Statewide Medicaid Managed Care Long-term Care Program Coverage Policy

Coverage Policy Review

June 16, 2017

Today's Presenters

D.D. Pickle, AHC Administrator

Objectives

- Provide an overview of the changes the Agency has deployed in its rulemaking process related to Medicaid
- Review the following newly adopted Statewide Medicaid Managed Care Long-term Care Program Coverage Policy

Introduction

The Florida Medicaid coverage and limitations handbooks/policies provide the minimum requirements for all providers of services.

What Will Change?

The following changes have been initiated across all coverage and limitations handbooks:

- We no longer will call them “coverage and limitations handbooks.” They are now “coverage policies” or simply “policies.”
- We created a new layout and format, which includes the use of standard language

Managed Care Plan Responsibilities

Managed care plans are required to comply with all current coverage policies.

Limitations and exclusions imposed by the managed care plan cannot be more stringent than coverage policies or fee schedules.

Results

The Agency currently has updated the majority of its related rules

Services Coverage Template	
1.0 Introduction	1.1 Description 1.1.1 Florida Medicaid Policies 1.1.2 Statewide Medicaid Managed Care Plans 1.2 Legal Authority 1.3 Definitions
2.0 Eligible Recipient	2.1 General Criteria 2.2 Who Can Receive 2.3 Coinsurance, Copayment, or Deductible
3.0 Eligible Provider	3.1 General Criteria 3.2 Who Can Provide
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Services Coverage Template	
5.0 Exclusion	5.1 General Non-Covered Criteria 5.2 Specific Non-Covered Criteria
6.0 Documentation	6.1 General Criteria 6.2 Specific Criteria
7.0 Authorization	7.1 General Criteria 7.2 Specific Criteria
8.0 Appendix	

What Will Change?

- Practice standards have been removed
- Policies are not provider specific, but rather procedure/service specific
- Redundant documentation requirements have been removed
- References to specific ICD diagnosis codes have been removed

What Will Change?

We will not recite the **exact same** requirements that are specified in state statute or in federal regulations unless an interpretation is required to implement

General Policies

Rule Chapter 59G-1

Examples include:

- Definitions
- Provider and Recipient General Requirements
- Copayments and Coinsurance Requirements
- Third Party Liability Payment Requirements
- Authorization Requirements
- Enrollment Requirements
- Recordkeeping and Documentation Requirements
- Fraud and Abuse Requirements

Reimbursement Policies

General reimbursement policies are specific to the fee-for-service delivery system:

- Fee Schedules
- General Reimbursement Policies
- Claims Reimbursement Form Requirements

Fee Schedules are a source of service codes and descriptions, but health plans may negotiate mutually agreed-upon rates with providers as permitted by Florida law.

Statewide Medicaid Managed Care Long-term Care Program Coverage Policy

This policy must be used with Florida Medicaid's general policies, any applicable service-specific policies, and the SMMC contract

1.0 Introduction

1.1 Description and Program Goal

- Under the SMMC Long-term Care (LTC) program, managed care plans (LTC plans) are required to provide an array of home and community-based services that enable enrollees to live in the community and to avoid institutionalization

1.2 Legal Authority:

- Statewide Medicaid Managed Care LTC program services are authorized by the following:
  - Section 1915(c) of the Social Security Act
  - Title 42, Code of Federal Regulations (CFR), Part 438, and Part 441 Subpart G
  - Section 409 Part IV, Florida Statutes (F.S.)

1.0 Introduction

1.3 Definitions

"Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

The definition of medically necessary is refined for LTC purposes and states:

1.3.14 Medically Necessary or Medical Necessity

For the purposes of this policy, the service must meet either of the following criteria:

a) Nursing facility services and mixed services must meet the medical necessity criteria defined in Rule 59G-1.010, F.A.C.

b) All other LTC supportive services must meet all of the following:
   - Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs
   - Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
   - Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

And, one of the following:
   - Enable the enrollee to maintain or regain functional capacity; or
   - Enable the enrollee to have access to the benefits of community living, to achieve person-centered goals, and to live and work in the setting of his or her choice.

