

FLORIDA MEDICAID PROGRAM

SUMMARY OF SERVICES

2002

DISCLAIMER

The Florida Medicaid Summary of Services provides only brief information. It is not a legally binding document and is not to be relied upon for specific information on recipient eligibility, service reimbursement, or service limitations.

This publication may be obtained from the Agency's website at www.myflorida.com. Printed copies may be obtained from the Area Medicaid offices or from Medicaid Contract Management.

*The Agency for Health Care Administration champions accessible, affordable,
quality health care for all Floridians.*

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SECTION I—GENERAL INFORMATION

PURPOSE OF THE SUMMARY OF SERVICES

The Summary of Services booklet describes the services offered by the Florida Medicaid Program. Information is included on Medicaid eligibility, Medicaid services and Medicaid's managed care programs. The Summary is intended as an introduction to Medicaid for new Medicaid employees and for non-Medicaid personnel working in other programs, agencies, and departments. The Summary is to be used as a quick reference. Detailed information is available in the Florida Medicaid Coverage and Limitations Handbooks and the Provider Reimbursement Handbooks.

BACKGROUND OF THE FLORIDA MEDICAID PROGRAM

Florida implemented the Medicaid program on January 1, 1970, to provide medical services to low-income people. Over the years, the Florida Legislature has authorized Medicaid reimbursement for additional services. A major expansion occurred in 1989, when the United States Congress mandated that states provide all Medicaid services allowable under the Social Security Act to children under the age of 21.

FUNDING AND ADMINISTRATION

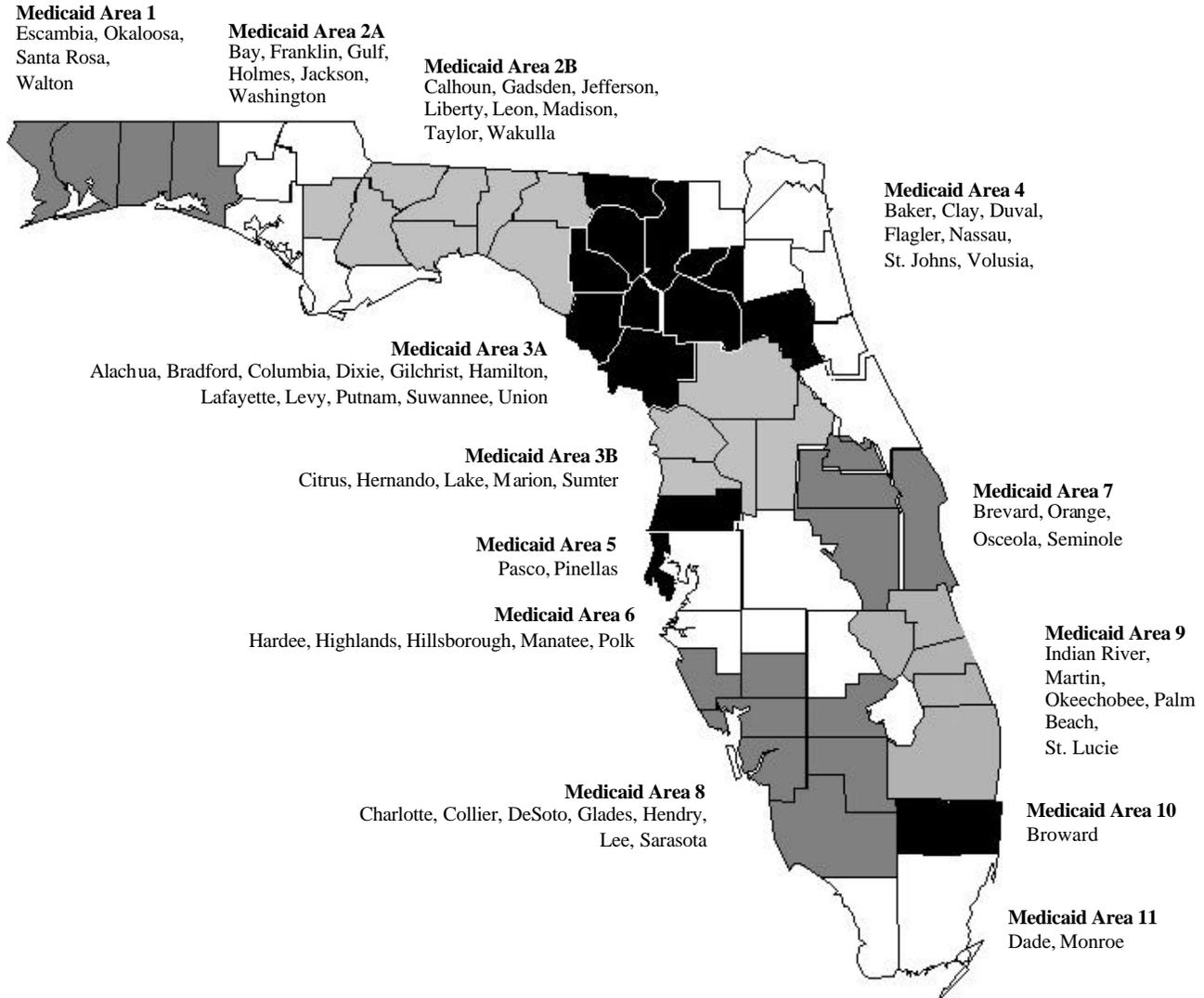
The Medicaid program is funded through federal and state participation with counties contributing to the cost of inpatient hospital and nursing facility services. Matching federal funds are contingent upon the state's continued compliance with the federal laws in Title XIX of the Social Security Act and regulations in Title 42 of the Code of Federal Regulations. Estimated expenditures for fiscal year 2001-2002 (July 2001 through June 2002) is approximately \$9.9 billion. The appropriated average monthly caseload is 1,931,831.

The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. It is administered by the Agency for Health Care Administration (AHCA). The Medicaid fiscal agent enrolls non-institutional providers and processes claims. The Department of Children and Families and the Social Security Administration determine Medicaid recipient eligibility.

AHCA has eleven area offices that serve as the local liaisons to providers and recipients. The area offices are responsible for exceptional claim processing; provider relations and training; consumer relations; managing the Child Health Check-Up, Transportation and School Match programs on a local level; and conducting credentialing site visits to MediPass providers.

Medicaid Summary of Services

MAP OF AREA OFFICES



See the next page for the telephone numbers and addresses for each area office.

IMPORTANT TELEPHONE NUMBERS AND ADDRESSES

Area Medicaid Offices

Areas—Counties Covered	Address	Phone
Area 1—Escambia, Okaloosa, Santa Rosa, and Walton	6425 Pensacola Boulevard, Building 2, Suite 1 Pensacola, Florida 32505-1701	Escambia and Santa Rosa— (850) 494-5840 Okaloosa and Walton— (800) 303-2422
Area 2A—Bay, Gulf, Franklin, Holmes, Jackson, and Washington	651-K West 14 Street Panama City, Florida 32401	(850) 872-7690 (800) 226-7690
Area 2B—Calhoun, Gadsden, Jefferson, Liberty, Leon, Madison, Taylor, and Wakulla	2002 Old St. Augustine Road Building D, Room 194 Tallahassee, Florida 32301	(850) 921-8474 (800) 248-2243
Area 3A—Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, and Union	14101 North Hwy. 441, Suite 600 Alachua, Florida 32615-5669	(386) 418-5350
Area 3B—Citrus, Hernando, Lake, Marion, and Sumter	2441 Silver Springs Boulevard Ocala, Florida 34475	(352) 732-1349
Area 4—Baker, Clay, Duval, Flagler, Nassau, St. Johns and Volusia	Duval Regional Service Center 921 North Davis Street Building A, Suite 160 Jacksonville, Florida 32209-6806	(904) 353-2100 (800) 273-5880
Area 5—Pasco and Pinellas	525 Mirror Lake Drive North Suite 510 St. Petersburg, Florida 33701	(727) 552-1191 (800) 299-4844
Area 6—Hardee, Highlands, Hillsborough, Manatee, and Polk	6800 North Dale Mabry Hwy. Suite 220 Tampa, Florida 33614	(813) 871-7600 (800) 226-2316
Area 7—Brevard, Orange, Osceola, and Seminole	400 West Robinson Street Suite 309 – South Tower Orlando, Florida 32801	(407) 317-7851 (877) 254-1055
Area 8—Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota	2295 Victoria Avenue, Room 309 Ft. Myers, Florida 33901 All mail should be addressed to: P. O. Box 60127 Ft. Myers, Florida 33906	(941) 338-2620 (800) 226-6735

Medicaid Summary of Services

Area Medicaid Offices, continued

Areas—Counties Covered	Address	Phone
Area 9—Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie	1710 East Tiffany Drive, Suite 200 West Palm Beach, Florida 33407	(561) 881-5080 (800) 226-5082
Area 10—Broward	1400 West Commercial Boulevard Suite 110 Ft. Lauderdale, Florida 33309	(954) 202-3200
Area 11—Dade and Monroe	Koger Center Manchester Building 8355 NW 53 Street, 2 nd Floor Miami, Florida 33166	(305) 499-2000

Medicaid Headquarters

Title	Address	Phone	Fax
Deputy Secretary for Medicaid	2727 Mahan Drive, Mail Stop 8 Tallahassee, Florida 32308	(850) 488-3560	(850) 488-2520
Assistant Deputy Secretary for Medicaid Operations	2727 Mahan Drive, Mail Stop 8 Tallahassee, Florida 32308	(850) 488-3560	(850) 488-2520
Medicaid Program Development	2727 Mahan Drive, Mail Stop 20 Tallahassee, Florida 32308	(850) 488-9347	(850) 922-7303
Medicaid Program Analysis	2727 Mahan Drive, Mail Stop 21 Tallahassee, Florida 32308	(850) 414-2756	(850) 414-2767
Medicaid Program Integrity	2727 Mahan Drive, Mail Stop 6 Tallahassee, Florida 32308	(850) 921-1802	(850) 922-3806
Medicaid Contract Management/ Provider Enrollment	2308 Killlearn Center Blvd. Suite 200 Tallahassee, Florida 32309	(850) 922-2726	(850) 410-1430
Medicaid Pharmacy Services	2727 Mahan Drive, Mail Stop 38 Tallahassee, Florida 32308	(850) 487-4441	(850) 414-6236
Bureau of Managed Health Care	2727 Mahan Drive, Mail Stop 26 Tallahassee, Florida 32308	(850) 922-6830	(850) 414-5418

Medicaid Fiscal Agent

Title	Address	Phone
Provider Inquiry	ACS State Healthcare Provider Inquiry P.O. Box 7070 Tallahassee, Florida 32314-7070	1-800-289-7799 (inside Florida) 1-800-955-7799 (outside Florida)
Provider Enrollment Questions	(same as above)	1-800-377-8216
Electronic Claims Submission Services	(same as above)	1-800-829-0218

Helpful Websites

All Executive Agencies and E-Health Portal	Go to: www.myflorida.com
Agency for Health Care Administration (AHCA)	Click on Directory, Health Care Admin.
Medicaid	Click on Directory, Health Care Admin., Medicaid
Department of Children and Families (DCF)	Click on Directory, Children and Families
Department of Health (DOH)	Click on Directory, Health
Florida KidCare	www.floridakidcare.org
Florida Statutes	www.leg.state.fl.us
Code of Federal Regulations	www.access.gpo.gov/nara/cfr
Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS)	www.cms.gov
Centers for Disease Control Recommended Immunization Schedules	www.cdc.gov/nip
Medicaid Fiscal Agent—ACS State Healthcare (formerly known as Consultec)	http://floridamedicaid.acs-inc.com
Provider Enrollment	Click on Provider Support, Enrollment
Provider Handbook	Click on Provider Support, Handbooks
Fee Schedules	Click on Provider Support, Fees
Downloadable Medicaid Forms	Click on Provider Support, Medicaid Forms

Medicaid Summary of Services

Department of Children and Families District Offices

Client relations toll-free: 1-800-342-0825

Districts	Address	Phone
District 1—Escambia, Okaloosa, Santa Rosa, and Walton	8190 Pensacola Boulevard Pensacola, Florida 32501	(850) 494-5805
District 2—Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington	2639 North Monroe Street Building A, Suite 100 Tallahassee, Florida 32399-2949	(850) 487-1756
District 3—Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, and Union	P. O. Box 390 Gainesville, Florida 32602	(352) 955-5293
District 4—Baker, Clay, Duval, Nassau, and St. Johns	Roberts Building 5920 Arlington Expressway Jacksonville, Florida 32211	(904) 727-3700
Suncoast Region—DeSoto, Hillsborough, Manatee, Pasco, Pinellas, and Sarasota	9393 North Florida Avenue Suite 700 Tampa, Florida 33612-7236	1-800-342-0825
District 7—Orange, Brevard, Osceola, and Seminole	400 W. Robinson Street—1009 Orlando, Florida 32801-1782	(407) 245-0450
District 8—Charlotte, Collier, Glades, Hendry and Lee	2295 Victoria Avenue Fort Myers, Florida 33906	(941) 338-1377
District 9—Palm Beach	111 S. Sapodilla Avenue West Palm Beach, Florida 33401	(561) 837-5574
District 10—Broward	201 West Broward Boulevard Suite 510 Fort Lauderdale, Florida 33301	(954) 467-4373
District 11—Dade and Monroe	401 NW 2 Avenue, Room S-1007 Miami, Florida 33128	(305) 377-7154
District 12—Flagler and Volusia	210 North Palmetto Avenue Daytona Beach, Florida 32114-3284	(386) 238-4910

Department of Children and Families District Offices, continued

Districts	Address	Phone
District 13—Citrus, Hernando, Lake, Marion, and Sumter	1601 West Gulf Atlantic Highway Wildwood, Florida 34785	(352) 330-2177 Ext. 6230
District 14—Hardee, Highlands, and Polk	4720 Old Highway 37 Lakeland, Florida 33813	(863) 619-4192
District 15—Indian River, Martin, Okeechobee, and St. Lucie	Ft. Pierce Regional Service Center 337 North 4th Street, Suite 320 Ft. Pierce, Florida 34950-4206	(561) 595-1306

ELIGIBILITY FOR MEDICAID SERVICES

The Department of Children and Families and the Social Security Administration determine Medicaid recipient eligibility. (See pages 6 and 7 for the telephone numbers and addresses of the Department of Children and Families' district offices.)

Two basic groups of people are eligible for Medicaid: low income children and families and the aged, blind and disabled. Within these two groups, there are several categories of eligibility. In addition to qualifying under one of these two basic groups, an eligible Medicaid recipient must meet income and asset limits. These vary by category.

Following are the categories for Medicaid eligibility in Florida:

Families and Children

Emergency Medicaid for Aliens reimburses emergency services provided to aliens who meet all Medicaid eligibility requirements except for citizenship or alien status.

Family Planning Waiver extends eligibility for family planning services for 24 months to women who have had a Medicaid-financed delivery or other pregnancy-related service within two years before losing Medicaid eligibility.

Foster Care, Adoption Subsidy and Emergency Shelter include dependent children in the care and control of the state and children with special medical needs whose adoption was supported by the state or a private adoption agency.

Low Income Families include single-parent families and families with a disabled or unemployed parent.

Medicaid Expansion Designated by SOBRA (MEDS) includes children up to age 19 and pregnant women.

Medicaid for Teens includes children up to age 19 who were born before October 1, 1983, and have incomes at or 100 percent below federal poverty level.

Medically Needy includes individuals whose income is too high to qualify for other Medicaid programs but who have large monthly medical bills. Their Medicaid eligibility is redetermined every month.

Mary Brogan Breast and Cervical Cancer Program includes women who are screened and diagnosed with breast or cervical cancer through the Florida Breast and Cervical Cancer Early Detection Program administered by the Department of Health. Women entitled through this program must have income at or below 200 percent of the federal poverty level and will receive all Medicaid benefits.

Public Medical Assistance (PMA) includes children in intact families and children born after September 30, 1983, not living with relatives.

Aged, Blind and Disabled (SSI-Related)

Supplemental Security Income (SSI) eligibility is determined by the Social Security Administration. Individuals who receive SSI in Florida are automatically eligible for full Medicaid benefits. To be eligible for SSI, an individual must be age 65 or older or totally and permanently disabled, and meet the income and asset limits.

Medicaid for the Aged and Disabled (MEDS-AD) covers individuals who are age 65 or older or totally and permanently disabled, have income less than 90 percent of the Federal Poverty Level, and meet the asset limit.

Institutional Care Program (ICP) includes individuals requiring long-term institutional care or hospice.

Medicaid Waiver Assistance (MWA) covers individuals in a special income group who are participating in home and community-based waiver programs.

Qualified Medicare Beneficiaries (QMB) entitles individuals who have income not exceeding 100 percent of the Federal Poverty Level and who are entitled to Medicare Part A and who are not otherwise eligible for Medicaid to receive Medicaid payment of their Medicare premiums, deductibles, and coinsurances.

Special (Specified) Low-Income Medicare Beneficiaries (SLMB) entitles individuals who have income above 100 percent but less than 120 percent of the Federal Poverty Level and who are entitled to Medicare Part A to receive Medicaid payment of their Part B premium.

Medically Needy includes individuals whose income is too high to qualify for other Medicaid programs, but who have large monthly medical bills. Their Medicaid eligibility is redetermined every month.

Refugees include aliens who are eligible under a special general assistance program.

Qualifying Individuals I (QI 1—formerly PBMO, Part B Medicare Only) are individuals who are entitled to Medicare Part A and who have incomes of at least 120 percent but less than 135 percent of the Federal Poverty Level and who are not otherwise eligible for Medicaid. Medicaid benefits are limited to full payment of the Medicare Part B premiums. Entitlement of individuals is limited by the availability of the capped federal funding allocated to the state.

