



STATE OF FLORIDA  
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

February 16, 1987

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

Dear Mr. Warren:

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

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

Sincerely,

A handwritten signature in cursive script that reads 'Judy E. Mitchell'.

Judy E. Mitchell  
Deputy Assistant Secretary  
for Medicaid

JEM:JL:nr

RECEIVED

RECORD  
PROGRAM DEVELOPMENT

WAIVERS OF STATE PLAN PROVISIONS

State: Florida

Type of Waiver

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

Title of Waiver and Brief Description:

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

Approval Date: June 14, 1991

Renewal Date(s): July 14, 1994

Effective Date: July 01, 1991

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

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

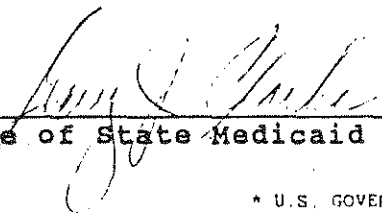
**Statewideness:** N/A


**Freedom of Choice:** N/A

**Services:** Case management and respite care.

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

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

 \_\_\_\_\_  
Signature of State Medicaid Director

 \_\_\_\_\_  
Date

Amendment 92-53  
 Effective 10/1/92  
 Supersedes New  
 Approval Date DEC 29 1992

WAIVERS OF STATE PLAN PROVISIONS

State:

Type of Waiver

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

Title of Waiver and Brief Description:

Channeling Waiver

Approval Date: 6/5/85

Renewal Date(s): 7/1/88 (approved 6/16/88)

Effective Date: 7/85

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

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

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

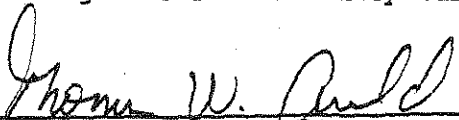
**Freedom of Choice:** N/A

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

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

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

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

  
 \_\_\_\_\_  
 Signature of State Medicaid Director

8/15/88  
 \_\_\_\_\_  
 Date

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

Approved 11/10/88

WAIVERS OF STATE PLAN PROVISIONS

State:

Type of Waiver

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

Title of Waiver and Brief Description:

Mentally Retarded and Developmentally Disabled

Approval Date: 6/14/85

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

Effective Date: 5/15/85

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

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

**Statewideness:** N/A

**Freedom of Choice:** N/A

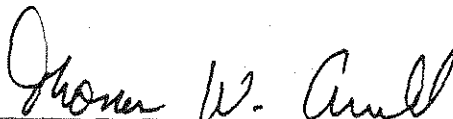
**Services:**

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

**Eligibility:**

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

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

  
 \_\_\_\_\_  
 Signature of State Medicaid Director      Date 8/15/88

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

Approved 11/10/88

WAIVERS OF STATE PLAN PROVISIONS

State:

Type of Waiver

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

Title of Waiver and Brief Description:

Aged and Disabled

Approval Date: 4/26/82

Renewal Date(s): 4/1/85 (Approved 3/6/85)  
Extension 4/1/88 - 6/29/88

Effective Date: 4/1/82

6/30/88 (Approved 6/24/88)

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

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

Statenwideness: N/A

Freedom of Choice: N/A

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

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

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

  
Signature of State Medicaid Director

9/15/88  
Date

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

Approved 11/10/88

WAIVERS OF STATE PLAN PROVISIONS

State:

Type of Waiver

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

Title of Waiver and Brief Description:

Services to Residents of Homes for Special Services

Approval Date: 9/4/86

Renewal Date(s):

Effective Date: 8/1/86

Cancelled effective 6/30/88

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

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

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

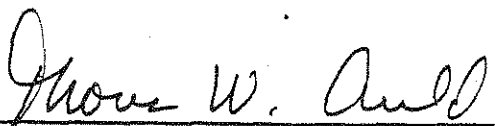
**Freedom of Choice:** N/A

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

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

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

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

  
Signature of State Medicaid Director

8/15/88  
Date

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

Approved 11/10/88

WAIVERS OF STATE PLAN PROVISIONS

State:

Type of Waiver

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

Title of Waiver and Brief Description:

Home and Community-Based Frail and Elderly

Approval Date: 1/23/85

Renewal Date(s):

Effective Date: 1/85

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

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

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

Freedom of Choice: N/A

**Services:**

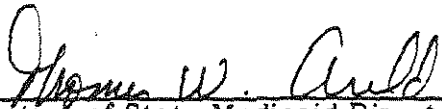
Medical case management, caregiver health support training, respite care, personal care, escort services, health support services, and specialized home management services.

**Eligibility:**

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

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

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

  
 \_\_\_\_\_  
 Signature of State Medicaid Director

8/15/88  
 \_\_\_\_\_  
 Date

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

Approved 11/10/88

State: Florida

Type of Waiver

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

Title of Waiver and Brief Description:

"AIDS/ARC WAIVER"

Case management and 13 home and community-based services for persons with AIDS and ARC who would otherwise be confined to an institution.

Approval Date: 7/21/89

Renewal Date(s): Nov. 1, 1992

Effective Date: January 1, 1990

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

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

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

Freedom of Choice: N/A

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

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

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

Fee for service - established fee schedule for services covered under this waiver.