2.0 Eligible Recipient

2.1 General Criteria

An eligible recipient must be enrolled in the LTC program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.0 Eligible Recipient

2.2 Who Can Receive

- Florida Medicaid recipients requiring medically necessary LTC services who are enrolled in a LTC plan and have a nursing facility level of care determined by the CARES program. Some services may be subject to additional coverage criteria as specified in section 4.0

2.0 Eligible Recipient

2.3 Patient Responsibility

Providers may not change a recipient's patient responsibility without DCF approval

3.0 Eligible Provider

3.1 General Criteria

- Services are provided directly by an LTC plan or through its network of contracted providers
- Services must be rendered by an entity, facility, person, or group meeting the minimum qualifications specified in this policy

3.0 Eligible Provider

3.2 Who Can Provide

- See Appendix 8.0 for a list of minimum provider qualifications for each LTC covered service

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid LTC plans cover services that meet all of the following:

- Are determined medically necessary, as defined in this rule
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.0 Coverage Information

4.2 Specific Criteria

Florida Medicaid LTC plans cover services that meet all of the following:

- Consistent with the type, amount, duration, frequency, and scope of services specified in an enrollee's authorized plan of care
- Provided in accordance with a goal in the enrollee's plan of care
- Intended to enable the enrollee to reside in the most appropriate and least restrictive setting

4.0 Coverage Information

4.2.1 Home and Community-Based Supportive Services

- The LTC program benefit includes coverage of the following home and community-based supportive services:
  - **4.2.1.1 Adult Companion Care**
  - **4.2.1.2 Adult Day Health Care**
  - **4.2.1.3 Assisted Living**
  - **4.2.1.4 Behavioral Management**
  - **4.2.1.5 Care Coordination or Case Management**
  - **4.2.1.6 Caregiver Training**
  - **4.2.1.7 Home Accessibility Adaptation**
  - **4.2.1.8 Home Delivered Meals**
  - **4.2.1.9 Homemaker Services**
  - **4.2.1.10 Medication Administration**
  - **4.2.1.11 Medication Management**
  - **4.2.1.12 Nursing Facility**
  - **4.2.1.13 Nutritional Assessment or Risk Reduction**
  - **4.2.1.14 Personal Emergency Response Systems**
  - **4.2.1.15 Respite Care**

4.0 Coverage Information

4.2.2 Mixed Services

- Mixed services may exceed State Plan limits on those services in accordance with this policy. The Long-term Care benefit includes coverage of the following mixed services**:**
  - **4.2.2.1 Assistive Care**
  - **4.2.2.2 Attendant Nursing Care**
  - **4.2.2.3 Hospice**
  - **4.2.2.4 Intermittent Skilled Nursing**
  - **4.2.2.5 Medical Equipment and Supplies**
  - **4.2.2.6 Personal Care**
  - **4.2.2.7 Occupational Therapy**
  - **4.2.2.8 Physical Therapy**
  - **4.2.2.9 Respiratory Therapy**
  - **4.2.2.10 Speech Therapy**
  - **4.2.2.11 Transportation**

5.0 Exclusion

The LTC program benefit does not include coverage for the following:

- Adaptations which add to the total square footage of the home.
- Food or the cost of meals when provided other than through home-delivered meal services.
- Personal emergency response system services for enrollees who do not live alone or who are not home alone for significant parts of the day and would not otherwise require high intensity or constant supervision.
- Respite care services for enrollees residing in a nursing facility or an assisted living facility (ALF).
- Services provided to enrollees in a:
  - Hospital licensed pursuant to Chapter 395, F.S.
  - Group home licensed pursuant to Chapters 393, 394, or 397, F.S.
  - State mental health hospital licensed pursuant to Chapter 395, F.S.
  - Intermediate care facility for individuals with intellectual disabilities licensed pursuant to Chapter 400, F.S.
- Room and board payments to ALFs or adult family care homes.
- Transportation services when transportation is available to the enrollee without charge from family, neighbors, friends, or community agencies.