Qualifying Individuals II (QI 2) are individuals who are entitled to Medicare Part A and who have incomes at least 135 percent but not exceeding 175 percent of the Federal Poverty Level and who are not otherwise eligible for Medicaid. Medicaid benefits are limited to partial payment of the Medicare Part B premiums. Entitlement of individuals is limited by the availability of the capped federal funding allocated to the state.

CATEGORIES WITH LIMITED MEDICAID BENEFITS

The following categories of Medicaid eligibility have limited Medicaid benefits:

- Aliens who do not meet citizenship or permanent residency requirements are eligible only for emergency services.
- Family Planning Waiver recipients are not eligible for any Medicaid services except for family planning services, family-planning-related pharmacy and laboratory services, antibiotics and antifungals to treat sexually-transmitted diseases, sterilization, colposcopy, and transportation to family planning services.
- Individuals who are not eligible for the institutional care program because they transferred assets may be eligible for other Medicaid services.
- Medically Needy recipients are not eligible for long term care services, such as nursing facility, state mental hospital and intermediate care facility for the developmentally disabled (ICF/DD), community based waiver services and the payment of Medicare premiums by Medicaid.
- Presumptively Eligible Pregnant Women (PEPW) are eligible only for outpatient and office services. County Health Departments, Regional Perinatal Intensive Care Centers, and other qualified medical facilities make presumptive determinations of Medicaid eligibility for low-income pregnant women. This presumptive determination allows these women access to prenatal care while the Department of Children and Families makes regular determinations of eligibility.
- Qualifying Individuals 1 (QI 1) are not eligible for any Medicaid services except for Medicaid full payment of their Medicare Part B premiums.
- Qualifying Individuals 2 (QI 2) are not eligible for any Medicaid services except for Medicaid partial payment of their Medicare Part B premiums.
- Qualified Medicare Beneficiaries (QMB) who are otherwise ineligible for Medicaid are not eligible for any Medicaid services except for Medicaid payment of their Medicare premiums, deductibles and coinsurance on Medicaid-covered services.
- Special (Specified) Low Income Medicare Beneficiaries (SLMB) are not eligible for any Medicaid services except for Medicaid payment of their Medicare Part B premium.

Medicaid providers are responsible for verifying a recipient's eligibility for a Medicaid service prior to providing the service.

FLORIDA KIDCARE PROGRAM

The Florida KidCare Program is a child health insurance program for children ages birth through 18 who are not currently covered by health insurance and whose parents may both be working. Eligible families pay an average premium of \$15 per month, per household. With the exception of MediKids, Children’s Medical Services, and Medicaid-enrolled children, all other KidCare enrollees pay copayments for services.

KidCare consists of four programs:

- MediKids—for children ages 1 to 5 years.
- Healthy Kids—for children ages 5 to 19 years.
- Children’s Medical Services—for children ages 1 to 19 years with special health care needs.
- Medicaid—for children under 21 whose family income qualifies them for services through Medicaid Title XIX.
 - Medicaid for Children under One—a Medicaid expansion for infants to age one whose family income is above 133 percent but no more than 200 percent of the Federal Poverty Level.
 - Medicaid for Teens—a Medicaid expansion for teens up to age 19 born before October 1, 1983, and whose family income is 100 percent or below the Federal Poverty Level.

MEDIKIDS

MediKids is the Florida KidCare insurance program for children age one to age five that is administered by the Agency for Health Care Administration.

- MediKids enrollees receive most Medicaid services, including immunizations, dental, and transportation.
- MediKids enrollees receive services from Medicaid participating providers.
- MediKids is not an entitlement program.
- Families pay low monthly premiums.
- Children can enroll only during open enrollment periods.

Only health care providers or health maintenance organizations (HMOs) that are enrolled or contracted as Medicaid providers may serve MediKids enrollees. By state law, families must choose either a Medicaid-participating HMO or a MediPass provider before a child’s MediKids coverage begins. Section 409.8132(7), Florida Statutes, lists the options that are available to a family:

- If a child lives in a county that has two or more Medicaid-participating HMOs, the family may choose only an HMO.
- If a child lives in a county that has one Medicaid-participating HMO, the family may choose that HMO or a MediPass provider.
- If a child lives in a county with no Medicaid-participating HMOs, the family may choose a MediPass provider.

COPAYMENTS AND COINSURANCES

Medicaid recipients who do not meet one of the exceptions described below are required to pay a copayment or coinsurance for certain services. A copayment is a set fee. A coinsurance is a percentage of the cost of the service. The descriptions of the specific services in this booklet indicate when a copayment or coinsurance must be paid.

The following recipients are not required to pay a **copayment** :

- Children under 21 years of age.
- Pregnant women when the services relate to the pregnancy, other medical conditions that may complicate the pregnancy, or conditions or complications of the pregnancy up to 60 days after the termination of the pregnancy.
- Recipients who are inpatients in long-term care facilities, hospitals, or other medical institutions if as a condition of receiving services in the institution, the recipient is required to spend all of his income for medical care costs, except for a minimal personal needs allowance.
- Recipients requiring emergency services after the sudden onset of a medical condition that left untreated would place the recipient's health in serious jeopardy.
- Recipients receiving family planning services or supplies.
- Recipients enrolled in Medicaid HMOs.
- Recipients receiving hospice services.

The following recipients are not required to pay a **coinsurance** :

- Children under 21 years of age.
- Recipients living in nursing facilities, ICF/DDs or state mental hospitals.

A provider cannot deny services to a recipient solely because the recipient cannot pay a Medicaid copayment or coinsurance. However, if the recipient is unable to pay at the time the service is rendered, the provider may bill the recipient for the copayment or coinsurance amount, and the recipient is liable for the charge. Medicaid reimburses the provider the difference between the established Medicaid payment and the Medicaid copayment or coinsurance amount.

Medicaid deducts the copayment or coinsurance amount from the provider's Medicaid reimbursement regardless of whether the provider bills or collects the copayment.

MEDICARE PREMIUMS, DEDUCTIBLES AND COINSURANCES

Medicare Hospital Insurance, referred to as Part A, provides coverage for inpatient hospital care, limited skilled nursing care, some home health services, some outpatient hospital services, and other services.

Medicare Supplemental Medical Insurance, referred to as Part B, provides basic health care coverage for the services provided by doctors, suppliers, therapists, and other licensed health care practitioners.

Medicare imposes cost sharing expenses for Part A and Part B by requiring a deductible and coinsurance amount. These expenses are usually paid by the Medicare beneficiary or a supplemental insurance policy. However, for individuals who are eligible for both Medicare and Medicaid, Medicaid pays the following deductibles and coinsurances:

- Medicare Part A hospital inpatient deductible up to Medicaid's rate and skilled nursing home facility coinsurance amounts,
- Medicare Part B deductibles and coinsurance amounts up to Medicaid's rate, and
- Medicare deductibles for blood supplied under Part A and Part B.

Medicaid does not pay crossover claims for services that are not covered by Medicaid.

Medicaid does not pay the deductible and coinsurance for medical supplies and durable medical equipment that are covered by nursing facility services and included in the nursing facility's per diem payment.

Medicaid does not pay copayments or deductibles for Medicare Health Maintenance Organizations (HMOs).

Medicaid pays Medicare premiums for all Medicaid eligible recipients who are entitled to receive Medicare. An exception is Medically Needy recipients unless they are also eligible as Part B Medicare Only, Qualified Medicare Beneficiaries or Special (Specified) Low-Income Medicare Beneficiaries.

Medicaid reimburses the following amounts for Medicare premiums, deductibles and coinsurances:

Part A crossover claims:

- For inpatient hospitals, Medicaid reimburses 100 percent of the deductible and the first three pints of blood up to \$25 per pint during each "benefit period." A new benefit period begins each time a recipient is admitted to a hospital if there has been a 60-day break between hospitalizations.
- For skilled nursing facilities, Medicaid reimburses either the Part A skilled nursing facility coinsurance rate or the Medicaid per diem for the facility, whichever is less.

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Medicare Premiums, Deductibles and Coinsurances, continued

Part B crossover claims:

- For emergency transportation providers, Medicaid pays 100 percent of both the deductible and coinsurance.
- For rural health centers, federally qualified health centers, and county health departments, Medicaid reimburses the deductible and coinsurance up to the difference between Medicare's payment and the facility's Medicaid rate.
- For outpatient hospitals, Medicaid reimburses 100 percent of the deductible and 100 percent of the coinsurance, based on the Medicare allowable amount, in addition to the first three pints of blood up to \$25 per pint. Medicaid will pay no portion of the Medicare deductible and coinsurance when the payment that Medicare has made for the service equals or exceeds what Medicaid would have paid if it had been the sole payer. The combined payment of Medicare and Medicaid shall not exceed the amount Medicaid would have paid had it been the sole payer.
- For dialysis centers, Medicaid reimburses 100 percent of the deductible and 100 percent of the coinsurance, based on Medicaid's rate.
- For all other Part B suppliers such as physicians, chiropractors, podiatrists, durable medical equipment suppliers, ambulatory surgery centers, and optometrists, Medicaid reimburses 100 percent of the deductible and coinsurance up to the Medicaid allowable fee for the procedure code. The combined amounts received from Medicare, any other third party, and Medicaid cannot exceed the Medicaid fee for the procedure.

MEDICAID MANAGED CARE — MEDICAID OPTIONS

Medicaid Options is a state-sponsored program that helps Medicaid recipients enroll in Medicaid managed care programs: Medicaid Health Maintenance Organizations (HMOs), the Medicaid Provider Access System (MediPass), Provider Service Networks (PSNs), and the Children's Medical Services (CMS) Network for children with special health care needs.

MANAGED CARE MANDATORY ASSIGNMENT

Florida law mandates that Medicaid recipients (low-income family and child recipients and SSI recipients without Medicare) eligible for managed care must enroll with a MediPass provider, in a Medicaid health maintenance organization (HMO), Provider Service Network (PSN), or the CMS Network.

Eligible recipients are given 30 days from the date that Medicaid eligibility begins to select a managed care option. If recipients do not select MediPass, an HMO, a PSN, or the CMS Network, AHCA assigns them to MediPass, an HMO, or a PSN.

ANNUAL OPEN ENROLLMENT PERIOD

Recipients who become eligible for Medicaid and enroll with a managed care plan will begin a 12-month enrollment period in which they have 90 days to try the plan. After the initial 90 days, they will remain with their plan for the next nine months, as long as they do not lose Medicaid eligibility. Only plan changes for "good cause" will be allowed during these nine months. Each year thereafter, recipients will receive notification of their open enrollment period when they can change plans for the following year.

SSI recipients under age 19, foster care children, children in subsidized adoption arrangements, children enrolled with Children's Medical Services, dually eligible individuals and American Indians are allowed to change managed care plans at any time.

Recipients who wish to receive information regarding their managed care options may call the Medicaid Options toll-free help line at 1-888-367-6554.

Medicaid Summary of Services

Annual Open Enrollment Period, continued

Recipients may change primary care providers within their current plans. To change their primary care provider, recipients should contact the program in which they are enrolled (the HMO's member services office, the PSN's enrollee services office, or the MediPass area Medicaid office, respectively).

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

The Florida Medicaid program supports the development of managed health care systems by entering into contracts with Health Maintenance Organizations (HMOs) to provide prepaid Medicaid services to a defined population of enrolled Medicaid recipients. Most counties have at least two plans from which recipients can choose; however, some counties have no HMOs.

The services provided under contract are negotiated with each contractor. However, contractors must provide the following services:

- Child Health Check-Up (formerly known as Early and Periodic Screening, Diagnosis and Treatment [EPSDT])
- Community mental health services (AHCA Areas 1 and 6 only)
- Dialysis services in a freestanding center
- Durable medical equipment and medical supplies
- Family planning services
- Hearing services
- Home health services
- Hospital services (inpatient, outpatient and emergency services)
- Laboratory services, including independent laboratory services
- Mental health targeted case management services (AHCA Areas 1 and 6 only)
- Prescribed drug services
- Physician services (as described on the next page)
- Therapy services
- Vision services
- X-ray services

Health Maintenance Organizations (HMOs), continued

Physician services include services rendered by a licensed physician, psychiatrist, advanced registered nurse practitioner, physician assistant, podiatrist, chiropractor, ambulatory surgical center, rural health clinic, federally qualified health center, birthing center, and county health department clinic.

In addition, plans are required to provide the following quality and benefit enhancements:

- **Smoking Cessation:** Regularly scheduled smoking-cessation programs must be conducted by the plan as an option for all plan members. Members must also have access to smoking-cessation counseling. The plan must provide primary care physicians with the Quick Reference Guide for Smoking Cessation Specialists, published by the U.S. Department of Health and Human Services, to assist in identifying tobacco users and supporting and delivering effective smoking-cessation interventions.
- **Substance Abuse:** The plan must have primary care physicians screen enrollees for signs of substance abuse as part of prevention evaluation. Targeted enrollees must be asked to attend community or plan-sponsored substance abuse programs. The plan must provide substance-abuse screening training to its providers on a regular basis.
- **Domestic Violence:** The plan must have primary care physicians screen enrollees for signs of domestic violence and must provide referral services to applicable, domestic-violence prevention community agencies. The plan must provide domestic-violence screening training to its providers on a regular basis.
- **Pregnancy Prevention:** Regularly scheduled pregnancy-prevention programs must be conducted by the plan or the plan must make a good faith effort to involve members in existing community pregnancy-prevention programs. The workshops must be targeted toward teen members, but must be open to all enrollees.
- **Prenatal/Postpartum Pregnancy Programs:** The plan must provide regular home visits conducted by a home health nurse or aide, counseling and educational materials to pregnant members and postpartum members who are not in compliance with the plan's prenatal and postpartum programs. Plans must coordinate with Healthy Start Care Coordinators to prevent duplication of services.
- **Children's Programs:** The plan must provide regular general wellness programs targeted specifically toward plan members from birth to the age of five or the plan must make a good faith effort to involve members in existing community children's programs. Programs must promote increased utilization of prevention and early intervention services for at-risk families with children in the target population. The plan must provide training for providers that promotes immunizations, Child Health Check-Ups (wellness and prevention), and early intervention services.

Medicaid Summary of Services

Health Maintenance Organizations (HMOs), continued

Plans are responsible for paying for family planning services for their members, regardless of whether the service provider is a plan subcontractor.

Other services that plans may provide include dental, transportation, nursing facility and home and community-based services. Plans may also provide services under the contract that Medicaid does not cover, such as over-the-counter drugs.

HMO Limitations:

An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service. All services must be prior authorized by the plan, except for emergency, family planning, chiropractic, podiatric, some dermatology services and OB/GYN services for one annual visit and for medically necessary follow-up care detected at that visit. For chiropractic, OB/GYN, podiatry, and dermatology services, the recipient must use a plan provider.

HMO Eligibility:

Enrollment in any particular plan is specific to certain eligibility categories, counties, and zip codes within counties.

The following Medicaid recipients are not eligible to enroll in Medicaid HMOs:

- Recipients who reside in an intermediate care facility for the developmentally disabled (ICF/DD), nursing facility, state mental hospital, correctional institution, or state-operated residential program;
- Recipients who are enrolled in a MediPass or a Provider Service Network;
- Recipients who are under the age of 21 and are enrolled in Children's Medical Services or attend a prescribed pediatric extended care center;
- Recipients who receive hospice or Assisted Living for the Elderly or Project AIDS Care home and community-based waiver services;
- Recipients who are enrolled in a Medicare or private HMO or other major medical insurance such as CHAMPUS;
- Recipients enrolled in the Family Planning waiver; and
- Recipients who are eligible for Medicaid under the Medically Needy or Qualified Medicare Beneficiary (QMB) coverage groups.

HMO Reimbursement:

Contractors are prepaid a fixed monthly rate per member in each of the various eligibility categories, by age group, to provide all the covered services required by each member during the month. This is known as a capitation rate. The rate is based on actual fee-for-service Medicaid claims experience for each eligibility category in the plan's operating area.

Health Maintenance Organizations (HMOs), continued

Prepaid Mental Health Plan:

Recipients in AHCA Areas 1 and 6 have the option of enrolling with MediPass and a prepaid mental health plan or in an HMO that will provide medical and mental health care services. All the options cover inpatient and outpatient hospital services, psychiatric and physician services, community mental health services, and targeted case management services. Medicaid contracts with Access Behavioral Health, Inc., (ABH) in Area 1 and Florida Health Partners, Inc. (FHP) in Area 6 for mental health services provided to recipients who enroll in MediPass. These recipients receive physical health care services from an assigned MediPass primary care provider and mental health care services from the prepaid mental health plan contractor. MediPass primary care providers and the prepaid mental health plan contractor providers coordinate the recipient's health care needs to assure that medical and psychiatric services are provided collaboratively for continuity of care.

Recipients who are enrolled in a Medicaid HMO in Area 1 and 6 receive both physical health care and mental health care services from HMO providers. Services provided under all plans are approved by the contract provider (the prepaid mental health contractor or the Medicaid HMO).

Long Term Care Community Pilot Project:

Residents in AHCA Areas 7 and 9 have the option of enrolling in the Long-Term Care Community Pilot Project. The Pilot Project provides a quality alternative for dually-eligible Medicare/Medicaid frail elderly recipients who choose to remain at home or in their community, rather than be admitted to a nursing facility. The Pilot Project integrates the delivery of acute and long-term care services through case management. Enrollment in the program is voluntary and a recipient may disenroll at any time. Enrollment in the pilot project is capped by appropriations.