  
\_\_\_\_\_  
Signature of State Medicaid Director



WAIVERS OF STATE PLAN PROVISIONS

State: Florida

Type of Waiver

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

Title of Waiver and Brief Description: Managed Health Care

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

Approval Date: January 24, 1990 Renewal Date(s): ~~October 1, 1993~~ 11-8-91 P&I (HCFM)

Effective Date: October 1, 1991

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

Comparability: 1902(a)(10)

Statewideness: 1902(a)(1)

Freedom of Choice: 1902(a)(23)

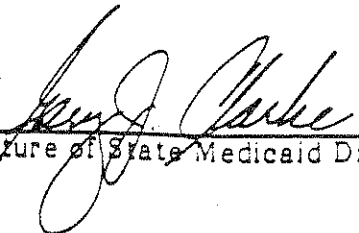
Services: Physician services, except ophthalmology, psychiatry, an obstetrical care; pharmacy when the prescription is issued by the primary physician, hospital inpatient, hospital outpatient, home health agency, laboratory and X-ray, ambulatory surgical center, rural health center, podiatry, ARNP, and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

Eligibility:

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

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

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

Signature of State Medicaid Director:  Date: 8/4/91

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

WAIVERS OF STATE PLAN PROVISIONS

State:

Type of Waiver

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

Title of Waiver and Brief Description:

Mentally Retarded and Developmentally Disabled

Approval Date: 6/14/85

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

Effective Date: 5/15/85

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

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

Statewideness: N/A

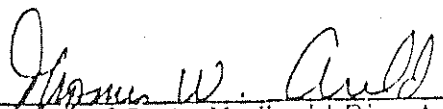
Freedom of Choice: N/A

Services:

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

Eligibility:

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

  
 \_\_\_\_\_  
 Signature of State Medicaid Director                      Date 8/15/88

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

WAIVERS OF STATE PLAN PROVISIONS

State:

Type of Waiver

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

Title of Waiver and Brief Description:

Home and Community-Based Frail and Elderly

Approval Date: 1/23/85

Renewal Date(s):

Effective Date: 1/85

CANCELLED EFFECTIVE 11/1/89

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

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

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

Freedom of Choice: N/A

Services:

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

Eligibility:

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

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

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

James W. Auld  
Signature of State Medicaid Director

8/15/89  
Date

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

Attachment 1.1-B  
Supplement 1

STATE OF FLORIDA  
COOPERATIVE AGREEMENT  
FOR MEDICAID  
BETWEEN  
THE AGENCY FOR HEALTH CARE ADMINISTRATION  
AND  
THE DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

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

Revised Submission JUL 22 1994

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### Supplements

1. Medicaid Eligibility
2. Women, Infants, and Children (WIC) Program
3. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
4. Healthy Start
5. Utilization Control for Institutional Care

COOPERATIVE AGREEMENT

FOR MEDICAID

BETWEEN

THE AGENCY FOR HEALTH CARE ADMINISTRATION

AND

THE DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

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

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

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

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

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

C. Maintain the Medicaid state plan, initiate and approve all amendments prior to submission to HCFA, and

distribute state plan updates to HRS and other interested parties. AHCA will coordinate with HRS on any amendment that impacts on the mission of HRS, its programs or its budget.

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

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

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

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

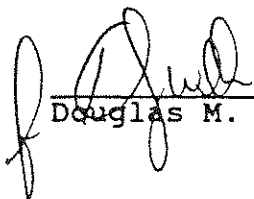
2. Obtain the consultation of the Secretary of HRS on any rule that indirectly impacts on the mission of HRS, its programs or its budget.

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

G. Handle all payment of Medicaid claims.

H. Enroll all Medicaid providers.

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

  
\_\_\_\_\_  
Douglas M. Cook

6/22/94  
Date

  
\_\_\_\_\_  
H. James Towey

7/1/94  
Date

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

Revised Submission 10/22/93

2 Revised Submission JUL 22 1994

J. Process all overpayment reports and all benefit recovery activities for providers of Medicaid services.

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

**II. Department of Health and Rehabilitative Services will:**

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

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

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

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

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

F. Remain the designated single state agency to receive Beneficiary and Earnings Data Exchange (Bendex) and State Data Exchange (SDX) tapes from the Social Security Administration.

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

3 Revised Submission 10/22/93

Revised Submission JUL 22 1994



### III. Transfer of Title XIX funding:

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

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

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

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

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

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

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

H. AHCA will prepare the quarterly reports for the

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

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

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

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

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

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

A. AHCA will earn funding and financial participation for expenditures incurred related to the State Legalization Impact Assistance Grant (SLIAG), the Infants With Disability

Education Act Part H Grant (Toddlers and Infants Grant), the Refugee Assistance Grant, and to other grants that may arise in the future.

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

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

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

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

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

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

H. HRS will prepare the reports for the estimating of

federal grant funding requirements based on the estimated allowable costs projected by HRS and on the estimated allowable costs projected and reported by AHCA to HRS.

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

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

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

L. The State Legalization Impact Assistance Grant (SLIAG). Effective, July 1, 1993 through September 30, 1994 or whenever SLIAG is discontinued by HRS, AHCA is responsible for documenting the federal reimbursement for the state Medicaid program, administered by AHCA and approved in the state's application to the Department of Health and Human Services, Division of State Legalization and Repatriation. AHCA will submit appropriately structured Cost Documentation System (CDS) tapes to the HRS Refugee Programs Administration Office for processing to determine

Eligible Legalized Alien (EtLA) prior and current year service utilization and reimbursement of approved AHCA administered service programs. AHCA will prepare the appropriate invoice for reimbursement based on the results of the CDS tape match and submit the invoice to the HRS Refugee Programs Administration Office for approval. In addition, administrative costs (current positions approved by the Refugee Programs Administration Office, tape processing, etc.) will be reimbursed through the invoice process. Position costs currently paid as a direct HRS salary cost to SLIAG will no longer be considered a salaried cost of HRS effective July 1, 1993. All AHCA SLIAG costs (service programs and administration) must be reimbursed through the invoice process. Once the invoice is approved by Refugee Programs Administration Office, the HRS Revenue Management Office will transfer the approved amount of SLAIG reimbursement to AHCA.

**V. Exchange of Information:**

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

**VI. Safeguarding Information:**

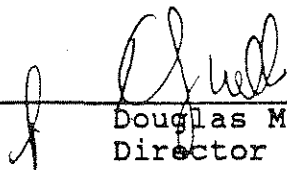
AHCA and HRS agree to safeguard the use and disclosure of and restrict access to information concerning applicants for or recipients of Title XIX services in accordance with federal and state laws and regulations.

