of a lead analyst:
  - Are 18 years or older with a high school diploma or equivalent with at least:
    - Two years of experience providing direct services to recipients with mental health disorders, developmental or intellectual disabilities
    - Complete 20 hours of documented in-service trainings in the treatment of mental health, developmental or intellectual disabilities, recipient rights, crisis management strategies, and confidentiality
  - Has a bachelor's degree from an accedited university or college in a related human services field.

Allowable Benefits

- One behavioral assessments per recipient, per fiscal year.
  - The behavior assessment is used to identify specific factors associated with the occurrence of maladaptive behaviors, functional capacity, strengths and service needs used in the development of a behavior plan.
- Up to three behavior reassessments per recipient, per fiscal year.
- Up to 40 hours of behavior analysis services, per week.
  - The implementation of BA interventions and ongoing monitoring of the recepient's progress towards goals in the behavior plan
  - Behavior analysis interventions may include but are not limited to discrete trial teaching, chaining, prompting, fading, and shaping

Behavior analysis services require prior authorization from the Agency for Health Care Administration (Agency) or the Agency's designee.

In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary.

Exclusions

- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provision of the Individuals with Disabilities Education Act.

Early and Periodic Screening and Diagnosis of recipients under the age of 21 years, and Treatment of conditions found:

4. Description

Visual aid services provide visual aids to recipients to alleviate visual impairments.

Who Can Receive

Visual aid services are available to Florida Medicaid recipients under the age of 21 years who require medically necessary visual aid services.

Who Can Provide

Practitioners certified or licensed within their scope of practice.

Allowable Benefits

- Eyeglasses
  Up to two pairs per 365 days

- Contact Lenses
  For limited conditions and requires prior authorization by the Agency for Health Care Administration or its designee

- In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary. The provider is required to obtain prior authorization from the Agency or its designee.

Early and Periodic Screening and Diagnosis of recipients under the age of 21 years, and Treatment of conditions found:

5. 11c. Description

Hearing services are designed to provide screening, assessment, testing, or corrective services to recipients in order to detect and mitigate the impact of hearing loss in accordance with Title 42, Code of Federal Regulations, section 440.110 (c).

Who Can Receive

Hearing services are available to Florida Medicaid recipients under the age of 21 years who require medically necessary hearing services.

Who Can Provide

Practitioners certified or licensed within their scope of practice:

- Audiologists licensed in accordance with Chapter 468, F.S.
- Physicians licensed in accordance with Chapter 458 or 459, F.S., with a specialty in otolaryngology or otology
- Audiology assistants or provisionally licensed individuals directly supervised by a federally qualified and Florida-licensed audiologist

Allowable Benefits

- The periodicity schedule for hearing services screening adheres to the Recommendations by the American Academy of Pediatrics and the Committee on Screening and Ambulatory Medicine. The periodicity schedule also meets the requirements of Section 1905(r) of the Act. Benefits include:
    - Diagnostic audiological tests
    - Corrective services, when clinical improvement can be reasonably expected.
    - One routine hearing assessment or reassessment every three years. This limit can be exceeded based upon medical necessity.
    - Newborn and infant hearing screening up to one screening for recipients under the age of 12 months
- In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary. The provider is required to obtain prior authorization from the Agency for Health Care Administration or its designee.

Early and Periodic Screening and Diagnosis of recipients under the age of 21 years, and Treatment of conditions found:

6. 12c. Description
Hearing devices are provided to recipients in order to mitigate the impact of hearing loss.

Who Can Receive
Hearing device services are available to Florida Medicaid recipients under the age of 21 years who require medically necessary hearing services.

Who Can Provide
In accordance with section 440.120, prosthetic devices must be prescribed by a physician or other licensed practitioner of the healing arts. Practitioners certified or licensed within their scope of practice include:

- Audiologists licensed in accordance with Chapter 468, F.S.
- Hearing aid specialists licensed in accordance with Chapter 484, F.S.
- Physicians licensed in accordance with Chapter 458 or 459, F.S., with a specialty in otolaryngology or otology
- Audiology assistants or provisionally licensed individuals directly supervised by a federally qualified and Florida-licensed audiologist

Allowable Benefits
Hearing aid devices are available for recipients under the age of 21 years as determined medically necessary by a licensed otolaryngologist, otologist or general physician. Benefits include:

  - BAHA up to one per ear with prior authorization by the Agency for Health Care Administration (AHCA) or its designee
  - Cochlear implants up to one per ear with prior authorization by the AHCA or its designee
  - Repairs and replacements of implant external parts after the one year warranty period has expired

- In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary. The provider is required to obtain prior authorization from the AHCA or its designee.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

7/1/98 (6d) Respiratory Services

Medicaid recipients under the age of 21 may receive medically necessary respiratory therapy services which are reimbursable to Medicaid enrolled providers. Services must be prescribed in writing by the recipient's primary care physician (or designated physician assistant or advanced registered nurse practitioner) or a designated MD specialist. Services must be provided by a registered respiratory therapist who is licensed by the state of Florida, has met the requirements of 42 CFR 440.60 and has been enrolled as a Medicaid provider. The registered respiratory therapist must administer treatment according to the primary care provider's specific approved written plan of care and written prescription. Florida allows all eligible licensed registered respiratory therapists to enroll as providers to ensure freedom of choice of providers in accordance with 42 CFR 440.70.

Reimbursement for one evaluation or re-evaluation per recipient is allowed every six months. Respiratory therapy visits must be a minimum of fifteen (15) minutes in duration with reimbursement available for a maximum of two individual treatment sessions per day. Exceptions to these limitations may be made based on medical necessity.

Therapy treatments are subject to prior authorization.

TELEMEDICINE SERVICES

Telemedicine services under Florida Medicaid are subject to the specifications, conditions, and limitations set by the State. Telemedicine is defined as the practice of health care delivery by a practitioner who is located at a site other than the site where the patient is located for the purposes of evaluation, diagnosis, or recommendation of treatment.

Providers rendering telemedicine within their scope of practice must involve the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time, interactive communication between the recipient and the practitioner to provide and support care when distance separates participants who are in different geographical locations. Telephone conversations, chart review, electronic mail messages, or facsimile transmissions are not considered telemedicine.

All equipment required to provide telemedicine services is the responsibility of the providers.

Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found

Home Health Nursing Visits

(7a) Description

Home health nursing services provide care to recipients whose medical conditions, illness, or injury require the care to be delivered in the recipient's place of residence or other community setting. Home health nursing services are provided in accordance with Title 42, Code of Federal Regulations 440.70.

Who Can Receive

Home health nursing services are available to recipients under the age of 21 years who require medically necessary home health visit services.

Who Can Provide

- Home health agencies licensed in accordance with section 408.810, Florida Statutes (F.S.), and Rule Chapter 59A-8, Florida Administrative Code.
- Licensed practical nurses licensed in accordance with Chapter 464, F.S.
- Registered nurses licensed in accordance with Chapter 464, F.S.

Allowable Benefits

Florida Medicaid reimburses for up to four intermittent home health nursing visits, per day, when prior authorized by the Agency for Health Care Administration (Agency) or its designee.

The four visit limit is a combined limit for both home health nursing and home health aide services.

In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary when prior authorized by the Agency or its designee.

Exclusions

Florida Medicaid does not reimburse for the following:

- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services furnished by relatives as defined in section 429.02, F.S., household members, or any person with custodial or legal responsibility for the recipient
- Services provided in any of the following locations:
  - Hospitals
  - Intermediate care facility for individuals with intellectual disabilities
  - Nursing facilities
  - Prescribed pediatric extended care centers
  - Residential facilities or assisted living facilities when the services duplicate those provided by the facility

Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found

Home Health Aide Visits

(7b) Description

Home health aide services provide care to recipients whose medical conditions, illness, or injury require the care to be delivered in the recipient's place of residence or other community setting. Home health aide services are provided in accordance with Title 42, Code of Federal Regulations 440.70.

Who Can Receive

Home health aide services are available to recipients under the age of 21 years who require medically necessary home health visit services.

Who Can Provide

- Home health agencies licensed in accordance with section 408.810, Florida Statutes (F.S.), and Rule Chapter 59A-8, Florida Administrative Code.
- Licensed practical nurses licensed in accordance with Chapter 464, F.S.
- Registered nurses licensed in accordance with Chapter 464, F.S.

Allowable Benefits

Florida Medicaid reimburses for up to four intermittent home health visits, per day, when prior authorized by the Agency for Health Care Administration (Agency) or its designee.

The four visit limit is a combined limit for both home health nursing and home health aide services.

In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary when prior authorized by the Agency or its designee.

Exclusions

Florida Medicaid does not reimburse for the following:

- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services furnished by relatives as defined in section 429.02, F.S., household members, or any person with custodial or legal responsibility for the recipient
- Services provided in any of the following locations:
  - Hospitals
  - Intermediate care facility for individuals with intellectual disabilities
  - Nursing facilities
  - Prescribed pediatric extended care centers
  - Residential facilities or assisted living facilities when the services duplicate those provided by the facility

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

(24f) Description

9 Personal care services provide medically necessary assistance, in the home or the community, with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) to enable recipients to accomplish tasks they would normally be able to do for themselves if they did not have a medical condition or disability. Personal care services are provided in accordance with 42 Code of Federal Regulations 440.167.

Who Can Receive

Personal care services are available to recipients under the age of 21 years who require medically necessary personal care services.

Who Can Provide

- Home health agencies licensed in accordance with section 408.810, Florida Statutes (F.S.), and Rule Chapter 59A-8, Florida Administrative Code.
- Independent personal care providers who:
  - Are 18 years or older.
  - Are trained in the areas of cardiopulmonary resuscitation, HIV/AIDS, and infection control.
  - Have at least one year of experience working in a medical, psychiatric, nursing or child care setting or working with recipients who have an intellectual disability. College, vocational, or technical training in medical, psychiatric, nursing, child care, or intellectual disabilities equal to 30 semester hours, 45 quarter hours, or 720 classroom hours can be substituted for the required experience.

Allowable Benefits

Personal care services are reimbursed for up to 24 hours per day, per recipient, in order to provide assistance with ADLs and age appropriate IADLS when the recipient meets the following criteria:

- Is under the care of a physician and has a physician's order for personal care services
- Requires more extensive and continual care than can be provided through a home health visit
- Requires services that can be safely provided in their home or the community
- Has a medical condition or disability that substantially limits their ability to perform ADLs or IADLs and does not have a parent or legal guardian able to provide the required care

In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary. The provider is required to obtain prior authorization from the Agency or its designee.

Exclusions

Florida Medicaid does not reimburse for the following:

- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services furnished by relatives as defined in section 429.02(18), F.S., household members, or any person with custodial or legal responsibility for the recipient. (Except when a recipient is enrolled in the Consumer-Directed Care Plus program)
- Services provided in any of the following locations:
  - Hospitals
  - Institutions for Mental Disease (IMDs)
  - Intermediate care facility for individuals with intellectual disabilities
  - Nursing facilities
  - Prescribed pediatric extended care centers
  - Residential facilities or assisted living facilities when the services duplicate those provided by the facility

PPECs are licensed by the State, and must meet all State licensure laws and regulations based on established criteria and policies in 59A-13 FAC. Staffing includes the following, at a minimum:

1. Medical Director: National Board Certified Pediatrician
2. Director of Nursing: Licensed Registered Nurse (RN) with current certification in cardio pulmonary resuscitation (CPR) and a minimum of 2 years pediatric nursing experience and 6 months caring for medically fragile infants or children in a pediatric intensive care, neo-natal intensive care, PPEC or similar care setting during the last 5 years.
3. Registered Nursing Staff: Licensed RNs with 2 or more years of pediatric experience, 6 months caring for medically dependent or technologically dependent children, and current certification in CPR.
4. Licensed Practical Nurses: 2 years of experience in pediatrics and current certification in CPR. All LPNs must be supervised by an RN.
5. Direct Care Personnel: 1 year experience in care of infants and toddlers with employment references and current CPR certification. Must be supervised by an RN.

Physicians, Registered Nursing staff and Licensed Practical Nurses are also provided and described elsewhere in the plan, pursuant to 42 CFR 440.

All willing and qualified providers will be permitted to participate in accordance with 42 CFR 431.51. All medically necessary services will be provided to individuals qualifying under the EPSDT mandate.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

## PRIVATE DUTY NURSING SERVICES

Description

Private duty nursing services provide care to recipients whose medical condition, illness, or injury requires the care to be delivered in the home or community setting. Private duty nursing services are provided in accordance with 42 Code of Federal Regulations 440.80.

Who Can Receive

Private duty nursing services are available to recipients under the age of 21 years who require medically necessary private duty nursing services.

Who Can Provide

- Home health agencies licensed in accordance with section 408.810, Florida Statutes (F.S.), and Rule Chapter 59A-8, Florida Administrative Code.
- Independent licensed practical nurses licensed in accordance with Chapter 464, F.S.
- Independent registered nurses licensed in accordance with Chapter 464, F.S.

Allowable Benefits

Private duty nursing services are authorized for up to 24 hours per recipient, per day and must be prior authorized by the Agency for Health Care Administration or its designee.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

1/1/98 (11) Therapy Services

Services must be prescribed in writing by the recipient's primary care provider (or designated physician assistant or advanced registered nurse practitioner) or a designated MD specialist. One evaluation or re-evaluation per recipient is allowed every six months. Exceptions to the service limitations can be granted based on medical necessity. All therapists must meet the requirements of 42 CFR 440.110.

Medically necessary occupational, physical and speech therapy services may be provided for recipients under 21 years of age. Therapy sessions administered to recipients on an individual basis must be a minimum of 15 minutes in duration with reimbursement available for a maximum of two individual treatment sessions per day. Speech therapy may also be administered in group sessions, provided that the group contains a maximum of six children, for a minimum of thirty (30) minutes per group. Therapy sessions are subject to prior authorization.

Evaluations for Augmentative and Alternative Communication (AAC) systems must be conducted and documented by the speech therapist. An initial evaluation as well as a follow-up evaluation upon delivery of the system are required to ensure appropriateness of the unit. Re-evaluation of both the unit and the user is required every six months. One initial AAC evaluation is allowed every three (3) calendar years. The follow-up/re-evaluations are limited to two (2) per calendar year. Exceptions to these limitations may be made based on medical necessity.

Fitting/adjustment/training sessions for AAC systems are limited to eight (8) 30 minute sessions per year, per device. Exceptions to these limitations may be made based on medical necessity.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

1/1/93 (12c) 12. Services for prosthetic and orthotic devices must be service authorized by the state agency and approved based on medical necessity. Prosthetic eyes are limited to one initial prosthetic eye for each eye per individual. Exceptions are granted based on medical necessity. Examples of medically necessary replacements are that the prosthetic eye is no longer the appropriate size or the eye has been inadvertently damaged, destroyed or stolen.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

Home Health Services

3/1/97 (7c) Medical supplies and durable medical equipment must be prescribed in writing by the recipient's primary care provider or a designated MD specialist and are limited to the items listed in the agency's provider handbook. Exceptions can be granted based on medical necessity.

Amendment 97-05
Effective 3/1/97
Supersedes 93-05

Approval 9/22/97

Revised Submission 8/29/97

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

1/1/94 14. Chiropractic Services: Chiropractic services are limited to twenty-four visits within a calendar year. Exceptions to the service limitations can be granted based on medical necessity.

Amendment 94-01
Effective 1/1/94
Supersedes 93-02

Approval JUN 17 1994

## 1. INPATIENT HOSPITAL SERVICES OTHER THAN THOSE PROVIDED IN AN INSTITUTION FOR MENTAL DISEASE:

Description

Inpatient hospital services may be provided in accordance with 42, Code of Federal Regulations 440.10. Inpatient hospital services for all ages require authorization from the Agency or the Agency's designee, with the exception of emergency services.

Who Can Receive

Recipients enrolled on the date of service and requiring medically necessary inpatient hospital services.

Who Can Provide

Services must be performed by a facility that meets state requirements for licensure as an inpatient hospital.

Allowable Benefits

- Up to 365/6 days per fiscal year for recipients under the age of 21 years
- Up to 45 days per fiscal year for recipients age 21 years of age or older

Inpatient hospital services beyond the 45 day limit can be reimbursed with prior authorization when medically necessary, for emergency services, or for the treatment of tuberculosis.

Sterilization and abortion procedures, which meet federal requirements, can be reimbursed.

OUTPATIENT HOSPITAL SERVICES: Pursuant to Florida Statutes, services are limited to a maximum of $1,500 for non-EPSDT recipients 21 years of age and over per fiscal year. There is no limitation for EPSDT recipients. To best serve the needs of Florida's Medicaid population, the Agency has exempted the following services from the $1500 limitation: emergencies, outpatient surgeries, and life sustaining treatments such as chemotherapy and dialysis.

Amendment: 05-001
Effective: 01/01/05
Supersedes: 2000-05
Approved: 05/20/05

7/1/92 (23e) EMERGENCY HOSPITAL SERVICES: Same limitations as for Outpatient or Inpatient Hospital Services.

Amendment 93-02
Effective 1/1/93
Supersedes NEW

Approval Date APR 22 1993

FAMILY PLANNING

4/1/2001
(4c)

An initial/annual family planning visit is limited to one per year and a supply visit is limited to one every month. Sterilizations are limited to recipients who meet the requirements of 42 CFR 441.253.

HIV testing and counseling are limited to four per year for recipients acknowledging HIV risks.

HIV testing and counseling are limited to two per lifetime for preventive measures.

# PHYSICIAN SERVICES

Description
Physician services are provided to maintain the recipient's health, prevent disease, and treat illness, in accordance with 42 CFR 440.

Who Can Receive
An eligible recipient, enrolled on the date of service, and requiring a medically necessary physician service.

Who Can Provide
Physicians licensed within their scope of practice to perform this service.

Allowable Benefits

- Health screenings for recipients under the age of 21 years in accordance with the American Academy of Pediatrics periodicity schedule.
- Office visits as medically necessary for recipients under the age of 21 years and pregnant recipients age 21 years and older.
- Up to two primary care office visits per month for recipients age 21 years and older.
- Up to one evaluation and management visit per month, per recipient in a custodial care or nursing care facility.
- Up to one adult health screening every 365 days for recipients age 21 years and older.

*Exceptions to the limits will be authorized on a case by case basis and will be evaluated based on medical necessity.

1/1/91 (6a) PODIATRISTS: Limits visits outside the hospital to not more than one per recipient per day per podiatrist not to exceed two visits per month (except for emergencies) and one per recipient per month per podiatrist upon referral from the recipient's attending physician in long term care facilities (except for emergencies). One hospital visit per day per recipient per provider is allowed. A visit is not allowed on the same day as a surgical procedure unless it is indicated by an asterisk in the provider handbook. All elective surgical procedures require prior authorization or an EPSDT referral to determine medical necessity. Excludes routine foot care unless medically indicated (ex., allowed for diabetics), also excludes experimental and clinically unproven surgical procedures.

Amendment 93-02
Effective 1/1/93
Supersedes NEW

Approval Date APR 22 1993

'0/1/97 Optometric Services
6b)

For non-EPSDT recipients twenty-one years of age and older, visual examinations are limited to two per year per recipient for the purpose of determining the refractive powers of the eyes. Exception authorization for any service limitation may be made by the state agency based on medical necessity. Service limitations for EPSDT recipients are listed in the EPSDT section.