Potentially-eligible individuals are referred to the Comprehensive Assessment and Review for Long-Term Care Services (CARES) in the area. The Department of Elder Affairs administers CARES. CARES will determine if the recipient meets the clinical criteria for nursing home level of care. The Department of Children and Families will determine the recipient's financial eligibility to receive services under Medicaid. The CARES staff will present alternatives to nursing home care and will help complete enrollment with the chosen HMO. The managed care entity must enroll the recipient who is determined to be eligible by CARES.

The case management staff in consultation with the recipient develops an integrated plan of care of services needed to maintain the individual safely in the community. The managed care entity is responsible for providing the following long-term care waiver services: adult companion; adult day health; assisted living; case management; chore; consumable medical supplies; environmental accessibility and adaptation; escort; family training; financial assessment and risk reduction; home health; nursing facility services; personal care; personal emergency response systems; respite care; and occupational, physical and speech therapies. The acute care services

Medicaid Summary of Services

Health Maintenance Organizations (HMOs), continued

Long Term Care Community Pilot Project, continued

that must be provided include: community mental health, dental, hearing, visual, independent laboratory, portable x-ray, inpatient/outpatient hospital, physician, prescribed drugs, and optional transportation. The managed care entity is also responsible for Medicare copayments and deductibles.

MEDICAID PROVIDER ACCESS SYSTEM (MediPass)

MediPass is a Medicaid primary care case management program designed to ensure adequate access to primary care, reduce inappropriate utilization, and control program costs. MediPass is available statewide.

MediPass primary care providers are responsible for providing or arranging for the recipient's primary care and for referring the recipient for other necessary medical services on a 24-hour basis. Recipients select the primary care provider of their choice from those participating in MediPass.

Enrolled recipients must receive all of the following services either through the MediPass provider or referral from the MediPass provider to another Medicaid provider. If a recipient receives any of these services without a referral from the MediPass provider, Medicaid will not reimburse the service, and the recipient may be liable for the charges.

- Advanced registered nurse practitioner services
- Ambulatory surgical center services
- Birth center services
- Child Health Check-Up (formerly known as Early and Periodic Screening, Diagnosis and Treatment [EPSDT])
- Chiropractic services (first ten visits per calendar year do not need MediPass authorization)
- County health department services
- Durable medical equipment and medical supply services
- Federally qualified health center services
- Home health services
- Hospital inpatient services
- Hospital outpatient services
- Laboratory services (independent laboratories do not need MediPass authorization.)
- Licensed midwife services
- Physician services
- Physician assistant services
- Podiatric services (first four visits per calendar year do not need MediPass authorization)

Medicaid Provider Access System (MediPass), continued

- Prescribed drug services
- Rural health clinic services
- Therapy services
- X-ray services including portable x-rays

MediPass Limitations:

Up to 1,500 recipients may be under the care of each full-time equivalent physician. An additional 750 recipients are allowed for each full-time equivalent advanced registered nurse practitioner and physician assistant who works for the physician.

Independent advanced registered nurse practitioners and physician assistants may enroll as MediPass providers. They can only be assigned recipients who enroll voluntarily. Regardless of whether a nurse practitioner or physician assistant enrolls independently or with a physician, he or she cannot receive more than 750 recipients.

MediPass Exceptions:

Prior authorization or a referral from the MediPass provider is not required for vision, hearing, dental, mental health (except in Medicaid Areas 1 and 6), family planning, early intervention, or dialysis services.

Prior authorization is not required for emergency services and care provided to a recipient experiencing an emergency medical condition. The MediPass provider must be notified that care has been provided, and medical records should be forwarded to the MediPass provider to be retained in the patient's comprehensive medical record.

MediPass Eligibility:

The following categories of recipients are eligible to enroll in MediPass:

- Low income families and children
- Children in foster care
- Children in subsidized adoptions
- Supplemental Security Income (SSI) recipients who do not receive Medicare

MediPass Reimbursement:

MediPass providers are paid a \$3 monthly patient management fee for each eligible person who selects them, plus Medicaid reimbursement for services that are rendered.

Medicaid Summary of Services

Medicaid Provider Access System (MediPass), continued

MediPass Disease Management Initiative

The Disease Management Initiative is a statewide endeavor aimed at improving health outcomes and quality of life for MediPass members who have certain chronic illnesses. All MediPass recipients with applicable diagnoses are eligible to participate in this initiative. Exceptions are children who are enrolled in the Children's Medical Services Network, attend prescribed pediatric extended care centers, or reside in institutional settings.

MediPass recipients can be enrolled in only one Disease Management Organization (DMO). If the recipient has more than one of the covered diseases, he or she will be enrolled in the DMO responsible for the more life threatening disease condition.

The main focus of the disease management initiative is nursing care management. DMO nurse care managers work with the primary care physician, the MediPass recipient and the recipient's family, as well as specialists and case management agencies. Care managers provide disease-specific education to the recipient and family and monitor compliance with the physician's treatment plan. They also provide feedback to the primary care physician/specialist on a regular basis. Care managers become an extension of the physician's services by helping the recipient better understand his or her disease and make necessary life style and behavioral changes with the goal of self-management.

All services provided by DMOs are offered free of charge to MediPass physicians and their recipients.

PROVIDER SERVICE NETWORKS (PSNs)

A Provider Service Network (PSN) is an integrated health care delivery system owned and operated by Florida hospitals and physician groups. The PSN is a Medicaid managed care option for Medicaid recipients in Miami-Dade and Broward Counties, along with HMOs, MediPass, and the CMS Network. The South Florida Community Care Network (SFCCN) PSN is composed of the Public Health Trust of Miami-Dade County (PHT), Memorial Healthcare System (MHS), and the North Broward Hospital District (NBHD).

Provider Service Networks (PSNs), continued

SFCCN enrollees receive the majority of their health care through the PSN. Out of network care provided to PSN enrollees (for PSN-managed services) must be authorized by and claims must be submitted to the PSN in order for the claims to be paid by the Medicaid fiscal agent. All Medicaid covered services are available to PSN enrollees. However, the SFCCN does not manage community mental health, targeted case management, hospice, nursing facility, dental, transportation, early intervention, medical foster care, prescribed pediatric extended care, school based, or waiver services. Claims for non-PSN managed services may be submitted directly to the Medicaid fiscal agent for processing.

The following services are managed by the PSN:

- Advanced registered nurse practitioner services
- Ambulatory surgical center services
- Birth center services
- Child Health Check-Up (formerly known as Early and Periodic Screening, Diagnosis and Treatment [EPSDT])
- Chiropractic services
- County health department services
- Dermatology services
- Durable medical equipment and medical supply services
- Family planning
- Federally qualified health center services
- Home health services
- Hospital inpatient services
- Hospital outpatient services
- Laboratory services
- Licensed midwife services
- Optometric services
- Physician services
- Physician assistant services
- Podiatric services
- Rural health clinic services
- Therapy services
- Visual services
- X-ray services including portable x-rays

Claims for PSN-managed services must be submitted to the PSN. Although PSN enrollees may self-refer for family planning, FQHC, chiropractic (10 visits per calendar year), podiatric (5 visits per calendar year), and school based services, claims for these services must be submitted through the PSN. The enrollee must use a PSN provider for chiropractic, podiatric, and dermatology services.

Medicaid Summary of Services

Provider Service Networks (PSNs), continued

PSN Limitations:

Although the PSN services cannot be more restrictive than those provided under Medicaid fee-for-service, the following services require PSN prior authorization:

- PSN managed services from out-of-network providers
- Chemotherapy
- Outpatient consultations
- Out-of-network referrals
- Specialist to specialist referrals
- Dialysis (peritoneal/hemodialysis)
- Elective surgery (inpatient/outpatient)
- Emergency visits (payment only, not service approval)
- Endoscopy
- Growth evaluation and treatment
- Hearing aids
- Home health care
- Durable medical equipment and medical supply services
- Oxygen related equipment and services
- Hyperbaric oxygen therapy
- Inpatient admissions
- Magnetic resonance imaging (MRI)
- Nerve conduction studies/electromyogram (EMG)
- Observational stays
- Obstetrical care (block authorization)
- Oral surgery
- Orthotics/prosthetics/prosthetics and braces
- Outpatient procedures with a facility fee
- Pharmacological stress tests (Thallium, Cardiolyte, etc.)
- Plastic surgery and related care
- Stress echo
- Physical therapy
- Occupational therapy
- Speech therapy
- Transplants and related care
- Vestibular testing
- Any service authorization/pending cases prescribed or authorized before the enrollee's effective date with the PSN.

PSN Eligibility:

The following categories of recipients are eligible to enroll in a PSN:

- Low income families and children
- Sixth Omnibus Budget Reconciliation Act (SOBRA) children
- Children in foster care
- Children in subsidized adoptions
- Supplemental Security Income (SSI) recipients who do not receive Medicare

PSN Reimbursement:

The PSN is paid a monthly administrative allocation payment for the management of its enrollees. PSN primary care providers are paid a monthly case management fee of \$3. Providers rendering services to PSN enrollees are reimbursed on a fee-for-service basis.

ASSESSMENT FOR MEDICAID SERVICES

Comprehensive Assessment and Review for Long-Term Care Services (CARES)

Comprehensive Assessment and Review for Long-Term Care Services (CARES) is a federally mandated Medicaid funded program administered by the Department of Elder Affairs. CARES provides on-site assessments of nursing facility applicants by a registered nurse and/or a social worker. The assessment evaluates the emotional, cognitive, medical, psychosocial and the activities of daily living of the individual.

The goal of CARES is to place the applicant in the least restrictive, most appropriate setting with emphasis on community placement. After the assessment, interdisciplinary staff including a physician determine the placement and level of care (LOC) needed.

All individuals age 21 and older applying for Medicaid nursing facility services and certain home and community-based services waivers must receive a CARES' assessment. All Project AIDS Care (PAC) waiver applicants, regardless of age, must receive a hospital LOC from the CARES' interdisciplinary staff.

Medicaid nursing facility residents changing LOC do not need another CARES' assessment. However, all nursing facility residents converting to Medicaid from Medicare, private pay or Veterans Administration benefits must apply for the Medicaid Institutional Care program (ICP). All ICP applicants must have a CARES' assessment for LOC.

CARES will periodically perform assessments on nursing facility residents to ascertain continued LOC and the potential for returning to the community. Private pay individuals will be monitored for adhering to the federal requirements for mental illness and mental retardation.

Private pay individuals may be assessed at their request at no charge.

Medicaid Summary of Services

Assessment For Medicaid Services, continued

Children's Multidisciplinary Assessment Team (CMAT)

The Children's Multidisciplinary Assessment Team (CMAT) is funded by Medicaid and administered by the Department of Health, Children's Medical Services. The CMAT is composed of individuals from multiple disciplines and programs, including the family, who provide an assessment, recommendations, and decisions for services for medically-complex children based on medical necessity. Each Children's Medical Services district has a CMAT.

The following Medicaid services require a recommendation by the CMAT:

- Medical foster care
- Nursing facility placement
- Prescribed pediatric extended care (PPEC) services
- Private duty nursing in excess of 16 hours per day
- Wheelchairs that cost more than \$12,000
- Model Waiver recommendations

CMAT assessments are available to all medically-complex children under the age of 21. Children do not have to be Medicaid eligible to have an assessment.

PRIOR AUTHORIZATION OF MEDICAID SERVICES

Some services require that providers obtain prior authorization (or post authorization in an emergency) before the services are performed in order to be reimbursed by Medicaid. Some services have limitations on the number of times Medicaid will reimburse for them. Exceptions to some limitations can be obtained through the prior authorization process.

The following services have specific procedure codes that require prior authorization or require prior authorization for services that exceed the service limitations:

- Chiropractic
- Community mental health services
- Dental
- Durable medical equipment and medical supplies
- Hearing
- Home health
- Hospital
- Optometric
- Prescribed drug services
- Physician
- Podiatry
- Transportation
- Visual

If the service is covered under MediPass, the provider must obtain a MediPass referral in addition to prior authorization. Medicare crossover claims do not require prior authorization.

SERVICE AUTHORIZATION OF MEDICAID SERVICES

Service authorization by the Medicaid area office, service authorization nurse is required before providing certain services to recipients under 21 years of age. Medicaid will not reimburse for these services without service authorization when it is required.

The following services require service authorization:

- Medical foster care
- Personal care through the home health services program
- Prescribed pediatric extended care (PPEC)
- Private duty nursing through the home health services program
- Custom wheelchairs

UTILIZATION REVIEW OF MEDICAID SERVICES

Some services are subject to utilization review by a Peer Review Organization (PRO) under contract with AHCA. Those services selected for review by the PRO are based on a sample selection of specified providers. The purpose of the utilization review program is to safeguard against unnecessary and inappropriate medical care rendered to Medicaid recipients. Medical records are reviewed for medical necessity of billed services, quality of care, appropriateness of place of service and length of stay (inpatient hospital).

The PRO develops quality improvement initiatives that are designed to improve quality and/or reduce the cost of care for Medicaid recipients and conducts annual provider seminars on new and updated policies and recommendations that will improve the provider's performance on utilization review.

Medicaid utilization review staff also prior authorize nursing home requests for supplemental payments from nursing facilities for Medicaid patients diagnosed with AIDS.

The following provider types are subject to review by the PRO:

- Community mental health centers
- Hospitals (inpatient only)
- Home and community-based waiver services for the developmentally disabled
- Home health

HOME AND COMMUNITY-BASED SERVICES

The federal Omnibus Budget Reconciliation Act of 1981 authorized the Secretary of Health and Human Services (HHS) to waive federal requirements to allow states to provide home and community-based services to individuals who would require institutionalization without these services. Florida Medicaid has twelve home and community-based waiver programs:

- Aged/Disabled Adult Waiver
- Assisted Living for the Elderly Waiver
- Channeling Waiver
- Consumer-Directed Care Research and Demonstration Waiver
- Developmental Services Waiver
- Family Planning Waiver
- Model Waiver
- Nursing Home Diversion Waiver
- Project AIDS Care Waiver
- Statewide Inpatient Psychiatric Program (SIPP)
- Supported Living Waiver
- Traumatic Brain and Spinal Cord Injury Waiver

Home and Community-Based Services, continued

Medicaid home and community-based waiver services include adult day health, case management, habilitatory respite care, homemaker, home health aide, personal care, and other approved services needed to avoid institutional placement.

Eligibility:

Medicaid reimburses for specific home and community-based services authorized in a written plan of care for waiver-enrolled Medicaid recipients who meet the target group criteria for the specific waiver. Home and community-based services cannot be provided to recipients who reside in a hospital, nursing facility or intermediate care facilities for the developmentally disabled (ICF/DD).

Limitations:

Medicaid reimbursement for home and community-based services is limited to individuals who are at risk of placement in an institution.

- The Aged/Disabled Adult, Assisted Living for the Elderly Waivers, Brain and Spinal Cord Injury, and Channeling waivers serve individuals who are at risk of placement in a nursing facility.
- The Developmental Services and Supported Living Waivers are limited to individuals who are at risk of placement in an intermediate care facility for the developmentally disabled (ICF/DD).
- The Project AIDS Care Waiver serves disabled individuals with AIDS who are at risk of hospitalization or nursing facility placement.
- The Model Waiver serves individuals with specific spinocerebellar diseases who would be hospitalized without waiver services.

Section II

Medicaid-Covered Services

ADVANCED REGISTERED NURSE PRACTITIONER SERVICES

DESCRIPTION:

Medicaid reimburses for services rendered by licensed, Medicaid-participating advanced registered nurse practitioners (ARNPs). The services must be rendered in collaboration with a physician. Reimbursement for anesthesia, obstetrical and psychiatric services is limited to ARNPs who have completed the educational program in the appropriate specialty and are authorized to provide these services by Chapter 464, Florida Statutes, and protocols filed with the Board of Medicine.

Medicaid reimburses ARNPs who are Medicaid-participating independent providers with formal relationships with Florida licensed physicians.

LIMITATIONS:

Medicaid reimbursement for ARNP services is limited to:

- One ARNP-recipient contact per day (except for emergencies);
- One long-term care facility service, per ARNP, per month, per recipient (except for emergencies);
- Ten low-risk prenatal and two postpartum visits per pregnancy; and
- One new patient evaluation and management service, per ARNP, per recipient, every three years, if no services were rendered by the ARNP to the recipient during the three years. Subsequent encounters must be reimbursed as established patient evaluation and management services.

EXCEPTIONS:

The ARNP may request authorization for reimbursement for services in excess of the service limitations.

ELIGIBILITY:

Medicaid reimburses for ARNP services for all Medicaid recipients based on medical necessity.

Medicaid Summary of Services

Advanced Registered Nurse Practitioner Services, continued

REIMBURSEMENT:

Medicaid reimbursement for ARNP services is the maximum Medicaid fee or the provider's customary fee, whichever is lower. ARNPs are reimbursed at 80 percent of the physician's rate for services that are approved by the Centers for Medicare and Medicaid Services (CMS), formerly known as HCFA. If an ARNP is salaried by a hospital or other facility that is reimbursed on a cost-related basis, the ARNP cannot be paid on a fee-for-service basis if the costs for the ARNP's salary are included in the facility's cost report.

There is a \$2 recipient copayment for ARNP services, per provider, per day, unless the recipient is exempt.

AMBULATORY SURGICAL CENTERS

DESCRIPTION:

Ambulatory Surgical Centers (ASCs) provide scheduled, elective, medically-necessary surgical care to patients who do not require hospitalization.