**VII. Effective Period of Agreement:**

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

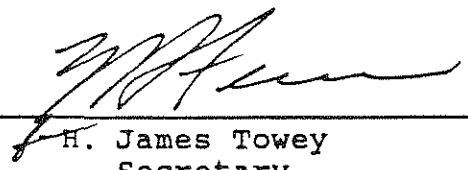
July 1, 1993

Date

  
\_\_\_\_\_  
Douglas M. Cook  
Director  
Agency for Health Care  
Administration

July 1, 1993

Date

  
\_\_\_\_\_  
H. James Towey  
Secretary  
Department of Health and  
Rehabilitative Services

Amendment 93-39  
Effective 7/1/93  
Supersedes 91-24

Approved 10/21/94

Revised Submission 10/22/93

9 Revised Submission JUL 22 1994

**MEDICAID ELIGIBILITY**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. Provide HRS with all necessary data for



Medicaid overpayment and recovery activities and Medicaid Quality Control;

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

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

8. Provide HRS with access to FMMIS; and

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

D. Provide instruction to HRS in county billing procedures, assist HRS in resolving county billing problems, and maintain certificate of residency forms.

**II. The Department of Health and Rehabilitative Services (HRS) will:**

A. Conduct eligibility determinations in accordance with the approved Medicaid state plan; Title XIX of the Social Security Act; 42 Code of Federal Regulations (CFR) Part 431 (Medical Assistance Programs, State Organization and General Administration) and 42 CFR Part 435 (Medical Assistance Programs, Eligibility); and all other applicable federal and state laws and regulations as directed by AHCA.

B. Develop and implement Medicaid eligibility policy. HRS will obtain AHCA's approval of Medicaid eligibility policy prior to implementation.

C. Promulgate all administrative rules relative to Medicaid eligibility. HRS will obtain the approval of the Director of Medicaid prior to adoption of any rule that pertains to Medicaid.

D. Process all overpayment reports and all benefit recovery activities for recipients.

E. Obtain information for Medicaid Third Party Liability from all recipients when the presence of health insurance is indicated. HRS eligibility staff will take appropriate action in accordance with 42 CFR Part 433, Subpart D (Third Party Liability) when informed by AHCA that a recipient failed to cooperate in the pursuit of third party resources.

F. Maintain the FLORIDA system, the HRS information system to determine eligibility and authorize benefits.

HRS will:

1. Transmit recipient eligibility information via an electronic interface with FMMIS;

2. Ensure that the recipient eligibility information is accurate and up to date; and collaborate with AHCA in correcting any incorrect information that is transmitted via the electronic interface;

3. Receive and load onto the FLORIDA system, the Bendex and SDX tapes from the Social Security Administration;

4. Provide AHCA the Bendex and SDX data that pertains to Medicaid eligibility, third party resources, and Medicare Part A and B entitlement; and

5. Operate applicable data exchanges to comply with the IEVS requirement and third party recovery laws and regulations, and transmit this data to AHCA.

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

H. Conduct Medicaid eligibility Quality Control and Claims Processing system (CPAS) reviews, be fully responsible for Medicaid Quality Control sampling and meeting the federal review requirements, and the submission of the annual corrective action plan.

I. Pursue estate recovery on deceased recipients per applicable federal and state laws and regulations.

J. Distribute FMMIS error reports and nursing home discharge reports to the district offices.

**WOMEN, INFANTS, AND CHILDREN (WIC)**

The Department of Health and Rehabilitative Services, State Health Office administers health services programs in county public health units and oversees the Special Supplemental Food Program for Women, Infants and Children (WIC). The Department of Health and Rehabilitative Services, Economic Service Program Office administers eligibility determinations for pregnant women, families and children, and refugees. The Agency for Health Care Administration, Medicaid Office and Department of Health and Rehabilitative Services, State Health Office and Economic Services Program Office agree to the following provisions:

**I. The Department of Health and Rehabilitative Services, Economic Services Program Office will ensure that:**

All newly approved Aid to Families with Dependent Children (AFDC) and other Medicaid recipients who are pregnant, breastfeeding or postpartum women (as defined in section 17 of the Child Nutrition Act of 1966), or children below the age of five, and those reapproved after a period of ineligibility, are:

1. Advised of the benefits of the WIC program during the eligibility determination interview;
2. Referred to the local WIC program; and

3. Given the brochure "How to Apply for WIC",  
HRS/PI form 150-7.

II. The Agency for Health Care Administration, Medicaid  
Office will ensure that:

A. The Florida Medicaid Management Information System (FMMIS), Early and Periodic Screening, Diagnosis and Treatment (EPSDT) computerized subsystem will automatically inform through computer generated notices all Medicaid EPSDT eligible children under age five and all eligible recipients under age twenty-one who might be pregnant, postpartum or breastfeeding of the benefits of participation in the WIC program. Annual notices will also be provided that include instructions for obtaining further information about the WIC program.

B. WIC program information is included in local Medicaid outreach efforts.

C. All EPSDT Medicaid eligible pregnant, breastfeeding or postpartum young women under the age of 21 or children below the age of five who have been diagnosed by an EPSDT screening to have a medical problem or nutritional related deficiency are appropriately referred to the local WIC program.

D. Medicaid Health Maintenance Organizations (HMOs) providing prenatal care and EPSDT services refer all appropriate recipients to the local WIC program.

III. The Department of Health and Rehabilitative Services, State Health Office will ensure that all Medicaid eligible referrals to the WIC program are:

A. Assessed for determination of eligibility for WIC services.

B. Provided WIC services if eligible within the limitation of the local program.

C. Referred for or provided an EPSDT screen if not previously screened in accordance with the established periodicity schedule.