Amendment 97-17
Effective 10/1/97
Supersedes 93-02

Approval 1/20/98

1/1/95 (6c) CHIROPRACTIC SERVICES: Visits to a chiropractor are limited to twenty-four visits within a calendar year. Nursing home and ICF/DD residents require a referral from a physician (M.D. or D.O.). Service limitations for EPSDT recipients are listed in the EPSDT section.

ADVANCED REGISTERED NURSE PRACTITIONER SERVICES

(6d) Description

Advanced registered nurse practitioner services are provided to maintain the recipient's health, prevent disease, and treat illness, in accordance with 42 CFR 440.60.

Who Can Receive

An eligible recipient enrolled on the date of service, and requiring a medically necessary medical service.

Who Can Provide

Advanced registered nurse practitioners licensed within their scope of practice to perform this service.

Allowable Benefits

- Health screenings for recipients under the age of 21 years in accordance with the American Academy of Pediatrics periodicity schedule.
- Office visits as medically necessary for recipients under the age of 21 years and pregnant recipients age 21 years and older.
- Up to two primary care office visits per month for recipients age 21 years and older.
- Up to one evaluation and management visit per month, per recipient in a custodial care or nursing care facility.
- Up to one adult health screening every 365 days for recipients age 21 years and older.

Exceptions to the limits will be authorized on a case by case basis and will be evaluated based on medical necessity.

Home Health Nursing Visits

(7a) Description

Home health nursing services provide care to recipients whose medical conditions, illness, or injury require the care to be delivered in the recipient's place of residence or other community setting. Home health nursing services are provided in accordance with Title 42, Code of Federal Regulations 440.70.

Who Can Receive

Home health nursing services are available to recipients age 21 years and older who require medically necessary home health visit services.

Who Can Provide

- Home health agencies licensed in accordance with section 408.810, Florida Statutes (F.S.), and Rule Chapter 59A-8, Florida Administrative Code.
- Licensed practical nurses licensed in accordance with Chapter 464, F.S.
- Registered nurses licensed in accordance with Chapter 464, F.S.

Allowable Benefits

Florida Medicaid reimburses for the following when prior authorized by the Agency for Health Care Administration or its designee:

- Up to four intermittent home health visits, per day, for pregnant recipients
- Up to three intermittent home health visits, per day, for non-pregnant recipients

The three and four visit limits are a combined limit for both home health nursing and home health aide services.

Service limitations for Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions (EPSDT) recipients are listed in the EPSDT section.

Exclusions

Florida Medicaid does not reimburse for the following:

- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services furnished by relatives as defined in section 429.02, F.S., household members, or any person with custodial or legal responsibility for the recipient
- Services provided in any of the following locations:
  - Hospitals
  - Intermediate care facility for individuals with intellectual disabilities
  - Nursing facilities
  - Prescribed pediatric extended care centers
  - Residential facilities or assisted living facilities when the services duplicate those provided by the facility

Home Health Aide Visits

(7b) Description

Home health aide services provide care to recipients whose medical conditions, illness, or injury require the care to be delivered in the recipient's place of residence or other community setting. Home health aide services are provided in accordance with Title 42, Code of Federal Regulations 440.70.

Who Can Receive

Home health aide services are available to recipients age 21 years and older who require medically necessary home health visit services.

Who Can Provide

- Home health agencies licensed in accordance with section 408.810, Florida Statutes (F.S.), and Rule Chapter 59A-8, Florida Administrative Code.
- Licensed practical nurses licensed in accordance with Chapter 464, F.S.
- Registered nurses licensed in accordance with Chapter 464, F.S.

Allowable Benefits

Florida Medicaid reimburses for the following when prior authorized by the Agency for Health Care Administration or its designee:

- Up to four intermittent home health visits, per day, for pregnant recipients
- Up to three intermittent home health visits, per day, for non-pregnant recipients

The three and four visit limits are a combined limit for both home health nursing and home health aide services.

Service limitations for Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions (EPSDT) recipients are listed in the EPSDT section.

Exclusions

Florida Medicaid does not reimburse for the following:

- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services furnished by relatives as defined in section 429.02, F.S., household members, or any person with custodial or legal responsibility for the recipient
- Services provided in any of the following locations:
  - Hospitals
  - Intermediate care facility for individuals with intellectual disabilities
  - Nursing facilities
  - Prescribed pediatric extended care centers
  - Residential facilities or assisted living facilities when the services duplicate those provided by the facility

## Coverage Template for Freestanding Birth Center Services

**Attachment 3.1A: Freestanding Birth Center Services**

**28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers**

Provided: ☒ **No limitations** With limitations None licensed or approved

Florida Medicaid birth centers provide prenatal and delivery services for recipients expected to experience a medically low risk pregnancy and delivery.

**28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center**

Provided: No limitations ☒ **With limitations (please describe below)**

Please describe any limitations: Florida Medicaid limits prenatal visits to a maximum of 10 visits provided in a licensed birth center to a recipient expected to experience a low-risk pregnancy and delivery, however, additional visits may be provided based on medical necessity in a medically appropriate setting.

Please check all that apply:

☒ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

☒ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

(c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services: Florida Licensed Midwives

10/1/93 CLINIC SERVICES: Ambulatory Surgical Centers

For ambulatory surgical centers, services are limited to those procedures which can be safely done outside of the inpatient hospital setting as determined by Medicare and the state agency policy.

Amendment 93-61
Effective 10/1/93
Supersedes NEW

Approval FEB 18 1994

1/1/93 CLINIC SERVICES: County Public Health Units

For county public health units, services are limited to one clinic encounter per recipient, per day, per provider for preventive or primary care.

Amendment 93-61
Effective 10/1/93
Supersedes NEW

Approval FEB 18 1994

7/1/98 CLINIC SERVICES: Freestanding Dialysis Center Services

Services are limited to one hemodialysis treatment per recipient, per day, up to three times per week provided by a freestanding dialysis center.

Peritoneal dialysis treatments occur as medically indicated and all care is coordinated by the freestanding dialysis center.

All dialysis treatments include: supervision, management, and training of the dialysis treatment routine, durable and disposable medical supplies, equipment, laboratory tests, support services, parenteral drugs and applicable drug categories (including substitutions) provided by and at the freestanding dialysis center.

(10)
(12.b)

DENTAL SERVICES: For non-EPSDT recipients twenty-one years of age and older, services that are provided in accordance with 42 CFR 440.100 and 440.120(b) are limited to:

a. Dentures. The dental services provided are limited to procedures related to dentures and those procedures necessary to seat the dentures. The recipient is limited to either a complete upper denture, a complete lower denture, or one complete set of dentures per lifetime. Replacement of broken or lost dentures is excluded from coverage. Repairs of dentures are covered services. Adjustments and relines are covered after three months for immediate dentures and six months for non-immediate dentures from the date service.

b. Partial Dentures. The dental services provided are limited to the fabrication, repair, reline and adjustment of a removable partial denture. The recipient is limited to either an upper partial, a lower partial, or one set of partials per lifetime. Replacement of a broken or lost partial is excluded from coverage. Adjustments and relines are covered up to six months after original seating of partial. Repairs of partial dentures are covered.

c. Oral and maxillofacial surgery for injury or disease when provided by a qualified oral surgeon (dentist).

d. Emergency dental services are medically necessary emergency procedures to relieve pain or infection. The services are limited to emergency oral examinations, necessary radiographs, extractions, and the incision and drainage of an abscess.

Dental services limitations for EPSDT recipients, provided in accordance with 42 CFR 441.56, are listed in the EPSDT section.

For non-Early and Periodic Screening and Diagnosis recipients 21 years of age and older:

11c. Description

Hearing services are designed to provide screening, assessment, testing, and corrective services to recipients in order to detect and mitigate the impact of hearing loss in accordance with Title 42, Code of Federal Regulations, section 440.110 (c).

Who Can Receive

Hearing services are available to Florida Medicaid recipients 21 years of age or older who require medically necessary hearing services.

Who Can Provide

Practitioners certified or licensed within their scope of practice:

- Audiologists licensed in accordance with Chapter 468, F.S.
- Physicians licensed in accordance with Chapter 458 or 459, F.S., with a specialty in otolaryngology or otology
- Audiology assistants or provisionally licensed individuals directly supervised by a federally qualified and Florida-licensed audiologist

Allowable Benefits

- Diagnostic audiological tests
- Corrective services, when clinical improvement can be reasonably expected.
- One routine hearing assessment or reassessment every three years. This limit can be exceeded when medically necessary.

Service limitations for recipients under the age of 21 years are listed in the Early and Periodic Screening Diagnosis and Treatment section.

For non-Early and Periodic Screening and Diagnosis recipients 21 years of age and older:

12c. Description

Hearing devices are provided to recipients in order to mitigate the impact of hearing loss.

Who Can Receive

Hearing device services are available to Florida Medicaid recipients 21 years of age or older who require medically necessary hearing services.

Who Can Provide

In accordance with section 440.120, prosthetic devices must be prescribed by a physician or other licensed practitioner of the healing arts. Practitioners certified or licensed within their scope of practice include:

- Audiologists licensed in accordance with Chapter 468, F.S.
- Hearing aid specialists licensed in accordance with Chapter 484, F.S.
- Physicians licensed in accordance with Chapter 458 or 459, F.S., with a specialty in otolaryngology or otology
- Audiology assistants or provisionally licensed individuals directly supervised by a federally qualified and Florida-licensed audiologist

Allowable Benefits

- BAHA up to one per ear with prior authorization by the Agency for Health Care Administration (AHCA) or its designee
- Cochlear implants up to one per ear with prior authorization by the AHCA or its designee
- Repairs and replacements of implant external parts after the one year warranty period has expired.

Service limitations for recipients under 21 years are listed in the Early and Periodic Screening Diagnosis and Treatment section.

For non-Early and Periodic Screening and Diagnosis Recipients 21 years of age and older:

12d. Description - Eyeglasses
Visual aid services provide visual aids to recipients to alleviate visual impairments.

Who Can Receive
Visual aid services are available to Florida Medicaid recipients 21 years of age or older who require medically necessary visual aid services.

Who Can Provide
Practitioners certified or licensed within their scope of practice:

- Optometrist and certified optometrist licensed in accordance with Chapter 463, F.S.
- Ophthalmologist licensed in accordance with Chapter 458, F.S.
- Optician licensed in accordance with Chapter 484, F.S.

Allowable Benefits

- Eyeglasses
  Up to one frame every two years
  Up to two lenses every 365 days

- Additional eyeglass frames, lenses, pairs of glasses, and special order frames may be provided with prior authorization by the Agency for Health Care Administration (Agency) or its designee.

- Contact Lenses

  For limited conditions and requires prior authorization by the Agency for Health Care Administration or its designee.

- Prosthetic eyes and services related to measuring, fitting, and dispensing.

Service limitations for EPSDT recipients are listed in the EPSDT section.

7/1/97 TRANSPORTATION: Excludes the provision of transportation by ambulance for ambulatory patients; ambulance services to a physician's private office; transportation to pharmacies; and transportation of nursing home patients to a physician's private office to fulfill utilization control requirements.

Transportation to and from school is allowed for students who are eligible under the provisions of Parts B and H of the Individuals with Disabilities Education Act (I.D.E.A.) and receive Medicaid reimbursable services listed in their Individual Education Plans (IEP) or Family Support Plans (FSP) at the school site on the date transportation is provided. Transportation service must be listed as a required service in the IEP or FSP.

10/1/89 HOSPICE: Benefit periods are the same as those established by Medicare.

Amendment 93-02
Effective 1/1/93
Supersedes NEW

Approval Date APR 22 1993

7/1/98 OTHER PRACTITIONERS SERVICES

(6d) RESPIRATORY THERAPY: Services are available for non-EPSDT recipients 21 years of age and older in the outpatient and inpatient hospital settings and in nursing facilities. Refer to the EPSDT section for EPSDT limitations.

Amendment 98-14
Effective 7/1/98
Supersedes NEW
Approval 10/12/98

PERSONAL CARE SERVICES:

(23f) Description

Personal care services are not available for non-EPSDT recipients 21 years of age and older. Service limitations for EPDST recipients are listed in the EPSDT section.

10/1/90 (8) PRIVATE DUTY NURSING SERVICES: No services are available for non-EPSDT recipients 21 years of age and older. Refer to the EPSDT section for EPSDT limitations.

Amendment 93-02
Effective 1/1/93
Supersedes NEW

Approval Date APR 22 1993

1/01/2003 THERAPIES

(11a) Physical Therapy: Services are available for non-EPSDT recipients 21 years of age and older in the outpatient and inpatient hospital settings and in nursing facilities, and in community settings for the provision of wheelchair evaluations, re-evaluations, and fittings. Refer to the EPSDT section for EPSDT limitations.

(11b) Occupational Therapy: Services are available in nursing facilities for non-EPSDT recipients 21 years of age and older, and in community settings for the provision of wheelchair evaluations, re-evaluations, and fittings. Refer to the EPSDT section for EPSDT limitations.

(11c) Speech Therapy: Services are available in nursing facilities for non-EPSDT recipients 21 years of age and older. In addition, for non-EPSDT recipients 21 years of age and older, one initial evaluation for Augmentative and Alternative Communication (AAC) systems and eight (8) 30-minute fitting/adjustment/training sessions for AAC systems are available per person, per device, per year. Refer to the EPSDT section for EPSDT limitations.

Amendment 2003-03
Effective 1/01/2003
Supercedes 98-14
Approved 05/30/03

Nurse Midwives

7/1/2011 Nurse Midwives provide services to recipients with medically low risk pregnancies for prenatal, delivery and postpartum care, within their scope of practice under State law.

EXTENDED SERVICES FOR PREGNANT WOMEN

4/1/93 The same services that are offered to any categorically needy recipient, as described in Attachment 3.1-A, are available to women for 60 days after the pregnancy ends. No additional coverage beyond what is provided to the general categorically needy recipient is provided and the group receiving services under this provision are subject to the same service limitations as the general categorically needy recipients as outlined in Attachment 3.1-A.

Ten prenatal obstetrical visits to low risk pregnant women and fourteen visits to high risk pregnant women are provided. Additional visits can be authorized if the Medicaid program medical consultant finds the additional visits medically necessary.

THIS PAGE INTENTIONALLY LEFT BLANK

**Covered Legend Drugs:**

Covered outpatient drugs are those produced by any manufacturer that has entered into and complies with an agreement under Section 1927(a) of the Act, and which are prescribed for a medically accepted indication. Drugs must be prescribed and dispensed in accordance with medically accepted indications for uses and dosages.

Coverage for immunizations is limited to the following recipients who are not covered by Medicare Part D:

- Influenza and pneumococcal vaccine for institutionalized recipients age 21 through 64 ; and
- Herpes Zoster (Shingles) vaccine for institutionalized recipients age 60 through 64

Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B as provided by Section 1935(d)(1) of the Act.

The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D.

As provided by Section 1927(d)(2) of the Act, certain outpatient drugs may be excluded from coverage. Those excluded are DESI drugs; experimental drugs; anorectics (unless prescribed for an indication other than obesity); non-legend drugs (except as specified below), aspirin, aluminum and calcium products used as phosphate binders, sodium chloride for specific medical indications; and any drugs for which the manufacturer has not entered into rebate agreements with the Department of Health and Human Services, the Veteran's Administration and the Public Health Service.

As provided by Section 1935(d)(2) of the ACT:

☑ **The following excluded drugs are covered:**

☐ (a) agents when used for anorexia, weight loss, weight gain
☑ *None of the drugs under this drug class are covered*

☐ (b) agents when used to promote fertility
☑ *None of the drugs under this drug class are covered*

☐ (c) agents when used for cosmetic purposes or hair growth
☑ *None of the drugs under this drug class are covered*

☑ (d) agents when used for the symptomatic relief cough and colds
☑ *Some drugs categories covered under the drug class*

- Legend cough and cold preparations, including antitussives, decongestants, and expectorants are covered for recipients under the age of 21 years.
- Legend or OTC single entity guaifenesin products are covered for all recipients.

☑ (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride.

☑ *Some drug categories covered under the drug class*

- Legend vitamin and mineral products are covered for dialysis patients.

☑ (f) nonprescription drugs

☑ *Some drug categories covered under the drug class*

- Aspirin; 650mg acetaminophen tablets; aluminum and calcium products used as phosphate binders; sodium chloride for specific medical indications for all recipients

When prescribed the following OTC medications that have previously been legend drugs are covered:

- Topical antiparasitics
- Vaginal antifungals
- OTC single-entity antihistamines (Loratidine and Cetirizine with age restrictions on liquids) and antihistamine-decongestant combinations (Loratidine D and Cetirizine D with age restrictions on liquids).

☐ (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee

☑ *None of the drugs under this drug class are covered*

Drug Rebate Agreement: The state is in compliance with Section 1927 of the Act. Based on the requirements for Section 1927 of the Act, the state has the following policies for drug rebate agreements:

- The drug file permits coverage of participating manufacturers' drugs.

- Compliance with the reporting requirements for state utilization information and restrictions to coverage.

- A supplemental rebate agreement, Version 05/20/2013, between the state and a drug manufacturer that is separate from the drug rebate agreements of Section 1927 is authorized by the Centers for Medicare and Medicaid Services. The agreement to be used between the State of Florida and drug manufacturers for supplemental rebates for drugs provided to the Medicaid population has been reviewed and authorized by the Centers for Medicare and Medicaid Services. The state reports rebates from separate agreements to the Secretary for Health and Human Services. The state will remit the federal portion of any cash state supplemental rebates collected.

- Manufacturers are allowed to audit utilization data.

- The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification.

- Prior authorization programs provide for a 24-hour turn-around on prior authorization from receipt of a completed request, and at least a 72-hour supply in emergency situations.

**13c** **Preventive Services:**

10/1/09 Licensed Medicaid providers practicing within their scope of practice will administer the H1N1 influenza vaccine to adult recipients age 21 and over, following recommendations by the Centers for Disease Control and Prevention.



Amendment TN: 2009-025
Effective: 10/1/09
Supersedes: NEW
Approval Date: 02-04-10

Rural Health Clinic Services

Services are limited to one visit per day in a rural health clinic. Exceptions will be granted based on medical necessity. For example, a recipient seen at a rural health clinic who subsequently experiences an accident or his condition worsens, may seek the necessary additional medical care from the rural health clinic on the same day.

Federally Qualified Health Center Services

Services provided in a federally qualified health center are limited to one medical, one dental, and one mental health visit per day, per recipient. Exceptions will be granted based on medical necessity. For example, a recipient seen at a federally qualified health center who subsequently experiences an accident or his condition worsens, may seek the necessary additional medical care from the federally qualified health center on the same day.

Other Laboratory Services

The recipient must be referred by a physician or other practitioner of the healing arts and the services must be preformed in a Clinical Laboratory Improvement Amendment of 1988 (CLIA) certified independent laboratory.

Other X-Ray Services

The service must be ordered by a physician or other practitioner of the healing arts and must be provided in either:
(1) a physician's office, including an independent, private, diagnostic x-ray facility; or
(2) if the recipient is homebound, at the recipients' residence, including an ICF/MR or nursing home.

Licensed Midwives

7/1/2011 Licensed Midwives provide services to recipients with medically low risk pregnancies for prenatal, delivery and postpartum care, within their scope of practice under State law.