Medicaid reimburses surgical procedures that have been approved by the federal Centers for Medicare and Medicaid Services (CMS), that are provided in a licensed, Medicare-approved, Medicaid-participating ASC entity that is separate and distinguishable from any other entity or type of facility, and is not part of a hospital. The reimbursed facility fee is all-inclusive of the following:

- Nursing, technical and related services;
- Use of ASC facilities;
- Drugs, biologicals, intraocular lens, surgical dressings, supplies, splints, casts, appliances, and equipment directly related to providing surgical procedures;
- Diagnostic or therapeutic services or items directly related to providing surgical procedures;
- Blood, blood plasma and components;
- Administrative, record keeping, and housekeeping items and services; and
- Materials for anesthesia.

LIMITATIONS:

Reimbursable surgical procedures are limited to services that:

- Require a dedicated operating room;
- Do not exceed a total of 90 minutes operating time;
- Do not exceed a total of four hours recovery or convalescent time;
- Do not usually result in heavy loss of blood;
- Are normally not emergency or life threatening in nature; and
- Do not require major invasion of body cavities or directly involve major blood vessels.

Anesthesia is limited to local, regional or general anesthesia that lasts 90 minutes or less.

Medicaid cannot reimburse ASC surgical procedures that are commonly performed or can be safely performed in a physician's office.

ELIGIBILITY:

Medicaid reimburses for ASC services for all Medicaid recipients.

REIMBURSEMENT:

Medicaid reimbursement is the amount billed or the Medicare established allowable amount for the facility, whichever is lower.

ASSISTIVE CARE SERVICES

DESCRIPTION:

The Assistive Care Service is a Medicaid state plan service that provides care to eligible recipients requiring an integrated set of component services on a 24-hour per day basis. Residents of licensed Assisted Living Facilities (ALFs), adult family care homes (AFCHs) and residential treatment facilities (RTFs) must be provided unscheduled care on a 24-hour per days basis.

Assistive Care Service recipients must demonstrate functional deterioration that makes it medically necessary for them to live in congregate living facilities and receive integrated assistive care services on a 24-hour scheduled and unscheduled basis.

ELIGIBILITY:

To receive assistive care services, recipients in this program must be at least 18 years of age or older and meet the following requirements:

1. Be Medicaid eligible;
2. Have a health assessment completed by a physician or other licensed practitioner of the healing arts acting within the scope of their practice under state law which indicates the medical necessity of assistive care services;
3. Be determined to need at least two service components of the assistive care service;
4. Reside in an ACS-enrolled ALF, RTF, or AFCH; and
5. Not participate in any Medicaid managed care program such as Medicaid HMOs, or the Long-Term Care Community Pilot Project where the capitated payment is designed to cover all Medicaid services.

Assisted Living for the Elderly (ALE) waiver recipients can receive ASC services provided the waiver and ACS component services are not duplicative and appear on the ALE service plans.

EXCEPTIONS:

Medicaid recipients residing in institutions such as nursing facilities, state mental hospitals, institutions of mental disease, or intermediate facilities for the developmentally disabled cannot receive ACS.

REIMBURSEMENT:

Assistive care service components are reimbursed at a single per diem rate.

BIRTH CENTER SERVICES

DESCRIPTION:

Birth Centers are licensed facilities that provide obstetrical, gynecological and family planning services.

Medicaid reimburses for services rendered by licensed, Medicaid-participating birth centers. Medicaid reimbursable services include:

- Initial comprehensive and prenatal examinations
- Labor management for recipients who transfer to a hospital
- Post delivery examinations
- Vaginal delivery
- Post delivery recovery
- Newborn assessment
- Related pregnancy services
- Family planning services
- Gynecological services

LIMITATIONS:

Medicaid reimbursement for birth center services is limited to:

- One family planning comprehensive visit, per year, per recipient;
- One family planning supply visit, per 75 days, per recipient;
- One ultrasound per pregnancy;
- Ten low-risk prenatal visits;
- Two postpartum visits, which include an examination of both mother and baby; and
- One newborn assessment.

Post delivery recovery at the birth center is limited to 24 hours.

ELIGIBILITY:

Medicaid reimburses for birth center services for all Medicaid recipients whose pregnancies are determined to be low risk. Recipients whose eligibility is determined through the Presumptively Eligible Pregnant Women program are not eligible for services associated with labor, delivery, postpartum, and inpatient hospitalization. The Department of Children and Families must complete an eligibility determination and find the recipient eligible under another coverage group before the recipient is eligible for these services.

REIMBURSEMENT:

Birth centers are reimbursed on a fee-for-service basis. Medicaid reimbursement for birth center services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.

There is a \$2 recipient copayment for gynecological services, per provider, per day, unless the recipient is exempt.

CHILD HEALTH CHECK-UP

DESCRIPTION:

Child Health Check-Up (formerly known as Early and Periodic Screening, Diagnosis and Treatment [EPSDT] services) consists of a comprehensive, preventive health screening that is performed on a periodic basis on children under the age of 21.

A Child Health Check-Up includes a comprehensive:

- (1) Health and developmental history; an assessment of past medical history, developmental history and behavioral health status; unclothed physical exam; nutritional assessment; developmental assessment; updating of routine immunizations; laboratory tests (including blood lead screening); vision, hearing, and dental screening (including dental referral); and health education/anticipatory guidance.
- (2) Referral and follow-up for further diagnosis and treatment as indicated as a result of the screening process.

Medicaid reimburses county health departments, Children's Medical Services clinics, physicians, community health centers (rural health clinics and federally qualified health centers), physician assistants and advanced registered nurse practitioners for Child Health Check-Ups. Birth centers and licensed midwives may be reimbursed only for the initial Child Health Check-Up newborn evaluation.

The Child Health Check-Up schedule is as follows:

- Birth
- Two to four days if newborn is discharged in less than 48 hours
- By one month
- Two months
- Four months
- Six months
- Nine months
- Twelve months
- Fifteen months
- Eighteen months
- Once per year from age two through 20.*

* Note: Florida Medicaid recommends check-ups at 7 and 9 years of age for those children at risk.

Additional screening examinations may be provided on referral, if medically necessary, from a health care, developmental, or education professional or on request of a parent, guardian or the recipient.

Child Health Check-Up, continued

A dental referral is provided for recipients beginning at age three, or earlier if indicated. Subsequent examinations by a dentist are recommended every six months or as prescribed by a dentist or other authorized provider. Vision and hearing screenings are provided according to an established periodicity schedule.

ELIGIBILITY:

Medicaid recipients under the age of 21 and children from age one through age 4 who are enrolled in the MediKids program are eligible for Child Health Check-Ups.

REIMBURSEMENT:

Reimbursement for a Child Health Check-Up is an all-inclusive fee under Title XIX (Medicaid) and Title XXI (MediKids). Immunizations and laboratory tests are reimbursed separately.

CHIROPRACTIC SERVICES

DESCRIPTION:

Medicaid reimburses for services rendered by licensed, Medicaid-participating chiropractors. Medicaid reimbursable services include a new patient visit, manipulation of the spine, and spinal x-rays. The new patient visit consists of a screening and any required manipulation of the spine.

LIMITATIONS:

Medicaid reimbursement for chiropractic services is limited to one visit per provider, per recipient, per day.

A new patient visit is limited to one per provider, per recipient. A new patient is one who has not received any professional services from the provider or provider group within the past three years.

Visits are limited to a total of 24 during a calendar year.

Medicaid does not reimburse massage or heat treatments.

EXCEPTIONS:

The provider may request authorization for reimbursement for services in excess of the service limitations for recipients under the age of 21.

ELIGIBILITY:

Medicaid reimburses for chiropractic services for all Medicaid recipients.

REIMBURSEMENT:

Medicaid reimbursement for chiropractic services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.

There is a \$1 recipient copayment for chiropractic services, per provider, per day, unless the recipient is exempt.

COMMUNITY MENTAL HEALTH SERVICES

DESCRIPTION:

Community mental health services include mental health and substance abuse services that are provided for the maximum reduction of the recipient's mental disability and restoration to the best possible functional level. Services are limited to those rendered or recommended by a psychiatrist or other physician and included in a treatment plan.

LIMITATIONS:

Most services have limitations, and certain services are limited to children under 21 years of age.

ELIGIBILITY:

Medicaid reimburses for community mental health services for all Medicaid recipients who meet the service criteria.

REIMBURSEMENT:

Medicaid reimbursement for community mental health services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.

There is a \$2 recipient copayment for community mental health services, per provider, per day, unless the recipient is exempt.

COUNTY HEALTH DEPARTMENT CLINIC SERVICES

DESCRIPTION:

Medicaid reimburses for clinic services rendered by county health departments. County health departments provide primary and preventive health care to diagnose, treat and refer patients who need more extensive care. County health department clinic services are rendered by licensed health professional staff at the clinics, including physicians, dentists, registered nurses, advanced registered nurse practitioners and physician assistants.

Medicaid reimbursement to county health departments includes:

- Adult health screening services
- Child Health Check-Ups
- Dental services
- Family planning services
- Medical primary care services
- Nursing protocol services

County health departments participate in the Vaccines for Children Program.

LIMITATIONS:

Medicaid reimbursement is limited to one county health department encounter, per day, per recipient.

ELIGIBILITY:

Medicaid reimburses for county health department clinic services for all Medicaid recipients.

REIMBURSEMENT:

County health department clinics are reimbursed an encounter rate, as determined by cost-based reporting.

DENTAL SERVICES—CHILDREN

DESCRIPTION:

Medicaid reimburses for children's dental services rendered by licensed, Medicaid-participating dentists. Medicaid reimbursable children's dental services include:

- Diagnostic examinations
- Radiographs necessary to make a diagnosis
- Preventive services
- Restorations
- Endodontics
- Periodontal treatment
- Dentures, complete and partial
- Oral surgery
- Orthodontic treatment

LIMITATIONS:

Medicaid does not reimburse for the following services:

- Fixed bridge work or
- Sealants applied to deciduous (baby) teeth.

Medicaid reimburses for the application of sealants on permanent first and second molars once per three years, per tooth.

For orthodontics, Medicaid services are limited to treatment of severely handicapping malocclusions or correction of a dental condition deterring physical development. Prior authorization is required for all orthodontic services except the initial evaluation.

EXCEPTIONS:

The provider may request prior authorization for reimbursement for services in excess of the service limitations.

ELIGIBILITY:

Medicaid reimburses for children's dental services for all Medicaid recipients under the age of 21.

Medicaid Summary of Services

Dental Services–Children, continued

REIMBURSEMENT:

Medicaid reimbursement for children's dental services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.

For orthodontic treatment, an initial payment is made at the start of treatment, but regardless of the severity or duration of treatment, total payment may not exceed the fee for banding and 24 monthly adjustment visits.

DENTAL SERVICES—ADULTS

DESCRIPTION:

Medicaid reimburses for adult dental services rendered by licensed, Medicaid-participating dentists. Medicaid reimbursable adult dental services are provided to recipients age 21 and older. Services include:

- Diagnostic examination for the denture services;
- Radiographs necessary for dentures;
- Extractions and other surgical procedures essential to the preparation of the mouth for dentures if the recipient is to receive dentures;
- Provision of complete dentures;
- Repairs and relines of the dentures, if warranted;
- Oral prophylaxis; and
- Emergency extractions and abcess treatment to alleviate pain or infection.

LIMITATIONS:

Medicaid reimbursement is limited to one set of complete dentures, upper or lower or both, for the life of the recipient. Relines are limited to one per denture, per 12-month period. Oral prophylaxis is limited to one per 12-month period.

Recipients who reside in a nursing facility, intermediate care facility for the developmental disabled or state mental hospital must have the oral examination requested by their attending physician and the Director of Nurses.

EXCEPTIONS:

The provider may request authorization for reimbursement for services in excess of the service limitations.

ELIGIBILITY:

Medicaid reimburses for adult dental services for all Medicaid recipients 21 years of age and older.

Medicaid Summary of Services

Dental Services—Adults, continued

REIMBURSEMENT:

Medicaid reimbursement for adult dental services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.

Recipients are required to pay the provider a five-percent coinsurance on adult dental services. The coinsurance is five percent of the Medicaid fee or the provider's charge, whichever is lower. Recipients who reside in nursing facilities, intermediate care facilities for the developmentally disabled, or state mental hospitals are exempt from the coinsurance.

DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

DESCRIPTION:

Durable medical equipment (DME) is equipment that can be used repeatedly, serves a medical purpose, and is appropriate for use in the patient's home. Medical supplies are medical or surgical items that are consumable, expendable, disposable or non-durable, and are appropriate for use in the patient's home.

Medicaid reimburses for DME and medical supplies provided by Medicaid-participating providers.

Medicaid reimbursable DME may be rented or purchased. Examples of reimbursable equipment include, but are not limited to:

- Ambulatory equipment (canes, crutches, walkers)
- Augmentative and assistive communication devices
- Commodes
- Hospital type beds and accessories
- Orthotics and prosthetics
- Oxygen and oxygen-related equipment
- Suction pumps
- Wheelchairs

Examples of reimbursable medical supplies include, but are not limited to, ostomy and urological supplies.

Medical necessity for DME or supplies must be documented by a prescription, a statement of medical necessity, a plan of care, or a hospital discharge plan. The documentation must be signed and dated by the attending physician and include specific information on the item needed, the duration of need, and the recipient's diagnosis.

LIMITATIONS:

Medicaid reimbursement for DME and medical supplies includes some of the following limitations:

- Most medical supplies are limited to one per day, per recipient.
- DME and supplies are not covered for recipients in a hospital, nursing facility or intermediate care facility for the developmentally disabled (ICF/DD).
- Some DME services and medical supplies are reimbursable only for recipients under 21 years of age.
- Wheelchairs for children under age 21 that cost more than \$12,000 must be recommended by the Children's Multidisciplinary Assessment Team (CMAT).
- Custom wheelchairs must be prior-authorized by the area Medicaid office service authorization nurse.

Medicaid Summary of Services

Durable Medical Equipment and Medical Supplies, continued

EXCEPTIONS:

The following services may be reimbursed for recipients under the age of 21 in nursing facilities or intermediate care facilities for the developmentally disabled (ICF/DD):

- Some customized orthotics and prosthetics
- Customized wheelchairs
- Augmentative and assistive communication devices for children under age 21

ELIGIBILITY:

Medicaid reimburses for DME and medical supplies for all Medicaid recipients.

REIMBURSEMENT:

Medicaid reimbursement for services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.

The total amount reimbursed for rental payments for DME cannot exceed the established maximum allowed purchase fee.

EARLY INTERVENTION SERVICES

DESCRIPTION:

Early intervention services are medical and remedial services designed to enhance the capacity of children with a developmental delay or conditions that cause a delay in normal development.

Medicaid reimburses for early intervention services rendered by Medicaid-participating providers who are licensed health care professionals and paraprofessionals.

Medicaid reimbursable early intervention services include screenings, evaluations, and early intervention sessions to provide medically-necessary services for identified delays in one or more of the areas of cognition: physical/motor, sensory, communication, social, emotional or adaptive development.

LIMITATIONS:

Medicaid reimburses one initial psychosocial and developmental evaluation per lifetime, per recipient.

Ongoing early intervention sessions are limited to one hour per type of session, per day.

EXCEPTIONS:

The provider may request authorization for reimbursement for services in excess of the service limitations.

ELIGIBILITY:

Medicaid reimburses for early intervention services for Medicaid recipients under the age of 21 who meet the service criteria. Although the term “children” encompasses those up to 21 years of age for Medicaid purposes, the intent is to serve young children, birth to three years of age.

REIMBURSEMENT:

Medicaid reimbursement for services is the maximum Medicaid fee or the provider’s customary fee, whichever is lower.

FEDERALLY QUALIFIED HEALTH CENTERS

DESCRIPTION:

A Federally Qualified Health Center (FQHC) is a clinic that is receiving a grant from the Public Health Service. FQHCs provide primary and preventive outpatient health care. FQHC services are performed by advanced registered nurse practitioners, chiropractors, clinical psychologists, clinical social workers, dentists, optometrists, physicians, physician assistants, and podiatrists.

Medicaid reimbursement to FQHCs includes:

- Adult health screening services
- Child Health Check-Ups
- Chiropractic services
- Dental services
- Family planning services
- Medical primary care services
- Mental health services
- Optometric services
- Podiatry services

FQHCs participate in the Vaccines for Children program. Immunization services are reimbursed separately from the FQHC's cost-based reimbursement rate.

LIMITATIONS:

Medicaid reimbursement for FQHC services is limited to one encounter, per day, per recipient.

The service limitations that apply to the Medicaid program for a particular service, such as dental, apply to the services when rendered by an FQHC. FQHC mental health services are limited to 26 visits, per recipient, per calendar year.

ELIGIBILITY:

Medicaid reimburses for FQHC services for all Medicaid recipients.

REIMBURSEMENT:

Medicaid reimburses the FQHC a clinic-specific, all-inclusive encounter rate for clinic services. Immunizations, emergency services, and services rendered away from the clinic are reimbursed on a fee-for-service basis. There is a \$3 recipient copayment for FQHC services, per clinic, per day, unless the recipient is exempt.

FREESTANDING DIALYSIS CENTER SERVICES

DESCRIPTION:

Freestanding dialysis center services are hemodialysis and Erythropoietin (Epogen or EPO) treatments provided at a freestanding dialysis center, or the home peritoneal dialysis training and supplies provided by a freestanding dialysis center. The services must be provided under the supervision of a physician licensed to practice medicine or osteopathic medicine in Florida. The dialysis treatment includes routine laboratory tests, dialysis-related supplies and ancillary and parenteral items.