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT  
(EPSDT) OF MEDICAID ELIGIBLE CHILDREN UNDER AGE 21

The following Department of Health and Rehabilitative Services program offices provide or coordinate the provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. The Economic Service Program Office administers eligibility determinations for pregnant women, families and children, and refugees. The Children and Families Program Office administers child welfare programs. The State Health Office administers health services programs. Children's Medical Services administers services for children with special health needs and programs for children from birth to three years of age with developmental disabilities. The Developmental Services Program Office administers programs for individuals, three years of age and older, with developmental disabilities. The Alcohol, Drug Abuse and Mental Health Program Office is responsible for the provision of a continuum of mental health care and evaluations through contractual agreement with local mental health centers.

The Agency for Health Care Administration (AHCA) office of Medicaid and Department of Health and Rehabilitative Services (HRS) offices of Economic Service; Children's Medical Services; Children and Families; State Health;

Attachment 93-39  
Effective 7/1/93  
Supersedes 91-24  
Approval 10/21/94  
1 Revised Submission 10/22/93  
Revised Submission JUL 22 1994

Developmental Services; and Alcohol, Drug Abuse and Mental Health agree to the following provisions:

I. The AHCA Medicaid Office and all coordinating HRS headquarters program offices will:

A. Ensure that the EPSDT screen is utilized as the initial health care assessment for all EPSDT eligible children served by HRS.

B. Ensure the EPSDT screening and treatment services are utilized for the provision of preventive and primary health care for all EPSDT eligible children served by HRS.

C. Coordinate with and obtain the approval of the AHCA Medicaid Office on issuance of policy guidelines, training and technical assistance procedures regarding the EPSDT program.

D. When established, serve on the statewide EPSDT coordinating committee with the function of providing technical assistance and statewide coordination of the EPSDT program.

E. Share applicable child health information, reports and statistical data with coordinating program offices.

F. Coordinate with the AHCA Medicaid Office in the development of Medicaid reimbursable services which promote a continuum of health care for children in the least restrictive, most cost effective setting possible.

G. Abide by federal regulations pertaining to



confidentiality and the disclosure of information regarding Medicaid applicants and eligible recipients as outlined in Section IX of this agreement.

**II. Headquarters AHCA Medicaid Office will:**

A. Provide through Medicaid fiscal agent contractor and the Medicaid contract management unit, monthly reports of EPSDT recipients informed of services, due screenings, screened and requiring treatment. Reports will be distributed monthly to the area Medicaid offices. The area EPSDT administrative case managers will distribute the reports to the county public health units.

B. Ensure that reimbursement is made to eligible providers based upon correct billing procedures as outlined in the appropriate provider handbook.

C. Serve as liaison among all offices involved in the EPSDT program.

D. Ensure through coordination with the headquarters HRS offices of Economic Service; Children and Families; State Health; Children's Medical Services; Developmental Services; and Alcohol, Drug Abuse and Mental Health that procedures for EPSDT case management as mandated by federal regulations are implemented.

E. Ensure that training in EPSDT screening, treatment, and case management services is provided to area AHCA Medicaid office staff and providers.

F. Ensure that area AHCA procedures for EPSDT case management are accurate and up-to-date to ensure that parents, guardians and eligible individuals are informed of the availability of initial and periodic screening services and that arrangements are made for eligible individuals to receive these services, as well as needed support services. Information should also be provided on the benefits of screening and follow-up diagnostic and treatment services.

G. Ensure that EPSDT subsystem informing letters are developed and mailed to recipients in accordance with EPSDT informing standards.

H. Share applicable screening data and statistical reports with coordinating program offices.

I. Coordinate EPSDT special projects with other social service agencies, public health units and other program offices.

J. Develop and disseminate EPSDT outreach materials to recipients, area staff, providers and community groups in accordance with federal EPSDT regulations.

**III. Headquarters HRS Economic Service Program Office will:**

A. Ensure that all newly approved Aid to Families with Dependent Children (AFDC), other Medicaid recipients, and those reapproved after a period of ineligibility are advised of the availability of initial and periodic screening services in accordance with procedures outlined in the EPSDT

area procedures guide and documented in the case file.

B. Ensure that HRS Form 1248 is issued and forwarded to the EPSDT case managers and to district Women, Infants and Children (WIC) coordinators.

C. Ensure that the indicator on the FLORIDA System regarding EPSDT referrals is accurate and up-to-date for each newly eligible, reapproved or reenrolled public assistance or Child In Care (CIC) recipient. The indicator should be completed as follows:

Y = Yes, acceptance of EPSDT services

N = No, refusal of EPSDT services

D. Ensure that correct information pertaining to EPSDT is transmitted from the FLORIDA system to FMMIS via the electronic interface.

**IV. Headquarters HRS Children and Families Program Office will:**

A. Ensure that Medicaid Administrative Case Management activities are provided in accordance with state and federal Title XIX regulations.

B. Ensure that all Medicaid eligibles for whom the Children and Families Program Office has lead responsibility are issued a valid Medicaid identification card.

C. Ensure that case managers are notified when a child in HRS care becomes eligible for EPSDT services.

D. Ensure that changes that may affect the recipient

eligibility file for all Medicaid eligibles for whom the Children and Families Program Office has lead responsibility are reported to public assistance staff in a timely manner.

V. HRS State Health Office will:

A. Supervise the administration of screening services in HRS county public health units serving as Medicaid providers.

B. Ensure that HRS county public health units are provided procedural standards to assure uniformity in statewide program administration and timely scheduling of Medicaid eligibles for screening.

C. Ensure that HRS county public health units act as screening providers and coordinate activities with the area Medicaid office.

D. Ensure that children referred to the WIC program are screened for eligibility and provided services as appropriate within existing program limitations.

E. Coordinate with other existing HRS county public health unit services (well-baby visits, school visits, maternal-infant care visits) to avoid unnecessary duplication of such services and maximize Title XIX services between HRS county public health units and the EPSDT program.

F. Ensure that Medicaid funded case management staff provide case management services in accordance with state

and federal Title XIX regulations.