# PHYSICIAN ASSISTANT SERVICES

(6d) Description

Physician assistant services are provided to maintain the recipient's health, prevent disease, and treat illness, in accordance with 42 CFR 440.60.

Who Can Receive

An eligible recipient enrolled on the date of service, and requiring a medically necessary medical service.

Who Can Provide

Physician assistants licensed within their scope of practice to perform this service.

Allowable Benefits

- Health screenings for recipients under the age of 21 years in accordance with the American Academy of Pediatrics periodicity schedule.
- Office visits as medically necessary for recipients under the age of 21 years and pregnant recipients age 21 years and older.
- Up to two primary care office visits per month for recipients age 21 years and older.
- Up to one evaluation and management visit per month, per recipient in a custodial care or nursing care facility.
- Up to one adult health screening every 365 days for recipients age 21 years and older.

Exceptions to the limits will be authorized on a case by case basis and will be evaluated based on medical necessity.

Amendment 2016-022
Effective 8/15/16
Supersedes 2012-014
Approval 10-12-16

7/1/97 (6d) REGISTERED NURSE FIRST ASSISTANT:

Assistant at surgery fees are limited to surgical codes that allow an assistant surgeon.

Amendment 97-08
Effective 7/1/97
Supersedes NEW
Approval 9/25/97

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Florida Agency for Health Care Administration

MEDICAID PROGRAM: REQUIREMENTS RELATING TO
COVERED OUTPATIENT DRUGS FOR THE MEDICALLY NEEDY

| Citation (s) | Provision (s) |
|---|---|
| 1935(d)(1) | Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B. |

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Florida Agency for Health Care Administration

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE MEDICALLY NEEDY

| Citation (s) | | Provision (s) |
|---|---|---|
| 1927(d)(2) and 1935(d)(2) | 1. | The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D. |
| | X | **The following excluded drugs are covered:** |
| | ☐ | (a) agents when used for anorexia, weight loss, weight gain (see specific drug categories below) |
| | ☐ | (b) agents when used to promote fertility (see specific drug categories below) |
| | ☐ | (c) agents when used for cosmetic purposes or hair growth (see specific drug categories below) |
| | ☐ | (d) agents when used for the symptomatic relief cough and colds (see specific drug categories below) |
| | X | (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride (see specific drug categories below) |
| | X | (f) nonprescription drugs (see specific drug categories below) |

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Florida Agency for Health Care Administration

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE MEDICALLY NEEDY

| Citation (s) | | Provision (s) |
|---|---|---|
| 1927(d)(2) and 1935(d)(2) | ☐ | (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below) |
| | X | (h) barbiturates (see specific drug categories below) |
| | X | (i) benzodiazepines (see specific drug categories below) |
| | | **(The Medicaid agency lists specific category of drugs below)** |
| | | Benzodiazepines – all<br>Barbiturates – all |
| | | Other excluded drugs that are covered are referenced in Attachment 3.1-A and Attachment 3.1-B of the State Plan |
| | __ | **No excluded drugs are covered.** |

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Florida

STANDARDS AND METHODS OF ASSURING HIGH QUALITY CARE

The State of Florida has formally implemented a utilization review program to provide review of all services rendered under the auspices of the Florida Medicaid Program (Title XIX). Internal monitoring at the state office level includes review of computer printouts, editing of all claims presented for payment and investigation of reports and complaints from any source that allege possible improper utilization/provision of services. External monitoring includes a systematic review of all categories of providers by utilization review field representatives. Review of practitioners to assure medical necessity and appropriateness of services is accomplished by examination of medical records by nurse and M.D. consultants with referral to Peer Review as indicated. Utilization control of inpatient hospital services to assure proper hospitalization and quality of care is performed by the PRO under contract with the department. The PRO also reviews community mental health services providers, Health Maintenance Organizations, and outpatient hospitals.

Pharmacy providers submit documentation of prescribed drugs in behalf of recipients whose monthly costs require an increase in the standard drug grant. Requests for prescribed drug services exceeding criteria established by the Medicaid program are reviewed by the pharmacy or medical consultant as appropriate and acted on accordingly. Routine requests are approved systematically.

In addition to utilization review activity in institutions, there is at least an annual medical or quality of care review of all institutional residents by the single state agency. All applicants for nursing home care receive a comprehensive admission assessment conducted by a team consisting of a registered nurse and social services counselor. Furthermore, the regulatory agency licenses and certifies nursing homes and hospitals within federal and state rules and regulations. There is a close liaison between the regulatory agency and the Title XIX agency.

Amendment 87-25
Effective 7-1-87
Supersedes 1973



app. 12/21/87

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

Methods Used to Assure Transportation

Emergency and non-emergency transportation services are available to eligible Medicaid recipients.

Transportation services are available from public, private and commercial sources. The Agency for Health Care Administration (Agency) delegates oversight of non-emergency and emergency transportation services to managed care plans for recipients enrolled in a managed care plan as authorized under the 1115 Managed Medical Assistance Waiver and the 1915 (b)(c) Long-term Care Waiver. The Agency delegates oversight of non-emergency transportation services to qualified contracted entities (e.g., transportation brokers) for recipients not enrolled in a managed care plan as authorized under the 1915(b)(4) Non-Emergency Transportation Waiver. The Agency reimburses for emergency transportation services through a fee-for-service arrangement for recipients not enrolled in a managed care plan.

Non-emergency Transportation Services

Non-emergency transportation services are available to eligible Medicaid recipients who are unable to obtain transportation to a Medicaid-compensable service or make arrangements through any other available means. Medicaid reimburses for non-emergency transportation services that are provided by any of the following:

- Commercial airlines.
- Non-emergency medical vehicles (Wheelchair or stretcher vans).
- Taxi.
- Private vehicle.
- Private Non-profit agencies.
- Multi-load passenger van.
- Mass transit and public transportation systems.
- Ground and air ambulances.
- Ground ambulances subcontracted for use as Stretcher vans.

Non-emergency transportation services require prior approval by the managed care plan for recipients enrolled in a managed care plan or by the Agency's contracted transportation broker for recipients who are not enrolled in a managed care plan.

Medicaid does not reimburse the following for non-emergency transportation:

- Services provided in an inappropriate vehicle.
- Services available to the public free of charge.
- The time spent waiting on a recipient to receive a medical service.
- Services for inter-facility transfers based upon the preference of the recipient or the recipient's family.
- Transport to home and community-based waiver services.
- Recipients in the following eligibility categories are not eligible to receive non-emergency transportation services:

- Recipients who have their own means of transportation;
- Recipients who, at the time of application for enrollment and/or at the time of enrollment, reside in an institution with the exception of nursing facilities;
- Qualified Medicare Recipients;
- Special Low Income Medicare recipients;
- Qualified Medicare Recipients Renal Dialysis;
- Qualified Individuals at Level 1;
- Recipients who reside in residential commitment programs/facilities operated through the Department of Juvenile Justice;
- Undocumented non-citizens; and
- Recipients who are enrolled in the Family Planning Waiver.

Emergency Transportation Services

Medicaid reimburses for emergency transportation services via land ambulance or air ambulance.

Medicaid does not reimburse the following for emergency transportation:

- Services for interfacility transfers based upon the preference of the recipient or the recipient's family.
- Transporting recipients who expire prior to pick up.

Transportation is also available to and from school under the provisions of Part B or Part C of the Individuals with Disabilities Education Act (I.D.E.A.) for children who receive school-based Medicaid compensable services that are indicated on their Individual Education Plans (IEP) or Individual Family Support Plans (IFSP).

State/Territory: FLORIDA

## STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

Medicaid payment is restricted to those organ transplants currently considered as accepted therapeutic modalities in this state and does not include experimental procedures. For children under age 21, Florida covers organ transplants that are medically necessary and appropriate. For recipients age 21 and older, Florida Medicaid covers kidney, liver, cornea, heart, lung, pancreas, intestine, multivisceral and hematopoietic progenitor cell transplants that are medically necessary. An exception is that Medicaid covered emergency services for 5-year bar qualified aliens and non-qualified aliens do not include care and services related to organ transplant procedures. Cornea transplants involve tissue and not solid organs. Medicaid enrollment is required for those facilities that provide cornea transplants, but separate transplant facility designation is not required.

Organ transplants for Florida Medicaid recipients must be performed by Medicaid-designated programs that:

- Have been approved by the State of Florida with a Certificate of Need;
- Are located in hospitals or parts of hospitals that meet the requirements for participation in Medicare as a hospital per 42 CFR 440.10 and 482;
- Are approved by the Centers for Medicare and Medicaid Services (CMS) for the specific organ being transplanted;
- Are certified by the Organ Procurement and Transplantation Network (OPTN) for the specific organ being transplanted;
- Meet additional organ-specific standards provided in Attachment 3.1-E, Supplement I.

If a program loses CMS or OPTN approval for an organ, the program must reapply for Medicaid- designation and meet all the criteria listed above.

For multiple simultaneous organ transplants within the same patient, the program must be approved for each of those organs.

## ORGAN-SPECIFIC TRANSPLANTATION PROGRAM REQUIREMENTS
## LIVER TRANSPLANTATION PROGRAM CRITERIA

In addition to approval by Centers for Medicare and Medicaid Services (CMS) and the Organ Procurement and Transplantation Network (OPTN), patients considered for liver transplantation are those who meet the American Association for the Study of Liver Diseases (AASLD) guidelines.

## INTESTINAL AND MULTIVISCERAL TRANSPLANTATION PROGRAM CRITERIA

In addition to approval by Centers for Medicare and Medicaid Services (CMS) and the Organ Procurement and Transplantation Network (OPTN), the following are required of intestinal and multivisceral transplantation programs:

- Must perform 10 or more intestinal/multivisceral transplants per year;
- Must have one year actuarial survival rate for intestinal/multivisceral transplants greater than 65%.

Patients considered for intestinal or multivisceral transplantation are those with intestinal failure who have failed total parenteral nutrition.

## HEMATOPOIETIC PROGENITOR CELL TRANSPLANTATION PROGRAM CRITERIA

Hematopoietic progenitor cell transplantation must be performed in a medical facility that has been accredited by the Foundation for the Accreditation of Cellular Therapy (FACT).

## CARDIAC TRANSPLANTATION PROGRAM CRITERIA

In addition to approval by Centers for Medicare and Medicaid Services (CMS) and the Organ Procurement and Transplantation Network (OPTN), the following are required of cardiac transplantation programs:

- Programs with transplant patients under age 12 must have pediatric sub-specialists in the areas indicated for program personnel as referenced in the Organ Procurement and Transplantation Network guidelines.
- Programs with neonatal transplant patients must have a level 3 neonatal intensive care unit with neonatology support.

Patients considered for cardiac transplantation are those with end-stage cardiac disease, in accordance with the International Society for Heart and Lung Transplantation (ISHLT) guidelines.

## RENAL TRANSPLANTATION PROGRAM CRITERIA

In addition to approval by Centers for Medicare and Medicaid Services (CMS) and the Organ Procurement and Transplantation Network (OPTN), the following is required of renal transplantation programs:

Programs transplanting pediatric patients must meet all program requirements for a Comprehensive Children's Kidney Failure Center (CCKFC) including pre-dialysis, dialysis, transplantation and post-transplantation services.

## PANCREAS TRANSPLANTATION PROGRAM CRITERIA

Programs performing pancreas transplantation must have the approval by Centers for Medicare and Medicaid Services (CMS) and the Organ Procurement and Transplantation Network (OPTN).

## LUNG TRANSPLANTATION PROGRAM CRITERIA

In addition to approval by Centers for Medicare and Medicaid Services (CMS) and the Organ Procurement and Transplantation Network (OPTN), the following are required of lung transplantation programs:

- Programs transplanting patients under age 12 must have pediatric sub-specialists in the areas indicated for program personnel as referenced in the Organ Procurement and Transplantation Network guidelines.
- Programs transplanting neonates must have a level 3 neonatal intensive care unit with neonatology support.

Patients considered for lung transplantation are those with chronic, end-stage lung disease, in accordance with the International Society for Heart and Lung Transplantation (ISHLT) guidelines.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE FLORIDA

COORDINATION OF TITLE XIX WITH PART A AND PART B OF TITLE XVIII

The following method is used to provide benefits under Part A and Part B of title XVIII to the groups of Medicare-eligible individuals indicated:

A. Part B buy-in agreements with the Secretary of HHS. This agreement covers:

1. [ ] Individuals receiving SSI under title XVI or State supplementation, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

   Yes [X] No [ ]

2. [X] Individuals receiving SSI under title XVI, State supplementation, or a money payment under the State's approved title IV-a plan, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

   Yes [X] No [ ]

3. [ ] All individuals eligible under the State's approved title XIX plan.

4. [X] Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

B. Part A group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups:

   Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

C. Payment of Part A and Part B deductible and coinsurance costs. Such payments are made in behalf of the following groups:

1. Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

2.

3.

# STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Florida

## STANDARDS FOR INSTITUTIONS

---

Hospitals:

Chapter 395, Hospital Licensing and Regulations, Florida Statutes.

Chapter 100-28 Hospital Licensure (Revised 3/19/72), Rules, State of Florida, Office of Health.

Nursing Homes and Related Facilities:

Chapter 400, Nursing Home, Florida Statutes.

Chapter 10-D-29, Nursing Home and Related Facilities Licensure, Rules, State of Florida, Department of Health and Rehabilitative Services, Office of Health.

All nursing homes and related facilities must comply with all provisions of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87).

Amendment 89-34
Supercedes 76-13
Effective 7/1/89

Approved 10/11/89

Received 9/29/89

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Florida

METHODS OF UTILIZATION REVIEW IN INSTITUTIONS

Utilization review in institutions is accomplished as follows:

(a) In Title XVIII/XIX nursing facilities and swing bed hospital, utilization review is suspended in accordance with the provision of OBRA '87.

(b) In mental hospitals, utilization review is performed by the Institutional Utilization Review Committee.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Florida

METHODS OF UTILIZATION REVIEW IN INTERMEDIATE CARE FACILITY SERVICES

Utilization review in XIX facilities is accomplished as follows:

The Agency or designee will conduct utilization reviews in intermediate care facilities for individuals with intellectual disabilities. If the utilization reviews are delegated the designee must conduct reviews in accordance with terms of an agreement with the Medicaid agency.

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

COOPERATIVE ARRANGEMENTS WITH STATE HEALTH AND STATE VOCATIONAL REHABILITATIVE AGENCIES AND WITH TITLE FIVE GRANTEES

---

The following agreements are attached:

1. Agreement between the Medicaid Office, Economic Services Program Office, Children Youth and Families Program Office, Children's Medical Services Program Office, Developmental Services Program Office and the State Health Office for Early and Periodic Screening, Diagnosis and Treatment of Medicaid Eligible Children under 21. (Part I).

2. Cooperative Agreement between the Department of Health and Rehabilitative Services, the Medicaid Program Office and the Department of Labor and Employment Security, the Division of Vocational Rehabilitation. (Part II).

3. Agreement between the Medicaid Office and the Department of Highway Safety and Motor Vehicles. (Part III).

4. Agreement between the Medicaid Office and the Office of Licensure and Certification. (Part IV).

5. Agreement between Medicaid Office and Developmental Services Office. (Part V).

6. Agreement between the Medicaid Office and the Office of Licensure and Certification. (Part VI).

7. Agreement between the Medicaid Office, the State Health Office and the Economic Services Program Office. (Part VII).

8. Agreement between the Medicaid Office and the Alcohol, Drug Abuse and Mental Health Program Office. (Part VIII).

9. Agreement between the Medicaid Office and the Aging and Adult Services Program Office. (Part IX).

10. Agreement between the Medicaid Office and the Department of Education. (Part X).

11. Agreement between the Department of Health and Rehabilitative Services and the Department of Labor and Employment Security. (Part XI).

12. Memorandum of agreement between the State Health Office and the Medicaid Program Office regarding the Healthy Start Initiative. (Part XII).

13. Agreement between HRS offices and the Agency for Health Care Administration for the utilization control program. (Part XIII).

Amendment 93-11
Effective 1/1/93
Supersedes 92-49
Approved JUN 28 1993
Revised Submission 5-6-93

**STATE OF FLORIDA**
**DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES**

**AGREEMENT BETWEEN THE**
**MEDICAID OFFICE,**
**ECONOMIC SERVICES PROGRAM OFFICE,**
**CHILDREN, YOUTH, AND FAMILIES PROGRAM OFFICE,**
**CHILDREN'S MEDICAL SERVICES PROGRAM OFFICE,**
**DEVELOPMENTAL SERVICES PROGRAM OFFICE,**
**ALCOHOL, DRUG ABUSE AND MENTAL HEALTH PROGRAM OFFICE**
**AND THE**
**STATE HEALTH OFFICE,**
**FOR**
**EARLY AND PERIODIC SCREENING, DIAGNOSIS AND**
**TREATMENT OF MEDICAID ELIGIBLE CHILDREN**
**UNDER 21**

The Medicaid office (PDDM) is designated as the administering office for the Title XIX (Medicaid) Program in the state of Florida; the Economic Services Program Office (PDES) has responsibility for the administration of categorical assistance programs, including the Title IV-A program; the Children, Youth, and Families Program office (PDCYF) has responsibility for the Children's Emergency Shelter, Foster Care, and Adoption Programs; the Children's Medical Services Program office (PDCM) under statutory Authority and the Maternal and Child Health Block Grant provides diagnosis and treatment to children with chronic health conditions; the State Health office (PDHE) has statutory responsibility for statewide supervision of the administration of health services programs in county public health units; the Developmental Services Program office (PDDS) has responsibility for training, residential care and related services for children and adults with developmental disabilities; and the Alcohol, Drug Abuse and Mental Health Program Office (PDADM) has responsibility for the provision of a continuum of outpatient, community-based mental health care through contractul agreements with local community Mental Health Centers. Therefore, the programs agree to the following:

I. **All Coordinating Headquarters Program Offices**

Ensure that the EPSDT screen is utilized as the initial health care assessment for all EPSDT eligible children served by the department.

Ensure the EPSDT screening and treatment services are utilized for the provision of preventive and primary health care for all EPSDT eligible children served by the department.

Coordinate with the Medicaid Program office on issuance of policy guidelines, training and monitoring procedures regarding the EPSDT program.

Serve on a statewide EPSDT coordinating committee with the function of providing technical assistance and statewide coordination of the EPSDT program.

Share applicable child health information, reports and statistical data with coordinating program offices.

Coordinate with the Medicaid program office in the development of Medicaid reimbursable services which promote a continuum of health care for children in the least restrictive, most cost effective setting possible.

Abide by federal regulations pertaining to confidentiality and the disclosure of information regarding Medicaid applicants and eligible recipients as outlined in Section IX of this agreement.

II. **Headquarters Medicaid Program Office**

Provide through Florida's Medicaid fiscal agent and the office of Medicaid contract management, monthly reports of EPSDT recipients informed of services, due screenings, screened and requiring treatment. Reports will be distributed monthly to the district Medicaid program office.

Coordinate with Economic Services to ensure that eligible individuals are issued a valid Medicaid ID card.

Ensure that reimbursement is made to eligible providers based upon correct billing procedures as outlined in the appropriate provider handbook.

Ensure that program regulations, instructions and billing guidelines are issued to all program office staff, district staff and providers.