A freestanding dialysis center is one that is not supervised, managed or controlled by a hospital or hospital staff.

LIMITATIONS:

Medicaid reimbursement for either hemodialysis or Erythropoietin (Epogen or EPO) treatments provided in a freestanding dialysis center is limited to payment for one treatment per recipient, per day, up to three times per week. Medicaid reimbursement for home peritoneal dialysis training and supplies provided by a freestanding dialysis center is limited to payment for one treatment per recipient, per day.

EXCEPTIONS:

The weekly maximum number of treatments may be exceeded if additional treatments are determined to be medically necessary by the recipient's nephrologist or primary care physician.

EXCLUSIONS:

Medicaid does not cover any services other than the dialysis treatment itself when provided by a freestanding dialysis center.

ELIGIBILITY:

Medicaid reimburses freestanding dialysis center services for all Medicaid recipients.

REIMBURSEMENT:

Medicaid reimbursement for freestanding dialysis center services is the maximum Medicaid fee or the provider's customary fee, whichever is lower. The fee includes payment for all routine laboratory tests, dialysis-related supplies, and ancillary and parenteral items used in the dialysis procedure.

HEARING SERVICES

DESCRIPTION:

Medicaid reimburses for hearing services rendered by licensed, Medicaid-participating otolaryngologists, otologists, audiologists, and hearing aid specialists. Medicaid reimbursable hearing services include:

- Cochlear implants services
- Diagnostic testing
- Hearing aids
- Hearing aid evaluations
- Hearing aid fitting and dispensing
- Hearing aid repairs and accessories
- Newborn hearing screening

Note: See *Hearing Services – Newborn Screening* section for more information on these services.

LIMITATIONS:

Medicaid reimbursement for hearing services has the following limitations:

- Medicaid reimbursement for evaluations and hearing devices is limited to one every three years from the date of the last evaluation.
- Binaural fittings for recipients age 21 and older require prior authorization.
- Medicaid does not reimburse for routine maintenance; batteries, cord or wire replacement; or cleaning.
- Medicaid does not reimburse for repairs until after the manufacturer's warranty has expired.

EXCEPTIONS:

The provider may request authorization for reimbursement for services in excess of the service limitations.

ELIGIBILITY:

Medicaid reimburses for hearing services for all Medicaid recipients according to medical necessity and hearing loss criteria.

Hearing Services, continued

REIMBURSEMENT:

Medicaid reimbursement for hearing services is the maximum Medicaid fee or the provider's customary fee, whichever is lower. Recipients are required to pay the provider a five-percent coinsurance on hearing aid devices and the fitting and dispensing of the aids. The coinsurance is five percent of the Medicaid fee or the provider's charge, whichever is lower. Recipients who are under age 21 or who live in nursing facilities, intermediate care facilities for the developmentally disabled or state mental hospitals are exempt from the coinsurance.

HEARING SERVICES—NEWBORN SCREENING

DESCRIPTION:

The Florida Legislature 2000, (CS/HB 399) provided for a statewide comprehensive and coordinated interdisciplinary program of early hearing impairment screening, identification, and follow-up care for newborns. The legislative goal was to screen all newborns for hearing impairment in order to alleviate the adverse effects of hearing loss on speech and language development, academic performance, and cognitive development. A separate appropriation of funds authorized Medicaid to reimburse hospital providers for hearing screening for newborns.

LIMITATIONS:

Newborn hearing screening in the hospital must be performed by a licensed audiologist, a physician licensed under Chapter 458 or Chapter 459, Florida Statutes, or *an appropriately supervised individual* who has completed documented training specifically for newborn hearing screening. The individual selected by the hospital to do the screening may be a current employee of the hospital or the screening services may be contracted out to an individual in the community who meets the same qualifications and who comes to the hospital to furnish the service.

Screening of a newborn's hearing must include auditory brainstem responses, or evoked otoacoustic emissions, or appropriate technology as approved by the U. S. Food and Drug Administration.

EXCEPTIONS:

If the parent or legal guardian of the newborn objects to the screening, it may not be performed. In such cases, the physician or other person attending the newborn must maintain a record that the screening was not performed and attach a written objection that must be signed by the parent or guardian. These documents must be placed in the newborn's medical chart.

ELIGIBILITY:

The legislative goal was to screen all newborns for hearing impairment in order to alleviate the adverse effects of hearing loss on speech and language development, academic performance, and cognitive development.

REIMBURSEMENT:

Medicaid reimbursement for hearing screening services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.

HOME HEALTH SERVICES

DESCRIPTION:

Home health services are provided in a recipient's home or other authorized setting to promote, maintain or restore health or to minimize the effects of illness and disability.

Medicaid reimburses for home health services rendered by licensed, Medicaid-participating home health agencies. Medicaid reimbursable services include:

- Home visit services provided by a registered nurse or a licensed practical nurse;
- Home visits provided by a qualified home health aide;
- Private duty nursing;
- Personal care services;
- Therapy (occupational and physical therapy and speech-language pathology) services; and
- Medical supplies, appliances and durable medical equipment.

LIMITATIONS:

Medicaid reimbursement for home health services has the following limitations:

- Nursing and home health aide visit services are limited to:
 - a total of four visits by nurses and/or aides per day, per recipient and
 - a total of 60 visits by nurses and/or aides per lifetime, per recipient.
- Private duty nursing, personal care and therapy services are limited to children under 21 who are medically complex. Private duty nursing and personal care services must be service authorized by the area Medicaid office, service-authorization nurse.
- Private duty nursing and personal care services are limited to:
 - Two to 24 hours of private duty nursing per day, per recipient and
 - Two to 24 hours of personal care provided by home health aides per day, per recipient.
- Dually-eligible Medicaid/Medicare recipients must receive Medicare reimbursable home health services from a Medicare-enrolled home health agency.

EXCEPTIONS:

Exceptions to the 60-visit limit for children and adults must be requested through the Medicaid contracted peer review agency.

Service Authorization requests should be submitted before services are provided or billed.

Medicaid Summary of Services

Home Health Services, continued

ELIGIBILITY:

Medicaid reimburses for home health services that are medically necessary and that can be safely, effectively and efficiently provided in the home when either leaving home is medically contraindicated or the Medicaid recipient is unable to leave home without the assistance of another person.

REIMBURSEMENT:

Medicaid reimburses home health agencies the maximum allowable Medicaid fee or the provider's customary fee, whichever is lower.

There is a \$2 recipient copayment for home health services, per provider, per day, unless the recipient is exempt.

HOSPICE SERVICES

DESCRIPTION:

Hospice services are forms of palliative health care and supportive services for terminally ill patients and their families. The services are administered by a hospice agency and coordinated by the hospice nurse assigned to the patient.

Hospice employs an interdisciplinary team to meet the special needs arising out of the physical, emotional, spiritual, and social stresses associated with the final stages of illness and during dying and bereavement.

Medicaid reimburses Medicaid-participating hospice providers who are licensed by the Agency for Health Care Administration and meet the requirements to participate in Medicare. Medicaid reimbursement includes:

- Hospice care provided by the designated hospice,
- Direct care services of a hospice physician, and
- Nursing facility room and board.

LIMITATIONS:

Once a recipient elects to receive hospice care, Medicaid will not reimburse for other Medicaid services that treat the terminal condition. Medicaid will reimburse for services that are required for conditions that are unrelated to the terminal condition.

ELIGIBILITY:

Medicaid reimburses for hospice services for all Medicaid recipients who meet the eligibility criteria. The recipient must be certified by a physician as being terminally ill and having a life expectancy of six months or less, if the disease runs its normal course; must elect a hospice; and must complete and sign an election statement to receive hospice services from the designated hospice.

REIMBURSEMENT:

Medicaid reimburses for hospice services on an established daily rate based on the recipient's level of care.

For eligible individuals who live in nursing facilities and elect hospice care, Medicaid may reimburse the hospice a per diem rate for room and board. This rate is in addition to the daily rate for hospice services.

HOSPITAL SERVICES—INPATIENT

DESCRIPTION:

Medicaid reimburses licensed, Medicaid-participating hospitals for inpatient services. The services must be provided under the direction of a licensed physician or dentist.

Medicaid reimbursement for inpatient hospital services includes: room and board, medical supplies, diagnostic and therapeutic services, use of hospital facilities, drugs and biologicals, nursing care, and all supplies and equipment necessary to provide the appropriate care and treatment of patients.

To participate in Medicaid, the hospital must be maintained primarily for the care and treatment of patients with disorders other than mental diseases.

LIMITATIONS:

Medicaid reimbursement for inpatient hospital care for adults age 21 and older is limited to 45 days per state fiscal year (July 1 through June 30). There is no limit on the number of days that Medicaid can reimburse for recipients under age 21.

Inpatient psychiatric or substance abuse admissions must be prior authorized for all Medicaid recipients, except for recipients who are:

- enrolled in an HMO,
- dually-eligible for Medicare and Medicaid, or
- have other private insurance.

EXCEPTIONS:

Medicaid will reimburse inpatient hospital services to a non-Medicaid-participating hospital in an emergency, for the duration of the emergency, subject to the established limitations.

ELIGIBILITY:

Medicaid reimburses for inpatient hospital services for all Medicaid recipients. An exception is recipients whose eligibility is determined through the Presumptively Eligible Pregnant Women program are not eligible for services associated with labor, delivery, postpartum, and inpatient hospitalization. The Department of Children and Families must complete an eligibility determination and find the recipient eligible under another coverage group before the recipient is eligible for these services.

Hospital Services—Inpatient, continued

REIMBURSEMENT:

Medicaid reimburses for inpatient hospital services prospectively based on cost-reported, per diem rates that are subject to caps. Teaching, specialty, and community health education hospitals are exempted from the caps contingent upon counties contributing to the state's share of the cost of the exemption. Details of the reimbursement plan are explained in the Florida Medicaid (Title XIX) Inpatient Hospital Reimbursement Plan. The plan is available on the AHCA web site at www.myflorida.com. Additional payments are made to disproportionate share hospitals.

Inpatient newborn hearing screening services are reimbursed using an established fee. These are the only inpatient services to which the per diem reimbursement does not apply. There is a \$3 recipient copayment for each admission to a hospital, unless the recipient is exempt.

HOSPITAL SERVICES–OUTPATIENT

DESCRIPTION:

Outpatient hospital services are preventive, diagnostic, therapeutic or palliative care and service items provided to an outpatient. The services must be provided under the direction of a licensed physician or dentist.

Medicaid reimburses licensed, Medicaid-participating hospitals for outpatient services. Medicaid reimbursement includes medical supplies, nursing care, therapeutic services and drugs.

LIMITATIONS:

Medicaid reimbursement for outpatient hospital services is limited to \$1,500 per recipient, per state fiscal year (July 1 through June 30) for recipients who are age 21 and older. There is no reimbursement limitation for children under the age of 21.

EXCEPTIONS:

Exceptions to the outpatient fiscal year limitation are made for the surgical procedures that are performed in an outpatient setting. Services include, but are not limited to, cataract surgery, myringotomy with insertion of tube, single mastoidectomy, ligation and stripping of varicose lower limb veins, inguinal hernia repair, tubal ligation, ligation of vas deferens, dilation and curettage, vaginal child delivery, and dialysis services.

Medicaid will reimburse outpatient hospital services furnished by a non-Medicaid-participating hospital in an emergency, for the duration of the emergency.

ELIGIBILITY:

Medicaid reimburses for outpatient hospital services for all Medicaid recipients.

REIMBURSEMENT:

Outpatient reimbursement is made on the basis of a payment plan in the form of a prospective rate as detailed in the Florida Medicaid (Title XIX) Outpatient Hospital Reimbursement Plan. The plan is available on the AHCA web site at www.myflorida.com. An exception is diagnostic laboratory procedures, which are reimbursed the maximum Medicaid fee or the provider's customary fee, whichever is lower. Another exception to the outpatient prospective rate is newborn hearing screening. This service is reimbursed using an established fee.

There is a \$3 recipient copayment for each hospital outpatient department or clinic visit and emergency room visit to receive non-emergency services, unless the recipient is exempt.

INDEPENDENT LABORATORY SERVICES

DESCRIPTION:

Independent laboratory services are clinical laboratory procedures performed in freestanding laboratory facilities. A doctor of medicine or osteopathy or other licensed health care practitioner authorized within the scope of practice to order clinical laboratory tests must authorize the services.

Medicaid reimburses for services rendered by licensed, Clinical Laboratory Improvements Act (CLIA) certified, Medicaid-participating independent laboratories.

Medicaid does not reimburse hospitals, ambulatory surgical centers, federally qualified health centers, rural health clinics, or practitioners for services performed in their offices for independent laboratory services.

LIMITATIONS:

Medicaid reimbursement is limited to the specific procedures that an independent laboratory facility has been certified under CLIA to provide. The frequency of some tests is also limited.

EXCEPTIONS:

If medically necessary, the provider may request reimbursement for services in excess of the established limits by billing with a modifier.

ELIGIBILITY:

Medicaid reimburses independent laboratory services for all Medicaid recipients.

REIMBURSEMENT:

Medicaid reimbursement for independent laboratory services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.

There is a \$1 recipient copayment for independent laboratory services, per provider, per day, unless the recipient is exempt.

INTERMEDIATE CARE FACILITY SERVICES FOR THE DEVELOPMENTALLY DISABLED

DESCRIPTION:

Medicaid reimburses for services rendered by state owned and operated intermediate care facilities for the developmentally disabled (ICF/DD).

Medicaid reimbursement for ICF/DD services includes:

- Room and board
- Food and food supplements
- Nursing services
- Rehabilitative care
- Therapy
- Basic wardrobe
- Training and help with daily living skills
- Medical supplies, durable medical equipment, eyeglasses, hearing aids
- Dental care
- Transportation

LIMITATIONS:

There is no Medicaid limitation on the length of stay in an ICF/DD. However, Medicaid reimbursement for a reserved bed is limited to:

- 15 days per hospital stay,
- 30 days per 12 months for infirmary stays, and
- 45 days per state fiscal year (July 1—June 30) for therapeutic leave.

ELIGIBILITY:

Medicaid reimburses for ICF/DD services for all Medicaid recipients except for Medically Needy recipients. All admissions to ICF/DDs must be prior approved by the Department of Children and Families, Developmental Disabilities Program Office. The Developmental Disabilities Program Office is responsible for determining the medical necessity for ICF/DD services. Individuals admitted to ICF/DDs must have been determined to be eligible for, to require, and to have chosen ICF/DD placement prior to admission.

REIMBURSEMENT:

Medicaid reimbursement for ICF/DD is made in accordance with the Florida Medicaid (Title XIX) ICF/DD Reimbursement Plan. Payment is an all-inclusive prospective per diem rate, based on cost reports and staff ratios for each level of care, and is subject to AHCA's established annual inflation allowance for cost increases by level of care.

LICENSED MIDWIFE SERVICES

DESCRIPTION:

Medicaid reimburses Medicaid-participating, licensed midwives for obstetrical care services rendered to women during the antepartum and postpartum phases of pregnancy and home deliveries.

Medicaid reimbursable services include:

- Initial comprehensive and prenatal examinations
- Labor management for recipients who transfer to a hospital
- Post delivery examinations
- Vaginal delivery
- Post delivery recovery
- Newborn assessment
- Related pregnancy services

LIMITATIONS:

Medicaid reimbursement for licensed midwife services is limited to one visit, per day, per recipient. Visits are limited to a total of ten low-risk antepartum visits and two postpartum visits per pregnancy. Newborn assessments are limited to one per recipient.

ELIGIBILITY:

Medicaid reimburses for licensed midwife services for Medicaid recipients whose pregnancy is determined to be low risk. Recipients whose eligibility is determined through the Presumptively Eligible Pregnant Women program are not eligible for services associated with labor, delivery, postpartum, and inpatient hospitalization. The Department of Children and Families must complete an eligibility determination and find the recipient eligible under another coverage group before the recipient is eligible for these services.

REIMBURSEMENT:

Medicaid reimbursement for licensed midwife services is the maximum Medicaid fee or the provider's customary fee, whichever is lower. Licensed midwives are reimbursed at 80 percent of the physician's rate for services that are approved by the Centers for Medicare and Medicaid Services (CMS), formerly known as HCFA.

MEDICAL FOSTER CARE SERVICES

DESCRIPTION:

Medical foster care (MFC) services enable medically-complex children whose parents cannot care for them in their own homes to live and receive medical care in alternative-home settings rather than hospitals or other institutions. The Department of Health, Children's Medical Services (CMS) administers the medical foster care program. The Department of Children and Families (DCF) reimburses the medical foster parent for the child's room, board and other living expenses.

Medicaid reimburses the medical foster parent for providing the child with medically-necessary care needed in daily living activities. These activities include, but are not limited to, feeding, bathing, administering medications, changing dressings, and turning and positioning the medical foster child.

LIMITATIONS:

Medicaid will reimburse only one medical foster care provider per day, per child.

Medicaid does not reimburse for additional services to allow the medical foster care parent to obtain respite from caring for the child.

Medical foster care providers must be supervised by the MFC staff.

ELIGIBILITY:

Medicaid reimburses for medical foster care services for all Medicaid eligible, medically-complex recipients under the age of 21 when the following criteria have been met:

- MFC services are recommended by the Children's Multidisciplinary Assessment Team (CMAT),
- DCF and CMS have placed the child in a MFC home, and
- The MFC services are authorized by the area Medicaid office service authorization nurse.

REIMBURSEMENT:

Medicaid reimbursement for medical foster care services is based on the level of medical foster care required by the child.