**VI. Headquarters HRS Children's Medical Services (CMS)**

**Program Office will:**

A. Supervise the administration of screening services in CMS clinics serving as Medicaid providers.

B. Ensure that Children's Medical Services clinics act as screening and treatment providers for CMS patients and coordinate EPSDT-related activities with the area Medicaid Office.

C. Ensure that targeted case management services are provided to eligible recipients as appropriate within a coordinated health care delivery system.

D. Provide medical consultation to the Medicaid Office concerning the appropriate service provision for medically fragile children or children with special health care needs including organ transplantations.

**VII. Headquarters HRS Developmental Services Program Office will:**

A. Coordinate with other existing screening services in order to avoid duplication of such services under the EPSDT program and maximize Title XIX services between Developmental Services and the EPSDT program.

B. Provide consultation to the Medicaid office concerning appropriate service provision for children with developmental disabilities.

VIII. Headquarters HRS Alcohol, Drug Abuse and Mental Health Program Office will:

A. Coordinate with district ADM program offices to maximize the utilization of Medicaid funded substance abuse and mental health services through eligible providers for eligible recipients.

B. Provide technical assistance to district ADM program offices and substance abuse and mental health providers to improve the capacity, capability and expertise of providers to serve children within a coordinated system of health care delivery.

C. Ensure that targeted case management services are provided to eligible recipients as appropriate within a coordinated system of health care delivery.

IX. Confidentiality:

A. The use or disclosure of information concerning applicants and recipients is restricted to purposes directly related to administration of the Medicaid State Plan.

B. EPSDT services including examination, diagnosis, treatment, outreach, informing, and assistance with transportation and scheduling appointments for services are considered activities directly related to State Plan administration.

C. Medical information is privileged and may only be released with the patient's permission.

D. Any agency or provider with a written cooperative or provider agreement to perform EPSDT services which includes the activities of outreach and/or assistance with transportation or scheduling appointments is considered an extension or arm of the Medicaid agency and may be furnished, without the consent of the individual, such information as name, address and Medicaid identification number, providing the following confidentiality requirements are met.

E. The following criteria specifies the conditions for release and use of information about applicants and recipients:

1. Information access is restricted to persons or agency representatives subject to legal sanctions or standards of confidentiality that are at least comparable to those of the Medicaid agency.

2. Release of names of applicants and recipients which may be used by outside sources (sources not under agreement with the agency to provide EPSDT services for recipients) is prohibited.

3. Written permission must be secured from a family or individual before responding to a request for information from an outside source.

4. Information may be exchanged when the agency is located within the state structure if the regulatory

requirements for safeguarding information on applicants and recipients are met.



## HEALTHY START

The State Health Office within the Department of Health and Rehabilitative Services is responsible for administering the Healthy Start Initiative, as defined in the Healthy Start Act of 1991, and for specifically selecting and administering prenatal and infant health care coalitions.

The purpose of the Healthy Start Initiative is to assure that all pregnant women and infants have access to prenatal and infant care through development of locally coordinated systems of care, with emphasis in assuring access for Medicaid eligible women and infants. A local Healthy Start coalition will be the agency under contract with the department to coordinate and develop the system of care. The coalition consists of a broad base of community organizations and agencies, both public and private, as well as health care providers and client advocates who have an active interest in maternal and child health.

**I. The Department of Health and Rehabilitative Services is responsible to:**

A. Select local coalitions through an application process.

B. Prepare contracts with selected coalitions detailing the required work products and time frames.

C. Ensure that the coalitions develop coordinated

systems of care and perform the following functions:

1. Assess community service area (for example: demographics, estimate of numbers eligible, location of groups);
  2. Develop resource inventories of service area;
  3. Determine components of local provider networks and recruit a network of providers;
  4. Identify at risk groups;
  5. Identify unmet service needs;
  6. Identify barriers to care (for example: access to affordable care, provider availability, acceptance of Medicaid reimbursement, Medicaid eligibility);
  7. Develop outreach programs to identify and intervene with patients early in their care;
  8. Develop outcome objectives;
  9. Develop prenatal and infant health care services plans that will lead to coordinated systems of care;
  10. Allocate HRS State Health Office funding resources to providers;
  11. Implement the health care services plans; and
  12. Monitor service delivery, and implement a quality improvement program.
- D. Identify state funding resources in the State Health Office budget for coalitions to allocate to providers for providing non-Medicaid covered services;
- E. Assure that local agencies including HRS county

public health units (CPHUs), district offices and other parties remain informed and participate in these coordinated systems of care;

F. Serve as contract manager for the coalitions and monitor contracts to assure that stated deliverables are provided and established objectives are met. This will be done through review of deliverables, quarterly reporting by the coalitions throughout the contract year, site visits by State Health Office staff, attendance at coalition meetings, and quarterly meetings of coalitions;

G. Provide training and technical assistance to coalitions as needed to assist in compliance with contract provisions and facilitate development of coordinated systems of care.

**II. The Agency for Health Care Administration is responsible to:**

A. Provide training and technical assistance to coalitions on Medicaid programs and policies.

B. Provide to the coalitions information regarding Medicaid providers as required for conducting community assessment.

C. Assist the State Health Office in monitoring the coalition contracts.

D. Assist coalitions in efforts to develop a comprehensive provider network that serves indigent clients.

E. Actively recruit providers to participate in the Medicaid program.

F. Provide information regarding Healthy Start to recipients and providers as necessary to assure an understanding of the program and to encourage acceptance and active participation.

### III. Funding:

A. Funding shall be earned by the Department of Health and Rehabilitative Services through Title XIX, Medicaid. Allowable costs for the coalition contracts shall be allocated to Medicaid at a rate of match equalling 45 percent of the total funding awarded through contract with each coalition. The 45 percent matching rate assumes that 90 percent of coalition services relate to Medicaid eligible women. If upon audit the percent is adjusted downward and funding is disallowed at the 45 percent rate, HRS is responsible for the funding of the disallowance.

