STATE PLAN UNDER TITLE XIX
OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: FLORIDA

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TN No. 91-39 HCFA ID: 7982E

Supersedes Approval Date SEP 18 1992 Effective Date 10/1/91

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* Forms Provided

TN No. 93-34

Effective Date 6/3/93

Supersedes

JUL 30 1993
As a condition for receipt of Federal funds under title XIX of the Social Security Act, the Agency for Health Care Administration Single State Agency submits the following State Plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this State Plan, the requirements of Titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.
SECTION 1  SINGLE STATE AGENCY ORGANIZATION

1.1 Designation and Authority

(a) The Agency for Health Care Administration is the single State agency designated to administer or supervise the administration of the Medicaid program under Title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named in this paragraph.)

Effective Date 7/1/93
Approval Date 10/21/94
SECTION 1 SINGLE STATE AGENCY ORGANIZATION

Citation
42 CFR 431.10
AT-79-29

1.1 Designation and Authority

ATTACHMENT 1.1-A is a certification signed by the State Attorney General identifying the single State agency and citing the legal authority under which it administers or supervises administration of the program.

Effective Date 7/1/93
Approval Date 10/21/94
The State agency that administered or supervised the administration of the plan approved under title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that part of this plan which relates to blind individuals.

☐ Yes. The State agency so designated is

This agency has a separate plan covering that portion of the State plan under title XIX for which it is responsible.

☒ Not applicable. The entire plan under title XIX is administered or supervised by the State agency named in paragraph 1.1(a).
<table>
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<td>Yes. ATTACHMENT 1.1-8 describes these waivers and the approved alternative organizational arrangements.</td>
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<td>Not applicable. Waivers are no longer in effect.</td>
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The agency named in paragraph 1.1(a) has responsibility for all determinations of eligibility for Medicaid under this plan. Determinations of eligibility for Medicaid under this plan are made by the agency(ies) specified in ATTACHMENT 2.2-A. There is a written agreement between the agency named in paragraph 1.1(a) and other agency(ies) making such determinations for specific groups covered under this plan. The agreement defines the relationships and respective responsibilities of the agencies.
1.1(e) All other provisions of this plan are administered by the Medicaid agency except for those functions for which final authority has been granted to a Professional Standards Review Organization under title XI of the Act.

(f) All other requirements of 42 CFR 431.10 are met.
1.2 Organization for Administration

(a) ATTACHMENT 1.2-A contains a description of the organization and functions of the Medicaid agency and an organization chart of the agency.

(b) Within the State agency the Medicaid Office has been designated as the medical assistance unit. ATTACHMENT 1.2-B contains a description of the organization and functions of the medical assistance unit and an organization chart of the unit.

(c) ATTACHMENT 1.2-C contains a description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities.

(d) Eligibility determinations are made by State or local staff of an agency other than the agency named in paragraph 1.1(a). ATTACHMENT 1.2-D contains a description of the staff designated to make such determination and the functions they will perform.

/ / Not applicable. Only staff of the agency named in paragraph 1.1(a) make such determinations.
1.3 Statewide Operation

The plan is in operation on a Statewide basis in accordance with all requirements of 42 CFR 431.50.

\[\checkmark\] The plan is State administered.

\[\square\] The plan is administered by the political subdivisions of the State and is mandatory on them.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Florida

1.4 State Medical Care Advisory Committee (42 CFR 431.12(b))
There is an advisory committee to the Medicaid agency director on health and medical care services
established in accordance with and meeting all the requirements of 42 CFR 431.12.

The State enrolls recipients in MCO, PIHP, PAHP, and/or 
PCCM programs. The State assures that it complies with 42 CFR
438.104(c) to consult with the Medical Care Advisory Committee in the
review of marketing materials.

Tribal Consultation Requirements
Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian
Health Programs or Urban Indian Organizations furnish health care services to establish a process for the
State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health
programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the
Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations
under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1) of the Act was also amended
to apply these requirements to the Children’s Health Insurance Program (CHIP). Consultation is required
concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban
Indian organizations. Direct impact is defined as any Medicaid or CHIP program changes that are more
restrictive for eligibility determinations, changes that reduce payment rates or payment methodologies to
Indian Health Programs, Tribal Organizations, or Urban Indian Organization providers (I/T/U), reductions
in covered services, changes in consultation policies, and proposals for demonstrations or waivers that
may impact I/T/U providers.

02/09/12 - Florida has two known federally recognized tribes: the Miccosukee Tribe of Florida and the
Seminole Tribe of Florida. Each tribe has their own Indian Health Service (IHS) program. Florida will
notify the two tribes in writing 30 days in advance of the following: Medicaid Title XIX state plan
amendments, an initial waiver, a waiver amendment or a waiver renewal, when it is anticipated to have a
direct impact on the tribe. If no response is received from the Tribe within 30 days, Florida Medicaid
will proceed with the submission to the Centers for Medicare and Medicaid Services (CMS).

This Tribal Consultation Process was finalized through two telephone conferences: February 1, 2012,
with Denise Ward of the Miccosukee Tribe, and February 9, 2012, with Kathy Wilson of the Seminole
Tribe. Linda Macdonald and Robin Ingram of Florida Medicaid were on the calls. Further consultation
was held via formal written communication January 31, 2012, to Cassandra Osceola, Health Director,
Miccosukee Tribe of Florida, and Connie Whidden, Health Director, Seminole Tribe of Florida.

TN No: 2012-006 Approval Date: 04-26-12 Effective Date: 02/09/12
Supersedes TN: 2010-011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1098. The time required to complete this information collection is estimated to average 1 hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS-10293 (07/2013)
1.5 Pediatric Immunization Program

1. The State has implemented a program for the distribution of pediatric vaccines to program-registered providers for the immunization of federally vaccine-eligible children in accordance with section 1928 as indicated below.

a. The State program will provide each vaccine-eligible child with medically appropriate vaccines according to the schedule developed by the Advisory Committee on Immunization Practices and without charge for the vaccines.

b. The State will outreach and encourage a variety of providers to participate in the program and to administer vaccines in multiple settings, e.g., private health care providers, providers that receive funds under Title V of the Indian Health Care Improvement Act, health programs or facilities operated by Indian tribes, and maintain a list of program-registered providers.

c. With respect to any population of vaccine-eligible children a substantial portion of whose parents have limited ability to speak the English language, the State will identify program-registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.

d. The State will instruct program-registered providers to determine eligibility in accordance with section 1928(b) and (h) of the Social Security Act.

e. The State will assure that no program-registered provider will charge more for the administration of the vaccine than the regional maximum established by the Secretary. The State will inform program-registered providers of the maximum fee for the administration of vaccines.

f. The State will assure that no vaccine-eligible child is denied vaccines because of an inability to pay an administration fee.

g. Except as authorized under section 1915(b) of the Social Security Act or as permitted by the Secretary to prevent fraud or abuse, the State will not impose any additional qualifications or conditions, in addition to those indicated above, in order for a provider to qualify as a program-registered provider.
2. The State has not modified or repealed any Immunization Law in effect as of May 1, 1993 to reduce the amount of health insurance coverage of pediatric vaccines.

3. The State Medicaid Agency has coordinated with the State Public Health Agency in the completion of this preprint page.

4. The State agency with overall responsibility for the implementation and enforcement of the provisions of section 1928 is:

   State Medicaid Agency

   X State Public Health Agency
SECTION 2 - COVERAGE AND ELIGIBILITY

Citation  2.1 Application, Determination of Eligibility and Furnishing Medicaid
42 CFR
435.10 and
Subpart J

(a) The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.

Supersedes Approval Date SEP 18 1992
TN No. 91-39 Effective Date 10/1/91
TN No. 76-02

HCFA ID: 7982E
Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6-A.

For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month which the individual is first determined to be a qualified Medicare beneficiary. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.

Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.
The Medicaid agency has procedures to take applications, assist applicants, and perform initial processing of applications from those low income pregnant women, infants, and children under age 19, described in Section 1902(a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), and (a)(10)(A)(ii)(IX), at locations other than those used by the title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the AFDC form except as permitted by HCFA instructions.
2.2 Coverage and Conditions of Eligibility

Medicaid is available to the groups specified in ATTACHMENT 2.2-A.

- Mandatory categorically needy and other required special groups only.
- Mandatory categorically needy, other required special groups, and the medically needy, but no other optional groups.
- Mandatory categorically needy, other required special groups, and specified optional groups.

The conditions of eligibility that must be met are specified in ATTACHMENT 2.6-A.

All applicable requirements of 42 CFR Part 435 and sections 1902(a)(10)(A)(i)(IV), (V), and (VI), 1902(a)(10)(A)(ii)(XI), 1902(a)(10)(E), 1902(l) and (m), 1905(p), (q) and (s), 1920, and 1925 of the Act are met.
2.3 Residence

Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403, regardless of whether or not the individuals maintain the residence permanently or maintain it at a fixed address.
2.4 Blindness

All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in ATTACHMENT 2.2-A.
All of the requirements of 42 CFR 435.540 and 435.541 are met. The State uses the same definition of disability used under the SSI program unless a more restrictive definition of disability is specified in Item A.13.b. of ATTACHMENT 2.2-A of this plan.
2.6 Financial Eligibility

(a) The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in ATTACHMENT 2.6-A.
<table>
<thead>
<tr>
<th>Citation</th>
<th>2.7</th>
<th>Medicaid Furnished Out of State</th>
</tr>
</thead>
<tbody>
<tr>
<td>431.52 and 1902(b) of the Act, P.L. 99-272 (Section 9529)</td>
<td></td>
<td>Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State.</td>
</tr>
</tbody>
</table>

**Effective Date:** 10/1/86
**HCFA ID:** 0053C/0061E
Citation

42 CFR
Part 440,
Subpart B
1902(a), 1902(e),
1905(a), 1905(p),
1915, 1920, and
1925 of the Act

3.1 Amount, Duration, and Scope of Services

(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.

(1) Categorically needy.

Services for the categorically needy are described below and in ATTACHMENT 3.1-A. These services include:

(i) Each item or service listed in section 1902(a)(10)(A) and 1905(a) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.

(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

Not applicable. Nurse-midwives are not authorized to practice in this State.
Amount, Duration, and Scope of Services: Categorically Needy (Continued)

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

(iv) Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.

(v) Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Amount, Duration, and Scope of Services: Categorically Needy (Continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1901(a)(10)(D)</td>
<td>Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.</td>
</tr>
<tr>
<td>1902(e)(7) of the Act</td>
<td>Inpatient services that are being furnished to infants and children described in section 1902(1)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.</td>
</tr>
<tr>
<td>1902(e)(9) of the Act</td>
<td>X Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.</td>
</tr>
<tr>
<td>1902(a)(52) and 1925 of the Act</td>
<td>(ix) Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.</td>
</tr>
<tr>
<td>1905(a)(23) and 1929</td>
<td>(x) 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.</td>
</tr>
</tbody>
</table>

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.
3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

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

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage that is in excess of established service limits for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)
State of Florida

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

Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1915(j)

X Self-Directed Personal Assistance Services, as described and limited in Supplement 4 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.

TN No: 2007-007
Supersedes Approval Date: 03/28/08
TN No: NEW Effective Date: 3/01/08
Revision: HCFA-PM-91-4 (BPD)  AUGUST 1991

State/Territory: FLORIDA

Citation: 42 CFR Part 440, Subpart B

42 CFR Part 440, Subpart B

42 CFR 440.220

42 CFR 440.220

1902(a)(10)(C)(iv) of the Act

1902(a)(10)(C)(iv) of the Act

1902(e)(5) of the Act

1.1 Amount, duration, and scope of services (continued.

Medically needy.

This State plan covers the medically needy.

The services described below and in ATTACHMENT 1-5 are provided.

Services for the medically needy include:

(i) If services in an institution for mental diseases (42 CFR 440.140 and 440.160) or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1) through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in sections 1902, 1905, and 15 of the Act.

Not applicable with respect to nurse-midwife services under section 1902(a)(17). Nurse-midwives are not authorized to practice in this State.

(ii) Prenatal care and delivery services for pregnant women.

Supersedes TN No. 88-20

Supersedes TN No. 91-50

Effective Date 10/1/91

HCFA ID: 7982E

Revised Submission FEE 10/1/91
Citation: 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

(iv) Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.

(v) Ambulatory services, as defined in ATTACHMENT J.1-B, for recipients under age 18 and recipients entitled to institutional services.

Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.

(vi) Home health services to recipients entitled to nursing facility services as indicated in item J.1(b) of this plan.

42 CFR 440.140, 440.150, Subpart B, 442.441, Subpart C 1902(a)(20) and (21) of the Act

(vii) Services in an institution for mental diseases for individuals over age 65.

(viii) Services in an intermediate care facility for the mentally retarded.

(ix) Inpatient psychiatric services for individuals under age 21.
Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.

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.

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.
3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

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

ATTACHMENT 3.1-B identifies services provided to each covered group of the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)
State of ____________
1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print

Citation
3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

1915(j)
Self-Directed Personal Assistance Services, as described and limited in
Supplement _____ to Attachment 3.1-B.

ATTACHMENT 3.1-B identifies medical and remedial services provided to each
covered group of the medically needy.

TN No: 2007-007
Supersedes
TN No: NEW

Approval Date: 03/28/08  Effective Date: 3/01/08
3.1 Amount, Duration, and Scope of Services (continued)

(a)(3) Other Required Special Groups: Qualified Medicare Beneficiaries

1902(a)(10)(E)(i) and clause (VIII) of the matter following (F), and 1905(p)(3) of the Act

Medicare cost sharing for qualified Medicare beneficiaries described in section 1905(p) of the Act is provided only as indicated in item 3.2 of this plan.

(a)(4)(i) Other Required Special Groups: Qualified Disabled and Working Individuals

1902(a)(10)(E)(ii) and 1905(s) of the Act

Medicare Part A premiums for qualified disabled and working individuals described in section 1902(a)(10)(E)(ii) of the Act are provided as indicated in item 3.2 of this plan.

(ii) Other Required Special Groups: Specified Low-Income Medicare Beneficiaries

1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act

Medicare Part B premiums for specified low-income Medicare beneficiaries described in section 1902(a)(10)(E)(iii) of the Act are provided as indicated in item 3.2 of this plan.

(iii) Other Required Special Groups: Qualifying Individuals - 1

1902(a)(10)(E)(iv)(I)1905(p)(3)(A)(ii), and 1933 of the Act

Medicare Part B premiums for qualifying individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.
1902(a)(10) (E)(iv)(II), 1905(p)(3) (A)(iv)(II), 1905(p)(3) the Act

(iv) Other Required Special Groups: Qualifying Individuals - 2

The portion of the amount of increase to the Medicare Part B premium attributable to the Home Health provisions for qualifying individuals described in 1902(A)(10)(E)(iv)(II) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

1925 of the Act (a)(5) Other Required Special Groups: Families Receiving Extended Medicaid Benefits

Extended Medicaid benefits for families described in section 1925 of the Act are provided as indicated in item 3.5 of this plan.
Sec. 245A(h) (a)(6) Limited Coverage for Certain Aliens of the Immigration and Nationality Act

(i) Aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who meet the financial and categorical eligibility requirements under the approved State Medicaid plan are provided the services covered under the plan if they--

(A) Are aged, blind, or disabled individuals as defined in section 1614(a)(1) of the Act;

(B) Are children under 18 years of age; or

(C) Are Cuban or Haitian entrants as defined in section 501(e)(1) and (2)(A) of P.L.96-422 in effect on April 1, 1983.

(ii) Except for emergency services and pregnancy-related services, as defined in 42 CFR 447.53(b) aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who are not identified in items 3.1(a)(6)(i)(A) through (C) above, and who meet the financial and categorical eligibility requirements under the approved State plan are provided services under the plan no earlier than five years from the date the alien is granted lawful temporary resident status.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Amount, Duration, and Scope of Services: Limited Coverage for Certain Aliens (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a) and 1903(v) of the Act (iii) Aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law who meet the eligibility conditions under this plan, except for the requirement for receipt of AFDC, SSI, or a State supplementary payment, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903(v)(3) of the Act.</td>
<td></td>
</tr>
</tbody>
</table>

| 1905(a)(9) of the Act (a)(7) Homeless Individuals. |
| Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished. |

| 1902(a)(47) and 1920 of the Act (a)(8) Presumptively Eligible Pregnant Women |
| Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan. |

| 42 CFR 441.55 (a)(9) EPSDT Services. |
| The Medicaid agency meets the requirements of sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services. |
Amount, Duration, and Scope of Services: EPSDT Services (continued)

The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.**

42 CFR 441.60

42 CFR 440.240
and 440.250

(a)(10) Comparability of Services

Except for those items or services for which sections

(i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.

(ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.

(iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.

(iv) Additional coverage for pregnancy-related service and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

** Describe here.

The continuing care provider submits annual encounter data reflecting the number of examinations completed, the number of examinations where a referable condition was identified, and the number of follow-up treatment encounters. Medicaid staff make periodic on-site reviews to monitor the provider's record of case management.
<table>
<thead>
<tr>
<th>Citation</th>
<th>3.1(b)</th>
<th>Home health services are provided in accordance with the requirements of 42 CFR 441.15.</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR Part 440, Subpart B 42 CFR 441.15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MT-78-90</td>
<td>(1) Home health services are provided to all categorically needy individuals 21 years of age or over.</td>
<td></td>
</tr>
<tr>
<td>MT-80-34</td>
<td>(2) Home health services are provided to all categorically needy individuals under 21 years of age.</td>
<td></td>
</tr>
<tr>
<td>Section 1905(a)(4)(A) of Act (Sec. 4211(f) of P.L. 100-203).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Yes
- Not applicable. The State plan does not provide for nursing facility services for such individuals.

| | (3) Home health services are provided to the medically needy: |
| | Yes, to all |
| | Yes, to individuals age 21 or over; nursing facility services are provided. |
| | Yes, to individuals under age 21; nursing facility services are provided. |
| | Not applicable; the medically needy are not included under this plan |

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TN # 91-03 Approval Date 5/10/91
Supersedes TN # 86-08 Effective Date 1/1/91

Revisions: HCFA - Region VI November 1990
State: FLORIDA
State/Territory: FLORIDA

Amount, Duration, and Scope of Services (continued)

42 CFR 431.53  
(c)(1) Assurance of Transportation  
Provision is made for assuring necessary transportation of recipients to and from providers. Methods used to assure such transportation are described in ATTACHMENT 3.1-D.

42 CFR 483.10  
(c)(2) Payment for Nursing Facility Services  
The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10 (c) (8) (i).

Approval Date 2/18/94 Effective 10/1/93
Methods and Standards to Assure Quality of Services

The standards established and the methods used to assure high quality care are described in ATTACHMENT 3.1-C.
Citation: 42 CFR 441.20
AT-78-90

3.1(e) Family Planning Services

The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.
Optometric services (other than those provided under §§435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

Yes.

No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform.

Not applicable. The conditions in the first sentence do not apply.

Organ transplant procedures are provided.

Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at ATTACHMENT 3.1-E.
Participation by Indian Health Service Facilities

Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

Respiratory Care Services for Ventilator-Dependent Individuals

Respiratory care services, as defined in section 1902(e)(9)(C) of the Act, are provided under the plan to individuals who—

1. Are medically dependent on a ventilator for life support at least six hours per day;

2. Have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs or ICFs for the lesser of—

   - 30 consecutive days;
   - 365 days (the maximum number of inpatient days allowed under the State plan) for recipients under 21 years of age participating in EPSDT.

3. Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF, or ICF for which Medicaid payments would be made;

4. Have adequate social support services to be cared for at home; and

5. Wish to be cared for at home.

Yes. The requirements of section 1902(e)(9) of the Act are met.

Not applicable. These services are not included in the plan.
Citation
1905(a)(24) and
1930 of the Act
P.L. 101-508
(Section 4712
OBRA 90)

State/Territory: FLORIDA

Revision: HCFA-PM-91-
1991

Community supported living
arrangements services

Community supported living
arrangements services
provided to developmentally disabled
individuals in accordance with section
1930 of the Act.

X Yes.

No.

Attachment 3.1-F identifies the
community supported living arrangement
services provided.
3.2 Coordination of Medicaid with Medicare and Other Insurance

(a) Premiums

(1) Medicare Part A and Part B

1902(a)(10)(E)(1) and 1905(p)(1) of the Act

(1) Qualified Medicare Beneficiary (QMB)

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group defined in Item A.25 of ATTACHMENT 2.2-A, through the group premium payment arrangement, unless the agency has a Buy-in agreement for such payment, as indicated below.

Buy-In agreement for:

X Part A  X Part B

The Medicaid agency pays premiums, for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.
1902(a)(10)(E)(ii) and 1905(s) of the Act

(ii) Qualified Disabled and Working Individual (QDWI)

The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in ATTACHMENT 4.18-E, for individuals in the QDWI group defined in item A.26 of ATTACHMENT 2.2-A of this plan.

1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act

(iii) Specified Low-Income Medicare Beneficiary (SLMB)

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the SLMB group defined in item A.27 of ATTACHMENT 2.2-A of this plan.

1902(a)(10)(E)(iv)(I), 1905(p)(3)(A)(ii), and 1933 of the Act

(iv) Qualifying Individual-1 (QI-1)

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act.
Other Medicaid Recipients

All individuals who are:
(a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI);
(b) receiving State supplements under title XVI; or
(c) within a group listed at 42 CFR 431.625(d)(2).

Individuals receiving title II or Railroad Retirement benefits.

Medically needy individuals (FFP is not available for this group).

Other Health Insurance

The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).
Citation (b) Deductibles/Coinsurance

(1) Medicare Part A, B, and C

Section 1902(n) of the Act
Attachment 4.19-B describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.

Sections 1902(a)(10)(E) and 1905(p) of the Act
Qualified Medicare Beneficiaries (QMBS)
The Medicaid agency pays deductibles and coinsurance for QMBs (subject to any nominal Medicaid copayment) only for the amount, duration, and scope of services otherwise available under this plan.

42 CFR 431.625 (ii) Other Medicaid Recipients
The Medicaid agency pays Medicare deductibles and coinsurance (subject to any nominal Medicaid copayment) for services furnished to individuals who are described in section 3.2(a)(1)(iii) above, as follows:

/ / For the entire range of services available under Medicare Part B, except for physician services and physician type services.

/ X/ Only for the amount, duration, and scope of services otherwise available under this plan.

(iii) Dual Eligible—QMB plus Other Medicaid Recipients
The Medicaid agency pays deductibles and coinsurance for services furnished to individuals eligible both as QMBs and categorically or medically needy (subject to any nominal Medicaid copayment).
3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases

Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

☐ Yes. The requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620(c) and (d) are met.

☐ Not applicable. Medicaid is not provided to aged individuals in such institutions under this plan.
3.4 Special Requirements Applicable to Sterilization Procedures

All requirements of 42 CFR Part 441, Subpart F are met.
Families Receiving Extended Medicaid Benefits

Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

(b) Services provided to families during the second 6-month period of extended Medicaid benefits under Section 1925 of the Act are:

- Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:
  - Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
  - Medical or remedial care provided by licensed practitioners.
  - Home health services.

Supersedes Approval Date Oct 6, 1992
Effective Date 10/1/91
HCFA ID: 7982E
Private duty nursing services.
Physical therapy and related services.
Other diagnostic, screening, preventive, and rehabilitation services.
Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases.
Intermediate care facility services for the mentally retarded.
Inpatient psychiatric services for individuals under age 21.
Hospice services.
Respiratory care services.
Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.
The agency pays the family's premiums, enrollment fees, deductibles, coinsurance, and similar costs for health plans offered by the caretaker's employer as payments for medical assistance—

- 1st 6 months
- 2nd 6 months

The agency requires caretakers to enroll in employers' health plans as a condition of eligibility.

- 1st 6 mos.
- 2nd 6 mos.

The Medicaid agency provides assistance to families during the second 6-month period of extended Medicaid benefits through the following alternative methods:

- Enrollment in the family option of an employer's health plan.
- Enrollment in the family option of a State employee health plan.
- Enrollment in the State health plan for the uninsured.
- Enrollment in an eligible health maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).
SECTION 4 - GENERAL PROGRAM ADMINISTRATION

4.1 Methods of Administration

The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.
4.2 Hearings for Applicants and Recipients

The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.
4.3 Safeguarding Information on Applicants and Recipients

Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.

All other requirements of 42 CFR Part 431, Subpart F are met.
4.4 Medicaid Quality Control

(a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.

(b) The State operates a claims processing assessment system that meets the requirements of 431.800(e), (g), (h) and (k).

☐ Yes.

☐ Not applicable. The State has an approved Medicaid Management Information System (MMIS).
State/Territory: Florida

4.5 Medicaid Agency Fraud Detection and Investigation Program

The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.
36a

State: FLORIDA

Citation
Section 1902(a)(64)
of the Social Security
Act P.L. 105-33

4.5a Medicaid Agency Fraud Detection and
Investigation Program

The Medicaid agency has established a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title.

TN No. 99-08
Supersedes
TN No. NEW

Approval Date 9/28/1993
Effective Date 7/1/99
### PROPOSED SECTION 4 - GENERAL PROGRAM ADMINISTRATION

**4.5b Medicaid Recovery Audit Contractor Program**

<table>
<thead>
<tr>
<th>Citation</th>
<th>____ The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1902(a)(42)(B)(i) of the Social Security Act</td>
<td><strong><strong>X</strong></strong> The State is seeking an exception to establishing such program for the following reasons:</td>
</tr>
<tr>
<td></td>
<td>Beginning in 2013 and 2014, the Florida Medicaid Program initiated a major shift toward use of a managed health care delivery system that pays plans based on established capitation rates. Subsequently, approximately 82% of Florida’s Medicaid recipients are now enrolled in a health plan. Florida is requesting an extension to the current exception to establish a Medicaid RAC program for the following reasons:</td>
</tr>
<tr>
<td></td>
<td>1) The current Medicaid RAC audit program requirements generally address auditing providers furnishing services under a fee-for-service delivery system,</td>
</tr>
<tr>
<td></td>
<td>2) The Medicaid RAC Rule 42 CFR ss455.506(a)(1) provides that “States may exclude managed care claims from review by the Medicaid RAC,</td>
</tr>
<tr>
<td></td>
<td>3) As managed care enrollment continues to increase in Florida, the number of fee-for-service claims are continuing to decline,</td>
</tr>
<tr>
<td></td>
<td>4) Florida’s Office of Medicaid Program Integrity will continue to perform audits, and</td>
</tr>
<tr>
<td></td>
<td>5) As an adjunct to the audits performed by Florida’s Office of Medicaid Program Integrity, the Office of Medicaid Program Integrity coordinates audits with a vendor that performs audits on providers furnishing services under a fee-for-service delivery system.</td>
</tr>
<tr>
<td></td>
<td>____ The State/Medicaid agency has contracts of the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute.</td>
</tr>
<tr>
<td></td>
<td>Place a check mark to provide assurance of the following:</td>
</tr>
<tr>
<td></td>
<td>____ The State will make payments to the RAC(s) only from amounts recovered.</td>
</tr>
</tbody>
</table>

TN No. **2016-019**  
Supersedes:  
TN No. **2015-001**  
Approval Date: **08-29-16**  
Effective Date: **6/30/16**
Section 1902 (a)(42)(B)(ii)(II)(aa) of the Act

_____ The State will make payments to the RAC(s) on a contingent Basis for collecting overpayments.

The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee):

_____ The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register.

_____ The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RAC as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate.

_____ The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.

_____ The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee):

_____ The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).

_____ The State assures that the amounts expended by the State to Carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.

_____ The State assures that the recovered amounts will be subject to a State’s quarterly expenditure estimates and funding of the State’s share.

_____ Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.
4.6 Reports

The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.
4.7 Maintenance of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.
Availability of Agency Program Manuals

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.
4.9 Reporting Provider Payments to Internal Revenue Service

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.
Section 1902(a)(23) Of the Social Security Act
P.L. 100-93 (section 8(f))
P.L. 100-203 (Section 4113)

4.10 Free Choice of Providers

(a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy person, or organization that is qualified to perform the services, including of the Act an organization that provides these services or arranges for their availability on a prepayment basis.

Providers who elect not to provide services based on a history of bad debt, including copayments, shall give recipients advance notice and a reasonable opportunity for payment. Recipients retain the ability to seek services from other enrolled providers.

(b) Paragraph (a) does not apply to services furnished to an individual –

(1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or

(2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or

(3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act,

(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services, or

(5) Under an exception allowed under 42 CFR 438.50 or 42 CFR 440.168, subject to the limitations in paragraph (c).

(c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1905(t), 1915(a), 1915(b)(1), or 1932(a); or, managed care organization, prepaid inpatient health plan, a prepaid ambulatory health plan, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905 (a)(4)(c).
4.11 Relations with Standard-Setting and Survey Agencies

(a) The State agency utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. This agency is Health Facility Regulation, Agency for Health Care Administration

(b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are): Health Facility Regulation, Agency for Health Care Administration

(c) ATTACHMENT 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Health Care Financing Administration on request.
Revised Submission: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Florida

Citation
42 CFR 431.610
AT-78-90
AT-89-34

4.11(d) The Health Facility Regulation, Agency for Health Care Administration which is the State agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements for participation in the Medicaid program. The requirements in 42 CFR 431.610(e), (f) and (g) are met.

TN § 93-39
Supersedes
TN § 76-13

Approval Date 10/21/94 Effective Date 7/1/93
Revised Submission JUL 22 1994
Consultation to Medical Facilities

(a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105(b).

(b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105(b).

☐ Yes, as listed below:

☐ Not applicable. Similar services are not provided to other types of medical facilities.
4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

(a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.

(b) For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.

(c) For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.

(d) For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920(b)(2) and (c) are met.

Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.
For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

(1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, health maintenance organizations and health insuring organizations are required to do the following:

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

(b) Provide written information to all adult individuals on their policies concerning implementation of such rights;

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State Law (whether
45(b)  

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

(2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:

(a) Hospitals at the time an individual is admitted as an inpatient.

(b) Nursing facilities when the individual is admitted as a resident.

(c) Providers of home health care or personal care services before the individual comes under the care of the provider;

(d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and

(e) Managed care organizations, health insuring organizations, prepaid inpatient health plans, and prepaid ambulatory health plans (as applicable) at the time of enrollment of the individual with the organization.

(3) Attachment 4.34A describes law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives.

Not applicable. No State law or court decision exist regarding advance directives.

Supersedes TN # 91-48  

Effective Date 7/1/03  

Approval Date DEC 03 2003
Citation 4.14 Utilization/Quality Control
42 CFR, 431.50; (a) A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR, Part 456 are met:

___ Directly

__ By undertaking medical and utilization review requirements through a contract with the Agency’s designee selected under 42 CFR, Part 475. The contract with the designee---

1. Meets the requirements of 42 CFR, 434.6(a)
2. Includes a monitoring and evaluation plan to ensure satisfactory performance;
3. Identifies the services and providers subject to the designee’s review;
4. Ensures that the designee’s review activities are not inconsistent with the QIO review of Medicare services; and
5. Includes a description of the extent to which the designee determinations are considered conclusive for payment purposes.
Citation 42 CFR 456.2 50 FR 15312

4.14 (b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:

- All hospitals (other than mental hospitals).

- Those specified in the waiver.

- No waivers have been granted.

NOTE: The functions of Section 1154 of Public Law 97-248 are performed on a statewide basis by contract with a utilization and quality control review organization that has entered into a contract with the Secretary in accordance with the provisions of Section 1862(g).
The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.

Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:

- All mental hospitals.
- Those specified in the waiver.

No waivers have been granted.

Not applicable. Inpatient services in mental hospitals are not provided under this plan.
(d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

☐ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

☐ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:

☐ All skilled nursing facilities.

☐ Those specified in the waiver.

☐ No waivers have been granted.

Revision: HCFA-PM-85-3 (BKRC)
MAY 1985
State: FLORIDA

Citation
42 CFR 456.2
50 FR 15312

4.14

OMO NO. 0938-0193

TN No. 85-8
Supersedes

Approval Date 9-23-85
Effective Date 7-1-85

HCFA ID: 0048P/0002P
The Medicaid agency meets the requirements of CFR 456, Subpart F, for control of the utilization of intermediate care facilities for individuals with disabilities. Utilization review in facilities is provided through:

- Facility-based review.
- Direct review by personnel of the medical assistance unit of the State agency.
- Personnel under contract to the medical assistance unit of the State agency.
- Quality Improvement Organization
- Another method as described in ATTACHMENT 4.14-A.
- Two or more of the above methods. Attachment 4.14-B describes the circumstances under which each method is used.

Not applicable. Intermediate care facility services are not provided under this plan.
Citation 4.14 Utilization/Quality Control (Continued)

42 CFR 438.356(e) For each contract, the State must follow an open, competitive procurement process that is in accordance with State law and regulations and consistent with 45 CFR part 74 as it applies to State procurement of Medicaid services.

42 CFR 438.354 The State must ensure that an External Quality Review Organization and its subcontractors performing the External Quality Review or External Quality Review-related activities meets the competence and independence requirements.

Not applicable.
A qualified External Quality Review Organization performs an annual External Quality Review that meets the requirements of 42 CFR 438 Subpart E each managed care organization, prepaid inpatient health plan, and health insuring organizations under contract, except where exempted by the regulation.
Citation: 4.15

Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals

42 CFR Part 456, Subpart A and 1902(a)(31) and 1903(g) of the Act

The State has contracted with a Peer Review Organization (PRO) to perform inspection of care for:

- ICFs/MR;
- Inpatient psychiatric facilities for recipients under age 21; and
- Mental Hospitals.

All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services.

Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan.

Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.
State: Florida

Citation 42 CFR 431.615(c) AT-78-90

4.16 Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615.

ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

TN # 77-10
Supersedes Approval Date 9/11/78 Effective Date 11/1/77
The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917(a) of the Act and regulations at 42 CFR 433.36(c)-(g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

The State imposes liens on real property on account of benefits incorrectly paid.

The State imposes TEFFA liens 1917(a)(1)(B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care plus but a minimal amount of income required for personal needs.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State plan that it is imposing TEFFA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

The State imposes liens on both real and personal property of an individual after the individual's death.
(b) Adjustments or Recoveries

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36(c)-(g).