NURSING FACILITY SERVICES

DESCRIPTION:

Nursing facility services are 24-hour-a-day nursing and rehabilitation services provided in a facility that is licensed and certified by the Agency for Health Care Administration (AHCA) to participate in the Medicaid program. Nursing facility services include special care for AIDS patients and medically-fragile children; reimbursement for swing bed services provided in a rural acute care hospital; and skilled nursing services provided in a hospital-based, skilled-nursing unit.

The recipient's care and services must be ordered by a doctor of medicine or osteopathy. There are two levels of nursing facility care: skilled and intermediate. The Department of Elder Affairs, Comprehensive Assessment and Review for Long Term Care Services (CARES) unit recommends the level of care for recipients age 21 and older. The Department of Health, Children's Medical Services, Children's Multidisciplinary Assessment Team (CMAT) recommends the level of care for recipients under the age of 21.

LIMITATIONS:

There is no limitation on the length of stay in a nursing facility. However, Medicaid reimbursement for a reserved bed (subject to specific criteria) is limited to:

- Eight days per hospital stay and
- Sixteen days per state fiscal year (July 1 - June 30) for home visits.

Swing bed services cannot exceed 60 days unless a longer stay has been prior authorized by CARES.

Hospital-based skilled-nursing unit services cannot exceed 30 days, unless one 15-day extension has been prior authorized by CARES.

ELIGIBILITY:

Medicaid reimburses for nursing facility services for Medicaid recipients who meet the Medicaid Institutional Care Program (ICP) eligibility requirements. The Department of Children and Families determines if recipients meet the ICP eligibility requirements.

REIMBURSEMENT:

Reimbursement is made in accordance with the Florida Medicaid (Title XIX) Long-Term Care Reimbursement Plan. The plan is available on the AHCA web site at www.myflorida.com. A daily rate is determined for each nursing facility based on an audited cost report submitted by the nursing facility. There is no rate difference between the skilled and intermediate levels of care. Rural swing-bed providers receive the average statewide nursing-facility rate. Hospital-based skilled-nursing units receive the average nursing-facility rate for the county in which the hospital is located. Supplemental reimbursement is available for approved recipients who have AIDS or are medically-fragile children under the age of 21. Prior authorization is required for a supplemental reimbursement.

OPTOMETRIC SERVICES

DESCRIPTION:

Medicaid reimburses for services rendered by licensed, Medicaid-participating optometrists.

Medicaid reimbursable services include:

- Visual examinations when there is a reported vision problem, illness, disease or injury
- Consultation and referral services
- Custodial care facility services
- Nursing facility services
- Evaluation and management services
- General and special ophthalmological services
- Pathology and laboratory services
- Surgical services within the optometrist's scope of practice
- Post-operative management

LIMITATIONS:

Medicaid reimbursement for all post-operative, follow-up services must be ordered by the operating surgeon. A written referral signed by the surgeon must be filed in the recipient's medical record.

ELIGIBILITY:

Medicaid reimburses for optometric services for all Medicaid recipients.

REIMBURSEMENT:

Medicaid reimbursement for optometric services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.

There is a \$2 recipient copayment for optometric services, per provider, per day, unless the recipient is exempt.

PHYSICIAN SERVICES

DESCRIPTION:

Medicaid reimburses for services rendered by licensed, Medicaid-participating doctors of medicine or osteopathic medicine. The services can be rendered in the physician's office, the patient's home, a hospital, a nursing facility or other approved places of services as necessary to treat a particular injury, illness, or disease.

LIMITATIONS:

Medicaid reimbursement for physician services is limited to:

- One physician-recipient contact per provider specialty, per day (except for emergencies);
- One long-term care facility service per physician, per month, per recipient (except for emergencies);
- One physician consultation per 365 days, per physician of any specialty, per recipient (for non-hospitalized Medicaid recipients);
- Ten prenatal visits for low-risk pregnancy, fourteen visits for high-risk pregnancy, and two postpartum visits per pregnancy; and
- One new patient evaluation and management service per physician specialty, every three years, if no services were rendered by the physician to the recipient during the prior three years. Subsequent encounters must be reimbursed as established patient evaluation and management services.

Medicaid does not reimburse cosmetic surgery, experimental procedures and eye exams unless related to reported vision problems, illness, disease or injury.

Elective surgery performed within the inpatient hospital setting must be medically necessary and prior authorized, except for recipients under 21 who have been screened in the Child Health Check-Up (formerly known as Early and Periodic Screening, Diagnosis and Treatment [EPSDT]) program within 12 months prior to the date of surgery.

Medicaid does not reimburse abortions except for one of the following reasons:

- The woman suffers from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.
- The pregnancy is the result of incest.
- The pregnancy is the result of rape.

Medicaid Summary of Services

Physician Services, continued

EXCEPTIONS:

The provider may request authorization for reimbursement for services in excess of the service limitations.

ELIGIBILITY:

Medicaid reimburses for physician services for all Medicaid recipients. Recipients whose eligibility is determined through the Presumptively Eligible Pregnant Women program are not eligible for services associated with labor, delivery, postpartum, and inpatient hospitalization. The Department of Children and Families must complete an eligibility determination and find the recipient eligible under another coverage group before the recipient is eligible for these services.

REIMBURSEMENT:

Medicaid reimbursement for physician services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.

An exception is certain obstetrical and neonatal services provided in Regional Perinatal Intensive Care Centers (RPICCs), whose payment is based on a Diagnosis Related Group (DRG). DRG payments are prospective and based on average patient lengths of stay in a hospital.

There is a \$2 recipient copayment for physician services, per provider, per day, unless the recipient is exempt.

PHYSICIAN ASSISTANT SERVICES

DESCRIPTION:

Medicaid reimburses for services provided by licensed, Medicaid-participating physician assistants. The services must be provided in collaboration with a practitioner licensed pursuant to Chapter 458 or 459, Florida Statutes.

LIMITATIONS:

Medicaid reimbursement for physician assistant services is limited to:

- One physician assistant-recipient contact per day (except for emergencies);
- One long-term care facility visit per month, per recipient (except for emergencies); and
- One new patient evaluation and management service per physician assistant, per recipient every three years, if no services were rendered by the physician assistant to the recipient during the three years. An additional new patient visit cannot be billed by the supervising physician for a patient already seen as a new patient by a physician assistant.

Medicaid cannot reimburse a physician assistant and a physician for the same procedure, same recipient, and same date of service. Medicaid may reimburse a surgeon for a surgical service and a physician assistant for the assist-at-surgery service.

EXCEPTIONS:

The provider may request authorization for reimbursement for services in excess of the service limitations.

ELIGIBILITY:

Medicaid reimburses for physician assistant services for all Medicaid recipients.

REIMBURSEMENT:

Medicaid reimbursement for physician assistant services is the maximum Medicaid fee or the provider's customary fee, whichever is lower. Physician assistants are reimbursed at 80 percent of the physician's rate for services that are approved by the Centers for Medicare and Medicaid Services (CMS), formerly known as HCFA. If a physician assistant is salaried by a hospital or other facility, such as a nursing facility, that is reimbursed on a cost-related basis, the physician assistant cannot be reimbursed on a fee-for-service basis if the costs for the physician assistant's salary are included in the facility's cost report. There is a \$2 recipient copayment for physician assistant services, per provider, per day, unless the recipient is exempt.

PODIATRY SERVICES

DESCRIPTION:

Medicaid reimburses for podiatry services rendered by licensed, Medicaid-participating podiatrists. The services can be provided in the podiatrist's office, inpatient hospital, outpatient/emergency department of a hospital, ambulatory surgical center, nursing facility, intermediate care facility for the developmentally disabled (ICF/DD), boarding home, recipient's home, or other custodial facility.

LIMITATIONS:

Podiatry services are limited to:

- One podiatrist-recipient contact per day, not to exceed two per month (except for emergencies);
- One long-term care facility service per month, per recipient (except for emergencies); and
- One new patient evaluation and management service per recipient, every three years, if no services were rendered by the podiatrist to the recipient during the three years. Subsequent encounters must be reimbursed as established patient evaluation and management services.

Medicaid reimburses for routine foot care if the recipient is under a physician's care for a metabolic disease, has conditions of circulatory impairment, or has conditions of desensitization of the legs or feet.

Medicaid does not reimburse assistant fees for minor surgery, cosmetic surgery, and experimental or clinically unproven surgical procedures.

All elective surgical procedures require prior authorization, except for recipients under 21 who have been screened in the Child Health Check-Up program within 12 months of the date of surgery.

Recipients are able to receive up to four podiatry visits without authorization from their MediPass provider.

EXCEPTIONS:

The provider may request authorization for reimbursement for services in excess of the service limitations.

ELIGIBILITY:

Medicaid reimburses for podiatry services for all Medicaid recipients.

Podiatry Services, continued

REIMBURSEMENT:

Medicaid reimbursement for podiatry services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.

There is a \$2 recipient copayment for podiatry services, per provider, per day, unless the recipient is exempt.

PORTABLE X-RAY SERVICES

DESCRIPTION:

Portable x-ray services are interpretive and technical mobile x-ray services that are provided at the recipient's residence. A doctor of medicine or osteopathy or other licensed health care practitioner authorized within the scope of practice to order x-rays must authorize the services.

Medicaid reimburses for services rendered by licensed, Medicaid-participating portable x-ray providers who are certified in accordance with Medicare standards.

Medicaid does not reimburse hospitals, ambulatory surgical centers, federally qualified health centers, rural health clinics, or physicians for portable x-ray services rendered in their offices.

In addition to the radiographs supplied by mobile x-ray equipment and their interpretation, Medicaid pays a fee for the transportation of the equipment and x-ray personnel to the place of service. The set up of the equipment is not a separately reimbursed service.

LIMITATIONS:

Medicaid reimbursement for portable x-ray services is limited to one unit of service, per procedure, per recipient, per day.

ELIGIBILITY:

Medicaid reimburses for portable x-ray services for all Medicaid recipients.

REIMBURSEMENT:

Medicaid reimbursement for portable x-ray services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.

There is a \$1 recipient copayment for portable x-ray services, per provider, per day, unless the recipient is exempt.

PRESCRIBED DRUG SERVICES

DESCRIPTION:

Medicaid reimburses licensed, Medicaid-participating pharmacies. Medicaid reimburses for most legend drugs used in outpatient settings, including injectable drugs, and specified non-legend drugs. Brand name prescriptions are limited to four per month with some exceptions. Generic drugs, insulin and diabetic supplies, contraceptives, mental health drugs, and antiviral drugs used to treat HIV are exempt from these limits. Based on the treatment needs of the Medicaid recipient, the agency may authorize exceptions to the four-brand-name drug restriction. The non-legend drugs include:

- Insulin;
- Sodium chloride solution for inhalation;
- Urine ketone test strips for insulin dependent recipients under age 21;
- Disposable insulin syringe-needle combinations used to administer subcutaneous insulin;
- Blood glucose test strips and meters (limited to a contracted manufacturer unless an exception is approved. The current manufacturer is Lifescan.);
- Contraceptive devices and supplies;
- Aluminum and calcium products used as phosphate binders and multivitamin supplements for dialysis patients;
- Enteral nutritional supplements when prior authorized;
- Specified iron supplements;
- Aspirin when prescribed as an anti-inflammatory agent;
- Vaginal antifungal creams;
- Guaifenesin as a single entity expectorant, in either liquid or solid dosage form; and
- Specified smoking cessation products.

Medicaid does not reimburse pharmacies for any over-the-counter products dispensed to institutionalized recipients that could be floor stock and included in the institution's per diem.

Medicaid does not reimburse pharmacies for the following products:

- DESI ineffective drugs as designated by the Centers for Medicare and Medicaid (CMS);
- Experimental drugs;
- Cough and cold combination medications for recipients age 21 and older;
- Anorectics (unless prescribed for an indication other than obesity);
- Prostheses, appliances and devices (except products for diabetics and products used as contraceptives);
- Hair growth restorers and other drugs for cosmetic use;
- Drugs for patients who are hospitalized or being treated in outpatient hospital facilities or ambulatory surgical centers;
- Drugs to treat the terminal condition of hospice recipients;

Medicaid Summary of Services

Prescribed Drug Services, continued

- Floor stock items required to be furnished by institutions;
- Vitamins (except prenatal vitamins for pregnant and lactating women and folic acid as a single entity; one vitamin or vitamin/mineral prescription monthly for dialysis patients, fluoridated pediatric vitamins for children under age 13); and prescribed ferrous sulfate, gluconate, or fumarate for non-institutionalized patients (ferrous sulfate, gluconate, or fumarate is available as floor stock to institutionalized patients);
- Immunizations for non-Child Health Check-Up 221 recipients 21 years of age and older, except for influenza and pneumococcal vaccines for institutionalized recipients;
- Drugs used to treat infertility; and
- All other over-the-counter products not specified above.

Medicaid does not reimburse for drugs not included in a manufacturer's rebate agreement. Drugs must be prescribed for medically-accepted indications.

LIMITATIONS:

Medicaid reimbursement for recipients age 21 and older is limited to four brand name prescriptions per month. Generic drugs, insulin and diabetic supplies, contraceptives, mental health drugs, and antiviral drugs used to treat HIV are exempt from these limits. There is no limitation on the number of prescriptions for recipients under the age of 21.

Prior authorization is required for albumin, Botox[®], Cytogam[®], immune globulins, food supplements, Neupogen[®], Neutrexin[®], Panretin[®], Proleukin[®], Provigil[®], Procrit[®], Targretin[®] gel and capsules, Regranex[®] in long term care facilities and adult human growth hormone for HIV/AIDS.

Prior authorization is required for all prescribed drugs that are not on the Preferred Drug List (PDL). Mental health drugs and anti-retrovirals for HIV are exempt from PDL restrictions.

Medicaid processes all prescription claims through Drug Utilization Review and will not reimburse for prescriptions that are refilled too often or too soon, that duplicate other prescriptions, or that result in excessively high dosages for the recipient.

EXCEPTIONS:

The provider may request authorization for reimbursement for services in excess of the service limitations. The prescriber must request the exception to the four-brand-name limit and drugs not on the PDL.

Prescribed Drug Services, continued

ELIGIBILITY:

Medicaid reimburses for prescribed drug services for all Medicaid recipients, except for those in limited programs, such as Qualified Medicare Beneficiary (QMB) and aliens.

REIMBURSEMENT:

Medicaid reimbursement for prescribed drugs is the lowest of:

- Estimated acquisition cost of the drug, plus the dispensing fee;
- Federal or state maximum-allowable cost, plus the dispensing fee;
- Wholesaler Acquisition Cost plus 7%;
- Average wholesale price less 13.25% plus the dispensing fee; or
- Amount billed by the pharmacy, which cannot exceed the pharmacy's usual and customary charge for the prescription.

PRESCRIBED PEDIATRIC EXTENDED CARE SERVICES

DESCRIPTION:

A prescribed pediatric extended care (PPEC) center is a non-residential health care center in which the needed continuum of care for children who are medically complex is provided. PPEC includes an array of services focused on meeting the medical, developmental, physical, nutritional and social needs of these children. The PPEC provides a less restrictive alternative to institutionalization and reduces the isolation that a homebound, medically-complex child may experience.

Medicaid reimbursement for PPEC services includes nursing care and personal care services that are ordered by the physician. PPECs that provide other Medicaid services, such as therapies and durable medical equipment, must be enrolled as Medicaid providers of those services.

ELIGIBILITY:

Medicaid reimburses for PPEC services for Medicaid-eligible, medically-complex recipients under the age of 21 years who meet the following requirements:

- The child must be medically complex or need acute medical care;
- The services must be prescribed by the attending physician;
- Services must be recommended by the Children's Multidisciplinary Assessment Team (CMAT); and
- The service must be authorized by an area Medicaid office service authorization nurse.

REIMBURSEMENT:

Medicaid reimbursement for PPEC services is an all-inclusive half-day or whole-day per diem rate for each child.

REGISTERED NURSE FIRST ASSISTANT SERVICES

DESCRIPTION:

Medicaid reimburses for services provided by licensed, Medicaid-participating registered nurse first assistants (RNFA). The services must be rendered in collaboration with a physician and in accordance with Chapter 464, Florida Statutes.

LIMITATIONS:

Medicaid reimbursement for RNFA services is limited as follows:

- One surgical assistant may be reimbursed per operative session.
- Services provided by an RNFA must be within the specialty of the supervising physician.

Medicaid cannot reimburse a registered nurse first assistant and an assistant surgeon for the same recipient and same date of service.

ELIGIBILITY:

Medicaid reimburses for RNFA services for all Medicaid recipients.

REIMBURSEMENT:

Medicaid reimbursement for RNFA services is the maximum Medicaid fee or the provider's customary fee, whichever is lower. RNFAs are reimbursed at 80 percent of the physician's rate for services that are approved by the Centers for Medicare and Medicaid Services (CMS).

If an RNFA is salaried by a hospital or other facility that is reimbursed on a cost-related basis, the RNFA cannot be paid on a fee-for-service basis if the costs for the RNFA's salary are included in the facility cost report.

There is a \$2 recipient copayment for RNFA services, per provider, per day, unless the recipient is exempt.

RURAL HEALTH CLINIC SERVICES

DESCRIPTION:

A Rural Health Clinic (RHC) is a clinic that is located in a rural area that has a health care provider shortage. RHCs provide primary and preventive health care and related diagnostic services. In addition, RHCs may provide optometric, podiatry, chiropractic and mental health services. RHC services are performed by advanced registered nurse practitioners, chiropractors, clinical psychologists, clinical social workers, optometrists, physicians, physician assistants, and podiatrists.