Serve as liaison among all offices involved in the EPSDT program.

Ensure through coordination with Headquarters Economic Services; Children, Youth and Families; State Health Office; Children's Medical Services; Developmental Services; and Alcohol, Drug Abuse and Mental Health offices that procedures for

EPSDT case management as mandated by federal regulations are implemented.

Ensure that training in EPSDT screening, treatment, and case management services is provided to district Medicaid program office staff and providers.

Coordinate the development of district procedures for EPSDT case management to ensure that parents, guardians, and eligible individuals are informed of the availability of initial and periodic screening services and that arrangements are made for eligible individuals to receive these services, as well as needed support services. Information should also be provided on the benefits of screening and follow-up diagnostic and treatment services.

Ensure that EPSDT subsystem informing letters are developed and mailed to recipients in accordance with EPSDT informing standards.

Share applicable screening data and statistical reports with coordinating program offices.

Coordinate EPSDT special projects with other social service agencies, county health units and other program offices.

Develop and disseminate EPSDT outreach materials to recipients, district staff, providers and community groups in accordance with federal EPSDT regulations.

## III. Headquarters Economic Services Program Office

Ensure that eligibles are issued a valid Medicaid ID card.

Ensure that the recipient eligibility file is accurate and up-to-date.

Ensure that all newly approved Aid to Families with Dependent Children (AFDC) Public Medical Assistance, AFDC-related medically needy recipients and those reapproved after a period of ineligibility are advised of the availability of initial and periodic screening services in accordance with procedures outlined in the EPSDT District Procedures Guide.

Ensure that the assistance payments' indicator regarding EPSDT referrals is accurate and up-to-date for each newly eligible, reapproved or reenrolled Public Assistant recipient. The indicator should be completed as follows:

Y = Yes, acceptance of EPSDT services
N - No, refusal of EPSDT services

IV. **Headquarters Children, Youth and Families Program Office**

Coordinate, through district CYF program offices, the provision of EPSDT case management activities as outlined in this agreement to all Medicaid eligible children for whom CYF has lead responsibility.

Ensure that all Medicaid eligibles for whom CYF has lead responsibility are issued a valid Medicaid ID Card.

Ensure that the recipient eligibility file for all Medicaid eligibles for whom CYF has lead responsibility is accurate and up-to-date.

V. **State Health Office**

Supervise the administration of screening services in HRS county public health units serving as Medicaid providers.

Ensure that HRS county public health units are provided procedural standards to assure uniformity in statewide program administration and timely scheduling of Medicaid eligibles for screening.

Ensure that HRS county public health units act as screening providers and coordinate activities with the district Medicaid program office.

Ensure that children referred to the WIC program are screened for eligibility and provided services as appropriate within existing program limitations.

Coordinate with other existing HRS county public health unit services (well-baby visits, school visits, maternal-infant care visits) to avoid unnecessary duplication of such services and maximize Title XIX services between HRS county public health units and the EPSDT program.



Amendment: 91-24
Effective: 7/1/91
Supersedes: 88-10
Approval: 10-15-91

Ensure that Medicaid funded case management staff provide case management services in accordance with state and federal Title XIX regulations.

VI. **Headquarters Children's Medical Services Program Office**

Supervise the administration of screening services in CMS clinics serving as Medicaid providers.

Ensure that Children's Medical Services clinics act as screening and treatment providers for CMS patients and coordinate EPSDT-related activities with the district Medicaid program office.

Ensure that targeted case management services are provided to eligible recipients as appropriate within a coordinated health care delivery system.

Provide medical consultation to the Medicaid office concerning the appropriate service provision for medically fragile children or children with special health care needs including organ transplantations.

VII. **Headquarters Developmental Services Program Office**

Coordinate with other existing screening services in order to avoid duplication of such services under the EPSDT program and maximize Title XIX services between Developmental Services and the EPSDT program.

VIII. **Headquarters Alcohol, Drug Abuse and Mental Health Program Office**

Coordinate with district ADM program offices to maximize the utilization of Medicaid funded substance abuse and mental health services through eligible providers for eligible recipients.

Provide technical assistance to district ADM program offices and substance abuse and mental health providers to improve the capacity, capability and expertise of providers to serve children within a coordinated system of health care delivery.

IX **Confidentiality**

The use or disclosure of information concerning applicants and recipients is restricted to purposes directly related to administration of the Medicaid State Plan.

EPSDT services including examination, diagnosis, treatment, outreach, informing, and assistance with transportation and scheduling appointments for services are considered activities directly related to State Plan administration.

Medical information is privileged and may only be released with the patient's permission.

Any agency or provider with a written interagency or provider agreement to perform EPSDT services which includes the activities of outreach and/or assistance with transportation or scheduling appointments is considered an extension or arm of the Medicaid agency and may be furnished, without the consent of the individual, such information as name, address and medical identification number, providing the following confidentiality requirements are met.

The following criteria specifies the conditions for release and use of information about applicants and recipients:

Information access is restricted to persons or agency representatives subject to legal sanctions or standards of confidentiality that are at least comparable to those of the Medicaid agency.

Release of names of applicants and recipients which may be used by outside sources (sources not under agreement with the agency to provide EPSDT services for recipients) is prohibited.

Written permission must be secured from a family or individual before responding to a request for information from an outside source.

Information may be exchanged when the agency is located within the State structure if the regulatory requirements for safeguarding information on applicants and recipients are met.

Amendment: 91-24
Effective: 7/1/91
Supersedes: 88-10
Approval: 10-15-91

Assistant Secretary
for Alcohol, Drug Abuse
and Mental Health

6/18/91
Date

Assistant Secretary
for Medicaid

4/8/91
Date

Acting Assistant Secretary
for Economic Services

4/19/91
Date

Assistant Secretary
for Children, Youth, and
Families

4/15/91
Date

Assistant Secretary
for Children's Medical
Services

4/22/91
Date

Assistant Secretary
for Developmental Services

5/1/91
Date

Deputy Secretary
for Health
State Health Office

4/9/91
Date

Acting Deputy Secretary
for Programs

5/14/91
Date



Amendment: 91-24
Effective: 7/1/91
Supersedes: 88-10
Approved: 10-15-91

# COOPERATIVE AGREEMENT

BETWEEN

THE DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
THE MEDICAID PROGRAM OFFICE

AND

THE DEPARTMENT OF LABOR AND EMPLOYMENT SECURITY
THE DIVISION OF VOCATIONAL REHABILITATION

This agreement is made between the Department of Health and Rehabilitative Services, Medicaid Program Office, and the Department of Labor and Employment Security, Division of Vocational Rehabilitation, to assure payment by Medicaid for Medicaid compensable medical services provided to Medicaid eligible individuals, and to assure referral by Vocational Rehabilitation to the appropriate agency for Medicaid eligibility determination for those who appear eligible.

Federal Regulations for Vocational Rehabilitation and for Title XIX (Medicaid) Programs require that the respective State Plans provide and describe cooperative working agreements. Medicaid funds may be used as a first-dollar resource for medical assistance provided to Medicaid eligible clients of the Vocational Rehabilitation agency. This agreement differentiates and describes responsibilities of each agency. The agencies have responsibility for statewide supervision of this cooperative program.

The Medicaid Office is designated as the administrative office for the Florida Title XIX (Medicaid) Program, a Federal/State Medical Care Program, provided for in the Social Security Act, which helps meet the cost of health care for those persons who meet the eligibility requirements. The Division of Vocational Rehabilitation has responsibility for administration of general Vocational Rehabilitation programs (excluding services for the blind) in the State of Florida. District Vocational Rehabilitation Offices provide vocational rehabilitation services, including medical and remedial treatment for those determined eligible for vocational rehabilitation.

I. The Division of Vocational Rehabilitation Headquarters Office of the Department of Labor and Employment Security will:

   A. Obtain individual provider numbers for each District Office;

   B. Promulgate procedural regulations to District Vocational Rehabilitation Offices;

   C. Provide the Medicaid Office with information requested by the Department of Health and Human Services;



Amendment 91-45
Supersedes 86-15
Effective 10/1/91
Approval 1-22-92

D. Assure that reports showing the extent of medical services provided to Medicaid eligible individuals are maintained for continuity of care and avoidance of unnecessary repetition, and that these records shall be subject at all times to inspection, review or audit by duly authorized state personnel.

E. Assure that a Program Specialist within the Bureau of Client Services is assigned with liaison responsibility.

II. The District Offices of Vocational Rehabilitation of the Department of Labor and Employment Security will:

A. Assure that individuals who might be eligible for Medicaid are referred to the appropriate agency (local Economic Services, Aging and Adult Services or Social Security Office) for Medicaid eligibility determination.

B. When feasible, refer Medicaid eligible clients to participating Medicaid providers for treatment, offering freedom of choice; providers will seek payment directly from the Medicaid fiscal agent.

C. Will identify clients under 21 years of age in need of Medicaid sponsored treatment or remedial programming.

D. In case of emergency or other exceptional circumstance, make arrangements to provide medical assistance to Medicaid eligible individuals and receive the fee schedule reimbursement as a Medicaid provider by submission of a "Request for Payment" form to the Medicaid fiscal agent.

E. Follow the accepted procedures for billing purposes as outlined in the Medicaid Provider Handbooks.

F. Assure that all exchange of information will be subject to applicable State and Federal laws, agency regulations and policy, and will be accompanied by the written consent of the individual.

G. The District Program Administrator or a designated alternate will assure that a liaison individual is provided.

III. The Medicaid Office of the Department of Health and Rehabilitative Services will:

A. Coordinate with the Economic Services and Aging and Adult Services Program Offices to assure that eligible individuals are informed of the availability of Medicaid services and that applications for Medicaid eligibility are processed in a timely manner with proof of Medicaid eligibility provided to all individuals determined eligible.

B. Assure that program regulations and instructions, including detailed billing procedures, are issued to the Division of Vocational Rehabilitation for distribution to the District Vocational Rehabilitation Offices;

C. Assure that reimbursement will be made to Medicaid providers for services rendered to Medicaid eligible individuals (reimbursement will be made according to the provider's usual and customary charge or maximum allowable Medicaid fee whichever is less);

D. Assure that the Medicaid fiscal agent provides training, as needed, to the District Vocational Rehabilitation Offices on billing procedures for Medicaid services;

E. Serve as the liaison between the Division of Vocational Rehabilitation and the HRS Contract Management Team regarding computer involvement in the operation of the program;

F. Assure that eligible individuals are informed of the availability of collateral social services such as transportation, and that such services are provided or arranged for when requested;

G. Assure that the recipient eligibility file is accurate and up to date;

H. Assure that eligible individuals have been issued a valid Medicaid I.D. card.

I. Provide to each District Vocational Rehabilitation Office and the Headquarters Office, access to information regarding Medicaid eligibility.

J. Assure that all exchanges of information will be subject to applicable State and Federal laws, agency regulations and policy, and will be accompanied by the written consent of the individual.

K. Assure that a Program Specialist within the Medicaid Program Development Unit is assigned with ongoing liaison responsibility.

This agreement by and between the Department of Health and Rehabilitative Services, Medicaid Office, and the Department of Labor and Employment Security, Division of Vocational Rehabilitation, is effective until otherwise revised in writing and signed by both parties, or cancelled by either party upon written notice of at least thirty (30) days prior to proposed termination date. This agreement is to be reviewed jointly at least annually by both parties. Continued efforts will be made to expand the scope of this agreement with new and innovative procedures which may be added to the agreement as required.

W. Calvin Melton
Division Director
Division of Vocational Rehabilitation
4/14/91
Date

Assistant Secretary
for Medicaid
3/25/91
Date

Thomas W. Arnold
Assistant Secretary
for Economic Services
3/3/91
Date

Ralph Alcinda
Assistant Secretary
for Aging and Adult Services
3-4-91
Date

Mark Singer
Secretary
Department of Labor
and Employment Security
8/26/91
Date

for Secretary
Department of Health and
Rehabilitative Services
3/15/91
Date

State of Florida

An Agreement Between
The Florida Medicaid Agency,
Florida Department of Health and Rehabilitative Services
And
The Florida Department of Highway Safety and Motor Vehicles

THIS AGREEMENT entered into on this 29th day of May, 1992, by and between the Florida Medicaid Agency, the Florida Department of Health and Rehabilitative Services (hereinafter referred to as Medicaid) and the Department of Highway Safety and Motor Vehicles (hereinafter referred to as HSMV) regarding the identification of Medicaid eligible individuals on HSMV accident records by means of matching computerized records of both agencies.

WHEREAS, Medicaid and HSMV, two agencies of the State of Florida, are desirous of entering into this agreement in order to facilitate the identification of Medicaid eligibles within the records of HSMV for the purpose of identifying sources of potential third party reimbursement of the State Medicaid program; and

WHEREAS, the Florida State Plan for Medical Assistance, Section 1902(1)(25) of the Social Security Act charges Medicaid with the responsibility of seeking out all potential sources of third party reimbursement of the Medicaid program; and

WHEREAS, regulations at 42 CFR 433.138 requires Medicaid, to the extent possible, conduct data exchanges with state highway accident files;

NOW THEREFORE, in consideration of the above premises and the mutual promises contained herein, Medicaid and HSMV intending to be mutually bound agree as follows:

1. Medicaid will forward to HSMV a request for the state highway accident files on a quarterly basis. Such request will be made in writing by any of the following employees of the Office of Medicaid Third Party Recovery: Planner IV, Medical Health Care Program Analyst or Staff Director.

2. HSMV will provide computer tapes or cassettes of accidents to the appropriate individual within 30 days of the request. The tape(s) or cassette(s) furnished to Medicaid will be fixed block and fixed record length format, in the record layout used by HSMV.

3. HSMV will waive any charges for production processing cost pursuant to this agreement.

4. Medicaid or its fiscal agent will write application software for the production of a system to perform the cross-match of all individual Medicaid eligibility records to records received from HSMV on a quarterly basis.

5. Medicaid, through its fiscal agent, will perform the cross-match.

6. The use or disclosure of information concerning applicants or, or recipients of medical assistance is subject to the limitations of 45 CFR 303.21. In addition, the HSMV report information is subject to the limitations of Section 440.515, Florida Statutes.

7. This agreement will continue until cancelled by either party at any given time upon written notice to the other party given at least ninety (90) days prior to any termination date.

Signature
~~Executive Director~~
Department of Highway Safety and Motor Vehicles
Chief of General Services

Signature
~~Secretary~~
Department of Health and Rehabilitative Services
State Director
Medicaid Plan Policy

TN No. 92-48 DATE/EFF 9-21-92
SUPERSEDES DATE 10-16-92
TN No. New 7-1-92

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
AGREEMENT BETWEEN THE
Office of the Assistant Secretary for Medicaid
and the
Office of Licensure and Certification

The Medicaid Office is responsible for the administration of the Title XIX (Medicaid) program. The Office of Licensure and Certification (OLC) is responsible for the licensing of health care facilities and administering the surveys and inspections necessary to ensure compliance with certification conditions of participation. In the interest of conducting the survey process in the most expeditious and efficient manner, the responsibility for determining if healthcare facilities meet the requirements for participation in the Medicaid program shall be assigned to the Office of Licensure and Certification.

I. Medicaid

A. The Medicaid headquarters office shall exercise administrative direction in the development and administration of the Medicaid State Plan.

B. The Medicaid headquarters office will issue all policies, rules and regulations on Medicaid program matters.

C. The Medicaid agency has final authority over the Medicaid program. Medicaid rules, regulations and decisions shall not be revised by any other state agency.

D. The headquarters Medicaid office shall make the final decision on all certification for Medicaid participation.

II. Licensure and Certification

A. OLC staff shall use current federal standards to determine provider eligibility and certification under Medicaid.

B. Copies of all completed survey reports and necessary accompanying documentation must be kept on file in the central office of OLC for all facilities surveyed.

C. All information and reports shall be readily accessible to staff of the Department of Health and Human Services (HHS) and to staff of the Department of Health and Rehabilitative Services (HRS).

D. Necessary action shall be taken by OLC to require facility compliance, impose moratoriums, levy civil penalties, or to recommend termination of Medicare or Medicaid certification.

E. OLC staff shall perform on-site surveys at least once during each certification period.

III. Survey Staff

Responsibilities of field survey staff include, but are not limited to:

A. Completing all inspection reports.

B. Annotating on report whether each requirement is satisfied.

C. Documenting all deficiencies in report.

D. Reviewing and evaluating all medical and independent professional review team reports obtained under 42 CFR 456.

E. Reviewing an irregular sample of facility payroll records to determine the average number and types of personnel.

IV. Funds

A. Funding shall be earned by the Office of Licensure and Certification through the Title XIX (Medicaid) program. Costs for the Office of Licensure and Certification staff are allocated to Medicaid based on the actual percentage of time spent performing Medicaid certification, in accordance with the HCFA approved cost allocation plan.

B. Federal financial participation is not available in expenditures that are the state's responsibility.

V. Renegotiation or Modification

A. Modifications of this agreement shall be valid only when reduced to writing and duly signed.

B. The parties respective liabilities and responsibilities under this agreement shall be contingent upon the availability of Federal and State monies for the funding of the Title XIX Program.

VI. Termination. This agreement may be terminated by either party upon no less than 30 days written notice, without cause. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery.

VII. Effective Period of Agreement. This agreement by and between the Medicaid Office and the Office of Licensure and Certification will be effective on 09-01-89, and shall continue in full force and effect until otherwise revised in writing and signed by both parties or cancelled by any one of the two parties upon written notice of at least ninety (90) days prior to the proposed termination date.

STATE OF FLORIDA

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

9/1/89
Date

Gary J. Clarke
Assistant Secretary for Medicaid

10/3/89
Date

Robert Griffin
Assistant Secretary for
Regulation and Health Facilities

10/26/89
Date

Robert B. Williams
Deputy Secretary for Programs

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
AGREEMENT BETWEEN THE
Office of the Assistant Secretary for Medicaid
and the
Developmental Services Program Office

The Medicaid Office (PDDM) is responsible for the administration of the Title XIX (Medicaid) Program and the Developmental Services Office (PDDS) is responsible for the administration of the treatment programs for retarded and other developmentally disabled individuals. In the interest of coordinating services and maximizing resources to better serve Title XIX (Medicaid) eligible retarded and developmentally disabled citizens of Florida, the Medicaid Office and the Developmental Services Office agree to the following:

I. The Medicaid Office will:

A. Review preadmission screening and admission review policies and procedures which are developed by the Developmental Services program office for compliance with Medicaid state and federal rules and regulations.

B. Validate on a periodic basis, whether or not admission review and utilization review is performed timely and appropriately by the developmental services utilization control team.

C. Develop, distribute, implement and maintain validation and monitoring procedures.

D. Perform a comprehensive review of federal regulations and report any changes in ICF/DD admission and utilization review requirements to PDDS.

E. Provide technical assistance and consultation as necessary.

F. Serve as the Medicaid liaison with HHS regarding Title XIX (Medicaid) state plan requirements, representing the Developmental Services position on Medicaid issues that affect Florida residents with developmental disabilities.

G. Perform a comprehensive review of applicable administrative rules for the purpose of determining compliance and recommend rule updates or changes as necessary.

H. Perform a comprehensive review of policy and procedure manuals and forms developed by PDDS for compliance with applicable Medicaid federal and state regulations and rules.