Adjustments or recoveries for Medicaid claim correctly paid are as follows:

(1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual’s estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

(2) The State determines “permanent institutional status” of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917(a)(1)(B) (even if it does not impose those liens).

(3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual’s estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State plan as listed below:

All services paid by the Florida Medicaid program.
4.17 (b) Adjustments or Recoveries

(3) (Continued)

Limitations on Estate Recovery - Medicare Cost Sharing:

(i) Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles: QMB, SLMB, QI, QDWI, QMB+, SLMB+. This protection extends to medical assistance for four Medicare cost sharing benefits: (Part A and B premiums, deductibles, coinsurance, co-payments) with dates of service on or after January 1, 2010. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid Agency. The date of service for premiums is the date the State Medicaid Agency paid the premium.

(ii) In addition to being a qualified dual eligible the individual must also be age 55 or over. The above protection from estate recovery for Medicare cost sharing benefits (premiums, deductibles, coinsurance, co-payments) applies to approved mandatory (i.e., nursing facility, home and community-based services, and related prescription drugs and hospital services) as well as optional Medicaid services identified in the State plan, which are applicable to the categories of duals referenced above.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Florida

1917(b)(1)(C) (4) X If an individual covered under a long-term care insurance policy received benefits for which assets or resources were disregarded as provided for in Attachment 2.6-A, Supplement 8c (State Long-Term Care Insurance Partnership), the State does not seek adjustment or recovery from the individual's estate for the amount of assets or resources disregarded.

TN No.: FL-06-010
Supersedes

TN No.: 95-22

Approval Date: 11/27/06
Effective Date: 01/01/07
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

(c) Adjustments or Recoveries: Limitations

The State complies with the requirements of section 1917(b)(2) of the Act and regulations at 42 CFR §433.36(h)-(i).

(1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.

(2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustment or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:

(a) a sibling of the individual (who was residing in the individual’s home for at least one year immediately before the date that the individual was institutionalized), or

(b) a child of the individual (who was residing in the individual’s home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.

(3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.
(1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36(d).

(2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).

(3) Defines the following terms:

- estate (at a minimum, estate as defined under State probate law).
  Except for the grandfathered States listed in section 4.17(b)(3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangement),

- individual's home,

- equity interest in the home,

- residing in the home for at least 1 or 2 years,

- on a continuous basis,

- discharge from the medical institution and return home, and

- lawfully residing.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

(4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.

(5) Defines when adjustment or recovery is not cost-effective. Defines cost-effective and includes methodology or thresholds used to determine cost-effectiveness.

(6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.
Citation 4.18 Recipient Cost Sharing and Similar Charges

42 CFR 447.51 through 447.58 (a) Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.

1916(a) and (b) (b) of the Act Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:

(1) No enrollment fee, premium, or similar charge is imposed under the plan.

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

[ ] Age 19
[ ] Age 20
[X] Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.
42 CFR 447.51 through 447.58 (Continued)

(iii) All services furnished to pregnant women.

Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution to spend for medical care costs all but a minimal amount of his or her income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished by a managed care organization, health insuring organization, prepaid inpatient health plan, or prepaid ambulatory health plan in which the individual is enrolled, unless they meet the requirements of 42 CFR 447.60.

[X] Managed care enrollees may be charged deductibles, coinsurance rates, and copayments in an amount equal to the State Plan service cost-sharing.

[] Managed care enrollees are not charged deductibles, coinsurance rates, and copayments.

(viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.
(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(2) above.

Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age groups:

- 18 or older
- 19 or older
- 20 or older
- 21 or older

Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.
For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:

(A) Services for which a charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

/\ Not applicable. There is no maximum.
A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(ii)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met.

ATTACHMENT 4.18-D specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.

For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act.

A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. ATTACHMENT 4.18-E specifies the method and standards the State uses for determining the premium.
42 CFR 447.51 through 447.58

(1) □/ An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the state's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.

447.51 through 447.58

(2) □/ No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(1) Services to individuals under age 18, or under—

□/ Age 19

□/ Age 20

X/ Age 21

Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable:

TN No. 91-50
Supersedes Approval Date OCT 6 1992 Effective Date 10/1/91
TN No. 86-18

HCFA ID: 7982E
(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

(iii) All services furnished to pregnant women. Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

(viii) Services provided by a health maintenance organization (HMO) to enrolled individuals. Not applicable. No such charges are imposed.
Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.

☐ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age group:

☐ 18 or older
☐ 19 or older
☐ 20 or older
☐ 21 or older

Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable.
(iii) For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the:

(A) Service(s) for which charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.

[Not applicable. There is no maximum.]
Citation 4.19 Payment for Services

(a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a)(13) and 1923 of the Act with respect to payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.

Inappropriate level of care days are not covered.

Supersedes Approval Date 4/26/95 Effective Date 1/1/95

HCFA ID: 7982E
Citation 4.19(b) In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the following requirements:

(1) Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905(a)(2)(C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys).

(2) Sections 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan.

ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.

1902(a)(10) and 1902(a)(30) of the Act

SUPPLEMENT 1 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.
Revision: HFA-AT-80-38 (BPP)
May 22, 1980

State Florida

Citation 42 CFR 447.40 AT-78-90

4.19(c) Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

☑ Yes. The State's policy is described in ATTACHMENT 4.19-C.

☑ No.

TN # 77-11
Supersedes

Approval Date 1/30/78 Effective Date 1/1/78
The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for nursing facility services and intermediate care facility services for the mentally retarded.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for nursing facility services and intermediate care facility services for the mentally retarded.

(2) The Medicaid agency provides payment for routine nursing facility services furnished by a swing-bed hospital.

- At the average rate per patient day paid to NFs for routine services furnished during the previous calendar year.
- At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.
- Not applicable. The agency does not provide payment for NF services to a swing-bed hospital.
The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims.

ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.
The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15.

No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.
The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.
Revisions: HCFA-AT-80-60 (BPP)  
August 12, 1980

State: Florida

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<td>42 CFR 447.201</td>
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The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

Supersedes

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State: Florida

Citation: 42 CFR 447.201
          42 CFR 447.204
          AT-78-90

4.19(i) The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

TN & MED-71-01
Supersedes

Approval Date 12/7/79 Effective Date 2/6/79
The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.

The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.
4.19(1) The Medicaid agency meets the requirements of section 1903(i)(14) of the Act with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physician to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act.
State/Territory: FLORIDA

Citation

4.19(m) Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program

1928(c)(2)(C)(ii) of the Act

(i) A provider may impose a fee for the administration of a qualified pediatric vaccine as stated in 1928(c)(20)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows:

(ii) The State:

_____ sets a payment rate at the level of the regional maximum established by the Secretary.

X____ sets a payment rate below the level of the regional maximum established by the Secretary. (If this is checked, fill in information below)

The State pays the following rate for the administration of a vaccine:

$10.00 for physicians
$8.00 for physician's assistants and advanced registered nurse practitioners
$5.00 for CPHUs and FQHCs

1926 of the Act

(iii) Medicaid beneficiary access to immunizations is assured through the following methodology:

As of 10/1/94, Medicaid no longer reimburses for the vaccine - only for the administration of the vaccine. Therefore, physicians and other practitioners may be reimbursed only if they participate in the Vaccine for Children program. The recruitment and participation of providers are conducted by the Florida Immunization Program of the State Health Office.

Other:

TN No. 94-18 Supersedes

Effective Date 4/1/95 Approval Date 6-14-95
4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

☐ Yes, for ☐ physicians' services
☐ dentists' services

ATTACHMENT 4.20-A specifies the conditions under which such payments are made.

☒ Not applicable. No direct payments are made to recipients.

Revision: ECPA-AT-80-38 (REP)
May 22, 1980

State: Florida

Citation
42 CFR 447.25 (b)
AT-78-90

TN § 77-11
Supersedes
TN # Approval Date 1/30/78 Effective Date 1/1/78
Prohibition Against Reassignment of Provider Claims

Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447.10.
433.137(a) 4.22 Third Party Liability
(a) The Medicaid agency meets all requirements of 42 CFR 433.138 and 433.139.

433.137(b) 52 FR 1423
(1) For medical assistance provided on or after October 1, 1984:
(A) The requirement of 433.145 through 433.148 are met for assignment of rights to benefits and cooperation.
(B) The requirements of 433.151 through 433.154 are met for cooperative agreements and incentive payments for third party collections.

433.138(e) 52 FR 5967
(b) ATTACHMENT 4.22-A -
(1) Specifies the frequency with which the data exchanges required in §433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;

433.138(g)(1)(ii) and (2)(ii) 52 FR 5967
(2) Describes the methods the agency uses for meeting the followup requirements contained in §433.138(g)(1)(i) and (g)(2)(i);

433.138(g)(3)(i) and (iii) 52 FR 5967
(3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources; and

433.138(g)(4)(i) through (iii) 52 FR 5967
(4) Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources.
(c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.

Providers may bill the agency when services covered under a plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency. Claims are paid and billed to the appropriate insurance carrier for reimbursement by the third party.

(d) ATTACHMENT 4.22-B specifies the following:

(1) The method used in determining a provider's compliance with the third party billing requirements at §433.139(b)(3)(ii)(C).

(2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.

(3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.

(e) The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.
The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with at least one of the following:

(Check as appropriate.)

X State title IV-D agency. The requirements of 42 CFR 433.152(b) are met. See attached Page 70a.

- Other appropriate State agency(s)—

- Other appropriate agency(s) of another State—

- Courts and law enforcement officials.

The Medicaid agency meets the requirements of 42 CFR and 433.153 and 433.154 for making incentive payments and for distributing third party collections.

The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

______ The Secretary’s method as provided in the State Medicaid Manual, Section 3910.

XX The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C.
Memorandum of Understanding Between the Offices of
Child Support Enforcement
Financial Management
Economic Services
Children, Youth and Families
Deputy Assistant Secretary for Medicaid
Pursuant to Section 1912 of the Social Security Act

WHEREAS Section 1912 of the Social Security Act was amended effective October 1984 to mandate that the Medicaid and Child Support Enforcement agencies enter into cooperative arrangements to enforce and collect medical support on behalf of Medicaid recipients who are also receiving cash assistance under Title IV-A or IV-E of the Act and; WHEREAS Section 1912 of the Social Security Act was further amended effective October 1985 to mandate that the Medicaid agency enter into cooperative arrangements to enforce and collect medical support on behalf of Medicaid recipients who are not receiving cash assistance under Title IV-A or IV-E of the Act, it is mutually agreed as follows:

1. That any new court orders entered by the Office of Child Support Enforcement field staff against absent parents or orders referred for court action will include wording to the following effect: "The absent parent shall subscribe to any health insurance for his children included in a public assistance family when such health insurance is available at a reasonable cost. For purposes of this order, public assistance shall be construed to mean cash assistance or medical assistance."

2. That the Office of Child Support Enforcement will provide to the Office of Financial Management information on all public assistance (cash and Medicaid only) related absent parents listing the absent parent's name, address, and social security number, the policy name(s) and number(s), the names and Medicaid numbers of each spouse/child covered, and the child support field unit handling the case. The Office of Child Support Enforcement will inform the Office of Financial Management of any modification or change in court orders affecting the possibility of Medicaid recovery from third parties.

Amendment 87-19
Effective 4/1/87
Supersedes 86-16
3. That the Office of Financial Management will refer to the Office of Child Support Enforcement any absent parents whose court-ordered insurance has lapsed. The Office of Child Support Enforcement will proceed with enforcement of such orders upon receipt of notice from the Office of Financial Management that court-ordered insurance has lapsed when it is reasonably available.

4. That the Office of Children, Youth and Families district intake staff will seek court orders for medical support at the time any adjudicated dependent child is placed in the custody of the state by court order. Furthermore, the Office of Children, Youth and Families will send copies of said orders to the Office of Child Support Enforcement and advise the Office of Child Support Enforcement of any orders which require enforcement activity.

5. That the Office of the Deputy Assistant Secretary for Medicaid will authorize payment in the amount of $25.00 for each case involving the absent parent of a Medicaid recipient who is not receiving Title IV-A or IV-E cash assistance. Payment of the $25.00 application fee and signing of the application entitles the Medicaid recipient to those activities conducted by the Office of Child Support Enforcement in accordance with their established policies and procedures. Specifically, the Medicaid recipient is entitled to support collection or paternity determination and the securing and enforcing of medical support obligations.

6. That the Office of Child Support Enforcement will establish and maintain case records of medical support enforcement activities in accordance with the provisions of 45 CFR 302.15.

7. That the use or disclosure of information concerning applicants for, or recipients of, medical support enforcement services is subject to the limitations in 45 CFR 303.21.

8. That the Office of Child Support Enforcement will maintain an accounting system and supporting fiscal records adequate to assure that claims for payment of the application fee from the Office of the Deputy Assistant Secretary for Medicaid are in accordance with applicable federal requirements in 45 CFR Part 74.
9. That the Offices of Economic Services and Deputy Assistant Secretary for Medicaid shall coordinate the above efforts and reflect compliance with Section 1912 in the Medicaid State Plan or any other relevant document.

10. That this memorandum shall remain in full force and effect until such time as amendment or revocation is approved by all offices concerned.

[Signatures and dates]

Signature  Date
Office of Child Support Enforcement

Signature  Date
Office of Financial Management

Signature  Date
Economic Services Program Office

Signature  Date
Children, Youth and Families Program Office

Signature  Date
Deputy Assistant Secretary for Medicaid
Citation 4.23 Use of Contracts

42 CFR 434.4 48 FR 54013

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.

Not applicable. The State has no such contracts.

42 CFR Part 438

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 438. All contracts meet the requirements of 42 CFR Part 438. Consistent with 45 CFR Part 74, risk contracts are procured through an open, competitive procurement process, or through an open application process to allow contracting with all qualified providers.

The risk contract is with (check all that apply):

- X Managed Care Organization that meets the definition of 1903(m) of the Act and 42 CFR 438.2
- X Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2
- X Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2.
- Not applicable.
With respect to skilled nursing and intermediate care facilities, all applicable requirements of 42 CFR Part 442, Subparts B and C are met.

☐ Not applicable to intermediate care facilities; such services are not provided under this plan.
State: Florida

Citation: 42 CFR 431.702
AT-78-90

4.25 Program for Licensing Administrators of Nursing Homes

The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

TN § 74-1
Supersedes
TN §

Approval Date 9/12/74
Effective Date N/A
Drug Utilization Review Program

A.1. The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.

1927(g)(1)(A)

2. The DUR program assures that prescriptions for outpatient drugs are:

- Appropriate
- Medically necessary
- Are not likely to result in adverse medical results

B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs as well as:

- Potential and actual adverse drug reactions
- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug-disease contraindications
- Drug-drug interactions
- Incorrect drug dosage or duration of drug treatment

* Drug-allergy interactions
- Clinical abuse/misuse

C. The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia:

- American Hospital Formulary Service Drug Information
- United States Pharmacopeia-Drug Information
- American Medical Association Drug Evaluations

* Our DUR program will not target individual drug allergies, as that information cannot be maintained in the recipient information file. However, as part of the Pharmacy Practice Act requiring prescription/patient profiles, all pharmacists will be expected to capture drug allergy information before filling any prescriptions.
DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has never-the-less chosen to include nursing home drugs in:

- Prospective DUR
- Retrospective DUR.

The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient.

Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to:

- Therapeutic duplication
- Drug-disease contraindications
- Drug-drug interactions
- Drug-interactions with non-prescription or over-the-counter drugs
- Incorrect drug dosage or duration of drug treatment
- Drug allergy interactions
- Clinical abuse/misuse

Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles.

The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify:

- Patterns of fraud and abuse
- Gross overuse
- Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs.
The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for:

- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug-disease contraindications
- Drug-drug interactions
- Incorrect drug dosage/duration of drug treatments
- Clinical abuse/misuse

The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.

The DUR program has established a State DUR Board either:

- [X] Directly, or
- [ ] Under contract with a private organization

The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacists and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following:

- Clinically appropriate prescribing of covered outpatient drugs.
- Clinically appropriate dispensing and monitoring of covered outpatient drugs.
- Drug use review, evaluation and intervention.
- Medical quality assurance.

The activities of the DUR Board include:

- Retrospective DUR,
- Application of Standards as defined in section 1927(g)(2)(C), and
- Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR.

The actual retrospective DUR profile reviews will be done through a contract with the pharmacy association, not the DUR Board. However, the Board will determine criteria or standards and will assess interventions performed under this contract.

The pharmacy association is obliged to meet with all 5 regional review committees each month, and the DUR Board will only meet quarterly, so the Board will monitor what the regional review committees actually do.
The interventions include in appropriate instances:

- Information dissemination
- Written, oral, and electronic reminders
- Face-to-face discussions
- Intensified monitoring/review of prescribers/dispensers

The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, procedures as described in the report.

The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system to perform on-line:

- Real time eligibility verification
- Claims data capture
- Adjudication of claims
- Assistance to pharmacists, etc. applying for and receiving payment.

Prospective DUR is performed using an electronic point of sale drug claims processing system.

Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs, in the hospital's per diem rate.
4.27 Disclosure of Survey Information and Provider or Contractor Evaluation

The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.
Revision: HCFA-PM-93-1
January 1993

State/Territory: FLORIDA

Citation

42 CFR 431.152;
AT-79-18
52 FR 22444;
Secs.
1902(a)(28)(D)(I)
and 1919(e)(7) of
the Act; P.L.
100-203 (Sec. 4211(c)).

4.28 Appeals Process

(a) The Medicaid agency has established appeals procedures for NFs as specified in 42 CFR 431.153 and 431.154.

(b) The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C.
4.29 Conflict of Interest Provisions

The Medicaid agency meets the requirements of Section 1902(a)(4)(C) of the Act concerning the Prohibition against acts, with respect to any activity Under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.

The Medicaid agency meets the requirements of 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).
Exclusion of Providers and Suspension of Practitioners and Other Individuals

(a) All requirements of 42 CFR Part 1002, Subpart B are met.

The agency, under the authority of State law, imposes broader sanctions.
The Medicaid agency meets the requirements of—

1902(p) of the Act

(1) Section 1902(p) of the Act by excluding from participation—

(A) At the State’s discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).

(B) An MCO (as defined in section 1903(m) of the Act), or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that—

(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or

(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.

(2) An MCO, PIHP, PAHP, or PCCM may not have prohibited affiliations with individuals (as defined in 42 CFR 438,610(b)) suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. If the State finds that an MCO, PCCM, PIHP, or PAHP is not in compliance the State will comply with the requirements of 42 CFR 438.610(c).
(2) Section 1902(a)(39) of the Act by--

(A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and

(B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.

(c) The Medicaid agency meets the requirements of--

(1) Section 1902(a)(41) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and

(2) Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.
4.31 Disclosure of Information by Providers and Fiscal Agents

The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections 1128(b)(9) and 1902(a)(38) of the Act.

4.32 Income and Eligibility Verification System

(a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960.

(b) ATTACHMENT 4.32-A describes, in accordance with 42 CFR 435.948(a)(6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.
4.33 Medicaid Eligibility Cards for Homeless Individuals

(a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.
The State Medicaid Agency has established procedures for the verification of alien status through the Immigration and Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1998.

- X - The State Medicaid Agency has elected to verify alien status through INS designated system (SAVE).

- The State Medicaid Agency has received the following types(s) of waiver from participation in SAVE.

- Total waiver
- Alternative system
- Partial implementation

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<td>4.34 Systematic Alien Verification for Entitlements</td>
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<tr>
<td>P.L.99-603 (sec.121)</td>
<td>The State Medicaid Agency has established procedures for the verification of alien status through the Immigration and Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1998.</td>
</tr>
</tbody>
</table>

**Notes:**

- Supersedes TN No. 88-22
- Approval Date: Feb 23, 1998
- Effective: 10/1/98
Citation 4.35 Remedies for Skilled Nursing and Intermediate Care Facilities that Do Not Meet Requirements of Participation

1919(h)(1) and (2) of the Act, P.L. 100-203 (Sec. 4213(a))

(a) The Medicaid agency meets the requirements of section 1919(h)(2)(A) through (D) of the Act concerning remedies for skilled nursing and intermediate care facilities that do not meet one or more requirements of participation. ATTACHMENT 4.35-A describes the criteria for applying the remedies specified in section 1919(h)(2)(A)(i.) through (iv) of the Act.

Not applicable to intermediate care facilities; these services are not furnished under this plan.

(b) The agency uses the following remedy(ies):

(1) Denial of payment for new admissions.

(2) Civil money penalty.

(3) Appointment of temporary management.

(4) In emergency cases, closure of the facility and/or transfer of residents.

1919(h)(2)(B)(ii) of the Act

(c) The agency establishes alternative State remedies to the specified Federal remedies (except for termination of participation). ATTACHMENT 4.35-B describes these alternative remedies and specifies the basis for their use.

1919(h)(2)(F) of the Act

(d) The agency uses one of the following incentive programs to reward skilled nursing or intermediate care facilities that furnish the highest quality care to Medicaid residents:

(1) Public recognition.

(2) Incentive payments.
4.35 Enforcement of Compliance for Nursing Facilities

(a) Notification of Enforcement Remedies

When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR 488.402(f).

(i) The notice (except for civil money penalties and State monitoring) specifies the:

1. nature of noncompliance,
2. which remedy is imposed,
3. effective date of the remedy, and
4. right to appeal the determination leading to the remedy.

(ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.

(iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.

(iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.

(b) Factors to be Considered in Selecting Remedies

(i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404(b)(1) & (2).

The State considers additional factors. Attachment 4.35-A describes the State's other factors.
c) Application of Remedies

(i) If there is immediate jeopardy to resident health or safety, the State terminates the NF's provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.

(ii) The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within 3 months after the last day of the survey.

(iii) The State imposes the denial of payment for new admissions remedy as specified in §488.417 (or its approved alternative) and a State monitor as specified at §488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.

(iv) The State follows the criteria specified at §488.408(a), when it imposes remedies in place of or in addition to termination.

(v) When immediate jeopardy does not exist, the State terminates an NF's provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR §488.412(a) are not met.

(d) Available Remedies

(i) The State has established the remedies defined in 42 CFR §488.406(b).

- Termination
- Temporary Management
- Denial of Payment for New Admissions
- Civil Money-Penalties
- Transfer of Residents; Transfer of Residents with Closure of Facility
- State Monitoring

Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies.
The State uses alternative remedies. The State has established alternative remedies that the State will impose in place of a remedy specified in 42 CFR 488.406(b).

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<tbody>
<tr>
<td>(1)</td>
<td>Temporary Management</td>
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<tr>
<td>X</td>
<td>Denial of Payment for New Admissions</td>
</tr>
<tr>
<td>(3)</td>
<td>Civil Money Penalties</td>
</tr>
<tr>
<td>(4)</td>
<td>Transfer of Residents; Transfer of Residents with Closure of Facility</td>
</tr>
<tr>
<td>(5)</td>
<td>State Monitoring</td>
</tr>
</tbody>
</table>

Attachments 4.35-E through 4.35-G describe the alternative remedies and the criteria for applying them.

State Incentive Programs

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<tbody>
<tr>
<td>X</td>
<td>(1) Public Recognition</td>
</tr>
<tr>
<td>X</td>
<td>(2) Incentive Payments</td>
</tr>
</tbody>
</table>
The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.
Nurse Aide Training and Competency Evaluation for Nursing Facilities

(a) The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.

(b) The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).

(c) The State deems individuals who meet the requirements of 42 CFR 483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.

(d) The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.

(e) The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.

(f) The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

(g) If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the State reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request.

(h) The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.

(i) Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.

(j) Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.

(k) For program reviews other than the initial review, the State visits the entity providing the program.

(l) The State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b)(2) and (3).
(m) The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requester whether or not the program has been approved or requests additional information from the requester.

(n) The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.

(o) The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).

(p) The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b)(2) or (3).

(q) The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR 483.154.

(r) The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State.
When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing, indicating the reasons for withdrawal of approval.

The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.

The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.

The State provides advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.

Competency evaluation programs are administered by the State or by a State-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.

The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).

The State has a standard for successful completion of competency evaluation programs.
State/Territory: FLORIDA

Citation: 42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

(z) The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.

(aa) The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).

(bb) The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.

(cc) The State includes home health aides on the registry.

(dd) The State contracts the operation of the registry to a non-State entity.

X (ee) ATTACHMENT 4.38 contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156(c)(1)(iii) and (iv).

(ff) ATTACHMENT 4.38-A contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).
Citation
Secs.
1902(a)(28)(D)(1)
and 1919(e)(7) of
the Act;
P.L. 100-203
(Sec. 4211(c));
P.L. 101-508
(Sec. 4801(b)).

4.39 Preadmission Screening and Annual
Resident Review in Nursing Facilities

(a) The Medicaid agency has in effect a
written agreement with the State mental
health and mental retardation authorities
that meet the requirements of 42 (CFR)
431.621(c).

(b) The State operates a preadmission and
annual resident review program that meets
the requirements of 42 CFR 483.100-138.

(c) The State does not claim as "medical
assistance under the State Plan" the cost
of services to individuals who should
receive preadmission screening or annual
resident review until such individuals are
screened or reviewed.

(d) With the exception of NF services
furnished to certain NF residents defined
in 42 CFR 483.118(c)(1), the State does
not claim as "medical assistance under the
State plan" the cost of NF services to
individuals who are found not to require
NF services.

(e) ATTACHMENT 4.39 specifies the State's
definition of specialized services.

TN No. 93-14
Supersedes Approval Date JUN 23 1993 Effective Date 1/1/93
TN No. NEW
(f) Except for residents identified in 42 CFR 483.118(c)(1), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFs and that a more appropriate placement should be utilized.

(g) The State describes any categorical determinations it applies in ATTACHMENT 4.39-A.
<table>
<thead>
<tr>
<th>Citation</th>
<th>4.40 Survey &amp; Certification Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sections</td>
<td>(a) The State assures that the requirements of 1919(g)(1)(A) through (C) and section 1919(g)(2)(A) through (E)(iii) of the Act which relate to the survey and certification of non-State owned facilities based on the requirements of section 1919(b), (c) and (d) of the Act, are met.</td>
</tr>
<tr>
<td>1919(g)(1) thru (2)</td>
<td>(b) The State conducts periodic education programs for staff and residents (and their representatives). Attachment 4.40-A describes the survey and certification educational program.</td>
</tr>
<tr>
<td>1919(g)(4) thru (5) of the Act</td>
<td>(c) The State provides for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility. Attachment 4.40-B describes the State's process.</td>
</tr>
<tr>
<td>1919(g)(1) (B) of the Act</td>
<td>(d) The State agency responsible for surveys and certification of nursing facilities or an agency delegated by the State survey agency conducts the process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property. If not the State survey agency, what agency?</td>
</tr>
<tr>
<td>1919(g)(1) (C) of the Act</td>
<td>(e) The State assures that a nurse aide, found to have neglected or abused a resident or misappropriated resident property in a facility, is notified of the finding. The name and finding is placed on the nurse aide registry.</td>
</tr>
<tr>
<td>1919(g)(1) (C) of the Act</td>
<td>(f) The State notifies the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property in a facility.</td>
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</table>
The State has procedures, as provided for at section 1919(g)(2)(A)(i), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. Attachment 4.40-C describes the State's procedures.

The State assures that each facility shall have a standard survey which includes (for a case-mix stratified sample of residents) a survey of the quality of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participation, and sanitation, infection control, and the physical environment, written plans of care and audit of resident's assessments, and a review of compliance with resident's rights not later than 15 months after the date of the previous standard survey.

The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 months.

The State may conduct a special standard or special abbreviated standard survey within 2 months of any change of ownership, administration, management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility.

The State conducts extended surveys immediately or, if not practicable, not later that 2 weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary's or State's discretion.

The State conducts standard and extended surveys based upon a protocol, i.e., survey forms, methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary.
1919(g)(2) (D) of the Act (m) The State provides for programs to measure and reduce inconsistency in the application of survey results among surveyors. Attachment 4.40-D describes the State's programs.

1919(g)(2) (E)(i) of the Act (n) The State uses a multidisciplinary team of professionals including a registered professional nurse.

1919(g)(2) (E)(ii) of the Act (o) The State assures that members of a survey team do not serve (or have not served within the previous two years) as a member of the staff or consultant to the nursing facility or has no personal or familial financial interest in the facility being surveyed.

1919(g)(2) (E)(iii) of the Act (p) The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification techniques approved by the Secretary.

1919(g)(4) of the Act (q) The State maintains procedures and adequate staff to investigate complaints of violations of requirements by nursing facilities and onsite monitoring. Attachment 4.40-E describes the State's complaint procedures.

1919(g)(5) (A) of the Act (r) The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies, plans of correction, copies of cost reports, statements of ownership and the information disclosed under section 1126 of the Act.

1919(g)(5) (B) of the Act (s) The State notifies the State long-term care ombudsman of the State's finding of non-compliance with any of the requirements of subsection (b), (c), and (d) or of any adverse actions taken against a nursing facility.

1919(g)(5) (C) of the Act (t) If the State finds substandard quality of care in a facility, the State notifies the attending physician of each resident with respect to which such finding is made and the nursing facility administrator-licensing board.

1919(g)(5) (D) of the Act (u) The State provides the State Medicaid fraud and abuse agency access to all information concerning survey and certification actions.
State/Territory: FLORIDA

<table>
<thead>
<tr>
<th>Citation</th>
<th>4.41 Resident Assessment for Nursing Facilities</th>
</tr>
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<tbody>
<tr>
<td>Sections</td>
<td>(a) The State specifies the instrument to be used by</td>
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<tr>
<td>1919(b)(3)</td>
<td>nursing facilities for conducting a</td>
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<tr>
<td>and 1919</td>
<td>comprehensive, accurate, standardized,</td>
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<tr>
<td>(e)(5) of</td>
<td>reproducible assessment of each resident's</td>
</tr>
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<td>the Act</td>
<td>functional capacity as required in</td>
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<td></td>
<td>§1919(b)(3)(A) of the Act.</td>
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</table>

1919(e)(5) (A) of the Act

(b) The State is using:

- the resident assessment instrument designated by the Health Care Financing Administration (see Transmittal #241 of the State Operations Manual) [§1919(e)(5)(A)]; or

1919(e)(5) (B) of the Act

X a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the State Medicaid Manual for the Secretary's approval criteria) [§1919(e)(5)(B)].

TN No. 92-16
Supersedes Approval Date NOV 3 1992 Effective Date 4/1/92
TN No. NEW
HCFA ID:
4.42 Employee Education About False Claims Recoveries.

(a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities’ compliance with these requirements.

(1) Definitions.

(A) An “entity” includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an “entity” (e.g., a state mental...
health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

(2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

TN No. 2007-004
Supersedes
TN No. NEW

Approval Date: 04/30/07
Effective Date: 01/01/07
(3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

(4) The requirements of this law should be incorporated into each State's provider enrollment agreements.

(5) The State will implement this State Plan amendment on January 1, 2007.

(b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Florida

Citation
1902(a)(69) of the Act, P.L. 109-171 (section 6034)

4.43 Cooperation with Medicaid Integrity Program Efforts. The Medicaid agency assures it complies with such requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936 of the Act.
PROPOSED SECTION 4 – GENERAL PROGRAM ADMINISTRATION

4.44 Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States

Citation

Section 1902(a)(80) of the Social Security Act, P.L. 111-148 (Section 6505)

X The State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.
4.46 Provider Screening and Enrollment

The State Medicaid agency gives the following assurances:

PROVIDER SCREENING X Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.

ENROLLMENT AND SCREENING OF PROVIDERS X Assures enrolled providers will be screened in accordance with 42 CFR 455.400, et seq.

X Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.

4/1/12 - In 2011, Florida adopted legislation to expand its Medicaid managed care delivery system statewide. CMS is currently reviewing waivers and renewal requests submitted to facilitate this expansion. If Florida is granted approval by CMS, approximately 85% of the Florida Medicaid population will be enrolled in risk based managed care. Note that Medicaid providers who serve Medicaid recipients via managed care organizations are registered as Medicaid providers.

VERIFICATION OF PROVIDER LICENSES X Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.

REVALIDATION OF ENROLLMENT X Assures that providers will be revalidated regardless of provider type at least every 5 years.

TERMINATION OR DENIAL OF ENROLLMENT X Assures that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.

REACTIVATION OF PROVIDER ENROLLMENT X Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.

4/1/12 - Florida Medicaid does not allow providers who were previously terminated to re-enroll in the program unless terminated voluntarily. Additionally, per 1866(j)(2)(C)(ii) of the Act, Florida Medicaid has been granted a hardship waiver by CMS for collection of application fees from ICF/DD and SIPP providers (the only provider types in Florida that could not be Medicare providers).
42 CFR 455.422  APPEAL RIGHTS

X Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.

SITE VISITS

42 CFR 455.432  X Assures that pre-enrollment and post-enrollment site visits of providers who are in “moderate” or “high” risk categories will occur.

CRIMINAL BACKGROUND CHECKS

42 CFR 455.434  X Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse for that category of provider.

FEDERAL DATABASE CHECKS

42 CFR 455.436  X Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.

NATIONAL PROVIDER IDENTIFIER

42 CFR 455.440  X Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

SCREENING LEVELS FOR MEDICAID PROVIDERS

42 CFR 455.450  X Assures that the State Medicaid agency complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.

APPLICATION FEE

42 CFR 455.460  ___ Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.

4/1/12 – Per 1866(j)(2)(C)(ii) of the Act, Florida Medicaid has been granted a hardship waiver by CMS for collection of application fees from ICF/DD and SIPP providers (the only provider types in Florida could not be Medicare providers).

TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS

42 CFR 455.470  X Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries’ access to medical assistance.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1151. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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SPA TN: 2012-008
Effective Date: April 1, 2012
Supersedes: NEW
Approval Date: 06-27-12
<table>
<thead>
<tr>
<th>Citation</th>
<th>Standards of Personnel Administration</th>
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<tbody>
<tr>
<td>42 CFR 432.10 (a)</td>
<td>(a) The Medicaid agency has established and will maintain methods of personnel</td>
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<tr>
<td>AT-78-90</td>
<td>administration in conformity with standards prescribed by the U.S. Civil</td>
</tr>
<tr>
<td>AT-79-23</td>
<td>Service Commission in accordance with Section 208 of the Intergovernmental</td>
</tr>
<tr>
<td>AT-80-34</td>
<td>Personnel Act of 1970 and the regulations on Administration of the Standards</td>
</tr>
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<td>for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. All</td>
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<td>requirements of 42 CFR 432.10 are met.</td>
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<td></td>
<td>The plan is locally administered and State-supervised. The requirements of 42</td>
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<tr>
<td></td>
<td>CFR 432.10 with respect to local agency administration are met.</td>
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</tbody>
</table>

(b) Affirmative Action Plan

The Medicaid agency has in effect an affirmative action plan for equal employment opportunity that includes specific action steps and timetables and meets all other requirements of 5 CFR Part 900, Subpart F.
March 30, 1983

Mr. Alan M. Wandling  
Director's Representative  
Office of Personnel Management  
Richard B. Russell Federal Building  
75 Spring Street, S.W.  
Atlanta, Georgia 30303

Dear Mr. Wandling:

This is to advise you that it is the State of Florida's intention to comply with 5 C.F.R. Part 900 Standards for a Merit System where such standards apply to the various agencies of the State of Florida.

With kind regards,

Sincerely,

Governor

BG/jd
Revisions: HCFA-AT-80-38 (BPP)
May 22, 1980
State: Florida

5.2 [Reserved]
5.3 Training Programs; Subprofessional and Volunteer Programs

The Medicaid agency meets the requirements of 42 CFR Part 432, Subpart B, with respect to a training program for agency personnel and the training and use of subprofessional staff and volunteers.
SECTION 6  FINANCIAL ADMINISTRATION

The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met.
Revision: HCPA-NM-81- (BPP)

State: Florida

Citation
42 CFR 433.34
47 FR 17490

6.2 Cost Allocation

There is an approved cost allocation plan on file with the Department in accordance with the requirements contained in 45 CFR Part 95, Subpart E.
6.3 State Financial Participation

(a) State funds are used in both assistance and administration.

☐ State funds are used to pay all of the non-Federal share of total expenditures under the plan.

☑ There is local participation. State funds are used to pay not less than 40 percent of the non-Federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration under the plan in any part of the State.

(b) State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.
SECTION 7 - GENERAL PROVISIONS

Plan Amendments

The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation.
In accordance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seg.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subject to discrimination under this plan on the grounds of race, color, national origin, or handicap.

The Medicaid agency has methods of administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with title VI regulations. These methods for title VI are described in ATTACHMENT 7.2-A.
Citation 7.3 Maintenance of AFDC Efforts

1902(c) of the Act

The State agency has in effect under its approved AFDC plan payment levels that are equal to or more than the AFDC payment levels in effect on May 1, 1988.
7.4 State Governor’s Review

The Medicaid Agency will provide opportunity for the Office of the Governor to review State plan amendment long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Health Care Financing Administration with such documents.

Not Applicable. The Governor--

[ ] Does not wish to review any plan materials.
[ ] Wishes to review only the plan materials specified in the enclosed documents.

I hereby certify that I am authorized to submit this plan on behalf of

Agency for Health Care Administration
(Designated Single State Agency)

Date: March 1, 2009

Deputy Secretary for Medicaid
(Title)

TN No: 2009-010
Supersedes
TN No. 1993-39

Effective Date: March 1, 2009
Approval Date: 04/13/09
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ATTORNEY GENERAL'S CERTIFICATION

Current Attorney General's certification dated June 24, 1993 is attached.

TN No. 93-39  Effective Date  7/1/93
Supersedes  Approval Date  10/21/94
TN No. 74-01
June 24, 1993

Mr. Eugene A. Grasser  
Associate Regional Administrator  
HCFA Region IV - Division of Medicaid  
101 Marietta Tower, Suite 601  
Atlanta, Georgia 30323

Dear Mr. Grasser:

Pursuant to the Social Security Act, 42 USC, section 1396(a)(1965), and Florida's Health Care and Insurance Reform Act of 1993, Chapter 93-129, section 58, Laws of Florida (signed into law by the Governor on April 29, 1993), the Agency for Health Care Administration will be designated as the single state agency responsible for the administration of Title XIX of the Social Security Act, effective July 1, 1993.

Chapter 93-129, section 58, Laws of Florida, provides:

All powers, duties and functions, records, personnel, property, and unexpended balances of appropriations, allocations, or other funds of the Medicaid program within the Department of Health and Rehabilitative Services, as well as the infrastructure and support services that support the program, including, but not limited to, investigative, licensing, legal, and administrative activities, are transferred by a type four transfer, as defined in s. 20.06(4), Florida Statutes, to the Agency for Health Care Administration. Such transfer shall take effect July 1, 1993.

It is certified that effective July 1, 1993, the Agency for Health Care Administration is the single state agency designated to administer Title XIX of the Social Security Act as amended in the State of Florida.

Sincerely,

Robert A. Butterworth  
Attorney General

RAB/fjl
February 16, 1987

Mr. Richard L. Warren  
Acting Associate Regional Administrator  
Health Care Financing Administration  
Division of Program Operations  
101 Marietta Tower, Suite 702  
Atlanta, Georgia 30323

Dear Mr. Warren:

We have reviewed the eligibility sections of the Waivers of State Plan Provisions, preprint of page 13-52 of Section 13100 of the State Medicaid Manual, for the Aged and Disabled Waiver, the Home and Community-Based Frail Elderly Waiver and the Channeling Waiver. Please note that the regulatory reference to CFR 435.232 in these documents should be updated to CFR 435.217 since the federal regulations redesignated CFR 435.232 to CFR 435.217. Pen and ink changes have been made to our copies of these documents in order to reflect this regulatory redesignation.

Please contact John Lenaerts at (904) 487-2618 if you have any questions or need any additional information.

Sincerely,

[Signature]

Judy B. Mitchell  
Deputy Assistant Secretary  
for Medicaid

JEM: JL: nr

1317 WINEWOOD BLVD. • TALLAHASSEE, FL 32301
Bob Martinez, Governor
State: Florida

Type of Waiver

- 1915(b)(1) - Case Management System
- 1915(b)(2) - Locality as Central Broker
- 1915(b)(3) - Sharing of Cost Savings (through:
  Additional Services
  Elimination of Copayments
- 1915(b)(4) - Restriction of Freedom of Choice
- 1915(c) - Home and Community-Based Services Waiver (non-model format)
- 1915(c) - Home and Community-Based Services Waiver (model format)
- 1916(a)(3) and/or (b)(3) - Nominality of Copayments

Title of Waiver and Brief Description:

"Degenerative Spinocerebellar Condition Model Waiver"
Case Management and respite care for individuals with degenerative diseases of the central nervous system who would otherwise be confined to a hospital.

Approval Date: June 14, 1991
Renewal Date(s): July 14, 1994
Effective Date: July 01, 1991

Specific State Plan Provisions Waived and Corresponding Plan Section(s):

- Comparability: Section 1902(a)(10)(B) of the Act.
- Statewideness: N/A
- Freedom of Choice: N/A
- Services: Case management and respite care.

Eligibility: Individuals diagnosed as having a degenerative spinocerebellar disease, who meet risk of hospitalization level of care as well as the requirements of the special home and community-based optional categorically needy group specified in section 1902(a)(10)(A)(ii)(IV) of the Act. Individuals whose projected total cost of care under this waiver exceeds the total cost of institutional and acute care without the waiver are not eligible for participation.

Reimbursement Provisions (if different from approved State Plan Methodology):
Fee for service - established fee schedule for services covered under this waiver.

Signature of State Medicaid Director Date

13-52

Amendment 92-53
Effective 10/1/92
Supersedes New
Approval Date DEC 29 1992
WAIVERS OF STATE PLAN PROVISIONS

State:

Type of Waiver:
- 1915(b)(1) - Case Management System
- 1915(b)(2) - Locality as a Central Broker
- 1915(b)(3) - Sharing of Cost Savings (through):
  - Additional Services
  - Elimination of Copayments
- 1915(b)(4) - Restriction of Freedom of Choice
- 1915(c) - Home and Community-Based Services Waiver (non-model format).
- Home and Community-Based Services Waiver (model format).
- 1916(a)(3) and/or (b)(3) - Nominality of Copayments

Title of Waiver and Brief Description:
Channeling Waiver

Approval Date: 6/5/85
Renewal Date(s): 7/1/88 (approved 6/16/88)
Effective Date: 7/85

Specific State Plan Provisions Waived and Corresponding Plan Section(s):

Comparability: Section 1902 (a)(10)(B) of the Act

Statewideness: Section 1902 (a)(1) of the Act

Freedom of Choice: N/A

Services: Homemaker/personal care, case management, skilled nursing services, special home delivered meals, physical therapy, housekeeping/chore services, minor physical adaptations to the home, consumable medical supplies, home health aide, companion, adult day care, respite care, mental health services, occupational and speech therapy, medical/alert response system, caregiver training/support, spec.

Eligibility: drug and nutritional assessments, and financial education and protection.

Persons 65 years of age or older and eligible under Florida's categorical financial assistance program or financially eligible under ICP. Eligible persons must meet the provisions of CFR 435.120, 435.217 and 435.726.

Reimbursement Provisions (if different from approved State Plan Methodology):

Medicaid will reimburse the Miami Jewish Home and Hospital for the Aged, Inc., and other Channeling providers on a monthly basis for the provision of channeling home and community-based services.

Signature of State Medicaid Director: [Signature]
Date: 9/15/88

Amendment 88-29
Effective 7/1/88
Supercedes 87-5
Approved 11/10/88
WAIVERS OF STATE PLAN PROVISIONS

State:

Type of Waiver

☐ 1915(b)(1) - Case Management System
☐ 1915(b)(2) - Locality as a Central Broker
☐ 1915(b)(3) - Sharing of Cost Savings (through:)
  Additional Services
  Elimination of Copayments
☐ 1915(b)(4) - Restriction of Freedom of Choice
  1915(c) - Home and Community-Based Services Waiver (non-model format).
  ☐ Home and Community-Based Services Waiver (model format).
☐ 1916(a)(3) and/or (b)(3) - Nominality of Copayments

Title of Waiver and Brief Description:

Mentally Retarded and Developmentally Disabled

Approval Date: 6/14/85
Effective Date: 5/15/85
Renewal Date(s): Extension 5/15/88-6/30/88
                 7/1/88 (approved 8/3/88)

Specific State Plan Provisions Waived and Corresponding Plan Section(s):

Comparability: Section 1902 (a)(10)(B) of the Act.

Statewideness: N/A

Freedom of Choice: N/A

Services:
Adult day health, case management, respite care, specialized home management/homemaker, transportation, developmental training, diagnosis, and evaluation, family placement, training, and therapy services.

Eligibility:
Categorically needy and medically needy who would require ICF/MR level of care that are retarded, autistic, have cerebral palsy, epilepsy or disabled under the definition of P.L. 95-602.

Reimbursement Provisions (if different from approved State Plan Methodology):

Signature of State Medicaid Director

Amendment 88-29
Effective 7/1/88
Supercedes 87-5
Approved 11/10/88
WAIVERS OF STATE PLAN PROVISIONS

State:

Type of Waiver

☐ 1915(b)(1) - Case Management System
☐ 1915(b)(2) - Locality as a Central Broker
☐ 1915(b)(3) - Sharing of Cost Savings (through:)
  Additional Services
  Elimination of Copayments
☐ 1915(b)(4) - Restriction of Freedom of Choice
  1915(c) - Home and Community-Based Services Waiver (non-model format).
  ☐ Home and Community-Based Services Waiver (model format).
☐ 1916(a)(3) and/or (b)(3) - Nominality of Copayments

Title of Waiver and Brief Description:

Aged and Disabled

Approval Date: 4/26/82  Renewal Date(s): 4/1/85 (Approved 3/6/85)
Effective Date: 4/1/82  Extension 4/1/88 - 6/29/88
6/30/88 (Approved 6/24/88)

Specific State Plan Provisions Waived and Corresponding Plan Section(s):

Comparability: Section 1902 (a)(10)(B) of the Act

Statewideness: N/A

Freedom of Choice: N/A

Services: Adult day health care services, case management services, respite care, transportation and specialized homemaker/home management services, counseling services, escort services, health support services, personal care and placement.

Eligibility: Includes categorically eligible persons and the special income group. The procedures in 42 CFR 435.217, 435.726 and 435.120 are followed.

Reimbursement Provisions (if different from approved State Plan Methodology):

Signature of State Medicaid Director Date

Amendment 88-29
Effective 7/1/88
Supercedes 87-5

Approved 11/10/88
WAIVERS OF STATE PLAN PROVISIONS

State:

Type of Waiver

☐ 1915(b)(1) - Case Management System
☐ 1915(b)(2) - Locality as a Central Broker
☐ 1915(b)(3) - Sharing of Cost Savings (through):
  - Additional Services
  - Elimination of Copayments
☐ 1915(b)(4) - Restriction of Freedom of Choice
☐ 1915(c) - Home and Community-Based Services Waiver (non-model format).
☐ 1916(a)(3) and/or (b)(3) - Nominality of Copayments

Title of Waiver and Brief Description:

Services to Residents of Homes for Special Services

Approval Date: 9/4/86
Renewal Date(s):
Effective Date: 8/1/86
Cancelled effective 6/30/88

Specific State Plan Provisions Waived and Corresponding Plan Section(s):

Comparability: Section 1902 (a)(10)(B) of the Act

Statewideness: Section 1902 (a)(1) of the Act

Freedom of Choice: N/A

Services: Case Management, Personal Care, Occupational Therapy, Physical Therapy.

Eligibility: Persons 18 years of age and older and eligible under Florida categorical financial assistance program or financially eligible under ICP. Eligible persons must meet provisions of CFR 435.120, 435.217 and 435.726.

Reimbursement Provisions (if different from approved State Plan Methodology):

Medicaid will reimburse the provider on a monthly per diem basis for the provision of home and community-based services.

Signature of State Medicaid Director

Amendment 88-29
Effective 7/1/88
Supercedes 87-5
Approved 11/10/88
WAIVERS OF STATE PLAN PROVISIONS

State:

Type of Waiver

☐ 1915(b)(1) - Case Management System
☐ 1915(b)(2) - Locality as a Central Broker
☐ 1915(b)(3) - Sharing of Cost Savings (through):
  Additional Services
  Elimination of Copayments
☐ 1915(b)(4) - Restriction of Freedom of Choice
  1915(c) - Home and Community-Based Services Waiver (non-model format).
☐ 1915(c) - Home and Community-Based Services Waiver (model format).
☐ 1916(a)(3) and/or (b)(3) - Nominality of Copayments

Title of Waiver and Brief Description:

Home and Community-Based Frail and Elderly

Approval Date: 1/23/85

Renewal Date(s):

Effective Date: 1/85

Specific State Plan Provisions Waived and Corresponding Plan Section(s):

Comparability: Section 1902 (a)(10)(B) of the Act
Statewideness: Section 1902 (a)(1) of the Act
Freedom of Choice: N/A
Services:
Medical case management, caregiver health support training, respite care, personal care, escort services, health support services, and specialized home management services.

Eligibility:
Individuals who meet SNF or ICF admission criteria, ICP level of income standard for the medically dependent, frail and elderly or Florida's categorical financial assistance program. The procedures in 42 CFR 435.217, 435.726, and 435.120 are followed.

Reimbursement Provisions (if different from approved State Plan Methodology):

Medicaid will reimburse providers on an interim basis for the provision of home and community-based services to the frail and elderly.

Signature of State Medicaid Director

Date:

Amendment 88-29
Effective 7/1/88
Supercedes 87-5

Approved 11/10/88
State: Florida

Type of Waiver:
- [ ] 1915(b)(1) - Case Management System
- [ ] 1915(b)(2) - Locality as a Central Broker
- [ ] 1915(b)(3) - Sharing of Cost Savings (through: Additional Services Elimination of Copayments
- [ ] 1915(b)(4) - Restriction of Freedom of Choice
- [X] 1915(c) - Home and Community-Based Services Waiver (non-model format).
- [ ] Home and Community-Based Services Waiver (model format).
- [ ] 1916(a)(3) and/or (b)(3) - Nominality of Copayments

Title of Waiver and Brief Description:
"AIDS/ARC WAIVER"
Case management and 13 home and community-based services for persons with AIDS and ARC who would otherwise be confined to an institution.

Approval Date: 7/21/89
Renewal Dates: Nov. 1, 1992
Effective Date: January 1, 1990

Specific State Plan Provisions Waived and Corresponding Plan Section(s):

- Comparability: Section 1902(a)(10)(B) of the Act.
- Statewideness: Section 1902(a)(1) of the Act.
- Freedom of Choice: N/A

Services: Case management, homemaker, specialized personal care to foster children, personal care, home delivered meals, day health care, respite care, skilled nursing, chore services, home modification, adaptive equipment, consumable medical supplies, home substance abuse, and educational and support services.

Eligibility: Individuals diagnosed as having AIDS or ARC or related conditions, who meet SNF or hospital level of care, and who are categorically eligible under the state plan or otherwise meet special requirements of 42 CFR 435.217 and 42 CFR 435.726.

Reimbursement Provisions (if different from approved State Plan Methodology):
Fee for service - established fee schedule for services covered under this waiver.

Signature of State Medicaid Director

13-52
State: Florida

Type of Waiver

- 1915(b)(1) - Case Management System
- 1915(b)(2) - Locality as a Central Broker
- 1915(b)(3) - Sharing of Cost Savings (through):
  - Additional Services
  - Elimination of Copayments
- 1915(b)(4) - Restriction of Freedom of Choice
- 1915(c) - Home and Community-Based Services Waiver (non-model format).
- 1915(c) - Home and Community-Based Services Waiver (model format).
- 1916(a)(3) and/or (b): - Nominality of Copayments

Title of Waiver and Brief Description: Managed Health Care

Medicaid Physician Access System (MediPass) is a physician primary care case management system designed to assure adequate access to primary care by Medicaid recipients, to reduce inappropriate utilization, and to control program costs.

Approval Date: January 24, 1990 Renewal Date(s): October 1, 1993

Effective Date: October 1, 1991

Specific State Plan Provisions Waived and Corresponding Plan Section(s):

Comparability: 1902(a)(10)

Statewideness: 1902(a)(1)

Freedom of Choice: 1902(a)(23)

Services: Physician services, except ophthalmology, psychiatry, or obstetrical care; pharmacy when the prescription is issued by the primary physician, hospital inpatient, hospital outpatient, home health agency, laboratory and X-ray, ambulatory surgical center, rural health center, podiatry, ARNP, and EPSDT.

Eligibility: AFDC and AFDC-related medical assistance only recipients in Pinellas, Pasco, Hillsborough, and Manatee counties.

Reimbursement Provisions (if different from approved State Plan Methodology):

A $3.00 per month, per enrollee management fee will be paid in addition to regular Medicaid fee-for-service reimbursement.

Signature of State Medicaid Director

Date: 8/4/91

Amendment 91-34
Effective 10/1/91
Supersedes NEW Approval 11-8-91
State: 

Type of Waiver:

- [ ] 1915(b)(1) - Case Management System
- [ ] 1915(b)(2) - Locality as a Central Broker
- [ ] 1915(b)(3) - Sharing of Cost Savings (through:)
  - Additional Services
  - Elimination of Copayments
- [ ] 1915(b)(4) - Restriction of Freedom of Choice
- [ ] 1915(c) - Home and Community-Based Services Waiver (non-model format).
- [ ] Home and Community-Based Services Waiver (model format).
- [ ] 1916(a)(3) and/or (b)(3) - Nominality of Copayments

Title of Waiver and Brief Description:

Mentally Retarded and Developmentally Disabled

Approval Date: 6/14/85

Effective Date: 5/15/85

Renewal Date(s): Extension 5/15/88-6/30/88
  7/1/88 (approved 8/1/88)

Specific State Plan Provisions Waived and Corresponding Plan Section(s):

Comparability: Section 1902(a)(10)(B) of the Act.

Statewideness: N/A

Freedom of Choice: N/A

Services:

Case management, respite care, transportation, developmental training, diagnosis and evaluation, family placement, training, and therapy services.

Eligibility:

Categorically needy and medically needy who would require ICF/MR level of care that are retarded, autistic, have cerebral palsy, epilepsy or disabled under the definition of P.L. 95-602. Eligible persons must meet the provisions of CFR 435.120, 435.217 and 435.736.

Signature of State Medicaid Director: [Signature] 8/15/85

Amendment 92-53
Effective 10/1/92
Supersedes 88-29
Approved DEC 29 1992
State:

Type of Waiver

☐ 1915(b)(1) - Case Management System
☐ 1915(b)(2) - Locality as a Central Broker
☐ 1915(b)(3) - Sharing of Cost Savings (through)
Additional Services
Elimination of Copayments
☐ 1915(b)(4) - Restriction of Freedom of Choice
1915(c) - Home and Community-Based Services Waiver (non-model format).
☐ Home and Community-Based Services Waiver (model format).
☐ 1916(a)(3) and/or (b)(3) - Nominality of Copayments

Title of Waiver and Brief Description:
Home and Community-Based Frail and Elderly

Approval Date: 1/23/85
Renewal Date(s):
Effective Date: 1/85
CANCELLED EFFECTIVE 11/1/89

Specific State Plan Provisions Waived and Corresponding Plan Section(s):

Comparability: Section 1902(a)(10)(B) of the Act
Statewideness: Section 1902(a)(1) of the Act
Freedom of Choice: N/A

Services:
Medical case management, caregiver health support training, respite care, personal care, escort services, health support services, and specialized home management services.

Eligibility:
Individuals who meet SNF or ICF admission criteria, ICP level of income standard for the medically dependent, frail and elderly or Florida's categorical financial assistance program. The procedures in 42 CFR 435.217, 435.726, and 435.120 are followed.

Reimbursement Provisions (if different from approved State Plan Methodology):
Medicaid will reimburse providers on an interim basis for the provision of home and community-based services to the frail and elderly.

Amendment 92-53
Effective 10/1/92
Supersedes 88-29
Approved DEC 29 1992
STATE OF FLORIDA
COOPERATIVE AGREEMENT
FOR MEDICAID
BETWEEN
THE AGENCY FOR HEALTH CARE ADMINISTRATION
AND
THE DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

Attachment 1.1-B
Supplement 1

Attachment 93-39
Effective 7/1/93
Supersedes 91-24
Approved 10/21/94

Revised Submission JUL 22 1994
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### Supplements

1. Medicaid Eligibility
2. Women, Infants, and Children (WIC) Program
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COOPERATIVE AGREEMENT
FOR MEDICAID
BETWEEN
THE AGENCY FOR HEALTH CARE ADMINISTRATION
AND
THE DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

The Agency for Health Care Administration (AHCA) is the single state agency responsible for the administration of Title XIX of the Social Security Act, Medicaid, in the state of Florida. The Department of Health and Rehabilitative Services (HRS) is authorized to administer eligibility determinations for Medicaid and to provide or coordinate the provision of certain Medicaid services as allowed by Title XIX. HRS is the Title V, Maternal and Child Health agency.

To better service the Title XIX, Medicaid eligible citizens of Florida, the Agency for Health Care Administration and the Department of Health and Rehabilitative Services agree to the following:

I. The Agency for Health Care Administration (AHCA) will:

A. Have final authority with respect to all Medicaid policy, procedures, rules and regulations.

B. Distribute Health Care Financing Administration (HCFA) Program Issuance Transmittal Notices and Program Memorandums to HRS.

C. Maintain the Medicaid state plan, initiate and approve all amendments prior to submission to HCFA, and
distribute state plan updates to HRS and other interested parties. AHCA will coordinate with HRS on any amendment that impacts on the mission of HRS, its programs or its budget.

D. Approve all Medicaid policy, prior to implementation, that is developed by HRS.

E. Approve all administrative rules pertaining to Medicaid, prior to implementation, which are promulgated by HRS.

F. Coordinate with HRS on all administrative rules that AHCA promulgates and that pertain to the mission of HRS, its program or its budget. AHCA will:

1. Obtain the consultation of the Secretary of HRS, prior to adoption, of any rule that has a direct impact on the mission of HRS, its programs or its budget; and

2. Obtain the consultation of the Secretary of HRS on any rule that indirectly impacts on the mission of HRS, its programs or its budget.

3. Provide HRS with written notice of new policy directives at least sixty (60) days prior to implementation, unless otherwise directed by state or federal law.

G. Handle all payment of Medicaid claims.

H. Enroll all Medicaid providers.

I. Assist recipients in locating enrolled providers, and assist recipients and providers with Medicaid claims resolution.

6/22/94 Date
Douglas M. Cook

2/1/94 Date
H. James Towey

Amendment 93-39
Effective 7/1/93
Supersedes 91-24
Approved 10/21/94

Revised Submission 10/22/93

2 Revised Submission JUL 22 1994
J. Process all overpayment reports and all benefit recovery activities for providers of Medicaid services.

K. Maintain the Florida Medicaid Management Information System (FMMIS), the Medicaid information system for recipient eligibility, provider enrollment, claims payment, and surveillance and utilization review.

II. Department of Health and Rehabilitative Services will:

A. Conduct Medicaid related functions in accordance with the approved Medicaid state plan, Title XIX of the Social Security Act, and all other applicable federal and state laws and regulations as approved and directed by AHCA.

B. Assist AHCA with identifying needed amendments to the Medicaid state plan, policy manuals, and administrative rules.

C. Obtain AHCA’s approval on all policy, procedures, and rules pertaining to Medicaid that HRS develops.

D. Conduct fair hearings pursuant to 42 CFR Part 431, Subpart E for Medicaid applicants and recipients pertaining to eligibility authorization and benefit authorization.

E. Investigate and report on civil rights complaints by Medicaid recipients.

F. Remain the designated single state agency to receive Beneficiary and Earnings Data Exchange (Bendex) and State Data Exchange (SDX) tapes from the Social Security Administration.
III. Transfer of Title XIX funding:

A. AHCA will be the sole source of receipt of federal matching funds for Title XIX, Medicaid, and will draw down on letter of credit the federal grant matching funds for allowable expenditures for AHCA and HRS.

B. HRS will earn funding and financial participation through Title XIX, Medicaid, for allowable direct costs and allowable indirect costs in accordance with the cost allocation plan approved by HCFA.

C. The draw down by letter of credit of federal funds by AHCA for HRS does not relieve either HRS or AHCA of the responsibility for compliance with federal and state rules and regulations regarding cash management and effective control over the accountability for funds.

D. HRS will submit monthly expenditure reports to AHCA for the allowable costs and will maintain supporting records for review by state and federal auditors.

E. At least biweekly, HRS will submit requests to AHCA for the draw down of federal matching funds.

F. AHCA will deposit the Title XIX funds requested by HRS into the accounts designated by HRS for the receipt of those funds.

G. AHCA will prepare the quarterly federal grant expenditure reports based on allowable expenditures made by AHCA and on the allowable expenditures reported by HRS to AHCA.

H. AHCA will prepare the quarterly reports for the
estimating of federal grant funding requirements based on
the estimated allowable costs projected by AHCA and on the
estimated allowable costs projected and reported by HRS to
AHCA.

I. AHCA will prepare quarterly reports for the Refugee
Medical Assistance Program as required by the grant that
funds the program.

J. HRS is responsible for the state share of all
administrative costs that it incurs.

K. AHCA will reduce future deposits to HRS for Title
XIX, Medicaid, federal earnings in an amount equal to any
funds received by HRS through the Title XIX grant that are
subsequently deferred or disallowed by HCFA, federal
auditors, or state auditors for failure to comply with the
terms and conditions of the grant award or for unallowable
expenses.

L. Upon request by AHCA, HRS agrees to transfer to the
accounts designated by AHCA the state matching funds
appropriated to HRS, which are intended to support payments
made by AHCA to Medicaid providers for allowable Medicaid
services rendered to Medicaid eligible recipients.

IV. Transfer of Funding for Grants for which HRS is the
Grantee:

A. AHCA will earn funding and financial participation
for expenditures incurred related to the State Legalization
Impact Assistance Grant (SLIAG), the Infants With Disability
Education Act Part H Grant (Toddlers and Infants Grant), the Refugee Assistance Grant, and to other grants that may arise in the future.

B. HRS will be the sole source for receipt of federal matching funds for the SLIAG, Toddlers and Infants, Refugee Assistance grants, and any future grants and will draw down on letter of credit the federal grant matching funds for allowable expenditures for HRS and AHCA.

C. The draw down by letter of credit of federal funds by HRS for AHCA does not relieve either AHCA or HRS of the responsibility for compliance with federal and state rules and regulations regarding cash management and effective control over the accountability for funds.

D. AHCA will submit quarterly expenditure reports to HRS for the allowable costs and will maintain supporting records for review by state and federal auditors.

E. Periodically AHCA will submit requests to HRS for the transfer of the federal funds earned by AHCA under the grants.

F. HRS will transfer the funds requested by AHCA into the accounts designated by AHCA for the receipt of those funds.

G. HRS will prepare the quarterly federal grant expenditure reports based on allowable expenditures made by HRS and on the allowable expenditures reported by AHCA to HRS.

H. HRS will prepare the reports for the estimating of
federal grant funding requirements based on the estimated allowable costs projected by HRS and on the estimated allowable costs projected and reported by AHCA to HRS.

I. AHCA is responsible for the state share of all administrative costs that it incurs.

J. HRS will reduce future deposits to AHCA for grant earnings in an amount equal to any funds received by AHCA through the grant that are subsequently deferred or disallowed by federal auditors or state auditors for failure to comply with the terms and conditions of the grant award or for unallowable expenses.

K. Based upon request by HRS, AHCA agrees to transfer to the accounts designated by HRS the state matching funds appropriated to AHCA but which are intended to support payments made by HRS to grant program providers for allowable grant services rendered to grant eligible recipients.

L. The State Legalization Impact Assistance Grant (SLIAG). Effective, July 1, 1993 through September 30, 1994 or whenever SLIAG is discontinued by HRS, AHCA is responsible for documenting the federal reimbursement for the state Medicaid program, administered by AHCA and approved in the state’s application to the Department of Health and Human Services, Division of State Legalization and Repatriation. AHCA will submit appropriately structured Cost Documentation System (CDS) tapes to the HRS Refugee Programs Administration Office for processing to determine
Eligible Legalized Alien (EtLA) prior and current year service utilization and reimbursement of approved AHCA administered service programs. AHCA will prepare the appropriate invoice for reimbursement based on the results of the CDS tape match and submit the invoice to the HRS Refugee Programs Administration Office for approval. In addition, administrative costs (current positions approved by the Refugee Programs Administration Office, tape processing, etc.) will be reimbursed through the invoice process. Position costs currently paid as a direct HRS salary cost to SLIAG will no longer be considered a salaried cost of HRS effective July 1, 1993. All AHCA SLIAG costs (service programs and administration) must be reimbursed through the invoice process. Once the invoice is approved by Refugee Programs Administration Office, the HRS Revenue Management Office will transfer the approved amount of SLAIG reimbursement to AHCA.

V. Exchange of Information:

Exchange of information between the agencies will be effected through an established referral process, joint consultation, exchange of social and medical summaries, pertinent correspondence, and forms devised for the purposes of exchange of specific information.
VI. Safeguarding Information:

AHCA and HRS agree to safeguard the use and disclosure of and restrict access to information concerning applicants for or recipients of Title XIX services in accordance with federal and state laws and regulations.

VII. Effective Period of Agreement:

This agreement by and between the Agency for Health Care Administration (AHCA) and the Department of Health and Rehabilitative Services (HRS) will be effective on July 1, 1993. It shall continue in full force and effect until otherwise revised in writing and signed by both parties or canceled by any one of the two parties upon written notice at least ninety (90) days prior to the proposed termination date.

July 1, 1993
Date

Douglas M. Cook
Director
Agency for Health Care Administration

July 1, 1993
Date

H. James Towey
Secretary
Department of Health and Rehabilitative Services

Amendment 93-39
Effective 7/1/93
Supersedes 91-24
Approved 10/21/94

Revised Submission 10/22/93
MEDICAID ELIGIBILITY

The Agency for Health Care Administration has authorized the Department of Health and Rehabilitative Services to administer eligibility determinations for Title XIX, Medicaid, benefits. The following HRS program offices determine eligibility. The Aging and Adult Services Program Office determines eligibility for institutional care programs and for aged, blind and disabled individuals, except determinations for Supplemental Security Income (SSI) are conducted by the Social Security Administration. The Economic Services Program Office determines eligibility for pregnant women, families and children, and refugees.

The Agency for Health Care Administration and the Department of Health and Rehabilitative Services agree to the following provisions pertaining Medicaid eligibility determinations:

I. Agency for Health Care Administration (AHCA) will:

A. Produce and distribute Medicaid identification cards for all eligible recipients.

B. Pursue payment for Medicaid claims from third party liability resources. AHCA will:

1. Enter into the necessary interagency agreements to perform the data exchanges required by the Income and Eligibility Verification System (IEVS) and other
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Medicaid Eligibility

federal and state laws and regulations pertaining to third party recovery.

2. Inform HRS, upon discovery, of any settlement awarded directly to a Medicaid recipient; and

3. Inform HRS of any recipient who fails to cooperate in the pursuit of third party resources.

C. Maintain the Medicaid recipient file on the Florida Medicaid Management Information System (FMMIS). AHCA will:

1. Obtain recipient eligibility information via an electronic interface with the HRS eligibility and benefit authorization system, Florida Online Recipient Integrated Data Access System (FLORIDA);

2. Obtain recipient eligibility information via manually completed forms for recipients who are not entered on the FLORIDA system or whose eligibility period is not entered on the FLORIDA system.

3. Inform HRS and collaborate with HRS in the correction of any incorrect recipient eligibility information that is received either by the electronic interface or manually completed forms;

4. Perform all required data exchanges to comply with the Income Eligibility Verification System (IEVS) requirement and third party recovery laws and regulations;

5. Provide HRS with all necessary data for
Medicaid overpayment and recovery activities and Medicaid Quality Control;

6. Provide HRS all necessary data pertaining to recipient enrollment in Health Maintenance Organizations (HMO) and the Medicaid Physician Access System (MediPass);

7. Assist HRS with the resolution of buy-in problems;

8. Provide HRS with access to FMMIS; and

9. Provide HRS with statistical and financial data as requested for policy analysis and research.

D. Provide instruction to HRS in county billing procedures, assist HRS in resolving county billing problems, and maintain certificate of residency forms.