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's recordkeeping and documentation policy

6.0 Documentation

6.2 Specific Criteria

In order to receive LTC services, services must be documented on an individualized plan of care based upon a comprehensive needs assessment. The comprehensive assessment includes the completion of the 701-B Comprehensive Assessment and the LTC Supplemental Assessment

6.0 Documentation

6.2.1 LTC Supplemental Assessment

The LTC Supplemental Assessment includes, at a minimum, the following components:

- The amount of time the enrollee can be safely left alone
- The ability of natural supports to assist with the enrollee's needs, including the following:
  - The role of each natural support in the enrollee's day-to-day life
  - Each natural support's day-to-day responsibilities, including an evaluation of each natural support's work, school, and other schedules and responsibilities in addition to caring for the enrollee
  - Each natural support's stress and well-being
  - Any medical limitation or disability the natural support may have that would limit their ability to participate in the care of an enrollee (e.g. lifting restrictions, developmental disorder, bed rest for pregnancy, etc.)
  - The willingness of the natural support to participate in the enrollee's care

6.0 Documentation

6.2.2 Person Centered Plan of Care

The plan of care template must include, at a minimum, the following components:

- Enrollee's name and Florida Medicaid identification number
- Plan of care effective date
- Plan of care review date (at least every 90 days)
- The enrollee's personal goals
- The enrollee's strengths and preferences
- Routine medical services needed, including documentation of the frequency, amount, and rendering providers
- Availability of natural supports to assist in the enrollee's care
- Long-term care waiver services, including documentation of the frequency, amount, and rendering providers

6.0 Documentation

6.2.2 Person Centered Plan of Care (continued)

- Each service authorization beginning and end date (if applicable)
- Comprehensive list of services and supports to be provided regardless of the funding source
- Medication oversight strategies
- Current living arrangement and choice of living arrangement
- If the enrollee's current living arrangement and choice of living arrangement differ, a goal toward achieving the desired living arrangement and barriers to be overcome in achieving the goal
- Document whether enrollees have advance directives, health care powers of attorney, do not resuscitate orders, or a legally appointed guardian
- If the enrollee resides in an ALF, the enrollee's assisted living service components provided by the ALF, including the amount and frequency of those services

6.0 Documentation

6.2.2 Person Centered Plan of Care (continued)

- Identify any existing care plans and service providers and assess the adequacy of existing services
- Identify the individual and/or entity responsible for monitoring the plan of care
- Case manager's signature
- A verbatim written statement preceding the enrollee signature field as follows:

  "I have received and read the plan of care. I understand that I have the right to file an appeal or fair hearing if my services have been denied, reduced, terminated, or suspended.", and
- Enrollee or enrollee's authorized representative's signature and date

6.0 Documentation

6.2.3 Plan of Care Summary

Long-term care enrollees will be provided a one-page summary of the services authorized on the plan of care. The summary will be provided by the LTC plan upon completion of the initial plan of care and after any subsequent updates to the plan of care, and must contain the following components:

- The enrollee's name
- The enrollee's date of birth
- The enrollee's Florida Medicaid identification number
- Authorized LTC services (including the amount and frequency)
- Begin date of services
- List of providers
- Case manager's signature
- Enrollee or the enrollee's authorized representative's signature and date.

7.0 Authorization

7.1 General Criteria

LTC services must be authorized by the enrollee's LTC plan prior to the delivery of services

8.0 Appendix

Statewide Medicaid Managed Care Long-term Care Provider Qualifications

Long-term Care Plan Benefit	Qualified Service Provider Types	Minimum Provider Qualifications
Adult Companion	Community Care for the Elderly (CCE) Provider	As defined in Chapter 410 or 430, F. S.
	Center for Independent Living	As defined under s. 413.371, F. S.
	Homemaker/Companion Agency	Registration in accordance with s. 400.509, F.S.
	Home Health Agency	Licensed per Chapter 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484.
	Nurse Registries	Licensed per Chapter 400.506, F.S.
	Health Care Service Pools	Licensed per Chapter 400, Part IX, F. S.
Adult Day Care (Adult Day Health Care)	Assisted Living Facility	Licensed per Chapter 429, Part I, F.S,
	Adult Day Care Center	Licensed per Chapter 429, Part III, F.S.