I. Provide technical assistance and consultation and training as necessary to developmental services utilization control staff.

II. The Developmental Services Program will:

A. Develop and implement admission and continued stay review policies and procedures in accordance with 42 CFR 456.372 and 42 CFR 456.431 through 438.

B. Provide to district staff, policy manuals, training and policy interpretation for performance of admission and continued stay review for ICF/DD applicants and recipients.

C. Develop and provide forms utilized in the ICF/DD admission and continued stay review process.

D. Represent the department at appeals hearings regarding a decision which denies admission or continued placement in an ICF/DD.

E. Supervise and coordinate district Developmental Services office implementation of Medicaid ICF/DD admission review, Level II preadmission and continued placement of mentally retarded nursing home recipients and continued stay review of Medicaid ICF/MR-DD recipients.

F. Establish methods and procedures to evaluate the performance of the developmental services utilization control teams and report findings to the central Medicaid office.

G. Provide, as appropriate, general revenue funds necessary to earn Title XIX matching funds.

H. Develop policies and procedures to be used by the district Developmental Services office to evaluate whether or not mentally retarded nursing home applicants or residents require the level of services provided by a nursing facility or by ICF/DD and whether or not such residents require active treatment.

I. Promulgate rule which defines ICF/DD admission and level of care criteria.

J. Evaluate each Medicaid applicant's or recipient's need for admission an ICF/DD.

K. Perform level II preadmission and continued placement screening of mentally retarded (Medicaid) nursing home applicants or recipients.

L. Perform continued stay review of each ICF/DD (Medicaid) recipient at least every six months.

M. Receive and process request from ICF/DD recipients for hearing regarding any adverse action (action which denies admission or continued stay)

N. Establish UC committees which meet federal requirements.

O. Contract for such psychiatric, medical and related staff as required to enable the UC committee to carry out the specific responsibilities detailed in this agreement.

P. Complete and maintain such records reports, and forms as required.

III. Exchange of Information:

Exchange of medical, social and related information between the programs, at the district or program office level, will be effected through an established referral procedure, through consultation, through exchange of social and medical summaries, any pertinent correspondence, and forms devised for purposes of exchange of specific information.

IV. Funding

Cost of these functions performed by the Developmental Services Office are charged to Medicaid, as administrative costs, in accordance with the DHRS Cost Allocation Plan. Staff cost (salaries & expenses) in Developmental Services related to diagnosis and evaluation (D&E) services are directly allocated to Medicaid based on statistical data (weighted) related to the number of reviews performed. Cost related to purchased D&E services are direct charged at a fixed amount per review. The cost related to preadmission screening of mentally retarded nursing home applicants or recipients are direct charged at a fixed amount per review.

V. Effective Period of Agreement:

This agreement by and between the Medicaid Office and the Developmental Services Office will be effective within 30 days of signature and shall continue in full force and effect until otherwise revised in writing and signed by both parties or cancelled by any one of the two parties upon written notice at least ninety (90) days prior to the proposed termination date.

5/7/90
Date

Robert B. Williams
Deputy Secretary for Programs

5/25/90
Date

Peter Digre
Deputy Secretary for Operations

5/3/90
Date

Gary J. Clarke
Assistant Secretary for Medicaid

4/17/90
Date

Kingsley R. Ross
Assistant Secretary for
Developmental Services

Amendment 90-26
Supersedes NEW
Effective 5/25/90



Approval Date 11-6-90

# COOPERATIVE AGREEMENT BETWEEN THE FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION AND THE ADMINISTRATION FOR CHILDREN AND FAMILIES, REGION 4 ON BEHALF OF THE FLORIDA HEAD START PROGRAMS FOR EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT OF MEDICAID ELIGIBLE CHILDREN UNDER AGE 21

Whereas, the Florida Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, within the Agency for Health Care Administration and Florida Head Start Programs under the direction of the Administration for Children and Families within the Department of Health and Human Services share a common objective of providing comprehensive health services to low-income eligible children.

Whereas, EPSDT and Head Start emphasize the importance of early identification of health problems and provision of treatment services before the problems become serious.

Whereas, EPSDT and Head Start promote linkage of the child and family to a medical home which will provide an on-going system of health care.

Whereas, each program is responsible for outreach and tracking of eligible children receiving services within their program.

Whereas, many children eligible for Head Start are also EPSDT eligible under the Medicaid program.

Therefore, the undersigned programs recognizing the need for collaboration and coordination agree to the following:

**General Provisions**

- The Florida Medicaid Program and the Florida Head Start programs agree to coordinate and promote screening, diagnosis and treatment of all Medicaid eligible children through the EPSDT program.

- All information exchanged between the Agency and the Head Start programs regarding children's eligibility, medical records and other case history shall be regarded as confidential.

The use or disclosure of information concerning applicants and recipients is restricted to purposes directly related to administration of the Medicaid State Plan.

EPSDT services including examination, diagnosis, treatment, outreach, informing, and assistance with transportation and scheduling appointments for services are considered activities directly related to State Plan administration.

Medical information is privileged and may only be released with the patient's permission.

Any agency or provider with a written cooperative or provider agreement to perform EPSDT services which includes the activities of outreach and/or assistance with transportation or scheduling appointments is considered an extension or arm of the Medicaid agency and may be furnished, without the consent of the individual, such information as name, address and medical identification number, providing the following confidentiality requirements are met.

The following criteria specifies the conditions for release and use of information about applicants and recipients:

Information access is restricted to persons or agency representatives subject to legal sanctions or standards of confidentiality that are at least comparable to those of the Medicaid agency.

Release of names of applicants and recipients which may be used by outside sources (sources not under agreement with the agency to provide EPSDT services for recipients) is prohibited.

Written permission must be secured from a family or individual before responding to a request for information from an outside source.

Information may be exchanged when the agency is located within the State structure if the regulatory requirements for safeguarding information on applicants and recipients are met.

- The EPSDT program federal requirements outlined in Code of Federal Regulation 42, Part 441.50; State Medicaid Manual, Part 5; and state operating procedures as outlined in the District Procedures Guide shall be upheld by the participants of the agreement.

**The Medicaid Program Office will:**

- Ensure that all Medicaid eligible children birth through age 20 years, are informed of the benefits of early and periodic

screening, diagnosis and treatment. Informing will occur at the time of initial eligibility determination and periodically thereafter based on the child's age and the American Academy of Pediatrics (AAP) recommended well child schedule for reexamination.

- Coordinate with the Department of Health and Rehabilitative Services, Economic Services Office to ensure timely determination of Medicaid eligibility and issuance of a valid Medicaid ID card.

- Designate a liaison for coordination with the Head Start Directors Association.

**The Medicaid District Office will:**

- Provide assistance with scheduling of EPSDT screening and treatment services to all eligibles requesting services.

- Provide scheduling assistance and Medicaid transportation services to assist families in accessing EPSDT screening and treatment services.

- Develop and disseminate EPSDT outreach materials to recipients, district staff, providers and community groups in accordance with federal EPSDT regulations.

- Provide EPSDT training to Head Start programs and providers upon request.

- Ensure that reimbursement is made to eligible providers based upon correct billing procedures as outlined in the appropriate provider handbooks.

**The Florida Head Start Directors' Association will:**

- Share federal and statewide policy information regarding Head Start and child health services with the state Medicaid program office.

- Designate a state level liaison for coordination with the EPSDT program.

**The Florida Head Start programs will:**

- Maximize Medicaid funded services in the provision of screening and treatment for Medicaid eligible children.

- Ensure that all potentially Medicaid eligible children are identified and referred for eligibility determination.

- Maintain a record keeping system which will provide for an exchange of case management information between Head Start and EPSDT.

This agreement by and between the Agency for Health Care Administration for Medicaid's Early and Periodic Screening, Diagnosis and Treatment Program and the Administration for Children and Families, Region 4 on behalf of the Florida Head Start Programs is effective when signed and shall continue in force unless otherwise revised in writing and signed by both parties upon written notice of at least ninety (90) days. This agreement is to be reviewed jointly at least annually by both programs.

William A. Fillmore Jr.

William Fillmore
Florida Head Start Association President
Region IV

7/20/93
Date

Dm Cook

Douglas M. Cook
Director
Agency for Health Care Administration

8/30/93
Date

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
AGREEMENT BETWEEN THE
MEDICAID OFFICE,
THE
STATE HEALTH OFFICE
SPECIAL SUPPLEMENTAL FOOD PROGRAM
FOR
WOMEN, INFANTS, AND CHILDREN
(WIC)
AND THE
ECONOMIC SERVICES PROGRAM OFFICE

WHEREAS, in recent years, a number of studies have been conducted to determine the value of the Special Supplemental Food Program for Women, Infants, and Children (WIC) in regard to positive birth outcomes and birthweight.

WHEREAS, such studies determined that participation in WIC by Medicaid pregnant women had positive results associated with birthweight and the health of newborns.

WHEREAS, a May, 1987 survey by the Southern Regional Project on Infant Mortality ascertained that in Florida, the percentage of WIC patients covered by Medicaid ranged from 10 percent of infants to 16 percent of pregnant women.

WHEREAS, action is needed to assure that Medicaid pregnant women who are at nutritional risk are enrolled in WIC and that WIC eligible women are aware of Medicaid benefits.

WHEREAS, Public Law 101-239, Section 6406, December 1989, requires notification in a timely manner of all individuals in the state who are determined to be eligible for medical assistance and who are pregnant women, breast-feeding or postpartum women (as defined in section 17 of the Child Nutrition Act of 1966), or children below the age of five, of the availability of benefits furnished by the special supplemental food program under such section, and for referring any such individual to the local WIC agency responsible for administering such program.

THEREFORE, the undersigned program offices of the Department of Health and Rehabilitative Services agree to the following:

The Economic Services Program will ensure that all newly approved AFDC, Public Medical Assistance, Medically Needy and Medical Assistance Only recipients who are pregnant, breastfeeding or postpartum women (as defined in section 17 of the Child Nutrition Act of 1966), or children below the age of five, and those reapproved after a period of ineligibility, are:

- Advised of the benefits of the WIC program during the eligibility determination interview.
- Referred to the local WIC program.
- Given the brochure "How to Apply for WIC", HRS/PI 150-7.

The Medicaid Program Office will ensure that:

- Florida's Medicaid Management Information System (FMMIS) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) computerized subsystem will automatically inform all Medicaid eligible children under age five, through computer generated notices, of the benefits of participation in the WIC program.
- WIC program information is included in local Medicaid outreach efforts.
- All EPSDT Medicaid eligible pregnant, breastfeeding or postpartum young women under the age of 21 or children below the age of five who have been diagnosed to have a nutritional related deficiency as a result of an EPSDT screen are appropriately referred to the local WIC program.
- Eligible individuals are issued a valid Medicaid identification card through coordination with Economic Services.

The State Health Office will ensure that all Medicaid eligible referrals to the WIC program, are:

- Assessed for determination of eligibility for WIC services.
- Provided WIC services if eligible within the limitations of the local program.
- Referred for or provided an EPSDT screen if not previously screened in accordance with the established periodicity schedule.

This agreement by and between the Medicaid Program Office, State Health Office and Economic Services Program Office is effective when signed and shall continue in force unless otherwise revised in writing and signed by all parties or cancelled by any one of the parties upon written notice of at least thirty (30) days. This agreement is to be reviewed jointly at least annually by all three program offices.

Signatures:

| | |
|---|---|
| for Assistant Secretary for Medicaid | 7/2/90 Date |
| Deputy Secretary for Health | 7/9/90 Date |
| Assistant Secretary for Economic Services | 7/19/90 Date |
| Deputy Secretary for Programs | 7/25/90 Date |
| Deputy Secretary for Operations | 8/6/90 Date |

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
AGREEMENT BETWEEN THE
Office of the Assistant Secretary for Medicaid
and the
Alcohol, Drug Abuse and Mental Health Program Office

The Medicaid Office (PDDM) is responsible for the administration of the Title XIX (Medicaid) Program. The Alcohol, Drug Abuse and Mental Health Program Office (PDADM) is responsible for the administration of the treatment programs for persons with alcohol, drug abuse and mental health conditions. In the interest of coordinating nursing home reform services and maximizing resources to better serve Title XIX (Medicaid) eligible mentally ill citizens of Florida, the Medicad Office and the Alcohol, Drug Abuse and Mental Health Program Office agree to the following.

I. The Medicaid Office will:

A. Serve as the liaison with Health and Human Services (HHS) regarding Title XIX (Medicaid) state plan requirements.

B. Perform a comprehensive review of mental health screening criteria, policies and procedures developed by the Alcohol, Drug Abuse and Mental Health Program Office for compliance with Medicaid state and federal rules and regulations.

C. Provide technical assistance and consultation, as requested.

D. Monitor the statewide mental illness screening program.

E. Perform a comprehensive review of policy and procedure manuals and forms developed by PDADMH for compliance with applicable Medicaid federal and state rules and regulations.

II. The Alcohol, Drug Abuse and Mental Health Program Office will:

A. Develop criteria, policies, procedures and forms for screening mentally ill nursing home applicants and residents in order to determine the need for active treatment.

B. Ensure the availability and provision of active treatment services to all nursing facility residents and applicants who are determined to require such services.

C. Render final determinations regarding the need for active treatment.

D. Provide documentation or evidence requested by the Medicaid Office or by federal reviewers regarding nursing home reform.

E. Represent the department at appeal hearings regarding any decision which denies admission or continued nursing home placement due to the mental health status of the individual.

III. Exchange of Information:

Exchange of information between programs, at the district or headquarters program office level, will be effected through an established referral procedure, including consultation, correspondence and the exchange of information.

IV. Effective Period of Agreement:

This agreement by and between the Medicaid Office and the Alcohol, Drug Abuse and Mental Health Program Office will be effective on the date of signature and shall continue in full force for one year.

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

4/28/91
Date

V. Sheffield Kenyon
Acting Deputy Secretary for Programs

4/22/91
Date

Gary J. Clarke
Assistant Secretary for Medicaid

4/25/91
Date

Ivor D. Groves, Ph.D.
Assistant Secretary for Alcohol, Drug Abuse and Mental Health

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
AGREEMENT BETWEEN THE
Office of the Assistant Secretary for Medicaid
and the
Aging and Adult Services Program Office

The Medicaid Office (PDDM) is responsible for the administration of the Title XIX (Medicaid) Program and the Aging and Adult Services Program Office (PDAA) is responsible for the administration of the health and related programs for aging and adult individuals.

In the interest of consolidation, the responsibilities of preadmission review screening and the actual service delivery system to better serve Title XIX (Medicaid) eligible aging and adult citizens of Florida, the Medicaid Office and the Aging and Adult Services Program Office agree to the following:

I. The Medicaid Office will:

A. Perform a comprehensive review of preadmission screening and admission review policies and procedures which are developed by the Aging and Adult Services Program Office for compliance with Medicaid state and federal rules and regulations.

B. Develop, distribute and maintain methods and procedures for monitoring the admission and preadmission screening programs.

C. Establish, distribute and maintain written criteria for evaluating the need for Medicaid institutional care services.

D. Perform a comprehensive review of federal regulations and report any changes to PDAA.

E. Provide technical assistance and consultation as necessary to PDAA.

F. Serve as the medicaid liaison with HHS regarding Title XIX (Medicaid) state plan requirements.

II. The Aging and Adult Services Office will:

A. Evaluate each Medicaid applicant's or recipient's need for nursing home and mental hospital admission.

B. Perform admission review and preadmission screening in accordance with applicable departmental policies and procedures.

C. Represent the department at hearings regarding a decision which denies admission or continued placement in an institutional care facility.

D. Ensure that all admission reviews are performed appropriately and timely.

E. Advise the district developmental services office of any nursing home applicant or resident who has a diagnosis of mental retardation or related condition for which a preadmission mental retardation screening and assessment of the need for active treatment may be required.

F. Provide any documentation or evidence requested by the Medicaid office or by federal reviewers.

G. Maintain individual applicant files and individual assessment forms and related documentation on each resident for whom an admission review, MI screening or MR screening was performed.

H. Participate in and respond, as necessary, to HHS regarding inquiry relating to admission review and screening.

I. Monitor the admission and preadmission screening program.

J. Establish written monitoring standards, methods and procedures which include at least the procedures which are specified in the Medicaid monitoring plan.

K. Prepare and submit written reports of monitoring findings to the Medicaid Program Development Office.

L. Enforce corrective action, when necessary.

M. Provide to admission review staff and providers policy manuals, training and policy interpretation.

N. Prepare and provide report data as needed and requested to respond to inquiries concerning the admission review and preadmission screening program.

III. Exchange of Information:

Exchange of information between the programs, at the district or program office level, will be effected through an established referral procedure, through joint

consultation, through exchange of social, medical summaries and pertinent correspondence; and forms devised for purposes of exchange of specific information.

V. Funding:

Funding and financial participation shall be earned by the Aging and Adult Services Program through the Title XIX (Medicaid) program funding.

VI. Effective Period of Agreement:

This agreement by and between the Medicaid Office and the Aging and Adult Services Program Office will be effective on the date of signature and shall continue in full force and effect until otherwise revised in writing and signed by both parties or cancelled by any one of the two parties upon written notice at least ninety (90) days prior to the proposed termination date.

STATE OF FLORIDA

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

| | |
|---|---|
| 2/2/90<br>Date | Robert B. Williams<br>Deputy Secretary for Programs |
| 12/3/90<br>Date | Peter M. Digre<br>Deputy Secretary for Operations |
| 1/18/90<br>Date | Gary J. Clarke<br>Assistant Secretary for Medicaid |
| 1/31/90<br>Date | Larry Polivka<br>Assistant Secretary for Aging and Adult Services |

**STATE OF FLORIDA**
**DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES**

**AGREEMENT BETWEEN THE**
**OFFICE OF THE ASSISTANT SECRETARY FOR MEDICAID**
**AND THE**
**DEPARTMENT OF EDUCATION**

The Medicaid Office is designated as the administering office for the Title XIX (Medicaid) program in the state of Florida. The Department of Education (DOE) is responsible for administering the Nursing Assistant Certification Program and maintaining the nurse aide registry. Therefore, the offices agree to the following:

I. The Medicaid Office will:

A. Provide technical assistance and consultation to DOE.

B. Review DOE policies and procedures to ensure compliance with Medicaid state and federal rules and regulations.

C. Ensure Title XIX funding to DOE for activities related to the nurse aide registry.

II. The Department of Education will:

A. Administer the Nursing Assistant Certification Program.

B. Ensure that the nurse aide training and competency evaluation program meets the minimum requirements for hours of training, qualifications of instructors, appropriate curriculum, and performance training as specified in 42 CFR 483.152.

C. Ensure that the nurse aide competency evaluation program meets the minimum requirements specified in 42 CFR 483.152(b) and 483.154.

D. Maintain the nurse aide registry as specified in 42 CFR 483.156 that details the registry requirements, operation, content, and disclosure of information.

E. Maintain documentation of all costs claimed under Title XIX to fully justify expenditures. DOE agrees to furnish, upon request, such information to be reviewed by the Health Care Financing Administration (HCFA), the department, and state auditors.

II. Funding

Funding shall be earned by the Department of Education through the Title XIX (Medicaid) program. Costs for staff are allocated to Medicaid based on the actual percentages of time spent performing activities related to the nurse aide registry. Costs related to expenses, travel and systems costs are directly charged to the Medicaid program.