II. The Department of Health and Rehabilitative Services (HRS) will:

A. Conduct eligibility determinations in accordance with the approved Medicaid state plan; Title XIX of the Social Security Act; 42 Code of Federal Regulations (CFR) Part 431 (Medical Assistance Programs, State Organization and General Administration) and 42 CFR Part 435 (Medical Assistance Programs, Eligibility); and all other applicable federal and state laws and regulations as directed by AHCA.

B. Develop and implement Medicaid eligibility policy. HRS will obtain AHCA's approval of Medicaid eligibility policy prior to implementation.
C. Promulgate all administrative rules relative to Medicaid eligibility. HRS will obtain the approval of the Director of Medicaid prior to adoption of any rule that pertains to Medicaid.

D. Process all overpayment reports and all benefit recovery activities for recipients.

E. Obtain information for Medicaid Third Party Liability from all recipients when the presence of health insurance is indicated. HRS eligibility staff will take appropriate action in accordance with 42 CFR Part 433, Subpart D (Third Party Liability) when informed by AHCA that a recipient failed to cooperate in the pursuit of third party resources.

F. Maintain the FLORIDA system, the HRS information system to determine eligibility and authorize benefits. HRS will:

1. Transmit recipient eligibility information via an electronic interface with FMMIS;

2. Ensure that the recipient eligibility information is accurate and up to date; and collaborate with AHCA in correcting any incorrect information that is transmitted via the electronic interface;

3. Receive and load onto the FLORIDA system, the Bendex and SDX tapes from the Social Security Administration;
4. Provide AHCA the Bendex and SDX data that pertains to Medicaid eligibility, third party resources, and Medicare Part A and B entitlement; and

5. Operate applicable data exchanges to comply with the IEVS requirement and third party recovery laws and regulations, and transmit this data to AHCA.

G. Transmit eligibility information via manually completed forms for recipients who are not entered on the FLORIDA system or whose eligibility period is not entered on the FLORIDA system.

H. Conduct Medicaid eligibility Quality Control and Claims Processing system (CPAS) reviews, be fully responsible for Medicaid Quality Control sampling and meeting the federal review requirements, and the submission of the annual corrective action plan.

I. Pursue estate recovery on deceased recipients per applicable federal and state laws and regulations.

J. Distribute FMMIS error reports and nursing home discharge reports to the district offices.
WOMEN, INFANTS, AND CHILDREN (WIC)

The Department of Health and Rehabilitative Services, State Health Office administers health services programs in county public health units and oversees the Special Supplemental Food Program for Women, Infants and Children (WIC). The Department of Health and Rehabilitative Services, Economic Service Program Office administers eligibility determinations for pregnant women, families and children, and refugees. The Agency for Health Care Administration, Medicaid Office and Department of Health and Rehabilitative Services, State Health Office and Economic Services Program Office agree to the following provisions:

I. The Department of Health and Rehabilitative Services, Economic Services Program Office will ensure that:

All newly approved Aid to Families with Dependent Children (AFDC) and other Medicaid 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:

1. Advised of the benefits of the WIC program during the eligibility determination interview;

2. Referred to the local WIC program; and
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Women, Infants, and Children (WIC)

3. Given the brochure "How to Apply for WIC", HRS/PI form 150-7.

II. The Agency for Health Care Administration, Medicaid Office will ensure that:

A. The Florida Medicaid Management Information System (FMMIS), Early and Periodic Screening, Diagnosis and Treatment (EPSDT) computerized subsystem will automatically inform through computer generated notices all Medicaid EPSDT eligible children under age five and all eligible recipients under age twenty-one who might be pregnant, postpartum or breastfeeding of the benefits of participation in the WIC program. Annual notices will also be provided that include instructions for obtaining further information about the WIC program.

B. WIC program information is included in local Medicaid outreach efforts.

C. 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 by an EPSDT screening to have a medical problem or nutritional related deficiency are appropriately referred to the local WIC program.

D. Medicaid Health Maintenance Organizations (HMOs) providing prenatal care and EPSDT services refer all appropriate recipients to the local WIC program.
III. The Department of Health and Rehabilitative Services, State Health Office will ensure that all Medicaid eligible referrals to the WIC program are:

A. Assessed for determination of eligibility for WIC services.

B. Provided WIC services if eligible within the limitation of the local program.

C. Referred for or provided an EPSDT screen if not previously screened in accordance with the established periodicity schedule.
EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT
(EPSDT) OF MEDICAID ELIGIBLE CHILDREN UNDER AGE 21

The following Department of Health and Rehabilitative Services program offices provide or coordinate the provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. The Economic Service Program Office administers eligibility determinations for pregnant women, families and children, and refugees. The Children and Families Program Office administers child welfare programs. The State Health Office administers health services programs. Children's Medical Services administers services for children with special health needs and programs for children from birth to three years of age with developmental disabilities. The Developmental Services Program Office administers programs for individuals, three years of age and older, with developmental disabilities. The Alcohol, Drug Abuse and Mental Health Program Office is responsible for the provision of a continuum of mental health care and evaluations through contractual agreement with local mental health centers.

The Agency for Health Care Administration (AHCA) office of Medicaid and Department of Health and Rehabilitative Services (HRS) offices of Economic Service; Children's Medical Services; Children and Families; State Health;

Attachment 93-39
Effective 7/1/93
Supersedes 91-24
Approval 10/21/94
Revised Submission 10/22/93
Revised Submission JUL 2 2 1994
Developmental Services; and Alcohol, Drug Abuse and Mental Health agree to the following provisions:

I. The AHCA Medicaid Office and all coordinating HRS headquarters program offices will:

A. Ensure that the EPSDT screen is utilized as the initial health care assessment for all EPSDT eligible children served by HRS.

B. 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 HRS.

C. Coordinate with and obtain the approval of the AHCA Medicaid Office on issuance of policy guidelines, training and technical assistance procedures regarding the EPSDT program.

D. When established, serve on the statewide EPSDT coordinating committee with the function of providing technical assistance and statewide coordination of the EPSDT program.

E. Share applicable child health information, reports and statistical data with coordinating program offices.

F. Coordinate with the AHCA Medicaid 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.

G. 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 AHCA Medicaid Office will:

A. Provide through Medicaid fiscal agent contractor and the Medicaid contract management unit, monthly reports of EPSDT recipients informed of services, due screenings, screened and requiring treatment. Reports will be distributed monthly to the area Medicaid offices. The area EPSDT administrative case managers will distribute the reports to the county public health units.

B. Ensure that reimbursement is made to eligible providers based upon correct billing procedures as outlined in the appropriate provider handbook.

C. Serve as liaison among all offices involved in the EPSDT program.

D. Ensure through coordination with the headquarters HRS offices of Economic Service; Children and Families; State Health; Children’s Medical Services; Developmental Services; and Alcohol, Drug Abuse and Mental Health that procedures for EPSDT case management as mandated by federal regulations are implemented.

E. Ensure that training in EPSDT screening, treatment, and case management services is provided to area AHCA Medicaid office staff and providers.
F. Ensure that area AHCA procedures for EPSDT case management are accurate and up-to-date 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.

G. Ensure that EPSDT subsystem informing letters are developed and mailed to recipients in accordance with EPSDT informing standards.

H. Share applicable screening data and statistical reports with coordinating program offices.

I. Coordinate EPSDT special projects with other social service agencies, public health units and other program offices.

J. Develop and disseminate EPSDT outreach materials to recipients, area staff, providers and community groups in accordance with federal EPSDT regulations.

III. Headquarters HRS Economic Service Program Office will:

A. Ensure that all newly approved Aid to Families with Dependent Children (AFDC), other Medicaid 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
area procedures guide and documented in the case file.

B. Ensure that HRS Form 1248 is issued and forwarded to the EPSDT case managers and to district Women, Infants and Children (WIC) coordinators.

C. Ensure that the indicator on the FLORIDA System regarding EPSDT referrals is accurate and up-to-date for each newly eligible, reapproved or reenrolled public assistance or Child In Care (CIC) recipient. The indicator should be completed as follows:
   \[ \begin{align*}
   Y &= \text{Yes, acceptance of EPSDT services} \\
   N &= \text{No, refusal of EPSDT services}
   \end{align*} \]

D. Ensure that correct information pertaining to EPSDT is transmitted from the FLORIDA system to FMMIS via the electronic interface.

IV. Headquarters HRS Children and Families Program Office will:

A. Ensure that Medicaid Administrative Case Management activities are provided in accordance with state and federal Title XIX regulations.

B. Ensure that all Medicaid eligibles for whom the Children and Families Program Office has lead responsibility are issued a valid Medicaid identification card.

C. Ensure that case managers are notified when a child in HRS care becomes eligible for EPSDT services.

D. Ensure that changes that may affect the recipient
eligibility file for all Medicaid eligibles for whom the Children and Families Program Office has lead responsibility are reported to public assistance staff in a timely manner.

V. HRS State Health Office will:

A. Supervise the administration of screening services in HRS county public health units serving as Medicaid providers.

B. 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.

C. Ensure that HRS county public health units act as screening providers and coordinate activities with the area Medicaid office.

D. Ensure that children referred to the WIC program are screened for eligibility and provided services as appropriate within existing program limitations.

E. 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.

F. Ensure that Medicaid funded case management staff provide case management services in accordance with state
and federal Title XIX regulations.

VI. Headquarters HRS Children’s Medical Services (CMS) Program Office will:

A. Supervise the administration of screening services in CMS clinics serving as Medicaid providers.

B. Ensure that Children’s Medical Services clinics act as screening and treatment providers for CMS patients and coordinate EPSDT-related activities with the area Medicaid Office.

C. Ensure that targeted case management services are provided to eligible recipients as appropriate within a coordinated health care delivery system.

D. 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 HRS Developmental Services Program Office will:

A. 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.

B. Provide consultation to the Medicaid office concerning appropriate service provision for children with developmental disabilities.
VIII. Headquarters HRS Alcohol, Drug Abuse and Mental Health Program Office will:

A. 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.

B. 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.

C. Ensure that targeted case management services are provided to eligible recipients as appropriate within a coordinated system of health care delivery.

IX. Confidentiality:

A. The use or disclosure of information concerning applicants and recipients is restricted to purposes directly related to administration of the Medicaid State Plan.

B. 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.

C. Medical information is privileged and may only be released with the patient's permission.
D. 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 Medicaid identification number, providing the following confidentiality requirements are met.

E. The following criteria specifies the conditions for release and use of information about applicants and recipients:

1. 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.

2. 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.

3. Written permission must be secured from a family or individual before responding to a request for information from an outside source.

4. Information may be exchanged when the agency is located within the state structure if the regulatory
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requirements for safeguarding information on applicants and recipients are met.
HEALTHY START

The State Health Office within the Department of Health and Rehabilitative Services is responsible for administering the Healthy Start Initiative, as defined in the Healthy Start Act of 1991, and for specifically selecting and administering prenatal and infant health care coalitions.

The purpose of the Healthy Start Initiative is to assure that all pregnant women and infants have access to prenatal and infant care through development of locally coordinated systems of care, with emphasis in assuring access for Medicaid eligible women and infants. 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 who have an active interest in maternal and child health.

I. The Department of Health and Rehabilitative Services is responsible to:

A. Select local coalitions through an application process.

B. Prepare contracts with selected coalitions detailing the required work products and time frames.

C. Ensure that the coalitions develop coordinated
systems of care and perform the following functions:

1. Assess community service area (for example: demographics, estimate of numbers eligible, location of groups);

2. Develop resource inventories of service area;

3. Determine components of local provider networks and recruit a network of providers;

4. Identify at risk groups;

5. Identify unmet service needs;

6. Identify barriers to care (for example: access to affordable care, provider availability, acceptance of Medicaid reimbursement, Medicaid eligibility);

7. Develop outreach programs to identify and intervene with patients early in their care;

8. Develop outcome objectives;

9. Develop prenatal and infant health care services plans that will lead to coordinated systems of care;

10. Allocate HRS State Health Office funding resources to providers;

11. Implement the health care services plans; and

12. Monitor service delivery, and implement a quality improvement program.

D. Identify state funding resources in the State Health Office budget for coalitions to allocate to providers for providing non-Medicaid covered services;

E. Assure that local agencies including HRS county
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public health units (CPHUs), district offices and other parties remain informed and participate in these coordinated systems of care;

F. Serve as contract manager for the coalitions and monitor contracts to assure that stated deliverables are provided and established objectives are met. This will be done through review of deliverables, 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;

G. Provide training and technical assistance to coalitions as needed to assist in compliance with contract provisions and facilitate development of coordinated systems of care.

II. The Agency for Health Care Administration is responsible to:

A. Provide training and technical assistance to coalitions on Medicaid programs and policies.

B. Provide to the coalitions information regarding Medicaid providers as required for conducting community assessment.

C. Assist the State Health Office in monitoring the coalition contracts.

D. Assist coalitions in efforts to develop a comprehensive provider network that serves indigent clients.

E. Actively recruit providers to participate in the Medicaid program.
F. 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.

III. Funding:

A. Funding shall be earned by the Department of Health and Rehabilitative Services through Title XIX, Medicaid. Allowable costs for the coalition contracts shall be allocated to Medicaid at a rate of match equalling 45 percent of the total funding awarded through contract with each coalition. The 45 percent matching rate assumes that 90 percent of coalition services relate to Medicaid eligible women. If upon audit the percent is adjusted downward and funding is disallowed at the 45 percent rate, HRS is responsible for the funding of the disallowance.

B. The Healthy Start Act requires a local cash or in-kind contribution of 25 percent of the cost of the coalition. Medicaid's financial participation shall be 50 percent of the net coalition expenditures (total less local cash or in-kind contributions).

C. Funds advanced under the coalition contracts will be funded 100 percent from state General Revenue funds. Only actual expenditures will be reimbursable under Medicaid.

D. The State Health Office shall provide the general revenue required to fund 50 percent of the net expenditures (less local cash or in-kind contributions).
E. The State Health Office is responsible for funding any expenditures disallowed by HCFA related to the coalition contracts.

F. The Medicaid Office will audit expenditures under these contracts at least annually in coordination with the annual financial and compliance audit conducted by HRS.
The following Department of Health and Rehabilitative Services program offices have responsibilities pertaining to institutional care. The Aging and Adult Services Program Office has responsibility for the administration of health and related programs for aged and adult individuals. Children's Medical Services has responsibility for the administration of programs and services for children with special health care needs (Title V). The Developmental Services Program Office has responsibility for the administration of supports and services for individuals who have a diagnosis of mental retardation or other developmental disability excluding epilepsy. The Alcohol, Drug Abuse and Mental Health Program Office has responsibility for the provision of a continuum of mental health care and evaluations through contractual agreements with local mental health centers.

The Agency for Health Care Administration, Division of Health Quality Assurance 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 HRS district and AHCA area office has responsibility of implementing, at the local level, prescribed utilization control policies and procedures in accordance with established state and federal rules and regulations 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 (OBRA) of 1987, and maximizing resources to better serve Medicaid institutional care applicants and recipients, these headquarters and HRS district and AHCA area offices agree to the following provisions relating to Medicaid provider facilities and their recipients (and not applicable to private pay facilities):

I. General Provisions

A. To coordinate, as applicable, with the Medicaid Office in the development and issuance of policy statements or policy changes, training, monitoring, and survey
procedures regarding applicants, recipients and providers of institutional care.

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 applicants and recipients of Medicaid institutional care 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 training to providers as necessary.

I. To provide administrative oversight and technical assistance to the district staff in the performance of designated functions.
II. The Agency for Health Care Administration (AHCA),
Medicaid Office

The Headquarters Medicaid Office shall perform the following functions:

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 the Department of Health and Human Services (HHS) regarding the Title XIX, Medicaid, 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 HRS and Health Quality Assurance, 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 Area Medicaid Offices shall perform the following functions:
A. Provide technical assistance when requested.
B. Provide oversight at the local level upon request or as deemed necessary.

III. HRS Aging and Adult Services Program Office

The State HRS 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 mental illness (MI) and mental retardation/developmental disabilities (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 pre-admission and continued placement reviews performed by the district pre-admission 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 HRS 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 Aging and Adult Services, 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 the Alcohol, Drug Abuse and Mental Health
Program Office 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 Aging and Adult Services 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. HRS Developmental Services Program Office

The State HRS 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. Provide input or respond, as necessary, to HHS inquiries relating to admission review and MR-DD screening.

D. Monitor the accuracy and timeliness of pre-admission and continued placement reviews performed by the district pre-admission teams.
The District HRS 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 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 Developmental Services 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.

K. Prepare and provide report data as needed concerning the admission review and MR-DD screening.

V. The HRS Children's Medical Services Program Office

The State HRS 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 Multiple Handicap Assessment Teams (MHAT) 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 pre-admission and continued placement reviews performed by district MHATs.

The District HRS Children's Medical Services Program Offices shall perform the following functions:

A. Ensure that each Medicaid applicant's or recipient's (age birth through 20) need for nursing facility services is evaluated by the MHAT and a level of care established or an alternate placement determination
B. Ensure that all admission reviews are performed appropriately and timely.

C. Ensure that all Medicaid nursing facility applicants (age birth through 20) who appear to have MI or MR-DD are identified.

D. Ensure that each Medicaid nursing facility applicant (age birth through 20) identified by the MHAT, or private pay applicant (age birth through 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. The MI or MR-DD evaluation must be available and considered prior to a final determination of placement of service.

E. Ensure that local Developmental Services offices are advised of all (age birth through 20) Medicaid nursing facility applicants or recipients determined to require MR-DD evaluations and ensure that the Alcohol, Drug Abuse, and Mental Health Program Office 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 through 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 in cooperation with Developmental Services or Alcohol, Drug Abuse and Mental Health when applicable perform continued placement reviews of all nursing facility residents (age birth through 20) referred by AHCA or HRS staff, and of all recipients (age birth through 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 through 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
through 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. HRS Alcohol, Drug Abuse and Mental Health Program Office

The State HRS Alcohol, Drug and Mental Health Program Office shall perform the following functions:

A. Ensure the development of a uniform MI nursing facility pre-admission 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 HRS 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 Alcohol, Drug Abuse and Mental Health 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.

VII. The Agency for Health Care Administration, Division of Health Quality Assurance will:

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;
Supplement 5

Utilization Control

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

ORGANIZATION AND FUNCTIONS OF THE MEDICAID STATE AGENCY

This attachment contains a description of the organization and functions of the state Medicaid agency, the Agency for Health Care Administration, and an organizational chart of the agency.

The head of the Agency for Health Care Administration is the director, who is appointed by the Governor.

To assist in the administration and operations of the agency, the Director appoints the Assistant Director, the General Counsel, and the Inspector General. The director also appoints deputy directors for:

- The Division of Administrative Services,
- The Division of Quality Assurance,
- The Division of Health Policy and Cost Control, and
- The Division of State Health Purchasing.

The Medicaid program is under the Division of State Health Purchasing.

The administration of the Medicaid program is the responsibility of the Director of Medicaid. The headquarters Medicaid office plans and implements policy. The eleven area Medicaid offices perform provider relations and claims resolution functions; and manage Early and Periodic Screening, Diagnosis and Treatment (EPSDT), transportation, and long term care screening programs at the local level. The area offices are headed by Area Medicaid Program Administrators, who are appointed and supervised by the Director of Medicaid.

The Florida Medicaid program is a complex operation. While the program is administered by the Medicaid Office, numerous other organizational entities have involvement in the program. The following outlines this involvement.

Amendment 93-39
Effective 7/1/93
Supersedes 89-10
Approval 10/21/94
<table>
<thead>
<tr>
<th>Agency</th>
<th>Office</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Agency for Health Care Administration</td>
<td>Division of Quality Assurance</td>
<td>Licenses or certifies Medicare and Medicaid facilities</td>
</tr>
<tr>
<td></td>
<td>Inspector General</td>
<td>Administers Medicaid utilization control and fraud and abuse investigative functions</td>
</tr>
<tr>
<td>Department of Health and Rehabilitative Services</td>
<td>Economic Services Program Office</td>
<td>Implements and determines Medicaid eligibility for AFDC-related categories, families, pregnant women and children</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Implements and determines Medicaid eligibility for SSI-related categories: aging, blind and disabled individuals</td>
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<tr>
<td></td>
<td></td>
<td>o Implements Medicaid waiver programs</td>
</tr>
<tr>
<td>Department of Health and Rehabilitative Services</td>
<td>Aging and Adult Services Program Office</td>
<td>Implements Medicaid waiver programs</td>
</tr>
<tr>
<td>Department of Health and Rehabilitative Services</td>
<td>Developmental Services Program Office</td>
<td></td>
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</tbody>
</table>

Amendment 93-39  
Effective 7/1/93  
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Approval 10/21/94
Department of Health and Rehabilitative Services

Alcohol, Drug Abuse and Mental Health Program Office

Assists with planning and implementing community mental health and state mental health programs

Department of Health and Rehabilitative Services

Children's Medical Services

Provides Medical care to children with chronic disabling conditions or potentially disabling conditions

Department of Health and Rehabilitative Services

State Health Office

- Assists with planning and implementing preventive health care programs and primary care programs
- Provides EPSDT, Family Planning and primary care services

Department of Professional Regulation

Division of Medical Quality Assurance

Licenses professional providers

Department of Labor and Employment Security

Division of Vocational Rehabilitation

Assists with the interprogram planning (spinal cord injury program)

Attachment 1.2-A

Amendment 93-39
Effective 7/1/93
Supersedes 89-10
Approval 10/21/94
<table>
<thead>
<tr>
<th>Office of the Auditor General</th>
<th>Medicaid Fraud Control Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Transportation</td>
<td>Transportation Disadvantaged Commission</td>
</tr>
<tr>
<td>Department of Education</td>
<td>Division of Blind Services</td>
</tr>
</tbody>
</table>

Attachment 1.2-A

Investigates and prosecutes Medicaid provider and recipient fraud

Coordinates planning for the transportation of disadvantaged individuals

Licenses Audiologists and Speech Pathologists

Service provider for Medicaid program

Amendment 93-39
Effective 7/1/93
Supersedes 89-10
Approval 10/21/94
AGENCY FOR HEALTH CARE ADMINISTRATION
MEDICAID OFFICE

Director of Medicaid

Personal Secretary

Sr. Human Serv. Program Administrator

Eleven Area Offices

Program Analysis

Third Party Liability and Contract Mgt.

Program Development

Managed Health Care

Amendment 93-39
Effective 7/1/93
Supersedes 89-10
Approved 10/21/94

Revised Submission JUL 22 1994
ORGANIZATION AND FUNCTION OF THE MEDICAID OFFICE

Attachment 1.2-B, Page 1 shows the organizational chart of the Medicaid Office. The major functions of the four administrative units and the eleven area offices are discussed below. Also listed is the Program Integrity unit, which is under the supervision the Inspector General for Health Care Administration.

Program Analysis
Provides the planning, research, evaluation, analysis and reporting capabilities required by the Medicaid program in the area of cost reimbursement, fiscal and budget planning, data analysis and forecasting, and alternative health plans. Directs audit programs.

Program Development
Develops, coordinates, implements and monitors Medicaid program policy so that compliance with state and federal laws is ensured and that services are made available in the most cost effective manner; and administers the program's medical authorization function. Plans and implements Medicaid provider and consumer relation activities and exceptional claims resolution, and enrolls Medicaid non-institutional providers.

Managed Health Care
Plans, develops, implements and monitors managed care programs, including home and community based waivers and freedom of choice waivers, prepaid health plans, and demonstration grant programs. Directs special projects.

Medicaid Third Party Liability and Contract Management
Plans, develops and implements third party liability policies and procedures. Manages contract for fiscal agent services to develop, operate and maintain the Florida Medicaid Management Information System (FMMIS). Oversees Medicaid eligibility program policies and procedures.

Area Medicaid Offices
The state is divided into eleven area Medicaid offices, which are under the direct supervision of the Director for Medicaid. The area offices are the local liaison to Medicaid providers and local Department of Health and Rehabilitative Services staff. The area offices are responsible for claims resolution, institutional quality of care monitoring, program training and program reviews.

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Area offices have the following professional medical personnel and supporting staff:

* **Registered Nurse Specialist** (30.5 positions): Plans, coordinates and directs activities for the medical review functions and requests for service authorizations relating to EPSDT services for children under 21 years of age.

* **Clerk Typist Specialist** (3 positions): Provides typing assistance for Registered Nurse Specialists.

* **Word Processing Systems Operator**: Provides word processing support for Registered Nurse Specialists.

**Office of Program Integrity** (Under supervision of the Agency for Health Care Administration's Inspector General's office)

Administers Medicaid utilization control and fraud and abuse investigative functions and monitors various quality of care requirements. This includes ensuring that appropriate services are furnished, detecting and investigating possible fraud and abuse; determining overpayments to providers and recouping inappropriate payments; educating providers concerning Medicaid policy; coordinating administrative sanctions and referring providers (when appropriate) to the Medicaid Fraud Control Unit in the Office of the Auditor General for criminal investigation.

Program Integrity has the following professional medical personnel:

* **Pharmaceutical Program Manager:** Supervises professional staff and coordinates functions of the medical records review and drug utilization review program.

* **Senior Pharmacist** (four positions): Professional staff for medical records review and drug utilization review activities.

AGENCY FOR HEALTH CARE ADMINISTRATION
MEDICAID OFFICE
Description of Staff

Administrative Unit

Director of Medicaid: Directs the program planning and development of the Florida Title XIX, Medicaid program.

Executive Secretary: Acts as personal secretary to the Director.

Senior Human Services Program Specialist: Serves as administrative assistant to the Director. Performs office management functions and duties related to special assignments and projects.

Program Analysis

Administrative Unit

Chief: Provides the planning, research, evaluation, analysis and reporting capabilities required by the Medicaid program in the areas of fiscal and budget planning, data analysis and forecasting, cost reimbursement, and alternative health plans.

Staff Assistant: Organizes and administers the daily administrative and operational functions of the office. Carries out public relations activities and performs research in connection with correspondence.

Fiscal Planning, Data and Research Section

Senior Management Analyst II/Coordinator: Develops the legislative budget request for Medicaid, represents the agency at the Social Services Estimating Conference, prepares data analysis and fiscal impacts.

Operations and Management Consultant Manager: Assists with development of legislative budget requests, prepares and tracks budget amendments, allocates and tracks the approved operating budget, and assists with drug rebate monitoring and tracking.

Medical/Health Care Program Analyst (five positions): Assists in the development of the legislative budget request and forecast, monitors and amends the budget, prepares extensive fiscal analyses, responds to all data requests, prepares drug rebate invoices, and tracks rebate receipts.

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Approval 10/21/94
Revised Submission 02/22/94
Cost Reimbursement Planning and Analysis Section

Regulatory Analyst Supervisor (one position): Directs the Medicaid Cost Reimbursement Planning and Analysis Administrators in the development, coordination and evaluation of Medicaid cost reimbursement plans, methodologies, special reimbursement policy studies, and rate-setting functions.

Medicaid Cost Reimbursement Planning and Analysis Administrator (three positions): Develops, directs, coordinates, and evaluates Medicaid cost reimbursement plans, methodologies, special studies, and rate-setting functions.

Administrative Secretary (two positions): Assists with the preparation and typing of special documents and correspondence. Answers phones, greets the public, and maintains files.

Regulatory Analyst III (seven positions): Performs desk audits of cost reports for hospitals, nursing homes, intermediate care facilities for developmentally disabled, federally qualified health centers, and county public health units that participate in the Medicaid program. Processes changes in ownership of facilities, and performs rate-setting functions.

Regulatory Analyst II (three positions): Performs desk audits of cost reports for hospitals, nursing homes, intermediate care facilities for developmentally disabled, federally qualified health centers, and county public health units that participate in the Medicaid program. Processes changes in ownership of facilities, and performs rate-setting functions.

Regulatory Analyst I (one position): Assists in desk audits and rate setting functions.

Medical/Health Care Program Analyst (two positions): Conducts research on cost reimbursement issues and methodologies. Prepares legislative reports and conducts special policy studies. Assists the Medicaid Cost Reimbursement Planning Administrator in the development and evaluation of Medicaid cost reimbursement plans and methodologies.

Senior Human Services Program Specialist (one position): Assists in the development, evaluation, and implementation of Medicaid cost reimbursement methodologies for institutional providers. Promulgates administrative rules and coordinates state plan amendments.

System Project Analyst (two positions): Designs and maintains the computer system and software for use by all staff in the Cost Reimbursement section. This system provides storage, retrieval, rate setting, and statistical analysis for all institutional provider reimbursement programs.

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Approval 10/21/94
Revised Submission JUL 22 1994
Computer Programmer Analyst II: Assists the System Project Analysts in maintaining the computer system and software and conducting statistical analysis for all institutional provider reimbursement programs.

Data Analysis Section

Systems Project Administrator: Develops, directs and coordinates all required systems development and data analysis required for the Medicaid office. Supervises preparation of budget forecast and reports. Analyzes computer hardware and software acquisitions and determines appropriate deployment. Develops and supervises rate-setting methodologies for the Medicaid programs.

Systems Project Analyst (three positions): Develops and maintains all required data systems. Performs required data analysis for policy decision-making, including budgeting, rate-setting and new program development. Coordinates data exchange with the fiscal agent, including ad hoc reporting and database extracts.

Audit Services Section

Audit Services Administrator (Chief Internal Auditor): Develops, directs, and coordinates audit programs, audits of cost reports for nursing homes, and initial fair rental value system asset base.

Administrative Secretary: Assists with preparation and typing of special documents and correspondence, and maintains files.

Audit Evaluation and Review Analyst (seven positions): Reviews cost reports of nursing homes and intermediate care facilities for developmentally disabled for acceptability, reviews audit working papers, represents the agency in the appeal process, and establishes the fair rental value system asset base.

Managed Health Care Administrative Unit

Chief: Provides the planning, development, implementation and monitoring of managed care programs, including home and community based waivers, freedom of choice waivers, prepaid health plans, and demonstration grant programs.

Administrative Secretary: Provides secretarial support in order to maintain smooth work flow and accurate and timely completion of work assignments. Organizes and administers daily administrative and operational functions of the office.

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Approval 10/21/94
Revised Submission JUL 22 1994
Home and Community Based Waivers Section

Program Administrator: Supervises the development of the Home and Community Based waivers and special projects. Coordinates the development of interprogram issues.

Administrative Secretary: Provides secretarial support in order to maintain smooth work flow and accurate and timely completion of work assignments.

Medical/Health Care Program Analyst (five positions): Develops program policies and procedures for waiver programs, monitors the provision of services and operation of the programs, and provides technical assistance to areas and other agency staff. Performs special projects as assigned.

* Registered Nursing Consultant: Plans, coordinates and directs activities for the medical review functions and requests for exceptions relating to Project Aids Care (PAC).

Health Maintenance Organization Section

Program Administrator: Supervises the development of program policies and procedures for prepaid health plan contracting, prepaid health plan contracts, and the development, implementation and operation of new prepaid health plan programs.

Administrative Secretary: Provides secretarial support in order to maintain smooth work flow and accurate and timely completion of work assignments.

Medical/Health Care Program Analysts (four positions): Develops prepaid health plan contracts and programs and demonstration grant projects.

Primary Care Case Management Section

Program Administrator: Supervises the development of the primary care case management program and the "Healthy Beginnings" contract. Coordinates interprogram issues.

Administrative Secretary: Provides secretarial support in order to maintain smooth work flow and accurate and timely completion of work assignments.

Medical/Health Care Program Analysts (five positions): Develops, expands and monitors the primary care case management program.
Medicaid Third Party Liability and Contract Management

Administrative Section

Chief: Supervises the development of third party liability policies and procedures, and manages the contract for fiscal agent services to develop, operate and maintain the Florida Medicaid Management Information System.

Staff Assistant: Provides administrative support to the chief in order to maintain smooth work flow and timely completion of assignments.

Third Party Liability
Program Policy/Resource Development Section

Medical Health Care Program Analyst: Coordinates the development of third party policies and procedures, electronic data matches, system changes, state plan, action plan, waiver requests, and System Performance Review. Serves as liaison for state and federal audits.

Planner IV: Coordinates the development of third party policies and procedures, electronic data matches, system changes, state plan, action plan, waiver requests, and System Performance Review. Serves as liaison for state and federal audits.

Casualty Section

Insurance Administrator B: Supervises the handling of casualty cases and negotiates settlements.

Insurance Specialist III (five positions): Notifies attorneys and insurance adjusters of Medicaid payment for injury cases, prepares liens, negotiates settlements, and prepares releases and satisfactions of lien.

Human Services Program Records Analyst: Mails questionnaires to injured recipients and identifies returned questionnaires.

Secretary Specialist: Provides word processing support to the Casualty and Insurance Resource staff in order to maintain smooth work flow and timely completion of assignments.

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Insurance Resources Section

Insurance Administrator B: Supervises the input of third party liability data into the Florida Medicaid Management Information System, reviews claims pended for third party liability review, monitors cost avoidance activities, monitors the carrier billing system, and resolves third party liability related claim problems.

Insurance Specialist III: Answers insurance company inquiries, instructs providers about billing with third party liability, reviews claims pended for third party liability review, performs third party liability overrides for force pay claims, and processes Transfer of Assets forms.

Senior Clerks (four positions): Processes Insurance Carrier Turn Around Documents, enters third party liability data from HRS form 1293As and SSA form 8019, insurance carrier billings, mail insurance carrier claims, and follows up on suspected third party liability.

Research and Training Section

Research and Training Specialist (three positions): Provides third party liability related training to HRS area staff involved in entering third party liability data into the Florida Online Recipient Integrated Data Access System, and provides training to area Medicaid claim resolution staff.

Senior Clerk: Provides word processing support to the trainers.

Accounting Section

Accounting Services Supervisor: Reviews third party hospital audits, monitors collections from hospital audits, approves provider refunds, and reviews the preparation of the third party liability portion of the HCFA 64 report.

Administrative Secretary: Provides word processing support to the Accounting and Hospital Audit sections, and provides administrative support to the third party liability office.

Accountant IV: Prepares the third party liability portion of the HCFA 64 report, initiates Medicaid recoupments, and handles accounting technical problems.

Fiscal Assistant II: Classifies and records deposits in State Automated Management Accounting System.