Assisted Living Facility Services	Assisted Living Facility	Licensed per Chapter 429, Part I, F.S. and ALF must agree to offer facility services with home-like characteristics.
Assistive Care Services	Adult Family Care Home (AFCH)	Licensed per Chapter 429, Part II, F.S.
Attendant Care	Center for Independent Living	As defined under Chapter 413.371, F.S.; have licensed direct care staff, if required, to perform the waiver services.
	Home Health Agency	Licensed per Chapter 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484.
Attendant Care (cont'd)	Registered Nurse (RN), Licensed Practical Nurse (LPN)	Licensed per Chapter 464, F.S.
	Nurse Registry	Licensed per s. 400.506, F.S. Services shall be provided by a licensed RN or LPN.

Behavior Management	Clinical Social Worker, Mental Health Counselor	Licensed per Chapter 491, F.S.
	Community Mental Health Center	As described in Chapter 394, F.S.
	Home Health Agencies	Licensed per Chapter 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484. Direct service provider shall have a minimum of two (2) years direct experience working with adult populations diagnosed with Alzheimer's disease, other dementias or persistent behavioral problems.
	Psychologist	Licensed per Chapter 490, F.S.
	Registered Nurse	Licensed per Chapter 464, Part I, F.S. and Rule 64B-9, F.A.C.; Minimum of 2 years direct experience working with adult populations diagnosed with Alzheimer's disease, other dementias or persistent behavioral problems.
	Center for Independent Living	As defined under Chapter 413.371, F.S.; have licensed direct care staff, if required, to perform the waiver services.

Caregiver Training	CCE Provider	As defined in Chapter 410 or 430, F.S.
	Clinical Social Worker, Mental Health Counselor	Licensed per Chapter 491, F.S.
Caregiver Training (cont'd)	RN, LPN	Licensed per Chapter 400, Part III, F.S.
	Home Health Agency	Optional to meet Federal Conditions of Participation under 42 CFR 484.
	Center for Independent Living	As defined under Chapter 413.371, F.S.; have licensed direct care staff, if required, to perform the waiver services.

Case Management	Case Managers employed or contracted by Managed Care Plans	Either: 2+ yrs. of relevant experience and; (1) BA or BS in Social Work, Sociology, Psychology, Gerontology or related social services field; (2) RN licensed in FL; (3) BA or BS in unrelated field, OR: 4+ yrs. relevant experience and LPN licensed in FL, OR: Professional human services experience can be substituted on a year-for-year basis for the educational requirements. All shall have four (4) hours of in-service training in identifying and reporting abuse, neglect and exploitation.
	Center for Independent Living	Either: 2+ yrs. of relevant experience and; (1) BA or BS in Social Work, Sociology, Psychology, Gerontology or related social services field; (2) RN licensed in FL; (3) BA or BS in unrelated field, OR: 4+ yrs. relevant experience and LPN licensed in FL, OR: Professional human services experience can be substituted on a year-for-year basis for the educational requirements. All shall have four (4) hours of in-service training in identifying and reporting abuse, neglect and exploitation.
	Case Management Agency	Either: 2+ yrs. of relevant experience and; (1) BA or BS in Social Work, Sociology, Psychology, Gerontology or related social services field; (2) RN licensed in FL; (3) BA or BS in unrelated field, OR: 4+ yrs. relevant experience and LPN licensed in FL, OR: Professional human services experience can be substituted on a year-for-year basis for the educational

Case Management (cont'd)	Case Management Agency (cont'd)	requirements. All shall have four (4) hours of in-service training in identifying and reporting abuse, neglect and exploitation. Designated a CCE Lead Agency by DOEA (per Chapter 430 F.S.) or other agency meeting comparable standards as determined by DOEA.
Home Accessibility Adaptation	Independent Provider	Licensed per state and local building codes or other licensure appropriate to tasks performed. Chapter 205, F.S.; Licensed by local city and/or county occupational license boards for the type of work being performed. Required to furnish proof of current insurance.
	Center for Independent Living	As defined under s. 413.371, F. S. and licensed under Chapter 205, F. S.
	General Contractor	Licensed per s. 439.131, F.S.