B. The Healthy Start Act requires a local cash or in-kind contribution of 25 percent of the cost of the coalition. Medicaid's financial participation shall be 50 percent of the net coalition expenditures (total less local cash or in-kind contributions).

C. Funds advanced under the coalition contracts will be funded 100 percent from state General Revenue funds. Only actual expenditures will be reimbursable under Medicaid.

D. The State Health Office shall provide the general revenue required to fund 50 percent of the net expenditures (less local cash or in-kind contributions).

E. The State Health Office is responsible for funding any expenditures disallowed by HCFA related to the coalition contracts.

F. The Medicaid Office will audit expenditures under these contracts at least annually in coordination with the annual financial and compliance audit conducted by HRS.

**UTILIZATION CONTROL PROGRAM FOR  
INSTITUTIONAL CARE APPLICANTS AND RECIPIENTS**

The following Department of Health and Rehabilitative Services program offices have responsibilities pertaining to institutional care. The Aging and Adult Services Program Office has responsibility for the administration of health and related programs for aged and adult individuals. Children's Medical Services has responsibility for the administration of programs and services for children with special health care needs (Title V). The Developmental Services Program Office has responsibility for the administration of supports and services for individuals who have a diagnosis of mental retardation or other developmental disability excluding epilepsy. The Alcohol, Drug Abuse and Mental Health Program Office has responsibility for the provision of a continuum of mental health care and evaluations through contractual agreements with local mental health centers.

The Agency for Health Care Administration, Division of Health Quality Assurance has responsibility for licensing of all long-term care facilities and administering the surveys and inspections necessary to ensure compliance with certification conditions and standards of participation.

In general, the above offices have responsibility for

ensuring that timely, appropriate, efficient, quality and effective institutional care services are provided to Medicaid institutional care recipients. Each HRS district and AHCA area office has responsibility of implementing, at the local level, prescribed utilization control policies and procedures in accordance with established state and federal rules and regulations and in accordance with prescribed policies and procedures.

Federal regulations for Title XIX mandate that the state implement a statewide surveillance and utilization control (UC) program that safeguards against unnecessary and inappropriate use of institutional care services by Medicaid recipients, against excessive institutional care payments and ensures the provision of quality care and services. Therefore, in the interest of meeting these federal mandates, coordinating the nursing home reform requirements of the Omnibus Budget Reconciliation Act (OBRA) of 1987, and maximizing resources to better serve Medicaid institutional care applicants and recipients, these headquarters and HRS district and AHCA area offices agree to the following provisions relating to Medicaid provider facilities and their recipients (and not applicable to private pay facilities):

**I. General Provisions**

A. To coordinate, as applicable, with the Medicaid Office in the development and issuance of policy statements or policy changes, training, monitoring, and survey

procedures regarding applicants, recipients and providers of institutional care.

B. To share institutional care information, reports and statistical data.

C. To collaborate in the development of a full continuum of Medicaid reimbursable health and related care services for applicants and recipients of Medicaid institutional care that encourage the least restrictive, efficient, and most cost effective use of facilities and services.

D. To collaborate in the development of institutional care admission and continued placement criteria.

E. To provide representation and ensure participation, as appropriate, in local intradepartmental pre-admission reviews of children who are applying for Medicaid reimbursement for nursing facility services.

F. To adhere to state and federal rules and regulations pertaining to Medicaid utilization control of institutional care services.

G. To provide representation and ensure participation in workgroups and committees as necessary to provide technical assistance and coordination of the statewide institutional utilization control program.

H. To provide training to providers as necessary.

I. To provide administrative oversight and technical assistance to the district staff in the performance of designated functions.



II. The Agency for Health Care Administration (AHCA),  
Medicaid Office

The Headquarters Medicaid Office shall perform the following functions:

- A. Promulgate, distribute and maintain institutional care admission and continued placement criteria;
- B. Provide technical assistance and consultation as necessary;
- C. Provide clarification of institutional care criteria;
- D. Serve as the Medicaid liaison with the Department of Health and Human Services (HHS) regarding the Title XIX, Medicaid, state plan and state plan requirements;
- E. Prepare and submit, on a timely basis, federally required preadmission screening and annual resident review reports, and inspection of care reports (Quarterly Showing Report);
- F. Provide clarification of federal requirements;
- G. Maintain and update administrative rules, in collaboration with HRS and Health Quality Assurance, relating to institutional utilization control and admission and continued placement criteria; and
- H. Monitor the statewide institutional utilization control program and the nursing facility pre-admission screening and annual resident review (PASARR) process.

The Area Medicaid Offices shall perform the following functions:

- A. Provide technical assistance when requested.
- B. Provide oversight at the local level upon request

or as deemed necessary.

**III. HRS Aging and Adult Services Program Office**

The State HRS Aging and Adult Services Program Office shall perform the following functions:

- A. Establish, distribute and maintain written admission review, follow-up placement and continued placement determination policies, procedures, and forms.
- B. Establish, distribute and maintain written screening and referral policies, procedures, and forms.
- C. Prepare and provide report data as needed concerning the admission review and mental illness (MI) and mental retardation/developmental disabilities (MR-DD) screening.
- D. Provide input or respond, as necessary, to HHS inquiries relating to admission review and MI and/or MR-DD screening.
- E. Monitor the accuracy and timeliness of pre-admission and continued placement reviews performed by the district pre-admission teams.
- F. Ensure the establishment of adequate teams, as available resources allow, to assure timely completion of functions performed by the teams in accordance with the provisions of this agreement.
- G. Provide or contract for such psychiatric, medical and related staff as required to enable the teams to carry

out the specific responsibilities detailed in this agreement.

The District HRS Aging and Adult Services Program Offices shall perform the following functions:

A. Ensure that each Medicaid applicant's or recipient's (age 21 and older) need for nursing facility, mental hospital or swing bed facility services is evaluated by the Comprehensive Assessment and Review for Long Term Services (CARES) teams and a level of care established or an alternate placement determination rendered.