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Effective 7/1/93
Supersedes 89-10
Approval 10/21/94
Revised Submission JUL 22, 1994
Fiscal Assistant I Produces cash receipts for all third party liability recoveries, assists with classifying and recording deposits, and reviews Medicare Part B cash receipts and denials.

Receipts Section

Accountant I: Processes provider request for refunds, and performs third party liability adjustments in Medicaid history claim files.

Fiscal Assistant II (two positions): Enters insurance carrier payments into the carrier billing file, handles applications of restitution payments, enters third party liability payments to adjust paid claim history, and follows up on outstanding claims on hospital audits.

Clerk Specialist: Receives and opens incoming mail and distributes to office staff, and prepares mail-in-log of refund checks.

Hospital Audit Section

Internal Auditor II (three positions): Conducts on-site audits of business records at Medicaid participating hospital providers to identify third parties who may be responsible for paying part or all of hospital services.

Eligibility Section

Program Administrator: Supervises the development of eligibility program policies and procedures including newborn processing and buy-in. Coordinates the recipient subsystem of the Florida Medicaid Management Information System and the development of interprogram issues.

Senior Human Services Program Specialist (three positions): Develops program policies and procedures for eligibility of Medicaid recipients, including States Legalization Impact Assistance Grant (SLIAG); monitors the provision of service and operation of programs, and provides technical assistance to the areas and other agency staff.

Administrative Secretary: Assists with typing documents and correspondence and maintaining files.

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Effective 7/1/93
Supersedes 89-10
Approval 10/21/94
Revised Submission [JJJJ 2 2 1994]
Medicaid Contract Management
Administrative Section

Administrative Secretary: Provides administrative support to the chief.

Senior Clerk: Receives and distributes incoming mail, maintains Customer Service Request files, maintains and updates the system documentation library, and performs incidental typing and data input.

Systems Section

Systems Project Administrator: Responsible for coordinating the operations, maintenance, and management reviews of the Florida Medicaid Management Information System.

Systems Project Analyst (two positions): Responsible for all systems hardware and software aspects of the contract for fiscal agent and other services for the Florida Medicaid Program.

Medicaid Management Review Monitor (two positions): Responsible for management information and operations analysis activities, and monitoring and overseeing the contractor's management.

Contract Administrative Section

Medicaid Management Review Monitor: Responsible for overall fiscal administration and operational review of all fiscal aspects of the Medicaid fiscal agent contract.

Budget Specialist: Assists in the fiscal administration and operational review of the fiscal agent contract. Prepares extensive fiscal analysis, monitors the fiscal agent budget, and assists in preparation of contract documents.

Audit Section

Computer Audit Analyst: Plans, conducts and supervises the audit activities relative to computerized payments made to medical care providers by the Medicaid fiscal agent.

Senior Contract Auditor (three positions): Plans and conducts audit activities relative to computerized payments made to medical care providers by the Medicaid fiscal agent.

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Effective 7/1/93
Supersedes 89-10
Approval 10/21/94
Revised Submission JUL 22 1994
Program Development
Administrative Unit

Chief: Plans, directs, organizes and coordinates the development of Medicaid program policies and procedures. Ensures program policies and procedures are consistent as presented in manuals, administrative rules, and the state plan and are in compliance with federal and state laws, rules and regulations. Plans and implements Medicaid program provider and consumer relations activities, exceptional claims resolution, provider enrollment policies, and provider data analysis.

Staff Assistant: Organizes and administers activities of the office from a business manager standpoint and assures the accuracy and completeness of all outgoing documents.

Medical Health Care Program Analyst: Coordinates the development of special programs which impact children. Serves as a liaison to the Department of Education on policy issues that impact schools, including Part H and Full Service Schools.

Senior Management Analyst II: Coordinates policy and management issues that cross section responsibilities. Serves as a liaison with other bureaus and state agencies on issues that impact program development.

Pharmacy Section

Human Services Analyst: Reviews and resolves claims processing problems and adjusts drug coverage codes as appropriate. Assists with file maintenance and review of requests for changes in coverage status.

Human Services Program Specialist: Coordinates drug file maintenance, insures accuracy of drug file pricing information, and makes recommendations for changes in coverage policy. Assists with development of provider notices and provider handbooks.

Medical Health Care Program Analyst (two positions): Coordinates system change requests as they affect the prescribed drug program and assists in development and analysis of ad hoc reports for other professional staff. Organizes and manages the development of provider manuals and training materials.

Systems Project Analyst (one position): Manages the administrative and prior authorization network systems, functions as technical liaison with the fiscal agent and manages data transfer between the pharmacy unit and the fiscal agent.
Administrative Secretary (three positions): Maintains office management records and correspondence files, processes travel expense requests, reviews incoming correspondence for assignment and outgoing correspondence for accuracy and appropriate format. Coordinates telephone coverage, vacation and leave scheduling and employee training schedules.

Senior Clerk (two positions): Assists with analysis and management of coverage requests for prior authorized services and preparation of responses to written or telephone inquiries.

Word Processing Systems Operator: Types outgoing correspondence, operates the switch board, refers inquiries to appropriate professional staff, and sorts incoming written correspondence.

* Senior Pharmacist (thirteen positions): Professional staff for review and processing of prior authorization requests, changes in coverage policy, and coordination of drug utilization review activities. Additional duties include analysis of utilization data for development of rebate agreements with manufacturers, negotiation with manufacturers and monitoring of prior authorization, DUR and rebate agreements impact on the prescribed drug program.

* Pharmaceutical Program Manager (three positions): Supervises professional and clerical staff, coordinates development of changes in coverage policy, responds to inquiries and program change notices from the Health Care Financing Administration, develops administrative rule revisions, and insures appropriate functioning of the prior authorization, drug utilization review and enhanced rebate programs.

Long Term Care Section

Program Administrator: Supervises the development of long term care program policies and procedures, and coordinates the development of interprogram issues.

Administrative Secretary: Provides secretarial support in order to maintain smooth work flow and accurate and timely completion of work assignments.

Amendment 93-39
Effective 7/1/93
Supersedes 89-10
Approval 10/21/94
Revised Submission JUL 22 1994
* Registered Nursing Consultant (three positions):
Plans, coordinates and directs activities for the medical review functions and out-of-state prior authorizations. Develops program policies and procedures for home health agencies, hospices, and level of care criteria for intermediate care facilities for the developmentally disabled and nursing facilities. Responsible for all prior authorization functions for the pressure ulcer therapy program.

Medical/Health Care Program Analyst: Plans, coordinates and directs the activities relating to nursing homes, intermediate care facilities for the developmentally disabled, and state mental health hospitals.

Senior Human Services Program Specialist (two positions):
Develops program policies and procedures for inpatient and outpatient hospitals and ambulatory surgical centers. Implements the functions of the dental and medical prior authorization request activity, and screens prior authorization requests for the physician consultant review and the utilization review functions.

Human Services Program Specialist: Responsible for file maintenance, institutional provider enrollment, and rule coordination.

Senior Clerk: Enrolls institutional providers; and assists with utilization control, the quarterly HCFA report, and semiannual HCFA PASSAR report.

Non-Institutional Section

Program Administrator: Supervises the development of program policies and procedures for non-institutional services; supervises the review, analysis and evaluation of policy, its implementation and operation; coordinates development of inter-program issues.

Administrative Secretary: Provides secretarial support in order to maintain smooth work flow and timely accurate completion of work assignments.

* Registered Nurse Consultant: Develops and assesses program policies and procedures for podiatry services, therapy services, prescribed pediatric extended care centers, medical foster care, and the multiple handicapped assessment team; provides technical assistance to area staff and other agency staff.
Medical/Health Care Program Analyst (two positions):
Develops and assesses program policies and procedures for independent laboratory services, Clinical Laboratory Improvement Amendments compliance, portable X-ray services, durable medical equipment, supplies, orthotics and prosthetics, and enteral and parenteral supplies and equipment. Provides technical assistance to area staff and other agency staff.

Senior Human Services Program Specialist (two positions):
Develop and assess program policies and procedures for eyeglasses and vision services, prosthetic eyes, hearing aids and hearing services, emergency and non-emergency transportation, customized and motorized wheelchairs, prior and services authorization and specialty item pricing for non-institutional providers; provide technical assistance to area staff and other agency staff.

Maternal and Child Health Section

Program Administrator: Supervises the development of program policies and procedures on non-institutional services; supervises the review and assessment of policy and its implementation and operation; and coordinates development of interprogram issues.

Administrative Secretary: Provides secretarial support in order to maintain smooth work flow and accurate and timely completion of work assignments.

* Registered Nursing Consultants (three positions):
Coordinates and directs the development and preparation of program policies, handbooks, and administrative rules for physician services, regional perinatal intensive care centers, advanced registered nurse practitioners, family planning, birthing centers, rural health centers, federally qualified health care centers, county public health units, Medicaid clinical services, and organ transplantation. Coordinates Healthy Start issues related to Medicaid. Provides technical assistance to area Medicaid offices.

Medical Health Care Program Analyst: Coordinates and directs the development and preparation of program policies, handbooks, and administrative rules for dental services. Maintains the procedure code file, healthcare common procedure coding system (HCPCS) for the Florida Medicaid Management Information System, and locally assigned procedure codes. Provides technical assistance to area Medicaid offices.

Amendment 93-39
Effective 7/1/93
Supersedes 89-10
Approval 10/21/94
Revised Submission 2/2/1994
Administrative and Medicaid Services Section

Program Administrator: Supervises the development of program policies and procedures for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and community mental health programs. Supervises the development and preparation of the state plan, administrative rules and program manuals. Oversees implementation of third party and crossover claims policy and procedures, and the claims processing subsystem of Florida Medicaid Management Information System, including System Performance Review (SPR) and quality control.

Administrative Secretary: Provides secretarial support in order to maintain smooth work flow and accurate and timely completion of work assignments.

* Registered Nursing Consultant: Coordinates and directs the development and preparation of program policies, handbooks, and administrative rules for Early and Periodic Screening, Diagnosis and Treatment program (EPSDT).

Medical Health Care Program Analyst (two positions): Coordinates and directs the development and preparation of program policies, handbooks, and administrative rules for community mental health. Coordinates and directs the development of Medicare crossover policy, claims processing quality control, provider handbook coordination, electronic data interchange (EDI), claim form standards, computer training and resource coordination. Coordinates and directs the development and preparation of program policies, handbooks, and administrative rules for chiropractic services.

Senior Human Services Program Specialist: Develops and drafts state plan amendments and cooperative agreements. Serves as liaison on the claims processing subsystem, system performance review, third party liability, and system documentation. Assists with the development of Medicare crossover policy.

Human Services Analyst: Prepares and processes state plan amendments, and coordinates review and updates to the Federal Register, Florida Administrative Weekly, State Medicaid Manual, Health Care Financing Administration program memorandums, program issuances, and the Commerce Clearing House publications.

Claims Resolution Section

Program Administrator: Supervises the planning, directing, monitoring and implementation of claims force payment procedures so that federal and state audit requirements are met, and serves as the primary consultative source in the area of claims processing policy and procedures for staff statewide.

Amendment 93-39
Effective 7/1/93
Supersedes 89-10
Approval 10/21/94
Revised Submission JUL 2 2 1994
Senior Human Services Program Specialist (three positions): Develops policies for and processes claims force payments, monitors area force payments, resolves eligibility file errors that prevent accurate claims payment. Trains staff statewide in the billing and reimbursement process.

Senior Clerk: Researches and compiles the results of findings concerning Medicaid recipient eligibility histories, recipient data affecting claims adjudication, provider entitlement history and associated data for the use of program specialists in force pay claims activities. Also provides secretarial support in order to maintain smooth work flow and timely completion of work assignments.

**Provider Relations Section**

Program Administrator: Supervises the planning, directing and coordination of activities relating to provider enrollment, publications, and maintenance of the Medicaid Management Information System provider file. Manages liaison activities with all area offices and professional health care associations.

Senior Human Services Program Specialist: Monitors the provider relations functions of fiscal agent contractor, and the provider enrollment requirements. Serves as liaison on system performance review.

Human Service Program Records Analyst: Oversees provider enrollment, recruitment, and publications. Develops confidentiality policies, monitors the fiscal agent contractor's provider files, and submits and maintains remittance voucher banner messages to providers.

Medical Health Care Analyst (two positions): Directs the plastic Medicaid card project and develops and prepares Medicaid publications. Serves as field representation liaison, researches and analyses provider error trends for policy development, and performs needs assessment for training efforts.

Amendment 93-39
Effective 7/1/93
Supersedes 89-10
Approval 10/21/94
Revised Submission JUL 2 2 1994
AGENCY FOR HEALTH CARE ADMINISTRATION
MEDICAID OFFICE
Description of Professional Medical Personnel

Long Term Care Section

* Registered Nursing Consultant (three positions): Plans, coordinates and directs activities for the medical review functions and out-of-state prior authorizations. Develops program policies and procedures for home health agencies, hospices, and level of care criteria for intermediate care facilities for the developmentally disabled and nursing facilities. Responsible for all prior authorization functions for the pressure ulcer therapy program.

Non-Institutional Section

* Registered Nurse Consultant: Develops and assesses program policies and procedures for podiatry services, therapy services, prescribed pediatric extended care centers, medical foster care, and the multiple handicapped assessment team; provides technical assistance to area staff and other agency staff.

Maternal and Child Health Section

* Registered Nursing Consultants (three positions): Coordinates and directs the development and preparation of program policies, handbooks, and administrative rules for physician services, regional perinatal intensive care centers, advanced registered nurse practitioners, family planning, birthing centers, rural health centers, federally qualified health care centers, county public health units, Medicaid clinical services, and organ transplantation. Coordinates Healthy Start issues related to Medicaid. Provides technical assistance to area Medicaid offices.

Administrative and Medicaid Services Section

* Registered Nursing Consultant: Coordinates and directs the development and preparation of program policies, handbooks, and administrative rules for Early and Periodic Screening, Diagnosis and Treatment program (EPSDT).

Amendment 93-39
Effective 7/1/93
Supersedes 89-10
Approved 10/21/94
Revised Submission JUL 22 1994
Pharmacy Section

* Senior Pharmacist (thirteen positions): Professional staff for review and processing of prior authorization requests, changes in coverage policy, and coordination of drug utilization review activities. Additional duties include analysis of utilization data for development of rebate agreements with manufacturers, negotiation with manufacturers and monitoring of prior authorization, DUR and rebate agreements impact on the prescribed drug program.

* Pharmaceutical Program Manager (three positions): Supervises professional and clerical staff, coordinates development of changes in coverage policy, responds to inquiries and program change notices from the Health Care Financing Administration, develops administrative rule revisions, and insures appropriate functioning of the prior authorization, drug utilization review and enhanced rebate programs.

Office of Program Integrity (Under supervision of the Agency for Health Care Administration's Inspector General's office)

* Pharmaceutical Program Manager: Supervises professional staff and coordinates functions of the medical records review program for fraud and abuse investigations.

* Senior Pharmacist (four positions): Professional staff for medical records review activities.


Medicaid Area Offices:

* Registered Nurse Specialist (30.5 positions): Plans, coordinates and directs activities for the medical review functions and requests for service authorizations relating to EPSDT services for children under 21 years of age.

* Clerk Typist Specialist (3 positions): Provides typing assistance for Registered Nurse Specialists.

* Word Processing Systems Operator: Provides word processing support for Registered Nurse Specialists.

Amendment 93-39
Effective 7/1/93
Supersedes 89-10
Approved 10/21/94
Revised Submission JUL 22 1994
THE DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
Description of Staff Designated to Make Eligibility Determinations

ECONOMIC SERVICES PROGRAM OFFICE:
Determines Eligibility for AFDC-Related Medicaid

Operational Unit
Public Assistance Unit

Public Assistance Specialist (4,311 positions - seven positions per unit): Determine initial eligibility and/or ongoing case management activities for public assistance (AFDC, Food Stamps, Medicaid) clients.

Interviewing Clerk (619 positions): Complete client registration for public assistance applicants, which includes screening for expedited food stamp processing; schedule intake interview.

Amendment 93-39
Effective 7/1/93
Supersedes NEW
Approval 10/21/94
Revised Submission JUL 22 1994
THE DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
Description of Staff Designated to Make Eligibility Determinations

AGING AND ADULT SERVICES OFFICE
Adult and Regulatory Services:
Determines Eligibility for SSI-related Medicaid

Public Assistance Specialists (626 positions): Determine eligibility for persons applying for SSI-related Medicaid and conduct eligibility reviews as needed for eligible recipients.

Interviewing Clerks (83 positions): Register clients in the FLORIDA system, schedule appointments for application interviews, and do information and referral.

Amendment 93-39
Effective 7/1/93
Supersedes NEW Approval 10/21/94
Revised Submission 2/2/1994
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Florida
DEFINITION OF A HEALTH MAINTENANCE ORGANIZATION

Health Maintenance Organizations (HMO) are limited to any public or private entity paid on a prepaid or fixed-sum basis which provides health service insurance coverage or provides health services to recipients and which:

1. Is organized primarily for the purpose of insuring or providing health care or other services of the type regularly offered to Medicaid recipients;

2. Ensures that services meet the standards set by the agency for quality, appropriateness, and timeliness;

3. Manages the care of Medicaid recipients and assigns patients to primary care physicians responsible for providing primary care services and authorizing specialty care;

4. Makes provisions satisfactory to the agency for insolvency protection and ensures that neither enrolled Medicaid recipients nor the agency will be liable for the debts of the entity;

5. Submits to the agency, if a private entity, a financial plan that the agency finds to be fiscally sound and that provides for working capital in the form of cash or equivalent liquid assets excluding revenues from Medicaid premium payments equal to at least the first 3 months of operating expenses or $200,000, whichever is greater;

6. Furnishes evidence satisfactory to the agency of adequate liability insurance coverage or an adequate plan of self-insurance to respond to claims for injuries arising out of the furnishing of health care;

7. Provides, through contract or otherwise, for periodic review of its medical facilities and services, as required by the agency;

8. Provides organizational, operational, financial, and other information required by the agency;

9. Maintains at all times, in addition to meeting any applicable statutory surplus requirements, short-term investments allowable as admitted assets by the Department of Insurance, and restricted funds or deposits controlled by the agency or the Department of Insurance, an amount equal to one-and-one-half times its monthly prepaid Medicaid revenues.

Amendment 96-02
Effective 1/1/96
Supersedes 94-10
Approval 5-6-96
In the event an entity's surplus falls below any applicable statutory requirements, or an entity's total of cash, short-term investments allowable as admitted assets by the Department of Insurance, and restricted funds or deposits controlled by the agency or the Department of Insurance falls below one-and-one-half times its monthly prepaid Medicaid revenues, the agency shall prohibit the entity from engaging in enrollment activities, shall cease to process new enrollments for the entity, and shall not renew the entity's contract until the required balance is achieved. The requirements of this subsection shall not apply:

(a) Where a public entity agrees to fund any deficit incurred by the contracting entity; or
(b) Where a public entity's performance and obligations are guaranteed in writing by a guaranteeing organization which:
1. Has been in operation for at least five years and has assets in excess of $50 million; or
2. Submits a written guarantee acceptable to the agency which is irrevocable during the term of the contracting entity's contract with the agency and, upon termination of the contract, until the agency receives proof of satisfaction of all outstanding obligations incurred under the contract.
(10) Provides organizational, operational, financial, and other information required by the agency;
(11) Does not know, or reasonably should not know that any officer, director, agent managing employee, or owner of stock or beneficial interest in excess of 5 percent common or preferred stock, or the entity itself, has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty, to:
(a) Fraud;
(b) Violation of federal or state antitrust statutes, including those prescribing price fixing between competitors and the allocation of customers among competitors;
(c) Commission of a felony involving embezzlement, theft, forgery, income tax evasion, bribery, falsification or destruction of records, making false statements, receiving stolen property, making false claims, or obstruction of justice; or
(d) Any crime in any jurisdiction which directly relates to the provision of health services on a prepaid or fixed-sum basis.
(12) If the entity is an insurer, it must be organized and licensed under applicable provisions of the Florida Insurance Code and is currently in good standing with the Department of Insurance;
(13) If the entity provides no prepaid health care services other than Medicaid services under contract with the agency, the entity shall be exempt from the provisions of Part 1 of Chapter 641, Florida Statutes, which provides authority to the Florida Department of Insurance to license and regulate health maintenance organizations.
(14) The agency may enter into a risk contract agreement either through a competitive bid process or through a sole source procurement with any qualified provider who meets all of the above.
Definition of Blindness: The following is the State's definition of blindness in terms of ophthalmic measurement: Ophthalmological measurements are defined as central visual acuity of 20/200 or less with glasses or a disqualifying field defect in which the peripheral field has contracted to such an extent that the widest diameter of visual field subtends at an angular distance of no greater than 20 degrees.

In any instance in which a determination is to be made whether an individual is blind according to the State's definition, there will be an examination by a physician skilled in the disease of the eye or by an optometrist, whichever the individual may select.

Each eye examination report form will be reviewed by a State supervising ophthalmologist who is responsible for the agency's decision that the applicant does or does not meet the State's definition of blindness.

Definition of Permanent and Total Disability: The following is the State's definition of permanent and total disability, showing that: (a) "permanently" is related to the duration of the impairment or combination of impairments; and (b) "totally" is related to the degree of disability: Permanent and total disability exists when a person has a major permanent impairment or combination of impairments which are totally disabling. A permanent impairment is a physical or mental condition of major significance which is expected to continue throughout the lifetime of an individual and is not expected to be removed or substantially improved by medical treatment. It is expected to continue for a prolonged period of disability and the eventual prognosis may be indefinite. Total disability exists when the permanent impairment or combination of permanent impairments substantially precludes the individual from engaging in a useful occupation. This includes gainful employment for which he has competence, or homemaking when the individual is maintaining a home for at least one person in addition to himself.

Each medical report form and social history will be reviewed by technically competent persons - not less than a physician and a social worker qualified by professional training and pertinent experience - acting cooperatively, who are responsible for the agency's decision that the applicant does or does not meet the State's definition of permanent and total disability.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

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<tr>
<th>Agency*</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
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<td>Department of Children and Family Services</td>
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</table>

The following groups are covered under this plan.

A. **Mandatory Coverage - Payment Standard Criteria (Categorically Needy) and Other Required Special Groups**

42 CFR 435.110

1. Recipients of AFDC

   The approved State AFDC plan includes:

   - Families with an unemployed parent for the mandatory 6-month period and an optional extension of 6 months.
   - Pregnant women with no other eligible children.
   - AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

   The standards for AFDC payments are listed in **Supplement 1 of ATTACHMENT 2.6-A**.

42 CFR 435.115

2. Deemed Recipients of AFDC

   a. Individuals denied a title IV-A cash payment solely because the amount would be less than $10.

*Agency that determines eligibility for coverage.

Effective Date: October 1, 1999

Approval Date: DEC 06 2000

Supersedes TN No. 91-39

TN No.: 99-09
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

2. Deemed Recipients of AFDC.

1902(a)(10)(A)(i)(I) of the Act
b. Effective October 1, 1990, participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482(e)(6) of the Act.

402(a)(22)(A) of the Act
c. Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds.

406(h) and 1902(a)(10)(A)(I)(I) of the Act
d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.

1902(a) of the Act
e. Individuals deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.

*Agency that determines eligibility for coverage.

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<td>407(b), 1902 (a)(10)(A)(i) and 1905(m)(1) of the Act</td>
<td>A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</td>
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<td>1902(a)(52) and 1925 of the Act</td>
<td>3. Qualified Family Members</td>
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<td>See Item A.10, page 5.</td>
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<td>4. Families terminated from Section 1931 Medicaid solely because of earnings, hours of employment, or loss of earned income disregards are entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This coverage is contingent upon this provision of Section 1925 remaining in effect.)</td>
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*Agency that determines eligibility for coverage.

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State: **FLORIDA**

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<th>Approval Date <strong>JUN 10 2002</strong></th>
<th>Effective Date <strong>April 1, 2002</strong></th>
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<td>Supersedes TN No. 98-30</td>
<td>Revised Submission <strong>5/31/02</strong></td>
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</table>
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

5. Individuals who are ineligible for AFDC solely because of eligibility requirements that are specifically prohibited under Medicaid. Included are:

   a. Families denied AFDC solely because of income and resources deemed to be available from--

      (1) Stepparents who are not legally liable for support of stepchildren under a State law of general applicability;

      (2) Grandparents;

      (3) Individual alien sponsors (who are not spouses of the individual or the individual’s parent);

   b. Families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit.

   c. Families denied AFDC because the family transferred a resource without receiving adequate compensation.

*Agency that determines eligibility for coverage.

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<td>86-18</td>
<td>SEP 18 1992</td>
<td>HCFA ID: 7983E</td>
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</table>
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.114  6. Individuals who would be eligible for AFDC except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.

Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).

X Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

Not applicable with respect to intermediate care facilities; State did or does not cover this service.

(A)(1)(III)
and 1905(n) of the Act

a. A pregnant woman whose pregnancy has been medically verified who--

(1) Would be eligible for an AFDC cash payment if the child had been born and was living with her;

*Agency that determines eligibility for coverage.

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Revised Submission FEB 11
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

7. a. (2) Is a member of a family that would be eligible for aid to families with dependent children of unemployed parents if the State had an AFDC-unemployed parents program; or

(3) Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

1902(a)(10)(A) (i)(III) and 1905(n) of the Act

b. Children born after September 30, 1983 who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

Children born after

(specify optional earlier date)

who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Florida

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s) Groups Covered

A. Mandatory Coverage — Categorically Needy and Other Required Special Groups (Continued)

8. Pregnant women and infants under 1 year of age with family incomes up to 133 percent of the Federal poverty level who are described in section 1902 (a) (10) (A) (I) (IV) and 1902 (1) (1) (A) and (B) of the Act. The income level for this group is specified in Supplement 1 to ATTACHMENT 2.6-A.

X The State uses a percentage greater than 133 but not more than 185 percent of the Federal poverty level, as established in its State plan, State legislation, or State appropriations as of December 19, 1989.

9. Children:

a. who have attained 1 year of age but have not attained 6 years of age, with family incomes at or below 133 percent of the Federal poverty levels.

b. born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.

Children born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.

Income levels for these groups are specified in Supplement 1 to ATTACHMENT 2.6-A.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

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<tr>
<td>1902(a)(10) (A)(i)(V) and 1905(m) of the Act</td>
<td>10. Individuals other than qualified pregnant women and children under item A.7. above who are members of a family that would be receiving AFDC under section 407 of the Act if the State had not exercised the option under section 407(b)(2)(B)(i) of the Act to limit the number of months for which a family may receive AFDC.</td>
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<tr>
<td>1902(e)(5) of the Act</td>
<td>11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved state plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.</td>
</tr>
<tr>
<td>1902(e)(6) of the Act</td>
<td>b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.</td>
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### FLORIDA

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

**State:** FLORIDA

### COVERAGE AND CONDITIONS OF ELIGIBILITY

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<td>A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</td>
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<tr>
<td>42 CFR 435.120</td>
<td>11. Aged, Blind and Disabled Individuals Receiving Cash Assistance</td>
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</tbody>
</table>

| 12. A child born to a woman who is eligible for and receiving Medicaid as categorically needy on the date of the child's birth. The child is deemed eligible for one year from birth as long as the mother remains eligible or would remain eligible if still pregnant and the child remains in the same household as the mother. |

| 13. Aged, Blind and Disabled Individuals Receiving Cash Assistance |

| a. Individuals receiving SSI. |

This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act. |

| X Aged |

| X Blind |

| X Disabled |

---

**TN No.:** 92-23  
**Supersedes:** Approval Date  
**TN No.:** 91-39  
**Effective Date:** 4/1/92
**A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)**

435.121

13. b. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.)

- Aged
- Blind
- Disabled

The more restrictive categorical eligibility criteria are described below:

*(Financial criteria are described in ATTACHMENT 2.2-A).*

*Agency that determines eligibility for coverage.*

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<td>TN No.</td>
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</table>

*State: FLORIDA*
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1902(a)  (10)(A)  (i)(II)
and 1905 (q) of
the Act

14. Qualified severely impaired blind and disabled individuals who --

a. For the month preceding the first month of eligibility under the requirements of section 1905(q)(2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or

b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must--

(1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;

(2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;

(3) Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;

*Agency that determines eligibility for coverage.

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HCFA ID: 7983E
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

(4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and

(5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI—(including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.

Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.
<table>
<thead>
<tr>
<th>Agency Citation(s)</th>
<th>Groups Covered</th>
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</thead>
<tbody>
<tr>
<td>A. 1619(b)(3) of the Act</td>
<td>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</td>
</tr>
</tbody>
</table>

The State applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b)(1) of the Act.

*Agency that determines eligibility for coverage.

TN No. 91-39 | Approval Date | Effective Date 10/1/91
Supersedes
TN No. NEW | SEP 18 1992 | HCFA ID: 7983E
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<td>A. 1634(c) of the Act</td>
<td>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</td>
</tr>
<tr>
<td></td>
<td>15. 42 CFR 435.122</td>
<td>Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who--</td>
</tr>
<tr>
<td></td>
<td>15a. Are at least 18 years of age;</td>
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<tr>
<td></td>
<td>15b. Lose SSI eligibility because they become entitled to OASDI child’s benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>15c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.</td>
<td></td>
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<td></td>
<td>15d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.</td>
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<tr>
<td></td>
<td>16. 42 CFR 435.130</td>
<td>Individuals receiving mandatory State supplements.</td>
</tr>
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*Agency that determines eligibility for coverage.*

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HCFA ID: 7983E
Revision: HCFA-PM-91-4  
AUGUST 1991  
(BPD)

AttACHMENT 2.2-A  
Page 6  
OMB NO.: 0938-

State: FLORIDA

Agency*  Citation(s)  Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.131  18. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.

In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):

   ___ Aged    ___ Blind    ___ Disabled

Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.

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*Agency that determines eligibility for coverage.

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</table>

HCFA ID: 7983E
**A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)**

19. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they--

   a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and
   
   b. Remain institutionalized; and
   
   c. Continue to need institutional care.

20. Blind and disabled individuals who--

   a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and
   
   b. Were eligible for Medicaid in December 1973 as blind or disabled; and
   
   c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

*Agency that determines eligibility for coverage.*

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**Supersedes**

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HCFA ID: 7983E
**A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)**

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<tbody>
<tr>
<td></td>
<td>42 CFR 435.134</td>
<td>Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).</td>
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<tr>
<td></td>
<td></td>
<td>Includes persons who would have been eligible for cash assistance in August 1972 if not in medical institution or nursing facility (this group was included in this State's August 1972 plan).</td>
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<tr>
<td></td>
<td></td>
<td>Not applicable with respect to intermediate care facilities; the State did or does not cover this service.</td>
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<td>TN No. 87-21</td>
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<td>HCFA ID: 7983E</td>
</tr>
</tbody>
</table>
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.135  22. Individuals who —

a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and

b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(1) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.

Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients.

Not applicable because the State applies more restrictive eligibility requirements than those under SSI.

The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

*Agency that determines eligibility for coverage.

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<td>87-21</td>
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</table>
A. **Mandatory Coverage - Categorically Needy and Other Required Special Groups** (Continued)

1634 of the Act

<table>
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<tr>
<th>Agency*</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
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<tbody>
<tr>
<td>23.</td>
<td>Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act.</td>
<td></td>
</tr>
</tbody>
</table>

\[X\] Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.

\[\] The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equalling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.

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*Agency that determines eligibility for coverage.

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<td>91-25</td>
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</table>

HCFA ID: 7983E
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

24. Disabled widows, disabled widowers, and disabled unmarried divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, who are receiving title II payments, and who because of the receipt of title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive title II payments, who would be eligible for SSI or SSP if the amount of the title II benefit were not counted as income, and who are not entitled to Medicare Part A.

The State applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program.

X In determining eligibility as categorically needy, the State disregards the amount of the title II benefits identified in § 1634(d)(1)(A) in determining the income of the individual, but does not disregard any more of this income than would reduce the individual's income to the SSI income standard.

In determining eligibility as categorically needy, the State disregards only part of the amount of the benefits identified in §1634(d)(1)(A) in determining the income of the individual, which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits to disregarded is specified in Supplement 4 to Attachment 2.6-A.

In determining eligibility as categorically needy, the State chooses not to deduct any of the benefit identified in § 1634(d)(1)(A) in determining the income of the individual.

*Agency that determines eligibility for coverage.

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A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

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</thead>
<tbody>
<tr>
<td>1902(a)(10)(E)(i) and 1905(p) of the Act</td>
<td>25. Qualified Medicare beneficiaries –</td>
</tr>
<tr>
<td></td>
<td>a. Who are entitled to hospital insurance benefits under Medicare Part A;</td>
</tr>
<tr>
<td></td>
<td>b. Whose income does not exceed the income level (established at an amount up to 100 percent of the federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and</td>
</tr>
<tr>
<td></td>
<td>c. Whose resources do not exceed three times the SSI standard indexed annually since 2006</td>
</tr>
<tr>
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<td>(Medical assistance for this group is limited to Cost sharing as defined in item 3.2 of this plan.)</td>
</tr>
<tr>
<td>1902(a)(10)(E)(ii) And 1905(s) and 1905(p)(3)(A)(i) Of the Act</td>
<td>26. Qualified disabled and working individuals –</td>
</tr>
<tr>
<td></td>
<td>a. Who are entitled to hospital insurance benefits under Medicare part A under section 11818A of the Act;</td>
</tr>
<tr>
<td></td>
<td>b. Whose income does not exceed 200 percent of the Federal income poverty level; and</td>
</tr>
<tr>
<td></td>
<td>c. Whose resources do not exceed twice the maximum standard under SSI.</td>
</tr>
<tr>
<td></td>
<td>(Medical assistance for this group is limited to Medicare Part A premiums under sections 1818 and 1818A of the Act.)</td>
</tr>
<tr>
<td>1905(s)</td>
<td>d. Who are not otherwise eligible for medical Assistance under Title XIX of the Act.</td>
</tr>
<tr>
<td></td>
<td>(Medical assistance for this group is limited to Medicare Part A premiums under sections 1818 and 1818A of the Act.)</td>
</tr>
<tr>
<td>1916 of the Act. Section 6408(d)(3) of P.L. 101-239</td>
<td>For qualified disabled working individuals (QDWI’s) whose income exceeds 150 percent of the Federal income poverty level. The State imposes a premium expressed as a percentage of the Medicare cost sharing described in Section 1905(p)(3)(A)(i), according to a sliding scale, in reasonable increments, as the individual’s income increases between 150 and 200 percent of the Federal income poverty level.</td>
</tr>
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</table>
State: FLORIDA

Citation(s) Groups Covered

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

1902(a)(10)(E)(iii) and 1902(a)(10)(E)(IV)
And 1905(p)(3)(A)(ii) Of the Act

27. Specified low-income Medicare beneficiaries –
   a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);
   b. Whose income is at least 100 percent but less than 120 percent of the Federal poverty level; and
   c. Whose resources do not exceed three times the SSI standard indexed annually since 2006.
   