Home Delivered Meals	Food Establishment	Permit under s. 500.12, F.S.
	Older American's Act (OAA) Provider	As defined in Rule 58A-1, F.A.C.
	CCE Provider	As defined in Chapter 410 or 430, F.S.
	Food Service Establishment	Licensed per s. 509.241, F.S.
Homemaker	Nurse Registry	Licensed per s. 400.506, F.S.
Homemaker (cont'd)	Home Health Agency	Licensed per Chapter 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484.
	CCE Provider	As defined in Chapter 410 or 430, F.S.
	Center for Independent Living	As defined under s. 413.371, F. S.
	Homemaker/Companion Agency	Registration in accordance with Chapter 400.509, F.S.
	Health Care Service Pools	Licensed per Chapter 400, Part IX, F.S.
	Pest Control	Licensed per Chapter 482.071, F.S.

Hospice	Hospice Organizations	Licensed per Chapter 400, Part IV, F. S. and meet Medicaid and Medicare conditions of participation annually.
Intermittent and Skilled Nursing	Home Health Agency	Licensed per Chapter 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484.
Medication Administration	RN, LPN	Licensed per Chapter 464, F.S.
	Home Health Agency	Licensed per Chapter 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484.
	Unlicensed Staff Member Trained per 58A-5.0191(5), F.A.C.	Trained per 58A-5.0191(5), F.A.C.; demonstrate ability to accurately read and interpret a prescription label.
	Nurse Registry	Licensed per s. 400.506, F.S.
	Pharmacist	Licensed per Chapter 465, F.S.

Medication Management	Home Health Agencies	Licensed per Chapter 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484. Individuals providing services shall be an RN or LPN.
	Nurse Registries	Licensed per s. 400.506, F.S. Individuals providing services shall be an RN or LPN.
Medication Management (cont'd)	Nurse Registries (cont'd)	
	Licensed Nurse, LPN	Licensed per Chapter 464, F.S.
	Pharmacist	Licensed per Chapter 465, F.S.
Medical Equipment & Supplies	Pharmacy	Licensed per Chapter 465, F.S. and Permitted per Chapter 465, F.S.
	Home Health Agency	Licensed per Chapter 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484.
	Home Medical Equipment Company	Licensed per Chapter 400, Part VII, F.S.

Nutritional Assessment and Risk Reduction	CCE Provider	As defined in Chapter 410 or 430, F.S.
	Home Health Agency	Licensed per Chapter 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484.
	Nurse Registry	Licensed per s. 400.506, F.S.
	Other Health Care Professional	Must practice within the legal scope of their practice.
	Dietician/Nutritionist or Nutrition Counselor	Licensed per Chapter 468, Part X, F.S.
	Center for Independent Living	As defined under Chapter 413.371, F.S.; have licensed direct care staff, if required, to perform the waiver services
Nursing Facility Care	See State Plan Requirements.	See State Plan Requirements.

Nursing Facility Care	See State Plan Requirements.	See State Plan Requirements.
Personal Care	Nurse Registry	Licensed per s. 400.506, F.S.
	Home Health Agency	Licensed per Chapter 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484.
Personal Care (cont'd)	CCE Provider	As defined in Chapter 410 or 430, F.S.
	Center for Independent Living	As defined under Chapter 413.371, F.S.; have licensed direct care staff, if required, to perform the waiver services
Personal Emergency Response System	Alarm System Contractor	Certified per Chapter 489, Part II, F.S.
	Low-Voltage Contractors and Electrical Contractors	Exempt from licensure in accordance with 489.503(15)(a-d), F.S. and 489.503(16), F.S.