Medicaid reimbursement to RHCs includes:

- Adult health screening services
- Child Health Check-Ups (formerly known as Early and Periodic Screening, Diagnosis and Treatment [EPSDT])
- Chiropractic services
- Family planning services
- Medical primary care services
- Mental health services
- Optometric services
- Podiatry services

RHCs participate in the Vaccines for Children program. Immunization services are reimbursed separately from the RHC's cost-based reimbursement rate.

LIMITATIONS:

Medicaid reimbursement for RHC services is limited to one encounter, per day, per recipient.

The service limitations that apply to the Medicaid program for a particular service, such as chiropractic, apply to the services when rendered by an RHC. RHC mental-health services are limited to 26 visits, per recipient, per calendar year.

ELIGIBILITY:

Medicaid reimburses for RHC services for all Medicaid recipients.

REIMBURSEMENT:

Medicaid reimburses the RHC a clinic-specific, all-inclusive encounter rate for clinic services. Immunizations, emergency services, and services rendered at a hospital are reimbursed on a fee-for-service basis. There is a \$3 recipient copayment for RHC services, per clinic, per day, unless the recipient is exempt.

SCHOOL–BASED SERVICES PROGRAMS SCHOOL DISTRICT PROGRAM

DESCRIPTION:

School districts may enroll as providers of a variety of Medicaid services. When the school district employs or contracts with staff who provide health care, the school district can enter into a provider agreement with Medicaid and receive the federal share of Medicaid payments for providing Medicaid-covered services to Medicaid-eligible children.

LIMITATIONS:

Medicaid coverage limitations are based on the type of service(s) that the school district elects to have Medicaid reimburse.

ELIGIBILITY:

Medicaid reimburses school districts for certain services rendered to Medicaid-eligible students under the age of 21 who qualify as disabled under the “Individuals with Disabilities Education Act,” Part B or C and who have the services referenced in their Individual Educational Plans or Family Support Plans.

REIMBURSEMENT:

Medicaid reimbursement for services provided by a school is the federal share of the Medicaid reasonable cost of service.

SCHOOL-BASED SERVICES PROGRAMS COUNTY HEALTH DEPARTMENT PROGRAM

DESCRIPTION:

County Health Departments (CHDs) may enroll as providers of a variety of nursing services in public schools. When the CHD employs or contracts with nurses who provide nursing services, the CHD can enter into a provider agreement with Medicaid and receive the federal share of Medicaid payments for providing Medicaid-covered nursing services to Medicaid-eligible children.

LIMITATIONS:

Medicaid reimbursement is limited to nursing services (personally rendered), and medication administration by a registered nurse or licensed practical nurse.

ELIGIBILITY:

Medicaid reimburses CHDs for services rendered to Medicaid-eligible students under the age of 21.

REIMBURSEMENT:

Medicaid reimbursement for services provided by a CHD is the federal share of the Medicaid maximum fee.

STATE MENTAL HEALTH HOSPITAL SERVICES

DESCRIPTION:

State mental hospitals provide all-inclusive psychiatric inpatient hospital care. Medicaid reimbursement for services includes: room and board, professional services, rehabilitative nursing services, supplies, and equipment necessary to provide the appropriate care.

ELIGIBILITY:

Medicaid reimburses for state mental hospital services for all Medicaid recipients, except for Medically Needy recipients who are age 65 and older and require long-term mental health services.

REIMBURSEMENT:

Inpatient reimbursement is made on the basis of a payment plan in the form of a prospective per diem cost rate as detailed in the Florida Medicaid (Title XIX) Inpatient Hospital Reimbursement Plan. The plan is available on the AHCA web site at www.myflorida.com.

TARGETED CASE MANAGEMENT

DESCRIPTION:

Targeted case management provides case management services to the Department of Health, Children's Medical Services (CMS) and Department of Children and Families, Office of Mental Health clients. Case management is defined as activities associated with ensuring access to necessary medical, social, educational, and other services as required by the individual.

Medicaid reimburses Department of Health, Children's Medical Services (CMS) clinic staff and contracted providers and Department of Children and Families, Office of Mental Health contracted providers for case management activities.

LIMITATIONS:

Medicaid reimbursement for individual case management services is limited to a maximum of 32 units per day/per recipient/per case manager. Only one claim for all cumulative units that occurred during the day is reimbursed per individual case manager, per recipient.

Medicaid reimbursement for mental health individual case management services is limited to 86 hours, per individual case manager, per month, per recipient. Reimbursement for intensive, team case management services is limited to 12 hours per day, per recipient. Only one claim for all cumulative units that occurred during the day is reimbursed per individual case manager, per recipient.

ELIGIBILITY:

To receive case-management services, a recipient must meet the individual eligibility criteria for one of the following target groups:

- Client of Children's Medical Services
- Client of the Office of Mental Health, Children's Mental Health Program
- Priority client of the Office of Mental Health, Adult Mental Health Program

REIMBURSEMENT:

Medicaid reimburses the provider an established fee based on a unit of service for each allowable case management service. A unit is from one to 15 minutes.

Case management services provided by CMS and the mental health staff must be adjusted annually to their actual cost.

THERAPY SERVICES—OCCUPATIONAL

DESCRIPTION:

Occupational therapy addresses the functional needs of an individual related to the performance of self-help skills; adaptive behavior; and sensory, motor, and postural development.

Medicaid reimburses for occupational therapy services provided by licensed, Medicaid-participating occupational therapists and by supervised, occupational therapy assistants.

Medicaid reimbursable services include evaluation and treatment to prevent or correct physical and emotional deficits or to minimize the disabling effect of these deficits. Typical activities are perceptual motor activity exercises to enhance functional performance, kinetic movement, guidance in the use of adaptive equipment, and other techniques related to improving motor development.

Services are available in the home or other appropriate setting.

LIMITATIONS:

Medicaid reimbursement is limited to:

- One initial evaluation per recipient, per provider;
- One re-evaluation every six months per recipient, per provider; and
- Up to four occupational therapy treatments per day, per recipient.

An occupational therapy treatment must have a minimum duration of 15 minutes of face-to-face contact between the therapist and the recipient.

The recipient's primary care physician must prescribe therapy treatments.

ELIGIBILITY:

Medicaid reimburses for medically necessary occupational therapy services for all Medicaid recipients under the age of 21.

REIMBURSEMENT:

Medicaid reimbursement for occupational therapy services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.

THERAPY SERVICES—PHYSICAL

DESCRIPTION:

Physical therapy addresses the development, improvement or restoration of neuromuscular or sensory motor function; relief of pain; or control of postural deviation to attain maximum performance.

Medicaid reimburses for physical therapy services provided by licensed, Medicaid-participating physical therapists and by supervised, physical therapy assistants.

Medicaid reimbursable services include the evaluation and treatment related to range-of-motion, muscle strength, functional abilities and the use of adaptive or therapeutic equipment. Activities include rehabilitation through exercises, massage, the use of equipment and rehabilitation through therapeutic activities.

These services are available in the home or other appropriate setting.

LIMITATIONS:

Medicaid reimbursement is limited to:

- One initial evaluation per recipient, per provider;
- One re-evaluation every six months per recipient, per provider; and
- Up to four physical therapy treatments per day, per recipient. A physical therapy treatment must have a minimum duration of 15 minutes of face-to-face contact between the therapist and the recipient.

The recipient's primary care physician must prescribe therapy treatments

ELIGIBILITY:

Medicaid reimburses for medically necessary physical therapy services for Medicaid recipients under the age of 21.

Recipients over the age of 21 can obtain physical therapy under the outpatient hospital services program. Services provided in the outpatient hospital are included in the hospital per diem and are subject to the \$1,500 outpatient cap.

REIMBURSEMENT:

Medicaid reimbursement for physical therapy services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.

THERAPY SERVICES—RESPIRATORY

DESCRIPTION:

Respiratory therapy is the evaluation and treatment of pulmonary dysfunction. Medicaid reimbursable services include: ventilator support, therapeutic use of medical gases, respiratory rehabilitation, management of life support systems, bronchopulmonary drainage, breathing exercises, and chest physiotherapy.

Medicaid reimburses for respiratory therapy services that are personally rendered by licensed registered respiratory therapists.

These services are available in the home or other appropriate setting.

LIMITATIONS:

Medicaid reimbursement is limited to:

- One initial evaluation per recipient, per provider;
- One re-evaluation every six months per recipient, per provider; and
- Up to four respiratory therapy treatments per day, per recipient.

A respiratory therapy treatment must have a minimum duration of 15 minutes of face-to-face contact between the recipient and the therapist.

The recipient's primary care physician must prescribe therapy treatments.

ELIGIBILITY:

Medicaid reimburses for medically necessary respiratory therapy services for Medicaid recipients under the age of 21.

Recipients over the age of 21 can obtain respiratory therapy under the outpatient hospital services program. Services provided in the outpatient hospital are included in the hospital per diem and are subject to the \$1,500 outpatient cap.

REIMBURSEMENT:

Medicaid reimbursement for respiratory therapy services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.

THERAPY SERVICES—SPEECH-LANGUAGE PATHOLOGY

DESCRIPTION:

Speech-language pathology services involve the evaluation and treatment of speech-language disorders.

Medicaid reimburses for speech-language pathology services provided by licensed, Medicaid-participating speech-language pathologists and by supervised, speech-language pathologist assistants.

These services are available in the home or other appropriate setting. Speech-language pathology services may be rendered to a group of children.

LIMITATIONS:

Medicaid reimbursement is limited to:

- One initial evaluation per recipient, per provider;
- One re-evaluation every six months per recipient, per provider; and
- Either up to four individual or one group speech-language pathology treatment per day, per recipient.

An individual speech-language pathology treatment must have a minimum duration of 15 minutes of face-to-face contact between the therapist and the recipient.

A group speech-language pathology treatment is limited to six children. The group must receive a minimum of 30-minutes of therapy.

The recipient's primary care physician must prescribe therapy treatments.

ELIGIBILITY:

Medicaid reimburses for medically necessary speech-language pathology services for Medicaid recipients under the age of 21.

Medicaid reimburses speech-language pathology services for the provision of augmentative and communication systems for recipients regardless of age.

REIMBURSEMENT:

Medicaid reimbursement for speech-language pathology services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.

TRANSPLANT SERVICES – ORGAN AND BONE MARROW

DESCRIPTION:

Bone marrow transplantation is performed for the treatment of certain types of cancers and aplastic anemias; solid organ transplantation is performed for failure of the organ due to a variety of illnesses. Medicaid reimburses for organ and bone marrow transplantation services provided by specialized transplant physicians in designated transplant centers.

Determinations for medically accepted transplant procedures are established within the guidelines of the Agency for Health Care Administration (AHCA) Organ Transplant Advisory Council, the Bone Marrow Transplant Advisory Panel, and Medicaid medical consultants.

Acceptance as a candidate for covered transplant services is determined by the designated transplant hospital, not by Medicaid. Pre-transplant and post-transplant care, including immunosuppressive medications, is reimbursed even if the transplant is not a Medicaid-covered transplant.

LIMITATIONS:

Medicaid reimbursement for transplant services has the following limitations:

- Recipients age 21 and older are eligible for kidney, cornea, liver, heart, and bone marrow when medically necessary and appropriate.
- Recipients under age 21 are eligible for transplants determined medically necessary and appropriate, including lung, heart/lung and those listed above for recipients age 21 and older.
- All out-of-state referrals for organ and bone marrow transplants require prior authorization from the Medicaid office.
- Out-of-state evaluations and transplants are not covered if the services are available in the state of Florida.
- Physician services limitations apply.

Adult heart transplants require prior authorization. Medicaid does not reimburse transplant procedures that are deemed investigative, experimental or those not yet proven clinically effective as determined by the Medicaid medical consultants.

ELIGIBILITY:

Medicaid reimburses for transplant services for all Medicaid recipients, except aliens who are eligible only for emergency services due to their alien status.

Medicaid Summary of Services

Transplant Services – Organ and Bone Marrow, continued

REIMBURSEMENT:

Medicaid reimbursement for physicians for transplant services is the maximum Medicaid fee or the provider's customary fee, whichever is lower. Medicaid reimbursement for hospitals for transplant services is the established per diem rate for that facility.

TRANSPORTATION SERVICES

DESCRIPTION:

Medicaid reimburses for transportation services provided by Medicaid-participating ambulances, non-emergency medical vehicles, taxicabs, private automobiles, multi-passenger vans and buses, and public and private organizations.

To be reimbursed by Medicaid, the transportation must be for the purpose of transporting the recipient to or from a Medicaid-covered service to receive medically-necessary care. When necessary, Medicaid may reimburse transportation of an escort for the recipient, such as a parent or guardian.

LIMITATIONS:

Transportation services are available only to eligible recipients who cannot obtain transportation on their own through any available means such as family, friends or community resources.

All transportation except for emergencies must be prior authorized by Medicaid, be provided by an enrolled provider, and must be the least expensive and most appropriate method of transportation available in each situation.

Medicaid does not reimburse private automobile transportation that is provided by the recipient.

EXCEPTIONS:

Post authorization may be granted only if the medical service is immediately necessary because of an urgent situation and the local authorizing entity is unavailable. The provider or recipient must request post authorization within a specified number of working days of the date transportation was provided.

ELIGIBILITY:

Medicaid reimburses for transportation for all Medicaid recipients who have no service limitations.

REIMBURSEMENT:

Transportation rates are negotiated by the area Medicaid offices with transportation providers and should be less than the local carriers' usual and customary charges.

Authorized private volunteer automobile transportation is compensable at 20 cents per mile.

Medicaid reimburses non-emergency medical carriers the published Medicaid fee, the carrier's customary fee, or an area-negotiated rate, whichever is lower.

Medicaid Summary of Services

Transportation Services, continued

Ambulance transportation, for either Basic Life Support Services or Advanced Life Support Services, is reimbursed at the Medicaid published allowable rate or the carrier's customary fee, whichever is lower.

There is a \$1 recipient copayment for transportation services for each one-way trip, unless the recipient is exempt.

VISUAL SERVICES

DESCRIPTION:

Medicaid reimburses for visual services rendered by licensed, Medicaid-participating ophthalmologists, optometrists and opticians.

Medicaid reimbursable services include eyeglasses, eyeglass repairs as required, prosthetic eyes, and contact lenses. Providers may use the Central Optical Laboratory, which is managed by Prison Rehabilitative Industries and Diversified Enterprises (PRIDE), for services for Medicaid recipients.

LIMITATIONS:

Medicaid reimbursement for eyeglasses is limited to the provision or replacement of medically-necessary eyeglasses. Reimbursement is further limited to no more than two pairs of eyeglasses per recipient, per 365 days.

All special eyeglasses and contact lenses must be prior authorized.

EXCEPTIONS:

The provider may request authorization for reimbursement for services in excess of the service limitations.

ELIGIBILITY:

Medicaid reimburses for visual services for all Medicaid recipients.

REIMBURSEMENT:

Medicaid reimbursement for visual services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.

WAIVER PROGRAMS

(in alphabetical order)

AGED/DISABLED ADULT WAIVER PROGRAM

DESCRIPTION:

The Aged/Disabled Adult (ADA) Waiver is a home and community-based services program that was implemented statewide on April 1, 1982. The Florida Department of Elder Affairs has operational responsibility for the ADA Waiver.

The waiver includes the following services: adult companion, adult day health care, attendant care, case aide, case management, chore services, consumable medical supplies, counseling, environmental accessibility adaptation, escort, family training, financial risk reduction, health support, home-delivered meals, homemaker and personal care services, nutrition, personal emergency response systems, pest control, physical risk reduction, physical therapy, respite care, skilled nursing, specialized medical equipment and supplies, and speech therapy.

Recipients make an informed choice of receiving home and community-based services in lieu of nursing facility care.

ELIGIBILITY:

To be eligible for the Aged/Disabled Adult Waiver services, an individual must meet the following criteria:

- Be 65 years old or older or be ages 18 to 64 and determined disabled according to Social Security standards;
- Meet Supplemental Security Income (SSI), MEDS-AD, or Medicaid Waiver Assistance (MWA) income and asset requirements;
- Meet nursing facility level-of-care criteria as determined by CARES;
- Receive case management and at least one other waiver service; and
- Be enrolled in the waiver.

REIMBURSEMENT:

Authorized services provided to enrolled waiver recipients are provided on a fee-for-service basis. Medicaid reimbursement for services is the Medicaid fee or the provider's customary fee, whichever is lower.

ASSISTED LIVING FOR THE ELDERLY WAIVER PROGRAM

DESCRIPTION:

The Assisted Living for the Elderly (ALE) Waiver is a home and community-based services program that was implemented statewide on February 1, 1995, for recipients who reside in qualified Assisted Living Facilities (ALFs). The Florida Department of Elder Affairs has operational responsibility for the ALE Waiver.

The waiver includes three services: case management, assisted living, and if needed, incontinence supplies. The components of assisted living include: attendant call system, attendant care, behavior management, chore, companion services, homemaker, intermittent nursing, medication administration (within the ALF license), occupational therapy, personal care, physical therapy, specialized medical equipment and supplies, speech therapy, and therapeutic social and recreational services.

Recipients make an informed choice of receiving home and community-based services in lieu of nursing facility care.

