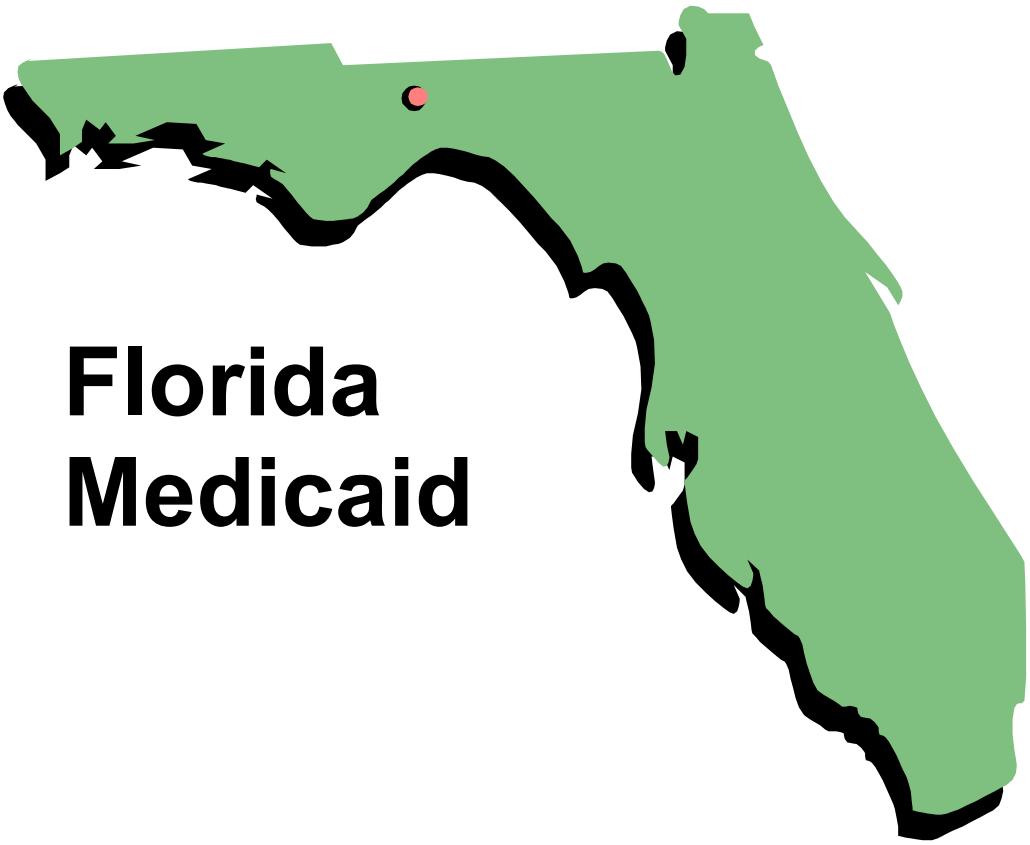

Florida Medicaid

Medical Foster Care Services Coverage Policy

Agency for Health Care Administration

December 2019

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1.0 Introduction

Florida Medicaid medical foster care (MFC) services provide care to recipients with complex medical needs to enable them to live in a foster care home.

1.1 Florida Medicaid Policies

This policy is intended for use by medical foster care providers that render services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's General Policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.

1.2 Statewide Medicaid Managed Care Plans

Florida Medicaid managed care plans must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

1.3 Legal Authority

Medical foster care services are authorized by the following:

- Title XIX of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR)
- Sections 409.903 and 409.905, Florida Statutes (F.S.)

1.4 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid Definitions Policy.

1.3.1 Activities of Daily Living (ADLs)

As defined in Rule 59G-1.010, F.A.C.

1.3.2 Claim Reimbursement Policy

A policy document found in Rule Division 59G, F.A.C. that provides instructions on how to bill for services.

1.3.3 Coverage and Limitations Handbook or Coverage Policy

A policy document found in Rule Division 59G, F.A.C. that contains coverage information about a Florida Medicaid service.

1.3.4 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1, F.A.C. containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.3.5 Instrumental Activities of Daily Living (IADLs)

As defined in Rule 59G-1.010, F.A.C.

1.3.6 Therapeutic Visits

Brief time intervals when a recipient is visiting biological or adoptive parents.

1.3.7 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.3.8 Medical Foster Care (MFC) Staff
A team consisting of a registered nurse specialist, a social work specialist, and a physician.

1.3.9 Provider
The term used to describe any entity, facility, person, or group enrolled with AHCA to furnish services under the Florida Medicaid program in accordance with the provider agreement.