Respite Care	CCE Provider	As defined in Chapter 410 or 430, F.S.
	Nurse Registry	Licensed per s. 400.506, F.S.
	Adult Day Care Center	Licensed per Chapter 429, Part III, F.S.
	Assisted Living Facility	Licensed per Chapter 429, Part I, F.S.
	Nursing Facility	Licensed per Chapter 400, Part II, F.S.
	Center for Independent Living	As defined under s. 413.371, F.S.
	Home Health Agency	Licensed per Chapter 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484.
	Homemaker/ Companion Agency	Registration in accordance with s. 400.509, F.S.
Transportation	Independent (private auto, wheelchair van, bus, taxi)	Licensed per Chapter 322, F.S.; Residential facility providers that comply with requirements of Ch. 427, F.S.
	Community Transportation Coordinator	Licensed per Chapter 316 and 322, F. S., in accordance with Chapter 41-2, F. A. C

Occupational Therapy	Home Health Agency	Licensed per Chapter 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484.
	Occupational Therapist	Licensed per Chapter 468, Part III, F.S.
Occupational Therapy (cont'd)	Assistant	
	Occupational Therapist	Licensed per Chapter 468, Part III, F.S.
	Center for Independent Living	As defined under Chapter 413.371, F.S.; have licensed direct care staff, if required, to perform the waiver services
	Hospital Outpatient Department	Licensed per Chapter 395, Part I and 408, Part II, F.S., and required licensure or be under supervision of a licensed professional qualified to provide the service.
	Nursing Facility	Licensed per Chapter 400, Part III, F.S.;

Physical Therapy	Physical Therapist	Licensed per Chapter 486, F.S.
	Physical Therapist Assistant	Licensed per Chapter 486, F.S.
	Home Health Agency	Licensed per Chapter 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484.
	Center for Independent Living	As defined under Chapter 413.371, F.S.; have licensed direct care staff, if required, to perform the waiver services
	Hospital Outpatient Department	Licensed per Chapter 395, Part I and 408, Part II, F.S., and required licensure or be under supervision of a licensed professional qualified to provide the service.
	Nursing Facility	Licensed per Chapter 400, Part III, F.S.