ELIGIBILITY:

To be eligible for ALE Waiver services, an individual must meet the following criteria:

- Be age 65 and older or be ages 60 to 64 and be determined disabled according to Social Security standards;
- Meet nursing facility level-of-care criteria as determined by CARES;
- Meet Supplemental Security Income (SSI), MEDS-AD or Medicaid Waiver Assistance (MWA) income and asset requirements; and
- Meet one or more of the following:
 1. Require assistance with four or more activities of daily living (ADLs).
 2. Require assistance with three ADLs plus supervision or administration of medication.
 3. Require total help with one or more ADLs.
 4. Have a diagnosis of Alzheimer's disease or another type of dementia and require assistance with two or more ADLs.
 5. Have a diagnosed degenerative or chronic medical condition requiring nursing services that cannot be provided in a standard ALF, but are available in an ALF licensed for limited nursing or extended congregate care.
 6. Be a Medicaid-eligible recipient who meets ALF criteria; be awaiting discharge from a nursing facility placement; and be unable to return to a private residence because of a need for supervision, personal care, periodic nursing services, or a combination of the three.

Assisted Living for the Elderly Waiver Program, continued

REIMBURSEMENT:

Medicaid reimburses for assisted living services at a daily rate and case management services at a monthly rate. Incontinence supplies are reimbursed separately on a monthly basis.

CHANNELING WAIVER PROGRAM

DESCRIPTION:

The Channeling Waiver is a home and community-based services program that was implemented on July 1, 1985, through a contractual agreement with an organized health care delivery system.

The Channeling Waiver offers comprehensive case management with authority to prescribe amount and duration of 19 core services described in required care plans that itemize service costs.

The waiver includes the following services: adult day health care, case management, chore services, companion services, counseling, environmental accessibility adaptations, family training, financial education and protection services, home health aide services, occupational therapy, personal care services, personal emergency response systems, physical therapy, respite care, skilled nursing, special home delivered meals, special drug and nutritional assessments, special medical supplies, and speech therapy.

Recipients make an informed choice of receiving care and home and community-based services in lieu of nursing facility care.

ELIGIBILITY:

To be eligible for Channeling Waiver services, an individual must meet the following criteria:

- Be age 65 or older;
- Meet the nursing facility level-of-care criteria as determined by CARES;
- Meet the Supplemental Security Income (SSI), MEDS-AD or Medicaid Waiver Assistance (MWA) income and asset requirements;
- Have two or more unmet long term care service needs; and
- Reside in Dade or Broward counties.

REIMBURSEMENT:

Payment is based on a negotiated per diem reimbursement rate. The cost of care may not exceed 85 percent of the average Medicaid nursing facility rates in Broward and Dade counties.

CONSUMER-DIRECTED CARE RESEARCH AND DEMONSTRATION WAIVER PROGRAM

DESCRIPTION:

The Consumer Directed Care Research and Demonstration (1115) Waiver is a coordinated effort between the Department of Elder Affairs, Department of Children and Families, Department of Health, and Agency for Health Care Administration. The demonstration is an experimental design, allowing a total of 3,000 individuals receiving services from either the Developmental Services HCBS Waiver, Aged and Disabled HCBS Waiver or Traumatic Brain Injury/Spinal Cord Injury HCBS waiver the opportunity to exchange their traditional waiver services for a cash option. Individuals chosen to participate in the experimental group are allowed to “cash out” services on their current care plans and receive a monthly benefit amount to purchase services directly from a provider of their choice. The monthly benefit amount goes through a fiscal intermediary under contract with the Department of Elder Affairs.

Consumer Directed Care is available to adults in the following counties for individuals receiving services from the Aged/Disabled Waiver and TBI/SCI Waiver: Brevard, Broward, Charlotte, Collier, Dade, Hillsborough, Lee, Manatee, Martin, Okeechobee, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Sarasota, Seminole and St. Lucie.

Consumer Directed Care is available to adults receiving services from the Developmental Services Waiver residing in the above mentioned counties as well as: Calhoun, Franklin, Jefferson, Liberty, Madison, Taylor, Holmes, Jackson, Washington, Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, Union, DeSoto, Glades, Hendry, Flagler, Volusia, Citrus, Hernando, Lake, Sumter, Marion, Hardee, Highlands, Indian River and Monroe. It is available to children receiving services from the Developmental Services Waiver on a statewide basis.

Total participation is limited to 6,000: 3,000 experimental group members and 3,000 control group members.

ELIGIBILITY:

To be eligible for Consumer Directed Care, an individual must be enrolled in one of the following home and community based services waivers:

- Developmental Services
- Aged/Disabled
- Traumatic Brain Injury/Spinal Cord Injury

Medicaid Summary of Services

Consumer-Directed Care Research and Demonstration Waiver Program, continued

REIMBURSEMENT:

The Department of Elder Affairs files claims on behalf of the fiscal intermediary, an enrolled Medicaid provider, for the monthly benefit amount for enrolled, eligible waiver participants.

Trained consultants in each program area who are enrolled as Medicaid waiver providers provide consultant services. Consultant services are available to Medicaid recipients eligible to enroll in the Consumer Directed Waiver and randomly assigned to the experimental group.

DEVELOPMENTAL SERVICES WAIVER PROGRAM

DESCRIPTION:

The Developmental Services (DS) Waiver was implemented on April 1, 1982, as a combined waiver with Aged/Disabled Adult Services. In order to meet the needs of these two diverse client populations, the waiver was split into separate waiver programs in 1985.

The waiver includes the following services: adult day training, adult dental, behavioral services, chore services, companion services, dietitian, environmental modification, homemaker, in-home supports, non-residential support services, occupational therapy, personal care assistance, personal emergency response systems, physical therapy, private duty nursing, psychological services, respiratory therapy, residential habilitation, residential nursing, respite, skilled nursing services, special medical equipment and supplies, special medical home care, speech, specialized mental health services, support coordination, supported employment, supported living coaching, therapeutic massage, and transportation.

ELIGIBILITY:

To be eligible for DS Waiver services, an individual must meet the following criteria:

- Be a Developmental Disabilities Program client;
- Meet the level-of-care criteria for intermediate care facilities for the developmentally disabled (ICF/DD);
- Meet Supplemental Security Income (SSI)-related Medicaid or Institutional Care Program income and asset requirements; and
- Be enrolled in the Developmental Services Waiver.

REIMBURSEMENT:

Medicaid reimbursement for DS Waiver services is based on rates approved by the Department of Children and Families, Development Disabilities Program, and the Agency for Health Care Administration, Medicaid Program.

FAMILY PLANNING WAIVER SERVICES

DESCRIPTION:

The family planning waiver extends eligibility for family planning services for 24 months to postpartum women who have lost Medicaid eligibility.

Recipients are eligible for all Medicaid-covered family planning services, family-planning related pharmacy and laboratory services, antibiotics and vaginal antifungals to treat sexually-transmitted diseases, sterilization, colposcopy, and transportation to family planning services.

EXCLUSIONS:

All other Medicaid services are excluded.

ELIGIBILITY:

Medicaid reimburses family planning waiver services for postpartum women who have had a Medicaid-financed delivery or other pregnancy-related service within two years prior to the date of losing Medicaid eligibility.

REIMBURSEMENT:

Medicaid reimbursement for family planning waiver services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.

MODEL WAIVER PROGRAM

DESCRIPTION:

The Florida Medicaid Program received approval from the Centers for Medicare and Medicaid Services (CMS), formerly known as HCFA, in 1991 to administer a home and community-based waiver in Florida that can help maintain children with certain medical conditions in their homes instead of an institution.

The waiver services include model waiver case management and respite care. Case management is provided by the Department of Health, Children's Medical Services. Individuals make an informed choice between hospital and home and community-based services.

ELIGIBILITY:

The waiver has six basic criteria for participation. If all these criteria are met, the individual may elect to participate in the model waiver if space is available. Florida can serve only five people at any one time in the waiver statewide. The six basic criteria are as follows:

- The individual must be diagnosed as having a degenerative spinocerebellar disease, commonly classified in the 330-337 range of ICD-9-CM diagnosis classifications.
- The individual must be under 21 years old.
- The individual must be determined disabled using criteria established by the Social Security Administration.
- The individual must require a level of care recommended by a Children's Multidisciplinary Assessment Team (CMAT) staffing that would normally be provided in an inpatient hospital setting.
- The individual must be able to remain safely in the home with a set of home and community-based services provided through Medicaid.
- The individual's total cost of care to Medicaid in the home setting cannot exceed the cost of inpatient hospital care to Medicaid, for that same individual.

REIMBURSEMENT:

Services are provided on a fee-for-service basis within prescribed budgets and caseloads. Medicaid reimbursement for services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.

NURSING HOME DIVERSION WAIVER PROGRAM

DESCRIPTION:

The Medicaid Nursing Home Diversion (NHD) Waiver provides home and community-based services to functionally impaired elderly that are 65 and over and are at risk of nursing home placement. Dual eligible (Medicare and Medicaid) individuals that meet clinical eligibility criteria may choose to receive Long-term Care and Acute Care services under the NHD Waiver. The waiver was implemented in December 1998 in the Orlando area and expanded to Palm Beach in October 1999. The waiver is approved to serve up to 868 elders in the pilot areas.

Long-Term Care Waiver Services include adult companion, adult day health, assisted living, case management, chore, consumable medical supply, environmental accessibility and adaptation, escort, family training, financial assessment and risk reduction, home delivered meals, homemaker, nutritional assessment and risk reduction, personal care, personal emergency response systems, respite care, occupational, physical and speech therapies, home health and nursing facility services. The Acute-Care Waiver Services include community mental health services, dental, hearing and visual services, independent laboratory and x-ray, inpatient hospital and outpatient hospital/emergency, physicians, prescribed drugs and transportation (optional) services. Managed care providers that have contracted with the state under the NHD Waiver are responsible for Medicare co-payments and deductibles.

The Department of Elder Affairs (DOEA) has operational responsibility for the NHD Waiver.

ELIGIBILITY:

Individuals that meet the following criteria are eligible to receive services under the Nursing Home Diversion Waiver:

- Age 65 and over
- Dual Eligible for Medicaid (institutional care level) and Medicare.
- Live in the pilot project areas of:
 - Orange, Osceola, Seminole and Brevard counties - Area 7
 - Palm Beach, Martin, Okeechobee, Saint Lucie and Indian River - Area 9
- Be determined by the CARES (Comprehensive Assessment and Review for Long-Term Care Services) unit at the Department of Elder Affairs to be at nursing home level of care and meet one or more established clinical criteria.

REIMBURSEMENT:

Providers are reimbursed at a capitated rate, on a per member, per month basis to enrolled Medicaid providers.

PROJECT AIDS CARE WAIVER PROGRAM

DESCRIPTION:

The Project AIDS Care Waiver is a home and community-based program that was implemented statewide on November 1, 1989.

The waiver services include: case management, chore services, companion, day health care, education and support, health assessment, substance-abuse treatment, home-delivered meals, homemaker, home modification, massage therapy, personal care, personal emergency response system, pest control, physical therapy, respiratory therapy, respite care, skilled care, specialized medical equipment and supplies, and specialized personal care for foster children.

An enrolled Project AIDS Care case manager must authorize services.

Recipients make an informed choice between hospital or nursing facility care and the home and community-based services provided under this waiver.

ELIGIBILITY:

In order to participate in Project AIDS Care, the individual must meet the following criteria:

- Have a medical diagnosis of AIDS;
- Be determined disabled according to Social Security Administration standards;
- Be Medicaid eligible by meeting the Supplemental Security Income (SSI) or Institutional Care Program (ICP) income and asset requirements;
- Be at risk of institutionalization in a hospital or nursing facility based on an assessment by the Department of Elder Affairs, Comprehensive Assessment and Review for Long Term Care Services (CARES); and
- Be able to safely reside in a home setting.

REIMBURSEMENT:

Authorized services to enrolled, waiver recipients are reimbursed on a fee-for-service basis. Medicaid reimbursement for services is the maximum Medicaid fee, the provider's customary fee, or the amount allowed on the individual care plan, whichever is lower.

STATEWIDE INPATIENT PSYCHIATRIC PROGRAM (SIPP) WAIVER PROGRAM

DESCRIPTION:

In June 2001, the Centers for Medicare and Medicaid Services approved a 1915(b) waiver authorizing the Agency for Health Care Administration to implement a statewide inpatient psychiatric program (SIPP) for Medicaid recipients under the age of eighteen (18). The approved waiver limits provider participation to one or two providers for each of AHCA's eleven geographic areas, selected through a competitive request for proposal process. SIPP services were implemented in fifteen facilities across the state on January 1, 2002. Children and adolescents must be referred for SIPP services by the Department of Children and Families, District Alcohol, Drug Abuse and Mental Health Program Offices and be prior-authorized by the state's utilization management contractor as meeting clinical level of care criteria for admission into a SIPP.

SIPP programs are in operation 24 hours a day, 7 days a week. The SIPP service array includes, but is not be limited to: comprehensive assessment; diagnosis; treatment planning with a multidisciplinary team; an active treatment program in a therapeutic milieu; psychiatric services; routine medical care; clinical therapy services; caretaker/family therapy services; peer support activities as appropriated; an education program; recreational and vocational therapies, as appropriate; comprehensive discharge and aftercare planning; and operation of a 24 hour, 7 days a week family help line.

PROGRAM GOALS:

Treatment in a SIPP is seen as component in the continuum of a child's care, with the goals of:

- Stabilization of presenting problems and symptoms and adequate resolution to allow a child's or adolescent's safe return to the family and community with expected stays not to exceed 120 days;
- Reduction of recidivism into acute psychiatric or SIPP services by providing aftercare services and/or linkages with appropriate community services;
- Design of aftercare treatment plans that can be effectively implemented; and
- For children in the state's custody, incorporation of permanency goals into the treatment and discharge plans and active coordination with Family Safety.

ELIGIBILITY:

Children and adolescents must be prior approved for admission into a SIPP program by AHCA's utilization management contractor as meeting the clinical criteria listed below.

- A reasonable course of acute inpatient treatment and/or intensive outpatient services has failed to bring about adequate resolution of significant symptoms to permit placement in a less restrictive, community setting. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.

Statewide Inpatient Psychiatric Program (SIPP), continued

- The services can be expected to improve, within a reasonable time frame of three to six months, the recipient's condition or prevent further regression.
- The child has a primary DSM IV diagnosis, established through a documented comprehensive bio-psychosocial diagnostic assessment, that indicates the presence of a psychiatric disorder, such as major depression, active post traumatic stress syndrome with fragility or a psychotic disorder, that is severe in nature and requires more intensive treatment than can be provided on an outpatient basis.
- The child or adolescent has a serious impairment of functioning compared to others of the same age due to the psychiatric diagnosis, in one or more major life roles including school, family, interpersonal relations, and/or self-care.
- The child or adolescents is assessed as being able to benefit from treatment in a SIPP.
- Due to the severity of the problem, intervention and support is needed beyond what can be provided in a non-inpatient community treatment and support system.
- The child or adolescent is has age appropriate cognitive ability, and is cognitively stable enough to benefit from this level of treatment.
- Because of the federal regulation that prohibits payment of federal Medicaid dollars for any other medical care when a recipient is receiving a per diem for these inpatient psychiatric services, children considered for admission must receive medical clearance certifying that the child is currently in good physical health, with no acute or chronic problems requiring medical treatment and that no medical care, other than routine, is anticipated. If, however, a medical crisis occurs with the child, he or she would have to be discharged from the SIPP to access other Medicaid health benefits

AUTHORIZATION:

AHCA's behavioral health care utilization management contractor must authorize all admissions and continued stays. Additionally, children in the care and custody of the state must have a suitability assessment by a qualified evaluator indicating the appropriateness of this level of care for the child.

REIMBURSEMENT:

SIPP providers are paid an all inclusive per-diem rate. In accordance with federal regulations, no other Medicaid services may be reimbursed for children and adolescents while enrolled in a SIPP, with the exception of targeted case management during the last thirty (30) days of a recipients stay in a SIPP.

SUPPORTED LIVING WAIVER PROGRAM

DESCRIPTION:

The Supported Living Waiver is a home and community-based services program that was approved by the Health Care Financing Administration, now known as the Centers for Medicare and Medicaid Services (CMS), effective October 1, 1995. This waiver replaced the Medicaid Community Supported Living Arrangement program.

The Department of Children and Families, Developmental Disabilities Office, has operational responsibility for the Supported Living Waiver Program.

The waiver services include: adult day training, in-home support services, supported living coaching, supported employment, and transportation.

ELIGIBILITY:

To be eligible for the waiver, individuals must meet the following criteria:

- Be age 18 or older;
- Be able to direct their own support in all but limited areas, participate in the planning and implementation of support necessary to manage their households, and participate in community life;
- Meet the level of care for intermediate care facilities for the developmentally disabled (ICF/DD);
- Meet SSI-related Medicaid or the Institutional Care Program (ICP) income and asset requirements;
- Be a client of Developmental Disabilities; and
- Be enrolled in the Supported Living Waiver.

REIMBURSEMENT:

Medicaid reimbursement for Supported Living Waiver services is based on rates approved by the Department of Children and Families, Developmental Disabilities, and the Agency for Health Care Administration, Medicaid Program.

TRAUMATIC BRAIN INJURY/SPINAL CORD INJURY WAIVER PROGRAM

DESCRIPTION:

The Department of Health, Brain and Spinal Cord Injury Program, operates the Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver.

Waiver services include: assistive technologies, attendant care, behavioral programming, case management, companion services, community support coordination, environmental accessibility adaptations, life skills training, personal adjustment counseling, personal care, and rehabilitation engineering evaluation.

ELIGIBILITY:

To be eligible for TBI/SCI Waiver services, an individual must meet the following criteria:

- Be a client of the Brain and Spinal Cord Injury Program;
- Meet at least level II care criteria for nursing facilities; and
- Meet the Supplemental Security Income (SSI)-related Medicaid or the Institutional Care Program (ICP) income and asset requirements.

REIMBURSEMENT:

Medicaid reimbursement for TBI/SCI waiver services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.