12/26/91
Date

V. Sheffield Kenyon
Deputy Secretary for Human Services

12/19/91
Date

Gary J. Clarke
Assistant Secretary for Medicaid

12/18/91
Date

Robert S. Howell
Director, Division of Vocational
Adult & Community Education

# MEMORANDUM OF INTERAGENCY AGREEMENT BETWEEN THE FLORIDA DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES AND THE FLORIDA DEPARTMENT OF LABOR AND EMPLOYMENT SECURITY

THIS AGREEMENT is entered into by and between the Florida Department of Health and Rehabilitative Services ("DHRS") and the Florida Department of Labor and Employment Security ("DLES") in order to assist in the identification of Medicaid-eligible individuals listed in the DLES accident records by authorizing the exchange of computerized records for comparison;

WHEREAS, DHRS and DLES, two agencies of the State of Florida, are desirous of entering into this agreement in order to facilitate the identification of Medicaid-eligible individuals listed in the DLES records for the purpose of identifying potential third party reimbursers of the State Medicaid program pursuant to Section 409.910, Florida Statutes and Section 1902(a)(25) of the Social Security Act (42 U.S.C. §1396a(a)(25));

WHEREAS, the Florida state plan for medical assistance, implemented pursuant to 42 USC Section 1902(a)(25) of the Social Security Act charges DHRS with the responsibility of seeking out all potential sources of third party liability for recovery of reimbursements for the state and federal governments pursuant to the Medicaid program; and

WHEREAS, the Federal regulations codified at 42 CFR 433.138(d)(4) require the Medicaid program administered in Florida by DHRS, to the extent possible, to conduct data exchanges with state agencies maintaining Industrial Accident Commission files;

NOW THEREFORE, in consideration of the above premises and the mutual promises contained herein, DHRS and DLES agree to the following terms and conditions:

1. DHRS will submit to DLES a request for specified data pertaining to work-related injuries on a quarterly basis. Such request will be made in writing by authorized employees of the Office of Medicaid Third Party Liability.

2. DLES will, upon request, provide authorized computer tapes or cassettes of data pertaining to work-related injuries to the appropriate individual within 30 days of the written request. The tape(s) or cassette(s) furnished to DHRS will be fixed-block and fixed-record length format, in the record layout used by DLES.

3. DLES may request reimbursement for the actual reasonable cost of production necessitated by this agreement, in accordance with Section 119.07, Florida Statutes.

4. DHRS or its fiscal agent will write application software for the production of a system to perform the cross-match of all individual Medicaid eligibility records to records received from DLES on a quarterly basis.

5. DHRS, through its fiscal agent, will perform the cross-match and will subsequently return the original computer tape(s) or cassette(s) to DLES.

6. The use or disclosure of information concerning applicants or recipients of medical assistance is subject to the limitations of 42 CFR Sections 431.300 and 431.304 confidentiality provisions. In addition, information contained in the DLES report shall not be used or disclosed in any manner that would violate the terms of this agreement.

7. This agreement will remain in force and effect until cancelled by mutual consent of both parties or cancellation by either party after having given written notice to the other party at least ninety (90) days prior to the intended termination date.

AGREED TO THIS 9th DAY OF August, 1992.

Signature
Secretary
Department of Labor and
Employment Security

Signature
Secretary
Department of Health and
Rehabilitative Services

# MEMORANDUM OF AGREEMENT
## between
## the State Health Office
## and
## the Medicaid Program Office

The Medicaid office is designated as the administering agency for the Title XIX (Medicaid) Program in the State of Florida. The State Health Office is responsible for administering the Healthy Start Initiative as defined in the Healthy Start Act of 1991 and specifically selecting and administering prenatal and infant health care coalitions.

The purpose of the Healthy Start Initiative is to assure that Medicaid pregnant women and infants have access to prenatal and infant care through local development of coordinated systems of care. A local Healthy Start coalition will be the agency under contract with the department to coordinate and develop the system of care. The coalition consists of a broad base of community organizations and agencies, both public and private, as well as health care providers and client advocates that have an active interest in maternal and child health.

<u>The State Health Office is responsible for the following</u>:

1. Select local coalitions through a competitive selection process.

2. Prepare contracts with selected coalitions detailing the required work products and time frames.

3. Ensure that the coalitions develop coordinated systems of care and perform the following functions:

   a. Assess community service area (i.e., demographics, estimate of numbers eligible, location of groups).
   b. Develop resource inventories of service area.
   c. Determine components of local provider networks and recruit a network of providers.
   d. Identify at risk groups.
   e. Identify unmet service needs.
   f. Identify barriers to care (e.g. access to affordable care, provider availability, acceptance of Medicaid reimbursement , Medicaid eligibility)
   g. Develop outreach programs to identify and intervene with patients early in their care.
   h. Develop outcome objectives.
   i. Develop prenatal and infant health care services plans that will lead to coordinated systems of care.
   j. Allocate other funding resources to providers.
   k. Implement the health care services plans.

1. Monitor service delivery, and implement a quality management program.

4. Identify state funding resources in the State Health Office budget for coalitions to allocate to providers for providing non-Medicaid covered services.

5. Assure that local agencies including HRS County Public Health Units (CPHUs), district offices and other parties remain informed and participate in these coordinated systems of care.

6. Serve as contract manager and monitor contracts to assure that stated deliverables are provided and established objectives are met. This will be done through quarterly reporting by the coalitions throughout the contract year, site visits by State Health Office staff, attendance at coalition meetings, and quarterly meetings of coalitions.

7. Provide training and technical assistance to coalitions as needed to assist in compliance with contract provisions and facilitate development of coordinated systems of care.

<u>The Medicaid Program Office is responsible for the following</u>:

1. Provide training and technical assistance to coalitions on Medicaid programs and policies.

2. Provide to the coalitions information regarding Medicaid providers as required for conducting community assessment.

3. Assist the State Health Office in monitoring the coalition contracts.

4. Assist coalitions in efforts to develop a comprehensive provider network that serves indigent clients.

5. Actively recruit providers to participate in the Medicaid program.

6. Provide information regarding Healthy Start to recipients and providers as necessary to assure an understanding of the program and to encourage acceptance and active participation.

TN No. 92-49 DATE/RECEIPT 9-21-92
SUPERSEDES DATE APPROVED 10-16-92
TN No. NEW DATE EFFECTIVE 9-3-92

Funding:

1. Funding shall be earned by the State Health Office through the Title XIX (Medicaid) Program. Allowable costs for the coalition contracts shall be allocated to Medicaid based on the population served.

2. The Healthy Start Act requires a local cash or in-kind contribution of 25% of the cost of the coalition. Medicaid's financial participation shall be 50% of the net coalition expenditures (total less local cash or in-kind contributions).

3. Funds advanced under the coalition contracts will be funded 100% from state General Revenue funds. Only actual expenditures will be reimbursable under Medicaid.

4. The State Health Office shall provide the general revenue required to fund 50% of the net expenditures (less local cash or in-kind contributions).

5. The State Health Office is responsible for funding any expenditures disallowed by HCFA related to the coalition contracts.

6. The Medicaid Office will audit expenditures under these contracts at least annually.

8/31/92
Date

Gary J. Clarke
Gary J. Clarke
Assistant Secretary for Medicaid

9/3/92
Date

Charles S. Mahan, MD
Deputy Secretary for Health and
State Health Officer

TN No. 92-49 DATE/EFFECTIVE 9-21-92
SUPERSEDES DATE/EFFECTIVE 10-16-92
TN No. New DATE/EFFECTIVE 9-3-92

INTERAGENCY AGREEMENT BETWEEN
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES (HRS)
THE MEDICAID PROGRAM OFFICE
AGING AND ADULT SERVICES PROGRAM OFFICE
DEVELOPMENTAL SERVICES PROGRAM OFFICE
CHILDREN'S MEDICAL SERVICES PROGRAM OFFICE
ALCOHOL, DRUG ABUSE AND MENTAL HEALTH PROGRAM OFFICE
DISTRICT ADMINISTRATION
AND THE
AGENCY FOR HEALTH CARE ADMINISTRATION
FOR

UTILIZATION CONTROL PROGRAM FOR
INSTITUTIONAL CARE APPLICANTS AND RECIPIENTS

The Medicaid Program office (PDDM) is designated as the administering office for the Title XIX (Medicaid) program in the state of Florida; the Aging and Adult Services Program Office (PDAA) has responsibility for the administration of health and related programs for aging and adult individuals; the Children's Medical Services Program Office (PDCM) has responsibility for the administration of programs and services for children with special health care needs (Title V); the Developmental Services Program Office (PDDS) has responsibility for the administration of supports and services for mentally retarded and other developmentally disabled individuals; the Alcohol, Drug Abuse and Mental Health Program Office (PDADM) has responsibility for the provision of a continuum of mental health care and evaluations through contractual agreements with local mental health centers; and the Agency for Health Care Administration (AHCA) has responsibility for licensing of all long term care facilities and administering the surveys and inspections necessary to ensure compliance with certification conditions and standards of participation. In general, the above offices have responsibility for ensuring that timely, appropriate, efficient, quality and effective institutional care services are provided to Medicaid institutional care recipients. Each district office has responsibility of implementing, at the local level, prescribed utilization control policies and procedures in accordance with established state and federal rules and regulation and in accordance with prescribed policies and procedures.

Federal regulations for Title XIX mandate that the state implement a statewide surveillance and utilization control (UC) program that safeguards against unnecessary and inappropriate use of institutional care services by Medicaid recipients, against excessive institutional care payments and ensures the provision of quality care and services. Therefore, in the interest of meeting these federal mandates, coordinating the nursing home reform requirements of the Omnibus Budget Reconciliation Act of 1987, and maximizing resources to better serve Medicaid institutional care applicants and recipients, these headquarters and district program offices agree to the following provisions relating to Medicaid provider facilities and their recipients (and not applicable to private pay facilities):



Amendment 93-11
Effective 1/1/93
Supersedes NEW
Approval JUN 28 1993

## I. PDDM, PDAA, PDCM, PDDS, PDADM and AHCA GENERAL PROVISIONS

A. To coordinate, as applicable, with the Medicaid program office in the development and issuance of policy statements or policy changes, training, monitoring, and survey procedures regarding institutional care applicants, recipients and providers.

B. To share institutional care information, reports and statistical data.

C. To collaborate in the development of a full continuum of Medicaid reimbursable health and related care services for Medicaid institutional care applicants and recipients that encourage the least restrictive, efficient, and most cost effective use of facilities and services.

D. To collaborate in the development of institutional care admission and continued placement criteria.

E. To provide representation and ensure participation, as appropriate, in local intradepartmental pre-admission reviews of children who are applying for Medicaid reimbursement for nursing facility services.

F. To adhere to state and federal rules and regulations pertaining to Medicaid utilization control of institutional care services.

G. To provide representation and ensure participation in workgroups and committees as necessary to provide technical assistance and coordination of the statewide institutional utilization control program.

H. To provide staff and provider training as necessary.

I. To provide administrative oversight and technical assistance to the district staff in the performance of designated functions.

## II. Medicaid Program Office

<u>The State Medicaid Program Offices shall perform the following functions:</u>

A. Promulgate, distribute and maintain institutional care admission and continued placement criteria;

B. Provide technical assistance and consultation as necessary;

C. Provide clarification of institutional care criteria;

D. Serve as the Medicaid liaison with Health and Human Services (HHS) regarding the Title XIX state plan and state plan requirements;

E. Prepare and submit, on a timely basis, federally required preadmission screening and annual resident review reports, and inspection of care reports (Quarterly Showing Report);

F. Provide clarification of federal requirements;

G. Maintain and update administrative rules, in collaboration with PDARS, PDDS, PDCMS, PDADM, and AHCA, relating to institutional utilization control and admission and continued placement criteria; and

H. Monitor the statewide institutional utilization control program and the nursing facility pre-admission screening and annual resident review (PASARR) process.

The District Medicaid Program Offices shall perform the following functions:

A. Provide technical assistance when requested.

B. Provide oversight at the local district level upon request or as deemed necessary.

**III. Aging and Adult Services Program Office**

The State Aging and Adult Services Program Office shall perform the following functions:

A. Establish, distribute and maintain written admission review, follow-up placement and continued placement determination policies, procedures, and forms.

B. Establish, distribute and maintain written screening and referral policies, procedures, and forms.

C. Prepare and provide report data as needed concerning the admission review and MI and MR-DD screening.

D. Provide input or respond, as necessary, to HHS inquiries relating to admission review and MI and/or MR-DD screening.

E. Monitor the accuracy and timeliness of preadmission and continued placement reviews performed by the district preadmission teams.

F. Ensure the establishment of adequate teams, as available resources allow, to assure timely completion of functions performed by the teams in accordance with the provisions of this agreement.

G. Provide or contract for such psychiatric, medical and related staff as required to enable the teams to carry out the specific responsibilities detailed in this agreement.

The District Aging and Adult Services Program Offices shall perform the following functions:

A. Ensure that each Medicaid applicant's or recipient's (age 21 and older) need for nursing facility, mental hospital or swing bed facility services is evaluated by the Comprehensive Assessment and Review for Long Term Services (CARES) teams and a level of care established or an alternate placement determination rendered.

B. Ensure that all admission reviews are performed appropriately and timely.

C. Ensure that all Medicaid nursing facility applicants (age 21 and older) who appear to have mental illness (MI) or mental retardation/developmental disability (MR-DD) are identified.

D. Ensure that each Medicaid nursing facility applicant (age 21 and older) identified by PDOAA, or private pay applicant (age 21 and older) identified by a nursing facility, as possibly having MI or MR-DD is appropriately referred by CARES for an evaluation and a determination made regarding the need for specialized services.

E. Ensure that local Developmental Services offices are advised of all Medicaid nursing facility applicants or recipients determined to require MR-DD evaluations and ensure that PDADM is advised of all applicants or recipients who require a final determination regarding their need for specialized MI services.

F. Ensure that each Medicaid recipient's need for continued placement in a swing bed facility, beyond the initial 60 day period, is evaluated. Upon request by the facility for authorization of extended Medicaid reimbursement, when appropriate, authorize swing bed extensions.

G. Review all decisions rendered by institutional care facilities (nursing facilities and mental hospitals) and district staff that deny continued placement of any Medicaid recipient who is (age 21 and older) and render a final determination regarding continued placement. When there is concurrence with the facility's decision, provide adequate and timely written notification of the final determination to the local eligibility and payments staff for recipient notification.

H. Perform continued placement reviews of all nursing facility and mental hospital recipients referred by AHCA or other HRS staff, and of all recipients approved for short-term placement, and render a final determination regarding continued placement. When Medicaid eligibility for continued placement is denied, provide adequate and timely written notification to the local eligibility and payments staff for recipient notification.

I. Ensure appropriate departmental representation at any administrative or legal proceeding regarding any decision that is rendered by DPOAA staff which denies an applicant's or recipient's admission or continued placement or renders the facility unable to provide the level of services required by the individual in a nursing facility, swing bed or mental hospital.

J. Ensure that documentation which reflects each admission and continued stay review performed, and each MI or MR-DD screening performed for nursing facility applicants and recipients is maintained at the local level and available for review by authorized federal and/or state representatives, and substantiates the level of services required by each applicant or recipient or an alternative placement determination when applicable.

## IV. Developmental Services Program Office

The State Developmental Services Program Office shall perform the following functions:

A. Establish, distribute and maintain written admission review, follow-up placement and continued placement determination policies, procedures, and forms.

B. Establish, distribute and maintain written screening and referral policies, procedures and forms.

C. Prepare and provide report data as needed concerning the admission review and MR-DD screening.

D. Provide input or respond, as necessary, to HHS inquiries relating to admission review and MR-DD screening.

E. Monitor the accuracy and timeliness of preadmission and continued placement reviews performed by the district preadmission teams.

The District Developmental Services Program Offices shall perform the following functions:

A. Ensure that each Medicaid applicant's or recipient's need for Intermediate Care Facility for the Developmentally Disabled (ICF/MR-DD) services is evaluated and a level of care or

alternate placement determination rendered and to ensure that continued stay reviews are performed in accordance with 42 CFR 456.431 through 42 CFR 456.436.

B. Ensure that all admission reviews are performed appropriately and timely.

C. Review all decisions rendered by ICFs/MR-DD that deny continued placement of any Medicaid recipient and render a final determination regarding the need for continued placement. When there is concurrence with the facility's decision, provide adequate and timely written notification of the final determination to the recipient.

D. Perform continued placement reviews of all MR-DD nursing facility recipients referred by AHCA or HRS staff, and of all MR-DD recipients approved for short-term nursing facility placement, and render a final determination regarding continued placement within the nursing facility.

E. Ensure that each nursing facility applicant or recipient requiring a MR-DD evaluation is evaluated prior to admission (under the Medicaid institutional care program) and no less than annually thereafter and a determination rendered with regard to whether or not specialized services for MR-DD are required.

F. Ensure the establishment of adequate teams to assure timely completion of admission, continued stay and annual reviews of ICF/MR-DD applicants and recipients, and MR-DD screenings for nursing facility applicants and recipients.

G. Provide or contract for such psychiatric, medical and related staff as required to enable the admission and continued stay review teams to carry out the specific responsibilities detailed in this agreement.

H. Develop, distribute and maintain UC plans for each ICF/MR-DD and ensure the UC plans meet federal and state requirements.

I. Ensure departmental representation at any administrative or legal proceeding regarding any decision that is rendered by district DPODS staff which denies an applicant's or recipient's admission or continued placement, or renders the facility unable to provide the level of services required by the individual, in an ICF/MR-DD or nursing facility.

J. Ensure that documentation which reflects each ICF/MR-DD admission and continued stay review performed, and each MR-DD screening and annual review performed for nursing facility applicants and recipients is maintained at the local level and available for review by authorized federal and/or state

representatives, and substantiates the level of services required by each applicant or recipient or an alternate placement determination when applicable.

## V. The Children's Medical Services Program Office

The State Children's Medical Services Program Office shall perform the following functions:

A. Establish, distribute and maintain written admission review, follow-up and continued placement determination policies, procedures, and forms;

B. Establish, distribute and maintain written policies, procedures and forms for first level screening by MHATs of MI and MR-DD and referrals for further assessment.

C. Prepare and provide report data as needed concerning the admission review and MI and MR-DD screening;

D. Provide input or respond, as necessary, to HHS inquiries relating to admission review and MI and/or MR-DD screening; and

E. Monitor the accuracy and timeliness of preadmission and continued placement reviews performed by district Multiple Handicap Assessment Teams (MHATs).

The District Children's Medical Services Program Offices shall perform the following functions:

A. Ensure that each Medicaid applicant's or recipient's (age birth thru 20) need for nursing facility services is evaluated by the Multiple Handicap Assessment Team and a level of care established or an alternate placement determination rendered.

B. Ensure that all admission reviews are performed appropriately and timely.

C. Ensure that all Medicaid nursing facility applicants (age birth thru 20) who appear to have MI or MR-DD are identified.

D. Ensure that each Medicaid nursing facility applicant (age birth thru 20) identified by the MHAT, or private pay applicant (age birth thru 20) identified by a nursing facility, as possibly having MI or MR-DD is appropriately referred by the MHAT for an evaluation and a determination made regarding the need for specialized services.