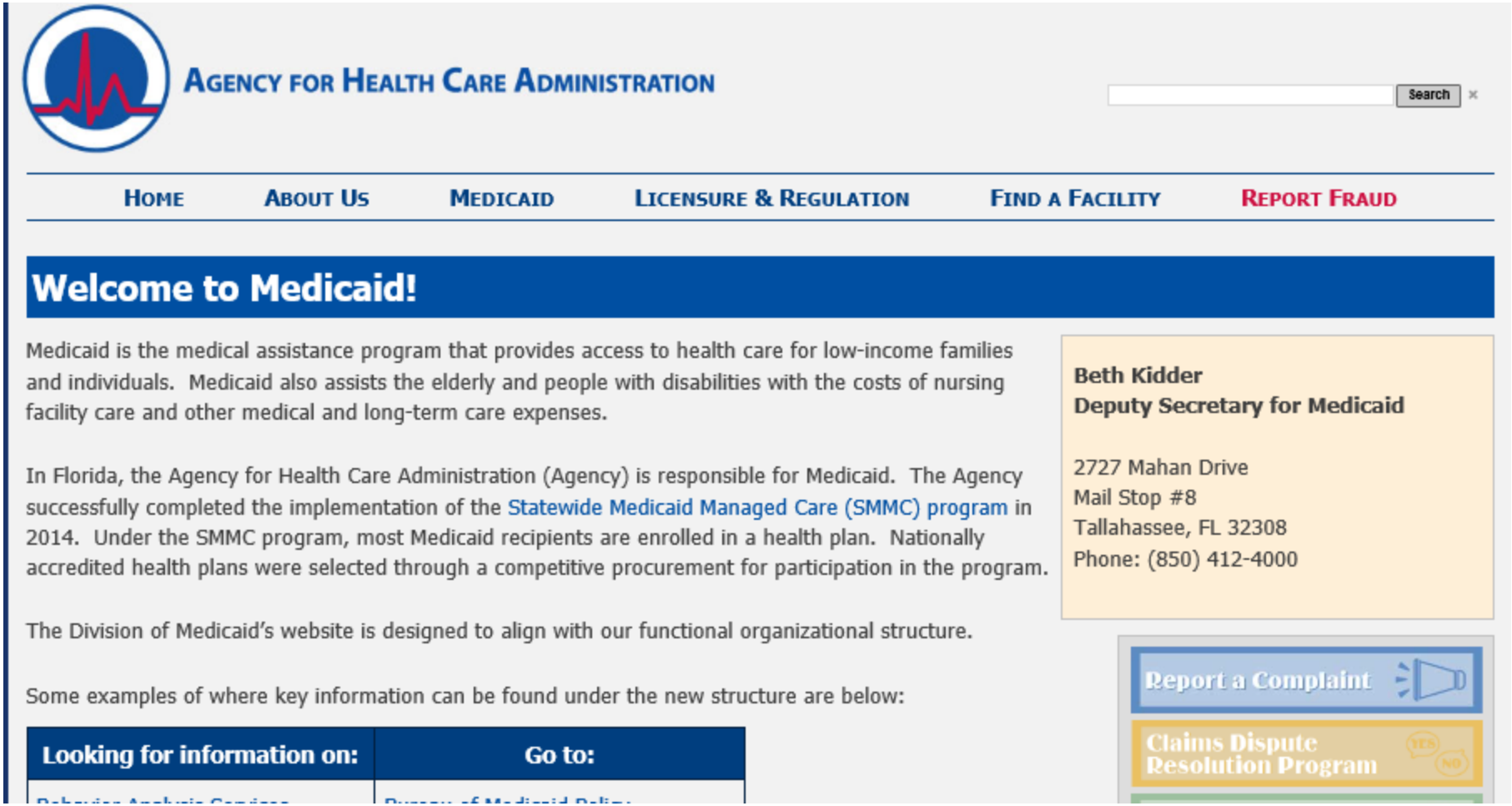
Respiratory Therapy	Home Health Agency	Home Health Agencies licensed per Chapter 400, Part III,F. S, employing certified respiratory therapists licensed under Chapter 468, F. S and may meet Federal conditions of Participation under 42 CFR 484 or individuals licensed per Chapter 468, F. S. as certified respiratory therapists.
Respiratory Therapy (cont'd)	Respiratory Therapist	Licensed per Chapter 468, F.S.
	Health Care Service Pools	Licensed per Chapter 400, Part IX, F. S.
	Center for Independent Living	As defined under Chapter 413.371, F.S.; and registered, certified or licensed under s. 468, Part V, F.S., as a respiratory therapist or under the direct supervision of such registered, certified or licensed respiratory therapists.
	Hospital Outpatient Department	Licensed per Chapter 395, Part I and 408, Part II, F.S., and required licensure or be under supervision of a licensed professional qualified to provide the service.
	Nursing Facility	Licensed per Chapter 400, Part III, F.S.;

Speech Therapy	Speech-Language Pathologist	Licensed per Chapter 468, Part I, F.S.
	Home Health Agency	Licensed per Chapter 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484.
	Center for Independent Living	As defined under Chapter 413.371, F.S.; have licensed direct care staff, if required, to perform the waiver services
	Hospital Outpatient Department	Licensed per Chapter 395, Part I and 408, Part II, F.S.

Statewide Medicaid Managed Care Long-term Care Program Procedure Codes for Home and Community-Based Supportive Services

Procedure Code	Modifier 1	Description
S5135		Adult companion care
S5100		Adult day health care
T2030		Assisted living service
T1020		Assistive care services
S5125		Attendant care
H2020		Behavioral management, assessment
H2019		Behavioral management, intervention
S5110		Caregiver training group
97537		Caregiver training individual
G9002		Case management
S5165		Home accessibility adaptation services

Resources



AGENCY FOR HEALTH CARE ADMINISTRATION

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Welcome to Medicaid!