B. Ensure that all admission reviews are performed appropriately and timely.

C. Ensure that all Medicaid nursing facility applicants (age 21 and older) who appear to have mental illness (MI) or mental retardation/developmental disability (MR-DD) are identified.

D. Ensure that each Medicaid nursing facility applicant (age 21 and older) identified by Aging and Adult Services, or private pay applicant (age 21 and older) identified by a nursing facility, as possibly having MI or MR-DD is appropriately referred by CARES for an evaluation and a determination made regarding the need for specialized services.

E. Ensure that local Developmental Services offices are advised of all Medicaid nursing facility applicants or recipients determined to require MR-DD evaluations and ensure that the Alcohol, Drug Abuse and Mental Health

Program Office is advised of all applicants or recipients who require a final determination regarding their need for specialized MI services.

F. Ensure that each Medicaid recipient's need for continued placement in a swing bed facility, beyond the initial 60 day period, is evaluated. Upon request by the facility for authorization of extended Medicaid reimbursement, when appropriate, authorize swing bed extensions.

G. Review all decisions rendered by institutional care facilities (nursing facilities and mental hospitals) and district staff that deny continued placement of any Medicaid recipient who is (age 21 and older) and render a final determination regarding continued placement. When there is concurrence with the facility's decision, provide adequate and timely written notification of the final determination to the local eligibility and payments staff for recipient notification.

H. Perform continued placement reviews of all nursing facility and mental hospital recipients referred by AHCA or other HRS staff, and of all recipients approved for short-term placement, and render a final determination regarding continued placement. When Medicaid eligibility for continued placement is denied, provide adequate and timely written notification to the local eligibility and payments staff for recipient notification.

I. Ensure appropriate departmental representation at

any administrative or legal proceeding regarding any decision that is rendered by Aging and Adult Services staff which denies an applicant's or recipient's admission or continued placement or renders the facility unable to provide the level of services required by the individual in a nursing facility, swing bed or mental hospital.

J. Ensure that documentation which reflects each admission and continued stay review performed, and each MI or MR-DD screening performed for nursing facility applicants and recipients is maintained at the local level and available for review by authorized federal and/or state representatives, and substantiates the level of services required by each applicant or recipient or an alternative placement determination when applicable.

#### IV. HRS Developmental Services Program Office

The State HRS Developmental Services Program Office shall perform the following functions:

- A. Establish, distribute and maintain written admission review, follow-up placement and continued placement determination policies, procedures, and forms.
- B. Establish, distribute and maintain written screening and referral policies, procedures and forms.
- C. Provide input or respond, as necessary, to HHS inquiries relating to admission review and MR-DD screening.
- D. Monitor the accuracy and timeliness of pre-admission and continued placement reviews performed by the district pre-admission teams.

The District HRS Developmental Services Program Offices shall perform the following functions:

- A. Ensure that each Medicaid applicant's or recipient's need for Intermediate Care Facility for the Developmentally Disabled (ICF/MR-DD) services is evaluated and a level of care or alternate placement determination rendered and ensure that continued stay reviews are performed in accordance with 42 CFR 456.431 through 42 CFR 456.436.
- B. Ensure that all admission reviews are performed appropriately and timely.
- C. Review all decisions rendered by ICFs/MR-DD that deny continued placement of any Medicaid recipient and render a final determination regarding the need for continued placement. When there is concurrence with the facility's decision, provide adequate and timely written notification of the final determination to the recipient.
- D. Perform continued placement reviews of all MR-DD nursing facility recipients referred by AHCA or HRS staff, and of all MR-DD recipients approved for short-term nursing facility placement, and render a final determination regarding continued placement within the nursing facility.
- E. Ensure that each nursing facility applicant or recipient requiring a MR-DD evaluation is evaluated prior to admission (under the Medicaid institutional care program) and no less than annually thereafter and a determination rendered with regard to whether or not specialized services

for MR-DD are required.

F. Ensure the establishment of adequate teams to assure timely completion of admission, continued stay and annual reviews of ICF/MR-DD applicants and recipients, and MR-DD screenings for nursing facility applicants and recipients.

G. Provide or contract for such psychiatric, medical and related staff as required to enable the admission and continued stay review teams to carry out the specific responsibilities detailed in this agreement.

H. Develop, distribute and maintain UC plans for each ICF/MR-DD and ensure the UC plans meet federal and state requirements.

I. Ensure departmental representation at any administrative or legal proceeding regarding any decision that is rendered by district Developmental Services staff which denies an applicant's or recipient's admission or continued placement, or renders the facility unable to provide the level of services required by the individual, in an ICF/MR-DD or nursing facility.

J. Ensure that documentation which reflects each ICF/MR-DD admission and continued stay review performed, and each MR-DD screening and annual review performed for nursing facility applicants and recipients is maintained at the local level and available for review by authorized federal and/or state representatives, and substantiates the level of services required by each applicant or recipient or an

alternate placement determination when applicable.

K. Prepare and provide report data as needed concerning the admission review and MR-DD screening.

V. **The HRS Children's Medical Services Program Office**  
The State HRS Children's Medical Services Program  
Office shall perform the following functions:

A. Establish, distribute and maintain written admission review, follow-up and continued placement determination policies, procedures, and forms;

B. Establish, distribute and maintain written policies, procedures and forms for first level screening by Multiple Handicap Assessment Teams (MHAT) of MI and MR-DD and referrals for further assessment.

C. Prepare and provide report data as needed concerning the admission review and MI and MR-DD screening;

D. Provide input or respond, as necessary, to HHS inquiries relating to admission review and MI and/or MR-DD screening; and

E. Monitor the accuracy and timeliness of pre-admission and continued placement reviews performed by district MHATs.

The District HRS Children's Medical Services Program  
Offices shall perform the following functions:

A. Ensure that each Medicaid applicant's or recipient's (age birth through 20) need for nursing facility services is evaluated by the MHAT and a level of care established or an alternate placement determination



rendered.