1.3.10 Recipient
For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

1.3.11 Substitute Medical Foster Care Provider
Individual who has received the required Department of Health's (DOH) Children's Medical Services competency-based training.

2.0 Eligible Recipient

2.1 General Criteria
An eligible recipient must be enrolled in the Florida Medicaid 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.

2.2 Who Can Receive
Florida Medicaid recipients under the age of 21 years requiring medically necessary MFC services who meet the following criteria:

- Are able to have his or her health, safety, and well-being maintained in a foster home
- Are in the custody of the Department of Children & Families (DCF), in a voluntary placement agreement, or in extended foster care, in accordance with section 409.175, F.S.
- Have a completed staffing by the Children's Multidisciplinary Assessment Team (CMAT)

Some services may be subject to additional coverage criteria as specified in section 4.0.

2.3 Coinsurance and Copayments
There is no coinsurance or copayment for this service in accordance with section 409.9081, F.S. For more information on copayment and coinsurance requirements and exemptions, please refer to Florida Medicaid's Copayments and Coinsurance Policy.

3.0 Eligible Provider

3.1 General Criteria
Providers must meet the qualifications specified in this policy in order to be reimbursed for Florida Medicaid MFC services.

3.2 Who Can Provide
Services must be rendered by foster home caretakers who are licensed by DCF in accordance with Rule 65C-13.025, F.A.C., and who have successfully completed MFC parent competency-based training classes through the DOH.

4.0 Coverage Information

4.1 General Criteria
Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary

- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid covers 365/366 days of MFC services per year, per recipient**,** in accordance with the applicable Florida Medicaid fee schedule, or as specified in this policy, including the following:

- Assisting with ADLs and IADLs
- Coordination of care:
  - Arranging for the provision of primary medical care and support services needed to safely maintain the recipient in a community-based setting (e.g., durable medical equipment and supplies)
  - Ensuring access to, and coordination with, an accredited educational program for each recipient that complies with the requirements of the Florida Board of Education
  - Facilitating opportunities for the recipient to participate in a range of age-appropriate indoor and outdoor recreational and leisure activities, including activities for nights and weekends based on group and individual interests and developmental needs
  - Scheduling medical appointments
- Health care management and monitoring
- Medication monitoring and administration
- Monitoring vital signs
- Participating in and coordinating all educational activities for the recipient
- Providing transportation to all scheduled appointments and activities
- Provision of skilled interventions to the extent the services are medically necessary and the MFC provider has the requisite training to perform the necessary task

4.2.1 Leave Days

Florida Medicaid covers up to 15 leave days during any 90-day period for hospitalization or therapeutic visits.

4.2.2 Alternate Provider

Florida Medicaid covers up to 30 days of MFC services provided by a substitute MFC provider per year, per recipient, when the primary MFC provider is unable to provide the service.

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d (a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's Authorization Requirements Policy.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not covered when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not cover the following as part of this service benefit:

- Respite care

- Services when the recipient is absent from the MFC home for more than 24 hours, except for leave days or when receiving services from an alternative MFC provider

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's Recordkeeping and Documentation Requirements Policy.

6.2 Specific Criteria

Providers must maintain the following in the recipient's file:

- A plan of care (POC) that is updated every 180 days (or upon a change in the recipient's condition requiring an alteration in services), signed, dated, and credentialed by a physician who is experienced in providing services to children with complex medical needs
- Written MFC Staff physician's order
- Daily progress notes that document all services and care provided, as specified in the recipient's POC

6.2.1 Recipient Absences Exemption

Providers must maintain documentation in the recipient's file demonstrating that the provider continued to render services during the recipient's leave days for hospitalization, including a physician's statement specifying that the provider was present during the recipient's hospital stay, as applicable.

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid's Authorization Requirements Policy.

7.2 Specific Criteria

Providers must ensure that the MFC staff obtains authorization from AHCA for:

- Initial services
- Ongoing services
- Reimbursement level changes

The MFC staff must include the results of the CMAT staffing with the authorization request must be submitted to:

The Agency for Health Care Administration
Bureau of Medicaid Quality
2727 Mahan Drive, Mailstop #38
Tallahassee, FL 32308

8.0 Reimbursement

8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system.

8.2 Claim Type

Professional (837P/CMS-1500)

8.3 Billing Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, as incorporated by reference in Rule 59G-4.002, F.A.C.

8.4 Diagnosis Code

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

8.5 Rate

For a schedule of rates, incorporated by reference in Rule 59G-4.002, F.A.C., visit AHCA's Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.

8.5.1 Provider Reimbursement

Florida Medicaid reimburses for one MFC provider per recipient, per date of service.