   (Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)

28. Qualifying Individual –
   a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);
   b. Whose income is at least 120 percent of the Federal Poverty Level but less than 135 percent of the Federal Poverty Level; and
   c. Whose resources do not exceed three times the SSI standard indexed annually since 2006.
   
   (Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)

1634(e) of the Act

29. Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) of (v) of Section 1611(e)(3)(A) shall be treated, for purposes of Title XIX, as receiving SSI benefits for the month.
### B. Optional Groups Other Than the Medically Needy

<table>
<thead>
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<th>Agency Citation(s)</th>
<th>Groups Covered</th>
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<tbody>
<tr>
<td>42 CFR 435.210</td>
<td>1. Individuals described below who meet the income and resource requirements of AFDC, SSI, or an optional State supplement as specified in 42 CFR 435.230, but who do not receive cash assistance.</td>
</tr>
<tr>
<td>1902(a) (10)(A)(ii) and 1905(a) of the Act</td>
<td>The plan covers all individuals as described above.</td>
</tr>
<tr>
<td>42 CFR 435.211</td>
<td>2. Individuals who would be eligible for AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.</td>
</tr>
</tbody>
</table>

*Agency that determines eligibility for coverage.*

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B. Optional Groups Other Than the Medically Needy
(Continued)


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<tr>
<td>3.</td>
<td>The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act or a managed care organization</td>
</tr>
<tr>
<td></td>
<td>(MCO), or a primary care case management (PCCM) program, but who have been enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this section is limited to MCO or PCCM services and family planning services described in section 1905(a)(4)(C) of the Act.</td>
</tr>
<tr>
<td></td>
<td><em>X</em> The State elects not to guarantee eligibility.</td>
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<td>_ ___ The State elects to guarantee eligibility. The minimum enrollment period is _ months (not to exceed six).</td>
</tr>
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<td>The State measures the minimum enrollment period from:</td>
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<td>[ ] The date beginning the period of enrollment in the MCO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility.</td>
</tr>
<tr>
<td></td>
<td>[ ] The date beginning the period of enrollment in the MCO or PCCM as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.</td>
</tr>
<tr>
<td></td>
<td>[ ] The date beginning the last period of enrollment in the MCO or PCCM as a Medicaid patient (not including periods when payment is made under this section) without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).</td>
</tr>
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*Agency that determines eligibility for coverage.
### State: Florida

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<tr>
<td>1932(a)(4) of Act</td>
<td>B.</td>
<td>Optional Groups Other Than Medically Needy (continued)</td>
</tr>
</tbody>
</table>

The Medicaid Agency may elect to restrict the disenrollment of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56.

This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.

**X** Disenrollment rights are restricted for a period of **12** months (not to exceed 12 months).

During the first three months of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.

**_** No restrictions upon disenrollment rights.

1903(m)(2)(H), 1902(a)(52) of the Act P.L. 101-508 42 CFR 438.56(g) | In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.

**X** The agency elects to reenroll the above individuals who are ineligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.

**_** The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.

* Agency that determines eligibility for coverage.

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**TN #** 2003-17 **Effective Date** 7/01/03 **Approval Date** DEC 08 2003

Supersedes TN # 92-02
B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.217

X 4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.
B. Optional Groups Other Than the Medically Needy
(Continued)

<table>
<thead>
<tr>
<th>Agency</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1902(a)(10)</td>
<td>Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(c) of the Act.</td>
</tr>
</tbody>
</table>

- The State covers all individuals as described above.
- The State covers only the following group or groups of individuals:
  - __ Aged
  - __ Blind
  - __ Disabled
  - __ Individuals under the age of __________
    - __ 21
    - __ 20
    - __ 19
    - __ 18
  - __ Caretaker relatives
  - __ Pregnant women

*Agency that determines eligibility for coverage.*

<table>
<thead>
<tr>
<th>TN No.</th>
<th>Approval Date</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>91-39</td>
<td></td>
<td>10/1/91</td>
</tr>
<tr>
<td>NEW</td>
<td>SEP 18 1992</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>HCFA ID: 7983E</td>
</tr>
</tbody>
</table>
B. Optional Groups Other Than the Medically Needy
(Continued)

6. Individuals who would be eligible for AFDC if their work-related child care costs were paid from earnings rather than by a State agency as a service expenditure. The State's AFDC plan deducts work-related child care costs from income to determine the amount of AFDC.

The State covers all individuals as described above.

6. Individuals who would be eligible for AFDC if their work-related child care costs were paid from earnings rather than by a State agency as a service expenditure. The State's AFDC plan deducts work-related child care costs from income to determine the amount of AFDC.

The State covers only the following group or groups of individuals:

- Individuals under the age of--
  - 21
  - 20
  - 19
  - 18
- Caretaker relatives
- Pregnant women

7. a. All individuals who are not described in section 1902(a)(10)(A)(i) of the Act, who meet the income and resource requirements of the AFDC State plan, and who are under the age of--

The State covers all individuals as described above.

- Individuals under the age of--
  - 21
  - 20
  - 19
  - 18
- Caretaker relatives
- Pregnant women

7. a. All individuals who are not described in section 1902(a)(10)(A)(i) of the Act, who meet the income and resource requirements of the AFDC State plan, and who are under the age of--

- 21
- 20
- 19
- 18
### Optional Groups Other Than the Medically Needy

(Continued)

42 CFR 435.222

<table>
<thead>
<tr>
<th>Agency*</th>
<th>Citation (s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>42 CFR 435.222</td>
<td><strong>b.</strong> Reasonable classifications of individuals described in (a) above, as follows:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(a) In foster homes (and are under the age of <strong>21</strong>).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(b) In private institutions (and are under the age of <strong>21</strong>).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(c) In addition to the group under b. (1) (a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of <strong>21</strong>).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of <strong>18</strong>).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(3) Individuals who have reached age 18 and are under 21 who were in foster care when they turned 18, or after reaching 16, were adopted from foster care or placed with a court-approved dependency guardian and spent a minimum of 6 months in foster care within the 12 months immediately preceding placement or adoption, without regard to any categorical eligibility test otherwise required.</td>
</tr>
</tbody>
</table>
### B. Optional Groups Other Than the Medically Needy

(Continued)

<table>
<thead>
<tr>
<th>Agency*</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>42 CFR 435.222</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(4) Individuals in NFs (who are under the age of ____). NF services are provided under this plan.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(5) In addition to the group under (b) (3), under the age of ____).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(6) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of ____). Inpatient psychiatric services for individuals under age 21 are provided under this plan.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(7) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.</td>
<td></td>
</tr>
</tbody>
</table>
### B. Optional Groups Other Than the Medically Needy (Continued)

<table>
<thead>
<tr>
<th>Agency</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1902(a)(10) (A)(ii)(VIII)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. A child for whom there is in effect a State adoption assistance agreement (other than under title IV-E of the Act), who, as determined by the State adoption agency, cannot be placed for adoption without medical assistance because the child has special needs for medical or rehabilitative care, and who before execution of the agreement—

a. Was eligible for Medicaid under the State's approved Medicaid plan; or

b. Would have been eligible for Medicaid if the standards and methodologies of the title IV-E foster care program were applied rather than the AFDC standards and methodologies.

The State covers individuals under the age of—

- 21
- 20
- 19
- \( \times \) 18

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**TN No.** 91-39  
**Supersedes**  
**TN No.** 90-51  
**Approval Date** SEP 18 1992  
**Effective Date** 10/1/91  
**HCFA ID:** 7983E
### B. Optional Groups Other Than the Medically Needy (Continued)

<table>
<thead>
<tr>
<th>Agency Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.223</td>
<td>Individuals under the age of--</td>
</tr>
<tr>
<td>1902(a)(10) (A)(ii) and 1905(a) of the Act</td>
<td></td>
</tr>
<tr>
<td></td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Caretaker relatives</td>
</tr>
<tr>
<td></td>
<td>Pregnant women</td>
</tr>
</tbody>
</table>

Supersedes 91-39

Approval Date SEP 18 1992

Effective Date 10/1/91

HCFA ID: 7983E
B. Optional Groups Other Than the Medically Needy
(Continued)

States using SSI criteria with agreements under sections 1616 and 1634 of the Act.

The following groups of individuals who receive only a State supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in the State.

d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.

(1) All aged individuals.

(2) All blind individuals.

(3) All disabled individuals.
B. Optional Groups Other Than the Medically Needy  
(Continued)

<table>
<thead>
<tr>
<th>Agency*</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>42 CFR 435.230</td>
<td>(4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(7) Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(9) Individuals in additional classifications approved by the Secretary as follows:</td>
</tr>
</tbody>
</table>

TN No. 91-39  
Supersedes Approval Date SEP 15 1992  
Effective Date 10/1/91  
TN No. 86-18  
HCFA ID: 7983E
### Groups Covered

<table>
<thead>
<tr>
<th>Agency</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. Optional Groups Other Than the Medically Needy
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

- [ ] Yes.
- [ ] No.

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.2-A.

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TN No. 91-39  
Supersedes  
TN No. NEW  

Approval Date SEP 18 1992  
Effective Date 10/1/91  

HCFA ID: 7983E
### B. Optional Groups Other Than the Medically Needy

(Continued)

11. Section 1902(f) States and SSI criteria State without agreements under section 1616 or 1619 of the Act.

The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is:

- Based on need and paid in cash on a regular basis.
- Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.
- Available to all individuals in each classification and available on a State-wide basis.
- Paid to one or more of the classification of individuals listed below:

<table>
<thead>
<tr>
<th>Classification</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>All aged individuals</td>
</tr>
<tr>
<td>(2)</td>
<td>All blind individuals</td>
</tr>
<tr>
<td>(3)</td>
<td>All disabled individuals</td>
</tr>
</tbody>
</table>

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**TN No.** 91-39  
**Supersedes**  
**Approval Date** SEP 18 1992  
**Effective Date** 10/1/92  
**HCFA ID:** 7983E  
**Revised Submission**
<table>
<thead>
<tr>
<th>Agency* Citation(s)</th>
<th>Groups Covered</th>
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</thead>
<tbody>
<tr>
<td>(Continued)</td>
<td></td>
</tr>
<tr>
<td>(4)</td>
<td>Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.</td>
</tr>
<tr>
<td>(5)</td>
<td>Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.</td>
</tr>
<tr>
<td>(6)</td>
<td>Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.</td>
</tr>
<tr>
<td>(7)</td>
<td>Individuals receiving federally administered optional State supplement that meets the conditions specified 42 CFR 435.230.</td>
</tr>
<tr>
<td>(8)</td>
<td>Individuals receiving a State administered optional State supplement that meets the conditions specified 42 CFR 435.230.</td>
</tr>
<tr>
<td>(9)</td>
<td>Individuals in additional classifications approved by the Secretary as follows:</td>
</tr>
</tbody>
</table>
B. Optional Groups Other Than the Medically Needy
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

<table>
<thead>
<tr>
<th>TN No.</th>
<th>91-39</th>
<th>Approval Date</th>
<th>SEP 18 1992</th>
<th>Effective Date</th>
<th>10/1/91</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supersedes</td>
<td></td>
<td>HCFA ID:</td>
<td>7983E</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TN No.</td>
<td>NEW</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
B. Optional Groups Other Than the Medically Needy
(Continued)

12. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to ATTACHMENT 2.6-A, page 9a.

The State covers all individuals as described above.

The State covers only the following group or groups of individuals:

<table>
<thead>
<tr>
<th>Groups Covered</th>
<th>1902(a)(10)(A)</th>
<th>1905(a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals under the age of...</td>
<td>21</td>
<td>20</td>
</tr>
<tr>
<td>Caretaker relatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnant women</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

X Aged
X Blind
X Disabled
B. Optional Groups Other Than the Medically Needy
(Continued)

1902(e)(3) of the Act

13. Certain disabled children age 18 or under who are living at home, who
would be eligible for Medicaid under the plan if they were in a medical institution, and for whom
the State has made a determination as required under section 1902(e)(3)(B) of the Act.

Supplement 3 to ATTACHMENT 2.2-A describes the
method that is used to determine the cost effectiveness of caring for this group of
disabled children at home.

1902(a)(10) (A)(ii)(IX)
and 1902(1)
of the Act

14. The following individuals who are not
mandatory categorically needy whose income
does not exceed the income level (established
at an amount above the mandatory level and
not more than 185 percent of the Federal
poverty income level) specified in Supplement
to ATTACHMENT 2.6-A for a family of the same
size, including the woman and unborn child or
infant and who meet the resource standards
specified in Supplement 2 to ATTACHMENT 2.6-A:

a. Women during pregnancy (and, during the
60-day period beginning on the last day of
pregnancy); and

b. Infants under one year of age.
Optional Groups Other Than the Medically Needy
(Continued)

16. Individuals—

a. Who are 65 years of age or older or are disabled, as determined under section 1614(a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group.

b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to Attachment 2.6-A for a family of the same size; and

c. Whose resources do not exceed the maximum amount allowed under SSI; or under the State's medically needy program as specified in Supplement 2 to Attachment 2.6-A.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

COVERAGE AND CONDITIONS OF ELIGIBILITY

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(47) and 1920 of the Act</td>
<td>X 17. Pregnant women who are determined by a &quot;qualified provider&quot; (as defined in §1920(b)(2) of the Act) based on preliminary information, to meet the highest applicable income criteria specified in this plan under ATTACHMENT 2.6-A and are therefore determined to be presumptively eligible during a presumptive eligibility period in accordance with §1920 of the Act.</td>
</tr>
</tbody>
</table>
State: FLORIDA

<table>
<thead>
<tr>
<th>Citation</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(e)(12) of the Act</td>
<td>The following reasonable classifications of children described above who are under age 19 with family income at or below the percent of the Federal poverty level specified for the classification:</td>
</tr>
<tr>
<td>X</td>
<td>20. A child who has attained the age of 5 and who is under age 19 who has been determined eligible is deemed to be eligible for a total of 6 months regardless of changes in circumstances other than attainment of the maximum age stated above.</td>
</tr>
<tr>
<td>X</td>
<td>20a. A child under age 5 who has been determined eligible is deemed to be eligible for a total of 12 months regardless of changes in circumstances other than attainment of the maximum age stated above.</td>
</tr>
<tr>
<td>1902 of the Act</td>
<td>21. Children under age 19 who are determined by a “qualified entity” (as defined in s. 1920A(b)(3)(A)) based on preliminary information, to meet the highest applicable income criteria specified in this plan. The presumptive eligibility period begins on the day that the determination is made. If an application for Medicaid is filed on the child’s behalf by the last day of the following month in which the determination of presumptive eligibility was made, the presumptive period ends on the day that the State agency makes a determination of eligibility based on that application. If an application is not filed on the child’s behalf by the last day of the month following the month the determination of presumptive eligibility was made, the presumptive period ends on that last day.</td>
</tr>
</tbody>
</table>

TN No. 98-22 Supersedes TN No. 98-11

Effective 1/1/99

Approval Date 6/10/99
B. Optional Coverage Other Than the Medically Needy (continued)

1902 (a) (10) (A) (ii) (XVIII) of the Act

[24] Women who:

a. have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under XV of the Public Health Service Act in accordance with the requirements of section 15 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix;

b. are not otherwise covered under creditable coverage, as defined in section 2701 (c) of the Public Health Service Act;

c. are not eligible for Medicaid under any mandatory categorically needy eligibility group and

d. have not attained age 65.

1920(B) of the Act

[25] Women who are determined by a “qualified entity” as defined in 1920 (b) based on preliminary information, to be a woman described in 1902 (aa) of the Act related to certain breast and cervical cancer patients.

The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman’s eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on that last day.
### State/Territory:

Florida

<table>
<thead>
<tr>
<th>Citation</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>B. Optional Groups Other Than the Medically Needy</strong> (Continued)</td>
<td></td>
</tr>
<tr>
<td>1902(a)(10)(A) (ii)(XIII) of the Act</td>
<td>[] 23. BBA Work Incentives Eligibility Group - Individuals with a disability whose net family income is below 250 percent of the Federal poverty level for a family of the size involved and who, except for earned income, meet all criteria for receiving benefits under the SSI program. See page 12c of Attachment 2.6-A.</td>
</tr>
<tr>
<td>1902(a)(10)(A) (ii)(XV) of the Act</td>
<td>[] 24. TWWIIA Basic Coverage Group - Individuals with a disability at least 16 but less than 65 years of age whose income and resources do not exceed a standard established by the State. See page 12d of Attachment 2.6-A.</td>
</tr>
<tr>
<td>1902(a)(10)(A) (ii)(XVI) of the Act</td>
<td>[] 25. TWWIIA Medical Improvement Group - Employed individuals at least 16 but less than 65 years of age with a medically approved disability whose income and resources do not exceed a standard established by the State. See page 12h of Attachment 2.6A. Note: If the State elects to cover this group, it MUST also cover the eligibility group described in No. 24 above.</td>
</tr>
</tbody>
</table>

---

**TN No:** 2003-07  
**Supersedes:** TN No. 2002-01  
**Approval Date:** JUN 27, 2003  
**Effective Date:** January 1, 2003  
**CMS ID:**
### C. Optional Coverage of the Medically Needy

<table>
<thead>
<tr>
<th>Agency Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.301</td>
<td>This plan includes the medically needy.</td>
</tr>
<tr>
<td></td>
<td>☑ Yes. This plan covers:</td>
</tr>
<tr>
<td>1902(e) of the Act</td>
<td></td>
</tr>
<tr>
<td>1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.</td>
<td></td>
</tr>
<tr>
<td>2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.</td>
<td></td>
</tr>
<tr>
<td>1902(a)(10) (C)(ii)(I) of the Act</td>
<td>3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(I) of the Act.</td>
</tr>
</tbody>
</table>
C. Optional Coverage of Medically Needy (Continued)

<table>
<thead>
<tr>
<th>Agency* Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(e)(4) of the Act</td>
<td>4. Newborn children born on or after October 1, 1984 to a woman who is eligible as medically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible for one year so long as the woman remains eligible, or would remain eligible if she were pregnant, and the child is a member of the woman's household.</td>
</tr>
<tr>
<td>42 CFR 435.308</td>
<td>5. a. Financially eligible individuals who are not described in section C.3. above and who are under the age of--</td>
</tr>
<tr>
<td></td>
<td>- X 21</td>
</tr>
<tr>
<td></td>
<td>- X 20</td>
</tr>
<tr>
<td></td>
<td>- X 19</td>
</tr>
<tr>
<td></td>
<td>- 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training</td>
</tr>
<tr>
<td></td>
<td>- /X/ b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19, or 18 as specified below:</td>
</tr>
<tr>
<td></td>
<td>- X (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:</td>
</tr>
<tr>
<td></td>
<td>- X (a) In foster homes (and are under the age of 21).</td>
</tr>
<tr>
<td></td>
<td>- X (b) In private institutions (and are under the age of 21).</td>
</tr>
</tbody>
</table>
C. Optional Coverage of Medically Needy (Continued)

(c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of 21).

(2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of 18).

(3) Individuals in NFs (who are under the age of _____). NF services are provided under this plan.

(4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of _____).

(5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of _____). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

(6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.
C. **Optional Coverage of Medically Needy** (Continued)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.326</td>
<td></td>
<td>10. Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.</td>
</tr>
<tr>
<td>435.340</td>
<td></td>
<td>11. Blind and disabled individuals who:</td>
</tr>
<tr>
<td></td>
<td>a.</td>
<td>Meet all current requirements for Medicaid eligibility except the blindness or disability criteria;</td>
</tr>
<tr>
<td></td>
<td>b.</td>
<td>Were eligible as medically needy in December 1973 as blind or disabled; and</td>
</tr>
<tr>
<td></td>
<td>c.</td>
<td>For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.</td>
</tr>
<tr>
<td>1906 of the Act</td>
<td></td>
<td>12. Individuals required to enroll in cost effective employer-based group health plans remain eligible for a minimum enrollment period of ____ months.</td>
</tr>
</tbody>
</table>

---

**TN No.** 91-39  
**Supersedes**  
**TN No.** NEW  
**Approval Date** 8/1992  
**Effective Date** 10/1/91  
**HCFA ID:** 7983E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Florida

REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

<table>
<thead>
<tr>
<th>Agency</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>1935(a) and 1902(a)(66)</td>
<td>42 CFR 423.774 and 423.904</td>
<td>The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act.</td>
</tr>
</tbody>
</table>

1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act;

2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined;

3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.

Approval Date: 08/09/05  Effective Date: 07/01/05
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. General Conditions of Eligibility</td>
<td></td>
</tr>
<tr>
<td>Each individual covered under the plan:</td>
<td></td>
</tr>
<tr>
<td>42 CFR Part 435, Subpart G</td>
<td>1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.</td>
</tr>
<tr>
<td>a. For the categorically needy:</td>
<td></td>
</tr>
<tr>
<td>(i)</td>
<td>Except as specified under items A.2.a.(ii) and (iii) below, for AFDC-related individuals, meets the non-financial eligibility conditions of the AFDC program.</td>
</tr>
<tr>
<td>(ii)</td>
<td>For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.</td>
</tr>
<tr>
<td>1902(m) of the Act</td>
<td>(iv) For financially eligible aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.</td>
</tr>
<tr>
<td>Citation</td>
<td>Condition or Requirement</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>1905(p) of the Act</td>
<td>b. For the medically needy, meets the non-financial eligibility conditions of 42 CFR Part 435.</td>
</tr>
<tr>
<td>1905(s) of the Act</td>
<td>c. For financially eligible qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(1) of the Act, meets the non-financial criteria of section 1905(p) of the Act.</td>
</tr>
<tr>
<td>1902(a) and 1903(v) of the Act and 245A(h)(3)(B) of the Immigration and Nationality Act</td>
<td>d. For financially eligible qualified disabled and working individuals covered under section 1902(a)(10)(E)(11) of the Act, meets the non-financial criteria of section 1905(s).</td>
</tr>
<tr>
<td>Sec. 245A of the Immigration and Nationality Act</td>
<td>3. Is residing in the United States and--</td>
</tr>
<tr>
<td>42 CFR 435.402</td>
<td>a. Is a citizen;</td>
</tr>
<tr>
<td>1902(a) and 1903(v) of the Act and 245A(h)(3)(B) of the Immigration and Nationality Act</td>
<td>b. Is an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law, as defined in 42 CFR 435.408.</td>
</tr>
<tr>
<td>1902(a) and 1903(v) of the Act and 245A(h)(3)(B) of the Immigration and Nationality Act</td>
<td>c. Is an alien granted lawful temporary resident status under section 245A and 210A of the Immigration and Nationality Act if the individual is aged, blind, or disabled as defined in section 1614(a)(1) of the Act, under 18 years of age or a Cuban/Haitian entrant as defined in section 501(e)(1) and (2)(A) of P.L. 96-422;</td>
</tr>
<tr>
<td>Citation</td>
<td>Condition or Requirement</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>d. Is an alien granted lawful temporary resident status under section 210 of the Immigration and Nationality Act not within the scope of c. above (coverage must be restricted to certain emergency services during the five-year period beginning on the date the alien was granted such status); or</td>
<td></td>
</tr>
<tr>
<td>e. Is an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law (coverage must be restricted to certain emergency services).</td>
<td></td>
</tr>
<tr>
<td>42 CFR 435.403 1902(b) of the Act</td>
<td>4. Is a resident of the State, regardless of whether or not the individual maintains the residence permanently or maintains it at a fixed address.</td>
</tr>
</tbody>
</table>

State has interstate residency agreement with the following States:

- CA
- LA
- MD
- S.D.
- AK
- Miss
- Minn
- N.D.
- KS
- WV.
- N.J.
- TX
- ID
- S.C.
- GA
- NM.
- KY
- TN
- OH
- IA
- AL

State has open agreement(s).

Not applicable; no residency requirement.

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TN No. 91-39  SEP 18 1992  Approval Date  Effective Date 10/1/91
TN No. 87-21  HCFA ID: 7985E
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.1008 5. a</td>
<td>Is not an inmate of a public institution. Public institutions do not include medical institutions, nursing facilities and intermediate care facilities for the mentally retarded, or publicly operated community residences that serve no more than 16 residences, or certain child care institutions.</td>
</tr>
<tr>
<td>42 CFR 435.1008 1905(a) of the Act d.</td>
<td>Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program. Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided under the plan.</td>
</tr>
<tr>
<td>42 CFR 433.145 1912 of the Act 6.</td>
<td>Is required, as a condition of eligibility, to assign his or her own rights, or the rights of any other person who is eligible for Medicaid and on whose behalf the individual has legal authority to execute an assignment, to medical support and payments for medical care from any third party. (Medical support is defined as support specified as being for medical care by a court or administrative order.)</td>
</tr>
</tbody>
</table>
An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself or herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in §1902(1)(l)(A) of the Social Security Act (pregnant women and women in the post-partum period) are exempt from these requirements involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

An applicant or recipient must also cooperate in identifying any third party who may be liable to pay for care that is covered under the State plan and providing information to assist in pursuing these third parties. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

Assignment of rights is automatic because of State law.

42 CFR 435.910

7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number) except for aliens seeking medical assistance for the treatment of an emergency medical condition under section 1903(v)(2) of the Social Security Act, (section 1137(f)), and newborn children who are eligible under Section 1902(e)(4).
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(c)(2)</td>
<td>8. Is not required to apply for AFDC benefits under title IV-A as a condition of applying for, or receiving, Medicaid if the individual is a pregnant woman, infant, or child that the State elects to cover under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(i)(IX) of the Act.</td>
</tr>
<tr>
<td>1902(e)(10)(A) and (B) of the Act</td>
<td>9. Is not required, as an individual child or pregnant woman, to meet requirements under section 402(a)(43) of the Act to be in certain living arrangements. (Prior to terminating AFDC individuals who do not meet such requirements under a State's AFDC plan, the agency determines if they are otherwise eligible under the State's Medicaid plan.)</td>
</tr>
<tr>
<td>1906 of the Act</td>
<td>10. Is required to apply for enrollment in an employer-based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).</td>
</tr>
</tbody>
</table>
Is required to apply for coverage under Medicare Parts A, B and/or D if it is likely that the individual would meet the eligibility criteria for any or all of those programs. The state agrees to pay any applicable premiums and, if eligible, cost-sharing (except those applicable under Part D) for individuals required to apply for Medicare. Application for Medicare is a condition of eligibility unless the state does not pay the Medicare premiums, deductibles or co-insurance (except those applicable under Part D) for persons covered by the Medicaid eligibility group under which the individual is applying. [This requirement is based on decision in U.S. Supreme Court case New York State Department of Social Services v. Dublino, 413 U.S. (1973).]
B. Posteligibility Treatment of Institutionalized Individuals' Incomes

1. The following items are not considered in the posteligibility process:

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(o) of the Act</td>
<td>a. SSI and SSP benefits paid under §1611(e)(1)(E) and (G) of the Act to individuals who receive care in a hospital, nursing home, SNF, or ICF.</td>
</tr>
<tr>
<td>Bondi v Sullivan (SSI)</td>
<td>b. Austrian Reparation Payments (pension (reparation) payments made under §500 - 506 of the Austrian General Social Insurance Act). Applies only if State follows SSI program rules with respect to the payments.</td>
</tr>
<tr>
<td>1 (a) of P.L. 103-286</td>
<td>d. Japanese and Aleutian Restitution Payments.</td>
</tr>
<tr>
<td>6(h)(2) of P.L. 101-426</td>
<td>f. Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.).</td>
</tr>
<tr>
<td>1902(r)(1) of the Act</td>
<td>h. VA pensions limited to $90 per month under 38 U.S.C. 5503.</td>
</tr>
</tbody>
</table>

TN No. 98-16 Supersedes Approval Date FEB 1 0 2001 Effective Date 10/1/98

TN No. 95-03 Revised Submission 1/30/2001
2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual’s or couple’s income to the cost of institutionalized care:

Personal Needs Allowance (PNA) of not less than $30 For Individuals and $60 For Couples For All Institutionalized Persons.

a. Aged, blind disabled:
   Individuals $ 105
   Couples $ 210

For the following persons with greater need:

Supplement 15 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.

b. AFDC related:
   Children $ 105
   Adults $ 105

For the following persons with greater need:

Supplement 15 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.

c. Individual under age 21 covered in the plan as specified in Item B.7. of Attachment 2.2-A.
   $ 105
For the following persons with greater need:

Supplement 15 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.

1924 of the Act

3. In addition to the amounts under item 2., the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse:

a. The monthly income allowance for the community spouse, calculated using the formula in §1924(d)(2), is the amount by which the maintenance needs standard exceeds the community spouse's income. The maintenance needs standard cannot exceed the maximum prescribed in §1924 (d)(3)(C). The maintenance needs standard consists of a poverty level component plus an excess shelter allowance.

_x_ The poverty level component is calculated using the applicable percentage (set out §1924(d)(3)(B) of the Act) of the official poverty level.

_ _ The poverty level component is calculated using a percentage greater than the applicable percentage, equal to ___ % of the official poverty level (still subject to maximum maintenance needs standard).

_ _ The maintenance needs standard for all community spouses is set at the maximum permitted by §1924(d)(3)(C).

Except that, when applicable, the State will set the community spouse's monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse's income, or at the amount of any court-ordered support.
In determining any excess shelter allowance, utility expenses are calculated using:

- X the standard utility allowance under §5(e) of the Food Stamp Act of 1977; or

- the actual unreimbursable amount of the community spouse’s utility expenses less any portion of such amount included in condominium or cooperative charges.

b. The monthly income allowance for other dependent family members living with the community spouse is:

- X one-third of the amount by which the poverty level component (calculated under §1924(d)(3)(A)(i) of the Act, using the applicable percentage specified in §1924(d)(3)(B)) exceeds the dependent family member’s monthly income.

- a greater amount as calculated as follows:

The following definition is used in lieu of the definition provided by the Secretary to determine the dependency of family members under §1924(d)(1):

c. Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party:

(i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.

(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to ATTACHMENT 2.6-A.)
4. In addition to any amounts deductible under the items above, the following monthly amounts are deducted from the remaining monthly income of an institutionalized individual or an institutionalized couple:

a. An amount for the maintenance needs of each member of a family living in the institutionalized individual's home with no community spouse living in the home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the:
   - AFDC level; or
   - Medically needy level:

   (Check one)
   - X AFDC levels in Supplement 1
   - Medically needy level in Supplement 1
   - Other: __

b. Amounts for health care expenses described below that have not been deducted under 3.c. above (i.e., for an institutionalized individual with a community spouse), are incurred by and for the institutionalized individual or institutionalized couple, and are not subject to the payment by a third party:

   (i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.

   (ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amount are described in Supplement 3 to ATTACHMENT 2.6-A.)

5. At the option of the State, as specified below, the following is deducted from any remaining monthly income of an institutionalized individual or an institutionalized couple:

A monthly amount for the maintenance of the home of the individual or couple for not longer than 6 months if a physician has certified that the individual, or one member of the institutionalized couple, is likely to return to the home within that period:

   -- No.
   -- Yes (the applicable amount is shown on page 5a.)
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️</td>
<td>Amount for maintenance of home is: $0</td>
</tr>
<tr>
<td></td>
<td>Amount for maintenance of home is the actual maintenance costs not to exceed $_____</td>
</tr>
<tr>
<td></td>
<td>Amount for maintenance of home is deductible when countable income is determined under §1924(d)(1) of the Act only if the individuals' home and the community spouse's home are different.</td>
</tr>
<tr>
<td></td>
<td>Amount for maintenance of home is not deductible when countable income is determined under §1924 (d)(1) of the Act.</td>
</tr>
</tbody>
</table>

TN No. 98-16
Supersedes
TN No. NEW

Approval Date  FEB 16 2001
Effective Date 10/1/98
Revised Submission 1/30/2001
C. Financial Eligibility

For individuals who are AFDC or SSI recipients, the income and resource levels and methods for determining countable income and resources of the AFDC and SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902(f) of the Act, or more liberal methods under section 1902(z)(2) of the Act, as specified below.

For individuals who are not AFDC or SSI recipients in a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section C apply.

State: FLORIDA

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.</td>
</tr>
<tr>
<td></td>
<td>Supplement 7 to ATTACHMENT 2.6-A specifies the income levels for categorically needy aged, blind and disabled persons who are covered under requirements more restrictive than SSI.</td>
</tr>
<tr>
<td></td>
<td>Supplement 4 to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.</td>
</tr>
<tr>
<td></td>
<td>Supplement 5 to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.</td>
</tr>
<tr>
<td>X</td>
<td>Supplement 8a to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.</td>
</tr>
<tr>
<td>X</td>
<td>Supplement 8b to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.</td>
</tr>
<tr>
<td>X</td>
<td>Supplement 14 to ATTACHMENT 2.6-A specifies income levels used by States for determining eligibility of Tuberculosis-infected individuals whose eligibility is determined under §1902(z)(1) of the Act.</td>
</tr>
</tbody>
</table>

TN No. 02-18
Supersedes
TN No. 95-17

Approval Date 3/25/03
Effective 5/1/03
<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(r)(2) of the Act</td>
<td>1. Methods of Determining Income</td>
</tr>
<tr>
<td></td>
<td>a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).</td>
</tr>
<tr>
<td></td>
<td>(1) In determining countable income for AFDC-related individuals, the following methods are used:</td>
</tr>
<tr>
<td></td>
<td>(a) The methods under the State's approved AFDC plan only; or</td>
</tr>
<tr>
<td></td>
<td>(b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.</td>
</tr>
<tr>
<td>1902(e)(6) the Act</td>
<td>3. Agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.</td>
</tr>
</tbody>
</table>
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.721, 435.311, and 1902(m)(1)(B)(m)(4) and 1902(r)(2) of the Act</td>
<td>b. Aged individuals. In determining countable income for aged individuals, including aged individuals with incomes up to the Federal poverty level described in section 1902(m)(1) of the Act, the following methods are used:</td>
</tr>
</tbody>
</table>

- The methods of the SSI program only.
- The methods of the SSI program and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.
For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.