B. Ensure that all admission reviews are performed appropriately and timely.

C. Ensure that all Medicaid nursing facility applicants (age birth through 20) who appear to have MI or MR-DD are identified.

D. Ensure that each Medicaid nursing facility applicant (age birth through 20) identified by the MHAT, or private pay applicant (age birth through 20) identified by a nursing facility, as possibly having MI or MR-DD is appropriately referred by the MHAT for an evaluation and a determination made regarding the need for specialized services. The MI or MR-DD evaluation must be available and considered prior to a final determination of placement of service.

E. Ensure that local Developmental Services offices are advised of all (age birth through 20) Medicaid nursing facility applicants or recipients determined to require MR-DD evaluations and ensure that the Alcohol, Drug Abuse, and Mental Health Program Office is advised of all applicants or recipients who require a final determination regarding their need for specialized MI services.

F. Ensure that local MHATs review all decisions rendered by Medicaid nursing facilities that deny continued placement of any Medicaid recipient (age birth through 20), and render a final determination through the staffing process regarding the need for continued placement. When

there is concurrence with the facility's decision, provide adequate and timely written notification of the final determination to the local eligibility and payments staff for notification to the recipient and the recipient's responsible party.

G. Ensure that local MHATs in cooperation with Developmental Services or Alcohol, Drug Abuse and Mental Health when applicable perform continued placement reviews of all nursing facility residents (age birth through 20) referred by AHCA or HRS staff, and of all recipients (age birth through 20) approved for short-term nursing facility placement, and render a final determination regarding continued placement. When Medicaid eligibility for continued placement is denied, provide adequate and timely written notification to local eligibility and payments staff for recipient notification.

H. Ensure appropriate departmental representation at any administrative or legal proceeding regarding any decision that is rendered by a MHAT which denies an applicant's or recipient's (age birth through 20) admission or continued placement in a nursing facility or renders the facility unable to provide the level of services required by the individual.

I. Ensure that documentation which reflects each admission review and continued stay review performed, and each MI or MR-DD screening and annual review performed for nursing facility applicants and recipients (age birth

through 20) is maintained at the local level and available for review by authorized federal and/or state representatives, and substantiates the level of services required by each applicant or recipient or an alternate placement determination when applicable.

**VI. HRS Alcohol, Drug Abuse and Mental Health Program Office**

The State HRS Alcohol, Drug and Mental Health Program Office shall perform the following functions:

A. Ensure the development of a uniform MI nursing facility pre-admission and annual screening/assessment tool and criteria for statewide use.

B. Provide input or respond, as necessary, to HHS inquiries relating to admission review and MI screenings.

C. Monitor the accuracy and timeliness in making determinations for specialized services in accordance with the provisions of this agreement.

The District HRS Alcohol, Drug and Mental Health Program Office shall perform the following functions:

A. Ensure that a final determination is rendered regarding each referred nursing facility applicant's or recipient's need for specialized services for MI.

B. Ensure the provision of specialized services to all nursing facility residents who are determined to require such services and who are allowed to enter or remain in the nursing facility.

C. Ensure that documentation is maintained and available to authorized federal and state reviewers which

substantiates the final determination regarding whether or not specialized MI services are required for nursing facility residents and applicants.

D. Ensure departmental representation at any administrative or legal proceeding regarding any admission or continued decision that is rendered by Alcohol, Drug Abuse and Mental Health staff which denies an applicant's or recipient's admission or continued placement, or renders the nursing facility unable to provide the level of services required by the individual.

E. Prepare and provide periodic report data as needed concerning MI final determinations for specialized services.

VII. The Agency for Health Care Administration, Division of Health Quality Assurance will:

A. Ensure that an Inspection of Care (IOC) review is conducted in each Medicaid participating ICF/MR-DD and mental hospital in which there is one or more residents approved for the Medicaid institutional care program (ICP).

B. Ensure that all IOC reviews are conducted in accordance with federal law and regulations.

C. Ensure the IOC teams prepare and distribute IOC reports which reflect the IOC team's findings on recipient services as well as specific findings and recommendations with respect to individual need for continued placement. The cover sheet of the IOC reports shall also contain at least the following:

- Facility name, address and provider number;

- Number of Medicaid recipients, by level of care, under facility care at the time of the IOC;
- Number of beds allocated or certified for care of Medicaid recipients;
- Date(s) the IOC was performed. If review lasted more than one day, the beginning and ending dates;
- Date on which the IOC report was prepared; and
- Signatures and credentials of team members.

D. Ensure that IOC teams obtain and maintain individual recipient profiles or assessment findings for each Medicaid applicant or recipient observed and medically reviewed during the IOC and to provide such documentation or evidence when requested by federal and/or state validators.

E. Respond, as necessary, to HHS regarding inquiries relating to inspection of care.

F. Ensure that each IOC team is appropriately composed.

G. Ensure that each MI and MR-DD nursing facility resident is reviewed during the annual facility survey and an assessment made regarding his MI or MR-DD status and his need for an MI/MR-DD evaluation.

H. Refer to district HRS CARES staff or MHAT staff, as age appropriate, each MI or MR-DD nursing facility resident who is identified through a Mini-Gates assessment as needing an evaluation of the MI or MR-DD status and a determination of the need for specialized services or alternative placement.

I. Ensure that each Medicaid nursing facility resident who appears to no longer require the level of services provided by a nursing facility is referred to district HRS CARES or MHAT staff, as age appropriate, for a final continued placement determination.

J. Ensure that each facility has implemented the initial and annual resident review and that each facility is using the Minimum Data Set for review purposes.

K. Ensure agency representation at any administrative or legal proceeding regarding any information provided or action taken by AHCA staff which denies continued placement in an institutional care facility or renders the facility unable to provide the level of services required by the individual.

L. Monitor the accuracy and timeliness of functions performed by the survey teams in accordance with the provisions of this agreement.