Medicaid is the medical assistance program that provides access to health care for low-income families and individuals. Medicaid also assists the elderly and people with disabilities with the costs of nursing facility care and other medical and long-term care expenses.

In Florida, the Agency for Health Care Administration (Agency) is responsible for Medicaid. The Agency successfully completed the implementation of the Statewide Medicaid Managed Care (SMMC) program in 2014. Under the SMMC program, most Medicaid recipients are enrolled in a health plan. Nationally accredited health plans were selected through a competitive procurement for participation in the program.

The Division of Medicaid's website is designed to align with our functional organizational structure.

Some examples of where key information can be found under the new structure are below:

Looking for information on:	Go to:
Behavior Analysis Services	Bureau of Medicaid Policy

Beth Kidder
Deputy Secretary for Medicaid

2727 Mahan Drive
Mail Stop #8
Tallahassee, FL 32308
Phone: (850) 412-4000

Report a Complaint

Claims Dispute Resolution Program

Looking for information on:	Go to:
Behavior Analysis Services Information	Bureau of Medicaid Policy
Health Plan Contracts and Information	Statewide Medicaid Managed Care
Health Plan Enrollment	Bureau of Medicaid Data Analytics
Health Plan Rates	Bureau of Medicaid Data Analytics
HEDIS Performance Measures	Bureau of Medicaid Quality
Institutional Rates	Bureau of Medicaid Program Finance
LIP/DSH/GME Operations	Bureau of Medicaid Program Finance
Medicaid Eligibles	Bureau of Medicaid Data Analytics
MES Procurement Strategy	Bureau of Medicaid Fiscal Agent Operations
Nursing Home Prospective Payment System	Bureau of Medicaid Program Finance
Pharmacy Policy	Bureau of Medicaid Policy
Provider Fee Schedules and Provider Handbooks	Bureau of Medicaid Policy
Recent Presentations and Reports	Medicaid Program Coordination
Recipient Support and Provider Services	Bureau of Medicaid Recipient and Provider Assistance
State Plan	Bureau of Medicaid Policy

Please click on the link below to view a high level organizational chart of the Medicaid Division. This organizational chart will help you navigate our site.

Medicaid High Level Organizational Chart, May 2017 [93KB PDF]


Local Navigation
» Medicaid
» Medicaid Policy and Quality
Medicaid Policy
Federal Authorities
Federal Waivers and Programs
Managed Care Contracting and Policy Development
Medical and Behavioral Health Coverage Policy
Primary and
entive Care Policy
Health Care Polic
Research
Specialized
lth Services
Behavioral Healt
Health Facilities
Pharmacy Policy
Program Policy
Florida KidCare
MediKids
Rules
Medicaid Quality
Rules
The Rules Unit is responsible for coordinating and providing support to Florida Medicaid staff related to administrative rules promulgated in the Florida Administrative Code.
Below you can access rule information about adopted rules and rules currently in the promulgation process including, any incorporated reference material such as coverage policies (formally handbooks), fee schedules, forms and drafts.
Rules in Progress
Draft Florida Medicaid rule reference materials, if available, for the public to access during the rule promulgation process. These documents are not final until they are adopted into rule. Agendas for the public meetings/workshops/hearings are available on this page.
Adopted Rules
General Policies - Rules that
rsally applicable to the Florida Medicaid program.
Service-Specific Policies - R
or individual Florida Medicaid covered services and waiver programs.
Other Policies - Rules pertaining to other aspects of the Florida Medicaid program.
Reimbursement Policies and Fee Schedules - Rules pertaining to submitting claims for reimbursement and reimbursement methodologies.
Fee Schedules and Billing Codes - Florida Medicaid fee schedules and billing codes
Florida Medicaid Forms - Forms pertaining to the Florida Medicaid program.

DISCUSSION