For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--

SSI methods only.
SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.
Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.

TN No. 91-39 Supersedes Approval Date SEP 15 1992 Effective Date 10/1/91
TN No. 91-27

HCFA ID: 7985E
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.721 and 435.831 and 1902(m)(1)(B), (m)(4), and 1902(f)(2) of the Act</td>
<td>c. Blind individuals. In determining countable income for blind individuals, the following methods are used:</td>
</tr>
<tr>
<td></td>
<td>The methods of the SSI program only.</td>
</tr>
<tr>
<td></td>
<td>X SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A, and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--</td>
</tr>
<tr>
<td></td>
<td>SSI methods only.</td>
</tr>
<tr>
<td></td>
<td>X SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
</tbody>
</table>

TN No. 91-39 Supersedes Approval Date SEP 8 1992 Effective Date 10/1/91
TN No. 90-40

HCFA ID: 7985E
In determining relative responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.721, and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act</td>
<td>d. <strong>Disabled individuals.</strong> In determining countable income of disabled individuals, including individuals with incomes up to the Federal poverty level described in section 1902(m) of the Act the following methods are used:</td>
</tr>
<tr>
<td></td>
<td>___ The methods of the SSI program.</td>
</tr>
<tr>
<td></td>
<td>X SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>___ For optional State supplement recipients under §435.230: income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>___ For individuals other than optional State supplement recipients (except aged and disabled individuals described in section 1903(m)(1) of the Act): more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
</tbody>
</table>

**TN No.** 91-39
**Supersedes** 88-07
**Approval Date** SEP 8 1992
**Effective Date** 10/1/91

HCFA ID: 7985E
State: FLORIDA

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--</td>
</tr>
<tr>
<td></td>
<td>SSI methods only.</td>
</tr>
<tr>
<td></td>
<td>SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in section 1902(m)(1) of the Act. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
</tbody>
</table>

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

---

TN No. 91-39  
Supersedes  
TN No. 87-21  
Supersedes  
Approval Date SEP 15 1992  
Effective Date 10/1/91  
HCFA ID: 7985E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(1)(I)(E) and 1902(r)(2) of the Act</td>
<td>e. Poverty level pregnant women, infants, and children. For pregnant women and infants or children covered under the provisions of sections 1902(a)(10)(A)(I)(IV), (VI), and (VII), and 1902(a)(10)(A)(II)(IX) of the Act--</td>
</tr>
<tr>
<td></td>
<td>(1) The following methods are used in determining countable income:</td>
</tr>
<tr>
<td></td>
<td>X The methods of the State's approved AFDC plan.</td>
</tr>
<tr>
<td></td>
<td>X The methods of the approved title IV-E plan.</td>
</tr>
<tr>
<td></td>
<td>The methods of the approved AFDC State plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>The methods of the approved title IV-E plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
</tbody>
</table>

Supersedes IN No. 91-39

IN No. 92-23 Approval Date OCT 13 1992 Effective Date 4/1/92

Revised Submission 9/17/92
## ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(e)(6) of the Act</td>
<td>2. In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.</td>
</tr>
<tr>
<td>1902(p)(1), 1902(m)(4), and 1902(r)(2) of the Act</td>
<td>3. The agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.</td>
</tr>
<tr>
<td>f. Qualified Medicare beneficiaries.</td>
<td>f. Qualified Medicare beneficiaries. In determining countable income for qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, the following methods are used:</td>
</tr>
<tr>
<td>X SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.</td>
<td>X SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>For institutional couples, the methods specified under section 1611(e)(5) of the Act.</td>
<td>For institutional couples, the methods specified under section 1611(e)(5) of the Act.</td>
</tr>
<tr>
<td>Citation</td>
<td>Condition or Requirement</td>
</tr>
<tr>
<td>------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1905(s) of the Act</td>
<td>If an individual receives a title II benefit, any amount attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a &quot;transition period&quot; beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level. For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period. For individuals not receiving title II income, the revised poverty levels are effective no later than the date of publication.</td>
</tr>
<tr>
<td>1905(p) of the Act</td>
<td>(1) Qualified disabled and working individuals. In determining countable income for qualified disabled and working individuals covered under 1902(a)(10)(E)(ii) of the Act, the methods of the SSI program are used.</td>
</tr>
<tr>
<td></td>
<td>(2) Specified low-income Medicare beneficiaries. In determining countable income for specified low-income Medicare beneficiaries covered under 1902(a)(10)(E)(iii) of the Act, the same method as in f. is used.</td>
</tr>
<tr>
<td>Citation</td>
<td>Condition or Requirement</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>1902(a)(10)(A) (ii)(XV) of the Act</td>
<td>(ii) Working Individuals with Disabilities - Basic Coverage Group - TWWIIA</td>
</tr>
</tbody>
</table>

In determining financial eligibility for working individuals with disabilities under this provision, the following standards and methodologies are applied:

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The agency does not apply any income or resource standard.</td>
</tr>
<tr>
<td></td>
<td><strong>NOTE:</strong> If the above option is chosen, no further eligibility-related options should be elected.</td>
</tr>
<tr>
<td></td>
<td>The agency applies the following income and/or resource standard(s):</td>
</tr>
<tr>
<td></td>
<td><strong>Income Limit:</strong> Current Meds-AD income limit in effect</td>
</tr>
<tr>
<td></td>
<td><strong>Resource Limit:</strong> $8,000 (individual) $9,000 (couple)</td>
</tr>
</tbody>
</table>

Effective Date: January 1, 2003
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(A) (ii)(XV) of the Act (cont.)</td>
<td><strong>Income Methodologies</strong></td>
</tr>
<tr>
<td></td>
<td>In determining whether an individual meets the income standard described above, the agency uses the following methodologies:</td>
</tr>
<tr>
<td></td>
<td>____ The income methodologies of the SSI program.</td>
</tr>
<tr>
<td></td>
<td>____ The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6 - A.</td>
</tr>
<tr>
<td></td>
<td>____ The agency uses more liberal income methodologies than the SSI program. More liberal income methodologies are described in Supplement 8a to Attachment 2.6-A.</td>
</tr>
</tbody>
</table>

**Effective Date** January 1, 2003

**Approval Date** JUN 27 2003

**TN No:** 2003-07

**Supersedes** TN No. 2002-01

**Effective Date** January 1, 2003

**TN No:** 2003-07
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(A) (ii)(XV) of the Act (cont.)</td>
<td>Resource Methodologies</td>
</tr>
</tbody>
</table>

In determining whether the individual meets the resource standard described above, the agency uses the following methodologies:

Unless one of the following items is checked, the agency, under the authority of 1902(r)(2) of the Act, disregards all funds held in retirement funds and accounts, including private retirement accounts such as IRAs and other individual accounts, and employer-sponsored retirement plans such as 401(k) plans, Keogh plans, and employer pension plans. Any disregard involving retirement accounts is separately described in Supplement 8b to Attachment 2.6-A.

- The agency disregards funds held in employer-sponsored retirement plans, but not private retirement plans.
- The agency disregards funds in retirement accounts in a manner other than those described above. The agency’s disregards are specified in Supplement 8b to Attachment 2.6-A.
The agency does not disregard funds in retirement accounts.

The agency uses resource methodologies in addition to any indicated above that are more liberal than those used by the SSI program. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.

The agency uses the resource methodologies of the SSI Program.

The agency uses methodologies for treatment of resources that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 5 to Attachment 2.6-A.
1902(a)(10)(A)(ii)(XIII) (XV), (XVI), and 1916(g) of the Act

Payment of Premiums or Other Cost Sharing Charges

For individuals eligible under the BBA eligibility group described in No. 23 on page 23d of Attachment 2.2-A:

The agency requires payment of premiums or other cost-sharing charges on a sliding scale based on income. The premiums or other cost-sharing charges, and how they are applied are described below:

TN No. 2003-07
Supersedes TN No. 2002-01

Effective Date January 1, 2003

Approval Date 2003

CMS ID:
For individuals eligible under the Basic Coverage Group described in No. 24 on page 23d of Attachment 2.2-A, and the Medical Improvement Group described in No. 25 on page 23d of Attachment 2.2-A:

NOTE: Regardless of the option selected below, the agency MUST require that individuals whose annual adjusted gross income, as defined under IRS statute, exceeds $75,000 pay 100 percent of premiums.

The agency requires individuals to pay premiums or other cost-sharing charges on a sliding scale based on income. For individuals with net annual income below 450 percent of the Federal poverty level for a family of the size involved, the amount of premiums cannot exceed 7.5 percent of the individual’s income.

The premiums or other cost-sharing charges, and how they are applied are described on page 120.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sections 1902(a)(10)(A) (ii)(XV), (XVI), and 1916(g) of the Act (cont.)</td>
<td><strong>Premiums and Other Cost-Sharing Charges</strong>&lt;br&gt;For the Basic Coverage Group and the Medical Improvement Group, the agency's premium and other cost-sharing charges, and how they are applied, are described below.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TN No.</th>
<th>2003-07</th>
<th>Effective Date</th>
<th>January 1, 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supersedes</td>
<td>2002-01</td>
<td>Approval Date</td>
<td>JUN 30 2003</td>
</tr>
<tr>
<td>TN No.</td>
<td>2002-01</td>
<td>CMS ID:</td>
<td></td>
</tr>
</tbody>
</table>
2. Medicaid Qualifying Trusts

In the case of a Medicaid qualifying trust described in section 1902(k)(2) of the Act, the amount from the trust that is deemed available to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded. These policies apply to trusts established prior to October 1, 1993.

/X/ The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship.

3. Medically needy income levels (MNILs) are of based on family size.

Supplement 1 to ATTACHMENT 2.6-A specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, Supplement 1 so indicates.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.732, 435.831</td>
<td>4. Handling of Excess Income - Spend-down for the Medically Needy in All States and the Categorically Needy in 1902(f) States Only</td>
</tr>
</tbody>
</table>

**a. Medically Needy**

1. Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for periods of 1 month(s) (not to exceed 6 months) to determine the amount of excess countable income applicable to the cost of medical care and services.

2. If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order:

   a. Health insurance premiums, deductibles and coinsurance charges.

   b. Expenses for necessary medical and remedial care not included in the plan.

   c. Expenses for necessary medical and remedial care included in the plan.

   **Reasonable limits on amounts of expenses deducted from income under a.(2)(a) and (b) above are listed below.**

   Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government and is financed by the state or local government.

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1902(a)(17) of the Act

**TN No.** 91-39  **Supersedes**  **Approval Date** SEP 15, 1992  **Effective Date** 10/1/91

**TN No.** 90-40  **HCFA ID:** 7985E  **Revised Submission** 6/26/92
State/Territory: FLORIDA

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1903(f)(2) of the Act</td>
<td>a. Medically Needy (Continued)</td>
</tr>
<tr>
<td></td>
<td>(3) If countable income exceeds the MNIL standard, the agency deducts spend down payments made to the State by the individual.</td>
</tr>
</tbody>
</table>

Subject to the 42 CFR 435.602 and the provisions in Supplement 8a to Attachment 2.6-A of the state plan, the state will use MAGI-based income methodologies for purposes of determining medically needy eligibility for the following categories of individuals:

- pregnant women,
- children,
- parent/caretaker relatives

Supersedes Approval Date 09-04-15  
Effective Date 4/1/15
**Condition or Requirement**

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.732</td>
<td>The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income:</td>
</tr>
<tr>
<td>(1)</td>
<td>Any SSI benefit received.</td>
</tr>
<tr>
<td>(2)</td>
<td>Any State supplement received that is within the scope of an agreement described in sections 1616 or 1634 of the Act, or a State supplement within the scope of section 1902(a)(10)(A)(ii)(XI) of the Act.</td>
</tr>
<tr>
<td>(3)</td>
<td>Increases in OASDI that are deducted under §§435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section.</td>
</tr>
<tr>
<td>(4)</td>
<td>Other deductions from income described in this plan at Attachment 2.6-A, Supplement 4.</td>
</tr>
<tr>
<td>(5)</td>
<td>Incurred expenses for necessary medical and remedial services recognized under State law.</td>
</tr>
</tbody>
</table>

1902(a)(17) of the Act, P.L. 100-203

Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

**TN No.** 91-39  
**Supersedes**  
**TN No.** 87-37  
**Approval Date** SEP 18 1992  
**Effective Date** 10/1/91  
**HCFA ID:** 7985E
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1903(f)(2) of the Act</td>
<td>(6) Spenddown payments made to the State by the individual. NOTE: FFP will be reduced to the extent a State is paid a spenddown payment by the individual.</td>
</tr>
</tbody>
</table>

TN No. 91-39  
Supersedes  
TN No. NEW  
Approval Date  
Effective Date 10/1/91  
HCFA ID: 7985E/
5. Methods for Determining Resources

a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).

(1) In determining countable resources for AFDC-related individuals, the following methods are used:

(a) The methods under the State's approved AFDC plan; and

(b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8B to ATTACHMENT 2.6-A.

(2) In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
### 5. Methods for Determining Resources

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r) of the Act</td>
<td>b. Aged individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, the agency used the following methods for treatment of resources:</td>
</tr>
<tr>
<td></td>
<td>The methods of the SSI program.</td>
</tr>
<tr>
<td></td>
<td>X SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods.</td>
</tr>
</tbody>
</table>

**Supersedes** 91-39

**Approval Date** SEP 8 1992

**Effective Date** 10/1/91

**HCFA ID:** 7985E
In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B), and 1902(r) of the Act</td>
<td>c. <strong>Blind individuals.</strong> For blind individuals the agency uses the following methods for treatment of resources:</td>
</tr>
<tr>
<td></td>
<td>The methods of the SSI program.</td>
</tr>
<tr>
<td></td>
<td>SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>Methods that are more restrictive and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describe the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specify the more liberal methods.</td>
</tr>
</tbody>
</table>

In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
<table>
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<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r)(2) of the Act</td>
<td>d. Disabled individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act. The agency uses the following methods for the treatment of resources:</td>
</tr>
<tr>
<td></td>
<td>X The methods of the SSI program.</td>
</tr>
<tr>
<td></td>
<td>X SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal that those under the SSI program. More restrictive methods are described in Supplement 5 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8b to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>The agency uses the following methods in the treatment of resources:</td>
</tr>
<tr>
<td></td>
<td>X The methods of the SSI program only.</td>
</tr>
<tr>
<td></td>
<td>X The methods of the SSI program and/or any more liberal methods described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</td>
</tr>
</tbody>
</table>

TN No. 91-39
Supersedes TN No. 90-22
Approval Date 8-1-92
Effective Date 10/1/91
HCFA ID: 7985E
Methods that are more liberal than those of SSI. The more liberal methods are specified in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.

X Not applicable. The agency does not consider resources in determining eligibility.

In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

<table>
<thead>
<tr>
<th>Condition or Requirement</th>
<th>Citation</th>
</tr>
</thead>
<tbody>
<tr>
<td>f. Poverty level infants covered under section 1902(a)(101A)(1)(IV) of the Act.</td>
<td>1902(1)(3) and 1902(r)(2) of the Act</td>
</tr>
<tr>
<td>The agency uses the following methods for the treatment of resources:</td>
<td></td>
</tr>
<tr>
<td>The methods of the State's approved AFDC plan.</td>
<td></td>
</tr>
<tr>
<td>Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(1)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A.</td>
<td></td>
</tr>
<tr>
<td>Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</td>
<td></td>
</tr>
<tr>
<td>Not applicable. The agency does not consider resources in determining eligibility.</td>
<td></td>
</tr>
</tbody>
</table>

TN No. 91-39 Supersedes Approval Date 8/32 Effective Date 10/1/91
TN No. 90-22

HCFA ID: 7985E
## ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
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<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(1)(3) and 1902(r)(2) of the Act</td>
<td>1. Poverty level children covered under section 1902(a)(10)(A)(VI) of the Act. The agency uses the following methods for the treatment of resources: The methods of the State's approved AFDC plan. Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(1)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A. Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 8b to ATTACHMENT 2.6-A. Not applicable. The agency does not consider resources in determining eligibility. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.</td>
</tr>
</tbody>
</table>
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
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<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(1)(3) and 1902(r)(2) of the Act</td>
<td>g. 2. Poverty level children under section 1902(a)(10)(A)(VII)</td>
</tr>
<tr>
<td>1902(1)(3)(C) of the Act</td>
<td>Methods more liberal than those in the State's approved AFDC plan (but not more restrictive) as described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>1902(r)(2) of the Act</td>
<td>Methods more liberal than those in the State's approved AFDC plan (but not more restrictive) as specified in Supplement 5a of ATTACHMENT 2.6-A.</td>
</tr>
</tbody>
</table>

X Not applicable. The agency does not consider resources in determining eligibility.

In determining relative responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
5. h. For Qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act the agency uses the following methods for treatment of resources:

- The methods of the SSI program only.
- X The methods of the SSI program and/or more liberal methods as described in Supplement Bb to ATTACHMENT 2.6-A.

5. i. For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the agency uses SSI program methods for the treatment of resources.

5. j. For COBRA continuation beneficiaries, the agency uses the following methods for treatment of resources:

- The methods of the SSI program only.
- More restrictive methods applied under section 1902(f) of the Act as described in Supplement 5 to Attachment 2.6-A.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The agency uses the same method as in 5.h. of Attachment 2.6-A.</td>
</tr>
</tbody>
</table>

6. Resource Standard - Categorically Needy

a. 1902(f) States (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals:
   - Same as SSI resource standards.
   - More restrictive.

The resource standards for other individuals are the same as those in the related cash assistance program.

b. Non-1902(f) States (except as specified under items 6.c. and d. below)

The resource standards are the same as those in the related cash assistance program.

Supplement 8 to ATTACHMENT 2.6-A specifies for 1902(f) States the categorically needy resource levels for all covered categorically needy groups.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(1)(3)(A), (B) and (C) of the Act</td>
<td>c. For pregnant women and infants covered under the provisions of section 1902(a)(10)(A)(i)(IX) of the Act, the agency applies a resource standard.</td>
</tr>
<tr>
<td>1902(1)(3)(A) and (C) of the Act</td>
<td>d. For children covered under the provisions of section 1902(a)(10)(A)(i)(IX) of the Act, the agency applies a resource standard.</td>
</tr>
</tbody>
</table>

Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which, for pregnant women, is no more restrictive than the standard under the SSI program; and for infants is no more restrictive than the standard applied in the State's approved AFDC plan.

X No. The agency does not apply a resource standard to these individuals.

Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard applied in the State's approved AFDC plan.

X No. The agency does not apply a resource standard to these individuals.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(m)(1)(C) and (m)(2)(B) of the Act</td>
<td>e. For aged and disabled individuals described in section 1902(m)(l) of the Act who are covered under section 1902(a)(10)(A)(ii)(X) of the Act, the resource standard is:</td>
</tr>
<tr>
<td></td>
<td>Same as SSI resource standards.</td>
</tr>
<tr>
<td></td>
<td>X Same as the medically needy resource standards, which are higher than the SSI resource standards (if the State covers the medically needy).</td>
</tr>
</tbody>
</table>

Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for these individuals.
### Citation | Condition or Requirement
--- | ---
7. Resource Standard – Medically Needy |  
  a. Resource standards are based on family size.
  b. A single standard is employed in determining resource eligibility for all groups.
  c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for—
    - Aged
    - Blind
    - Disabled  

Supplement 2 to ATTACHMENT 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., Supplement 2 so indicates.

8. Resource Standard – Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, and Qualifying Individuals |  
For Qualified Medicare Beneficiaries, Specified Low-Income Beneficiaries and Qualifying Individuals covered under section 1902(a)(10)(E)(i), 1902(a)(10)(E)(iii), and 1902(a)(10)(E)(iv) of the Act, the resource standard is three times the SSI Standard indexed annually since 2006. For subsequent years, the resource standard will be increased by the annual percentage increase in the consumer price index rounded to the nearest multiple of $10.

9. Resource Standard – Qualified Disabled and Working Individuals |  
For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the resource standard for an individual or a couple (in the case of an individual with a spouse) is twice the SSI resource standard.
10. Excess Resources

a. Categorically Needy, Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, and Specified Low-Income Medicare Beneficiaries

Any excess resources make the individual ineligible.

b. Categorically Needy Only

X This State has a section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources.

c. Medically Needy

Any excess resources make the individual ineligible.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.914</td>
<td>Effective Date of Eligibility</td>
</tr>
<tr>
<td></td>
<td>a. Groups Other Than Qualified Medicare Beneficiaries</td>
</tr>
<tr>
<td></td>
<td>(1) For the prospective period.</td>
</tr>
<tr>
<td></td>
<td>Coverage is available for the full month if the following individuals are eligible at any time during the month.</td>
</tr>
<tr>
<td></td>
<td>- X Aged, blind, disabled.</td>
</tr>
<tr>
<td></td>
<td>- X AFDC-related.</td>
</tr>
<tr>
<td></td>
<td>Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.</td>
</tr>
<tr>
<td></td>
<td>Medically Needy recipients must incur medical expenses in order to become eligible.</td>
</tr>
<tr>
<td></td>
<td>- X Aged, blind, disabled.</td>
</tr>
<tr>
<td></td>
<td>- X AFDC-related.</td>
</tr>
<tr>
<td></td>
<td>(2) For the retroactive period.</td>
</tr>
<tr>
<td></td>
<td>Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:</td>
</tr>
<tr>
<td></td>
<td>- Aged, blind, disabled.</td>
</tr>
<tr>
<td></td>
<td>- AFDC-related.</td>
</tr>
<tr>
<td></td>
<td>Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied:</td>
</tr>
<tr>
<td></td>
<td>- Aged, blind, disabled.</td>
</tr>
<tr>
<td></td>
<td>- X AFDC-related.</td>
</tr>
</tbody>
</table>

TN No. 91-39 Supersedes TN No. 90-03
Approval Date 8/32 Effective Date 10/1/91
HCFA ID: 7985E
# STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

## State: FLORIDA

### ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1920(b)(1) cf the Act</td>
<td>X (3) For a presumptive eligibility for pregnant women only. Coverage is available for ambulatory prenatal care for the period that begins on the day a qualified provider determines that a woman meets any of the income eligibility levels specified in ATTACHMENT 2.6-A of this approved plan. If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the period ends on the day that the State agency makes the determination of eligibility based on that application. If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the period ends on that last day.</td>
</tr>
<tr>
<td>1902(e)(8) and 1905(a) of the Act</td>
<td>X b. For qualified Medicare beneficiaries defined in section 1905(p)(1) of the Act coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under section 1905(p)(1). The eligibility determination is valid for--</td>
</tr>
<tr>
<td></td>
<td>X 12 months</td>
</tr>
<tr>
<td></td>
<td>- 6 months</td>
</tr>
<tr>
<td></td>
<td>- ___ months (no less than 6 months and no more than 12 months)</td>
</tr>
</tbody>
</table>

---

**TN No.** 92-23  
**Supersedes** Approval Date 4/1/92  
**TN No.** 91-39  
**OCT 13 1992**  
**Effective Date** 4/1/92
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(51)(B) and 1902(f) of the Act</td>
<td>Transfer of Resources - Categorically and Medically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals. The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources.</td>
</tr>
</tbody>
</table>

TN No. 91-39
Supersedes
TN No. NEW

Approval Date: SEP 18, 1992
Effective Date: 10/1/91
HCFA ID: 7985E
Revised Submission: 6/26/92
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1924 of the Act</td>
<td>15. The agency complies with the provisions of §1924 with respect to income and resource eligibility and posteligibility determinations for individuals who are expected to be institutionalized for at least 30 consecutive days and who have a spouse living in the community. When applying the formula used to determine the amount of resources in initial eligibility determinations, the State standard for community spouses is:</td>
</tr>
<tr>
<td></td>
<td>x the maximum standard permitted by law;</td>
</tr>
<tr>
<td></td>
<td>_ the minimum standard permitted by law; or</td>
</tr>
<tr>
<td></td>
<td>$ a standard that is an amount between the minimum and the maximum.</td>
</tr>
</tbody>
</table>

FEB 16 2001 Effective 10/1/98

Approval Date

Revised Submission 1/30/2001
## FLORIDA

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 13611 OBRA 1993</td>
<td>The agency complies with the provisions of section 13611 of OBRA 1993 with respect to the transfer of income and assets and the exclusion of income trusts.</td>
</tr>
</tbody>
</table>

---

**TN No.** 93-59

**Supersedes**

**TN No.** NEW

**FEB 18 1994**

**Approval**

**Effective** 10/1/93
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 13611</td>
<td>The agency complies with the provisions of section 13612 of OBRA 1993 with respect to recovering the Medicaid costs of long term care from the estates of recipients. Procedures have been established to waive recovery due to undue hardship.</td>
</tr>
</tbody>
</table>

TN No. 93-60
Supersedes
TN No. NEW

Approval 2-9-94
Effective 10/1/93
A. MANDATORY CATEGORICALLY NEEDY
1. TANF-Related Groups Other Than Poverty Level Pregnant Women and Infants:

PAYERMENT STANDARDS

<table>
<thead>
<tr>
<th>FAMILY SIZE</th>
<th>PAYMENT STANDARD (INCLUDES MAXIMUM SHELTER)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>180</td>
</tr>
<tr>
<td>2</td>
<td>241</td>
</tr>
<tr>
<td>3</td>
<td>303</td>
</tr>
<tr>
<td>4</td>
<td>364</td>
</tr>
<tr>
<td>5</td>
<td>426</td>
</tr>
<tr>
<td>6</td>
<td>487</td>
</tr>
<tr>
<td>7</td>
<td>549</td>
</tr>
<tr>
<td>8</td>
<td>610</td>
</tr>
<tr>
<td>9</td>
<td>671</td>
</tr>
<tr>
<td>10</td>
<td>733</td>
</tr>
<tr>
<td>10+</td>
<td>795</td>
</tr>
</tbody>
</table>

The need standard is based on 100 percent of the official Federal income poverty line.

Adjustment for each addition.

1. Pregnant Women and Infants under Section 1902(a)(10)(I)(IV) of the Act:

Effective May 1, 1992, based on the following percent of the official Federal income poverty level--

- 133 percent (specify)
- 185 percent (no more than 185 percent)

Based on family size
Monthly Residential Group Care Rates

<table>
<thead>
<tr>
<th>Age 0-11</th>
<th>Age 12 - 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Rate</td>
<td>$605</td>
</tr>
<tr>
<td>Enhanced Rate</td>
<td>$715</td>
</tr>
<tr>
<td>up to Maximum of</td>
<td>$1,395</td>
</tr>
</tbody>
</table>

Included in the above monthly rates for foster family homes, foster family group homes and non-psychiatric residential group care are funds for the child's allowance and incidentals at the following rates:

<table>
<thead>
<tr>
<th>Allowance</th>
<th>Incidentals</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5</td>
<td>$7</td>
</tr>
</tbody>
</table>

In addition to the board payment, an initial and a yearly clothing allowance is provided for all departmental foster care children. The funds to purchase school clothes for these children will be provided directly to the parents. If the children are in residential group care, the funds will be provided to the caregivers. The rates are as follows:

**Initial Clothing Allowance**

<table>
<thead>
<tr>
<th>Age 0-11</th>
<th>Age 12 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>$50</td>
<td>$70</td>
</tr>
</tbody>
</table>

**Annual Clothing Allowance**

<table>
<thead>
<tr>
<th>Age 0-4</th>
<th>Age 5 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100 per child</td>
<td>$200 per child</td>
</tr>
</tbody>
</table>

As in the past, these rates are to be treated as the budgeted average. Exceptional circumstances may require paying an additional amount to obtain needed services.

Amendment 91-07
Effective 1/1/91
Supersedes 87-37
Approval Date 4/15/91
### Emergency Shelter Care Rates

<table>
<thead>
<tr>
<th>Type of Shelters</th>
<th>Monthly Subsidy</th>
<th>Per Diem Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-11 Family Shelters</td>
<td>$50</td>
<td>$11.74</td>
</tr>
<tr>
<td>12 over Family Shelters</td>
<td>$50</td>
<td>$12.86</td>
</tr>
<tr>
<td>0-11 Continuous Supervision</td>
<td>0</td>
<td>$26.83</td>
</tr>
<tr>
<td>12 over Continuous Supervision</td>
<td>0</td>
<td>$28.00</td>
</tr>
<tr>
<td>24 Hour Awake Supervision</td>
<td>0</td>
<td>$45.55</td>
</tr>
</tbody>
</table>

### Monthly Family Foster Care Board Rates

<table>
<thead>
<tr>
<th>Age 0-11</th>
<th>Age 12 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum</td>
<td>$296</td>
</tr>
<tr>
<td>Moderate</td>
<td>$314</td>
</tr>
<tr>
<td>Intensive</td>
<td>$332</td>
</tr>
</tbody>
</table>

### Monthly Foster Family Group Home Rates

$473 per child
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY (Continued)

3. For children under Section 1902(a)(10)(i)(VI) of the Act (children who have attained age 1 but have not attained age 6), the income eligibility level is 133 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.

4. For children under Section 1902(a)(10)(i)(VII) of the Act (children who were born after September 30, 1983 and have attained age 6 but have not attained age 19), the income eligibility level is 100 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.
B. OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women and Infants

The levels for determining income eligibility for optional groups of pregnant women and infants under the provisions of sections 1902(a)(1)(A)(ii)(IX) and 1902(1)(2) of the Act are as follows:

Based on 185 percent of the official Federal income poverty level (more than 133 percent and no more than 185 percent).

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Income Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$___________</td>
</tr>
<tr>
<td>2</td>
<td>$___________</td>
</tr>
<tr>
<td>3</td>
<td>$___________</td>
</tr>
<tr>
<td>4</td>
<td>$___________</td>
</tr>
<tr>
<td>5</td>
<td>$___________</td>
</tr>
</tbody>
</table>

Supersedes TN No. 91-39

TN No. 93-45 Approval Date 11-19-93 Effective Date 7/1/93
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State:  FLORIDA

INCOME ELIGIBILITY LEVELS (Continued)

B.  OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LINE

2.  Children under the age of 19

The levels for determining income eligibility for groups of children who are born after September 30, 1983 and who have attained 6 years of age under the provisions of section 1902(1)(2) of the Act are as follows:

Based on ____100____ percent (no more than 100 percent) of the official federal income poverty line.

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Income Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$___________</td>
</tr>
<tr>
<td>2</td>
<td>$___________</td>
</tr>
<tr>
<td>3</td>
<td>$___________</td>
</tr>
<tr>
<td>4</td>
<td>$___________</td>
</tr>
<tr>
<td>5</td>
<td>$___________</td>
</tr>
<tr>
<td>6</td>
<td>$___________</td>
</tr>
<tr>
<td>7</td>
<td>$___________</td>
</tr>
<tr>
<td>8</td>
<td>$___________</td>
</tr>
<tr>
<td>9</td>
<td>$___________</td>
</tr>
<tr>
<td>10</td>
<td>$___________</td>
</tr>
</tbody>
</table>
INCOME ELIGIBILITY LEVELS (Continued)

3. Aged and Disabled Individuals

The levels for determining income eligibility for groups of aged and disabled individuals under the provisions of section 1902 (m) (1) of the Act are based on ____ percent of the official Federal income poverty line.