E. Ensure that local Developmental Services offices are advised of all (age birth thru 20) Medicaid nursing facility applicants or recipients determined to require MR-DD evaluations

and ensure that PDADM is advised of all applicants or recipients who require a final determination regarding their need for specialized MI services.

F. Ensure that local MHATs review all decisions rendered by Medicaid nursing facilities that deny continued placement of any Medicaid recipient (age birth thru 20), and render a final determination through the staffing process regarding the need for continued placement. When there is concurrence with the facility's decision, provide adequate and timely written notification of the final determination to the local eligibility and payments staff for notification to the recipient and the recipient's responsible party.

G. Ensure that local MHATs perform continued placement reviews of all nursing facility residents (age birth thru 20) referred by AHCA or HRS staff, and of all recipients (age birth thru 20) approved for short-term nursing facility placement, and render a final determination regarding continued placement. When Medicaid eligibility for continued placement is denied, provide adequate and timely written notification to local eligibility and payments staff for recipient notification.

H. Ensure appropriate departmental representation at any administrative or legal proceeding regarding any decision that is rendered by a MHAT which denies an applicant's or recipient's (age birth thru 20) admission or continued placement in a nursing facility or renders the facility unable to provide the level of services required by the individual.

I. Ensure that documentation which reflects each admission review and continued stay review performed, and each MI or MR-DD screening and annual review performed for nursing facility applicants and recipients (age birth thru 20) is maintained at the local level and available for review by authorized federal and/or state representatives, and substantiates the level of services required by each applicant or recipient or an alternate placement determination when applicable.

**VI. Alcohol, Drug Abuse and Mental Health Program Office**

<u>The State Alcohol, Drug and Mental Health Program Office shall perform the following functions</u>:

A. Ensure the development of a uniform MI nursing facility preadmission and annual screening/assessment tool and criteria for statewide use.

B. Provide input or respond, as necessary, to HHS inquiries relating to admission review and MI screenings.

C. Monitor the accuracy and timeliness in making determinations for specialized services in accordance with the provisions of this agreement.

The District Alcohol, Drug and Mental Health Program Office shall perform the following functions:

A. Ensure that a final determination is rendered regarding each referred nursing facility applicant's or recipient's need for specialized services for MI.

B. Ensure the provision of specialized services to all nursing facility residents who are determined to require such services and who are allowed to enter or remain in the nursing facility.

C. Ensure that documentation is maintained and available to authorized federal and state reviewers which substantiates the final determination regarding whether or not specialized MI services are required for nursing facility residents and applicants.

D. Ensure departmental representation at any administrative or legal proceeding regarding any admission or continued decision that is rendered by DPOADM staff which denies an applicant's or recipient's admission or continued placement, or renders the nursing facility unable to provide the level of services required by the individual.

E. Prepare and provide periodic report data as needed concerning MI final determinations for specialized services.

## VIII. Agency for Health Care Administration

A. Ensure that an Inspection of Care (IOC) review is conducted in each Medicaid participating ICF/MR-DD and mental hospital in which there is one or more residents approved for the Medicaid institutional care program (ICP).

B. Ensure that all IOC reviews are conducted in accordance with federal law and regulations.

C. Ensure the IOC teams prepare and distribute IOC reports which reflect the IOC team's findings on recipient services as well as specific findings and recommendations with respect to individual need for continued placement. The cover sheet of the IOC reports shall also contain at least the following:

- Facility name, address and provider number;
- Number of Medicaid recipients, by level of care, under facility care at the time of the IOC;
- Number of beds allocated or certified for care of Medicaid recipients;
- Date(s) the IOC was performed. If review lasted more than one day, the beginning and ending dates;
- Date on which the IOC report was prepared; and
- Signatures and credentials of team members.

D. Ensure that IOC teams obtain and maintain individual recipient profiles or assessment findings for each Medicaid applicant or recipient observed and medically reviewed during the IOC and to provide such documentation or evidence when requested by federal and/or state validators.

E. Respond, as necessary, to HHS regarding inquiries relating to inspection of care.

F. Ensure that each IOC team is appropriately composed.

G. Ensure that each MI and MR-DD nursing facility resident is reviewed during the annual facility survey and an assessment made regarding his MI or MR-DD status and his need for an MI/MR-DD evaluation.

H. Refer to district HRS CARES staff or MHAT staff, as age appropriate, each MI or MR-DD nursing facility resident who is identified through a Mini-Gates assessment as needing an evaluation of the MI or MR-DD status and a determination of the need for specialized services or alternative placement.

I. Ensure that each Medicaid nursing facility resident who appears to no longer require the level of services provided by a nursing facility is referred to district HRS CARES or MHAT staff, as age appropriate, for a final continued placement determination.

J. Ensure that each facility has implemented the initial and annual resident review and that each facility is using the Minimum Data Set for review purposes.

K. Ensure agency representation at any administrative or legal proceeding regarding any information provided or action taken by AHCA staff which denies continued placement in an institutional care facility or renders the facility unable to provide the level of services required by the individual.

L. Monitor the accuracy and timeliness of functions performed by the survey teams in accordance with the provisions of this agreement.

## VIII. Exchange of Information

Exchange of information between the programs, at the local and program office level, will be effected through an established referral procedure, through joint consultation, through exchange of reports and pertinent correspondence, and forms devised for the purposes of exchange of specific information.

## IX. Funding

A. Funding shall be earned by each HRS program and AHCA through Title XIX program based on the performance of functions as required in this agreement by staff of the respective office.

B. Allowable costs for HRS program office or district staff and AHCA may be charged directly or allocated to Medicaid based on the actual percentages of time spent performing activities applicable to this agreement in accordance with the HCFA approved cost allocation plan. Additionally, costs for physician consultant services may be charged directly to the Medicaid program.

C. Each HRS program office and AHCA is responsible for management of its Title XIX budget, ensuring that all funds are spent properly, accounted for, and budget information is available for review.

D. Each applicable HRS office and AHCA is responsible for funding any disallowances from HCFA related to its respective responsibilities.

## X. Amendments

A. Amendments to this agreement shall be valid only when reduced to writing and duly signed.

B. Any party to this agreement may propose an amendment to any provision of the agreement and shall give all parties the opportunity to assess the impact of any proposed amendments. Any section of this agreement may be amended at any time with the agreement of all parties impacted by the provisions that are amended.

## XI. Termination.

This agreement may be terminated by any party upon no less than 90 days written notice to all parties, without cause. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery.

## XII. Effective Period of Agreement

This agreement by and between the above specified HRS program offices and AHCA will be effective on January 1, 1993, and shall continue in full force and effect until June 30, 1993.

The parties hereto have caused this agreement to be executed by their undersigned officials as duly authorized.

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

MEDICAID PROGRAM OFFICE

Gary J. Clarke
Assistant Secretary for Medicaid

AGING AND ADULT SERVICES

Ralph Schunk
Acting Assistant Secretary for Aging and Adult Services

DEVELOPMENTAL SERVICES

Richard Lepore
Assistant Secretary for Developmental Services

CHILDRENS MEDICAL SERVICES

Michael Cupoli, M.D.
Assistant Secretary for Childrens Medical Services

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH SERVICES

Randy Wilcox
Acting Assistant Secretary for
Alcohol, Drug Abuse and Mental Health Services

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

Douglas M. Cook, Director

CF OPERATING PROCEDURE
NO.

Family Safety

INTERSTATE COMPACT ON ADOPTION AND MEDICAL ASSISTANCE

Purpose. This operating procedure describes the functions and requirements for the administration of the Interstate Compact on Adoption and Medical Assistance (ICAMA).

Scope. This operating procedure is applicable to all districts/regions, Family Safety program staff and Child Welfare Legal Services attorneys as well as providers of child welfare services under contract with the department, who are involved in the interstate interests of adopted special needs children.

Authority. ICAMA joinder and participation is authorized by Section 409.406 and 409.407, Florida Statutes (2002).

P.L. 96-272, Adoption Assistance and Child Welfare Act of 1980, Social Security Act, Section 473, et seq.

Consolidated Omnibus Reconciliation Act of 1985 (COBRA) made two changes in Title XIX, Medicaid: (1) Requires the state of residence to provide Medicaid to all children adopted under the federally assisted adoption subsidy program; and (2) Gives states the option of extending Title XIX Medicaid to children adopted pursuant to state-funded adoption subsidy programs if they meet specific eligibility criteria.

P.L. 105-89, Adoption and Safe Families Act of 1997

Definitions.

"Adoption Assistance" means payments and services provided to a special needs child and his or her adoptive family, as specified in the Adoption Assistance Agreement. Such assistance may include maintenance adoption subsidy, medical subsidy, Medicaid and reimbursement of non-recurring expenses associated with the legal adoption.

"Adoption Assistance Agreement" is an agreement between the adoptive parents and a state, agency, or subdivision thereof, in accordance with which the adoptive parents are to receive financial assistance and services on behalf of a child with special needs.

"Adoption Assistance State" is the state that is the signatory to an Adoption Assistance Agreement on behalf of a particular child.

"Adoptive Parents" is the party(ies) entering into the Adoption Assistance Agreement with the state, agency or subdivision.

"Certification" is the guarantee, as stated on the Notice of Medicaid Eligibility/Case Activation Form (Form 6.01) from the Adoption Assistance State, that the attached

Adoption Assistance Agreement is a true copy of the Agreement which is current and in effect.

"Child with Special Needs" is a child on whose behalf adoption assistance payments are being made to facilitate and maintain an adoption. A child with special needs is defined in Section 409.166, F.S.

"COBRA" is the Consolidated Omnibus Budget Reconciliation Act of 1986. COBRA mandates that children receiving Title IV-E adoption assistance payments are categorically eligible to receive Medicaid in the state of residence.

"COBRA Option" is the provision in COBRA that provides states with the flexibility of providing Medicaid coverage for non-IV-E children who have special needs and are receiving state funded adoption assistance. In order for a child to be eligible for the COBRA option, the child must have a special medical or rehabilitative need, which is specified on the Adoption Assistance Agreement.

"District ICAMA Specialist" is the person in the district/region that has responsibility for the local administration of ICAMA.

"Fair Hearing" is a system under which adoptive parents may appeal the denial of or exclusion from adoption assistance. The types of situations which would constitute grounds for a fair hearing include: (a) relevant facts regarding the child, the birth family, or child's background were known and not presented to the adoptive parents prior to the legalization of the adoption; (b) denial of assistance which was based on a means test of the adoptive parents; (c) erroneous determination by the state that a child is ineligible for adoption assistance; and (d) failure by the agency to advise adoptive parents of the availability of adoption assistance.

"ICAMA" means the Interstate Compact on Adoption and Medical Assistance.

"ICAMA State Office" means the central state ICAMA office responsible for statewide administration of ICAMA and for maintaining contact and coordinating assistance with other ICAMA member states.

"Medicaid Identification Document" is a Medicaid card.

"Party State" is a state that is a member of the Interstate Compact on Adoption and Medical Assistance.

"Resident State" is the state in which the child lives.

"Third Party Insurance" is any health insurance, other than Medicaid, the adoptive parents have that provides coverage for the adopted child.

"Title IV-E" is a federal funding source for a child who meets the technical eligibility requirements that were in place as of July, 1996 for the Aid To Families of Dependent Children (AFDC) or a child who is eligible for Social Supplemental Income (SSI). The child's eligibility for Title IV-E must be determined at the time of the child's latest removal from the home and at the time the adoption petition is filed. To be eligible for Title IV-E,

the child, at the time of entry into foster care, must (a) have been residing with a specified relative or lived with a specified relative within the six month period prior to removal, (b) have been deprived of the care or support of at least one parent, (c) must have met the income and resources requirements for Title IV-E, and (d) there must be a judicial determination that it was "contrary to the welfare of the child" to remain in the home. The child's eligibility for SSI must be determined by the Social Security Administration no later than the time the adoption petition is filed and is based on (a) income level and (b) disability.

Procedures. There are three different situations that fall under the Interstate Compact on Adoption and Medical Assistance (ICAMA). The three situations and the procedures that must be followed are described below.

I. Child Moves Between ICAMA Party States

A. Responsibilities of Florida as the Adoption Assistance State (When A Child Moves FROM Florida To Another ICAMA State)

1. Notify the new state of residence of the child's eligibility for Medicaid.

Thirty (30) calendar days prior to the child's move to another ICAMA state, the district/region ICAMA specialist sends two copies of each of the following documents, attached to the District ICAMA Transmittal Form, to the ICAMA headquarters office at DCF for forwarding to the new state of residence:

a. A completed Notice of Medicaid Eligibility/Case Activation (Form 6.01) to the new state of residence. The ICAMA specialist must sign Section E, Certification, on page 3 of Form 6.01.

b. A copy of the most current Adoption Assistance Agreement, which must show that the child is eligible for Medicaid based on Title IV-E eligibility or state option.

c. A cover letter signed by the adoption counselor and supervisor that identifies any unique concerns about the child and/or the adoptive family.

2. Inform the adoptive family that the new Resident State has been notified that the child is eligible to receive Medicaid benefits in the new state of residence.

The district/region ICAMA specialist sends the family:

a. A copy of the Notice of Medicaid Eligibility/Case Activation (Form 6.01); and

b. The original Notice of Action (Form 6.02);and

c. A copy of the most current Adoption Assistance Agreement.

3. A copy of the above referenced documents for each adopted child will be maintained in the child's adoption case file.

B. Responsibilities of Florida as the Resident State (When A Child From Another ICAMA State Moves TO Florida)

To ensure that documentation for the child's Medicaid eligibility is complete, within ten (10) working days of receipt of a child's ICAMA documents from the State ICAMA Office, the district/region ICAMA specialist will:

1. Open a case in each child's name.

   a. Make copies of the documents; and
   b. Create a file for each adopted child in the family.

2. Facilitate the issuance of a Medicaid card based on the documentation provided.

   a. Forward the documentation to appropriate local Medicaid office; or
   b. Apply whatever procedures are followed in the district/region.

3. Notify the Adoption Assistance state of the child's Medicaid status by:

   a. Completing Sections A, B, and C of Report of Change in Child/Family Status (Form 6.03); make two copies of this completed form; and
   b. Send it to the ICAMA headquarters office at DCF informing them that the Medicaid case was opened and whether or not a Medicaid card has been issued.

II. Florida Child Moves into Non-Party State
(Even though the child is moving into a non-party state, both the Adoption Assistance State and the non-party state may use ICAMA forms.)

A. Responsibilities of Florida as the Adoption Assistance State

1. Notify the new state of residence of the child's eligibility for Medicaid.

Thirty (30) calendar days prior to the child's move to a non-party state, the district/region ICAMA specialist sends two copies of the following documents, attached to the District ICAMA Transmittal form, to the ICAMA headquarters office at DCF for forwarding to the new non-party state of residence:

a. A completed Notice of Medicaid Eligibility/Case Activation (Form 6.01) to the new state of residence along with:

b. A copy of the Adoption Assistance Agreement, which must show that the child is eligible for Medicaid based on Title IV-E eligibility or state option.

2. Inform the adoptive family that the new Resident State has been notified that the child may be or is eligible to receive Medicaid benefits in the new state of residence. If the adoptive family is not eligible to receive Medicaid benefits in the new state of residence see section IV.,A., 1 through 3 of this operating procedure.

The district/region ICAMA specialist sends the family:

a. A copy of the Notice of Medicaid Eligibility/Case Activation (Form 6.01); and

b. The original Notice of Action (Form 6.02); and

c. A copy of the current Adoption Assistance Agreement.

## III. Child Moves from First Resident State (Florida) to a Second Resident State

A. Responsibilities of the district/region ICAMA specialist in First Resident State

1. Ensure that the necessary documentation is forwarded to the second state of residence.

Thirty (30) calendar days prior to the child's move from the first resident state (Florida) to a second resident state, the district/region ICAMA specialist will:

a. Notify the local Medicaid office of the date that the child is moving to another state and that the Medicaid card must be closed;

b. Complete Sections A, B, D and E of the Report of Change in Child/Family Status (Form 6.03) and send two copies, attached to the District ICAMA Transmittal form, to the ICAMA headquarters office at DCF for forwarding to the Adoption Assistance state, which from then on is responsible for communicating directly with the second state of residence in matters involving the child's continuing eligibility for Medicaid in the new state.

2. Close child's case.

B. Responsibilities of Florida as the Second Resident State

Within ten (10) working days of receipt of a child's ICAMA documents, the district/region ICAMA specialist will:

1. Open a case in each child's name.

   a. Make copies of the documents; and
   b. Create a file for each adopted child in the family; and,

2. Facilitate the issuance of a Medicaid card based on the documentation provided.

   a. Forward the documentation to appropriate local Medicaid office; or
   b. Apply whatever procedures are followed in the district.

3. Notify the Adoption Assistance state of the child's Medicaid status by:

   a. Completing Section A, B, and C of Report of Change in Child/Family Status (Form 6.03); and
   b. Send it to the ICAMA headquarters office at DCF for forwarding to the Adoption Assistance State informing them whether or not the child's new Medicaid card has been issued.

## IV. Medicaid Coverage of Children Receiving State-Funded Adoption Assistance

Children receiving state-funded adoption assistance and Medicaid from the adoption assistance state are not automatically eligible to receive Medicaid in the new state of residence.

The child is eligible IF:

1. the adoption assistance state has elected to provide Medicaid to children receiving state-funded adoption assistance and included Medicaid as a benefit in the adoption assistance agreement;
2. the new residence state has elected the COBRA option; and
3. the new residence state has agreed to provide this benefit to all eligible children with adoption assistance agreements, not just children with adoption assistance agreements with their state.

Note: Under ICAMA, residence states are required to provide Medicaid to children receiving state-funded adoption assistance when: (1) both states are members of ICAMA; (2) both States have elected the option to provide Medicaid to this category of children; and (3) the child meets the eligibility criteria.

### A. When Florida is the Adoption Assistance State

1. The district/region ICAMA specialist will determine, based on Exhibit A State's List, if the new residence state has elected the COBRA option
2. If the state does not have the option, the district/region ICAMA specialist will inform the family that they will not be eligible for Medicaid in the new state of residence and assist them in (1) finding a provider that will take the adoption assistance state's Medicaid, or (2) assist them in finding a way to get medical assistance.
3. If the state does have the option and will reciprocate, the district/region ICAMA specialist will fill out the ICAMA forms as outlined above.

### B. When Florida is the Resident State

Florida provides Medicaid for children receiving state-funded adoption assistance from another state when the child has been determined eligible for Medicaid under the COBRA option by the adoption assistance state. The responsibilities of the district/region ICAMA specialist is the same as when a child moves between ICAMA party states.

# INTERSTATE COMPACT ON ADOPTION AND MEDICAL ASSISTANCE

***Signature Page***

Pursuant to the authority conferred upon me by Section 409.406, Florida Statutes (2002), the undersigned hereby enters into the **Interstate Compact on Adoption and Medical Assistance** on behalf of the state of **Florida**, and signifies that the agency which the undersigned represents has the authority to perform the actions required by the Compact and to provide or cause to be provided the services and benefits required by the Compact in the manner and to the extent necessary for compliance therewith.

Executed this 18th day of February, 2003

on behalf of the state of Florida by:

Jerry Regier

Jerry Regier

Secretary

Title

State of Florida
Department of Children and Families

Agency

# INTERSTATE COMPACT ON ADOPTION AND MEDICAL ASSISTANCE

## Designation of Compact Officials Form

The following individuals have been designated as the Compact Administrator and Deputy Compact Administrators for the state of Florida effective this 18th day of February, 2003.