If an individual receives a title II benefit, any amount attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the beginning of the month following the date of publication.
C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

The levels for determining income eligibility for groups of qualified Medicare beneficiaries under the provisions of section 1905(p)(2)(A) of the Act are as follows:

1. NON-SECTION 1902(f) STATES

a. Based on the following percent of the official Federal income poverty level:

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Income Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eff. Jan. 1, 1989:</td>
<td>85%</td>
<td>(no more than 100)</td>
</tr>
<tr>
<td>Eff. Jan. 1, 1990:</td>
<td>90%</td>
<td>(no more than 100)</td>
</tr>
<tr>
<td>Eff. Jan. 1, 1991:</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Eff. Jan. 1, 1992:</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

b. Levels:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Income Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$1</td>
</tr>
<tr>
<td>2</td>
<td>$2</td>
</tr>
</tbody>
</table>
The income of Qualified Disabled Working Individuals will not exceed 200 percent of the Federal Poverty Level.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

state: FLORIDA

INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

2. SECTION 1902(f) STATES WHICH AS OF JANUARY 1, 1989 USED INCOME STANDARDS MORE RESTRICTIVE THAN SSI

a. Based on the following percent of the official Federal income poverty level:

   Eff. Jan. 1, 1987: □ 80 percent □ percent (no more than 100)
   Eff. Jan. 1, 1990: □ 85 percent □ percent (no more than 100)
   Eff. Jan. 1, 1991: □ 95 percent □ percent (no more than 100)
   Eff. Jan. 1, 1992: 100 percent

b. Levels:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Income Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$</td>
</tr>
<tr>
<td>2</td>
<td>$</td>
</tr>
</tbody>
</table>

TN No. 91-39
Supersedes Approval Date SEP 8 1992 Effective Date 10/1/91
TN No. NEW HCFA ID: 7985E
Revised Submission FEB 11 1992
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

**INCOME LEVELS (Continued)**

<table>
<thead>
<tr>
<th>D. MEDICALLY NEEDY</th>
</tr>
</thead>
<tbody>
<tr>
<td>X Applicable to all groups.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Net Income Level</th>
<th>Amount by which Column (2) exceeds limits specified in 42 CFR 435.1007(1)</th>
<th>Net Income Level</th>
<th>Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007(1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 urban only</td>
<td>$180</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 urban only</td>
<td>$241</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 urban &amp; rural</td>
<td>$303</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 urban &amp; rural</td>
<td>$364</td>
<td>$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For each additional person, add: $62

For each additional person, add: $62

The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

<table>
<thead>
<tr>
<th>TN No.</th>
<th>Supersedes</th>
<th>Approval Date</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>92-03</td>
<td>91-39</td>
<td>SEP 18 1992</td>
<td>1/1/92</td>
</tr>
</tbody>
</table>

HCFA ID: 7985E
## INCOME LEVELS (Continued)

### D. MEDICALLY NEEDED

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Net Income Level protected for maintenance for months</th>
<th>Amount by which Column (2) exceeds limits specified in 42 CFR</th>
<th>Net Income Level for persons living in rural areas for months</th>
<th>Amount by which Column (4) exceeds limits specified in 42 CFR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 urb. only</td>
<td>$426</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 urb. &amp; rur.</td>
<td>$487</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>$549</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>$610</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>$671</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>$733</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For each additional person, add: $62

The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

---

**TN No.** 92-03
**Superscedes** 91-39
**Approval Date** SEP 18 1992
**Effective Date** 1/1/92
**HCFA ID:** 7985E
E. Optional Groups Other Than the Medically Needy

1. Institutionalized Individuals Under Special Income Levels as follows:

<table>
<thead>
<tr>
<th>Payment Category</th>
<th>Administered by</th>
<th>Gross Income Level</th>
<th>Net Income Level</th>
<th>Income Disregards Employed</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Reenumberable Classification)</td>
<td>Federal</td>
<td>State</td>
<td>1 person</td>
<td>Couple</td>
</tr>
<tr>
<td>(1)</td>
<td>(2)</td>
<td></td>
<td></td>
<td>(3)</td>
</tr>
<tr>
<td>A. Skilled Nursing Facility</td>
<td>X</td>
<td></td>
<td>300% of SSI FBR</td>
<td>300% of SSI FBR x 2</td>
</tr>
<tr>
<td>B. Mental Hospitals &amp; Psychiatric Facilities</td>
<td>X</td>
<td></td>
<td>&quot;</td>
<td>&quot;</td>
</tr>
<tr>
<td>C. Intermediate Care Facility</td>
<td>X</td>
<td></td>
<td>&quot;</td>
<td>&quot;</td>
</tr>
<tr>
<td>D. Intermediate Care Facility for the Mentally Retarded</td>
<td>X</td>
<td></td>
<td>&quot;</td>
<td>&quot;</td>
</tr>
</tbody>
</table>

*Agency that determines eligibility for coverage.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

RESOURCE LEVELS

A. CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women - Not applicable. The state agency does not consider resources in determining eligibility.
   a. Mandatory Groups

      [ ] Same as SSI resources levels.
      [ ] Less restrictive than SSI resource levels and is as follows:

      | Family Size | Resource Level |
      |-------------|---------------|
      | 1           |               |
      | 2           |               |

   b. Optional Groups

      [ ] Same as SSI resources levels.
      [ ] Less restrictive than SSI resource levels and is as follows:

      | Family Size | Resource Level |
      |-------------|---------------|
      | 1           |               |
      | 2           |               |

TN No. 91-39 Approval Date SEP 18 1992 Effective Date 10/1/91
Supersedes TN No. 87-37
HCFA ID: 7985E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

state: FLORIDA

2. Infants - Not applicable. The state agency does not consider resources in determining eligibility.

a. Mandatory Group of Infants

☐ Same as resource levels in the State's approved AFDC plan.

☐ Less restrictive than the AFDC levels and are as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
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<tr>
<td>7</td>
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<tr>
<td>9</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

b. Optional Group of Infants - Not applicable. The state agency does not consider resources in determining eligibility.

- Same as resource levels in the State's approved AFDC plan.
- Less restrictive than the AFDC levels and are as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
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<td></td>
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<tr>
<td>7</td>
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<tr>
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<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
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<tr>
<td>10</td>
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</tr>
</tbody>
</table>

TN No. 91-39  Supersedes TN No. 89-07  Approval Date 6/1992  Effective Date 10/1/91

HCFA ID: 7985E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

3. Children - Not applicable. The state agency does not consider resources in determining eligibility.
   a. Mandatory Group of Children under Section 1502(a)(10)(i)(VI) of the Act. (Children who have attained age 1 but have not attained age 6.)

   Same as resource levels in the State's approved AFDC plan.
   Less restrictive than the AFDC levels and are as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
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<td>4</td>
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</tr>
<tr>
<td>9</td>
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<tr>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

Supersedes Approval Date OCT 13 1992
Effective Date 4/1/92
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

b. Mandatory Group of Children under Section 1902(a)(10)(i)(VII) of the Act. (Children born after September 30, 1983 who have attained age 6 but have not attained age 19.) Not applicable. The state agency does not consider resources in determining eligibility. Same as resource levels in the State's approved AFDC plan. Less restrictive than the AFDC levels and are as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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</tr>
<tr>
<td>2</td>
<td></td>
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<tr>
<td>3</td>
<td></td>
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<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
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<tr>
<td>6</td>
<td></td>
</tr>
<tr>
<td>7</td>
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<tr>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

Supersedes Approval Date 92-16  Effective Date 4/1/92
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

4. Aged and Disabled Individuals

- Same as SSI resource levels.
- More restrictive than SSI levels and are as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

Same as medically needy resource levels (applicable only if State has a medically needy program)

TN No. 91-39
Supersedes Approval Date SEP 18 1992
TN No. NEW Effective Date 10/1/91

HCFA ID: 7985E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

RESOURCE LEVELS (Continued)

B. MEDICALLY NEEDY

Applicable to all groups –

☐ Except those specified below under the provisions of section 1902(f) of the Act.

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$5000</td>
</tr>
<tr>
<td>2</td>
<td>6000</td>
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<tr>
<td>3</td>
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</tr>
<tr>
<td>4</td>
<td>6500</td>
</tr>
<tr>
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<td>7000</td>
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<tr>
<td>6</td>
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<tr>
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<td>8000</td>
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<tr>
<td>8</td>
<td>8500</td>
</tr>
<tr>
<td>9</td>
<td>9000</td>
</tr>
<tr>
<td>10</td>
<td>9500</td>
</tr>
</tbody>
</table>

For each additional person $ 500

Refer to Supplement 8b to Attachment 2.6-A for more liberal treatment of resources for MAGI-based eligibility groups of parents and other caretaker relatives, children, and pregnant women.
Post-Eligibility Treatment of Institutionalized Individuals’ Incomes

The following policy will be applied in considering medical expense deductions for institutionalized medical care cases in the post-eligibility treatment of income pursuant to 42 CFR § 435.725. The State will recognize as an uncovered medical expense and deduct from an institutional resident’s income any premium, deductible, or coinsurance charges for health insurance coverage.

The following reasonable limits will be placed on other incurred medical expense deductions for residents of medical institutions in the post-eligibility treatment of income:

1. The service or item claimed as a deduction from the resident’s income must:
   a. be a medical or remedial care service recognized under state law;
   b. be medically necessary;
   c. have been incurred no earlier than the 3 months preceding the month of application; and
   d. have not been paid for under the Medicaid State Plan.
2. For medically necessary care, services and items not paid for under the Medicaid State Plan, the actual billed amount will be used as the deduction, not to exceed the maximum payment or fee recognized by Medicare, commercial payers or any other third party payer for the same or similar item, care, or service.
3. Other resident health insurance policies will be treated as first payer and the beneficiary will have to demonstrate that other insurance has not/will not cover the expense.
4. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

METHODS FOR TREATMENT OF INCOME THAT DIFFER FROM THOSE OF THE SSI PROGRAM

(Section 1902(f) more restrictive methods and criteria and State supplement criteria in SSI criteria States without section 1634 agreements and in section 1902(f) States. Use to reflect more liberal methods only if you limit to State supplement recipients. DO NOT USE this supplement to reflect more liberal policies that you elect under the authority of section 1902(r)(2) of the Act. Use Supplement 8a for section 1902(r)(2) methods.)

Not applicable.

TN No. 91-39
Supersedes Approval Date 18 1592 Effective Date 10/1/91
TN No. NEW

HCFA ID: 7985E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

MORE RESTRICTIVE METHODS OF TREATING RESOURCES THAN THOSE OF THE SSI PROGRAM - Section 1902(f) states only

Not applicable.

TN No. 91-39 Supersedes Approval Date SEP 8991 Effective Date 10/1/91
TN No. 89-11              HCFA ID: 7985E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

METHODS FOR TREATMENT OF RESOURCES FOR INDIVIDUALS WITH INCOMES RELATED TO FEDERAL POVERTY LEVELS

(Do not complete if you are electing more liberal methods under the authority of section 1902(r)(2) of the Act instead of the authority specific to Federal poverty levels. Use Supplement 8b for section 1902(r)(2) methods.)

Not applicable.

TN No. 91-39
Supersedes
TN No. 87-21

Approval Date SEP 18 1992
Effective Date 10/1/91

HCFA ID: 7965E
## Standards for Optional State Supplementary Payments

<table>
<thead>
<tr>
<th>Payment Category (Reasonable Classification)</th>
<th>Administered by</th>
<th>Gross Income Level</th>
<th>Net Income Level</th>
<th>Income Disregards Employed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Federal</td>
<td>State</td>
<td>1 person</td>
<td>Couple</td>
</tr>
<tr>
<td>(1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Skilled Nursing Facility</td>
<td>X</td>
<td></td>
<td>300% of SSI FBR</td>
<td>300% of SSI FBR x 2</td>
</tr>
<tr>
<td>B. Mental Hospitals &amp; Psychiatric Facilities</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Intermediate Care Facility</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Intermediate Care Facility for the Mentally Retarded</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TN No. 88-26**  
**Supersedes Approval Date** 1/10/89  
**Effective Date** 1/1/89  
**TN No. 87-1**
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Territory:

VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

Disclosure Statement for Post-Eligibility Preprint

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is #0938-0673. The time required to complete this information collection is estimated at 3 hours per response, including the time to review instructions, searching existing data resources, gathering the data needed and completing and reviewing the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland, 21244-1850 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C., 20503.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

RESOURCE STANDARDS FOR 1902(f) STATES - CATEGORICALLY NEEDY

TN No. 91-39
Supersedes Approval Date 8-92 Effective Date 10/1/91
TN No. 85-03

HCFA ID: 7985E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State: FLORIDA  

MORE LIBERAL METHODS OF TREATING INCOME  
UNDER SECTION 1902(r)(2) OF THE ACT*  

☐ Section 1902(f) State  ☑ Non-Section 1902(f) State

Coverage Groups  

1902(a)(10)(E) and 1902(m) of the Act  
When income is received more often than once per month (weekly, biweekly), the monthly income from that source will be computed by first determining the weekly income amount and then multiplying that amount by 4. We will not treat 4 week months any differently than 5 week months.

The anticipated weekly income for fluctuating income will be projected at the time of application by using the most recent six weeks of income (or less, if appropriate). After that, it will be recomputed every six months or when the client reports a change.

In the event an individual would be denied or terminated by the use of this methodology, actual income (if less), will be used.

In-kind support and maintenance (ISM) is not considered in determining income eligibility.

1902(r)(2) of the Act  
All wages paid by the Census Bureau for temporary employment related to Census activities are excluded for the mandatory and optional eligibility groups listed below:

Mandatory groups  

Optional Groups  
1902(a)(10)(A)(ii)(I) and 1905(a)(i),(ii),and (viii), 1902(a)(10)(A)(ii)(VIII), 1902(a)(10)(A)(ii)(IV), 1902 (a)(10)(C)(i)(III)and 1905(a)(i),(ii),and (viii)  

*More liberal methods may not result in exceeding gross income limitations under §1903(f).
State Plan Under Title XIX of the Social Security Act

State: FLORIDA

LESS RESTRICTIVE METHODS OF TREATING INCOME UNDER SECTION 1902(r)(2) OF THE ACT

X For all eligibility groups not subject to the limitations on payment explained in section 1903(f) of the Act*: All wages paid by the Census Bureau for temporary employment related to Census 2000 activities are excluded.

X For infants described in 1902(l)(1)(B), all family income between 185% and 200% of the federal poverty level is disregarded as revised annually in the federal register.

X For children who have reached age 18 and are under 21 who were in foster care when they turned 18, or after reaching 16, were adopted from foster care or placed with a court-approved dependency guardian and spent a minimum of 6 months in foster care within the 12 months immediately preceding placement or adoption, without regard to an income test that is otherwise required.

*Less restrictive methods may not result in exceeding gross income limitations under § 1903(f).

Coverage Groups

1902(a)(10)(A)(ii)(XV) of the Act

Countable earned income up to 250% of the federal poverty level is disregarded as revised annually in the federal register.

TN No: 2008-013 Approval Date: 11/17/08 Effective Date: August 1, 2008

TN No: 2003-07
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

LESS RESTRICTIVE METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT

The following disregards for the difference between the MNIL standard and the converted standard will apply to the following groups:

- pregnant women,
- children,
- parent/caretaker relatives

<table>
<thead>
<tr>
<th>Unit Size</th>
<th>MNIL</th>
<th>Medically Needy Pregnant</th>
<th>Medically Needy Children 0-17</th>
<th>Medically Needy Parents or Caretaker Relatives</th>
<th>Medically Needy 18, 19, &amp; 20 Year Olds</th>
<th>All MAGI-related Medically Needy Groups</th>
<th>Disregard to be Applied</th>
<th>MNIL + Disregard</th>
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TN No. 2015-005
Supersedes Approval Date 09-04-15 Effective Date 4/1/15
TN No. NEW
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

MORE LIBERAL METHODS OF TREATING RESOURCES

UNDER SECTION 1902(r)(2) OF THE ACT

\/_ Section 1902(f) State /X / Non-Section 1902(f) State

Coverage Groups

435.211 The methodologies of the SSI program regarding availability
435.231 of resources are used except when the applicant or recipient
435.320 is comatose and there is no known legal guardian or other
435.322 individual who can access and expend the applicant’s/
435.324 recipient’s resources. In such circumstances, the resources
1902(a)(10)
(A)(ii)(XV) are considered not available until such time as legal
of the Act
guardianship is established.

1902(a)
(10)(E) If resources are below the applicable standard at any time
and 1902(m) during the month, the individual is eligible on the factor
of the Act
of resources for that month.

Hospice
435.217
1902(a)
The methodologies used in the SSI program in the determination of amounts
(10)(A)(ii)
(XV)
set aside for burial shall be used with the following exceptions:

- Up to $2500 of resources may be excluded if designated as burial funds.
- Burial funds must be kept separate from, and not commingled with, non-burial resources unless the resources cannot be separated or it is unreasonable to require it. Burial fund accounts for prior months may be commingled with non-burial funds.
- Resources may be designated as burial funds for any month including the three months prior to the month of application.
- The $2500 exclusion is not reduced by the value of excluded life insurance policies or irrevocable burial contracts.

Any income producing real or personal property with a financial transaction date prior to March 1, 2005 may be excluded from assets if it produces income consistent with its fair market value.

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TN No. 2009-026
Supersedes Approval Date: 03-15-10
Effective Date 01/01/10
TN No. 2007-006
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: FLORIDA

MORE LIBERAL METHODOLOGIES OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

☐ Section 1902(f) State  ☒ Non-Section 1902(f) State

Coverage Groups

1902(a)(10)(A)(i)(III)
1902(a)(10)(A)(i)(IV)
1902(a)(10)(A)(i)(VI)
1902(a)(10)(A)(i)(VII)
1902(a)(10)(A)(ii)
of the Act
435.200-.236
1902(a)(10)(A)(ii)(XV)

Pursuant to 42 CFR 435.601(d) and (f)(2), the value of property which exceeds the $2,000 asset limit may be excluded if the applicant or recipient provides evidence of good faith effort to sell the property.

Proceeds from the sale of the property will be countable resources to the individual unless the individual plans to use them to buy an excluded home within three calendar months of receiving them.

Coverage provided to children who have reached age 18 and are under 21 who were in foster care when they turned 18, or after reaching 16, were adopted from foster care or placed with a court-approved dependency guardian and spent a minimum of 6 months in foster care within the 12 months immediately preceding placement or adoption, without regard to a resource test that is otherwise required.

TN No: 2008-013
Supersedes Approval Date: 11/17/08 Effective Date August 1, 2008
TN No: 2007-006
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

MORE LIBERAL METHODOLOGIES OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

☐ Section 1902(f) State    ☒ Non-Section 1902(f) State

Coverage Groups

42 CFR 435.301(b)(1)     In applying MAGI-like income counting methodologies, all
42 CFR 435.308            assets/resources used to determine eligibility for medically
42 CFR 435.310            needy pregnant women, children, and parent/caretaker
42 CFR 435.350            relatives will be disregarded.

TN No. 2015-005
Supersedes Approval Date 09-04-15 Effective Date 4/1/15
TN No. NEW
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Florida

LONG-TERM CARE INSURANCE PARTNERSHIP

1902(r)(2) The following more liberal methodology applies to individuals who are 1917(b)(1)(C) eligible for medical assistance under one of the following eligibility group:

1902(a)(10)(A)(ii)(V)

An individual who is a beneficiary under a long-term care insurance policy that meets the requirements of a “qualified State long-term care insurance partnership” policy (partnership policy) as set forth below, is given a resource disregard as described in this amendment. The amount of the disregard is equal to the amount of the insurance benefit payments made to or on behalf of the individual. The term “long-term care insurance policy” includes a certificate issued under a group insurance contract.

The Agency for Health Care Administration (Agency) stipulates that the following requirements will be satisfied in order for a long-term care policy to qualify for a disregard. Where appropriate, the Agency relies on attestations by the State Insurance Commissioner (Commissioner) or other State official charged with regulation and oversight of insurance policies sold in the state, regarding information within the expertise of the Office of Insurance Regulation.

- The policy is a qualified long-term care insurance policy as defined in section 7702B(b) of the Internal Revenue Code of 1986.

- The policy meets the requirements of the long-term care insurance model regulation and long-term care insurance model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) as those requirements are set forth in section 1917(b)(5)(A) of the Social Security Act.

- The policy was issued no earlier than the effective date of this State plan amendment.

- The insured individual was a resident of Florida or another state that has entered into a reciprocal agreement with Florida when coverage first became effective under the policy. If the policy is later exchanged for a different

TN No. FL-06-009
Supersedes Approval Date: 11/27/06
Effective Date: 01/01/07

TN No. New
LONG-TERM CARE INSURANCE PARTNERSHIP

long-term care policy, the individual was a resident of Florida or another state that has entered into a reciprocal agreement with Florida when coverage under the earliest policy became effective.

- The policy meets the inflation protection requirements set forth in section 1917(b)(1)(C)(iii)(IV) of the Social Security Act.

- The Commissioner requires the issuer of the policy to make regular reports to the Secretary that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.

- The State does not impose any requirement affecting the terms or benefits of a partnership policy that the state does not also impose on non-partnership policies.

- The Office of Insurance Regulation assures that any individual who sells a partnership policy receives training, and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

- The Agency provides information and technical assistance to the Insurance Department regarding the training described above.

TN No. FL-06-009
Supersedes Approval Date: 11/27/06
Effective Date: 01/01/07

TN No. New
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: FLORIDA

1917(c)(2)(D) of the Act

TRANSFER OF RESOURCES

An institutionalized spouse who (or whose spouse) transferred resources for less than fair market value shall not be found ineligible for nursing facility services, for a level of care in a medical institution equivalent to that of nursing facility services, or for home and community based services where the State determines that denial of eligibility would work an undue hardship under the provision of section 1917 (c)(2)(D) of the Social Security Act.

TN No. 91-09
Supersedes NEW

Approval Date 4/15/91
Effective 1/1/91

HCFA ID: 4093E/0002P
FOR TRANSFERS OF ASSETS FOR LESS THAN FAIR MARKET VALUE MADE ON OR AFTER FEBRUARY 8, 2006, the agency provides for the denial of certain Medicaid services.

1. Institutionalized individuals are denied coverage of certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

   The agency does not provide medical assistance coverage for institutionalized individuals for the following services:

   - Nursing facility services;
   - Nursing facility level of care provided in a medical institution;
   - Home and community-based services under a 1915(c) or (d) waiver.

2. Non-institutionalized individuals:

   The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

   The agency withholds payment to non-institutionalized individuals for the following services:

   - Home health services (section 1905(a)(7));
   - Home and community care for functionally disabled elderly adults (section 1905(a)(22));
   - Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

   The following other long-term care services for which payment for medical assistance is otherwise made under the agency plan:
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

TRANSFER OF ASSETS

3. **Penalty Date** - The beginning date of each penalty period imposed for an uncompensated transfer of assets is the later of:

- the first day of a month during or after which assets have been transferred for less than fair market value;
- The State uses the first day of the month in which the assets were transferred
- The State uses the first day of the month after the month in which the assets were transferred

or

- the date on which the individual is eligible for medical assistance under the State plan and is receiving institutional level care services described in paragraphs 1 and 2 that, were it not for the imposition of the penalty period, would be covered by Medicaid;

AND

which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.

4. **Penalty Period - Institutionalized Individuals**

In determining the penalty for an institutionalized individual, the agency uses:

- the average monthly cost to a private patient of nursing facility services in the State at the time of application;

5. **Penalty Period - Non-institutionalized Individuals**

The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

- imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

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TN No.: 06-011
Supersedes
TN No.: New
Approval Date: 11/28/06
Effective Date: 01/01/07
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

TRANSFER OF ASSETS

6. Penalty period for amounts of transfer less than cost of nursing facility care

X Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency imposes a penalty for less than a full month, based on the option selected in item 4.

X The state adds together all transfers for less than fair market value made during the look-back period in more than one month and calculates a single period of ineligibility, that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.

7. Penalty periods - transfer by a spouse that results in a penalty period for the individual

(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

8. Treatment of a transfer of income

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

X For transfers of individual income payments, the agency will impose partial month penalty periods using the methodology selected in 6. above.

X For transfers of the right to an income stream, the agency will base the penalty period on the combined actuarial value of all payments transferred.

Approval Date: 11/28/06    Effective Date: 01/01/07
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

TRANSFER OF ASSETS

9. Imposition of a penalty would work an undue hardship

The agency does not impose a penalty for transferring assets for less than fair market value in any case in which the agency determines that such imposition would work an undue hardship. The agency will use the following criteria in making undue hardship determinations:

Application of a transfer of assets penalty would deprive the individual:

(a) Of medical care such that the individual's health or life would be endangered; or

(b) Of food, clothing, shelter, or other necessities of life.

10. Procedures for Undue Hardship Waivers

The agency has established a process under which hardship waivers may be requested that provides for:

(a) Notice to a recipient subject to a penalty that an undue hardship exception exists;

(b) A timely process for determining whether an undue hardship waiver will be granted; and

(c) A process, which is described in the notice, under which an adverse determination can be appealed.

These procedures shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the individual's personal representative.

11. Bed Hold Waivers For Hardship Applicants

The agency provides that while an application for an undue hardship waiver is pending in the case of an individual who is a resident of a nursing facility:

Payments to the nursing facility to hold the bed for the individual will be made for a period not to exceed ____ days (may not be greater than 30).

TN No.: 06-011
Supersedes
TN No.: New
Approval Date: 11/28/06  Effective Date: 01/01/07
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: FLORIDA

CONSIDERATION OF MEDICAID QUALIFYING TRUSTS--UNDUE HARDSHIP

1902(k)(4) of the Act, P.L. 99-272 (Section 9506) The following criteria will be used to determine whether the agency will not count the funds in a trust as specified in ATTACHMENT 2.6-A, section C.2., because it would work an undue hardship for categorically and medically needy individuals:

For the applicant or recipient who is subject to the requirements at section 1904(k)(4) of the Act, governing Medicaid qualifying trusts, the State will waive application of these requirements to the applicant or recipient in cases where the State determines that application of these rules would result in undue hardship.

TN No. 91-39 Approval Date SEP 1992 Effective Date 10/1/91
Supersedes TN No. 91-09

HCFA ID: 7985E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: FLORIDA

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

The State covers low income families and children under section 1931 of the Act.

The following groups were included in the AFDC State plan effective July 16, 1996:

- Pregnant women with no other eligible children.
- AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.
- In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996 without modification.
- In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996 with the following modifications.
- The agency applies the lower income standards which are no lower than the AFDC standards in effect on May 1, 1988, as follows:
- The agency applies higher income standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:
- The agency uses less restrictive income and/or resource methodologies than those in effect as of July 16, 1996, as provided below:

More Liberal Income Methodologies Allowed Under Welfare Reform for Low Income Families

Effective January 1, 1997, applicants and recipients of Medicaid under the low income families coverage group who have earned income and meet other eligibility requirements will be eligible for an earned income disregard of the first $200 plus one-half of the remainder of earned income applied when determining eligibility for benefits.

Applicants for and recipients of Medicaid are eligible for the $200 and one-half earned income disregard if they meet one of the following criteria:

1) have been eligible for and received Medicaid benefits under sec. 1931 in one of the past four months; or

2) have gross income, less the $90 standard earned income disregard and dependent care expenses, which is less than the applicable consolidated need standard.

Attachment 2.6-A
Supplement 12, Page 1

TN No. 22-02
Supersedes
TN No. 27-06
Effective 10/1/99
Approval Date DEC 6 2000

No. ~
Supersedes
TN No.~
The $90 standard earned income disregard is included in the first $200 earned income disregard. Therefore, in calculating the $200 earned income disregard, the $90 standard earned income disregard is subtracted. This amount, minus any allowable dependent care expenses, is compared to the consolidated need standard for the size of the standard filing unit. If the amount is below the consolidated need standard, then subtract an additional $110 for a total of $200. The remaining one-half earned income disregard is then subtracted. (The $200 and one-half of the remainder earned income disregard without a time limit effectively replace the $90 standard earned income disregard plus the $30 and 1/3 disregards.) This is calculated as follows:

A) - the $90 standard disregard  
B) + deemed and unearned income to arrive at a countable income figure  
C) - dependent care expenses  
D) compare the result to the consolidated need standard  
E) if the net countable income is < the consolidated need standard, the individual is eligible for the disregard.

When an individual with income joins an existing standard filing unit, that individual’s income must meet all disregard tests.

For applicants who fail to meet the above standard, the AFDC standard in effect on July 16, 1996, will apply.

All wages paid by the Census Bureau for temporary employment related to Census activities are excluded.

More Liberal Resource Methodologies Allowed Under Welfare Reform for Low Income Families

1) Effective January 1, 1997, low income families are eligible for an additional $1,000 resource exclusion over the AFDC standard in effect on July 16, 1996. (This effectively raises the resource standard to $2,000.)

2) In determining the resources of a family, the following shall be excluded:

a) One licensed vehicle valued at no more than $8,500 and/or, if vehicles are needed for training, employment, or education, one vehicle per employable adult in the unit, the combined value which does not exceed $8,500.

b) Funds paid to a homeless shelter which are being held for the family to enable the family to pay deposits or other costs associated with moving to a new shelter arrangement.

The income and/or resource methodologies that the less restrictive methodologies replace are as follows:

_____ The agency terminates medical assistance (except for certain pregnant women and children) for individuals who fail to meet TANF work requirements.

_____ The agency continues to apply the following waivers of provisions of Part A of Title IV in effect as of July 16, 1996, or submitted prior to August 22, 1996 and approved by the Secretary on or before July 1, 1997.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

The State covers low-income families and children under section 1931 of the Act.

The agency uses less restrictive income and resource methodologies than those in effect as of July 16, 1996, as follows:

All wages paid by the Census Bureau for temporary employment related to Census 2000 activities are excluded.

All TANF payments including regular monthly payments, all diversion payments, and Retention Incentive Training Accounts payments are excluded in determining the applicant or recipient's Medicaid eligibility.

The income and resource methodologies that the less restrictive methodologies replace are as follows:

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TN. No. 2002-07
Supersedes TN No. 2000-06

Approval Date JUL 25 2002
Effective Date 4/1/02
Receipt of Lump Sum Payment

The following policy applies to all Medicaid eligible individuals, whether eligible through temporary cash assistance or Medicaid only.

A lump sum is considered an asset in the month of receipt and is excluded as income.

Lump sum payments are defined as unearned money received in the form of non-recurring lump sum payments including, but not limited to: income tax returns, rebates or credits, retroactive lump-sum Social Security, SSI, public assistance, railroad retirement benefits, or other payments; lump sum insurance settlements; or refunds of security deposits on rental property or utilities.

If the lump sum is earned income, such as a bonus or commission, it must be counted as earned income in the month of receipt. Any earned income left over after the month of receipt will be considered an asset.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Florida

ELIGIBILITY UNDER SECTION 1925 OF THE ACT

TRANSITIONAL MEDICAL ASSISTANCE

The State covers low-income families and children for Transitional Medical Assistance (TMA) under section 1925 of the Social Security Act (the Act). This coverage is provided for families who no longer qualify under section 1931 of the Act due to increased earned income, or working hours, from the caretaker relative’s employment, or due to the loss of a time-limited earned income disregard. (42 CFR 435.112, 1902(a)(52), 1902(e)(1), and 1925 of the Act)

The amount, duration, and scope of services for this coverage are specified in Section 3.5 of this State plan.

For Medicaid eligibility to be extended through TMA, families must have been Medicaid eligible under section 1931 (months of retroactive eligibility may be used to meet this requirement):

___ During at least 3 of the 6 months immediately preceding the month in which the family became ineligible under section 1931.

___ For fewer than 3 of the 6 previous months immediately preceding the month in which the family became ineligible under section 1931. Specify:

The State extends Medicaid eligibility under TMA for an initial period of:

___ 6 months. For TMA eligibility to continue into a second 6-month extension period, the family must meet the reporting, technical, and income eligibility requirements specified at section 1925(b) of the Act.

___ 12 months. Section 1925(b) does not apply for a second 6-month extension period.

The State collects and reports participation information to the Department of Health and Human Services as required by section 1925(g) of the Act, in accordance with the format, timing, and frequency specified by the Secretary and makes such information publicly available.

TN No.: 2009-023
Supersedes TN No.: New Approval Date: 12/22/09 Effective Date: 12/1/09
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: FLORIDA

SECTION 1924 PROVISIONS

A. Income and resource eligibility policies used to determine eligibility for institutionalized individuals who have spouses living in the community are consistent with section 1924.

B. In the determination of resource eligibility the State resource standard is the maximum allowed by Title XIX of the Social Security Act, (The community spouse allocation standard.)

C. The definition of undue hardship for purposes of determining if institutionalized spouses receive Medicaid in spite of having excess countable resources is described below:

**Spousal Impoverishment, Section 1924(c)(3)(C)**

An institutionalized spouse who (or whose spouse) has excess resources shall not be found ineligible under Title XIX of the Social Security Act, per section 1924(c)(3)(C), where the State determines that denial of eligibility on the basis of having excess resources would work an undue hardship.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

INCOME AND RESOURCE REQUIREMENTS FOR TUBERCULOSIS (TB) INFECTED INDIVIDUALS

For TB infected individuals under §1902(z)(1) of the Act, the income and resource eligibility levels are as follows:

Each individual covered under the plan meets the applicable financial and non-financial conditions as specified in Attachment 2.6-A. These requirements are defined by 42 CFR 435 and 1902 of the Social Security Act.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Florida

VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

An additional personal needs allowance is permitted in an amount equal to $\frac{1}{2}$ of the gross amount of therapeutic wages up to a maximum of $111.00 per month. The Department of Children and Families eligibility worker makes the determination. The higher personal needs allowance provides support for the working individual.

An additional personal needs allowance is permitted in an amount equal to the amount of court ordered child support paid by the individual to meet his court ordered obligation. Funds are protected only to the extent that the income was not already deducted under another provision in the post eligibility process.

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TN No. 2012-004
Supersedes TN No. 2009-21

Approval Date: 06-21-12  Effective: 03/30/12
1940(a) 1. The agency will provide for the verification of assets for purposes of determining or redetermining Medicaid eligibility for aged, blind and disabled Medicaid applicants and recipients using an Asset Verification System (AVS) that meets the following minimum requirements.

A. The request and response system must be electronic:

   (1) Verification inquiries must be sent electronically via the internet or similar means from the agency to the financial institution (FI).

   (2) The system cannot be based on mailing paper-based requests.

   (3) The system must have the capability to accept responses electronically.

B. The system must be secure, based on a recognized industry standard of security (e.g., as defined by the U.S. Commerce Department’s National Institute of Standards and Technology, or NIST).

C. The system must establish and maintain a database of FIs that participate in the agency’s AVS.

D. Verification requests also must be sent to FIs other than those identified by applicants and recipients, based on some logic such as geographic proximity to the applicant’s home address, or other reasonable factors whenever the agency determines that such requests are needed to determine or redetermine the individual’s eligibility.

E. The verification requests must include a request for information on both open and closed accounts, going back up to 5 years as determined by the State.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

ASSET VERIFICATION SYSTEM

2. System Development

   A. The agency itself will develop an AVS.
      In 3 below, provide any additional information the agency wants to include.

   X B. The agency will hire a contractor to develop an AVS.
      In 3 below provide any additional information the agency wants to include.

   C. The agency will be joining a consortium to develop an AVS.
      In 3 below, identify the States participating in the consortium. Also, provide any other information the agency wants to include pertaining to how the consortium will implement the AVS requirements.

   D. The agency already has a system in place that meets the requirements for an acceptable AVS.
      In 3 below, describe how the existing system meets the requirements in Section 1.

   E. Other alternative not included in A. – D. above.
      In 3 below, describe this alternative approach and how it will meet the requirements in Section 1.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

ASSET VERIFICATION SYSTEM

3. Provide the AVS implementation information requested for the implementation approach checked in Section 2, and any other information the agency may want to include.

Florida has prepared an ITN and will be reviewing bids during the months of April and May, 2012. The vendor will be required to implement the AVS system as of October 1, 2012.

The vendor selected will have a system that meets the requirements of Supplement 16 to Attachment 2.6-A, page 1.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH SUBSTANTIAL HOME EQUITY

1917(f) The State agency denies reimbursement for nursing facility services and other long-term care services covered under the State plan for an individual who does not have a spouse, child under 21 or adult disabled child residing in the individual’s home, when the individual’s equity interest in the home exceeds the following amount:

X $500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

An amount that exceeds $500,000 but does not exceed $750,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

The amount chosen by the State is ____________________.

____ This higher standard applies statewide.

____ This higher standard does not apply statewide. It only applies in the following areas of the State:

____ This higher standard applies to all eligibility groups.

____ This higher standard only applies to the following eligibility groups:

The State has a process under which this limitation will be waived in cases of undue hardship.

TN No.: 06-011
Supersedes
TN No.: New

Approval Date: 11/28/06
Effective Date: 01/01/07