**Compact Administrator:**

Samuel G. Ashdown, Jr.
Name

Program Administrator,
Family Safety Program Office
Title

State of Florida
Department of Children & Families
Agency

**Deputy Compact Administrator:**

Wendy Leader Johnston
Name

Program Administrator,
Medicaid
Title

State of Florida
Agency for Health Care Administration
Agency

**Deputy Compact Administrator:**

Nathan J. Lewis
Name

Program Administrator, Health Care Access Unit, Economic Self-Sufficiency Services Program Office
Title

State of Florida
Department of Children & Families
Agency

**Deputy Compact Administrator:**

Sandra D. Erickson
Name

Government Operations Consultant II,
Family Safety Program Office
Title

State of Florida
Department of Children & Families
Agency

**Deputy Compact Administrator:**

Barbara K. Stephens
Name

Government Operations Consultant II,
Family Safety Program Office
Title

State of Florida
Department of Children & Families
Agency

**Deputy Compact Administrator:**

Kevin O. Askew
Name

Government Operations Consultant II,
Family Safety Program Office
Title

State of Florida
Department of Children & Families
Agency

Jerry Regier
Jerry Regier

Secretary
Title

State of Florida
Department of Children & Families
Agency

February 18, 2003
Date

LIENS AND ADJUSTMENTS OR RECOVERIES

1. The State uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home:

   Florida assumes that all institutionalized individuals whose home is not counted due to a statement of their intent to return home when they are able will return home when they are able. Florida Medicaid current policy is not to file liens against homestead property. Florida does recover other estate assets.

2. The following criteria are used for establishing that a permanently institutionalized son or daughter provided care as specified under regulations at 42 CFR §433.36(f):

   Florida Medicaid current policy is not to file liens against homestead property. Florida does recover other estate assets.

3. The State defines the terms below as follows:

   - estate

   Property of a decedent that is the subject of administration. (Section 731.201, Florida Statutes)

   A. individual's home

   Permanent residence means that place where a person has his true, fixed and permanent home and principal establishment to which, whenever absent, he has the intention of returning.

   B. equity interest in the home

   Not applicable. Florida Medicaid current policy is not to file liens against homestead property. Florida does recover other estate assets.

   C. residing in the home for at least one or two years

   Not applicable. Florida Medicaid current policy is not to file liens against homestead property. Florida does recover other estate assets.

   D. on a continuing basis

   Not applicable. Florida Medicaid current policy is not to file liens against homestead property. Florida does recover other estate assets.

   E. discharge from the medical institution and return home

   Not applicable. Florida Medicaid current policy is not to file liens against homestead property. Florida does recover other estate assets.

F. lawfully residing

Not applicable. Florida Medicaid current policy is not to file liens against homestead property. Florida does recover other estate assets.

4. The State defines undue hardship as follows:

An undue hardship might exist when:

A. There is property in the estate, and the property is listed as residential property by the County Tax Assessor's Office, and the heir(s):
   - o owns a business, including farming and ranching, that is located at the residential property, and
   - o the business has been in operation at the residential property for at least 12 months preceding the death of the decedent;
   - o the business produces more than 50% of the heir's livelihood; and
   - o the recovery of the property would result in the heir(s) loss of their means of livelihood; or

B. The heir(s) currently reside in the residence, and
   - o resided there at the time of the death of the decedent;
   - o has made the residence his or her primary residence for the 12 months immediately preceding the death of the decedent; and
   - o owns no other residence;

C. The only asset is a homestead of modest value;

D. The heir(s) would be deprived of food, clothing, shelter, or medical care necessary for the maintenance of life or health;

E. The heir(s) can document that they provided full-time care to the recipient that delayed the recipient's entry into a nursing home. The individual must be either the decedent's sibling or the son or daughter of the decedent and have resided in the individual's home for at least one year prior to death; or

F. The cost involved in the sale of property would be equal to or greater than the value of the property.

"Heirs" means those persons, including the surviving spouse, who are entitled under the statutes of intestate succession to the property of a decedent.

An undue hardship does not exist solely because recovery will prevent any heirs from receiving an anticipated inheritance.

5. The following standards and procedures are used by the State for waiving estate recoveries when recovery would cause an undue hardship, and when recovery is not cost effective:

Hardship Waiver:

The State's claim form contains a provision that informs the personal representative that a procedure exists to apply for a hardship waiver and to contact the contractor for a copy of the Request for Hardship Waiver.

Upon receiving a request for a Hardship Waiver Request Form (by telephone or mail), the contractor will send to the requester, the following forms that are provided below:

RECEIPT OF REQUEST FOR WAIVER

(DATE)

Name of Personal Representative
Address
City, State Zip Code

Dear_____:

RE: Estate of:_____
MEDICAID I.D. #:_____

(NAME OF CONTRACTOR), on behalf of the State of Florida, by and through the Agency for Health Care Administration (AHCA), has received your request for waiver of AHCA's claim against the above-named estate. Your request will be given every consideration.

So that we may evaluate your request, please complete the attached form and provide documentation that justifies your basis for the request.

Send the completed form and documentation to:

Contractor Name
Address
City, State Zip Code

If we do not receive the necessary documentation within 30 days from the date given above, we will assume that you have withdrawn your request and that you will proceed to honor the State's claim accordingly.

(NAME OF CONTRACTOR)

REQUEST FOR WAIVER OF ESTATE RECOVERY

Mail to:
CONTRACTOR
On Behalf of the State of Florida
Address
City, State Zip

DECEDENT NAME:_____
DECEDENT'S STREET ADDRESS:_____
DECEDENT'S SOCIAL SECURITY NUMBER:_____
DECEDENT'S MEDICAID ID NUMBER :_____

Based upon the payment of medical services paid by the State of Florida, Agency for Health Care Administration (the Agency) on behalf of the decedent, the Agency intends to seek recovery for the services paid. The purpose of seeking recovery is to offset the cost of medical services paid by the taxpayers. Recovery will be sought from the proceeds of the decedent's estate.

The Agency's action is based upon its rights found in 42 CFR 433.136, Section 409.910, Florida Statutes, and the Omnibus Budget Reconciliation Act of 1993 (OBRA). Federal law prohibits recovery from the estate of a recipient only if the individual is survived by: 1) a spouse; 2) a child under 21 years of age; 3) a blind or disabled child; or 4) if recovery would place an undue hardship on the survivors. Where the State determines that estate recovery would work an undue hardship on the survivors or heirs, recovery may be compromised or waived.

(Continued below)

Undue Hardship may exist when:

1. There is property in the estate, and the property is listed as residential property by the County Tax Assessor's Office, and the heir(s): owns a business, including farming and ranching, that is located at the residential property, and the business has been in operation at the residential property for at least 12 months preceding the death of the decedent;
   - the business produces more than 50% of the heir's livelihood; and
   - the recovery of the property would result in the heir(s) loss of their means of livelihood; or
2. The heir(s) currently reside in the residence, and
   - resided there at the time of the death of the decedent;
   - has made the residence his or her primary residence for the 12 months immediately preceding the death of the decedent; and
   - owns no other residence;
3. The only asset is a homestead of modest value;
4. The heir(s) would be deprived of food, clothing, shelter, or medical care necessary for the maintenance of life or health;
5. The heir(s) can document that they provided full-time care to the recipient that delayed the recipient's entry into a nursing home. The individual must be either the decedent's sibling or the son or daughter of the decedent and have resided in the individual's home for at least one year ; or
6. The cost involved in the sale of property would be equal to or greater than the value of the property.

"Heirs" means those persons, including the surviving spouse, who are entitled under the statutes of intestate succession to the property of a decedent.

An undue hardship does not exist solely because recovery will prevent any heirs from receiving an anticipated inheritance, but rather exists based on criteria 1 - 6 as stated above.

When establishing the amount of reduction in the State's claim, consideration will be given to:

1. contributions by the beneficiary to the value of the asset or to the support or care of the decedent;
2. any outstanding debt with a higher priority (e.g., mortgage) which has been assumed by the heir; and
3. other compelling circumstances.

The personal representative must complete the following section (Part 1) and provide a written explanation of his/her justification for the requested waiver or compromise of the State's claim against the estate (Part 2). Attach the explanation to this form. All requests should be accompanied by documented evidence of your basis. For example, if your basis for waiver or compromise is that the surviving heir is disabled, proof of the permanent disability must be attached to this form. Only requests that are accompanied by documentation will be considered.

PART 1:
I have read the criteria provided above and believe that recovery of the state's expenditures would result in an undue hardship.

Signature of Personal Representative _____ Date _____

Personal Representative's Street Address, City, State, Zip Code _____

Personal Representative's Telephone Number (including area code) _____

PART 2:

Attach documentation to justify your claim of undue hardship. Letters of Administration must be included if issued. Alternatively, provide a statement signed by all heirs or potential heirs which supports the claim of undue hardship. The statement must identify all heirs or potential heirs, providing the full name, street address, telephone numbers, and relationship to decedent.

Examples of acceptable documentation include, but are not limited to:

- marriage license
- birth certificate
- Social Security Administration or Veteran's Administration Disability
- mortgage
- deed
- IRS forms (such as 1040 or Farm deduction form)
- proof of residency such as driver's license or W-2
- canceled checks
- court orders
- realtor's statements (on corporate letterhead)
- physician's statements
- tax records.

AFFIDAVIT

STATE OF FLORIDA
COUNTY OF _____

Before me this day personally appeared _____
(Name of Affiant)

who, being duly sworn, deposes and says: I hereby swear that the attached documentation is true and correct to the best of my knowledge.

_____
(Signature of Applicant)

Sworn to (or affirmed) and subscribed before me this _____ day of _____, 19_____, by _____.
(Name of person making statement.)

Personally known _____
OR Produced Identification _____
Type of Identification Produced _____

(SEAL)

_____
PRINT, TYPE OR STAMP NAME OR NOTARY

Upon receipt of the Request, the contractor reviews the Request for completeness and the presence of documentation. If the package is not complete, the contractor marks the deficiency and returns the package to the requester with instructions to complete the missing or incomplete items.

If the Request is complete, the contractor makes a recommendation to the State indicating their opinion as to whether the request meets the criteria for a hardship waiver. The Request, along with the documentation and recommendation, is forwarded to the State for approval or disapproval. All requests are received by the Estate Recovery staff, logged, reviewed, and transferred to the Chief, Medicaid Third Party Liability and Contract Management for final approval or disapproval. Within 15 days of receipt, the State will notify the Personal Representative and contractor of the State's decision.

All personnel who have responsibilities for reviewing requests from attorneys who are asking Medicaid to reduce or eliminate its claim will review the following questions prior to making a recommendation or decision about such request:

A. Is there a letter from an attorney, or representative of the estate, which requests Medicaid to reduce or eliminate its claim?
B. Is the request for reduction of Medicaid's claim fully documented and supported with specific, verifiable and relevant information?
C. Is there a complete estate inventory attached to the request that details the estate's total value; and, is there a document that shows current and proposed distribution of all financial and real property assets of the estate in the event the request for Medicaid to reduce its claim is approved?
D. Does the request confirm the presence of a competing and legitimate heir to the estate, as defined in Florida Statutes?
E. Is there any information presented in the request to suggest or confirm that Medicaid's claim is flawed?
F. Is there adequate information to support that if disposition of the estate is argued in court, a decision against Medicaid would create an adverse precedent and be harmful to the estate recovery program.?
G. If the petition is based upon humanitarian reasons, is there enough strong and corroborating information presented to shock the conscious, and forcefully argue that the claim should be reduced or eliminated?
H. Is the total recoverable potential of the claim worthy of a prolonged and costly dispute?
I. If the request is for disposition of property, is there any documentation detailing the description and location of the property and its current market appraised value, and what efforts have been made to liquidate same?
J. Is there convincing information to support that if the rights to the estate's asset are argued in a court of law, Medicaid would lose?

All disapproval notices include a statement informing the Personal Representative that he may appeal the State's decision pursuant to Section 120.57, Florida Statutes, which provides an administrative hearing process for appealing decisions made by a State agency which affect the substantial interest of a party.

The State may compromise its claim when an undue hardship would result from full collection.

Cost Effectiveness
The standards are included in the response to question 6 below.

The contractor determines the amount of the state's claim by reviewing the FMMIS. If the claim is under $100, no claim is filed.

When the contractor determines from inspection of the inventory that only exempted property exists, no claim is filed. If a claim has already been filed, the claim may be withdrawn.

When the State determines that the amount of time, effort, and cost expended by the contractor are not equal to or greater than the net proceeds to be recovered, the State may instruct the contractor to cease recovery efforts.

6. The State defines cost-effective as follows (includes methodology/thresholds used to determine cost-effectiveness):

A. Liquid assets: $100.00

Agency staff have determined that the State would expend at least $100 in the processing of a claim. This amount includes $15 for filing of the claim with the appropriate clerk of the court, $25 for opening and closing a file, and $60 for processing a check. In the event the Agency made a recovery in the amount of $100, the Agency would spend an equal amount for processing the claim and check. This would not be cost effective for the State.

B. Non-liquid assets:

automobile - $1,000 minimum value. The State will pursue its right of recovery only if the net proceeds based upon the National Automobile Dealers Association (NADA) wholesale price is at least equal to or more than twice the cost of disposition of the automobile. This provision applies only to automobiles included in the estate (not the first exempt automobile).

non-homestead real property - $50,000 equity. The State may compromise its claim when the claim amount is equal to or greater than the county tax assessor's value of the real property. Because of the high cost of disposing of real property, the State may not accept the transfer of real property in payment of the claim. Therefore, it becomes necessary that the personal representative sell the property. The Estate Recovery program may compromise its claim to the extent that the heirs may receive an amount equal to the actual attorney's fees awarded or personal representative's fees, awarded, whichever is less, provided it does not conflict with other provisions of Florida law. In such cases, the State must anticipate that it will receive an amount equal to or more than the amount received by the heirs in order to compromise. The individual's equity in the property becomes a countable resource effective with the first day of the month following the month it is no longer his or her principal place of residence unless there is a surviving spouse or surviving child who is under age 21 or blind or disabled.

C. Pursuit of the State's claim may be terminated or compromised when in the opinion of the program's administration, in conjunction with the General Counsel, it is unlikely that the State would prevail in court based on current case law.

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

D. Pursuit of the State's claim may be compromised when the personal representative's attorney fails to raise a legitimate defense that, if litigated, would likely be upheld by the court.

7. The State utilizes the following collection procedures (including specific elements contained in the advance notice requirement, the method for applying for a waiver, hearing and appeals procedures, and time frames involved):

The State may pursue its right of third party recovery after the death of the recipient and his/her surviving spouse, if any, and only when the individual has no surviving child under age 21, or a blind or disabled child as defined in §1614 of the Act. When a recipient's estate contains the proceeds from a tort recovery for which Medicaid paid the medical services, the State may continue to seek third party reimbursement from the estate of a recipient of any age.

At the time of Medicaid eligibility determination and redetermination, the applicant is informed in writing that acceptance of State aid creates a debt to the State, and that this debt may be recovered in full or in part after the death of the recipient. The applicant is provided a copy of the "Rights and Responsibilities Form" (HRS-ES Form 2064), which advises the applicant or representative of his/her rights and responsibilities under the program.

The Florida Constitution protects homestead from forced sale by creditors. Therefore, the State does not file any claimss against the homestead property of living or deceased Medicaid recipients.

Beneficiary deaths are reported by district eligibility workers by use of a paper form (HRS Form 325). The contractor has instituted a process whereby he/she receives reports, on a monthly basis, from the 67 county Clerks of the Court that identify opened estates. The contractor matches names of decedents whose estates have been opened with the Medicaid eligibility file. The contractor files claims in the estates of deceased Medicaid recipients. This claim apprises the personal representative, court, interested parties, and other creditors of the State's intention to pursue recovery on the debt.

In addition, the contractor receives leads from the following sources:

1. direct notice from personal representative's attorneys;
2. direct notice from Medicaid staff (Agency for Health Care Administration);
3. direct notice from nursing home and hospital staff;
4. heirs; and
5. notices issued in Florida newspapers.

Florida Medicaid Estate Recovery staff estimate that the following process takes approximately six months to one year before reimbursement is received by the State. Much of this process is governed by Florida probate law (Chapters 731 - 735, Florida Statutes) and the Rules of Probate and Appellate Procedures. Such provisions apply to all creditor claims - not solely to the Florida Medicaid program.

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

Upon the death of a Florida resident, the personal representative's attorney files a Notice of Administration with the Clerk of the Court in the last known county of residence. Florida law requires personal representatives to locate and notify all ascertainable creditors. Creditors have 30 days from receipt of a Notice of Administration or within 90 days of issuance of the Notice to file a claim with the Clerk of the Court. The contractor researches data received from various sources to identify newly opened estates. The names identified are matched against the individuals maintained on the Florida Medicaid Management Information System (FMMIS). Upon matching the records, the FMMIS is searched for paid claim history. All claims paid by the Florida Medicaid program on or after October 1, 1993, are included in the claim.

As the facts of the case become known, it is sometimes necessary to reduce the amount of the State's claim for various reasons. In each case where the State reduces its' claim, the justification is documented in the case file and in the settlement offers. All reductions of the State's claim must be approved by the Agency for Health Care Administration's General Counsel's office and Chief, Medicaid Third Party Liability and Contract Management.

In the event the personal representative disagrees with the State's claim, an Objection to Claim is filed with the Clerk of the Court. All Objections are received and reviewed by the State's contractor and must be answered within 30 days. Objections are addressed depending on the legal defenses claimed in the Objection. The contractor files a Motion for Summary Judgment for Objections which appear to be frivolous or have no statutory basis. In the event the personal representative's attorney filed the Objection for a frivolous reason, the contractor attempts to resolve the issue without court intervention. Suit is filed in court for Objections that involve legitimate legal questions and frivolous cases that are unresolved. The court then awards the amount to be distributed to the State. Once Medicaid has received the money owed, a Satisfaction form is prepared by the contractor and executed. The Satisfaction is mailed to the person remitting the funds (usually the personal representative or their attorney). It is their responsibility to file the Satisfaction with the Clerk of the Court.

OPTIONAL FORM 99 (7-90) Call when received

FAX TRANSMITTAL

# of pages ▶ 17

To Robbie Barefield
Dept./Agency
Fax # 904-922-4502

From Carol Lanahan
Phone # 404-331-0064
Fax # 404-331-0068

NSN 7540-01-317-7368 5099-101 GENERAL SERVICES ADMINISTRATION

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:

Medically Needy- Premium

NOT APPLICABLE IN FLORIDA

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

A. The following charges are imposed on the medically needy for services:

| 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 share of cost 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 medically needy for services:

| 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~~ medically 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 medically needy individuals:

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

/_/ The agency reimburses providers the full Medicaid rate for services 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:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

Premiums Imposed on Low Income Pregnant Women and Infants

A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

C. State or local funds under other programs are used to pay for premiums:

/_/ Yes /_/ No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

Optional Sliding Scale Premiums Imposed on
Qualified Disabled and Working Individuals

A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

C. State or local funds under other programs are used to pay for premiums:

/_/ Yes /_/ No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

*Description provided on attachment.